

ACEP23 TIPS
**The Most Philly
Thing Ever**
SEE PAGE 10

SKEPTICS' GUIDE TO EM
**Can You
Etomidate Me?**
SEE PAGE 16



PRACTICE CHANGERS
**When Potassium
is Poppin'**
SEE PAGE 21

WILEY

American College of
Emergency Physicians®
ADVANCING EMERGENCY CARE

ACEPNow

The Official Voice of Emergency Medicine

AUGUST 2023 Volume 42 Number 8

f FACEBOOK/ACEPFAN

Instagram/ACEPNATION

Twitter/ACEPNOW

ACEPNOW.COM

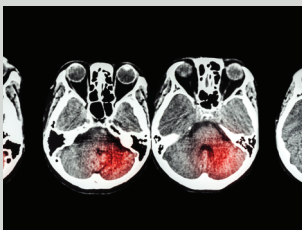
PLUS



FORENSIC FACTS

**Do I Need to Call
the Police?**

SEE PAGE 18



PEARLS FROM EM LIT

**Gradually Circling
Around "Reasonable
Practice"**

SEE PAGE 19



FIND IT ONLINE

For more clinical stories and
practice trends, plus commen-
tary and opinion pieces, go to:
www.acepnow.com

2023 ACEP ELECTIONS PREVIEW ✓

MEET THE PRESIDENT-ELECT AND COUNCIL OFFICER CANDIDATES

*The candidates discuss ACEP strategy
and member needs*

Each year, ACEP's Council elects new leaders for the College at its meeting. The Council, which represents all 53 chapters, 40 sections of membership, the Association of Academic Chairs of Emergency Medicine, the Council of Emergency Medicine Residency Directors, the Emergency Medicine Residents' Association, and the Society for Academic Emergency Medicine, will elect four members to the ACEP Board of Directors when it meets in October, along with a new President-Elect, Council Speaker and Council Vice Speaker.

Last month, we learned about the emergency physicians running for the Board. This month, let's meet the candidates for President-Elect, Council Speaker, and Council Vice Speaker.

CONTINUED on page 6

Mindfulness for the EM Doc

Three simple and quick
ways to practice mind-
fulness before, during,
and after shift

by ALEX KOO, MD

Emergency medicine is stressful. There are charged moments of powerful highs and lows. In one shift, you may achieve return of spontaneous circulation in a college student with a massive pulmonary embolism, who will survive neurologically intact. The next shift you may feel inadequate as you realize the antibiotics you prescribe will never be picked up by your patient. You may alleviate pain and anxiety for a dying great-grandfather and his family or listen to an underserved veteran recount their service and struggles. You may ponder your life decisions and over a decade of specialized education, while a patient calls you slurs and hurls a turkey sandwich at your face.

The emotions and thoughts associated with our work are one of the reasons that burnout rates and levels of mental illness are high in emergency medicine.¹⁻³ Also, on shift, time is short. Emergency physicians spend only 5 to 10 percent of their time for

CONTINUED on page 11

WILEY PERIODICALS LLC
C/O THE SHERIDAN PRESS
PO BOX 465,
HANOVER, PA 17331
If you have changed your address or wish
to contact us, please visit our website
www.wileycustomerhelp.com

ACEPNow

PERIODICAL



NEW SPIN

**Being a Patient, or
Being Adjacent**

PAGE 14

ACEP Now

The Official Voice of Emergency Medicine

EDITORIAL STAFF

MEDICAL EDITOR	EDITOR
Cedric Dark, MD, MPH, FACEP cdark@acep.org	Danielle Galian, MPS dgalian@wiley.com
ASSOCIATE EDITOR	ART DIRECTOR
Catherine A. Marco, MD, FACEP cmarco@acep.org	Chris Whissen chris@quillandcode.com
ASSISTANT EDITOR	RESIDENT FELLOW
Amy Faith Ho, MD, MPH, FACEP amyho@acep.org	Carmen Lee, MD, MAS carmen.marie.lee@gmail.com

ACEP STAFF

EXECUTIVE DIRECTOR/CHIEF EXECUTIVE OFFICER Susan Sedory, MA, CAE ssedory@acep.org	SENIOR VICE PRESIDENT, COMMUNICATION Jana Nelson jnelson@acep.org
CHIEF OPERATING OFFICER Robert Heard, MBA, CAE rheard@acep.org	MANAGING DIRECTOR, CONTENT AND COMMUNICATION INTEGRATION Nancy Calaway, CAE ncalaway@acep.org
SENIOR CONTENT MANAGER Jordan Grantham jgrantham@acep.org	

PUBLISHING STAFF

PUBLISHING DIRECTOR Lisa Dionne Lento ldionnelen@wiley.com	ASSOCIATE DIRECTOR, ADVERTISING SALES Tracey Davies tdavies@wiley.com
--	--

ADVERTISING STAFF

DISPLAY & CLASSIFIED ADVERTISING
Kelly Miller
kmiller@mrvica.com
(856) 768-9360

EDITORIAL ADVISORY BOARD

James J. Augustine, MD, FACEP	Ricardo Martinez, MD, FACEP
Richard M. Cantor, MD, FACEP	Sandra M. Schneider, MD, FACEP
L. Anthony Cirillo, MD, FACEP	Jeremiah Schuur, MD, MHS, FACEP
Jonathan M. Glauser, MD, MBA, FACEP	Robert C. Solomon, MD, FACEP
Michael A. Granovsky, MD, FACEP	Annalise Sorrentino, MD, FACEP
Sarah Hoper, MD, JD, FACEP	Peter Viccellio, MD, FACEP
Mitchell Kentor, MD	Rade B. Vukmir, MD, JD, FACEP
Phillip Luke LeBas, MD, FACEP	

INFORMATION FOR SUBSCRIBERS

Subscriptions are free for members of ACEP and SEMPA. Free access is also available online at www.acepnow.com. Paid subscriptions are available to all others for \$334/year individual. To initiate a paid subscription, email cs-journals@WILEY.com or call (800) 835-6770. ACEP Now (ISSN: 2333-259X print; 2333-2603 digital) is published monthly on behalf of the American College of Emergency Physicians by Wiley Periodicals LLC, 111 River Street, Hoboken, NJ 07030-5774. Periodical postage paid at Hoboken, NJ, and additional offices. Postmaster: Send address changes to Wiley Periodicals LLC, c/o The Sheridan Press, PO Box 465, Hanover, PA 17331. Readers can email address changes and correspondence to acepnow@ACEP.org. Printed in the United States by Sheridan of Ohio (SOH), Brimfield, OH. Copyright ©2023 American College of Emergency Physicians. All rights reserved. No part of this publication may be reproduced, stored, or transmitted in any form or by any means and without the prior permission in writing from the copyright holder. ACEP Now, an official publication of the American College of Emergency Physicians, provides indispensable content that can be used in daily practice. Written primarily by the physician for the physician, ACEP Now is the most effective means to communicate our messages, including practice-changing tips, regulatory updates, and the most up-to-date information on healthcare reform. Each issue also provides material exclusive to the members of the American College of Emergency Physicians. The ideas and opinions expressed in ACEP Now do not necessarily reflect those of the American College of Emergency Physicians or the Publisher. The American College of Emergency Physicians and Wiley will not assume responsibility for damages, loss, or claims of any kind arising from or related to the information contained in this publication, including any claims related to the products, drugs, or services mentioned herein. The views and opinions expressed do not necessarily reflect those of the Publisher, the American College of the Emergency Physicians, or the Editors, neither does the publication of advertisements constitute any endorsement by the Publisher, the American College of the Emergency Physicians, or the Editors of the products advertised.



WILEY



NEWS FROM THE COLLEGE

UPDATES AND ALERTS FROM ACEP

JACEP Open Earns its First Impact Factor

The *Journal of the American College of Emergency Physicians Open (JACEP Open)* has achieved a major milestone in scientific publishing. ACEP’s international, open access, peer-reviewed, online journal has received its first calculated Impact Factor of 2.3. This ranks the journal 21 of 54 in the emergency medicine subject category (62nd percentile).

“Emergency physicians can be incredibly proud of the contributions *JACEP Open* is making to advance medical research, health care, and public health since its launch just a few years ago,” said Henry Wang, MD, MS, editor in chief of *JACEP Open*.

As a companion to *Annals of Emergency Medicine*, *JACEP Open* publishes high-quality original peer-reviewed research, clinical reports, opinion, and educational information related to emergency medicine in an open access format. Learn more at www.jacepopen.com.

ACEP Calls for Action on Boarding, Corporatization, and Surprise Billing

ACEP’s advocacy team has been busy this summer, advocating for emergency physicians on important issues. In late June, ACEP organized a congressional briefing with the Emergency Nurses Association (ENA) and the National Alliance on Mental Illness (NAMI) to express strong concerns to legislators about the impact of emergency department boarding on our health care safety net. Read more at acep.org/boarding-briefing.

Regarding the corporatization of medicine, ACEP submitted a statement to the Senate Finance Committee outlining its concerns about mergers and acquisitions contributing to decreasing wages, increasing workloads, financial pressures, and challenges finding or keeping a job. On an AMA panel discussion, ACEP President-Elect Aisha Terry, MD, MPH, FACEP, spoke passionately about the impact of private equity and outlined the ways ACEP fights to restore physician autonomy and reduce threats from the increasing corporatization of medicine. Read more at acep.org/corporatizationSFR.

In July, ACEP and the Emergency Department Practice Management Association (EDPMA) wrote the Senate Health, Education, Labor and Pensions (HELP) Committee to outline recommendations to improve the flawed implementation of the *No Surprises Act*. The letter followed ACEP’s participation in a June 29 roundtable hosted by the Committee. Read

more at acep.org/NSA-HELP-letter.

2023 CPT Documentation Guidelines FAQ Updated, Expanded

ACEP has updated its 2023 CPT Documentation Guidelines, expanding from 39 to 70 questions. It now includes a modified medical decision-making grid that features emergency medicine-specific examples in the risk column. View this resource at acep.org/CPT-FAQ.

Member Benefit Spotlight: Resolve

Resolve is your top source for physician contract review and negotiations. Their team handles contracts for emergency physicians nationwide and provides the most up-to-date salary data available, so you can maximize your earning potential. Access the data you need and the top legal experts in the industry. Learn more at acep.org/resolve.

ACEP Announces Winners of Teaching Awards

ACEP values the contributions of educators in emergency medicine and is honored to recognize their efforts. Congratulations to the winners:

National Emergency Medicine Excellence in Bedside Teaching Award:

- Cynthia Hernandez, MD
- Rosanne Naunheim, MD, FACEP
- Kirsten Pennell, MD
- Lisa Rapoport, MD
- Christopher Russell, MD, FACEP

National Emergency Medicine Faculty Teaching Award:

- James Ahn, MD, FACEP
- Roderick Fontenette, MD, FACEP
- Tarlan Hedayati, MD, FACEP
- Sara Krzyzaniak, MD, FACEP
- Catherine Marco, MD, FACEP
- Nicole McCoin, MD, FACEP
- Kaushal Shah, MD, FACEP
- Craig Smollin, MD

National Emergency Medicine Junior Faculty Teaching Award:

- Leen Alblaihed, MD, MBBS, MHA, FACEP
- Lauren Page Black, MD
- Guy Carmelli, MD, FACEP
- Nida Degesys, MD, FACEP
- Daniel Eraso, MD
- Moises Gallegos, MD
- Shayne Gue, MD, FACEP
- Matthew Heimann, MD, FACEP
- Kyle Martin, DO, FACEP
- Kelly Mayo, MD

WHAT ARE YOU THINKING?



SEND EMAIL TO ACEPNOW@ACEP.ORG; LETTERS TO ACEP NOW, P.O. BOX 619911, DALLAS, TX 75261-9911; AND FAXES TO 972-580-2816, ATTENTION ACEP NOW.



September 12-14, 2023
Las Vegas, Nevada

Join us in Las Vegas for an immersive educational experience created to substantially increase your confidence in your ability to optimally manage pediatric emergencies.

Produced by the developers of the **Emergency Medicine & Acute Care Courses**, the **The National Emergency Medicine Board Review**, and the **EM Boot Camp Course Series**.

EM board-certified or not, managing the acutely ill or injured child can be among the most challenging scenarios in emergency medicine – that’s why the **Mastering Pediatric Emergencies** course was created.

- ✓ An intensive, comprehensive review covering newborn to adolescence
- ✓ Taught by 9 energetic and knowledgeable Peds/EM educators
- ✓ A focus on data-driven, literature-based content
- ✓ Incorporates the leading authoritative guidelines
- ✓ A 3-day deep dive experience that will create a renewed confidence in your ability to diagnose and treat pediatric emergencies

Meet Our Peds/EM Faculty



Emily Rose, MD, FAAP
Course Director



W. Richard Bukata, MD
Course Advisor



Martha Roberts, PNP
Faculty Forum Coordinator



Christopher Amato, MD
Goryeb Children's Hospital



Solomon Behar, MD
Miller Children's Hospital



Ilene Claudius, MD
Harbor-UCLA Medical Center



Timothy Horeczko, MD
Harbor-UCLA Medical Center



Sujit Iyer, MD, FAAP
Dell Children's Medical Center



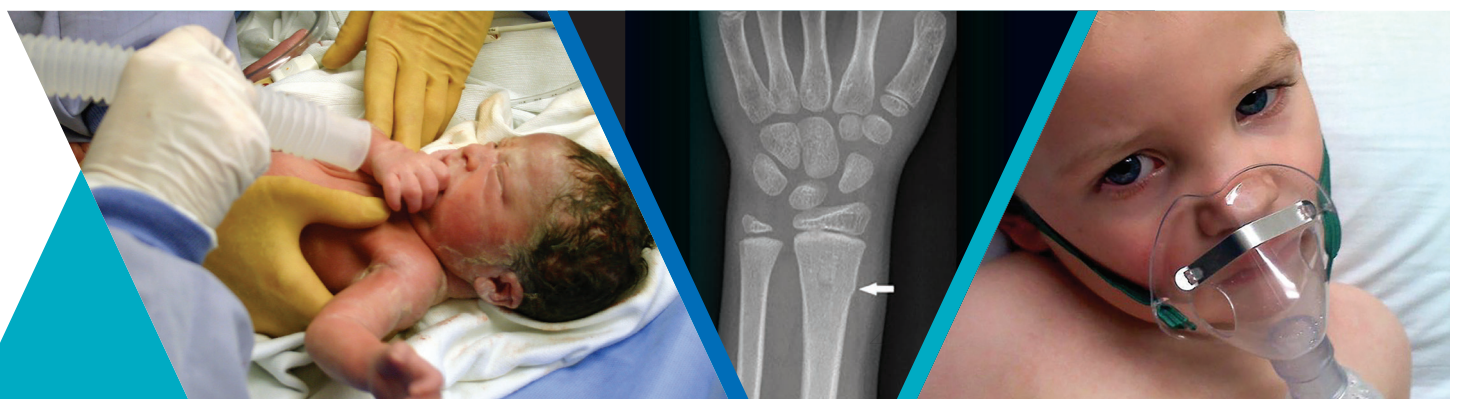
Le "Mimi" Lu, MD
Benioff Children's Hospital



Alfred Sacchetti, MD
Virtua Our Lady of Lourdes Hospital

34 Course Topics

- Approach to the Sick or Injured Child
- Managing the Precipitous Delivery
- Early Management of the Child and Mom
- The Crashing Neonate
- The Inconsolable Crying Infant and BRUE
- Fever in the Neonate and Young Infant
- Fever in Toddlers and Young Children
- Upper Respiratory Tract Disorders
- Acute Asthma Exacerbations
- Pediatric Pneumonia – Causes and Treatment
- Pediatric Cardiovascular Emergencies
- Approach to the Infant with Jaundice
- GI Disorders of the Infant and Toddler
- Appendicitis and Related Disorders
- Pediatric Endocrine Emergencies
- Pediatric Rashes (Parts 1 & 2)
- Pediatric Head Trauma (Parts 1 & 2)
- Cervical Spine Injuries
- Thoracic Trauma in Children
- Pediatric Abdominal Trauma
- Back Pain in Children
- Pediatric Upper Extremity Injuries
- Pediatric Elbow and Forearm Fractures
- Wrist and Fingertip Injuries in Kids
- Pediatric Lower Extremity Problems
- Hematologic and Oncologic Emergencies
- Ear, Face, and Dental Emergencies
- Psychosocial and Behavioral Disorders
- Essentials of Pediatric Procedures
- Pediatric Genitourinary Emergencies
- Neurological Emergencies in the Child
- Pediatric Toxicologic Emergencies
- **Plus 6 Faculty Panels**



EMERGENCY IMAGE QUIZ with VISUAL DX



Question: A 32-year-old man presents with sore throat. What is the diagnosis?

