



Reflections of a Past ACEP President

Sandra M. Schneider, MD FACEP, Professor of Emergency Medicine, University of Rochester

As life begins to return to normal, I want to take time to reflect on my years on the Board of ACEP and especially my year as President. First and most importantly I want to thank New York ACEP, its Executive Director JoAnne, and her staff, the State Board members and leadership with whom I served, and my colleagues at Rochester. Without them, I would never have survived. Andy Sama supplied very needed support during some of my most difficult days. JoAnne even wrapped my gifts in my hotel room while I ran to yet one more meeting. My group shuffled their schedules and filled in shifts at a moment's notice. Thanks to all! I travelled 170 days that year, and slept in 64 different beds! In the end, it was an incredible experience!

So what did I learn...

It is clear that the world of healthcare is changing. And that change is frightening. Our reimbursement system is turning on its head. But we have seen change before. In the early 1930s insurance was a rarity, purchased by only a handful of wealthy individuals. There was even a debate on the AMA floor as to whether physicians should accept insurance – “should we let a for-profit insurance company come between a patient and their physician?” A short 15 years later nearly every employer was offering insurance and nearly every physician accepted it. Medicare and Medicaid were implemented in a very short time frame and clearly that was an enormous change. Now the very poor and elderly had access to care leaving the working poor to struggle.

I had the privilege of attending the 50th anniversary of the start of Emergency Medicine when we celebrated the Alexandria Plan in 2011. In 1961, James Mills was growing tired of covering the ER (forgive me but it was a room). At that time, like all other ERs, the medical staff responded from home or the office when one of their patients needed care. If they could not respond or the patient did not have a physician, the medical staff rotated coverage. Dr. Mills recruited three other docs, each of whom worked five 12 hour day shifts, then had five days off, worked five 12 hour night shifts, followed by five days off. They charged \$5 per patient. By the end of the year, this new system of care caught on and their volume had doubled, and the pay was good. This system of care rapidly spread throughout the country, with physicians eventually contracting with hospitals and groups in order to have a more steady income. Emergency medicine changed medical care. Surgeons saw less primary care, primary care did less hospital care, pediatricians began to stay home, comfortable now there was someone who could see their patients. Academic centers eventually provided supervision to the junior trainees who covered these patients. All was not smooth. There were debates at the AMA and other forums on whether emergency medicine was good for medicine. In those days patients could be admitted to the hospital without a

clear diagnosis and the admitting physician decided the antibiotics. The world changed.

It is clear the evolution of emergency medicine is not over. We must restructure our work to fit into the new model of healthcare. Patient centered homes offer more focused care for patients and carry the promise of improved care for the chronically ill. However, patient centered homes will not be able to care for as many patients as

continued on page 23

inside this ISSUE

president's message	3
ultrasound column	4
call for abstracts.....	5
new york acep well represented	6
prehospital medication shortages	7
toxicology column	8
medical student symposium.....	9
ads	2, 9, 12, 15, 17, 20, 22, 29, 30, 32
albany update.....	10
new york state of mind	13
education column	21
pediatric column.....	24
graduate medical education	26
the summer house.....	27
calendar.....	30
call for board/councillor nominations.....	31



Emergency
Medical
Associates

Emergency Medical Associates has expanded in Hudson, New York



Enjoy the best of both worlds only two hours to New York City.

Emergency Medical Associates is seeking a BC EM Physician for a Director Position and BC/BE EM physicians for staff opportunities at Columbia Memorial Hospital

Historic Hudson, located on the scenic Hudson River, offers small town charm, a lively downtown area, 4 season recreational activities and numerous cultural events and activities. Conveniently located 1/2 hour south of Albany and 2 hours from NYC.

Columbia Memorial Hospital ~ Hudson, New York

- 34K volume ED
- 192-bed hospital
- Fast Track
- Scribes
- EMR
- PACS

Explore these positions, as well as exciting career opportunities in NJ, NY, RI and NC, with one of the country's most respected, truly democratic EM groups.

EMA Physicians Enjoy:

- Unparalleled support allows you to live the life you deserve
- Superior Compensation
- Comprehensive Benefits
- An Equal Voice in Everything We Do
- An Equal Share in Everything We Own
- 95% Physician Retention Rate

Contact EMA — Recruiting

(973) 251-1162 • Careers@EMA.net • www.EMA.net/careers

Learn why most physicians stay with us for their entire careers



What Pain!

Long Island is where I practice and Long Island has had its fair share of tragedy related to those who are addicted to prescription narcotics.

As the New York Times put it this time last year, "Pharmacies throughout the country have been shaken by a rash of bold robberies by gun-wielding criminals hunting for narcotic painkillers, anti-anxiety drugs and other controlled medications, either to quench their own addictions or to sell. But nowhere has the face of this epidemic been more frightful than on Long Island, where a pair of pharmacy robberies 30 miles apart resulted in six deaths."

Pain control can be a contentious issue among emergency physicians. It starts with our universal desire to treat acute pain but we get divided

and confounded when the pain is chronic, poorly understood or claimed by patients with suspect veracity, addiction, and recidivism.

Some of us consider addiction and its consequent behaviors something that needs our help in the emergency department. To be honest, others of us have less patience and prefer to prioritize the needs of other patients. Never forget that some of us are addicted as well.

Years ago, the Joint Commission began to focus on the importance of pain control. Simultaneously, patient satisfaction scores became an important driver of incentive compensation for some. Like the infamous IV antibiotics for CAP within four hours, we do what we are told to do, whether or not the evidence of benefit is compelling.

Perhaps we've gone too far in the last decade with respect to emergency

department pain control and discharge prescriptions for outpatient pain control. While I do think that there is some truth in that, I know that we are not the drivers of this epidemic.

The DEA is appropriately and effectively getting tough. Some of the practitioners they detain have acted negligently and criminally. The public domain web site of the New York State DOH OPMC has no dearth of suspensions and revocations because of this issue.

In the year that followed the New York Times article quoted above, Albany acted, New York City acted and your New York ACEP was very involved in the regulations, guidelines and statutes that have emerged. Please contact us if you have questions or seek to get involved in our Practice Management or Government Affairs Committees. ■



National ACEP Leadership and Advocacy Conference
May 19-22, 2013 ~ Omni Shoreham Hotel ~ Washington, DC



new york acep
SCIENTIFIC ASSEMBLY
July 8-10, 2013

at the Sagamore Resort
on Lake George

New York
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

Join over 230 emergency physicians from around the state for a truly unique opportunity for stimulating, advanced education.

For more information and to register, go online to
www.nyacep.org



Ultrasound Evaluation of the Lower Extremity for DVT

Guest authors: Anita R. Datta, MD RDMS FACEP, Director, Emergency Ultrasound Division and Fellowship, New York Hospital Queens, Department of Emergency Medicine

Omar Corujo, MD RDMS, Director, Resident Ultrasound Education, New York Hospital Queens, Department of Emergency Medicine

Indications

- Leg swelling or redness
- Calf pain
- Suspicion for deep venous thrombosis (DVT) in the lower extremity
- Unexplained shortness of breath
- Unexplained hypotension
- Suspicion for pulmonary embolism

Technique

- Evaluate patient in the supine position with the head of bed elevated 30-45 degrees. Alternatively, the stretcher can be placed in reverse trendelenburg position.
- Expose the patient's leg. Place in an externally rotated position with partially flexed hip and knee. See Figure 1a.

- Use the high frequency linear array transducer (5-10 MHz). A lower frequency (curvilinear) probe may be used for obese patients.
- Point the probe marker towards the patient's right side in the transverse orientation.
- Two areas should be assessed for signs of DVT: common femoral vein (CFV) and popliteal vein (PV). See Figure 1b and 1c.
 - CFV: Begin your exam in the proximal inguinal area of the leg. Identify the intersection of the CFV and the greater saphenous vein (GSV). See Figure 2. Perform sequential compressions following the CFV distally to the bifurcation of the superficial femoral vein (SFV) and deep femoral vein (DFV).



Figure 1a, 1b and 1c: Leg placed in external rotation and partially flexed at hip and knee (1a) with linear probe distal to the inguinal crease for evaluation of the common femoral vein (1b) and then at the popliteal fossa for evaluation of the popliteal vein (1c)

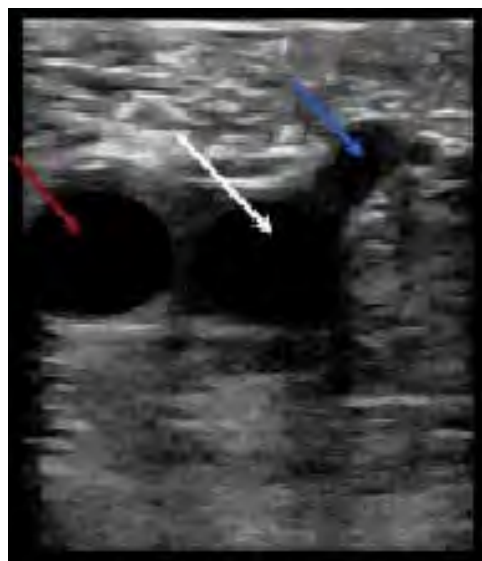


Figure 2: Normal common femoral artery (red arrow), common femoral vein (white arrow) and greater saphenous vein (blue arrow).

- Popliteal vein: Visualize the PV and perform sequential compressions distally to the trifurcation of calf veins (anterior tibial, posterior tibial and peroneal veins).

- Components of the ultrasound examination:

- Compressibility: Apply mild compression to the vein to cause collapse of the venous walls. See Figure 3a and 3b.
- Visualization: Assess for the presence of a thrombus in the venous system. See Figure 4.

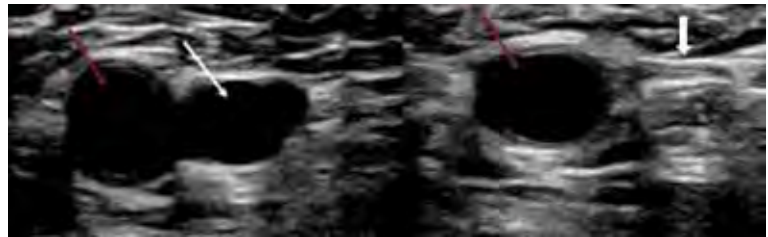


Figure 3a (left) and 3b (right): Normal common femoral artery (red arrow) and common femoral vein (thin white arrow) with normal collapse of the vein with extrinsic compression (thick white arrow).

Table 1

Signs of Deep Vein Thrombosis on Bedside Ultrasound
Lack of compressibility
Visualization of blood clot
Lack of augmentation
Lack of respiratory variation

Tips

- Other causes of swelling or pain found on ultrasonography: cellulitis, abscess, baker’s cyst, hematoma, tendon rupture.
- The exam can be limited by pain, obesity, subcutaneous air or history of a venous bypass surgery.
- Be sure to distinguish between an artery (thick wall, non-compressible), a vein (thin wall, low resistance flow) and lymph nodes (superficial with kidney-like appearance).
- The superficial femoral vein is part of the deep venous system despite its name. A thrombus in the SFV is a DVT.
- In general, if the first ultrasound is negative, strongly consider a repeat ultrasound in one week.

Featuring practical point-of-care ultrasound applications for the emergency physician. Have an ultrasound question? Email it to Dr. Lema at nyacep@nyacep.org for possible inclusion in the next issue of the EPIC. ■

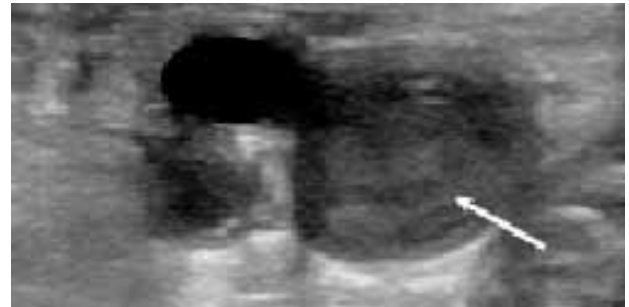


Figure 4: Visualization of a thrombus in the common femoral vein (white arrow).

We've gone social!

Become a fan and "Like" our Page. Join the conversation!

Now accepting abstracts for review for oral & poster presentation

New York ACEP 2013 Research Forum

Monday, July 8 , 1:00-4:00 pm

Sagamore Resort on Lake George

DEADLINE: APRIL 1, 2013

For abstract guidelines, go online to <http://nyacep.org/content/103-call-for-abstracts>

New York well represented on ACEP Committees

Academic Affairs Committee

Mark A Clark, MD
Jordana Haber, MD
Nicholas Nacca, MD

Education Committee

Suzanne K Bentley, MD
Richard M Cantor, MD FACEP
Eric Lane Legome, MD FACEP

EMS Committee

Robert M Bramante, MD
Donald M Doynow, MD FACEP
Suzanne Garber, MD
James Matthew Halfpenny, DO FACEP
Bradley J Kaufman, MD FACEP
Joshua Jeremiah Lynch, DO
Joseph A Zito, MD

Finance Committee

Joshua B Moskovitz, MD MPH
Andrew Sama, MD FACEP

Federal Gov't Affairs Committee

Zachary Ginsberg, MD
David C Lee, MD, FACEP

Emergency Medicine Practice Committee

James Matthew Halfpenny, DO FACEP
Hanson Hsu, MD FACEP
Jon C Kerr, MD
Stuart Gary Kessler, MD FACEP
Rahul Sharma, MD MBA FACEP
Todd Slesinger, MD FACEP

Clinical Policy Subcommittee

David S Cherkas, MD FACEP
Andy S Jagoda, MD FACEP
William F Paolo, MD
Kaushal Shah, MD FACEP
Bradley D Shy, MD
Brian Wright, MD MPH FACEP

Research Committee

Jason Erik Cohen, DO
Peter W Crane, MD MBA FACEP
Lynne D Richardson, MD FACEP
Manish Shah, MD FACEP
Muhammad Waseem, MD MS FACEP

Bylaws Committee

Virgil W Smaltz, MD MPA FACEP

Public Health/

Injury Prevention Committee

Isabel Araujo Barata, MD FACEP
Elaine Beth Josephson, MD FACEP
Eduardo Joaquin La Calle, MD
Lynne D Richardson, MD FACEP

