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Workplace Violence and Mental Health in EM

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Intimate Partner Sexual Assault Case

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EM CASES

Can't-Miss Drug Interactions

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AI in the ED: Ethical Issues

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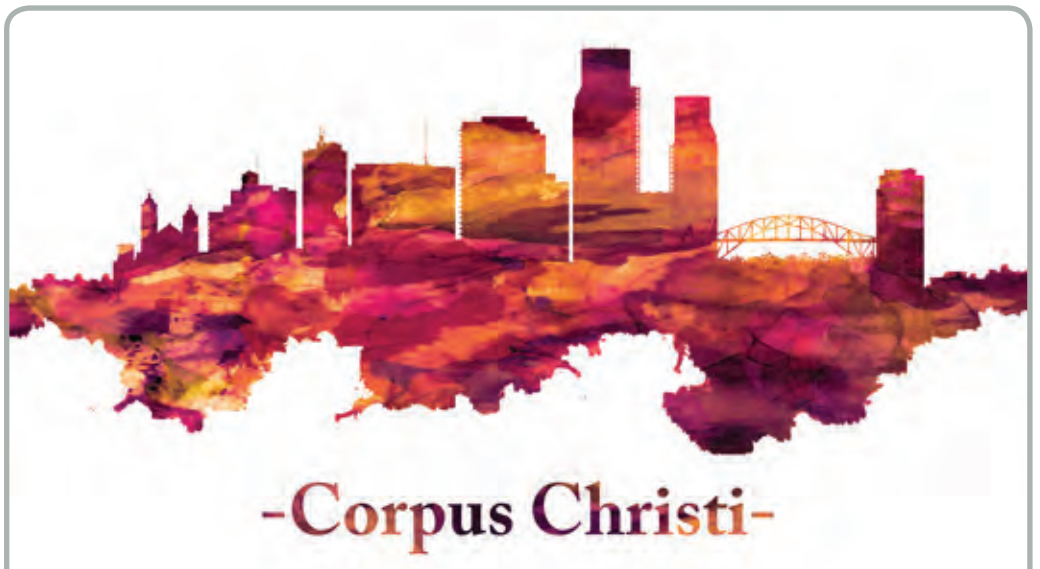

The EM Residency Program in Corpus Christi Resuscitated

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.

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 Residen-

CONTINUED *on page 14*

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. Daven 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 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

CONTINUED *on page 8*

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EQUITY EQUATION

Things Aren't Always Black or White

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NEWS FROM THE COLLEGE

UPDATES AND ALERTS FROM ACEP

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 its 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.

ACEP ACCELERATE

Fuel Your Future with ACEP Accelerate, March 9-15

Your favorite educational tracks are now in one location during the same week at ACEP Accelerate:

- Reimbursement & Coding
- ED Directors' Academy
- Teaching Fellowship
- The Advanced Pediatric EM Assembly

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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.

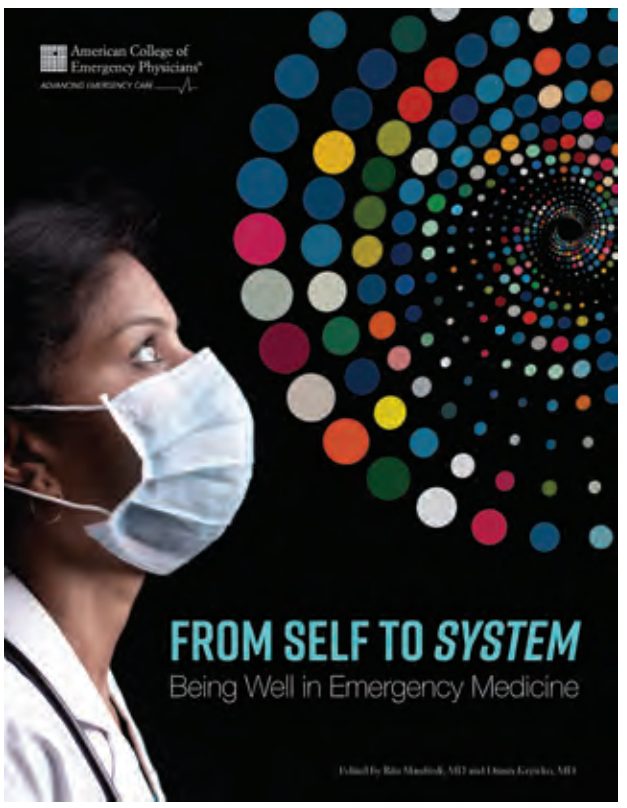
PEERprep For Physicians

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.



ACEP's New Wellness Guide Now Available

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."

RESIDENCY SPOTLIGHT

UNIVERSITY OF TENNESSEE HEALTH SCIENCE–MURFREESBORO/NASHVILLE EMERGENCY MEDICINE RESIDENCY

Instagram: @utnash_em

Location: Murfreesboro, TN

Year founded: 2010

Number of residents: 24

Program length: 3 years

MARK REITER

Residents at journal club.

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.

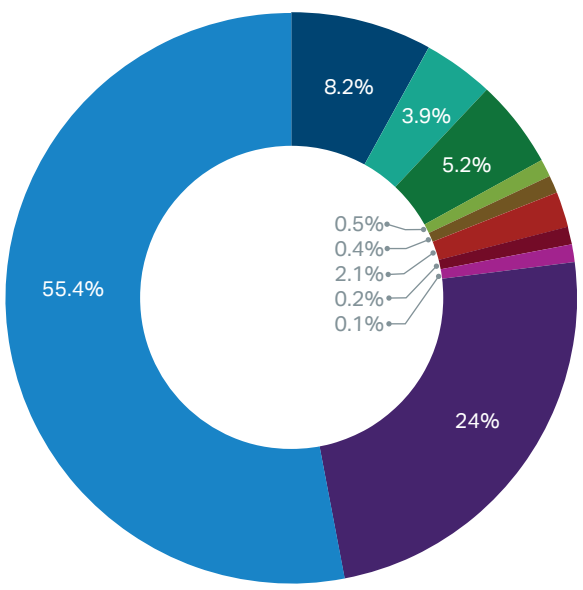
Learn more about our residency program at: https://comnashville.uthsc.edu/content/emergency-medicine

—Mark Reiter, MD, MBA, residency director

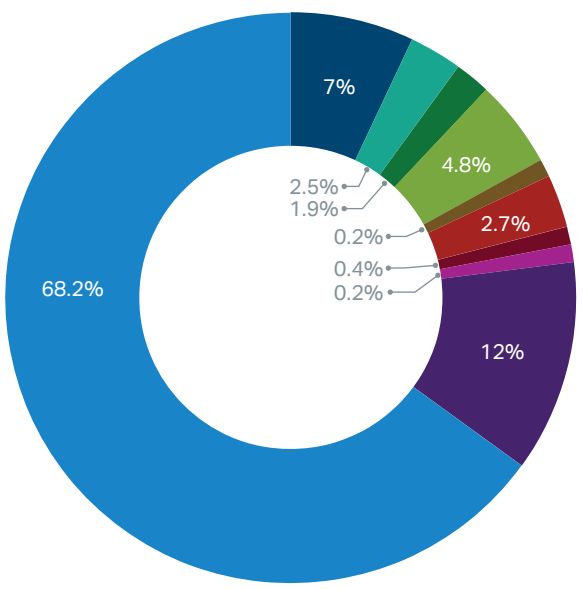
By the Numbers

ACEP Members Self-Reported Ethnicity Demographics

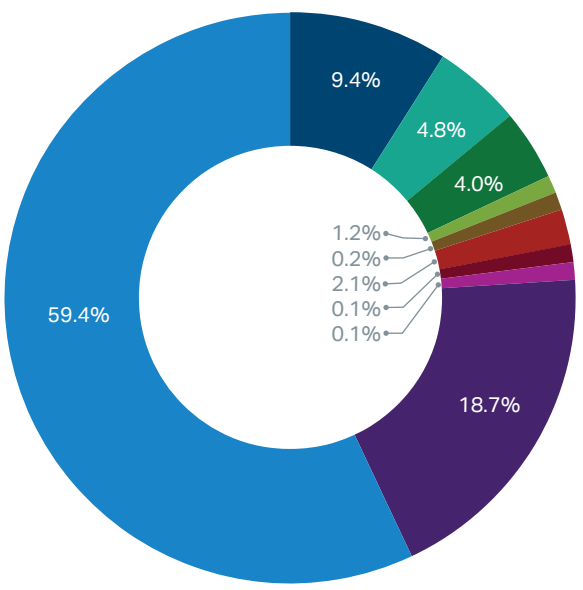
ALL MEMBERS



COUNCILLORS AND ALTERNATE COUNCILLORS



ALL COMMITTEE 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

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.