- Diphtheria
- Peritonsillar abscess
- Retropharyngeal abscess
- Uvulitis

ANSWER on page 22

By the Numbers

2023 MATCH: Emergency Medicine Residency Programs with Unfilled Positions



HOSPITAL TYPE

COMMUNITY

844

FILLED

412

UNFILLED



OWNERSHIP STRUCTURE

CORPORATE

339

FILLED

157

UNFILLED

COUNTY

465

FILLED

50

UNFILLED

PARTNERSHIP

463

FILLED

168

UNFILLED

UNIVERSITY

1,147

FILLED

92

UNFILLED

HEALTH SYSTEM

1,654

FILLED

229

UNFILLED

SOURCE: Preiksaitis C, Krzyzaniak S, Bowers K, et al. Characteristics of emergency medicine residency programs with unfilled positions in the 2023 match [published online ahead of print, 2023 Jul 11]. *Ann Emerg Med*. 2023;S0196-0644(23)00429-8.

GRANT FUNDING AVAILABLE

Visit acep.org/paced for more information

Listen to our podcast acep.org/paced/newsroom

3-year accreditation term

Become an Accredited Pain and Addiction Care Emergency Department Today

Apply for ACEP's pain and addiction care accreditation and validate your hospital's commitment to:

Accelerating the distribution and implementation of best practices in pain and addiction management.

Ensuring emergency physicians and nurses have the necessary resources, protocols, pathways, and training to provide optimal pain management and addiction care.

Supporting your community by implementing effective pain and addiction strategies towards fighting the opioid epidemic.

Providing effective treatment for pain and addiction, while minimizing opioid exposure.

Improving patient outcomes and satisfaction scores.



APPLY TODAY AT acep.org/paced



American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

A Commitment to High-Quality Care

PACED accreditation is more than completing a checklist, it's a commitment to best practice pain management and addiction care.

Health system applications welcome.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

CAN YOU BE MORE SPECIFIC?

Emergency medicine means a lot of things to a lot of people, but your passion within the specialty is undeniable.

Pediatrics, Ultrasound, Health Policy, DEI – whatever gets you up in the morning... there's an ACEP Section for that.

YOU HAVE ENERGY AND PASSION.
WE HAVE 40 SECTIONS TO CHOOSE FROM.
LET'S GET TOGETHER.

JOIN A SECTION TODAY
acep.org/sections

SEND YOUR THOUGHTS
AND COMMENTS TO
ACEP NOW@ACEP.ORG

THE BREAK ROOM



Re: “Space Medicine: Emergency Physicians Voyage into the Final Frontier”

We read the article in *ACEP Now* titled, “Space Medicine: Emergency Physicians Voyage into the Final Frontier,” by Sophia Gorgens, MD, with interest, since, as physicians certified by the American Board of Preventive Medicine (ABPM) in Aerospace Medicine, we are also excited about the prospects of expansion of commercial and private spaceflight and its promise to open space travel to a larger and more diverse group of people. We also fully agree with Dr. Gorgens that with this promise comes a responsibility to ensure the health and safety of those who participate in suborbital and orbital spaceflight.

However, we must respectfully disagree with several points and assumptions made in the article, several of which are materially important and, left unaltered, will result in an increased risk of injury or death to crew and passengers in both commercial and government-sponsored spaceflight.

As an initial matter, and maybe most surprisingly, throughout the article, the entire specialty of Aerospace Medicine, which encompasses space medicine, including its history of innovation and its contributions to space travel and the safety of astronauts, is consistently ignored or dismissed. Space medicine is not a “whole new field of study” as it is described in the article but instead, an area of practice that for over 50 years has been incorporated into the robust Aerospace Medicine curriculum. In fact, Aerospace Medicine specialists have been training in and practicing space medicine since the 1950s and, since 1953 the ABPM, a member board of the American Board of Medical Specialties (ABMS) has certified physicians in Aerospace Medicine.

Although Dr. Gorgens asserts that “our understanding of the effects of space on human anatomy and physiology is ever-expanding, and space medicine has grown to fill that niche,” Aerospace Medicine specialists have studied the effects of space on humans since the dawn of the space age and have created and continue to refine countermeasures for the physiological effects of aviation and spaceflight. We applaud emergency medicine physicians for their “new” interest in what is, in reality, a long history of space medicine practiced by experts in the field and who are certified by the ABPM in Aerospace Medicine.

—Cheryl L. Lowry, MD, MPH

Continue reading the remainder of the letter on [acepnow.com](https://www.acepnow.com)



Re: “How to Avoid Missing an Aortic Dissection”

In a recent article, the authors have provided a thoughtful review of aortic dissection (AOD) cases while promoting the aortic dissection detection risk score (ADD-RS) to improve the ED diagnosis of these patients.¹ Unfortunately, the ADD-RS was not constructed using appropriate methodology for creating clinical decision rules (CDRs) and should not be relied upon.^{2,3} The ADD-RS was derived by cardiologists via a consensus and retrospectively tested on patients entered into an AOD registry.^{4,5}

Relying on a chart review of clinical features, potentially obtained after hospital admission, when the final diagnosis is known is unreliable and inappropriate for creation of a CDR. Importantly, that “validation study” did not follow standard chart review methodology and did not follow basic reporting guidelines for observational studies (STROBE). There was no blinding to final diagnoses, no prospective evaluation of individual criteria, no assessment of interrater reliability for individual features, no statistical evaluation of the contribution of each criterion to a final model, no purposeful model building, no inclusion of patients without AOD, and no comparison of this rule to clinical judgement. A prior meta-analysis of the ADD-RS included eight retrospective chart reviews and one prospective study with no study being registered, no study following STROBE guidelines with comprised populations already suspected of having AOD, and

most patients already selected to undergo advanced aorta imaging (CT or transesophageal echocardiography).⁶

Importantly, flaws in patient selection and data collection within these studies would tend to over inflate the sensitivity of the ADD-RS and D-dimer in diagnosing AOD potentially missing AOD cases scored as low or indeterminate risk. Looking at individual ADD-RS features, trained emergency physicians are already aware of classic AOD high risk historical features (connective tissue disease, aortic valve disease, known aneurysm), high risk complaints (abrupt onset, tearing/ripping, severe), and examination findings (pulse deficit, new aortic regurgitation murmur, neurologic deficit, shock). Many of these “high risks” may be absent from ED medical records or unknown to patients (connective tissue disease, valvular heart disease), are subjective (onset, pain descriptors, and severity) while the interrater reliability of physical examination and subjective historical features is unknown. In particular, the suggestion that abrupt chest pain requiring morphine should be a red flag is anecdotal and not evidence based while the term “abrupt” can be interpreted in multiple different manners by patients and providers (i.e., potentially poor interrater reliability and thus useless for CDRs). While the ADD-RS might be useful to remind physicians of selected known risk factors for AOD, current studies only show this to be a potential predictor in those already suspected of having AOD. It is unknown if this score (with/without D-dimer)

can accurately predict AOD in a general ED population that includes patients not initially suspected of AOD. As such, this score cannot and should not be promoted as a proven predictor of AOD in the general ED population of patients with chest pain, back pain, syncope, weakness, or the multitude of other potential presentations.

References

1. Pilcher C, Dajani A. How to avoid missing an aortic dissection. *ACEP NOW* 2023; 42 (6): 14.
2. Green SM, Schrager DL, Yealy DM. Methodologic standards for interpreting clinical decision rules in emergency medicine: 2014 update. *Ann Emerg Med* 2014; 64: 286-291
3. Phillips B. Clinical decision rules: how to build them. *Arch Dis Child Educ Pract Ed* 2010; 95: 83-87.
4. Hiratzka LF, Bakris GL, Beckman JA, et al. 2010 ACCF/AHA/AATS/ACR/ASA/SCA/SCAI/SIR/STS/SVM Guidelines for the diagnosis and management of patients with thoracic aortic disease: executive summary. *Circulation* 2010; 121: 1544-1579.
5. Rogers AM, Hermann LK, Booher AM, et al. Sensitivity of the aortic dissection detection risk score, a novel guideline-based tool for the identification of acute aortic dissection at initial presentation. *Circulation* 2011; 123: 2213-2218.
6. Tsutsumi Y, Tsujimoto Y, Takahashi S, et al. Accuracy of aortic dissection risk score alone or with D-dimer: a systematic review and meta-analysis. *Eur Heart J Acute Cardiovasc Care* 2020; 9: S32-S39.

—Steven G. Rothrock MD, FACEP, FAAP

Re: “Toxicology Q&A: The Fig Tree”

I read with great interest Dr Hack’s article on the toxicity of fig trees. Growing up in my village of Deir-el-Qamar, or Monastery of the Moon, a reference to a Phoenician temple in

the mountains of Lebanon, we had native fig trees everywhere. The delicious “refreshing waterdrop-shaped packages of goodness” as he describes their fruit so aptly was a daily late summer treat for us. There were so many varieties, including white figs, brown figs, and the late early-winter ripening red figs. Figs were called “the king of fruits” with many varieties and even more lovers. To Dr. Hack’s point, we were always warned, as kids, while picking figs to never touch our eyes. The white milky sap that oozes from the stem once you pick the fruit can cause blindness. And indeed, my dad often referenced an elder in the village who had lost his sight because of that; he was sadly blinded as a child in the 1920s. On a historical note, it is well known in modern Lebanese history that around 1798–1799, during Napoleon Bonaparte’s Egypt-Syria campaign and his two-month siege of the old city of Acre, his troops who were starving, were saved by Emir Bashir al-Shihaby, ruler of Deir-el-Qamar and the Emirate of Mount-Lebanon, after he sent him caravans loaded with dried figs.

And to come full circle with the story, my wife and I have a beach house on Emerald Isle, NC, not too far from Dr. Hack’s East Carolina University. And we have a native fig tree in the sandy soil, but the birds eat all the fruit before they ripen. That fig tree in particular has a smell that I hate, but my wife loves it. For years, we argued. So what was the denouement? The rest of the story will be for another day.

—Rashid Baddoura, MD, FACEP, FCCP

2023 ACEP ELECTIONS PREVIEW

CONTINUED FROM PAGE 1

MEET THE PRESIDENT-ELECT AND COUNCIL OFFICER CANDIDATES

President-Elect Candidates



Council Speaker Candidate



Council Vice Speaker Candidates



PRESIDENT-ELECT

The candidates for ACEP President-Elect responded to this prompt:

What new thoughts do you have in balancing board certified emergency physician workforce distribution gaps and safe scope of practice for non-physicians?

Jeffrey M. Goodloe, MD, FACEP

Current Professional Positions: Attending emergency physician, Hillcrest Medical Center Emergency Center, Tulsa, Oklahoma; professor of emergency medicine, EMS section chief, and director, Oklahoma Center for Prehospital & Disaster Medicine, University of Oklahoma School of Community Medicine, Tulsa; chief medical officer, medical control board, EMS System for Metropolitan Oklahoma City & Tulsa; medical director, Oklahoma Highway Patrol; medical director, Tulsa Community College EMS Education Programs

Internships and Residency: Emergency medicine residency, Methodist Hospital of Indiana/Indiana University School of Medicine, Indianapolis; EMS fellowship, University of Texas Southwestern Medical Center, Dallas

Medical Degree: MD, Medical School at University of Texas Health Science Center at San Antonio (1995)

Response

✓ Advances often come through focusing on executing fundamental actions particularly well. Coach John Wooden was famous for focusing on the fundamentals, sometimes called “little things.” When those same fundamentals done right achieve great success, they aren’t little at all. How does that apply to the role of the board certified emergency physician? Fundamentally, I believe every patient coming to an emergency department is best served by care delivered by board certified emergency physicians. Period.

So, to that end, I don’t believe there is a “balance” when it comes to board certified emergency physician

anything and scope of practice for non-physicians anything. If that sounds distinctly definitive, then point purposefully made.

Does this lack of balance I promote equate to no role(s) for non-physicians in an emergency department? Considering I’ve worked with numerous physician assistants and nurse practitioners in emergency departments over my 25 years post-residency, you may correctly surmise I have found successful inclusion, which by my definition “successful” includes safety for all involved, of physician assistants and/or nurse practitioners on a physician-led team in an emergency department. Did I bold type “physician-led” in that last sentence? Good. Another point purposefully made.

As your national ACEP liaison to the American Academy of Emergency Nurse Practitioners (AAENP), I have the incredible honor, privilege, and responsibility to be your “voice” during AAENP Board of Director meetings. I assure you that I speak for you clearly, respectfully, responsibly, and always in a manner that promotes, first and foremost, the principle that board certified emergency physicians must be the leaders of care in any emergency department.

Today’s reality is many rural emergency departments are staffed solely by physician assistants and/or nurse practitioners. On functionally useless in real time to patient care on-call rosters, these same physician assistants and/or nurse practitioners may be “backed up” by physicians. Often these “backups” are located 20-30 minutes from being physically present when called to

assist patient care at the bedside. Factoring such, an order to transfer the patient immediately by ground or air EMS is the only actual support per se these non-physicians receive. I believe that’s an untenable risk to everyone involved, particularly the patient expecting safe, clinically accurate emergency care.

Our Indiana ACEP colleagues have helped us all as emergency physicians in championing the passage of state legislation mandating a physician leading a hospital’s emergency department to be physically present in that hospital. While that law today does not specify that physician must be a board certified emergency physician, we can readily understand that to be the next step of progress in a future legislative bill that builds upon today’s advance in care. This is an important opportunity for board certified emergency physicians to secure those positions today, impressing upon hospital administrations the essential benefits to the patients, the medical staff, and the hospital itself uniquely enabled by board certified emergency physicians.

In select situations, technology may provide opportunities in the interim until similar laws can be promulgated nationwide. Colleagues at the University of Mississippi Medical Center have developed a robust telehealth network with over 25 critical access hospitals in that state. Physician assistants and/or nurse practitioners receive real-time telehealth consults from residency faculty, board certified emergency physicians in

CONTINUED on page 8

Hidradenitis suppurativa

HS hides in the shadows

TOGETHER, WE CAN CHANGE THAT

Under-recognized and undiagnosed, patients with HS may suffer an average of up to 10 years before accurate diagnosis.¹⁻³ Meanwhile, HS may wreak havoc, causing irreversible scarring, debilitating pain, and emotional burden.²⁻⁵ If your patient suffers from recurring or persistent abscesses at flexural sites, consider referring them to a dermatologist. This may be HS.



Learn more about recognizing
HS and referral options at
[HS-Awareness.com](https://www.hs-awareness.com)



 NOVARTIS

Patient portrayal.

References: 1. Daxhelet M, Suppa M, White J, et al. Proposed definitions of typical lesions in hidradenitis suppurativa. *Dermatology*. 2020;236(5):431-438. 2. Garg A, Neuren E, Cha D, et al. Evaluating patients' unmet needs in hidradenitis suppurativa: results from the Global Survey Of Impact and Healthcare Needs (VOICE) Project. *J Am Acad Dermatol*. 2020;82(2):366-376. 3. Kokolakis G, Wolk K, Schneider-Burrus S, et al. Delayed diagnosis of hidradenitis suppurativa and its effect on patients and healthcare system. *Dermatology*. 2020;236(5):421-430. 4. Kirby JS. Qualitative study shows disease damage matters to patients with hidradenitis suppurativa. *J Am Acad Dermatol*. 2016;74(6):1269-1270. 5. Matusiak Ł, Bieniek A, Szepietowski JC. Psychophysical aspects of hidradenitis suppurativa. *Acta Derm Venereol*. 2010;90(3):264-268.