Clinical Policy Committee

Sigrid Alena Hahn, MD
Devorah Nazarian, MD

Pediatric Emergency Medicine Committee

Jahn Thomas Avarello, MD FACEP
Isabel Araujo Barata, MD FACEP, Chair
Richard M Cantor, MD, FACEP
Jeffrey Hom, MD, FACEP
Denis Robert Pauze, MD FACEP
Muhammad Waseem, MD MS FACEP

Coding & Nonmenclature Advisory Committee

Qiuping Zhou, DO, FACEP

Ethics Committee

Jeremy Simon, MD, FACEP

Compensation Committee

Sandra M Schneider, MD FACEP

Public Relations Committee

Richard M Cantor, MD FACEP
Kristin E Harkin, MD FACEP
Jose R Torradas, MD

Well-Being Committee

Michelle Fox-Slesinger, MD FACEP
Brent E Gottesman, MD FACEP
Elaine Beth Josephson, MD FACEP

Reimbursement Committee

Brahim Ardolic, MD FACEP
Salvatore R Pardo, MD FACEP

Medical Legal Committee

Nicholas Caputo, MD
Kael Duprey, MD JD
Cheryl Schreiber Lewison, MD JD
Paul A Testa, MD JD MPH

State Legislative/Regulatory Committee

Corita R Grudzen, MD MSHS FACEP

Quality & Performance Committee

Jay Miller Brenner, MD FACEP
Michael Richard Jorolemon, DO FACEP
Salvatore R Pardo, MD FACEP
Todd Slesinger, MD FACEP

Disaster Preparedness & Response Committee

Jason Erik Cohen, DO
David S Markenson, MD FACEP
Joan Ellen McInerney, MD FACEP

2012-13 Officers

President

Daniel G. Murphy, MD MBA FACEP
Good Samaritan Hospital Medical Center; Catholic Health System of Long Island, 631/376-4094

President-elect

Louise A. Prince, MD FACEP
SUNY Upstate Medical University, 315/464-4235

Secretary-Treasurer

Brahim Ardolic, MD FACEP
Staten Island University Hospital, 718/226-9158

Immediate Past President

Joel M. Bartfield, MD FACEP
Albany Medical Center, 518/262-7302

Executive Director

JoAnne Tarantelli
New York ACEP, 585/872-2417

2012-13 Board Members

Jay M. Brenner, MD FACEP
SUNY Upstate Medical University, 315/464-4363

Susan Cheng, MD *resident representative*
SUNY Health Sciences Center at Brooklyn,
718/245-3318

Jeremy T. Cushman, MD MS FACEP
University of Rochester, 585/463-2900

Keith E. Grams, MD FACEP
Rochester General Health System, 585/276-3653

Sanjey Gupta, MD FACEP
New York Hospital Queens, 718/670-1426

Stuart G. Kessler, MD FACEP
Elmhurst Hospital Center, 718/334-3050

David C. Lee, MD FACEP
North Shore University Hospital, 516/562-1252

Penelope C. Lema, MD RDMS FACEP
University of Rochester, 585/463-2925

David H. Newman, MD FACEP
Mount Sinai School of Medicine, 212/824-8067

Gary S. Rudolph, MD FACEP
North Shore University Hospital, 526/562-3090

Andrew E. Sama, MD FACEP
North Shore University Hospital, 516/562-3090

Kaushal Shah, MD FACEP
Elmhurst Hospital Center, 718/334-1454



Prehospital Medication Shortages

*David Lobel, MD, FACEP, Medical Director, Prehospital Care;
Assistant Medical Director, Emergency Department,
Maimonides Medical Center*

Emergency physicians who have been in practice for more than a few years have certainly seen a medication or two become temporarily unavailable. In the last few years however, there has been an unprecedented increase in the number of medications that have been unavailable for extended periods of time. As I write this article there are approximately 120 medications listed on the Federal Drug Administration's Current Drug Shortages Index. Included among these are dextrose solution, diazepam, atropine, etomidate, epinephrine, sodium bicarbonate, lorazepam, midazolam and succinylcholine. That is enough to make you reach for the ondansetron which is also on the list. These shortages are at best a minor inconvenience in the emergency department where we might have to reach out to a central hospital pharmacy for alternative medications, but in the prehospital setting where our paramedics must work within the confines of the ambulance's drug bag and the confines of specified protocols this is a substantial obstacle. The lack of availability of a medication or class of medications poses several problems for prehospital providers, including adaptation of protocols and credentialing and dispatch of the correct level of provider. In this article I will elaborate on the hurdles medication shortages pose for prehospital providers and address some of the ways it may affect us as receiving physicians.

While in the emergency department we can execute a quick switch from methylprednisolone to dexamethasone with only a brief pause to recall the difference in dose. Executing that swap in a protocol driven environment with regional and state oversight requires an emergency protocol change that must be approved by one or more governing bodies, and may then be subject to public review. Once a protocol revision is approved, providers must be educated with regards to the change and

familiarized with the alternative medication – dose, route of administration, contraindications, preparation and specifics of administration (solution, push versus infusion, etc.). The final step then is to distribute the medication to the ambulances utilizing proper safety and storage techniques. In some instances this may take more time than it takes for the original medication to become available again. Once the original medication does become available, the question remains whether protocol changes will again be required.

In some instances we are dealing with medications that do not have within class substitutions, or in the case of the benzodiazepines, several medications within that class that have all been unavailable at the same time. In these instances the stakes are considerably higher. Dispatch is based on the expectation that certain illnesses require a certain level of care. In the case of a patient with seizures, Basic Life Support (BLS) will not have the ability to administer medications to stop active seizures so Advanced Life Support (ALS) may be dispatched. If benzodiazepines are not available the question then arises whether BLS should be dispatched to transport the patient without treatment or whether perhaps ALS should be dispatched anyway in the event that the seizures might be controlled by other means. In the New York City Region the issue is even further complicated by the number of different services that participate in the 911 system, each with its own supply and shortage of medications. Here the question has risen what is the minimum availability of medications to qualify an ambulance to be suited for dispatch as an ALS unit. We certainly would not want a patient waiting on the scene for an ALS unit only to find that the needed therapy is unavailable. One solution is to dispatch the nearest unit – BLS or ALS, and either transport or call dispatch for specific modalities as needed

once on the scene. Another possibility is the use of non-transporting "fly-cars" bringing the limited resources to where they are needed.

The medications that have had the most impact in the New York Region include etomidate, which is frequently employed as a sole agent to facilitate orotracheal intubation, benzodiazepines which are used for management of seizures, agitation, and for sedation after intubation, and fentanyl which has been used for prehospital analgesia.

For those of us involved in Emergency Medical Services coordination and planning, our work is cut out for us. As we adapt new protocols to update the science and pharmacology offered in prehospital care we will need to anticipate and provide for medication shortages that have become all too common place. For the practicing emergency medicine physician we may first and foremost wish to prepare ourselves by having second and even third line medications readily available in our department and near the bedside.

From a practical perspective medication shortages in the field could translate into more patients presenting with ongoing seizures or agitation. When medications used to facilitate intubation are unavailable, we may even see more patients arriving in respiratory distress who might otherwise have arrived intubated in the field. Likewise, the shortages can affect our patterns of dispatch so that we don't always see advanced providers in situations where we are accustomed. In anticipation of these situations we should be prepared to have the proper medications available at the bedside, we should be prepared to take control of the airway rapidly, and we should anticipate some of the secondary disturbances that may result from prolonged seizures, agitation or hypoxia.

As emergency physicians we are generally entrusted with the responsibilities of emergency preparedness. The lack of availability of certain medications may pose such an emergency and so we should be prepared to respond with alternative medications in our department and close to the bedside. In response to the effect of shortages on prehospital care we should be prepared to receive patients who may not have been treated to the extent they would have under normal circumstances. ■



How Does Alcohol Cause “Holiday Heart?”

Guest author Andrew Sturm, MD, Attending, North Shore University Hospital-Manhasset

Atrial fibrillation is the most commonly diagnosed arrhythmia, affecting more than 2.2 million Americans. From the Framingham data, the lifetime risk of developing atrial fibrillation after age 40 has been found to be 26.0 percent for men and 23.0 percent for women.^{1,8} In addition patients have a 1.5-2 fold increase in mortality rate when compared with the general population.¹

Atrial fibrillation (AF) is usually associated with underlying heart disease that is complicated by heart failure and atrial enlargement, an elevation in atrial pressure, or infiltration or inflammation of the atria. However, some patients have Lone Atrial Fibrillation (LAF), in which there is no underlying structural heart disease. Patients with LAF often associate certain triggers with episodes of AF. In a prospective study of 181 patients with atrial fibrillation and a normal echocardiography reported triggers for atrial fibrillation included sleeping (44%), exercise (36%), alcohol use (36%), and eating (34%).¹²

In 1978, Ettinger et al, evaluated 24 patients who experienced 32 arrhythmias after taking part in a weekend or holiday drinking binge. He noticed that these patients developed supraventricular tachyarrhythmias (primarily atrial fibrillation) and coined the term “Holiday Heart Syndrome.” Since then, there have been various mechanisms proposed in an attempt to better understand the association of alcohol and atrial fibrillation. These include, but are not limited to, increased catecholamine secretion, increased sympathetic output and the effect of alcohol on ion currents.

In an article by Howes et al, changes in plasma free 3,4-dihydroxyphenylethylene glycol (NE metabolite) and noradrenaline

levels after acute alcohol administration were investigated.⁶ The effects of alcohol (0.9 g/kg) were compared with placebo (400 ml of orange juice) in eight normal male volunteers. Alcohol caused a rise in noradrenaline levels and a decrease in the levels of its metabolite, suggesting that alcohol not only increases NE but decreases its metabolism. In addition, an article by Perman et al, alcohol was shown to increase the amounts of adrenaline and noradrenaline in the blood from one adrenal in anesthetized cats. Recently an article by Maki et al, studied the heart rate variability and parameters of the adrenergic system during alcohol intake, hangover and exercise. Although the study did not show a significant difference in the catecholamine levels between the AF group and controls, the AF group had a significant increase in B-adrenoceptor density. In addition, the analysis of heart rate variability revealed an increase in sympathetic/parasympathetic component ratio in the AF patients. From these articles, alcohol ingestion is shown to effect the release of catecholamine’s and the sympathetic response.

An article by Klein et al, investigated the effect of ethanol on HEK-293 cells over expressing the human cardiac sodium channel (Na1.5). Single channel availability, open probability and peak average current were assessed baseline and after addition of ethanol in increasing concentrations (0.5%, 1%, 2% and 4%). The authors found a concentration-dependent reduction of open probability which was statistically significant at 2 and 4% ethanol (66.5 of control). This resulted in a significant decrease of peak average current at 2% and at 4% ethanol (61.8 and 53.0% of control). Sodium current has been shown to play a major

role in the upstroke of the action potential in atrial myocytes and has been found to be an important determinant of conduction velocity in cardiac tissue.⁵

Another article by Laszlo et al, analyzed whether sustained short-term alcohol infusion can induce atrial remodeling in rabbits. Rabbits in the ethanol group received 120 hrs of ethanol infusion (BAC >158mg/dl), while the control group received normal saline. Ethanol infusion resulted in a significant reduction in calcium and sodium current densities. Previous studies have show that attenuation of I_{Na} and I_{Ca} result in shortening of the atrial action potential duration.⁵ This decrease in atrial wavelength is believed to be the cause for the pro-arrhythmic effect.

In contrast, Fenelon et al, evaluated the effects of alcohol in dogs at baseline, and after two cumulative ethanol doses. They discovered that although ethanol depressed LV systolic function, it did not affect atrial electrophysiological parameters. Their findings suggested that acute alcohol ingestion does not directly promote atrial arrhythmias.

From these articles, the mechanism of alcohol induced atrial fibrillation is multifaceted and remains unclear.

References

1. Benjamin EJ, Wolf PA, D’Agostino RB, Silbershatz H, Kannel WB, Levy D. Impact of atrial fibrillation on the risk of death: the Framingham Heart Study. *Circulation*. Sep 8 1998;98(10):946-52.
2. Conen D, Tedrow UB, Cook NR, Moorthy MV, Buring JE, Albert CM. Alcohol consumption and risk of incident atrial fibrillation in women. *JAMA* 2008;300:2489-96.

continued on next page

continued from page 8

3. Ettinger, PO, Wu, CF, De La Cruz, C Jr, et al. Arrhythmias and the "holiday heart." Alcohol associated cardiac rhythm disorders. *Am Heart J* 1978; 95:555.
4. Fenelon G, Balbao CE, Fernandes R, Arfelli E, Landim P, Ayres O, et al. Characterization of the acute cardiac electrophysiologic effects of ethanol in dogs. *Alcohol Clin Exp Res*. Sep 2007;31(9):1574-80.
5. Gaspo R, Bosch RF, Talajic M, et al. Functional mechanisms underlying tachycardia-induced sustained atrial fibrillation in a chronic dog model. *Circulation*. 1997;96:4027-4035
6. Howes LG, Reid JL: Changes in plasma free 3,4-dihydroxyphenylethylene glycol and noradrenaline levels after acute alcohol administration. *Clin Sci* 69:423, 1985
7. Klein G, Gardiwal A, Schaefer A, Panning B, Breitmeier D. Effect of ethanol on cardiac single sodium channel gating. *Forensic Sci Int*. Sept 2007;171:131-5.
8. Lloyd-Jones DM, Wang TJ, Leip EP, et al: Lifetime risk for development of atrial fibrillation: the Framingham Heart Study. *Circulation* 2004; 110:1042.
9. Maki T, Toivonen L, Koskinen P, Naveri H, Harkonen M, Leinonen H. Effect of ethanol drinking, hangover, and exercise on adrenergic activity and heart rate variability in patients with a history of alcohol induced atrial fibrillation. *Am J Cardiol* 1998;82:317-22.
10. Mukamal KJ, Tolstrup JS, Friberg J, Jensen G, Gronbaek M. Alcohol consumption and risk of atrial fibrillation in men and women: the Copenhagen City Heart Study. *Circulation* 2005;112:1736-42.
11. Perman S: The effect of ethyl alcohol on the secretion from adrenal medulla in man. *Acta Physiol Scand* 44:241, 1958
12. Patton, KK, Zacks, ES, Chang, JY, et al. Clinical subtypes of lone atrial fibrillation. *Pacing Clin Electrophysiol* 2005; 28:630.

