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A Conversation with Dr. Haddock
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Sleep Concepts and Strategies for Shift Work

EM CASES

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

Sleep is essential to life. The better we sleep, the better we concentrate, make decisions, and perform.

Better sleep minimizes the chance of making errors on shift.[1] Better sleep makes us learn better because it plays a key role in consolidating both declarative and procedural memory.[2] Better sleep means better adaptive capacity to stressful situations, which are plentiful in emergency medicine.[3]

The better we sleep, the better mood we tend to be in and the better our relationships.[4] The better we sleep, the lower our

CONTINUED *on page 15*

2025 Emergency Physician Compensation

Key insights from ACEP's latest Salary Survey

by ACEP NOW

As emergency medicine continues to evolve amid changing reimbursement, workforce pressures, and shifting practice models, understanding physician compensation remains critical. With the retirement of long-time *ACEP Now* columnist Barbara Katz, who has traditionally performed an annual compensation report, ACEP solicited its own 2025 Salary Survey, conducted in partnership with Readex Research. The 2025 Salary Survey offers a timely and comprehensive snapshot of how emergency physicians are compensated across the country—and how those figures vary by role, region, gender, and practice setting.

With more than 1,600 qualified responses from actively practicing emergency physicians, the survey provides both topline insights and deep dives into critical demographic and professional variables. The results reveal compensation gaps, regional disparities, and persistent differences across gender and practice type, while also affirming that in many ways, the survey sample closely reflects ACEP's broader membership.

CONTINUED on page 8

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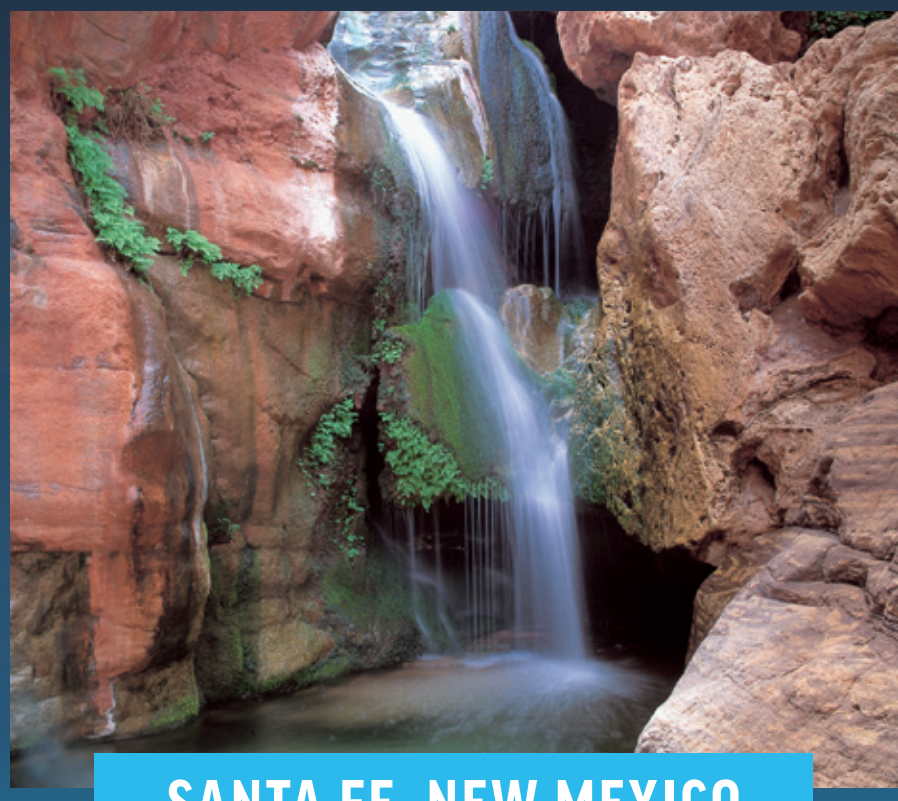

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ACEP Now Recognized for Publication Excellence

by ACEP NOW

ACEP Now is happy to announce that it has received two APEX Awards of Excellence this year for content published in 2024.

- **Award of Excellence for Writing** – Diversity, Equity & Inclusion for "Emergency Physicians Volunteer to Deliver Care," published in the December 2024 issue, which detailed the eye-opening and rewarding work involved in street medicine movements and free clinics in several U.S. cities.
- **Award of Excellence for Magazines/ Entire Issue** for its September 2024 issue, which featured an article discussing private equity in health care, reporting detailing a 24-hour labor strike called by a union representing emergency physicians at Ascension St. John Hospital in Detroit, Mich., and some of its regular columns like Pearls from the Medical Literature by Ryan Radecki, MD, MS, FACEP, and Kids Korner by Landon Jones, MD, and Richard M. Cantor, MD, FAAP, FACEP.

The annual APEX Awards are given by Communication Concepts to recognize excellence in writing, digital content, graphic design, social media, public relations, and marketing.

ACEP Now Welcomes Dr. Vanya Zvonar as Its New Resident Fellow


ACEP

by ACEP NOW

Vanya Zvonar, MD, is the newest member of *ACEP Now's* editorial team. As the 2025–26 Resident Fellow, Dr. Zvonar will oversee the Resident Voice column while contributing the perspective of emergency medicine residents to the editorial board.

Dr. Zvonar is a third-year resident at The Mount Sinai-Elmhurst Emergency Residency Program in New York City. Her interests include medical education, immigrant and refugee health, and global health.

CORRECTIONS

"Toxin-Induced Hypotension" (*ACEP Now*, July 2025, p. 17) gave an incorrect dose for activated charcoal. The correct dose is 25–100 g for adults and 0.5—1.0 g/kg with maximum dose of 50 g in children.

"A 'Killer' Bug" (*ACEP Now*, July 2025, p. 2, 19-20) mislabeled the included images. The caption for Image 1 (p. 19) should have read: The milkweed assassin bug (*Zelus longipes*). The caption for Image 2 (p. 20) should have read: The wheel bug (*Arilus cristatus*). We regret the errors.

"I really liked the course. It could have been the best course I have attended."

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"Excellent. Glad I attended."

"Easily one of the highest value courses for me."

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"Have been attending this course for 30 years. I really like the format change. Excellent CME opportunity."

"I totally enjoyed it. It was informative yet a relaxed atmosphere to learn in!"

"This was an impressive course. The faculty were excellent."

"Great! I am never bored. Very fast paced but exactly what we need as ER providers."

"My fourth course. Easily one of the highest value (for me) on offer."

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2026 COURSE LOCATIONS ANNOUNCED!
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THE YEAR IN REVIEW

EMERGENCY MEDICINE & ACUTE CARE

2026 COURSE

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March 9–13, 2026
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Maui, HI
March 9–13, 2026
Wailea Beach Resort - Marriott, Maui

Hilton Head, SC
April 22–25, 2026
Hilton Beachfront Resort & Spa

New Orleans, LA
April 29–May 2, 2026
New Orleans Marriott
NOLA JAZZ FEST

San Diego, CA
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Tag-Team Faculty Format

Two physician faculty will jointly present and critique the studies, adding their perspectives based on prior research and clinical experience. Our faculty are knowledgeable, well-versed in the medical literature, and enthusiastic about engaging with participants.

No PowerPoint Slides

We keep the lights on and leave the slides at home to foster an interactive learning environment. Each topic is presented by a pair of our award-winning faculty, allowing you to follow along in our detailed manual.

"Really like the new fomat."

"Great course. Distilled so much information down to accessible amounts that can help in real practice."

"Extremely useful and well-designed course."

"Exactly what I wanted, needed, and have come to expect."

"I have been a supporter of these courses since the 1990s. That speaks for itself!"

"Awesome. Format of the literature review is a great way to challenge "the way we've always done it."

"I love that there were no slides."

"I always leave feeling that my time was well spent."

"It was fast moving which kept your interest."

"Clinically relatable and timely. Would come back again."

"Nice to have research dissected for me."

"Absolutely loved it."

"It was different from what I've experienced before but in a way was better than just sitting through PowerPoints."

"Fantastic - I would do it again."

"I liked the rapid-fire, highlights style that the course utilized."

"Excellent (once again)."

"I've been attending CME conferences for the past 36 years and this course is in my top 5."

"Excellent new format. Really current and useful. I think the standardization of presentation format really helps convey the info effectively."

"I love the new format!"

"The best course I've attended in years. The enthusiasm of the instructors was evident."

"I overall loved the new format of the course with multiple presenters taking turns presenting the topics."

"Best one yet. Like the new format. Will come again."

"Great. It was my first course done in this format without slides and focusing on studies. I liked it and learned a lot."

"I love the format, especially the quick end summary of each article at the end of each session."

"I have never attended this course before, and can say I will HIGHLY recommend this to colleagues."

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LETTER TO THE EDITOR

Dignity and Respect

by RAJ PARIKH, MD

DR. PARIKH is a recently retired emergency physician in North Carolina.

Regarding your recent interview with ABEM President Dr. Diane Gorgas (*ACEP Now*, May 2025, p. 1), I'd like to share a few thoughts as I think it's critical to show a different viewpoint. In 1992, I graduated from the University of Texas Southwestern Medical School at Dallas, known for Parkland Hospital. At that time, the hospital had five separate emergency departments, each controlled by its supervising specialty—surgery/trauma, medicine, obstetrics/gynecology, pediatrics, and psychiatry. There were no emergency medicine rotations, much less an emergency medicine residency. Emergency medicine was not promoted as a potential residency or specialty there. After completing two years of general surgery and three years of family medicine residency, I am board certified in family medicine, but I have been practicing emergency medicine for more than 30 years.