Jackson. The volume over time has allowed for full-time faculty shifts focused on telehealth consults. Today, not in spirit, but in true impact, care is increasingly emergency physician led in these networked emergency departments. We must always work against a balance. The weighting must strongly be on patient safety and on expanding the opportunities for board certified emergency physicians. ACEP advocacy, both nationally and increasingly through state chapter support, is more important than ever in achieving these goals.

Alison J. Haddock, MD, FACEP

Current Professional Positions: Assistant professor of emergency medicine, director of health policy: advocacy, assistant director of faculty development, department of emergency medicine, Baylor College of Medicine, Houston

Internships and Residency: Emergency medicine residency, University of Michigan, Ann Arbor

Medical Degree: MD, Cornell Medical College (2007)

Response

✓ No patient should be seen in an emergency department (ED) without the involvement of a residency-trained, board-certified (or board-eligible) emergency physician (EP). ACEP defines this as the gold standard in emergency care. However, we cannot forget that rural areas face significant shortages of emergency physicians. Despite the growth we have seen in residency programs, we are not seeing more emergency physicians working in remote EDs. Recent data published in *Annals* showed that between 2013 and 2019, the percentage of clinicians working in rural areas who were emergency physicians actually dropped slightly.

It is critical for our specialty to work on our rural pipeline. This means supporting efforts to recruit college students from rural areas in their pre-med years and support their transition into medical school, then continuing to expose medical students to the experience of rural medicine during their clerkship years. If we wait until residency for trainees from urban areas with only urban experiences to get firsthand experience in a rural setting, it may be too late to persuade them of the value of a rural career. This limitation does not mean that rural rotations should not be supported. Rural rotations for emergency medicine residents need to be prioritized and made much more accessible. Trainees should be incentivized to participate in these rotations with optimized scheduling, supported housing, and an additional stipend to cover the expense of being away from home. We must work to reduce structural and accreditation barriers to the availability of these rotations through enhanced collaboration with the ACGME, COD and program directors, rural EPs and rural hospitals. Practicing in a rural area can be deeply rewarding with opportunities to spend more time at the bedside and develop deeper relationships with a smaller cadre of ED staff. The more positive experiences we can create for trainees within rural practices, the more EPs we can

attract to these areas.

As the problem of strengthening the rural pipeline cannot be solved overnight, in the interim, we will continue to see some nurse practitioners and physician assistants developing careers in rural emergency departments. Evidence shows that their presence has been increasing in rural EDs, and ACEP's own Rural Task Force identified in 2020 that some rural EDs may not have sufficient volume to support dedicated ED physician staffing. However, both the Rural Task Force (2020) and the Telehealth Task Force (2021) agreed that telehealth supervision of NPs and PAs in rural practice environments by board-certified emergency physicians is a viable model for improving patient safety and extending the reach of the BC EP through the use of a physician-led team. A "hub and spoke" model allows a centrally located board-certified EP to collaboratively supervise NPs and PAs in multiple hospitals simultaneously. Continuous improvements in technology and broadband capability mean that this kind of supervision will become easier every year and can allow true team-based care even without an emergency physician physically present at the bedside. To optimize this kind of care, we must ensure that our trainees are learning the skills they will need to be effective in this role, including strategies for effectively supervising NPs and PAs and how to effectively use telehealth technologies to evaluate patients, from building rapport to performing video physical exams.

Finally, in order to incentivize emergency physicians to practice in rural areas where patient volumes may be lower, we must seek out ways to compensate them for the hours they put in standing at the ready for critically ill patients to arrive. We do not fund rural fire departments solely based on the number of fires they respond to per year, and we should not pay rural emergency physicians based solely on the number of patients they see. A rural ED staffed by a well-trained EP is an essential resource in small communities that may be otherwise lacking in readily available healthcare resources. Both rural EDs and rural EPs should receive compensation reflecting the critical nature of that resource. All EPs are currently experiencing the pain of our current boarding crisis, and the lack of sufficient funding of our safety net and surge capacity is a contributor to that crisis. We cannot continue to make that mistake in rural America, where our neighbors deserve the same access to high-quality emergency physicians delivered in urban areas.

Ryan A. Stanton, MD, FACEP

Current Professional Positions: Emergency physician, Central Emergency Physicians, Lexington, Kentucky; medical director, Lexington Fire/EMS; medical director, AMR/NASCAR Safety Team; public safety medical director, Blue Grass Airport, Lexington; Kentucky and Florida medical director, AirMed International

Internships and Residency: Surgery internship, James H. Quillen College of Medicine, Johnson City, Tennessee;

emergency medicine residency, University of Kentucky
Medical Degree: MD, James H. Quillen College of Medicine (2003)

Response

✓ The workforce study shook the foundation of emergency medicine (EM). After decades of assumptions that we would "never fill all the seats," we have been faced with the threat of an overabundance of emergency physicians which has led to some of the downstream impacts, including the match struggles. What is even more clear is that we continue to have a significant distribution issue within EM with abundance pushing down larger markets while rural and critical access setting still struggle to fill shifts. More recent data has demonstrated that the initial study significantly underestimated physician career longevity and attrition (which is an issue in itself), but it has provided an opportunity to address challenges that were known and unknown. The workforce efforts must continue with opportunities to guardrail residency growth, raise the bar on the skillsets of emergency physicians, and ensure we continue to recruit the best and brightest to this wonderful specialty. One of the major areas of focus must be on the distribution of emergency physicians with opportunities within residency to have substantive rural and critical access experience. This also means advocating for incentives that can assist attracting physicians of all career stages to rural and critical access settings.

I have long felt that every emergency patient deserves access to an emergency physician. Non-physician practitioners have played an important role in the U.S. health care system, but ongoing efforts for expanded scope of practice and independence is not in the best interest of our patients. I absolutely believe in the physician led team. Within my own PDG, I continue to push towards more physician coverage with selective NPP coverage where appropriate. I believe the best care is provided by an emergency physician—period. If we truly are experiencing saturation of available emergency jobs, then we need to see growing access to emergency physicians in all environments of emergency medicine. Three take home points for what I believe.

1. There is no substitution for the physician led team. Every patient in a U.S. emergency department deserves access to an emergency physician no matter their zip code.
2. At no point should a physician role be replaced by a NPP for any reason, but especially as a perceived profit/control strategy.
3. ACEP must continue to fight expanded scope of practice or independent practice on the state and federal level. Independent practice is the privilege earned with having a MD or DO after your name.

The workforce dilemma is a challenge we will face for years to come. I am proud that ACEP has been willing to tackle tough questions and work towards realistic solutions in the promotion of EM and our physicians.

COUNCIL OFFICER CANDIDATES

The candidates for ACEP Council Speaker and Vice Speaker responded to this prompt:

How would you navigate through the challenges that may arise when the Council and the Board of Directors do not share the same view on an issue?

COUNCIL SPEAKER CANDIDATE

Melissa W. Costello, MD, FACEP

Current Professional Positions: Staff emergency physician, Baldwin Emergency Group, PC, Mobile Infirmary Medical Center, Mobile, Alabama; staff emergency physician, Emergency Room Group, LLC, Singing

River Hospital System, Pascagoula, Mississippi; staff emergency physician, Envision Healthcare, Ascension Sacred Heart Hospital, Nine Mile Free Standing ED, Pensacola, Florida; clinical appeals consultant/utilization review, AirMethods Corporation, Denver, Colorado; EMS medical director for Mobile Fire & Rescue and Urban Search and Rescue, Federal Bureau of Investigation Mo-

bile Division SWAT Medical, Baptist LifeFlight/Alabama Lifesaver/AirMethods, and Mobile Police Department and Police Surgeon; medical officer, Trauma Critical Care Team—South, U.S. Department of Health and Human Services

Internships and Residency: Emergency medicine residency, Johns Hopkins University School of Medicine,

Baltimore

Medical Degree: MD, University of Alabama School of Medicine (2000)

Response

✓ The work to avoid serious discord at the Board-level starts long before the resolutions come from Council to the Board for approval. Participation in resolution writing workshops and mentorship of resolution authors is the responsibility of all members of the Council, but it is particularly important for the Council officers. Getting solid ideas with sound language in front of the Council on the first try will significantly “grease the skids” towards making new policy. Writing and editing the background material in order to help frame the debate and allowing asynchronous testimony to hash out the arguments ahead of time all help us arrive at our annual Council meeting at “first-and-goal” rather than “fair-catch at the 50,” or (to further torture this analogy) it is like arriving at Council as an SEC football team rather than ____ (fill in your team here) _____. [cough—Roll Tide—cough]. Building friendships and relationships over the long term is also critical so that coalition-building around any issue begins long before the gavel taps to open debate at the Council meeting or at the Board.

The biggest challenge when the Council and the Board have different views is the same as in any organization: how to “disagree without being disagreeable.” After many years of Council meetings, it is not hard to predict which issues will be contentious on the floor and contentious in the Board meetings. The beauty of our parliamentary process is that we do not close debate until both sides have been heard on an issue. This allows the Speaker and Vice-Speaker to prepare solid arguments in favor of the Council’s position and be well prepared to refute opposition from the Board members who try to alter the intent of a resolution passed by Council. Ultimately, it is about maintaining respect and decorum so that common ground can be found and the group can arrive at a constructive solution that contributes to the success of ACEP as a whole.

COUNCIL VICE SPEAKER CANDIDATES

Kurtis A. Mayz JD, MD, MBA, FACEP

Current Professional Positions: Chairman of pediatric emergency medicine and medical director of the Pediatric Emergency Center, Saint Francis Hospital, Tulsa, Oklahoma; attending physician, Heart of Mary Hospital, Urbana, Illinois

Internships and Residency: Emergency medicine residency, Stony Brook University Medical Center, Stony Brook, New York

Medical Degree: MD, University of Illinois, Champaign-Urbana (2011)

Response

✓ The Vice Speaker and Speaker are the advocates in chief for the Council to the Board. My primary responsibility as Vice Speaker is to ensure that your voice is heard and the goals of the Council are achieved. When there are differing views I will use my skill as an attorney and registered parliamentarian to anticipate the challenges, collaborate with the Board, engage relevant parties, and propose alternative solutions.

As Vice Speaker, when conflict arises it is important that I clearly understand the intent and will of the Council. That work begins with careful study of the resolutions prior to and after council and thoughtful consideration and understanding of the testimony provided at Council. With the Council’s clear intent in mind, I can then anticipate the conflict and determine whether it is based on the position or viewpoint expressed or the underlying interest and intent of the Council. I will then advocate for positions that represent the underlying interests of the Council in a way that best represents the intent of the Council while addressing the concerns of the Board.

Just as the Council floor can be a challenging place to work out the finer details of a resolution, the boardroom too can be a difficult place to resolve conflict. Fostering relationships with individual board members and hav-

ing personalized discussions regarding their concerns in advance, can help get to the heart of the underlying reasons, motivations, or values driving the disagreement. As Vice Speaker, I will work to anticipate specific conflicts, engage board members early in the process of discussing our differences, and collaborate to find solutions that satisfy the intent of the Council and allay the concerns of the Board.

As an advocate for the Council, I will also look to you, the Council membership for your expertise and opinions. I will use the engagED forum to disseminate information regarding Board discussions and concerns and use it as a place for councillors to bring up concerns, discussion points and proposed solutions. I recognize that to be your voice I also need to hear your voice throughout the process and not just on the Council floor.

If the Board makes a decision that does not reflect the will of the Council I will bring that decision back to you with detailed information regarding the Board’s decision including the positions and votes of individual Board members. I will then work with Council members to propose additional resolutions and alternative solutions to help resolve the disagreements in favor of the will of the Council.

As Vice Speaker I will listen as effectively as I speak, guide as effectively as I lead, and encourage as effectively as I advocate.

Ultimately I will work to foster a spirit of collaboration and engage with the Board in ways which will allow the collective wisdom of College leadership to emerge in a way that meets our unified purpose, a strong College which represents all of its members well and ensures that your voice is heard.

Michael J. McCrea, MD, FACEP

Current Professional Positions: Attending physician and core faculty, Mercy Emergency Care Services, Team Health, and Lucas County Emergency Physicians, Inc., Premier Physician Services, Toledo, Ohio

Internships and Residency: Emergency medicine residency, The Ohio State University Medical Center, Columbus

Medical Degree: MD, Medical College of Ohio at Toledo (2004)

Response

✓ The Council Officers actively participate in ACEP Board Meetings to ensure that the Council’s will and voice is represented. Similarly, the Board attends and listens to Council debate to understand each resolutions’ intent along with the tenor of discussion so they can understand the impetus behind each Council action. In the rare instance the Board would propose an action contrary to Council’s will, the Council Officers are the crucial link between the Board and the Council to assure ACEP keeps members’ interests at the core. While not burdened with a vote, the Council Officers can devote their time fostering debate and building consensus that considers Councils’ directives.

The most likely scenario in which the Board would differ from Council would be on a controversial issue, especially a late breaking issue after the resolution deadline. We saw this just this past year during the rapidly changing landscape around reproductive health with its potential profound effect on both our members and our patients. Our Council Officers ensured that the original intent and will of the Council was maintained while the Board amended the original resolution adopted by Council.

When it comes to maintaining our principles and building consensus around a time critical issue that impacts our members, I have proven expertise. I acted as our council officers did when I was serving as Ohio Chapter president. In our state a residency program was thrown into turmoil when a contract group was abruptly changed. Over several days I actively listened to our members and gathered information to inform our Board how we could best help our members, especially the program’s residents. In the end, we were able to facilitate placement for many of the program residents to stay in Ohio and provide employment guidance for numer-

ous faculty. Additionally, I helped arrange free access for the residents to the Chapter’s educational materials during the unexpected transition. Through this difficult time, I made sure all sides were heard to help build consensus within our Board while continuing to serve our members’ interests.

From this experience, I demonstrated the leadership skills to facilitate dialogue and navigate debate when viewpoints diverge. Combined with my experience on the Council Steering Committee and having served as Chair of Reference Committee and the College Bylaws Committee, I have the proven experience to represent the Council as your voice at Board meetings. If and when differences arise, I have the expertise to bring all sides together while adhering to our governing principles. As your council officer, I commit to ensuring your voice contributes to the best outcome for our College, our members, EM residents, and our patients.

Larissa M. Traill, MD, FACEP

Current Professional Positions: Clinical assistant professor, Michigan State University department of emergency medicine; attending physician (locums), Windsor Regional Hospital, Ontario, Canada

Internships and Residency: Emergency medicine residency, Sinai-Grace Hospital Wayne State University/Detroit Medical Center

Medical Degree: MD, St. George’s University School of Medicine

Response

✓ A Council Officer must possess substantial experience in moderating debate; I possess the skills necessary including the diplomatic talent and emotional and social intelligence, to not only negotiate interpersonal conflicts, but also to encourage a spirit of collaboration essential for the achievement of our shared goals. Anyone, who has successfully, and affably, chaired such excitements as Reference Committee A, as I have, has proven to be capable of advocating for all manner of issues, ranging from the esoteric to the straightforward. Moreover, there may be resolutions for which a novel or innovative way to present the background information might help to better inform the Council’s discussion (e.g., tables, graphics, hyperlinks, etc.). Greater clarity might minimize either anticipated or unexpected challenges on the Council floor.

The Council’s efficiency is paramount to navigating the challenges that may result from differing opinions. I will ensure that all opposing voices are heard, and I will also solicit opinions or considerations that may not have been previously expressed. I believe that with informed discussion, the Council would have the ability to reach a consensus, enabling it to cast a majority vote decision without having to repeatedly refer issues to the Board. The expertise of the Board should be primarily reserved for issues related to the strategic mission of the College, issues which require executive level insight and deliberations. I would also offer a friendly reminder to the Council Officers and the Board of their deliberative and strategic responsibilities to the College. Just as physicians have a fiduciary obligation to act in good faith and loyalty, not allowing their personal interests to conflict with their professional duty, so must the elected bodies of the College act in it its best interests and attempt to reach consensus whenever possible. I am invested in exploring innovative approaches to optimize the potential of the Council. We must all strive for clarity of purpose in the pursuit of growth, change, and development: I am committed to this agenda.

