

New York American College of Emergency Physicians

ADVANCING EMERGENCY CARE 



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President's Message

In Their Shoes



Louise A. Prince
MD FACEP

Associate Professor, Emergency Medicine,
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I attended one of the Cleveland Clinic Patient Experience relationship centered communication courses meant to transform patient and provider experience. I knew I did not need to attend this all day session as my communication skills are excellent, honed over the years. But, I went hoping to bring back ideas to share with others. This course takes a different tact than many others, EMPATHY in our interpersonal communications. Quickly, I realized that I had a lot to learn and that even though I may have sympathy and compassion for my patients, I had not developed empathy well. Being able to feel and communicate empathy to our patients, their families, and even our staff and colleagues will change how you and they experience health care.

Empathy is unique from compassion and sympathy. It is the feeling that you understand and share the other person's experiences and emotions. Sympathy is caring and concern; compassion, the feeling that you want to help someone in need. Empathy requires discerning what the other person is thinking or feeling.

Put yourself in the shoes of the patients in the waiting room or hallway bed. What are they feeling? Fear, pain, anxiety, anger, frustration, withdraw, awareness that they are being judged, and also awareness that they may have a disease that will ultimately claim their life. Not to mention, awareness that medicine is not perfect and that mistakes are made in hospitals every day, will they be the next? Have you been a patient recently? Interestingly, I have. It is quite the eye opening experience. Distinguished emergency physician Charlotte Yeh, MD recently recounted her experience as a patient after she became a victim of a pedestrian vs car accident in Health Affairs (<http://content.healthaffairs.org/content/33/6/1094.full>). It is a description of care that should be of concern to us; fragmented, incomplete, callous, and poorly if not completely uncoordinated.

Many hospitals have put into place orientation for new employees that involves having them become a patient for a day or having the employee or resident shadow a patient. This helps create or enhance the feeling of empathy. Letting patients tell their stories and involving patients in education as well as quality improvement committees and conferences completely changes the tenor and environment helping providers to feel empathy. We can use patient experiences,

even our own, to help us develop empathy and create change.

Of primary importance is our ability to listen and then communicate our empathy to the patient despite the situation confronting us. When looking at patient complaints and satisfaction surveys, the most significant issues surround communication. It starts with respecting privacy, good introductions, identifying what role the provider plays on the team, creating expectations for the care, communicating waiting times, assessing and reassessing pain, and ensuring that discharge instructions are mutually developed, understood, and can be followed. All of this seems so very hard in an overflowing, hectic emergency department. Or is it?

Stand back and watch your next trauma code evaluation on an awake, alert patient. You will see very task driven providers who are efficiently conducting a history and physical, making interventions as they go. They will be rendering excellent care. Now listen to them, is anyone truly speaking to the patient other than to get historical information? Are we addressing all of the patients' concerns? Who is communicating each step to the patient making them aware of what is happening, what to expect next? Have you listened to the discharge instructions as they are given to the patient by a provider? Think about being the patient yourself. What would you walk away with? Despite our reticence, patient experience and satisfaction is and will be measured in our Emergency Departments. CMS is currently piloting the Emergency Department version of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The survey is likely to be officially released and used in 2015. Rather than just seeing this measurement as bad science, angry patients, and too much governmental oversight, ignore the numbers and listen to our patients. How would you feel if you were a patient in your Emergency Department? That is empathy. Could we improve the patient's experience by our listening and communication style even though our environment continues to be overwhelming?

There are two excellent videos produced by the Cleveland Clinic that are a must see for every provider and administrator. The first is Empathy: The Human Connection to Patient

Care (https://www.youtube.com/watch?v=cDDWvj_q-o8). Watch it with your staff and frankly, watch it with your teenagers. The second is Patients: Afraid and Vulnerable (<https://www.youtube.com/watch?v=1e1JxPCDme4>). This one comes with a twist, a must see for providers. And, no, I am not shamelessly promoting the Cleveland Clinic (or the state of Ohio!), but instead simply recommending inspiring, well made educational videos.

During my last shift, my empathy and attempts at frequent good communication were short lived as we became overwhelmed with patients and multitasking reached a fevered pitch. There is no doubt these will be hard qualities to develop and maintain. It will require time and slow steps often unlearning prior behaviors and thought patterns. It is also a great tool in the other relationships in your life. In the end, I think empathy will help us to keep our focus on our patients as well as help keep our specialty and us alive and well. I am willing to give it a try.

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Practice Update: The Use of Capnography in the Emergency Department

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Capnography is the noninvasive measurement of the partial pressure of carbon dioxide in exhaled breath expressed as the CO₂ concentration over time. This relationship is represented by the CO₂ waveform/capnogram (see figure 1) or a numeric display of exhaled carbon dioxide concentrations (ETCO₂). Capnography provides instantaneous information regarding patient ventilatory (gas movement between alveoli and pulmonary capillaries), perfusion (transport of oxygen between cells and pulmonary capillaries), and cellular metabolic status (O₂ consumption and CO₂ production). In recognizing the wealth of information provided by ETCO₂ monitoring, the clinical applications for this technology with emergency patients are rapidly expanding. This article will discuss the current utilization of capnography in the care of emergency patients and the opportunities for expanded use within emergency medicine.

Resuscitation

In the 2010 update to the American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, continuous waveform capnography, in addition to physical assessment, was recommended as the most reliable method of confirming and monitoring correct placement of an endotracheal tube (ETT). Continuous observation of a capnographic waveform verifies correct ETT placement and allows for monitoring of the tube placement through all in-hospital or out-of-hospital transport.

Continuous waveform capnography can be utilized to help drive management in the treatment of cardiac arrest. First, in untreated cardiac arrest, CO₂ continues to be produced, but cannot be delivered to the lungs due to the lack of circulation. With CPR, cardiac output is the major driver of CO₂ delivery to the lungs. If ventilation remains constant during CPR, then the ETCO₂ correlates well with cardiac output. The performance of CPR can be optimized for depth and rate when gauged against the ETCO₂ reading. A gradual decline in ETCO₂ suggests fatigue in the person performing compressions, signaling the time for change to a new compressionist. Second, a persistently low ETCO₂ (<10 mm Hg) in intubated patients receiving CPR indicates that ROSC is unlikely to occur and a decision for cessation of CPR can be made early. Further, an abrupt and sustained increase in ETCO₂ to near normal levels (35-40 mm Hg) during CPR is an indicator of ROSC, often occurring well before the return of detectable pulses.

Procedural Sedation

Pulse oximetry alone is not adequate for monitoring during procedural sedation. Pulse oximetry is a measure of blood oxygen saturation and its value does not reflect the adequacy of ventilation. In 2014, the American College of Emergency Physicians released an update to its 2005 clinical policy regarding procedural sedation in the emergency department. Critical questions relevant to the current practice in sedation were developed for the 2014 revision. One of the questions posed was whether “in patients undergoing procedural sedation and analgesia in the emergency department, does the routine use of capnography reduce the incidence of

adverse respiratory events?” Capnography received a level B recommendation that it may be used as an adjunct to clinical assessment and pulse oximetry to detect hypoventilation and apnea earlier than pulse oximetry or clinical assessment alone in patients receiving procedural sedation. A level B recommendation indicates that the particular strategy or range of strategies reflects moderate clinical certainty.

It is well documented that desaturation is delayed on pulse oximetry in relation to the decline of the oxygen tension in the central arterial circulation secondary to respiratory hypoventilation or apnea. Bradypneic and hypopneic hypoventilation have recognizable waveforms on capnography. Apnea is nearly instantaneously recognized by capnography with the loss of the capnogram. This is the earliest indication of the cessation of ventilation, and in conjunction with the absence of chest wall movement and breath sounds, confirms apnea. Recognition of the hypoventilatory waveforms or absence of the capnogram allows the provider to adjust the dose and administration of sedative medication and to prepare for emergency airway management prior to the onset of hypoxia.

Future Directions

Several emerging uses for capnography in the emergency department (ED) are currently being suggested and explored.

Physical and chemical restraints are often required to manage the acutely agitated patient in the ED. Commonly utilized drugs for chemical restraint like benzodiazepines and haloperidol may lead to hypoxia. The concomitant drug or alcohol use by the patient may potentiate the risk of respiratory compromise. Sub-optimal physical restraint with poor body positioning may result in positional asphyxia. A recently published pilot study revealed that almost half of observed patients receiving chemical restraint (+/- physical restraint) in the ED developed hypoxia and respiratory depression. Capnography monitoring in the management of these types of patients should be considered as most people who develop hypoxia have capnography detected respiratory depression prior to decrease in pulse oximetry.

Opioid analgesics rate as one of the drugs most frequently associated with adverse drug reactions. The most serious of the adverse drug events involves unintended advancing sedation and respiratory depression, sometimes resulting in death. The utilization of capnography as an adjunct to physical assessment and pulse oximetry may help to recognize respiratory depression earlier in more vulnerable populations receiving narcotics, e.g. elderly, obese, those with obstructive sleep apnea, narcotic naïve, etc. Further, capnography may be utilized to monitor respiratory effort and efficacy in patients being treated and observed in the ED after overdose of prescription opioid pain relievers or heroin. As rates of overdose from these drugs have increased in the past decade, appropriate respiratory monitoring protocols must be developed to help optimize survival in the pre-hospital and ED setting.

Capnography has an increasingly expanding role in the care of the emergency patient. It is non-invasive, easily initiated, easily

interpreted, and has a myriad of uses in emergency medicine. An ETCO₂ monitor should be considered a required device in every emergency department.

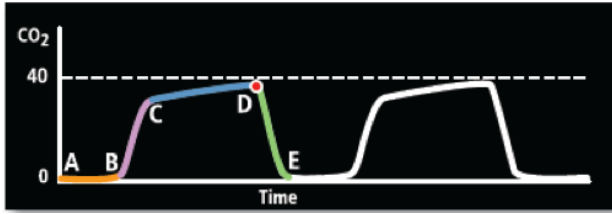


Figure 1: Capnogram and explanation of phases A-B=End inhalation, begin exhalation (essentially zero concentration of CO₂)

- B-C=Early exhalation, rapid rise in CO₂
- C-D=Ongoing exhalation, CO₂ alveolar plateau
- D=End of expiration, maximum CO₂ concentration, ETCO₂ level
- D-E Inhalation, CO₂ concentration decreases to zero

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Sound Rounds

Practical Applications for the Emergency Physician

Ultrasound Evaluation of Soft Tissue Infections

Indications

To evaluate patients who present with localized skin erythema, warmth, swelling, induration, fluctuance or tenderness and concern for possible cellulitis versus abscess.

Technique

- Use a high frequency linear array transducer (7–14MHz).
- Scan an unaffected location to obtain images of normal anatomy first (Figure 1).
- Obtain images in both longitudinal and transverse planes.

Normal Anatomy

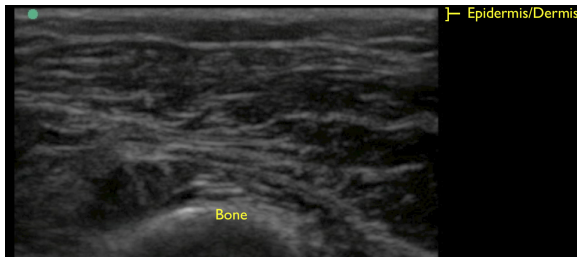


Figure 1. Ultrasound image of normal soft tissue anatomy obtained with a linear array transducer. The epidermis and dermis is located at the top of the screen (near field).

