

COMMON SENSE

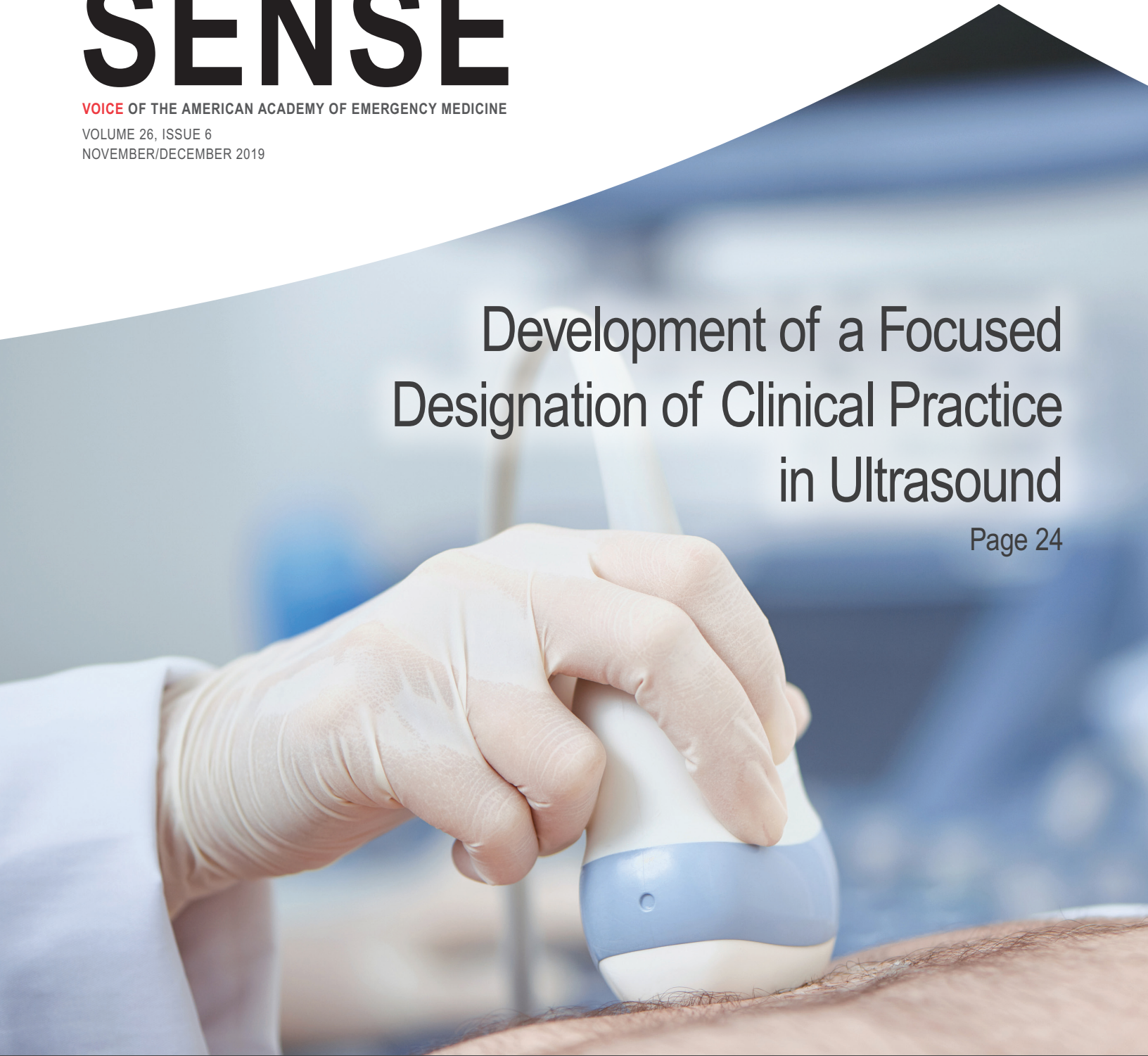


VOICE OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

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Mission Statement

The American Academy of Emergency Medicine (AAEM) is the specialty society of emergency medicine. AAEM is a democratic organization committed to the following principles:

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.
2. The practice of emergency medicine is best conducted by a specialist in emergency medicine.
3. A specialist in emergency medicine is a physician who has achieved, through personal dedication and sacrifice, certification by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
4. The personal and professional welfare of the individual specialist in emergency medicine is a primary concern to the AAEM.
5. The Academy supports fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care. Such an environment includes provisions for due process and the absence of restrictive covenants.
6. The Academy supports residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine and to ensure a high quality of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.
8. The Academy supports the establishment and recognition of emergency medicine internationally as an independent specialty and is committed to its role in the advancement of emergency medicine worldwide.

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Fellow and Full Voting Member (FAAEM): \$525* (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)
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MEMC19: An Inclusive and Collaborative Educational Experience

David A. Farcy, MD FAAEM FCCM — President, AAEM



AAEM held its bi-annual international conference, the Xth Mediterranean Emergency Medicine Congress (MEMC19) this past September in Dubrovnik, Croatia at the Sun Gardens Hotel. I had the privilege of attending and speaking at this conference and am proud

of our organization for putting on yet another outstanding event. I would like to extend a personal thank you to the MEMC19 Executive, Scientific, and Abstract committees for diligently working behind the scenes as well as the exceptional faculty who presented at MEMC19.

MEMC embraces a true multinational collaboration of teaching and learning, based on the belief that every emergency care practitioner has knowledge and experience that will benefit all of us. Its focus is to move away from a uni-centric practice model towards a model of best practices that embraces genuine cultural competency, diversity, and respect for the variety of resource availability that characterizes the true practice of emergency medicine on a global scale.

This year, we had over 700 delegates join us in Dubrovnik, representing 41 countries. Night one kicked-off with a Disco open to all delegates and we danced into the early morning. The second night we hosted a Gala dinner where we gathered at the Revelin Fortress, a majestic defense fort standing over the eastern gates to the Old City of Dubrovnik.