Our Council should function not in rivalry with other organizations, not imitating others, but serving as an example to them, whether or not we all share the same views; such should be the Council in the hands of the many, not the few.

“Our form of government does not enter into rivalry with the institutions of others. Our government does not copy our neighbors’ but is an example to them. It is true that we are called a democracy, for the administration is in the hands of the many and not of the few.” —Pericles Athenian General and Statesman. 🗳️



KYLE - STOCK ADOBE.COM

The Most Philly Thing Ever

Dr. Basile posing with friends at the game in front of the Philadelphia Eagles BIRDS sign.



Dr. Basile, has been part of the Cara Liom Brigade that marches in Philadelphia's Mummer's Parade for 11 years. He was still decked out in this costume when he saved the life of a fellow fan at an Eagles game in early 2023.

Sure, he made the national news for saving a life at an Eagles game while wearing an elaborate Mummer's Day costume, but did you know he's also his residency's social chair and has all the best local recommendations for ACEP23 attendees? Read on!
by JORDAN GRANTHAM

Vincent Basile, DO, an emergency medicine resident at Einstein Medical Center in north Philadelphia, was focused on cheering for his hometown Eagles on January 1, 2023, when he realized a fellow fan was experiencing a medical crisis. Fresh off marching in Philly's annual New Year's Day Mummer's Parade and still wearing his shiny pink and blue costume with rainbow paint on his face, Dr. Basile had to quickly convince the security team surrounding the fallen fan that he was, indeed, an emergency physician.



Scientific Assembly
PHILADELPHIA, PA
2023

The patient had lost consciousness as he was walking back to his seat and rolled head-over-heels down the concrete stairs, tangling himself in the guardrail and occluding his airway. Dr. Basile and a nurse worked together to reposition him on his back on the landing between the stairs, and they couldn't feel a pulse.

Deciding to err on the side of caution, they began CPR, alternating in two-minute intervals. The growing crowd of onlookers exhaled in relief as the color began to return to the man's face, and eventually he regained consciousness. Shortly after, the EMS team arrived and transported the patient for further care. Dr. Basile found out later that the patient was on blood thinners and suffered a brain bleed.

"The whole thing was probably 10 minutes, but it felt like an eternity," Dr. Basile remembered. He was in autopilot mode at the time, Dr. Basile said, and his training kicked in. He didn't think about his wild costume, and he definitely didn't realize he was wearing his costume's sunglasses the whole time. It wasn't until the crisis was over and paramedics had taken the patient for additional care that the "the ridiculousness of it set in."

The contrast of his silly costume and the serious situation made for a great news story, though, and Dr. Basile's story was featured by several local outlets and even *People Magazine*.

Since we're heading to his hometown for ACEP23 in October, we asked Dr. Basile, the social chair of his residency, to

share his go-to places in the city.

What is the Mummer's Day Parade?

It's one of the oldest parades in the country, and it happens every New Year's Day. It's almost like Mardi Gras for Philadelphia. I'm part of the Cara Liom Brigade, which is Latin for "friend of mine." We're a comic group that wears fun outfits and dances around. I've been doing it for 11 years now.

How's the Philly food scene?

I think it's the most underrated food city in the entire country. Little like mom-and-pop places, corner places are always the best. People think of Italian food, but we also have our Chinatown, with incredible Asian food, and numerous Middle Eastern and even African cuisine places throughout the city.

Best cheesesteak?

I think Angelo's is the best. It's actually a pizzeria that's known as the best pizza in Philly, but I think that's the best cheese steak in Philly, too.

Unexpected entertainment?

Philly is the Mural Capital of the World. There are more than 4,000 murals. They're very, very, impressive and they're all over scattered throughout the city. There are tours you can do that will take you from place to place.

Best adventure outside the city?

Wissahickon Valley Park has tons of hiking trails. You can spend hours hiking or just do a quick 30-minute trail. New Jersey is very close so you could also go to the beach for the day.

Best place to grab a beer?

Independence Beer Garden is one of my favorite spots. It's outdoor. It's right across the street from the Liberty Bell. I like Yards Brewery, and McGillin's is the oldest bar in the city. There are a lot of speakeasies, including one called Blind Barber that's owned by Bryce Harper.

Best place to run?

Kelly Drive on the Schuylkill River. It goes by Boat House Row which is another famous spot in Philly. It's only minutes from the city, and it's beautiful out there. ➕

JORDAN GRANTHAM is senior content manager at ACEP.

Philly, for the Foodies

Friends don't let friends eat at bad restaurants. We crowdsourced ACEP members who live near Philadelphia to help you make the most of your time in the City of Brotherly Love.

FAVORITE BAR OR RESTAURANT FOR CATCHING UP WITH OLD FRIENDS?

“Parc—bustling French Bistro on iconic Rittenhouse Square.”
—Edward T. Dickinson, MD FACEP

“Graffiti Bar Happy Hour”
—Angela Cai, MD, MBA

“Laser Wolf is fun because they have great cocktails, and it is easy to order for a group because everything is family style. The Goodbye, Horses cocktail is spicy and delicious.”
—Julie Cooper, MD, FACEP

“Vedge (vegetarian) or Zahav (Mediterranean). Any Steven Starr restaurant, any Michael Solomonov restaurant, any Schulson restaurant.”
—Mark Zwanger, MD, FACEP

TOP CHEESESTEAK SPOT?

“Steve’s Prince of Steaks in the Reading Terminal Market. It’s close to convention center, as good as any other steak in the city without traveling.”
—Bernard Lopez, MD, MS, FACEP

“Dalessandro’s Steaks. It is a bit out of the way in the Roxborough section of Philadelphia, but worth the 20-minute trip from the Convention Center. There is often a line to get in, but you will understand why when you taste your cheesesteak (with sauce and onions).”
—Steven M. Selbst, MD

“Get the roast pork at John’s instead. Also, Paesano’s on Passyunk has really interesting and delicious sandwiches.”
—Julie Cooper, MD, FACEP

BEST UNDER-THE-RADAR RESTAURANT?

“Laurel. Top notch food from a Top Chef winner.”
—Steven Katz, MD, FACEP

“Any place in our version of Chinatown is awesome—lots of great dim sum spots.”
—Aneesha K. Dhargalkar, MD

“Melograno—an excellent Italian restaurant with good prices and always fantastic food. It is BYOB, so you save even more on the alcohol bill.”
—Steven M. Selbst, MD

BEST PLACE TO EAT IN READING TERMINAL?

“Sang Kee Peking Duck, a great little Chinese spot—a must if you cannot make it to the actual restaurant in nearby Chinatown. Go to Beiler’s Bakery or Termini Brothers bakery for dessert, or world famous Bassetts ice cream (all are Philly originals).”
—Steven M. Selbst, MD



MINDFULNESS | CONTINUED FROM PAGE 1

personal activities on shift.^{4,5} That amounts to as little as 24 minutes on an eight-hour shift to include going to the bathroom and eating. While there has been ample discussion of “the practice of mindfulness” in health care workers that improves mental well-being, when do we have this time?⁶

What’s Your Pre-Shift Ritual?

We can leverage pre-shift rituals that many of us do already to exercise mindfulness. Some of us bike to work or chat with colleagues just before shift. While the activity is different for everyone, these rituals are primed for stress-reducing mindfulness because they are routines we already use to prepare for stressful shifts.

Mindfulness involves being present—experiencing the moment you’re in—and being an *accepting observer* of those experiences, thoughts, and emotions. For example, my pre-shift ritual is a cup of hot, black coffee that I either buy or brew myself. I am being present as I smell and taste its sour and sweet parts, like an orange. I feel warmth as I drink and often feel content to enjoy the taste of the coffee. I’m observing the moment, accepting whatever feelings or experiences are occurring.

However, it’s natural for our mind to wander from the present or to experience negative emotions. When we do this, we may experience reflective thoughts like, “I must’ve burnt the grounds ... again” or future thoughts like, “I should really go to a coffee shop next time.” That’s okay. We should *decenter our viewpoint*, shifting our perspective from internal to external, to that of a listening friend, observing our own thoughts and emotions. It helps one to realize that many thoughts and emotions, whether good or bad, are only transient. Future worries or past ruminations are natural, but the stress attached to them is fleeting.

If you find yourself meandering from the present too much, you can always refocus to the present pre-ritual activity. It’s another sip of coffee, another pedal on your bike, or intently listening to your colleague’s recollection of their latest vacation.

The Art of Breathing ... on Shift

It is non-stop on shift. It feels impossible to fit in a moment to go to the bathroom or take a sip of water. Staff interrupt you while you’re in Room 3 with a patient you’ve placed on BiPAP, “We have an incoming patient with CPR in progress in five minutes,” the nurse says before adding, “Room 4’s family really wants to talk with you again.” And as you power-walk to prepare for the incoming ambulance and tell Room 4 you will be delayed, thoughts interrupt you: “I’m worried about Room 3; if BiPAP doesn’t turn her around, I’ll have to intubate her.” and, “I hope I make it out on time to tuck my kid into bed tonight.”

You may have heard of “mindful breathing” or “tactical breathing,” which is associated with a decrease in acute stress, anxiety, and mental illnesses—and on the flip side, even improving performance.⁷⁻¹⁰ But when do we have a moment to—figuratively and literally—just breathe? After patient contact, the 15-20 seconds we take to use alcohol-based sanitizer and/or wash our hands is an opportune time to “habit

stack.”^{11,12} As James Clear describes in his book, “Atomic Habits,” by linking a new behavior (mindful breathing) to an existing habit (hand washing) you use less cognitive energy and are more likely to successfully adopt this practice.

While there are multiple techniques for mindful breathing, the general concepts include: Focusing on the present process of breathing, and breathing in through your nose and out through your mouth.

To give an example, “box breathing” starts with exhaling for four seconds, inhaling for four seconds, holding the breath for four seconds, and exhaling again for four seconds. As a plus, the breathing technique can even be helpful to coach an anxious patient, a patient in pain, and your patient who doesn’t know how to use a metered-dose inhaler!

During and After Shift: Expressing Gratitude

It may sound counterintuitive to say “thank you” during or after difficult shifts. You may be ruminating on the unsuccessful resuscitation of a cardiac arrest in a young mother, all the notes to be done, or the dread of possibly missing something on the patients you signed out or discharged. However, expressing genuine gratitude for yourself and others is powerful for your mental and physical well-being.¹³⁻¹⁵ Even the thought of gratitude can positively influence mental wellness.¹⁵

Remember that turkey sandwich that was flung back in your face? After shift, think of the person who spent their time making hundreds of those sandwiches, which are free of charge, for your patients. It’s amazing that someone provides these comforts—turkey sandwiches, warm blankets—that allow us to do what many of us went into medicine for: care for patients. When you think of that person who made the sandwiches, the comfort some patients receive from these simple gestures, that turkey sandwich may just not seem that contentious anymore.

Think of the team after shift. The senior nurse who was the key lead in a resuscitation when you were occupied with a crash femoral central line. The security personnel who kept you and the team safe during a violent interaction with an intoxicated patient. The environmental-services worker who cleaned the room after a patient with a gastrointestinal bleed hemorrhaged all over the floor. If you’re up to it, say a genuine “thank you” to those individuals. They deserve your gratitude and, on top of that, you might feel better too.

Planning for the Unknowns

Emergency medicine is not, and will never be, an easy job. The unknowns are constant, whether it’s the boarding situation, the future of the Match, or whether your “black cloud” status will come onto your next shift. Every day, we face the challenges and celebrate the successes we see in our patients, our coworkers, and our health care systems. These experiences and thoughts rightfully evoke strong emotions. However, they should not define our wellness.

In “Man’s Search for Meaning,” psychologist Viktor Frankl describes his observations in Nazi death camps: “Everything can be taken from a man but one thing: the last of the human

CONTINUED on page 13



ED Boarding

by NISHAD A. RAHMAN, MD; KEITH C. HEMMERT, MD; AND JESSE M. PINES, MD, MBA, MSCE

In November 2022, the American College of Emergency Physicians sent a letter to President Biden on behalf of 34 organizations, asking to convene stakeholders to identify solutions to address the emergency department (ED) boarding crisis.¹ The letter detailed ED physician stories, highlighting the preventable harms from boarding, crowding, long waits, staff shortages, burnout, and the disproportionate impact on behavioral health and pediatric populations. Hospital crowding and ED boarding have been longstanding and persistent crises for more than two decades, yet have progressively worsened over the COVID-19 pandemic.²

Early pandemic days brought uncertainty, personal risks to clinicians, and waves of COVID-19 patients. Over time, this caused attrition among ED physicians. Even more so, nurses left practice or migrated to non-hospital settings. There is no easy fix to the nurse-supply problem. A pre-pandemic analysis estimated a shortage of 500,000 registered nurses by 2030.³ Given the current attrition rate, this is most likely an underestimate. Today, many hospital inpatient units, EDs, and post-acute care locations cannot adequately staff due to nursing shortages.

Emerging data on ED crowding are stark. Left without treatment (LWOT) rates increased from a median of 1.1 percent pre-pandemic (interquartile range [IQR], 0.5-2.5 percent) to 2.1 percent post-pandemic (IQR 0.6-4.6 percent).⁴ LWOT rates were as high as 10 percent in the 95th percentile. Internal data from US Acute

Care Solutions EDs show similar trends, with progressively lengthening ED length of stay (LOS) and increasing LWOTs. Here's what the government can do to impact the hospital crowding and ED boarding crisis.

Solution 1: Immediately reintegrate the admitted ED LOS measure into public reporting and Medicare stars for hospitals

Historically, hospitals measured and reported ED LOS for admitted patients, a proxy for the ED boarding time. The Centers for Medicare and Medicaid Services (CMS) developed and maintained the measure. It was submitted in 2008 to the National Quality Forum (NQF), which convenes external groups to endorse measures. NQF re-endorsed the measure in 2014. In November 2018, CMS withdrew the measure. NQF endorsement was removed. CMS used the following justification: "Costs associated with the measure outweigh benefit of its continued use in the program."⁵ CMS also "... respectfully disagree[s] that the removal will result in hospitals not working to maintain low boarding time."⁶

It's time to bring the measure back. It should be publicly reported so patients can assess how long they might have to stay in the ED boarding prior to transfer to their inpatient bed. It should be included in Medicare star ratings for hospitals, which is a summary measure of hospital quality for consumers. The admission LOS measure formerly reported only the median time. Future versions should also report the 75th and 90th percentile times for full transparency. It should also differentiate boarding times for psychiatric patients,

who are at high risk for very prolonged boarding. Public data on boarding times, ideally tied to hospital reimbursement, will help change the perverse financial incentive that hospitals make more money when they preferentially give beds to patients with lucrative scheduled procedures over ED patients.⁷

Solution 2: Unload the nursing workforce of less complex tasks by allowing related professionals to increase their scope of practice

To reduce crowding, the central issue hospitals need to address is a shortage of nursing labor. Allowing some lower-level tasks performed by nurses to be completed by related professionals would rapidly address the issue. An immediate step would be the federal government working from the top down with local regulatory bodies to adopt new scopes of practice for workers and delegate some, less complex, currently nurse-only, tasks to others. For example, EMS personnel, certified nursing assistants, and medical assistants could reduce the nursing work burden for tasks such as drawing blood, hanging simple fluids, placing IVs, and other tasks. This would involve partnering with groups like the American Nurses Association or the Emergency Nurses Association to develop programs for nurse extenders. ED physicians lead teams of advanced practice clinicians in some hospitals. Similarly, nurses could lead their own teams with these new roles. Some hospitals have already embraced the concept of nursing extenders.⁸ Additionally, military branches have skilled workers with complementary skills where an existing workforce could be immediately de-

ployed to meet these needs. Navy corpsmen deliver a wide range of nursing-related tasks in U.S. military facilities. Another idea would be to expand the National Health Services Corps to include graduating high school seniors who could serve in these novel roles for two years, gaining skills and loan forgiveness for college or trade school.

