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Emergency Department***

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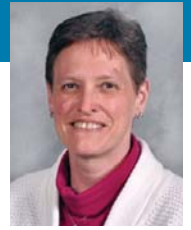


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PRESIDENT'S MESSAGE



Louise A. Prince, MD FACEP
Associate Professor, Emergency Medicine
SUNY Upstate Medical University

Is There A Doctor In The House?

Do doctors like the beloved and ever compassionate Marcus Welby from television fame still exist? Or are they as fictional as his TV character? I believe he is in the Emergency Department at 2 AM on Christmas dressed in scrubs caring for the sick, comforting the dying, and even holding onto the holiday reveler who had too much to drink. Dr. Welby looks and sounds a bit different than the beloved TV doctor, but he or she is still there 24 hours a day, 7 days a week, 365 days a year ready to care for patients despite whether it is a holiday, whether they are in pain, dying, abusive, intoxicated, angry, dangerous or infectious.

Emergency physicians care for all patients who come to their door despite time of day, ability to pay, or reason for the request for care. We have agreed to do so as our life's vocation. Over the last 50 years, Emergency Medicine has grown and established itself as the specialty that provides our nation's safety net of health care. Our Emergency Departments have seen continuing increases in volume as well as level of illness in a time where there are less inpatient beds, more care regulations, administrative burdens, litigation, and less access to both primary and specialty care. On any given day, our Emergency Departments are overcrowded, teaming with patients, loud and even unsightly. Our providers are there standing in the breach, compassionately treating all who come despite how many.

In addition to the daily provision of care, we have already cared for patients of the 9/11 disaster, the Boston Marathon bombing, the massive flooding on New York's east coast during hurricane Sandy, hurricane Katrina in the Gulf Coast, flu epidemics and are even ready for Ebola should it come. Our providers run to disasters rather than away. We do not see treating the sick and injured as "voluntary" but

rather our calling.

Our nation is currently in a health care delivery crisis. Our patients' ability to access medical care is limited. The doctor-patient relationship is broken and at times now adversarial. This hurts not only the patients who seek our care but the providers. Intentionally or unintentionally, concerns over quality of care, medical errors, litigation, regulations, payment structures, insurance models, pharmaceutical industry involvement and politics with all of the sensational media stories have widened and deepened the chasm.

Can the days of Marcus Welby be recovered? Perhaps the answer lies outside of the media, regulations, measurements, insurance structures and money. It lies in each provider to patient interaction despite how short. "Walk in the others' shoes." The Emergency Department may be the most difficult environment to live this principle but is just the right environment. The door is always open. We welcome our patients despite their ability to pay or the time of day. Our patients need us and frankly we need them. Thank each other for being there. Work mutually to create care plans – "shared decision making." Respect each other's walk in life. Feel and show empathy. This will help us live our vocations well.

The unique environment of the Emergency Department is a place where Dr. Welby is found 24/7/365. We must continue to grow the sense of "vocation" in the next generation and even in our own generation when we see it waning. We have a "calling" not a "job." As health care changes, and it will, keeping our hearts on the sense of vocation will help see us through. Dr. Welby may be fictional, but we should remember Dr. William Osler the Father of Modern Medicine. "It cannot be too often or too forcibly brought home to us that the

hope of the profession is with the men who do its daily work in general practice." We are the hope of the profession.

"The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head." Let's Live It.

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SOUND ROUNDS

Ultrasound Diagnosis of Long Bone Fractures



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Indications:

- Trauma
- Pain from falling on outstretched hand (FOOSH)
- Long bone pain, deformity, tenderness or swelling

Technique:

- Use a linear-array, high frequency (5-10MHz) transducer.
- Scan in the longitudinal, transverse and oblique planes. (Figures 1 and 2)
- Convention is to direct the transducer indicator marker cephalad when scanning longitudinally and towards the patient's right, when a transverse image is obtained.
- Alternatively, the transducer indicator marker can be directed towards the nearest joint in the longitudinal plane.



Figure 1: Linear-array, high frequency transducer in the longitudinal plane.



Figure 2: Linear-array, high frequency transducer in the transverse plane.

- Move the transducer along the long bone to view its diaphysis, metaphysis and epiphysis. Views of the dorsal, volar and lateral aspect of the bone should be obtained when feasible.
- Bone cortex is visualized as a hyperechoic line beneath the hypoechoic soft tissue and superficial fascia (Figures 3a and 3b).



Figure 3a: Longitudinal view of intact cortex. Note the continuous hyperechoic line (arrow).



Figure 3b: Transverse cross-sectional view of the radius. Posterior acoustic shadowing (arrow) beneath intact hyperechoic bone cortex.

- Fractured bones may have step-off deformities, avulsion fragments or a disruption of the hyperechoic bony cortex of the long bone (Figures 4a, 4b).



Figure 4a: Longitudinal view of a distal radius fracture. Disruption of the hyperechoic bony cortex (arrow) with overlying hematoma.

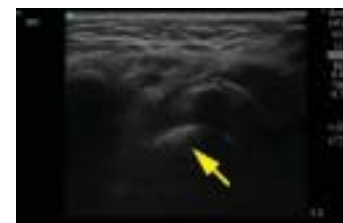


Figure 4b: Transverse view of a fracture. Note the step off or 'skipping' (arrow) of fractured hyperechoic bone cortex.

SOUND ROUNDS



Figure 5a: Longitudinal view of the elbow.

Figure 5b: Transverse view of the elbow.

- When evaluating for fractures of the distal humerus, proximal radius or ulna, visualize the posterior fat pad of the elbow joint (Figures 5a, 5b, 6a and 6b).
- There is no lipohemarthrosis or elevation of the posterior fat pad above the distal humeral line when no fracture is present in the elbow joint.
- An elevated or raised posterior fat pad will be present secondary to lipohemarthrosis when a fracture is present (Figure 7).

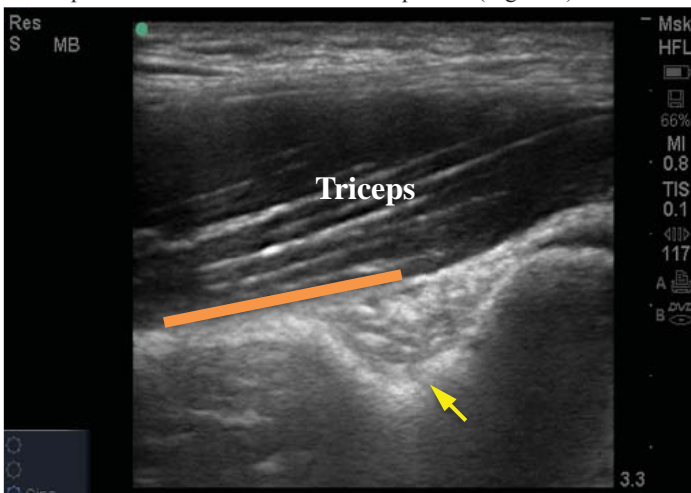


Figure 6a: Longitudinal view of normal hyperechoic, non-elevated posterior fat pad (arrow) beneath the distal humeral line (orange line). The fat pad is located within the olecranon fossa with triceps muscle overlying the fat pad.



Figure 6b: Transverse view of normal appearing posterior fat pad (arrow).

- Fracture of any bone (e.g supracondylar or radial head) within the elbow joint will result in elevation of the posterior fat pad or lipohemarthrosis.

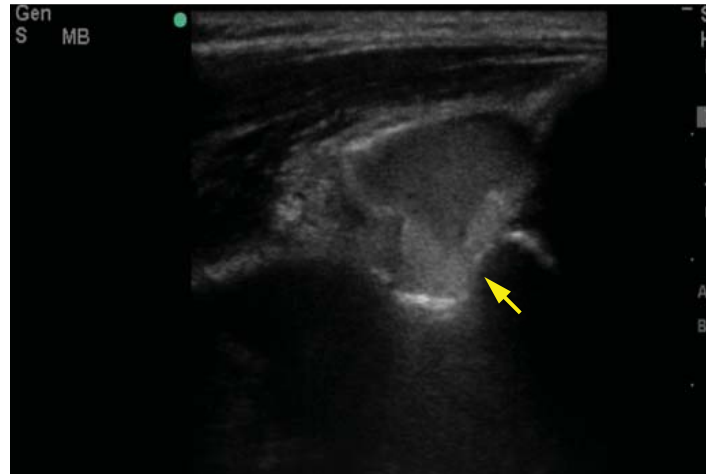


Figure 7: Raised posterior fat pad with hypoechoic signal (arrow) indicating lipohemarthrosis within the olecranon fossa.

- Compare the affected extremity with the asymptomatic side to increase accuracy of fracture diagnosis (Figure 8).

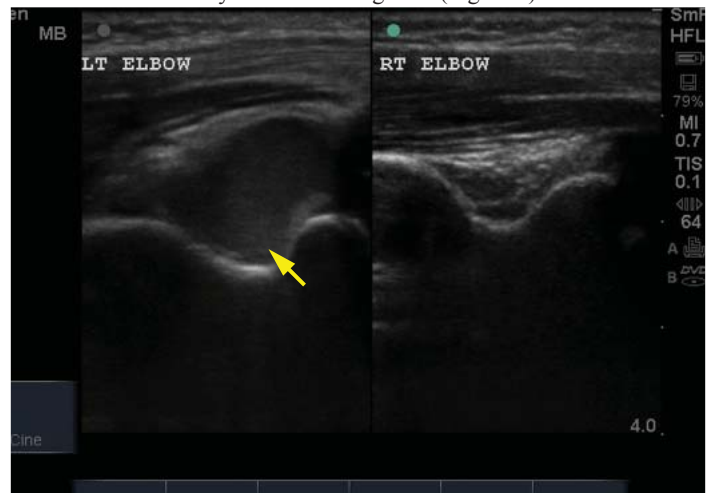


Figure 8: Left posterior fat pad is abnormal (arrow) compared to normal right posterior fat pad.

Tips:

- Provide the patient with adequate analgesia.
- Use liberal amounts of cool gel when performing the ultrasound exam to minimize patient discomfort.
- Image the contralateral, unaffected side for comparison.
- Obtain longitudinal, transverse and oblique views to increase the sensitivity and specificity of diagnosing a long bone fracture.
- Knowledge of long bone anatomy, ossification centers and growth plates in the pediatric population will help with image interpretation.

Pitfalls and Limitations:

- Fractures may be confused with small bones, joint articulations, or growth plates in children.
- Medial epicondyle fractures of the humerus may not produce an elevated posterior fat pad in the elbow.
- Inadequate analgesia, gel or excessive pressure with the probe on the fracture site can cause patient discomfort and limit a complete and thorough ultrasound exam.

TOXICOLOGY



Guest Author:
David M. Reens, MD
 Emergency Medicine Resident
 North Shore University Hospital



David C. Lee, MD FACEP
 Research Director and Associate
 Professor, Department of Emergency
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How to Administer 3% NaCl in TCA Overdose

Tricyclic antidepressants (TCA) are a class of pharmaceuticals used to treat depression, neuropathic pain, migraines and attention deficit hyperactivity disorder. TCAs work by inhibiting the presynaptic reuptake of norepinephrine and/or serotonin. These drugs were noted to have significant cardiovascular and central nervous system toxicity early in their use. TCAs have a low toxicity threshold as acute ingestions of 10-20 mg/kg can cause significant toxicity. These side effects are secondary to multiple mechanisms. First, TCAs are competitive antagonists of muscarinic acetylcholine receptors responsible for dry mouth, urinary retention, blurred vision, and sedation. TCAs also antagonize peripheral alpha1-adrenergic receptors, producing vasodilation and orthostatic hypotension. Cardiovascular toxicity is primarily responsible for the morbidity and mortality attributed to TCA. They cause cardiac conduction abnormalities by blocking inward movement into fast sodium channels, slowing phase 0 of depolarization causing widening of the QRS, RBB pattern and rightward shift of the terminal 40-msec QRS axis. Importantly, of patients with a limb lead QRS interval of 100 msec or longer, 33% develop seizures. When the QRS duration prolongs to 160 msec, there is a 50% incidence of ventricular dysrhythmias. Finally they inhibit the GABA receptor chloride-ionophore complex. The combination of increased norepinephrine, antidopamine/anticholinergic properties and GABA inhibition likely account for the seizure activity seen with TCAs. Delirium, disorientation, agitation, and/or psychotic behavior with hallucinations may also be present secondary to these mechanisms. As such, newer tricyclic antidepressants were developed to improve the therapeutic index, and reduce the incidence of serious toxicity (tertiary vs secondary amines); however, all TCAs still cause toxicity.

