

The Fast Track



Spring 2016 Issue

An Emergency Medicine Publication

**BEING AN
ADVOCATE
FOR
EMERGENCY
MEDICINE**

**WHAT
NURSES WISH
YOU KNEW**

**HEALTH
CARE
AND THE
2016
PRESIDENTIAL
RACE**

The Fast Track

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Letter from the Editor

Advocacy. From the moment we start contemplating medicine, we encounter this word. We must be an advocate for our patients. We must learn to advocate for what is in their best interest. We must stand up to those in power that would disenfranchise our most vulnerable. Yet, in order to attain the title we all strive so hard to achieve, we must first learn to advocate for ourselves.

The second step in self-advocacy is asking for what you want. And what's the first? Figuring out what you want, of course! Any good advocate starts by learning about the goals the individual has. For many of us, the goal is to become an emergency physician. This takes years to achieve and has multiple steps along the way.

The way ahead can seem confusing, and it's hard to say what will make us the happiest, or what's attainable. It can help to find a mentor. Being your own advocate involves putting yourself into situations that will teach you something new, introduce you to someone you've never met before, or help you realize whether or not you are on the correct path.

This issue of *The Fast Track* is full of recommendations on how to be an advocate for your patients, and I truly hope you will read what these talented authors have to say on the subject. But before you can become an advocate for your patients, you have to become a doctor first! If I can make one recommendation to the readers it would be this... get involved!. Whether you attend a conference, run for a national position, or get involved on a local level, participation is the single greatest step you can take towards both learning what you want and achieving it.

I hope you are holding this issue while at Spring Seminar, browsing through the pages as you wait for the next session to begin. If, however, you clicked through from your email, or picked up a copy from your local group, I hope to see you at one of our upcoming one-day symposiums (some which may even be in your backyard) or at Scientific Assembly in beautiful San Francisco. After all, being your own advocate involves pushing yourself beyond boundaries, and doing things you've never done before.

Warmest Regards,
Christina Hornack, OMS-II
Edward Via College of Osteopathic Medicine, Virginia Campus
ACOEP-SC National Publications Co-Chair

INTERESTED IN CONTRIBUTING?
Let us know: FastTrack@ACOEP.org

Contents

Presidential Messages.....	04
Being an Advocate for Emergency Medicine.....	07
How to Advocate Nationally as a Student.....	10
Perspectives from the Front Lines.....	12
What Nurses Wish You Knew.....	14
AAEM Advocacy Day.....	16
Lessons from the Emergency Department: As Told by an ED Scribe.....	18
Health Care and the 2016 Presidential Race.....	20
Get Involved with ACOEP's Committees.....	23
Are You Ready to be Pimped in the ER?.....	26
Combining Work with Play: Nature PRN.....	28
Pitfalls in the Diagnosis and Management of Testicular Torsion.....	33
North Carolina Regional Symposium Recap.....	34



12 PERSPECTIVES
FROM THE
FRONT LINES



28 COMBINING WORK
WITH PLAY: NATURE
PRN



34 NORTH CAROLINA
REGIONAL
SYMPOSIUM RECAP

PRESIDENTIAL MESSAGE

Resident Chapter

I hope everyone had a great holiday season! Match Day has come and gone, and I want to welcome our new resident members starting this July! Matching into emergency medicine is becoming more and more difficult, and it is a great accomplishment to have matched into your program. We are all very proud of you!

As the ACOEP Resident Chapter President, I have the honor of sitting on the ACOEP Board of Directors. The leaders of the college hold our residents in the highest regard and working with them throughout this process is a privilege. Our RC board is working with both the ACOEP and EMRA leadership to enhance what we offer to the Resident Chapter.

This is a tumultuous time for many DO residents going through the transitions and changes as we proceed through ACGME accreditation. ACOEP and the Resident Chapters are here to support any questions and concerns you may have. Although not all of the final decisions have been made at this time, my goal over the next year is to keep you updated through e-blasts, website updates, and personal communication. A member of the Board of Directors will also personally visit each resident chapter over the next year. Please use this opportunity to gain knowledge and understanding of your college. Ask questions. Be engaged. The only way for us to properly understand your individual concerns is for you to have an active voice in the community.

We are also gearing up for the Spring Seminar, DO Day on the Hill, and the Leadership and Advocacy Conference. If you haven't had a chance to check out these three events, I strongly encourage you to take a look. Although as residents we are sometimes removed from the higher level perspectives that shape our field, it is never too early to start understanding the process. With this year being an election year, there are many topics which affect both the field of EM as well as GME. Please contact me directly if you are interested in participating at this year's D.O. Day or the Leadership and Advocacy Conference!


Sincerely,

John Downing, DO
ACOEP National Resident Chapter President
ACOEP Board of Directors
Midwestern University
Emergency Medicine



PRESIDENTIAL MESSAGE

Student Chapter

 On behalf of the entire student chapter board I wanted to congratulate all of the fourth years who matched at the beginning of February. What an incredible accomplishment! We also want to thank you, as our upperclassmen for your mentorship and support as the rest of us continue our journey towards matching into a great EM residency program.

I wanted to personally and publicly thank Dr. Judith Tintinalli for taking time out of her busy schedule to be our keynote speaker at the recent regional symposium at Campbell COM in North Carolina. She is truly an exemplary leader in the Emergency Medicine world. Everyone in attendance left feeling greatly enriched by her comments. Thank you to all the students that made that event such a huge success. Don't forget about our other upcoming student symposiums in Scottsdale, Arizona on Wednesday March 30th at the Westin Kierland Resort and in Wyandotte, Michigan on Saturday April 30th at Henry Ford Wyandotte EM residency program. Find more information at acoep.com/student.

As your student chapter president I am humbled by the honor of being your representative to the ACOEP Board of Directors. In this role I get the chance to spend one-on-one time with the leaders of this college expressing your needs and concerns to them. I want to personally attest to you how much those leaders understand your value in this organization. They know that all of you are the foundation and future of this organization and Emergency Medicine across the nation. They continue to listen to our concerns and adjust their goals, time, and resources to address those concerns and needs accordingly.

I wanted to finish by inviting all of you to approach any of the board members at any symposium or conference or by email. Tell us your feedback, questions, and concerns. You are the leaders and the future of this profession, and we are always here to help you along the way.

"Leaders become great, not because of their power, but because of their ability to empower others. "
-John Maxwell

Sincerely,

Timothy Bikman, OMS-III

ACOEP National Student Chapter President

WVSOM, Lewisburg, WV

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BEING AN ADVOCATE FOR EMERGENCY MEDICINE

Jonathan Meadows, OMS-II MS, MPH, CPH
Touro College of Osteopathic Medicine- Harlem

Emergency medicine is the most thrilling and exciting specialty attracting students that desire a dynamic, fast-paced, team-oriented medical practice. EM physicians are expert diagnosticians, taking care of multiple acute, undifferentiated patients during each shift. Residents and attending physicians performing life-saving procedures and resuscitation efforts through evidence-based standards and algorithms, as well as assuring the integrity of the US Health Care System by providing emergency care to any person that enters the emergency department.¹ Residents and attending physicians, even students, can advocate for better standards and rules that govern the standards of practice in Emergency Medicine, which is explored here.

The clinical challenges in emergency medicine (EM) are tremendous as are the reward in managing the patient in dire situations (e.g. motor vehicle accidents, trauma secondary to gunshot wounds, etc.). Many experienced attending EM physicians have noticed that there are issues that transcend the emergency department, such as a higher incidence of motor vehicle accidents, drug-seeking patients, cardiac diagnoses, or environmental poisoning. While treating the patient will alleviate the direct impact of these issues, the incidence (e.g. new cases) may not decrease. Therefore, emergency medicine physicians, residents and strongly interested medical students are charged to play a role addressing the root cause of the problems that impact multitudes of patients, just like medical students are trained to find the etiological cause of the diagnosis of individual patients. This may have determinants that are rooted in policy making, social factors, health services, individual behavior, biology and genetics². Healthcare professionals can address a variety of determinants through their individual practice of medicine and research. An additional and exciting avenue is advocacy and legislative affairs.

Advocacy is defined as '[the] act or process of supporting a cause or proposal; the act or process of advocating something,' which is derived from the Latin word *advocare*, meaning 'to call to one's aid'.³ It is described by public policy experts as 'attempting to influence public policy through education,

lobbying, or political pressure.'⁴ This definition is broad and encompasses common areas and duties of medical students and physicians as taught in the classroom and experienced in the ED examination room. Advocacy starts in our medical practice through patient centered care. This is defined as 'providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.'⁵ Physician can play a dual role as patient advocates (the individual level) and health advocacy (representing a group of patients or members of the patient's social networks), sharing stories and broad trends about ED patients to illustrate the problem and their solutions. There are few professions that have caring as an identifiable public and direct feature about their profession, and this should be leveraged in our advocacy efforts.

Students can play a vital role by being present in person at advocacy days, such as participating in the American Osteopathic Association's DO Day on the Hill. Students can participate in grassroots campaigns to bring awareness to important issues and educate the public and persons in leadership. Well written and well-researched editorials and communications to elected officials of their respective voting districts as a voting constituent is another avenue for student involvement, as well as residents and attending physicians. These avenues include online efforts, such as email messaging

and interacting with web page specific to a bill, phone –a-thons held at school, or coordinating in-person legislative district office visits.⁶

In the aforementioned grassroots tactic, students and all clinicians in emergency medicine can reach out to their elected official by simply stating their position or idea about a current bill through physically writing a letter or an email. Making a phone call is another way to do this. Across all these forms, describing your topic, stating explicit position, providing evidence, and stating clearly what you want the elected official to do is effective. Legislative affairs staff records and uses this information to help the legislator learn and take positions on the issues you are interested in. Start by reaching out to the ACOEP Governmental Affairs team as well as your state emergency medicine advocacy groups to help get you started on crafting your message. With the advent of social media, like Facebook and Twitter, legislators are reaching out to younger demographics to gain their support and all members of ACOEP can inform them of our positions through this medium as well.

Younger members of ACOEP can take great initiative by organizing right in their own school. Under the guidance of administration, the faculty advisor of the emergency medicine interest group, and an official advocacy staff member that represents emergency medicine, an effective and compelling phone-a-thon campaign can be completed, alongside internet-based emailing through automated email systems to get out not only the vote but the message as well. Again, reaching out to the ACOEP Governmental Affairs team as well as your state emergency medicine advocacy groups can begin this exciting activity for students. Student at Touro College of Osteopathic Students were exhilarated when they participated in the Grassroot Osteopathic Advocacy Link (GOAL) 2015 phonathon campaign. They called to get elected officials to vote Yes for the HR 2, the 'Medicare Access and CHIP Reauthorization Act of 2015" and contribute to the repeal of SGR. This excitement can be captured for emergency medicine issues and we can mobilize to help effect change on them.