Have a toxicology question? Email it to Dr. Lee at nyacep@nyacep.org for possible inclusion in the next issue of the EPIC. ■

**New York American College of
Emergency Physicians**
1130 Crosspointe Lane, Suite 10B
Webster, NY 14580-2986
(585) 872-2417 phone
(585) 872-2419 fax
www.nyacep.org online

empire state
EPIC


© 2013

EMPIRE STATE EPIC is the newsletter of the New York American College of Emergency Physicians (New York ACEP). The opinions expressed in this newsletter are not necessarily those of New York ACEP. New York ACEP makes a good faith effort to ascertain that contributors are experts in their field. Readers are advised that the statements and opinions expressed by the author are those of the author and New York ACEP does not accept responsibility for information or statements made by contributing authors.

NEWS STAFF . JoAnne Tarantelli, *Executive Director*
Betsy Hawes, *Director of Marketing & Communications*

New York ACEP presents
**Careers in Emergency Medicine
MEDICAL STUDENT SYMPOSIUM**

THURSDAY MARCH 14, 2013
SUNY DOWNSTATE MEDICAL CENTER
ALUMNI AUDITORIUM



6:00-9:00 pm Symposium
9:00-10:00 pm Refreshments & Residency Fair
An opportunity to speak with residency directors and residents from New York State Emergency Medicine Residency Programs

Registration for medical students is free.
Pre-registration required at www.nyacep.org



Maimonides
Medical Center

The Department of Emergency Medicine at Maimonides Medical Center has an available position for a BC/BE Emergency Physician interested in working in our high volume, high acuity academic community facility. Maimonides, a nationally recognized teaching hospital and research center, is a 705 bed tertiary medical center with an annual ED census of 118,000 patients, a dedicated Pediatric ED, Level 2 trauma designation, 48 Emergency Medicine residents, and fellowships in Pediatric Emergency Medicine, Medical Education, Emergency Ultrasonography, and Simulation. Maimonides offers a highly competitive salary and consistently receives accolades for patient outcomes and its cutting edge IT infrastructure. Emergency Physicians who enjoy working in an academic environment as well as living in or around New York City are encouraged to contact:

John Marshall, MD, Chairman
Department of Emergency Medicine
Maimonides Medical Center
4802 Tenth Avenue, Brooklyn, NY 11219
Tel: (718) 283-6031; fax (718) 635-7274
email: jmarshall@maimonidesmed.org



Albany Update

Weingarten, Reid & McNally, New York ACEP
Legislative & Regulatory Representatives

2013-14 Proposed State Budget

On Tuesday, January 22, 2013, Governor Cuomo released his 2013-14 proposed State Budget. The plan provides All Funds spending of \$142.6 billion, including \$6 billion in extra federal funds for Hurricane Sandy relief and Medicaid under President Obama's Affordable Healthcare Act. The proposal raises spending by more than five percent over the current budget plan.

The Governor's Budget contains many new proposals of interest to New York ACEP, including significant revisions to the Excess Medical Malpractice Insurance Pool (MMIP), expansions in scope of practice for health care providers, and consolidation of the State's EMS program. These and other key programs are highlighted below.

Excess Medical Malpractice Insurance Pool (MMIP)

The Budget appropriation for the MMIP program is reduced by approximately \$12.7 million, from \$127.4 million to \$114.7 million.

In addition, the current law governing the program, Section 18 of Chapter 266 of the Laws of 1986, is repealed and a new Section 23 is added to the Public Health Law which prioritizes funding to support doctors in high-risk specialties who practice at hospitals in high risk areas. The bill contains no definition of "high risk." Once the high risk physicians are enrolled in MMIP, any remaining enrollment will be on a "first-come, first-served" basis subject to the availability of remaining funds, if any, in the pool.

The proposal limits eligibility for Excess coverage to a physician or dentist who:

- has professional privileges in the general hospital that is certifying the physician's or dentist's eligibility;

- from time-to-time provides emergency medical or dental services, including emergency medical screening examinations, treatment for emergency medical conditions, including labor and delivery, or treatment for emergency dental conditions to persons in need of such treatment at the general hospital that is certifying their eligibility; and
- accepts Medicaid

In addition, the physician or dentist must have in force coverage under an individual policy or group policy written in accordance with the provisions of the insurance law from an insurer licensed in this state to write personal injury liability insurance of primary malpractice insurance coverage in amounts of no less than \$1.3M/\$3.9M; or is endorsed as an additional insured under a voluntary attending physician ("channeling") program previously permitted by the superintendent of insurance and covering the same time period as the equivalent excess coverage.

Scope of Practice

The Governor's Budget includes a series of proposals for scope of practice changes as recommended by the Medicaid Redesign Team (MRT). Summarized below are those of interest to New York ACEP.

- *Nurse Practitioner:* Eliminates the requirements for written collaboration agreements and written practice protocols between certified nurse practitioners and licensed physicians for nurse practitioners providing only primary care services, if they demonstrate to New York State Department of Health (NYSDOH) in consultation with

the Education Department that it is not reasonable to require such agreement or practice protocols.

- *Physician Assistant:* Revises the number of physician assistants that can be supervised by a physician from two to four in the physician's private practice and from supervising four to six assistants when such physician is employed by or renders services to the Department of Corrections and Community Supervision (DOCCS).
- *Registered Dental Hygienist:* Clarifies that a registered dental hygienist may not administer or monitor nitrous oxide analgesia or local infiltration anesthesia except under certain specified conditions.
- *Registered Dental Hygienist:* Authorizes a registered dental hygienist working for a hospital to practice pursuant to a collaborative arrangement with a licensed dentist pursuant to regulations promulgated under Public Health Law (PHL) Article 28.
- *Registered Dental Hygienist:* Repeals language providing that a registered dental hygienist may perform dental supportive services only under a dentist's supervision in conformance with the other changes made in the bill.
- *Registered Dental Hygienist:* Clarifies that a registered dental hygienist who x-rays the mouth or teeth of a patient during the performance of dental services must work under the direct supervision of a dentist. This section would also require a registered dental

hygienist who practices in collaboration with a licensed dentist for a hospital to be certified in cardiopulmonary resuscitation (“CPR”).

- **Registered Dental Hygienist:** Authorizes a registered dental hygienist to sign a dental health certificate, thereby certifying the dental health of students in public schools. This section would also add dental practices and registered dental hygienists to the current list of dental services provided on a free or reduced cost basis that schools must make available upon request.

Emergency Medical Services (EMS)

Significant changes are proposed to the State’s EMS program including consolidation into a single State Emergency Medical Services Advisory Board (SEMSAB) the following four bodies:

State Emergency Medical Services Council (SEMSCO);

State Emergency Medical Advisory Committee (SEMAC);

State Trauma Advisory Committee (STAC); and

Emergency Medical Services for Children Council (EMS-C).

The new board, SEMSAB, would be authorized to form technical advisory groups to address issues currently under the purview of SEMAC, SAC and EMS-C. In addition, the 18 Regional Emergency Medical Services Council (REMSCOs) would be consolidated into 10 units.

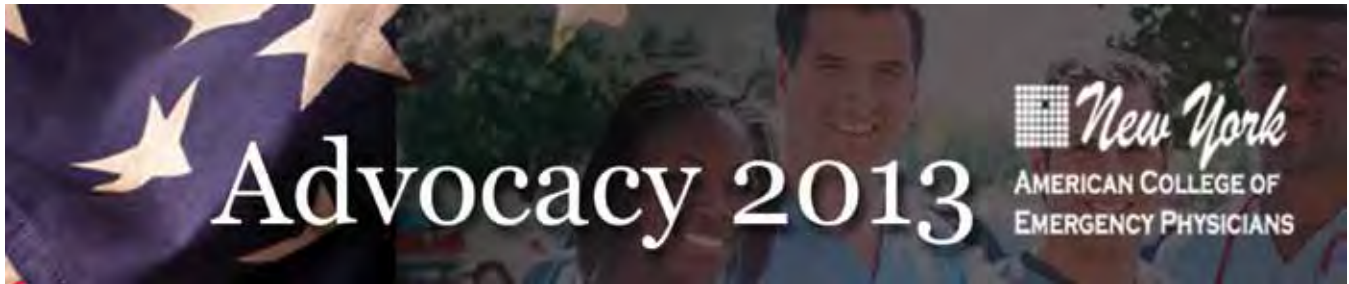
New York ACEP Annual Lobby Day, February 12, 2013

On Tuesday, February 12, members of the New York ACEP Board and some of their colleagues travel to Albany for the

annual lobby day to meet with key legislators and staff on New York ACEP’s 2013 legislative priorities: Access to Care; Fair Payment for Emergency Physicians; Medical Liability Protection for Emergency Care Providers under EMTALA; Opposition to Nurse Practitioners’ Scope of Practice Expansion; and Physician Involvement in Emergency Medical Services.

Members will meet with top staff in the Department of Health, the Department of Financial Services, and the Chairpersons of the Health and Insurance Committees in both houses. Members will also meet with their own Senators and Assembly members while in Albany.


Following Lobby Day, we will work with New York ACEP to continue to keep members apprised of activities in Albany through Action Alerts and other calls for grassroots activities to advance New York ACEP’s goals. ■



empire state epic

advertising

Reach over 2,300
emergency physicians



Size (width x height)	Full Color	Black & White	
Outside Back Cover (7" x 7.5")	\$1,300	n/a	Reserved for 2013
Inside Front Cover (7" x 9.5")	\$1,200	n/a	Reserved for 2013
Inside Back Cover (7" x 9.5")	\$1,100	n/a	
Full Page (7" x 9.5")	\$1,000	\$500	
Half Page (7" x 4.75" or 3.5" x 9.5")	\$600	\$300	
Quarter Page (3.5" x 4.75")	\$400	\$200	
One-Eighth Page (3.5" x 2.375" or 2.375" x 3.5")	\$300	\$150	

Classified Advertising
Sixty words or less, \$100 per issue; \$1 for each additional word. Minimum line charge \$100.

To advertise, contact New York ACEP at nyacep@nyacep.org

DOES YOUR WORKLOAD RESEMBLE RAGING BULLS?



Let MMP turn your chaos to calm.

If your day-to-day operations are chaotic, Medical Management Professionals (MMP) can deliver state-of-the-art billing processes, sophisticated chart reconciliation, denial management and payor specific coding services to your practice. In fact, it has billed over 93 million visits since its inception. The results for emergency medicine practices are increased revenues, reduced compliance risk and reduced stress for administrators and physicians.

Counter your chaos with a calming force.



1.877.541.9690 | www.cbizmmp.com

New York State of Mind



This column is compiled by Theodore J. Gaeta, DO MPH FACEP, Residency Program Director at New York Methodist Hospital; and Member, New York ACEP Research Committee.

Hyperkalemic Recurrent Bilateral Lower Extremity Weakness in a Patient on Hemodialysis.

Hassen GW, Newstead S, Giordano LM, Department of Emergency Medicine, Metropolitan Hospital Center, New York; Case Rep Emerg Med. 2012;2012:243501

Hyperkalemia is a severe life-threatening electrolyte disorder that commonly affects the cardiac conductivity and contractility. Ascending paralysis affecting the extremities with focal neurological deficit as well as quadriplegia and a seizure associated with hyperkalemia has been reported in the literature. Here, we describe a case of isolated recurrent lower extremity paralysis and an episode of seizure in an 83-year-old patient with end-stage renal disease on hemodialysis.

Isolated Torticollis May Present as an Atypical Presentation of Meningitis.

Chirurgi R, Kahlon S, Emergency Department, New York Medical College, Metropolitan Hospital Center, New York; Case Rep Emerg Med. 2012;2012:193543

BACKGROUND: Bacterial meningitis is a life-threatening medical emergency that requires urgent diagnosis and treatment. Diagnosis is infrequently missed if the patient presents with the classic symptoms of fever, headache, rash, nuchal rigidity, or Kernig or Brudzinski sign. However, it

may be less obvious in neonates, elderly, or immunocompromised patients. Meningitis which presents as isolated torticollis, without any other signs or symptoms, is exceedingly rare.

OBJECTIVE: To identify an abnormal presentation of meningitis in an adult immunocompromised patient.

CASE REPORT: We present a case of an adult diabetic male who presented multiple times to the ED with complaint of isolated torticollis, who ultimately was diagnosed with bacterial meningitis.

CONCLUSION: We propose that in the absence of sufficient explanation for acute painful torticollis in an immunocompromised adult patient, further evaluation, possibly including a lumbar puncture may be warranted.

Opioid Receptor Polymorphism A118G Associated with Clinical Severity in a Drug Overdose Population.

Manini AF, Jacobs MM, Vlahov D, Hurd YL, Division of Medical Toxicology, Department of Emergency Medicine, Mount Sinai School of Medicine, Elmhurst Hospital Center, New York; J Med Toxicol. 2013 Jan 15

Genetic variations in the human mu-opioid receptor gene (OPRM1) mediate individual differences in response to pain and opiate addiction. We studied whether the common A118G (rs1799971) mu-opioid receptor single nucleotide polymorphism (SNP) was associated with overdose severity in humans. In addition, we examined an SNP responsible for alternative splicing of OPRM1 (rs2075572). We assessed allele frequencies of the above SNPs and as-

sociations with clinical severity in patients presenting to the emergency department (ED) with acute drug overdose. This work was designed as an observational cohort study over a 12-month period at an urban teaching hospital. Participants consisted of consecutive adult ED patients with suspected acute drug overdose for whom discarded blood samples were available for analysis. Specimens were linked with clinical variables (demographics, urine toxicology screens, clinical outcomes) then deidentified prior to genetic SNP analysis. Blinded genotyping was performed after standard DNA purification and whole genome amplification. In-hospital severe outcomes were defined as either respiratory arrest (RA; defined by mechanical ventilation) or cardiac arrest (CA; defined by loss of pulse). We analyzed 179 patients (61% male, median age 32) who overall suffered 15 RAs and four CAs, of whom three died. The 118G allele conferred 5.3-fold increased odds of CA/RA ($p < 0.05$), while the rs2075572 variant allele was not associated with CA/RA. The 118G variant allele in the OPRM1 gene is associated with worse clinical severity in patients with acute drug overdose. These findings mark the first time that the 118G variant allele is linked with clinical drug overdose vulnerability.

