TOXICOLOGY Q&A
A "Killer" Bug
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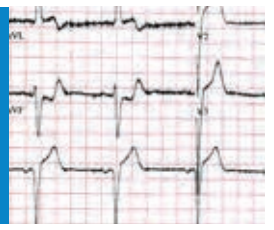
ECG OF THE MONTH
ACEP Now Highlights an ECG Case from *Annals*
SEE PAGE 3



NEWS FROM THE COLLEGE
ACEP to Congress: Reject Medicaid Changes
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BEING PATIENT
Sharing Our Stories Can Save a Life
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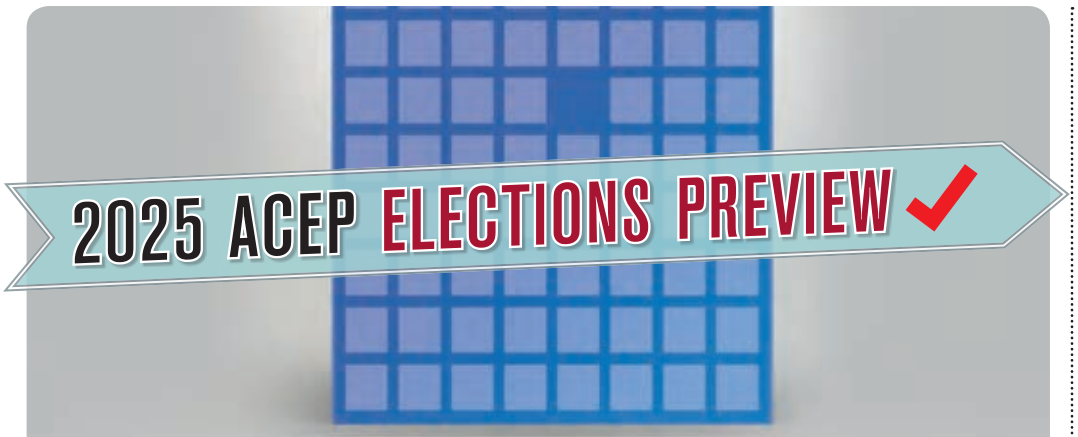

MEET THE PRESIDENT-ELECT, BOARD OF DIRECTORS, AND COUNCIL CANDIDATES

Each year, ACEP's Council elects new leaders for the College at its annual meeting. When it meets Sept. 5-6 in Salt Lake City, the Council, which represents 53 Chapters, 40 Sections of membership, the Association of Academic Chairs of Emergency Medicine, the Council of Emergency Medicine Residency Directors, the Emergency Medicine Residents' Association, and the Society for Academic Emergency Medicine, will select a President-Elect, four members to the ACEP Board of Directors, a Council Speaker, and Council Vice Speaker.

Here's how each candidate answered questions submitted by ACEP staff for publishing in *ACEP Now*. Candidates in each category are listed in alphabetical order.

CONTINUED *on page 12*

Four Perfect Days in Salt Lake City

by DARRIN SCHEID, CAE

Alison Smith, MD, MPH, FACEP, graduated residency in 2017 from the University of Utah Health and remained in Salt Lake City as an attending emergency physician. Dr. Smith is a former Emergency Medicine Residents' Association (EMRA) representative to the ACEP Board of Directors and currently serves as president of the Utah ACEP Chapter. Dr. Smith offers some advice for ACEP members traveling to her city for ACEP25.

ARRIVAL DAY: Saturday, Sept. 6

After checking into a hotel and taking a minute to recover from the flight, Dr. Smith recommends getting your bearings via an outdoor activity. There are plenty of options. "On a Saturday afternoon, I might take my kids to the children's museum or the planetarium," Dr. Smith said. On a normal Saturday evening, you'll find her on a hike or mountain bike ride with her friends or family.

"I typically do something outdoors every day," she said. "Tonight, for example, my girlfriends and I are going for a trail run, and then we might go to a brewery afterward."

Some favorite breweries Dr. Smith suggests include the following:

CONTINUED *on page 10*

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ACEP

Councillors at ACEP24 respond to a question from the Council Speaker with a show of hands.

ACEP4U: The ACEP Council

THE ACEP COUNCIL SHAPES POLICY, ADVANCES THE MISSION

The ACEP Council is the representative body of the College, composed of Councillors elected by state Chapters, Sections, and other partner organizations such as the Emergency Medicine Residents Association. *ACEP Now* recently spoke with the outgoing ACEP Council Speaker, Melissa Costello, MD, FACEP, about how the ACEP Council shapes policy and advances the College's mission.

As Speaker, Dr. Costello manages the Council's flow of business to ensure procedural integrity, and that work isn't done in isolation. She described the rhythm of ACEP's Council as predictable but energized: Reference Committees hear testimony on resolutions ahead of time, and these comments help shape the debate on the floor.

"The thing that attracts people to this process is that people who make a living working in chaotic, uncontrolled environments can come into a place—even one with 400 people from all over the country, with all different political views, backgrounds, experiences—and agree on a method for forming policy that serves our specialty," Dr. Costello said. "For me, it has been a privilege to be an arbiter of the process. The shared sense of purpose is what makes the ACEP Council not just functional, but exceptional."

To read more about The ACEP Council, how Councillors are chosen, and how to access the Council 101 Webinar visit the QR code below.

TOXICOLOGY Q&A

A "Killer" Bug

PHOTO: JASON HACK (OLEANDER PHOTOGRAPHY)

by JASON B. HACK, MD, FACEP

QUESTION: Which garden variety bug's "bite" might hurt 10 times more than a bee sting?

ANSWER *on page 19*

CORRECTION

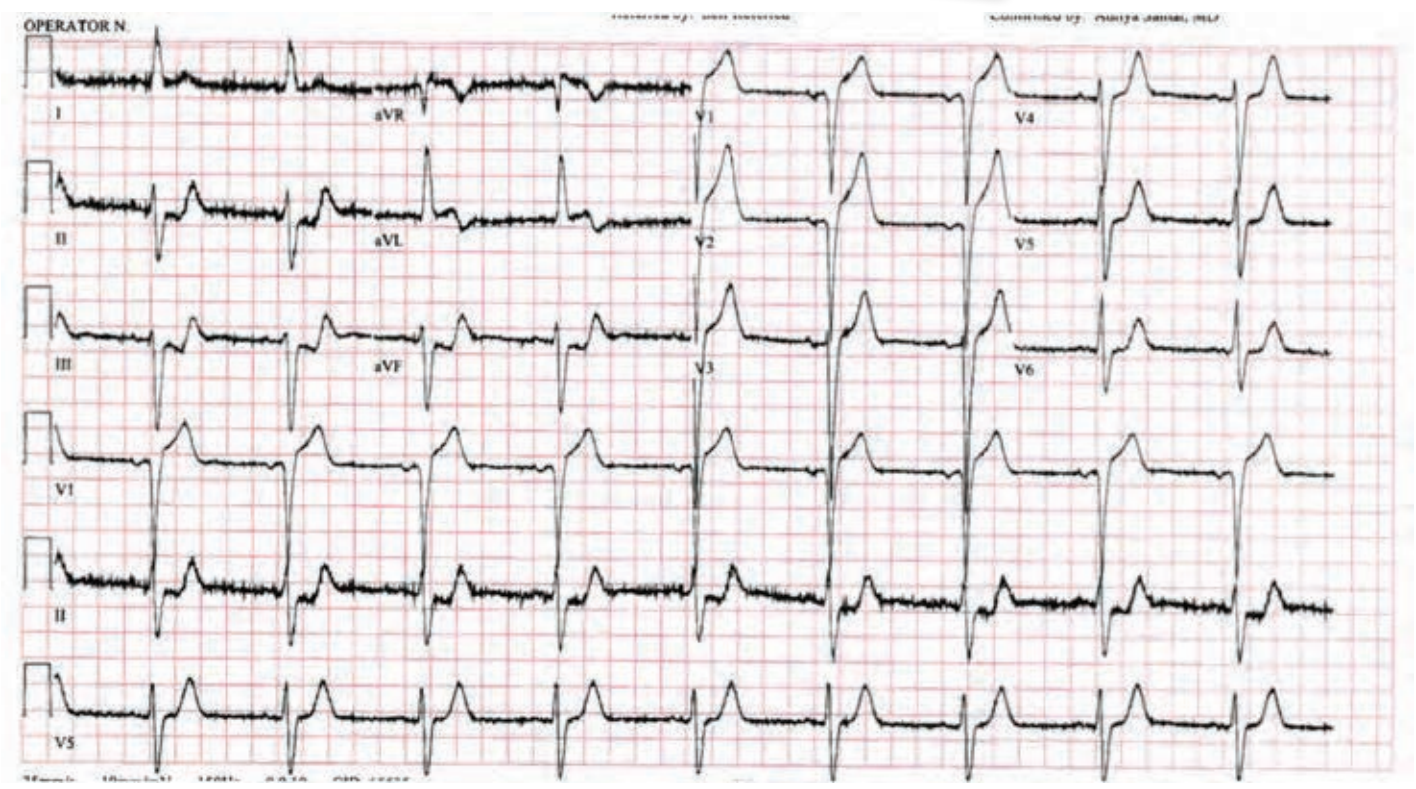
"A Simplified Protocol for Intralipid Administration in the ED" (*ACEP Now*, May 2025, p. 18), contained superfluous text in the opening paragraph and was erroneously modified under the section "Highland ED Protocol for Intralipid Administration." We regret these errors, which were the result of the editorial process and not the fault of the authors. Scan the QR code to view the corrected article.

ACEP Now Features *Annals* ECG of the Month

An 86-year-old man with a history of hypertension, hyperlipidemia, cardiomyopathy, and four-vessel coronary artery bypass five years prior presented to the emergency department (ED) with one hour of sudden-onset retrosternal, pressure-like chest pain radiating to the left arm. The patient was afebrile with reassuring hemodynamics, well-appearing, and with an unremarkable physical examination. The ECG obtained in the ED is shown in Figure 1.

For the diagnosis visit:

This article was published in *Annals of Emergency Medicine*, 82, Saffire LM, Niforatos JD, Valentine J, et al, Sgarbossa negative with concordant ST depression—occlusion myocardial infarction diagnosed by the BARCELONA Algorithm, 475-477, © 2023 by the American College of Emergency Physicians.



ANNALS OF EMERGENCY MEDICINE

Figure 1: This ECG was obtained from an 86-year-old man in the ED.

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Reference: 1. KEDRAB [package insert]. Fort Lee, NJ: Kedrion Biopharma Inc.; 2021.

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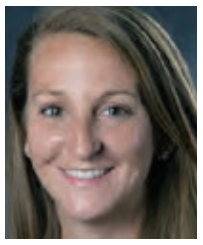
UPDATES AND ALERTS FROM ACEP

NEWS FROM THE COLLEGE

JACEP Open Study Finds Waiting Room Treatment Does Not Have Higher Rate of 72-Hour Returns

This is not the research Cynthia Gaudet, DO, ever imagined conducting when she first got into medicine. Dr. Gaudet and colleagues evaluated the rate of return visits to the emergency department (ED) within 72 hours of discharge for patients evaluated in the waiting room. Because of ED crowding challenges, they hypothesized that some patients may be suitable for the completion of evaluation without rooming.

"It's disheartening, but this is where we are right now," said Dr. Gaudet, an emergency physician at Beth Israel Deaconess Medical Center. "I worry about the impact it has on patients. Our group is looking into that as well."



Dr. Gaudet

Published in the June 2025 issue of *JACEP Open*, researchers found no significant increase in the rate of return for patients seen primarily in the waiting room or for those where the initial work-up started in the waiting room compared with those who were placed in a treatment space prior to a physician evaluation. The retrospective study evaluated more than 1,500 patients seen at a single academic ED, comparing those who began care in standard treatment rooms with those initially evaluated in alternative care spaces because of ED crowding.

Key metrics included lab utilization, imaging, time to admission, and return visits. The conclusion: patients managed outside private rooms received comparable care.

"We wanted to understand the downstream effects of what is happening because of these trying times and the pressure in the emergency department," said Dr. Gaudet, who also serves as Director of Quality Assurance at UMass Memorial Health – Harrington. "I think the emergency department gives us a unique lens into all the places that the hospital system and the medical system are breaking down. We become the catch-all for everyone that comes in the door."

The way waiting room medicine is practiced varies. Some hospitals carve out evaluation zones in hallways or create temporary exam spaces off to the side. Others designate teams to circulate through the waiting room itself.