TABLE 71-1. Cyclic Antidepressants—Classification by Chemical Structure

Tertiary Amines	
Amitriptyline Clomipramine Doxepin Imipramine Trimipramine	
Secondary Amines	
Desipramine Nortriptyline Protriptyline	
Amoxapine	
Maprotiline	

The treatment of TCA overdose begins with early stabilization as these patients typically deteriorate rapidly. Consider early intubation for patients with altered mental status or hemodynamic instability and orogastric lavage in intentional overdose as the anticholinergic effects of the drug may decrease gastric emptying. The main treatment for wide-complex dysrhythmias, conduction delays and hypotension is sodium loading. “The optimal dosing and mode of administration of hypertonic sodium bicarbonate, is not well defined. A bolus, or rapid infusion over several minutes, of hypertonic sodium bicarbonate (1–2 mEq/kg) should be administered initially. Additional boluses every 3–5 minutes may be administered until the QRS interval narrows and the hypotension improves.” Furthermore, add 3 ampules (132 mEq) of sodium bicarbonate to 1 L of 5% dextrose in water (D5W)

and infusing this fluid at twice maintenance for 12-24 hours with a target pH of 7.5-7.55. Of note, after sodium bicarbonate, lidocaine is the antidysrhythmic of choice. Class IA (quinidine, procainamide, disopyramide, and moricizine) and class IC (flecainide, propafenone) antidysrhythmics are contraindicated as their mechanism of actions are similar to TCA.⁴

The efficacy of sodium bicarbonate in the treatment of TCA overdose is secondary to the sodium, not the alkalization from the sodium bicarbonate. Early studies on rats helped to establish this point by showing that normal saline was as effective as sodium bicarbonate in decreasing QRS duration in rats poisoned with TCA.⁹ Furthermore, a review by Blackman et al of 115 publications looked at the evidence behind plasma alkalization in TCA overdose. They found that the practice of alkalization is based on animal studies, case reports and opinion. The fact that many different animal models and TCA were used makes extrapolation difficult and they do not recommend prophylactic alkalization in the absence of life-threatening cardiotoxicity.²

The use of hypertonic saline in TCA overdose is still controversial. Some experiments have been conducted in order to assess its efficacy. Early experiments on dogs poisoned with amitriptyline to induce ventricular tachydysrhythmias showed no improvement when hypertonic saline was added to sodium bicarbonate.⁸ Later animal studies on a pig model found the contrary. In a study by McCabe et al, nortriptyline was used to induce hypotension and QRS widening. These animals then received either 10 cc/kg of 7.5% saline in 6% dextrose or an equal volume of normal saline. Ultimately the hypertonic saline group had reversal of hypotension and QRS widening with improved survival times.⁵ McCabe et al conducted another experiment on pig models this time randomizing to 10cc/kg D5W, 10 cc/kg 7.5% NaCl, 3 mEq/Kg

8.4% sodium bicarbonate plus D5W to equal 10cc/kg and finally a 10cc/kg D5W group hyperventilated to pH of 7.5. Again McCabe showed that the hypertonic saline group had better blood pressures and shorter QRS durations than all other groups.⁶

A recent case report in the *Annals of Emergency Medicine* described a 29 year old female who ingested 8g of nortriptyline who had coma, hypotension and widened QRS. The patient was intubated, had gastric lavage, hyperventilated, given multiple boluses of normal saline, sodium bicarbonate boluses, levophed and dopamine with persistent deterioration. At this point the patient was given one 200cc 7.5% NaCl IV push and narrowing of her QRS and improved blood pressure within 3 minutes.⁷

In a review by Banks and Furyk other case reports are cited. Hoegholm and Clementsen used 194cc of 3% hypertonic saline in a TCA overdose unresponsive to sodium bicarbonate with good effect. Finally, Seitz et al used 30 cc of 10% hypertonic saline to reverse a wide complex tachycardia in a patient with TCA overdose. They conclude that the precise dose of hypertonic saline is unclear and while hypertonic saline is a reasonable treatment for TCA toxicity resistant to sodium bicarbonate, it is a grade D recommendation supported by level IV evidence.¹

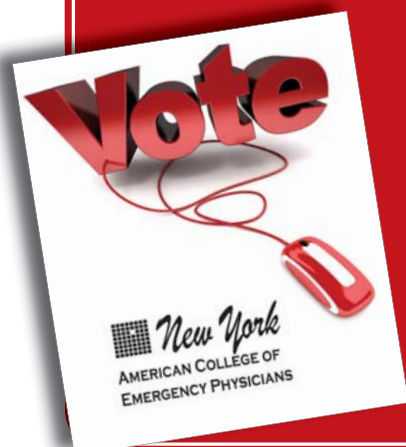
In summary, the treatment of TCA overdose begins with early stabilization as these patients typically deteriorate rapidly. Consider early intubation for patients with altered mental status or hemodynamic instability and orogastric lavage in intentional overdose as the anticholinergic effects of the drug

may decrease gastric emptying. The main treatment for wide-complex dysrhythmias, conduction delays and hypotension is sodium loading. "The optimal dosing and mode of administration of hypertonic sodium bicarbonate, is not well defined. A bolus, or rapid infusion over several minutes, of hypertonic sodium bicarbonate (1–2 mEq/kg) should be administered initially. Additional boluses every 3–5 minutes may be administered until the QRS interval narrows and the hypotension improves." Furthermore, add 3 ampules (132 mEq) of sodium bicarbonate to 1 L of 5% dextrose in water (D5W) and infusing this fluid at twice maintenance for 12-24 hours with a target pH of 7.5-7.55. Of note, after sodium bicarbonate, lidocaine is the antidysrhythmic of choice. Class IA (quinidine, procainamide, disopyramide, and moricizine) and class IC (flecainide, propafenone) antidysrhythmics are contraindicated as their mechanism of actions are similar to TCAs.

For the patient in extremis, clinicians should consider the use of hypertonic saline to treat the wide-complex dysrhythmias, conduction delays and hypotension seen with TCA overdose. Multiple animal studies and case reports have demonstrated the rapid improvement of QRS widening and hypotension after the administration of hypertonic saline. While the precise dose and survival benefits of hypertonic saline in TCA overdose are still to be determined, a reasonable approach based on compelling animal and case report data would be to administer 200cc of 7.5% NaCl IV push (3% NaCl may be used if 7.5% NaCl is not available) in a patient who has TCA toxicity resistant to sodium bicarbonate and in whom other measures have failed.

References

1. Banks & Furyk. 2008. Review article: Hypertonic saline use in the emergency department. *Emergency Medicine Australasia*. 20, 294-305.
2. Blackman, K. et al. 2001. Plasma alkalization for tricyclic antidepressant toxicity: A systematic review. *Emergency Medicine Australasia*. Vol 13, Iss 2, 204-210.
3. Eken, C. 2008. Hypertonic Saline: An alternative therapy in TCA overdose failed to respond to sodium bicarbonate. *Clinical Toxicology*. Vol 46, no. 5.
4. Hoffman et al. 2007. *Goldfrank's Manual of Toxicologic Emergencies*. New York. 608 – 614.
5. McCabe JL, Menegazzi JJ, Cobaugh DJ, Auble TE. Recovery from severe cyclic antidepressant overdose with hypertonic saline/dextran in a swine model. *Acad Emerg Med*. 1994;1(2):111–5.
6. McCabe JL, Cobaugh DJ, Menegazzi JJ, Fata J. Experimental Tricyclic Antidepressant Toxicity: A Randomized, Controlled Comparison of Hypertonic Saline Solution, Sodium Bicarbonate, and Hyperventilation. *Ann Emerg Med* 1998; 32:329–333
7. McKinney, P.E. & Rasmussen, R. 2003. Reversal of severe tricyclic antidepressant-induced cardiotoxicity with intravenous hypertonic saline solution. *Annals of Emergency Medicine*. Volume 42, Issue 1, July 2003, Pages 20–24
8. Nattel S, Mittleman M. Treatment of ventricular tachyarrhythmias resulting from amitriptyline toxicity in dogs. *J Pharmacol Exp Ther*. 1984; 231:430–5.
9. Pentel, P. & Benowitz, N. 1984. Efficacy and mechanism of action of sodium bicarbonate in the treatment of desipramine toxicity in rats. *JPET July 1984 vol. 230 no. 1 12-19*



Board of Directors Election

This June, New York ACEP members will receive the 2016 Candidate Profile. Through this proxy, members will elect four board candidates to serve three-year terms on the New York ACEP Board of Directors.

Members can cast their vote on board positions by proxy no later than July 1. Proxies will be sent by email to all New York ACEP member in June. Members may cast a proxy in person at the New York ACEP Annual Meeting Thursday, July 7 at 12:45 pm at The Sagamore Resort on Lake George in Bolton Landing.

Ever Think About Public Health?



Jeremy T. Cushman, MD MS EMT-P FACEP

Associate Professor and Chief, Division of
Prehospital Medicine, University of Rochester

You are probably saying of course I think about it! I work in the trenches of the ED every day providing public health to the thousands that do not have routine access to care, the immigrants that just moved to this country, or the third patient this shift that I had to treat for GC and Chlamydia. But what I really mean is Public Health as a career choice. I admit I had never even given it a first look, forget a second one. But if there is one thing I learned in the past year, it's that we need more emergency physicians leading the field of public health.

I just recently finished one of the most professionally challenging years of my life as the Interim Commissioner of Public Health in Monroe County (that's Rochester!). Forget about the administrative challenges – a budget of nearly \$80 million, more than 300 staff and contractors, nearly 99% of services mandated by New York State; or the diversity of programs: everything from STD clinics to WIC, Early Intervention and Preschool Education Programs to water supply, food, and bathing inspections; a medical examiner's office to TB clinics and dozens of other programs. But what became ever so apparent working with all these programs is how the presence (or absence) of them impacts our ED environment.

So much of what public health faces today is what we see in our waiting room. Social determinants of health play a far greater role than the health system ever imagined, but as emergency physicians, this is nothing new. Does it surprise you that having stable, safe housing is more predictive of one's health than nearly any other factor? Probably not, since many of our treatment plans or dispositions hinge on that information. The man that cannot get his dressings changed because he is homeless; the woman that presents with irregular vaginal spotting who is found to have an

aggressive cervical cancer; the fourth heroin overdose this shift; the 30-something that already has diabetes, hypertension, hypercholesterolemia and a stent presenting with chest pain, again. We are witness to the failure of the health care system to care for the people's health.

I found that when I met with community organizations and individuals on various issues, that my being an emergency physician immediately created an olive branch of respect and empathy that I was admittedly not prepared for. Sure you got the usual stories of their time in the ED; but I did not realize how my experience as an emergency physician allowed me to almost immediately relate to almost any public health issue and how deeply we are respected by those advocating for the same things that frustrate us when working a shift. If they only had follow-up, if they only had the social resources, if they only...

Certainly Public Health may not be as glamorous, lucrative, or as immediately gratifying (at times) as being an emergency physician; but our ability to make decisions based on limited data, and our role as both healers and advocates for those that so often fall through the sieve of our health care system, truly make us ideal leaders in public health (and medicine in general, but that's a different EPIC article). So the next time you are in the doldrums of your career, contemplating the meaning of four years of medical school and three (or four) of residency, think about the amazing opportunity that you have just by your training and experience in emergency medicine to be a leader in Public Health. With all due respect to my colleagues trained through residencies in Preventive Medicine, I truly believe we have what it takes to be a Public Health leader in our community. And although now is not the right time for me

to leave the clinical practice of emergency medicine to stay in public health, if it were, I at least know where my first look would be.

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2016 Scientific Assembly



SCIENTIFIC ASSEMBLY 2016

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JULY 6-8, 2016

Calendar

June 2016

- 1 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 8 Education Committee Conference Call, 2:45 pm
- 8 Professional Development Conference Call, 3:30 pm
- 9 Practice Management Conference Call, 1:00 pm
- 15 Government Affairs Conference Call, 11:00 am
- 15 Research Committee Conference Call, 3:00 pm
- 16 EMS Committee Conference Call, 2:30 pm

July 2016

- 6 Board of Directors Meeting, The Sagamore Hotel, 11:00-12:15 pm
- 6-8 Scientific Assembly, The Sagamore Hotel
- 7 Annual Meeting and Legislative Update, The Sagamore Hotel, 12:45 pm - 1:45 pm
- 7 New York ACEP Committee Meetings, The Sagamore Hotel, 1:45 pm - 2:15 pm
- 8 Board of Directors Meeting, The Sagamore Hotel, 7:00 am - 8:00 am

August 2016

- 3 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 31 Emergency Medicine Resident Career Day, The New York Academy, 8:00 am - 12:30 pm

September 2016

- 14 Education Committee Conference Call, 2:45 pm
- 14 Professional Development Conference Call, 3:30 pm
- 8 Practice Management Conference Call, 1:00 pm
- 21 Government Affairs Conference Call, 11:00 am
- 21 Research Committee Conference Call, 3:00 pm
- 15 EMS Committee Conference Call, 2:30 pm
- 27 Board of Directors Meeting, Mohonk Mountain House 1:30 pm - 5:50 pm

**Wednesday,
November 9, 2016**

8:30 am - 12:30 pm

Location
Stern Auditorium
Icahn School of Medicine at
Mount Sinai

More information
online at
www.nyacep.org



EDUCATION



Guest Author:

Jeffrey J. Thompson, MD FACEP

Faculty and Associate Program Director, University at Buffalo, Department of Emergency Medicine



Kaushal H. Shah, MD FACEP

Residency Director Emergency Medicine
Icahn School of Medicine at Mt. Sinai

Whipping Them Into Shape

Every year I try to watch as many of the Oscar® nominated films as possible. One of my favorites of last year was *Whiplash*, the story of a gifted young jazz drummer (Andrew) in a New York City conservatory who is challenged beyond conventional limits by his abusive yet legendary director, Terrance Fletcher. Throughout the film Fletcher is seen berating, humiliating, threatening and even physically abusing his students in order to mold them into the world's finest jazz musicians. Although the students cower and wince, they are all too eager to endure his abuse in order to reach their goals. At the core of the film is the philosophical question, "How far is too far to push someone to reach their full potential?"

The film resonates with me on several levels. As a freelance professional musician I have encountered this kind of director (maybe not quite as extreme) and I understand first hand the pressure placed upon music students to practice until their fingers are bloody in order to be the best. But Fletcher was more familiar on a different level. He reminded me of several attending physicians I had throughout the course of my medical training. In one of the most compelling scenes, Fletcher focuses his attention on Andrew and badgers him repeatedly about his tempo until the young man is completely demoralized. Whenever I watch this scene I am reminded of some of the "pimping rounds" I experienced where a student or resident would be similarly pounded with questions until they could no longer provide an answer and conceded their inferiority.

I am sure that most of us in the medical profession can identify with this scenario; after all, it has been a traditional component of American and European medical education for over a century.¹ Perhaps some of us still use a version of this technique in order to

assess our trainees' medical knowledge and establish or maintain a hierarchy. Even though this is much less common in emergency medicine than in other disciplines, it is still a lively remnant of past generations of physician educators.

