A Newsletter for the Members of NCCEP

**Fall 2013**

## From the President
## Stephen Small, MD, FACEP

I just returned from Seattle where the ACEP Council and ACEP *Scientific Assembly* (now ACEP 13) were held. Seattle provided uncommonly great weather and very warm hospitality. I enjoy the CME lectures and catching up with friends and mentors, but I always return home amazed about the ACEP Council. It is truly an awe-inspiring phenomenon. There are so many emergency medicine dignitaries, luminaries, and aficionados packed into one room discussing the future of Emergency Medicine. If you have ever wanted to see democracy in action – this is it. We spent 2 days debating a multitude of timely issues and ultimately electing new ACEP leaders. In this issue of EPIC, you will get an overview of the fate of the resolutions at hand and a view of the Council floor from the perspective of a new Councillor.

With regard to local issues, NCCEP has been busy. At our most recent board meeting, the NCCEP BOD voted to pursue a membership initiative to encourage emergency medicine interest at the medical student level and to develop a 5 year strategic plan. In addition, I recently represented Emergency Medicine at the NCMS annual specialty summit in Raleigh. As you can imagine, NC Medicaid and the NC Tracks system were widely discussed. If you are having trouble receiving timely payments from NC Medicaid, please visit the NCMS website and report your issues as they have been helping to intervene.


**North Carolina College of Emergency Physicians**

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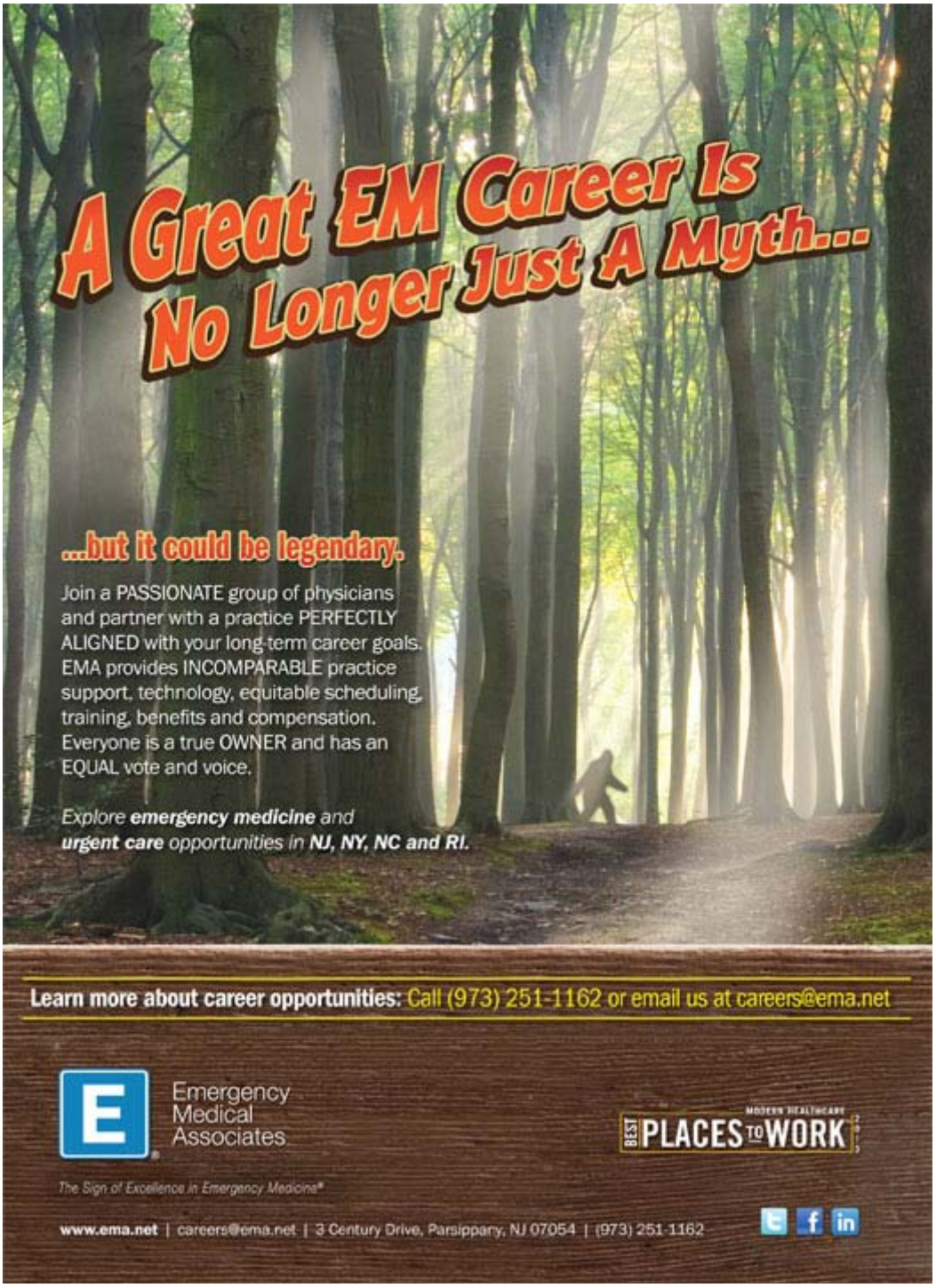