The Usefulness of Procalcitonin in the Diagnosis of Appendicitis in Children: A Pilot Study.

Khan AN, Sawan A, Likourezos A, Schnellinger M, Garcia E, Department of Emergency Medicine, Maimonides Medical Center, Brooklyn; Emerg Med Int. 2012;2012:317504

OBJECTIVE: To assess the predictive value of procalcitonin in detecting acute appendicitis (AP) in children, and to determine a cutoff value of procalcitonin which can safely include/exclude the diagnosis of acute appendicitis in children with acute abdominal pain.

METHODS: Prospective cohort study of children aged 5-17 years presenting to the emergency room with right lower quadrant (RLQ) tenderness and strong suspicion for acute AP. In addition to standard diagnostic workup for acute AP, a quantitative procalcitonin level was measured using immunoluminometric assay. Recursive partitioning model was used to assess the usefulness of procalcitonin in the diagnosis of appendicitis.



New York State of Mind

RESULTS: Of the 50 children studied, 48% were diagnosed to have AP. The mean procalcitonin level was higher among the children with appendicitis ($P = 0.3$). Using the recursive partitioning model, we identified a cutoff value of procalcitonin level of 0.39 with a likelihood ratio presence of appendicitis 3.25 and absence of appendicitis 0.8. None of the study subjects with procalcitonin level <0.39 and WBC count of <6.76 K had appendicitis.

CONCLUSIONS: In conjunction with the clinical symptoms, a procalcitonin level and WBC count could be a strong predictor of acute appendicitis in children.

Disasters and Women's Health: Reflections from the 2010 Earthquake in Haiti.

Bloem CM, Miller AC, Departments of Emergency Medicine, State University of New York Downstate Medical Center and Kings County Hospital Center, Brooklyn; Prehosp Disaster Med. 2013 Jan 4:1-5

INTRODUCTION: Increasing attention is being focused on the needs of vulnerable populations during humanitarian emergency response. Vulnerable populations are those groups with increased susceptibility to poor health outcomes rendering them disproportionately affected by the event. This discussion focuses on women's health needs during the disaster relief effort after the 2010 earthquake in Haiti.

REPORT: The Emergency Department (ED) of the temporary mobile encampment in L'Hôpital de l'Université d'Etat d'Haïti (HUEH) was the site of the team's disaster relief mission. In February 2010, most of the hospital was staffed by foreign physicians and nurses, with a high turnover rate. Although integration with local Haitian staff was encouraged, implementation of this practice was variable. Common presentations in the ED included infectious diseases, traumatic injuries, chronic disease exacerbations, and follow-up care of post-earthquake injuries and infections. Women-specific complaints included vaginal infections, breast pain or masses, and pregnancy-related concerns or complications. Women were also targets of gender-based violence.

DISCUSSION: Recent disasters in Haiti, Pakistan, and elsewhere have challenged the international health community to provide gender-balanced health care in suboptimal environments. Much room for improvement remains. Although the assessment team was gender-balanced, improved incorporation of Haitian personnel may have enhanced patient trust, and improved cultural sensitivity and communication. Camp geography should foster both patient privacy and security during sensitive examinations. This could have been improved upon by geographically separating men's and women's treatment areas and using a barrier screen to generate a more private examination environment. Women's health supplies must include an appropriate exam table, emergency obstetrical and midwifery supplies, urine dipsticks, and sanitary and reproductive health supplies. A referral system must be established for patients requiring a higher level of care. Lastly, improved inter-organization communication and promotion of resource pooling may improve treatment access and quality for select gender-based interventions.

CONCLUSION: Simple, inexpensive modifications to disaster relief health care settings can dramatically reduce barriers to care for vulnerable populations.

Even 'Safe' Medications Need to Be Administered with Care.

Lutwak N, Howland MA, Gambetta R, Dill C, Department of Emergency Medicine, VA New York Harbor Healthcare Center, NYU School of Medicine, New York; BMJ Case Rep. 2013 Jan 2

A 60-year-old man with a history of hepatic cirrhosis and cardiomyopathy underwent transoesophageal echocardiogram. He received mild sedation and topical lidocaine. During the recovery period the patient developed ataxia and diplopia for about 30 mins, a result of lidocaine toxicity. The patient was administered a commonly used local anaesthetic, a combination of 2% viscous lidocaine, 4% lidocaine gargle and 5% lidocaine ointment topically to the oropharynx. The to-

tal dose was at least 280 mg. Oral lidocaine undergoes extensive first pass metabolism and its clearance is quite dependent on rates of liver blood flow as well as other factors. The patient's central nervous system symptoms were mild and transient but remind us that to avoid adverse side effects, orally administered drugs with fairly high hepatic extraction ratio given to patients with chronic liver disease need to be given in reduced dosages. Even 'Safe' medications need to be carefully administered.

Diagnosing Pulmonary Edema: Lung Ultrasound Versus Chest Radiography.

Martindale JL, Noble VE, Liteplo A, Kings County/SUNY Downstate, Brooklyn; Eur J Emerg Med. 2012 Dec 20

BACKGROUND: Diagnosing the underlying cause of acute dyspnea can be challenging. Lung ultrasound may help to identify pulmonary edema as a possible cause.

OBJECTIVE: To evaluate the ability of residents to recognize pulmonary edema on lung ultrasound using chest radiographs as a comparison standard.

METHODS: This is a prospective, blinded, observational study of a convenience sample of resident physicians in the Departments of Emergency Medicine (EM), Internal Medicine (IM), and Radiology. Residents were given a tutorial on interpreting pulmonary edema on both chest radiograph and lung ultrasound. They were then shown both ultrasounds and chest radiographs from 20 patients who had presented to the emergency department with dyspnea, 10 with a primary diagnosis of pulmonary edema, and 10 with alternative diagnoses. Cohen's κ values were calculated to describe the strength of the correlation between resident and gold standard interpretations.

RESULTS: Participants included 20 EM, 20 IM, and 20 Radiology residents. The overall agreement with gold standard interpretation of pulmonary edema on lung ultrasound (74%, $\kappa=0.51$, 95% confidence interval 0.46-0.55) was superior to chest radiographs (58%, $\kappa=0.25$, 95% confidence interval 0.20-0.30) ($P<0.0001$). EM residents interpreted lung ultrasounds more accurately than IM residents. Radiology residents interpreted chest radiographs more accurately than did EM and IM residents.

CONCLUSION: Residents were able to more accurately identify pulmonary edema with lung ultrasound than with chest radiograph. Physicians with minimal exposure to lung ultrasound may be able to correctly recognize pulmonary edema on lung ultrasound.

Baclofen Withdrawal Presenting as Irritability in a Developmentally Delayed Child.

Lim CA, Cunningham SJ, Pediatric Emergency Medicine, Jacobi Medical Center/Albert Einstein College of Medicine, Bronx; West J Emerg Med. 2012 Sep;13(4):373-5

Irritability in children has a broad differential diagnosis, ranging from benign processes to life-threatening emergencies. In children with comorbid conditions and developmental delay, the diagnostic process becomes more challenging. This case report describes a developmentally delayed 14-year-old boy who presented with pain and crying caused by a malfunction of a surgically implanted baclofen pump. We describe recommendations concerning the diagnostic evaluation, medical management, and surgical repair.

The Accuracy of the Olfactory Sense in Detecting Alcohol Intoxication in Trauma Patients.

Malhotra S, Kasturi K, Abdelhak N, Paladino L, Sinert R, Department of Emergency Medicine, SUNY Downstate Medical Center and Kings County Hospital, Brooklyn; Emerg Med J. 2012 Dec 14

INTRODUCTION: A common presentation to the emergency department (ED) is the trauma patient with altered sensorium who is presumed to be alcohol intoxicated by physicians based on their olfactory sense. ED physicians may often leave patients suspected of alcohol intoxication aside until the effects wear off, potentially missing trauma as the source of confusion. This often results in delays in diagnosing acute potentially life-threatening injuries in patients with presumed alcohol intoxication.

OBJECTIVE: This study aimed to determine the accuracy of a physician's olfactory sense for diagnosing alcohol intoxication.

METHODS: Patients suspected of major trauma in the ED underwent an evaluation

by the examining physician for alcohol odour and a blood alcohol level. Alcohol intoxication was defined as a serum ethanol level ≥ 80 mg/100 ml. Data were reported as means with 95% CI or proportions with IQR 25-75%.

RESULTS: 151 patients (70% men) were enrolled, with a median age of 45 years (IQR 33-56). The prevalence of alcohol intoxication was 43% (95% CI 35% to 51%).

OPERATING CHARACTERISTICS: Physician assessment of alcohol intoxication: sensitivity 84% (95% CI 73% to 92%), specificity 87% (95% CI 78% to 93%), positive likelihood ratio 6.6 (95% CI 3.8 to 11.6), negative likelihood ratio 0.18 (95% CI 0.1 to 0.3) and accuracy 86% (95% CI 80% to 91%). 7.3% (95% CI 4% to 13%) of patients were falsely suspected of being intoxicated.

CONCLUSIONS: Although the physicians had a high degree of accuracy in identifying patients with alcohol intoxication based on their olfactory sense, they still falsely overestimated intoxication in significant numbers of non-intoxicated trauma patients.

OUTSTANDING EM OPPORTUNITIES

- ✓ Earn up to \$250/hour (depending on the site)
- ✓ Programs for Residents: availability varies—ask for details
- ✓ Career development/advancement opportunities
- ✓ 6 sites to choose from with volumes ranging from 12K to 45K
- ✓ Many sites are commutable from the New York City metro area

MedExcel USA, Inc. MedExcel USA, Inc. is a regional Emergency Medicine, Urgent Care and Hospitalist Management Service Organization that has openings for EM physicians and residents looking to practice in New York state and Missouri. From low volume EDs to state-of-the-art urban trauma centers, MedExcel USA, Inc. provides physicians with a wide variety of practice settings. We have been recognized for our programs designed to improve patient flow and offer a quality driven, physician friendly environment with unparalleled career opportunities and professional development.

MedExcel USA, Inc. offers a compensation package that includes an extremely competitive hourly rate, modified RVU bonus system, profit sharing and occurrence malpractice.



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



New York State of Mind

Experience Curves as an Organizing Framework for Deliberate Practice in Emergency Medicine Learning.

Pusic MV, Kessler D, Szyld D, Kalet A, Pecaric M, Boutis K, Department of Emergency Medicine, New York University School of Medicine, New York; Acad Emerg Med. 2012 Dec;19(12):1476-80

Deliberate practice is an important skill-training strategy in emergency medicine (EM) education. Learning curves display the relationship between practice and proficiency. Forgetting curves show the opposite, and demonstrate how skill decays over time when it is not reinforced. Using examples of published studies of deliberate practice in EM we list the properties of learning and forgetting curves and suggest how they can be combined to create experience curves: a longitudinal representation of the relationship between practice, skill acquisition, and decay over time. This framework makes explicit the need to avoid a piecemeal, episodic approach to skill practice and assessment in favor of more emphasis on what can be done to improve durability of competence over time. The authors highlight the implications for both educators and education researchers.

Acute Pain Management in Older Adults in the Emergency Department.

Hwang U, Platts-Mills TF, Department of Emergency Medicine, Mount Sinai School of Medicine, New York; Clin Geriatr Med. 2013 Feb;29(1):151-64

Effective treatment of acute pain in older patients is a common challenge faced by emergency providers. Because older adults are at increased risk for adverse events associated with systemic analgesics, pain treatment must proceed cautiously. Essential elements to quality acute pain care include an early initial assessment for the presence of pain, selection of an analgesic based on patient-specific risks and preferences, and frequent reassessments and retreatments as needed. This article describes current knowledge regarding the assessment and treatment of acute pain in older adults.

Evisceration of Small Bowel After Cauterization of an Umbilical Mass.

Kondrich J, Woo T, Ginsburg HB, Levine DA, Division of Pediatric Emergency Medicine, New York University Langone Medical Center, New York; Pediatrics. 2012 Dec;130(6):e1708-10

The omphalomesenteric duct (OMD), a temporary structure essential to fetal development, normally involutes completely by week 8 or 9 of gestation. On occasion, the OMD persists, the clinical presentations of which vary widely. We describe a case of a 6-week-old male with a patent OMD remnant that was initially treated as an umbilical granuloma, which then potentially allowed for prolapse of the small bowel through the umbilical ring. The patient required resection of the incarcerated bowel but had an otherwise uneventful and complete recovery.

Predicting Intracranial Hemorrhage After Traumatic Brain Injury in Low and Middle-Income Countries: A Prognostic Model Based on a Large, Multi-Center, International Cohort.

Subaiya S, Roberts I, Komolafe E, Perel P, Department of Emergency Medicine, New York Presbyterian, New York; BMC Emerg Med. 2012 Nov 19;12(1):17

BACKGROUND: Traumatic brain injury (TBI) affects approximately 10 million people annually, of which intracranial hemorrhage is a devastating sequelae, occurring in one-third to half of cases. Patients in low and middle-income countries (LMIC) are twice as likely to die following TBI as compared to those in high-income countries. Diagnostic capabilities and treatment options for intracranial hemorrhage are limited in LMIC as there are fewer computed tomography (CT) scanners and neurosurgeons per patient as in high-income countries.

METHODS: The Medical Research Council CRASH-1 trial was utilized to build this model. The study cohort included all patients from LMIC who received a CT scan of the brain (n=5669). Prognostic variables investigated included age, sex, time from

injury to randomization, pupil reactivity, cause of injury, seizure and the presence of major extracranial injury.

RESULTS: There were five predictors that were included in the final model; age, Glasgow Coma Scale, pupil reactivity, the presence of a major extracranial injury and time from injury to presentation. The model demonstrated good discrimination and excellent calibration (c-statistic 0.71). A simplified risk score was created for clinical settings to estimate the percentage risk of intracranial hemorrhage among TBI patients.

CONCLUSION: Simple prognostic models can be used in LMIC to estimate the risk of intracranial hemorrhage among TBI patients. Combined with clinical judgment this may facilitate risk stratification, rapid transfer to higher levels of care and treatment in resource-poor settings.

Nasal Cannula End-Tidal CO₂ Correlates with Serum Lactate Levels and Odds of Operative Intervention in Penetrating Trauma Patients: A Prospective Cohort Study.