Surprisingly, many trainees find this very effective, even though at the extreme it borders on harassment and abuse.² There are those who argue that this sort of toughness is needed in order to cultivate a culture of independent learning and encourage (even demand) professional excellence. Consider these words from Terrance Fletcher:

"I wasn't there to conduct. Any...moron can wave his arms and keep people in tempo. I was there to push people beyond what's expected of them. I believe that is...an absolute necessity. Otherwise we're depriving the world of the next Louis Armstrong. The next Charlie Parker."³

It is not difficult to see the parallels to medical education. We could passively precept our trainees without prodding beyond a basic minimal competence. Our risk, however, is depriving the world of expert physicians capable of consistently and accurately diagnosing and treating disease. In our case, the stakes are much higher.

So, how far do we push our trainees? Until they squirm? Cry? Quit? Most of us would agree that probing and challenging these students and residents is necessary, but we must also be aware of the potential consequences. Like Andrew in *Whiplash*, many medical trainees are adversely affected by the expectations and frequently undue pressure placed upon them, and the psychological effects can be devastating. Depression and suicidal thoughts are common among medical trainees and physicians^{4,5} and reports of resident suicide have been frequent over the

past few years. As faculty we must constantly be sensitive to this while working within our professional mandate to train excellent emergency physicians.

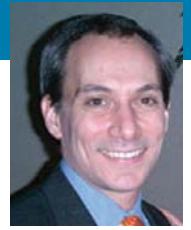
Still, there is something compelling about encouraging our students and residents to push themselves to reach their full potential. In my opinion we need not completely abandon the Socratic practice of direct questioning, even with progressively difficult and obscure questions. There is certainly something valuable in challenging the limits of their knowledge and promoting independent learning. But we must do so with noble intentions and without creating a hostile environment.

I encourage you to watch *Whiplash* and decide for yourself how far is too far to push someone to greatness.

References

1. Detsky AS. The art of pimping. *JAMA*. 2009; 301(13): 1379-81
2. Wear D, et al. Pimping: perspectives of 4th year medical students. *Teach Learn Med*. 2005 Spring.
3. <http://www.imdb.com/title/tt2582802/quotes>
4. Goebert D, et al. Depressive symptoms among medical students and residents: A multischool study. *Academic Medicine*. 2009; 84:236-41
5. Lindeman S, et al. A systematic review on gender-specific suicide mortality in medical doctors. *Br J Psych*. 1996; 168(3): 274-9

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Photographing Injuries in the Acute Care Setting: Development and Evaluation of a Standardized Protocol for Research, Forensics, and Clinical Practice.

Bloemen EM, Rosen T, Cline Schiroo JA, Clark S, Mulcare MR, Stern ME, Mysliwiec R, Flomenbaum NE, Lachs MS, Hargarten S.; Division of Emergency Medicine, Weill Cornell Medical College, New York; Acad Emerg Med. 2016 Mar 2.

BACKGROUND: Photographing injuries in the acute setting allows for improved documentation as well as assessment by clinicians and others who have not personally examined a patient. This tool is important, particularly for telemedicine, tracking of wound healing, the evaluation of potential abuse, and injury research. Despite this, protocols to ensure standardization of photography in clinical practice, forensics, or research have not been published. In preparation for a study of injury patterns in elder abuse and geriatric falls, our goal was to develop and evaluate a protocol for standardized photography of injuries that may be broadly applied.

METHODS: We conducted a literature review for techniques and standards in medical, forensic, and legal photography. We developed a novel protocol describing types of photographs and body positioning for 8 body regions, including instructional diagrams. We revised it iteratively in consultation with experts in medical photography, forensics, elder, child, and domestic abuse. The resulting protocol requires a minimum of four photos of each injury at multiple distances with and without a ruler/color guide. To evaluate the protocol's efficacy, multiple research assistants without previous photography experience photographed injuries from a convenience sample of elderly patients presenting to a single large, urban, academic emergency department. A selection of these patients' images were then evaluated in a blinded fashion by four non-treating emergency medicine phy-

sicians and the inter-rater reliability between these physicians was calculated.

RESULTS: Among the 131 injuries, from 53 patients, photographed by 18 photographers using this protocol, photographs of 25 injuries (10 bruises, 7 lacerations, and 8 abrasions) were used to assess characterization of the injury. Physicians' characterizations of the injuries were reliable for the size of the injury ($\kappa=0.91$; 95% CI 0.77, 1.00), side of the body ($\kappa=0.97$; 95% CI 0.88, 1.00), precise location of the injury ($\kappa=0.74$; 95% CI 0.63, 0.81), and type of abrasion ($\kappa=0.76$; 95% CI 0.45, 1.00). The exact shape of the injury ($\kappa=0.44$; 95% CI 0.17, 0.51) and the primary color of bruises ($\kappa=0.37$; 95% CI 0.25, 0.48) were not as reliably characterized.

CONCLUSIONS: Standardizing the documentation of injuries with photographs for clinical and research assessment can be conducted by non-professional photographers. A photography protocol will ensure that this important mechanism for documentation is optimized.

Increased Identification of Emergency Department 72-hour Returns Using Multi-Hospital Health Information Exchange.

Shy BD, Kim EY, Genes NG, Lowry T, Loo GT, Hwang U, Richardson LD, Shapiro JS.; Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York; Acad Emerg Med. 2016 Mar 2.

OBJECTIVES: Emergency departments (EDs) commonly analyze cases of patients returning within 72 hours of initial ED discharge as potential opportunities for quality improvement. In this study, we tested the use of a Health Information Exchange (HIE) to improve identification of 72-hour return visits compared to individual hospitals' site-specific data.

METHODS: We collected de-identified patient data over a five-year study period from

Healthix, an HIE in the New York metropolitan area. We measured site-specific 72-hour ED returns and compared these data to those obtained from a regional 31-site HIE (Healthix) and to those from a smaller, antecedent 11-site HIE. Though only ED visits were counted as index visits, either ED or inpatient revisits within 72-hours of the index visit were considered as early returns.

RESULTS: A total of 12,669,657 patient encounters were analyzed across the 31 HIE EDs, including 6,352,829 encounters from the antecedent 11-site HIE. Site-specific 72-hour return visit rates ranged from 1.1% to 15.2% (median 5.8%) among the individual 31 sites. When using the larger HIE to identify return visits to any site, individual EDs had a 72-hour return frequency of 1.8% to 15.5% (median 6.8%). HIE increased the identification ability of 72-hour ED return analyses by an average of 11.16% [95% confidence interval = 11.10 to 11.22] compared with site-specific (no HIE) analyses.

CONCLUSION: This analysis demonstrates incremental improvements in our ability to identify early ED returns using increasing levels of HIE data aggregation. Although intuitive, this has not been previously described using HIE. ED quality measurement and patient safety efforts may be aided by using HIE in 72-hour return analyses. This article is protected by copyright. All rights reserved.

Diagnosing Acute Heart Failure in the Emergency Department: A Systematic Review and Meta-analysis.

Martindale JL, Wakai A, Collins SP, Levy PD, Diercks D, Hiestand BC, Fermann GJ, de-Souza I, Sinert R.; SUNY Downstate Medical Center, Brooklyn; Acad Emerg Med. 2016 Mar;23(3):223-42.

BACKGROUND: Acute heart failure (AHF) is one of the most common diagnoses assigned to emergency department (ED) patients who are hospitalized. Despite its high preva-

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lence in the emergency setting, the diagnosis of AHF in ED patients with undifferentiated dyspnea can be challenging.

OBJECTIVES: The primary objective of this study was to perform a systematic review and meta-analysis of the operating characteristics of diagnostic elements available to the emergency physician for diagnosing AHF. Secondary objectives were to develop a test-treatment threshold model and to calculate interval likelihood ratios (LRs) for natriuretic peptides (NPs) by pooling patient-level results.

METHODS: PubMed, EMBASE, and selected bibliographies were searched from January 1965 to March 2015 using MeSH terms to address the ability of the following index tests to predict AHF as a cause of dyspnea in adult patients in the ED: history and physical examination, electrocardiogram, chest radiograph (CXR), B-type natriuretic peptide (BNP), N-terminal proB-type natriuretic peptide (NT-proBNP), lung ultrasound (US), bedside echocardiography, and bioimpedance. A diagnosis of AHF based on clinical data combined with objective test results served as the criterion standard diagnosis. Data were analyzed using Meta-DiSc software. Authors of all NP studies were contacted to obtain patient-level data. The Quality Assessment Tool for Diagnostic Accuracy Studies-2 (QUADAS-2) for systematic reviews was utilized to evaluate the quality and applicability of the studies included.

RESULTS: Based on the included studies, the prevalence of AHF ranged from 29% to 79%. Index tests with pooled positive LRs ≥ 4 were the auscultation of S3 on physical examination (4.0, 95% confidence interval [CI] = 2.7 to 5.9), pulmonary edema on both CXR (4.8, 95% CI = 3.6 to 6.4) and lung US (7.4, 95% CI = 4.2 to 12.8), and reduced ejection fraction observed on bedside echocardiogram (4.1, 95% CI = 2.4 to 7.2). Tests with low negative LRs were BNP < 100 pg/mL (0.11, 95% CI = 0.07 to 0.16), NT-proBNP < 300 pg/mL (0.09, 95% CI = 0.03 to 0.34), and B-line pattern on lung US LR (0.16, 95% CI = 0.05 to 0.51). Interval LRs of BNP concentrations at the low end of "positive" results as defined by a cutoff of 100 pg/mL were substantially lower (100 to 200 pg/mL; 0.29, 95% CI = 0.23 to 0.38) than those associated with higher BNP concentrations (1000 to 1500 pg/mL; 7.12, 95% CI = 4.53 to 11.18). The interval LR of NT-proBNP concentrations even at very high values (30,000 to 200,000 pg/mL) was 3.30 (95% CI = 2.05 to 5.31).

CONCLUSIONS: Bedside lung US and echocardiography appear to be the most useful tests for affirming the presence of AHF while NPs are valuable in excluding the diagnosis. \neq

Interrater Reliability of Emergency Physician-Performed Ultrasonography for Diagnosing Femoral, Popliteal, and Great Saphenous Vein Thromboses Compared to the Criterion Standard Study by Radiology.

Mulcare MR, Lee RW, Pologe JI, Clark S, Borda T, Sohn Y, Sacco DL(2), Riley DC.; Division of Emergency Medicine, Weill Cornell Medical College, New York; J Clin Ultrasound. 2016 Feb 18.

PURPOSE: To assess the interrater reliability and test characteristics of lower limb sonographic examination for the diagnosis of deep venous and proximal great saphenous vein thrombosis when performed by Emergency Physicians (EPs) as compared to that by the Department of Radiology (Radiology). The secondary objective was to assess the effects of patient body mass index and EP satisfaction with bedside ultrasound on sensitivity and specificity.

METHODS: A prospective study was conducted for patients with clinical suspicion for lower extremity thrombus. EPs evaluated for venous thrombosis in the common femoral vein, femoral vein of the thigh, popliteal vein, and proximal great saphenous vein. Subsequently, all patients received ultrasounds by Radiology, the criterion standard.

RESULTS: One hundred ninety-seven patients (257 individual legs) were evaluated. There was 90-95% agreement between EP and Radiology, moderate kappa agreement for common femoral vein, and femoral vein of the thigh and fair kappa agreement for great saphenous vein and popliteal vein. The sensitivity and specificity of EP ultrasounds compared with criterion standard were lower than previously reported. There was no trend in patient body mass index or provider satisfaction influencing the test characteristics.

CONCLUSIONS: Our study suggests that point-of-care sonography should not replace Radiology-performed scans. The required amount of training for EPs to be competent in this examination needs further investigation.

The Focused Assessment With Sonography For Trauma (FAST) Examination And Pelvic Trauma: Indications And Limitations.

Shaukat NM, Copeli N, Desai P.; Department of Emergency Medicine, Weill Cornell Medical College, New York-Presbyterian Queens; Flushing; Emerg Med Pract. 2016 Mar;18(3):1-24.

Pelvic trauma accounts for only 3% of all skeletal injuries but may have mortality as high as 45% in cases of severe trauma. Significant high-grade-mechanism trauma to the pelvis must always take the abdomen into consideration for evaluation. The focused assessment with sonography for trauma (FAST) examination has been shown to be a valuable tool in assessing the unstable trauma patient with blunt abdominal injury, though its diagnostic utility is much less well-defined than in primary pelvic trauma. This systematic review explores the utility and limitations of the FAST examination in patients with blunt pelvic trauma and discusses the timing for the examination during the trauma survey. Newer techniques for emergency department management of the unstable trauma patient are also addressed.

Specialist Availability in Emergencies: Contributions of Response Times and the Use of Ad Hoc Coverage in New York State.

Rabin E, Patrick L.; Department of Emergency Medicine, The Icahn School of Medicine at Mount Sinai, New York; Am J Emerg Med. 2016 Apr;34(4):687-93.

OBJECTIVES: Nationwide, hospitals struggle to maintain specialist on-call coverage for emergencies. We seek to further understand the issue by examining reliability of scheduled coverage and the role of ad hoc coverage when none is scheduled.

METHODS: An anonymous electronic survey of all emergency department (ED) directors of a large state. Overall and for 10 specialties, respondents were asked to estimate on-call coverage extent and "reliability" (frequency of emergency response in a clinically useful time frame: 2 hours), and use and effect of ad hoc emergency coverage to fill gaps. Descriptive statistics were performed using Fisher exact and Wilcoxon sign rank tests for significance.

RESULTS: Contact information was obtained for 125 of 167 ED directors. Sixty responded (48%), representing 36% of EDs. Forty-six percent reported full on-call coverage scheduled for all specialties. Forty-six percent reported consistent reliability. Coverage and reliability were strongly related ($P < .01$; 33% reported both), and larger ED volume correlat-

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ed with both ($P < .01$). Ninety percent of hospitals that had gaps in either employed ad hoc coverage, significantly improving coverage for 8 of 10 specialties. For all but 1 specialty, more than 20% of hospitals reported that specialists are “Never”, “Rarely” or “Sometimes” reliable (more than 50% for cardiovascular surgery, hand surgery and ophthalmology).