## Viewpoint of the First-Time Councillor

## Keia VR Hewitt, MD, FACEP, Councillor, NCCEP

The 2013 ACEP Council Meeting was held on October 12-13 in Seattle, WA. The ACEP Council serves as an assembly representing all of the members of ACEP and is responsible for considering the resolutions that are submitted by members. The Council consists of 53 chapters, the membership sections of ACEP, the Council of Emergency Medicine Residency Directors, the Emergency Medicine Residents' Association, the Society for Academic Emergency Medicine, and the Association of Academic Chairs in Emergency Medicine, and convenes prior to the Scientific Assembly annually to consider these regulatory, policy and pecuniary initiatives that were presented to the College by its members.

Attending the Council Meeting for the first time was an exciting and inspiring experience! Initially, the parliamentarian proceedings and procedural regulations of the meeting seemed daunting. However, this concern was quickly assuaged once our contingency divided into groups to attend reference committee meetings, which provided a more informal setting to better understand the process.

The Council is tasked with electing the Leadership of the College and it was interesting to interact with the future directors of the College and better understand their stance on the forthcoming challenges for emergency physicians. The impact of the Affordable Care Act on Emergency Medicine was emphasized during the meeting and the projected outlook for the future our specialty. Furthermore, the Town Hall Meeting was an informative session that allowed experts to sound off regarding the effect of the new federal guidelines and how it will shape our practice of emergency medicine.

Having the opportunity to attend the Council Meeting provided an incredible occasion to interact with the leaders in Emergency Medicine. Serving at this meeting was satisfying because the Council provides the platform within ACEP that cultivates the policy that impacts how we, as emergency physicians, care for our patients daily. It was certainly gratifying knowing that the efforts of the Council, and the representation of our Chapter, would impact ACEP's agenda in the upcoming years as it continues to represent the interests of Emergency Physicians nationwide.

## ACEP13 Council Update: Just Like Congress, Except…
## Jennifer Casaletto, MD, FACEP
## Councillor, NCCEP and Chair, Academic Affairs Committee and Young Physicians Section

Jay Leno recently quipped, "According to a Washington Post poll, 84 percent of Americans do not approve of the way Congress is doing its job. Sixteen percent weren't even aware Congress is doing a job." Well, I'm happy to report that ACEP's Council considered and came to an agreement on 43 of 49 resolutions during its annual two day meeting.

For those members unfamiliar with the Council, it is a deliberative body of ACEP members representing the 53 chartered ACEP chapters (50 states, District of Columbia, Government Services, and Puerto Rico), the Sections of Membership (Young Physicians, EMS, etc.), Emergency Medicine Residents Association (EMRA), Council of Residency Directors (CORD), Association of Academic Chairs of Emergency Medicine (AACEM), and Society for Academic Emergency Medicine (SAEM). The Council debates and votes on resolutions submitted by no less than two members or component bodies. Ultimately, the actions of the Council are considered and ratified by the ACEP Board of Directors (BOD). In addition, the Council elects the members of the Board of Directors and the ACEP President-Elect.

At this October's meeting in Seattle, Dr. Alex Rosenau, of Pennsylvania, was installed as ACEP President. The Council elected

Dr. Michael Gerardi, of the New Jersey Chapter, as its President-Elect. Drs. Robert O'Connor and Paul Kivela, of Virginia and California, respectively, were re-elected to their BOD positions. Drs. James Augustine and Debra Perina, of Ohio and Virginia, respectively, were voted as new members to the BOD.

Each year, the Council adopts multiple resolutions calling for bylaws and policy changes to better serve College membership, and this year was no different. However, the Council chose not to adopt a resolution aimed at eliminating medical students from state membership roles for the purpose of determining each state's additional Councillor allotment, as many Councillors expressed concern that adoption of such a resolution would compromise efforts to engage medical students in ACEP.

The Council also considered multiple resolutions regarding the College's position on health policy issues. There was nearly unanimous support for a resolution calling for the College's support of a best practice-based, voluntary, federally funded, nationally accessible prescription drug monitoring program. Equally popular in its adoption was a resolution calling for ACEP to partner with the AMA to advocate for adequate funding for firearm injury prevention research, while a resolution calling for the development of an ED research network to study firearm violence was referred to the BOD based on concerns that an ACEP appointed task force may limit ACEP's ability to collaborate with federal and private organizations interested in pursuing this research goal. The Council also adopted resolutions in support of a national Health Information Exchange and national recommendations regarding end-of-life issues. Finally, ACEP joined the AMA in support of its long-standing policy requiring any non-physician using the title "doctor" in a hospital patient care setting to "specifically and simultaneously declare themselves a 'non-physician' and define the nature of their doctorate degree."