Solution 3: Fund EDs and hospitals to address hospital crowding and ED boarding

With direct funding from the federal government, there would be additional resources to address local issues, customized to hospital needs. Such uses of funds could include hiring ancillary staff to offset nursing tasks, which would address the staff shortages that have caused many hospitals to close available, but now empty, beds. These bed closures directly worsen boarding because there are fewer spaces to send ED patients after hospital admission. Those beds need to reopen. Funding could also be directed further downstream to post-acute facilities where decreases in bed availability have caused upstream congestion in hospitals, also leading to ED boarding.

Alternatively, funding could be deployed to provide resources to internal hospital teams to address remediable flow issues. Funds could be used to hire additional physicians or advanced practice clinicians to augment clinical gaps, or to provide leadership. Such funding would create an imperative for hospitals to focus on ED boarding with additional dedicated human resources at a time when hospital budgets are strained.

Solution 4: Further increase funding to bolster the nursing pipeline

U.S. nursing schools turned away 80,407 qualified applicants in 2019 due to a lack of faculty, education space, and resources.⁹ Simultaneously, the median age of registered nurse faculty is 52 years, suggesting a wave of near-term retirements that will further diminish capacity to train new nurses.¹⁰ Increased funding is necessary to ensure each class includes the maximal number of qualified applicants.

On October 3, 2022, the Department of Labor announced \$80 million in funding to expand the nursing pipeline through the Nursing Expansion Grant Program. This included multiple pathways: the nurse education professional track to increase the number of clinical and vocational nursing instructors; the nursing career pathway track to train frontline health care professionals; and special grants to support accelerated learning and expanded access to clinical residencies and specialty care rotations.¹¹ While these are steps in the right direction, the U.S. Bureau of Labor Statistics projects that more than 275,000 additional nurses are needed from 2020 to 2030.¹² That \$80 million is less than \$300 per needed nurse. More funding is needed.

Solution 5: Fund emergency physicians to manage population health, thereby reducing ED volume through innovative care delivery and payment models

If there's one thing we've learned from the pandemic, novel technologies can improve our ability to manage patients remotely. Telemedicine is already being used to change how low-acuity patients are cared for, with off-site physicians diverting patients to the right setting. But these programs are primarily local. It's time to create payment models to expand them. Expanding these models would allow ED physicians to embrace our role as "available-ists." It would also enhance our ability to impact population health and reduce total cost of care. Additionally, pre-ED telehealth, post-ED telehealth, and other programs that address frequent use are effective ways for ED physicians to improve patient safety, increase efficiency, and unload hospitals of patient care that may be better delivered in other settings.

One innovative way to do this would be by changing the way that ED physicians get paid, moving to capitated payment models or global budgets that EDs could opt into. Traditional fee-for-service makes telehealth and frequent-user programs more challenging to fund. Global budget pilots would need to keep ED physicians whole and provide additional resources for real population health activity led by ED physicians. Global budgets may be the long-term solution to bridge the funding gap for emergency medicine's participation in population health.

Ultimately, there are many ways to address ED crowding and boarding. What's clear from the emerging data: our experience as clinicians as well as our patients' is that the system is unraveling. ED crowding and boarding are causing patient experiences and outcomes to worsen. The question is not whether the government should act, but how. The time is now to address this longstanding, progressively worsening, public-health crisis. 🗳️

References

1. American College of Emergency Physicians, et al. Letter to President Biden. ACEP website. [https://www.acep.org/globalassets/new-pdfs/advocacy/emergency-department-boarding-crisis-sign-on-](https://www.acep.org/globalassets/new-pdfs/advocacy/emergency-department-boarding-crisis-sign-on-letter-11.07.22.pdf)

- letter-11.07.22.pdf. Published November 7, 2022. Accessed July 13, 2023.
2. Bernstein SL, et al. The effect of emergency department crowding on clinically oriented outcomes. *Acad Emerg Med.* 2009;16(1):1-10.
3. Zhang X, et al. United States registered nurse workforce report card and shortage forecast: A revisit. *Am J Med Qual.* 2018;33(3):229-236.
4. Janke AT, et al. Monthly rates of patients who left before accessing care in us emergency departments, 2017-2021. *JAMA Netw Open.* 2022;5(9):e2233708.
5. Centers for Medicare & Medicaid Services. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and policy changes and fiscal year 2022 rates; quality programs and Medicare promoting interoperability program requirements for eligible hospitals and critical access hospitals; changes to Medicaid provider enrollment; and changes to the Medicare shared savings program. CMS website. <https://www.federalregister.gov/documents/2021/08/13/2021-16519/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the>. Published August 13, 2021. Accessed July 13, 2023.
6. Weiner S, Venkatesh A. Despite CMS reporting policies, emergency department boarding is still a big problem—the right quality measures can help fix it. Health Affairs website. <https://www.healthaffairs.org/doi/10.1377/forefront.20220325.151088/>. Published March 29, 2022. Accessed July 13, 2023.
7. Kelen GD, et al. Emergency department crowding: The canary in the health care system. Catalyst website. <https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217>. Published September 28, 2021. Accessed July 13, 2023.
8. Huynh AP, Haddad LM. Nursing Practice Act. Stat Pearls/NCBI website. <https://www.ncbi.nlm.nih.gov/books/NBK559012/>. Last updated July 18, 2022. Accessed July 13, 2023.
9. Hamlin K. Why is there a nursing shortage? Nurse Journal website. Available at: <https://nursejournal.org/articles/why-is-there-a-nursing-shortage/>. Updated March 21, 2023. Accessed July 13, 2023.
10. American Nurses Association. Nurses in the workforce. ANA website. <https://www.nursingworld.org/practice-policy/workforce>. Accessed July 13, 2023.
11. U.S. Department of Health and Human Services. FOIA-ETA-22-16, DOL Nursing Expansion Grant Program Department of Labor Employment and Training Administration. Grants.gov website. <https://www.grants.gov/web/grants/view-opportunity.html?oppld=341995>. Published October 3, 2022. Updated December 15, 2022. Accessed July 13, 2023.
12. U.S. Department of Labor. News release 22-1946-NAT: US Department of Labor announces \$80m funding opportunity to help train, expand, diversify nursing workforce; address shortage of nurses. US DOL website. <https://www.dol.gov/newsroom/releases/eta/eta20221003>. Published October 3, 2022. Accessed July 13, 2023.



DR. RAHMAN is a 2022–2023 clinical innovations fellow at US Acute Care Solutions and works clinically at LifeBridge Health in Baltimore. He went to medical school at Sidney Kimmel Medical College at Thomas Jefferson University in Philadelphia, and completed emergency medicine residency at St. John's Riverside Hospital in Yonkers, N.Y., where he served as chief resident.



DR. HEMMERT is the medical director for the Department of Emergency Medicine at the Hospital of the University of Pennsylvania in Philadelphia, and an assistant professor of clinical emergency medicine at the Perelman School of Medicine at the University of Pennsylvania in Philadelphia. He is also the founder and associate fellowship director for the emergency medicine administration and leadership fellowship, a groundbreaking collaboration with the Wharton School in Philadelphia.



DR. PINES (@DRJESSPINES) is the chief of clinical innovation at US Acute Care Solutions and a professor of emergency medicine at Drexel University in Philadelphia. He works clinically as an emergency physician at George Washington University Hospital in Washington and Allegheny General Hospital in Pittsburgh.

MINDFULNESS

CONTINUED FROM PAGE 11

freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way.”¹⁶ While we can't and shouldn't prevent the way we feel or experience things, by taking a mindful approach, we can transform our own attitudes towards them. Listening to ourselves and accepting these emotions openly, taking a breath, and showing gratitude are simple and accessible ways to practice mindfulness. In the end, we may just realize the burden we feel is transient, like the ebb and flow of our emergency department census.

References

1. Verougstraete D, Hachimi Idrissi S. The impact of burn-out on emergency physicians and emergency medicine residents: a systematic review. *Acta Clin Belg.* 2020;75(1):57-79.
2. Lloyd S, Streiner D, Shannon S. Burnout, depression, life and job satisfaction among Canadian emergency physicians. *J Emerg Med.* 1994;12(4):559-65.
3. Lu DW, et al. Impact of burnout on self-reported patient care among emergency physicians. *West J Emerg Med.* 2015;16(7):996-1001.
4. Chisholm CD, et al. Emergency department workplace interruptions: are emergency physicians "interrupt-driven" and "multitasking"? *Acad Emerg Med.* 2000;7(11):1239-43.
5. Fuchtbauer LM, Nørgaard B, Mogensen CB. Emergency department physicians spend only 25% of their working time on direct patient care. *Dan Med J.* 2013;60(1):A4558.
6. Chisholm CD, et al. A task analysis of emergency physician activities in academic and community settings. *Ann Emerg Med.* 2011;58(2):117-22.
7. Burton A, et al. How effective are mindfulness-based interventions for reducing stress among healthcare professionals? A systematic review and meta-analysis. *Stress Health.* 2017;33(1):3-13.
8. Cho H, et al. The effectiveness of daily mindful breathing practices on test anxiety of students. *PLoS One.* 2016;11(10):e0164822.

9. Lotfabadi R, et al. Effect of guided tactical breathing with biofeedback on acute stress attenuation and marksmanship performance of novice shooters. *Proceedings of the Human Factors and Ergonomics Society Annual Meeting.* 2020;64(1):641-645.
10. Burg JM, Michalak J. The healthy quality of mindful breathing: Associations with rumination and depression. *Cogn Ther Res.* 2011;35:179-185.
11. Melnyk BM, et al. Interventions to improve mental health, well-being, physical health, and lifestyle behaviors in physicians and nurses: A systematic review. *Am J Health Promot.* 2020;34(8):929-941.
12. Clear, J. *Atomic Habits: Tiny Changes, Remarkable Results: An Easy & Proven Way to Build Good Habits & Break Bad Ones.* New York, New York, Avery: Penguin Random House; 2018.
13. Centers for Disease Control and Prevention. Hand Hygiene in Healthcare Settings. CDC Website. <https://www.cdc.gov/handhygiene/index.html>. Updated April 28, 2023. Accessed July 12, 2023.
14. Leavy B, O'Connell BH, O'Shea D. Gratitude, affect balance, and stress buffering: A growth curve examination of cardiovascular responses to a laboratory stress task. *Int J Psychophysiol.* 2023;183:103-116.
15. O'Connell BH, O'Shea D, Gallagher S. Feeling thanks and saying thanks: A randomized controlled trial examining if and how socially oriented gratitude journals work. *J Clin Psychol.* 2017;73(10):1280-1300.
16. Frankl, VE. *Man's Search for Meaning: an Introduction to Logotherapy.* Boston: Beacon Press, 1962.



DR. KOO is an emergency physician and attending at MedStar Washington Hospital Center in Washington, and St. Mary's Hospital in Leonardtown, Maryland. He is an assistant professor of emergency medicine at MedStar Health and Georgetown University Hospital and assistant professor of military and emergency medicine at the Uniformed Services University of the Health Sciences.

FINGERS COUNT
AND YOUR PATIENTS ARE COUNTING ON YOU

EMERGENCY & TRAUMA CARE
(ELSEVIER, Sept. 2019)

“Traditional methods of tourniquet application to digits (e.g **silicon ring, surgical glove, Penrose drain**) all exceed the pressure required for digital hemostasis, and **dramatically increase the risk of neurovascular injury.** These potential injuries can be devastating for the patient.”



“THE T-RING™ TOURNIQUET is now used to replace these other methods. It applies even pressure to any digit, creating the required bloodless field with minimal pressure.”

MAKE EVERY FINGER COUNT

Start using the **T-RING**, the **ONLY** tourniquet for digits proven to apply a **safe pressure** on all digit sizes.”



www.theTring.com



info@theTring.com

©2020 T-Ring. All Rights Reserved.



Relating Back to the Medical System

A doctor's reflections on being a patient and patient advocate

by ERIC SCHWAM, MD, FACEP

After almost 40 years as a physician, with a career as an emergency physician, quality-assurance reviewer, and medicolegal consultant, I have finally retired. Surprisingly, I still spend a fair amount of time searching and reading topics in UpToDate. Like many physicians, I get a lot of requests for medical advice and evaluation of medical care from friends and family. Retirement has not put an end to this. Friends are getting joint replacements, cancer, and other illnesses, and I am now having some of those same ailments as well. Some of the care has been excellent, but unfortunately there have been some distressingly bad outcomes.

As a physician, how should one relate to the medical system when you are not the one providing care? Most of us have been told not to act as our own physician or the physician to our family. There are medical, medicolegal, and interpersonal risks in doing so. The AMA Code of Medical Ethics' Opinion on Physicians Treating Family Members advises against it.¹ Nevertheless, most physicians do not follow this dictum.² In the real world, it is not so clear-cut, especially at the margins. If you are not going to be the treating physician, how should you interact with the physicians caring for your friends and family members? I could find nothing in the medical literature on this topic. Personally, I was never taught how to navigate these dilemmas, so I have had to learn the hard way. These are the lessons I've garnered through experience.

First, Stay in (or Close To) Your Lane

An orthopedist, for example, has little business opining on the care of a family member with an ST-elevation myocardial infarction, unless the care is egregiously inappropriate. Yet they can still become involved in the routine aspects of care as a highly educated layperson. As someone who was board certified in both internal medicine and emergency medicine, my lane has been fairly wide. However, the farther I get from the centerline, the more circumspect I have become. The very last thing you want to do is disrupt good medical care.

Be Judicious About Being Your Own or Your Family's Doctor

Most laypeople make their own decisions when to seek medical attention for themselves and their family. Until that time, they treat themselves, rightly or wrongly. Physicians do the same thing, just with a lot more medical knowledge. It is convenient and efficient and often effective to handle simple or clear-cut things yourself, but be aware that your medical decision making is often impacted by affective bias, where your feelings about the patient impact your decision making. Often, I have made good decisions, but many times I have not.

For example, I missed my 2-year-old daughter's post-varicella cerebellar ataxia. Our babysitter told me that she was "walking like she's drunk," but I dismissed this as I watched her run right by me that day at the beach. The next morning, unable to walk, she crawled into our bedroom. Fortunately, she recovered in a few weeks and eventually became an athlete.



Then there was the time that my 9-year-old son lacerated his chin when he fell off his bicycle. Judging that I could do a better job closing the laceration than an intern, I had my wife bring him to the community ED where I was working. I have seen a lot of gore, but this was the only time in my entire medical career when I very nearly passed out at the sight of blood—just as I was gloved and had him prepped and draped and ready to begin the procedure. I recovered without fainting and after about 10 sutures, so did he. However, I could have fallen, been injured, and needed laceration repair myself.

On the other hand, being a do-it-yourself physician can come in handy. So far, I have managed all my episodes of renal colic with ibuprofen, a urine dipstick, and a coffee filter. When I fracture-dislocated my ankle on Mount Rainier, there was no one to do the emergency reduction; so, aided by a rush of endorphins and the lack of swelling, I did it myself. It should go without saying that unless you have no alternative, you have no business handling high-risk situations yourself.

Pay Attention to Everything

Today's physicians suffer with an overload of information and responsibility. Even the best will occasionally overlook things. No one cares about your health as much as you do. I was recently hospitalized for a fever of unknown origin at a well-respected teaching hospital. My doctors were wonderful. Eventually they made a diagnosis, and I was cured. I continue to go to this hospital for my medical care. Yet there were logistical issues and interservice communication breakdowns that delayed aspects of my care.

With access to my patient portal, I was able to read every physician note, diagnostic report, and laboratory result while I was in the hospital. At times, it was distressing to find out what diagnoses my physicians were considering, but there were a few instances where I uncovered clinically significant incidental findings that were overlooked by my medical team. They had so many other things to focus on and I was only one of their many patients.

This advice to scrutinize one's own medical records is more appropriate for physicians than laypersons, because as physicians we often know what is important and what is not. An incidental nodule on a CT may be important, but an "abnormally low" serum lipase is not. With this new access to medical information, patients often become unnecessarily anxious about irrelevant or insignificant

things that the computer has flagged as statistically abnormal.