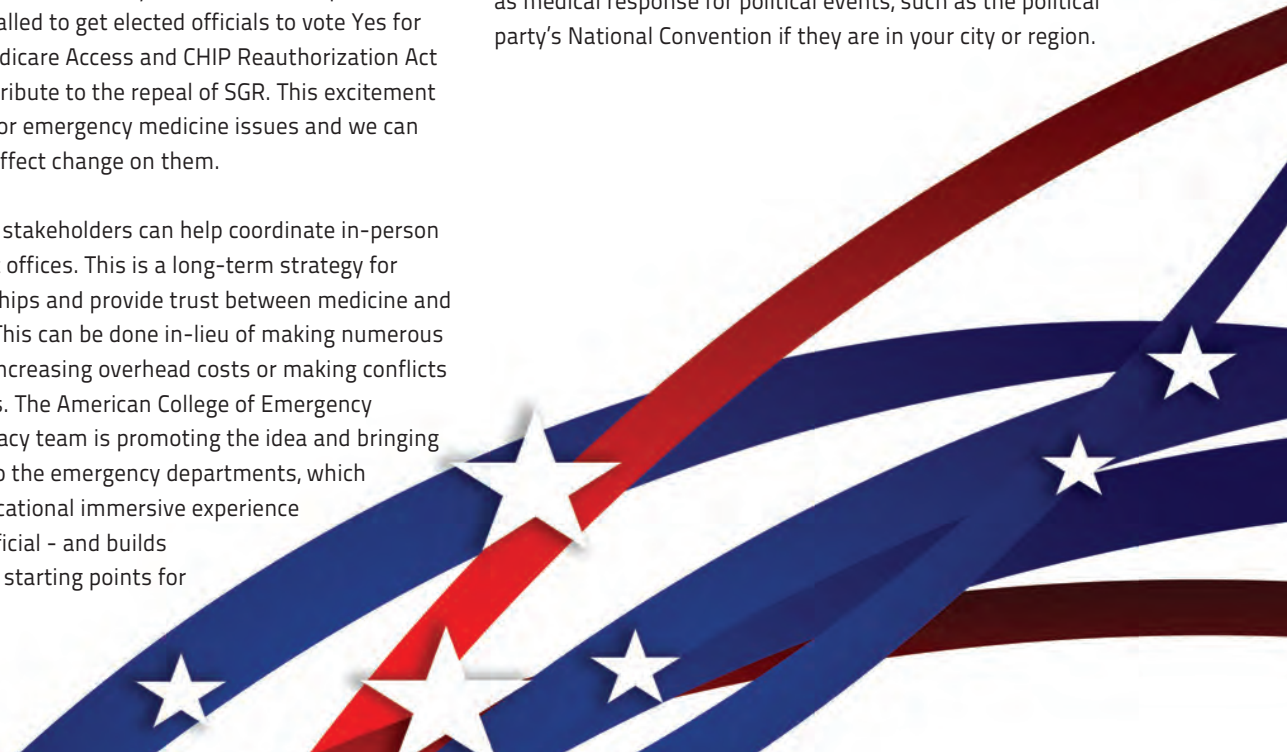
Finally, all ACOEP stakeholders can help coordinate in-person legislative district offices. This is a long-term strategy for building relationships and provide trust between medicine and elected officials. This can be done in-lieu of making numerous trips to capitals, increasing overhead costs or making conflicts in work schedules. The American College of Emergency Physicians Advocacy team is promoting the idea and bringing elected officials to the emergency departments, which is a powerful educational immersive experience for the elected official - and builds relationships and starting points for

discussions on major issues that affect emergency medicine and our patients.

There are numerous issues that students can advocate and help improve emergency medical care for patients, such as the following:

- Payment Incentives within the Medicare Access and CHIP Reauthorization Act (MACRA) that will change income for emergency physicians and all practitioners in the House of Medicine.⁷
- Medicare reimbursement changes that may adversely affect Emergency Departments - the safety net of the Nation's Health Care System..⁸
- The White House's commitment to bringing more education to physicians and the public in order to address Prescription Drug Abuse and Heroin Use and to reduced mortality.⁹

After being introduced to basic advocacy through the American College of Osteopathic Emergency Physicians (ACOEP) or the American Osteopathic Association (AOA), medical students, residents, and established emergency physicians can participate in more advanced ways. This includes direct political process involvement by volunteering on campaigns of emergency physicians and across all specialties that favor strengthening EM. They can also complete additional political campaign training, such as the AMA AMPAC's political education courses, get involved in local and state level politics, and provide funding directly to candidates or to the ACOEP Political Action Committee that supports new candidates running for elected office or incumbents. Many times, this funding is simply used for operational costs of campaigns. Emergency physicians and emergency medicine technicians can also volunteer to serve as medical response for political events, such as the political party's National Convention if they are in your city or region.



Advocating as an emergency medicine physician is a natural step based on the quality and quantity of care that is provided, and the patients that are impacted. It give current practitioners a career-long compilation of stories and source of joy that attracts students to the profession continually. The speciality is positioned to take those features of dynamic, fast-paced, team-oriented professional ED environments and target them to respond and shape fast changing advocacy and health policy changes. There are challenges in emergency medicine as noted before, and there are multitudes of solutions to many of them. Through advocacy, the resulting compelling stories can fuel efforts that will forward the house of emergency medicine as a whole, forward the advocacy priorities of ACOEP, and improve the lives of our patients that present with the greatest need through our doors 24 hours every day.

FOR IMMEDIATE INDIVIDUAL ADVOCACY ACTION, GO TO THE FOLLOWING WEBSITES:

ACOEP's Grassroots Advocacy at <http://www.acep.org/pages/grassroots>.

Details and action recommendations can be found at www.acep.org/pages/advocacy

ACOEP Staff Member for the Governmental Affairs Committee: Senior Coordinator Chapter Affairs Staff Member Mrs. Jaclyn McMillin (jmcmillin@acoep.org)

MORE ISSUES AND BASIC RESOURCES ARE FOUND AT OTHER EMERGENCY MEDICINE ADVOCACY WEBSITES:

American College of Emergency Physician's advocacy page (<https://www.acep.org/advocacy>)

Emergency Medicine Resident Associations Health Policy Committee page (<http://www.emra.org/committees-divisions/Health-Policy-Committee>)

Link for an EKG:
https://en.wikipedia.org/wiki/Atrial_fibrillation#/media/File:RapidAFib150.jpg

Photo Courtesy of UptoDate Adult ACLS www.uptodate.com/contents/advanced-cardiac-life-support-acls-in-adults

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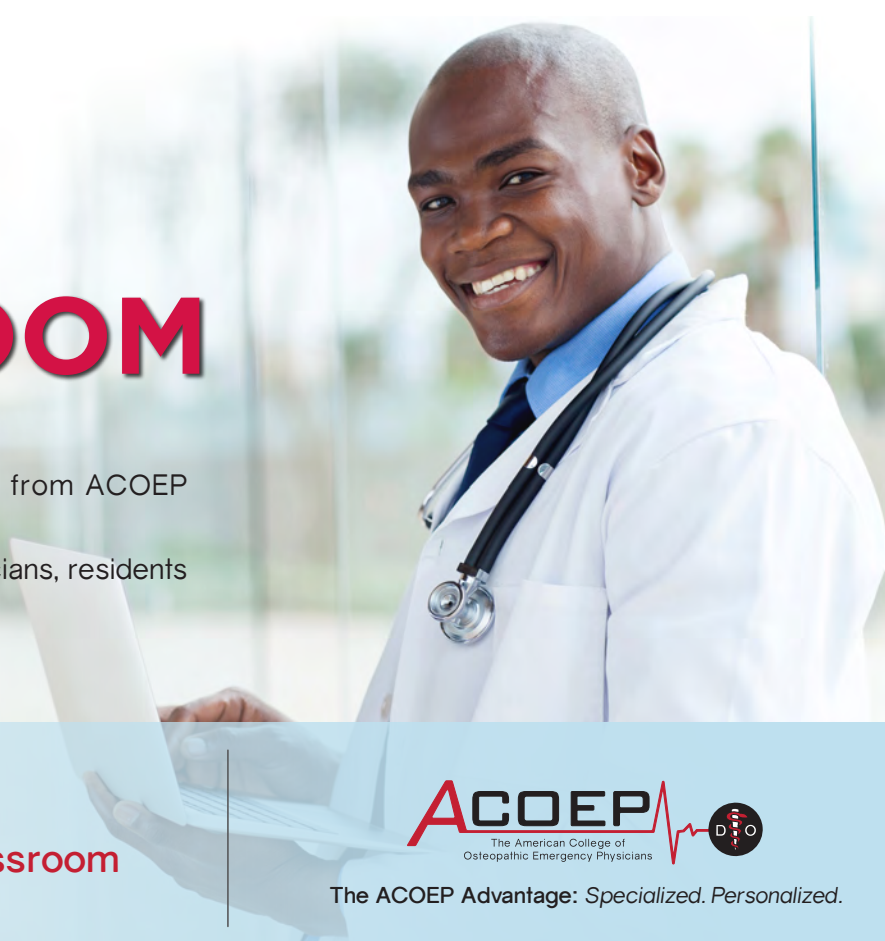
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HOW TO ADVOCATE NATIONALLY AS A STUDENT ★ ★ ★

Katherine Kirby, OMS-II

Edward Via College of Osteopathic Medicine

What if you were told you could make a monumental impact in a patient's life without even seeing the patient? What about impacting your future patients while you are still in school? Would you be interested?

As a medical student, you dream of being able to make a monumental impact in a patient's life one day as a physician. You study and prepare yourself for every possible diagnosis, surgery, or treatment that the patient could possibly need because you know that all of your time and sacrifice will be made worth it when you save that one person's life or discover the diagnosis to finally help your patient. Your toughest of days will be when you are tired beyond belief and have worked more than most people could ever imagine, but your energy is renewed every time you walk back into the room with the mother who once more thanks you for saving her child.

When I talk to other medical students, we all want to do everything for our patients to help them heal, have a better life and prevent future suffering. However, when I say the word 'advocacy,' there is often a slight change of tone. The conversation veers from a sense of pride and urgency to statements like, 'Someone else can do that.' Yet, if we erase any negative context we have with the words advocacy, policy, government, or laws we can find new ways to enhance positive outcomes for our patients.