SEND YOUR THOUGHTS AND COMMENTS TO ACEPNOW@ACEP.ORG

THE BREAK ROOM

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), which we assert is more useful.

—Michael Mullins, MD, FACEP, FAACT

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 bronchosopy or even appropriate sectioning.

—Joseph Shiber, MD, FACEP, FACP, FCCM

Re: 'Tackling Emergency Department Crowding'

Until we solve the post-acute care shortage, we're doomed.

—Chuck Pilcher, MD,FACEP

Re: 'VACEP Legal Victory Illustrates Why the Prudent Layperson Standard Still Matters'

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, FACEP

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 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 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 too review the EMR when dealing with frequent flyers with chronic medical conditions.

—Edward Walkley, MD, FACEP, FAAP

ACEP4U: ACEP Leadership Diversity Efforts Continue to Evolve

ELEVATING THE VOICES IN OUR SPECIALTY

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, subspecialities, 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."

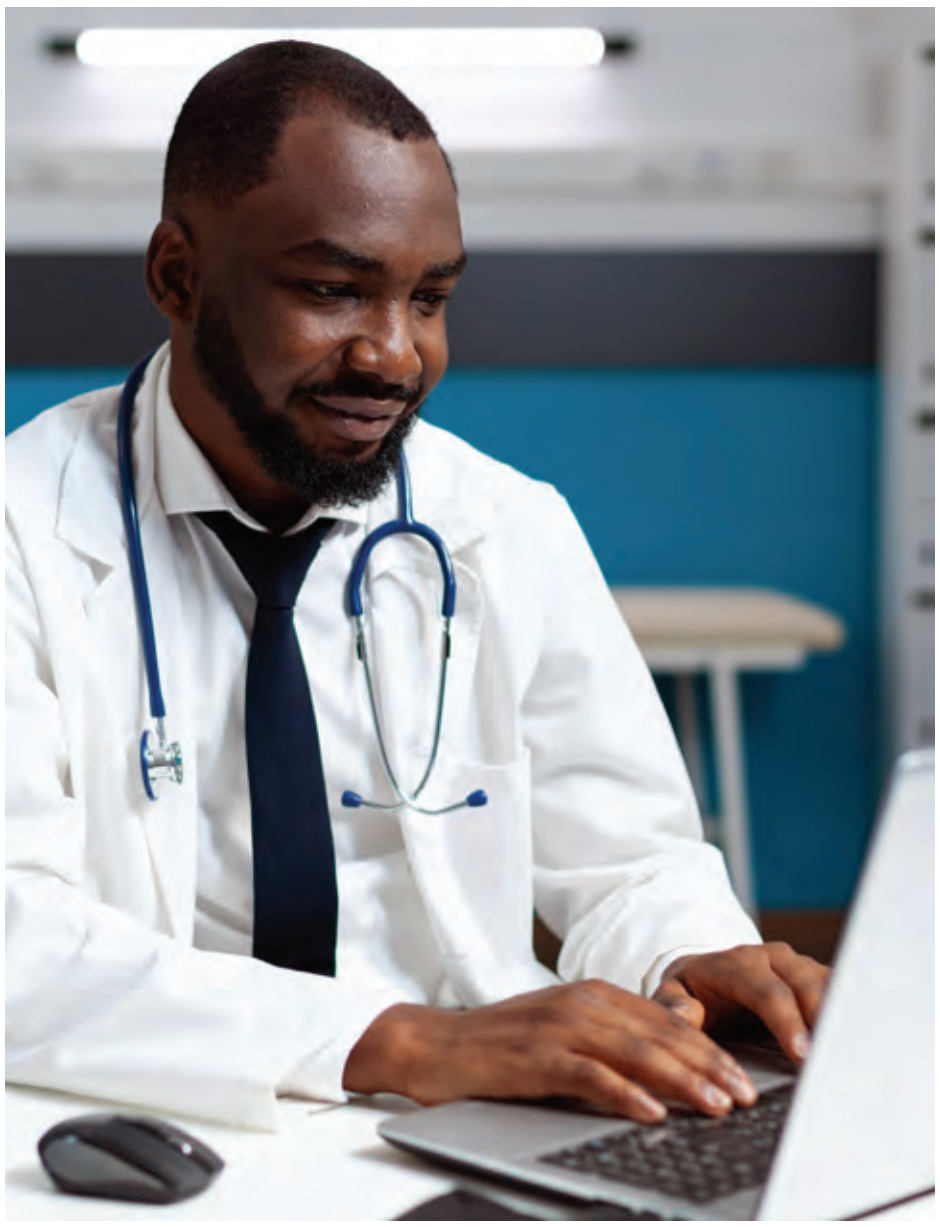
2023 ACEP Member Self-Reported Demographics

ETHNICITY	BOARD	ALL MEMBERS	SECTION LEADERS	COMMITTEE MEMBERS
White	60.0	55.4	59.0	60.2
Asian	13.3	8.2	6.0	9.5
More than One/Mutliracial	6.7	2.1	5.0	2.1
Black	6.7	3.9	4.0	4.9
Hispanic	0	5.2	3.0	4.0
Other	13.3	25.2	24.0	19.4

GENDER	BOARD	ALL MEMBERS	SECTION LEADERS	COMMITTEE MEMBERS
Male	73.3	64.4	60.4	60.0
Female	26.7	35.5	39.6	40.0
Other	0	0.1	0	0

PRACTICE ENVIRONMENT	BOARD	ALL MEMBERS	SECTION LEADERS	COMMITTEE MEMBERS
Rural	11.0	8.3	7.9	6.0
Suburban	34.2	41.7	23.8	26.1
Urban	54.8	50.0	68.3	67.8

AGE	BOARD	ALL MEMBERS	SECTION LEADERS	COMMITTEE MEMBERS
20 to 30	0.0	21.3	0.6	14.4
31 to 40	0.0	32.2	28.6	31.3
41 to 50	60.0	21	36	27
51 to 60	26.7	13.4	16.5	14.8
61 to 70	6.7	8.2	10.2	9
Greater Than 70	6.7	4	8.3	3.6



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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 Case Report

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

- 200-word introduction of the patient's presentation, followed by,
- 600 word description of the diagnosis and management of the case including up to three bulleted teaching points,
- 10 reference maximum.

Rare, but not unusual, cases with clinical importance to emergency medicine will be considered. Those with clinical images preferred.

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.