"Some places have a few feet in the hallway or an extra room to pull people in momentarily for a history and exam," Gaudet explained. "Other times, you're just trying to find a sliver of space to assess patients quickly."

Gaudet emphasized that this should not become standard. "We're not trying to normalize hallway care," she said. "Our goal is to gather evidence, understand what's happening, and hopefully make a case for change."

Read the research in *JACEP Open*.

ACEP to Congress: Reject Medicaid Changes That Would Leave Millions Uninsured

ACEP recently joined 42 national medical organizations in a letter to express concern that drastic changes to Medicaid under consideration will disproportionately affect emergency departments (EDs) already under significant strain, leaving emergency physicians with fewer resources to respond to patient needs, and threatening patient access to lifesaving emergency care.

"Emergency departments are one of the few settings where patients are treated 24/7/365, regardless of their insurance status or ability to pay," said ACEP President Alison Haddock, MD, FACEP. "The impact of policies that will leave millions of people without any health coverage falls squarely onto emergency physicians and patients. Patients with unmet health care needs will delay treatment and their conditions will worsen, leaving them with no other option than the ED. This creates avoidable health risks and threatens the viability of an already strained health care safety net."

Under the provisions passed by the House of Representatives, the Congressional Budget Office projects an additional 7.6 million people will go without any health coverage, resulting in an additional $5.5 billion in losses for emergency physician payments.

"The very idea of emergency medicine as we now know it—lifesaving care available for anyone at any time—is under direct threat from these proposed policy changes," said Dr. Haddock.

To read more scan the QR Code below.

Dr. Joe Sachs and "The Pitt" Are Redefining Public Health Education Through Storytelling

"The Pitt" and the power of realism in emergency medicine

by LEONA SCOTT

When a viewer sent a message saying they sought help for post-traumatic stress disorder (PTSD) after watching an episode of "The Pitt," Joe Sachs, MD, FACEP, knew he was accomplishing something far beyond entertainment. For Dr. Sachs—a practicing emergency physician and executive producer of the Max original series—the comment underscored what he's been working toward for decades: using scripted television to tell deeply human stories that double as public health education.

Dr. Sachs' initial goal was to find a more effective way to educate the public beyond public service announcements and flyers. With "The Pitt," he is taking "public health education" to a level and scale that he once thought impossible.

Audiences are responding. From first-year medical students to residents and attending physicians in emergency medicine, the show has sparked discussion, driven empathy, and even influenced real-time clinical decision-making. One clinician shared that she recognized a rare diagnosis described in a case presented in Episode 14. Another emergency physician said the show captured their experience during COVID-19 better than any documentary ever could.

This is more than entertainment. This is education with a heartbeat.

From Trauma Bays to TV Scripts

Long before Dr. Sachs was rewriting the rules of public health education for television, he was charting a path that bridged science and storytelling. While studying at Stanford University School of Medicine, Dr. Sachs also pursued a master's degree in filmmaking—an unusual combination that turned out to be prescient. After completing a combined residency in emergency medicine and internal medicine at UCLA, he began a part-time emergency medicine practice at Northridge Hospital Medical Center, Los Angeles, where he has worked for more than 30 years.

Dr. Sachs' foray into Hollywood started in 1994 when he joined NBC's "ER" as a technical advisor. He stayed with the groundbreaking series for its entire 15-season run, ultimately becoming executive producer and penning 35 episodes. He later worked on "Mercy, Off the Map," and "NCIS: Los Angeles" before helping launch "The Pitt" in 2023.

Despite a rigorous production schedule—nine 12-hour days for a single 45-minute episode—Dr. Sachs remains grounded in medicine. He continues to work in urgent-care settings to maintain his clinical edge and gather real-world inspiration.

"Emergency medicine isn't a hobby for me," Dr. Sachs said. "It's a passion. It feeds the creative process and keeps our stories authentic."

The Power of Realism

Unlike the fast-paced, idealized drama of "ER," "The Pitt" presents a more raw and contemporary view of a U.S. emergency department (ED). It's been described as gritty, chaotic, and honest.

"We wanted to show the real issues: the boarding crisis, the pressure of waiting room medicine, the amazing teachers during rounds," Dr. Sachs said.

HBO MAX

Behind the scenes with the creative minds of "The Pitt": where medicine meets storytelling to educate, inspire, and heal. Dr. Joe Sachs is seated in the center with a hat. Standing in the second row, far right, is Noah Wyle, who plays Dr. Michael "Robby" Robinavitch.

To achieve that level of realism, the production brings in residency-trained, board-certified emergency physicians as technical advisors. These doctors undergo a 200-hour training session led by Sachs himself, and the show writers receive extensive medical briefings—up to 20 pages per episode. The goal is to get every detail right, from terminology to trauma choreography.

Their efforts are paying off. One viewer, an ED nurse, wrote, "OMG, this is the first medical show I can actually watch."

Another episode, focused on the emotional strain of boarding, led to a moment of real-life empathy: A patient hugged their physician after watching "The Pitt," saying they finally understood why the ED felt so overwhelmed.

When Fiction Heals

Dr. Sachs discovered that using entertainment and realistic storytelling is a surprisingly effective way to convey health messages. "The Pitt" has become an unintentional case study in effective health communication, offering scenarios that mirror everyday challenges for physicians and patients alike.

An episode involving a 90-year-old patient facing difficult end-of-life decisions prompted a viewer to approach their own family's care with new clarity. Another showcased a physician with PTSD from the COVID-19 pandemic, resonating with many health care workers still processing that trauma.

"We're not just educating the public," Dr. Sachs noted. "We're educating physicians too, reminding them they're not alone in their experiences."

Noah Wyle, who starred in both "ER" and "The Pitt," has heard from fans who entered the medical field because of their exposure to "ER." Dr. Sachs said he hopes "The Pitt" can have a similar, if not more profound, long-term impact. After the COVID-19 pandemic, emergency medicine residencies had more openings than ever before. However, in the last year, interest has rebounded, and there is no longer a lack of interest.

Public Health Messaging Needs More Artists

Dr. Sachs believes that to truly move the needle on public health understanding, the medical community must embrace more creative avenues. "The Pitt" doesn't replace peer-reviewed journals or continuing medical education courses. Instead, it fills a different need—connecting with the public and professionals on emotional and empathetic levels.

That's why Dr. Sachs and his team obsess over accuracy, but the primary goal is entertainment. The makeup department creates prosthetics so convincing that some viewers worried about HIPAA violations. Camera movements are choreographed to mimic the kinetic energy of a busy ED. This dedication stems from Sachs' belief that the ED is the last true safety net in U.S. health care—a place worthy of respect, advocacy, and accurate portrayal.

"In a time when cuts to Medicaid and Medicare threaten that safety net, we need the public to understand what's at stake," Dr. Sachs said.

In short, Dr. Sachs is proof that the intersection of medicine and media doesn't have to be shallow or sensational. When done right, it can save lives, shape perceptions, and rekindle purpose. With "The Pitt," Dr. Sachs has created more than a medical drama. He's helped build a public health classroom—one compelling, pulse-pounding episode at a time.

LEONA SCOTT is a freelance journalist based in Dallas, Texas.

5 Fun Things with Dr. Sachs

1. **Currently Watching:** "Love on the Spectrum"
2. **Listening to:** An eclectic mix of music from 1970s funk—Parliament, George Clinton—to traditional jazz of Miles Davis.
3. **How he decompresses:** Intensive 45-minute bike ride in the morning, along the Pacific Ocean.
4. **Guilty pleasure:** Banana cream pie from The Apple Pan, a 1940s-style diner/shack among towering high-rises in Los Angeles.
5. **Looking forward to:** Sleep! After grueling 12-hour days and working up to 100 hours a week, it's no wonder Dr. Sachs looks forward to some shut-eye. With only a week off, he'll begin filming Season 2 in mid-June, as new episodes will drop in January 2026.

"THE PITT" COMES TO ACEP25

Don't miss an exclusive opportunity at ACEP25 in Salt Lake City to learn how art imitates life on Max's must-see series "The Pitt."

Star Noah Wyle, along with writer and producer Joe Sachs, MD, FACEP, and medical advisor Mel Herbert, MD, FACEP, will deliver an exclusive panel discussion at 10 a.m. on September 7, the first day of the four-day conference. Discover how they capture the chaos, intensity, and humanity of the emergency department with stunning realism, and why the show resonates so deeply with emergency physicians across the country.

Wyle previously led the genre-defining hit TV drama "ER" as Dr. John Carter across 15 seasons, a role for which he earned three Golden Globe Award nominations and five Primetime Emmy Awards. A talented multihyphenate since 2021, Wyle has starred in the critically acclaimed Freevee action crime-drama "Leverage: Redemption," for which he has also written and directed several episodes. Wyle also starred in CBS' limited series "The Red Line," produced by Ava DuVernay and Greg Berlanti. He can also be seen in "The Romanoffs" by Matthew Weiner and TNT's fantasy-adventure series, "The Librarians." Wyle also executive produced and appeared in the TNT sci-fi series "Falling Skies," for which he also wrote and directed multiple episodes.

Dr. Herbert, a consultant on "The Pitt," is a renowned emergency physician known for his entrepreneurial endeavors, philanthropy, and educational contributions. He founded both EM:RAP and the non-profit, EM:RAP GO, which creates and distributes emergency medicine education in more than 160 countries. Despite his success, he believes in the power of ordinary individuals to achieve greatness, as outlined in his book "The Extraordinary Power of Being Average." Dr. Herbert was also a consultant for "ER."

Dr. Mel Herbert's Favorite Scenes from Season 1 of "The Pitt"

Episode 1: "7:00 A.M."

DR. MICHAEL "Robby" Robinavitch opens the door to the emergency department (ED) and sees an already crowded ED. After a quick exchange with the triage nurse, he asks, "Where's Abbot?" The nurse replies, "Getting some air." Dr. Robby opens the door to the roof and sees Dr. Jack Abbot standing at the edge, looking down to the street several stories below.

DR. ROBBY: Good morning, Jack.

DR. ABBOT: What are you doing here?

DR. ROBBY: I'm working. And you?

DR. ABBOT: Oh, I don't know. I had a guy come in, hit by a drunk driver in a crosswalk, 39-year-old vet. Survived three tours without a scratch. I spent the last two hours coding him.

DR. ROBBY: That's always a rough way to end the night.

DR. ABBOT: I must have had a reason at one time to keep coming back. But I can't think of it right now.

DR. ROBBY: Because this is the job that keeps on giving. Nightmares. Ulcers. Suicidal tendencies. Besides, if you jump on my shift, that's just rude, man.

DR. ABBOT: I hope I'm never one of your patients.

DR. ROBBY: That makes two of us, my friend.

THEY WALK back in together and continue with the last minutes of Dr. Abbot's shift.

Dr. Herbert: So powerful, an attending on the roof clearly thinking about self-harm. Robby's line is classic. If you jump on my shift, that would be just rude. That line breaks the tension and yet also notes the desperation of the work and the sadness it can bring.

Episode 8: "2:00 P.M."

A YOUNG girl arrives at the ED after being pulled from the family swimming pool. Dr. Robby and his team work to revive her. In the meantime, the grandmother arrives and explains what happened. Later, when the parents arrive, they are allowed into the room to watch efforts to save her life.

WHEN THE little girl's temperature hits 88°, Dr. Robby steps out of the room and says, "Come find me when it's over 90." He then tells the triage nurse, "Parents are going to need the family room."

DR. ROBBY returns to the room and breaks the news to the family. "There is absolutely no chance of recovery. Amber has died."

THE LITTLE girl's sister, Bella is in a room coloring with crayons and a piece of paper. The doctors approach and ask if she knows what's going on with her sister Amber.

BELLA: She's really sick but the doctors and the nurse are trying to make her better. She saved me. I fell in the pool. She helped me get out, but then she couldn't get out. I'm making her a card.

LATER, BELLA is given a stuffed bear and speaks to it as if it's her sister.

BELLA: Hi Amber. It's me, Bella. Thank you for saving me. When you come home, I promise I won't touch your toys without asking. And I'll try not to fight because you're my best friend in the whole entire world. I love you.

Dr. Herbert: The tragedy and the love of a sister all revealed at once. You have to be dead inside not to cry over this.

Episode 9: "3:00 P.M."

TWO WOMEN have an argument in the ED about putting a mask on the woman's kid who has been coughing. One woman who says, "Masks are bull s#*t," punches another woman in the face. One woman ends up with a cracked tooth while the other has a portion of the tooth lodged in her hand. Dr. Frank Langdon explains how dangerous this type of injury can be, particularly if the injury has entered the joint space. That requires antibiotics and a trip to the hand surgeon, he explains. Dr. Langdon goes on to say how human mouths are filthy. He injects saline into the joint. It sprayed back into the wound, which means the patient is headed for hand surgery.