However, MEMC19 was more than just networking and social events. Delegates could earn up to 32.25 credits for continuing education by attending premier educational talks. This year's keynote address came from a past president of the American Board of Emergency Medicine (ABEM), Terry Kowalenko, MD FAAEM, regarding the value of board certification, a topic near and dear to mine and AAEM's heart. Our six plenary talks covered a variety of topics and featured speakers from various backgrounds. Delegates then could also choose from over 150 didactic talks, 170 Breve Dulce talks, and 140 oral abstract presentations. Overall, MEMC19 featured 280 speakers, representing 27 different countries.

Why do I think it's important to share all of these numbers with you? Because AAEM strives to bring you preeminent educational events, keeping you at the forefront of emergency medicine while also focusing on diversity. Diversity in practice setting, diversity in geographical locations, and diversity in backgrounds. MEMC19 really embodied this intention. I am honored to be leading such an organization with such noble aspirations and we are already looking ahead to an even greater MEMC21.

In the meantime, I encourage you to stay engaged with AAEM. Membership is now open for 2020 and we continue to see exciting opportunities for education and advocacy as we dive in to planning our Annual Scientific Assembly in Phoenix, AZ, April 19-23, 2020. Renew your membership today and attend yet another outstanding educational event that AAEM offers for free with a refundable deposit. Learn more about AAEM20 at: www.aaem.org/aaem20.

After MEMC19, the theme of collaboration continued. As I am writing this, I am on the way home from ACEP meeting in Denver where we had a meeting with the Society of Academic Emergency Medicine (SAEM), the American Board of Emergency Medicine (ABEM), and the Association of Academic Chairs of Emergency Medicine (AACEM). We continued to advance the discussion on the finalization of the Focused Practice Designation (FPD) in Advance Emergency Medicine Ultrasonography. For more information, read the EUS-AAEM article on p24. I am also very excited to report that all who have obtained certification in surgical critical care (SCC) in a ACGME fellowship who did not qualify for the board once the initial board certification started; will now be able to sit for the board as long as you are active in critical care. You will have 3 years to qualify and take the exam. I continue to look forward to what we can accomplish as we continue to collaborate and work together to better the specialty of emergency medicine. ●

Total number of delegates: over 700 – representing 41 countries

Number of speakers: 280 – representing 27 countries

Number of abstract submissions: 346

Number of oral abstracts presented: 148 – representing 22 countries

Number of posters presented: 156 – representing 21 countries

Available CME credits: 32.25

Impressions on the #MEMC19 hashtag: 1,339,000

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MEMC19

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Journal of Emergency Medicine Oral Abstract Awards

1st Place

Richard M. Nowak, MD MBA FAAEM FACEP
(United States)

2nd Place

Ejaz Latiff (Singapore)

3rd Place

Howard Andrew Klausner, MD FAAEM
(United States)

4th Place

Ozlem Yigit, MD (Turkey)

Western Journal of Emergency Medicine Outstanding Poster Awards

1st Place

Denise M. Langabeer, PhD (United States)

2nd Place

Victor M. Cisneros, MD (United States)

3rd Place

Michael Chia (Singapore)

The State Board

Andy Mayer, MD FAAEM — Editor, *Common Sense*



The issue of independent practice for nurse practitioners seems to be heating up around the country. Many states have already enacted statutes which give nurse practitioners the right to practice independently of a physician. This has become a heated political issue with the nurse practitioners

usually out lobbying physicians who often tend overall to be seemingly complacent or even fatalistic about what is going on in modern medicine. I certainly understand the conclusion that we have lost and to just put your head down and try and make a living while being a MD or DO still carries some significance. However, I think this is the wrong approach and that some of these political battles can be won if we make a concerted effort.

This issue has reared its ugly head in my own home state of Louisiana. Louisiana physicians have up to this point been able to prevent an independent practice statute from being passed. This has not been easy but the edges are crumbling none the less. The penetration of midlevel providers whether it be nurse practitioners or physician assistants has been drastically increasing even in states without the independent practice statute. In the July/August issue of this publication, an interview of an emergency physician from Louisiana was published. This board certified emergency physician was working part time at a busy department in a larger Louisiana city when she was notified that the shifts which she had been working where in the future going to then be filled by a midlevel provider. This cost saving measure was done by a large corporate management group who may simply see midlevels as a means to increase profits by cutting their labor costs. Again, why pay a doctor if you can pay a mid-level far less particularly in a double or triple coverage situation? Why not

simply force the single doctor to sign all of the charts and bill the same amount for less overhead? Remember that to the corporate mind you are just expensive overhead. Think of the money that can be made by a physician staffing company if there was no longer a need to hire physicians!

Another disturbing incident recently occurred in a rural Louisiana hospital. A board certified emergency physician was working a shift for a corporate management group at this hospital. This small hospital typically admitted some cases but transferred patients needing specialty care to a larger facility in the city. The emergency physician saw two patients requiring admission on this particular shift. One with a subacute stroke and another with a pulmonary embolus. He typically called an admitting physician and wrote holding orders placing them into a bed and the physician assumed care as the attending physician. He did so in this case but instead spoke to a nurse practitioner who he assumed was working with the hospitalist. He wrote orders admitting the patients to the physician he assumed would be the attending physician.

The situation quickly changed when he was called by administration and was told he had to change the attending of record to the nurse practitioner. The emergency physician who was writing these orders refused thinking that there must have been some sort of mistake as Louisiana is not an independent practice state. He thought that it would be inappropriate and possibly illegal to admit a patient with a serious medical condition or really any medical condition directly to a nurse practitioner. The emergency physician brought his concerns to the CEO and to the medical staff. This quickly led to the emergency physician being summarily fired by the corporate management group without any due process. He wrote to the Louisiana State Board of Medical Examiners about this incident and submitted a narrative of the incident to them.

AAEM became aware of this case and became involved. I attended the Louisiana State Board of Medical Examiners meeting in New Orleans

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FROM THE EDITOR'S DESK to represent AAEM and express our views. I have been a physician in Louisiana for over thirty years but had never attended one of these state board meetings. The monthly meeting was held in a nice room with the board and several staff members present including a lawyer. These are usually public meetings open to all unless they are in some sort of executive session. The meeting was very professional and went through many small issues while I listened for about two hours before the issue for which I attended was discussed.