Finally, the Council also debated the merits of many resolutions regarding the College's stance on emergency medicine practice and emergency department operational issues. Perhaps the most controversial resolution debated on the Council floor this year dealt with ACEP's "Clinical Policy: Use of Intravenous tPA for the Management of Acute Ischemic Stroke in the Emergency Department." After much debate, ACEP's Board of Directors will reconsider the clinical policy, including opening the discussion regarding the use of tPA in acute ischemic stroke to the ACEP membership. The Council also asked that any subsequent ACEP clinical policy be open to comment by the ACEP membership for a period of at least 60 days before consideration of adoption. There was unanimous support for adoption of a resolution furthering ACEP's current policy stating that ABEM/AOBEM certification with participation in maintenance of certification (MOC) is sufficient for maintenance of hospital privileges, health plan participation, medical group inclusion, and maintenance of licensure (MOL), specifically stating that additional certifications (e.g. ACLS, ATLS, etc.) and maintenance programs (i.e. additional educational programs/CME) are redundant and unnecessary. In addition, there was unanimous support for inclusion of a private, non-bathroom area for emergency department employees who are nursing mothers located inside or directly proximal to the emergency department, citing that emergency department providers are often unable to use the area provided by the hospital during their shifts due to its location further from the emergency department. As a result of other resolutions adopted, the College will also: develop guidelines and standards for community paramedicine, develop a transitions of care and care coordination toolkit, provide resources for establishment of hospital-based violence intervention programs, and create a document offering best-practice solutions to impact the epidemic of prescription drug overdoses.

Lastly, after much debate at the 2012 Council Meeting, ACEP joined Choosing Wisely, a multi-year effort of the American Board of Internal Medicine (ABIM) Foundation to promote conversations among physicians and patients about use of appropriate diagnostic testing and treatment and avoiding care when harm may outweigh benefits. This year, after a multi-step process that included careful review and input from an expert panel of emergency physicians and the ACEP Board of Directors, ACEP released its list of five tests and procedures that may not be cost effective. These include:

- Avoid CT of the head in emergency department patients with minor head injury who are at low risk based on validated decision rules.
- Avoid placing indwelling urinary catheters in the emergency department for either urine output monitoring in stable

patients who can urinate on their own, or for patient or staff convenience.

- Do not delay available palliative and hospice care services in the emergency department for patients likely to benefit.
- Avoid antibiotics and wound cultures in emergency department patients with uncomplicated skin and soft tissue abscesses after successful incision and drainage and with adequate medical follow-up.
- Avoid instituting IV fluids before doing a trial of oral hydration in uncomplicated emergency department cases of mild to moderate dehydration of children.

Please feel free to e-mail me with any questions regarding the Council and/or specific resolutions. Until next year, we only have Congress's progress to follow. Lucky for all of us, that shouldn't require much time!

## 24-7-365

### Abhi Mehrotra, MD, FACEP

That is the calling card of Emergency Medicine. We are the resource of first, and frequently, last resort. At this year's ACEP meeting, the Emergency Medicine Resident's Association unveiled the premiere of a professionally produced documentary chronicling the inception and development of our specialty.

What began as a proposal in 2011 at an EMRA Representative Council meeting culminated in a viewing and discussion with some of our most prominent founders. With the seed funding coming from EMRA, a fund-raising campaign was undertaken in order to be able to develop and produce this film. NCCEP contributed to the effort as a Gold ACEP Chapter Sponsor given the importance of the program.

An appreciation of the development of our specialty and the early struggles provides an important reflection as we look forward to our role in the future of healthcare. From a loading dock entrance with a crudely constructed sign to becoming the "front door" to the hospital, Emergency Medicine has had a rapid trajectory in a brief period of time.

Unfortunately, that time is limited and this documentary allows us to capture those stories before we lose them. At the premiere viewing, North Carolina was well represented with Dr. Judith Tintinalli and Dr. George Podgorny recognized on stage as founders of our specialty. In the time since that viewing, we have come to learn of the sad news that Dr. Podgorny is no longer with us to share his story. This underscores the need for this type of preservation for our future generations to understand the early struggles. I encourage you to view the trailer and consider purchasing a copy – I will treasure mine.

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## Sued for Malpractice? You are not Alone! …and, you could help others

**Louise B. Andrew, MD, JD, FACEP**

The ACEP Medical-Legal Committee all member survey conducted in 2010[1] suggested that the majority of emergency physician members had been named in a claim for malpractice at least once. Almost 10% of survey respondents had been named five or more times. Of cases litigated, over 85% of cases resulted in a defense verdict. However, 40% of respondents reported that some payment was made on their behalf in one or more claims.

