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 evaluation and management.4

Mindfulness for the EM Doc

Three simple and quick ways to practice mindfulness before, during, and after shift

by ALEX KOO, MD

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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. JACEP’s international, open access, peer-reviewed, online journal has received its first calculated Impact Factor of 2.3. This ranks the journal 21st in the emergency medicine subject category (62 and 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, peer-reviewed research, clinical reports, opinions, and educational information related to emergency medicine in an open access format. Learn more at www.jaceopen.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/barding/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/corporatization/SFR.

In July, ACEP and the Emergency Department Practice Management Association (EDP-MA) 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-HelpLetter.

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 Naumheim, 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 Hedaya, MD, FACEP
- Sara Kryzanowski, MD, FACEP
- Catherine Marco, MD, FACEP
- Nicole McCoil, MD, FACEP
- Kaushal Shah, MD, FACEP
- Craig Smollin, MD

National Emergency Medicine Junior Faculty Teaching Award:
- Lean Alibajehd, MD, MBBS, MHA, FACEP
- Lauren Page Black, MD
- Guy Carmelli, MD, FACEP
- Nida Degensy, MD, FACEP
- Daniel Eraso, MD
- Meiers Gallegos, MD
- Shayne Ge, MD, FACEP
- Matthew Heimann, MD, FACEP
- Kyle Martin, DO, FACEP
- Kelly Mayo, MD
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.

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
  Virtue 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
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- Neurological Emergencies in the Child
- Pediatric Toxicologic Emergencies
- Plus 6 Faculty Panels

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.

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EMERGENCY IMAGE QUIZ with VISUAL DX

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

a. Diphtheria  
b. Peritonsillar abscess  
c. Retropharyngeal abscess  
d. Uvulitis  

ANSWER: Diphtheria
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 interested in 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 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 “true” 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

Re: “How to Avoid Missing an Aortic Dissection”

In a recent article, the authors have provided a thoughtful review of aortic dissection (AAD) cases while promoting the aortic dissection detection tool (ADDT) to improve the ED diagnosis of these patients. Unfortunately, the ADDT was not constructed using appropriate methodology for creating clinical decision rules (CDRs) and should not be relied upon.1 The ADDT was derived by cardiologists via a consensus and retrospectively tested on patients entered into an AED registry.2,3 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 AAD, and no comparison of this rule to clinical judgment. A prior meta-analysis of the ADDT included eight retrospective chart reviews and one prospective study with no study being required, no study following STROBE guidelines with comprised populations already suspected of having AAD, and most patients already selected to undergo advanced aorta imaging (CT or transesophageal echocardiography).1

Importantly, flaws in patient selection and data collection within these studies would tend to over inflate the sensitivity of the ADDT and under-inflating the specificity of AADT potentially missing AAD cases scoring as low or interrater missing. Looking at individual ADDT features, trained emergency physicians are already aware of classic AAD 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), and 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 CDAD). Whether the ADDT might be useful to remind physicians of selected known risk factors for AAD, current studies only show this to be a potential predictor in those already suspected of having AAD. It is unknown if this score (with/without D-dimer) can accurately predict AAD in a general ED population that includes patients not initially suspected of AAD. As such, this score cannot and should not be promoted as a proven predictor of AAD in the general ED population of patients with chest pain, back pain, syncope, weakness, or the multitude of other potential presentations.

References

—Steven G. Rothrock MD, FACEP, FAAFP

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 waterfall-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 opening red figs. Figs were called “the king of fruits” with many variates 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-Shibab, ruler of Deir-el-Qamar and the Emir 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 demarcation? The rest of the story will be for another day.

—Rashid Baddoura, MD, FACEP, FACP
MEET THE PRESIDENT-ELECT AND COUNCIL OFFICER CANDIDATES

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

Many have focused on 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

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

Assistant 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 to day’s advances 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 putting a patient at the center of every decision. These are goals I hope to see advanced as we navigate the future of emergency medicine.