Caputo ND, Fraser RM, Paliga A, Matarlo J, Kanter M, Hosford K, Madlinger R, Department of Emergency Medicine, Lincoln Medical and Mental Health Center, Bronx; J Trauma Acute Care Surg. 2012 Nov;73(5):1202-7

BACKGROUND: Penetrating trauma patients in shock often require urgent operative intervention. Studies have demonstrated that variables obtained in the emergency department, such as lactate levels, can help the physician determine the presence of hemorrhagic shock, leading to more rapid intervention and improve prognosis in trauma patients. The purpose of the study is to determine if end-tidal (ET) CO₂ correlates with serum lactate levels, a measure of tissue hypoxia and subsequently shock, in penetrating trauma patients. Secondly, we sought to determine whether ET CO₂ could be used to determine the patient's odds of requiring operative intervention.

METHODS: A prospective observational cohort study was undertaken at an urban Level 1 trauma center. Baseline ET CO₂ from nasal cannula and serum lactate level were recorded in all patients in whom the trauma team was activated. Outcomes defined were whether operative intervention was needed. Pearson correlation (R), correlation coefficient (r(2)), and odds ratio were calculated.

Emergency Medicine Physician Opportunities in Upstate NY!

Alice Hyde Medical Center, Malone, NY

- 17,500 annual volume Emergency Department
- Full Time Positions Available
- Located in Adirondack Lake Country
- 12 hour Physician Shifts
- Medical Directorship Opportunity available

Requirements:

- BC/ BP/ PGY III in a Primary Care Specialty
- New York License
- Emergency Medicine Experience
- ACLS Certified if not ABEM
- Directorship Candidates must be ABEM

Lewis County General Hospital, Lowville, NY

- 11,000 annual volume Emergency Department
- Full Time Positions Available
- Close proximity to Syracuse, NY
- 12 hour Physician shifts

Requirements:

- BC/ BP in a Primary Care Specialty
- New York License
- Emergency Medicine Experience
- ACLS Certified if not ABEM

*NES HealthCare Group
offers competitive
remuneration,
comprehensive malpractice
insurance and flexible
scheduling as an independent
contractor!*



Patricia Rosati, Physician Recruiter

Phone: 1.800.394.6376

Fax: 631.265.8875

prosati@neshold.com

www.neshealthcaregroup.com



New York State of Mind

RESULTS: One hundred five patients were enrolled. Pearson correlations and coefficients calculated for serum lactate level to ET CO₂ were $R = -0.86$ ($r(2) = 0.74$, $p < 0.0001$). Of patients requiring operative intervention, 81.97% had abnormally low ET CO₂ and 54.1% had abnormally high serum lactate levels. Odds ratios of patients needing an emergent operation with abnormally low ET CO₂ was 20.4 (95% confidence interval, 7.47-55.96) and with abnormally high serum lactate levels was 4 (95% confidence interval, 1.68-5.93).

CONCLUSION: ET CO₂ has a strong inverse correlation to serum lactate levels. Abnormally low ET CO₂ values were associated with greater increased odds compared with serum lactate levels of penetrating trauma patients requiring operative intervention.

Fresh Frozen Plasma for Progressive and Refractory Angiotensin-Converting Enzyme Inhibitor-induced Angioedema.

Hassen GW, Kalantari H, Parraga M, Chirugi R, Meletiche C, Chan C, Ciarlo J, Gazi F, Lobaio C, Tadayon S, Yemane S, Velez C, Department of Emergency Medicine, New York Medical College, Metropolitan Hospital Center, New York; *J Emerg Med.* 2012 Oct 28. pii: S0736-4679(12)00877-3

BACKGROUND: Angioedema secondary to angiotensin-converting enzyme inhibitors (ACEI) is a commonly encountered problem in the Emergency Department (ED). The treatment of ACEI-induced edema with conventional methods such as epinephrine, steroids, and antihistamines is usually not effective. There is limited experience using bradykinin receptor blockers and fresh frozen plasma (FFP) as a treatment modality for ACEI-induced angioedema.

OBJECTIVE: To emphasize alternative treatment option for ACEI-induced angioedema in the ED.

CASE REPORTS: We report a case series of progressive and refractory presumed ACEI-induced angioedema that all improved in temporal association with

administration of FFP, with a brief review of the literature.

CONCLUSION: There was a temporal association between the administration of FFP and improvement in angioedema in seven cases of presumed ACEI-induced angioedema that were refractory to antihistamines, corticosteroids, and epinephrine.

Geographical Distribution of Patients Visiting a Health Information Exchange in New York City.

Onyile A, Vaidya SR, Kuperman G, Shapiro JS, Department of Emergency Medicine, Mount Sinai School of Medicine, New York; *J Am Med Inform Assoc.* 2012 Oct 27

OBJECTIVE: For a health information exchange (HIE) organization to succeed in any given region, it is important to understand the optimal catchment area for the patient population it is serving. The objective of this analysis was to understand the geographical distribution of the patients being served by one HIE organization in New York City (NYC).

MATERIALS AND METHODS: Patient demographic data were obtained from the New York Clinical Information Exchange (NYCLIX), a regional health information organization (RHIO) representing most of the major medical centers in the borough of Manhattan in NYC. Patients' home address zip codes were used to create a research dataset with aggregate counts of patients by US county and international standards organization country. Times Square was designated as the geographical center point of the RHIO for distance calculations.

RESULTS: Most patients (87.7%) live within a 30 mile radius from Times Square and there was a precipitous drop off of patients visiting RHIO-affiliated facilities at distances greater than 100 miles. 43.6% of patients visiting NYCLIX facilities were from the other NYC boroughs rather than from Manhattan itself (31.9%).

DISCUSSION: Most patients who seek care at members of NYCLIX live within a well-defined area and a clear decrease in patients visiting NYCLIX sites with distance was identified. Understanding the

geographical distribution of patients visiting the large medical centers in the RHIO can inform the RHIO's planning as it looks to add new participant organizations in the surrounding geographical area.

A Pediatric Massive Transfusion Protocol.

Chidester SJ, Williams N, Wang W, Groner JJ, Bellevue Hospital Center, Department of Emergency Medicine, New York University, New York; *J Trauma Acute Care Surg.* 2012 Nov;73(5):1273-7

BACKGROUND: Pediatric massive blood transfusions occur widely at hospitals across the nation; however, there are limited data on pediatric massive transfusion protocols (MTPs) and their impact. We present a pediatric MTP and examine its impact on morbidity and mortality as well as identify factors that may prompt protocol initiation.

METHODS: Using a prospective cohort, we collected data on all pediatric patients who required un-cross-matched blood from January 1, 2009, through January 1, 2011. This captured patients who received blood products according to the protocol as well as patients who were massively transfused at physician discretion. Outcomes between groups were compared.

RESULTS: A total of 55 patients received un-cross-matched blood, with 22 patients in the MTP group and 33 patients receiving blood at physician discretion (non-MTP group). Mortality was not significantly different between groups. Injury Severity Score for the MTP group was 42 versus 25 for the non-MTP group ($p \leq 0.01$). Thromboembolic complications occurred more exclusively in the non-MTP group ($p \leq 0.04$). Coagulopathy, evidenced by partial thromboplastin time (PTT) greater than 36, was associated with initiation of the MTP.

CONCLUSION: MTPs have been widely adopted by hospitals to minimize the coagulopathy associated with hemorrhage. Blood transfusion via MTP was associated with fewer thromboembolic events. Coagulopathy was associated with initiation of the MTP. These results support the institution of pediatric MTPs and suggest a need for further research on the protective relationship between MTP and thromboembolic events and on identifying objective factors associated with MTP initiation.

Dynamic Anatomic Relationship of the Esophagus and Trachea on Sonography: Implications for Endotracheal Tube Confirmation in Children.

Tsung JW, Fenster D, Kessler DO, Novik J, Department of Emergency Medicine, Mount Sinai School of Medicine, New York; J Ultrasound Med. 2012 Sep;31(9):1365-70

OBJECTIVES: Sonographic visualization of an empty esophagus to confirm endotracheal tube placement during intubation may be more reliable than identifying an endotracheal tube within the trachea. Our objective was to determine the frequency in which the normal empty esophagus can be identified at or below the level of the cricoid ring in children.

METHODS: A prospective cohort of children and young adults presenting to the emergency department were examined by sonography to determine the dynamic anatomic relationship of the trachea and esophagus at or below the level of the cricoid ring. For children with the esophagus behind or partially behind the trachea, cricoid pressure was applied using a linear array transducer to visualize the presence of lateral sliding of the esophagus from behind the trachea.

RESULTS: A total of 55 patients 21 years or younger were examined; 51% (28) were male. Sixty-two percent (34) had esophagi positioned partially to the left of the cricoid ring, 20% (11) completely to the left of the cricoid ring, 16% (9) behind the cricoid ring, and 2% (1) partially to the right of the cricoid ring. When cricoid pressure was applied using the ultrasound transducer, the esophagus was visualized lateral to the trachea in all patients (54 to the left and 1 to the right; n = 55 of 55; 95% confidence interval, 94%-100%).

CONCLUSIONS: With cricoid pressure applied using a linear transducer, the esophagus was visualized lateral to the trachea in all children and young adults. Visualizing an empty esophagus by point-of-care sonography may be feasible to confirm endotracheal tube placement by a process of elimination.

A Novel Internet-Based Geriatric Education Program for Emergency Medical Services Providers.

Shah MN, Swanson PA, Nobay F, Peterson LK, Caprio TV, Karuza J, Department of Emergency Medicine, University of Rochester Medical Center, Rochester; J Am Geriatr Soc. 2012 Sep;60(9):1749-54

Despite caring for large numbers of older adults, prehospital emergency medical services (EMS) providers receive minimal geriatrics-specific training while obtaining their certification. Studies have shown that they desire further training to improve their comfort level and knowledge in caring for older adults, but continuing education programs to address these needs must account for each EMS provider's specific needs, consider each provider's learning styles, and provide an engaging, interactive experience. A novel, Internet-based, video podcast-based geriatric continuing education program was developed and implemented for EMS providers, and their perceived value of the program was evaluated. They found this resource to be highly valuable and were strongly supportive of the modality and the specific training provided. Some reported technical challenges and the inability to engage in a discussion to clarify topics as barriers. It was felt that both of these barriers could be addressed through programmatic and technological revisions. This study demonstrates the proof of concept of video podcast training to address deficiencies in EMS education regarding the care of older adults, although further work is needed to demonstrate the educational effect of video podcasts on the knowledge and skills of trainees.

Solutions to Emergency Department 'Boarding' and Crowding are Underused and May Need to be Legislated.

Rabin E, Kocher K, McClelland M, Pines J, Hwang U, Rathlev N, Asplin B, Trueger NS, Weber E, Department of Emergency Medicine at Mount Sinai School of Medicine in New York City; Health Aff (Millwood). 2012 Aug;31(8):1757-66

The practice of keeping admitted patients on stretchers in hospital emergency department hallways for hours or days, called "boarding," causes emergency department crowding and can be harmful to patients. Boarding increases patients' morbidity, lengths of hospital stay, and mortality. Strategies that optimize bed management reduce boarding by improving the efficiency of hospital patient flow, but these strategies are grossly underused. Convincing hospital leaders of the value of such solutions, and educating patients to advocate for such changes, may promote improvements. If these strategies do not work, legislation may be required to effect meaningful change.

Validation of a Pre-Existing Formula to Calculate the Contribution of Ethanol to the Osmolar Gap.

Garrard A, Sollee DR, Butterfield RC, Johannsen L, Wood A, Bertholf RL, Department of Emergency Medicine, Upstate New York Poison Center at Upstate Medical University, Syracuse; Clin Toxicol (Phila). 2012 Aug;50(7):562-6

PURPOSE: The aim of this study was to validate the formula derived by Purssell et al. that relates blood ethanol concentration to the osmolar gap and determine the best coefficient for use in the formula. The osmolar gap is often used to help diagnose toxic alcohol poisoning when direct measurements are not available.

METHODOLOGY: Part I of the study consisted of a retrospective review of 603 emergency department patients who had a concurrent ethanol, basic metabolic panel and a serum osmolality results available. Estimated osmolality (excluding ethanol) was calculated using a standard formula. The osmolar gap was determined by subtracting estimated osmolality from the actual osmolality measured by freezing point depression. The relationship between the osmolar gap and the measured ethanol concentration was assessed by linear regression analysis. In Part II of this study, predetermined amounts of ethanol were added to aliquots of plasma and the estimated and calculated osmolarities were subjected to linear regression analysis.

RESULTS: In the cases of 603 patients included in Part I of the study, the median ethanol concentration in these patients was 166 mg/dL (Q1: 90, Q3: 254) and the range ethanol concentrations was 10-644 mg/dL. The mean serum osmolality was 338 mOsm/kg (SD: 30) and a range of 244-450 mOsm/kg. The mean osmolar gap was 47 (SD:29) and a range of - 15 to 55. There was a significant proportional relationship between ethanol concentration and osmolar gap ($r(2) = 0.9882$). The slope of the linear regression line was 0.2498 (95% CI: 0.2472-0.2524). The slope of the linear regression line derived from the data in Part II of the study was 0.2445 (95% CI: 0.2410-0.2480).

CONCLUSIONS: The results of our study are in fairly close agreement with previous studies that used smaller samples and suggest that an accurate conversion factor for estimating the contribution of ethanol to the osmolar gap is $[\text{Ethanol (mg/dL)}]/4.0$.



New York State of Mind

Identification of Current Priorities for Research in Humanitarian Action: Proceedings of the First Annual Un Ocha Policy and Research Conference.