Dr. Herbert: Dr. Langdon offers a patient the option for surgeons to forgo masks during her surgery, despite doctors believing masks minimize risk. This offer is a clever way to challenge the patient's anti-mask views, ultimately leading her to choose for the surgeons to wear masks. There is so much of this anti-science BS, this was just a great way to expose a little of people's hypocrisy. You say you know more than the doctors when it doesn't matter, but when it does, you expect us to be there and use science to save them. Frustrating!

Episode 13: "7:00 P.M."

DOCTORS ARE treating a large patient, preparing for blood transfusion, and doing chest compressions when Dr. Langdon intervenes.

DR. SAMIRA MOHAN: What are you doing?

DR. LANGDON: Giving this guy a chance. He needs a big central line for a fast transfusion.

DR. MOHAN: You can't do an IJ without an ultrasound, especially on a guy this big.

NURSE MATEO DIAZ: You'll kill him if you collapse a lung or hit the carotid.

DR. LANGDON: I'm not doing an IJ. Unhook that blood line. Bring it up here. This … is a supraclavicular subclavian. If you have to go in blind, it's the only safe way to access a giant vein. And hold compressions. A centimeter from the lateral head of the sternocleidomastoid, a centimeter from the clavicle, aiming at the contralateral nipple. I'm in. OK, resume compressions. And squeeze blood.

DR. MOHAN: Where'd you learn that?

DR. LANGDON: EM:RAP podcast. We'll be ready for a second unit in under a minute. Boom!

Dr. Herbert: I learned it on the EM:RAP podcast is dropped after he does a supraclavicular subclavian line. I did not have anything to do with that line, but it made my day!

Episode 15: "9:00 P.M."

EVEN FOR an urban ED in a big city, the day this season depicts would have been a challenging shift without the mass shooting event. Add in the steady stream of patients with critical injuries, this day tested the grit, expertise, and teamwork of the staff. At the end of the shift, Dr. Robby gathers the team together to thank them for their efforts. Clearly exhausted, he starts his speech:

DR. ROBBY: Today should never have happened. It's impossible to imagine what would possess somebody to commit such a horrific act. It's the worst of humanity. But it brought out the best in the rest of us. We saw our better angels come to the aid of our patients. Each of you rose to the occasion.

HIS VOICE starts to break, and his eyes fill with tears.

DR. ROBBY: I can't tell you how proud I am of all of you.

HE GATHERS himself and continues.

DR. ROBBY: This place will break your heart. But it is also full of miracles, and that's a testament to all of you coming together and doing what we do best. Thank you for everything you did here today. We saw 112 mass casualty patients come through here in the last four hours, and 106 of them are going to live. None of us are going to forget today. Even if we really, really want to. So go home, let yourselves cry. You'll feel better. It's just grief leaving the body.

Dr. Herbert: This scene was a powerful moment showcasing the resilience and dedication of the medical staff in the face of overwhelming stress. It also demonstrates Noah Wyle's acting prowess.

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ACEP 2025 Leadership & Advocacy Conference—Showing Up on Behalf of EM!

by L. ANTHONY CIRILLO, MD, FACEP

ACEP

10 Essentials for Your ED Fanny Pack

by ANDREW PARK, MD, AND CHANDANA CHERUKUPALLI, DO

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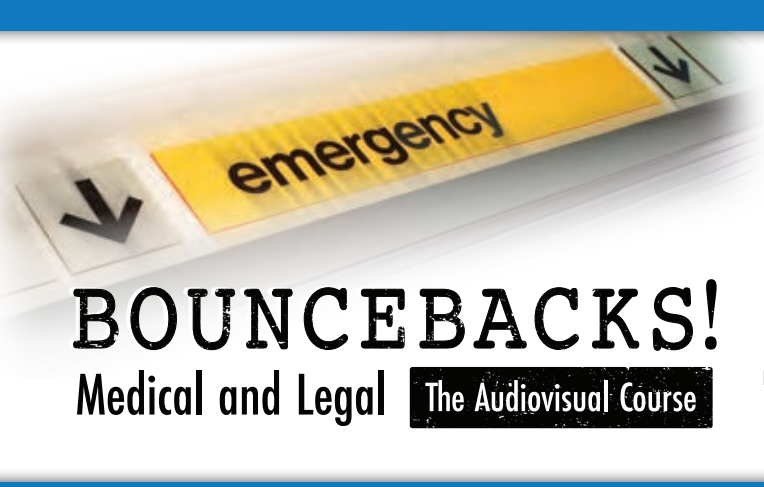
A Mandated Four-Year Residency

by ANDREW GARRETT LITTLE, DO, FACEP, AND MEGAN HEALY, MD, FAAEM



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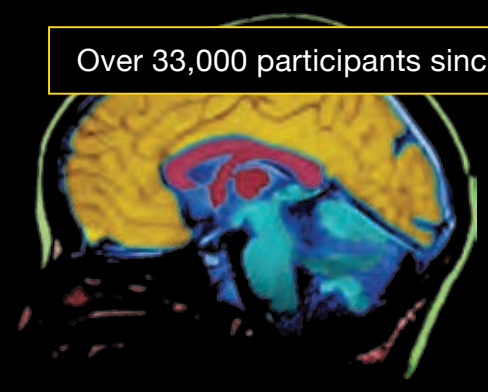

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Dr. Smith goes on a family hike with James, Knock (4), and Finn (2) to Delicate Arch in Arches National Park.

PHOTOS: ALISON SMITH

ABOVE: On a backcountry ski tour day, Dr. Smith poses for a picture with friends at Summit Park, Utah.

LEFT: With fall colors popping, Dr. Smith takes a ride at Biking Corner Canyon in Draper, Utah.

FOUR PERFECT DAYS | CONTINUED FROM PAGE 1

- TF (Templin Family Brewing), located in the Granary District close to downtown Salt Lake City, specializes in traditional and barrel-aged beers.
- Fisher Brewing Company, located in the Granary District, serves fine ales and lagers on draft in the brewery taproom.

"You could also get food from one of the food trucks outside these breweries and find some live music," Dr. Smith said.

Although she doesn't eat out much, Dr. Smith said a tourist coming into town for ACEP25 might enjoy dinner at Urban Hill, Avenues Proper, Takashi Sushi, or Aker.

ACEP25 DAY ONE: Sunday, Sept. 7

Dr. Smith said she never wants to miss the ACEP25 Opening Session and she is excited about this year's lineup. For breakfast she recommended the Sweet Lake Biscuits & Limeade, located on W. 1700 St., about a 10-minute drive from the Salt Lake City Convention Center. Tulie Bakery, on E. 700 St., is also a great option, as is the Rose Establishment, a coffee and breakfast spot closer to downtown.

For those who just drink coffee for breakfast, Dr. Smith said there are several good coffee shops within walking distance of the conference hotels and convention center. From there, it's straight to the Opening Session.

This year, ACEP welcomes Olympic Gold Medalist figure skater Scott Hamilton, who will tell his story of perseverance and hope. Hamilton won a gold medal in the 1984 Winter Olympics and is a four-time World Champion who battled cancer later in life, enduring three brain tumor diagnoses. Hamilton channels his cancer battle into charitable work and uses his platform to speak about resilience.

Later in the session "The Pitt" actor Noah Wyle, along with writer and producer Joe Sachs, MD, FACEP, and medical advisor Mel Herbert, MD, FACEP, sit for an exclusive panel discussion moderated by incoming ACEP President L. Anthony Cirillo, MD, FACEP. Wyle, Dr. Sachs, and Dr. Herbert will share how they capture the chaos, intensity, and humanity of the emergency department with stunning realism, and why the show has deeply resonated with emergency physicians across the country. Shown on Max, "The Pitt" has been picked up for a second season.

"I'm really looking forward to those. I'll get there in plenty of time to get a good seat," said Dr. Smith, who, as President of the hosting Utah Chapter, will also be giving a brief welcome speech during Opening Session.

With an hour or so before lunch and dozens of education options, Dr. Smith said she will scan the schedule and try to find an interesting session related to pediatrics, cardiology, or a specific clinical topic on which she wants to brush up. She has a few favorite speakers—Amal Mattu, MD, FACEP; Scott Weingart, MD, FACEP; and Corey Slovis, MD, are at the top of the list.

At lunchtime, Spitz or Ivey & Varley are great options near downtown, she said. Spitz is a Greek and Mediterranean option whereas Ivey & Varley offers American food and one of the largest balconies in the city.

Back at the convention, Dr. Smith said she would probably try to stop by the Exhibit Hall, but not for too long, as sessions are in full swing. Then, it's time for the Section Hall Crawl at 5 p.m., followed by dinner.

"I always enjoy the Exhibit Hall, but I'm the kind of person who will spend some time there and try to see as much as I can in one trip," she said. "I may pop back in here and there, but probably not go every day of the convention. At the end of the first day, I'd probably go to dinner somewhere downtown like Whiskey Street, White Horse, Current, or Copper Common. Or consider Aker—which is more upscale—or Franklin House, which has great cocktails and delicious food."

ACEP25 DAY TWO: Monday, Sept. 8

The second day is tricky because Dr. Smith starts early, but she knows the EMRA party is at 10 p.m.

After a quick cup of coffee, or something small for breakfast, she will attend some education sessions and catch up with old friends in the hallways. Because ACEP25 attendees aren't locked into sessions they choose in advance, Dr. Smith said flexibility allows for a more enjoyable conference, more time for networking, and more time to recharge.

Lunch is usually another walkable local spot—Eva's Bakery, Red Rock Brewing, or Laziz Kitchen are great options—followed by more time in the education halls. A couple of hours later, she will have been inside for a huge portion of the conference so far, and that's too much.

"I try to be present every day, but I also give myself permission to step outside." she said. "It's only 10 minutes from downtown to some trails, so I'd suggest you rent a city bike and ride around or head up to the Foothills for a hike and great views of downtown and the Great Salt Lake!" One hike she recommended is called The Living Room, which has chairs of stone at the top that look out over the entire Salt Lake Valley.

Back at the convention center, panel discussions featuring high-profile speakers or hot topics will close out the day. Dr. Smith loves infectious disease and anything related to public or global health.

Dinner gets Dr. Smith ready for the EMRA party.

"I love the EMRA party because I'm able to catch up with old friends I haven't seen in years," she said. "It's always a great time."

ACEP25 DAY THREE: Tuesday, Sept. 9

Dr. Smith said there's a good chance she will have to work a shift on one of the final two days of the convention, so it's time to fit in some things she has missed. Rather than go out for lunch on this day, she might try to find a noon

ALISON SMITH

Dr. Smith rappels on a canyoneering day in southern Utah.

session—perhaps one of the lunch education sessions in the Exhibit Hall. She might stop by Research Forum and see what's at the EMF Silent Auction. This might be another day to slip away for a hike for a couple of hours.

She also plans to attend ACEP's Block Party, which is back by popular demand. This high-energy bash from 5 p.m. to 7 p.m. is where attendees come to celebrate, network, unwind, and enjoy fantastic food, drinks, and entertainment. With live music, games, and local vibes, it's the perfect way to wrap up your day.

ACEP25 DAY 4: Wednesday, Sept. 10

Dr. Smith called herself a conference nerd, so she wouldn't recommend slipping out early on the final day of the convention. What she does recommend is getting away from the convention center during the afternoon before heading back home.

"This is crucial," she said. "I think this convention being in Salt Lake City is the perfect chance to get a balance of education and outdoor activities. The weather this time of year is going to be perfect. Try to get outside with your friends—whether it's an outdoor restaurant, brewery, or hike through the hills."

Dr. Smith said guests, particularly first-timers to Utah, should rent a car and drive into the Cottonwood Canyons or drive up to Park City. Even if you don't go for a hike—which is invigorating—at least get above the tree line.

"That's the quintessential Utah experience," she said. "Get outside and see those views. It's amazing, and it's why people live here."

MR. SCHEID is the Content Director at ACEP.

Sharing Our Stories Can Save a Life

by TERI PENN, MD, FACEP

As a 47-year-old woman in medicine, I am accustomed to the balancing act we perform regarding our families, careers, and our well-being. In March 2024, I was planning my next six months, as we typically do in emergency medicine. I was accepted into a part-time master's degree program at Georgetown University. I was looking forward to my mother's birthday cruise to Alaska, and was gearing up for my 14th medical mission trip, this time to Malawi.