For my entire career, I feel that both ACEP and ABEM have disparaged non-ABEM–boarded emergency physicians such as myself. Your interview states, "you need to do something 10,000 times to be an expert at it." Yet, both organizations have convinced hospital administrators across the country that an ABEM-eligible, recent residency graduate is more qualified to work in their emergency department than a multi-year experienced non-ABEM–boarded physician. You also claim that "every patient should have access to an ABEM-certified physician when they come to an emergency department." However, even in 2025, there are not enough ABEM-certified physicians to staff every emergency department in the United States. In fact, residency vacancies persist in emergency medicine, with 2023 being one of the worst matches in the history of this young specialty.

Thanks to the narrative from both organizations, a colleague and I were forced into "voluntary resignation" by our employer under the guise of not being ABEM-boarded and thus, unqualified to teach emergency medicine residents.

My membership in ACEP has been mandated by employers over the years, but I will not renew my membership this year because it has failed to protect and advocate for a significant minority in the profession, who are held to the same standards as their ABEM-certified colleagues, but are treated as unworthy.

I implore you both, as the representatives of your organizations, to treat our small, but essential, group of physicians with respect and dignity, which we have earned by providing exceptional care to our patients over decades.

FROM THE EDITOR

The Legacy of the Emergency Physician

by CEDRIC DARK, MD, MPH, FACEP

DR. DARK (@RealCedricDark) is associate professor of emergency medicine at Baylor College of Medicine and the medical editor in chief of *ACEP Now*.

Several years ago, two of my colleagues who trained as internal medicine physicians, but who worked in our emergency department, were no longer able to do so after a restructuring that placed residents in each of our clinical areas. It brought to my attention the rule from the Accreditation Council on Graduate Medical Education (ACGME) regarding program requirements for emergency medicine that states that emergency medicine residents can only be supervised by faculty members who have been, or are eligible to be, board-certified by ABEM or AOBEM.[1] This rule, which has been in place for many years, is similar to rules for other specialties, but is outside the control of a membership organization such as ACEP.

The specialty of emergency medicine has benefited greatly from legacy emergency physicians, such as yourself, and although ACEP membership has been closed to new non-EM residency–trained physicians since December 31, 1999, many have continued to contribute greatly to the largest and most influential membership organization for our specialty and all have remained welcome within the College.[2]

Your letter brings up a painful reminder from 2018, when the duly elected president-elect of ACEP, Dr. John Rogers, chose to resign to avoid fragmentation of the specialty—many in the College did not agree that someone who trained as a surgeon should be the elected leader of ACEP.[3] Dr. Rogers has been and remains an emergency physician, as are all legacy physicians with ACEP membership.[4] ACEP policy, as reaffirmed last year, states that "legacy emergency physicians should not be forced out of the workforce solely on the basis of their board certification status."[5] Thus, I am similarly disheartened to see you and your colleague forced to resign. However, requirements governing who may sit for the emergency medicine boards and who can be faculty at a residency program are outside of ACEP's purview.

In my interview with Dr. Gorgas, the President of ABEM, my mention of the 10,000-hour rule, popularized by Malcolm Gladwell, is an analogy to the training of elite musicians. I once played the trumpet, but I am no Miles Davis. For anyone who practices an art, including the art of medicine, practice improves performance. Even though it doesn't make perfect, we continue to practice medicine and aspire for the best for our patients.

This is one reason why the College and its Chapters continue to advocate for a physician—and preferably an emergency physician—in every emergency department; we know that one in 13 does not have one.[6] As emergency physicians we believe this provides the best care for our patients and will prevent the wholesale replacement and undervaluing of our specialty by corporate interests of staffing groups and hospitals. As you point out, there is complexity and difficulty with making that aspiration a reality.[7] At *ACEP Now*, we have presented that dynamic and also the perspective of physicians trained in family medicine who work primarily in the rural emergency setting who similarly want to see collaboration, respect, and dignity for our legacy emergency physicians.

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NEWS FROM THE COLLEGE

UPDATES AND ALERTS FROM ACEP

Annals: Fewer Than Half of ED Visits Staffed by Majority Physician-Owned Practices

Most emergency department (ED) visits are staffed by physicians employed by health systems or private equity-owned staffing groups, according to a first-of-its-kind analysis of physician group market share by ownership structure published in *Annals of Emergency Medicine*.

"The rapid pace of consolidation across emergency medicine raises critical questions about care quality and physician employment," said Angela G. Cai, MD, MBA, study author, emergency physician at Penn Medicine, and assistant professor of clinical emergency medicine at the University of Pennsylvania.

Health system-owned groups staffed one-third (33 percent) of all emergency visits. Nearly one in four (24.7 percent) of visits were staffed by physicians in private equity-owned groups.

Regional clinician partnership-owned groups accounted for 20.8 percent of visits, national clinician-owned partnerships groups were 13.4 percent of visits, and single-site clinician partnership-owned groups staffed 8.1 percent of visits. These findings showed that fewer than half of emergency visits are staffed by majority physician-owned employers.

The study sample included 3,998 hospital-based EDs accounting for 109.7 million visits.

The study also revealed trends of market concentration within ownership categories and within geographic regions. In the private equity ownership category, 93 percent of all ED visits were seen by physicians under three employers.

Regional concentration is high; of 306 hospital referral regions across the country, 84 percent qualified as highly concentrated.

A lack of transparency in practice ownership has impaired the ability to understand market trends and health outcomes, the authors wrote. At the same time, emergency physicians continue to raise strong concerns about care quality and workplace satisfaction.

"This study does the foundational work to define market trends, that non-physician owned groups staff most ED visits and the emergency physician employer market is highly concentrated," Dr. Cai said. "Researchers and policymakers have a critical opportunity to connect these trends to patient outcomes and physician employment."

ACEP Campaign to Capture the Passion of Emergency Physicians

You didn't just choose a specialty. You answered a call. ACEP wants to hear what drove you to choose emergency medicine—and what drives you to stay. Tell us your story! If you're at ACEP25, drop by ACEP Central in the Exhibit Hall and record your most memorable moments in the ED.

EM Heads to Salt Lake City for ACEP25

ACEP25 has the gold standard in emergency medicine education, but that's just the start. From Sept. 7–10 in Salt Lake City, we're mixing clinical excellence with can't-miss fun. See actor Noah Wyle and the real docs behind "The Pitt." Get inspired by Olympic champ Scott Hamilton. Make new connections at the return of the Section Hall Crawl. Don't forget the Day 3 Block Party with food, friends, and unbeatable views. This is more than a conference—it's your next favorite memory. Here are some highlights (check the onsite program and mobile app for times and more details):

Keynote and "The Pitt"

Join us as Olympic gold medalist Scott Hamilton shares his inspiring journey of resilience—from childhood illness to cancer battles—offering a powerful message of perseverance, hope, and turning obstacles into opportunities.

Join actor Noah Wyle, along with writer and producer Joe Sachs, MD, FACEP, and medical advisor Mel Herbert, MD, FACEP, for an exclusive panel discussion at ACEP25, moderated by incoming ACEP President L. Anthony Cirillo, MD, FACEP.

Section Hall Crawl and Networking

Explore ACEP's diverse Sections. Like a pub crawl, stroll through the Hall of Sections. Meet new faces, share ideas, and enjoy food, drinks, and music. Connect with the ACEP community and find your people! Also on tap:

- EMRA Party
- ACEP25 Block Party
- ACEP25 After Dark

Wellness Hike Highlights Salt Lake Scene

Get outside and explore the stunning natural beauty of Salt Lake City with a wellness hike! Join fellow attendees for a refreshing outdoor adventure, where you can enjoy scenic views, breathe in the fresh mountain air, and connect with nature while recharging your mind and body. Experience the great outdoors and unwind during the event. Price: $195. Also see:

- Temple Square
- City Creek Canyon
- Utah's Hogle Zoo
- The Great Salt Lake

Featured Lectures

ED Treatment of Opioid Use Disorder: Innovation and Discovery
(*The Brooks F. Bock Lecture and Abstract Session*)
Speaker: Gail D'Onofrio, MD, MS, FACEP

Leaving Levine's Sign Behind: Rethinking ACS for All
(*James D. Mills Memorial Lecture*)
Speaker: Amal Mattu, MD, FACEP

The Rise of Anti-DEI Politics in Healthcare: Impacts on Physicians, Patient Care, and Medical Education Lecture
(*Colin C. Rorrie, Jr. Lecture*)
Speaker: Aisha Terry, MD, MPH, FACEP

Navigating the Journey of a Transgender Physician: Fostering Allyship in Medicine
(*Leon L. Haley, Jr. Memorial Lecture*)
Speaker: Jailyn Avila, MD, RDMS

How Critical Care Was Won: Frontiers in EM Resuscitation
(*Nancy J. Auer Lecture*)
Speaker: Scott D. Weingart, MD, FACEP

EMS, Pre-Conference, Immersive Courses

Join EMS medical directors, thought leaders, and field experts for a dive into the latest innovations, protocols, and controversies shaping prehospital care. This high-impact program from 8 a.m.–5 p.m. on Sept. 6 delivers hard-hitting discussions, real-world case reviews, and game-changing insights to keep you at the forefront of EMS medicine. Also on the docket:

- Resident Teaching Fellowship
- Research Academy Session 1
- Emergency Ultrasound Management Course
- Demystifying AI in Emergency Medicine
- Ultrasound-Guided Regional and Joint Anesthesia
- Age-Friendly Hospital Measures from CMS
- PEM Essentials
- EM:RAP Live at ACEP25

In The Exhibit Hall

Sunday, September 7 | 10 a.m.–4 p.m.
Monday, September 8 | 9:30 a.m.–3:30 p.m.
Tuesday, September 9 | 9:30 a.m.–12:30 p.m.