Before you think that you must enjoy politics to be an advocate, know that I have never strongly aligned myself with a specific political party nor dutifully watched the recent debates. However, I am interested in my patients, in the quality of healthcare that I can provide as a future physician, in the funding of research for disease cures, and in finding financial solutions to our healthcare debt. Participating in patient advocacy and healthcare policy initiatives is a simple way that we as students begin to speak on behalf of our

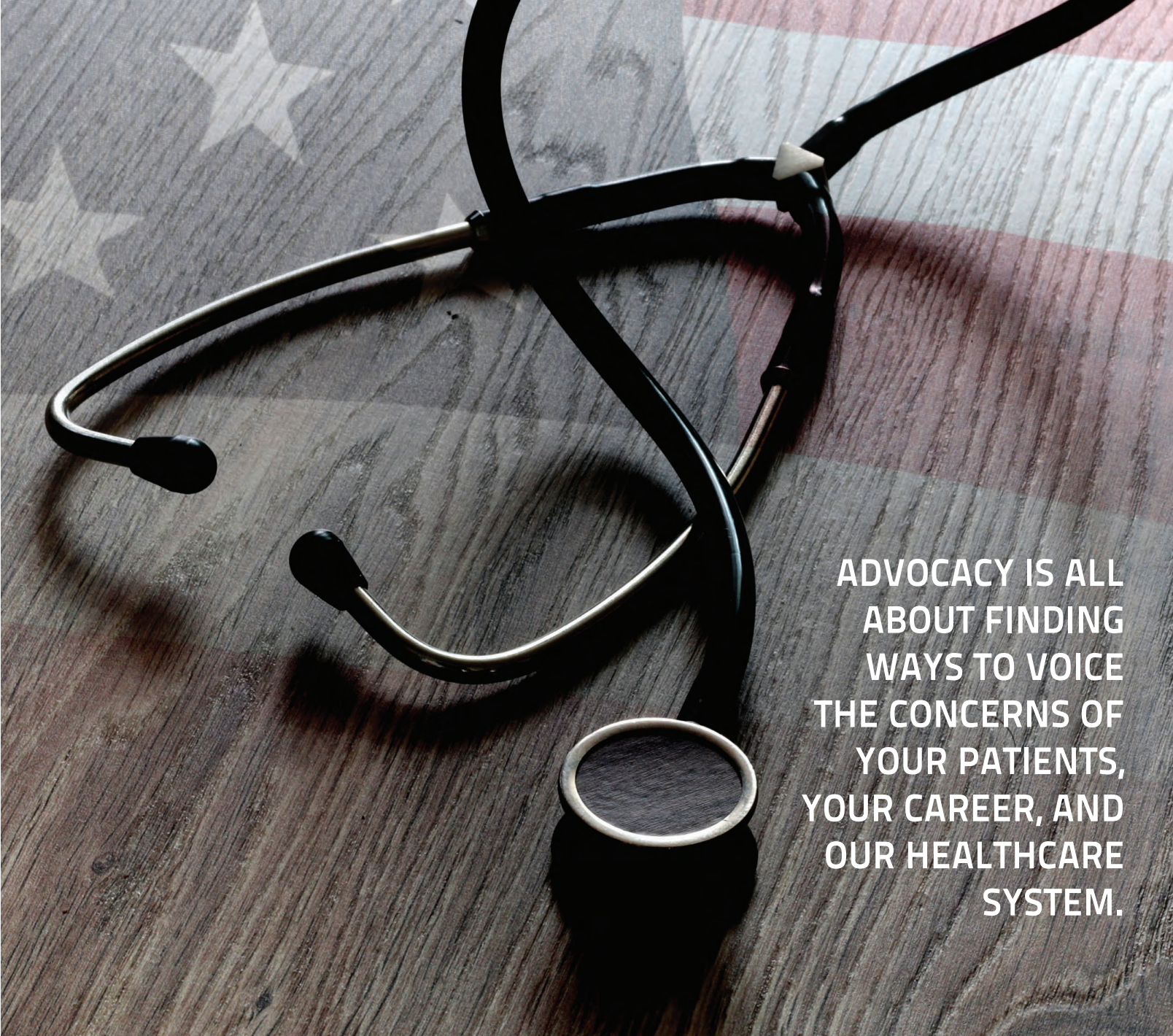
patients' needs and start to make those monumental changes that impact the future.

Indeed, there are so many possibilities of things you can do for patient advocacy on a community, state, federal, and even specialty level. I encourage you to look through a few of my suggestions to begin making a difference today.

First, stay in the know. Sign up today to receive the bi-weekly newsletter titled: Grassroots Osteopathic Advocacy Link (GOAL) through the AOA website. Glancing over this advocacy email will strengthen your knowledge of current topics and inform you of how to become involved in areas of your personal interests.

Second, find a way in your school or community to become involved. At Edward Via College of Osteopathic Medicine-Virginia, our Student Osteopathic Medical Association (SOMA) chapter encourages students monthly to wear a similar color in honor of a National Awareness Month campaign. For example, in January we shared a picture on social media of students wearing turquoise and red to support Thyroid Cancer Awareness. By supporting these organizations as a group, we increase awareness for the needs of those patients. Indeed, advocacy can be in the form of a relay run, a walk, or a donation drive!

What about on a state level? First, participate in your state's Osteopathic Medical Association to interact with and learn how physicians in your state are impacting health policy and patient concerns. Then, take that knowledge and inform your



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local representative of the needs at hand. Often, there are prewritten letters you can send to your state representative that explain in detail your opinion on a current policy. If you want something to change you have to be willing to tell someone it should change.

Finally, there are three national avenues by which you can make your voice heard. These include joining the ACOEP Governmental Affairs Committee to specifically learn current topics impacting emergency physicians nation-wide, the Osteopathic Political Action Committee (OPAC) to financially support pro-physician candidates during elections, and attending the upcoming AOA DO Day on Capitol Hill on April 13, 2016.

Advocacy is all about finding ways to voice the concerns of your patients, your career, and our healthcare system. Participating in one thing today will begin making a difference and help you impact the lives of your future patients.

Katherine Kirby, OMS II, Edward Via College of Osteopathic Medicine-Virginia. She is currently the National Liaison Officer for their Student Osteopathic Medical Association chapter and recent honorary inductee into Omega Beta Iota- National Osteopathic Political Honor Society.

PERSPECTIVES FROM THE FRONT LINES

Matt Voll, DO
Affinity Medical Center
Massillon, OH

The cold rush of wind from the rotors above that blew through the open doors on either side of the Blackhawk helicopter provided some immediate relief from the foul garbage smell that I could nearly taste. The bird quickly rose to a height where the wheels wouldn't hit any power lines or small huts and raced forward. The Blackhawk quickly lurched to the left, then right, attempting to evade incoming fire. I was kept inside thanks to the green bungee cord attached to my tactical belt, which in turn was attached to the floor of the helicopter. I could hear the two snipers located in the doorways snickering and laughing, telling me, 'hold on tight, Doc.' In my struggle not to be ejected out of the bird, I was simultaneously attempting not to stab myself or others with the needle in my right hand. The bird flattened out and the vibrations of the helicopter were reverberating up my knees into my arm and hand as I leaned closer to the injured Ranger lying on the floor. I could feel the sweat running from my helmet down the back of my neck. It trickled down my spine and around my face, dripping off the end of my nose. The heat from the rotors and smell of exhaust was making me nauseous. I was surrounded by green light as that was the only color that shone through my night vision goggles. I leaned in as close as I could to the injured soldier, praying there wouldn't be any large movements. I palpated his naked arm and felt a fairly large spherical lump near his elbow. I moved the needle closer and with one deep breath and a sigh, plunged the needle into what I thought was his vein. Through my night vision, I could see the catheter began to fill with a dark black substance: blood. I quickly advanced the catheter forward, removed the needle and started fluids. I thought to myself, 'One arm down, one more to go.' While I was frantically trying to keep myself from falling out of a moving helicopter, I knew starting multiple lines on my injured friend was going to be the least of my concerns that night.

In my previous life, before going to medical school I spent four years as a Special Operations Army Ranger, spending time in Afghanistan hunting Al Qaeda and the Taliban. Not only was I a Ranger, but I was also a Ranger medic, which meant I was both an active shooter and medic who took care of injured Rangers, civilians and combatants. As a Ranger medic, I was trained on starting IV's, chest tubes, crics, Tactical Medical Care under Fire, as well as a full array of other medical skills needed on the front lines of Iraq and Afghanistan. When medical school started I was sure I had a significant advantage over my peers, especially during my 3rd and 4th years. Even as an Emergency Medicine resident, I thought procedures would be easy. I couldn't have been more wrong.

Why the difference? As a physician, the patient population we deal with, regardless of our specialty, is significantly different than what is seen on the battlefield. When dealing with casualties on the front lines, the vast majority were young men, 18-25 who are in unbelievable shape. Most were previous high school and college varsity athletes with a limited body fat content. Their body's ability to compensate under extreme stress, volume loss, or fatigue is unmatched. To prove this point, during training, we inflated mass casualty trousers on a fellow Ranger, laid him flat on the ground with a foley catheter and began giving him Lasix in an attempt to artificially create a hypovolemic state. After significant volume loss -he peed like no other- we quickly stood him up and evaluated his vital signs. None had changed! He was able to maintain a normal blood pressure and heart rate even after becoming that dehydrated.

Fast forward several years, and I am now a second year ER resident. A cross-section of the patient population I now see on a daily basis consists of vasculopathic dialysis patients. What does that exactly mean? Well, the vast majority have an unusable fistula in one arm, decreasing my vascular access points in a trauma. Add this to the fact that the other veins



that are accessible are extremely small and fragile, if you can find them. As a medical student, it never dawned on me that I would eventually need ultrasound to obtain vascular access for patients, let alone need it on a daily basis.

Starting IV's had once been a strength for me as a Special Operator, but had now become a weakness and a new learning point in the ED. What I quickly learned was that

anatomy, palpating your landmarks as best as possible and proceeding with extreme caution.

As I reflect back on the training I had in the military as well as now as a resident, the procedures themselves are exactly the same; however the process couldn't be more different. They both have their independent levels of complexity. In one scenario the procedure may be undertaken while in a

WHILE I WAS FRANTICALLY TRYING TO KEEP MYSELF FROM FALLING OUT OF A MOVING HELICOPTER, I KNEW STARTING MULTIPLE LINES ON MY INJURED FRIEND WAS GOING TO BE THE LEAST OF MY CONCERNS THAT NIGHT.

the same issues were abundant with other procedures as well. Staying within the Triangle of Safety in regards to a chest tube was once based solely on palpating the fifth rib and inserting the chest tube over the top of it. The patients I was working on were again, athletic, thin males where the anatomy was pristine. This procedure has an added level of complexity today as our patients are significantly older and often times obese. One needs to truly understand the

moving aircraft, at night under hostile fire; while the other involves a crashing patient, no venous access, and a multitude of underlying comorbidities. Anyway you cut it, each is a less than desirable situation, and both take a special kind of person to manage these catastrophes. In all honesty, I can't imagine doing anything else.

Rangers Lead The Way.

WHAT NURSES WISH YOU KNEW

Christina Hornack, OMS-II
Edward Via College of
Osteopathic Medicine

The work of caring for patients in the Emergency Department, by its very nature, fosters teamwork amongst employees and dissolves barriers between functions. While my own experience is limited, I will say that the lines between doctors and nurses was far less prevalent in the emergency department than during my time as an oncology nursing assistant. That being said, even the most circumspect of physicians may not be aware of the differences in roles, and therefore some of the pains of working with doctors.

In celebration of our colleagues and in preparation for National Nurses Week – (Friday May 6th – Thursday May 12th 2016), I asked a variety of nurses from several different emergency departments and intensive care units to share some of the things they wish doctors knew about their roles and their difficulties with us.

They worked very hard to get where they are.

Being a nurse requires, at minimum an Associate's degree, and in most places a Bachelor's. Most programs have a minimum SAT score required or a pre-entry test minimum competency score. Pre-requisites include courses in English, ethics, microbiology, anatomy, physiology, and human growth and development. The curriculum is often demanding, with 18-24 credits per term in 16 week blocks. These courses cover topics similar to the pre-requisites as well as specific nursing topics, pharmacology, and nursing in special phases of life or situations. In addition to coursework, most states require a certain number of clinical hours to attain the degree, with some states requiring nearly 1000 hours.

They also had to pass a board exam.