A Rube Goldberg situation ensued when I was transferred between hospitals with incompatible electronic medical record systems. The physicians at the receiving institution could not easily access many of my test results from the referring hospital. In contrast, I was receiving real-time notifications from its patient portal, which I would dutifully report to my physicians on their morning rounds.

Medical Errors Don't Just Happen To Other People

The frequency of medical errors is high enough that you or someone close to you will likely be on the receiving end of one.³ Several years ago, about to undergo arthroscopic shoulder surgery, I told the anesthesiologist that I was not feeling any effects of the brachial plexus block that he had just administered. He responded that the onset would take a few more minutes, but before I could insist that there was a problem, I had been injected with propofol and was unconscious. I emerged from anesthesia with excruciating shoulder pain due to the complete lack of regional anesthesia.

In my own extended family, there has been a metastatic spread of melanoma following a misread skin biopsy, mismanaged care of a tibial-fibular fracture in a teenaged athlete resulting in a malunion, a death from semi-elective surgery, and a misplaced breast biopsy sample that degraded before it was located. Many of these occurred at "world class" institutions. Even the best physicians at the best hospitals



"A New Spin" is the personal perspective of the author and does not represent an official position of *ACEP Now* or ACEP.

can make mistakes.

I even uncovered a more sinister side of medicine. A relative told me that she was newly diagnosed with severe aortic stenosis because on her initial visit with a gastroenterologist, he had listened to her heart and heard a murmur. I took this to be prima facie evidence of primary care negligence and advised her to switch primary care physicians (PCPs). She then confided that her PCP routinely made inappropriate comments about her breast size while ostensibly listening to her heart. Until then she had been too ashamed to tell anyone. She filed a complaint, and the PCP was professionally sanctioned.

Informal "Second Opinions" Can Be a Minefield

Friends and family members frequently ask me for advice or for my opinion of their medical care. This can be very difficult to untangle. Invariably, you are not there, looking at the patient. You don't have all the information. You probably have affective bias regarding the patient. The patient may have misunderstood what happened or what they were told. Frequently the physician is of a different specialty, and you are rightfully concerned that you are out of your lane. As a physician, you wouldn't appreciate outside meddling if the shoe was on the other foot. And yet, you may sense that something is not right.

A relative whose alcohol use disorder was an open secret within my family had refused treatment for decades. They presented to their long-term PCP with anxiety, tremors, abdominal pain, and vomiting. Unaware of the alco-

hol history, he diagnosed "diverticulitis and a UTI" and prescribed oral antibiotics. I found out from the spouse later that day. This was shocking to me.

What history was related? What were the vital signs? Was the patient tremulous? What was the abdominal exam? What did the doctor really say? It made my head want to explode.

This sounded to me like alcohol withdrawal, so ultimately, I told the spouse to bring them to an ED, where they were admitted to the hospital. COVID-19 protocols prohibited visitors, and the spouse had difficulty communicating with the treatment team by phone. As a physician, I had an easier time getting through. I made sure to inform the clinicians of the relevant history, and the proper diagnosis was made. For the first time ever, my relative went into an alcohol treatment program.

Strategies for Interacting with Loved Ones' Physicians

The easiest scenario that you might encounter is when the patient is getting care within your own medical system. We all know doctors in whose hands we would place our lives and those in whose we would prefer not to do so. This inside information is invaluable.

With doctors you don't already know, if possible, vet them before the first patient visit. Check out their credentials online and look in the state medical board's website for complaints or disciplinary action. But this tells you only so much. I don't usually look at patient review sites, but that probably reflects my bias about such things.

When the physician-patient relationship is

already underway, I usually try to talk to the physician by phone. Of course, you need patient permission to do this. On several occasions I have accompanied the patient to the appointment, or if unable to be there, had them telephone me at the beginning of their medical encounter, so that I could listen to the evaluation and hear the doctor's conclusions. You will learn a lot about their clinical thinking, and you will avoid getting incorrect information via second- or third-hand communication. Usually, the physician is both open and capable and I am reassured, but sometimes the physician will be defensive or dismissive and it becomes difficult to sort out ego from competence. This is a nuance that I am still learning.

When dealing with physicians making potentially questionable medical decisions, the best strategy is to ask them to explain their reasoning. Often, they will hear their own logical errors and will self-correct. I was in the wilderness with only satellite phone access when my wife called to relate that my 3-year-old granddaughter was in the pediatrician's office for the third time with five days of fever and a diagnosis of influenza despite two negative rapid-flu tests. My wife said she was going to demand "more tests," but I told her to ask the doctor to do "more thinking." She asked him, "How many times have you seen a child with influenza who had fever for five days with no respiratory symptoms and two negative flu tests?" He answered, "Never," promptly concluded that he had ignored some potential important diagnoses, and sent her to the children's hospital for some

focused testing. My granddaughter was admitted and successfully treated for Kawasaki disease.

You Can Always Demur

After all, it may not be your specialty, you may be retired, or have other good reasons not to get involved.

As physicians, we have specialized knowledge and perspective that laypeople lack. Most medical care in the United States is good, but there is significant variation in quality. With the right approach, you can put your expertise to work to help someone close to you navigate the complexities of the medical system and get the best care possible. 📌

References

1. American Medical Association. AMA code of medical ethics' opinion on physicians treating family members. *AMA J Ethics*. 2012;14(5):396-397.
2. La Puma J, et al. When physicians treat members of their own families. *N Engl J Med*. 1991;325(8):1290-4.
3. Blendon, RJ, et al. Views of practicing physicians and the public on medical errors. *N Engl J Med*. 2002;347:1933-1940.



DR. SCHWAM was previously the director of quality assurance for the emergency department at Sturdy Memorial Hospital in Attleboro, Mass., an attending physician at Rhode Island Hospital in Providence, R.I., and a clinical assistant professor of emergency medicine at the Warren Alpert Medical School of Brown University in Providence, R.I. He is now retired, but still lectures on clinical decision making and medical malpractice.



IT'S BEEN A TOUGH SEASON, BUT YOU'RE READY. IT'S TIME TO BE REVOLUTIONARY.

OCTOBER 9-12, 2023 | PHILADELPHIA, PA

CONNECT



With old friends and new.

EXPLORE



The city. The possibilities.

LEARN



How to do things differently.

REGISTER TODAY!

Save \$50 with promo code BELL



Approved for AMA PRA Category 1 Credit™



DR. MILNE is chief of emergency medicine and chief of staff at South Huron Hospital, Ontario, Canada. He is on the Best Evidence in Emergency Medicine faculty and is creator of the knowledge translation project the Skeptics' Guide to Emergency Medicine (www.TheSGEM.com).

Should You Etomidate Me?

Risk of mortality by using etomidate for induction remains uncertain



ILYASKA - STOCKADOBEL.COM

by KEN MILNE, MD

Case

A critically ill patient presents to the emergency department (ED) requiring an emergent, definitive airway. While preparing to perform the endotracheal intubation with video laryngoscopy, you remember a randomized controlled trial (RCT) recently suggesting etomidate could increase mortality if used as the induction agent.

Background

Etomidate has been a popular induction agent for critically ill patients for more than a decade. This is due to its being hemodynamically neutral and its fast onset of action. However, a 2012 systematic review and meta-analysis (SRMA) reported that etomidate was associated with adrenal insufficiency and increased mortality in septic patients.¹

There have been multiple randomized trials studying the effect of etomidate as an induction agent on adrenal function and mortality. These studies have reported mixed results—with some finding a statistically significant increase in mortality. A recent, single-center, randomized trial compared etomidate versus ketamine in adult patients requiring emergency endotracheal intubation.² The primary outcome was all-cause mortality at seven days and showed an eight percent absolute increase for patients allocated to the etomidate group. This outcome was no longer statistically different at 28 days. There were multiple issues with this trial including a lack of masking and potential selection bias.

A new SRMA was published in 2021 that reported an associated increase in adrenal suppression and mortality with etomidate. However, this review combined high-level studies (five randomized controlled trials)

with low-level studies (nine post hoc and 15 retrospective studies).³

Clinical Question

Will using etomidate as an induction agent in critically ill adult patients cause an increase in mortality?

Reference: Kotani, et al. Etomidate as an induction agent for endotracheal intubation in critically ill patients: A meta-analysis of randomized trials. *J Crit Care.* 2023;77:154317.

Population: Critically ill adult patients requiring emergency endotracheal intubation

- **Exclusions:** Pediatric patients less than or equal to 15 years old, etomidate as an infusion, non-randomized trials, systematic reviews, commentaries or editorials, literature reviews, studies not addressing the review question
- **Intervention:** Etomidate
- **Comparison:** Any other induction agent
- **Outcomes:**
 - » **Primary Outcome:** Mortality at the main time point defined by trial authors
 - » **Secondary Outcome:** Adrenal insufficiency

Authors' Conclusions

"This meta-analysis found a high probability that etomidate increases mortality when used as an induction agent in critically ill patients with a number needed to harm [NNH] of 31."

Results

Eleven randomized trials were included in this study (n=2,704 patients). Etomidate was compared in four studies to ketamine, in four studies to midazolam, in one study to thiopental, in one study to ketamine with midazolam, and in one study to ketamine with propofol.

Key Result

There is a high probability that etomidate increases mortality when used as an induction agent in critically ill patients.

- **Primary Outcome:** All-cause mortality
Etomidate increased mortality at the main timepoint defined by trial authors in 23 percent versus comparator 20 percent; NNH 31; risk ratio = 1.16 (95 percent confidence interval [CI], 1.01 to 1.33; *P*=0.03)
- **Secondary Outcome:** Adrenal insufficiency
Etomidate increased development of adrenal insufficiency in 21 percent versus comparator 10 percent; risk ratio=2.01 (95 percent CI, 1.59 to 2.56, *P*<0.001)

EBM Commentary

1. **Risk of Bias:** Five studies were graded as having a low risk of bias, five had some concerns, and one was graded high-risk. The majority (57 percent) of patients included in the trials were in open-label studies. Another 24 percent of the patients included in the SRMA came from a single-blinded trial. This large lack of masking could have introduced bias into the results, which increases the uncertainty of the results.
2. **Mortality Outcome:** There was a wide range of time points for all-cause mortality (24 hours to 30 days). The primary outcome for the SRMA was all-cause mortality at the main time point defined by the trial, which did demonstrate a statistically significant increase with etomidate use. However, if you include the secondary outcome of 28-day all-cause mortality data from the Matchett trial, which represented 30 percent of the SRMA data, the statistical dif-

ference is lost (RR, 1.07 [95 percent CI, 0.95 to 1.21]).

3. **Diversity of Patients:** These were patients from a variety of settings including out-of-hospital, ED, and intensive care unit. There was also a diversity of critically ill medical and surgical patients. Some patients had more cardiovascular morbidities than other patients. This might make the results more generalizable but could also mean that the results do not apply to the individual patient presenting to the emergency department.

Bottom Line

There remains uncertainty whether using etomidate as an induction agent increases mortality in critically ill adult ED patients requiring emergent endotracheal intubation.

Case Resolution

You decide to use ketamine as your induction agent in this case and successfully intubate the critically ill patient.

Thank you to Dr. Amber Gombash, who is an emergency physician in Concord, N.C., for her help with this article.

Remember to be skeptical of anything you learn, even if you heard it on the Skeptics' Guide to Emergency Medicine. ☛

References

1. Chan CM, et al. Etomidate is associated with mortality and adrenal insufficiency in sepsis: a meta-analysis. *Crit Care Med.* 2012;40(11):2945-53.
2. Matchett G, et al. Etomidate versus ketamine for emergency endotracheal intubation: a randomized clinical trial. *Intensive Care Med.* 2022;48(1):78-91.
3. Albert SG, Sitaula S. Etomidate, Adrenal insufficiency and mortality associated with severity of illness: A meta-analysis. *J Intensive Care Med.* 2021;36(10):1124-1129.

PROTECT YOUR
POT OF GOLD FROM
BAD ADVICE

THE END OF THE RAINBOW



DR. DAHLE blogs at www.whitecoatinvestor.com and is a best-selling author and podcaster. He is not a licensed financial adviser, accountant, or attorney and recommends you consult with your own advisers prior to acting on any information you read here.

The Simple Way to Build Wealth

Save for your future early and reap the rewards later

by JAMES M. DAHLE, MD, FACEP

Question

I am overwhelmed by all things financial. What is the simplest, most reliable way for me to have a secure retirement?

Answer

As much as I enjoy learning, talking, and writing about “all things financial,” I recognize that most doctors are not hobbyists when it comes to personal finance and investing. While this may be the best-paying hobby ever (especially when you consider that even a fairly priced financial advisor may be charging you up to \$10,000 per year), it is not required in order to achieve a well-deserved, financially secure, comfortable retirement after a career “in the pit.”

While there may be faster pathways to becoming wealthy, there is a very reliable method that does not require any entrepreneurial skills, excessive borrowing, risk taking, stock picking, cryptocurrency, or a second job in real estate. It *does* require a little bit of discipline applied over several decades, but so does showing up and taking care of whatever comes through the door 15 shifts a month throughout a career. Let me describe this method to you.

Save Your Money

The first requirement is to save money. You cannot invest money that you do not have and for most full-time physicians, there is no money other than what they earn taking care of patients. Carve out 20 percent of your gross income to invest for retirement. The average emergency physician makes about \$375,000 per year. Twenty percent of that is \$75,000. This is money that you cannot spend if you want to have a secure retirement. Pay yourself first by carving this money off the top and putting it away for retirement.

Protected Retirement Accounts

Ideally, you will be able to protect most or all of this money from the tax man and any potential creditors using tax- and asset-protected retirement accounts such as 401(k)s, 403(b)s, 457(b)s, profit-sharing plans, cash balance plans, individual 401(k)s, and Roth IRAs (usually funded via the “backdoor” method). Your investments grow faster when you do not have to pay taxes on the earnings each year. If you run out of retirement account space before you get to 20 percent, then contribute the rest to a regular, non-qualified, taxable, brokerage account.

Index Funds

Once you have the money, you need to invest it. Investing is actually the simplest part of personal finance. It turns out that the vast majority of what is happening on Wall Street does not add value to your nest egg. Your goal as a long-term investor is to invest for the long term, so you do not need to pay attention to



the “hot money managers,” the latest tech stock, or really any financial news at all. You can simply buy all the stocks and bonds using dirt cheap, broadly diversified, index funds. You will be guaranteed the market return. By accepting average returns, in the long run you will outperform 80 to 90 percent of investors. Any reasonable mix of a handful of index funds will do. One simple combination might be 50 percent of your money in a U.S. stock index fund, 30 percent in an international stock index fund, and 20 percent in a U.S. bond index fund. Maintaining these ratios is done by directing new investments at whichever asset class (type of investment) has underperformed over the previous few months or years. This “rebalancing” helps maintain the same portfolio risk level over time.

So far, so good. You’re saving 20 percent of your earnings, preferentially putting it into retirement accounts, and investing it into index funds. This can be set up to happen automatically, but even if you’re doing it manually, it takes just a few minutes a month to maintain

an investing plan. It seems very simple, but over time produces powerful results through the miracle of compound interest.

Compound Interest

While there are no guarantees about future returns and there is wild variability in the returns of stocks and bonds in any given year, over decades all that variability more or less evens out. A reasonably conservative assumption would be that your investments would earn eight percent before inflation and perhaps five percent after inflation over decades. If you start upon graduating residency at 30 and work and save until you retire at 60, that \$75,000 per year would grow to be about \$5 million, in today’s dollars. (In reality, by saving 20 percent of a gradually increasing income, you would likely end up with more than \$10 million, but it would only purchase as much as \$5 million does today).

\$5 million allows a retiree to safely spend about \$200,000 per year in retirement. Adding Social Security to that (and yes, Social Security

will still be there for you in some form) will allow you to maintain a similar lifestyle to what you enjoyed during your career. Keep in mind a net worth of greater than \$5 million will put you into the top 10 percent of physicians. Despite the simplicity of this plan, most doctors are not doing this due to ignorance, lack of financial discipline, or misfortune.