- Battle Docs Arena
- Expert Theaters
- InnovatED Skills Zone
- Research Forum
- EMF Research Showcase at Research Forum
- ACEP Central

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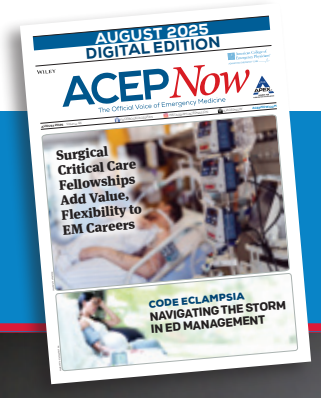

IN CASE YOU MISSED IT:
AUGUST DIGITAL EDITION

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ACEP Member Uses ED, Military Training to Set Standards at FEMA

by LISA MCREYNOLDS

ANDY PENNARDT

Management of ED Crowding vs. Mass Casualty Incidents: Is There an Ethical Difference?

by KENNETH MARSHALL, MD, MA, FACEP; CANDACE LEIGH, MD, FACEP; HALEY M. SAUDER, MD, MBA; AND KELLY BOOKMAN, MD

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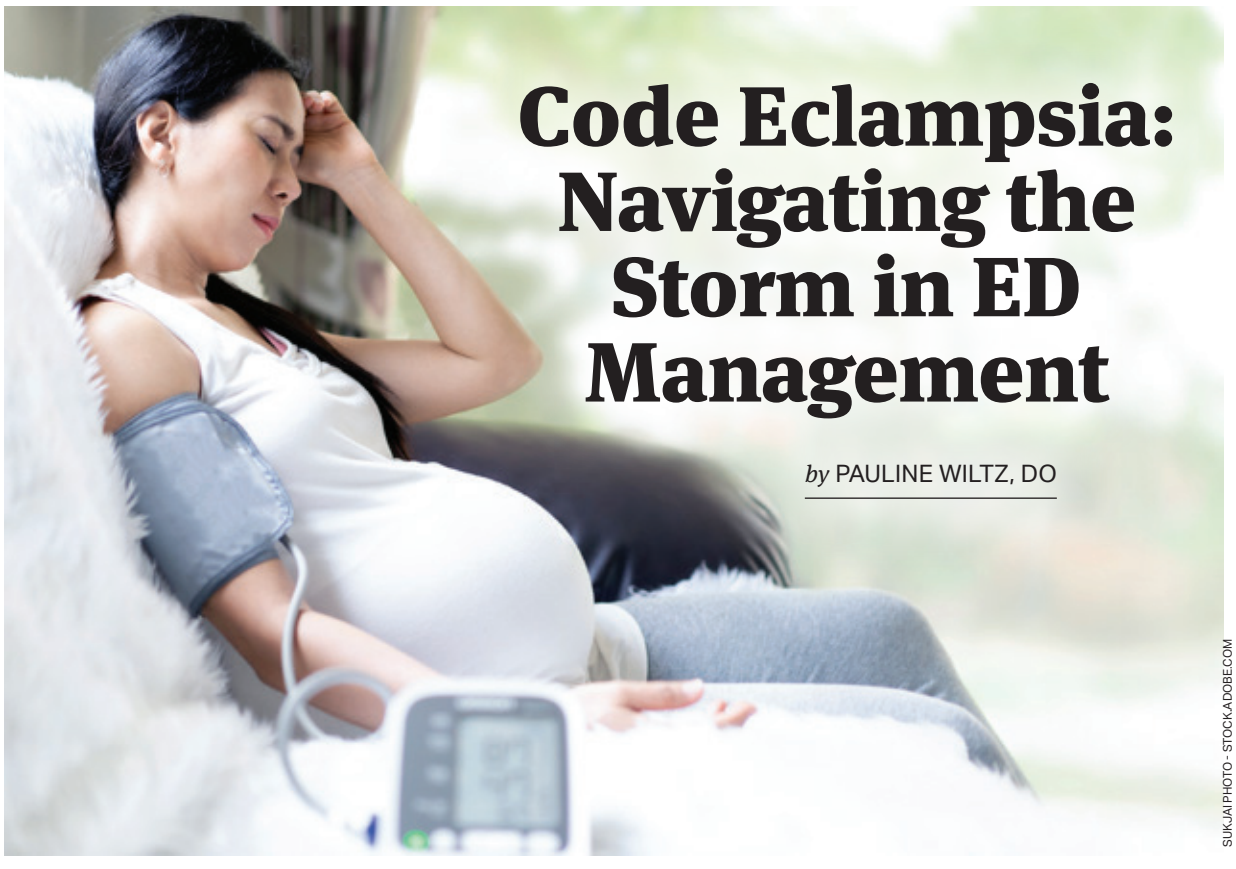

Code Eclampsia: Navigating the Storm in ED Management

by PAULINE WILTZ, DO

SUKJAI PHOTO - STOCK.ADOBE.COM

ACEP Nowcast
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What Emergency Physicians Need To Know About The One Big Beautiful Bill

Topline Compensation Trends

The median hourly clinical base pay for all respondents was $222, translating to a median annual total compensation of $330,000 when including bonuses, profit-sharing, and partner distributions. Physicians at the 75th percentile reported total compensation nearing $432,000, whereas those at the 25th percentile earned closer to $248,400.

Among roles, emergency physicians reported the highest median hourly base pay at $225 and a total compensation of $360,000. Faculty and academic physicians trailed with a median base pay of $210 and total compensation of $249,100, reflecting both the ongoing pay disparity and the uncompensated non-clinical responsibilities often associated with academic roles.

Administrators reported a similar median hourly rate of $223, but significantly lower total compensation of $180,700, likely because of lower clinical hours that are often offset by administrative stipends not fully captured in the survey.

Gender and Age Gaps

One of the most significant findings remains the gender compensation gap. Men earned $13 more per clinical hour than women on average ($225 vs. $212), and their total compensation was $62,000 higher annually at the median level. Although this gap is consistent with national trends, it remains a stark reminder of ongoing inequities within health care.

Age also plays a role in compensation trends. The survey found a gradual increase in income through mid-career, with a leveling off or slight decrease among physicians aged 60 and older. The median age of respondents was 43, which closely matches ACEP's overall member demographics, and validates that the results are broadly representative.

Geography Still Matters

Where you practice continues to have a noticeable effect on pay. The Northeast reported the lowest median hourly rate at $210, whereas physicians in the South, Midwest, and West all reported $225 per hour. Total compensation in the South and Midwest exceeded $350,000 compared with $300,300 in the Northeast.

These differences may reflect regional variations in cost of living, payer mix, or hospital employment structures. The relatively higher pay in the South and Midwest may also help explain why these regions comprised the largest shares of respondents.

Rural Work: Higher Pay, Still Underserved

One surprising finding showed that physicians practicing in rural settings reported the highest median hourly base pay at $236 and the highest median total compensation at $389,500—outpacing both urban and suburban counterparts. Yet only 15 percent of respondents indicated they practiced in a rural environment.

This contradiction—higher compensation but lower physician density—raises critical questions about what truly drives workforce shortages in rural areas. The issue appears to extend beyond pay, likely involving work-life balance, access to resources, and geographic preference.

Practice Setting Affects Pay

Emergency physicians working in community hospitals reported a median hourly rate of $230, notably higher than those working in academic/teaching affiliates ($210). Community-based physicians also had higher total compensation—$374,300 vs. $260,000—further highlighting the financial trade-offs between academic and community practice models.

A Representative Sample

Although a 3 percent response rate sounds low, it is similar to other surveys of this type, and respondents' demographic breakdown aligns well with ACEP's broader membership:

- 71 percent male / 28 percent female, similar to ACEP's gender distribution of 63/37;
- Age distribution centered around the early-to-mid career stages;
- Geographic and practice setting breakdowns also mirror known ACEP member patterns, suggesting the findings can be confidently generalized to the broader workforce.

Final Takeaway

The 2025 ACEP Salary Survey reinforces known trends—academic and female physicians earn less, rural work pays more but remains underfilled—and provides current benchmarks for emergency physicians to evaluate their own compensation. The findings also raise strategic questions for ACEP's ongoing advocacy and workforce planning efforts.

For those looking to dig deeper into the data—including detailed tables by employment type, tenure, and compensation structure—ACEP members can access the full report online at acep.org/compensation-report-2025.

Pediatric Patients in Acute Mental Health Crisis Face Long Waits

by LEAH LAWRENCE

The average emergency department (ED) is set up for medical emergencies and is not well-equipped to handle patients' mental health needs, explained Jennifer Hoffmann, MD, MS, a pediatric emergency physician at Ann & Robert H. Lurie Children's Hospital of Chicago.


Dr. Hoffmann

"These environments can be loud, chaotic, and overly stimulating, especially for children experiencing an acute mental health crisis," Dr. Hoffmann said.

Unfortunately, an increasing number of children experiencing mental health emergencies are finding themselves boarding in EDs. Dr. Hoffmann and colleagues recently conducted a retrospective study of more than five million mental health ED visits for children aged five to 17 and found that about one in three visits that resulted in admission or transfers saw children in the ED for more than 12 hours.[1]

"One in eight visits exceeded 24 hours," Dr. Hoffmann added. The stays exceeding 24 hours were more likely to occur in certain patient populations including the youngest children, non-Hispanic Black children, and those with public insurance.[1]

Although this is not a new issue, it does appear to be getting worse. Prior to the COVID-19 pandemic, data had begun to indicate that the total number of visits to the ED for children with mental health disorders was increasing, and in the years since, monthly rates of hospitalizations and ED visits have continued to put a strain on available resources.[2,3]

Fewer Resources, More Patients

The reasons for the increase in pediatric mental health boarding are multifactorial, and vary by state, according to Moshe D. Bitterman, MD, an attending psychiatrist in the ED at Lurie Children's Hospital.