A 2012 study of closed claims involving all specialties covered by a nationwide malpractice insurer revealed that emergency physicians received just over the average number of claims for all specialties; and was just under the average for all specialties in the percentage of physicians making payouts on claims. Average payment was approximately $175,000.[2] Average duration of claims against physicians range from 11 months to 43 months.

In the ACEP Medical Legal Survey, fully 60% of sued respondents reported that they had experienced litigation stress. Few felt that they had any preparation or education in dealing with the stress. Considering the duration of most claims, lost productivity and diminished life satisfaction while a case is ongoing, the costs are far beyond monetary.

The stress of ongoing or impending malpractice claims can prompt a variety of intrusive feelings. Physicians undergoing litigation stress often feel isolation and sadness or irritability and anger, disbelief, a sense of betrayal or of being unjustly singled out. They may experience denial, anxiety, insomnia, inertia, or depression which can be low level or occasionally debilitating. The onset or exacerbation of physical illness, including gastrointestinal or cardiac symptoms is not uncommon but is often ascribed to tension, and therefore medical evaluation is typically delayed. Self treatment is common.

Litigation or medical malpractice stress also typically causes significant immediate changes in practice patterns, nearly all of which are deleterious to good practice and to patient relationships. Sued physicians emotionally distance themselves from patients, whom they may begin to view as potential future litigants. They become less confident in their capabilities, second guessing diagnoses, calling for more consultations, requiring more confirmatory lab tests, and admitting or transferring patients more liberally. They become much more obsessive in record keeping, which could be viewed as protective except that this often comes at the cost of effectively communicating with patients. It has been shown that physicians who have recently received claims may be more vulnerable to subsequent claims.

Physician litigation stress also can result in long range changes, especially if the physician already suffers from an emotional deficit or is sued early or multiple times over a career. Such physicians are more likely to consider changing practice locations or medical specialty, to consider retiring early, or changing careers altogether to something less stressful. In the worst cases, disability or even suicide may emerge as a result of medical malpractice stress.

There are a variety of approaches to dealing with the stress of litigation. The most important, after taking steps to insure a defense team is in place, is to identify all personal sources of support and renewal. For example, sharing the fact of the lawsuit with spouse, counselor or clergy provides a protected mechanism for offloading the feelings engendered by the case, and is also a way of getting valuable feedback on how you are coping. Sharing is also possible with sympathetic colleagues, as long as the facts of the case and identifying information is not divulged. Contact with a peer who has “been there” and survived, can be life and career affirming. Educating yourself about the legal process, mastering the details and learning the legal strategies involved in your case, and practicing successful approaches to stress can begin to restore a sense of control over the situation

(litigation) which is otherwise so alien to our sensibilities and daily operations as physicians and healers.

Last year, a multi-committee collaboration was begun within ACEP in order to address the unmet needs of members with respect to malpractice litigation stress. The Medical-Legal, Well-being, and Academic Affairs committees have been assigned objectives including the development of a centralized, web-based clearinghouse of educational materials and resources on litigation stress; the further development of a network of member peer counselors who have experienced litigation stress, and working with the Education Committee to develop CME specific to the issue of litigation stress as a way of increasing awareness of principles and resources available to members on this issue.

If you have suggestions of resources on litigation stress management, or if you have experienced litigation and are interested in serving as a peer counselor in the Peer to Peer Counseling program, please contact the author or Marilyn Bromley, ACEPs Director of Practice Management. More volunteers will make this a stronger program.

And if you are personally experiencing litigation stress, please be assured that you are not alone. You have many colleagues who have survived the experience and who will gladly share coping techniques and strategies with you.

ACEPs volunteer member peer support program is available to any member who is experiencing litigation related stress. Please click here to contact Marilyn Bromley or call 800.798.1822, ext 3234.


1. Andrew LB. ACEP Member Medical-Legal Survey Results. ACEP News. March 2012.
2. Jena AB, Seabury S, Lakdawalla D, et al. Malpractice risk according to physician specialty. N Engl J Med. 2011; 365(7):629-36.



*Dr. Andrew is a senior member of the Medical-Legal Committee, past and present chair of the Well-being Committee, and a medical malpractice litigation stress educator and counselor. She can be contacted by clicking here.*

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## Community Care of North Carolina – Project Lazarus


The North Carolina College of Emergency Physicians has been working with Community Care of North Carolina (CCNC) to address chronic pain and opioid abuse. We encourage our members to attend one of these trainings throughout the State which will address the multi-dimensional character of chronic pain, the role of opioids, screening tools and risk stratification, intervention and the use of the CSRS (Controlled Substance Reporting System).