CONCLUSIONS: Significant holes in scheduled on-call specialist coverage are compounded by frequent unreliability of on-call specialists, but partially ameliorated by ad hoc specialist coverage. Regionalization may help because a 2-tiered system may exist: larger hospitals have more complete, reliable coverage. Better understanding of specialists’ willingness to treat emergencies ad hoc without taking formal call will suggest additional remedies.

Geographic Distribution of Disaster-Specific Emergency Department Use After Hurricane Sandy in New York City.

Lee DC, Smith SW, Carr BG, Doran KM, Portelli I, Grudzen CR, Goldfrank LR.; Ronald O. Perelman Department of Emergency Medicine, New York University School of Medicine, New York; Disaster Med Public Health Prep. 2016 Feb 9:1-11.

OBJECTIVE: We aimed to characterize the geographic distribution of post-Hurricane Sandy emergency department use in administrative flood evacuation zones of New York City.

METHODS: Using emergency claims data, we identified significant deviations in emergency department use after Hurricane Sandy. Using time-series analysis, we analyzed the frequency of visits for specific conditions and comorbidities to identify medically vulnerable populations who developed acute postdisaster medical needs.

RESULTS: We found statistically significant decreases in overall post-Sandy emergency department use in New York City but increased utilization in the most vulnerable evacuation zone. In addition to dialysis- and ventilator-dependent patients, we identified that patients who were elderly or homeless or who had diabetes, dementia, cardiac conditions, limitations in mobility, or drug dependence were more likely to visit emergency departments after Hurricane Sandy. Furthermore, patients were more likely to develop drug-resistant infections, require isolation, and present for hypothermia, environmental exposures, or administrative reasons.

CONCLUSIONS: Our study identified high-risk populations who developed acute medical and social needs in specific geographic areas after Hurricane Sandy. Our findings can inform coherent and targeted responses to disasters. Early identification of medically vulnerable populations can help to map “hot spots” requiring additional medical and social attention and prioritize resources for areas most impacted by disasters.

Emergency Department Presentations for Injuries in Older Adults Independently Known to be Victims of Elder Abuse.

Rosen T, Bloemen EM, LoFaso VM, Clark S, Florenbaum NE, Lachs MS; Division of Emergency Medicine, Weill Cornell Medical College, New York; J Emerg Med. 2016 Mar;50(3):518-26.

BACKGROUND: Elder abuse is under-recognized by emergency department (ED) providers, largely due to challenges distinguishing between abuse and accidental trauma.

OBJECTIVE: To describe patterns and circumstances surrounding elder abuse-related and potentially abuse-related injuries in ED patients independently known to be physical elder abuse victims.

METHODS: ED utilization of community-dwelling victims of physical elder abuse in New Haven, CT from 1981-1994 was analyzed previously. Cases were identified using Elderly Protective Services data matched to ED records. Sixty-six ED visits were judged to have high probability of being related to elder abuse and 244 were of indeterminate probability. We re-examined these visits to assess whether they occurred due to injury. We identified and analyzed in detail 31 injury-associated ED visits from 26 patients with high probability of being related to elder abuse and 108 visits from 57 patients with intermediate probability and accidental injury.

RESULTS: Abuse-related injuries were most common on upper extremities (45% of visits) and lower extremities (32%), with injuries on head or neck noted in 13 visits (42%). Bruising was observed in 39% of visits, most commonly on upper extremities. Forty-two percent of purportedly accidental injuries had suspicious characteristics, with the most common suspicious circumstance being injury occurring more than 1 day prior to presentation, and the most common suspicious injury pattern being maxillofacial injuries.

CONCLUSION: Victims of physical elder abuse commonly have injuries on the upper

extremities, head, and neck. Suspicious circumstances and injury patterns may be identified and are commonly present when victims of physical elder abuse present with purportedly accidental injuries.

Ultrasound-Guided Nerve Blocks for Intracapsular and Extracapsular Hip Fractures.

Dickman E, Pushkar I, Likourezos A, Todd K, Hwang U, Akhter S, Morrison S; Department of Emergency Medicine, Maimonides Medical Center, Brooklyn; Am J Emerg Med. 2016 Mar;34(3):586-9.

OBJECTIVES: To compare pain relief between patients with intracapsular and extracapsular hip fractures who received an ultrasound-guided femoral nerve block (USFNB).

DESIGN: A multicenter, prospective, randomized, clinical trial.

SETTING: The study was conducted in the emergency departments of 3 academic hospitals located in New York City.

SUBJECTS: Patients aged ≥ 60 years presenting to the emergency department with hip fracture.

METHODS: A subgroup analysis from a larger data set was conducted of patients with intracapsular and extracapsular hip fractures who received an USFNB. We compared pain scores at baseline and then at 2 and 3 hours after the nerve block was performed, and also assessed pain relief at 2 and 3 hours.

RESULTS: Seventy-seven patients were randomized to receive USFNB, of which 68 had follow-up data at 2 and 3 hours and were included in the data analysis. Thirty-one were diagnosed with intracapsular and 37 with extracapsular hip fractures. In both groups, reductions in pain scores were clinically and statistically significant. In the intracapsular group, mean pain scores decreased from 6.23 to 3.81 ($P < .0001$) at 2 hours and from 6.23 to 3.87 ($P < .0001$) at 3 hours. In the extracapsular group, mean pain scores decreased from 6.62 to 3.89 ($P < .0001$) at 2 hours and from 6.62 to 3.46 ($P < .0001$) at 3 hours. These differences were similar between the extracapsular and intracapsular groups at 2 hours ($P = .92$) and at 3 hours ($P = .58$), thus demonstrating similar reductions in pain in the 2 groups. The differences in pain relief between the intracapsular and extracapsular groups were also similar: 1.61 (confidence interval [CI], 1.14-2.08) vs 1.35 (CI, 0.96-1.75) at 2 hours ($P = .39$) and 1.68 (CI, 1.21-2.15) vs 1.38 (CI, 0.89-1.87) at 3 hours ($P = .38$).

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CONCLUSION: Ultrasound-guided femoral nerve block was equally effective in reducing pain for patients with both intracapsular and extracapsular hip fractures.

Perceived Appropriateness of Shared Decision-Making in the Emergency Department: A Survey Study.

Probst MA, Kanzaria HK, Frosch DL, Hess EP, Winkel G, Ngai KM, Richardson LD; Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York; Acad Emerg Med. 2016 Jan 25.

OBJECTIVE: To describe perceptions of practicing emergency physicians regarding the appropriateness and medicolegal implications of using shared decision-making (SDM) in the emergency department (ED).

METHODS: We conducted a cross-sectional survey of emergency physicians (EPs) at a large, national professional meeting to assess perceived appropriateness of SDM for different categories of ED management (e.g. diagnostic testing, treatment, disposition) and in common clinical scenarios (e.g. low-risk chest pain, syncope, minor head injury). A 21-item survey instrument was iteratively developed through review by content experts, cognitive testing, and pilot testing. Descriptive and multivariate analyses were conducted.

RESULTS: We approached 737 EPs; 709 (96%) completed the survey. Two thirds (67.8%) of respondents were male, 51% practiced in an academic setting; 44% in the community. Of the 7 management decision categories presented, SDM was reported to be most frequently appropriate for deciding on invasive procedures (71.5%), computed tomography (CT) scanning (56.7%), and post-ED disposition (56.3%). Among the specific clinical scenarios, use of thrombolytics for acute ischemic stroke was felt to be most frequently appropriate for SDM (83.4%), followed by lumbar puncture to rule out sub-arachnoid hemorrhage (73.8%), and CT head for pediatric minor head injury (69.9%). Most EPs (66.8%) felt that using and documenting SDM would decrease their medicolegal risk while a minority (14.2%) felt it would increase their risk.

CONCLUSIONS: Acceptance of SDM among emergency physicians appears to be strong across management categories (diagnostic testing, treatment, and disposition) and in a variety of clinical scenarios. SDM is perceived by most EPs to be medicolegally

protective.

Reducing Emergency Department Utilization Through Engagement in Telemedicine by Senior Living Communities.

Gillespie SM, Shah MN, Wasserman EB, Wood NE, Wang H, Noyes K(3), Nelson D, Dozier A, McConnochie KM; Department of Emergency Medicine, University of Rochester School of Medicine and Dentistry, Rochester; Telemed J E Health. 2016 Jan 7.

BACKGROUND: High-intensity telemedicine has been shown to reduce the need for emergency department (ED) care for older adult senior living community (SLC) residents with acute illnesses. We evaluated the effect of SLC engagement in the telemedicine program on ED use rates.

MATERIALS AND METHODS: We performed a secondary analysis of data from a prospective cohort study evaluating the effectiveness of high-intensity telemedicine for SLC residents. We compared the annual rate of change in ED use among subjects who resided in SLC units that were more engaged in telemedicine services with that among subjects who resided in SLC units that were less engaged in telemedicine and control subjects who lived at facilities without access to telemedicine services.

RESULTS: During the study, subjects had 503 telemedicine visits, with 362 (72.0%) in the more engaged SLCs and 141 (28.0%) in the less engaged SLCs. For subjects residing in more engaged SLCs, ED use decreased at an annualized rate of 28% (rate ratio [RR]=0.72; 95% confidence interval [CI], 0.58-0.89), whereas in the less engaged (RR=0.962; 95% CI, 0.776-1.19) and control (RR=0.909, 95% CI, 0.822-1.07) groups there was no significant change in ED use ($p=0.036$ for group \times time interaction).

CONCLUSIONS: Individuals residing in more engaged SLCs experienced a greater decrease in ED use compared with subjects residing in less engaged SLCs or those without access to high-intensity telemedicine for acute illnesses. We identified potential factors associated with more engaged SLCs, but further research is needed to understand resident and staff engagement and how to increase it.

A Multicenter Evaluation of the Impact of Sex on Abdominal and Fracture Pain Care.

Siddiqui A, Belland L, Rivera-Reyes L, Handel D, Yadav K, Heard K, Eisenberg A, Hwang U;

Emergency Department, Icahn School of Medicine at Mount Sinai, New York; Med Care. 2015 Nov;53(11):948-53.

BACKGROUND: Previous studies examining sex-based disparities in emergency department (ED) pain care have been limited to a single pain condition, a single study site, and lack rigorous control for confounders.

OBJECTIVE: A multicenter evaluation of the effect of sex on abdominal pain (AP) and fracture pain (FP) care outcomes.

RESEARCH DESIGN: A retrospective cohort review of ED visits at 5 US hospitals in January, April, July, and October 2009.

SUBJECTS: A total of 6931 patients with a final ED diagnosis of FP (n=1682) or AP (n=5249) were included.

MEASURES: The primary predictor was sex. The primary outcome was time to analgesic administration. Secondary outcomes included time to medication order, and the likelihood of receiving an analgesic and change in pain scores 360 minutes after triage: Multivariable models, clustered by study site, were conducted to adjust for race, age, comorbidities, initial pain score, ED crowding, and triage acuity.

RESULTS: On adjusted analyses, compared with men, women with AP waited longer for analgesic administration [AP women: 112 (65-187) minutes, men: 96 (52-167) minutes, $P<0.001$] and ordering [women: 84 (41-160) minutes, men: 71 (32-137) minutes, $P<0.001$], whereas women with FP did not (Administration: $P=0.360$; Order: $P=0.133$). Compared with men, women with AP were less likely to receive analgesics in the first 90 minutes (OR=0.766; 95% CI, 0.670-0.875; $P<0.001$), whereas women with FP were not ($P=0.357$).

DISCUSSION: In this multicenter study, we found that women experienced delays in analgesic administration for AP, but not for FP. Future research and interventions to decrease sex disparities in pain care should take type of pain into account.

Suicide Screening Tools and Their Association With Near-Term Adverse Events in the ED.

Chang BP, Tan TM; Department of Emergency Medicine, Columbia University Medical Center, New York; Am J Emerg Med. 2015 Nov;33(11):1680-3.

OBJECTIVES: The goal of this study was to evaluate the relationship between various suicide screening tools and clinical impression with subsequent patient psychiatric admission

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and near-term adverse emergency department (ED) events.

METHODS: We performed a prospective observational study of 50 patients with suicidal ideation in the ED. Subjects completed a series of depression/suicide screening tools: the Columbia Suicide Severity Scale, SAD PERSONS scale, Patient Health Questionnaire 9, and Beck Scale for Suicidal Ideation. Clinicians were also asked about their impression on likelihood of patient admission. Outcome measures were as follows: need for psychiatric hospital admission, prolonged stay at psychiatric facility, and any adverse events during ED stay including need for unscheduled psychiatric or sedating medications, need for physical restraints, and need for intervention by security staff.

RESULTS: The Beck Scale for Suicidal Ideation, Patient Health Questionnaire 9, and Columbia Suicide Severity Scale did not significantly predict within-ED adverse events or admissions to psychiatric facilities. Wald test for individual parameters at an α of .10 level found that patients who were screened positive by their nurse had 3.37 times the odds of adverse within-ED events; patients with a positive SAD PERSONS score had 8.18 times the odds of psychiatric admission greater than 5 days. However, at the α of .05 level, no screening tools correlated with patient ED course or likelihood of psychiatric admission.

CONCLUSION: Clinical impression alone and the suicide screening tools showed poor predictive value for near-term events. Data from this study highlight the need for the development of ED-based suicide screening instruments capable of identifying those patients with suicidal ideation at greatest risk.

Ultrasound Accurately Identifies Soft Tissue Foreign Bodies in a Live Anesthetized Porcine Model.

Saul T, Siadecki SD, Rose G, Berkowitz R, Matilsky D, Godbold J, Moshier E; Department of Emergency Medicine, Mount Sinai St. Luke's Hospital and Mount Sinai Roosevelt Hospital, New York; Acad Emerg Med. 2015 Aug;22(8):950-4.