Dr. Bitterman

"The amount of inpatient beds available to these populations has decreased, and there has also been a decrease in community resources over time," Dr. Bitterman said.

For example, in its 2023 report, Mental Health America found that more than 2.7 million children and adolescents are living with severe major depression, with more than half receiving no mental health treatment at all.[4]


Dr. Herman

"It is a stress on the system," said Sandy Herman, MD, an emergency physician who recently retired from a position with the Tennessee Department of Mental Health. "We are seeing an increased use of psychiatric services by pediatric patients, and more patients at a younger age."

NATIONAL ALLIANCE ON MENTAL ILLNESS

Emergency physicians can tell their patients about the 988 Suicide & Crisis Lifeline, which offers 24/7 judgment-free support for mental health, substance use, and thoughts of suicide. Text or call 988, or chat at 988Lifeline.org for confidential support, offered at no cost.

Appropriate Treatment

Most pediatric patients presenting to the ED with acute mental health crisis will fall into one of two categories, Dr. Bitterman said. First is internalizing patients with thoughts or intention of self-harm; second is externalizing patients who may be harmful or aggressive towards others.

Dr. Bitterman is one of two attending psychiatrists hired at Lurie in the last few years who splits his time between the ED and medical floors.

"My colleague, Dr. Jonathon Wanta, and I are able to start a behavioral assessment immediately and use a framework to see how we can intervene to decrease a patient's risk," Dr. Bitterman said. "That includes behavioral analysis, medical evaluations or recommendations, and interventions."

Starting this process in the ED and then continuing another day or two if a patient is boarding on the medical floor, allows some patients to go home without the need for inpatient hospitalization. Since they took on this role, Dr. Bitterman said about two-thirds of pediatric patients who arrive to the ED for mental health issues who were placed in behavioral health observation were discharged home before the need for inpatient psychiatric admission.

In contrast, in EDs where there is no psychiatrist available, emergency physicians may more frequently be forced to use involuntary medication or restraints to manage behavior. "These physicians are doing what they need to do to keep the patients and themselves safe," Dr. Bitterman said, but these interventions may unintentionally exacerbate issues.

Even if a patient leaves the ED and is admitted to the hospital, pediatric patients in acute mental health crisis are often still not getting the care they need.

Kathleen D. Snow, MD, MPH, an attending physician in hospital medicine at Boston Children's Hospital, described this decision to keep a kid boarding in the ED or boarding on the hospital floor as a "push-pull challenge faced by many hospital administrators." Dr. Snow and colleagues recently studied pediatric mental health boarding across EDs and inpatient medical units at 40 children's hospitals and found the median length of stay had increased from three days in 2017 to four days in 2023, with a range of two to 589 days.[5]


Dr. Snow

"Key factors associated with prolonged boarding were kids with underlying medical complexity, and those with underlying psychiatric complexity," Dr. Snow said, adding that the level of boarding that is occurring is probably "unimaginable to the majority of the population."

What Can Be Done?

There is no one-size-fits-all solution. At least part of the solution will be to decrease the number of children presenting to the ED for mental health crises.

"We need to ensure that youth are aware of a new national 988 crisis hotline," Dr. Hoffmann said. "Many children could be linked to community services and not require emergency visits."

There are also emerging models of mobile mental health services that physically go to the location where a child is in crisis, whether that is at home or at school.

"These are only available in certain geographic areas but hold a lot of promise to reducing ED visits," Dr. Hoffmann said. "There are also emerging models of psychiatric urgent care or walk-in clinics where patients can receive same-day services that could reduce emergency visits."

Additionally, Dr. Hoffmann said there are emerging ED diversion models in which ambulance crews have pre-set criteria to bring patients directly to freestanding psychiatric facilities instead of the ED.

Once a patient is in the ED, emergency physicians must try to improve and not exacerbate mental health symptoms. Dr. Herman said an important step in minimizing the issue will be an increase in psychiatric training for emergency physicians. "Emergency physicians will have to become more comfortable initiating treatment in the ED," Dr. Herman said. This might include obtaining training in verbal de-escalation or trauma-informed care.

Use of brief interventions, such as the Safety Planning Intervention, have been shown to be effective in adult EDs, reducing return visits by as much as 43 percent, with emerging evidence showing they may be effective for children as well.[6,7]

"There is also a move toward self-guided digital mental health interventions deployed within the ED," Dr. Hoffmann said.

Dr. Snow said that Boston Children's has an in-patient psychiatric unit embedded within its hospital and has opened two additional off-site locations with psychiatric beds.

"Obviously that requires a ton of additional hiring, training, and support to create those facilities," Dr. Snow said. Within the hospital, a lot of additional staff has been added including psychiatrists, social workers, and others who can help triage these admissions and at least do some level of check-in everyday while they board.

One thing remains clear, though. More attention on the problem and more potential solutions are sorely needed. Indeed, incoming ACEP President L. Anthony Cirillo, MD, said that the health care community "cannot continue to celebrate getting a 59-year-old STEMI patient to the cath lab in less than 30 minutes when a nine-year-old suicidal patient has been sitting in the ED for 30 days waiting for an inpatient psychiatric bed."

MS. LAWRENCE is a freelance health writer and editor based in Delaware.

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A CONVERSATION WITH ACEP PRESIDENT DR. ALISON HADDOCK

by CEDRIC DARK, MD, MPH, FACEP

Twice a year, the *ACEP Now* Medical Editor-in-Chief speaks with the ACEP President. This conversation between Cedric Dark, MD, MPH, FACEP, and Alison J. Haddock, MD, FACEP, serves as a year-in-review as her presidency ends this month in Salt Lake City.

Dr. Cedric Dark: You came into office on a platform of physician autonomy a year ago. What do you think has been your greatest single accomplishment on that front?

Dr. Alison Haddock: This is tricky because of the complexities of these issues. It's hard to get a single thing done. You also need to take the opportunities that come to you as a leader. I would say that our biggest areas of progress are the ongoing activities of the work group focused on employer closure. That group has been looking at the fact that NES Health and American Physician Partners both happened and were highly detrimental to the individual emergency physicians working under those groups—whether they were employees or 1099s. We have a team evaluating what the College can do to help protect emergency physicians in similar situations in the future.

We know there will always be turnover in physician employers, so we are working on ways to ensure that no one is left without pay for shifts they've worked or without tail coverage. Tail coverage is especially high on my mind. We've explored what is needed in terms of state advocacy and state law to prevent these gaps, and how we can hold employers accountable when contracts specify tail coverage.

A broader conversation includes other autonomy-related issues like non-competes. I'm happy to see progress on non-competes both at the state level and with a federal ban being introduced. These contracts limit a physician's ability to change employers, which is a loss of autonomy. Emergency physicians, whether in academic hospitals, private equity groups, or any other setting, should not be bound by non-competes. I'm proud of our progress in those areas, even if it's incomplete. There is still much to be done.

Dr. Dark: One of the things I think some people are looking at to improve their autonomy has been unionization. Over the past couple of years, we've featured stories about emergency physician groups that went on strike, or residency programs that nearly did. We've also covered rules around unionization. I'm curious to hear your view on the pros and cons of unionization for emergency physicians.

Dr. Haddock: I think unionization is an option emergency physicians need to know more about and be able to consider, depending on their employment situation. We know that partnership groups can't have unionized members. If you're a partner, you can't be in a union, so seeing the growth of those groups in order to restore autonomy is wonderful. But if you're not in a position to be a partner, unionization can be a way for individual emergency physicians to gain leverage with their employers to secure better compensation and benefits.

I was excited to see that the group in Oregon, which finalized its contract, negotiated not just substantial raises but also improvements in the working environment. One of the key items negotiated was about limiting how much emergency physicians are pulled from the emergency department (ED) to provide care elsewhere in the hospital. It's not just about pay. It's about whether you can focus on your job, which is predominantly taking care of patients in the ED, and only responding to calls outside the ED for truly emergent situations. That kind of negotiation can help reduce burnout and the feeling of lost autonomy. The union also negotiated increased shift differentials for night shifts. Previously, nocturnists weren't paid enough extra for those hours, and now that's been addressed. That's a win.

ACEP

Dr. Alison Haddock will complete her tenure as ACEP President at ACEP25.

Dr. Dark: Alright, let's talk about private equity. Everybody's talking about it these days. Just this week I saw that a beloved, local Houston doughnut shop, Shipley's, was acquired by a California private equity firm. It went from one private equity firm to another.[1] The doughnut shop cited "transformational growth" as a benefit of the private equity partnership. My question to you is, "Why aren't doughnuts and doctors the same kind of commodity?"

Dr. Haddock: I love that question. We've seen many challenges with treating health care like a commodity. Emergency physicians choose this specialty because we believe in the mission to care for anyone, anytime, for any problem. The private equity model is focused on short-term profits, which doesn't align well with that mission.

Many emergency physicians working for private equity-owned companies feel their work is undervalued. This year, I've been giving a talk across the country titled "Financialization and Emergency Medicine." It's about the corporatization and market forces that have transformed our field over the last 20 years. Evidence on how private equity affects quality and cost of care is mixed, especially in emergency medicine. We need more data and research.

But consolidation isn't driven solely by private equity. The consolidation of insurers is pushing health care organizations to con-

solidate in response. We're also seeing academic consolidation. The problem is that consolidation limits emergency physicians' choices about where and how to work. If the market in your area is highly consolidated, your options for employers may be limited. A recent *Annals* article found that 84 percent of hospital referral regions are considered highly consolidated in terms of emergency physician labor markets (*Editor's Note: see News from the College on page 5*).