The NCLEX, (National Council Licensure Examination) is a standardized exam used by each state to determine if a candidate is competent for

entry-level nursing. The exam is anywhere from 75-265 items, with a time limit of six hours. The first time pass rate in 2015 was 85.49%

They had a lot of choice in where they decided to work.

There are 104 areas you can specialize in, broadly including different areas in surgical, emergency, managerial, and even research subspecialties. Median wages are around \$66k per year, with some states over \$120k. Hours range from 36-40 hours per week for full time and less than 30 for part time. Nurses have a lot of choice in regard to their area of practice, schedules, and specialty area with the need for nurses expected to grow by 20% through 2022.

Ordering tests on a computer is a lot faster than completing those tests on a patient.

ER Nurse N says, 'When you order a bunch of labs all at once on a patient with horrendous veins and then five minutes later ask where your labs are, you have to keep in mind that I might be waiting on phlebotomy to come and start the line.' ER Nurse J says, 'Clicking a button ten times for ten different patients is a lot faster than going into ten separate rooms, talking to ten separate families, drawing multiple tubes, taking someone to the bathroom, cleaning up a wound, and

giving someone directions to the cafeteria."

Nurses work with a lot of different people to complete your orders.

ICU Nurse R says, 'Things are as fast as they can be, but they are not instant. Sometimes the medication you want depends on the pharmacy mixing it, the lab finishing the type and cross, and the patient actually being in their room and not off at a test in some other part of the hospital.'

The nurse also has 'clinical gestalt' and appreciates when you recognize that.

Nurse N says, 'Insisting that a difficult patient needs imaging without ordering sedating meds is difficult, frustrating for everyone involved, and downright unsafe for the patient and the staff. Consider obstacles that may make the process of imaging a patient difficult, for instance if they are agitated or cannot lie flat.'

Nurse N goes on to say, 'If I just don't feel right about a patient, I may ask the doctor to come take a look. A lot of times, I can avoid having to hit the code button and send everyone in to run a full code if nurses and docs work together to provide the best care for our patients. I may not even be able to explain what I think is wrong, but I've seen enough people head for the drain that I know when someone's on the edge.'

Difficult patients and families are everyone's concern.

ER Nurse NP says, 'Completely avoiding difficult patients or family members and forcing the nurse to deal with them is probably the most frustrating situation. It makes me look bad, only irritates the patient more,

and forces me to cover for the doctor more than they probably realize. Sometimes a couple of words from the doctor can do a lot to soothe people, even if they are just repeating what I've said several times already.'

Your mood and reaction to a shift does a lot to the department.

ER Charge Nurse says, 'There are some doctors that are always pleasant, whether we have fifty people in the waiting room, choppers on the roof, or stretchers in the hallways. These are the doctors that I would do anything for because despite everything hitting the fan, they still treat us like equals and not errand boys. They make us feel like a real team, and you'd go to the mat again and again for someone like that.'

A little appreciation goes a long way.

Nurse N finishes her statements by reminding us, 'Nurses love docs, this isn't meant to bash them, but we all work hard for the best outcome and sometimes it gets hard when you don't feel appreciated.'

For the most part, a lot of our colleagues said they generally felt valued by the physicians they worked with. There were obviously some discrepancies and outliers, but most of the nurses I spoke with said they would never want to work anywhere else, and those feelings were largely because they felt like a valuable member of a team that appreciated their insight, efforts, and contributions.

Speaking of appreciation, National Nurses Week is held every year to finish on Florence Nightingale's birthday – May 12th. Nightingale was a prolific writer, social reformer, and

prominent nurse manager during the Crimean War. She went on to start the first secular nursing school in London, and the Nightingale Pledge, a modified version of the Hippocratic oath written by Lystra Gretter, is taken at a number of pinning ceremonies to this day.

Hopefully these comments can help shed light on the work that our nursing colleagues do, the struggles they face, and the challenges we put before them. Together, we can encourage better teamwork and stronger relationships. And as Nurse N says, 'Just offering to help can sometimes do a lot to make nurses realize you see them as your equals.'



Explore ACOEP's New Online Home!

Take a moment to look at ACOEP's new, interactive website. Find the answers to your CME FAQs, peruse the member benefits, check out upcoming meetings, find a committee that fits your interests, and see the latest updates in the new blog.

www.acoep.org

AAEM ADVOCACY DAY

Phillip Dixon, MD MPH
University of Mississippi Medical Center
Jackson, MS

It's a September morning in Washington DC. In an unfamiliar conference room at 7am, I enter and sit down. It's advocacy day for the American Academy of Emergency Medicine (AAEM), and we discuss the plan for the day.

Advocacy Day, or the 'fly-in,' is a scheduled meeting with leaders of our specialty to meet with the men and women of Congress to express our viewpoints on important legislation. This was unfamiliar territory for me, and I would imagine it to be unfamiliar territory for really anyone who has ever participated in this event. I traded my familiar scrubs for a suit; a day in the hospital for a conference room; and patients for politicians. Although I was advocacy chair for the AAEM Resident and Student Association (RSA) and was part of the committee that created our talking points for the day, reality didn't set in until I was walking up the steps of the Capitol Building.

regardless of financial standing. The ED is the 'safety net' for these patients, and it is easy to forget that we have to act in the best interest of those patients who are often forgotten. Schizophrenics, the homeless, the indigent all come to the ED for their care and often have no way to pay their medical bills. Asking a subspecialist to see an uninsured patient in the middle of the night can create conflicts with these physicians who are more accustomed to those with insurance. Advocacy in our specialty involves not only doing what is in the best interest of emergency physicians, but also advocating for our vulnerable patient population. Insisting that the homeless man with an open fracture, acute subdural, or appendicitis be seen in the middle of the night can be daunting and difficult; however, it is a fight worth fighting.

At the same time, we cannot allow ourselves to give the well-insured patients special treatment. Hospital administrators

ADVOCACY IN OUR SPECIALTY INVOLVES NOT ONLY DOING WHAT IS IN THE BEST INTEREST OF EMERGENCY PHYSICIANS, BUT ALSO ADVOCATING FOR OUR VULNERABLE PATIENT POPULATION.

The good news is that emergency medicine prepares us for all sorts of situations that lie beyond our comfort zone. Communication, multi-tasking, improvisation, and advocating for our patients are all things we have done or do on a daily basis. I would encourage all emergency medicine physicians and residents to consider going to a 'fly-in.' ACOEP, AAEM, and American College of Emergency Physicians (ACEP) are all affiliated with fly-in days, which are critical opportunities for us to advocate for our patients. Emergency medicine patients are the most vulnerable and underserved patients in the country. Unlike many subspecialties who rarely care for the uninsured, emergency medicine physicians see every patient

often push for admissions from well-insured patients, but this practice drives up unnecessary costs if those admissions could be treated as an outpatient and do not serve in the patient's best interests. Emergency medicine physicians should not feel pressured to treat an uninsured or well-insured patient differently. Our obligation is to our patients and what is best for them. The variety of patients we care for in the ED is one of the most valuable parts of an emergency physician's job. Doing what's best for the individual patient, regardless of payment, will likely increase our job satisfaction.

AAEM's Advocacy Day in September 2015 was centered on another similar issue for many emergency physicians. Partly due to the rise of contract management groups, emergency physician contracts are increasingly including the forfeit of due process rights. This would enable hospital administration to terminate an emergency medicine physician without being judged through a fair and independent process. AAEM supported the stance of abolishing these clauses in contracts throughout the country. It was argued that this measure is not to protect delinquent or incompetent physicians, but to allow for a fair and independent evaluation over the reasons for termination. This stance was taken alongside the American Academy of Family Physicians (AAFP), ACEP, the American Society of Anesthesiologists, the American College of Legal Medicine, the Emergency Medicine Resident's Association (EMRA), the Society of General Internal Medicine, and the Council of Emergency Medicine Residency Directors. These organizations urged the Centers for Medicare and Medicaid Services (CMS) to protect the physician's right to due process.

A different topic from a resident physician perspective included support from the AAEM/RSA on The Resident Physician Shortage Reduction Act of 2015 (H.R. 2124/S.1148), which calls for expanding residency positions by 3,000 slots per year from 2017 to 2021. The Association of American of Medical Colleges (AAMC)

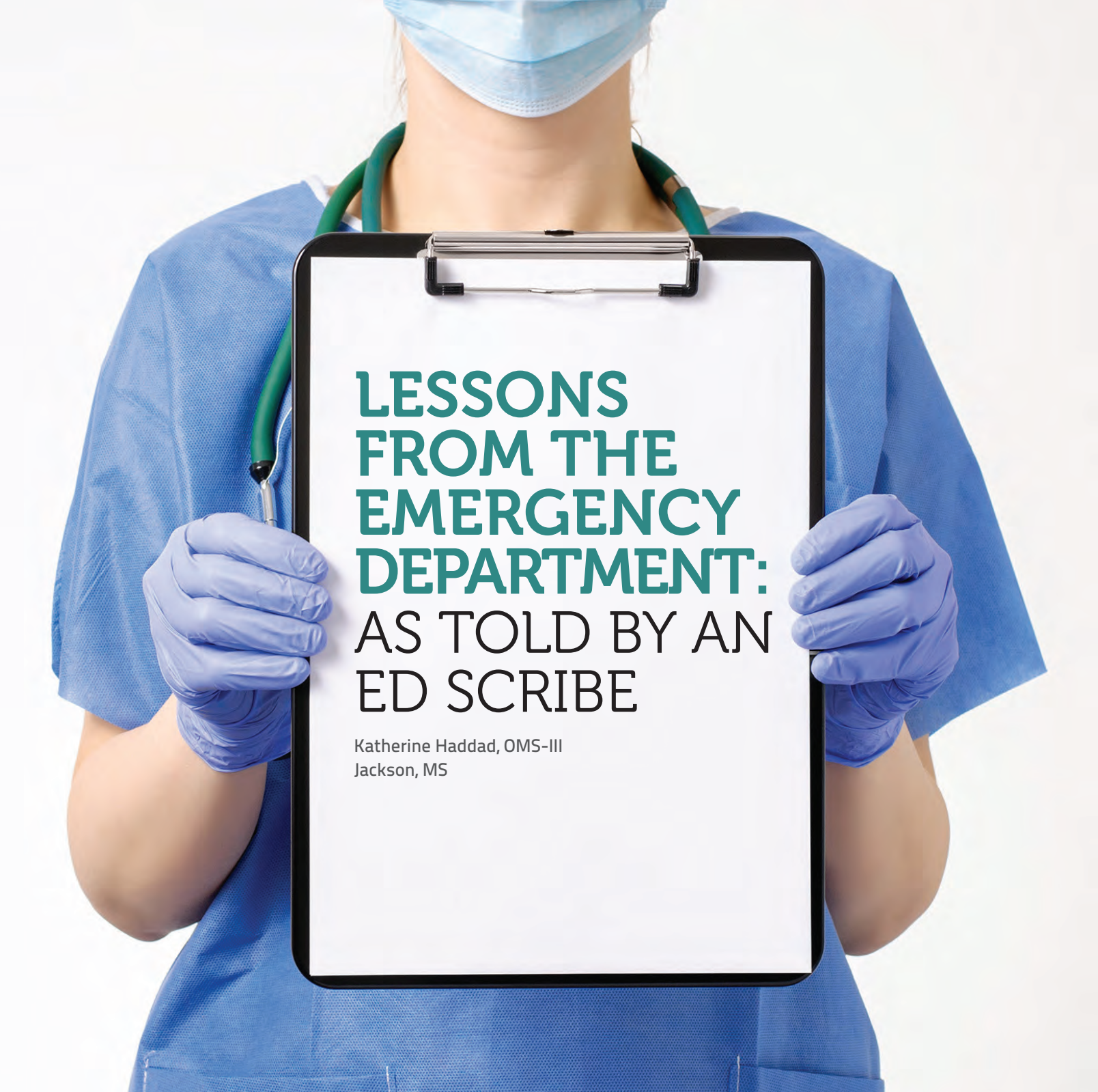
residents work. Approximately 40% of charity care is performed at teaching hospitals where residents play an integral role. Further, residents care for underserved patient populations with a fraction of the salary of a board certified physician.