**Project Lazarus Training Schedule: 2013-2014 CME Trainings**

- **Pinehurst, NC**
  - Moore Regional Medical Center
  - January 23rd
  - Speaker: Dr. David Marks & Dr. Paul Kuzma

- **Concord, NC**
  - Cabarrus Family Medicine
  - January 30th
  - Speaker: Dr. James Finch

**Non-CME Trainings:**

- Charlotte, NC – January

**Agenda**
5:30-6:00: Registration and Dinner
6:00-6:10: Introduction to Seminar Objectives
6:10-6:30: Nature of Pain/Role of Opioids
6:30-7:00: Risk Stratification and Initiating Treatment
7:00-7:30: Case discussion 1: Getting started (involving local pain management experts)
7:30-7:45: Break
7:45-8:15: Monitoring, Intervening and When to Stop
8:15-8:45: Case discussion 2: Monitoring and adapting the treatment plan
8:45-9:00: Wrap up/Next steps

*** All speakers and specific venue locations are subject to change. Please click here for more information and to register for trainings.**

## George Podgorny, MD
## Daniel G. Sayers, MD, FACEP

Dr. George Podgorny is among the patron saints of Emergency Medicine. He was present at the earliest stages of the development of the American College of Emergency Physicians. He has been steady and constant in providing leadership

energy to the organization which now has evolved into the dominant driving force behind our thriving medical specialty. He strongly supported developing state chapters of ACEP to help bring together the diverse groups of doctors in the country who chose to practice this novel and demanding form of patient care. By the effort of literally a handful of doctors in North Carolina, led by Dr. Podgorny, a fledgling NC Chapter was brought together from a meeting in Greensboro in 1974. He was instrumental in the development of the residency review process within our specialty training programs and he oversaw the process by which the care rendered among a chaotic mix of patients presenting the Emergency Department became a disciplined core curriculum. He represented the interests of emergency physicians in the struggle to obtain the Holy Grail of medical education, specialty status with a Medical Board Examination process, thereby achieving equality in the AMA and upgrading the quality and uniformity of individual practitioners in the field. This goal was achieved during his presidency with the formation of a conjoint board. After shepherding the training programs through his chairmanship on the Residency Review Committee of ACEP and helping negotiate the certification processes as president of ABEM from 1976-1981, he proceeded to function as the pivotal individual in the United States for the development of an international community of emergency physicians who meet together for education aimed at improving the specialty throughout the world. Dr. Podgorny has functioned effectively as a mentor among emergency physicians and as a uniformly positive force for educational excellence, improvement in patient care and strong representation within the community of organized medicine.

Dr. Podgorny came to the US from Iran after his secondary school education because he and his father, a Physical Education Minister and Olympic Coach to the Shah of Iran, felt that the educational opportunities were greater in the western hemisphere. His father was Czech and his mother was Armenian and they played a prominent role in the Christian community in Iran. He graduated from Maryville College in Tennessee, where he roomed with the first black student admitted to the College and achieved striking academic superiority. He chose to attend medical school at Bowman Gray School of Medicine (now Wake Forest School of Medicine), where he matriculated into the General Surgery residency under Dr. Bradshaw. He became widely renowned within the Bowman Gray and Wake Forest community because, in his second year, he was able to act as translator for a very important Russian Delegation who addressed the University as a panel and expertly interpreted the difficult discussions so that they were clearly understood by both groups. He completed fellowship in cardiothoracic surgery with some work on the development of cardioplegic solution, a mainstay of modern surgical bypass technique. He was asked to serve as Chief Administrative Resident during his fellowship, strengthening his contacts within the General Surgery community and cementing his academic credentials.

His interest in the care of the traumatized patient led to observations regarding the preliminary care of patients arriving at the hospital and the fact that interns were delivering care to the least stabilized patients in the hospital. This coincided with the rising awareness of Prehospital care and the maturation of ambulance services that provided fertile ground for the new graduate, who chose to practice in the Emergency Department of the community hospital in Winston-Salem, Forsyth Memorial Hospital. At the BGSM medical center, strong interest and much discussion was occurring regarding the new development of physician graduates choosing to practice in the ED with Dr. Jesse Meredith and Dr. Eben Alexander being enthusiastic about incorporating training into the curriculum addressing such issues as trauma to the head and trunk and the care of patients who were unstable on arrival. People were much more interested and capable due to improvements in emergent medical care stimulated by the conflict in Viet Nam and rapid transportation of the sick patient. The Physician Assistant program was initiated and he helped to educate the students by lecturing and by having rotators in his ED. Dr. Podgorny and Dr. Lewellyn Stringer with the younger doctors at Forsyth Memorial, including Drs. Bill Bostic, Frank Pollock, and Blucher Taylor joined to develop a strong EMS service in Forsyth County by training EMTs then graduating to a Paramedic Course, in which Dr. Podgorny was fully invested.

In 1972, Dr. Podgorny joined Dr. Joyce Reynolds and Dr. David Nelson to form Forsyth Emergency Services, PA to staff the increasingly busy Emergency Department. The first Physician Assistants from the new program at Bowman Gray were recruited and with additional MDs and PAs, the practice matured and served a major hospital, the second busiest Emergency Department in North Carolina during the ’70s, ’80s, and ’90s. He was an active Medical examiner and had the Forsyth County

Jail medical program run by the group.