As I've traveled and spoken with members, I've tried to explain that these forces go beyond emergency medicine—they're affecting the entire U.S. health care system and economy. Despite the complexity, ACEP can and should continue advocating for individual emergency physicians.

Dr. Dark: The ACGME recently proposed changes to emergency medicine residency programs, including increasing all programs to four years and adding rural health care exposure. Currently, four out of five programs would have to lengthen training, and fewer than 25 percent now require a rural rotation.[2] What are the College's thoughts on how these changes might affect our specialty?

Dr. Haddock: For some time, we've been concerned about the maldistribution of emergency physicians. It's been a key issue for me as both a board member and President. We know that to increase the rural workforce, emergency physicians need exposure to working in under-resourced areas. Residency can provide that exposure and help improve access to care, something ACEP strongly supports. It aligns with our advocacy for ensuring there's a physician in every ED, which several states are already supporting through legislation.

On the three- versus four-year program debate, we've received feedback in both directions. Our policy continues to support the existence of both formats. We also recognize that training time is essential to prepare emergency physicians for the realities they'll face.

In addition, we must also factor in duty hour requirements. These limits are good for physicians, patients, and trainees, and I wouldn't want to see them weakened. The proposed ACGME changes also touch on how we teach ultrasound and other key skills. ACEP is working hard to bring expert voices into the conversation.

I'm proud of our town halls and how open we were to member feedback. Now, we're mostly waiting to see what the final ACGME decision will be. I'm hopeful that many of the changes could be positive for both the specialty and our patients.

The ACEP Council has requested additional content to be added to the ACGME program requirements multiple times since 2004, including topics on rural medicine, telehealth, physician-led teams, climate change, early pregnancy loss, buprenorphine initiation and harm reduction skills, professional liability litigation, risk management, sexual assault, telehealth, and implicit bias training.

Dr. Dark: Finally, let's talk about The One Big Beautiful Bill Act (OBBBA) that passed in July. It includes a provision allowing co-pays for Medicaid patients receiving non-emergency care in the ED. A 15-year-old study in *Health Affairs* shows these copays don't reduce ED use for such visits.[3] What do you think will happen once this is rolled out?

Dr. Haddock: ACEP has serious concerns about this law. The most concerning part of it is the Medicaid cuts. Emergency physicians care for many patients who lack access to other parts of the health care system. Substantial Medicaid cuts will worsen access. Patients will continue to face barriers to primary care and may even lose their Medicaid coverage altogether. What's worse is that we're shifting money from health care delivery to administrative overhead by implementing work requirements and other bureaucratic systems.

As a former state legislative leader with ACEP, I've seen many states try to determine which ED visits are "non-emergency," and these efforts almost always violate the prudent layperson standard. This standard ensures that if someone believes they are experiencing an emergency, they can access care, and it will be covered fairly by insurance.

MORE ONLINE

WATCH the Member Exclusive webinar, **"Congressional Crash Cart: Responding to the One Big Beautiful Bill Act's Impacts on EM."** (ACEP members only)

ACEP has clear policy opposing Medicaid co-pays because they don't just deter non-emergency visits. They deter necessary care, too. This won't solve the reimbursement problem, especially with Medicaid cuts looming.

I encourage everyone to watch the webinar our D.C. staff hosted about the OBBBA. There are a lot of concerning provisions in the bill, and we spoke out against them. I'm hopeful we'll see some key aspects reversed in the future to protect access to patient care and fair compensation for emergency physicians.

DR. DARK (@RealCedricDark) is associate professor of emergency medicine at Baylor College of Medicine and the medical editor in chief of *ACEP Now*.

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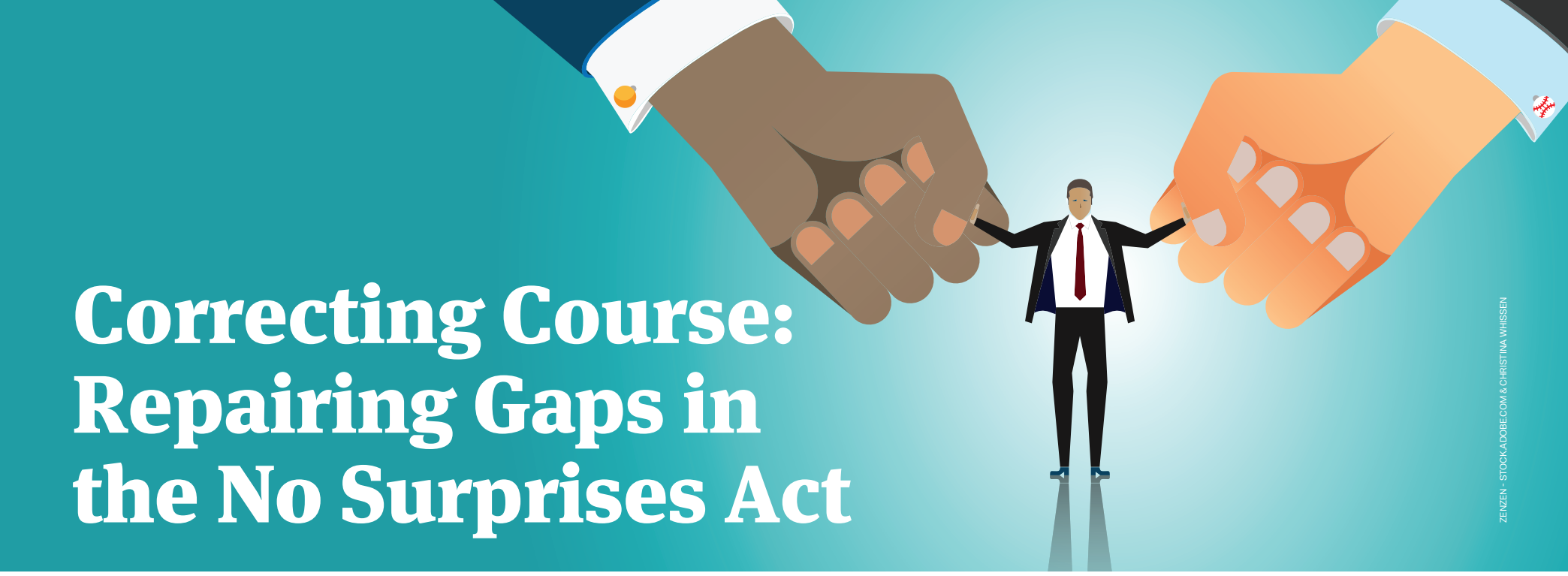

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Correcting Course: Repairing Gaps in the No Surprises Act

by ANDREA BRAULT, MD, MMM, FACEP

When the No Surprises Act (NSA) went into effect in 2022, it had two main goals: to protect patients from unexpected medical bills and to create a fair way for health plans and physicians to settle payment disputes. More than three years later, the law's impact tells a different story.

Flawed regulation and ineffective oversight have altered the balance between payers and physicians, enabling some insurers using the NSA as leverage to shift reimbursement dynamics and, in some cases, cancel longstanding contracts altogether. Physicians face a difficult choice: accept unreasonably low in-network rates or be forced out-of-network (OON) and rely heavily on the Independent Dispute Resolution (IDR) process to recoup some of their losses.

Emergency physicians must treat all patients, regardless of their insurance status or ability to pay. This makes them disproportionally affected by the regulations and the lack of enforcement of the NSA as written that have greatly favored the insurance payers.

Undermining Progress

Despite challenges, the process has seen some improvements. According to an Emergency Department Practice Management Association (EDPMA) member study, the timeline for adjudicating disputes has gone down from 211 days in 2023 to 164 days in 2024.[1] The volume of IDR determinations increased more than fivefold in 2024, with emergency physicians a consistent win rate of more than 85 percent.[2]

However, there are still some elements that remain worryingly burdensome.

Even with clear rules requiring payment within 30 days of an IDR outcome, many health plans ignore the law and refuse to comply with IDR payment determinations. In 2024, noncompliance rose sharply to 69.2 percent, with more than 8 percent of payments being paid incorrectly.[3] These patterns have left physicians and practices to bear the financial burden, even in cases where disputes were resolved in their favor.

Many practices report that delayed reimbursements and underpayments are straining operations and disrupting their ability to provide care. If insurers face no consequences for ignoring IDR rulings, then they have little incentive to follow the law or negotiate fair in-network agreements.

More troubling, some practices report a pattern of health plans shifting costs back to the patient after IDR determinations don't go their way, which is a clear violation of the law and a clear encroachment of the patient protections afforded under the NSA.[4]

What Needs to Change

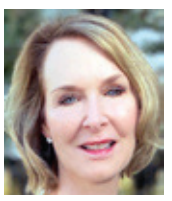
Physician advocacy groups say that unless key flaws are addressed, physicians will continue to face financial strain—and patients may eventually feel the effects too. They outline several priorities for reforming current regulations and enforcement.