- The epidermis and dermis appear as a unified hyperechoic layer with the subcutaneous layer and fat beneath it.
- The subcutaneous layer appears mostly hypoechoic often containing hypoechoic fat interspersed between hyperechoic connective tissue, nerves, and anechoic vessels.
- Muscle and hyperechoic fascia are located distally in the far field.

Cellulitis

- Place the ultrasound transducer over the point of maximal tenderness, swelling or erythema
- In early cellulitis, there is increased echogenicity of the epidermal-dermal layer and subcutaneous tissue.
- As cellulitis progresses, fluid accumulates within the subcutaneous layer causing a “cobblestoning” appearance of the tissue (Figure 2).

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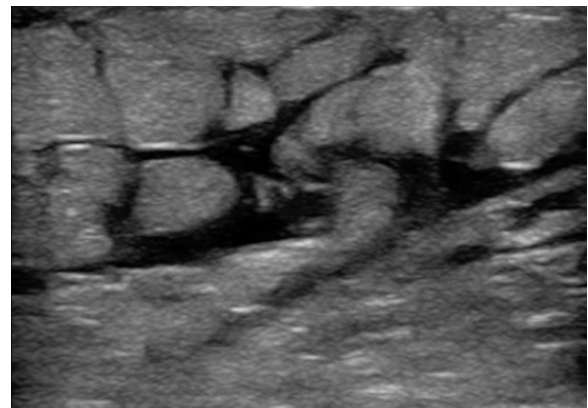


Figure 2. Ultrasound image of cellulitis “cobblestoning”.

Abscess



Figure 3a. Ultrasound image of an abscess

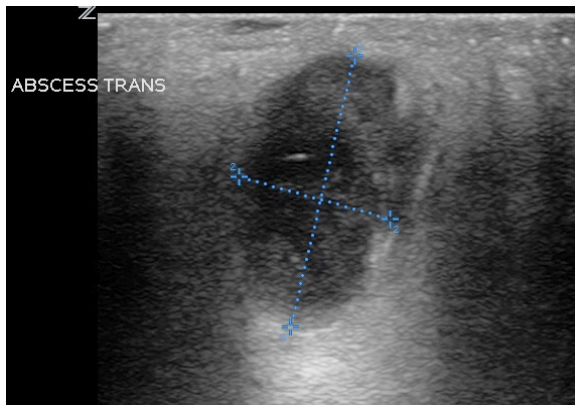


Figure 3b. *Ultrasound image of an abscess with measurements.*

- The sonographic appearance of an abscess can be variable. It is often a round, hypoechoic, fluid-containing structure, which may include internal, hyperechoic debris with posterior acoustic enhancement.
- Compression of an abscess with the ultrasound transducer may induce motion to the material within it.
- An abscess should not demonstrate color doppler flow within it as opposed to lymph nodes (Figure 4b).
- Measure the abscess in 2 planes (Figure 3b).
- Obtain a post procedure ultrasound image of the infected site to ensure complete abscess drainage.

Tips

- Scan the opposite side or uninfected area to appreciate normal anatomy.
- Use of a water bath eliminates the need for direct skin contact between the transducer and area of concern. This may be helpful in obtaining images of areas that are extremely painful, irregularly shaped or superficial, such as fingers and toes.
- The endocavitary transducer is necessary to evaluate for a peritonsillar abscess

Pitfalls and Limitations

- Lower frequency transducers, such as a curvilinear transducer, may be necessary for deeper abscesses.
- Differentiate lymph nodes from abscesses. Lymph nodes are discrete with an hypoechoic rim and hyperechoic center. Color flow doppler may help distinguish lymph nodes from avascular abscesses (Figures 4a, 4b).
- Color flow doppler can help identify vascular structures that may be mistaken as an anechoic abscess.
- “Cobblestoning” may be encountered in other medical conditions that increase subcutaneous fluid (i.e. congestive heart failure).
- Necrotizing fasciitis should be considered if air artifacts are encountered. Additional diagnostic imaging modalities for further evaluation may be necessary.

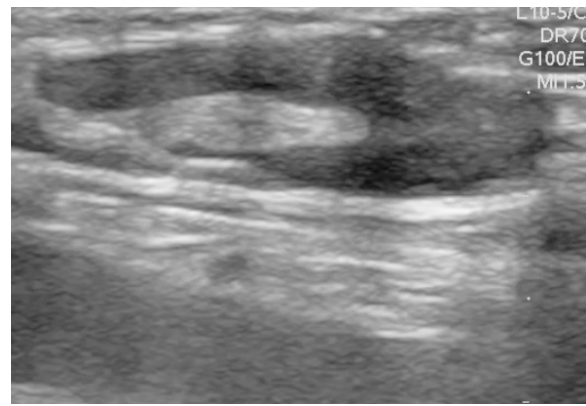


Figure 4a. *Ultrasound image of a lymph node with hyperechoic hilum and hypoechoic rim.*

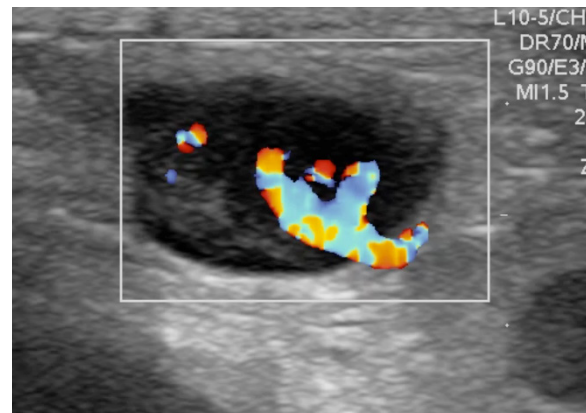


Figure 4b. *Ultrasound image of a lymph node with color doppler.*



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All Hands on Deck

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This is an interesting time of year. The recent holiday season's proximity to one of the most challenging times within the emergency department provides a stark contrast to the senses. From the sight of holiday decorations to the visual chaos of a crowded emergency department. From the laughter of friends and family to the cacophony of packed hallways and waiting rooms. From the sweet smell of sugar cookies to whatever is wafting out of room three.

If your department is similar to ours, this time of year is especially challenging. The number of patients within the emergency department (ED) seems to grow each year. There is a general increase in ED volume. Respiratory illnesses complicate underlying physiology, further adding to this volume increase. The New Year's surgical cases are fully represented after a small holiday lull, with less inpatient beds available from this artificial variability. Inpatient discharges to nursing homes and long-term care facilities are more limited due to lack of availability. Several of these components result in higher inpatient length-of-stays. The elements of a perfect storm are present, ballooning ED occupancies and providing an extreme challenge for staff and patients.

As part of our overcapacity response this year we did something slightly different. I'll have to admit, I was initially skeptical when the idea was first suggested. As a rule, I dislike the phrase "We already tried that and it didn't work." During the initial conversations this statement started to form within my brain. Thankfully, my frontal lobe was functioning that day and I was able to keep my mouth shut. I'm glad I did.

During this year's overcapacity planning (aka reaction) it was recommended to implement a "nonclinical" volunteer program to help respond to the ED. We already had a process to enlist clinical personnel (nurses, patient care technicians, etc.) but the focus for the new program was upon the indirect portion of patient care. The number and range of the nonclinical volunteers was quite vast. Individuals came from multiple departments - coding, billing, administration, food services, etc. - and responded to the call for help.

The basic goal was to round on patients and their family members, offering some additional services and

amenities. The first volunteer group was quite active and helped with the fundamentals, developing a list of items to offer patients. Working in the department daily we had lost focus of some of the basic comforts that could be offered. The volunteer group provided a different vantage point and generated other ideas. They developed a cart to take around to patients that consisted of multiple items; cookies, crackers, water, coffee, earplugs, eye covers, crossword books, etc. All were low cost and could be easily provided to patients. This "nonclinical" response resulted in several significant and sometimes surprising benefits.

The intervention helped to informally improve patient satisfaction via a couple of ways. Although these interventions are exceedingly simple, the clinical staff was generally too overwhelmed to even consider these measures since they were busy taking care of medical needs. Having these additional volunteers greatly facilitated patient care from an indirect angle and provided these basic comforts. It was also a great way to have a group of team members who were free to just interact and talk with the patients. These interactions left a lasting imprint for the patients during times of stress.

We have had numerous compliments from patients and family members due to this relatively benign intervention. In most of our EDs, we do fairly well with patients and families during times of high occupancy. They observe that we are functioning under extreme situations and often give us the benefit of the doubt. They see the entire staff working hard to take care of their friends and loved ones. Having this extra intervention has really set our care apart, with several compliments citing this portion of their ED experience as going "above and beyond". Not surprisingly, another benefit of the program was the ability to spread word of the challenging situation throughout the organization. It was common (and somewhat comical) to observe dinner-plate-sized eyes on volunteers as they entered the department. No degree of meeting explanations can do justice describing how the ED functions under these circumstances. With these volunteers circulating through the department and observing the situation firsthand, it helped to spread the story and exponentially

increased the understanding throughout the organization.

An additional benefit was the effect on ED staff morale. Previously during high capacity situations, the staff often felt that they were alone on the front lines with no support. This extra support from the organization helped bolster the crew as they provided care during especially difficult situations. With some extra help focusing on these basic amenities, the ED team was able to focus on the medical care. This helped the team feel as if they were supported in providing better patient care.

One thing we learned early during this program was that it couldn't be managed within the department itself. This is probably the reason that past attempts failed early during the process. The initial temptation was to coordinate the efforts through the ED charge nurse. This was clearly a disaster as a charge nurse was busy working on multiple other things. The charge nurse was not prepared to deal with several nonclinical personnel who were now perceived as "in the way". Instead of using an overtaxed charge nurse, we were able to obtain the help of our director of volunteer services. He kindly offered to help coordinate the volunteer schedule and organize the response. His department also provided general materials to the volunteers as to what to expect, as well as the different duties that would be helpful within the department. It was truly a team effort that has been well appreciated.

We still occasionally have some bumps with the process. However, after only a few weeks the process is relatively mature and indicates a sustainable program. All in all, we learned several things; volunteers spread the ED story faster than we can, a simple smile can go a long way, a brief conversation is remembered long after it occurs, and something as simple as a package of cookies or cup of coffee can result in exponential returns. Along the way you may find yourself in a similar situation, with folks offering to help set up "nonclinical" rounding for your patients. If so, I would suggest it beneficial to practice some "frontal lobe exercises", turn the folks with the idea loose, and see what they can do. I'll wager the results will surprise you.



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Emergency Ultrasound Certification

Emergency ultrasound use across the country has expanded greatly over the past several decades. Today in major academic centers and small community hospitals alike, ultrasound technology is utilized in EDs to guide invasive procedures, confirm or eliminate complex diagnoses, and treat and resuscitate our sickest patients. As the use of ultrasound in Emergency Medicine (EM) has grown, we have also witnessed an evolution of ultrasound education and training, but by no means is EM ultrasound clinical practice uniform in all hands. This may be dependent on prior experience, expertise, or practice setting where its use is supported or at times frowned upon. Political battles still exist within many institutions on administrative and interdepartmental levels. Reimbursement issues also persist with individual third party payors. Previously it was felt that certification could be the answer to aid EM physicians in solving some of these issues. EM physicians are certainly accustomed to certification processes—board certification, advanced cardiac life support, advanced trauma life support are all commonly pursued. But is certification the answer for clinicians desiring to improve the care of their patients using ultrasound?