BACKGROUND: Some subcutaneous foreign bodies (FBs) are not easily visualized during physical examination and may not be detected on radiographic evaluation. Ultrasound (US) is capable of visualizing FBs of varying compositions. Previous studies have examined the use of US to detect FBs in

deceased animal or human tissue. This study used live anesthetized porcine tissue to more closely model clinical conditions.

OBJECTIVES: The objectives were to examine the test characteristics of US in the evaluation of FBs in living tissue and to evaluate if secondary findings such as surrounding edema and hematoma improve diagnostic accuracy.

METHODS: Institutional Animal Care and Use Committee (IACUC) approval was obtained. FBs 1 cm in length and 1 to 3 mm in width were created from toothpicks (wood), 21-gauge needles (metal), and a broken ampule (glass) and inserted subcutaneously into an anesthetized 20-kg Yorkshire swine. There were 72 sites implanted with equal proportions of each FB type and null sites. Half of the FBs were inserted at time 0 and half were inserted after 2 hours. Immediately after placement, four blinded physicians performed US evaluations of the first 36 sites. At 2 hours after placement, they evaluated each of the original 36 sites and the 36 new sites. They documented the presence or absence of FBs and surrounding edema.

RESULTS: After initial FB placement, 122 of the 144 interpretations (85%) were correct, with a sensitivity of 85% (95% confidence interval [CI] = 79% to 92%) and a specificity of 86% (95% CI = 76% to 98%). No sites demonstrated surrounding edema. At 2 hours after placement, 127 of 144 interpretations (88%) for these same sites were correct, with a sensitivity of 87% (95% CI = 82% to 93%) and a specificity of 89% (95% CI = 81% to 97%). Of the 108 observations (27 sites that contained FBs), eight of the 108 (7%) observations had surrounding edema (four glass, three wood, one metal). For the 36 new sites with FBs placed 2 hours later, 126 of the 144 interpretations (83%) were correct, with a sensitivity of 88% (95% CI = 82% to 94%) and a specificity of 83% (95% CI = 73% to 95%). No sites had surrounding edema present.

CONCLUSIONS: Ultrasound was sensitive, specific, and accurate in identifying FBs in live anesthetized porcine tissue. Surrounding edema or hematoma 2 hours after placement was so infrequently observed that it was not possible to determine its influence on the test characteristics.

The Association Between Medicolegal and Professional Concerns and Chest Pain Admission Rates.

Brooker JA, Hastings JW, Major-Monfried H,

Maron CP, Winkel M, Wijeratne HR, Fleischman W(1.), Weingart S(1.), Newman DH; The Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York; Acad Emerg Med. 2015 Jul;22(7):883-6.

OBJECTIVES: For patients in whom acute coronary syndrome (ACS) is a concern, disposition decisions are complex and multifactorial and have traditionally been a source of considerable variation. An important factor in disposition decisions for these patients may be physician-perceived medicolegal risk and related professional concerns. The study aim was to determine, at the point of care, how much less frequently physicians report that they would admit possible ACS patients if there was either zero or a defined medicolegal risk.

METHODS: This was a point-of-care emergency physician survey. Research assistants approached physicians at or immediately following the moment of disposition decisions for patients who were being admitted for ACS. The primary outcome measures were the proportion of physicians reporting that patients would not have been admitted if medicolegal issues were of no concern and the proportion of physicians reporting that patients would not have been admitted if there was an "acceptable miss rate" of 1% to 2% for ACS patients.

RESULTS: During the 3-month study period, 576 patients were admitted to an inpatient unit or to the ED observation protocol. Physicians were approached in 271 cases, and 259 surveys were completed. When presented with hypothetical zero medicolegal risk, physicians answered that they would not have admitted the patients in 30% of cases. With a hypothetical 1% to 2% acceptable miss rate, physicians indicated that they would not have admitted the patients in 29% of the cases.

CONCLUSIONS: ED medicolegal and professional concerns may substantially increase admissions for possible ACS. An acceptable miss rate or a zero medicolegal risk environment could potentially lead to a major reduction in admissions that physicians feel to be clinically unnecessary.

The Baseline Diameter of the Inferior Vena Cava Measured by Sonography Increases With Age in Normovolemic Children.

Kathuria N, Ng L, Saul T, Lewiss RE; Department of Emergency Medicine, Mount Sinai St

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Luke's-Roosevelt Hospital Center, New York; *J Ultrasound Med.* 2015 Jun;34(6):1091-6.

OBJECTIVES: To evaluate normative sonographic measurements of the inferior vena cava (IVC) diameter in healthy pediatric patients.

METHODS: We performed a prospective observational study of a convenience sample of healthy patients between the ages of 0 and 22 years presenting to a pediatric emergency department. Exclusion criteria included abnormal vital signs, pregnancy, or illnesses thought to influence volume status. During quiet respiration, the maximum and minimum IVC diameters were measured in the sagittal plane distal to the hepatic vein-IVC junction. As second measurements, the maximum diameters of the IVC and aorta were measured in the transverse plane distal to the insertion of the left renal vein into the IVC.

RESULTS: From February 2013 through April 2014, 63 children (51% female; mean age, 11 years) were enrolled. There were 20 children in each age group of 2 to 7, 7 to 12, and 12 to 22 years. The correlations between

IVC and aortic diameters as a function of age were calculated using the Spearman rank correlation coefficient. The correlation coefficients were all statistically significant ($P < .001$): sagittal maximum IVC diameter (0.81), sagittal minimum IVC diameter (0.79), transverse maximum IVC diameter (0.79), and transverse maximum aortic diameter (0.81).

CONCLUSIONS: This pilot study of sonographic measurements of the IVC diameter in normovolemic children suggests a statistically significant positive correlation between age and IVC diameter. Future studies should focus on multicenter enrollment, children in the youngest age group, and the development of normative growth curves for the IVC by age, sex, and body mass index.


Emergency Department Bouncebacks: Is Lack of Primary Care Access the Primary Cause?

Moskovitz JB, Ginsberg Z; Department of Emergency Medicine, Hofstra North Shore-LIJ School of Medicine, Hempstead; *J Emerg Med.* 2015 Jul;49(1):70-77.

BACKGROUND: National emergency department (ED) bounceback rates within 30 days of previous ED discharge have been found to be as high as 26%. We hypothesize that having a primary care physician (PCP) would prevent bouncebacks to the ED because a patient would have a medical resource for follow-up and continued care.

METHODS: We performed a prospective, consecutive, anonymous survey study of adult ED patients at a suburban teaching hospital with 88,000 visits annually, from July 5, 2011 through August 8, 2011. Using chi-squared and Fisher's exact tests, we compared patients with an initial visit to those returning within 30 days of a previous visit to our ED.

RESULTS: We collected 1084 surveys. Those in the bounceback group were more likely to have no insurance (10.2% vs. 4.4%) or Medicaid (17.7% vs. 10.8%) and less likely to have a PCP (79% vs. 86%). Of those with a PCP, 9% in both groups had seen their PCP that day, 58% (initial visit) and 49% (bouncebacks) could have been seen that day, and 35% & 36%, respectively, within 1 week. Of



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those with a PCP, 38% of initial visits and 32% of bouncebacks stated they had already seen their physician at least once.

CONCLUSION: Our results suggest that patients who bounce back to the ED might have already contacted their PCP. Although insurance status and the lack thereof predict a higher likelihood to bounce back to the ED, many bouncebacks are insured patients with PCPs able to be seen the same day.

Determining the Utility of Metabolic Acidosis for Trauma Patients in the Emergency Department.

Summersgill A, Kanter M, Fraser RM, Caputo ND, Simon R; Department of Emergency Medicine, Lincoln Medical and Mental Health Center, Bronx; J Emerg Med. 2015 Jun;48(6):693-8.

BACKGROUND: Metabolic acidosis has been proposed as the gold standard to define shock in trauma patients. Other studies determine the presence of shock by use of serum lactate. However, not all medical centers have the ability to utilize point-of-care lactate at bedside.

OBJECTIVE: This study seeks to determine the relationship between serum lactate and metabolic acidemia in trauma patients, and if metabolic acidemia can be used to guide therapy. We hypothesized that acidemia would be strongly correlated with lactate levels and would be associated with activation of massive transfusion (MT) in the presence of shock in trauma.

METHODS: This was a prospective observational cohort study, level II evidence; this study aids in decision-making. Setting was a Level I academic, urban trauma center. The study took place from July 1, 2012 to March 1, 2013 and included patients who were ≥ 18 years old and required trauma team activation. Observations included baseline demographics (age, gender, type of injury), vital signs, point-of-care arterial blood gas, lactate, and need for MT.

RESULTS: One hundred patients were enrolled over the study period. The average age was 34 years, and 82% were male. Forty patients were acidemic ($\text{pH} < 7.35$), and there was a significant difference in lactate levels between the acidemic and non-acidemic groups ($p < 0.002$). We found a strong correlation between pH and lactate: $r_s = -0.38$, $t = -4.03$, $p < 0.001$. In addition, using a logistic regression, we show that pH was associated with activation of MT ($p = 0.002$).

CONCLUSION: This is a prospective observational cohort study with level II evidence. This study demonstrates that acidemia was strongly correlated to serum lactate, lactate levels were higher in the acidemic group, and metabolic acidemia was associated with the activation of MT for trauma patients at our institution.

Provider Perspectives on the Use of Indwelling Urinary Catheters in Older Adults in Emergency Department Settings: Developing a Novel Clinical Protocol.

Mulcare MR, Rosen T, Clark S, Scherban BA, Stern ME, Flomenbaum NE; Department of Medicine, Division of Emergency Medicine, Weill Cornell Medical College, New York; Am J Infect Control. 2015 Apr 1;43(4):341-7.

BACKGROUND: Indwelling urinary catheters (IUCs) are commonly placed in older adult (aged ≥ 65 years) patients in emergency department (ED) settings, often for inappropriate indications. The aim of our qualitative study was to explore ED provider knowledge, attitudes, and practice patterns surrounding use of IUCs in older adult patients in the ED setting, to better guide development of a clinical protocol.

METHODS: We conducted 4 focus groups with 38 participants at a large academic medical center. Each focus group was conducted with a single ED provider type: attending physicians, residents, physician assistants, or nurses. Focus groups used a semistructured format, ranging in duration from 23-33 minutes. The sessions were audiorecorded, fully transcribed, and data were coded and analyzed to identify themes.

RESULTS: Participants reported believing that IUCs are overutilized in ED settings, confirming that IUCs are infrequently removed once placed and often inserted for staff convenience. Participants reported that current clinical decision making about IUC placement varies widely; yet all acknowledged the known risks for patient safety and willingness to adopt a clinical protocol to standardize practice. Focus groups were a critical component for the development of a user-friendly protocol, identifying 10 key elements for successful implementation and 11 potential barriers.

CONCLUSIONS: An evidence-based clinical protocol guiding ED providers in appropriate placement and management of IUCs in older

adults would be welcomed.

Do Emergency Medicine Residents Receive Appropriate Video Laryngoscopy Training? A Survey to Compare the Utilization of Video Laryngoscopy Devices in Emergency Medicine Residency Programs and Community Emergency Departments.

Swaminathan AK, Berkowitz R, Baker A, Spyres M; Department of Emergency Medicine, New York University School of Medicine/Bellevue Hospital, New York; J Emerg Med. 2015 May;48(5):613-9.

BACKGROUND: Video laryngoscopy (VL) has emerged as a critical tool in the “difficult airway” armamentarium of emergency physicians. The resultant increase in the types of available VL devices has made Emergency Medicine Residency (EMR) training in VL increasingly challenging. Additionally, the prevalence of VL devices in the community is unknown. Because Emergency Medicine (EM) residents go on to work in diverse settings, many in non-EMR emergency departments (EDs), it is preferable that they receive training on the airway modalities they will encounter in practice.

OBJECTIVE: To compare the prevalence and type of VL devices in EMR programs to non-EMR EDs.

METHODS: This was a survey study conducted from July 2012 to October 2012 of Accreditation Council for Graduate Medical Education-accredited, MD EMR programs in the United States and non-EMR EDs in New York State. A chi-squared test was performed to determine whether the difference in VL prevalence was significant.

RESULTS: There were 158 EMR programs and 132 non-EMR EDs surveyed; 97.8% of EMR and 84.3% of non-EMR EDs reported having some form of VL in their departments. The difference in proportion of EMR vs. non-EMR EDs that have VL was $\chi(2) = 13$ ($p < 0.001$). The Glidescope® device (Verathon Medical, Bothell, WA) was present in 87.7% of EMR programs and 79.3% of non-EMR EDs.

CONCLUSIONS: The majority of EMR programs trained residents in VL. The Glidescope device was used most frequently. Non-EMR EDs in New York State had a lower presence of VL devices, with the Glidescope device again being the most common. These results demonstrate that VL is pervasive in both practice environments.

PEDIATRICS



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Concussion Management in the Emergency Department

Editor's Note: Today's excellent article by Dr. Paul from Mt. Sinai Hospital focuses on concussion management. Concussions remain a very important public health concern and are commonly encountered by Emergency Medicine Providers. It is estimated that nearly two million people a year in the United States are diagnosed with some type of traumatic brain injury. Dr. Paul presents a commonly encountered concussion case with excellent diagnostic and management discussion. Further details of the Sports Concussion Assessment Tool (SCAT 3) can be found at <http://bjsm.bmj.com/content/47/5/259.full.pdf>.

History: A 16 year old female presents to your emergency department seven hours after sustaining an elbow to the head during a soccer play-off game. She denies loss of consciousness or vomiting, but is now complaining of a severe headache and feels foggy. She has final exams next week and another major soccer game tomorrow. Her mother mentions that she is the star player on the team and has to play tomorrow.