1. **Correcting QPA calculations and transparency:** Many physicians contend that current rules surrounding the Qualifying Payment Amount (QPA) make it easier for health plans to justify lower payments while making it harder for physicians to contest them without going through IDR. Suggested fixes include:
   - » Stricter rules on what can be included in QPA calculations (e.g., excluding "ghost rates" that don't reflect actual contracted rates).
   - » Transparency around how insurers calculate the QPA.
   - » Enforced requirements to include the QPA in the initial payment.
   - » Regular audits of QPA data, as mandated by law.[5]
   - » QPA updates that account for inflation and the increasing cost of care.
2. **Improving the IDR process and data standards:** Improving the IDR process itself is another priority. Although physicians currently win most of their cases, the process remains burdensome and inconsistent. Proposed improvements include:
   - » Enforcing the use of standardized claim codes so physicians and practices can easily identify claims that fall under the NSA.[6]
   - » Creating a more functional portal with the ability to document communication between insurers and physicians to empower better enforcement.
   - » Increasing transparency by publishing more detailed IDR data to promote accountability and compliance.
3. **Enforcing rules that already exist:** There is also widespread concern that current enforcement is too weak to deter bad behavior. Physician groups are urging regulators to:
   - » Enforce statutory timelines for all IDR decisions and required payments.
   - » Monitor QPA methodologies to ensure they comply with the law.
   - » Resolve ongoing IDR backlogs that delay payments—even after favorable rulings.
   - » Respond promptly and consistently to complaints from both patients and physicians.[7]
4. **Addressing bad-faith payment offers :** Another growing concern is the submission of $0.00 payment offers from insurers during IDR disputes. These are not just lowball offers—they're bad-faith tactics that undermine the integrity of the IDR process, violate statutory requirements for emergency care coverage, and contradict initial payment amounts.[8]

Advocacy Matters

As the implementation of the NSA continues to evolve, physician voices remain critical to shaping its future. The opportunity to course-correct still exists, but doing so will require sustained advocacy to close enforcement gaps, fix regulatory flaws, and ensure that payers are held accountable. By engaging with ACEP at both the state and national levels, physicians can help push for the policy changes needed to restore balance and make the NSA work as intended.

Now is the time to get involved—whether it's sharing data for member surveys, submitting feedback on your current IDR experiences, or engaging in grassroots advocacy. Every action counts!



DR. BRAULT is the immediate past Chair of the Emergency Department Practice Management Association. She is also current Chair of the ACEP Coding and Nomenclature Committee (Group 1) and a member of the ACEP Reimbursement Committee.

Footnotes

1. In August 2024, EDPMA captured data from a member survey related to the IDR process of the NSA. The survey period included January 1, 2024, through June 30, 2024. In this survey, EDPMA members reported the average time from entering the portal to the IDR initiation. The average timeline was 164 days, a 22 percent improvement compared with the 211 days reported in EDPMA's Deep Dive Survey in 2023.
2. Data from CMS' quarterly "Supplemental Background on Federal IDR Public Use Files (PUF)" shows a prevailing rate greater than 85 percent for physician/hospitals/air ambulance providers in 2024 (86 percent in Q1/Q2, 85 percent in Q3/Q4). The NSA requires the Department of Health and Human Services, Labor, and the Treasury (the Departments) to publish this information each calendar quarter. https://www.cms.gov/nosurprises/policies-and-resources/reports
3. The August 2024 EDPMA Survey found a worsening pattern of non-compliance among health plans following IDR payment determinations. Non-payments after an IDR determination jumped from 24 percent in 2023 to 69.2 percent in 2024. Incorrect payments also rose from 2.8 percent to 8.3 percent during the same period.
4. The August 2024 EDPMA Survey found that 2.5 percent (760 instances) of respondents received communication that changed the patient cost-sharing amount after the health plan did not prevail in IDR, despite the law making it clear that the amount owed by patients may never change as a result of the IDR process.
5. The NSA provides for two types of health plan QPA audits: (1) shall conduct audits based on samples (per year up to 25 group health/individual governed by 42 U.S. Code § 300gg–111 and up to 25 group health plans as governed by 26 U.S. Code § 9816); and (2) may conduct audits in response to complaints; to date, Departments have only announced complaint-based audits. Current reports present data from just CMS on enforcement, providing an incomplete picture of NSA enforcement efforts.
6. Physician advocates propose adopting policies included in the IDR Operations proposed rule. The proposed rule was released on October 27, 2023, and included requiring the use of existing RARC/CARC codes that communicate state versus federal jurisdiction. According to CMS' IDR PUF report data (as of May 28, 2025), the primary cause of delays in processing disputes is the complexity of determining whether disputes are eligible for the Federal IDR process.
7. The Departments have created a few avenues to submit complaints and request assistance for noncompliance. However, since states, the Department of Labor, and the Department of Health and Human Services all share responsibility for enforcement, complaints do not consistently filter to the appropriate federal or state entity responsible for enforcement. Many physicians receive no response or are asked to re-route their complaint months later.
8. Earlier this year, CMS paused the resolution of payment disputes where a health plan submits a "$0.00" offer in the IDR process. CMS has since instructed the IDREs to resume processing these disputes, but physicians continue to urge CMS to explicitly direct IDR entities to treat a "$0.00" offer as a non-offer, which would result in a default win for the physicians' submitted amount.

ACEP STATEMENT

ACEP recently issued a statement in support of the No Surprises Enforcement Act, legislation that would hold insurance companies accountable for continued and willful violations of the federal law designed to keep patients out of the middle of billing disputes between payers and physicians. Scan the QR code to read more.

Choose-Your-Own Shift-Venture

Some emergency physicians thrive outside the traditional schedule

by LEONA SCOTT

James Neuenschwander II, MD, FACEP, FASAM, is a mission-driven night-shifter who turned a 30-year career into a purpose-built locums life.

When Dr. Neuenschwander finished residency in 1998 he did what many new emergency physicians did then: He joined a private two-hospital group, became an owner, board member, and vice chair. He participated in the meetings, joined the committees, the whole thing.

In 2006, he pivoted to teaching residents and medical students at Ohio State University. At the same time, he was discovering how much he enjoyed the locum tenens cadence while covering a 25-bed critical access hospital in Washington State where he worked as an emergency physician, hospitalist, intensive care unit physician, and even the nursing home physician.

Dr. Neuenschwander returned to community practice, adding skills in wound care and observation medicine to his toolbox. He earned board certification in addiction medicine, and today practices as a traveling physician with U.S. Acute Care Solutions. In 2024, he worked at 14 hospitals and for seven health systems.

It's a Lifestyle

"I like the locums lifestyle," Dr. Neuenschwander said. "The money is good. There are no hospital meetings or committees, and I'm far more focused on patient care and teamwork." At age 60, nights are "a little tough," he admitted, "but I've always gravitated to nights—and to the smartasses who work them." ("Print that at your own risk," he joked.)

The tradeoffs are real, he said, mostly dealing with office politics and consistency.

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"You can get thrown under the bus—few people know you or what you stand for, and sometimes any accusation, no matter how ridiculous, is treated as valid," Dr. Neuenschwander said. "The travel can be tough. Some days I feel like an animal—work, eat, sleep, repeat, repeat, repeat."

What keeps him steady is a personal North Star he repeats often: "My mission is to provide the greatest opportunities for health and healing. I've learned I can do that anywhere, at any time."

That clarity—plus the infrastructure of a contract management group that handles licensure, onboarding, and logistics (and a wife who's all-in on the lifestyle, sometimes joining him for multi-week stints)—lets him keep practicing on terms that match this season of life. The perks don't hurt either: three grown kids in Denver, Dallas, and Orlando, a Southwest Airlines companion pass, and the freedom to turn off-weeks into "mini-honeymoons" after 34 years of marriage.

He's blunt with early-career physicians who eye locums purely for the paycheck.

"Don't do it just for the money," he said. "You'll need to be flexible, self-aware, internally driven, and humble enough to learn each site's culture fast. But if you are—and if your purpose is clear—there's real joy here.

"I've been called to do this work and still feel drawn to it. For now, this is my purpose."

Variety Meets Consistency

Kevin McGann, DO, wanted the variety of locums but with the support and cultural consistency of a single organization.

Envision's Envoy Clinical Travel Program is an internal travel team that supplies physicians to Envision contracts with surges, vacancies, or brand-new launches.

There are two traditional options when it comes to hiring physicians, Dr. McGann said. You can take your sweet time to hire a permanent physician for a traditional role, or you can rent a physician sight unseen to fill a gap. One is slow. The other is risky. This pushed Envision to formalize what Dr. McGann had been doing informally for years.

An Envoy employee interviews every clinician, pairs operations staff with practicing physician leaders, then builds long-term relationships.

"Money isn't enough to prevent burnout," he said. "People need to feel known, supported, and part of a team—even if they're on the road."

Because Envoy doctors are already wired for mobility, the group also runs a Disaster Response Team that has deployed

CONTINUED *on page 14*

to hurricanes, COVID-19 surges in Texas, and six months of round-the-clock care for Afghan refugees at Holloman Air Force Base.

"We're used to living out of a suitcase, adapting fast, and practicing with whatever resources are available," Dr. McGann said. "That makes us useful when the country calls."

ACEP's Locum Tenens Section

Jamila Goldsmith, MD, FACEP, likes the idea of flexibility, autonomy—and, yes, having a schedule that works for a mom.

"An ER is an ER everywhere—the foundations don't change," said Dr. Goldsmith, the chair of ACEP's Locum Tenens Section. "What changes is the backdrop: new teams, new electronic medical records (EMRs), new workflows. Your core job is still the same—build trust fast with patients and with staff so the shift runs smoothly."

Dr. Goldsmith said many who reach out to the section are looking to buy back their time—to be paid fairly for the work they do, set firmer personal boundaries, and rediscover the parts of emergency medicine that they love. As a mother of a 4-year-old, Dr. Goldsmith's unapologetically structured.

"I never work Wednesdays," she said. "My son's swim lesson is non-negotiable. When I'm on, I'm on. When I'm home, I'm 100 percent home."

The Locum Tenens Section is also pushing policy. One current ACEP resolution asks certifying bodies like the American Board of Emergency Medicine to recognize that short contracts can make traditional hospital-based quality improvement projects unrealistic, even though locum physicians can still create meaningful specialty-wide impact (through national committee work, education, and policy).

