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Conversations on Burnout: Part Two
by Mitchell Kentor, MD, MBA, FACEP

This is the second part of a discussion with experts about the important topic of physician burnout. The first can be found in the May 2023 issue of ACEP Now or online at acepnow.com.

I’m (MK) joined by several experts, Dr. Davien Morrison (DM), Dr. Greg Couser (GC), and Dr. Andrew Brown (AB), all of whom are psychiatrists and published authors on burnout, to explore the crucial problem of physician burnout and how we can begin to address it.

MK: In your work, you talked a lot about ESG. Can you define that term and talk a bit about why it matters to this conversation on burnout?

DM: ESG is an acronym for environment, social, and governance. Essentially, the “E,” environment, is what are you doing to ensure that the planet is a healthy planet to live on. Are you actively looking to reduce your carbon footprint or doing something else along those lines to keep, basically, planet Earth healthy? The “S,” social, is more along the lines of race, gender, and issues related to things like pay equity and employment equity.

In Corpus Christi, Texas, the Nueces County Hospital District (NCHD) Board of Managers unanimously voted on December 12 its final approval of an agreement to keep the EM residency program at Christus Spohn open for the next six years. The EM Residency Program in Corpus Christi Resuscitated

by Larry Beresford

After six weeks of tense negotiations, a health system that planned to shutter its emergency medicine (EM) residency program came to an agreement with the local county hospital district to keep the program open.

CONTINUED on page 14

CONTINUED on page 8
Respiratory Virus Season—Get Helpful Pediatric Resources Online

Find on-demand videos from ACEP’s Pediatric Emergency Medicine Committee that may come in handy when treating patients this winter with a variety of respiratory viruses, whether it’s RSV, influenza, bronchiolitis, or COVID, these videos offer clinical information about risk factors, diagnosis, and management that may be helpful. Find them at acep.org/by-medical-focus/pediatrics.

Enroll Today to Improve Care: Venous Thromboembolism, Stroke, and More

Want to improve clinical outcomes, coordinate care, and reduce costs in your emergency department? E-QUAL, a FREE online, low-burden quality improvement program is now enrolling for its 2024 initiatives, including venous thromboembolism and stroke. Learn more and sign up today at acep.org/equal.

Celebrating 2,200 Questions in PEERprep

PEERprep—ACEP’s emergency medicine board review product—is now equipped with more than 2,200 rigorous core content questions, more than 1,300 eye-catching PEER Pearl infographics, and more than 2,100 bonus Key Point rapid review questions. That’s nearly five times the number of questions published in PEER IX. Find out more about how PEERprep’s enhanced features, including creating your own custom quiz sets, will help you be the best physician you can be. Learn more at acep.org/peerprep2200questions.

Annals Moves to Digital This Month

Annals of Emergency Medicine transitioned to a digital-only publication beginning with its January issue this month. If you prefer print, ACEP members can subscribe separately to print-on-demand for $75/year at ussocieties@elsevier.com or by calling 800-654-2452, option 2. If you are not a member, you can subscribe through Annals’ journal website www.annemergmed.com.

Get practical solutions to many of the personal and systemic issues that plague emergency physicians with ACEP’s new wellness guide, “From Self to System—Being Well in Emergency Medicine.”

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Get practical solutions to many of the personal and systemic issues that plague emergency physicians with ACEP’s new wellness guide, “From Self to System—Being Well in Emergency Medicine.”
The University of Tennessee Health Science—Murfreesboro/Nashville Emergency Medicine Residency began in 2015. Our community-based three-year residency program is based at a high volume, efficient community hospital, while also having the advantages of the academic resources of a major university medical school. Residents play a hands-on role in managing their patients and have the opportunity to perform numerous resuscitations and procedures.

What Are Some of The Unique Aspects of Your Residency Program?

We have a large emergency medicine faculty and a relatively small (eight residents/year) residency, so our faculty are able to interact very closely with our residents. The majority of resident clinical shifts are one-on-one with their attending. There is much faculty participation in our didactics and workshops, and we foster strong mentoring relationships.

Our residency is one of the few in the country where the faculty are part of an independent, democratic physician group. Our emergency medicine faculty will give you much exposure to the “real world” of emergency medicine, including a robust education on the business of emergency medicine, leadership development, and career development.

What Are Some Of The Fun Activities Your Residents Participate In?

Our residents take advantage of the many exciting activities available in the Nashville area, which was recently voted the number one best city to visit (Travel & Leisure), number one best city to live (Kiplingers), number one best music scene (Rolling Stone), and third best local food scene (USA Today). In addition, there are many great outdoor activities nearby. Our residents often participate in event medicine for several of the major venues in the area (Nissan Stadium, Ryman Auditorium, etc.)—recent events include top musical artists (Taylor Swift, Elton John), pro sports (Titans football) and other big events (NFL draft). Recent residency wellness events have included NHL Predators skybox event, Nashville scavenger hunt, escape room, our weekend resident retreat at a lake house, resident Olympics, Women in Emergency Medicine socials, and more.

Learn more about our residency program at: https://comnashville.uthsc.edu/content/emergency-medicine

—Mark Reiter, MD, MBA, residency director

By the Numbers

ACEP Members Self-Reported Ethnicity Demographics

ALL MEMBERS

ETHNICITY

- Asian
- Black or African American
- Hispanic or Latino
- I Prefer Not to Answer
- Middle Eastern/North African
- More Than One/Multiracial
- Native American or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Other/Not Listed
- White

COUNCILLORS AND ALTERNATE COUNCILLORS

ALL COMMITTEE MEMBERS

Members can voluntarily choose to indicate their ethnicity on their member profile. About 2/3 of the membership opt to provide this information. Data was gathered from ACEP in December 2023.

Find more demographic breakdowns of ACEP membership on page 5.
Re: ‘Toxicology Answer: An Illustrated Case of Ethylene Glycol, Direct and Indirect’

On behalf of my colleagues (Dr. Shenoi and Dr. Filip), I offer our letter to the editor responding to misconception in Dr. Hack’s recent case report of ethylene glycol poisoning. In his case report, Dr. Hack strongly recommended using UV light from Wood’s lamp to examine the urine for fluorescence. Dr. Hack included the published evidence against this approach and then again recommended this. We believe that this “test” is useless and misleading. We disagree with his endorsement of this approach. We also take the opportunity to point out one of the indirect clues (apparent lactate elevation with his endorsement of this approach. Until we solve the post-acute care shortage, we’re doomed.

—Chuck Pilcher, MD, FACEP

Re: ‘A Seven-Step Approach to Massive Hemoptysis’

I enjoyed the article by Dr. Helman on Massive Hemoptysis and would like to add some suggestions. If a focal source of bleeding can be determined (by CXR or bronchoscopy) then specific interventions can be done to isolate the bleeding segment/lobe/lung while still safely ventilating the uninvolved lung. A left mainstem intubation with a standard ETT (but possibly requiring bronchoscopic guidance for correct placement) isolates a right-lung source of bleeding but while a right mainstem intubation is easy to achieve blindly and isolates a left-lung bleed, it unfortunately is difficult to position the ETT without also blocking the right upper-lobe bronchus. A better strategy for left-lung bleeding is to position a balloon-tipped catheter, such as a Fogarty, into the left mainstem bronchus (or further into either LUL or LLL bronchi if the specific source of bleeding is confined to one lobe) and keep the ETT in the standard tracheal position. Double-lumen ETT are not recommended for lung isolation during pulmonary hemorrhage as they can be challenging to position optimally (and keep in place) and do not offer lumens large enough for bronchoscopy or even appropriate sectioning.

—Joseph Shiber, MD, FACEP, FACP, FCCM

Re: ‘‘Test’’ is Useless and Misleading. We disagree with his endorsement of this approach. We also take the opportunity to point out one of the indirect clues (apparent lactate elevation) which we assert is more useful.

—Michael Mullins, MD, FACEP, FAACT

Re: ‘Tackling Emergency Department Crowding’

Great article that showcases the vigilance and tenacity needed to protect patient access and to ensure reimbursement for PLP services. A victory of patients, families, hospitals and ED physicians.

—Susan Nedza, MD, MBA, ACEP

Re: ‘Your Employer Should be an Open Book’

When I look for a job, I am concerned about adequate staffing and an accurate volume. Many recruiters are given a volume and you start and the volume is 50 percent higher. Also, there should be an orientation, but sometimes to a new department there is little or none. Is it there should be an orientation, but sometimes to a new department there is little or none. Is it a toxic environment? Many things like, “what if the ICU is full,” [we] are not oriented to. Can you get a stat consult for a specialist? What if you get a stat consult for a specialist? What if the hospitalist refuses to admit? An attending emergency physician needs to know [these things]. Our patients always come first and [for us] to deliver the best care. You get the feeling that what the recruiter only wants is the commission. They should want us to be satisfied with the job.

—Steven M. Winograd, MD, FACEP

Re: ‘How To Identify and Work With Neglected Children in the ED’

As a retired PEM physician, I want the thank the authors for this excellent reminder that child abuse and neglect includes medical neglect. With today’s fractured and fragmented care, the ED is often the only common point of care for these children. Keep alert to physical signs of abuse and neglect. But also take a few minutes to review the EMR when dealing with frequent flyers with chronic medical conditions.

—Edward Walkley, MD, FACEP, FAAP
Inclusion of diverse perspectives is an important part of the ACEP mission—we recognize the need for both the voices of members and those of patients. The current Board leadership continues to move closer to being reflective of the evolving diversity of the ACEP membership.

Board leaders have been intentional in finding strategic ways to get closer to being representative of the membership, including ways to promote interest in a leadership track and entering a pipeline to help diversify the future of the specialty.