Final Best Practices

While saving up a retirement nest egg is the greatest financial task of your life, it does not need to be overly complicated. You need enough discipline to start early, to save 20 percent of your gross income for retirement, and to leave your investments alone when markets seem destined to implode, but you don’t need to have any sort of specialized knowledge or put in an inordinate amount of time or effort. You can focus on your patients, your family, and your own wellness and enjoy a wonderful career in emergency medicine. You can have your cake and eat it too. 🍪

BE A MEDICAL
DETECTIVE—
BONE UP ON YOUR
FORENSIC SKILLS

FORENSIC FACTS

DR. ROZZI is an emergency physician, director of the Forensic Examiner Team at WellSpan York Hospital in York, Pennsylvania, and chair of the Forensic Section of ACEP.

DR. RIVIELLO is chair and professor of emergency medicine at the University of Texas Health Science Center at San Antonio.

Do I Need to Call the Police?




How to manage
your duties
both legally and
medically

by RALPH J. RIVIELLO, MD, MS, FACEP,
AND HEATHER V. ROZZI, MD, FACEP

Case

A 16-year-old female presents to the emergency department (ED) after being sexually assaulted by two males at a party at her friend's house. She denies any complaints or injuries. She is asking for an exam, as well as medications to avoid pregnancy and diseases. She refuses to allow her parents or the police to be notified. What do you do?

CONTINUED on page 20





ACEP HAS A NEW APP!

Access some of the most popular ACEP web features even without the best connection -

- Clinical Policies
- News
- Reimbursement FAQs
- Advocacy Alerts

Log in to access even more features!

More features added regularly. Simply visit your preferred app store and search for "ACEP" to install!



American College of Emergency Physicians
ADVANCING EMERGENCY CARE

Act Now: Safety from Workplace Violence

Contact Your Senators: Medicare Payment Cuts

Join Us For Unconventional ACEP22 - Nov. 2-4

Featured

What happens when the system is broken?

Get New Scope of Practice Resolutions

Bookmarks

EM Workforce Section Town Hall - April 30, 2022

Value based Care in Emergency Medicine—an Overview

President Biden Releases Initial Fiscal Year 2022 Budget Proposal: Will Congress listen?

Biden Administration Releases Drug Policy Priorities: What's the Potential Impact on Emergency Care?


Acute Heart Failure Syndromes

Community-Acquired Pneumonia

Opiside

Headache


Non-ST-Elevation Acute Coronary Syndrome




Meet Your State CME Requirements With NEW, On-Demand Course Bundles

Learn the latest about some of the most common, yet most difficult presentations you will experience.


Trusted EM experts teach more than 20 courses in each comprehensive bundle on:




Cardio



Neuro



Trauma



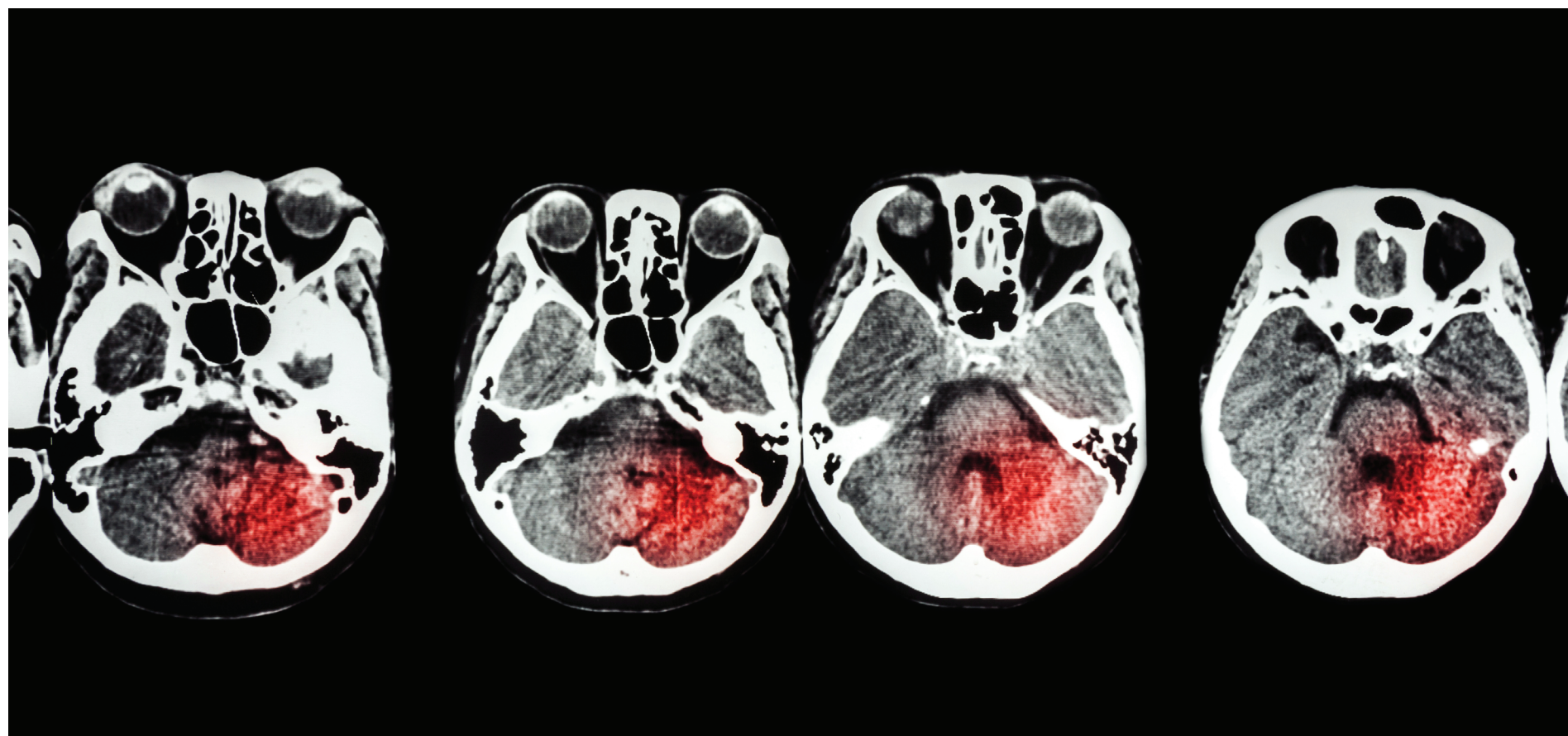
PURCHASE TODAY!

acep.org/OLC-bundles

Approved for AMA PRA Category 1 Credit™

PEARLS FROM THE
MEDICAL LITERATURE

DR. RADECKI is an emergency physician and informatician with Christchurch Hospital in Christchurch, New Zealand. He is the Annals of Emergency Medicine podcast co-host and Journal Club editor and can be found on Twitter @emlitofnote.



Gradually Circling Around “Reasonable Practice”

Guidelines for the GRACE project

by RYAN RADECKI, MD, MS

There is no shortage of guidelines, protocols, or quality measures across emergency medicine. Regardless of the domain, somewhere an expert panel has convened to issue a pronouncement informing all of the ideal care of patients under their specialty umbrella, indirectly extending to their care in the emergency department. A common limitation

to many of these guidelines, however, is the lack of recognition of available resources or the unique challenges of certain patient groups. In an environment in which patients may have their entire work-up in the waiting room, or attend a critical access hospital staffed by non-emergency physicians,

or lack the financial support to follow up with an appropriate specialist, a pragmatic approach to care is required.

This real-world pragmatism is the guiding principle embodied by the Guidelines for Reasonable and Appropriate Care in the Emergency Department (GRACE) project, published by the Society for Academic Emergency Medicine. Rather than focus on the narrow evidence supporting recommendations for a precisely diagnosed clinical syndrome, these guidelines try to create an expert consensus for the approach, as stated on their website, “to the care of the most common chief complaints that can be seen on the tracking board of any emergency department in the country.”¹

To date, there have been three GRACE publications. The first describes approaches to chest pain, the second, abdominal pain, and the more recent third, vertigo.²⁻⁴ A fourth is planned

for publication in late 2023, and will address non-opioid substance dependence. Each of these chooses a set of practice-based questions and applies the grading of recommendations assessment development and evaluation (GRADE) methodology, a framework for rating the quality of the best available evidence and developing clinical practice recommendations.

The first, GRACE-1, addresses adult patients with “recurrent, low-risk chest pain,” a patient population commonly encountered in emergency departments. The specific recommendations from this publication have already been covered in a prior issue by Lauren Westafer, DO, MPH, MS, with an overview of the mixed-strength clinical guidance across the spectrum of chest-pain representations.⁵ An important theme, however, begins to emerge regarding how little evidence directly informs a substantial fraction of clinical practice, and the extent to which we rely on indirect generalization.

The second, GRACE-2, addresses adult patients with “low-risk, recurrent abdominal pain” in the emergency department. While “low-risk” chest pain is more easily described using scoring systems, undifferentiated abdominal pain is less well-defined. In this instance, the authors describe a population based in sensible clinical judgement, including an absence of trauma, recent abdominal surgery, cancer, and concerning physical findings.

However, unlike with chest pain, there are far fewer industry partners performing research tied to marketing new imaging technology or diagnostic assays. The net result is an even more disappointing spectrum of recommendations than in GRACE-1. For example, addressing the common question regarding the necessity of repeat CT scanning in this “low-risk” population, the authors could not find any relevant evidence, and were therefore unable to formulate any recommendation regarding imaging avoidance on a subsequent visit. The authors did make

conditional recommendations based on “very low certainty of evidence” regarding avoidance of ultrasound following a normal CT scan, and, as in recurrent chest pain, consideration of depression or anxiety screening for patients with intractable recidivism. In spite of lack of evidence, the authors make a very reasonable recommendation of good clinical practice to avoid treating with opiates when feasible.

The third, GRACE-3, garnered a greater measure of controversy. These guidelines address the approach to acute dizziness and vertigo in the ED; they diverge from the preceding two guidelines. The most striking difference is the number of recommendations, 14, published along with several bespoke, companion, systematic reviews informing the recommendations. GRACE-3 also includes substantially more educational content relevant to the approach to acute dizziness in the ED, breaking down the important diagnoses and their clinical features. There is, finally, dramatically better evidence informing these guidelines, with several recommendations carrying “high certainty of evidence.”

Those recommendations with “high certainty” pertain primarily to the use of advanced imaging in the diagnostic approach to acute dizziness. Importantly, these authors strongly recommend *against* the use of either non-contrast CT or CT angiography of the brain to distinguish between a central or peripheral cause for dizziness. Due to its wide availability and accessibility in most EDs, the allure of ordering a CT in the context of possible intracerebral pathology runs high. However, fewer than one percent of patients with dizziness will have a cause identified on CT, virtually all of whom have additional neurologic findings. The consideration to use CT for exclusion of intracranial hemorrhage is noted to be unfounded, as pa-

CONTINUED on page 21

Discussion

The answer to that question varies with your practice location. Federal and state laws dictate what actions you will take in this scenario. The key to answering this question, no matter where you are, is to engage your hospital attorney or risk manager. They are very familiar with the laws in play in these scenarios and can easily work with you throughout the process.

First, the federal Violence Against Women Act (VAWA), 42 USC.A § 3796gg-4(d)(1) (2005), allows for sexual assault survivors to undergo medical forensic examination without reporting to law enforcement and at no cost to them. VAWA specifies which components must be included in the exam for free. Failure to follow these forensic compliance provisions of VAWA can result in loss of funding for your state. Sexual assault nurse examiners (SANE nurses) are very familiar with the options available to patients regarding reporting to law enforcement and evidence collection. They should be consulted to assist in the discussion with the patient.

Reporting to Law Enforcement

The first decision is whether your state requires you to report sexual violence to law enforcement. Some states mandate that certain crimes, including rape and sexual assault, must be reported to law enforcement

KEY POINTS

- Care of sexual-assault patients is governed by federal and state laws.
- The hospital's risk manager or attorney should be involved in cases whenever there is confusion over what can or cannot be done.
- In most states, minors have limited rights to consent for health care.
- Mandated reporting laws may require reporting in minors under the age of sexual consent in your state.

regardless of the wishes of the patient. If you must report, you can tell the patient that, “by law I must report to law enforcement that you are here because of a sexual assault, however, you are under no obligation to talk to them and can tell them you do not wish to speak to them.”¹

Age of Patient

The next consideration is the age of consent in your state. If the patient is under the age of consent, you may be a mandated reporter. Therefore, you may be obligated to report the assault both to law enforcement and to child protective services. Even if the patient is above the age of consent, as a mandated reporter you may need to still notify authorities in cases where the perpetrator is a parent,

guardian, family member, coach, teacher, or someone who may have regular contact with the patient. Once again, you should inform the patient of your duty, under the law, to report the assault to law enforcement and child protective services.

Consent for Care

The final consideration in this case is the patient’s ability to provide consent for care. Usually, the teenaged patient needs parental consent to seek care in the ED unless it falls under the emergency-consent exception. The exception is based on the premise that a reasonable person would not want to be denied necessary medical care because they were too incapacitated to consent to the treatment. This usually applies to potentially life-

or limb-threatening conditions. Many states specifically authorize minors to consent to contraceptive services, testing and treatment for human immunodeficiency virus and other sexually transmitted diseases, prenatal care and delivery services, treatment for alcohol and drug abuse, and outpatient mental health care, without parental involvement or consent. Each state has different nuances within these categories and legal consultation can be crucial in the ED when dealing with these issues.

Case Resolution

You place a call to your on-call hospital lawyer. The state does not require mandatory reporting of sexual violence, and the age of consent is 16 years of age. In addition, the ages of the perpetrators do not fall under the mandated-reporter statute. The SANE nurse is consulted, and she is able to discuss the reporting options available; the patient chooses to do an anonymous report with evidence collection. Lastly, because she is seeking care around a sexual health/sexually transmitted infection issue, you are able to treat her without parental consent. 📌

Reference

1. Bailey C, et al. Mandatory reporting and adolescent sexual assault. *Trauma, Violence, & Abuse*. 2023;24(2):454-467.



Badge of Honor


Now more than ever, the FACEP distinction allows you to show your pride and commitment to EM as you wear this badge of honor for your specialty.

Find out if you are eligible
Apply Now!


acep.org/facep

Livia Santiago-Rosado, MD, FACEP, FAAEM
Poughkeepsie, NY







YOUR DUES DOLLARS AT WORK




Thanks to ACEP member dues, ACEP is the only EM organization with a seat on the RUC, the highly influential group that makes recommendations to the federal government on how physicians are paid.




This year alone, ACEP prevented proposed reductions in the relative value units (RVUs) assigned to the ED Evaluation and Management (E/M) codes.



So what does that mean? ACEP's work prevented a **\$30 MILLION DOLLAR LOSS** for just Medicare patients treated with code 99284. When you factor in all patient visits using this code, the prevented loss is even greater!




Still unsure how that translates to your wallet? This alone keeps around **\$800** in every emergency physician's pocket - more than the cost of national ACEP annual dues!



ACEP TELLS FEDS ABOUT EPS BILLING DISPUTE ISSUES

ACEP sat down with federal officials to discuss issues related to the federal dispute resolution process under the No Surprises Act and explained the unique aspects of emergency care and billing. We offered specific improvements to address issues ACEP members experience at every phase of the current IDR process.



FIGHT AGAINST NON-COMPETE CLAUSES

ACEP is amplifying concerns and opposition to non-compete clauses, which limit the right of emergency physicians to freely practice medicine in their communities. Share your stories of how these predatory clauses have impacted you.

[Learn more at acep.org/acep4u](http://acep.org/acep4u)

PUTTING
RESEARCH TO
WORK FOR YOU

PRACTICE CHANGERS



DR. WESTAFER (@Lwestafer) is an attending physician and research fellow at Baystate Medical Center, clinical instructor at the University of Massachusetts Medical School in Worcester, and co-host of FOAMcast.