The North Carolina Chapter of ACEP had as its first president in 1974, Dr. David Nelson, who worked quite hard to coordinate things within the grassroots of ACEP while managing the FESPA group in a time of rapid growth. The second president was Dr. Podgorny. There were only a handful of physicians in NC who were practicing full time Emergency Medicine and there were many, many moonlighters in smaller EDs. Residency graduates were by then trickling out, with the first graduates of the first residency program in the state, the BGSM Section on Emergency Medicine of the Department of Surgery, joining their faculty mentors at the Forsyth Memorial Hospital group. The Chapter grew rapidly thereafter and participated actively in the affairs of the national organization, always with a boost from Dr. Podgorny, who always kept us apprised of cutting edge issues in Emergency Medicine.

Simultaneously, he helped to design the form and facilitated the embryonic residency training program that Dr. Richard Myers started in the Department of Surgery with Dr. McRae and then Dr. Fredrick Glass, both of whom were very enthusiastic supporters of Dr. Podgorny. The first thing I heard when interviewing for Residency at BGSM in 1976 was how strong the program was to be because of his presence on the faculty. We rotated one half of our second and third years under Dr. Podgorny's direction because their emergency department had a critical mass of patient visits. By then, of course, his strengths were very well appreciated within the representative group of ACEP and he was rapidly becoming a spokesman after he adroitly headed off a strong assault on the legitimacy of the full time practice of Emergency Medicine at "The Workshop Conference on Education of the Physician in Emergency Medicine" in 1973. By 1978, he had worked his way up through the Board of Directors of ACEP to become President and was able to catalyze the College into concerted action in support of certification and was quoted in 2000 as saying, “What I remember the most about the early years of the American Board of Emergency medicine is the Singular, concerted and unified efforts of all emergency physicians without regard to personal agenda in pursuing the single goal in establishing emergency medicine as a rightful specialty.” (Academic Emergency Medicine. 2000; 7:235)

The International Conference on Emergency Medicine is a wonderful product of the tenacity and energy which Dr. Podgorny brought to all the things he did. He was able to identify and draw together a disparate group of physicians speaking different languages for the purpose of educating each other in the practices that were successful in their environments and stimulating further reliable research into emergency medicine. These meetings have been thrilling and highly educational for participants. The job of the practitioner of unscheduled emergency medical care around the clock grows more accurate and effective throughout the world, largely due to the combined efforts of Dr. Podgorny and his colleagues.

Dr. Podgorny always maintained balance in his life. He was intensely proud of his family both immediate and extended, He balanced his professional life with a close and loving family life with his wife, Ernestine, accompanying him to meetings, as did the children who are well known to the long term attendees at Scientific Assembly (known now as ACEP13). His eldest, Adele, is an RN, MA with a loving medically oriented family of her own, George is a lawyer, Emanuel (Eman) is an emergency physician, and Gregory, a sculptor. His grandchildren were the light of his life and it is fitting that he was visiting with them after the ACEP meeting. Dr. Podgorny was very well traveled and knew every restaurant of worth in every city he visited. He had a breadth of knowledge which was shockingly eclectic. He knew history, especially medical history, and geography with language skills far beyond the capabilities of even educated people. He delighted in giving short impromptu lectures on topics completely different from medicine and displaying scholarship which pleased and surprised everyone.

Until two weeks prior to his death, Dr. Podgorny provided insight and advice to the policy makers in ACEP and ABEM, where he was as highly respected as anyone among the leadership. Placing the interests of other groups of people before his own benefit became his style although he preferred to find a match between the two. His talent in creating a position which satisfied both our current and future needs was quite well known. His sudden and unexpected death was from a STEMI which was due to diffuse coronary artery disease and was inoperable. His death is a loss to all of us and to Emergency Medicine. He will

always be remembered for his unflagging loyalty, keen political foresight, sturdy advocacy for emergency physicians and encyclopedic knowledge of the world.

## Practice Management Resources
## Bret A Nicks, MD, MHA, FACEP

One of the greatest challenges in emergency medicine is remaining a lifelong learner. For some it is a focus on the clinical aspects of the specialty and the dynamic changes and approaches to healthcare. For others, it is navigating the challenges of electronic health records – or perhaps being in charge of the ED side of a system-wide EHR transition.

Regardless of the situation, actively pursuing additional knowledge – and perhaps knowing where to look – is essential for ongoing learning.

From a practice management perspective, there are many resources that are available to help ED providers of any type (clinical, administrative, academic, etc) – many of which are immediately available on the ACEP website:

- Clinical & Practice Management

This website provides a robust amount of information on current EM-related clinical policies as well as policy statements related to the practice of emergency medicine. Clinical policies include assessment of the literature, standards of care and recommended care considerations for many conditions. Under the 'Resources' link, there are numerous additional links to further ones understanding in areas such as reimbursement, medical legal, quality care / patient safety, and transitions of care that are routinely updated by experts in those areas. In addition to this link, there are several others that may assist your educational appetite. One that is an essential to review is the 'Urgent Matters' link to the online resource funded by the Robert Wood Johnson Foundation dedicated to finding, developing and delivering strategies for improved patient flow and reduction of ED crowding. It includes links to active toolkits, webinars and additional resources for those eager to learn and participate in this ongoing initiative.