I had my mammogram on a Friday afternoon and by Monday morning, I was called with the report of a spiculated mass in my right breast. That word just stuck in my head—spiculated.

I quickly scheduled an ultrasound, which also revealed the mass. The radiologist awkwardly delivered the news to me, without making eye contact. The ultrasound technician shooed her out and explained that I needed an ultrasound-guided biopsy. I had to wait two weeks before getting the definitive diagnosis, and during this time, I did not tell anyone what was happening. I researched breast cancer programs in the area and looked up everything I could about breast cancer diagnosis, treatment, and prognosis while waiting for the biopsy.

I also marveled at how burdensome it was for people with less flexible schedules to make these appointments. After the biopsy confirmed ductal carcinoma in situ, I was determined to get through this and back to my life.

Starting Treatment

I finally told my husband, who went with me to my breast surgeon appointment. He is not in the medical field but was there for support and a second set of ears. The plan was to get a lumpectomy with lymph node biopsy at the end of May 2024, after my mother's birthday cruise. I told my boss, who was amazing in getting my schedule cleared for surgery and recovery. I had physical therapy, medical oncology, lymphedema clinic, and radiation oncology appointments to schedule. The day after my surgery, I finally told my immediate family and close friends. I was overwhelmed by the number of people who confessed to skipping their routine mammograms because they didn't have the time.

I was prepared to cancel my mission trip to Malawi, but with the blessing of my radiation oncologist, I was able to reschedule my radiation therapy. Unfortunately, my treatments were scheduled to coincide with my first classes at Georgetown. The radiation was scheduled at 7:45 a.m., every weekday for three and a half weeks. I would wake up, drive to my radiation treatment, and on class days, immediately drive one and a half hours to campus. On workdays, I would go home to nap and then work my shift. It was exhausting. In mid-September, I completed my radiation treatments and rang the bell.

Sharing My Story

I planned to keep up with my appointments, take the daily tamoxifen for the next five years, and get back to my life as it was before. However, the knowledge that I changed the minds of two close acquaintances and encouraged them to get their screening mammograms was not lost on me. I wanted to tell no one—I told my boss that if someone came up to me at work with a sad look on their face, acting sorry for me, I would quit. I had to reframe my thinking: If I could change two minds within my tight personal circle of friends and family, how many more could I change by stepping out of my comfort zone and sharing my story?

So here I am, more than one year later, already in my second semester, and looking forward to my mission trips to Peru and Nepal. I am back to my normal self, with more insight and gratitude. This is only because I was able to catch my cancer early. There is a chance of recurrence, but I know that I beat it once, and if I need to face breast cancer again, I can triumph once more. I'm asking all of you to remember to take care of yourselves as much as you care for your patients and loved ones.

I am reminded of one of my patients. She was 56 when I diagnosed her with stage IV metastatic breast cancer in the emergency department. When I asked her the last time she had a mammogram, she joked about how it was probably before I was born. She had a good job and great health insurance. I can't help but imagine how her life would have been different had she just kept up with her screening. I wish I had the opportunity to have told her my story before our fateful meeting when I looked her in the eyes to tell her that she had cancer.

GBMC SANDRA AND MALCOLM BERMAN CANCER INSTITUTE, TOWSON, MD.

Teri Penn, MD, FACEP, rings the bell after completing radiation treatment for breast cancer.

DR. PENN is an attending physician for MedStar Medical Group and director of quality and education at the Good Samaritan Hospital Department of Emergency Medicine in Baltimore, Md.

CONTINUED FROM PAGE 1

MEET THE CANDIDATES

President-Elect Candidates

Board of Director Candidates *(four open positions)*

Council Speaker

Council Vice Speaker

PRESIDENT-ELECT

Candidates for ACEP President-Elect responded to this prompt:

In one sentence, describe what you would like your legacy to be at the conclusion of your term as president and then explain why.

Jeffrey M. Goodloe, MD, FACEP

Current Professional Positions: Attending Emergency Physician, Hillcrest Medical Center; Professor and EMS Section Chief, University of Oklahoma School of Community Medicine; Chief Medical Officer, EMS System for Metropolitan Oklahoma City and Tulsa

Internships and Residency: Emergency Medicine Residency, Methodist Hospital of Indiana / Indiana University School of Medicine (1998); EMS Fellowship, University of Texas Southwestern Medical Center (1999)

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

Response

✔ Emergency physicians are beyond essential—we are exceptional!

I don't want that as my legacy; I want that as our legacy. A shared legacy where we, as emergency physicians, reclaim value that has been stripped from our profession over decades. Why does this matter? Because every issue we fight for—fair reimbursement, workplace safety, scope of practice, and professional dignity, to highlight those among many—hinges on how we are valued. Since 2001, our reimbursement has dropped by 33 percent when adjusted for inflation. That is not just a number, it is a stark measure of how our education, training, skill, and commitment have been systematically undervalued by both government and commercial payers. And that loss ripples out. It affects our ability to repay educational loans, care for our families, contribute to our communities, and plan for our futures.

We practice in overcrowded emergency departments, forced to do more with less, while our voices are too often ignored by health systems focused elsewhere. We are treated as interchangeable, as line items on a staffing grid, at risk for being replaced not only by other physicians, but by less-trained practitioners given legislative authority to supplant us. That's not just a staffing issue; it is a threat to patient safety and the integrity of our profession.

This erosion did not happen overnight, and recovery will not either. The recent RAND report is a helpful validation in our cause to strengthen the future of emergency physicians and emergency systems of care across the United States.

During my more than 20 years in ACEP leadership, including serving as Secretary-Treasurer, Vice-President of Communications, and Chair of the Board of Directors, I have come to believe that this challenge is our call to action. We must collectively rebuild the recognition that we are proven leaders in crisis and stewards of

safety. Although we may embody the last line of defense in championing patient care, we are so much more. We are the frontline of diagnostic excellence and efficiency, delivered with humanity in a complicated, often unraveling health care system.

To secure a better future for emergency medicine, we need to restore the respect, investment, and opportunities our profession deserves, not for personal gain primarily, but for the future of the specialty we love, and for the patients who rely on us. Great missions are never individual; they are collective. Let us build that future, our future, together.

Gabor D. Kelen, MD, FACEP

Current Professional Positions: Chair, Department of Emergency Medicine, Johns Hopkins Medicine; Emergency Physician-in-Chief, Johns Hopkins Health System; Director, CEPAR, Johns Hopkins Institutions; Professor, Johns Hopkins University and Bloomberg School of Public Health
Internships and Residency: Emergency Medicine Residency, Johns Hopkins Hospital (1984)
Medical Degree: MD, University of Toronto, Ontario, Canada (1979)

Response

✔ "He advocated for me and my patients, fiercely championed the dignity and heroism of emergency medicine, and forged an essential new direction for the specialty."

Standing on the shoulders of giants who founded the field, and following their example, I aspire to inspire the emergency medicine community to usher in a new era of emergency medicine—one that elevates the standing of emergency medicine to its rightful and respected place in the house of medicine by advancing a unifying and transformative vision of the specialty. We will work together to envision this new paradigm that empowers emergency physicians to shape the specialty's future and unite an ever-fracturing discipline around a renewed sense of high common calling. This will promote professional dignity for individual emergency physicians, and fulfillment across expansive career pathways within a reimagined landscape of emergency medicine.

The fundamental nature of emergency medicine must evolve to overcome current malaise and pervasive disaffection. Our current model has led to extensive and persistent burnout, early retirement, and disillusionment with the field, sufficient to give medical students pause. Incremental advances, as important as they have been, have been matched with equal setbacks, and cannot by themselves overcome the fundamental structural difficulties that hinder the specialty and impede fulfilling long-term careers.

Just as the original visionaries of emergency medicine foresaw the creation of a new specialty, it is now time for another major paradigm shift. We need a visionary concept of emergency medicine that not only anticipates the rapidly changing landscape of health care but actively shapes the future and provides new opportunities on our terms. Our viability and ability to serve our patients depends on no less.

Lofty idea? Perhaps. But the original notion that emergency medicine should be an independent, autonomous specialty was also initially viewed as unrealistic and met with considerable skepticism. Many of you may doubt that a new transformation can occur. However, if we are to address the multiplicity of issues facing the emergency medicine community and our patients, and elevate our standing, we have to think and act boldly. Only by doing so can we advance the field for the benefit of emergency physicians and the patients we serve, and gain the deserved recognition for the heroic and noble profession that defines who we are.

BOARD OF DIRECTORS

Candidates for ACEP Board of Directors responded to this prompt:

What are the two most pressing issues facing members and how would you address them?

Daniel Freess, MD, FACEP

Current Professional Positions: Emergency Medicine Physician, Hartford Hospital Emergency Department; Assistant Professor, Department of Traumatology and Emergency Medicine, University of Connecticut School of Medicine
Internships and Residency: Emergency Medicine Residency, University of Connecticut Integrated Residency in Emergency Medicine (2010)
Medical Degree: MD, Jefferson Medical College, Thomas Jefferson University (2007)

Response

✔ How long can we keep doing this? Emergency physicians are experiencing increased work-related stressors, and this threatens our career sustainability. Every day we are faced with the influences of private equity and corporations, changing training and workforce standards, and increased violence in the workplace. Although multifactorial, I feel two of the most pressing factors affecting our future outlook are threats to reimbursement from payers and the emergency department boarding crisis.

Here in Connecticut, Medicaid rates have not changed in 17 years. There are currently additional efforts to limit out-of-network reimbursement, which will affect hospitals, emergency physicians, and the health care safety net. Nationally, Medicare rates are decreasing compared with inflation and the No Surprises Act has been badly misinterpreted to heavily favor insurance companies. Mandates under EMTALA leave us little negotiating power. Despite ACEP's tireless work on the legislative and regulatory front, we need help. We need the press to spotlight our crumbling health care safety net. We need patients to convince politicians, administrators, and the public that emergency medicine matters. We need to highlight how patients on Medicaid have no access to consultant care. We need patients calling their legislators to discuss predatory high-deductible health plans and lack of access to follow-up. We need to stimulate a national grassroots effort in order to stabilize financial insecurities, allowing for the maintenance of the high-quality care we provide.

The fight to reduce boarding begins with metrics and transparency. In Connecticut, we have passed novel legislation requiring hospitals to submit their boarding data and metrics to the state for public reporting. Although this does not fix the problem, it lifts the veil of secrecy and denial on the part of the government, administrators, and health systems. We need to highlight boarding as a patient safety and quality issue. Until hospitals and health systems are externally pressured to improve boarding, they will continue to follow the financial incentive of increased volume and decreased staffing. The Leapfrog Group has already committed to making boarding part of their quality surveys, but this must only be the beginning. We need to expand our coalition and engage patients, communities, regulators, and even payers to hold hospitals responsible for deficits in emergency department capacity and boarding. This will not only improve patient experiences, but also our own workplace well-being.

Robert Hancock, DO, FACEP

Current Professional Positions: Emergency Physician, Elite Hospital Partners; Clinical Assistant Professor, Oklahoma State University Center for Health Sciences; Core Faculty, Comanche County Memorial Hospital Emergency Medicine Residency
Internships and Residency: Emergency Medicine Residency, UT Southwestern/Parkland Memorial Hospital (2004–2007); Chief Resident (2007)
Medical Degree: DO, UNT Health Science Center, Fort Worth, Texas (2004)

Response

✔ Although boarding has been an issue since the beginning of our specialty, it has continued to worsen until it has become a crisis that threatens patient safety and adds unnecessary work and stress to a specialty that already has the highest rate of physician burnout.

During the COVID-19 crisis, boarding went from a longstanding dangerous practice to a crisis that compromised patient care and likely resulted in unnecessary morbidity and mortality. As emergency physicians, we quickly adapted and found new and innovative ways to continue to move patients through overwhelmed and saturated emergency departments. Unfortunately, many hospitals saw our innovation as a new solution to an old problem. Rather than working to resolve the root causes of boarding, they began to simply demand that we continue to do "more with less."

ACEP needs to continue to lobby for legislation that directly addresses boarding by developing systems to streamline transfers and direct EMS traffic to less saturated facilities when possible. We can utilize artificial intelligence to power these systems so bed status and patient volumes can be updated in real time. Additionally, legislation is needed to address the lack of psychiatric facilities, which has created a crisis of psychiatric holds languishing in emergency departments for days and weeks. ACEP must continue to work with CMS to re-establish boarding as a quality metric with real-world ramifications and offer solutions for poorly performing facilities. Boarding is a complex issue and ACEP must continue to look for new and innovative ways to address this decades-old issue.