Foran MP, Greenough PG, Thow A, Gilman D, Schütz A, Chandran R, Baiocchi A, NYU School of Medicine, Bellevue Hospital Center-Department of Emergency Medicine, New York; Prehosp Disaster Med. 2012 Jun;27(3):260-6

On December 12-13, 2011, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) hosted a humanitarian policy and research conference on the theme of “Risk, Adaptation and Innovation in Humanitarian Action.” The four sessions of the conference covered humanitarian action in a changing world, adaptation and innovation in humanitarian action, humanitarian action in protracted and violent conflict, and effective humanitarian action. This special report contains summaries of presentations in each session and the conclusions resulting from the discussions throughout. Through a process of open discussion, debate, and a closing survey, the conference participants identified four top priorities in humanitarian research for the coming years: evidence-driven humanitarian decision-making; accountability and transparency; risk and agility; and partnership. In addition to plans for a 2nd Annual Research and Policy conference in December of 2012, specific outcomes of the conference include a series of regional workshops in 2012 and 2013, launching with Asia, Africa and the Middle East; creation of Policy Working Groups (PWG) for each research priority identified; and a new flagship OCHA publication, to be launched in late 2012 or early 2013, which will share the progress made on the research priorities identified. ■



In our continuing effort to foster community and academic research, New York ACEP's Research Committee is here to serve as a resource for your research projects. For inquiries on how to get started, email nyacep@nyacep.org.



Quality people. Quality care. Quality of LIFE.

Care for Kids Exciting Pediatric EM Opportunities

Saint Peter's University Hospital has exciting new opportunities for Emergency Medicine clinicians in New Brunswick, NJ, less than one hour commute from New York City.

Positions Currently Available:

- ED Pediatric Medical Director (*Peds EM Trained with ED Management experience*)
- ED Pediatric Physicians (*BC / Peds EM with ED experience*)
- ED Physicians (*BC / EM*)
- ED Nurse Practitioners / Physician Assistants (*EM experience preferred*)

Started in 1907, Saint Peter's University Hospital is a 478-bed teaching hospital that provides a broad array of services to the community. The facility is located in New Brunswick, NJ and is a member of the Saint Peter's Healthcare System. This facility is a state-designated, acute care children's hospital and Regional Perinatal Center and is a regional medical campus of Drexel University College.

Emergency Department:

- 66,000 Combined Annual Volume between Pediatric and Adult Departments
- Pediatric ED treats more than 21,000 infants, children and young adults
- 33 hours of Pediatric Emergency Medicine coverage per day
- Brand NEW Emergency Department
- Scribe coverage

EmCare®

Emergency Medicine

Making Health Care Work Better.™

BRITTANY KULP, Associate Recruiter

CALL: 215-442-5135

800-247-8060 Ext. 25135

EMAIL: Brittany.Kulp@EmCare.com

Search hundreds of
jobs at EmCare.com

EDUCATION

feature column

Anand Swaminathan MD MPH, Assistant Professor
Emergency Medicine; Assistant Residency Director,
Bellevue/NYU Emergency Department



EM Lyceum – An On-line Resource to Support Clinical Teaching

There are few things emergency physicians encounter in the clinical setting that make them uncomfortable. Start an IV on a dehydrated chemo patient? No problem. Intubate the crashing COPDer with a sat of 84%? Check. Start the third vasoactive drip on the patient with severe sepsis? That all you got? Mix in some resident education during a busy clinical shift? Not so easy. The high volume and high acuity nature of clinical shifts in the emergency department makes discussion of quality, evidence-based research and nuanced academic debate a herculean task. Additionally, the practice of bedside and clinical teaching has been in decline for decades and literature has yet to address the utility of formal on-shift education.¹ The proliferation of educational websites and blogs should make this task easier but it is often difficult to figure out where to start. In this article, we review EM Lyceum (www.emlyceum.com), a website dedicated to clinical education. Full disclosure; while I did not design this site or act as its moderator: I am involved in the selection of topics and editing of the answers for EM Lyceum.

In 2010, a group of residents and faculty at the NYU/Bellevue Emergency Medicine Residency Program created the EM Lyceum curriculum. Our goal was to construct an educational curriculum that fostered critical thinking on various topics in emergency medicine and to standardize education across all clinical shifts.

How does the curriculum actually work? In short, we develop a set of questions each month centered on contentious areas in emergency medicine. Topic selection is driven by controversies we see arising recurrently during clinical shifts. Subjects cover the breadth of emergency medicine from atrial fibrillation (“Which patients do you cardiovert?”) to mammal

bites (“Which mammal bites get antibiotics?”) to Hyperkalemia (“What is the role of kayexalate in the treatment of hyperkalemia?”). Posters with the questions are prominently displayed in all clinical areas, and residents are encouraged to ask their attendings and senior residents about that month’s questions. Faculty members receive the questions a couple of days in advance along with relevant articles and citations to aid them in reviewing the critical issues for each topic. Although all the questions pertain to a specific topic, they also function in a “stand-alone” fashion permitting brief mini-lessons incorporated into the functioning of a busy emergency department. The “answers” are a summary of the best literature available and when little evidence is available, expert consultation.

Two years later, the curriculum has taken off. Residents and faculty are frequently found huddled around the posters discussing and debating questions during the relative “lulls” in the department. We often receive follow up questions leading to further exploration. In August of this year we discussed the utility of troponins (single troponins in chest pain, troponins in ESRD etc.) that led to a side topic regarding troponin testing in patients with blunt cardiac injury. We also found that the curriculum highlights the extensive variation in clinical management of disease processes. This allows the residents to become exposed to the art of emergency medicine.

In 2011, the EM Lyceum website was created to offer this curriculum to other emergency medicine residencies and departments in general. This website, www.emlyceum.com, offers the monthly set of questions and answers free of charge. The clinical area posters can be accessed from the website via hyperlink. Additionally,

registration with the site allows the user to receive two emails each month; one with the questions and one with the posted answers to the questions. The website also has a comment feature where users can leave their answers, remarks and questions allowing the emergency medicine community to further share information with others. The website also encourages users to offer clinical questions or topics they would like to see explored in the future.

A Lyceum is the proper name for a garden with covered walkways in Athens in ancient Greece where Aristotle would teach his students about philosophy. We adopted this term for our educational website because we see the emergency department as a lyceum where educators can instruct residents and medical students. Clinical education is a tricky field with the unpredictable nature of patient care often limiting time for instruction. EM Lyceum provides a framework to encourage debate and the exchange of ideas during shifts between providers. The on-line platform will hopefully lead to increased sharing of approaches to management. We welcome any comments, suggestions and criticisms.

References

1. Aldden AZ, Gisondi MA. Bedside teaching in the Emergency Department. *Acad EM* 2006; 13: 860-6.
2. Bryant WK, Swaminathan A, Wagner A, Bandhari S. EM Lyceum – A Novel Method to Encourage Academic Debate and Teaching Amongst Faculty and Residents. *Acad Emerg Med* 2012 19 (Suppl s1): S402-3. (Video: <http://vimeo.com/42020764>)
3. Faine B et al. Implementing evidency-based changes in emergency department treatment: alternative vitamin therapy for alcohol-related illnesses. *Ann EM* 2012; 59 (5): 408-12. ■

Full-Time Emergency Medicine Physician Opportunities

Lutheran Medical Center, Brooklyn, NY



*Lutheran Medical Center
is a Level I Trauma
Center, Stroke Center,
STEMI Center and
Hypothermic Center.
Lutheran Medical Center
has cared for the
citizens of Brooklyn
since 1883.*

Physicians Must be BC or BP in Emergency Medicine and Emergency Medicine Residency Trained

Emergency Department Summary:

- Annual Volume of 65,000 Visits
- 15 Full-Time Emergency Medicine Trained Physicians
- 35 Physician Assistants/Nurse Practitioners
- 75 Hours of Physician Coverage Per Day
- Dr. Bonnie Simmons, Chair of Emergency Medicine, is an expert in ED operations, patient flow, customer satisfaction and disaster preparedness.

NES HealthCare Group offers a very competitive compensation package with a monthly incentive bonus.

www.neshealthcaregroup.com

Please contact or send your CV to:

Megan Evans
NES HealthCare Group
(800) 394-6376 phone
(631) 265-8875 fax
mevans@neshold.com

Bonnie Simmons, DO FACEP
(718) 630-8383 phone
(718) 630-8653 fax
bsimmons@lmcmc.com



Reflections of a Past ACEP President

continued from page 1

the prior model, so they will have to select which patients stay and which go. As they will be publically graded for how well their patients are (cholesterol levels, BMIs, etc), I suspect obese, smoking, non compliant patients will soon be without a home (except that we are always home). We need to find ways to help reduce readmissions to the hospital, provide more cost effective care, and expand our services within the emergency department. We will establish larger observation units, walk-in coordinated care for the chronically ill and the recently discharged, and perhaps utilize our paramedics to make house calls. We will create care plans for our frequent patients (some call our most loyal customers). We will employ care coordinators, case managers, and others to provide these services while we continue to service the acutely ill population.

During healthcare debate, it was clear that the public and politicians were concerned about the increasing cost of healthcare. And it is clear they have a right to be very concerned. It seemed just about everyone — the public, the politicians, the insurance companies, the other specialties — were happy to point the finger at the emergency departments of this country as ‘unnecessary’ and ‘expensive.’ The radiologists were under scrutiny to reduce costs and radiation. They countered by suggesting that emergency physicians were ordering unnecessary tests. One of their quotes was that “up to 1/3 of all tests ordered in the ED were unnecessary.” While it is true that ‘up to’ 1/3 are unnecessary, the quote is misleading. But wait, it is referenced. It comes from a panel discussion at a conference on reducing radiation in children. The panel member asked what percentage of tests were unnecessary and that was the answer from a member of the audience! So much for science. The American College of Radiology along with the American Board of Medical Specialties established several examples of unnecessary tests — all done in the emergency department. And without the input of emergency physicians. Interestingly they did not want to reduce patients referred from private practices, during day time hours!

We also saw attempts to restrict our ability to perform conscious sedations as a part of our practice. After meeting with the Anesthesiologists, it became clear they were not that concerned with our 24/7/365 practice and actually were comfortable with our skill set, but were concerned about other specialties such as Pulmonary and GI who routinely use procedural sedation without their involvement.

These were just two examples of specialties who raise concerns about another member of the House of Medicine when pressure is applied. So what was the response of emergency medicine? Did we rally stand together to support our specialty? Yes and no. What I discovered is there is still a great deal of mistrust within our specialty. Large groups are suspicious of small groups, small groups of large; contract groups are suspicious of democratic groups, democratic groups of contract groups; and everyone seems suspicious of academics (who by the way are suspicious of everyone)! OK that last sentence might be a bit tongue in cheek but there were certainly times when that appeared to be true. During my time at national ACEP, the Emergency Medicine Action Fund (EMAF) was created and brought together all of these groups to work for our specialty. As I entered the meeting, I commented that we would be lucky if no one was killed. Instead the meeting went well, individuals spoke their minds, and over time things began to happen. Perhaps the House of Emergency Medicine could work together!

With the recent crisis in Washington State this was true. The government in Washington State decided to not pay for certain low acuity emergency department visits by Medicaid recipients. The problem was that they were using the Billing’s criteria to determine ‘unnecessary’. Billings himself has stated his data could not be used in this manner. EMAF rallied together and backed advocates in Washington State, along with other organizations and eventually a reasonable plan focused on truly cutting costs without eliminating access to patients and reimbursement for physicians for work they may be required by EMTALA to perform.

So what did I learn? I learned we must be vigilant. We must be involved. We

have few friends among politicians. We have few allies in the House of Medicine. We must come together at this time of change. We have significant differences, but those can be dealt with later. We must be creative in the role we play under these new rules. No longer can we assert that we only are interested in the ‘true emergencies.’ We must stop talking about ‘unnecessary’ care, but find ways to make it compensated and less costly care.

You must get involved. If you haven’t been active in New York ACEP, could there be a better time? Come to the Annual Meeting in July and listen to our state issues. If you can’t give us your time, give some money for the New York Emergency Medicine Political Action Committee (NYEMPAC) so those with the time can be productive. If you haven’t been active in national ACEP, this is the time! Give to EMAF, give to NYEMPAC. Come to the Leadership and Advocacy meeting in May. You will gain enormous knowledge, you will help forge the future, and you will make incredible friendships.

For me this was an incredible journey. ■

2012 Lifelong Learning and Self-Assessment Course

Friday, March 15, 2013
8:15 am - 1:15 pm

SUNY Upstate Medical University

Fee: * Member - \$199
Non-Member - \$275

**includes on-site testing,
excludes ABEM exam fee*



Register online at www.nyacep.org



Pediatric Articles: A Year in Review

Guest authors: Joe Vukovic MD, Senior Resident, Emergency Medicine, Albany Medical College;
Katherine Homann, MD, Senior Resident Emergency Medicine, Albany Medical College along with Dr. Pauze

Today we look at a few interesting journal articles from 2012. Our first three articles look at pain treatment in pediatric patients. We also look at another very important study, looking at positive cultures in patients < 60 days of age.

Analgesic Administration in the Emergency Department for Children Requiring Hospitalization for Long Bone Fracture.

Dong L et al., *Pediatric Emergency Care*. Volume 28, Number 2, February 2012

This retrospective cohort study looked at patients ages 0 to 15 with isolated upper and lower long bone fractures and both the dosing and timing of administration of pain medication. The results showed that the emergency department does a poor job of acute pain management in children, with less than ten percent of all children receiving appropriate weight based dosing and nearly two thirds receiving no medication in the first hour of their stay.

Acute pain management is something that we as physicians have the capability to control in the emergency department. While this single site study fails to incorporate pain scales, which does affect our decisions of when and how much pain medicine we give, it is probably an accurate representation of our everyday practices. We need to be more cognizant of pain control in our pediatric patients.

The Impact of Watching Cartoons for Distraction During Painful Procedures in the Emergency Department.

Downey LC and Zun SL; *Pediatric Emergency Care*. Volume 28:10, October 2012

Can watching cartoons reduce the perception of pain in kids? That is what Doctors Downey and Zun investigated during this study. The authors looked at pediatric patients that presented with pain. Children were randomized to watch a cartoon/ not watch a cartoon during their painful procedure. Of the 100 patients in the study, the authors did indeed find a statistical difference of improved pain control (a 20% reduction in pain) in those children watching a Barney or Tarzan cartoon.

Many pediatric patients present to our ED with fractures, lacerations, burns, or abscesses, all of which cause pain. Many studies have shown that pediatric patients are undertreated for pain. This article offers another tool to assist in the treatment of pain in the pediatric patient. It is as simple as watching a Barney cartoon!

A Randomized Comparison of Nitrous Oxide Versus Intravenous Ketamine for Laceration Repair in Children.