Physical Exam: T 37.0, BP 100/70, HR 68, RR 20, and O2 saturation 100%. She is lying on a stretcher in obvious discomfort from her headache. She has no palpable scalp hematoma, PERRLA, EOMI, no hemo-tympanum, no CSF rhinorrhea or otorrhea. She denies cervical spine tenderness. Cardiac, pulmonary examinations are normal. On her neurologic exam, her cranial nerves are intact, strength and reflexes are symmetric. She has a negative Romberg.

Assessment, Plan and ED Course:

The patient is a 16 year old female who has sustained a concussion. Based on her physical exam findings, she does not require neuro-imaging; however, given her complaints you suspect that she has sustained a concussion. You recently enrolled in a concussion symposium and are eager to assess her balance and vestibular function. You also make use of the SCAT 3 - a concussion sideline assessment tool (<http://bjsm.bmj.com/content/47/5/259.full.pdf>). SCAT 3 (Sports Concussion Assessment Tool) is a sideline tool that assesses signs of concussion, Glasgow Coma Scale, Maddocks score (sports based memory assessment), clinical symptoms, cognitive function through orientation, immediate memory, and concentration. The SCAT 3 also includes a neck exam, balance and coordination and delayed recall. Ideally, the SCAT 3 should be performed at the time of injury, but can also be performed in the emergency department. Her symptom severity score is 115 out of a maximum of 132. She has a GCS of 15 and denies neck pain. She has full recall on the memory assessment and Maddocks scores. You next perform the modified BESS or balance error scoring system. You have the patient stand with her eyes closed in a double leg stance, a single leg stance on the non dominant foot and a tandem stance led by the non dominant foot. Each position is tested for 20 seconds as you count the number of errors made. Errors include hands off the hips, opening the eyes, step, stumble or fall, moving the hip over 30 degrees, lifting the heel or forefoot and remaining out of position for more than five seconds. The maximum number of errors on each section is 10 with a total score of 30. Her BESS score is 17. Finally, you assess her

vestibular function using the vestibular ocular motor screening test or VOMS. The VOMS test assesses smooth pursuit eye movements, saccades, vestibular ocular reflex, visual motion sensitivity and near point convergence. Studies have shown that concussed adolescents frequently experience vestibular and visual symptoms. She experiences aggravation of her symptoms with smooth pursuits and saccadic movements.

After a thorough assessment, you decide that your patient is safe for discharge. You send her home with an ACE concussion discharge form and a referral to a local concussion center. Even though her mother insists that you clear her for return to play, you tell her that you are unable to do so. She is concussed and needs both cognitive and physical rest. She should be evaluated by a practitioner well versed in concussion management before resuming full school activity and then returning to soccer.

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The Impact of ABEM Certification on EMS Physicians



Paul Barbara, MD FACEP
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Division of Emergency Medical Services
Staten Island University Hospital

Several years ago I wrote an article regarding careers in Emergency Medical Services following EM residency training in the New York ACEP Empire State EPIC. The focus of this piece was to link EM providers with EMS as we uniquely share common goals, which may not be as commonly seen with other ABEM-credentialed subspecialties of Emergency Medicine.

EMS has now transitioned from a non-accredited / non-boarded EM area of training into a formally recognized EM subspecialty. Many of the readers may be considering subspecialty training or niche creation in EM. The experience EMS physicians have had in the last years will be useful for any EM physician seeking a unique training that is not currently accredited or boarded. As EM physicians are by nature, a resourceful and daring group of individuals, we are constantly finding new roles for our collaborative skill set. This is evident in the numerous post-residency opportunities available to our graduates. For example, emergency ultrasound has cemented itself as a cornerstone of EM training with numerous fellowships as well as an accreditation process for its providers, albeit in image acquisition. It's obvious to a novice sonographer like me that an emergency ultrasound-trained physician's value to an ED faculty is more than just as a credentialed sonographer. This is true for both academic and non-academic programs. Similarly, Global Health / International EM, Research, Administration, Geriatrics, Disaster Medicine, Forensics and Wilderness have each declared their unique skill set for its practicing EM physicians. Some of these physicians are likely your colleagues and bring a variety of expertise to broaden the capabilities of your faculty. SAEM has a list of available post-graduate fellowships online.

Thanks to the work of numerous national proponents for EMS Physician recognition, in September 2010 a landmark event occurred. The American Board of Medical Specialties formally recognized Emergency Medical Services as the 6th subspecialty of Emergency Medicine. In the past, EMS Physicians were mostly self-declared within an ED faculty. Their options for demarcating their career goals were limited, most commonly by one of two ways: either completion of a non-accredited post-graduate fellowship or though niche creation in their practice. The path to both of these practices required the proverbial leap of faith by the trainee. Many questions existed for those of us in this position. *What if the fellowship didn't merit recognition by a future employer? What kind of job security would this additional training afford? Was postponing a year of an attending's salary wise? Would the risk pay off after completion?*

I know I share many of my colleague's views when I say these, or any other rhetorical questions not mentioned, were minimally relevant compared to the upside of seeking specialty post-graduate education in prehospital care. I entered my fellowship in EMS in 2008, immediately after residency, and was selected by the Fire Department City of New York / Long Island Jewish Medical Center EMS Fellowship program. I still value the training I received there. I have since had an active career in prehospital care after graduation and now work as an Assistant EMS Director for Northwell Health / Staten Island University Hospital.

Prehospital care and emergency management is a passion for many of us in this field. In recent years the Board examination has provided formal benchmarking of our practice. ABEM's statement is that EMS is *"a medical subspecialty that involves prehospital emergency patient care, including initial patient stabilization, treatment, and transport to hospitals in specially equipped ambulances or helicopters."* Similarly, education standards of our current and future fellows have been initiated through the Accreditation Council of Graduate Medical Education (ACGME), unifying the training of our future practitioners. Even if the Board did not exist for years to come, this alone may have solidified the future of EMS physicians in the house of medicine.

Within five quick years, EMS has moved from a non-accredited fellowship, felt by some to be a fringe practice pathway for a graduating EM resident, into a formalized and recognized ABEM subspecialty. The additional consequences of this professional shift may surprise many of you. The outcomes of the work done by EMS physicians and supporters may be laying the groundwork for similar actions by other EM subspecialties.

To get a better understanding of the obstacles our EMS medicine leaders overcame, it's worth noting that this was no simple accomplishment. Prior attempts at seeking formal accreditation for EMS were discredited, with the general consensus that the field was overly administrative. For the recently successful accreditation, national leaders in prehospital care created the core content of "EMS Medicine". This core content formed the basis of the Initial Certification Examination in Emergency Medical Services for ABEM.

Initial Certification Examination

The EMS Initial Certification (IC) was first administered in October 2013 by ABEM with subsequent bi-annual administrations. Prerequisites existed based on either a candidate's practice track or a non-ac-

credited fellowship + practice track and are detailed on the ABEM website. Of the 484 applicants, almost 92% were approved by ABEM and 445 physicians were approved for the inaugural ABEM Initial Certification exam in EMS. A series of Board preparation courses were set up and held through the teamwork of the ACEP and the National Association of EMS Physicians (NAEMSP). The classes were universally filled in multiple cities and taught by some of the founders of modern EMS care.

The first test was received with mixed results. A total of 407 people took the test and 233 passed, for a passing rate of 57.2%. This pass rate was received with a collective uproar in our community, as first time Board pass rates for graduating senior residents in EM is much higher. It has been stated that other subspecialties underwent similar difficult initiations and this result was not entirely unexpected.

The second sitting of the ABEM EMS IC was administered in November 2015. As many physicians felt a repeat of the first exam’s dismal outcomes would be devastating to the growth of the field, many additional educational experiences sprang up. Thankfully the joint ACEP/NAEMSP board preparation curriculum was reconvened and held in multiple cities in the weeks leading up to the examination. Again, the classrooms were filled. Surprisingly, additional education options became available. The recognized textbook was updated and condensed, and we saw the creation of useful question banks written by both seasoned physicians and recent fellowship graduates. Study groups were formed, social media utilized, notes were shared, etc. The docs who took the exam a second time, including myself, almost universally banded together to pass together. I was expecting to clamor against competition for educational and study materials. In the end, so much study material was shared with me and passed on that I was only able to get through it all by adhering to a strict reading schedule. As we move forward for the next IC cycle, a new textbook has been published.

For any other specialty seeking formal accreditation, many lessons can be learned from our experience these last few years. I am simply thankful for the work of the leaders in this field, some of whom are contributing New York ACEP members, who gave physicians such as myself a chance to be subspecialty boarded.

Outcomes and Results – ABEM

In only two examination cycles of activity on the ABEM circuit, EMS has quickly become the most populous subspecialty within ABEM. This is not due to a recent surge in physicians seeking prehospital training but more likely due to existing doctors in practice becoming board certified. I can assure the readers that many more EMS physicians exist that either did not take the Board or were subject to another low pass rate, so this number could be potentially higher.

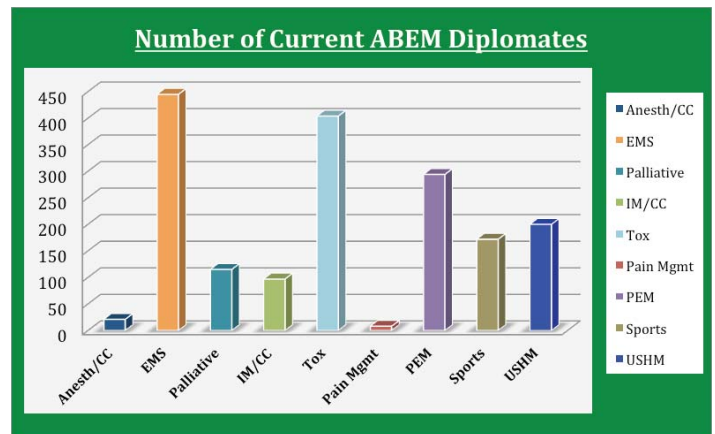


Figure 1 - Number of Current ABEM Diplomates. Demonstrates the current number of ABEM diplomates in the 9 currently recognized subspecialties as of March 2016. Table 1 has the same data in numerical format.

#ABEM Diplomates	
Anesthesiology/Critical Care	21
EMS	445
Hospice & Palliative Care	115
Internal Medicine/Critical Care	97
Medical Toxicology	404
Pain Management	8
Pediatric EM	294
Sports Medicine	172
Undersea & Hyperbaric	200

Table 1 - Number of Current ABEM Diplomates

This total number is likely to increase modestly with additional IC administrations in 2017 and 2019.

Fellowship Future

No professional benchmarking could be expected to continue without a coexisting unification of existing fellowship education. The ACGME currently serves as the body to credential EMS Fellowships, similar to other residencies and fellowships. In recent years, the Council of EMS Fellowship Directors was formed through NAEMSP, analogous to the Council of Residency Directors in EM. I have no official fellowship affiliation and so the data presented here is strictly from the ACGME website.

The ACGME publishes data on number and type of fellowship programs they accredit for Emergency Medicine trainees.

ACGME Approved Programs	Number of Programs	Number of Residents or Fellows
Emergency Medicine	168	6,210
Clinical Informatics	1	2
Emergency Medical Services	42	50
Medical Toxicology	25	62
Pediatric Emergency Medicine	22	104
Sports Medicine	6	11
Undersea & Hyperbaric Medicine	6	10

Table 2 – ACGME Approved Subspecialty Programs in Emergency Medicine

A more detailed investigation of these subspecialty programs reveals interesting trends in subspecialty training for EM. For simplicity, the smaller fields of Clinical Informatics, Sports Medicine and Undersea & Hyperbaric Medicine were removed from my secondary analysis. The ACGME categorizes the number of programs and fellows by academic calendar year. The following three graph figures comparing EMS, Medical Toxicology and Pediatric Emergency Medicine were constructed using data from the ACGME website.

The data on EMS only began to arrive in 2013 as accreditation began simultaneously with the ABEM validation. The initial number of fellowships in 2013 is deceiving. Prior to 2013, close to 80 EMS fellowships were listed on the NAEMSP website for interested graduating residents to seek training in. However, since not every existing EMS fellowship sought ACGME accreditation, and unfortunately some of them could not provide the core content required to train a fellow to these standards, the number here is lower than the true number of programs at that time. Figure 2 demonstrates the inauspicious entry of EMS into training accreditation, but with a concomitant rapid growth after initiation.

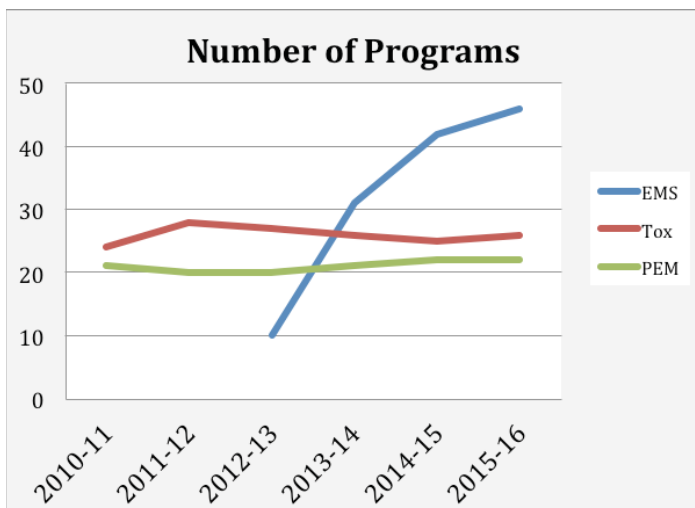


Figure 2 – Number of ACGME-Approved EM Subspecialty Programs

EMS currently has the most number of ACGME-approved programs

providing subspecialty training in EM.

Having the most number of programs does not mean the most number of fellows, as shown in Table 2. However, there are growth trends shown in all three of these fields; obviously reassuring for the future of Emergency Medicine, as evidenced in Figure 4 below. The growth of EMS is certainly noticeable, which is likely to level off as a steady state is reached. The growth of PEM fellows was certainly surprising, as their numbers have almost doubled in only a few years. This is also reassuring for our practice in general, as I know I have been lucky to have faculty development at my institution from PEM-trained physicians and Toxicologists!