The CEO of the hospital was allowed to speak first and he related the cost of hiring physicians at his small rural hospital and the difficulties he faced staffing his emergency department and inpatient beds. He related that the inpatient coverage for patients who were admitted to his hospital had changed. This rural hospital averaged a census of only seven. In the new plan, one hospitalist and one nurse practitioner would provide the inpatient services. The physician would work seven days on alternating with the nurse practitioner who would then work seven days. The NP would have no direct physician involvement in the care he proved unless he called the hospitalist who lived in another city. The CEO explained that the NP could call the hospitalist if needed and could also call local doctors who were in their offices or could also call the emergency physician who was always in the hospital. The attending of record was changed to reflect the nurse practitioner as the attending. Thus, if a patient was admitted during the week when the nurse practitioner was on service it would seem quite likely that they may never see any physician while they were an inpatient in the hospital. The CEO explained that he arranged it this way to help insure that there would be no billing errors when the patient was inadvertently billed for services performed by a physician when in actuality all the services would be performed by the midlevel.

The board next allowed me to speak in regards to the independent practice of nurse practitioners in specific reference to this case. I thanked the board for the opportunity and then commented that I had listened to the board discuss numerous issues including letters and requests for clarification. I noted to them that I found it fascinating that the previous two hours of the board of medical examiners meeting rarely even mentioned physicians. There were discussions related to what nurse practitioners, physician assistants, medical technologists, etc. could do in place of a physician. There were discussions related to Nano-needling whatever that is and who could perform it. Can a physician assistant hire a doctor to work at their clinic? Can a physician living in Florida really be the collaborative physician with multiple midlevels working in Louisiana? Several board members nodded their heads while I was speaking as I was expressing my shock that the state mandated body who regulates physicians and is empowered to sanction them was not discussing

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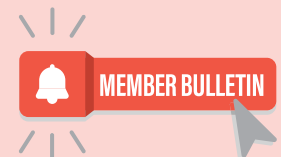
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medicine at least as I know it. I expressed my concern that the emergency physician was now required to write admission orders for patients who may never again be seen by a physician during their admission. This brings real liability issues to the involved emergency physician. I was thanked for my testimony and the issue was quickly tabled after comments from board members asking for clarification if this process of admitting patients to a nurse practitioner was in fact legal. They asked for their lawyer to contact the Attorney General. One older member of the board made a statement reflecting that they all knew this day was coming but that they just needed to follow the law. In fairness, they had not received copies of any of the documents prior to the meeting due to a clerical error. At this writing, no decision has been made as to this incident but hopefully the ability of a nurse practitioner to admit patients and the idea that the emergency physician may be required to be the backup physician for the "collaborating" physician will be clarified.

In the end, attending this meeting was eye opening as I realized more and more that many of the decisions affecting our future are made in a room like this. I appreciate the time commitment these physician on the state board are making to represent the physicians in my state and I hope that many are fighting the good fight representing physicians. The obvious concern is that if the only feedback they receive is from various non-physicians trying to expand their scope of practice and that the interests of physicians will not be adequately represented.

I am sure all of you have some sort of newsletter from your state board but most of us try to avoid meeting with or being involved with a state medical board action as this often does not mean good news for the physician. Attending one of these meetings was informative. Certainly, the topics discussed were not always very interesting but overall I recommend you consider attending one of these meeting in your state. Witnessing one of these meetings may be the thing you need to motivate you from your slumber when you realize the erosion of medicine as we know it. ●

Introducing the AAEM Member Bulletin



In an effort to keep our members connected, *Common Sense* will begin a column of member updates submitted by our members. We ask you to submit brief updates related to your career. We will also publish the unfortunate news of the passing of current or former members.

Visit the *Common Sense* website to learn more and submit your updates for publication!

www.aaem.org/resources/publications/common-sense ●

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Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from **1-1-2019 to 10-1-2019**.

AAEM established its Foundation for the purposes of (1) studying and providing education relating to the access and availability of emergency medical care and (2) defending the rights of patients to receive such care and emergency physicians to provide such care. The latter purpose may include providing financial support for litigation to further these objectives. The Foundation will limit financial support to cases involving physician practice rights and cases involving a broad public interest. Contributions to the Foundation are tax deductible.

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AAEM PAC is the political action committee of the American Academy of Emergency Medicine. Through AAEM PAC, the Academy is able to support legislation and effect change on behalf of its members and with consideration to their unique concerns. Our dedicated efforts will help to improve the overall quality of health care in our country and to improve the lot of all emergency physicians.

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The AAEM Institute for Leadership, Education & Advancement in the Development of Emergency Medicine, Inc. (LEAD-EM) was established after the tragic and unexpected death of AAEM president, Dr. Kevin G. Rodgers.

The Kevin G. Rodgers Fund and the Institute will LEAD-EM just like Dr. Rodgers did. The funds will support important projects such as development of leadership qualities, and clinical and operational knowledge of emergency physicians with a view toward improving and advancing the quality of medical care in emergency medicine, and public health, safety and well-being overall. LEAD-EM would like to thank the individuals below who contributed from 1-1-2019 to 10-1-2019.

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Upcoming Conferences: AAEM Directly, Jointly Provided & Recommended

AAEM is featuring the following upcoming conferences and activities for your consideration. For a complete listing of upcoming conferences and other meetings, please visit: www.aaem.org/education/aaem-recommended-conferences-and-activities.