Lee JH et al., *Pediatric Emergency Care*. Volume 28:12, December 2012

This article was a prospective randomized study comparing nitrous oxide (N2O) vs. ketamine in children needing laceration repair. They enrolled 32 patients (age 3-10 yrs), where the primary outcome was recovery time. Pain scale, adverse effects, and sedation depth were also measured. The authors found shorter sedation and recovery times with the Nitrous group. Pain scales and satisfaction scores were comparable. Ketamine, however, had a deeper sedation level.

Although a study with very, very small numbers, Dr. Lee and colleagues revealed a potential benefit of N2O for pain control in our pediatric patients. Little preparation time, fast on, fast off. Nitrous oxide may be another potential tool that reduces painful pediatric procedures.

Rates of Positive Blood, Urine and Cerebrospinal Fluid Cultures in Children Younger than 60 Days During the Vaccination Era.

Morley et al., *Pediatric Emergency Care*. Volume 28, Number 2, February 2012

Serious bacterial infections (SBI) are a major threat in younger febrile infants, especially in those less than sixty days old. This retrospective chart review compares the accepted five to ten percent SBI rate calculated in prior studies to those seen at a single tertiary care hospital. In this study of over two hundred patients, the authors found a slightly higher infection rate. Thirteen percent of infants less than 28 days of age had a positive culture of urine or blood (with no cases of bacterial meningitis). In the 29-60 day group, 11% of cultures were positive, predominately from urine and blood. One patient in this group had bacterial meningitis, and presented with irritability. Urinary tract infection (UTI) again proved to be the source of the majority of infections in both groups, with *E. coli* leading the way.

This is an important study --- how are we doing in the vaccination era? How is the landscape changing for this age group? In our most vulnerable pediatric population, those less than 60 days of age, infections

from vaccine preventable organisms *Haemophilus influenza* (zero) and *S. pneumonia* (only one case) were virtually nonexistent. The authors state that herd immunity may be playing a role. Interestingly, there were five cases of meningitis caused by enterovirus. UTIs were the most common source of positive cultures. *I really like this study, and it is certainly worth the read for more details and discussion.*

Yield of Emergent Neuroimaging Among Children Presenting with a First Complex Febrile Seizure.

Kimia AA et al., Pediatric Emergency Care. 2012;28, April 2012

Is routine imaging of complex febrile seizures necessary?

Twenty-five to thirty percent of febrile seizures are classified as complex febrile seizures (CFS) including, multiple seizures in 24 hours, seizures lasting more than 15 minutes and focal seizures. This article reviewed over 500 patients with CFS and found that while 50% had head imaging, only four patients (<1% of total) had clinically significant imaging results. Three of the four with abnormal imaging had

obvious findings on physical exam (signs of trauma, persistent altered mental status or persistent paralysis). Without atypical symptoms on physical exam, this article suggests neuroimaging provided little benefit.

The American Academy of Pediatrics is against routine imaging for simple febrile seizures, but no recommendations exist for complex febrile seizures. This article is important as it suggests that routine imaging for Complex Febrile Seizures alone is not necessary if there are no other clinical signs of intracranial pathology.

Survey in the Emergency Department of Parents' Understanding of Cough and Cold Medication Use in Children Younger than 2 Years.

Varney et al., Pediatric Emergency Care. Volume 28:9, September 2012

This article looked at parents understanding of the 2007 FDA guidelines that recommended children under the age of 2 not receive over the counter (OTC) cough and cold medications (CCM). Caregivers of children < 2 years of age were given a 14 question survey about CCM use and the

FDA guidelines. Results found that only 31% of parents were aware of the FDA guidelines. Fifty-seven percent of caregivers felt that CCM were safe to use in this age group.

This article is important because deaths have been reported in young children after taking OTC medications. These are unnecessary deaths for benign, self limiting illnesses. Parents may not know that giving an OTC medication can cause harm, and in some instances, even death. A majority of parents want something done to stop a cough, such as antibiotics or cough medicine. What they might not be aware of, is CCM can lead to adverse events. Informing parents that an upper respiratory illness is a benign, self limited illness, and CCM can be dangerous, remains an important goal.

This regular column features pediatric emergency medicine challenging cases, literature updates and interesting pediatric illnesses. Have a pediatric question? Email it to Dr. Pauze at nyacep@nyacep.org for possible inclusion in the next issue of the EPIC. ■



location
New York Academy
of Medicine
1216 Fifth Avenue
New York, NY

Presented by
New York
American College
of Emergency Physicians
1130 Crosspointe Lane
Suite 10B
Webster, New York
14580-2986

phone 585.872.2417
fax 585.872.2419
email nyacep@nyacep.org
online: www.nyacep.org

New York
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

2013 ED LEADERSHIP FORUM
FRIDAY MAY 3 ⌚ **8:00 AM - 4:00 PM**

Graduate Medical Education to See Dramatic Changes

Joel M. Bartfield, MD FACEP, DIO and Associate Dean, Graduate Medical Education, Professor, Emergency Medicine, Albany Medical Center

In the next several years, Graduate Medical Education will undergo dramatic changes. Beginning July 1, 2013, the Accreditation Council for Graduate Medical Education (ACGME) is phasing in a new accreditation system. The so called “Next Accreditation System (NAS)” focuses on educational outcomes, involvement of residents in patient safety and quality improvement, and innovation in education. In the old system, programs were visited every one to five years in static “accreditation visits.” The new system will focus on continuous oversight of educational outcomes and several other domains through electronic reporting. The key attributes of the new system include the following:

- Specialty specific educational milestones
- A focus on improvement and self study
- Development of national normative data
- Less prescriptive program requirements, revised less frequently
- Greater flexibility that allows educational innovation
- Reduced burden on accreditation
- Greater emphasis on institutional oversight

Educational outcomes for residents will be defined by milestones which are currently being developed by all residency review committees. These milestones will be competency based and specialty and level of training specific. Each residency program will be expected to establish “Clinical Competency Committees” which will be charged to triangulate the progress made by each resident in each of the milestones. The ultimate goal is to have residents graduate from residency with milestone criteria consistent with a level of proficiency allowing them to enter unsupervised practice. The ACGME will also regularly

review the results of house staff and faculty questionnaires, procedure and case logs, board certification examination rates, scholarly activities and other metrics.

NAS adopts a different methodology for on-site reviews of individual programs and institutions. Every 10 years, programs will undergo on-site reviews which will be more of a self-study approach, similar to the approach used by the Liaison Committee for Medical Education (LCME) for medical schools.

In contrast to individual programs, institutions will be visited every 18 months for a focused review and every six years for an Institutional Site Visit which is similar in format to the old accreditation system. The “Clinical Learning Environment Review (CLER)” program has been developed for the focused reviews every 18 months. This program calls for institutional visits to review seven focus areas including:

- Resident engagement in patient safety
- Resident engagement in quality improvement
- Enhancing practice for care transitions
- Identifying opportunities for reducing health disparities
- Promoting appropriate resident supervision
- Duty hours oversight and fatigue management
- Enhancing professionalism

Site visitors will use information contained in milestone data, (reported to the ACGME every six months [as described above]), resident questionnaires, faculty questionnaires, operative logs and case logs, scholarly activity of residents and faculty, and on-site interviews with residents and faculty to assure that institutions maintain a clinical environment that promotes resident education and patient safety.

Seven of the 26 ACGME accredited core specialties are involved in the Phase

I implementation of the NAS. These include: Emergency Medicine, Internal Medicine, Neurosurgery, Orthopedic Surgery, Pediatrics, Diagnostic Radiology, Urology, as well as all fellowships from these core specialty programs. The Emergency Medicine Residency Review Committee has largely completed work on the development of milestones. As previously mentioned, Phase I is beginning July 2013. Beginning July 2014, all remaining training programs will enter the Next Accreditation System paradigm. As programs enter the NAS paradigm, they will be assigned extended site visit dates, so long as they are fully accredited and are not newly established. Institutional reviews for these programs will be expected on an “as needed” basis. Individual institutions will be responsible to establish criteria which would trigger the need for such a review. Additionally, the ACGME will have the prerogative to conduct on-site as needed visits if the data regularly supplied to it is concerning. These on-site as-needed visits by both the institution and the ACGME will be problem specific rather than global.

The ultimate goal of the Next Accreditation System is to improve the health care delivery system by enhancing Graduate Medical Education. The ACGME anticipates that Undergraduate Medical Education and ongoing medical education for practicing physician (continuing medical education) may borrow some of the tenants of the NAS. For example, in the area of milestones, the goal for resident graduates is to attain milestones consistent with being able to practice in an unsupervised setting. The goal for medical student graduates should include being able to provide patient care under direct and indirect supervision and the goal for practicing physicians is to engage in continuous practice improvement and learning.

This is certainly a very exciting time to be involved in graduate medical education. As I have said to many colleagues, as these new challenges in graduate medical education loom, this is a fantastic time to be involved in medical education or alternatively not a bad time to contemplate retirement. ■



The Summer House

Judith Dattaro, MD FACEP,
NewYork-Presbyterian Hospital

“You’ll know when it’s time to go” he told her and he was right. And how timely this comment was for many things in my life just then.

The immediate reference was to the summer house. When does one let go of something so special? This place that was the dream house. It held so many good times, memories and hopes. I was very fortunate that I had a friend with a house in the Hamptons and a very generous open invitation. Bought in the wake of 9/11/01, it was a refuge from the “busyness” of life and a place to reconnect with a dear friend. It was an anchor in our lives. Could she really be thinking of letting this go?

Many conversations of incredible weight were held while lounging there. None were, perhaps, so poignant as today. She was as great at moving forward as I was at perseverating — she could change readily. I always struggled with it.

As fate would have it, she was also at a point in her career where she was about to move on. Thirty years as a dentist and she loved her job. But now, after all these years, she knew when it was time to go, to leave clinical practice.

When the next patient holds weariness for you and the management of the office was not a challenge, but a stress, it was time to see what else could be found as life’s work.

As she said that day, all the hours at the job keep you from doing many other things — quite true. As with the summer house, if

summers were planned and the happy rituals were only just that, what other things might one be pursuing? Was there not more to be done and experienced? Perhaps the house was also the place that kept you from moving forward. The previous owners knew that. Interestingly enough, they had left after thirty years.

So, when in emergency medicine do we follow alternate dreams and move on? When the next patient becomes another stress? When July 1 is not welcomed? When we feel we have contributed as much as we can? Or, when we can not reinvent ourselves (again) to fit the latest CMS, Press-Gainey, etc. requirements?

As a relatively young specialty, emergency medicine was one frequently associated with “burnout” and understandably so. Nights, weekends, holidays, critically ill patients, difficult situations all the time. Most other types of practice tend to improve with time: shorter hours, younger staff taking on the more grueling night, weekend and holiday hours. But emergency medicine will always be 24/7 and for the first time in its career, there are many later career physicians. The waves of people who worked transiently are gone and as a specialty, the current physicians chose to stay.

So when do we as the specialists in the field decide our future is outside of clinical emergency medicine practice?

When I spoke to a number of highly experienced emergency physicians who had

left clinical practice, the first question they all asked was “Why” someone is considering leaving clinical practice.

Are you leaving to go toward something or merely to get away? Are you leaving a position that, for a variety of reasons, is no longer a place where you feel you can continue to practice? Is it burnout, retirement, or simply a desire for change?

Some have gradually shifted out of emergency medicine, working fewer shifts until at some point, one has left clinical practice altogether. Some are able to modify the job to better suit their needs (fewer nights, weekends, holidays, shorter shifts or use of scribes).

This is a relatively new challenge for emergency medicine. As it becomes tougher to work the nights and increasingly demanding shifts, what are the alternatives for experienced emergency physicians? This is a topic gaining momentum in emergency medicine. How does one extend a functional working life that is satisfying? Where do we go from here? How do you keep doing what you’re good at and remain relevant?

Those who have successfully transitioned out of clinical practice have transitioned *into* something else. They stress having a goal, maintaining a purpose, and having a function. We must be honest with ourselves, realizing that our “jobs” are for many of us, a part of our sense of self worth. The challenge is to define the skill set we have and use this to transition forward. Successful non-clinical practitioners stress taking the time to plan out what the goals are, to see into what we can move forward. Leaving without a plan in place is unlikely to bring the kind of satisfaction that a well laid out plan can help deliver.

What is our skill set outside the obvious “able to take care of anything” medical care? Consider these: conflict management, managing complex systems and making them work, teaching, mentoring, organizational skills, being adaptable in a changing work environment, resourcefulness. These would appear to be skills sought in many different work environments.

In speaking with Dr. Greg Henry, who only recently left clinical practice after forty-two years, some of the goals include continuing to work at something where

continued on next page

The Summer House

continued from page 27

there is a sense of contributing to the profession and society, maintaining a sense of belonging to something larger than oneself and maintaining respect from one's peers. He advises taking the time to plan your career, starting with considering what it is you really want as a part of your career and life. This is a process that should begin right out of residency. As he says: good things only happen when they're planned; bad things happen all by themselves.

Some of the alternatives may be in industry, UrgiCenters, involvement with medical leadership, politics, mentoring and administrative activities. Additionally, using some of the skills listed above may bring a wider range of career paths that we are just beginning to consider.

We need to be the best we can be when we are in the emergency department and that means we have to really want to be there. Maintaining excellence is the goal. We must all consider how we can continue to do that.

Back at the summer house, I am listening to the breezes in the trees. Are these the winds of change? ■



New for 2013

New Speaker Forum

Build confidence and improve your speaking skills by participating in the New York ACEP New Speaker Forum at the 2013 Scientific Assembly. If you are considering professional speaking and would like to gain experience, this forum was designed for you. It provides an opportunity for New York ACEP to 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 inaugural New Speaker Forum is "Best Practices in Emergency Medicine." The Forum will be held Monday, July 8 at 4:00 pm at the Sagamore Hotel in Bolton Landing. Applicants will be selected to give a 15 minute presentation on this year's topic.