Fair reimbursement is another long-term issue in emergency medicine that has only worsened in recent years. The RAND report highlighted the decrease in emergency physician reimbursement from both governmental and commercial insurers. Health insurers have consistently demonstrated bad behavior in denials and underpayment to emergency physicians. Since 2001, Medicare reimbursement to physicians has actually decreased by 33 percent when adjusted for inflation. None of this is sustainable.

ACEP must continue to fight back against the bad behavior of the health insurers. This can be tackled through the legal system, legislation, and the media. ACEP must continue to lobby Congress to pass legislation to hold the insurers accountable and reinforce the "prudent layperson standard." Additionally, ACEP must continue to work with Congress to create a permanent reform to the Medicare payment system that is both fair to physicians and sustainable for the future.

Steven B. Kailes, MD, MPH, FACEP

Current Professional Positions: Emergency Medicine Physician, Emergency Resources Group (ERG); Director of Governmental Relations, ERG
Internships and Residency: Basic Surgery Internship and Emergency Medicine Residency, Naval Medical Center San Diego (1998–2004)
Medical Degree: MD, Tufts University School of Medicine (1998) MPH, Tufts University School of Medicine (1998)

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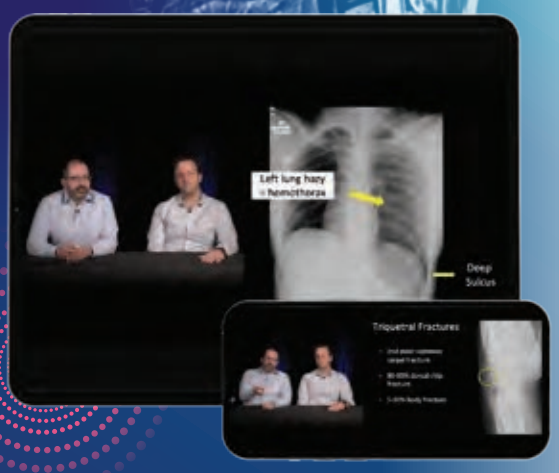
JUST RELEASED

MASTERING EMERGENCY IMAGING



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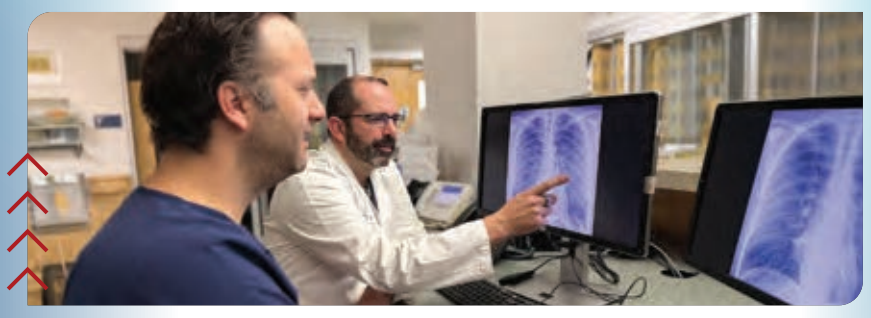

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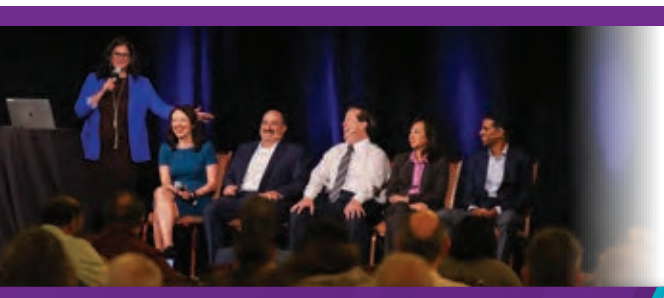

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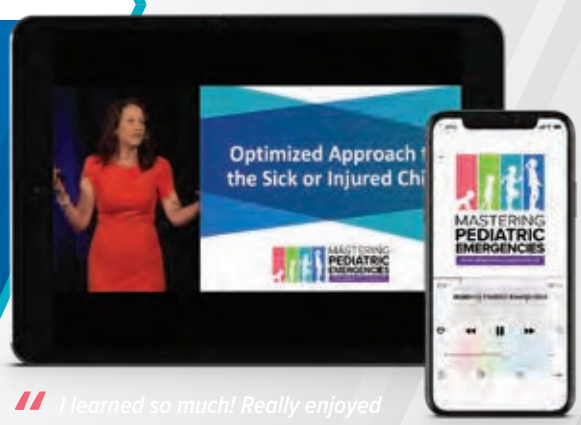

> *"I learned so much! Really enjoyed all of the presentations!"*

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THE YEAR IN REVIEW

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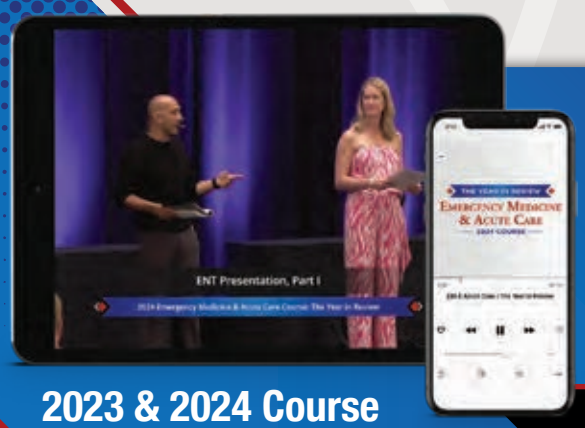

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Response

The two most pressing issues facing emergency physicians are the erosion of physician autonomy and the growing burdens on our specialty without adequate support or resources. First is the erosion of autonomy. Emergency physicians are being asked to do more with less: less time, support, compensation, and say in how we practice. Decisions that affect care and physician well-being are increasingly made by nonclinicians—administrators, insurers, and regulators. This fuels burnout and disconnection, as we're sidelined from decisions central to patient care.

To address this, ACEP must continue advocating for fair reimbursement, protection of independent practice models, and policies that return clinical decision-making to the bedside. Just as important, we must equip members with the tools to lead in their own institutions and communities—to advocate for themselves, their teams, and their patients.

Second, emergency medicine is increasingly stretched as the safety net for a fractured health care system. Patients arrive sicker and with more complex needs—often because they've been denied care or have nowhere else to go. Meanwhile, reimbursement continues to fall. Adjusted for inflation, we earn about 33 percent less than 20 years ago, even as the cost of becoming a physician has soared.

This threatens not just morale, but staffing and sustainability. To meet this moment, ACEP must fight for systemic reforms that improve access to care and reduce administrative burdens that interfere with the physician-patient relationship. This includes addressing insurer denials, down coding, excessive documentation, workplace violence, and emergency department crowding.

The recent RAND report on sustaining emergency care outlines needed policy changes: funding for unfunded mandates, legal and physical protections for our workforce, social support resources, and fairer insurer reimbursement. These are solvable challenges, but they require bold, informed action. I bring deep experience in reimbursement, advocacy, and leadership. I believe ACEP must go on offense: challenging harmful payer behavior, defending physician-led care, and opposing inappropriate expansions of non-physician independent practice. We must also ensure physicians have the tools to sustain their careers and well-being.

ACEP must lead with clarity and urgency. I'm ready to help guide that work—amplifying our members' voices and fighting to keep our specialty strong.

Kristin B. McCabe-Kline, MD, FACEP

Current Professional Positions: VP/Chief Medical Information Officer, AdventHealth Corporate Growth and Acquisitions and East Florida Division; EMS Medical Director, Flagler County; Medical Director, Flagler Technical College EMT Training Program

Internships and Residency: Emergency Medicine Residency, Advocate Christ Medical Center, Oak Lawn, Ill. (2005)

Medical Degree: MD, University of Texas Medical School, San Antonio, Texas (2002)

Response

I think the two most pressing issues facing our members are a sense of powerlessness and isolation. In the last decade, we have seen many changes in the health care landscape that have resulted in consolidation, employer/contract transitions, altered working conditions, and changes in reimbursement.

Many emergency physicians feel reduced to pieces on a chess board that are moved about without control or autonomy and given the respect of a widget maker or RVU producer. Continuing to provide our members with employer transparency in a forward-facing manner is a key task that we are focused on. Every emergency physician deserves to know what options they have and consider what employer would give them the opportunity to do their best work based on their individual goals. One of the most profound undertakings of ACEP has been the launch of the ED Accreditation Program, which will also help to improve transparency while simultaneously pressing health systems to improve the infrastructure emergency physicians depend upon to provide exceptional care to our patients.

In order for emergency medicine to attract the best and the brightest and ensure that emergency medicine–boarded physicians are encouraged to work in all areas of our country, reimbursement will continue to be a strong focus for ACEP with advocacy efforts.

As our specialty evolves, many practice environments are changing with emergency physicians not always feeling supported. The pandemic also contributed to isolation, sometimes even from our families. There are a variety of other issues that contribute to isolation such as difficult cases with poor outcomes and the polarization of attitudes or mindsets when confronted with differing opinions. Working to ensure that every member has a voice, an opportunity to connect with other members that have similar interests or needs and feels supported by ACEP is a key priority. There are far more components of our shared experience that unite us rather than divide us that should be highlighted, celebrated, and part of the infrastructure we provide for our members.

Bing S. Pao, MD, FACEP

Current Professional Positions: Senior Director of Provider Relations, Vituity; Employee, Pinnacle Emergency Physicians; Independent Contractor, Acute Care Specialists; Clinical Faculty, UC San Diego and UC Riverside

Internships and Residency: Internal Medicine Internship, University of Colorado Health Science Center (1993); Emergency Medicine Residency, University of California San Diego (1996)

Medical Degree: MD, Duke University (1992)

Response

The two most pressing issues facing ACEP members are:

1. Improving working conditions for emergency physicians to enhance physician wellness
2. Ensuring the financial sustainability of emergency medicine

Improving working conditions includes creating safer workplaces, reducing boarding, eliminating redundant administrative tasks, increasing autonomy, and ensuring sufficient resources.

To address workplace safety, I will urge ACEP to:

- Advocate for a national reporting system on emergency department workplace violence.
- Promote effective hospital protocols and training to prevent violence.
- Support legislation increasing penalties for assaulting health care workers.

To address boarding and overcrowding, I will insist that ACEP:

- Advocate for CMS to require solutions to boarding as a condition of Medicare/Medicaid participation.
- Push for financial incentives akin to hospital core measures.
- Leverage ACEP's accreditation program to encourage hospitals to implement evidence-based boarding solutions.

Regarding administrative burdens, I support ACEP's adoption of technologies, including artificial intelligence, to streamline workflows and improve quality of care. The ACEP Artificial Intelligence Committee should play a leading role in policy development. Artificial intelligence tools must be implemented with safeguards to ensure fairness, protect privacy, and maintain physician oversight. I will also advocate for reduced regulatory requirements that contribute to physician burnout. Emergency physicians deserve autonomy in decisions affecting patient care and practice management, including staffing, billing, and supervision. ACEP should provide resources for emergency physicians pursuing due process, unionization, or independent practice formation. I will continue to support legislative efforts to secure due process rights nationwide.

To ensure adequate emergency department resources, I will advocate for national standards regarding:

- required equipment for emergency procedures and care,
- adequate staffing,
- responsive specialty support, and
- timely access to radiology, pharmacy, social work, and case management.

The second pressing issue is the financial sustainability of emergency medicine. ACEP's RAND study confirms decreasing reimbursement from both commercial and government payers. This is compounded by the growing number of payment denials and a disproportionate amount of uncompensated care. I have the expertise to help ACEP secure funding for emergency care and address payment erosion. I have successfully supported litigation, regulatory reform, and legislation to protect emergency physician compensation. I will bring this experience to the Board to continue fighting for the financial viability of our specialty.

COUNCIL SPEAKER

The candidate for ACEP Council Speaker responded to this prompt:

How do you balance free and open debate versus meeting efficiency?

Michael J. McCrea, MD, FACEP

Current Professional Positions: Attending Physician and Residency Core Faculty, Mercy Emergency Care Services, TeamHealth; Simulation Director, TeamHealth Northeast Group

Internships and Residency: Emergency Medicine Residency, The Ohio State University Medical Center (2007)

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

Response

Balancing debate while running an efficient meeting is perhaps the most important duty of the presiding officer.