While this is only one of many available resources for those interested in fostering their practice management desires, it is great to know that it is immediately available through ACEP.

## Congratulations to all of the following NCCEP members who are newly elected Fellows!

**They were recognized at the 2013 Convocation Ceremony held at ACEP13 in Seattle, Washington.**

Josie B. Bowen, MD, FACEP
Charlotte, NC

David Wayne Callaway, MD, FACEP
Charlotte, NC

John P. Gaillard, MD, FACEP

Winston Salem, NC

Casey M. Glass, MD, FACEP
Lewisville, NC

Jeffrey Allen Klein, MD, FACEP
Waxhaw, NC

Dana R. Mathew, MD, FACEP
Raleigh, NC

Katherine Mayer, MD, FACEP
Charlotte, NC

Kraigher A. O'Keefe, MD, FACEP
Greenville, NC

Manoj Pariyadath, MD, FACEP
Winston Salem, NC

Luna C. Ragsdale, MD, FACEP
Chapel Hill, NC

David James Story, MD, FACEP
High Point, NC

Jefferson G. Williams, MD, FACEP
Chapel Hill, NC

## ACEP Member Appointed to NC Medical Board

Governor Pat McCrory recently appointed Timothy E. Lietz, MD, an Emergency Medicine physician with Mid-Atlantic Emergency Medical Associates (MEMA) in Charlotte, to a 3 year term on the North Carolina Medical Board. Dr. Lietz is fully committed to the work of the Board and to the health and safety of the people of North Carolina.

**Timothy E. Lietz, MD**

Timothy E. Lietz, MD, of Charlotte, graduated cum Laude with a BS in Biology from Vanderbilt University in Nashville, TN and earned his Doctor of Medicine from The Ohio State University School of Medicine, Columbus, OH. He completed his internship and residency in Emergency Medicine at Eastern Virginia Medical School in Norfolk, VA where he was Chief Resident. He joined Mid-Atlantic Emergency Medical Associates, (MEMA) upon completion of his training.

Dr. Lietz currently serves as Chief of Emergency Medicine and Emergency Department Medical Director for Novant Health Matthews Medical Center, and the Novant Health Emergency Services Council. He also serves on the Board of Directors of Mid-Atlantic Emergency Medical Associates, (MEMA). Dr. Lietz is a fellow of the American Board of Emergency Medicine and is a member of the North Carolina Medical Society and the Mecklenburg County Medical Society.

## SAVE THE DATE!

Coastal Emergency Medicine Conference
Jointly hosted by
GCEP, NCCEP, and SCCEP

The **Coastal Emergency Medicine Conference will be held June 6-8, 2014,** in Kiawah Island, South Carolina. This second annual regional conference will be jointly hosted by the North Carolina, Georgia, and South Carolina ACEP Chapters, and we hope to have a large turnout of our members. Please mark your calendars for this exciting event. More information to come in 2014!

## Clinical News

**Proposed FDA measures aim to reduce drug shortages**
The Food and Drug Administration announced on Oct. 31 two initiatives aimed at cutting down on drug shortages and improving communications with drug companies.
Read the entire article

**Antibiotics are overprescribed for sore throat, bronchitis**
Physicians continue to inappropriately prescribe antibiotics for sore throat and bronchitis, according to analyses of data from the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey.
Read the entire article

**A Model of Cost-effectiveness of Tissue Plasminogen Activator in Patient Subgroups 3 to 4.5 hours After Onset of Acute Ischemic Stroke**

Earn CME credit while reading the #1 journal in your specialty. Annals CME is designed for emergency physicians who want to learn about the latest emergency medicine advances and how they apply to patient care. Each month the CME Editor chooses one journal article for the activity. Participants take a pretest to establish a baseline score, then read and study the selected article, then take a post-test to measure improvement in cognitive expertise. And because Annals of Emergency Medicine is a benefit of ACEP membership, there is no additional charge for Annals CME for members.