ACEP leaders recognize that attention to diversity—which includes practice settings, geography, subspecialties, and more—is a commitment that will require time and dedication. With that in mind, the College is using its infrastructure to bring diversity issues and projects to the membership.

ACEP Diversity, Equity, and Inclusion Committee

At the close of 2021, the Board of Directors created a new ACEP committee to prioritize and address issues related to equity and inclusion. And in 2022, Ugo Ezenkwele, MD, FACEP, was named the first chair of the ACEP Diversity, Equity and Inclusion (DEI) Committee.

This past year, the DEI Committee set objectives and specific goals to develop projects and resources for ACEP members, including:

- An inclusive language guide as a reference tool for the College
- A road map to promote diversity, equity, and inclusion in emergency medicine and center the experiences and ideas of historically marginalized (for example women, LGBTQ+, people with disabilities, international medical graduates) and underrepresented (for example Black, Indigenous, Latinx, Asian) physicians.
- A plan to collect demographic information from all ACEP members, volunteers, and vendors by FY24-25.
- Fulfill a 2020 Council Resolution to create or select a framework to assess the work of the College (position statements, adopted resolutions, task forces) through the lens of health equity.

AAWEP Efforts to Showcase Women in EM

The American Association of Women Emergency Physicians (AAWEP), an ACEP section of membership, hosted a successful leadership workshop during ACEP’s Leadership and Advocacy Conference in DC last spring.

With a full room and packed agenda, section leaders discussed changing medicine through gender equality, burnout and boundaries, coaching, overcoming challenges, among other topical issues.

These informative conversations continued over the summer with AAWEP’s Webinar Series:

- Empowering Your Time: Practical Strategies to do More of What Matters
- Developing the Local Women Leaders
- Negotiation Frameworks for Success

ACEP members can watch the webinars by visiting the Online Learning Center at acep.org/olc and searching for “AAWEP Summer Series.”

### 2023 ACEP Member Self-Reported Demographics

<table>
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<tr>
<th>ETHNICITY</th>
<th>BOARD All Members</th>
<th>Section Leaders</th>
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<tr>
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HAVE AN IDEA?
Submit your story pitch to ACEP Now

If you have a story idea or drafted article, e-mail the word document file to Editor Danielle Galian-Coologeorgen, MPS, and Medical Editor in Chief Cedric Dark, MD, MPH, FACEP. We’ll review your submission and update you on next steps. To submit a story pitch, please send a 250 word summary along with bullet points of the following:
• Why our readers would value the story.
• How the story would influence the provision of emergency medicine.
• What you hope the reader would learn from your article.
• Potential outside experts or sources for the story.
The usual length of standard articles (departments, columns, one- to two-page articles) is about 800 words. The usual length of feature articles (two or more pages) is about 1,200 words. A reference list is also required to support researched material and the practice of evidence based medicine. Preference will be given to new voices.

Submit a Letter to the Editor
ACEP Now welcomes letters to the editor from our readers. Letters should be 250 words or less, may be edited for length and style, and are published online and/or in print at the editorial team’s discretion. Submit your letter including your name, title, organization, and contact information to Editor Danielle Galian-Coologeorgen, MPS.

Interested in Joining ACEP Now’s Medical Freelance Corps?
ACEP Now welcomes guest articles by physician writers. Send us an email with a brief writing sample to discuss opportunities.

Chart Your Own Course
with the Independent EM Group Master Class
February 6-8, 2024
Irving, Texas

The emergency medicine paradigm is changing.
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Building an army for disruption.
Unlock the power by creating or expanding physician-owned group practices to take control of your own destiny.

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Artificial Intelligence in the ED: Ethical Issues

by KENNETH V. ISERSON, MD, MBA, FACEP; EILEEN F. BAKER, MD, PHD, FACEP; PAUL L. BISSMEYER, JR., DO; ARTHUR R. DERSE, MD, JD, FACEP; HALEY SAUDER, MD; AND BRADFORD L. WALTERS, MD, FACEP

Artificial intelligence (AI) may radically alter the provision of emergency medicine (EM) over the coming decades. Before it does, we must consider this game-changing technology’s effect on emergency physicians and their patients. As we become increasingly dependent on AI, emergency physicians may lose their professional autonomy, decision-making abilities, and technical skills. Complex AI programs may become so embedded in the decision-making process that emergency physicians may not be able to explain or understand them, and patients may not be able to refuse its use or refute its findings, even when ethical dilemmas are present.

Overreliance on AI
Overreliance on AI clinical decision aids may lead to a decline in emergency physicians’ diagnostic and decision-making skills, potentially compromising patient care if the emergency physician does not recognize an erroneous AI response. AI programs’ ability to interpret medical imaging and cytopathology often exceed human capacities to perform repetitive, complex, or time-consuming tasks. Overreliance on AI medical decision aids may become a demanding taskmas-ter and an enigmatic diagnostic and treatment standard for the emergency physician, leading to understandable resistance to AI by emergency physicians.

As AI becomes involved in clinical decisions, patient autonomy and shared decision making will suffer. If emergency physicians rely solely on AI-generated suggestions based only on objective data, they are likely to recommend treatments or interventions that are not consistent with the patient’s values and preferences.

An example of this is shared decision-making regarding hospitalization in moderate-risk HEART score chest pain. Currently, the emergency physician may calculate the HEART score and then take the data to the patient for a discussion in which the patient is able to heavily influence their follow-up plan. Such shared decision making succeeds because the physician understands and can share with the patient how the data was applied and how the statistics and risks were generated. As AI models become more complex, clinicians may not be able to clearly discuss why the recommendations are being made, and patients may no longer be able to rely on the basis for their emergency physicians’ recommendations to make an informed decision.

Implementation of new technology within the medical field forces consideration of how patients and physicians will interact with it. A rarely discussed but vital ethical issue is that emergency physicians must remain aware that, when patients prefer to have humans interacting with them rather than an algorithm, they should maintain the right to refuse its application in their care. Emergency physicians must provide patients with sufficient information (e.g., inclusion, consequences, and significance) so that they can decide whether they will allow AI to be a part of their care. Such consent necessarily requires that AI cannot be so embedded in the EM process that its use cannot be refused; patients must be able to challenge or refuse an AI-generated recommendation. This helps ensure that the humanistic nature of medicine prevails, and EM care is tailored to patient preferences and values.

AI’s role in patient-care decisions involving ethical dilemmas, including those around the end of life, is unclear and problematic. In the early stages of AI development, and for decades to come, trained professionals, usually emergency physicians, will need to provide counseling to patients and families. AI cannot replace physician input in the nuanced and complex ethical decisions that need to be made. However, AI may be able to help frame questions that can guide physicians in determining therapies and predicting mortality. For example, in patients at a high risk of death within six months, AI helped to reduce the use of chemotherapy by three percent. A study of AI-triggered palliative-care considerations found a higher use of palliative-care consultations and a reduced hospital readmission rate. AI will undoubtedly be useful in providing emergency physicians with ethical guidance, but it cannot make ethical decisions itself.

As clinical AI systems develop and are carefully introduced into EM, emergency-department patients will undoubtedly benefit from the breadth and depth of knowledge they provide to emergency physicians. Preserving ethical and high-quality EM practice will require understanding the AI systems’ limitations and keeping emergency department patients well-informed.

References


DR. ISERSON is professor emeritus in the Department of Emergency Medicine at the University of Arizona, Tucson.

DR. BAKER is an emergency medicine physician practicing in Perrysburg, Ohio.

DR. BISSMEYER is a fourth-year student at Kansas City University College of Osteopathic Medicine.

DR. DERSE is director of the Center for Bioethics and Medical Humanities and professor of Bioethics and Emergency Medicine at the Medical College of Wisconsin.

DR. SAUDER is a board-certified emergency medicine physician in Dayton, OH.

DR. WALTERS is an emergency medicine physician in Royal Oak, MI.

The Official Voice of Emergency Medicine

JANUARY 2024 ACEPNOW.COM
of time before we’re at the desperate moment, wearing CPAs. How do we build a case ahead that it does make a difference to the proverbial dialogue like this. How do you build the case DM: emergency medicine?

MK: How do we incorporate ESG into monitoring and measuring burnout? Between management and the physicians about $53 trillion, could we introduce a dialogue because of burnout that harm patients. If there’s mistakes that are made because “How are we thinking about the human G, is, “How are we governing these organizations our university is invested in, look at what you say you’re about, look at what you’re actually about. There were several fairly progressive or forward-looking organizations that really targeted ESG in terms of their investments. And there’s a larger community of investors in ESG whose investments are fairly significant now... as much as $33 trillion. And that brought me to the idea of H in between all three of them, the E, the S, and the G, is, “How are we thinking about the human being?” There are mistakes that are made because of burnout that harm patients. If there’s this energy, there’s investment in the scale of $53 trillion, could we introduce a dialogue between management and the physicians about monitoring and measuring burnout?

MK: How do we incorporate ESG into emergency medicine?

DM: I think that’s the natural next step of a dialogue like this. How do you build the case that it does make a difference to the proverbial number-crunchers, with the green-eye-shade-wearing CPAs. How do we build a case ahead of time before we’re at the desperate moment, and the hospital’s about to close, or they have to shut down different services? How do we build that case that managing and monitoring burnout in ED doctors matters to the leadership? I saw this a lot in social media, that people were expressing angry sentiments like, “I do not want to come to another mandatory yoga class for dealing with my burnout at 6 in the morning. Seeing a stack of pizzas in the doctor’s lounge does not make me feel like the leadership cares.” Mitch, you and I know [a CEO], who does not ignore how the employees are doing. He is engaged at all levels. The guy that shows up to see what the employees are actually doing. He expects his leaders to get out into the hospital, get down into the emergency on the night shift and on the weekends.