As your current Council Vice Speaker, a two-term Chapter President, and former Chair of multiple committees and task forces, I am known for fostering an environment in which all voices have the chance to be heard while staying on schedule. Although it may seem counterintuitive, it is by ensuring balanced debate that the Speaker maintains control of the agenda and presides over an efficient meeting. Maintaining the equilibrium of the principle of majority rule versus the rights of the minority or any member to speak is at the forefront of my mind while at the podium monitoring debate. For example, if only those in support of a resolution have

CONTINUED *on page 16*

spoken, it is the Speaker's duty to actively inquire if there are any who wish to speak in opposition.

If not, further testimony supporting the resolution may not be needed and the assembly can proceed directly to a vote and efficiently move on to the next item of business. Similarly, if balanced testimony from both sides of the issue has been heard, although it may be appropriate to proceed to a vote, the Speaker should sense the desire from the Council to hear additional testimony. I gained this experience with parliamentary procedure first-hand these past two years as your Vice Speaker from working with our Speaker, Council parliamentarian, and ACEP staff. This service has provided me with the knowledge and expertise to facilitate balanced and efficient debate as your next Council Speaker.

COUNCIL VICE SPEAKER

Candidates for ACEP Council Vice Speaker responded to this prompt:

How do you balance free and open debate versus meeting efficiency?

Kurtis A. Mayz, JD, MD, MBA, FACEP

Current Professional Positions: Chairman of Pediatric Emergency Medicine; Medical Director, Pediatric Emergency Center, Saint Francis Hospital, Tulsa, Okla.

Internships and Residency: Emergency Medicine Residency, Stony Brook University Medical Center, Chief Resident (2014); Emergency Medicine, Patient Safety and Quality Improvement Pediatric Emergency Medicine Fellowship, University of Michigan Health System (2016)

Medical Degree: MD, University of Illinois, Champaign-Urbana (2011); JD and MBA also earned as part of Medical Scholars Program, University of Illinois

Response

The first key to balancing free and open debate and meeting efficiency is realizing that not all debate has to occur on the Council floor, and effectively using processes that allow us to discuss issues before the Council meeting even begins.

Encouraging the use of asynchronous testimony is instrumental in the success of the meeting and we should continue to develop this process further. Creation of Council workgroups on "hot button" issues could help facilitate resolution development and help limit the sometimes-duplicative nature of resolutions. In doing so, we create a more contemplative environment where ideas can be more thoroughly vetted and refined prior to the Council meeting, with the goal of a more streamlined and efficient meeting. This process also assists smaller Chapters and Sections with limited representation in ensuring that their voices can be heard in a way that is sometimes more challenging in the traditional reference committee process.

Before the Council meeting, structuring the agenda so there is sufficient time for the anticipated business is key.

Preparation before the Council, including having a strong working knowledge of the resolutions to be discussed and a sense of the areas of contention which might be addressed, can prepare the presiding officer to efficiently handle the debate.

During the Council meeting, the presiding officer must create a safe environment that encourages open dialogue and balanced participation, while keeping the Council on task. Knowledge of parliamentary procedure, maintaining impartiality, and collaboration with the parliamentarian also guides the efficiency of this process. For example, more effective use of the consent agenda, and education on its use, could help with meeting efficiency. As a registered parliamentarian, I can facilitate this. As the presiding officer, I will help guide discussions through active listening and the ability to summarize and clarify points that will move the discussion forward. I will guide Councillors to remain professional, respectful, and factual in their discussions.

Lastly, the presiding officer must recognize when everything that needs to be said has been said, even if not everyone has had an opportunity to say it, and help guide the Council to that same conclusion. Affirming that many good points have been heard and asking if there are any new points can help guide the debate to a close. The ultimate goal being that the Council feels that its collective voice is heard and that Councillors have a worthwhile experience in the process.

Larisa M. Traill, MD, FACEP

Current Professional Positions: Regional Medical Director, Emergency Department, McLaren Greater Lansing & Grand Ledge, McLaren Medical Group; Clinical Assistant Professor, Michigan State University, College of Human Medicine, Department of Emergency Medicine

Internships and Residency: Emergency Medicine Residency, Detroit Medical Center/Wayne State University (2008)

Medical Degree: MD, St. George's University School of Medicine (2005)

Response

Effective communication and collaboration are essential for productive Council meetings. I would promote inclusivity and an enriched dialogue by not only leveraging the existing debate structure but also enhancing asynchronous testimony to allow for greater debate prior to Council. Doing so will allow our in-person time to remain focused and efficient.

My approach would:

- Optimize asynchronous testimony: I would increase flexibility by allowing members to submit video statements, both asynchronously and during reference committees. This would not only accommodate those who cannot attend in person because of unforeseen circumstances, such as inclement weather or personal commitments, but also those who are unable to attend multiple concurrent reference committees. I would further optimize asynchronous debate by creating discussion groups. These forums would provide a platform for in-depth exploration of "hot topics," leading to more informed debates in the larger Council.
- Foster collaboration on resolutions: Collaboration is key to effective governance. To facilitate this, we should identify similar resolutions in advance, allowing authors the opportunity to consolidate similar proposals.
- Leverage consent agenda and a structured debate format: Continue to fully utilize a consent agenda for non-controversial items, allowing more time for contentious issues that require deeper discussion. Respect members' time, by moving promptly to a vote when it becomes evident that further discussion will not change opinions. By summarizing and clarifying key points during discussions, we can gauge the room's sentiment and adjust our approach as necessary. I would also explore increasing the number of reference committees and consider live-streaming and recording meetings, to enhance transparency and accessibility, enabling all members to stay informed and engaged.
- Solicit feedback for continuous improvement: To ensure that our meetings are effective and inclusive, we must solicit feedback from members regularly. Understanding whether members feel their voices were heard and if we achieved a balance between debate and efficiency is vital for continuous improvement.

In conclusion, enhancing our Council meetings requires a strategic approach that prioritizes collaboration, inclusivity, and efficiency. By leveraging asynchronous testimony, continuing to utilize a consent agenda, and fostering open dialogue through structured debate formats, we can create a Council environment that values diverse viewpoints and encourages productive discussions. Regular feedback and optimization of meeting formats will ensure that we remain responsive to the needs of our members, ultimately leading to more effective governance.

Aine Yore, MD, FACEP

Current Professional Positions: Physician, North Sound Emergency Medicine; Director and President, Physician Practice (includes roles as Claims Manager, Revenue Cycle Management Chair, and Human Resources Chair)

Internships and Residency: Emergency Medicine Residency, Johns Hopkins University School of Medicine (2000)

Medical Degree: MD, Northwestern University (1997)

Response

Council brings together 436 of the best and brightest members of our profession to discuss the most challenging issues facing emergency medicine—a huge investment, and a precious opportunity. As a Council Officer, I will work to leverage this valuable resource to its fullest.

The best part of Council is the debate: big personalities with big ideas engaging in thoughtful, passionate exchanges. Sometimes there are sharply differing viewpoints, and other times, there is general agreement with nuanced dialogue on the optimal way to craft a policy. Usually, the presiding officer doesn't need to intervene. Council is largely self-regulating. Both pro and con positions are presented, and a dialogue follows. Eventually, a motion is made to close debate. As long as both sides have been fairly represented, that motion is in order—and the Council (not the presiding officer) decides whether to proceed. Only rarely must the Chair overrule a premature motion if only one side has been heard.

The true challenge to efficiency? Emergency physicians' greatest strengths: We think on our feet, we solve problems, and we can't resist trying to improve things—even from the microphone. Thus appears the dreaded "friendly amendment" or "minor wordsmithing." The Chair must be firm in requiring that amendments follow standard procedures for submission. As Vice Speaker, I would ensure that expectation is clearly set and consistently upheld—for both fairness and efficiency.

The presiding officer must also navigate procedural complexities, as debate often wanders into the weeds of second-order amendments. Keeping testimony focused and on point is essential to sound decision-making. It takes a light touch to do this while respecting points of personal privilege, smiling through a few curmudgeonly declarations from Council elders, and helping the process feel not just efficient—but even a little fun.

Ultimately, this is about reading the room, respecting the process, and honoring the voices in it. After more than a decade attending Council, I look forward to serving in this role—to keep us continually thinking and moving forward, while ensuring every meaningful voice is heard.

TOXIN-INDUCED HYPOTENSION

Any treatment is best used in conjunction with a medical toxicologist, when available

by AESHA SHAH, MD; AND DANIEL JOHNSON, DO, FACEP

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Acute toxic ingestions are a common reason for presentation to the emergency department (ED) and clinical scenarios range from benign accidental ingestions to large overdoses resulting in hemodynamic instability. A wide variety of toxins cause hemodynamic instability, from cardiotoxic medication to plant-based toxins, and even inhaled substances.[1] In the ED, the most important consideration in management of these toxicities involves decontamination, evaluating for airway protection, and managing any hemodynamic instability.[1]

Medications such as beta blockers, calcium channel blockers, and digoxin can cause cardiogenic shock secondary to decreased inotropic and chronotropic effects. If the ingestion was within the first hour, activated charcoal should be considered for gastrointestinal decontamination and may prevent progression of toxidrome. The dose is 25 mg-100 mg for adults and 0.5 mg/kg-1 mg/kg with maximum dose of 50 mg in children.[1] Whole-bowel irrigation can be considered; however, it is not recommended in unstable patients or those at risk for aspiration.

Fluid resuscitation is the initial management of hypotension. However, it should be used with caution in patients with cardiogenic shock. One to two liters of crystalloid is a reasonable starting amount.[1,2] Reversal agents should be used for specific toxins such as digoxin immune fab for digoxin toxicity high-dose insulin for beta blocker toxicity, or calcium for calcium channel blocker toxicity.[2,3] Vasopressors, ideally norepinephrine or epinephrine, are the next step if fluid resuscitation and antidotes are not successful.[2,3]

Atropine or temporary pacing can be used for treatment of bradycardia. Lipid emulsion can be used as an adjunct to therapy and can act to bind lipophilic substrates of toxins and expedite their excretion. In addition, it is proposed to improve fatty acid phosphorylation, adenosine triphosphate production, and decrease nitric oxide production, which reduces vasodilation.[4,5] Amlodipine and verapamil toxicity have been shown to be responsive to this treatment.[6]

Methylene blue is an additional adjunct that can inhibit formation of nitric oxide, thus increasing vascular tone and blood pressure.[5] Finally, extracorporeal membrane oxygenation (ECMO) can be used temporarily if all other measures fail.[1] Some evidence suggests improved mortality in patients who received veno-arterial (VA) ECMO for refractory toxin-induced shock.[7] During this time, consultation with a cardiologist, intensivist, and medical toxicologist is required.

Dysrhythmias from Toxin Ingestion

Dysrhythmias can also be associated with toxin ingestion leading to cardiogenic shock. For example, tricyclic antidepressant overdose can lead to sodium channel blockade, which can cause QRS widening. In addition to supportive measures, sodium bicarbonate should be given as an initial bolus of 50 milliequivalents (mEq) to 100 mEq (or one mEq/kg-two mEq/kg).[7] A continuous sodium bicarbonate infusion can also be started at 150 mEq in 1 L D5W at 250 mL per hour over four hours after the initial bolus.[7] Toxicity from selective serotonin reuptake inhibitors and antipsychotic medications can lead to corrected QT interval (QTc) prolongation, which can lead to torsades de pointes. Ideally, these patients should be treated with magnesium sulfate until QTc normalizes.[1]

In addition, there is a growing abuse of tianeptine (street name "ZaZa"), which is an atypical tricyclic antidepressant. It also has opioid receptor agonism.[8] Thus, patients will present with hypotension and respiratory depression with QRS widening. Treatment should include a combination of sodium bicarbonate and naloxone.[8]

Alpha-2 agonists such as xylazine and clonidine also have the potential for abuse. The primary mechanism for hypotension from these agents is direct vasodilation from the adrenergic alpha receptor blockade. Initial management of hypotension should include resuscitation with crystalloid fluid but these individuals may require vasopressor support to improve adrenergic activity at the alpha receptors.[9] Vasopressor of choice should include norepinephrine or epinephrine. Finally, although xylazine is lipophilic, evidence of success in treating overdose with intralipid has not yet been shown.[8]

Hypotension from toxin ingestion could also be from hypovolemia from loss of fluids through vomiting or diarrhea. For instance, amanita mushroom toxicity specifically can cause large amounts of watery diarrhea, which can lead to hypovolemic shock.[1] Cholinergic toxicity can also lead to insensible fluid loss. Acetaminophen toxicity can also have a similar effect during stage two of disease. A combination of prolonged emesis and hepatic injury can lead to hypovolemia.[10] Specific antidotes for each toxicity should also be given in addition to the management of hypotension. For example, Digibind should be given for digoxin toxicity.