***Learning Objectives for this article**:*

- Describe the current incidence of acute ischemic stroke and FDA guidelines for TPA
- administration.
- Discuss the lifetime cost effectiveness of TPA treatment versus non-treatment in the expanded 3 to 4.5 hour window.
- List patient subgroups in which this strategy may not be cost-effective

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## National ACEP News

***All New CME Tracker***

As you probably are aware, earlier this year, ACEP launched CME Tracker 2.0 [http://www.acep.org/cmetracker/] as an important new member benefit. CME Tracker is designed to help members keep up with the changing CME requirements of their state medical boards and for certification boards, physician groups, and hospitals.
Here are some of the key features in CME Tracker 2.0:

- CME Tracker allows you to claim credit and access your certificates for ACEP-accredited activities – they’re added to CME Tracker automatically on completion. Additionally, you can manually add activities and upload certificates for non-ACEP CME activities. ACEP is always looking for ways to enhance this benefit, and we plan to be able to automatically include activities from ACEP chapters and other cosponsors sometime next year.
- You can also add a certificate to ACEP Tracker by e-mail. Simply attach an image or PDF of the certificate to an e-mail from your primary account (the one you get ACEP e-mail from). Put the name of the activity in the subject line, and send the e-mail to cmetracker@acep.org.
- You can set up profiles for requiring bodies that need your CME report. A default profile has been created based on your primary chapter if that state has CME requirements. It’s easy to add new profiles for other state medical boards and your certification board. And a future release of CME Tracker will allow you to add profiles for your group or hospital. These profiles allow CME Tracker to show you where you have gaps in meeting your requirements.

***ACEP’s 2014 Report Card***

“America’s Emergency Care Environment: A State-by-State Report Card” will be launched on Thursday, January 16, 2014.

**Chapter Services Department**

***Chapter Grant Applications***

There were seven chapter grant applications submitted on November 1st, six regular and one chapter development. The National/Chapter Relations Committee will review the applications and make a recommendation to the Board of Directors of the American College of Emergency Physicians. The Board of Directors will make a determination at the February 2014 Board meeting. A chapter is granted one year to complete the grant, and can request one six-month extension.

The Chapter Services Department notifies the chapters in July that the chapter grant application, schedule, and procedures are available on the website. The program allocates $45,000 annually for the entire program, of which $13,500 is set aside for chapter development grants.

Further information is available on our website or if you have any questions, contact Dawn Scrofano.

***Chapter Meetings***

If you are interested in finding out about chapter meetings--your chapter or a nearby chapter, check out our web page. Click on the link, “Chapter ACEP Meetings & Conferences”.

## Welcome New Members

Mathias W. Allen, MD
Bryant Allen, MD
Jon S. Andrews
Jaime S. Argila, MD
Tyler J. Armstrong, MD
Julio M. Arrieta, MD
Jacob Baalman, MD
Nathan Bach
Jessica Baxley, MD
Sandra K. Beverly, MD
Josh Boyd, MD
Jonathan B. Bringolf, MD
Michael WJ Brown, MD
Douglas Brtalik, DO
Devin Bustin, MD
Samuel J. Chang, MD
Matthew J. Chovaz, MD
Ryan Christensen, MD
Simon Chung, MD
Marc Cillo, MD
Mark J. Collin, MD
Stephen C. Cooke, MD
Idan Cudykier, MD
Robert T. Dahlquist, MD
Kory R. Dawson, MD
Rebecca J. Donohoe, MD
Nkemka Ezeamama, MD
Paul C. Flanders, MD
Christopher S. Forsythe, MD
Eric Fountain, MD
Samuel J. Francis, MD
Marame Khaled Gattan, MD
Eryka Ann F. Gayle, MD
Matthew N. Gentry, MD
Amy R. Gilleland, MD
Diana Godfrey, MD
Jessica M. Goldonowicz, MD
Graydon S. Goodman, MD
Michael G. Halsey, MD
Rachel A. Harper
Jessica B. Harrell
Nicholas Hartman, MD, MPH
Margaret G. Hauck, MD
Katie E Hughes, MD
Irfan Husain
Patrick M. Jackson, MD
Elias J. Jaffa, MD
Angela K. Johnson, MD
Stephen M. Keller, MD
Sopagna Kheang, MD
David Kiefer, MD
Lacey King, MD
Daniel A. Knott, MD
Christina Kopriva, MD
Katie W. Koval, MD
Dennis B. Langston, MD
Sarah C. Leeper, MD
Skyler A. Lentz, MD
Robert Lockwood, MD
Ling-chun Lu, MD
Shannon Matthews, MD
John Melchert
Juan D. Montoya, MD
Stuart P. Murray, MD
Carey Nichols, MD
Alexander W. Nickle, MD
Joseph B. Padgett, MD
Luke S. Poth, MD
Andrew Press, MD
Joseph W. Quinn, DO
Sarah Rackers, MD
Akef S. Rahman, MD
Mehreen Rathore, MD
Karina Reyner, MD
Samuel I. Ritter, MD
Joshua N. Robertson, MD
Elijah Robinson, III
Shakira L Sanchez-Collins
Audrey Sanford
Aaron Schmitt, MD
Deepak U. Sekaran, MD
Lauren Siewny, MD
Mark A. Smiley, MD
Zachary I. Stewart, MD
Jeremy H. Sutton, MD
Megan Taylor, MD
Wiley D. Thuet, MD
Tanner J. Van Dell, MD
Sean S. Wentworth
Gail L. Wiley, DO
Alexander Winters, MD
Liping Yang, MD
Kevin Yavorcik, MD
Bryan Zorko, MD

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