MK: We as physicians and certainly in the emergency department are all familiar with metrics such as patients per hour or time to discharge and admission. It seems like we often jump from one metric to another. Is it a potential solution to expand metrics to administration to be accountable for burnout percentages as a countermeasure to physician metrics?

GC: That also gets back to the business case though, because you need to look at turnover. It’s six figures to replace a physician. Retention is important for organizations. And when turnover gets to a certain point and everyone’s leaving, that is when hospitals start closing. Organizations that figure out how to retain physicians are at an extreme competitive advantage.

AB: While they are not easy problems to solve, they are simple in the sense that we already know what drives people, whether physicians or other professions, to look for other work.

DM: Carin Knoop, who directs the case writing department for Harvard Business School, has been writing and thinking about the importance of mental health in the workplace from the management perspective. And she talks about this catch that managers fall into, but physicians are particularly vulnerable to, is: The Hero. “I’m the only one. And when everything else fails, I will be there. I will show up.” So there’s this hero syndrome. Where we figure we have to do it all. They never say “no” to anything. And what ends up happening is they get worn down and by the time they realize that they’re worn down, it’s too late.

MK: It’s a really interesting topic and also comes back to staffing. With this idea of, if I don’t show up, who’s going to replace me? And these days that’s an increasingly big question mark in a lot of systems that struggle to have adequate staffing.

DM: It also ought to be encultured in the guild that we belong to, that taps into the idea of not only competition, but also perfectionism. I think those two come together. But perfectionism and hyper-competitiveness in particular can be a nasty blend.

MK: How do you find time to get together when your group of 30 docs is not all going to be there on the same day or you’re covering multiple hospitals? How do you find opportunities to do some of these interventions?

DM: It’s about “work and life-outside-of-work balance,” not work/life balance. If you...
MORE HOSPITALS ARE CLOSING

ARE HEALTH CARE WORKPLACE CONDITIONS TO BLAME?

by HARRY W. SEVERANCE, MD, FACEP

The wave of increasing hospital closures and average line closures continues to sweep the United States. A recent article documents 56 additional U.S. hospitals that are closing clinical departments or ending or reducing services. Cited are issues of “shoring up finances,” “stabilizing shortfalls,” or “focusing on more in-demand services” as driving forces. This adds to the more than 640 (mostly rural) hospitals that recently failed financial stress tests and are adjudged to be at imminent risk of closing.

Of these 56 additional hospitals, many are not rural; thus, this specter is expanding. One of the chief reasons cited, again, is inability to obtain adequate numbers of doctors, nurses, and other health care workers to keep service lines open, and thus inability to generate adequate revenues to stay afloat.

Conditions in the Workplace

More than 20 percent of our health care workforce left health care in the last two years, and 10 percent of all practicing U.S. physicians quit in 2021 alone.1-4 This exodus is largely due to disintegrating conditions in many of our nation’s health care workplaces, conditions that include: marginalization, denigration, evolving oppositional attitudes that increasingly divide clinical workers and their administrations (“suits versus scrubs”), unobtainable and overwhelming workloads and administrative demands, increasing corporatization and private equity “sell-offs” of health care systems, increasing corporate boardroom isolation (by choice) from those who work clinically, almost no remaining health care corporate leaders with any clinical background, federal laws that increasingly prevent physicians and other clinically practicing leaders from participating in health care-system business decision-making, escalating moral injury, and accelerating unchecked violence against health care workers, all leading to increasingly toxic workplace conditions.1-6

Failures to Act

Health care has now been declared last for employee satisfaction among all U.S. industries, and the most dangerous of all U.S. workplace professions.1-4 These are pathways available to repair and correct these workplace issues, but our leaders have so far failed to act.

Thus unchecked, health care workplaces will continue to remain toxic, and more doctors, nurses and other health care workers will continue to exit, leading to increasing numbers of hospitals and facilities closing or cutting back on critical services, thus expanding the disintegration of health care delivery and the further decline of our whole health care system.

References


Acute Urinary Retention and Fever in a Man

A rare, but sometimes fatal combination

by MATTHEW TURNER, MD; AND CATHERINE MARCO, MD, FACEP

Case

A 74-year-old man presents with five days of fever and urinary incontinence. He has a history of diabetes mellitus type 2. Vital signs are: blood pressure, 117/68; heart rate, 89; resting heart rate, 16; temperature, 37.7 degrees C (99.9 degrees F). On physical examination, he is confused and incoherent. What is the best management of this condition?

Acute urinary retention (AUR) is generally defined as a “painful, palpable, or percussable bladder, when the patient is unable to pass any urine.” It is typically seen in males older than 60 years and has a significantly higher incidence in men with benign prostatic hyperplasia.

However, AUR presenting simultaneously with fever is a particularly concerning presentation, due to a number of rare and severe etiologies. While AUR may occur due to obstruction, infectious etiologies, trauma, surgical complications, multiple drug interactions, neurogenic etiologies, and miscellaneous causes such as severe constipation, the simultaneous presentation of AUR and fever in the ED presents a narrower differential.

Prostatitis

Infectious etiologies may cause fever and urinary retention. Acute prostatitis, presenting with fever, back pain, perineal pain, and rectal pain, may be a cause of AUR and fever. Although not all males will develop the acute form, up to 50 percent will “develop some form of prostatitis during their lifetime,” and in males presenting with fever and urinary symptoms, prostatitis is the underlying condition in more than 90 percent of cases “in the absence of pyelonephritis symptoms.”

Typically caused by gram-negative bacteria, Escherichia coli is “the predominant organism in acute prostatitis and occurs in 75 percent of all cases.” Some studies estimate that E. coli is the causative organism in up to 80 percent of all cases.

Diagnosis of acute prostatitis is made through the patient’s clinical presentation and through the presence of bacteria in urine analysis. Rectal examination should be performed only cautiously—prostate massage “can release bacteria and inflammatory cytokines, triggering an abrupt clinical decompensation.” Postvoid residual urine volume and levels of prostatitis-specific antigen are useful for diagnostic purposes, as well as possible CT scan or ultrasound to evaluate for an enlarged and inflamed prostate.

For immediate relief of the patient’s AUR, catheterization should be performed. Most cases of acute prostatitis respond well to oral antimicrobials, due to the relatively easy penetration of the prostate’s cellular membrane in an acute inflammatory reaction. While therapy should be specifically tailored to the organism, recommendations such as trimethoprim-sulfamethoxazole and/or fluoroquinolones are often therapeutically successful, provided that the length of therapy is prolonged (four to six weeks). Repeat urine cultures during the course or hastens recovery. Fortunately, the disease is self-limiting over a period of several weeks, and there is no evidence of long-term neurological sequelae.

Meningitis-retention Syndrome

While acute prostatitis is a relatively common disease with a bimodal distribution, meningitis-retention syndrome (MRS) is a significantly rarer disease that is more likely to present in young, healthy adults.

MRS will typically present with neurological signs highly suggestive of aseptic meningitis, including “headache, drowsiness, fever... miscalculation and/or Brudzinski signs.” However, in many cases, the neurological signs may be so mild that the predominant symptom appears to be “isolated acute urinary retention.” One of the most notable presentations of MRS is the fever and AUR that patients with it will eventually develop. Only recently reported in the literature, the cause of MRS remains undetermined in most cases.

Distinguishing it further from acute prostatitis, MRS patients will display a neurogenic bladder during urodynamic studies. Unusually, MRS patients will not display any evidence of lower motor neuron involvement—with “a lack of leg numbness and paresthesias helping to differentiate MRS from Guillain-Barre syndrome, polyneuropathies and conditions affecting the lower motor neurons.” It is theorized that MRS affects upper motor neurons in the central nervous system responsible for the detrusor muscle. Likewise, patients with MRS display normal peripheral nerve conduction.

The presence of MRS may be confirmed by lumbar puncture, which will display “lymphocytic pleocytosis, elevated protein levels, and mildly decreased glucose levels.” MRI of the brain and spinal cord will not reveal any abnormalities—nor will blood or urine cultures.

Patients with MRS should have their AUR treated by catheterization and be admitted for observation. There is no evidence to suggest that treatment with steroids, antibiotics, or antivirals improves the disease course or hastens recovery. Fortunately, the disease is self-limiting over a period of several weeks, and there is no evidence of long-term neurological sequelae.

Pharmacology

In elderly patients, pharmacological causes of AUR with fever should also be considered, given the “decreased clearance, drug interactions, altered drug sensitivity and multiple comedication medical conditions more common with advancing age.”

Pharmacologic etiologies account for up to 10 percent of AUR cases. Drugs with anticholinergic effects should be strongly considered. Even localized anticholinergic drugs, such as short-acting and long-acting anticholinergic bronchodilators such as ipratropium and oxitremorin, may cause AUR. Antiparkinsonian drugs, such as levodopa and levodopa-carbaparbemone, may also cause AUR. Antidepressants and antipsychotics may also cause AUR. Antihypertensives, calcium channel blockers, and diuretics may also cause AUR. The patient’s treatment course should be performed to ensure that the causative organs are thoroughly eliminated.

References

Case

A 40-year-old female at 11 weeks, five days gestation presented to the emergency department (ED) with concern for lower abdominal pressure and inability to fully empty her bladder. She had urinary dribbling when standing and leaning forward. She denied fevers, back pain, saddle anesthesia, numbness, or weakness in the extremities. She reported no history of prior back surgeries, intravenous drug use, recent falls, trauma, or known inciting event. There was no vaginal bleeding or vaginal discharge. Transvaginal ultrasound (TVUS) performed in the outpatient setting a couple of weeks prior to presentation confirmed an intrauterine pregnancy (IUP) with a retroverted uterus. Straight catheterization resulted in approximately 1,500 mL of clear urine output and relief of symptoms. Urinalysis showed no evidence of infection, and the patient was discharged home.