Inhaled Toxins

Inhaled toxins such as cyanide, carbon monoxide, and arsenic can also cause hypotension. They present the unique challenge in decontamination. If there is concern for gastrointestinal ingestion, as in the case of cyanide and arsenic, activated charcoal should be utilized.[5] Otherwise the individual should be physically washed and decontaminated in case there are remnants of the poison on clothes and skin.

Like the other toxins, treatment for hypotension includes supportive management and specific treatment with antidotes, if possible. In the case of cyanide, there is a halt in aerobic metabolism.[11] This can lead to build up of lactic acid and eventually cause tissue necrosis, and end-organ damage, including cardiogenic shock.

Treatment includes hydroxocobalamin or sodium thiosulfate with amyl nitrate (Cyanokit®), which can help restore aerobic respiration. Hydroxocobalamin can also remove nitric oxide and improve vasoconstriction.[5] Excessive carbon monoxide exposure can lead to cardiac ischemia from poor aerobic respiration. Management should include high oxygen therapy to improve oxygen saturation and consequently aerobic respiration.[12] If necessary, hyperbaric oxygen can be utilized. Finally, arsenic poisoning can lead to severe gastroenteritis that causes vomiting and diarrhea. This can precipitate hypovolemic shock. Consequently, as no specific antidote is available, aggressive fluid resuscitation is the mainstay of treatment.[13]

The treatment of toxic exposures causing hemodynamic instability can represent a unique clinical challenge in the ED. In general, the mainstay of treatment includes decontamination followed by reversal agents if available. While these are being prepared, or in cases where they do not exist, supportive care is paramount.

For hypotension, fluid resuscitation followed by the initiation of vasopressors is the mainstay. Consider and manage sodium blockade and QT prolongation in the case of cardiac dysrhythmias, such as those that develop in tricyclic antidepressant overdose. Finally, consider adjunctive therapy such as high-dose insulin therapy or lipid emulsion for beta blocker or calcium channel blocker toxicity. In the most severe of cases, VA ECMO may be considered. All these treatments are best utilized in conjunction with a medical toxicologist, when available, or by calling the national poison control network at 1-800-222-1222.

DR. SHAH is a PGY-3 resident at Penn State Milton S. Hershey Medical Center.

DR. JOHNSON is an assistant professor of emergency medicine at the Penn State Milton S. Hershey Medical Center and College of Medicine.

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GUIDANCE ON THE CLINICAL MANAGEMENT OF EMERGENCY DEPARTMENT PATIENTS

CLINICAL POLICY

DR. LO is chief of emergency medicine at Sentara Norfolk General Hospital and professor at Eastern Virginia Medical School. He is the subcommittee chair for ACEP's Stroke Clinical Policy, and a partner at Emergency Physicians of Tidewater in Norfolk, Va. When he's not working, he enjoys eating small portions on large plates.

ACEP Clinical Policy on Thrombolytics for the Management of Acute Ischemic Stroke

by BRUCE M. LO, MD, MBA, RDMS, FACEP

On September 26, 2024, the ACEP Board of Directors approved a clinical policy developed by the ACEP Clinical Policies Committee on the use of thrombolytics for the management of acute ischemic stroke. This clinical policy was published in the December 2024 issue of the *Annals of Emergency Medicine*, can be found on ACEP's website, www.acep.org/patient-care/clinical-policies/, and will also be included in the ECRI Guidelines Trust, https://www.ecri.org/solutions/ecri-guidelines-trust, upon its acceptance.

Approximately 30 percent of all acute ischemic strokes have a large vessel occlusion, which contributes to 64 percent of all moderate-to-severe disability from stroke at three months and more than 95 percent of stroke deaths at six months. In the past decade, acute treatment for large vessel occlusion has expanded beyond thrombolytics with evidence supporting the use of endovascular therapy such as mechanical thrombectomy.

A recent international survey showed that 63 percent of stroke physicians consisting of neurologists, interventionalists, and neurosurgeons would still give intravenous thrombolysis prior to endovascular therapy. This practice trend may be because of conflicting consensus from experts on whether to support intravenous thrombolysis prior to endovascular therapy. This latest clinical policy from the ACEP Clinical Policies Committee is an update of the 2015 Clinical Policy on the use of tissue plasminogen activator for the management of acute ischemic stroke, and seeks to evaluate the outcomes for patients who present with an acute stroke from a large vessel occlusion who have received endovascular therapy with or without intravenous thrombolysis.

The critical question was based on feedback from ACEP membership. A systematic review of the evidence was conducted, and the committee made recommendations (Level A, B, or C) based on the strength of evidence available. This clinical policy underwent internal and external expert review, and was available for review by ACEP membership during an open comment period. Responses received were used to refine and enhance the final policy.

CRITICAL QUESTION

In adult stroke patients who are a candidate for mechanical thrombectomy, is the use of intravenous thrombolysis (IVT) prior to mechanical thrombectomy (bridge therapy) beneficial and safe versus mechanical thrombectomy alone?

Patient Management Recommendations

- **Level A recommendations.** None specified.
- **Level B recommendations.** In stroke patients who are candidates for both mechanical thrombectomy and IVT,* IVT should be offered and may be given prior to mechanical thrombectomy.

* IVT is given within 4.5 hours from symptom onset.

- **Level C recommendations.** When feasible, shared decision making between the patient (and/or their surrogate) and a member of the health care team should include a discussion of potential benefits and harms prior to the decision whether to administer intravenous thrombolytics (consensus recommendation).

More on ACEP's Class of Evidence framework and Recommendation Levels can be found at www.acep.org/patient-care/clinical-policies.

Toxicology Q&A Answer

QUESTION ON PAGE 2

ANSWER: Assassin Bugs

Assassin bugs might also be known as ambush bugs, wheel bugs, or North American wheel bugs.

The wheel bug (*Arilus cristatus;* see Image 1) and milkweed assassin bug (*Zelus longipes;* see Image 2 on page 20) are two types of assassin bugs you might find in your garden across North America. They are "true bug" members of the Hemiptera, because they have liquid sucking mouth parts, have a nymph stage in their development, and have six legs and three body parts. They are two of the 160 types of the Reduviidae family of insects found worldwide.

These two types (and others like them) are primarily beneficial bugs to agriculture, eating insects that cause harm to crops—including flies, mosquitos, roaches, beetles, aphids, armyworms, and caterpillars.

They aggressively eat these insects by grabbing them and using their rostrum (a three-jointed spear-like hollow mouth) to stab into prey, even when covered in "armor." They inject a venom mixture containing a paralytic, which immobilizes prey in about 30 seconds and liquifies their insides. The bugs begin digestion of the prey's internal nutrient-containing structures, which they suck out though their mouth-straw.

Identifying Common Assassin Bugs

Adult wheel bugs are usually 33-38 mm long, grey colored, have segmented antennae sprouting from a narrow head, and have a distinctive cog-wheel shaped armor on the dorsum of its prothorax with eight to 14 projections—hence "wheel bug."[1] The wheel bug also has bright orange scent-sacs on its posterior thorax that can release a pungent scented liquid when disturbed.[2]

Adult milkweed assassin bugs—also called the long-legged assassin bug or the *Zelus* assassin bug—are 16-18 mm in length, have orange coloration with white spots on the thorax, long segmented antennae extending from a narrow head, and have a business-end sharp rostrum designed for stabbing.

Another subfamily of assassin bugs are "kissing bugs" (*triatomine*). In contrast to the previously described garden-group of assassin bugs, these are blood-feeding, have much smaller rostrums, and eat through an essentially painless poke. They bite people's faces at night without waking them up. While they are drinking blood, the insect produces stool that is infected and full of the protozoan parasite *Trypanosoma cruzi*. This pathogen gets rubbed into the itchy wound producing Chagas disease in the victim.

Toxicological Importance

Normally, the garden variety assassin bugs have no interest in humans and prefer to hide. However, when disturbed and handled, they can inflict a painful response. Although repeatedly referred to as a "bite" in the literature, the injury actually occurs through a stab of your skin by their needle-like rostrum and a dose of their defensive/digestive product—described as "10 times worse" than stings from bees, wasps, or hornets. The sensation has been described as a burning, very sharp pain that can be followed by numbness in the local area for several days.

The local skin area reactions vary from focal pain and redness; to broad areas that are reddened, urticarial, and hot; to punctum-associated abscesses. Broad rash and anaphylaxis have been described in patients sensitized from previous bites.[3] Healing times vary but may take two weeks or longer for full resolution.

Dr. Hall described in detail the effects of two "bites" to the right fifth digit of his 10-year-old daughter from *Arilus c.*[4] The bite pain was

CONTINUED *on page 20*

PHOTOS: JASON HACK (OLEANDER PHOTOGRAPHY)

Image 1: The wheel bug (*Arilus cristatus*)

described by her as a "bee" sting. The wound later developed horn-like "papillomata" at the punctures, and compared with her other digits, the affected finger "still was warmer than the others a year later." More recent investigations into assassin bug venom—specifically in bee-killer assassin bug (*Pristhesancus plagipennis)*—revealed the production of two separate venoms (one for paralysis and digestion, and one for producing pain for defense) from two distinct groups of glands.[5]

Treatment

There is no antidote. Treatment of *A. cristatus* and other assassin bug stings depends on the reaction to the insult. Local reaction treatments are generally treated supportively with local corticosteroids and antihistamines. If more generalized allergic reactions occur, treat with standard oral antihistamines and steroids. Anaphylaxis treatment is again standard, with epinephrine and intravenous antihistamines as indicated. Infected bites should be treated with antibiotics, and abscesses incised and drained.[6,7]

DR. HACK is chief of the division of medical toxicology and vice chair for research at East Carolina University in Greenville, N.C.

PHOTOS: JASON HACK (OLEANDER PHOTOGRAPHY)

Image 2: The milkweed assassin bug (*Zelus longipes*)

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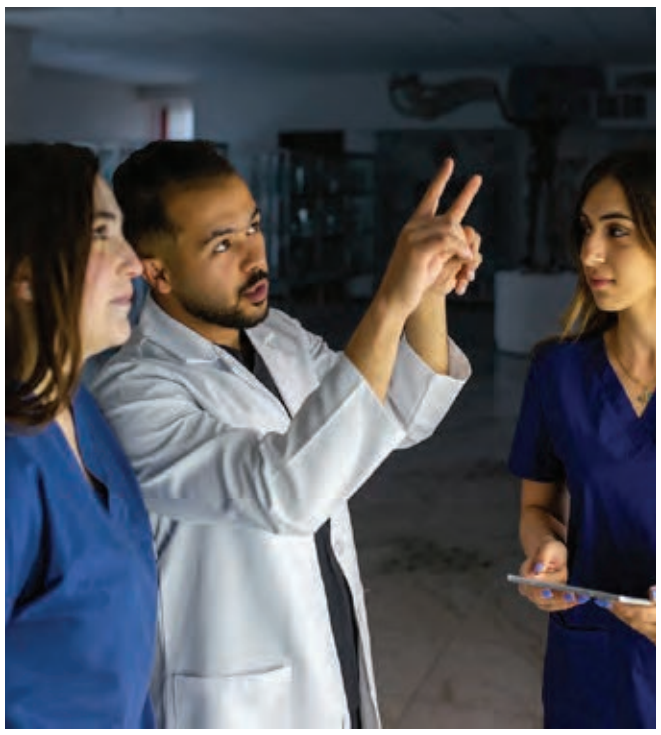

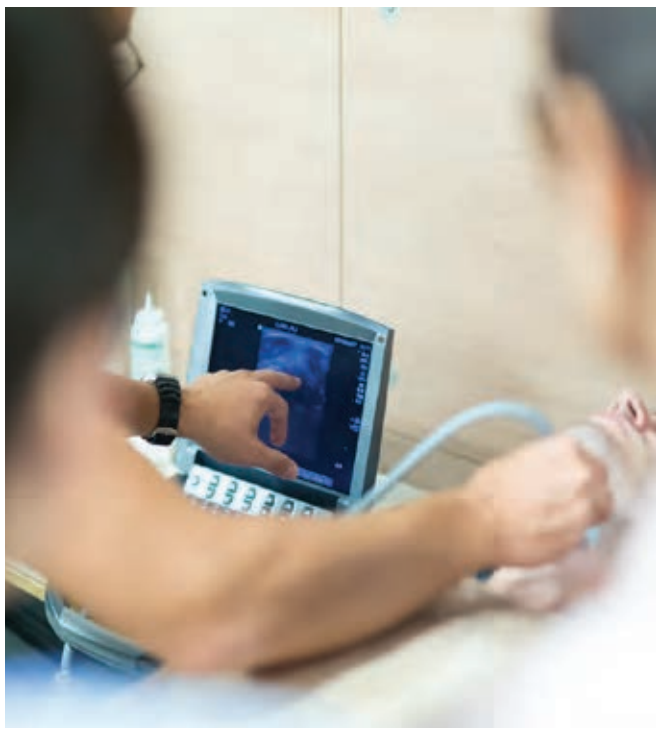

About Baylor College of Medicine

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

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

Minimum requirements

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

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

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TIPS FOR BETTER PERFORMANCE

SPECIAL OPs

DR. WELCH practiced emergency medicine for 35 years. She was an emegencry department (ED) quality director for Intermountain Healthcare. She has written articles and books on ED quality, safety, and efficiency. She is a consultant with Quality Matters Consulting, and her expertise is in ED operations, patient flow, and work flow.