AAEM Conferences

April 19-23, 2020
26th Annual Scientific Assembly – AAEM20
Phoenix, AZ
www.aaem.org/AAEM20

Jointly Provided

May 20, 2020
TNAEM 2020: Updates in Emergency Medicine
Nashville, TN
www.aaem.org/get-involved/chapter-divisions/tnaem/updates-in-em

May 22-23, 2020
9th Annual FLAAEM Scientific Assembly
Miami Beach, FL
www.aaem.org/flaaem/scientific-assembly

AAEM Recommended Conferences

December 4, 2019
Advances in Cancer Immunotherapy™ – SITC
Nashville, TN
www.sitcancer.org/education/aci/2019-20/nashville

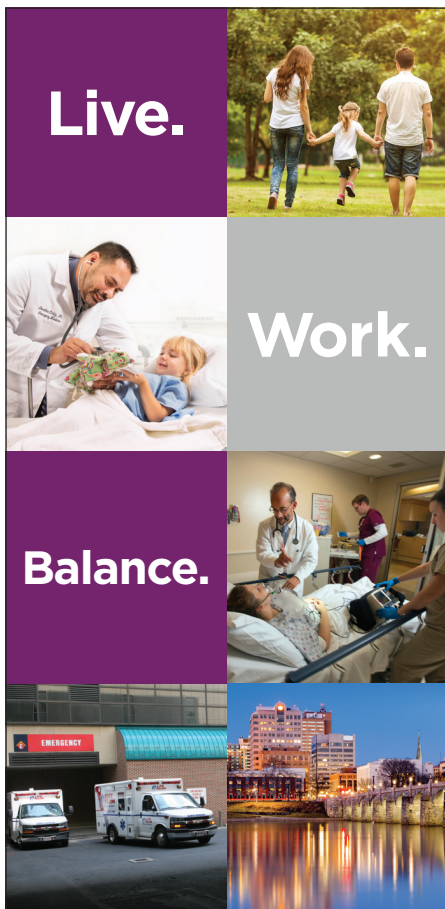
December 9-11, 2019
2019 ACMT Total Tox Course
Washington, DC
www.acmt.net/TotalTox.html

December 11-14, 2019
Emirates Society of Emergency Medicine Scientific Conference (ESEM19)
Abu Dhabi, United Arab Emirates
www.esemconference.ae

December 12, 2019
Advances in Cancer Immunotherapy™ – SITC
San Diego, CA
www.sitcancer.org/education/aci/2019-20/sandiego

January 23-24, 2020
2020 Oncologic Emergency Medicine Conference
Houston, TX
www.mdanderson.org/conferences

June 15-18, 2020
ICEM 2020 Conference
Buenos Aires, Argentina
www.icem2020.net



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Joelle Borhart, MD FAAEM FACEP and
Evie G. Marcolini, MD FAAEM FACEP FCCM
AAEM20 Co-Chairs

We are thrilled to bring you news of another exciting Scientific Assembly this coming April. Many things will stay the same – top notch speakers, bread and butter CME, along with some thought-provoking, inspirational talks and an opportunity to network. We will bring you more of the high-yield Breve Dulce talks, several of which will take place in a single track

really think about some of the new and controversial literature. There will be something for everybody.

Our goal every year is to get you the 'need to know' information to practice at your best, to inspire you to new horizons and to give you a venue in which to collaborate with your colleagues on issues important to you and to AAEM. There will be many opportunities to get involved, to reach out and mentor members and physicians early in their careers, and to learn about some of the issues that AAEM has been actively involved in by representing you. You are invited to attend any chapter, section or board meeting, and we encourage you to do so - perhaps you will become interested in becoming

- **Physicians** – We've heard your feedback about past conferences, and have made changes to AAEM20. We've also heard what you have said about the practice and business of EM and have specific talks that address your concerns.
- **Patients** – We've heard our patients ask for pain management, the best emergent care and advocacy to ensure health care is focused on patient care, not corporate dollars.
- **Public** – We've heard the public and the public wants social change. The public voice will be represented by our Keynote speaker, Thea James, MD as well as in other sessions which address topics such as #ThisIsOurLane and Social EM.



on the main stage. There will be small group hands-on sessions and traditional didactic sessions, as well as a patient panel to share their perspective. As always, AAEM20 will feature a number of pre-conference courses to extend your educational and CME opportunities – visit www.aaem.org/aaem20 for a full listing of courses available.

What to expect in 2020

Some things will change – we will be piloting more single-track sessions – unopposed talks so you don't have to choose between lectures. We will be introducing new, thought-provoking sessions where we ask the experts what they

more involved in helping to shape the world of emergency medicine through AAEM. We have been busy at AAEM leading emergency physicians on the topics of balanced billing, due process, independent practice of advance practice providers and diversity and inclusion. We want you to know how AAEM is representing your interests and to become involved.

Theme: All Voices Heard

This year's theme is "All Voices Heard." This means that whether you are a physician, a patient, or the public, your voice is important and is acknowledged. As physicians, we need to be strong advocates for our patients, the public, and each other. At AAEM, we hear you!

Wellness Events

We also want you to give to yourself by taking care of yourself. There will be plenty of opportunities at AAEM20 in Phoenix. There will be a fun run on Tuesday, April 21, a yoga opportunity on Wednesday, April 22, and a storytelling session on Tuesday, April 21, where you can tell your story or listen to some very engaging personal stories.

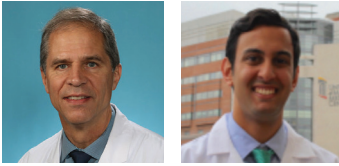
It is an honor to be charged with maintaining the high quality of emergency medicine's preeminent educational conference, the AAEM Scientific Assembly. Please join us this year in beautiful downtown Phoenix. ●

Learn more and register at:

www.aaem.org/AAEM20

A Call for Physician Advocacy: Supporting HR 1309

Gary M. Gaddis, MD PhD FAAEM FIFEM and Gregory Jasani, MD



On November 18, 2018 Dr. Tamara O'Neal was shot and killed by her ex-fiancé on the grounds of Mercy Hospital in Chicago.¹ This heinous act took place in front of the very emergency department where Dr. O'Neal worked. Her ex-fiancé took her life, then went into the hospital and exchanged gunfire with police. Before the rampage was over, pharmacist resident Dr. Dayna Lee and Chicago police officer Samuel Jimenez had also been killed.