CONTINUED ON PAGE 8
Hidradenitis suppurativa 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.2,3 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

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, supervision, 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, CODR 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 department personnel 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 (2007)
Response
The workforce study shook the foundation of emergency medicine (EM). After decades of assuming 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 we now see 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 guard against 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 FDG, I continue to push towards more physician coverage with selective NP 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.
As Vice Speaker, when conflict arises it is important to anticipate the conflict and determine whether it is based on an misinterpretation of the background material in order to help frame the debate and allow for an educational experience to help frame the arguments ahead of time all help us arrive at our annual Council meeting at “first-and-goal” rather than “fair-caught at the 50,” or (to further torture this analogy) it’s like arriving at Council as an SEC football team rather than (fill in your team here) __________. --- Roll Tide --- crouch. 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, OK; attending physician, Heart of Mary Hospital, Urbana, Illinois

Internships and Residency: Emergency medicine residency, Stony Brook University Medical Center, Stony Brook, NY; Internal Medicine residency, MD, University of Illinois, Champaign-Urbana (2011)

Response

The Speaker and Vice 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.

As the Council floor can be a challenging place to work for the goals of a resolution, thefield too can be a difficult place to resolve conflict. Fostering relationships with individual board members and having 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 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 councilors to bring up concerns, discussion points and proposed solutions. I recognize that to be your voice I also must work 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 ensure that the Board is aware of the intent and will of the Council.

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 that 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, OH; Medical Degree: MD, Medical College of Ohio at Toledo (2006)

Response

The Council Officers actively participate in ACEP Board Meetings to ensure that the Council’s will and voice are represented. Similarly, the Board attendees and listens to Council debate to understand each resolution’s intent along with the tone 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 focusing 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 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 numerous faculty. Additionally, I helped arrange free access for the residents to the College’s educational materials during the unexpected transition. Through this difficult time, I made sure all sides were heard to build consensus within our Board while continuing to serve our members.

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

Response

Council Officers 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 excitement 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 numerous issues that may result from the difference 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 conclusion, 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 its best interests and attempt to meet those needs 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 intimidating 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 the Republic desires a democracy, for the administration is in the hands of the many and not of the few.” —Pericles, Athenian General and Statesman.

The Official Voice of Emergency Medicine

August 2023

ACEPNOW.COM
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 Mummers 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.

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 Mummers 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?
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

“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 restaur- ant, any Schulson restaurant.”
—Mark Zwanger, MD, FACEP

**TOP CHEESESTEAK SPOT?**

“Steve’s Prince of Steaks in the Reading Terminal Mar- ket. 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, Paesan’s on Passyunk has really interesting and delicious sand- witches.”
—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.”
—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 Termin- ni Brothers bakery for dessert, or world famous Bassett’s ice cream (all are Philly originals).”
—Steven M. Selbst, MD

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**MINDFULNESS**

**CONTINUED FROM PAGE 1**

personal activities on shift.1 That amounts to as little as 24 minutes on an eight-hour shift to include going to the bath- room and eating. While there has been ample discussion of “the practice of mindfulness” in health care workers that im- proves mental well being, when do we have time?2

**What’s Your Pre-Shift Ritual?**

We can leverage pre-shift rituals that many of us do already to exercise mindfulness. Some of us like to work or chat with colleagues just before shift. While the activity is different for everyone, these rituals are primed for stress reducing mind- fulness 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 warm as I drink and often feel content to enjoy the taste of the coffee. I’m observ- ing the moment, accepting whatever feelings or experiences are occurring.

However, it’s natural for our mind to wander from the pre- sent 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 decemter 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 emo- tions, whether good or bad, are only transient. Future wor- ries 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 vaca- tion.

**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.3-4 But when do we have a mo- ment to—figuratively and literally—just breathe? After patient contact, the 15-20 seconds we take to use alcohol-based san- titizer and/or wash our hands is an opportune time to “habit stack.”5-6 As James Clear describes in his book, *Atomic Hab- its*, by linking a new behavior (mindful breathing) to an ex- isting habit (hand washing) you use less cognitive energy and are more likely to successfully adopt this practice.

While there are multiple techniques for mindful breath- ing, 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 unsuccess- ful 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, ex- pressing genuine gratitude for yourself and others is powerful for your mental and physical well being.6-7 Even the thought of gratitude can positively influence mental wellness.8

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 pro- vides 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 chal- lenges 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
ED Boarding

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. 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.