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

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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.[1]

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 intricate tasks without fatigue. Advocates assert that "losing certain skills to AI, much like the advent of calculators and the internet, is not only inevitable but also beneficial to human progress."[1]

However, the erosion of human expertise is problematic if the decline in physicians' diagnostic and decision-making skills results in clinical errors if (or when) the technology fails.[2] Educators find it challenging to instill essential critical-thinking skills when students rely on AI tools to solve problems for them.[3] Emergency physicians may become human mechanics, performing procedures, giving medications, and admitting patients only when instructed to do so by the AI program. Many fear that a declining emphasis on critical thought and the basic skills that comprise the art of medicine not only will compromise patient care, but also will contribute to an anti-intellectual "dumbing down" of medical practice.[4]

AI has the potential to reduce the amount of time needed for many repetitive tasks in the practice of the emergency physician. AI can analyze patterns of patient care and recommend more efficient patient throughput. The emergency physician might spend the time saved with patients, resulting in better patient satisfaction. However, that same increase of efficiency might result in a demand from the health care system for increased patient throughput, resulting in emergency physicians having to see more patients rather than spending more time with them.[5]

AI may suggest diagnoses for complex constellations of symptoms and findings, a potential boon to emergency physicians. But the danger is that, instead of consulting the literature for complex cases, the emergency physician will regard AI as an authoritative source. Emergency physicians may feel that they are giving up autonomy both in their choice of how to practice and in sorting complex and challenging analyses that are ceded to AI. Rather than helping with burnout, AI may instead become a demanding taskmaster 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 might 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 part of their care.[6] 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 about 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.[7] A study of AI-triggered palliative-care decisions found a higher use of palliative-care consultations and a reduced hospital readmission rate.[8] AI will undoubtedly be useful in providing emergency physicians with ethical guidance, but it cannot make ethical decisions itself.[9]

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.

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.

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BURNOUT | CONTINUED FROM PAGE 1

DEI [diversity, equity, and inclusion]. How systematic, how thoughtful, how comprehensive is the organization around addressing that? And finally, G is for governance. How carefully, how thoughtfully, how comprehensively are you governing or managing your organization? The broader term that ESG is used interchangeably with is *sustainability*.

ESG was really motivated by the millennials in a lot of ways, asking questions about endowments, asking questions about, is there something more than shareholder value? Asking questions about, look at the boards of these companies, look at the makeup of who's 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 $53 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: I think you're talking about the quadruple aim, and employee satisfaction is an important part of that. I think at times it's sort of a Dilbert-esque management philosophy that pushes employees toward these metrics without fully considering their mental health.

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.

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.

The first fact: A leader, and a supervisory staff more generally, that's capable of establishing a personal connection with the people who work with them: That's invaluable.

Secondly, we need to create workplaces where doctors and other health care workers actually like each other and enjoy each other's company. Under such circumstances people look forward to going to work because they look forward to seeing their friends and colleagues there.

I would like to see medicine develop the kinds of peer support systems that the police have developed. In Boston, this has helped mitigate some of the impacts of public hostility. A culture of collegiality and mutual support would go a long way toward improving the work experience of physicians.

GC: The doctors' lounge isn't billable. There aren't as many doctors' lounges around [anymore]. COVID changed that, too. It seems like people are more in their offices than they used to be. It's taken away from face-to-face contact. There are a few studies, one giving physicians time to get together in groups, and there's an assignment to take a few minutes to talk about a burnout topic, but the rest of the time they get to spend with their colleagues. If they're given time to meet counted as administrative time, it correlate[s] with decreased burnout.

DM: It also ought to be enculturated 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 man-

CONTINUED *on page 23*

MORE HOSPITALS ARE CLOSING

ARE HEALTH CARE WORKPLACE CONDITIONS TO BLAME?

by HARRY W. SEVERANCE, MD, FACEP

The wave of increasing hospital closures and service line cutbacks 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," "staffing shortages," or "focusing on more in-demand services" as driving forces.[1] 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.[2]

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

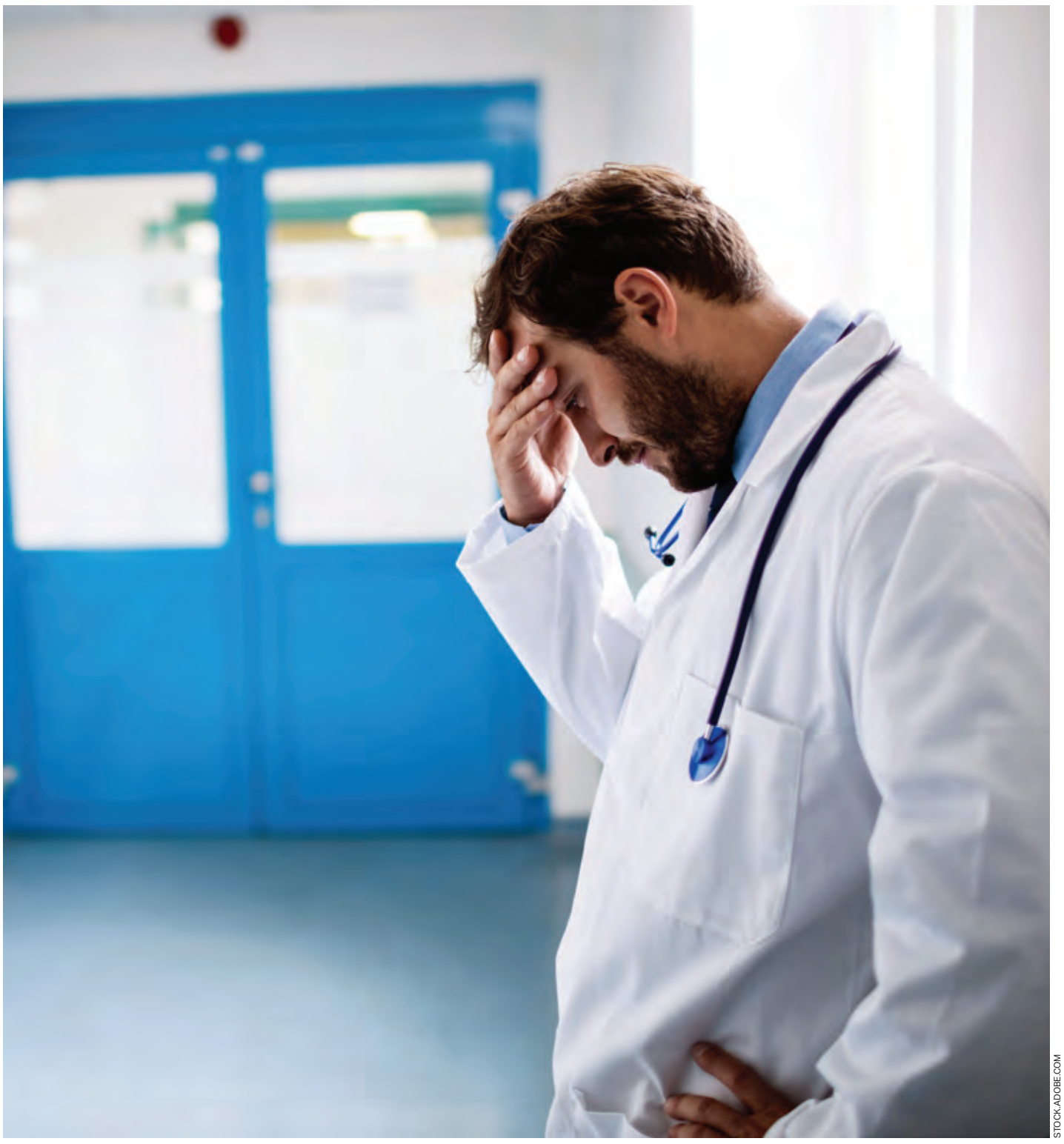
More than 20 percent of our health care workforce left health care in the last two years, and 10 percent of all practicing U.S. physicians quit in 2021 alone.[3,4] This exodus is largely due to disintegrating conditions in many of our nation's health care workplaces, conditions that include: marginalization, 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.[5–13]

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.[14,15] There 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.

DR. SEVERANCE is a clinically practicing physician, an educator, and researcher.