These acts shocked the nation. Hospitals are supposed to be safe places for healing of the sick and injured. However, similar despicable acts have occurred from time to time. For instance, back in 1981, a doctor and visitor were both killed at the Emergency Department of the University of Kansas Medical Center (KUMC) by a patient who had received treatment at KUMC for his history of paranoid schizophrenia.²

Instances of workplace violence or threatened violence against health care providers are unacceptably regular occurrences. The Government Accountability Office reported that there were over 730,000 reported assaults against health care

As emergency physicians, we and all of the nurses, technicians, clerks, and students with whom we work and train, are especially vulnerable to violence or threats of violence. Our doors are always open. However, security and weapons interdiction measures in emergency departments vary widely. At some emergency departments, patients do not have to undergo any type of security check before being brought to a treatment area.

In fact, sometimes hospital leaders have deliberately removed security measures that had

Such a view is difficult to reconcile with the fact that passengers who board aircraft have routinely submitted to metal detector screening before boarding a commercial flight since 2001 even though attacks on airlines occur much less frequently than attacks against health care workers. Even more concerning was the fact that the murder of a physician and visitor had occurred at an emergency department in that community, less than five miles away, at KUMC, in 1981. We hope that such short-sighted action has not been frequently repeated across our nation by other executives.



AS EMERGENCY PHYSICIANS, we and all of the nurses, technicians, clerks, and students with whom we work and train, are especially vulnerable to violence or threats of violence.

workers from 2009 to 2013. In this context, the term “assaults” means violence or threats of violence against health care workers. Health care providers are four times more likely to be assaulted in the workplace than practically any other field. The only other profession with similarly high numbers of workplace violence is law enforcement.

previously been in place for provider safety. One of us (GMG) worked in a community where the former chief executive officer of the city’s public hospital directed that metal detectors that had previously and prudently been placed in service at the Truman Medical Center be removed. The stated concern was that metal detectors sent the wrong message to the patients and visitors.

Additionally, those of us who work in emergency departments are often the ones who are called upon to treat the intoxicated, aggressive, and psychotic patients. All of this puts us in a uniquely vulnerable position within the health care industry, and our profession is starting to feel the effects. A survey sent out by the American College of Emergency Physicians (ACEP) found that over 75% of emergency physicians reported being the victim of at least one workplace violence incident per year. Another survey of emergency medicine residents found that nearly 25% reported “occasionally, seldom, or never” feeling safe at work.



AAEM NEWS Indeed, one of us (GMG) has followed up on an act of battery that occurred in a former workplace, to be sure that the perpetrator was prosecuted and sentenced.

We find these numbers both alarming and wholly unacceptable. Dr. Gaddis and I met at AAEM's Health Policy in Emergency Medicine (HPEM) conference earlier this year, and resolved to determine what laws surrounding the issue of hospital safety exist.

We learned that the Occupational Safety and Health Act of 1970 requires employers to provide an environment that is as free as possible from occupational hazards. Courts have interpreted this to mean that employers must take active steps to mitigate threats to their personnel.

It was endorsed by the Committee and sent to the floor of the House in June. The bill has over 190 sponsors, which might seem promising. However, all but six co-sponsors are Democrats. Even if this bill were to pass the House, Senate Republicans have not indicated if they would consider this bill. It likely faces an uphill battle to be passed.

We certainly feel that HR 1309 is a step in the right direction for making emergency departments safer. We encourage all AAEM members to advocate for it. Thus, we encourage you to contact your Representative and express your support for this legislation.

As a constituent and an emergency medicine provider, your voice is incredibly important in this debate. If this legislation passes the House, then we would encourage you to con-

Working in an emergency department will always carry with it certain risks. Yet, proper planning and security can mitigate many of these threats. Violence against health care providers has reached epidemic levels, and this appears to have finally spurred action from federal lawmakers.

While HR 1309 is encouraging, advocacy at all levels will be needed to reduce the amount of violence we experience. Dr. Gaddis and I sincerely hope you'll join us in fighting for safer emergency departments, beginning with an outreach to your United States Representative, imploring them to support HR 1309.

In your email or letter to your United States Representative, we suggest that you write something like this:

As one of hundreds of thousands of Americans who provide patient care in an emergency department, I write to you today regarding the issue of workplace violence, and potential measures to mitigate that violence. I write to ask you to co-sponsor (if you have not already done so) and support enactment of HR 1309, the "Workplace Violence Prevention for Health Care and Social Service Workers Act"

(Then, continue with your own personal story and appeal...)

Thank you for your interest in this matter. However, the greatest compliment that you can pay us, as authors of this column, is to reach out by letter, and/or email, and/or telephone call and contact your United States Representative about this matter. If you don't know the name of your US Representative, it is not difficult. Just go to: <https://www.house.gov/representatives/find-your-representative>. ●

References:

1. <https://www.chicagotribune.com/news/breaking/ct-met-chicago-mercy-hospital-shooting-tamara-oneal-20181120-story.html> Accessed July 26, 2019
2. <https://law.justia.com/cases/kansas/supreme-court/1984/55-368-1.html> Accessed July 26, 2019

HOSPITALS are supposed to be safe places for healing of the sick and injured.

Unfortunately, there is little guidance as to what that means. The Occupational Safety and Health Administration (OSHA) has guidelines for how to minimize violence in health care settings. These guidelines are advisory in nature and do not place any legal obligation on employers.

Nine states (Maine, Connecticut, New York, New Jersey, Maryland, Illinois, Washington, Oregon, and California) have laws that require hospitals to establish violence prevention programs for their employees, but we were stunned to learn that there are currently no federal laws on this subject.

A bill in the House of Representatives, HR 1309, the proposed "Workplace Violence Prevention for Health Care and Social Service Workers Act," seeks to correct this. HR 1309 would "require certain employers in the health care and social services sectors...to develop and implement a comprehensive workplace violence plan to protect health care workers." It points to OSHA's guidelines on preventing health care violence as a standard upon which these plans can be based.

HR 1309 was introduced in the House Education and Labor Committee in February.