The final issue discussed was medical student debt, and student debt reform. In 2014, the AAMC estimated that 84% of medical school graduates had educational debt with a median burden of \$180,000. This level of debt oftentimes dictates what specialty a medical student decides to pursue or what job a graduating resident decides to take. Graduating residents could focus more on philanthropic or underserved populations if going to medical school did not coincide with the immense debt it currently does. AAEM/ RSA supported the American Medical Association (AMA) and AAMC's endorsement of policies aimed at reducing tuition, such as tuition caps. AAEM/ RSA also supported tax deductions on loan payments, advocating for a cap on interest rates, and continuing the debt forgiveness programs. Curbing the substantial debt incurred by medical students will lead to more options for the future physicians of America.



predicts an upcoming physician shortage of 46,000-90,000 doctors by the year 2025. This is largely driven by the increasing number of people over the age of 65. These people, as a general rule, need more health care. According to the AAMC, medical schools have increased enrollment to help offset this shortage; however, GME (Graduate Medical Education) is lagging behind. It is projected that the number of American medical school graduates will soon exceed the number of available GME positions in the country. Residents participating in graduate medical education are important contributors to the care for underserved populations, as 28% of Medicaid hospitalizations occur at teaching hospitals where

But above all, it is important for emergency medicine physicians to advocate for themselves and for the patients who depend on us to make choices in their best interest. It is easy to forget on a shift, but emergency medicine is an integral part of society. It acts as a safety net, as well as many patients' entry point into the hospital. It cannot be emphasized enough that advocacy should be routine and done daily. 'Fly-Ins' are unique, but not different than what is required on a daily basis.



LESSONS FROM THE EMERGENCY DEPARTMENT: AS TOLD BY AN ED SCRIBE

Katherine Haddad, OMS-III
Jackson, MS

Dr. K turns away from the patient in search for absorbent material to soak up the copious amount of purulent, bloody drainage falling off of the bed onto the floor. Her eyes meet mine as she gives me a look of complete horror. Still facing the patient, I keep a kind but serious demeanor so as to not alarm him, however, upon leaving the room my stoicism waned.

As an ED scribe, I have smelled rooms filled with the noxious odor of *C. diff* diarrhea and the fetid scent of the severely

neglected elderly or indigent. I have seen a naked 400lb man seizing for 15 minutes straight in the trauma bay. I have witnessed head trauma, severe lacerations, an unsuccessful code, and a rapidly deteriorating previously healthy female patient with a splenic rupture. Many pre-medical students are made for this type of exposure and do not fret upon viewing something gruesome or disturbing. Occasionally, however, a student or physician may encounter a situation that makes even the hardest stomach churn.

Our patient was a relatively well-appearing 65 year old male with bilateral above-the-knee amputations with a deep abscess in his distal left stump. Upon removal of the bandage, the drainage flowed like water out of a dam. While Dr. K had non-verbally expressed her emotions to me with her back turned, with care and respect for her patient she took a swab sample from the abscess site and reassured him that he would be taken care of to the best of her abilities. **Lesson 1: While it's okay to be human, always maintain your patient's dignity no matter how startling or surprising the situation.**

Multiple e-mail and phone call blasts later, I'm finally awoken by a request to fill in on a shift for a heavily burdened ED. What kind of disaster has struck southeastern Michigan? I had been on some insanely busy shifts before, but have never been called in like this for a Jeopardy shift.

That shift, I began to see a trend with some patients in that many of them had recent lumbar punctures, and had returned to the ED to obtain an additional tap. The patients found in this predicament seemed particularly anxious, but I did not have the context to understand their fear despite these negative spinal taps. My attending was too busy to answer any questions, but I thought the patients would be pleased that there was nothing found in their CSF. I guessed they were likely suffering from some self-limiting illness or a chronic neck/back pain exacerbation. Right? Not exactly.

Fungal meningitis. At that time, the only known cases were seen in Tennessee, but the etiology, management, and treatment of the endemic illness were still unknown. But not anymore. With hundreds of cases found in Michigan, it was no longer only Tennessee's problem. The physicians managing these patients were navigating completely uncharted waters. So what do you do to alleviate the fears of tens of hundreds of patients coming through the ED with suspected fungal meningitis while also managing the usual patients seen on a day in the ED? You mobilize a team of ED physicians, radiologists, nurses, technicians, and clerks to innovate and execute the best management protocol. While I have witnessed teamwork in action during any typical shift, the fungal meningitis epidemic of 2012 truly exemplified the harmonious symphony of team-based medicine in the ER. **Lesson 2: The ED is the front door to the hospital and only functions with optimal teamwork.**

On a slow day in the ED, I am chatting with a fellow scribe about application season and mention I am applying to a particular osteopathic medical school. Feeling a little down that I had yet to receive interviews, I hear a loud, deep voice coming from across the pod. "What's your name?" asks the

chief resident of the EM program. I tell him my name and at that exact moment, he proceeds to pick up his cell phone, call his friend in the administration at the school I had just mentioned, and tells them to look out for my application. Overhearing my conversation with the chief resident, the program director offers to write me an additional letter of recommendation to put on my file, and provides advice about the application process.

A mere two days later, I receive an interview invitation from that school. While I was not granted acceptance into that program, I gained an overwhelming appreciation for those EM physicians that has remained with me ever since. **Lesson 3: Emergency medicine physicians make incredible mentors that go above and beyond the call of duty when it comes to guidance of medical students.**

As a scribe, it's common to lose track of your physician. While some physicians will always let you know when they are about to see a patient, some forget you are even there, see a patient without you, and return moderately upset that you were not there to document the case. Eventually you learn to follow your physician's patterns and these instances occur less and less.

Early in my scribing career, I recall losing track of my doctor for thirty minutes. I panicked, thinking she was seeing patients without me. At this point I still had not yet gained the "hunger tolerance" of an ER doctor, so my ghrelin secretion was at a maximum. Eventually she returned and it was evident that she had found time to eat on this extremely busy shift. I was still hungry. **Lesson 4: On an ER shift, always be aware of when you have time to eat.**

My time as a scribe taught me lessons on compassion, teamwork, mentorship, and so many more. This position gave me early access to the healthcare system, and one-on-one interaction with physicians that I hope to one day resemble. As to the arguments on the necessity of scribes, there are many policy-related criticisms and many contend that scribes are merely a result of an over bloated medical system. Further still, some argue that scribes are an invasion of patient confidentiality. Regardless of room for reform in this area of medicine, having this position prior to medical school gave me great insight into the field I chose to dedicate my life's work, and will hopefully contribute to becoming a better physician in the future.

HEALTH CARE AND THE 2016 PRESIDENTIAL RACE

Andy Leubitz, OMS-II OUHCOM

Brittany Kasturarachi, OMS- II OUHCOM

With the 2016 Presidential election heating up, it can seem difficult at times to keep up with the ever-changing political climate and rhetoric that is thrown around. One of the more important issues of this election is what policy changes the next Commander-in-Chief will implement for our health care system. We have compiled a brief list of what each of the top candidates have said about the Patient Protection and Affordable Care Act (PPACA) and what their policies will do for the country.

We gathered our information from a number of sources, including every candidate's website as well as trustworthy sources, Battopedia and Politico. We tried to make each profile fair and unbiased as we could. As with any election, we encourage you to read and learn more for yourself. As future and current healthcare providers, we must understand the political healthcare issues that are being debated.

*The candidates below were still running for the Presidential nomination at the time this article was submitted to the publisher. As we move through the primaries, the slate of candidates may change.

DEMOCRATS



HILLARY CLINTON:

Hillary Clinton has established herself as the natural successor of current President Obama. Noting

her success in the Senate and work as Secretary of State, she has built a long and impressive resume. Her website tagline, 'Let's elect a president who'll defend and build on President Obama's progress,' is an encouraging message that in terms of health care reform she plans to build upon the PPACA. Additionally, she has taken up more personal and specific healthcare issues. For example, she is very much involved with efforts to combat Alzheimer's disease- promising a \$2 billion investment between 2016 and 2025 as well as establish a specific action plan with researchers and other health officials in the area. She also has a long history of progressive healthcare reform and her biggest campaign promises related to health care include defending the PPACA, expanding prescription drug coverage, and pushing the delivery of healthcare to 'reward value and quality.' Additionally, as the only female front-runner, it is important to note that Secretary Clinton promises to defend programs like Planned Parenthood.

To find out more information visit: www.hillaryclinton.com/issues/health-care



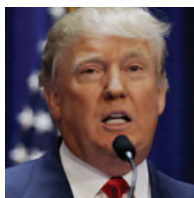
BERNIE SANDERS:

Despite serving in politics for most of his professional life, Sanders is not a national household name like Clinton

or Trump. Senator Sanders has embraced the grassroots movement of campaigning and has continued to push the issue of true finance reform in the election system. The Vermont Independent has caused a stir in the democratic primary as he continues to gain support, nipping at the heels of Secretary Clinton. He recently released his vision for a health care plan, which would again change the current ObamaCare System and move to a single payer, national health care program. 'Health care must be recognized as a right, not a privilege....The only long-term solution to America's healthcare crisis is a single payer national health care program.' Joining a single payer movement would put the United States in a similar system as Norway, Japan, the United Kingdom, Sweden, Canada, and Finland. In essence, Bernie's system would be, 'Medicare for All.'

For more information please visit: www.berniesanders.com/medicareforall

REPUBLICANS



DONALD TRUMP:

The Donald has made quite an impression on the American political system and around

the world, as the public seems to be ever enticed by his unique campaign style. He has strong positions on many economic fronts of the country, and has leaned into the right of the Republican base on famously key issues such as immigration reform and the second amendment. Mr. Trump opposes cuts to Medicare and supports the repeal of the PPACA. In an interview with CNN, Mr. Trump said that the ACA has 'gotta go' and that he would replace it with, 'something terrific.' He has not given a specific position on a replacement for the PPACA, but has said in interviews that his potential plan would, 'return authority to the states and operate under free market principles.'

For more information visit: www.donaldjtrump.com and www.forbes.com/sites/dandiamond/2015/07/31/donald-trump-hates-obamacare-so-i-asked-him-how-hed-replace-it/#351fad5e5d5e



DR. BEN CARSON:

Dr. Carson's policies and views on healthcare and even political party may surprise a few people.