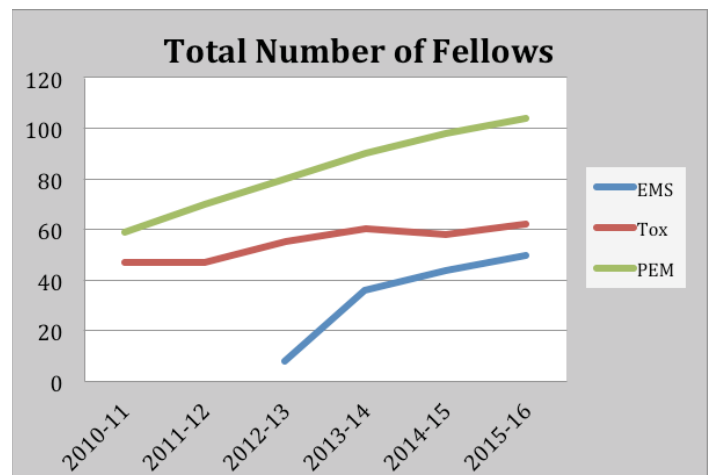


Figure 3 – Total Number of Fellows in ACGME-Approved EM Subspecialty Programs

By dividing the number of fellows by the number of programs, we can get a very basic idea of the type of academic environment each of these subspecialties will provide. The last graph, Figure 4, may not be a surprise to those of you involved in any of these fields of training. Obviously, practice and education patterns will vary the experience for each individual program so only generalizations can be drawn from this data. However, if you are seeking Pediatric EM, you are likely to have additional fellows with you in training. As an EMS fellow, you are likely to be solely “The Fellow”. Medical Toxicology exists somewhere in between.

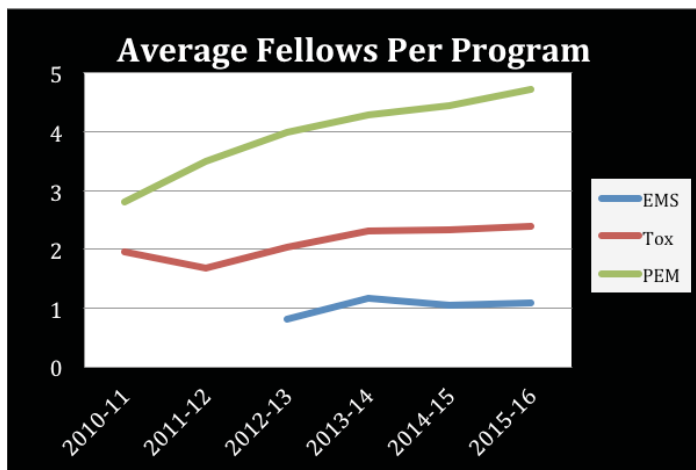


Figure 4 – Average Number of Fellows Per ACGME-Approved EM Subspecialty Program

In conclusion, non-accredited fellowship training began the declaration of my career as an EMS Physician. Without a practice in the field, however, my training would have been for naught. I am very happy to see our field move from a “happy niche” into a formal academic body bearing benchmarks and education standards. I am now boarded in EM with subspecialty boarding, and hopefully soon to be a Fellow of EMS Medicine.

For those of our readers seeking any type of additional EM training, or for those of you with additional training now moving toward ACGME accreditation, I hope the experiences shared here provide you with some basic insight on what can be expected as the governing bodies move forward.

References

1. Barbara P. Entering a Career As An EMS Physician. Empire State EPIC Vol 28:03:11, pp6-8.
2. <http://www.saem.org/membership/services/fellowship-directory>
3. <https://www.abem.org/public/subspecialty-certification/emergency-medical-services/ems-overview>
4. <https://www.abem.org/public/subspecialty-certification/emergency-medical-services/the-core-content-of-ems-medicine>
5. <https://www.abem.org/public/subspecialty-certification/emergency-medical-services/initial-certification/minimally-qualified-ems-subspecialty-candidate---2015-exam>
6. Cone DC. Update On EMS Board Certification. NAEMSP Annual Meeting 2015 Jan 15.
7. <http://www.wiley.com/WileyCDA/WileyTitle/productCd-1118865308.html>
8. <http://www.ems-medicine.com/#!/questionbank/cngp>
9. <http://accessemergencymedicine.mhmedical.com/book.aspx?bookID=1650>
10. <http://www.abem.org/public/docs/default-source/publication-documents/subspecialties-at-a-glance.pdf?Status=Temp&sfvrsn=28>
11. <http://www.naemsp.org/pages/council-of-ems-fellowship-directors.aspx>
12. <https://apps.acgme.org/ads/Public/Reports/ReportRun?ReportId=3&CurrentYear=2015&AcademicYearId=2015>
13. <https://apps.acgme.org/ads/Public/Reports/Report/3>
14. <http://www.naemsp.org/Lists/Announcements/DispForm.aspx?ID=73&-RootFolder=%2FLists%2FAnnouncements&Source=http%3A%2F%2Fwww%2E-naemsp%2Eorg%2FPages%2Fdefault%2Easpx>



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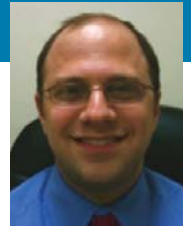
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ASK THE EXPERTS



Saadia Akhtar, MD
President, Council of Emergency Medicine Residency Directors (CORD); Associate Dean for Graduate Medical Education- MSBI; Program Director, Emergency Medicine Residency; Associate Professor, Department of Emergency Medicine, Mount Sinai Beth Israel Icahn School of Medicine at Mount Sinai



Moshe Weizberg, MD FACEP
Residency Program Director, Associate Chair for Education, Staten Island University Hospital

How To Get Ahead in Emergency Medicine Education

On February 9, 2016, I had the opportunity to interview Dr. Saadia Akhtar. Dr. Akhtar is the Residency Program Director and Associate Dean for Graduate Medical Education at Mount Sinai Beth Israel in New York City. She is also the current President of the Council of Emergency Medicine Residency Directors (CORD). We spoke about how young faculty can get involved in EM education and how they can further develop their careers.

How did you first get involved in EM education?

In my first year of residency, I knew I wanted to be a program director (PD). I made it clear to my PD that I wanted to get involved and work on enhancing the curriculum. I loved the aspect of helping people. That is what attracts me to being a PD. Helping residents become great clinicians is one of the best aspects of being a PD. I also wanted to help people with their professional and personal growth. Being there to help them along the way is an amazing feeling and I was fortunate to have great role models at work early in my career. Having great people around me inspired me to want to do great things and plan for a future leadership position.

When did you first become involved with CORD?

My program director, Dr. Kai Sturmman, knew I wanted to become a program director. He suggested I attend CORD Academic Assembly and go to the Navigating Academic Waters Track. At the conference, I met so many people who were completely devoted to education. During one of the CORD conferences, I heard Dr. Pam Dyne, who was President of CORD at that time, give a speech. I sat in the audience listening to her presidential speech, and I said, "I want to be her one day." All the wonderful people at CORD really impressed me and were willing to offer advice and

guidance. The CORD Academic Assembly is like going to summer camp. You catch up with all of your old friends and make new ones as well. You have an opportunity to interact with so many people who have the same interests as you and are going to help you get to where you want to be.

How did you climb the ranks in CORD?

It is all about doing a lot of hard work, having dedication and having the right mentorship. My mentors told me that I should bring something to the table that no one else is bringing. At that time, in 2001, my department was seeking someone to lead the ultrasound curriculum. I had never done any ultrasound before then, but Dr. Sturmman sent me to do an ultrasound course so that I could become the point person for our department. That is how I got involved in ultrasound and became the ultrasound director. I met Dr. Sarah Stahmer at an ultrasound course and she took me under her wing. She gave me advice about every opportunity I considered. I later presented as a Faculty Discussant at the national CPC Competition and won as Runner-Up for my division. I became very interested in the CPC Competition and later became a CPC judge. I had been in that role for a number of years and subsequently was asked to become the Chair of the CPC Competition. One of my key mentors is Dr. Doug McGee. I think he is an incredible leader and I admire his leadership style. I have learned so much from him especially how to lead the CPC Competition and how to be an effective President of CORD.

A key piece of advice that I think is important for junior faculty is to find something that there is a need for, get the right mentorship, and find something that you are passionate about.

Leaders often cite guidance they received from their mentors as having helped them achieve their goals. Do you have any memorable mentors that helped your career?

I already mentioned some of my mentors, but a mentor does not necessarily have to be someone who is more senior to you. Dr. Michael Epter is a very close friend and advisor to me. He was a year junior to me in our EM residency program at Beth Israel Medical Center in New York City. When he became a program director, we reconnected. He has offered advice to me at various stages of my professional career. He really pushed me to apply for the Associate Dean for GME position at my institution at Mount Sinai Beth Israel in New York City.

Another key mentor I had was Dr. Wallace Carter. I first met him at a CORD safari dinner where I ended up sitting next to him at the dinner table. During our conversation, I realized that he is a wealth of knowledge and loves to mentor people. I informed him that I wanted to get involved in CORD. He gave me some great ideas and has been a true mentor ever since.

Dr. Gloria Kuhn has always been there to advise me as well. Several years ago, Dr. Kuhn, along with Dr. Sarah Stahmer and Dr. Mary Jo Wagner, all encouraged me to run for the CORD Board of Directors. I knew then that it was not the right time for me since I was busy with a number of projects in my career. I waited a year and then ran for the board, which turned out to be the best decision for me.

Another key piece of advice for junior faculty is to know what is right for you at what time. Do not do something if you are not ready for it yet.

I feel very blessed to have had such great mentors at different stages of my career that I am still very close to and turn to for advice.

ASK THE EXPERTS

When a young faculty member is looking for mentorship, what should they look for in a mentor?

Look for someone who is really sincere and honest. They will be very forthcoming and willing to help you. Also, if you see someone who is literally connecting people as they are standing there talking, you know that is someone who is going to help you. They will connect you to the right people so that you can pursue your career goals.

For senior faculty, it is important to remember what it is like to be a junior person walking into a big conference hall and how overwhelming that can feel. Senior faculty should try to make junior people feel as comfortable as possible and be approachable.

For junior faculty – if you get involved with a project and do a great job, people will ask you to do other things, and then other opportunities will come your way.

Young faculty members often struggle with how to teach during a busy ED shift. What advice would you give them?

It is important to understand that you cannot teach a topic in a detailed lecture format during a clinical shift. What you can do is to understand what level your learner is at and teach them something appropriate for their level. For example, a first year resident sees a patient with a possible PE. Focus on teaching them one thing, such as what do you look for on EKG in PE or what are the Well's criteria? If it is a senior resident, you should focus on teaching them other aspects related to evidence based medicine.

Remember to refer your learners to on-line resources for some of these facts. So, for example, if you are discussing Well's criteria, have them look it up on-line.

Young faculty members often wonder about what area of EM to become involved in – education, research, administration. What guidance can you give them to help them choose the right career path for them?

The first step is finding a good mentor. They will help you navigate your thought process.

They will help elucidate what you are passionate about and what to pursue.

The key thing is to do a lot of soul

searching. Figure out if you are interested in operations, or education, or something else. Once you decide, focus in on one or two individual areas. Reach out to people who are really good in that area and get more information. It may take a few phone calls, but it will be well worth it. This should be the task of the first one to two years out of residency – figure out what you love and what you want to do.

Someone has made the decision that they want to pursue a career in education. Now they want to know, how do I do it? What advice would you give a young faculty member who wants to become a leader in EM education?

Join the relevant organizations. Whether it is CORD, AAEM, ACEP or SAEM – find the group of people that you can relate to at your level. Then join a task force or a committee. That involvement can lead to research and scholarly productivity. Also look at the local level within your own institution and your own medical school. Find out which committees relate to your area of interest.

Women in EM face unique challenges, and often look to accomplished women in EM as role models. What advice can you give the new female faculty member on how to develop her career?

It is much easier in today's world than it was several years ago. There are so many women leaders in EM. The key thing, again, is to join the big groups. ACEP, SAEM, and FemInEM have groups for women in EM. This will allow you to team up with women in leadership roles in EM and learn from them.

Learning how to negotiate is very important. It can be very intimidating for a young female faculty member to negotiate with a seasoned male Chairman. Fight for your rights in terms of salary and protected time. Biases still exist.

Do you have any specific scenarios that you encountered in your career that were unique due to the fact that you are a woman?

I have been very lucky and I have not personally faced that challenge. In my hospital, the majority of the “C-suite” consists of female leaders. I know other female physicians in other institutions who have faced challenges and did not receive the same salary structure

or the same amount of protected time in comparison to their male counterparts. The good news is, now females in that situation have great role models to reach out to for advice and guidance.

You have been involved in so many different roles in EM, including education, ultrasound research, Evidence Based Medicine, the list goes on. A young faculty member often looks at something like that and says, “How do you balance your time?” What would you tell them? What is the secret?

The secret is to be very organized and to have a great team. When I became Associate Dean for GME, I knew I could take on that role in addition to being a Program Director because I have a fantastic residency leadership team working with me. But, I had to set up that system. It took a lot of time and effort, but once you have a well-oiled machine, you are able to add additional responsibilities in your career. My residency leadership team, Dr. Thomas Nguyen, Dr. Eric Steinberg, Monique Smith and Melisa Persaud, is so good that they are basically on auto-pilot.

The same is true with my job as President of CORD. The CORD office, Michele Byers and DeAnna McNett, is a powerhouse and really makes sure everything gets done. The Associate Dean job is supported by the GME staff. So, I am able to take care of all my various responsibilities and not feel like I am drowning.

Setting up a solid foundation and having a high functioning support team are essential keys to being successful in fulfilling one's responsibilities in leadership roles.

It is often challenging for young faculty members to know when to say no. Meaning, what opportunities should they say yes to, and what opportunities should they say no to. What guidance would you give them?