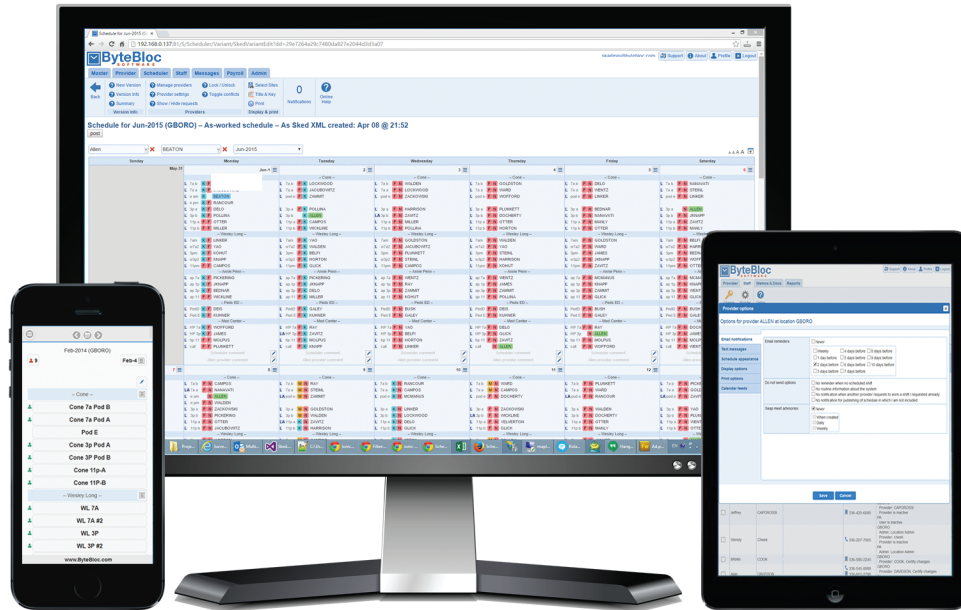
tact your Senators as well. The issue of health care provider safety should transcend party lines. It is our hope that we can engage lawmakers in a productive conversation about the importance of this issue and this legislation, not only to our profession but also to all who work in or visit to the emergency departments of our nation.

Advocacy does not just have to occur at the federal level, though. We encourage members to work at all levels to promote violence prevention. As mentioned above, only nine states have laws that mandate that employers develop violence prevention plans. Regardless of what happens at the federal level, working with local lawmakers and stakeholders in the other states to pass laws that help promote health care safety is incredibly important.

Even advocating at the level of your hospital and your emergency department can be beneficial. We implore you to work with your department leadership to identify ways to make your environment safer and reduce instances of violence. You and all with whom you work and/or train have a right to work in a safe environment.

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Coaching Advances Physician Careers, Improves Patient Outcomes Emotional and Mental Skills Facilitate Peak Performance

Barbara Walker, PhD



****Source: This research paper, "Coaching Surgeons and Emergency Room Physicians," was published by Barbara J. Walker in a special issue of Consulting Psychology Journal: Practice & Research, which focused on coaching elite performers in a wide range of occupational settings – athletics, performing arts, business, military, and medicine.*

Emergency physicians have to continuously maintain top performance in a fast-paced environment characterized by intense cognitive, physical, and technical demands. Because they are providing high-stakes medical treatment, the consequences of sub-optimal job performance are dire, including injury, disability, or death of the patient, and a potential lawsuit. Understandably, many emergency physicians struggle with burnout, anxiety, and depression.

With the Association of American Medical Colleges predicting a shortage of 100,000 doctors by 2030, it is vital for physicians to cope with these occupational and emotional challenges while keeping their skills sharp. Coaching equips physicians with high-performance strategies, communication techniques, and mental skills needed to maintain elite job performance.

SELF-CARE SKILLS ARE ESSENTIAL; it's impossible to maintain peak performance without allowing time to recover and consistently eating, sleeping, and maintaining proper hydration.

Growth of Coaching in Medicine

Here are three examples illustrating the growing acceptance of coaching in medicine:

- The American Medical Association advocates for coaching to be a part of medical training, from the student years into residency, and through the rest of a physician's career. The AMA recently published an article, "These Coaches can set Your Physician Career on a Winning Path," in which physicians explained how coaching helps in managing relationships, improving patient outcomes, and advancing one's career.
- Dr. Victoria Cleak published an article in The BMJ entitled "A Coach can Improve the Performance of any Doctor." She writes, "A skilled coach can enable a doctor to manage a range of problems, including lack of reflection, burnout, and a lack of resilience. A coach can also help a doctor develop and harness leadership potential."
- In "Coaching Physicians to Become Leaders," Richard Winters of the Harvard Business Review wrote that coaching can help physicians deal with a range of challenges, including navigating organizational politics, balancing the demands of leadership and clinical care, transitioning into leadership roles, and managing time pressure.

Confidential, Non-Judgmental Help

Physicians are often trained in a culture that emphasizes pushing oneself at the expense of personal well-being. Sleep deprivation, poor diet, and lack of work-life balance are common. Despite the struggles this culture creates, many physicians feel stigmatized when asking for help. Coaching begins by providing physicians with a confidential, non-judgmental, and empathic relationship in which they can openly discuss challenges without fear of losing status.

Coaches collaborate with physicians in the problem-solving process, helping them to develop strategies to maintain flexibility and mental readiness, as their jobs are often unpredictable and require them to work under time pressure. Self-care skills are essential; it's impossible to maintain peak performance without allowing time to recover and consistently eating, sleeping, and maintaining proper hydration. While this may sound obvious, attending to self-care runs against the competitive physician culture.

Fostering Practical Skills

Coaches can work with physicians on improving their communication skills, as they are often simultaneously managing relationships with the patient, the patient's family, and hospital staff. Other skills, including deep breathing and mindfulness meditation, offer physicians practical strategies for managing their overall stress level.

Biofeedback – a technique that involves teaching an individual to manage their physiological reactions to their environment – can be used to help physicians improve focus, decrease muscle tension, and monitor subtle changes in their body. Many of these techniques are similar to techniques used to coach elite performers in other fields, including business, sports, and the military. Research has shown these techniques improve health along with physical and occupational performance.