Scripps Mercy Hospital San Diego's Unique ED Culture Breeds Innovation

by SHARI WELCH, MD

The emergency department (ED) at Scripps Mercy Hospital San Diego is a different breed of ED. This can be felt upon entering the beautiful southern California facility through the patient entrance. During my visit the greeter area was quiet, uncluttered, and virtually empty at 4 p.m. Seeing more than 76,000 annual visits, this urban academic Level I Trauma Center is a STEMI-receiving hospital, geriatric emergency department (GED) certified, and a Stroke Center.

Other operating characteristics for this department are seen in Table 1. Interestingly, the geriatric rate is higher than the average for similar departments, and the pediatric rate is lower—both suggesting a higher acuity patient mix—yet the admission rate is only 21 percent. The EMS arrival rate is quite high and this is challenging from an operational standpoint. They have a high behavioral health (BH) population but only modest boarding.

The operations playbook of best practices for EDs in the 60,000–80,000 annual visits volume band is now well recognized and includes the following features:

- a physician in triage (PIT) intake process to ensure the timeliness of the patient/clinician encounter, even during times of surge and high boarding when the department is likely full,
- acuity-based patient care zones with like patients being treated in one area,
- a "fast track" for extremely low acuity patients who may be treated by an advanced practice provider (APP),
- a "mid-track" or vertical care area where middle acuity patients remain vertical to receive diagnostics and therapeutics, and are likely discharged home,
- an acute care or major care area reserving patient beds for the sickest patients that are likely to be admitted, and
- team-based, zone-based care delivery with a care team (physicians, nurses, and techs) all taking care of the same patients in a pod or a zone.

Doing Things Differently

The ED at Scripps Mercy Hospital San Diego does not have a PIT process. Instead, it actively pushes patients into care spaces. The department does have acuity-based care zones. Care is provided largely by teams in acute care zones. That said, the department incorporates floating and flexibility in the name of efficiency: Care of patients in hall beds and in the fast track is shared among all clinicians instead of using dedicated ones in those areas.

In fact, their patient flow model is more typical of a low-volume ED (see Figure 1).

In addition, the Scripps Mercy San Diego ED is unique in terms of its physician group: Pacific Emergency Providers (PEP), APC, is a single-department, independent, democratic physician group with 15 physician partners, eight APPs, and a cadre of other full-time and part-time practitioners. APPs function in a supportive role to physicians and every patient is seen by a physician!

PEP has had this contract for 20 years and is closely aligned with their hospital leadership. The hospital leadership does its part to support the emergency physician group by keeping the boarding burden to a minimum (103 minutes versus 189 minutes EDBA benchmark) and by providing efficient ancillary services, particularly imaging. Turnaround times for all imaging modalities are faster than recorded benchmarks.

Does this atypically staffed and run department work? As you can see in Table 2, PEP is an unusually high-performing ED.

How Do They Do It?

How does this department do so well without using all of the best practice tactics of other departments of the same volume? It all comes down to culture.

Both physicians and nurses are recruited to find stakeholders who share the same work ethic and commitment to efficiency, quality, and courtesy in caring for patients. On my tour, I was impressed at how often I heard the phrase "this is better for the patient." Conversely, I did not hear "that is not my job" or "that is not my patient." These "all-hands-on-deck" and "patients-first" imperatives embedded into the culture at Scripps Mercy San Diego are palpable.

The Scripps Mercy San Diego ED is continuously trialing improvements and this change-oriented culture has bred amazing innovation. In particular, they have responded to the BH crisis in their community by adopting BH order sets for patients awaiting psychiatric evaluation and placement. The ED has cordoned off four rooms to create a BH pod that moves these patients to a quieter area. The physicians have become comfortable discharging a high percentage of patients with BH issues and are comfortable with a number of BH therapeutic interventions for the sickest patients. They have gotten proficient at treating substance abuse and are credentialed to prescribe buprenorphine and naloxone (Suboxone) for patients who will follow-up in appropriate settings.

Because the ED has overperformed for many years, it has been rewarded with many amenities including a case manager 12 hours a day, 24-hour critical care/intensivist coverage, and 20-hours-a-day clinical pharmacist coverage.

The culture at Scripps Mercy San Diego is unique and hard to find. The department was extraordinarily quiet as I walked through, and yet there was an urgency to see the next patient, to make the next disposition. There was little tolerance for waits and delays, and the entire department was rowing in the same direction to keep the waiting room empty. This ED is a lesson on how a shared culture can overcome many ED obstacles.

No matter the operating model, an ED will likely struggle with achieving results without a strong team culture that puts patients first. I can't argue with the success story that is told by this department's metrics. And it all comes down to culture!

FIGURE 1: Scripps Mercy San Diego Flow Model

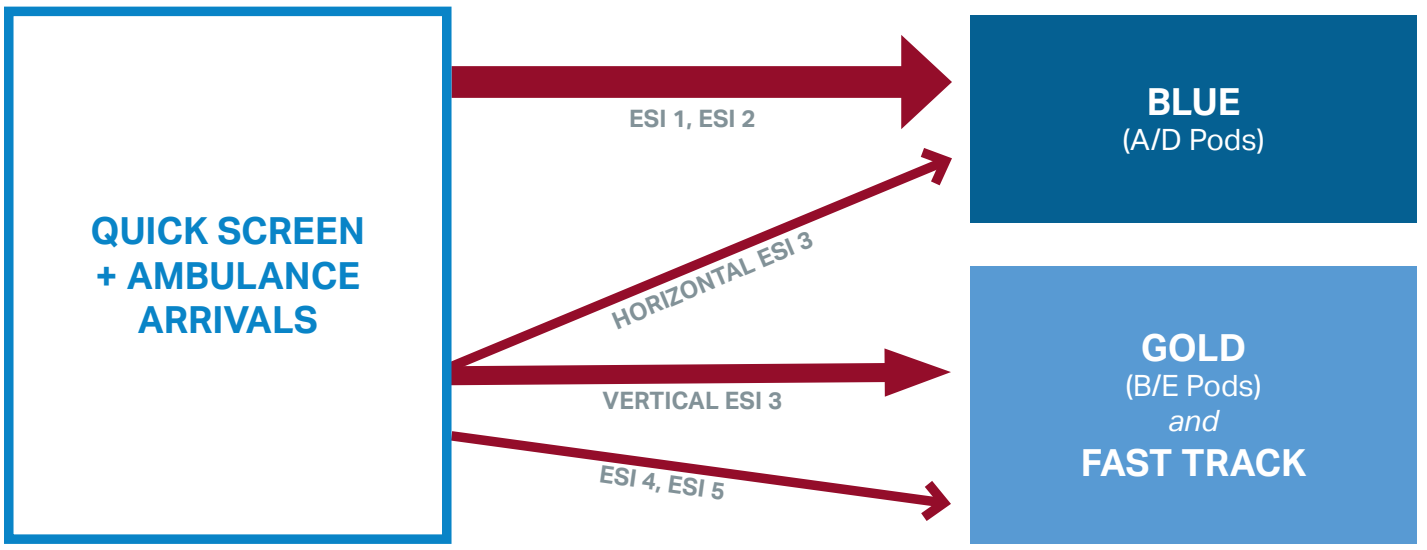

TABLE 1: Operating Metrics

CHARACTERISTIC	SCRIPPS MERCY SAN DIEGO	EDBA 60,000-80,000 VOLUME 2024 DATA
Volume	209 PPD	192 PPD
Admission Rate	21%	17%
Geriatric/Pediatric Rate	24%/2%	18%/13%
Beds	56 + 12 Hallway	64
EMA Arrival Rate	33%	23%

TABLE 2: Performance Characteristics

METRIC	SCRIPPS MERCY SAN DIEGO	EDBA 60,000-80,000 VOLUME 2024 DATA
Door to Doc	23 minutes	27 minutes
LOS Overall	217 minutes	277 minutes
LOS Admitted	312 minutes	425 minutes
LOS Discharged	192 minutes	214 minutes
Walkaway Rate	4.9%	4.7%
Admit Decision to Departure	103 minutes	189 minutes

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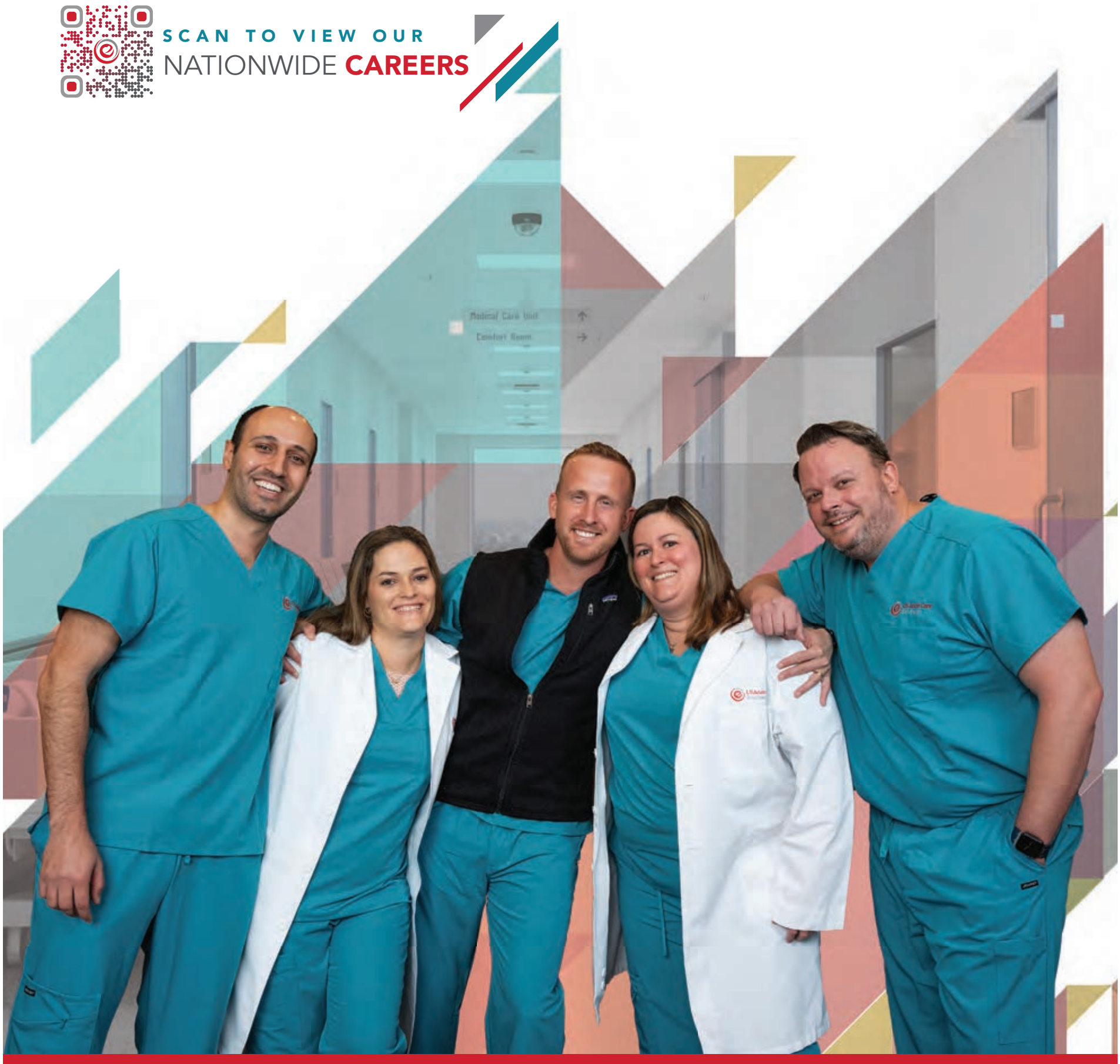

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