Early pandemic days brought uncertainty, personal risks to clinicians, andwaves 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 590,000 registered nurses by 2030. 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], 0.2-2.5 percent) to 2.1 percent post pandemic (IQR 0.6-4.6 percent). LWOT rates were as high as 1 percent in the 75th 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.” CMS also “...respectfully disagree[s] that the removal will result in hospitals not working to maintain low boarding time.”

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.

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 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 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.1 Simultaneously, the median working nurse faculty is 52 years, suggesting a wave of near-term retirements that will further diminish capacity to train new nurses.2 Increased funding is necessary to ensure each class includes the minimum number of qualified instructors.

On October 3, 2022, the Department of Labor announced $80 million in funding to expand the nursing pipeline through the Nursing Education and Clinical Labor Expansion Grant Program. The focus will be on three multiple pathways: the nurse education profession track to increase the number of clinical and vocational nursing instructors; the nursing career pathway track to train front line health care professionals; and special grants to support accelerated learning and expand access to clinical residencies and specialty care rotations.3 While these steps are in the right direction, the U.S. Bureau of Labor Statistics projects that more than 275,000 additional nurses are needed from 2020 to 2030.4 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 also 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 user 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.

The innovative way to do this would be by changing the way that ED physicians get paid, moving to capped payment models or global budgets that could opt into, Traditional fee-for-service makes telehealth and frequent-user programs more challenging to implement because physicians are paid for the work they do, not the outcomes. Expanding these models would allow ED physicians diverting patients to the right set-ting. But these programs are primarily local. It’s time to create payment models to expand them. Expanding these models would also 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 user 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.

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References


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 disheartening 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. Nevertheless, most physicians do not follow this dictum. 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 orthopedic surgeon, 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 angry 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. Several years ago, about to undergo arthroscopic shoulder surgery, I told the anesthesiologist that I was not a “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 bicy-
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 worsening had been treated for decades. They presented to their open secret within my family had refused communication 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, if 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

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.
Should You Etomidate Me?

Risk of mortality by using etomidate for induction remains uncertain

by KEN MILNE, MD

A critically ill patient presents to the emergency department (ED) requiring emergent, definitive airway. While preparing to perform the endotracheal intubation with video laryngoscopy, you remember 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.

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. The primary outcome was all-cause mortality at 28 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).

Clinical Question

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


Population: Critically ill adult patients requiring emergency endotracheal intubation

Exclusions: Pediatric patients less than or equal to 11 years old, etomidate as an infusion, non-randomized trials, systematic reviews, commentaries or editorials, literature reviews, studies not addressing the review question

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.”

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 time point defined by trial authors in 23 percent versus comparator 20 percent; NNT = 31; risk ratio = 1.16 (95 percent confidence interval [CI], 1.01 to 1.33; P<0.001)

• 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 (77 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 difference 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.
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 or 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 $175,000 per year. Twenty percent of that is $35,000. 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 save and work 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 $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.
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
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 Emergency medicine (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.”

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. 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. 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...
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 § 13796gg-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 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.”

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-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


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.

Forensic Facts

Continued from Page 18

Discuss the cases above with your local hospital’s risk manager and attorney. They are very familiar with the applicable laws in your state. Federal and state laws regulate specific procedures that must be included in your forensic examination.

The mandatory reporting statutes in your state will vary on several factors:

- The age of the patient.
- The nature of the assault.
- The patient’s ability or decision to consent.

Your state may have specific statutes governing the sexual assault forensic exam (SAFE) 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.

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FORENSIC FACTS

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Reference

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 overtreatment.

A Common Case

Hypoglycemia following insulin administration for hyperkalemia is common, occurring in approximately one in six patients (about 17 percent). 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). This effect was magnified when restricted to severe hypoglycemia (OR, 0.41; 95 percent CI, 0.27 to 0.64). 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 whoppin’ 20 units of IV insulin vs. 10 units of insulin over 30 minutes to a 10-unit strategy with 0.5 and 1.14 mmol/L. 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. 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 hyperkalemia, embraces the five-unit strategy.

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 150 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


Peritonsillar abscess (b).

Peritonsillar abscesses, 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 β-hemolytic 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 odynophagia 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).

**Reference**

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

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

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.

Learn more at: usacs.com