Pursuit of certification for those wanting to perform emergency ultrasound examinations was aimed at enhancing

credibility. Currently the American Registry for Diagnostic Medical Sonography (ARDMS) offers the only ultrasound certification available to emergency physicians. Registered Diagnostic Medical Sonographer (RDMS) certification is sought by physicians across multiple specialties and by ultrasound technicians. ARDMS is an independent, nonprofit organization that was founded in 1975 to “promote quality care and patient safety”. RDMS requirements include the completion of 800 supervised ultrasound examinations and passing a combination of two written examinations: ultrasound physics plus a choice of one clinical area (abdomen, breast, etc.). This sounds like a comprehensive pathway, but there are several significant issues with EM physicians pursuing this external certification.

Emergency physicians have been the clear leaders in the development of clinical or point-of-care ultrasound, and other non-traditional specialties have modeled use

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following EM. The integration of ultrasound into the practice of EM requires a unique knowledge base, technique, and skill set. Ultrasound is now a core procedural component of EM residency training and an ever-growing number of emergency ultrasound fellowship training programs have elevated ultrasound use to incorporate more advanced applications and research. In addition, the move towards ACGME subspecialty development is underway.

The RDMS examination focuses only on technical image acquisition. It does not focus on clinical integration --the core of point-of-care ultrasound use. Those locales where “RDMS” has been helpful classically are those where the very meaning and origin of the certification is unknown. Certification could, in some arenas, be linked to hospital credentialing or reimbursement. Furthermore, there is a cost tied to any certification program, a cost we do not control. Requirements for training or continuing

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medical education could be increased to extreme levels, and there is no true EM voice in an external certification program. ARDMS is also an organization with distinct linkage to the specialty of Radiology.

In 2015, Emergency Ultrasound is an established entity. There are national policies and guidelines covering education, training, competency, credentialing, reimbursement and scope of practice. All EM residents are required to achieve a level of competency in the use of clinical ultrasound upon graduation. While there may be local, real-time gains in achieving RDMS certification, what is best for our specialty and its future is to continue to improve, grow and promote programs to advocate for the appropriate use of ultrasound in our daily clinical practice.

This is what will benefit our patients. Like other “merit badges” ultrasound certification presents unnecessary obstacles to integrating ultrasound into EM practice to better the care of our patients, and these could increase in the future without our input. ACEP has firmly supported this stance (see recently approved ACEP Policy) and it is important that we recognize these issues and shift our focus toward improving our internal programs and expertise. The Clinical Ultrasound Accreditation Program under development by ACEP should soon provide an alternative to individual certification and will serve as a means to improve emergency ultrasound programs and standards across the country. ACEP Policy

Emergency Ultrasound Certification by External Entities

Approved by the ACEP Board of Directors
June 2014

The American College of Emergency Physicians (ACEP) believes that certification by non-emergency medicine external bodies, organizations, societies or other medical specialties or upon short course completion is inadequate to demonstrate comprehensive training, knowledge, and skill in the practice of emergency ultrasound.

Emergency ultrasound comprises a set of focused applications utilized to diagnose life-threatening conditions, guide invasive procedures, and treat emergency medical conditions. Both residency-based and practice-based pathways exist for emergency physicians to demonstrate competency in emergency ultrasound as detailed in the ACEP policy statement, “Emergency Ultrasound Guidelines.”

Any non-emergency medicine external certification process would impede the use of this critical clinical skill and adversely affect patient care.

ACEP strongly opposes the use of any non-emergency medicine external certification process to validate competency in the use of emergency ultrasound. Furthermore, any such process should not be utilized as a requirement for hospital privileges or credentialing, nor for reimbursement by accountable care organizations (ACOs), managed care organizations (MCOs), the Centers for Medicare and Medicaid Services (CMS) or

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Location

New York Academy
of Medicine
1216 Fifth Avenue
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Question: Does Nutritional Status Affect Susceptibility to Acetaminophen Toxicity?

Acetaminophen has become one of the most commonly used medications in the United States since its use began in 1955. Toxicity of this drug is well known and well documented to cause lethal and non-lethal hepatic necrosis, currently the most common cause of acute hepatic failure in the U.S. Hepatic injury occurs via a toxic metabolite of acetaminophen, N-acetyl-p-benzoquinoneimine (NAPQI). NAPQI results from cytochrome P450 metabolism and can be conjugated with glutathione (GSH) and excreted in the urine. When the glutathione stores are depleted, NAPQI causes irreversible oxidative injury and hepatocellular centrilobular necrosis.¹ Specific patient populations may be specifically susceptible to acetaminophen toxicity, especially those with decreased amounts of glutathione.

Nutritional status may play an important role in acetaminophen toxicity. During fasting, the hepatic concentration of glutathione falls by approximately 50% within 62 hours in rats². When these same rats are fed again, glutathione stores rapidly rise, suggesting that a lack of dietary amino acids are responsible for the fall in glutathione. Consistent with the protective role of glutathione against the toxicity of metabolites of xenobiotics, the hepatotoxicity of paracetamol and bromobenzene markedly increases in the fasted rats.² Human studies related to malnutrition and acetaminophen toxicity are sparse but available.

Patients with anorexia nervosa, according to the DSM-V, have a body mass index less than 17. Researchers Zenger et al evaluated glutathione levels in patients with anorexia to determine if they may be more susceptible to the toxic metabolite of acetaminophen. This question occurred to the researchers when a young patient with anorexia nervosa presented with markedly elevated serum transaminases and acetaminophen detected in her blood five days after hospitalization. Free glutathione was measured in their study subjects as a surrogate marker for total body glutathione

levels. The researchers found that free glutathione was significantly lower in patients with anorexia and there was a significant correlation with the BMI, $p=0.001$. Total glutathione levels were also markedly decreased in anorectic patients, $p=0.001$.³ Relation of BMI to glutathione levels suggests that the more anorexic a patient, the lower their glutathione stores, and possibly an increased susceptibility to acetaminophen toxicity.

Another potential susceptible population is the chronically malnourished alcoholics who are exposed to toxic levels of acetaminophen. Researchers Lauterburg et al found that chronic alcoholics had decreased circulating concentrations of GSH. These same subjects were then exposed to acetaminophen and demonstrated statistically significant lower glutathione levels at one, two, three and four hours after exposure. Either an increase in the catabolism of plasma glutathione or a decreased release of glutathione by the liver, possibly because of malnutrition or a direct effect of ethanol, could account for this observation.⁴ Depletion of glutathione is a known risk factor to hepatic injury after exposure to toxic levels of acetaminophen. Malnutrition seems to be an important risk factor in the development of liver injury as patients with chronic malnutrition such as chronic alcoholics and patients with anorexia nervosa have statistically significant decreases in levels of plasma and total glutathione. The studies provided have a small sample size and provide limited information in regard to the clinical question but do create an area for further research. Risk of hepatotoxicity in acetaminophen exposure is multi-factorial but current evidence demonstrates that malnutrition and depletion of glutathione stores are contributory. This suggests that hepatotoxicity may occur at lower doses of acetaminophen exposure secondary to faster depletion of glutathione stores.

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Empire State EPIC

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of the New York American College of Emergency Physicians

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¹ This Director will also serve as the Ambulance Program Director of the Fordham University EMS Program.



Thomas Eric Duncan heightened all of our awareness when he presented to Texas Health Presbyterian with fever, headache, and abdominal pain after traveling from his native country of Liberia. He was seen and evaluated by a triage nurse, who elicited the pertinent travel history. The physician saw and evaluated Mr. Duncan and found him to have signs and symptoms of sinusitis, in spite of a CT Head which showed no evidence of sinus infection. He was discharged with antibiotics, only to return two days later much sicker. He was eventually diagnosed with Ebola Virus Disease (EVD), and the rest is literally history.

EVD raises so many unique ethical issues that it is difficult to address them in the context of this newsletter article, but I am going to try to scratch the surface. The care of Thomas Eric Duncan in particular led to significant changes in the practice of emergency medicine. We now ask about EVD symptoms and travel history at registration at every entry point to our health care system prompted by an electronic health record (EHR) that may have been complicit in the original failure to correctly diagnose and disposition Mr. Duncan in the first place. The irony is not lost on me.

Thomas Eric Duncan was the first case of EVD diagnosed on US soil, but he was not the first case of EVD treated in the U.S. Health care workers at Emory University Hospital brought Dr. Kent Brantly back from the brink of death after he was medically evacuated from Liberia, where he had been serving on a medical humanitarian mission. He was given a hero's welcome, once he was rid of disease that is. Kaci Hickox, a nurse who returned from a similar mission, was not. She was placed in quarantine in a tent adjacent to Newark airport until she was given reprieve to go to her home in Maine, where she remained on

monitoring until she passed the standard three week incubation period. But not before she became the face of the debate between public health and individual civil liberties, and the age-old battle between beneficence and autonomy.

Dr. Craig Spencer, a fellow emergency physician training in International Emergency Medicine in New York, returned from treating EVD in West Africa. He experienced malaise on day nine (9) after return, but he felt well enough to go out bowling. When he spiked a fever, he initiated a pathway, which many have praised as the best way to respond to a health care worker fallen ill with EVD upon return to the U.S. He was seamlessly transferred from his residence by EMS to New York University-Bellevue, a hospital capable of caring for him in isolation.

Both Thomas Eric Duncan and Kaci Hickox have changed our practice. The Department of Health (DOH) now requires personal protective equipment (PPE) training for emergency care providers every 30 days. This seems excessive given that most mandatory training occurs every year, but I think that I stand together with most of my emergency physician colleagues when I say that I am glad that I am now trained in PPE.

It is amazing how far we have come from initial CDC and NIH officials attempting to assuage our fears about EVD arriving in the U.S. to driving the preparedness response. Many of our emergency departments have been reconstructed to have a decontamination room built adjacent to an isolation room with a bathroom as our ACEP leadership has requested of us. The millions of dollars invested in emergency preparedness do not seem pointless though. Even if EVD does not expand to epidemic status, the sporadic case of EVD or the patient presenting with something else hazardous will be

handled better as a result.

Ultimately, we as emergency physicians are on the front line of the battle against emerging infectious disease. It is our duty to be aware of the illnesses that may present and of the risk inherent in our jobs. EVD, however, has radically changed this equation. I say this as many of our emergency department administrators struggle to find coverage for staff struck by the flu. Influenza though carried 10% mortality at its worst during the Spanish Influenza of 1917-1918. EVD has 10% mortality at its best. The infectivity of EVD is much greater than the oft quoted 0.03% transmission rate of HIV with a needle stick. We can assume it to be closer to 4% based on the two nurses who became infected among the 50 health care workers who treated Mr. Duncan. Given the risk of transmission and mortality, I think that it is reasonable for some health care workers to opt out of treating patients infected with EBV. There are well-groomed arguments to withhold CPR as a futile and excessively risky intervention as well.