For a brand new grad, their top priority should be passing the boards. Until then, they should not take on any major responsibilities. Once they pass the boards, initially, they may need to say yes to some things that are not of great interest to them. Those may be opportunities where their niche actually develops. Often times, people think they have no interest in a certain content area and then they realize they

ASK THE EXPERTS

enjoy that niche after gaining some exposure. You definitely need to have some level of interest for you to say yes to something since you need to use your time wisely.

When you get into the mid-career level, you have a lot more opportunity to say no. At that point, you have a better sense of how much time various projects will take and which ones are a better use of your time.

A great example of this is book chapters. If you are a new grad and there is an opportunity to write a book chapter, you should say yes. If you have been out 10 years, a book chapter may not be the best use of your time, unless it is for a world renowned textbook such as Rosen's or Tintinalli's. Your time is probably better spent working towards a peer reviewed publication.

Another key point is to know about the promotions process at your institution. The goal should be to become at least an Associate Professor. When you know what it will take to get promoted, that's where you should focus your time.

If a young faculty member is going to say no to an opportunity, what is the

correct way to say no gracefully?

You always want to be professional. A great way to respond is, "I'm really glad that you gave me this opportunity and I think it is really interesting. I think at this point in time in my career, it would be better suited for me to spend my time on something else that I just recently started working on because I really want to give that project my full attention. I don't think I will logistically be able to give this project my time. I hope you are not disappointed in me. I would love to be able to work with you in the future on some other projects." That's a nice way of turning somebody down.

The new wave of EM education seems to be moving away from textbooks and more towards FOAMed and on-line blogs. What are your thoughts on that?

I think FOAMed is a phenomenal thing for EM education. I do think that there should be some oversight and some assessment of the accuracy and validity of the information being presented. Today's learner has so many resources available to them. Residency programs should be creative and incorporate these new modalities into their education.

Educators must have their fingers on the pulse of how today's learners get their information.

As President of CORD, you have achieved the pinnacle of EM education leadership. Where does your illustrious career take you from here?

It has to go to where my passion is which is graduate medical education. I would like to get involved with the ACGME. You never know when opportunities arise.

I think I was born to be a program director. Of all my roles, I love being a program director. I am very blessed to have wonderful residents that join our EM residency family every year. I love watching the residents develop into great clinicians and watch their careers take off. To know that you had a role in their career development is such an amazing feeling.

Is there anything else you want to add?

I want to thank all the mentors that have helped me to reach my career goals and I want to thank all the people that help me on a daily basis. I would not be able to take care of all my responsibilities without them.




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ALBANY UPDATE



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

The 2016-17 State Budget passed April 1, 2016. The final spending plan totals approximately \$147 billion and includes a phased-in increase in the minimum wage and paid family leave funded through employee paycheck deductions.

Legislators will return to Albany from their Spring Recess May 3 and will work to complete the business of the 2016 Legislative Session by the end of June. All 213 State Legislators are up for re-election November 8.

Provided below is a summary of final State Budget actions and other issues of interest to New York ACEP.

2016-17 State Budget

Excess Medical Malpractice Program

The final State Budget rejects the Governor's proposal to cut the Excess Medical Malpractice Program by \$25 million and redistribute funds to high risk specialties in high risk geographic areas. Funding for the program is fully restored to \$124.5 million. The program is extended until June 30, 2017.

Electronic Prescribing

The 2012 I-STOP law requiring electronic prescribing for all prescriptions become effective March 27, 2016.

The final State Budget provides for an exemption from the mandatory electronic prescribing law for practitioners who certify to the Department of Health that they will not issue more than 25 prescriptions during a 12-month period.

A practitioner may make a certification regardless of whether they have previously received a waiver from the New York State Department of Health. Under the current law, waivers may be obtained based on a showing of:

- economic hardship;
- technological limitations not reasonably within the control of the practitioner; or
- other exceptional circumstances

In addition, on March 16 New York State Health Commissioner Howard Zucker released a letter providing a one-year blanket waiver of the e-prescribing requirements for exceptional circumstances due to limitations in software functionality or economic issues.

For more information on the law go to: https://www.health.ny.gov/professionals/narcotic/electronic_prescribing/

Limited Service Clinics

The final State Budget does not include the Governor's proposal to authorize the establishment and regulation of Limited Service Clinics within retail establishments such as pharmacies, stores and shopping malls and to allow publically traded companies to operate such clinics.

Private Equity Pilot

The final State Budget does not include the Senate's One-House proposal to authorize the Public Health and Health Planning Council (PHHPC) to approve the establishment of up to five business corporations as the operator of a hospital or home care agency in affiliation with at least one academic medical center.

Out-of-Network Workgroup: Extension of Report

The Out-of-Network "surprise bill" law enacted in 2014 established a nine-member Workgroup to be appointed by the Governor with recommendations from the Legislature. The Superintendent of DFS and the Commissioner of the Department of Health were to serve as Co-Chairpersons.

The Workgroup was charged with reviewing current out-of-network rates and coverage and making recommendations to the Governor and the Legislature no later than January 1, 2016. The Workgroup was never constituted by the Governor's Office. The 2016-17 State Budget provides an extension for the Workgroup to report its findings October 1, 2016.

Pending Legislation

Date of Discovery (A285-A Weinstein/S6596 DeFrancisco)

Passage of legislation to change the statute of limitations for medical, dental and podiatric liability from two and half years to the "Date of Discovery" will be under serious consideration when the Legislature returns from Spring Recess on May 3. The bill provides that no actions can be filed more than 10 years after the date of the alleged incident.

Last year marked the first time that this legislation was taken up for a vote, with the Assembly passing it by a wide margin of 120 to 25. The Senate bill moved to the floor but no vote was taken.

The leaders of both houses, Senate Majority John Flanagan and Assembly Speaker Carl Heastie, have said that they will pass a bill before the end of the 2016 Legislative Session on June 16. Governor Cuomo has stated publicly that he will sign it if passed.

New York ACEP has developed a comprehensive, grassroots and Albany-based advocacy campaign designed to defeat or significantly alter the Date of Discovery proposal. Members of the Board of Directors and residents participated in a well-attended Advocacy Day March 1 to lobby against this bill and to address State Budget priorities. In addition, New York ACEP is also working with MSSNY, Greater New York Hospital Association (GNYHA), the Health Care Association of New York State (HANYS), and other stakeholders on this issue.

The bill is currently on the Senate floor and in the Health Committee in the Assembly.

Repeal of Attorney Contingency Fee Limits (S4002 DeFrancisco)

Legislation has been introduced to repeal the statutory limitation on contingency fees for attorneys in claims or actions for medical, dental, or podiatric malpractice.

Since the mid-1980s State law has limited contingency fees on a sliding scale basis ranging from 30% of the first \$250,000 to be

recovered, 25% of the next \$250,000, 20% of the next \$500,000, 15% of the next \$250,000, and 10% of any amount over \$1.25 million.

This law was enacted in response to a severe medical liability crisis in the State. It was designed to curb the increasing frequency and severity of malpractice claims. A critical goal of the law is to assure that an injured plaintiff receives their fair share of an award that a jury determined they were entitled to.

According to a recent actuarial study, passage of the bill would increase liability costs to physicians by over 10%. It would encourage frivolous lawsuits, increase payouts to lawyers in malpractice cases, and significantly reduce the amount that patients receive.

New York ACEP is working aggressively to oppose this legislation.

Mandatory Continuing Education (CME) S4348 (Hannon)/A355 (Rosenthal)

Legislation has been pending for the last two years to require the completion of three hours of course work developed by the New York State Department of Health and State Education Department (SED) every two years in pain management including ISTOP, DEA requirements for controlled substances, pain management, appropriate prescribing, managing acute pain, palliative medicine, prevention/screening of addiction, responses to abuse and addiction and end of life care.

New York ACEP is opposed to this bill. It was discussed with legislators March 1 in Albany during the Lobby Day.

The mandate applies to any practitioner who is licensed, registered, or certified under Title VIII of the State Education Law and who is registered under the Federal Controlled Substances Act.

The bill provides for an exemption for anyone who can demonstrate that there is no need to complete the course based on the nature, area or specialty of his or her practice or that equivalent course work has been completed.

The bill is on the floor in the Assembly and the Health Committee in the Senate.

The State Legislature is expected to complete its business for the 2015 State Legislative Session on June 16, 2016. Reid, McNally & Savage will continue to work with New York ACEP to represent and advocate for access to quality emergency care and services in New York State.

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WEDNESDAY JULY 6

11:00 am-12:30 pm	Board of Directors Meeting
12:30-5:00 pm	Registration
12:30-1:30 pm	Research Forum: Poster Presentations
1:40-3:10 pm	Research Forum: Oral Research
2:30-6:30 pm	Exhibits Open
3:10-3:30 pm	Break and Exhibits
3:30-4:30 pm	New Speakers Forum, Best Practices in Emergency Medicine
4:30-5:30 pm	Case Reports in Travel Medicine
5:30-6:30 pm	Exhibits and Networking Reception
9:30 pm	Airway: True Stories from the ED

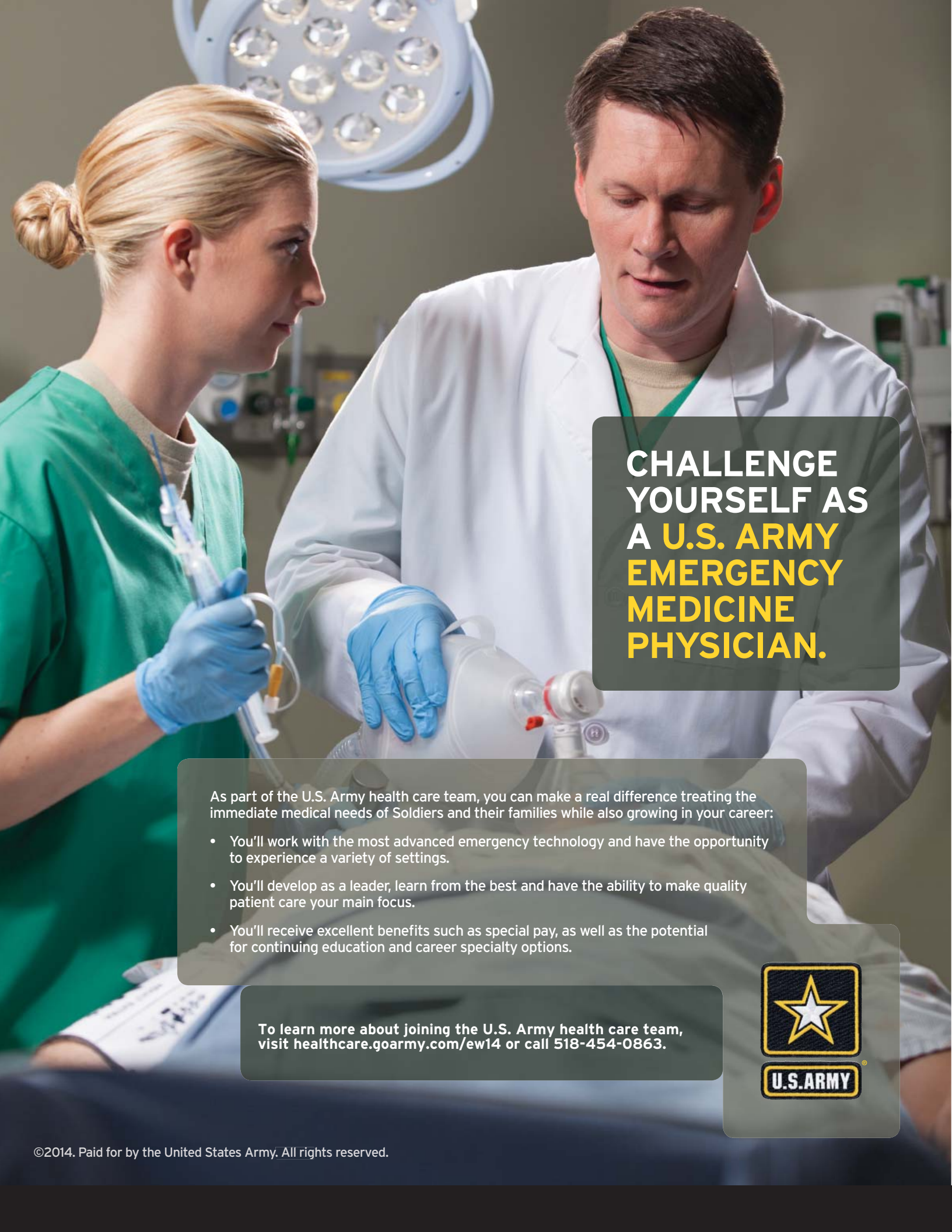
THURSDAY JULY 7

7:30-Noon	Registration
7:30-8:00 am	Exhibits and Continental Breakfast
7:30-11:00 am	Exhibits
8:00-9:00 am	The Heart Failure Management Paradigm: From the Emergency Department to Hospital Admission and Discharge
9:00-10:00 am	Trauma in the Elderly Patient
10:00-10:30 am	Break and Exhibits
10:30-11:30 am	Penetrating Trauma: Do The Holes Add Up?
11:30 am-12:30 pm	Toxicology Literature Update
12:45-1:45 pm	New York ACEP Annual Meeting and Legislative Update
1:45-2:15 pm	New York ACEP Committee Meetings
3:00 pm	Residency Volleyball Challenge

FRIDAY JULY 8

6:45-7:30 am	Fun Run
7:00-8:00 am	Board of Directors Meeting
8:00-8:45 am	Cerebral Venous Thrombosis (CVT): The Venous Side of Stroke
8:45-9:30 am	Medical Decision Making and Medical Error
9:30-10:15 am	Sleep Science for the Emergency Physician: Be a Professional
10:15 am	Break
10:30-11:30 am	Atrial Fibrillation
11:30 am-12:15 pm	Bariatric Surgery and the Emergency Practitioner

For more information or to register, go to www.nycep.org



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