The patient returned the next day with concern for ongoing urinary retention. She had only been able to void small amounts since the prior visit. Foley catheterization was again performed with approximately 1,200 mL of urine output and relief of symptoms. The obstetrics team was consulted due to the urinary retention. The cervix was not visualized during pelvic examination, but manual examination identified the cervix tucked under the pubic bone in an anterior position, concerning for an incarcerated gravid uterus (IGU). The patient was admitted to the obstetrics service and underwent spinal anesthesia in the operating room to manually reduce the uterus. A pessary was inserted during that procedure. On the next day, the Foley catheter was removed and the patient was able to spontaneously void. She was discharged in stable condition with close follow-up.

Analyzing a Rare Diagnosis

Incarcerated gravid uterus is a rare diagnosis with an estimated incidence of one in 3,000 to one in 10,000 pregnancies.1-3 It most commonly occurs in patients with a retroverted uterus during weeks 10 through 16 of pregnancy. As the uterus grows, it can spontaneously correct; however, if the uterine fundus remains in the pelvis it can become trapped against the sacral promontory while the cervix is trapped against the pubic symphysis.1,4 Approximately 15 to 20 percent of all pregnancies occur in a retroverted uterine position, however only a rare minority of those pregnancies lead to IGU.1,5

Risk factors include prior abdominal surgeries, history of pelvic inflammatory disease, or prior history of uterine incarceration.6 IGU can be identified via history and physical, pelvic examination, or MRI. Alternatively, ultrasound can be utilized as a diagnostic modality. Transabdominal ultrasound is more helpful for IGU diagnosis than TVUS as the transabdominal approach allows for better visualization of the cervix in relation to the uterus.5,7 Since IGU is a rare presentation, the literature primarily consists of case reports and case series. Treatment options include Foley catheterization until the uterus spontaneously reduces and adopts a normal vertex presentation, having the mother adopt a knee-to-chest position, or manual reduction with appropriate pain control. More invasive techniques such as colonoscopic or laparoscopic reduction have been described.1,5

CONTINUED on page 20
A CASE REPORT OF MICROCYTIC ANEMIA IN A PEDIATRIC PATIENT

Lead poisoning remains a significant public health concern for children

by EVAN P. COHEN, MD; AND MUHAMMAD SHEHZAD K. WAZIR, MD

Case

A 3-year-old male was brought to the emergency department (ED) by his mother, who reported the sudden onset of a rash (hives) covering his entire body, with no rash on his palms and soles. No other complaints were noted. The child’s skin appeared warm and dry. A review of systems revealed no abnormal findings. Vitals were within normal limits, with a pulse of 129, respiratory rate of 25, and oxygen saturation of 98 percent. On physical examination, the child was non-toxic, well-nourished, alert, awake, and not in acute distress. The child was diagnosed with hives and discharged to home with symptomatic management.

The next day, the patient’s mother was called to come to the emergency department with the patient due to abnormal labs. The patient had an abnormal lead screening test at age 2 and was advised to receive a comprehensive lead screening evaluation, which he did approximately one year later, shortly prior to this ED visit. Incidentally, the day after ED visit number one, the mother was called by the child’s pediatrician advising her to bring him for evaluation of lead poisoning. The initial laboratory results were abnormal, with a lead level of 56.9 µg/dL, hemoglobin of 6.4 g/dL, hematocrit of 23.9 percent, mean corpuscular volume of 53 fl, mean corpuscular hemoglobin of 14 pg, mean corpuscular hemoglobin concentration of 26.4 g/dL, and red cell distribution width of 20.84 percent.

A peripheral smear revealed mild anisocytosis, ovalocytes, hypochromia, microcytosis, and poikilocytosis. Blood type and screen, COVID-19 tests, and ECG were all within normal limits. An abdominal X-ray revealed particulate radiopaque foreign bodies involving the stool. The mother revealed a history of elevated blood lead levels when the child was two years old, indicating a previous exposure. The family had since relocated to a lead-safe environment. In the emergency department, consultations were made with the regional poison-control center and the regional lead center. A decision was made to transfer the patient to a tertiary center with inpatient pediatric capabilities. The patient was subsequently transferred to another medical center for treatment of anemia and lead chelation.

Discussion

Lead poisoning is a serious health concern. It can present in acute and chronic forms. It can occur due to accidental ingestion or occupational or environmental exposure.1 Children are particularly vulnerable.2 According to the latest definitions from the Centers for Disease Control and Prevention, blood lead concentrations equal to or exceeding 5 µg/dL are classified as elevated levels in both adults and children.2-5 Exposure to lead in humans can occur through a range of sources, encompassing lead-based paints, leaded gasoline, lead-containing pipes, lead smelting, coal combustion, and occupational activities like battery recycling.6 Lead poisoning primarily occurs through two main routes: ingestion and inhalation.

Ingestion is more prevalent among children due to their inclination to put objects in their mouths, whereas in adults, a higher proportion, around 94 percent, is deposited there. This difference in lead distribution is particularly prominent in specific tissues, including bones, teeth, hair, and nails, where it forms tight bonds and appears to be relatively inert, posing less immediate harm as it is less available to affect other bodily tissues.7 Interestingly, in children, approximately 70 percent of the absorbed lead accumulates in their bones, whereas in adults, a higher proportion, around 94 percent, is deposited there. This difference in lead distribution may contribute to the more pronounced clinical effects of lead poisoning in young children.6 Lead exerts its toxic effects by interfering with various organ functions, primarily targeting the nervous system and hematopoietic system, as well as impairing liver and kidney functions.1

Lead poisoning occurs most commonly in the developing world.9 There have also been numerous cases in the developed world, with higher lead burdens seen during the peak of the Flint, Michigan, water crisis.10 Lead interacts with human physiology in two significant ways: it strongly binds to sulfhydryl groups and other electron donor groups in proteins, affecting their functions. Additionally, its similarity to divalent cations like calcium and zinc disrupts various cellular processes regulated by these ions.11 From a neurological standpoint, lead is believed to disrupt the natural pruning of synapses in developing brains, which may explain cognitive and behavioral changes observed in children exposed to high levels of lead.12 Peripheral neuropathy is a common manifestation of lead toxicity in adults but its mechanism is poorly understood. Severe neurological manifestations seen in lead encephalopathy are thought to be at least in part due to lead-induced cerebral microvascular changes leading to cerebral edema and increased intracranial pressure.13 Lead-induced anemia occurs because it disrupts enzymes responsible for making heme and maintaining red blood cell membranes. This disruption reduces production of red blood cells and increases their destruction.14 From
a kidney standpoint, lead can cause problems in the proximal tubules, similar to Fanconi syndrome, and it competes with uric acid for reabsorption in the distal tubule, raising blood urate levels. Lead also has a multitude of effects on the endocrine system, thyroid function, skeletal growth, and development.6 Lead is associated with gastrointestinal symptoms such as abdominal pain, constipation, and anorexia but these effects are poorly understood.6 Our patient exhibited hematological manifestations of lead poisoning, but on examination was asymptomatic apart from a rash on initial presentation.

Chelation therapy is recommended for severe lead poisoning based on age, blood lead concentration, and clinical symptoms.4 Chelation therapy is recommended for patients with blood lead concentrations exceeding 45 μg/dL.1 In the past, a combination of dimercaprol and calcium disodium ethylenediaminetetraacetic acid (abbreviated EDTA) was the recommended chelation regimen. However, today, dimercaptosuccinic acid (aka DMSA or succimer) is approved and recommended for these patients. For those with mild to moderately increased lead levels, D-penicillamine was previously used orally but, due to toxic effects, has largely been replaced by succimer; DMSA (aka DMSA or succimer) is currently applied for a residency position in emergency medicine.

**Conclusion**

Our case highlights the importance of vigilant lead screening in young children, even in the absence of overt symptoms. Timely identification of elevated lead levels and appropriate intervention can prevent the detrimental effects of lead poisoning. Emergency physicians should remain vigilant in identifying potential sources of lead exposure in at-risk populations.

**References**

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

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American College of Emergency Physicians ADVANCING EMERGENCY CARE 

Defending you. Demanding better. We pick every single fight. For you.
by MICHAEL KENNETH TAYLOR, MD

Careers often align with personality, interests, morals, and aspirations. This allows professionals to develop a sense of passion for, and fulfillment from, their chosen field. I chose emergency medicine, like so many others, to care for patients who are in their most vulnerable state. We must know a little about a lot or, more accurately, a lot about a lot. We must be flexible. We must adapt to nuances that might be encountered. We must be ready to intervene.

Think about the person who served you your morning coffee with genuine friendliness, considering every detail in that process—from brewing to presentation—and everything in between. Their enjoyment for what they do is clear. Did you ever think about their safety as they are passing that cup of coffee over to you? Do they think about their safety as they are steaming milk or pressing espresso beans?

As a member of the Air Force, deployed to Afghanistan in 2011, I have seen war where I should have seen it—in a designated war zone. Unfortunately, I have also witnessed violence in places where in all regards I should not have. As an emergency medicine resident, I have seen the toll that workplace violence is taking on our specialty, our patients, and our entire medical community. A recent incident in which a colleague took his own life with a firearm while on shift has brought these issues into sharp focus for me, with the need to understand that workplace violence is not simply “part of the job.”