If there is any lesson that can be learned from Dr. Brantly and Dr. Spencer it is that the war against EVD needs to be won in West Africa where it originated. This will depend on our collective financial, medical, and political support. There is relative agreement that trials of new treatments such as antigen from survivors and new preventions such as vaccines will not have to undergo the same scrutiny of randomized clinical trials in an effort to save as many people as we can, while still learning what is working. May we hope that something does work.



New Speaker Forum

If you are considering professional speaking and would like to gain experience, **New York ACEP's New Speaker Forum** was designed for you. Here, New York ACEP will showcase members who are dynamic lecturers, but may be new to presenting at the state or regional level.

Speakers must be attending physicians, who are New York ACEP members, and have never presented at the national level.

The topic for the New Speaker Forum is "Best Practices in Emergency Medicine." The Forum will be held Tuesday, July 7 from 3:30-4:30 pm, at the Sagamore Resort on Lake George. Applicants will be selected to give a 15 minute presentation on this year's topic.

Candidates interested in presenting at New York ACEP's New Speaker Forum need to apply by **11:59 pm March 16, 2015.**

Read more at <http://nyacep.org/274-2015-new-speaker-forum>

March

- 11 Education Committee Conference Call, 2:45 pm
- 11 Professional Development Conference Call, 3:30 pm
- 12 Practice Management Conference Call, 1:00 pm
- 18 Government Affairs Conference Call, 11:00 am
- 18 Research Committee Conference Call, 3:00 pm
- 19 EMS Committee Conference Call, 2:30 pm
- 20 LLSA Review, SUNY Upstate Medical University, 8:00 am-1:00 pm

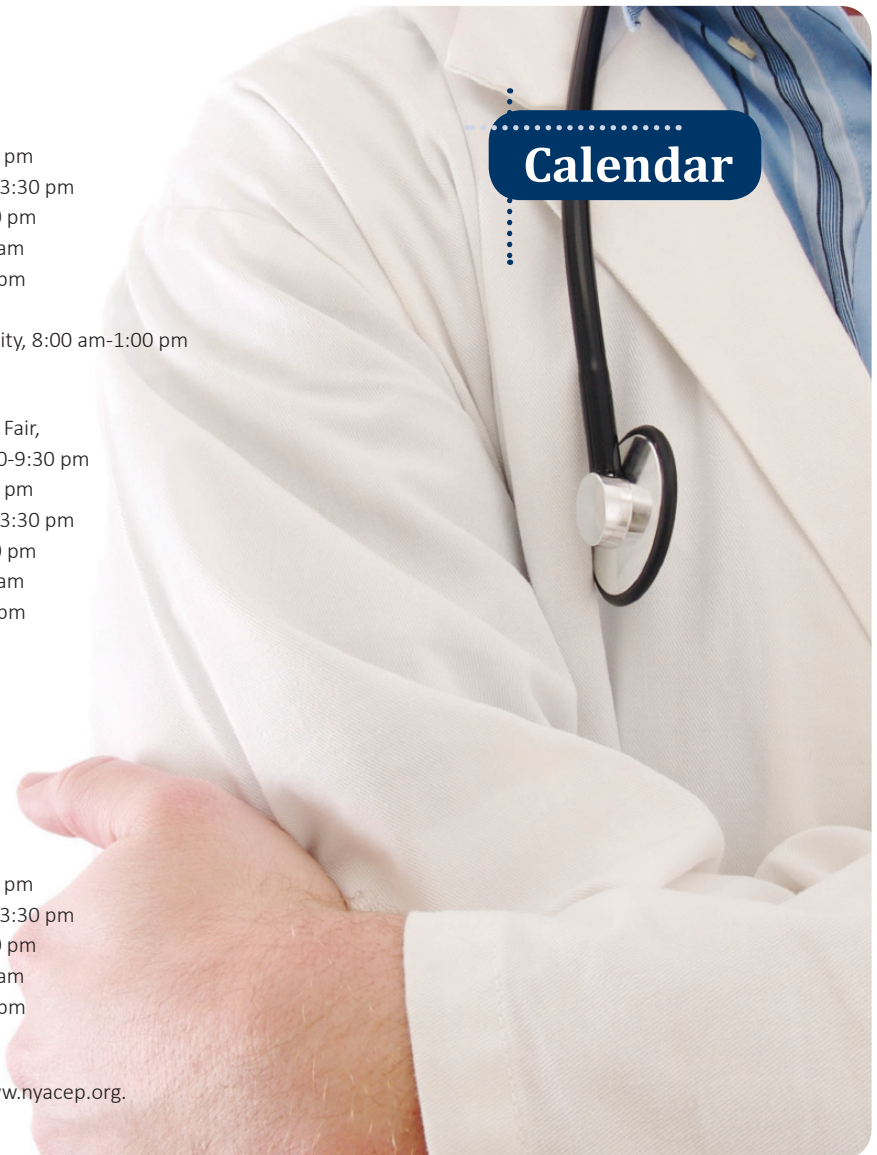
April

- 2 Medical Student Symposium and Residency Fair, Mount Sinai Beth Israel Medical Center, 6:00-9:30 pm
- 8 Education Committee Conference Call, 2:45 pm
- 8 Professional Development Conference Call, 3:30 pm
- 9 Practice Management Conference Call, 1:00 pm
- 15 Government Affairs Conference Call, 11:00 am
- 15 Research Committee Conference Call, 3:00 pm
- 16 EMS Committee Conference Call, 2:30 pm
- 30 Board of Directors Meeting, 1:30-5:30 pm

May

- 1 ED Leadership Forum, New York Academy of Medicine, 8:00 am-4:00 pm
- 3-6 ACEP Leadership & Advocacy Conference, Washington, DC
- 13 Education Committee Conference Call, 2:45 pm
- 13 Professional Development Conference Call, 3:30 pm
- 14 Practice Management Conference Call, 1:00 pm
- 20 Government Affairs Conference Call, 11:00 am
- 20 Research Committee Conference Call, 3:00 pm
- 21 EMS Committee Conference Call, 2:30 pm

For a complete schedule of events, visit www.nyacep.org.



Calendar

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Ask the Experts

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Residency Program Director
Department of Emergency Medicine
Staten Island University Hospital



Last fall, I had the opportunity to sit down with Hans House, MD FACEP and interview him regarding the value of getting involved with ACEP.

1. How did you first get involved with ACEP?

I've been an ACEP member since I was in residency and I have been attending the Scientific Assemblies all along. That was really what got me interested in ACEP. I was really amazed and impressed with the diversity of the specialty and the college. When I moved to Iowa from Los Angeles, I joined the state chapter and then joined the board of directors. Eventually I became president of the state chapter.

In terms of national activities, my first activity was with the newly formed section for Medical Humanities. One of the take home points for your readers is to get involved. Say yes to a lot of things early in your career. I had received that advice early on and I tried to take it to heart. That advice was ringing in my ears when I got an e-mail from ACEP asking if anyone wanted to get involved with this newly formed section. I almost hit delete, and then I heard that advice telling me to get involved. So, I joined and the next thing I knew I was the newsletter editor and then the section chair. Then I started going to several ACEP events and meeting various people from the college. That's what really kick-started my involvement in national ACEP.

2. If someone is a new grad, and wants to know how to get "more involved" with ACEP, what guidance can you offer them?

If you don't know where to begin, just go to a meeting. Go to Scientific Assembly and join a section. Go to a section meeting and

go to the Council meeting. The best way to get involved is to go to the Leadership and Advocacy meeting in Washington. That is a much tighter group, it's a smaller meeting, it's easier to get to know the people and meet the leaders of the college. It allows you to network with the most amazing, active and enthusiastic ACEP members. The energy of being there will just turn you on and you will get interested.

Join a section and get involved with the leadership of the section. Join a committee and that will help get you involved in the daily business of the college.

3. Which ACEP committees would you suggest for a new grad looking to join?

That depends on personal interest and what you want out of what you are doing. If you are involved in academics, the academic affairs committee is fantastic. The work of that committee is publishable and you can get papers out of your work on the committee.

There are many different committees for different interests from pediatrics to EMS to government affairs. Getting selected to a committee can be a challenge. To accomplish that, you should talk to the members of the committee. Get to know the members of the committee and the chair. You can do that when you go to meetings like Leadership and Advocacy.

4. How has ACEP shaped your career? What value has it given you that you would like to impart on those who are just starting out?

ACEP has really defined my career. I was a program director at the University of Iowa and that was a big part in getting started. But in terms of my career in academic medicine and my national reputation, that

all comes from my involvement in ACEP. That all comes from being the President of my state chapter, and being the chair of the section on medical humanities. It comes from being nominated to the national board of directors, going to council meetings and giving lectures to the board members. That was how my career path was. Being on the board and all the activities and travels and meeting with all the different sections and chapters was how I continued with my development. Now I can utilize that. As Vice Chair for Education, one of my responsibilities is faculty development. Now that I have a national network, it is much easier for me to develop my own faculty and connect them with people who have similar interests and get them involved with committees. It has been beneficial in every way.

5. For a new grad who is beginning to pay back loans, and looking to buy a house, and questions why they should spend money on ACEP membership. What would you tell them?

That's a very important question. Our job as the ACEP board of directors is to translate the value of ACEP to its members. In terms of career development, it is essential. You must be involved in organized medicine in some way, especially if you are in academics. This is a great way to do it. Being involved in organized medicine has direct benefit to your practice. ACEP works on regulations and legislation that directly affects how EM is practiced. Some examples include the Washington Medicaid issue, procedural sedation, reimbursement from CMS, fair payment, and our representation at the Relative Value Scale Update Committee (RUC). All of those things directly relate to your daily practice and reimbursement. We are there fighting for you and making sure that your patients are well cared for and you get compensated for what you do. You should participate in that process that everyone benefits from.



Hans R. House
MD FACEP
ACEP Board of Director

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6. So, you mentioned academics. You've been involved in academics for a long time. We sometimes hear from some academics that, "I'm academic. ACEP is not for me." Or, "I'm not into the organized medicine approach." Some people see this dichotomy between academics and organized medicine. How would you respond to something like that?

I think that some of the academic EM organizations such as CORD and SAEM are fantastic for academics. If you are involved in education, you really have to be part of CORD. If you are involved in research, you really have to be part of SAEM. ACEP is so much bigger than that. If you really want to build your network, that's what ACEP can do. It has academic arms, it has research forum at Scientific Assembly, it has grant money through EMF, and it has the teaching fellowship. ACEP has a very large umbrella.

Woody Allen was right when he said, "80% of life is showing up." Going to the meetings and meeting people in person and getting involved - that's how my career developed and that's how you can get started.

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New York State of Mind



compiled by
Theodore J. Gaeta
DO MPH FACEP
Residency Program Director
New York Methodist Hospital



Current Strategies in the Evaluation and Management of Cocaine-Induced Chest Pain.

Agrawal PR(1), Scarabelli TM, Saravolatz L, Kini A, Jalota A, Chen-Scarabelli C, Fuster V, Halperin JL.; Mount Sinai Medical Center, New York; Cardiol Rev. 2015 Jan 9.