When the Potassium is Poppin'

Just a spoonful of insulin makes the potassium go down

by LAUREN WESTAFER, DO, MPH, MS

More is not always better. This is notably true when it comes to the treatment of acute hyperkalemia. Emergent treatment of acute hyperkalemia is bread-and-butter emergency medicine. Many of us have order sets that simplify care: maybe calcium, an insulin shifter or two (intravenous [IV] insulin and/or inhaled beta-agonist), coupled with perhaps a diuretic and/or a potassium binder. Intravenous insulin shifts potassium into cells, thereby lowering serum potassium within an hour of administration. Despite the routine nature of hyperkalemia treatment, adverse events from IV insulin are common and largely attributable to over-treatment.

A Common Case

Hypoglycemia following insulin administration for hyperkalemia is common, occurring in approximately one in six patients (about 17 percent).^{1,2} Some groups are particularly at risk, especially those with renal insufficiency and those who have normal serum glucose levels. One other critical predictor of hypoglycemia is the dose of insulin administered. A meta-analysis found that reduced-dose insulin (either five units or 0.1 unit/kg) was associated with nearly half the odds of hypoglycemia when compared with 10 units of insulin (odds ratio [OR], 0.55; 95 percent CI, 0.43 to 0.69).³ This effect was magnified when restricted to severe hypoglycemia (OR, 0.41; 95% CI, 0.27 to 0.64).³ More insulin equals more hypoglycemia. The critical question is—does a reduced dose of insulin lower potassium as much as a 10-unit dose?

It appears that IV insulin doses between five and 10 units result in roughly similar reductions in serum potassium (somewhere between 0.5 and one mmol/L). A meta-analysis comparing studies using a whopping 20 units of IV insulin over 30 minutes to a 10-unit insulin bolus found no significant difference



between dosing strategies; all reduced serum potassium between 0.5 and 1.14 mmol/L.⁴ Larger observational studies have confirmed these results and extended the findings to even lower doses of IV insulin. The majority of studies examining reduced-dose insulin for hyperkalemia have found no significant difference in potassium reduction compared with 10 units of IV insulin (mean difference, -0.02; 95 percent CI, -0.11 to 0.07). Two studies have touted a “significant” difference between a five-unit strategy and a 10-unit strategy with regard to potassium reduction.^{5,6} However, the difference between strategies was 0.17 to 0.27 mmol/L, which is unlikely to be clinically significant, especially as most patients returned to near-normal potassium levels. In fact, a consensus statement, Kidney Disease: Improving Global Outcomes on the emergency-department management of acute hyper-

kalemia, embraces the five-unit strategy.⁷

Monitoring Strategies

Of course, additional strategies exist to prevent and recognize hypoglycemia. Patients should have frequent blood glucose monitoring for four to six hours and patients with a serum glucose less than 140 mg/dL should receive dextrose. However, in busy emergency departments crowded with dozens of inpatient boarders, the safest and least systemically taxing dose of intravenous insulin is a dose of five units (or 0.1 unit/kg) unless there is a compelling reason for a higher dose, where a potential reduction of zero to 0.3 mmol/L would likely translate into patient benefit. +

References

1. Scott NL, et al. Hypoglycemia as a complication of intravenous insulin to treat hyperkalemia

in the emergency department. *Am J Emerg Med.* 2019;37(2):209-213.

2. Chothia MY, et al. Hypoglycaemia due to insulin therapy for the management of hyperkalaemia in hospitalised adults: A scoping review. *PLoS One.* 2022;17(5):e0268395.
3. Moussavi K, et al. Reduced alternative insulin dosing in hyperkalemia: A meta-analysis of effects on hypoglycemia and potassium reduction. *Pharmacotherapy.* 2021;41(7):598-607.
4. Harel Z, Kamel KS. Optimal dose and method of administration of intravenous insulin in the management of emergency hyperkalemia: A systematic review. *PLoS One.* 2016;11(5):e0154963.
5. Finder SN, et al. 5 versus 10 units of intravenous insulin for hyperkalemia in patients with moderate renal dysfunction. *J Emerg Med.* 2022;62(3):298-305.
6. Moussavi K, et al. Comparison of IV insulin dosing strategies for hyperkalemia in the emergency department. *Crit Care Explor.* 2020;2(4):e0092.
7. Lindner G, et al. Acute hyperkalemia in the emergency department: a summary from a Kidney Disease: Improving Global Outcomes conference. *Eur J Emerg Med.* 2020;27(5):329-337.

PEARLS | CONTINUED FROM PAGE 19

tients with intracranial hemorrhage do not typically present with complaints of isolated vertigo or dizziness.

Many of the other recommendations, however, are enmeshed with the primary controversial issue in this guideline. The core element of the guideline is promotion of the head impulse, nystagmus, and test of skew (HINTS) examination. There is high certainty of evidence that clinicians trained in the HINTS examination are able to distinguish between central and peripheral causes of dizziness. Unfortunately, the training element is key, as there is ample evidence that clinicians who have not undertaken any special training are not able to apply HINTS cor-

rectly. Therefore, the authors of GRACE-3 call for wide training of the EM workforce in the use of HINTS.

The implication of such a call is magnified by the scope of the training. In the studies in which clinicians accurately applied the HINTS examination, the training consisted of an initial six hours of lectures and workshops which was repeated seven months later. It is costly to ask the entire emergency-medicine workforce to undergo specialized training with an in-person workshop, let alone a second, follow-up episode. There is no evidence yet whether other training frameworks are adequate, nor is there evidence to inform the frequency or intensity with which HINTS skills require re-

inforcement. Absent an easier path forward for upskilling the workforce, the reliance of GRACE-3 on HINTS to inform its practice recommendations limits its present real-world application.

These are just the initial pieces of work under the banner of attempting to inform “reasonable” care in the emergency department. The most striking aspect of most of this work is how little evidence directly informs the sorts of decisions facing clinicians every day. Having identified these gaps provides a road map for future research, and one hopes some of these questions can be revisited in the future with more robust recommendations. +

References

1. Society for Academic Emergency Medicine. About SAEM. SAEM website. <https://www.saem.org/publications/grace>. Accessed July 14, 2023.
2. Musey PI, et al. Guidelines for reasonable and appropriate care in the emergency department (GRACE): Recurrent, low-risk chest pain in the emergency department. *Acad Emerg Med.* 2021;28(7):718-744.
3. Broder JS, et al. Guidelines for reasonable and appropriate care in the emergency department 2 (GRACE-2): Low-risk, recurrent abdominal pain in the emergency department. *Academic Emergency Medicine.* 2022;29(5):526-560.
4. Edlow JA, et al. Guidelines for reasonable and appropriate care in the emergency department 3 (GRACE-3): Acute dizziness and vertigo in the emergency department. *Academic Emergency Medicine.* 2023;30(5):442-486.
5. Westafer, L. New guidelines aim to help the evaluation of chest pain. *ACEP Now.* 2021;40(9):17.

Answer

The correct answer is **peritonsillar abscess (b)**. Peritonsillar abscess, also known as quinsy, is a deep neck space infection characterized by a collection of pus in the peritonsillar space. This infection develops as a suppurative complication of acute tonsillitis or pharyngitis. As with other deep neck space infections, peritonsillar abscesses are frequently polymicrobial in nature and consist of mouth flora. Some important pathogens to consider when choosing empiric antibiotics include Group A *Streptococcus*, *Staphylococcus aureus*, *Haemophilus*, and *Fusobacterium*. Patients present with a muffled voice, fever, sore throat, and dysphagia. There is deviation of the uvula to the unaffected side. Trismus and otalgia may be present. This infection usually affects young adults, but all ages can be affected. Older adults may have subtle symptoms. Laboratory findings include leukocytosis. Treatment consists of antibiotic therapy and may require surgical drainage. Complications of this infection include airway obstruction or extension of the infection into contiguous spaces in the neck.

MEMBER BENEFIT: All ACEP members receive a 20 percent discount on VisualDX ([acep.org/visualDX](https://www.acep.org/visualdx)). 📍

Reference

1. Mendoza N, Prasad P. Peritonsillar abscess. VisualDx website. <https://www.visualdx.com/visualdx/diagnosis/?moduleid=101&diagnosisid=50514>. Updated January 18, 2021. Accessed July 15, 2023.



CLASSIFIEDS

Baylor
College of
Medicine

HENRY J.N. TAUB
DEPARTMENT OF
EMERGENCY
MEDICINE

The Henry JN Taub Department of Emergency Medicine at Baylor College of Medicine seeks a **Vice Chair of Research** to oversee research operations for the department.

Baylor College of Medicine (www.bcm.edu) is recognized as one of the nation's premier academic health science centers and is known for excellence in education, research, healthcare and community service. Located in the heart of the world's largest medical center ([Texas Medical Center](#)), Baylor is affiliated with multiple educational, healthcare and research affiliates ([Baylor Affiliates](#)).

Salary, rank, and tenure status are contingent upon candidate qualifications. The rank and tenure status awarded will be based upon qualifications in alignment with Baylor College of Medicine's promotion and tenure policy.

Qualified applicants are expected to have a research record with significant extramural funding and leadership skills to develop a strong multidisciplinary collaborative Emergency Medicine research program and continue to grow current departmental research efforts. In addition to the above responsibilities, other duties may be assigned by the Chair.

Please include a cover letter and current curriculum vitae to your application.

This position is open until filled. For more information about the position, please contact Dick Kuo, MD via email [dckuo@bcm.edu].

MINIMUM REQUIREMENTS Education: M.D. degree or equivalent
Experience: Research Fellowship not required for application
Licensure: Must be currently boarded in Emergency Medicine and eligible for licensure in state of Texas.

Baylor
College of
Medicine

HENRY J.N. TAUB
DEPARTMENT OF
EMERGENCY
MEDICINE

**Ultrasound and Academic Faculty
Openings**

The Henry JN Taub Department of Emergency Medicine at Baylor College of Medicine (BCM) is looking for **Faculty of all levels** who are interested in a career in Academic Emergency Medicine. Our Ultrasound team is currently seeking an **Assistant Director of US** to support current educational, clinical, and research elements of the program while and creating growth opportunities in our department. We are also hiring faculty of all ranks and seeking applicants who have demonstrated a strong interest and background in a variety of areas such as research, simulation, or administration. Clinical opportunities are available at our affiliated hospitals.

Baylor College of Medicine is located in the world's largest medical center in Houston, Texas. The Henry JN Taub Department of Emergency Medicine was established in Jan 2017. Our residency program, which started in 2010, has grown to 16 residents per year in a 3-year format. We offer a highly competitive academic salary and benefits commensurate to academic level and experience.

Our department features clinical practices at [Baylor St. Luke's Medical Center](#), [Ben Taub General Hospital](#), and [Texas Children's Hospital](#). Baylor St. Luke's Medical Center is a quaternary referral center with high acuity patients and is home to the Texas Heart Institute and multiple transplant programs. Ben Taub General Hospital is a public hospital with nearly 80,000 annual emergency visits each year and certified stroke, STEMI, and Level 1 trauma programs. Texas Children's Hospital is consistently ranked as one of the nation's best, largest, and most comprehensive specialty care pediatric hospitals. These affiliations, along with the medical school's preeminence in education and research, help to create one of the strongest Emergency Medicine experiences in the country.

MINIMUM REQUIREMENTS

Education: M.D. degree or equivalent
Experience: Previous experience in an academic area of expertise strongly preferred but not required
Licensure: Must be currently boarded or board eligible in Emergency Medicine and eligible for licensure in state of Texas.

Those interested in a position or further information may contact [Dr. Dick Kuo](#) via email at dckuo@bcm.edu. Please send a CV and cover letter with your past experience and interests.

HAVE AN IDEA?

Submit your article or story pitch to *ACEP Now*

If you have a story idea or drafted article, contact Editor Danielle Galian or Medical Editor in Chief Cedric Dark, MD, MPH, FACEP. Our editorial team will review your submission and update you on next steps. Include 250 words with bullet points if you're submitting a story pitch with the following:

- Why our readers would value the story.
- Potential experts or sources for the story.

- How the story would influence the provision of emergency medicine.
- What you hope the reader would learn from your article.

The usual length of standard articles (departments, columns, one- to two-page articles) is about 600 to 800 words. The usual length of feature articles (two or more pages) is about 800 to 1,200 words. A reference list is also required for researched material.

Submit a Case Report

To be considered for publication, send an outline of your case presentation to Medical Editor in Chief Cedric Dark, MD, MPH, FACEP with the following:

- 250-word description that explains the presentation and final diagnosis.
- Three bulleted teaching points.
- 800 word maximum.
- 10 reference maximum.

Cases with clinical images preferred.

Submit a Letter to the Editor

ACEP Now welcomes letters to the editor. Letters should be 250 words or less, may be edited for length and style, and are published online

and/or in print at the editorial team's discretion. Submit your letter including your name, title, organization, and contact information to Editor Danielle Galian.

Interested in Writing for *ACEP Now*?

ACEP Now welcomes guest columns by physician writers. Send us an email to discuss opportunities. ✉



CLASSIFIEDS

ACEP Now
The Official Voice of Emergency Medicine

CLASSIFIED ADVERTISING

ACEP Now has the largest circulation among emergency medicine specialty print publications with nearly 40,000 BPA-Audited subscribers including about 32,000 ACEP members.

**TO PLACE AN AD
IN ACEP NOW'S
CLASSIFIED
ADVERTISING SECTION
PLEASE CONTACT:**

Kelly Miller
kmiller@mrsvica.com
(856) 768-9360



Penn State Health Emergency Medicine

About Us:

Penn State Health is a multi-hospital health system serving patients and communities across central Pennsylvania. We are the only medical facility in Pennsylvania to be accredited as a Level I pediatric trauma center and Level I adult trauma center. The system includes Penn State Health Milton S. Hershey Medical Center, Penn State Health Children's Hospital, and Penn State Cancer Institute based in Hershey, Pa.; Penn State Health Hampden Medical Center in Enola, Pa.; Penn State Health Holy Spirit Medical Center in Camp Hill, Pa.; Penn State Health St. Joseph Medical Center in Reading, Pa.; Penn State Health Lancaster Pediatric Center in Lancaster, Pa.; Penn State Health Lancaster Medical Center (opening fall 2022); and more than 3,000 physicians and direct care providers at more than 126 outpatient practices in 94 locations. Additionally, the system jointly operates various health care providers, including Penn State Health Rehabilitation Hospital, Hershey Outpatient Surgery Center, Hershey Endoscopy Center, Horizon Home Healthcare and the Pennsylvania Psychiatric Institute.

We foster a collaborative environment rich with diversity, share a passion for patient care, and have a space for those who share our spark of innovative research interests. Our health system is expanding and we have opportunities in both academic hospital as well community hospital settings.

Benefit highlights include:

- Competitive salary with sign-on bonus
- Comprehensive benefits and retirement package
- Relocation assistance & CME allowance
- Attractive neighborhoods in scenic central Pa.



PennState Health

FOR MORE INFORMATION PLEASE CONTACT:
Heather Peffley, PHR CPRP - Penn State Health Lead Physician Recruiter
hpeffley@pennstatehealth.psu.edu

Penn State Health is fundamentally committed to the diversity of our faculty and staff. We believe diversity is unapologetically expressing itself through every person's perspectives and lived experiences. We are an equal opportunity and affirmative action employer. All qualified applicants will receive consideration for employment without regard to age, color, disability, gender identity or expression, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, and family medical or genetic information.



**At USACS, our
malpractice claims
are less than half
the national average.**



John Bedolla, MD

EM Residency: Mount Sinai West/
The Roosevelt Hospital
National Director of Risk

John Bedolla MD, FACEP
Director of Risk



More about USACS Risk Management:

- Dr. Bedolla supports his USACS colleagues with innovative, evidence-based clinical management tools.
- If you want a second opinion, a seasoned colleague is just a phone call away with our Failsafe Program.
- USACS even owns its own medical malpractice insurance, so **WE DECIDE TOGETHER** how to handle a case.



**EM CAREERS
NATIONWIDE**



**US Acute Care
Solutions**

All full-time physicians are provided:

Company stock ownership | 10% company-funded 401(k) | 24/7 on-shift clinical support
Great locations nationwide | The best health and wellness benefits | A mission that has real meaning

Learn more at: **usacs.com**