Candidates interested in presenting at New York ACEP's inaugural New Speaker Forum need to submit the following information by 11:59 pm **April 1, 2013:**

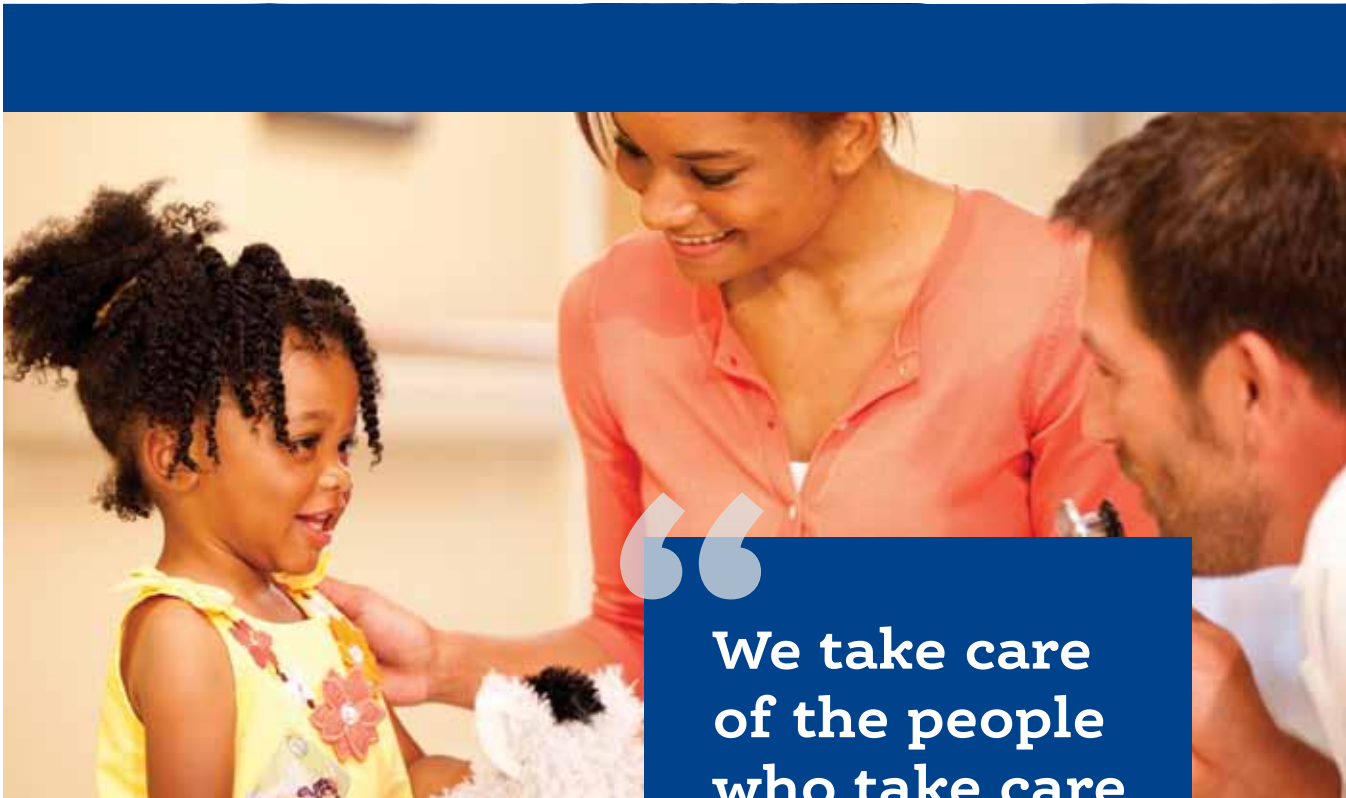
- Cover sheet with:
Lecture title; "Best Practice in Emergency Medicine:
_____"
Name, title and affiliation/institution
Mailing address, phone/fax and email address
History of previous oral presentations
Potential conflicts of interest and financial disclosures
- Lecture material in slide format (Microsoft PowerPoint)

All material must be sent electronically to nyacep@nyacep.org and include in subject line: New York ACEP 2013 New Speaker Forum. Firm deadline for applications: **April 1, 2013** (Midnight EST).

Presentations will be selected by a blind review process and notification will be provided to all applicants by April 22, 2013. Speakers selected will be responsible for their own expenses.

New York American College of Emergency Physicians
(585) 872-2417 **phone**
nyacep@nyacep.org **email**
www.nyacep.org **online**

NEW SPEAKER FORUM



“
**We take care
of the people
who take care
of patients.**
”



Emergency

CONSULTANTS, INC.
An ECI Healthcare Partner

Great partners. Great people.

When physicians are valued, patients benefit

We allow you to give patients the highest quality care by providing autonomy, strong leadership, no non-competes, accommodative scheduling, and occurrence-based malpractice protection.

CHECK OUT OUR NATIONWIDE CAREER OPPORTUNITIES

**newyorkEDjobs.com
(866) 915-8001**

Emergency Consultants, Inc. is a corporation providing management and administrative support to limited liability partnerships. It is not a direct provider of medical care services.



Though we've changed the way we look, we'll never change the values that have brought us success for over 40 years. Join us as we usher in a new era as an ECI Healthcare Partner.

march

- 13 Education Committee Conference Call, 1:30 pm
- 13 Professional Development Conference Call, 3:30 pm
- 14 Medical Student Symposium, SUNY Downstate Medical Center, Alumni Auditorium , 6:00 pm-10:00 pm
- 14 Practice Management Conference Call, 1:00 pm
- 15 2012 Lifelong Learning and Self-Assessment Course, SUNY Upstate Medical University, 8:15 am-1:15 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

april

- 10 Education Committee Conference Call, 1:30 pm
- 10 Professional Development Conference Call, 3:30 pm
- 11 Practice Management Conference Call, 1:00 pm
- 17 Government Affairs Conference Call, 11:00 am
- 17 Research Committee Conference Call, 3:00 pm
- 18 EMS Committee Conference Call, 2:30 pm

may

- 2 Board of Directors Meeting, New York Academy of Medicine, 1:30 pm-5:30 pm
- 3 ED Leadership Forum, New York Academy of Medicine, 8:00 am-4:00 pm
- 8 Education Committee Conference Call, 1:30 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
- 19-22 ACEP Leadership and Advocacy Conference, Omni Shoreham Hotel, Washington, DC

june

- 12 Education Committee Conference Call, 1:30 pm
- 12 Professional Development Conference Call, 3:30 pm
- 13 Practice Management Conference Call, 1:00 pm
- 19 Government Affairs Conference Call, 11:00 am
- 19 Research Committee Conference Call, 3:00 pm
- 20 EMS Committee Conference Call, 2:30 pm

july

- 8 Board of Directors Meeting, Sagamore Resort, 11:00 am-12:30 pm
- 8-10 New York ACEP Scientific Assembly, Sagamore Resort
- 9 New York ACEP Annual Meeting
- 10 Board of Directors Meeting, Sagamore Resort, 7:00 am-8:00 am

■ **NEW YORK-Brooklyn: Director of Medical Student/Residency Education Opportunity**

The Chair of Emergency Medicine at Lutheran Medical Center is seeking a BC/EM physician to assist with leadership of the Emergency Department team to achieve our goals of patient safety and overall quality. These positions include clinical shifts as well as administrative duties. Candidates must have emergency medicine and administrative experience. Very competitive compensation and bonus program. Contact: Patty Rosati, Physician Recruiter, at 1-800-394-6376, prosati@neshold.com.

■ **Arnot Health, an integrated, 3-hospital healthcare system**

in Elmira, NY, seeks ABEM-Certified Physicians for the region's busiest Emergency Department at Arnot Ogden Medical Center. A newly expanded and fully equipped ED creates the environment for you to blend your talents and skills in a progressive health system that services over 47,000 emergency medicine visits annually. Emergency angioplasty, 24 hour anesthesiology, double physician coverage with a low physician/patient ratio, Fast Track program and premier on-site ancillary services are but a few of the clinical amenities offered.

- Highly competitive salary guarantee
- Newly enhanced incentive package
- Sign-on bonus
- Educational Loan Forgiveness
- Relocation assistance
- CME allowance
- Paid malpractice
- Comprehensive health, dental, vision and retirement benefits
- Osteopathic training program with EM residencies beginning 2013

The Southern Finger Lakes Region of New York and the cities and suburbs of Elmira and Corning offer a truly exceptional life style. Excellent schools, convenient shopping, low crime rates, and high air and water quality combine to foster a superior environment with very affordable housing. Spring and summer seasons are simply superb and offer an abundance of outdoor activities including hiking, boating, golf, horseback riding, and a wealth of other activities. With its cool vistas and incredible foliage, autumn is a stunning time of year amenable to harvest winery tours, hunting and fishing. Winter offers an exciting array of seasonal activities with skiing and snowmobiling opportunities within an hour's drive.

For information contact: Eleanor or Linda, Arnot Health Elmira, NY, recruitment@aomc.org, www.arnothealth.org, 800-295-4555.

To submit a classified ad, contact New York ACEP by email at nyacep@nyacep.org, phone (585) 872-2417 or online at <http://nyacep.org/content/30-newsletter-advertising>.

New York ACEP assumes the statements made in classified advertisements are accurate, but cannot investigate the statement and assumes no responsibility or liability concerning their content. The Publisher reserves the right to decline, withdraw, or edit advertisements. Every effort will be made to avoid mistakes, but responsibility cannot be accepted for clerical or printer errors.



Call for Board and Councillor Nominations

Board Nominations

Active members of New York ACEP interested in serving on the Board of Directors are encouraged to submit their nominations to the 2013 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 Tuesday, July 9, 2013 at the Sagamore Hotel on Lake George.

Board Members whose term ends in 2013

David C. Lee, MD FACEP*
Louise A. Prince, MD FACEP*
Gary S. Rudolph, MD FACEP*
Kaushal Shah, MD FACEP*

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

Interested candidates should review the Board Criteria Policy, Board Member Duties & Responsibilities Policy and send a completed nomination form along with a copy of their CV to New York ACEP by **April 1, 2013**. Self nomination and nominations of colleagues are accepted.

For policies and nomination form go online to <http://www.nyacep.org/content/107-board-nominations>, email nyacep@nyacep.org or call New York ACEP at (585) 872-2417.

Successful nominees will be notified after May 2, 2013. 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 2013 Nominating Committee for consideration as the Committee develops the slate of candidates.

Councillors whose term ends July 2013:

Brahim Ardolic, MD FACEP
Joel M. Bartfield, MD FACEP
Jay M. Brenner, MD
Gerard X. Brogan, Jr., MD FACEP
Jeremy T. Cushman, MD FACEP
Theodore J. Gaeta, DO MPH FACEP
David C. Lee, MD FACEP
Daniel G. Murphy, MD MBA FACEP
Gary R. Rudolph, MD FACEP
resident representative to be appointed

Councillors Completing their Second Year

Michael Cassara, DO FACEP
Michael G. Guttenberg, DO FACEP
Raymond Iannaccone, MD FACEP
Stuart G. Kessler, MD FACEP
Penelope C. Lema, MD FACEP
David Newman, MD FACEP
Salvatore Pardo, MD FACEP
Louise A. Prince, MD FACEP
Christopher C. Raio, MD RDMS FACEP
Frederick M. Schiavone, MD FACEP
Todd Slesinger, MD FACEP
Peter Viccellio, MD FACEP

The Board of Directors will elect 10 councillors at the Wednesday, July 10, 2013 Board meeting at the Sagamore Hotel. Members interested in representing New York ACEP at the ACEP Annual Council Meeting, (October 12-13, 2013 in Seattle, WA), should submit a nomination form and their CV to New York ACEP. New York ACEP will be represented by 23 councillors at the 2013 ACEP Council meeting. ■

deadline for nominations: April 1, 2013



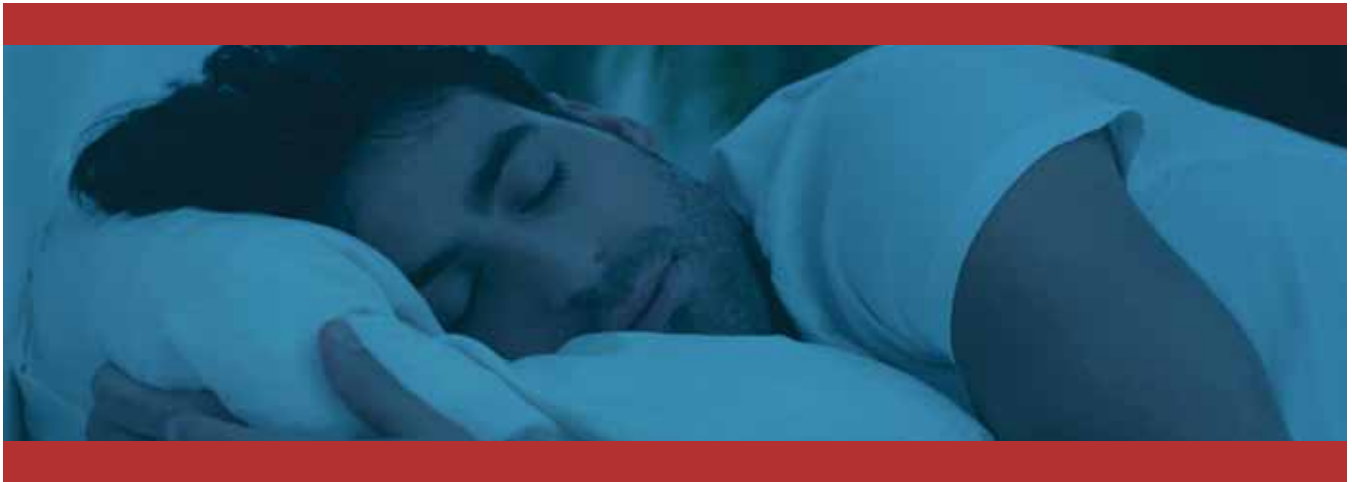
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

1130 Crosspointe Lane, Suite 10B
Webster, New York 14580-2986

PRSR STD
U.S. Postage
PAID
Rochester, New York
Permit No. 161

Tough questions:

Who's got your back?
Who will you trust
for your well being,
growth and protection?
Corporate suits or your
own physician partners?



EMP is 100% EM physician
owned and operated.
For over 20 years we've
excelled by serving
a powerful mission:
to care for patients.
EMP has 24/7 support
and the best occurrence
malpractice coverage.
Never worry about your
tail. Sleep well. We are
the right answer.



Visit emp.com/jobs or call Ann Benson at 800-828-0898.
Opportunities from New York to Hawaii. AZ, CA, CT, HI, IL, MI, NV, NY, NC, OH, OK, PA, WV