With each successive year, the number of Emergency Department (ED) visits related to illicit drug abuse has progressively increased. Cocaine is the most common illegal drug to cause a visit to the ED. Cocaine use results in a variety of pathophysiological changes with regards to the cardiovascular system, such as constriction of coronary vessels, dysfunction of vascular endothelium, decreased aortic elasticity, hemodynamic disruptions, a hypercoagulable state, and direct toxicity to myocardial as well as vascular tissue. The clinical course of patients with cocaine-induced chest pain is often challenging, and electrocardiographic findings can be potentially misleading in terms of diagnosing a myocardial infarction. In addition, there is no current satisfactory study regarding outcomes of use of various pharmacological drug therapies to manage cocaine associated chest pain. At present, calcium channel blockers and nitroglycerin are two pharmacological agents which are advocated as first-line drugs for cocaine-induced chest pain management, while the role of labetalol has been controversial and warrants further investigation. We performed an extensive search of available literature through a large number of scholarly articles previously published and listed on Index Medicus. In this review we put forward a concise summary of the current approach to a patient presenting to the ED with cocaine associated chest pain, and management of the clinical

scenario. The purpose of this review is to summarize the understanding of cocaine's cardiovascular pathophysiology, and examine the current approach for proper evaluation and management of cocaine-induced chest pain.

What does remediation and probation status mean? A survey of emergency medicine residency program directors.

Weizberg M, Smith JL, Murano T, Silverberg M, Santen SA.; Staten Island University Hospital, New York; Acad Emerg Med. 2015 Jan;22(1):113-6.

OBJECTIVES: Emergency medicine (EM) residency program directors (PDs) nationwide place residents on remediation and probation. However, the Accreditation Council for Graduate Medical Education and the EM PDs have not defined these terms, and individual institutions must set guidelines defining a change in resident status from good standing to remediation or probation. The primary objective of this study was to determine if EM PDs follow a common process to guide actions when residents are placed on remediation and probation.

METHODS: An anonymous electronic survey was distributed to EM PDs via e-mail using SurveyMonkey to determine the current practice followed after residents are placed on remediation or probation. The survey queried four designations: informal remediation, formal remediation, informal probation, and formal probation. These designations were compared for deficits in the domains of medical knowledge (MK) and non-MK remediation. The survey asked what process for designation exists and what actions are triggered, specifically if documentation is placed in a resident's file,

if the graduate medical education (GME) office is notified, if faculty are informed, or if resident privileges are limited. Descriptive data are reported.

RESULTS: Eighty-one of 160 PDs responded. An official policy on remediation and/or probation was reported by 41 (50.6%) programs. The status of informal remediation is used by 73 (90.1%), 80 (98.8%) have formal remediation, 40 (49.4%) have informal probation, and 79 (97.5%) have formal probation. There was great variation among PDs in the management and definition of remediation and probation. Between 81 and 86% of programs place an official letter into the resident's file regarding formal remediation and probation. However, only about 50% notify the GME office when a resident is placed on formal remediation. There were no statistical differences between MK and non-MK remediation practices. **CONCLUSIONS:** There is significant variation among EM programs regarding the process of remediation and probation. The definition of these terms and the actions triggered are variable across programs. Based on these findings, suggestions toward a standardized approach for remediation and probation in GME programs are provided.

Simulation-based Training for Emergency Medicine Residents in Sterile Technique During Central Venous Catheterization: Impact on Performance, Policy, and Outcomes.

Hoskote SS, Khouli H, Lanoix R, Rose K, Aqeel A, Clark M, Chalfin D, Shapiro J, Han Q.; Department of Medicine, St. Luke's-Roosevelt Hospital Center, New York; Acad Emerg Med. 2015 Jan;22(1):81-7.

OBJECTIVES: Central line-associated bloodstream infection (CLABSI) is

a preventable nosocomial infection. Simulation-based training in sterile technique during central venous catheter (CVC) placement for emergency medicine (EM) residents, and its effect on changing the medical intensive care unit (MICU) practice of routine replacement of CVCs placed under sterile technique in the emergency department (ED), has not been evaluated.

METHODS: Emergency medicine residents received simulation-based sterile technique training during CVC placement between May 2008 and September 2010. Between June 2008 and January 2011, the authors reviewed records of patients who had CVCs placed in the ED under sterile technique by EM residents and were admitted to the MICU (group 1) and CVCs placed in the MICU under sterile technique by internal medicine (IM) residents (group 2). IM residents completed similar simulation-based training before May 2008. Changes in EM residents' sterile technique performance scores were compared, as well as CLABSI rates in both groups. EM residents' CVC procedural skills were not assessed.

RESULTS: Seventy-six EM residents completed simulation-based training with significant improvement in performance (median scores 13 out of 24 before training, 24 out of 24 after training; $p < 0.001$). CLABSI rates per 1,000 catheter-days were 1.02 in group 1 and 1.02 in group 2 ($p = 0.99$). Both groups had similar demographics, acuity, and mortality ($p > 0.5$).

CONCLUSIONS: Routine replacement of CVCs placed in the ED under sterile technique after simulation-based training would appear to be unnecessary. These findings demonstrate patient-centered outcomes that are comparable for CVCs in ED-admitted MICU patients, regardless of whether the CVC was placed in the ED or MICU.

Retained drugs in the gastrointestinal tracts of deceased victims of oral drug overdose.

Livshits Z(1), Sampson BA, Howland MA, Hoffman RS, Nelson LS.; New York Presbyterian Weill Cornell Medical Center, New York; Clin Toxicol (Phila). 2014 Dec 30:1-6.

CONTEXT: The extent of non-absorbed drug burden in the GI tract following overdose is unknown. Patients who present with clinical signs of toxicity may not undergo decontamination due

to assumption that the drug has already been completely absorbed and because of limited scientific evidence of benefit for routine GI decontamination in poisoned patients.

OBJECTIVES: The goal of this study was to assess whether people who die of an oral overdose have an unabsorbed drug present in the GI tract. The secondary goal was to analyze pharmacologic characteristics of retained drugs when present.

MATERIALS AND METHODS: Retrospective review of autopsy reports from 2008 to 2010, whose cause of death was determined as "intoxication" or "overdose", performed at the Office of Chief Medical Examiner of the City of New York (OCME NYC). Decedents of all ages were identified via electronic OCME database. Inclusion criteria were as follows: 1) cause of death "intoxication" or "overdose" noted by forensic autopsy, 2) ingestion of a solid drug formulation.

RESULTS: 92 out of 1038 autopsies (9%) that met inclusion criteria had documentation of retained pill fragments, granules, paste, sludge, slurry, or whole pills in the GI tract. The most common drugs found were opioids and anticholinergics. Ninety-eight percent (98%) of the retained drugs were either modified-release preparations or drugs known to slow GI transit. Most decedents were dead on arrival; there were twelve in-hospital deaths and eleven patients died in the emergency department. Bupropion and venlafaxine were responsible for four deaths in those who received medical care. One person died in the ICU following bupropion ingestion.

DISCUSSION AND CONCLUSION: Overdose of an oral drug that either has modified-release properties or slows GI tract motility may result in substantial unabsorbed drug burden remaining in the GI tract.

Intercepting Wrong-Patient Orders in a Computerized Provider Order Entry System.

Green RA, Hripcsak G, Salmasian H, Lazar EJ, Bostwick SB, Bakken SR, Vawdrey DK. Ann Emerg Med. 2014 Dec 17 Columbia University Medical Center and NewYork-Presbyterian Hospital, New York.

STUDY OBJECTIVE: We evaluate the short- and long-term effect of a computerized provider order entry-based patient verification intervention to reduce

wrong-patient orders in five emergency departments.

METHODS: A patient verification dialog appeared at the beginning of each ordering session, requiring providers to confirm the patient's identity after a mandatory 2.5-second delay. Using the retract-and-reorder technique, we estimated the rate of wrong-patient orders before and after the implementation of the intervention to intercept these errors. We conducted a short- and long-term quasi-experimental study with both historical and parallel controls. We also measured the amount of time providers spent addressing the verification system, and reasons for discontinuing ordering sessions as a result of the intervention.

RESULTS: Wrong-patient orders were reduced by 30% immediately after implementation of the intervention. This reduction persisted when inpatients were used as a parallel control. After two years, the rate of wrong-patient orders remained 24.8% less than before intervention. The mean viewing time of the patient verification dialog was 4.2 seconds (SD=4.0 seconds) and was longer when providers indicated they placed the order for the wrong patient (4.9 versus 4.1 seconds). Although the display of each dialog took only seconds, the large number of display episodes triggered meant that the physician time to prevent each retract-and-reorder event was 1.5 hours.

CONCLUSION: A computerized provider order entry-based patient verification system led to a moderate reduction in wrong-patient orders that was sustained over time. Interception of wrong-patient orders at data entry is an important step in reducing these errors.

Meta-analysis of coronary computed tomography angiography versus standard of care strategy for the evaluation of low risk chest pain: Are randomized controlled trials and cohort studies showing the same evidence?

El-Hayek G, Benjo A, Uretsky S, Al-Mallah M, Cohen R, Bamira D, Chavez P, Nascimento F, Santana O, Patel R, Cavalcante JL.; Mount Sinai Saint Luke's Hospital, New York; Int J Cardiol. 2014 Nov 15;177(1):238-45.

BACKGROUND: Randomized control trials (RCTs) have established the use of Coronary Computed Tomography Angiography (CCTA) for the evaluation of

low to intermediate risk patients presenting with acute chest pain to the emergency department (ED). However, concerns remain regarding the downstream resource utilization and the clinical impact of such strategy.

METHODS: We performed a meta-analysis of existing studies to compare CCTA to the standard of care (SOC) strategies in the low to intermediate risk chest pain patients. We abstracted the reported incidence of acute coronary syndromes (ACS), the total number of invasive coronary angiography (ICA) and subsequent revascularization procedures, the rates of hospital readmissions and repeat ED visits. We stratified the results according to the type of the studies (randomized or not) and used random effect analysis for the studied outcomes.

RESULTS: Four RCTs and three case-control studies with 3306 patients undergoing CCTA and 2752 assigned to SOC were included in the analysis. Following the index visit, we observed a significant reduction in the risk of ACS (RR: 0.26, 95% CI, 0.08 to 0.87; $p=0.03$) and in the rates of repeat ED visits (RR: 0.58, 95% CI: 0.36 to 0.94; $p=0.03$). In addition, a trend toward less hospital readmission ($p=0.07$) was noted. There was no difference in ICA ($p=0.99$) but an increase in revascularization procedures (RR: 1.46, 95% CI: 1.09 to 1.94; $p=0.01$).

CONCLUSION: CCTA use in the ED for the triage of low to intermediate risk patients reduces the risk of future ACS and subsequent ED visits for chest pain.

Accuracy of Optic Nerve Sheath Diameter Measurement by Emergency Physicians Using Bedside Ultrasound.

Hassen GW, Bruck I, Donahue J, Mason B, Sweeney B, Saab W, Weedon J, Patel N, Perry K, Matari H, Jaiswal R, Kalantari H. J; New York Medical College (NYMC), Metropolitan Hospital Center, New York; Emerg Med. 2014 Dec 9.

BACKGROUND: Ultrasound (US) measurement of the optic nerve sheath diameter (ONSD) has been utilized as an indirect assessment of intracranial pressure. It is usually performed by trained ultrasonographers.