New Resource Available

Much of this information is taken from a recent research paper titled: "Coaching Surgeons and Emergency-Room Physicians" published in a special issue of Consulting Psychology Journal: Practice & Research (CPJ). The author is Barbara J. Walker, PhD, associate professor in psychiatry and behavioral neuroscience at the University of Cincinnati School of Medicine.

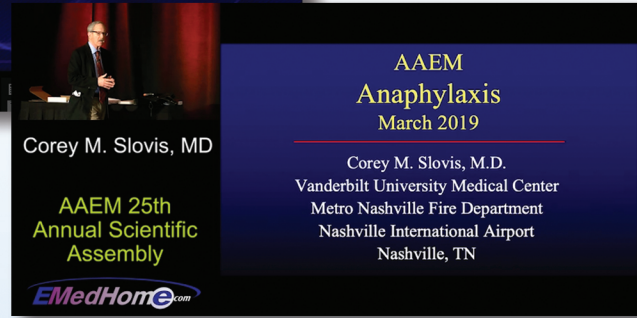
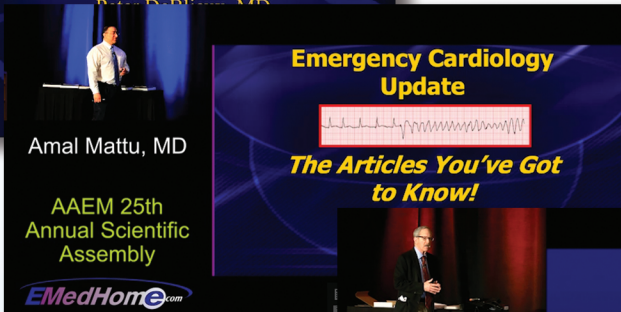
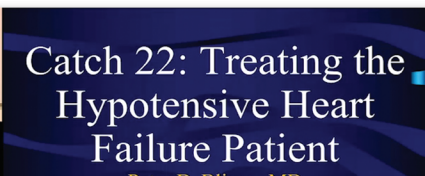
CPJ is a publication of the Society of Consulting Psychology (SCP), a division of the American Psychological Association. SCP represents over 1,000 psychologists who translate psychological science into practical methods for consulting with individuals, groups and organizations to catalyze growth and change. This particular CPJ issue focused on coaching elite performers in a wide range of occupational settings – medicine, athletics, performing arts, business, and military. ●



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Reviewing the Peer Review Process: The Reginelli Case

Sundeep Ekbote, MD FAAEM

The Reginelli case highlights the semantic nature of law in contrast to the **SPIRIT OF MEDICINE.**



Most emergency departments (EDs) have a chart review process, often completed by the department medical director or a designated departmental quality officer, which is done both for quality control and to review any cases that raise concern for patients or providers. These chart reviews are typically kept in a file for each provider. Some cases merit further review. While the vast majority of these cases are screened, reviewed and addressed at the department level, the few more concerning cases are escalated to the hospital Peer Review Committee, which consists of representatives from different disciplines within the hospital. In Pennsylvania, as in most states, this process is protected as confidential under the Peer Review Protection Act (PRPA), which is for the “proceedings and documents of a review committee.”

However, this protection may not be as straightforward as the act implies. The following case and subsequent lawsuit, both a matter of public record, put the peer review process under review.

Monongahela Valley Hospital (MVH) is a modest rural hospital that contracts their ED physician services to an outside group that was part of a larger university medical center. The ED physicians, including the director, were employees of the university group. In 2011, Eleanor Reginelli was seen in the ED at MVH with a complaint of gastric discomfort. She was treated and released by the ED physician. Unfortunately, several days later, the patient had a myocardial infarction. The ensuing lawsuit alleged failure to diagnose the myocardial infarction at the time of presentation in the ED.

In the multiple depositions that followed, among them was the director of the ED. She testified that she maintained a “performance file” on the defendant physician, as she did on all the ED medical staff. This consisted of, among other things, charts that were randomly reviewed for quality control purpose as part of each provider’s Ongoing Professional Practice Evaluation. The plaintiffs in the case requested the “performance file” on the defendant physician. Naturally, the ED group and MVH resisted, because publicizing the peer reviewed material would be in violation of the PRPA.

The protections of PRPA apply to “professional healthcare providers,” which applies not just to physicians, but to institutions as a whole. MVH asserted that the contract group hired to staff the ED was hired to manage all facets of the department, including, “evaluating the quality and efficiency of services ordered or performed by health care

providers,” and therefore, was part of the hospital institution. However, despite this argument, the court granted the motion to compel release of the performance file. Following that decision, the ED group contended that the performance file was maintained solely on behalf of the management group, and that the work of the Medical Director was an “outside peer review process.” This outside process had never been shared with MVH and was therefore irrelevant in the actions against MVH. The ED group and MVH were effectively presenting two different arguments – an institutional vs an outside peer review process – both in attempts to protect the peer review process.

Ultimately, the courts ruled that the performance file maintained by the ED director was not confidential. Part of their reasoning was that the ED group does not qualify as a “healthcare provider” under a strict interpretation of the statute. Another rationale was that an “individual physician” does not qualify as a peer review “committee.” As a result of this case, hospitals and management groups across the state struggled to find a workable solution to ensure compliance with the PRPA in this new legal realm.

At MVH, a two-pronged approach was used. First, MVH officially formed an ED Peer Review Committee. The statute did not require that the committee be composed of physicians, but rather allowed for nurses and administrators to be part of the committee, so the members included the hospital’s own director of quality and a senior vice-president whose domain included risk management. At MVH, cases are still primarily reviewed by the ED director, but then following the initial review, a written assessment is placed in a confidential file, and that file is shared with the other members of the ED Peer Review Committee. If needed, any significant issues are still elevated to the broader Peer Review Committee of the hospital. Secondly, the management group created a confidential file for medical directors of various EDs within the group’s system that could be used to review cases that merited some further discussion or input, as deemed by the ED director and the ED Peer Review committee at the respective hospital.