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Acute Urinary Retention and Fever in a Man

A rare, but sometimes fatal combination

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

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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."[1] It is typically seen in males older than 60 years and has a significantly higher incidence in men with benign prostatic hyperplasia.[2]

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.[2-4]

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.[5] 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."[6-7] Typically caused by gram-negative bacteria, *Escherichia coli* is "the predominant organism in acute prostatitis and occurs in 75 percent of all cases."[6] Some studies estimate that *E. coli* is the causative organism in up to 80 percent of all cases.[7]

Diagnosis of acute prostatitis is made through the patient's clinical presentation and through the presence of bacteria in urine analysis.[6] Rectal examination should be performed only cautiously—prostate massage "can release bacteria and inflammatory cytokines, triggering an abrupt clinical decompensation."[7] Postvoid residual urine volume and levels of prostate-specific antigen are useful for diagnostic purposes, as well as possible CT scan or ultrasound to evaluate for an enlarged and inflamed prostate.[7]

For immediate relief of the patient's AUR, catheterization should be performed.[7] 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 responsible, medications such as trimethoprim-sulfamethoxazole and/or fluoroquinolones are often therapeutically successful, provided that the length of therapy is prolonged (four to six weeks).[6] Repeat urine cultures during the patient's treatment course should be performed to ensure that the causative organisms are thoroughly eliminated.[7]

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.[6,8]

MRS will typically present with neurological signs highly suggestive of aseptic meningitis, including "headache, drowsiness, fever... nuchal rigidity and positive Kernig and/or Brudzinski signs."[8] However, in many cases, the neurological signs may be so mild that the predominant symptom appears to be "isolated acute urinary retention."[9] One of the most notable presentations of MRS is the fever and AUR that patients with it will eventually develop. Only newly reported in the literature, the cause of MRS remains undetermined in most cases.[8]

Distinguishing it further from acute prostatitis, MRS patients will display a neurogenic bladder during urodynamic studies.[8] Unusually, MRS patients will not display any evidence of lower motor neuron involvement—with a "lack of leg numbness and paresthesias help[ing] to differentiate MRS from Guillain-Barre syndrome, polyneuropathies and conditions affecting the lower motor neurons."[8] It is theorized that MRS affects upper motor neurons in the central nervous system responsible for the detrusor muscle.[8] Likewise, patients with MRS display normal peripheral nerve conduction.[9]

The presence of MRS may be confirmed with lumbar puncture, which will display "lymphocytic pleocytosis, elevated protein levels, and mildly decreased glucose levels."[8] MRI of the brain and spinal cord will not reveal any abnormalities—nor will blood or urine cultures.[9] 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.[9] Fortunately, the disease is self-limiting over a period of several weeks, and there is no evidence of long-term neurological sequelae.[8]

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 comorbid medical conditions more common with advancing age."[10]

Pharmacologic etiologies account for up to 10 percent of AUR cases.[2] 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 oxitropium, may cause AUR. Atropine eye drops have also been found to induce AUR.[2] Other medications at risk for causing AUR include antihistamines, class 1 antiarrythmics including disopyramide and flecainide, antipsychotic drugs, tricyclic antidepressants, fluoxetine, benzodiazepines, NSAIDs, calcium channel blockers, recent epidural analgesics, and D1 and D2 agonists for the treatment of Parkinson's disease.[2] The street drug—3,4-methylenedioxy—amphetamine (MDMA or ecstasy) has also been found to be associated with AUR.[2-4]

Ultimately, in elderly patients presenting with AUR and fever of an unclear etiology, rapid decompression of the bladder through catheterization should be achieved.[10] Afterward, the patient's medication list—including the use of over-the-counter medications such as NSAIDs—should be carefully reviewed for signs of any causative agents.[2,10]

In the case described, a postvoid residual ultrasound showed that the patient was retaining approximately 700 mL of urine. His bladder was successfully drained with the placement of a urethral catheter, and a UA showed him to have significant bacteriuria. Due to the possibility of acute prostatitis, a digital rectal exam was deferred. Ultrasound imaging showed evidence of a heterogeneous, inflamed prostate, and the patient was diagnosed with acute prostatitis. While the urine culture was pending, the patient was empirically started on a broad-spectrum intravenous antibiotic and admitted to the hospital, where he rapidly improved. 48 hours later, the patient's urine culture grew *E. coli* colonies, sensitive to trimethoprim-sulfamethoxazole. The patient was discharged on a four-week course of oral antibiotics, and followed up in clinic for repeat urine cultures. Ultimately, the patient made a full recovery.

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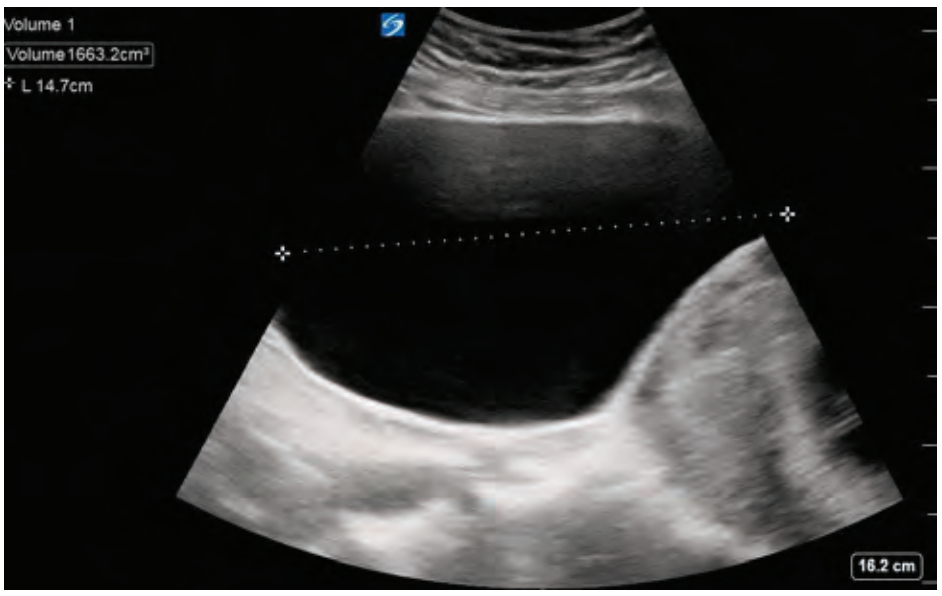
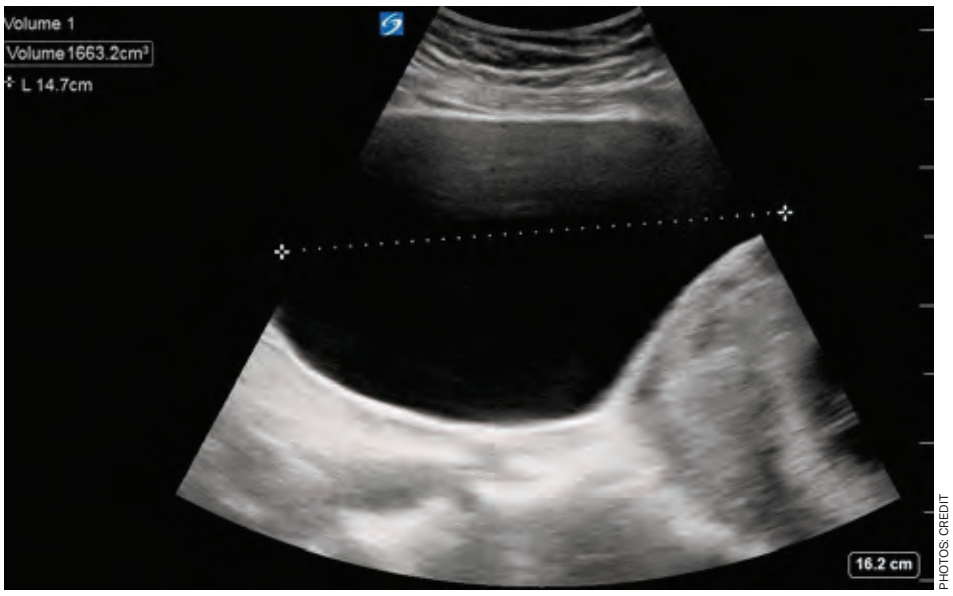