OBJECTIVES: To evaluate whether or not emergency physicians (EP) are capable of measuring the ONSD accurately by US. **MATERIALS AND METHODS:** A retrospective measurement of ONSD

was conducted on computed tomography (CT) scans of the head or facial bones. These patients had undergone ocular US performed by EPs prior to CT scanning. The CT scan measurements of ONSD read by a board-certified radiologist were compared with that of the US read by a registered diagnostic medical sonographer. A difference in measurements of the ONSD ≥ 0.5 mm between the two modalities was considered as significant for this study.

RESULTS: The ONSD measurements were performed with CT scan and compared to that of the US. Of the 61 patients studied, 36 (59%) were male and 25 (41%) were female. The average age was 56 ± 17 years. All but three patients had ONSD measurements that were between 5 and 6 mm. Discrepancy in measurements of the ONSD between US and CT for both groups fell within our predetermined value (0.5 mm) for the majority of cases. None of the measurements were above 6 mm. The intraclass correlation coefficient was 0.9 (95% confidence interval 0.8846-0.9303).

CONCLUSION: Emergency physicians were capable of accurately measuring the ONSD using bedside US. Prospective studies with a larger sample size are recommended to validate these findings.

Randomized Trial of a Novel ACLS Teaching Tool: Does it Improve Student Performance?

Nacca N, Holliday J, Ko PY; SUNY Upstate Medical University, Syracuse; West J Emerg Med. 2014 Nov;15(7):913-8.

INTRODUCTION: Mounting evidence suggests that high-fidelity mannequin-based (HFMB) and computer-based simulation are useful adjunctive educational tools for advanced cardiac life support (ACLS) instruction. We sought to determine whether access to a supplemental, online computer-based ACLS simulator would improve students' performance on a standardized Mega Code using high-fidelity mannequin based simulation (HFMB).

METHODS: Sixty-five third-year medical students were randomized. Intervention group subjects ($n = 29$) each received a two-week access code to the online ACLS simulator, whereas the control group subjects ($n = 36$) did not. Primary outcome measures included students' time to initiate chest compressions, defibrillate ventricular fibrillation, and pace symptomatic

bradycardia. Secondary outcome measures included students' subjective self-assessment of ACLS knowledge and confidence.

RESULTS: Students with access to the online simulator on average defibrillated ventricular fibrillation in 112 seconds, whereas those without defibrillated in 149.9 seconds, an average of 38 seconds faster [$p<.05$]. Similarly, those with access to the simulator paced symptomatic bradycardia on average in 95.14 seconds whereas those without access paced on average 154.9 seconds a difference of 59.81 seconds [$p<.05$]. On a subjective 5-point scale, there was no difference in self-assessment of ACLS knowledge between the control (mean 3.3) versus intervention (mean 3.1) [p -value = .21]. Despite having outperformed the control group subjects in the standardized Mega Code test scenario, the intervention group felt less confident on a 5-point scale (mean 2.5) than the control group. (mean 3.2) [$p<.05$].

CONCLUSION: The reduction in time to defibrillate ventricular fibrillation and to pace symptomatic bradycardia among the intervention group subjects suggests that the online computer-based ACLS simulator is an effective adjunctive ACLS instructional tool.

Evaluation of a Liquid Dressing for Minor Nonbleeding Abrasions and Class I and II Skin Tears in the Emergency Department.

Singer AJ, Chale S, Taylor M, Domingo A, Ghazipura S, Khorasonchi A, Bienenfeld A.; Stony Brook University, Stony Brook; J Emerg Med. 2014 Nov 20.

BACKGROUND: Minor abrasions and skin tears are usually treated with gauze dressings and topical antibiotics requiring frequent and messy dressing changes.

OBJECTIVE: We describe our experience with a low-cost, cyanoacrylate-based liquid dressing applied only once for minor abrasions and skin tears.

METHODS: We conducted a single-center, prospective, noncomparative study in adult emergency department (ED) patients with minor nonbleeding skin abrasions and class I and II skin tears. After cleaning the wound and achieving hemostasis, the wounds were covered with a single layer of a cyanoacrylate liquid dressing. Patients were followed every 1-2 days until healing.

continued on page 24



Call for Board and Councillor Nominations

Board Nominations

Active members of New York ACEP who meet the criteria and are interested in serving on the Board of Directors are encouraged to submit their nominations to the 2015 Nominating Committee for consideration as the Committee develops the slate of candidates.

Four directors will be elected by the membership through a proxy ballot distributed at least 30 days prior to the annual membership meeting. The annual membership meeting will be held Wednesday, July 8, 2015 at the Sagamore Resort on Lake George.

Board Members With Terms Ending in 2015

Jay M. Brenner, MD FACEP*
Keith E. Grams, MD FACEP
Sanjey Gupta, MD FACEP
Stuart G. Kessler, MD FACEP

**These board members are eligible for reelection to a second, three-year term.*

Interested candidates should review the Criteria for New York ACEP Board Nomination, Board Member Duties & Responsibilities, and send a completed nomination form along with a copy of their CV to New York ACEP by **April 1, 2015**. Self nomination and nominations of colleagues are accepted. To request the policies and nomination form, contact New York ACEP at (585) 872-2417 or by email at nyacep@nyacep.org.

Successful nominees will be notified after April 30, 2015. Board candidates are required to submit background information on their professional career, a photograph and answer questions posed to all board candidates. Candidates will have approximately two weeks to submit material.

Councillor Nominations

Active members of New York ACEP interested in serving as a New York ACEP Councillor are encouraged to submit their nomination(s) to the 2015 Nominating Committee for consideration as the Committee develops the slate of candidates.

Councillors With Terms Ending in 2015

Brahim Ardolic, MD FACEP
Joel M. Bartfield, MD FACEP
Gerard X. Brogan, Jr. MD FACEP
Jeremy T. Cushman, MD FACEP
Theodore J. Gaeta, DO MPH FACEP
Keith E. Grams, MD FACEP
Sanjey Gupta, MD FACEP
David C. Lee, MD FACEP
Gary R. Rudolph, MD FACEP
Nicole Yuzuk, MD, *resident representative*

Councillors With Terms Ending in 2016

Samuel F. Bosco, MD FACEP
Michael Cassara, DO FACEP
Michael G. Guttenberg, DO FACEP
Raymond Iannaccone, MD FACEP
Stuart G. Kessler, MD FACEP
Nestor B. Nestor, MD FACEP
David H. Newman, MD FACEP
Salvatore R. Pardo, MD FACEP
Louise A. Prince, MD FACEP
Christopher C. Raio, MD MBA FACEP
Frederick M. Schiavone, MD FACEP
Todd Slesinger, MD FACEP
Virgil W. Smaltz, MD MPA FACEP
Peter Viccellio, MD FACEP
resident representative

The Board of Directors will elect 9 councillors at the Thursday, July 9, 2015 Board meeting at the Sagamore Resort. Members interested in representing New York ACEP at the ACEP Annual Council Meeting, (October 26-29, 2015 in Boston, MA), should submit a nomination form and their CV to New York ACEP. New York ACEP will be represented by 24 councillors at the 2015 ACEP Council meeting.

Deadline for nominations: April 1, 2015

RESULTS: We enrolled 40 patients with 50 wounds including 39 abrasions and 11 skin tears. Mean (standard deviation) age was 54.5 (21.9) years and 57.5% were male. Wounds were located on the face (n = 16), hands (n = 14), legs (n = 11), and arms (n = 9). Pain scores (0 to 10 from none to worst) after application of the liquid dressing were 0 in 62% and 1-3 in the remaining patients. Follow-up was available on 36 patients and 46 wounds. No wounds re-bled and there were no wound infections. Only one wound required an additional dressing. Median (interquartile range [IQR]) time to complete sloughing of the adhesive was 7 (5.5-8) days. Median (IQR) time to complete healing and sloughing of the overlying scab was 10 (7.4-14) days.

CONCLUSIONS: Our study suggests that a single application of a low-cost cyanoacrylate-based liquid adhesive is a safe and effective treatment for superficial nonbleeding abrasions and class I and II skin tears that eliminates the need for topical antibiotics and dressings.

Debriefing in the Emergency Department After Clinical Events: A Practical Guide.

Kessler DO, Cheng A, Mullan PC; Columbia University Medical Center, New York Presbyterian Morgan Stanley Children's Hospital of New York, New York.

One vital aspect of emergency medicine management is communication after episodes of care to improve future performance through group reflection on the shared experience. This reflective activity in teams is known as debriefing, and despite supportive evidence highlighting its benefits, many practitioners experience barriers to implementing debriefing in the clinical setting. The aim of this article is to review the current evidence supporting post event debriefing and discuss practical approaches to implementing debriefing in the emergency department. We will address the who, what, when, where, why, and how of debriefing and provide a practical guide for the clinician to facilitate debriefing in the clinical environment.

Delayed Sequence Intubation: A Prospective Observational Study.

Weingart SD, Trueger NS, Wong N, Scofi J, Singh N, Rudolph SS.; Stony Brook University Medical Center, Stony Brook; Ann Emerg Med. 2014 Oct 23.

STUDY OBJECTIVE: We investigate a new technique for the emergency airway management of patients with altered mental status preventing adequate preoxygenation.

METHODS: This was a prospective, observational, multicenter study of patients whose medical condition led them to impede optimal preintubation preparation because of delirium. A convenience sample of emergency department and ICU patients was enrolled. Patients received a dissociative dose of ketamine, allowing preoxygenation with high-flow nonbreather mask or noninvasive positive pressure ventilation (NIPPV). After reoxygenation, patients were paralyzed and intubated. The primary outcome of this study was the difference in oxygen saturations after maximal attempts at preoxygenation before delayed sequence intubation compared with saturations just before intubation. Predetermined secondary outcomes and complications were also assessed.

RESULTS: A total of 62 patients were enrolled: 19 patients required delayed sequence intubation to allow nonbreather mask, 39 patients required it to allow NIPPV, and four patients required it for nasogastric tube placement. Saturations increased from a mean of 89.9% before delayed sequence intubation to 98.8% afterward, with an increase of 8.9% (95% confidence interval 6.4% to 10.9%).

Thirty-two patients were in a predetermined group with high potential for critical desaturation (pre-delayed sequence intubation saturations \leq 93%). All of these patients increased their saturations post-delayed sequence intubation; 29 (91%) of these patients increased their post-delayed sequence intubation saturations to greater than 93%. No complications were observed in the patients receiving delayed sequence intubation.

CONCLUSION: Delayed sequence intubation could offer an alternative to rapid sequence intubation in patients requiring emergency airway management who will not tolerate preoxygenation or peri-intubation procedures. It is essentially procedural sedation, with the procedure being preoxygenation. Delayed sequence intubation seems safe and effective for use in emergency airway management.

Including Frequent Emergency Department Users With Severe Alcohol Use Disorders in Research: Assessing Capacity.

McCormack RP(1), Gallagher T(2), Goldfrank LR(2), Caplan AL(3); New York University School of Medicine, New York; Ann Emerg Med. 2014 Oct 23.

STUDY OBJECTIVE: Frequent emergency department (ED) users with severe alcohol use disorders are often excluded from research, in part because assessing capacity to provide consent is challenging. We aim to assess the feasibility of using the University of California, San Diego Brief Assessment of Capacity to Consent, a 5-minute, easy-to-use, validated instrument, to screen for capacity to consent for research in frequent ED users with severe alcohol use disorders.