The questions raised by this tragedy are many: How did a gun make its way into the busy evening with a packed waiting room, where everyone feels comfortable asking for help when we need it, without fear of judgment or repercussions.

The incident in question also highlighted the impact that workplace violence and mental health can have on the victims who are present during such events. Those of us who were on shift at the time of the suicide attempted to resuscitate our colleague while still treating many other sick patients simultaneously.

The continuous hum of quiet voices, footsteps, alarms, the occasional shriek of a patient, the constant replay of every detail of what happened, persist as nagging psychological scars.

Reflecting on this, there were no obvious warning signs. Previously established mechanisms for staff and patient safety did not work and were not designed for this. Now I realize we need to be proactive and heed the opportunities that cross our paths every day. For example, the Journal of the American Medical Association recently reported that mental health related emergency room visits spiked between 2011 and 2020. Anyone complaining of mental health struggles, violent tendencies and warning signs must be taken as seriously as any high-risk chest pain patient stating that their chest pain feels just like their last heart attack! We must do better, and it starts with identifying the opportunities that present themselves to us on a daily basis. We owe it to ourselves, our patients, and our colleagues to create a safe and supportive work environment first, so we can give our vulnerable patients our very best.

A recent Association of American Medical Colleges article suggested that “physicians have a vital role in combating gun violence, which is a major public health issue in the United States.” It is time for us to address workplace violence in emergency medicine. We must work together to create a culture of safety and support, where everyone feels comfortable asking for help when they need it. This starts with a safe workplace. Just as the harriers who served you your coffee this morning is entitled to a safe workplace, so are we.

References

The Official Voice of Emergency Medicine

JANUARY 2024 ACEP NOW 15
Figure 1. 2024 Fees for E/M codes for E/M codes

Reimbursements for 2024

Medicare’s latest updates that affect you and your patients

by MICHAEL GRANOVSKY, MD, FACEP; AND DAVID MCKENZIE, CAE

The Centers for Medicare and Medicaid Services (CMS) released the 2024 Medicare Physician Fee Schedule Final rule on November 2. The 2,414-page final rule is the document that informs what Medicare payments will be for the following year.

Physician Fee Schedule Conversion Factor

As expected, the conversion factor, a dollar amount which, when multiplied by the relative value units assigned to a code, determines the payment amount, is expected to drop by 3.39 percent. The estimated impact on emergency medicine will be minus two percent to offset increases in new payments to maintain statute-driven budget neutrality across the entire fee schedule.

However, ACEP is lobbying Congress to step in with new funding to prevent or lessen these cuts. HR 2474, the Strengthening Medicare for Patients and Providers Act, would provide an annual update of the conversion factor equal to the increase in the Medicare Economic Index (MEI), but the cost of this legislation may be too high for broad support under our current national fiscal situation.

ED E/M RVUs Remain Stable

CMS did not make changes to the Work RVUs for the ED E/M codes, but there were a few small changes to the Practice Expense and Professional Liability Insurance RVUs at the second decimal place.

If we apply the revised 2024 final conversion factor of $32.7442 the ED E/M codes payments should look like Figure 1.

Split or Shared Services

CMS has finalized its policy on split or shared E/M visits by a physician, when the visit is performed in part by a physician and in part by an advanced practice provider (APP) who are in the same group, and when the physician meets certain criteria termed the “substantive portion” of the visit. CMS has accepted new language in the 2024 CPT code set, so the rules are aligned for both CPT and CMS in 2024. CMS is continuing to limit the split or shared concept to E/M codes only, not procedures.

In 2024, the definition of “substantive portion” means more than half the total time spent by both the physician and the APP for the encounter, or a substantive part of the medical decision making. CPT uses the example: the physician made or approved the order and takes responsibility for the inherent risk of complications and/or morbidity or mortality of patient management; thereby performing two of the three categories of medical decision making and the substantive portion of the visit.

CMS is proposing to allow split/shared visit billing for critical care because it believes the practice of medicine has evolved towards a more team-based approach to care, with greater integration of physicians and APPs into the clinical practice, particularly when care is furnished by clinicians in the same group in the facility setting. Since critical care is a time-based service, CMS requires practitioners to document in the medical record the total time that critical care services were provided and identify the provider who performed the majority of the patient-care time. The physician that provides more than 50 percent of the total time should be the one to report the critical care code.

Look for updated FAQ sets in the coming weeks both on the resource-based relative value scale equation and on split or shared services at acep.org/reimbursement-FAQs.

Telehealth

While no new codes were permanently added to the Medicare Telehealth Services list, the new rule finalizes a new process for adding, removing or otherwise changing codes on the list, and creates differential payment based on the place of service.

In this rule, CMS decided to maintain all five ED E/M codes (99281 to 99285). These codes are listed as provisional in Table 1 of the 2024 PFS Final Rule, meaning that they may be reported via telehealth at least through the end of 2024.

Additionally, some observation codes on the list of approved telehealth services are included at least through the end of calendar year 2024:

- Initial Hospital Inpatient or Observation Care—99221 to 99223
- Hospital Inpatient or Observation Care Services, Same Day Admission and Discharge—99234 to 99236
- Discharge from Hospital Inpatient or Observation Care—99238 to 99239

Additional Resources

Resources for these and other topics can be found on the reimbursement section of the ACEP website. Mr. McKenzie can also answer ACEP members’ specific, individual questions at dmckenzie@acep.org.

DR. GRANOVSKY is President of LogixHealth, an ED coding and billing company, and currently serves as the Course Director of ACEP’s annual Coding and Reimbursement Conferences.

MR. MCKENZIE is the reimbursement director at ACEP.
Intimate Partner Sexual Assault Case

by RALPH RIVIELLO, MD, FACEP, AND HEATHER ROZZI, MD, FACEP

Case

A 24-year-old female presents to the emergency department (ED) claiming to be sexually assaulted by her friend-with-benefits sexual partner. She wants to file a police report and have a sexual assault nurse examiner (SANE) exam performed. Medical screening examination is performed and she does not have injuries or complaints that need to be addressed. While waiting for the SANE nurse to arrive, the police arrive and take her complaint. Afterward she is visibly upset, angry, and crying. The officer informed her that this was not sexual assault, and that neither a formal complaint nor charges will be filed. You learn that she agrees to consensual sex with him, provided he wore a condom. During the intercourse, he removed the condom and ended up ejaculating in her vagina. She disagrees with the officer and is extremely worried about becoming pregnant and catching a sexually transmitted infection. What do you do?

Discussion

“Stealthing” is the practice of removing one’s condom during sex without the knowledge and consent of one’s partner. A study from Australia found that 32 percent of women and 19 percent of men, seeking care at a sexual health clinic, had been a stealthing victim. This is a form of reproductive coercion, which is defined as threats or acts of violence against a partner’s reproductive health or reproductive decision-making.

Why Do Men Do This?

Stealthing is a way abusers exercise power and control over a partner who is vulnerable and unaware. One study found that men with greater hostility toward women (odds ratio, 1.47) and more severe sexual aggression history (odds ratio, 3.06) had significantly higher odds of engaging in nonconsensual condom removal behavior. They think it is funny or they want to embarrass their partner. They often feel the sex is better or more pleasurable for themselves or their partner without the condom. Some men actually expect or pressure their partner to use a condom, but never put one on. This is facilitated by the partner’s trust or sexual positioning, making the partner unable to see if it was put on. Males who engaged in nonconsensual condom removal were significantly more likely to have had a sexually transmitted infection diagnosis (29.5 percent versus 15.1 percent) or have had a partner who experienced an unplanned pregnancy (46.7 percent versus 25.8 percent). Is Stealthing Rape?

The answer is, “not in most jurisdictions.” Most sexual assault and rape statutes do not include stealthing as part of their definition. California is currently the only state that has a stealthing law (California AB-453). That law makes it a civil offense, not a criminal one. No other state has enacted stealthing legislation. Worldwide, only a few countries actually recognize it as a criminal offense. One could argue that asking a partner to wear a condom for sexual intercourse is considered conditional consent. Simply, “I am giving consent, provided a certain condition is met.” In other words, “I consent to intercourse provided you wear a condom.” Therefore, if the partner does not wear or removes the condom, they have not lived up to the condition of the consent, therefore, there is no consent. So, in the present sense of the argument, no consent is rape or sexual assault. Unfortunately, many state laws have not added conditional consent to their rape statutes. That is why most jurisdictions will not charge or prosecute these cases as sexual assault or rape. The only recourse for the survivor is to seek damages in civil court. Often this can be based on psychological trauma, sexual assault, pain, suffering, mental anguish, etc. There is no data on how many of these cases have been successfully adjudicated.

What Does This Mean for the Patient Who Presents to the ED?

If law enforcement authorization is required for medical forensic examination (MFE) to be performed or paid for, it is most likely will be denied. This does not mean that a physical evidence kit (PEK) should not be collected. Studies have shown just the act of undergoing an MFE and PEK collection can validate and address sexual assault patients’ concerns, minimize the trauma they may experience, and promote healing. Additionally, if the patient decides to file a civil lawsuit, they can have the kit analyzed in a private laboratory. The presence of semen or DNA evidence is further proof stealing occurred. Most importantly, patients should be provided pregnancy, sexually transmitted infection, and HIV prophylaxis, as would be done for any sexual violence survivor.

Case Resolution

The SANE nurse arrived and explained to staff and the patient about stealthing and reviewed the options available to the patient. The rape crisis advocate was consulted and came to the ED to support the patient. An MFE was performed and a PEK was collected. The kit was stored as per the hospital’s anonymous kit storage policy. The patient received appropriate prophylaxis.