And because locums equals small business, the Section spends time teaching physicians how to set up limited liability companies, handle accounting, and file taxes—the practical pieces that can make (or break) sustainability.

What's the Right Path?

Is a nontraditional path right for you? Drs. Neuenschwander, McGann, and Goldsmith said you'll thrive on a nontraditional path if you are mission-driven and clear on your "why," can adapt fast to different EMRs, teams, and local cultures, are teachable, not territorial, want to focus on the medicine and not the politics (at least for long stretches of your career), and value time autonomy as highly as compensation—and are willing to run your practice like a business.

You'll struggle with a nontraditional path if you need daily validation from the same team, bristle at learning new systems or sharing control with a site's established workflows, or see the model as "just for the paycheck,"—an element that every one of these physicians called out as a fast track to disappointment.

The Fun Part: You Design It

For Dr. Neuenschwander, it's semi-retirement, combined with meaningful work near family. For Dr. McGann, it's a national bench of travel-ready clinicians who can jump from busy tertiary centers to hurricane shelters overnight. For Dr. Goldsmith, it's total schedule autonomy that lets her be fully present both in the emergency department and at a Wednesday swim lesson.

If the standard three to four shifts a week no longer fits your season of life, you're not stuck. ACEP's Locum Tenens Section, internal travel programs like Envoy, and physician-friendly contract groups offer legitimate, structured alternatives—complete with community, mentorship, and policy advocacy. And if you can't find a path that matches your goals? Take Dr. Goldsmith's advice: Bet on yourself and build it. Someone else is probably waiting to follow.

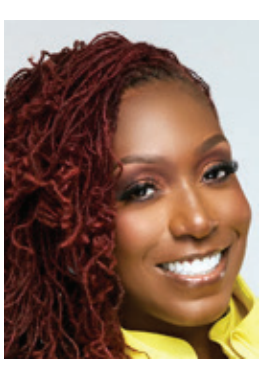
LEONA SCOTT is a freelance writer based in Dallas.

JAMES F. NEUENSCHWANDER II, MD, FACEP, FASAM

After 30 years in EM, Dr. Neuenschwander thrives in a purpose-driven locums career, working nights across 14 hospitals and seven health systems in 2024, with a clear mission: to provide the greatest opportunities for health and healing.

KEVIN MCGANN, DO

As director of Envision's Envoy Clinical Travel Program, Dr. McGann helps build a national team of trusted, travel-ready physicians. They deliver care during disaster response deployments and hospital surges while maintaining connection.



JAMILA GOLDSMITH, MD, FACEP

Dr. Jamila Goldsmith, chair of ACEP's Locum Tenens Section, champions flexible practice models that work for physicians and families alike, including moms. Her non-traditional path allows her to lead in policy and still make every Wednesday swim lesson.

chance of developing cancer, heart disease, depression, and the longer we live—better sleep is associated with a decreased mortality rate![5] So, the better we sleep, the happier and healthier we are.

And, as we're all too familiar with, shift work disturbs our wonderful sleep, because shift work interrupts our circadian rhythms and our sleep drive, leading to an increased risk for a motor vehicle crash on one's commute home.[6,7] In this column, I endeavor to provide you with some simple evidence-based strategies to improve your sleep architecture, minimize disruptions in circadian rhythm, and improve your sleep so that you can perform better on shift and improve your wellness and long-term health.

The Physiology of Sleep

Human sleep is governed by two primary physiologic processes: the homeostatic sleep drive (Process S) and the circadian rhythm (Process C).

Process S reflects the accumulation of adenosine in the brain during wakefulness, increasing the drive to sleep over time. This process accounts for the progressive sleepiness experienced after extended wakefulness or consecutive shifts.[8] Process C is regulated by the suprachiasmatic nucleus of the hypothalamus, which responds to environmental light cues—particularly blue-spectrum light—to synchronize the internal circadian rhythm to a roughly 24.2-hour cycle. Light exposure inhibits melatonin secretion via melanopsin-sensitive retinal ganglion cells, thereby promoting wakefulness.[9]

In contrast, darkness facilitates melatonin release and initiates sleep onset. Cortisol, a diurnal hormone, typically peaks 30–45 minutes after awakening, enhancing alertness during the daytime.[10] Disruption of either Process S or Process C—as occurs frequently in shift work—results in impaired sleep duration, efficiency, and architecture. This disruption has both acute consequences (e.g., decreased vigilance, increased errors) and long-term sequelae (e.g., metabolic, psychiatric, and oncologic disease).[11]

Sleep Hygiene

Optimal sleep hygiene includes interventions across three domains: pre-sleep behavior, sleep environment, and post-sleep routines. These recommendations are grounded in both circadian physiology and empirically supported behavioral strategies.[12]

Pre-sleep behavior: Avoid vigorous physical activity, cognitively stimulating tasks, and large meals for at least three hours before bedtime. These activities elevate core body temperature and sympathetic arousal, delaying sleep onset and reducing sleep efficiency.[13,14]

Caffeine, a competitive adenosine receptor antagonist, should be avoided for at least six hours prior to sleep initiation (or 12 hours in slow metabolizers). Daily intake should remain less than 400 mg.[8] Alcohol, despite its sedative effects via GABAergic activation, disrupts sleep architecture through rebound arousal once metabolized.[15] Similarly, chronic cannabis use reduces REM and slow-wave sleep, leading to fragmented sleep and long-term tolerance effects.[16] Both substances should be avoided at least three hours before sleep.

Light exposure: Exposure to high-intensity, blue-spectrum light in the evening suppresses melatonin and delays sleep onset.[9] Minimize screen use for at least three hours before bed. If screen use is unavoidable, use blue light filters or e-ink devices such as a Kindle. Light intensity should be minimized, and light sources should emit at lower Kelvin temperatures (e.g., 1,000–2,700 degrees Kelvin) to reduce circadian disruption. Consider using light bulbs that can switch to lower Kelvin temperatures three hours before sleep.[17]

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Sleep environment: The ideal sleep environment is dark, cool (approximately 20° C or 68° F), and quiet. Use blackout curtains or a sleep mask to block ambient light and consider earplugs or white noise machines to mitigate environmental noise. Avoid visible clocks in the bedroom, as time-checking reinforces arousal and promotes sleep-onset anxiety.[18]

Post-waking routine: Morning light exposure—particularly blue-spectrum light at 10,000 lux for 30 minutes upon waking either by natural sunlight, by a light emitting screen or light emitting eye glasses—promotes circadian alignment and may enhance mood.[19] This practice using artificial light is especially beneficial in regions with limited sunlight during winter months or in individuals with delayed sleep phase tendencies (e.g., adolescents and young adults).

Shift Work Adaptation

Several scheduling principles and physiological countermeasures can facilitate circadian alignment and performance optimization for emergency physicians engaged in shift work.

Shift scheduling: Casino shifts (e.g., 10 p.m.–4 a.m. and 4 a.m.–10 a.m.) preserve partial overnight sleep (anchor sleep), reduce circadian misalignment, and are less circadian disruptive than night shifts that start when it is dark outside and end when it is light outside.[20] If casino shifts are not an option where you work, night shifts should be clustered, scheduled consecutively (two to three shifts maximum). Spacing night shifts throughout the month prolongs maladaptation and may increase performance deficits. Recovery time between shifts should be no less than 11 hours to allow adequate rest between shifts for peak performance on shift.[21] Forward-rotating schedules (e.g., transitioning from evening to night to morning shifts) align with the natural tendency for phase delay and are preferred over backward rotations.[22] Chronotype identification enables allocation of night shifts to naturally nocturnal individuals (evening types), minimizing circadian disruption and associated morbidity.[23]

Pre-shift preparation: Napping with knowledge of the sleep cycle is important. A 20-minute nap (before deep sleep kicks in), or a full 90-minute sleep cycle nap before a night shift can reduce sleep inertia and improve cognitive performance.[24,25] However, napping for 30–60 minutes may cause increased fatigue because waking is generally during the phase of deep sleep. High-intensity cardiovascular exercise and caffeine ingestion 30–60 minutes prior to shift start can further enhance alertness.[26-28] Limit caffeine intake to the first half of the shift to avoid impairing post-shift sleep onset.

During shift: Use of bright blue-spectrum light (10,000 lux) in the early part of night shifts enhances alertness without impairing subsequent sleep if exposure ceases at least two hours before sleep onset.[9]

Post-shift wind-down: Wearing blue-blocking glasses or dark sunglasses on the commute home reduces light-induced melatonin suppression. Supplemental exogenous melatonin (0.3–5 mg) taken three to four hours prior to the desired sleep onset may support circadian re-entrainment and improve sleep continuity. Doses greater than 5 mg confer no added benefit and may paradoxically disrupt sleep in some individuals.[29]

Pharmacologic Approaches

Although behavioral interventions should remain the first-line approaches, pharmacologic therapies may be necessary in select cases of shift work sleep disorder (SWSD).