METHODS: We prospectively enrolled a convenience sample of 20 adults to assess their capacity to provide consent for participation in 30-minute mixed-methods interviews using the 10-question University of California, San Diego Brief Assessment of Capacity to Consent. Participants were identified through an administrative database, had greater than four annual ED visits for two years, and had severe alcohol use disorders. The study was conducted with institutional review board approval from March to July 2013 in an urban, public, university ED receiving approximately 120,000 visits per year. Blood alcohol concentration and demographic data were extracted from the medical record.

RESULTS: We completed assessments for 19 of 20 participants. One was removed because of agitation. Sixteen of 19 participants passed each question and were deemed capable of providing informed consent. Interventions to improve understanding (prompting and material review) were required for 15 of 19 participants. The mean duration to describe the study and perform the assessment was 10.4 minutes (SD 3 minutes). The mean blood alcohol concentration was 211.5 mg/dL (SD 137.4 mg/dL). The three patients unable to demonstrate capacity had blood alcohol concentrations of 226 and 348 mg/dL, with one not obtained.

CONCLUSION: This pilot study supports the feasibility of using the University of California, San Diego Brief Assessment of Capacity to Consent to assess capacity of frequent ED users with severe alcohol use disorders to participate in research. Blood alcohol concentration was not correlated with capacity.

Whole-body computed tomographic scanning leads to better survival as opposed to selective scanning in trauma patients: a systematic review and meta-analysis.

Caputo ND(1), Stahmer C, Lim G, Shah K; Lincoln Medical and Mental Health Center, Bronx; J Trauma Acute Care Surg. 2014 Oct;77(4):534-9.

BACKGROUND: Traumatic injury in the United States is the Number one cause of mortality for patients one to 44 years of age. Studies suggest that early identification of major injury leads to better outcomes for patients. Imaging, such as computed tomography (CT), is routinely used to help determine the presence of major underlying injuries. We review the literature to determine whether whole-body CT (WBCT), a protocol including a noncontrast scan of

the brain and neck and a contrast-enhanced scan of the chest, abdomen, and pelvis, detects more clinically significant injuries as opposed to selective scanning as determined by mortality rates.

METHODS: Scientific publications from 1980 to 2013 involving the study of the difference between pan scan and selective scan after trauma were identified. The Preferred Reporting Items for Systematic Reviews and Meta-analyses was used. Publications were categorized by level of evidence. Injury Severity Score (ISS) and pooled odds for mortality rate of patients who received WBCT scan versus those who received selective scans were compared.

RESULTS: Of the 465 publications identified, seven were included, composing 25,782 trauma patients who received CT scan following trauma. Of the patients, 52% (n = 13,477) received pan scan and 48% (n = 12,305) received selective

scanning. Overall ISS was significantly higher for patients receiving WBCT versus those receiving selective scan (29.7 vs. 26.4, p < 0.001, respectively). Overall mortality rate was significantly lower for WBCT versus selective scanning (16.9; 95% confidence interval [CI], 16.3-17.6 vs. 20.3; 95% CI, 19.6-21.1, p < 0.0002, respectively). Pooled odds ratio for mortality rate was 0.75 (95% CI, 0.7-0.79), favoring WBCT.

CONCLUSION: Despite the WBCT group having significantly higher ISS at baseline compared with the group who received selective scanning, the WBCT group had a lower overall mortality rate and a more favorable pooled odds ratio for trauma patients. This suggests that in terms of overall mortality, WBCT scan is preferable to selective scanning in trauma patients.



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The Office of Professional Medical Conduct: A Brief Overview

Sachin J. Shah
MD, MBA

Director of Emergency Services
Nyack Hospital

Partner, Emergency Medical Associates

Member, New York ACEP Practice Management Committee



What is the Office of Professional Medical Conduct (OPMC)?

The State Board for Professional Medical Conduct was created in 1976. Its mission is “to protect the public from medical negligence, incompetence and other kinds of professional misconduct.” The OPMC is a division of the Department of Health (DOH). It is charged with investigating complaints brought against physicians or physicians’ assistants. The investigators at the OPMC are generally health care professionals; likely nurses. In addition, the OPMC has Department of Health lawyers available to help draft charges, negotiate settlements and prosecute cases that elevate to a hearing level. The OPMC also has expert witnesses in different disciplines of medicine to help review cases to determine if standard of care was met or not. The expert witnesses are not employed by the OPMC, must be board certified in the field in question and must be actively practicing physicians licensed in New York.

How does the OPMC get complaints?

Anyone can file an anonymous complaint against a physician: a patient, a patient’s family member, a hospital employee, another physician, attorneys, etc.

How does this differ from the malpractice process?

For medical malpractice, typically there is a bad outcome for a patient. For OPMC cases, the outcome is not necessarily the determining factor. The treatment is looked at in terms of whether it meets a minimum standard of care and whether it could have placed a patient at harm.

How does the OPMC use malpractice information?

The OPMC monitors malpractice complaints for potential misconduct as directed by the law. Four specific criteria would trigger an OPMC investigation:

- Six or more payouts over the past five years
- Cancellation or non-renewal of the physician’s malpractice policy by the insurer due to a concern about quality

of care

- Addition of a surcharge of 75% or more to a physician’s policy
- A single payout amount higher than a specialty- and geography-specific 75th percentile dollar amount

An isolated malpractice claim typically would not meet the threshold for OPMC action.

How many cases does the OPMC deal with?

In 2010, the last year data is available for, 8,501 complaints were received, representing a 24% increase from 2005. Four thousand twenty-four cases (4,024) were closed after an investigation determined that no formal charges needed to be filed. One thousand three hundred (1,300) physicians were monitored during the year. Three hundred and seven (307) final actions were imposed with 182 resulting in loss or restriction of a physician’s medical license. This was higher than any other state in the nation. In addition, 82% of cases that were referred for hearing were settled or resulted in a signed “consent agreement.”

What is the process?

A complaint is reviewed to see if it warrants an investigation. The investigation typically consists of personal interviews, documents, medical records and consultation with medical experts. A Board Investigation Committee reviews all possible misconduct cases and recommends whether a hearing is needed or not. The attorney for the DOH

prepares the Statement of Charges. At this point, a settlement can be negotiated or a hearing moves forward with three panel members – two physicians and a lay member - presided over by an Administrative Law Judge. Both parties are able to present their cases.

The Hearing committee determines Findings of Fact and, if warranted, can impose a penalty. The DOH or the physician may appeal the decision to the Review Board which consists of five members of whom three are physicians. The Review Board decision is final.

What are the possible outcomes of a case?

- Serious Sanction (revocation, suspension or surrender of license)
- Censure and Reprimand
- Order of Conditions
- Dismissal

What should you do if you get an OPMC complaint?

If you receive a complaint from the OPMC, it means that a preliminary investigation was done and the case was not closed. Contact an attorney that has experience with the OPMC and their processes. This is different than a malpractice defense attorney. Most importantly, do not ignore any OPMC related correspondence.

References

http://www.health.ny.gov/professionals/doctors/conduct/annual_reports/2010/

Liametz, AR. “New OPMC Law May Affect Your Reputation and Your Practice, So Beware.” Empire State Epic Volume 27:02:09, November 2009.

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Announcing New York ACEP 2015 Research Forum Call for Abstracts



The New York American College of Emergency Physicians is now accepting abstracts for review for oral and poster presentation at the 2015 Scientific Assembly, July 7-9, at the Sagamore Resort on Lake George in Bolton Landing, New York.

The **Research Forum**, including both oral and poster presentations, will be held Tuesday, July 7 at 12:30 pm. This forum is designed to feature and foster resident and faculty research. Topics may address the broad range of emergency medicine practice and educational development. Preference will be given to work completed at the time of submission. **Authors and institutions should not be identified in any way on the page containing the abstract.**

Abstract submissions must be in electronic format (Microsoft Word) and must include the following subsections, Title, Objectives, Methods (include design, setting, type of participants), Results and Conclusion. The abstract should be written in complete sentences using grammatically correct English. Spell out all abbreviations on first usage. Abstracts are limited to 3,000 characters (excluding spaces). Accepted abstracts will be published as received; no copy editing will be done.

Illustrations are discouraged; however, if critical, one (1) small table may be included. Figures, tables and photos must be black and white with a resolution of at least 300 dpi. Note: tables, figures and illustrations will be considerably reduced when published causing loss of detail. Please consider this when determining whether to include these.

Including the following information on the submission form for each abstract:

1. title of the abstract;
2. author(s) and affiliations;
3. IRB approval or exemption;
4. contact person's mailing address, phone/fax numbers and e-mail address;
5. information regarding previous presentations or publication;
6. potential conflicts by author;
7. if accepted, indicate who will present the abstract July 7, 2015 and their role in the project; and
8. state preference for oral or poster presentation (or no preference).
9. identification of resident if s/he will likely be first or second author on manuscript.

Although we are interested in original work, consideration will be given to abstracts presented at other conferences (SAEM, ACEP).

Oral presentations will be allocated 10 minutes followed by 5 minutes of Q&A. Twenty-four poster presentations will be allocated 5 minutes followed by 3 minutes of Q&A. Other poster submissions will be selected for display. All presenters (oral or poster) are expected to have had a significant role in the execution and report preparation of the project being presented.

deadline
April 1, 2015
Midnight Eastern

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Governor Cuomo's 2015-16 Proposed State Budget

On Wednesday January 21, 2015, Governor Andrew Cuomo gave his 2015 State of the State Address jointly with his State Fiscal Year (FY) 2015-16 Executive Budget presentation calling it his "2015 New York State of Opportunity Agenda." The FY 2015-16 Executive Budget totals \$141.6 billion, a \$1.63 billion or 1.7% increase over the previous year.

The proposed State Budget includes a number of provisions of interest to New York ACEP as summarized below.

Excess Medical Malpractice Program

This program is continued at last year's level of \$127.4 million through June 30, 2016. It includes a new provision that requires physicians and dentists to receive clearance from the Department of Taxation and Finance of outstanding tax liabilities.

Minimum Wage

The proposal increases the hourly minimum wage to \$11.50 in New York City and \$10.50 in the rest of the State, effective December 31, 2016. Due to actions taken in 2013, the current minimum wage is \$8.75 and is slated to increase to \$9.00 on December 31, 2015.

Regulation of Urgent Care Centers

The Governor's proposal once again calls for regulation of urgent care centers. The use of the term "urgent care" is limited to Article 28 certified entities and fully accredited health care providers that meet specific criteria. The bill defines "urgent care" as the provision of treatment on an unscheduled basis to patients for acute episodic illness or minor traumas that are not life threatening or potentially disabling. An urgent care center cannot provide care for conditions that require monitoring and treatment over prolonged periods.

An urgent care center may not display signage, advertise or hold itself out as a provider of emergency medical services through the use of the term emergency, or through any other term or symbol that implies that it is a provider of emergency medical care.

The Commissioner of the New York State Health of Department (NYS DOH) is authorized to promulgate regulations governing urgent centers including but not limited to defining the scope of services to be provided, requiring providers to disclose to patients the scope of services provided, establishing standards for appropriate referral and continuity of care, staffing, equipment, and maintenance and transmission of medical records.