References

Things Aren’t Always Black or White
An analysis of racism in health care

by JAYNE KENDALL, MD, MBA, FACEP

“I matter, now what are you gonna do?”

That is the last line in Dr. Robert Ray, Jr.’s eye-opening and intensely raw blog, where he details his experiences with institutional and systemic racism during his emergency medicine residency. I have read his account several times now, and, as a white woman, I struggle with how to write about it.

Why Is It a Struggle for Me to Know How to Feel or What to Do with It?

I want to explore these feelings further and address my fellow white colleagues. The first thing some of us as white people might do when we read Dr. Ray’s blog is to say things like, “Oh, I feel so badly for him,” or “I can’t believe that happened!” We may think that there is nothing wrong with those responses. But that attitude is perpetuating the problem.

Those responses make Dr. Ray’s experience someone else’s problem. Those comments shield us inside a “white bubble” (or, as I like to call it, my “white force field”), which avoids recognition of racism and renders us impervious to its insidious effects.

We tell ourselves these stories to make sense of the world. But it’s just that, a story. White people do not exist under a non-racist force field that some of us like to believe we do. Look at the victims of racial injustice since 2020—including George Floyd, Daniel Prude, Breonna Taylor, Arabber Yarl, and Christian Cooper, just to name a few. While these discriminatory and brutal acts were shocking, they were not surprising to Black people.

Dear Fellow White People

Realize that all of these events happened inside our white force field. Racism lives among us. Some of us may think that the perpetrators committing these acts are unique outliers; they could not possibly be those with black and brown skin may induce guilt or defensiveness, which brings us back to pity and disbelief. Those feelings have been termed “white fragility,” which perpetuates racism, including racism in the house of medicine.

Racism is pervasive in medicine and has existed for centuries without being entirely eliminated. In 1978, Thomas Jefferson wrote false and incredibly racist physiological theories in his Notes on the State of Virginia. In 1910, Abraham Flexner, an educator without any background in medicine, examined the state of medical education and produced a report that revolutionized the future of physician training. To this day, you can read that Mr. Flexner espoused multiple racist views about the inferiority of black physicians in his report. He wrote that Black medical schools were “wasting small sums annually and sending out undisciplined men, whose lack of real training is covered up by the imposing MD degree.” As a repercussion of that report, just two out of seven Black medical schools remained by 1920, Meharry and Howard. Those two schools were responsible for educating nearly all Black American physicians through the 1960s.

At this point, the civil rights movement stepped in, and the Association of American Medical Colleges (AAMC) outlined its plan to increase the number of Black physicians. These affirmative actions created more Black representation and thereby increased “diversity” to a paltry 5.4 percent of physicians being Black (as of 2018). However, few genuine efforts to effect change occurred on “inclusion” and “belonging” beyond empty discussions and unanswered calls to action.

There were others before Dr. Ray who experienced racism inside the house of medicine. In the 1990s, Dr. Damon Tweedy recounted in his book, “A Black Man in a White Coat,” several racist experiences he had during medical training. He shared an early experience at Duke Medical School when his professor mistook him for a maintenance technician there to fix a dim light in the back of the class. The professor frowned and asked Dr. Tweedy that if he did not come to fix the light, why was he there? Tweedy replied, “I’m a student... in your class.” The professor unapologetically turned around and resumed teaching. Afterward, Dr. Tweedy consciously decided not to pursue the teacher, human resources, or any other means of calling attention to the incident to avoid repercussions.

Surely, these events have been eliminated now in the 21st century? Nope. A study published in 2020 demonstrated that in a cohort of more than 27,000 graduating medical students, 23 percent of Black students reported at least one episode of racial discrimination. Dr. Ray and Dr. Tweedy’s experiences are far from unique if nearly one in four Black medical graduates have reported the same thing.

To make matters worse, in 2020, Dr. Aysia Khoury was suspended and ultimately fired from Kaiser Permanente Bernard J. Tyson School of Medicine in Pasadena, Calif. without due process after leading a small-group discussion about her own experiences of bias in her medical education. Less than a year later, Dr. Derrick Morton sued that same institution for what he called a pervasive “anti-Black” culture at the school that included censoring and demoting Black employees. That Kaiser’s medical school is named after its own Black former CEO de-

CONTINUED on page 20

JANUARY 2024

The Official Voice of Emergency Medicine

18 ACEP NOW

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EQUITY

EQUATION

DR. KENDALL is the chief of clinician engagement at US Acute Care Solutions and has 15 years of emergency department leadership experience. She is the chair of the USACS diversity, equity, and inclusion committee, the social issues and equity in medicine committee co-chair, and leads physician leadership development for USACS.
Can’t-Miss Drug Interactions

Three patient groups and three categories of drugs to look out for

by ANTON HELMAN, MD, CCFP(EM), FCAP

Many common presentations to the emergency department (ED) are related to drug interactions that are commonly missed and largely preventable. We may be unaware of potentially dangerous drug interactions when we order and prescribe medications in the ED. The resulting morbidity and mortality is significant. Delirium, syncope, and falls are three presentations that should trigger a careful medication history and search for potential drug interactions. Clinical criteria validated to identify patients at especially high risk for drug interactions, in whom a medication review should be done, include: having a pre-existing medical condition; having taken antibiotics in the last week; age older than 80 years; and having a medication change in the past month. It is just only older patients who are at risk for drug interactions. Patients with psychiatric illness and renal disease should give us pause not only for unexplained presentations but also when ordering and prescribing medications for these patients in the ED. This column reviews key drug interactions in older patients, those with psychiatric illness and those with renal disease, as well as three essential categories of drugs where careful ED ordering and prescribing should be considered.

Three Groups of Patients at High Risk for Drug Interactions

Older patients are especially sensitive to medications with a narrow therapeutic range such as diabetes medications (insulin, sulfonylureas), anticoagulants, sedatives, immunosuppressants, and anticonvulsants. Whenever ordering or prescribing analgesics for an older patient careful consideration must be given to NSAIDs that can cause or exacerbate peptic ulcer disease and alter gastric control in people with diabetes.

Older patients are sensitive to the sedative effects of opioids, especially in combination with benzodiazepines, and avoidance of combinations or dosing adjustments should be made accordingly, to prevent mortality from this drug interaction in particular.

In patients with psychiatric illness, three consequences of drug interactions should always be considered with unexplained ED presentations or when ordering or prescribing medications: serotonin syndrome, neuroleptic malignant syndrome (NMS) and QT prolongation. Most antidepressants act on the serotonin system, and in combination, at high doses, and/or with other medications (antipsychotics, lithium, fentanyl, cocaine, methadone, or metoclopramide) may put patients at risk for life-threatening serotonin syndrome. We should be aware that fentanyl administration during procedural sedation in patients taking serotonin reuptake inhibitors may result in serotonin syndrome, which therefore should be on our differential diagnosis in patients who emerge from sedation with agitation. Antipsychotics in combination, at regular or at high doses, can increase the risk of NMS causing autonomic instability. QT prolongation depends on the number of potentially QT-prolonging drugs, the class of drugs, and the specific medication. Especially high risk drugs include cilostat or esmolol in combination with erythromycin, moxifloxacin or ondansetron.

Renal patients are at high risk for drug interactions owing to impaired clearance of some drugs and their tendency to be on multiple medication for their comorbidities. There are two specific drug-related scenarios in the patient with renal disease for emergency physicians to be aware of: hyperkalemia, and dose adjustments for drugs that are renally excreted. Many drugs can pre-dispose to hyperkalemia, including angiotensin-convert- ing enzyme inhibitors, angiotensin receptor blockers, spironolactone, triamterene-sulfamethoxazole, heparin, and NSAIDs. The risk of hyperkalemia increases when these medications are combined in renal patients who have a decreased ability to eliminate potassium. A particularly concerning drug interaction is trimethoprim-sulfamethoxazole in combination with spironolactone, which clearly increases the risk for hyperkalemia and sudden cardiac death. When it comes to impaired drug elimination direct oral anticoagulants, colchicine, and digoxin are particularly important and require dose or interval adjustment in renal patients.

Three Categories of Drugs Are Commonly Involved in Drug Interactions

Three categories of drugs prescribed commonly in EDs carry significant potentially dangerous drug interactions: antimicrobials, analgesics, and cardiovascular drugs. Aside from the trimethoprim-spiromolactone interaction mentioned above, trimethoprim-sulfamethoxazole also interacts with warfarin to cause supratherapeutic international normalized ratio values and increased bleeding risk, and with angiotensin-converting enzyme inhibitors or angiotensin receptor blockers to cause hyperkalemia. Macrolides are another group of antibiotics to be careful prescribing. Clarithromycin or erythromycin when combined with lipophilic statins such as atorvastatin, lovastatin, or simvastatin, increases the concentration of the statin, thus increasing the risk for rhabdomyolysis. Erythromycin or clarithromycin in combination with amlodipine can lead to clinically significant hypotension. When choosing a macrolide, azithromycin is generally considered the safest with regard to drug interactions.

Analgesics are another important category of drugs when it comes to drug interactions. Opioids in combination with any sedating medication should be avoided whenever possible. A well recognized drug interaction in this category includes nonsteroidal anti-inflammatory drugs in combination with acetaminophen acid, leading to a higher risk of arterial thrombosis.

The third category of drugs that are often involved in drug interactions are cardiovascular drugs. Important underrecognized interactions for emergency physicians include: warfarin plus acetaminophen increasing international normalized ratio and bleeding, beta-blockers plus cholinesterase inhibitors causing bradycardia and syncope, and insulin plus beta-blockers leading to hypoglycemia.