FIGURE 1



PHOTOS: CREDIT

FIGURE 2

PREGNANT WOMAN WITH ACUTE URINARY RETENTION

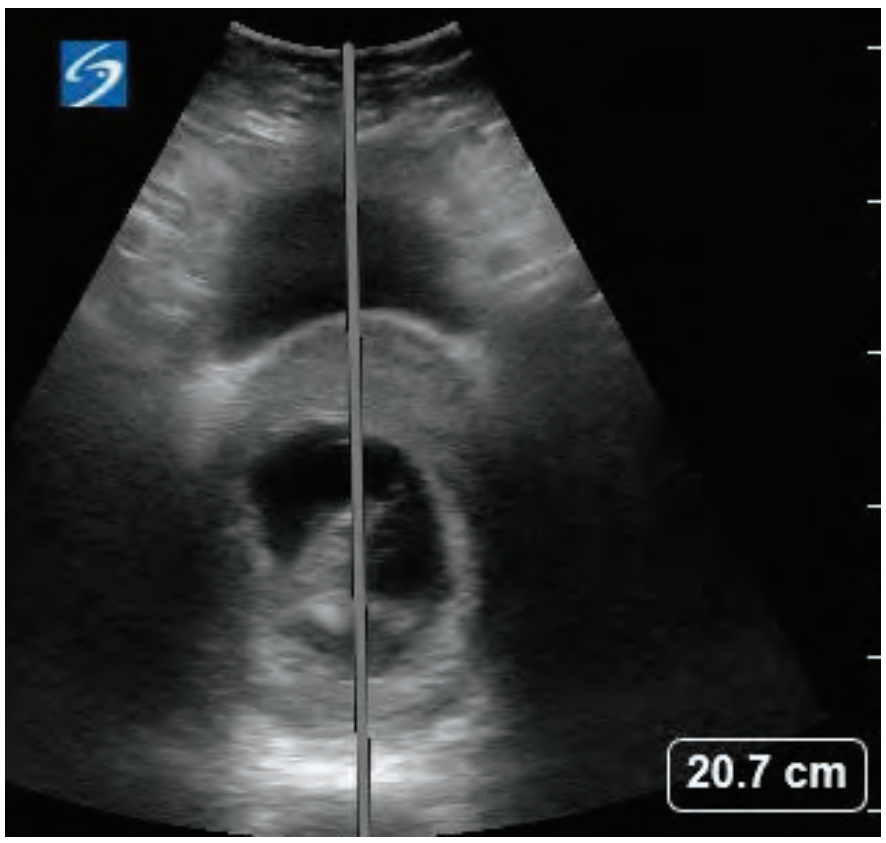


FIGURE 3

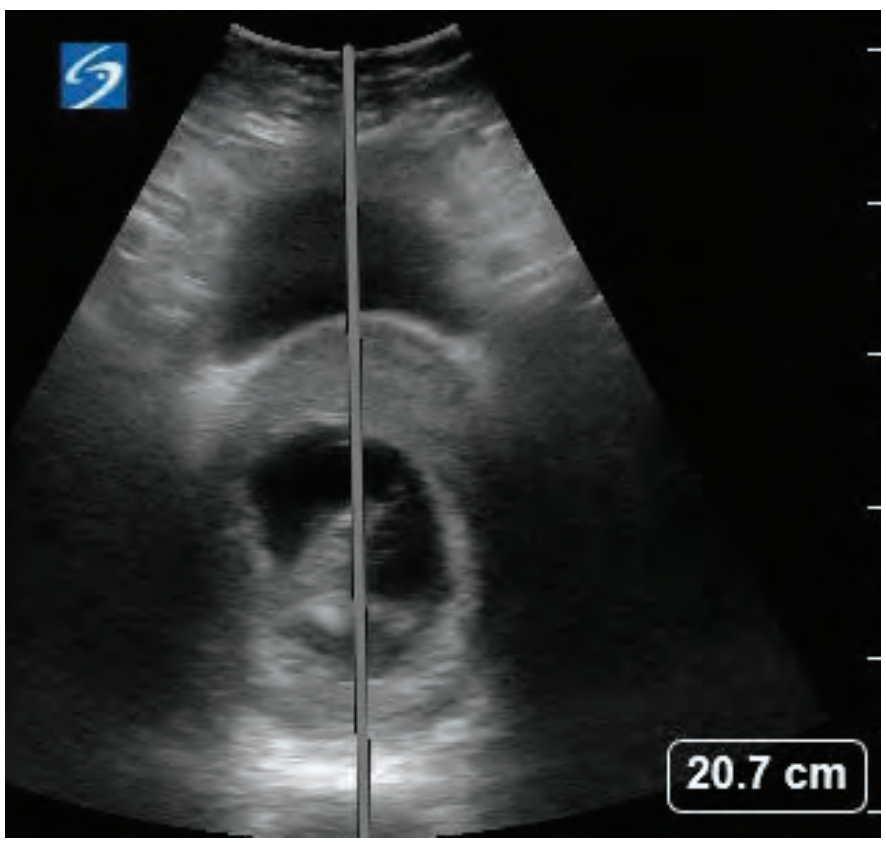


FIGURE 4

by HILLARY MCKINLEY, MD; WEEDEN BAUMAN, MD; ERIK CHRISTENSEN, MD; CYNTHIA GAUDET, DO; SAMANTHA WOOD, MD, FACEP; ELIZABETH LINNELL, MD; AND CHRISTINA WILSON, MD

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.[1,7]

CONTINUED *on page 20*

A CASE REPORT OF MICROCYTIC ANEMIA IN A PEDIATRIC PATIENT

Lead poisoning remains a significant public health concern for children

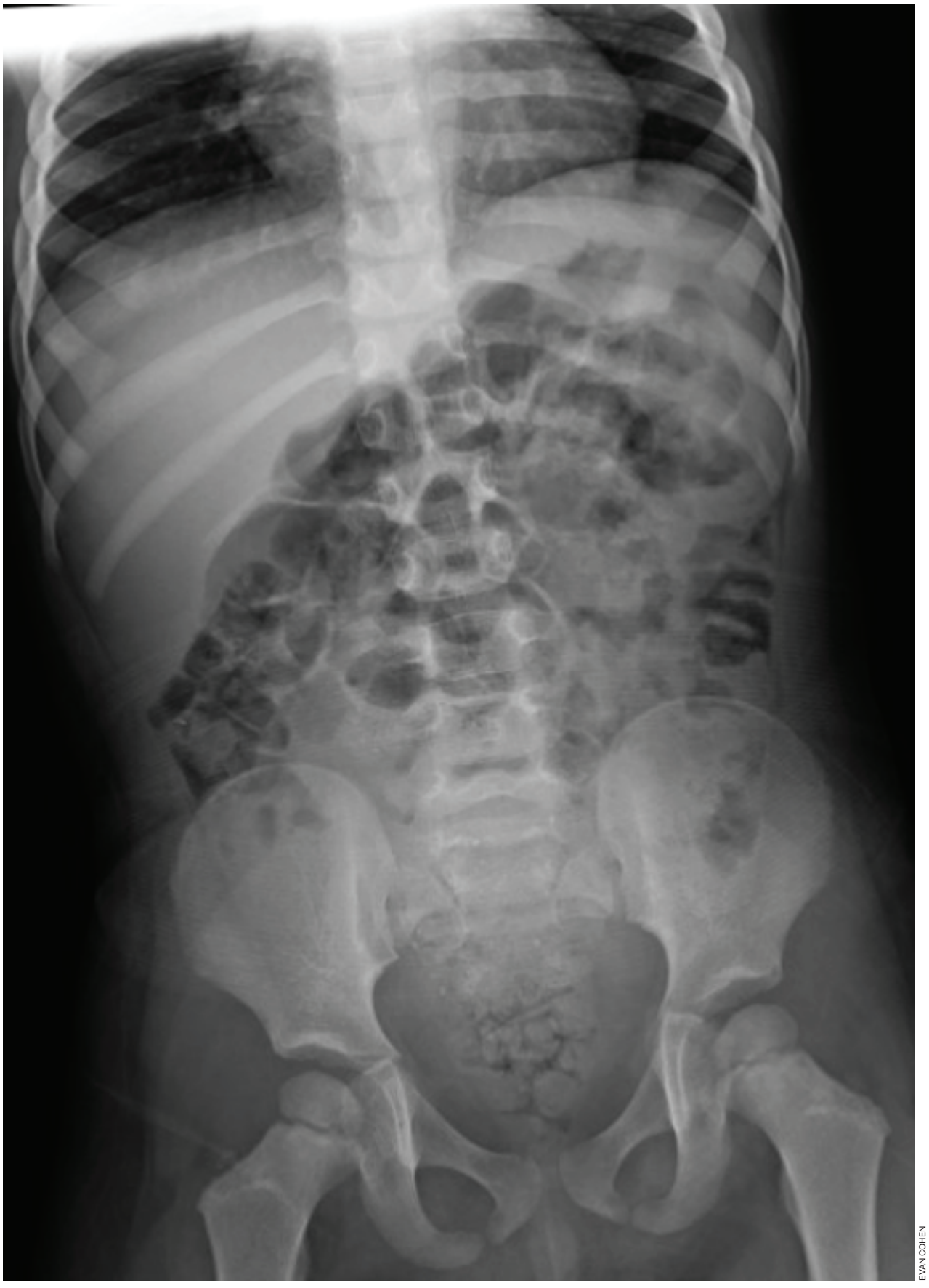
by EVAN P. COHEN, MD; AND MUHAMMAD SHEHZAD K. WAZIR, MD