Limited Service Clinics

The Governor's budget authorizes the establishment of "Limited Services Clinics" within retail establishments such as pharmacies, stores and shopping malls. These clinics are currently referred to as "retail clinics."

The Commissioner of the NYS DOH is required to promulgate regulations setting forth operational and physical plant requirements including but not limited to:

- accreditation;
- designating or limiting the treatments and services that may be provided;
- prohibiting the provision of services to patients under 18 years of age;
- prohibiting specific immunizations to patients under 18 years of age;
- requirements or guidelines for advertising and signage, disclosure of ownership interests, informed consent, record keeping, referral for treatment and continuity of care, case reporting to the patient's primary care or other health care providers; and
- design, construction, fixtures, and equipment.

Private Equity Demonstrations

The Executive Budget authorizes the establishment of five private equity pilot programs. The Public Health and Health Planning Council (PHHPC) is authorized to approve up to five business corporations to operate a hospital or home care agency in affiliation with at least one academic medical institution. Publically traded entities are not eligible to participate in the demonstration program.

Capital Funds

The Executive Budget provides \$1.4 billion in capital funds for hospitals and health care facilities, with \$700 million of that for the Upstate region: \$400 million is for supporting "debt restructuring and other capital projects to promote appropriate regional consolidations among health care providers and further health care transformation in rural communities" and \$300 million "to create an integrated delivery system in Oneida County."

Vital Access Provider (VAP)

The Executive Budget provides \$580 million for VAP (state and federal funds), including a \$10 million sub-allocation for rural or essential community providers and \$7.5 million for Critical Care Access Hospitals (CAHs).

Implementation of Out-of-Network Law

New York ACEP and Reid, McNally & Savage have been working since June of last year on the implementation of the 2014 law to regulate out-of-network health insurance, including billing, reimbursement and consumer disclosure for health care services provided to patients by "out-of-network" providers who do not participate in a patient's health insurance plan.

New York ACEP's focus has been on the development of regulations for the Independent Dispute Resolution (IDR) process for claims disagreements between providers, health plans and patients and a guidance document from the Department of Financial Services (DFS). The law is scheduled to take effect April 1, 2015. Proposed State regulations were published in the New York State Register December 31, 2014. The draft Guidance Document is expected to be finalized by the end of February.

New York ACEP has had detailed conversations with DFS over the past several months. As a result, we can confirm the following facts of benefit to members:

- The timeframe for the IDR entity to make a determination on a dispute is 30

days with no delays or requirements to first exhaust internal appeals with health care plans.

- Usual and Customary Cost (UCR) is defined as the 80th percentile of all charges for a particular health service performed by a particular provider in the same or similar specialty in the same geographic region as reported by a not-for-profit entity.
- Fair Health will be named in the Guidance Document as an entity that may be used as the independent source to determine UCR. At this time no other entity meets the criteria.
- There is no prohibition in the law on balance billing for emergency services.
- It is the responsibility of the health care plan to ensure that patients incur no greater out-of-pocket costs than they would if they had received the services from an in-network provider.

The proposed regulations require notice to patients that directs them to contact the health care plan in the event that the patient receives a bill from a non-participating physician.

- The IDR entity must utilize reviewers in the same or similar specialty as the physician who is the subject of the dispute resolutions process.

New York ACEP was successful last year in getting an exemption in the law from the IDR process for emergency services when the amount billed is under \$600 after any applicable patient cost sharing and it does not exceed 120% of the UCR for specific CPT codes. There is an annual inflation adjustment. Based on our analysis, this exemption will include claims for evaluation, management, and most observation care provided by emergency physicians. This is the only exemption granted to physicians in the law.

In several meetings last year with representatives of the DFS, New York ACEP recommended inclusion in the IDR regulations of authority for providers to batch substantially similar claims from the same insurance company for emergency services to keep the cost of the process manageable and affordable. It was noted that emergency physicians have an extremely high volume of claims at typically much lower rates than other physician specialties. There are a large number of frequently billed CPT codes where the amount billed is relatively modest (\$602.28 to \$1,024.80) but is in excess of

the statutory criteria for an exemption. If the cost of the IDR process is close to or greater than the potential benefit of winning an appeal against an insurance company, physicians will not be able to make use of the process.

DFS declined to put this recommendation in the proposed regulation. They believe that most disputes for emergency services will be brought by health care plans because their legal obligation to protect the patient from increased out-of-pocket costs will be a disincentive for them to pay lower fees to providers.

New York ACEP's strategy going forward is to carefully monitor the implementation of the law beginning April 1, 2015 and to bring any issues that arise to the attention of the DFS and key State legislators.

Medicaid Reimbursement for Nurse Practitioners (NPs) and Physician Assistants (PAs)

The New York State Department of Health recently implemented a new Medicaid billing policy to carve Medicaid fee-for-service reimbursement out of hospital and clinic rates and allow physicians to bill separately for their services. The professional component for all other practitioners, including NPs and PAs is included in the APG rate and cannot be billed separately. As a result, claims for services by NPs and PAs who are employed by professional practices that provide contractual services to hospitals are being denied.

On a joint call with the Medical Society of the State of New York (MSSNY) and the NYS DOH, New York ACEP objected to these payment denials and requested that the policy be revised to permit NPs and PAs who are employed by a professional practice to bill Medicaid directly for services. We stressed that it is inappropriate for the hospital to receive payment for a service that is being rendered by an employee of a professional provider group.

In addition, we expressed concern that this billing policy will discourage the use of NPs and PAs in hospitals and emergency departments and adversely impact access to care for Medicaid patients, particularly in rural and other underserved areas of the State where there are physician shortages.

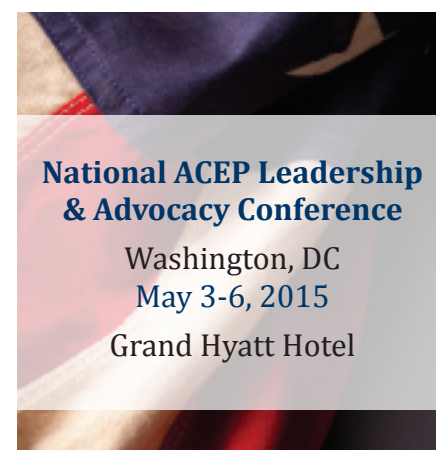
The NYS DOH is taking the position that it is the responsibility of the professional practice to obtain payment

from the hospital. Following the conference call, New York ACEP and MSSNY sent a joint letter to NYS DOH Acting Commissioner Howard Zucker asking him to reverse the payment policy. We will continue to work to allow NPs and PAs employed by professional groups to bill directly.

New York ACEP Lobby Day

On Tuesday, March 10 members of the New York ACEP Board and some of their colleagues will travel to Albany for the annual lobby day to meet with key legislators and staff on the College's 2015 legislative priorities including: fair payment to emergency physicians; out of network rules; and opposition to regressive liability reform.

Following the lobby day, we will work with Executive Director JoAnne Tarantelli to continue to keep members apprised of activities in Albany as they relate to New York ACEP's goals. As we have done in the past, we will be sending out Action Alerts and other calls for grassroots activities to advance your priorities. We greatly appreciate all of your local efforts which are critical to New York ACEP's success.



Education

On Learning to be Well

In August, two young doctors in separate residency programs in New York City tragically jumped to their deaths just weeks after beginning their intern year. These unfortunate events brought to light the sobering fact that physicians commit suicide at twice the rate of the national average.¹ Younger physicians may also be at higher risk compared to older physicians. A recent study reported that up to 9.4% of fourth-year medical students and interns admitted to having suicidal thoughts during the previous two weeks.² For most people, learning to be a good doctor is a tremendously stressful undertaking. Trainees must balance long work hours against time with family and friends, manage crushing student debt on a minimal salary, and also learn how to make life-or-death decisions for their patients each day.

Suicide represents the heartbreaking end of a wide spectrum of psychological distress that often begins with symptoms of burnout. Most of us intuitively understand burnout as a state of mental, and sometimes physical, fatigue due to work-related activities. More formally, it has been defined as a triad of emotional exhaustion, cynicism, and reduced professional efficacy.³ Although hospitals and residency programs have recently made efforts to address the physical and psychological demands of residency, such as mandating duty hour limits and providing confidential counseling services, there continues to be a general absence of formal wellness education on recognizing the early signs of burnout and teaching effective coping strategies.

Burnout is depressingly common. Multiple studies have looked at the prevalence of burnout in both medical students and residents using the Maslach Burnout Inventory (MBI), a widely validated 22-item self-report questionnaire designed to assess burnout, with specific cut offs for high emotional exhaustion, high cynicism, and low personal accomplishment. One systematic review found that as many as 75% of residents met criteria for burnout in some studies.⁴ Another study estimated a combined prevalence of burnout among medical students and residents to be anywhere from 40 to 76%.⁵ Students and residents suffering

from burnout demonstrate more absenteeism, less empathy with patients, decreased interpersonal communication skills, and more frequently self-report medical errors.³ They also have a higher risk of developing depression, anxiety, and substance abuse problems.³ Although burnout does not inevitably lead to suicide, we do know that it is associated with mood disorders that may contribute to an increased risk of contemplating self-harm.

These distressing statistics on physician burnout and its potentially tragic consequences have prompted a few medical schools and residency programs to create innovative educational programs that specifically address burnout and the importance of wellness. The different curricula vary widely in scope, content, and delivery, ranging from single-day small group workshops to longitudinal lecture-based sessions.⁶ Of the different approaches, the most promising burnout interventions focus on a concept known as mindfulness training. Originally developed in 1979 by Jon Kabat-Zinn at the University of Massachusetts Medical Center to help patients struggling with mood disorders, mindfulness-based stress reduction (MSBR) techniques have since been widely used and modified for a variety of different learners and situations.

Mindfulness programs developed for medical students generally consist of semester-long elective courses offered by the school during the first or second year based on the original eight-week MSBR course developed by Kabat-Zinn.⁷ Specific topics include gaining self-awareness, dealing with thoughts, managing stress, handling difficult emotions, communication, and compassion. Meditation acts as a focused method for practicing each of these different aspects of mindfulness. Essentially, mindfulness is thought to promote self-awareness and decrease emotional reactivity through the simple act of paying attention to one's thoughts and feelings. Although there have been almost no published studies investigating the effectiveness of mindfulness programs during residency training, the encouraging results from the medical student

studies suggest that similar interventions would also be successful for residents. Given that emotional exhaustion has been identified as the most significant factor in the burnout triad, it intuitively makes sense that a curriculum promoting the development of skills to handle negative emotions would be effective in combating burnout symptoms.

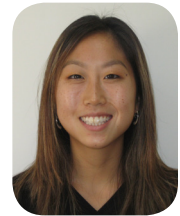
Each of us has spent countless hours learning to care for the health of others, but this does not mean that we have learned to take care of ourselves. In addition to anatomy, physiology, procedures, and clinical skills, we also have a duty to show our tired and overburdened learners how to be well. Consider this a call to action. Physician wellness deserves an essential place in undergraduate, graduate, and continuing medical education. Clearly a desperate need exists for more dedicated wellness programs such as mindfulness training in both medical student and resident education. While we cannot take back the lives of those young doctors who jumped, we can still educate, mentor, and provide support for the many others who remain, and hopefully in the not-too-distant future, create a culture of wellness to protect against the occurrence of such tragic events again.

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