Next time you are faced with a patient presenting with syncope or altered level of awareness, or you are considering prescribing antibiotics, analgesics, or cardiovascular drugs in the ED, consider these potentially life-threatening drug interactions—you may pick up an iatrogenic cause or narrowly avert an iatrogenic disaster!

Many thanks to Dr. David Juairelink and Dr. Walter Himmel for their expert contributions to the EM Cases podcast that inspired this article.

References


CONTINUED on page 21
Racism in Health Care

Implicitly and explicitly, racism in health care and medical education exists. It continues to exist because many of us, as white people, ignore it. Until we confront this head on and honestly acknowledge how we contribute to the perpetuation of this problem, these incidents will continue. Dr. Vanessa Grubbs, founder of Black Doc Village, articulates this well: “A white-dominated physician training system that unjustly excludes, punishes, and dismisses Black medical students, trainees, and attending physicians will continue on.”

If you have read this far, you have a choice. You can turn the page and never think about this topic, or you can work together to find solutions. I have chosen to be antiracist and join the movement to end racism in medicine. You can turn the page and never think about this topic, or you can work together to find solutions.

Dr. MCKINLEY completed an Emergency Medicine ultrasound fellowship at Maine Medical Center and is currently the Assistant Director of the Ultrasound Imaging program.

Dr. BAUMAN completed an Emergency Medicine ultrasound fellow at Maine Medical Center and is currently the Co-Director of Ultrasound at Southern Maine Health Care Medical Center where he practices as an attending physician.

Dr. CHRISTENSEN completed an emergency medicine ultrasound fellowship at Maine Medical Center and is currently the director of Point of Care Ultrasound with Blue Water Health in Brunswick, Maine.

Dr. GAUDET completed an emergency medicine residency at Maine Medical Center and is currently a fellow in Emergency Department Quality & Management at Beth Israel Deaconess Medical Center. She is a Clinical Instructor associated with Harvard Medical School.

Dr. WOOD is an associate professor of Emergency Medicine at Tufts University School of Medicine and an emergency medicine attending physician at Maine Medical Center.

Dr. LINNELL is an Obstetrician and Gynecology attending physician at Maine Medical Center. She is a clinical instructor for Tufts University School of Medicine and is the co-director of the Tufts University School of Medicine third year OB-GYN clerkship.

The decision to reduce the uterus should be made by the obstetrics specialist. Maintaining a high level of suspicion for this rare diagnosis will help establish early identification and treatment, therefore reducing risk of maternal and fetal complications.

EQUITY EQUATION

CONTINUED FROM PAGE 10

TEACHING POINTS

- High index of suspicion for incarcerated gravid uterus in any pregnant patient with acute urinary retention at weeks 10-16, especially with a retroverted or retroflexed uterus.
- Consider performing transabdominal rather than transvaginal ultrasound to identify the structural relationship of the cervix to the uterus when making this diagnosis.
- Diagnostic and treatment options should be made with recommendations after obstetrics consultation.

Private Democratic Group in Norfolk/Virginia Beach

Since 1972, Emergency Physicians of Tidewater has been providing exceptional patient care via several Emergency Departments in Southeastern Virginia. Our physicians enjoy their choice of practice settings from an academic Level 1, Quaternary Referral Center to a community-based practice. EPT leads the longest running Emergency Medicine Residency program in Virginia as well as multiple fellowships. EPT physicians enjoy coastal living in Virginia Beach and Norfolk, with history-rich areas like Colonial Williamsburg and the Blue Ridge Mountains within a short drive.

Opportunities:
- **EQUITY/OWNER/EQUITY.** Accelerated two-year partnership track.
- **LEADERSHIP.** Governing Board/Committee appointments.
- **TEACH.** Faculty appointment at Eastern Virginia Medical School.
- **COLLABORATE.** With a highly-cohesive, LOCALLY-governed group.

Visit EPT at www.ep11.com for more information.

REFERENCES


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17. Rep progression of neuroleptic malignant syndrome. 
Sci psychiatry and other drugs on the development and precipitated by fentanyl during procedural sedation. 

18. and severe adverse respiratory events. 


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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 Lancaster Medical Center in Lancaster, Pa.; Penn State Health St. Joseph Medical Center in Reading, Pa.; Pennsylvania Psychiatric Institute, a specialty provider of inpatient and outpatient behavioral health services, in Harrisburg, Pa.; and 2,450+ physicians and direct care providers at 225 outpatient practices. Additionally, the system jointly operates various healthcare providers, including Penn State Health Rehabilitation Hospital, Hershey Outpatient Surgery Center and Hershey Endoscopy Center.

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.

For more information please contact:
Heather Peffley, PHR CPRP - Penn State Health Lead Physician Recruiter
hepffley@pennstatehealth.psu.edu

Penn State Health is fundamentally committed to the diversity of our faculty and staff. We believe diversity is unapologetically expressing itself through every person’s perspectives and lived experiences. We are an equal opportunity and affirmative action employer. All qualified applicants will receive consideration for employment without regard to age, color, disability, gender identity or expression, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, and family medical or genetic information.
about the emergency medicine residents’ role in staffing the hospital’s medical and trauma ICUs? What would happen to the hospital’s accreditation status as a Level II Trauma Center?

It is not clear, especially given all of these questions, why Christus Spohn chose to close the residency program in October. Hospital leaders have not spoken to the press or made themselves available for interviews, including a request from ACEP Now. But in an October 17 statement and at public meetings, the hospital and its representatives cited financial concerns.

“The difficult decision to phase out the Emergency Medicine Residency Program was made with thorough consideration of our community’s needs and our available resources to serve those needs. We ultimately determined that our ability to sustain this program would end with graduating the current residents in 2026,” the hospital’s statement noted.

The hospital also expressed its intention to concentrate on residency training in family medicine, another need for rural areas such as South Texas. “Ultimately we are simply unable to sustain the [emergency medicine] program for the long-term future.”

The hospital noted that emergency medicine residencies in Texas have grown from three when its program was launched in 2007, to 18 programs today. On this year’s Resident Match Day, 555 emergency medicine slots initially went unfilled, compared with 219 from the Match Day in 2022, although most of the unfilled slots were filled through the Supplemental Offer and Acceptance Program (SOAP). An EM study projecting an oversupply of emergency physicians by 2030 was cited by Christus Spohn as another reason to close the program.1

ACEP responded with a letter to health system leaders explaining that the study, published in 2021, was based on pre-pandemic 2019 data and fails to reflect a maldistribution of the emergency physician workforce, unfilled needs for emergency medicine board-certified providers in rural and underserved areas, and high rates of burnout among emergency physicians.

“Emergency medicine residency training programs provide lasting benefits to an institution and the community it serves that are not captured on simple financial analysis,” states the letter, signed by ACEP President Aisha T. Terry, MD, MPH, FACEP. “There are numerous studies describing how EM residencies drive improvements in the quality of care, care coordination, addressing social determinants of health, and preparation and response to disasters and large-scale events.”

Gillian Schmitz, MD, FACEP, an ACEP Past President and associate professor at the Uniformed Services University of the Health Sciences in San Antonio, co-authored a recent editorial on the Workforce Study in Annals of Emergency Medicine stating, “The long-term effect of supply and demand remains complex and difficult to predict but the sky is not falling.”

She explained to ACEP Now, “From the perspective of the local environment, of course we want residents. From a national perspective, it gets more complicated.”

Dr. Schmitz credited Christus Spohn for planning to close the program gradually, allowing current residents to finish their training, instead of leaving them scrambling, as happened when Hahnemann University Hospital in Philadelphia closed in 2009. But an important takeaway is the effect on the pipeline of future physicians, she said. Physicians often tend to stay in an area where they enjoyed their medical training.

Christus Spohn provided a unique learning environment, far from academic settings and competing residency programs, Dr. Schmitz said, “By all accounts, it’s a wonderful place to train. It feels emotional to the people there … But people have to understand that training residents is expensive.”

Angela Gardner, MD, FACEP, an ACEP Past President and professor of emergency medicine at University of Texas Southwestern in Dallas, said the cost of supporting and teaching residents outweighs the inexpensive labor they provide.

“I still believe in our mission of having an emergency department residency-trained doctor in every emergency room in the country,” she said. “I never had to lift a finger to get a job in emergency medicine. People wanted emergency doctors back them. Maybe that’s what has changed.”

The University of Vermont is limiting interested candidates who can contribute to the diversity and inclusive excellence of the academic community through their teaching, service and research, scholarship or creative arts. Applicants are required to submit a separate statement of advancing diversity and inclusive excellence.

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2. Schmitz GT, Jaros JI. The emergency medicine match: Is the sky falling or is this just growing pains. Annals of Emergency Medicine. 2023 Nov; 82(5):608-610.

CLASSIFIEDS

The Department of Emergency Medicine at The Larner College of Medicine (LCOM) at The University of Vermont is seeking to recruit Principal Investigators at the Assistant, Associate Professor, or Professor level on the Tenure-Track.

The ideal candidate will engage in innovative scholarship and high-impact research that will complement existing departmental expertise in cardio-cerebrovascular, neuroscience, infectious disease, substance abuse, rural health outcomes, gender disparity, health equity, and mental health. The candidate is expected to maintain an independent, extramurally funded research program. The candidate also must be willing to teach in a medical and graduate school setting. Start-up funds will be competitive.

Successful candidates will have opportunities and expectations to contribute to furthering the academic, educational, and scholarly missions of the UVMHN. Candidates must have a record of excellent research and mentoring/teaching skills; a PhD or MD/PhD in a relevant field of study and postdoctoral experience; or a MD or equivalent degree and be Board Certified or Board Eligible by the American Board of Emergency Medicine (ABEM) and eligible for licensure in the State of New York and Vermont. Although all interested candidates are encouraged to apply, strong preference will be given to candidates with experience in the teaching, clinical, and research activities of academic emergency medicine.