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.



EVAN COHEN

FIGURE 1: Abdominal X-ray showing particulate radiopaque foreign bodies involving the stool.

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.[3-5] 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 inhalation is a more common route of exposure in occupationally exposed adults.[7] The human body can store lead 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.[8] 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.[9] 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.[3]

Lead poisoning occurs most commonly in the developing world.[10] There have also been numerous cases in the developed world, with higher lead burdens seen during the peak of the Flint, Michgan, water crisis.[11] 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.[12] 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.[13] 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.[14] 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.[12] From

a kidney standpoint, lead can cause problems in the proximal tubules, similar to Fanconi syndrome, and it competes with uric acid for excretion 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.[15] Lead is associated with gastrointestinal symptoms such as abdominal pain, constipation, and anorexia but these effects are poorly understood.[12] 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.[16] Chelation therapy is recommended for patients with blood lead concentrations exceeding 45 µg/dL.[17] 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 since 1991.[18]

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.

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DR. WAZIR is an ECFMG-certified international medical graduate from Pakistan. Dr. Wazir is currently applying for a residency position in emergency medicine.

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cy Program is actively recruiting 12 residents for the 2024 Match.

On October 13, the Christus Spohn hospital system, part of the larger multi-state Christus Health system, announced plans to gradually phase out its 36-member EM residency program, launched in 2007 in partnership with Texas A&M University, by 2026—when the last group of currently enrolled residents graduates. But public outcry against the move led to local government hearings and meetings with the NCHD, which authorized negotiations with Christus Spohn aimed at saving the program. NCHD is a county government entity whose mission is to arrange for indigent health care services for county residents.

On Nov. 8, local television station KRIS 6 reported a tentative agreement with the hospital to preserve the program, based on additional financial support from NCHD in the amounts of $1.4 million for 2024, $2.8 million for 2025, and then $4.25 million annually thereafter. NCHD already pays the hospital to provide indigent medical care to local residents through its Nueces Aid program.

But the NCHD voted not to give final approval to the proposed solution in a meeting on Nov. 14. KRIS 6 reported that doctors testifying at the meeting said the tentative agreement "isn't enough." Emergency physician John Herrick, DO, FACEP, the residency program's associate program director, said the residency "needs to be transitioned to a program that does want us." After hearing this testimony, the NCHD instructed its director to continue working on the plan.

J.D. Cambron, DO, an associate director of the Texas A&M-Spohn residency program, and a graduate of the program, told *ACEP Now* by phone from outside the board's meeting room that it is obvious that the NCHD and the community have the residency program's survival in mind. "This is a strong program with a cohesive vision to provide great care. I am hopeful that a long-term solution can come to life," he said.

Why Was it Being Closed?

Christus Spohn has stated that the hospital's emergency services would remain intact at all of its local hospitals. "It will not impact patient care at all," said hospital CEO Dominic Dominquez. But as the residency program's future was placed in doubt, numerous questions were raised in the local community about the potential impact on the hospital, the physicians, and the community itself.

Would all of the current residents have stuck it out knowing that the program was winding down? Would faculty have stayed once their teaching role went away? How would Christus Spohn have staffed the emergency department, and how would it have best delivered care to the community? What

CONTINUED *on page 22*

TCEP Supports Christus Spohn EM Residency Reversal

by JILL SUTTON, CMP

The Nueces County Hospital District approved funding for the Christus Spohn Emergency Medicine (EM) Residency Program in a unanimous 6-0 vote. The decision includes safeguards against potential closures, allowing for the transfer of the program to another institution, if necessary. The approval also permits the recruitment of full classes of 12 residents for the next six (6) years, marking a significant achievement as the program successfully reverses a closure decision.

The decision to close the EM Residency Program had initially raised concerns, leading to interventions by organizations including TCEP, ACEP, and the Nueces County Medical Society. ACEP urged the CHRISTUS Spohn Health System to consider various factors related to their workforce study, highlighting the importance of EM residency training programs in enhancing the quality of care, addressing social determinants of health, and preparing for emergencies. ACEP also emphasized the enduring benefits of such programs beyond simple financial analysis.

In response to the closure announcement, the Texas College of Emergency Physicians (TCEP) opposed the decision and took a lead role in educating the public and hospital administrators about the program's significance. TCEP engaged in discussions with ACEP leaders, legislators, and the media, with President Dr. Sandra Williams actively advocating against the closure. TCEP emphasized the program's crucial role in preparing emergency medicine physicians for critical and life-threatening situations, asserting the collective responsibility to prevent its closure.

The approval of funding by the Nueces County Hospital District represents a positive turn of events, ensuring the continued existence of the EM Residency Program.

JILL SUTTON is executive director for the Texas College of Emergency Physicians (TCEP).

OPINIONS FROM EMERGENCY MEDICINE

A NEW SPIN

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Workplace Violence and Mental Health in Emergency Medicine

A CALL TO ACTION

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."[1]

The questions raised by this tragedy are many: How did a gun make its way into the emergency department in the first place? Data from the National Institutes of Health suggests that up to three percent of ED visits result in a weapon being confiscated, and there has been an increase of 20 percent of firearm deaths since 2019.[2] But this was not a patient, it was a colleague! Why were there no safety measures in place to prevent this from happening? More than just security and metal detectors, where were the mental health resources to support this health care professional? Was anyone close to him checking on him, asking questions? Working in the emergency department, we are subject to high rates of burnout, depression, and anxiety that have all been exacerbated by the COVID-19 pandemic.[3] Perhaps most importantly, how was this individual able to function at a high level, caring for patients while in such psychological distress? These questions are impossible to answer, and uncomfortable to discuss, but they demand our attention. The medical profession cannot continue to ignore our own personal safety. The gaps in safety that exist in our workplaces need emergent attention. It is not just a matter of physical safety. It is also necessary to address the critical issue of mental health. Stigma surrounding mental health among those who provide health care must change. We must create an environment in which it is okay to ask 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 who just received a needle stick on a busy evening with a packed waiting room, was interrupted suddenly with a "BANG!" Did a patient just fall and smack their head? Did a stack of printer paper fall off the top shelf? Did a pile of crutches just go crashing to the ground? The gut-wrenching screams that followed solidified the reality of the situation.