Carson made it to the national stage and even has had a movie made about him, inspired by his life when he successfully separated conjoined twins, and developed a hemispherectomy technique to control seizures. He became famous in the medical world as he rose from very humble beginnings as an African American kid growing up in Detroit, to attending Yale University, and then University of Michigan Medical School, to becoming director of pediatric neurosurgery at Johns Hopkins. Carson has previously said he would dismantle the national social insurance program for the elderly (Medicare) and

replace it with a private voucher system. He recently changed his mind when asked on Facebook if he wanted to abolish Medicare and said he'll soon offer a plan to 'save money and deliver better service to our nation's seniors.' He'd use Health Savings Accounts (HSA) to reduce the need for government assistance programs like Medicare and Medicaid. He has also been quoted as saying Obamacare is the 'worst thing since slavery.' While Carson apparently is in favor of repealing the ACA, he does not appear to have suggested specific proposals to replace the ACA or provide methods for universal coverage and preventing exclusions for preexisting conditions.

For more information visit: www.bencarson.com/issues/health-care



JOHN KASICH:

Governor from a key battleground state, Ohio, John Kasich has made some interesting moves

as a Republican being one of the few Republicans to accept the federal funding provided for Medicare expansion. However, Kasich would repeal the PPACA. He cites initiatives in his home state that would improve the quality and delivery of care if expanded nationwide. He has become known to be the conservative choice and taglines his health care approach as 'A conservative approach to better health care.' He's silent on whether insurance companies can be allowed to exclude insurance due to pre-existing conditions, and he appears not to take any position on Medicare.

For more information visit: www.johnkasich.com/healthcare

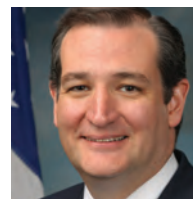


MARCO RUBIO:

'Repeal Obamacare, Replace it with a 21st Century, Market-Driven Alternative.'

Senator Rubio would make no changes for those in retirement or near retirement. He would transition Medicare to a premium support system, which would give seniors a fixed amount to purchase health insurance. They could have the option of either Medicare or a private provider. Rubio would repeal the PPACA. On his site, he states that he'd provide all Americans with a tax credit that can be used to purchase private insurance; although, he has no stated position on whether insurance companies can allow exclusions for pre-existing conditions

For more information visit: www.marcorubio.com/issues-2/marco-rubio-health-care-obamacare-repeal-replace



TED CRUZ:

Cruz would raise Medicare's eligibility age to save costs. He advocates appeal

of the ACA and has actively fought its implementation. He has proposed the Health Care Choice Act as an alternative to PPACA, although it is unclear if it allows universal coverage and prohibition of exclusions due to pre-existing conditions. In the Iowa Republican Debate on January 28th of this year, Cruz responded to the question of how he would repeal Obamacare by 'If I am elected president, we will repeal every word of Obamacare.' He also cited three specific reforms to replace it.

- 1.) We should allow people to purchase health insurance across state lines, creating a true 50 state marketplace.
- 2.) Expand health savings accounts so people can save in a tax advantaged way for more routine health care needs.
- 3.) Work to delink health insurance from employment.

For more information visit: www.tedcruz.org and Slate.com

Fall Research Competitions

FOEM Research Study Poster Competition

Sponsored by  Florida Emergency Physicians
Excellence in Emergency Medical Care

WEDNESDAY, NOVEMBER 2, 2016

7:30am – 11:00am

This annual competition takes place during the ACOEP Scientific Assembly and is open to residents and students that have completed a research project and would like to present it as a poster summarizing their findings.

FOEM Clinical Pathological Case Competition (CPC)

WEDNESDAY, NOVEMBER 2, 2016

7:30am – 3:30pm

This exciting annual competition pits residents against faculty in diagnosing a difficult case. It takes place during the ACOEP Scientific Assembly. Residents submit the case without final diagnosis, and the faculty member is given one month to develop a diagnosis. Both residents and faculty submit PowerPoint presentations. Each program must have a resident and faculty member in order to participate.

FOEM Oral Abstract Competition

WEDNESDAY, NOVEMBER 2, 2016

12:30pm – 3:30pm

This annual competition takes place during the ACOEP Scientific Assembly and is open to residents and students that have completed a research project and would like to present it as a PowerPoint presentation (multiple slides, not poster) summarizing their findings.

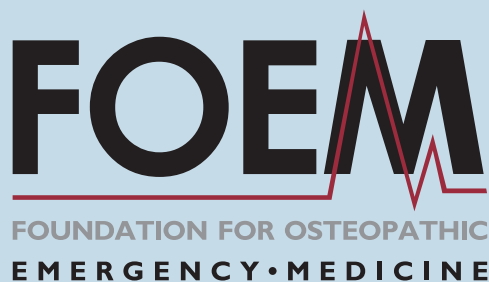
FOEM Resident Research Paper Competition

Sponsored by  WestJEM
Mapping Emergency Care with Precision

WEDNESDAY, NOVEMBER 2, 2016

11:00am – 12:30pm

This is FOEM's most prestigious event. Participants submit their full research papers for review by a panel of physician experts. The panel identifies the top 3 papers prior to conference, and the winning resident-authors present their findings at the ACOEP Scientific Assembly annually.



The deadline to apply to the Foundation's Fall Research Competitions is **July 31, 2016**. Apply now at **www.foem.org**

GET INVOLVED WITH ACOEP'S COMMITTEES

ACOEP's committees are a great way to learn more about emergency medicine, healthcare across the country, or to network with people making a difference at every level. Check out just some of the great opportunities available.

COMMITTEE ON CONTINUING MEDICAL EDUCATION (CME)- EDUCATION

PURPOSE: To offer its members and fellow healthcare professionals continuing medical education programs with an emphasis on medical updates, techniques, innovations, and general educational topics appropriate to the field of emergency medicine.

MEETINGS PER YEAR: Two to four meetings per year

RECENT ACTIVITIES: Successfully began planning and identifying speakers for the 2016 Scientific Assembly

RECENT ACCOMPLISHMENT: In the final stages of submitting our initial application for ACCME Accreditation as well as having been approved to provide AMA PRA Category 1 Credit™ to MDs through AAEM.

CONTACT INFORMATION: Scientific Assembly: Niles Patel, DO, nnpatel1291@hotmail.com; Spring Seminar: Chris Colbert, DO, chriscolbert1@comcast.net; Staff Liaison: Kristen Kennedy, Director of Education Services, kkennedy@acoep.org

COMMITTEE ON CONTINUING MEDICAL EDUCATION (CME)- EVENTS

PURPOSE: Creates educational content for the college by securing speakers for conferences and online education. It also ensures ACOEP remains accredited with the top standing to award CME. In the addition to the content side of education, the events division secures additional speakers, and ensures that all logistical elements for events and conferences ranging from 50-1500 are handled with the utmost care.

MEETINGS PER YEAR: Two to four meetings per year

RECENT ACTIVITIES: ACOEP recently completed the revamped Written Board Prep-An Intense Review, and Oral Board Review in Chicago. These events are longstanding events which

are board certification review courses designed for initial certification or recertifying physicians.

RECENT ACCOMPLISHMENT: ACOEP's Scientific Assembly 2015 in Orlando reached record numbers with nearly 1500 in attendance. Growth has been steady during the past three years.

CONTACT INFORMATION: Staff Liaison: Andrea Rayburn, Meetings and Education Coordinator, arayburn@acoep.org

COMMITTEE ON PUBLICATIONS AND COMMUNICATIONS

PURPOSE: Manages the publication of *The Pulse* four times per year and works with students and residents on *The Fast Track*. This Committee also contributes to social media initiatives, and in the future will play a larger role in marketing campaigns, blogging, and engaging fellow members in conversations.

MEETINGS PER YEAR: Two meetings per year, one at Spring Seminar and Scientific Assembly.

RECENT ACTIVITIES: Recently the Communications committee just launched new projects to bring the voices of our members into *The Pulse* through open questions on social media, and a new Member News section that will be in every issue.

RECENT ACCOMPLISHMENTS: The launching of the new ACOEP website includes a blog, where members can comment, submit posts, and where we can post extended content from *The Pulse*.

CONTACT INFORMATION: Staff Liaison: Erin Sernoffsky, esernoffsky@acoep.org

ACOEP's

SPRING SEMINAR

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*Their generous support helps make ACOEP's Spring Seminar
the best in emergency medicine.*

COMMITTEE ON EMERGENCY MEDICAL SERVICES (EMS)

PURPOSE: Provides input into training standards, writes position papers on certain public health and safety issues, and plans the EMS Tracks at the Spring and Fall Conferences.

MEETINGS PER YEAR: Two meetings per year, with participation in conference calls

RECENT ACTIVITIES: The leadership of the EMS committee developed an Active Shooter position paper that is currently being reviewed by the Practice Management Committee and then will be presented to the ACOEP Board.

RECENT ACCOMPLISHMENTS: The EMS Committee recently completed planning for the EMS track at Spring Seminar, which is already boasting record turnout.

CONTACT INFORMATION: Staff Liaison: Erin Sernoffsky, esernoffsky@acoep.org

COMMITTEE ON GOVERNMENTAL AFFAIRS

PURPOSE: The purpose of the Governmental Affairs Committee is to advocate for osteopathic emergency medicine physicians on health policy legislation. The committee takes a grassroots approach in order to provide training materials, education, resources, meetings, and numerous networking opportunities on a health policy level.

MEETINGS PER YEAR: Two to four meetings per year, quarterly conference calls

RECENT ACTIVITIES: The launch of the Advocacy and Health Policy section of the ACOEP website! Here you can find ways to get involved by contacting your representatives, attending meetings, and staying current on important emergency medicine policy related issues.

RECENT ACCOMPLISHMENTS: The Governmental Affairs Committee recently partnered with numerous organizations and the White House in order to commit to combating opioid misuse and abuse through educational meetings and activities.

CONTACT INFORMATION: Staff Liaison: Jaclyn McMillin, jmcmillin@acoep.org



EMERGENCY MEDICINE PHYSICIAN OPPORTUNITIES

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Are you ready to be **PIMPED** in the ER?

ATRIAL FIBRILLATION Q'S & A'S

Ashley Griswold, OMS-III, MS, NREMT-P

"Pimping" has been a long-term tradition in academic medicine. Whether you're used to the grilling or possibly nursing an old, post-traumatic wound from getting schooled by your attending, here are some questions and their answers to better prepare you.

Caution: be wary of this information morphing you into a gunner. Nobody likes a gunner.

Q: 'A patient presents with atrial fibrillation with rapid ventricular rate (Afib with RVR), which is more important: rate control or rhythm control?'

A: Rate control.

Q: 'What is wrong with having such a fast rate?'

A: Unable to properly fill and eject – may lead to poor perfusion and lead to ischemia.

Q: 'What is our goal maximum heart rate?'

A: 110 beats per minute.

Q: 'What tests would you order for a patient in Afib with RVR?'

A: 12-lead EKG, TSH & free T4, CMP for electrolytes & renal function, CBC, cardiac enzymes, BNP, TEE (transesophageal echocardiogram), CXR (chest x-ray)

Q: 'That seems like a lot of tests, justify your reasoning for each blood test.'