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Review of applications will begin immediately and continue until the position is filled. Include a CV, research plan, teaching statement and experience, and the names and email addresses of three references. After the initial review of applications, references may be contacted to submit their letters directly to the Search Committee.

Interested individuals should apply online at https://www.uvmjobs.com/postings/68837 (position number 00026874). Inquiries may be sent to Dr. Kaley Freeman, Dept. of Emergency Medicine, University of Vermont, Given Medical Building, 89 Beaumont Ave., Burlington VT 05405 or via email at: Kaley.Freeman@uvm.edu.

DEPARTMENT OF EMERGENCY MEDICINE

Given D311, 89 Beaumont Ave. Burlington, VT 05405

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date social gatherings, you may have some- body saying: “Well, I only want to work. That’s my contract with the hospital or the university. I just want to come in for work and that’s my deal. I’ll do work, you pay me. I’ll go home.” And then there’s the challenge as others are like: “Well, I want to know who you are. I want you to wear a shirt when we’re not working.” I would like to.” So, that gets to be a dilemma for manage- ment to figure out. Work is not just financial reimbursement. There’s psychological reimbursment. And if you’re only thinking about financial materiality— you’re going to miss the psychological materiality.

AB: The most important thing is that phys- sicians feel that the organization cares for them. In police culture one frequently hears people say, “we’re a family.” What they mean when they say this is, “We care about you.” If employers make transparent expressions of care and the intention to ensure that the phys- sicians feel appropriately valued, it will show how to induce quality work. And people who come to work with a sense of mission don’t re- ally have to be incentivized. The job isn’t nec- essarily how to create a set of incentives that will properly motivate the physician. The chal- lenge is how do we subtract the problems that obstruct physicians and induce feelings of de- moralization.

MK: Are there things that ER docs can do as individuals (not more pizza or yoga classes) to address burnout for them- selves?

GC: There are some burnout models that can be helpful as far as individual solutions, such as the demand-control-support model. What demands do you have? Anything that takes up time is a demand. Is there anything that you could potentially get off your plate, anything that you could control? There’s go- ing to be times that you can’t control things and that’s when spirituality, things like the serenity prayer can be helpful. We’ve got to be connected with people. We must reach out and be intentional about making sure that we have people in our lives. There’s the effort-reward [imbalance] model. We expect to get rewarded for our work. And sometimes that means taking a look at our work to find things that maybe we do like to spend a little bit more time on.

There are things that we can pivot or change within our own work.

DM: I think the [social] fabric is important. This is more about just being a worker. One of the things that can happen as a worker is you can let social connections fade away, particu- larly men, and that shortens the life, it leads to more morbidity. And so, to be specific to people I know, especially men, “I’m not go- ing to show up for the softball league,” or “I’m not going to go to book club.” They will say, “I’m too tired” or “I’m too busy.” And there are times when that’s reasonable, as Greg was say- ing, you have to be thoughtful about, “Should I be taking things off my plate?” or, “Should I also be making sure that I sustain those friendships and those social fabrics through the years?”

AB: Two basic principles are social connect- edness and physical exercise. You can find a form of physical exercise that you enjoy doing, that can be enormously helpful. With respect to the problem of burnout, sometimes a well thought-out, planned pe- riod of absence from work can do wonders. A few weeks or a few months off from the job to really try to process what one is experienc- ing, take some time talking with a therapist or another thoughtful person whom one trusts. Taking time to sort of recalibrate, reexamine. Ask oneself, “Why did I go into this profes- sion in the first place? Why is it driving me crazy? Why do I feel so apathetic? Is there anything I can do about it?”

DM: One of the healthy coping mechanisms of being a physician is altruism: caring for others. For example, at the end of your shift, you’re leaving and that other doctor is taking on for you. And you can use your altruism for them: not to be paying and not to be rude, but as col- leagues, you can check in with them.

I see this a lot in police and fire (and manag- ers), the other sort of hero specialties or pro- fessions that they don’t really own up to how worn out they are until someone comes over and asks them. And then they’re like, “Holy shit, you’re right!”

Author’s Note: this interview has been edited for brevity and clarity.

DR. KENTOR is a board-certified emergency phy- sician with an MBA from the Northwestern Kellogg School of Management in Evanston, Ill. He is a mem- ber of the editorial advisory board of ACP NOW.

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JANUARY 2024 ACEP NOW 23

ACEP NOW

The University of Vermont Health Network is Vermont’s largest and most comprehensive health system, serving over 2 million people annually, and the University of Vermont’s academic medical campus, located in Burlington, VT.

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Interested individuals should apply online at https://www.uvmjobs.com/postings/69099 (position number 00026882). Confidential inquiries to acquire further information about this position may be directed to Dr. Ramsey Herrington, Chair of the Department of Emergency Medicine at rmnsey.herrington@uvmhealth.org. Review of applications will begin immediately. Applications will be accepted until the position is filled.

The University of Vermont
VICE CHAIR OF RESEARCH
DEPARTMENT OF EMERGENCY MEDICINE
UNIVERSITY OF VERMONT

The University of Vermont (UVM) is seeking an Emergency Medicine Physician or a PhD-scientist to fill the role of Associate Professor or Professor in the Clinical Scholar Pathway, Research Scholar Pathway, or Tenure Pathway and serve as Vice Chair of Research (VCR).

The Department of EM provides clinical coverage at the seven clinical campuses of the University of Vermont Health Network in Vermont and upstate New York. Fifty-three academic faculty in the Department work with colleagues in community clinical practice to serve approximately 200,000 patient visits annually, and the Network hospitals serve a catchment of 40,000 square miles and 1.4M people. LCOM students and Emergency Medicine residents train clinically in three of the Network sites with elective rotations in multiple other sites. Our primary teaching campus is the University of Vermont Medical Center, the only Level I trauma center in the greater region. The majority of academic faculty provide clinical coverage at multiple sites in Network, including our rural and critical access sites, underscoring our commitment to high quality rural acute care delivery.

The Vice Chair of Research (VCR) is a new position in the UVM Department of Emergency Medicine. Emergency Medicine emerged as a new academic department at the University of Vermont in 2022, but the research program has been in development prior to organizational independence. At the time of this posting, the research portfolio includes more than $10M in extramural funding, largely from federal sources, including the NIH, HRSA, SAMHSA, and the DoD. Grant funding fully supports the Director of Research and seven research associates. The Department holds two positions on the Human Subjects arm of the Institutional Review Board, and we are actively recruiting participants into 25 IRB-approved studies. The Emergency Medicine Research Associate Program (EMRAP) provides infrastructure necessary to conduct clinical research projects in the Emergency Department. EMRAP provides training and support for student research associates who screen and assist in enrolling Emergency Department patients for ongoing clinical research and quality improvement projects. This program is supported from teaching revenues from four undergraduate and graduate research courses at LCOM. Research staff, in collaboration with the Emergency Medicine Research Associate Program, are present in the Emergency Department 24 hours per day, 7 days a week, conducting research activities on current studies, including consenting, sample acquisition, data extraction, and Electronic Health Record (EHR) chart review.

The Department’s research portfolio comprises both basic science and clinical and translational science in traumatic coagulopathy, brain health, substance use disorder, healthcare innovation, rural acute care, pediatric emergency medicine, infectious disease, gender disparity, and EMS. Departmental research priorities include but are not limited to: cerebrovascular disease, infectious disease, substance use disorder, mental health, geriatrics, population health, value-based care, healthcare innovation, gender disparity, health equity, implementation science, and rural and austere acute healthcare, including global health.

The VCR will be provided with nonclincial time allocation to achieve the roles and responsibilities across the following domains:

• Leadership and Strategic Planning
• Recruitment
• Mentorship
• Budgetary oversight and management
• Expansion of the current research portfolio
• Collaboration within the College and University
• Scholarship
• Establishment of UVM as a national leader in Emergency Medicine research

Qualifications: M.D., D.O., or M.D./Ph.D. degree or equivalent with credentials appropriate for an appointment at the rank of Associate Professor or Professor (Clinical Scholar, Research Scholar or Tenure Pathway) at the University of Vermont and with a record of accomplishments in research and a demonstrated record of research productivity, including NIH funding and/or significant experience obtaining and administering extramural funding from federal sources. Experience in mentorship of junior faculty and trainees is important, and success in budgetary management will be considered an asset.

Although all interested candidates are encouraged to apply, strong preference will be given to candidates with leadership experience in the research activities of academic emergency medicine. Consistent with all recruitments, we seek candidates that demonstrate empathy, humanism, and humility, and candidates with a commitment with an environment that employs transparency to create faculty and leadership accountability. Candidates must commit to our core values of Professionalism at the LCOM and are advised to review our Statement on Professionalism.

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The University of Vermont Health Network is Vermont’s largest and most comprehensive health system, serving over 2 million people annually, and the University of Vermont’s academic medical campus, located in Burlington, VT.

The University of Vermont is an Equal Opportunity/Affirmative Action Employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, protected veteran status, or any other category legally protected by federal or state law. The University encourages applications from all individuals who will contribute to the diversity and excellence of the institution.

Interested individuals should apply online at https://www.uvmjobs.com/postings/69099 (position number 00026882). Confidential inquiries to acquire further information about this position may be directed to Dr. Ramsey Herrington, Chair of the Department of Emergency Medicine at rmnsey.herrington@uvmhealth.org. Review of applications will begin immediately. Applications will be accepted until the position is filled.

The Official Voice of Emergency Medicine

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