The smell of gun powder hung in the air. Lying by my feet, someone was injured—or worse. Did he plan to do this today? Did something happen on shift to lead him to this? What was the last thing I said to him? Did I even say hello to him today? Was my calling in emergency medicine designed for this moment?

What happened next was a combination of the human spirit and fundamental training in its most raw state. A tornado of organized chaos managed to transport him to the resuscitation bay as the tasks of life-saving maneuvers began. In the end, I walked out of the resuscitation bay with a defeated look on my face and blood-soaked shoe prints that trailed behind me. A crowd formed outside the room of his colleagues and close friends. Hope turned into sadness and anger as reality became apparent. This traumatic experience left many of those who were there that night with moral injury and some with post-traumatic stress disorder. All were forever changed. The smells, the sights, the sounds, and 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.[4] 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."[5] 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 barista who served you your coffee this morning is entitled to a safe workplace, so are we.

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

DR. TAYLOR is a proud father, USAF veteran and graduate of the University of Nevada School of Medicine. Currently, he is a PGY-3 Stanford Emergency Medicine Resident.

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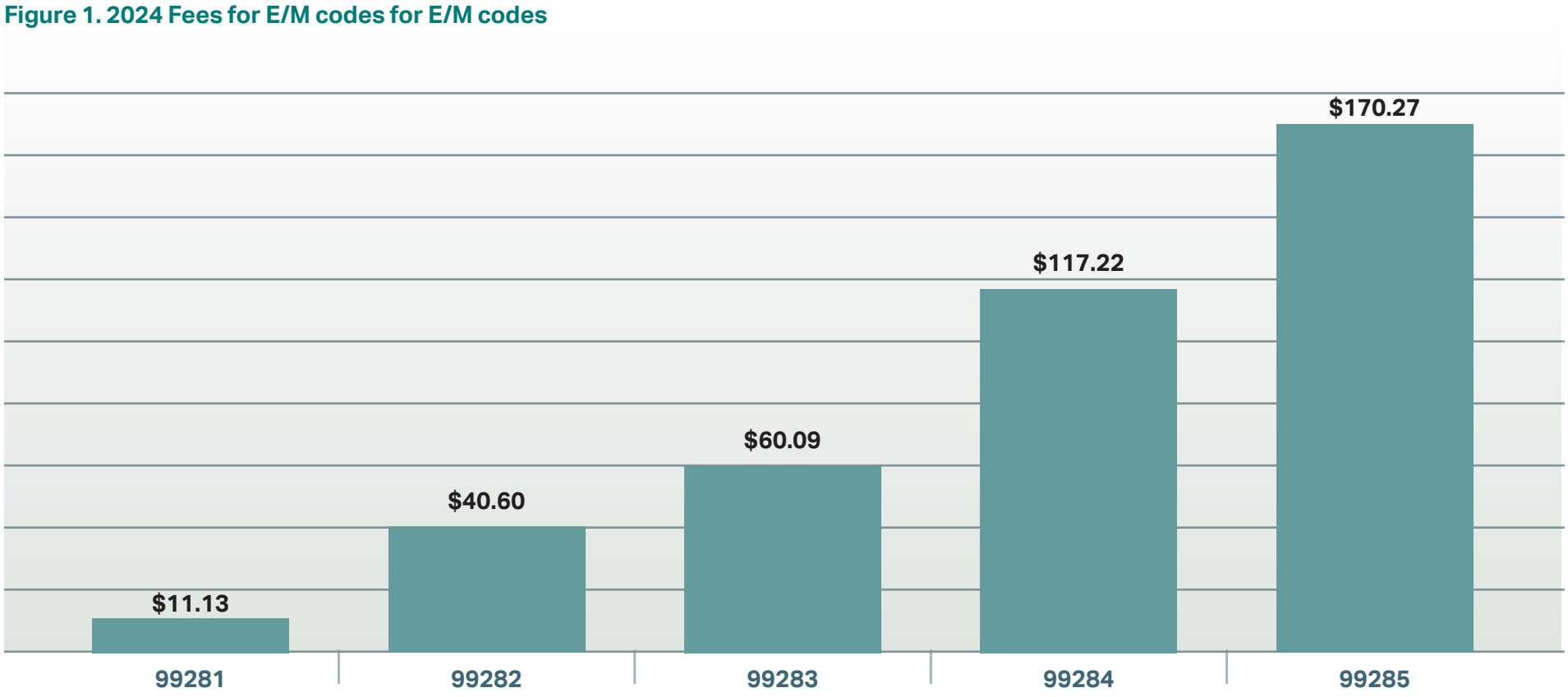
Figure 1. 2024 Fees for E/M codes for E/M codes



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 number and complexity of problems addressed at the encounter (known as COPA) 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 11 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.

Table 1. RVU changes year-over-year

CODE	2023 WORK	2024 WORK	2023 PE	2024 PE	2023 PLI	2024 PLI	2023 TOTAL	2024 TOTAL
99281	0.25	0.25	0.06	0.06	0.03	0.05	0.34	0.34
99282	0.93	0.93	0.21	0.21	0.10	0.10	1.24	1.24
99283	1.60	1.60	0.34	0.34	0.17	0.18	2.13	2.11
99284	2.74	2.74	0.57	0.56	0.29	0.29	3.58	3.59
99285	4.00	4.00	0.79	0.78	0.42	0.42	5.21	5.20

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.

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BE A MEDICAL DETECTIVE—BONE UP ON YOUR FORENSIC SKILLS

FORENSIC FACTS

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

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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 agreed 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.[1-4] 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.[5] 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, 1.06) had significantly higher odds of engaging in nonconsensual condom removal behavior.[6] 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 promise 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).[6]

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)[7,8] 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.[9] 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 purest 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.

RALPH RIVIELLO

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 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 their healing.[10-12] 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 stealthing occurred. Most importantly, patients should be provided pregnancy, sexually transmitted infection, and HIV prophylaxis, as would be done for any sexual violence survivor.[13]

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.

KEY POINTS

- Stealthing is the nonconsensual removal of a condom during intercourse.
- Almost every state does not recognize stealthing as sexual assault.
- The victim's only recourse is in civil court.
- Stealthing victims who present to the ED should be offered medical forensic examination, as well as pregnancy, sexually transmitted infection, and HIV prophylaxis.

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DOING THE MATH TO BENEFIT OUR SPECIALTY

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.

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?"[1]

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, Ralph 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 our friends or our neighbors. Or could they? People like Amy Cooper (the white woman who called the police on Christian Cooper, a Black man, while he was birdwatching in Central Park) may not be that rare—they are doctors, nurses, bosses, educators, colleagues, and, yes, we probably know them personally.[2]

Many white people rarely think of ourselves in racialized terms. Our worldview has not often been taught to us with that lens. If we have a white friend, we do not tell other white people in our group that our friend is also white because it is simply assumed.[3] Moreover, if we acknowledge race, many of us certainly aren't going to admit that being white bestows advantage (or "privilege," if you will). Admitting that we exist in a world of racial comfort significantly different from 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.[3,4]

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Racism is pervasive in medicine and has existed for centuries without being entirely eliminated. In 1784, Thomas Jefferson wrote false and incredibly racist physiological theories in his *Notes on the State of Virginia*.[5] 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 was "brilliant" and "creative." However, what is *not* highlighted is that Mr. Flexner espoused multiple racist views about the inferiority of black physicians in his report. He wrote that Black medical schools are "wasting small sums annually and sending out undisciplined men, whose lack of real training is covered up by the imposing MD degree."[6] 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.[7,8]