A: TSH & free T4- new onset of hyperthyroidism or sub-clinical hyperthyroidism could be causing the afib.

CMP- a complete metabolic panel will check for electrolytes and renal function

CBC- to evaluate for anemia or infection.

Cardiac enzymes (especially troponins)- to be used as serum

marker for ischemia/infarction.

BNP- to assess for heart failure.

Q: 'What are some possible causes of atrial fibrillation?'

A: Coronary artery disease, heart valve disease, rheumatic heart disease, heart failure, cardiomyopathy, pericarditis, hyperthyroidism, heart attack.

Q: 'If the patient is unstable – shows evidence of angina, organ hypoperfusion, heart failure—what is the recommended treatment for Afib with RVR?'

A: Cardioversion.

Q: 'If the patient is stable and the duration of the Afib with RVR is unknown, what is the recommended treatment?'

A: Beta blockers, verapamil, and diltiazem if no heart failure. Digoxin if the patient has Afib due to heart failure. The patient will also require a TEE to rule out any thrombus. The patient will require 3 weeks of anti-coagulation and then can undergo cardioversion.

Q: 'Why is there a need for anti-coagulation?'

A: An irregularly irregular rhythm predisposes a person to possible clot formation that could cause a stroke.

Q: 'What tools can we use to weigh the risks of bleeding vs clotting?'

A: CHA2DS2-VASc score can be used estimate stroke risk

QUICK FACTS ABOUT ATRIAL FIBRILLATION:

Afib is an irregularly irregular rhythm.

Afib has no p waves on an EKG. They are replaced by fib waves.

The best lead on an EKG to view p wave morphology (or lack thereof) is II.

Paroxysmal Afib is self-terminating or with intervention within 7 days of onset. May recur.

Persistent Afib is Afib that fails to self-terminate within 7 days.

Long-standing Afib is Afib lasting more than 12 months.

Lone Afib is paroxysmal or persistent afib with no structural heart disease typically involving a patient under the age of 60.

due to Afib. It utilizes CHF, HTN, age, diabetes, stroke/TIA/ thromboembolism, vascular disease, and gender to create a yearly risk of stroke and recommend a risk category. The HAS-BLED score can be used to estimate bleeding risk. It counts HTN, abnormal renal function, abnormal liver function, age, previous stroke, prior major bleeding or predisposition, labile INR (<60% of the time in therapeutic range), taking drugs that predispose to bleeding (anti-platelets, NSAIDs, etc), and alcohol use (>8 drinks/ wk) to generate a percent risk of major bleeding with 1 year of oral anti-coagulation. Using both tools combined with clinical judgment, the physician can evaluate whether the risk of stroke outweighs the risk hemorrhage while on oral anticoagulants.

Q: 'What is the most likely location of a stroke?'

A: Left Middle Cerebral Artery.

Q: 'Would you rather have a cardioembolic stroke or a thrombotic stroke?'

A: Thrombotic. Cardioembolic strokes have a higher mortality, more complications, and worse prognosis.

RECOMMENDED APPS:

UpToDate (costs money, subscription required)

Journal Club (costs money)

Epocrates (a free version exists)

Qx Calculate (free)

FURTHER RECOMMENDED READING:

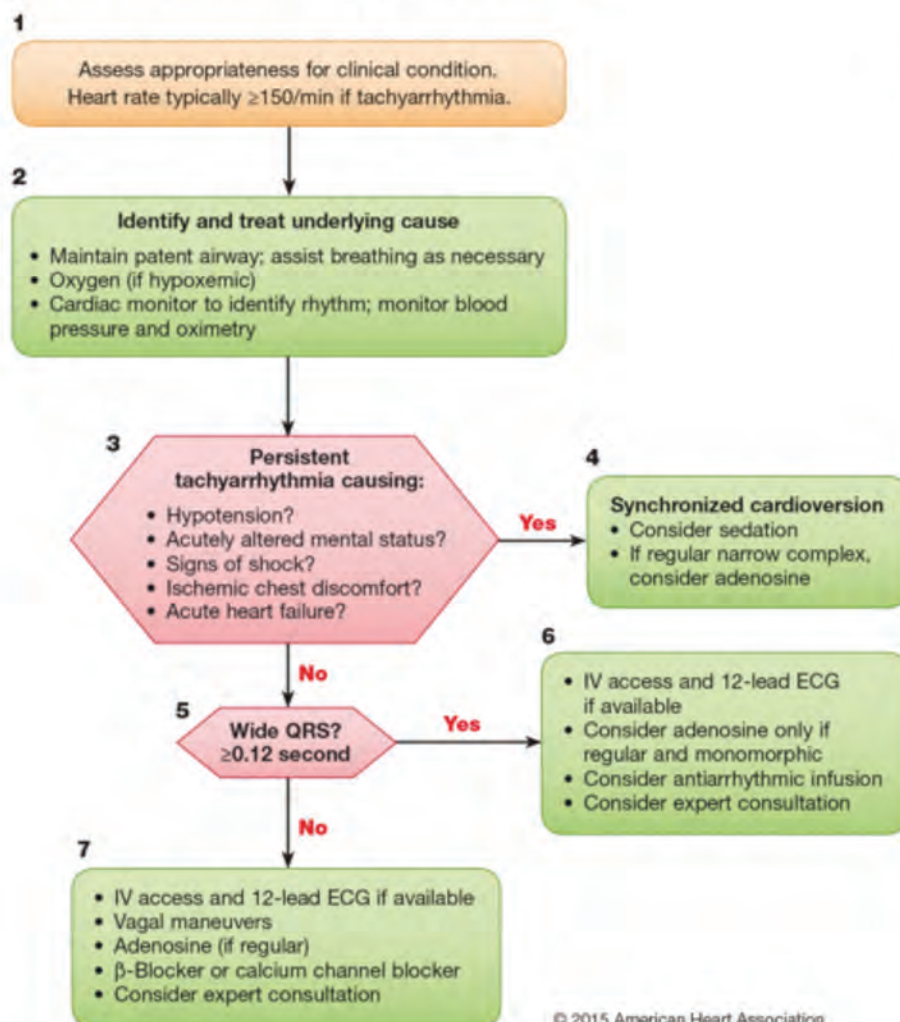
AFFIRM trial

Cox maze ablation

Pulmonary vein isolation for cardiac ablation

Ecgweekly.com

Adult Tachycardia With a Pulse Algorithm



Doses/Details

Synchronized cardioversion:

Initial recommended doses:

- Narrow regular: 50-100 J
- Narrow irregular: 120-200 J biphasic or 200 J monophasic
- Wide regular: 100 J
- Wide irregular: defibrillation dose (not synchronized)

Adenosine IV dose:

First dose: 6 mg rapid IV push; follow with NS flush.
Second dose: 12 mg if required.

Antiarrhythmic Infusions for Stable Wide-QRS Tachycardia

Procainamide IV dose:

20-50 mg/min until arrhythmia suppressed, hypotension ensues, QRS duration increases >50%, or maximum dose 17 mg/kg given. Maintenance infusion: 1-4 mg/min. Avoid if prolonged QT or CHF.

Amiodarone IV dose:

First dose: 150 mg over 10 minutes. Repeat as needed if VT recurs. Follow by maintenance infusion of 1 mg/min for first 6 hours.

Sotalol IV dose:

100 mg (1.5 mg/kg) over 5 minutes. Avoid if prolonged QT.

Combining Work with Play:

Nature PRN

Jarryd Reed, OMS-III, Nova Southeastern University College of Osteopathic Medicine

Campaign season can be a hectic time of year, and in order to escape 24/7 news stories it can be nice to get out and go do something fun. Normally, I try to keep a nice work-life balance; however, it can be good to blend the lines a little. When not in the hospital or with the nose in the books, I enjoy going out into nature to de-stress. Whether you enjoy scuba diving, trail running, snowboarding, rock climbing or just a walk off the beaten path, knowing how to apply your in house medical training outside can come in handy if you get stuck between a literal or figurative rock and a hard place.

Going out into nature has always been a passion of mine; however, if my training as a Boy Scout and a wilderness guide has taught me anything, you always need to be prepared. Recently, I had the opportunity to help put on a wilderness seminar to expand wilderness medical knowledge in our area. We had over 50 medical students from 5 different medical schools across South Florida and the Caribbean represented.

This is part of FLoWMA or the Florida Wilderness Medical Association, a group we set up in order to improve outdoor safety through wilderness medical training in Florida. FLoWMA brings different health care professionals together in order to collaborate, network, and explore the outdoors. The board consist of Dr. Ben Abo DO, Bianca Alvarez, Stephanie Fernandez, and myself.

With our location at Crandon Park right on a beautiful South Florida beach, the workshop involved six stations where students learned essential skills including primary and secondary patient surveys, evacuation and carries, knot-tying, splinting, anaphylaxis treatment, and venomous snake-bite management. Stations were led by emergency medicine physicians, residents, medical students with a WM background, and Miami-Dade Venom One Unit firefighters. Students were divided into groups and moved station to station for a hands-on learning experience.



With varying levels of experience present, the event catered to all levels of medical training. One of the stark differences of being away from medical resources is the ability to get crafty with the materials you have on hand. For example, if a friend of yours has a bee sting while out on a trail and you have already given him his EpiPen, there is a way to open the pen up with just a pocket knife to get more doses if necessary. While you might not have all the modern machines that we sometimes utilize during patient care, there are several tips to improvise what you need. While the goal is still to get them to a hospital as soon as possible that could potentially take hours or days. Therefore, training entails finding crafty ways to use shirts, water bottles, the environment and any other supplies you might have on hand to MacGyver the problems faced. These skills also apply to international or resource depleted regions where medical access is difficult.

So before your next adventure, mission trip, or outdoor de-stressing, look into brushing up on some helpful solutions with to use in a pinch, but most importantly have fun out there!



FUN FACTS FROM THE SEMINAR

- 1) How many doses can you get out of a single epipen? Sometimes up to three!
- 2) What can you use for traction splints? Anything from ski poles, canoe paddles, to long branches.
- 3) Snake bite with possible envenomation, who you going to call? Venom Unit (786)336-6600
- 4) What are some good basic knots to know? Square Knot, Clove Hitch, Bowline, Half Hitch, Figure 8



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TRICKS OF THE TRADE

Make your own Dental Bridge

Veronica Coppersmith, DO FAWM
St Luke's University Health Network,
Bethlehem PA



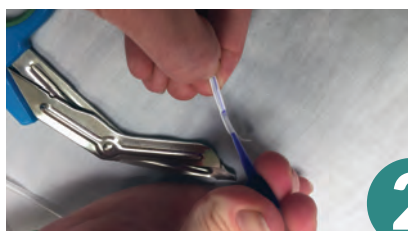
1

Supplies: surgical mask with metal nose piece

Skin Glue

Nasal Cannula/Oxygen Tubing

Trauma shears



2

If a patient has an oral trauma resulting in dental displacement (subluxation, lateral luxation, avulsion, or extrusion), the appropriate initial treatment is generally to splint the tooth in the anatomically correct position, the position prior to trauma. This helps keep the dental ligaments intact and keep the tooth and socket safe from further trauma and drying out. However, not all ED's have a dental box with the supplies to fix dental problems, and even if we have the supplies we may not know where they are when needed.