SUMMARY OF SLEEP STRATEGIES FOR EMERGENCY PHYSICIANS

Pre-sleep

- No caffeine six or more hours prior
- No alcohol or cannabis three or more hours prior
- No intense physical activity three or more hours prior
- Limit blue light and screens emitting blue light three or more hours prior

Sleep environment

- Temperature about 20° C (68° F)
- Complete darkness (blackout curtains or eye mask)
- Quiet (use earplugs or white noise)

Post-awakening

- Bright blue light exposure (≥10,000 lux for 30 min)

Shift work scheduling

- Prefer casino shifts and forward rotation
- Group night shifts (two to three in a row)
- Ensure 11 or more hours recovery between shifts
- Assign shifts based on chronotype when possible

Shift work countermeasures

- Pre-shift nap (20 or 90 minutes, not 40 minutes)
- Strategic caffeine in early shift only
- Bright light during first half of night shifts
- Blue light-blocking glasses post-shift
- Melatonin (0.3–5 mg) three to four hours before desired sleep

Exogenous melatonin, as noted above, facilitates circadian entrainment with minimal side effects when properly timed. In more severe cases, short-acting, non-benzodiazepine hypnotics (e.g., zolpidem, zopiclone) may aid with sleep initiation, although concerns regarding tolerance, dependency, and next-day sedation limit their long-term use.[29]

Wake-promoting agents such as modafinil and armodafinil have demonstrated efficacy

CONTINUED *on page 16*

in improving alertness and performance during night shifts in individuals diagnosed with SWSD.[30,31] However, these agents may pose cardiovascular and psychiatric risks and should be reserved for refractory cases under specialist supervision.[32]

Cannabinoids, including THC and CBD formulations, are not recommended because of evidence of impaired sleep architecture, increased sleep fragmentation, and the potential for adverse psychiatric outcomes including psychosis.[16]

By implementing the outlined evidence-based strategies, emergency physicians can mitigate the adverse consequences of shift work, improve clinical performance, and protect long-term health. Sleep should not be viewed as expendable, but rather as an essential element of professional sustainability and patient safety.

DR. HELMAN is an emergency physician at North York General Hospital in Toronto. He is an assistant professor at the University of Toronto, Division of Emergency Medicine, and the education innovation lead at the Schwartz/Reisman Emergency Medicine Institute. He is the founder and host of the Emergency Medicine Cases podcast and website.

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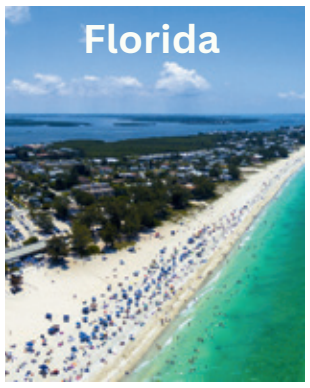

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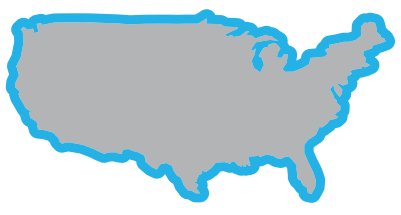

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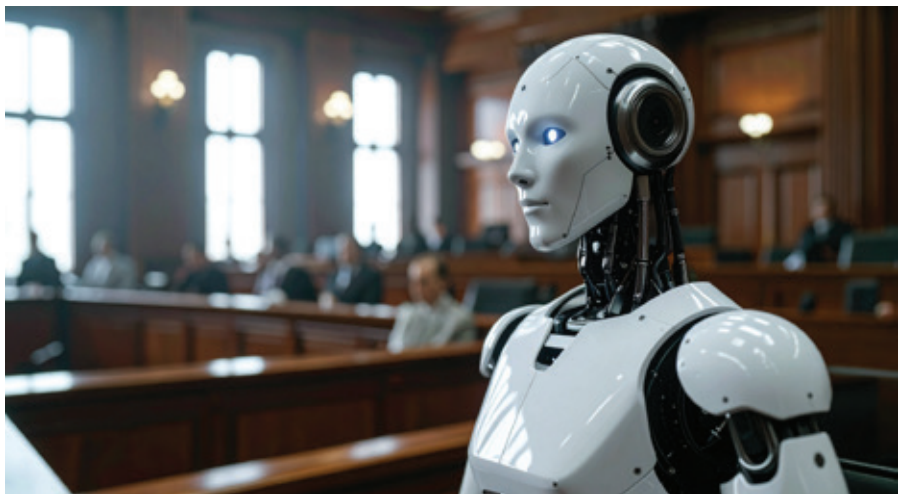

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The AI Legal Trap

by RYAN PATRICK RADECKI, MD, MS

The legal landscape surrounding the use of artificial intelligence (AI) within the medical setting remains in a state of flux.

There are a multitude of issues regarding liability yet to be tested, balancing the responsibility for errors between the clinician, the vendor of an AI product, and the hospital deploying an AI product. Each of these players has the potential to be included in the wide net typically cast during early malpractice filings.

That said, the ultimate responsibility is far more likely to come to rest on the clinician involved. *Read more here:*

EQUITY EQUATION

Unmasking a Crisis: The Resurgence of Measles, Mumps, and Health Equity Challenges

by JAYNE KENDALL, MD, MBA, FACEP, CPE

Across the nation, we are seeing a troubling resurgence of vaccine-preventable diseases, including measles, mumps, and whooping cough. These outbreaks present significant challenges for health care systems, particularly emergency departments where the acute consequences of these diseases are most pronounced. The intersection of these outbreaks with health equity issues demonstrates the disparities in vaccination rates and access to health care that disproportionately affects vulnerable populations.

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Differential Diagnosis of an Infant with Easy Bleeding, Bruising

by LANDON JONES, MD, AND RICHARD M. CANTOR, MD, FAAP, FACEP

Question: In a young infant with easy bleeding or bruising, how long do we really need to consider vitamin K-dependent bleeding on the differential?

The best questions often stem from the inquisitive learner. As educators, we love, and are always humbled by, those moments when we get to say, "I don't know." For some of these questions, you may already know the answers. For others, you may never have thought to ask the question. For all, questions, comments, concerns, and critiques are encouraged. Welcome to the Kids Korner.

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Do You Need a New Loan Strategy?

Learn how the One Big Beautiful Bill Act could affect you

by JAMES M. DAHLE, MD, FACEP

Question

I heard the One Big Beautiful Bill Act (OBBBA) made significant changes to the federal student loan programs. How should I be managing my student loans now?

Answer

Indeed, OBBBA will have a massive effect on student loan management going forward, particularly for new medical students. For the last decade or more, there was little reason for any student attending an institution eligible for federal loans to use private loans. However, a cap of $50,000 per year ($200,000 total) has now been instituted on professional school borrowing. That means that many medical students will again need to use private loans to pay for a substantial part of their education.

Private loans generally have higher interest rates and worse terms than federal programs, but perhaps most importantly, are not eligible for generous Income Driven Repayment (IDR) plans and the Public Service Loan Forgiveness (PSLF) program, the mainstays of physician student loan management techniques for the past 15 years. This change, along with others, will generally make staying in the federal student loan system and seeking student loan forgiveness less attractive as a strategy. Thus, the alternative strategy of refinancing your student loans (early and often) and paying them off rapidly by living frugally (live like a resident!) as a young attending has become more attractive.

For those who have already completed school but still have student loans, the picture is decidedly better. As expected, not only did PSLF remain completely intact, but current borrowers were mostly grandfathered into existing programs, at least for a while. The biggest changes have occurred with the IDR plans. Within a few years, the only IDR plans that will exist are Income Based Repayment (IBR) plans and a new one, called the Repayment Assistance Plan (RAP). Only RAP will be available to new borrowers.

Out with the Old

The alphabet soup of prior IDR programs, including ICR (Income-Contingent Repayment), PAYE (Pay As You Earn), REPAYE (Revised Pay As You Earn), and SAVE (Saving on a Valuable Education) will all be gone within three years. Although simplification of this system is likely good policy, RAP is not as generous to borrowers as prior programs, especially SAVE. Forbearance and deferment, although never very good options, are also even less generous than they were.

The payments in RAP are based not on discretionary income, like prior IDRs, but on adjusted gross income (AGI), a higher amount. A typical resident will pay something like five to seven percent of their AGI (perhaps $300 per month based on an AGI of $60,000) as a student loan payment and a typical attending will pay 10 percent of their AGI (perhaps $2,500 per month based on an AGI of $300,000). Nobody will have a $0 monthly payment anymore, as there is a minimum required payment of $10 per month.

Like the SAVE plan, unpaid interest will be waived (plus a $50 subsidy), although with the higher payments required, there will be fewer people with unpaid interest. This will have the nice benefit of ensuring federal student loans do not balloon during residency as they did prior to the implementation of SAVE. If applicable, every child you have will also reduce your monthly payment by $50. Current borrowers can (and often should) stay in their current IDR plan until mid-2028, when they must transition to either IBR or RAP. Given its legal challenges, those in SAVE may wish to transition even earlier.

The group of borrowers hurt the most by changes was those whose strategy had been PAYE forgiveness because of a very high debt-to-income ratio. Under PAYE, after making payments for 20 years, the remainder of the debt was to be forgiven. Although this was not as attractive as PSLF (which comes after 10 years and offers tax-free forgiveness), it did not require the borrower to work full-time for a non-profit employer. In fact, the borrower did not have to work at all if they had access to other funds to make required payments. Now, these borrowers will have to transition into either IBR (which offers forgiveness after 25 years) or RAP (which offers forgiveness after 30 years). That could make a difference of hundreds of thousands of dollars in additional payments and taxes.

Finding the Best Strategy

Although the new rules themselves can be confusing, the best student loan strategies require an even higher level of thinking. For example, taking a slight pay cut to work in academia and qualify for tax-free PSLF forgiveness six or seven years out of training might have made a lot of sense when all of the loans were federal. When half or more of the loans are private, the amount of forgiveness may now be substantially lower than the additional amount earned in a non-academic position.

Your student loan strategy can be affected by how you file your taxes, which type of retirement account you use, and which IDR program you choose. Given all of the changes, now is a good time to visit with an informed advisor or even consult with a specialized student loan advisor to work out the best personalized strategy for you moving forward. Although change is never fun, it is likely that student loan policy will be far more stable over the next four years than it has been since the onset of the pandemic, allowing physicians to plan their financial future better than has been possible in recent years.

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