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.[9] 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 27,500 graduating medical students, 23 percent of Black students reported at least one episode of racial discrimination.[10] 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. Aysha 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.[11] 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.[12] That Kaiser's medical school is named after its own Black former CEO de-

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BRINGING YOU CANADA'S BRIGHTEST MINDS IN EM

EM CASES

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Can't-Miss Drug Interactions

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

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

Many common presentations to the emergency department (ED) are related to drug interactions that are commonly missed and largely preventable.[1-3] 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.[4-6] Delirium, syncope, and falls are three presentations that should trigger a careful medication history and search for potential drug interactions.[7] 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.[8] 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.[9,10] 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.[11] 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 glycemic control in people with diabetes.[12,13] 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.[14]

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.[15] 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.[16] Antipsychotics in combination, at regular or at high doses, can increase the risk of NMS causing autonomic instability.[17] QT prolongation depends on the number of potentially QT-prolonging drugs, the class of drugs, and the specific medication.[18] Especially high-risk drugs include citalopram or escitalopram in combination with erythromycin, moxifloxacin or ondansetron.[19]

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-converting-enzyme inhibitors, angiotensin receptor blockers, spironolactone, trimethoprim-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.[20] 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.[21]

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-spironolactone 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.[22,23] 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.[24] Erythromycin or clarithromycin in combination with amlodipine can lead to clinically significant hypotension.[25] 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 less well recognized drug interaction in this category includes nonsteroidal anti-inflammatory drugs in combination with acetylsalicylic acid, leading to a higher risk of arterial thrombosis.[26]

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.[27-29]

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!

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Obstetrics Consultation

Given the rare presentation, the authors submit that acute urinary retention in a pregnant patient without clear identifiable cause (history of neurogenic bladder, recent medications with anticholinergic side effects, cauda equina signs or symptoms, etc.) should lead to obstetrics consultation. In addition, while abdominal MRI and/or ultrasound may aid in the diagnosis of IGU, this should not delay care. Bladder decompression and obstetrics consultation should be prioritized.

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.[2]

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.

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fines irony.

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 issue 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."[12]

If you have read this far, you have a choice. You can turn the page and never think about it again. You can read it, feel righteous indignation, and refuse to believe me that the white force field exists. Or you can work together to create solutions.

I have chosen to be antiracist and join the ACEP section for Diversity, Inclusion, and Health Equity (DIHE). What are you gonna do?

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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 physicians 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."[2] 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 2019. But an important take away 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 then. Maybe that's what has changed."

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date social gatherings, you may have somebody 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 to have time together when we're not working. I would like to."

So, that gets to be a dilemma for management to figure out. Work is not just financial reimbursement. There's psychological reimbursement. And if you're only thinking about financial materiality ... you're going to miss the *psychological* materiality.

AB: The most important thing is that physicians 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 authentic expressions of care and the intention to ensure that the physicians feel appropriately valued, it will show how to induce quality work. And people who come to work with a sense of mission don't really need to be incentivized. The job isn't necessarily how to create a set of incentives that will properly motivate the physician. The challenge is how do we subtract the problems that obstruct physicians and induce feelings of demoralization.

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

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 going 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 [im]balance 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, particularly 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 going 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 saying, 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 connectedness and physical exercise. If 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 period 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 experiencing, 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 profession 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 prying and not to be rude, but as colleagues, you can check in with them.

I see this a lot in police and fire (and managers), the other sort of hero specialties or professions 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 physician with an MBA from the Northwestern Kellogg School of Management in Evanston, Ill. He is a member of the editorial advisory board of *ACEP NOW*.

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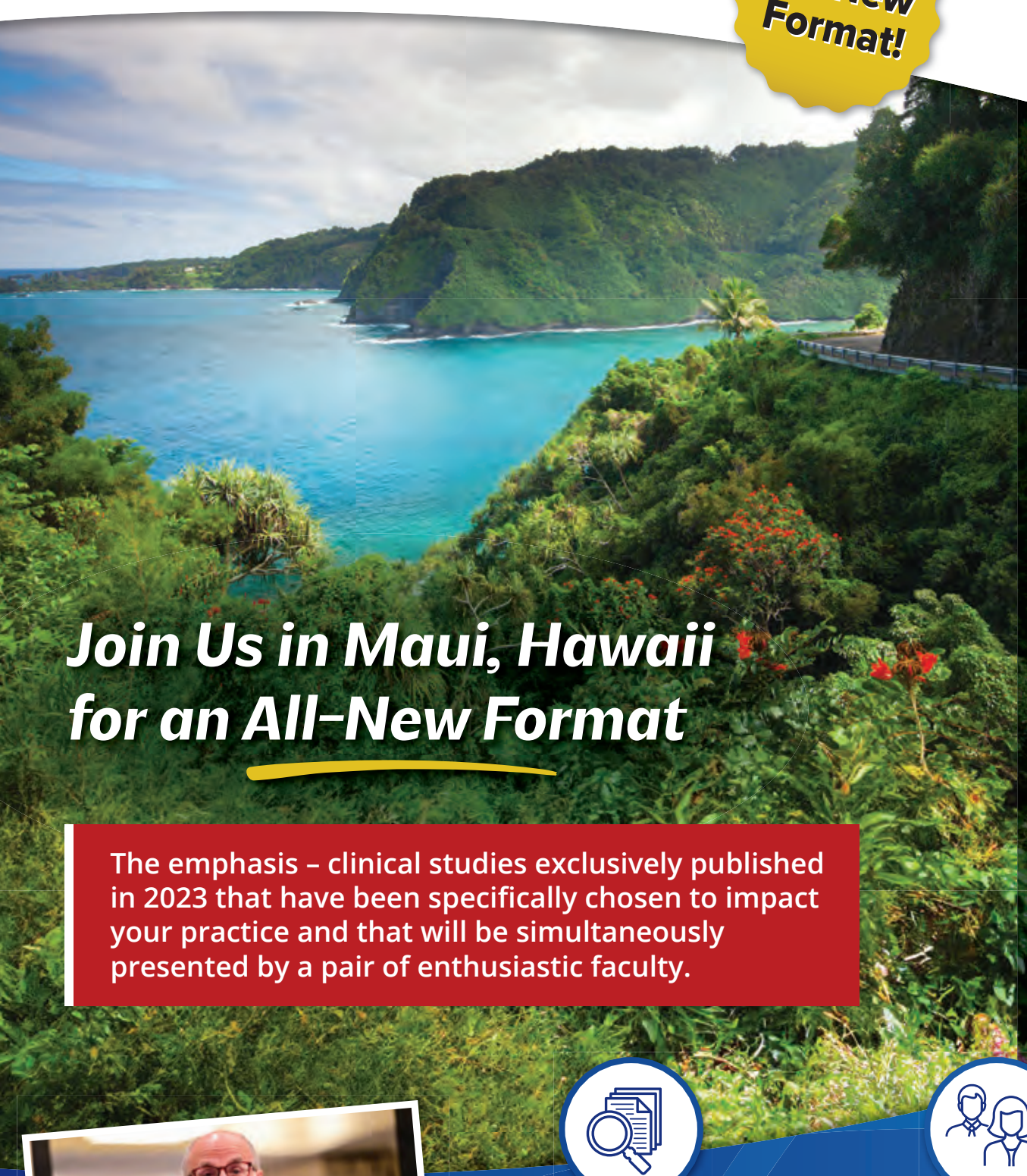

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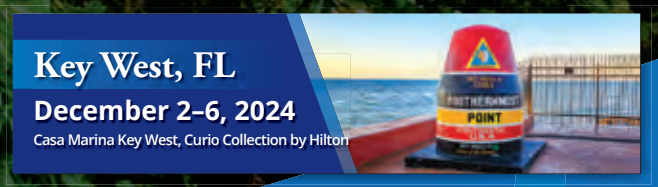

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