3

How to make your own Dental Bridge:

This dental bridge can be thought of as temporary braces to hold the teeth in place. Gather all supplies (mask, skin glue, Nasal cannula/O2 Tubing, and shears as pictured) so you are ready to create your dental bridge once the teeth are in the appropriate position. Use the trauma shears to remove the metal nose bridge out of the surgical mask, cut it down to make sure the size is appropriate for the dental bridge (a few teeth on either side of the injured teeth will be needed to secure it in place), and then trim down sharp corners. Bend the metal piece to make it fit the curvature of that patient's teeth. Put the oxygen tubing or the nasal cannula in the patient's mouth directed at the injured area that will need stabilization; the teeth will need to be dry for the dental bridge to stick. It is more aesthetically pleasing and comfortable for the patient to have the dental bridge glued on the inside of the teeth, so attempt this if possible. Once the teeth are sufficiently dry, move them to appropriate position (may require force), put a few drops of skin glue on the surface of the metal bridge that will contact the teeth, then firmly place the metal piece against the inside of the injured teeth requiring stabilization. Use the skin glue to affix the dental bridge in place, then use the oxygen tubing to quickly dry the glue and to ensure the strength of the bond to the teeth so the injured teeth are safely in place. You have essentially created improvised braces to keep the teeth in place until the patient can get to the dentist all with regular ED supplies.



4



5



Emergency Medicine Residency Program Director

Hershey, PA

Emergency Medicine Physician

Hershey, PA

Pediatric Emergency Medicine Physician

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Pitfalls IN THE Diagnosis AND Management OF Testicular Torsion

Dhimitri Nikolla, DO
AHN Saint Vincent Hospital

Testicular torsion is a surgical emergency that may not carry significant mortality, but the morbidity is profound. Although one study found that patients undergoing surgical detorsion and fixation less than eight hours after symptom onset had normal sized testicles and only slight structural changes of the testes, exocrine function of the testes was abnormal in 50% of the patients who had detorsion in less than 4 hours after symptom onset^[1]. This is a significant risk to the fertility of our patients and should be treated with the haste we manage other common emergencies, such as myocardial infarction and stroke. Here are some pitfalls to avoid in the diagnosis and management of testicular torsion including not evaluating the testicles with abdominal pain, not ordering an ultrasound for acute scrotal pain, and not treating epididymitis and/or orchitis once torsion has been ruled out.

Evaluate the Testicles in Abdominal Pain Patients

Like most acute conditions, many patients with testicular torsion do not present with the classic textbook syndrome of acute onset scrotal pain that wakes them up from sleep or occurs after physical activity^[2]. A common red herring is abdominal pain. In a retrospective study of 84 children who underwent surgical detorsion, nine presented with abdominal pain and without scrotal pain initially^[3]. Providers need to keep a wide differential in the evaluation of abdominal pain, especially lower abdominal pain. In patients with lower abdominal pain, remember to examine the testicles for possible torsion, palpate the groin feeling for a hernia, and perform a rectal exam to check for prostate tenderness consistent with prostatitis.

Order an Ultrasound for Acute Scrotal Pain

Some signs in the physical exam can be useful in the setting of an acute scrotum. The two findings with the strongest likelihood ratios are abnormal testicular lie and absence of a cremasteric reflex, 72 and 7.9, respectively^[4,5]. Combined with a duration of symptoms <12 hours and nausea/vomiting^[4], these findings should prompt the provider to call a stat urology consult, in some cases before color coded Doppler ultrasound imaging is done. Conversely, the two findings with the strongest negative

likelihood ratios are absent cremasteric reflex and a tender testicle, 0.04 and 0.09, respectively^[4,5]. A lack of these findings is reassuring, but in practice, their absence does not definitively rule out testicular torsion in the setting of an acute scrotum.

The presence of torsion can be difficult to predict. One study found that in five cases or 6% of 82 cases of surgically confirmed testicular torsion, the surgeon did not believe that it was the most likely diagnosis^[6]. Therefore, all patients with true acute scrotal pain, that are not going directly to the operating room, should be evaluated with color coded Doppler ultrasound imaging. This is because color coded Doppler ultrasound has a 100% sensitivity and 100% negative predictive value for testicular torsion^[7].

Treat Epididymitis and Orchitis

The key differential diagnosis for an acutely painful scrotum is testicular torsion, epididymitis, and orchitis^[8]. Once a testicular torsion has been ruled out by color coded Doppler ultrasound, there may or may not be findings present on the ultrasound or urinalysis consistent with epididymitis or orchitis^[2]. It is important to treat a clinical epididymitis and/or orchitis even if an ultrasound and urinalysis are negative. The pathogens responsible for either epididymitis or orchitis differ with the age of the patient. In men 14–35 years old, the responsible pathogens are usually *Neisseria gonorrhea* and/or *Chlamydia trachomatis*, whereas in males less than 14 and greater than 35 years old, the responsible pathogen is usually *Escherichia coli*^[8]. Be sure to obtain a urethral swab for *Neisseria gonorrhea* and *Chlamydia trachomatis*, obtain a urine culture, and choose the appropriate antibiotic(s) based off the most likely pathogen for the patient^[2]. In addition, if they are at risk for sexually transmitted infections (STI), it is essential to refer them for outpatient STI testing, including HIV, if not done in your ED.

Conclusion

Testicular torsion is a rare but catastrophic diagnosis that we must rule out in any male patient with acute testicular or lower abdominal pain. This is not a complete list of pitfalls, but a few mistakes you cannot afford to make.

NORTH CAROLINA REGIONAL SYMPOSIUM RECAP!

Jarryd Reed, OMS-III
Nova Southeastern College of Medicine

On February 6th, Campbell University School of Osteopathic Medicine (CUSOM) in Lillington, NC opened their doors to ACOEP-SC for our regional symposium. Our regional symposiums are designed to be a more locally focused option for the surrounding schools; however, any ACOEP-SC member is welcome. We reached our maximum capacity with 120 students participating in the symposium, coming from 12 different schools and traveling from the surrounding areas from Florida to Virginia. Bradenton came over 600 miles!

With an action-packed day, the morning started off with breakfast and coffee followed by a welcome message from Dr. Greg Christiansen, Chair and Associate Professor of Emergency Medicine at CUSOM. Campbell was gracious enough to host the event and help out with events throughout the day. The Student Chapter appreciated the leadership of Julie Aldrich, the CUSOM student organizer. Their medical school is located in a beautiful new building with state-of-the-art labs and ultrasound equipment that helped make this event a phenomenal experience. After the welcome address, students were split up into groups with half attending our Rapid Fire lecture series and the other half doing Skills Lab with the option of code simulations or ultrasound lab.

The Rapid Fire series consisted of 30-minute focused lectures designed to inform students on hot topics. Dr. Halm provided a lecture titled Professionalism and Leadership in the Medicine Setting (PaLMS) that detailed an exportable program that was started by two students at WVSOM, one of which is on our board – James (Buzz) Mason and the other is Zach Conrad. Next up was Dr. Elizabeth Gignac, Program Director at Southeastern Health in Lumberton, NC who talked about the residency process from application to tips on matching. Finishing up the series was Associate Dean for Osteopathic Medical Education Dr. Robert 'Bob' Foster from WVSOM, demonstrating general principles of using OMM in the ED.



While half the students were attending rapid fire lectures the rest were split into code simulation labs or an ultrasound clinic. The simulation labs also had mini side training sessions to quiz your knowledge on some of the more difficult physical exams findings pertaining to the ears and eyes. The code simulations concluded with 30 minute aviation style debriefings to help the participants learn what went well and what they could do better. The ultrasound clinic featured an overview of the FAST exam with other clinical pearls in which we practiced on our fellow students. After finding out who had full bladders and who didn't, we examined the heart, observing the anatomy and what pathology



to look for on an exam. In the afternoon, the groups were able to switch so that everyone had the opportunity to hear the rapid fire lectures and participate in the skills labs.

After the first group of sessions, we had our residency panel—a short presentation on helpful tips from boards to clinical away rotations. After the presentation, the floor was opened up to questions to be directed at Dr. Elizabeth Gignac, Dr. Will McCammon, residents from Southeastern Health, Dr. Daniel Schroeder, Dr. Jordana Ruffner and Chief Resident Dr. Heather McArthur at Ohio Valley Medical Center. The session provided valuable access to people involved in the selection of residents, and residents who just recently completed the match. By allowing a question and answer period, the session aimed to improve navigation of the somewhat tricky match process.

We were beyond thankful to have Judith E. Tintinalli, MD as our keynote speaker. A legend in the EM world, you may recognize her name from the front cover of the popular Emergency Medicine textbook that is likely in your emergency department. Dr. Tintinalli took us on a journey from the very beginning of Emergency Medicine all the way up into current day. She explained the unique position that Emergency Medicine physicians holds in the healthcare system. Did you know that ACOEP was created a year before ABEM?

After providing a brief wrap up in the late afternoon, students started their road trips and flights back home. The ACOEP-SC board, especially our conference co-chair Katherine Haddad with local help from Julie Aldrich OMS-II at CUSOM, put a lot of work into this event, but it wouldn't have been possible without all



the volunteers. We would, once again, like to thank everyone that made this event possible: Campbell University School of Osteopathic Medicine for providing a beautiful campus, skills equipment, and educators, Dr. Tintinalli for being a wonderful keynote speaker, our rapid fire guest speakers, the Southeastern Health residency program in Lumberton, NC along with all the residents that helped make this successful event come together.



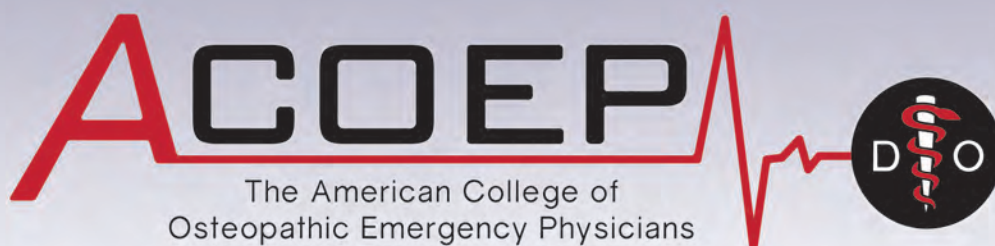
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LOCATION

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NUMBER OF RESIDENTS

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16 ACOEP approved positions

Four (4) OGME-1 positions open July 2015

ED VOLUME

~33,000 visits per year

PROGRAM HIGHLIGHTS

Level III Trauma Status

Trauma & Life Flight rotations at MetroHealth

Pediatric Emergency Medicine at Akron

Children's Hospital

Animal lab to practice ATLS procedures

ED Ultrasound training including a 1 month

Ultrasound Rotation

Oral Board Review, Journal Club, Skills Lab

ACLS & PALS annually

Educational Stipend

Community EMS experience

Resident Research Project

Attend Ohio ACEP & Chicago ACOEP Board Review Course

RECENT PROGRAM RECOGNITION

FOEM Research Flame Award 2015 – Presented to the ACOEP Residency Program that has achieved the highest average score for Senior Research Paper

2015 Winning Program of the Emergency Medicine Resident Association (EMRA) Quiz Bowl for the Ohio Chapter of ACEP

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