The obvious need for confidential peer review to allow continued improvement of patient care is supported by the PRPA. The intent of the PRPA, while seemingly obvious to any healthcare provider, is not as simple when viewed through a legal lens. The Reginelli case highlights the semantic nature of law in contrast to the spirit of medicine. We hope that sharing our experience will enable other ED providers to better protect themselves, and their peers, in the future. ●

Physician Burnout – A Systems Problem Requiring a Systems Solution

Aneesha Dhargalkar, MD



Physician burnout. What does this mean? Concepts such as exhaustion, wellness, mental, and emotional health are just some of the phrases that the term “burnout” conjures up in my mind.

My journey with this notion started in residency. I have always experienced an internal struggle managing my personal and professional life. Given our erratic work hours, it was a challenge to make sure I spent quality time with my husband, especially since he also

This starts with leadership. For me, this meant meetings with our senior leadership team as well as our medical executive board. It is imperative that these key leaders are on board with the importance of addressing physician burnout within an institution. All organizational change must have leadership support to be effective and buy in from senior leadership is essential if we are ever to enact the cultural change we desire. So, during these meetings, we worked towards aligning my goals for creating a culture of wellness within our institution with the values of our hospital

I had no mental or **EMOTIONAL ENERGY** to contribute to my family at home.

has a demanding job requiring a fair amount of travel. This feeling only increased exponentially after the birth of my children and the increasing demands my husband experienced in his work. At the same time, busy shifts with large volumes and high acuity of patients were making me feel more emotionally drained. I had no mental or emotional energy to contribute to my family at home. This was a cycle that then affected my empathy for patients and my experience at work.

While personally dealing with these concerns, I began to think that maybe some of my colleagues were feeling the same way. The six months I spent researching the topic of physician burnout sparked my passion into seeing what I could do to create a culture of wellness within first my ED group, and now my hospital organization.

I started by working within my ED group. I took a data-driven approach to addressing wellness by creating interventions based on the results of semi-annual surveys. The goal of these interventions was to address the issues driving burnout and disengagement within my own section. There were many different concepts incorporated, including a biweekly “wellness email.”

After two years, I wanted to do more and expanded my focus on physician wellness to the hospital level. It is important to understand that burnout is a systemic issue that requires change on an institutional level. We need to work to change the system so we can address factors affecting quality, efficiency, and access to medical care as well as patient satisfaction and compliance. It is vital that we work toward creating a culture of wellness in our community to address those drivers of burnout we encounter every day and that it be a physician that advocates for this change for his/her colleagues.

leadership so we could work together. The feedback from these meetings held recently was positive and I am optimistic about our ability to create significant improvements in our organization regarding physician burnout.

As “wellness champions,” my partner and I are now working on taking a top down approach to enlist community and peer support via colleagues from multiple medical departments. By working together, we hope that innovative and creative solutions to attack the issues of burnout that are specific to our hospital will arise. With the support of leadership, I believe much can be accomplished to decrease burnout and create a wellness culture within our hospital.

One challenge I have encountered along the way is maintaining patience. As John Heywood famously said “Rome was not built in a day” and solving the broad problem of physician burnout does take more than a few weeks or months, no matter how passionate one is. Much ground work needs to be accomplished before attacking this issue head on and creating a culture of wellness within any organization is often a paradigm shift that requires years to complete.

It is an arduous road with many a speed bump and detour along the way. But it feels good knowing that with each step I take, I am one step closer to decreasing burnout, improving mental and emotional health and working towards a culture of wellness within my organization. ●

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Your Words Matter: The Vocabulary of Microaggression

Marianne Haughey, MD



When my kids were small my husband and I often said “Use your words.” The idea is that by communicating with words we can prevent violent acts, and that the skill of learning how to use words instead of fists allows us to have our needs satisfied and discuss issues that are leading to confrontation. As words replace fists it is important to realize that words that are chosen have power

and implications. Violence and aggression can occur through the words selected, although in a more subtle form that the shoves my children were using when disagreeing.



“Hey Kiddo!” “Sweetie,” “Honey”...all words of endearment in the right setting, and the right setting is neither in the practice nor the teaching of medicine. These are words said from parent to child. They infantilize the recipient, whether or not there is a difference in age. These words imply that the speaker is not even dignifying the recipient of the greeting by remembering their name. And if there is a title involved related to education or achievement, omitting it also diminishes the recipient, and the position and education they hold. In fact, these words can be used to reinforce that power dynamic and undercut the power of the person addressed. If said between two adults it can presume a friendliness or casualness that may not be present. The infantilization can even go so far as to diminish the voice of the recipient of this address throughout whatever discussion follows. This is especially of concern if the two people involved have a power dynamic which is not equal. The power dynamics could include those between doctor to patient, chair to faculty, or program director to resident, all with concerns related to diminishing the less powerful person in the interaction and silencing. Given the unequal base there is the additional challenge that the less powerful person in the relationship is in an awkward position when it comes to challenging the terms of address used by the more powerful individual.

Microaggressions are meant to reinforce the power differential in a manner that can be dismissed or minimized by the aggressor. Druck, et al. state “Microaggressions include inappropriate humor, stereotyping, and questions of belonging that occur in three forms: microinsults, micro assaults, and microinvalidations.”¹ The use of these diminutives in referring to others is a clear example of microaggression. Often, when and if the senior is challenged by the junior, the response will be “Oh, but that was just a joke,” as a result also diminishing the interaction of calling the senior person out on their behavior.

Additionally, when the form of address is directed in a micro aggressive manner, it results in setting the tone for any discussion or interaction that follows. By calling someone “Kiddo” their contribution to further conversations is discredited. One would never value the opinion of a “kid” in the same way one would value the opinion of an adult. Conversations about substance following this form of address are likely to have less questions raised by the junior person, and more “authority” demonstrated by the senior person. There is not an equal and open playing field in the discussion which is an unstated goal of using such terms. And if people don’t feel empowered in a discussion, eventually they may choose to leave the conversation and relationship altogether.

It is important
for **EVERYONE’S VOICE**
to be heard.

What happens if people are addressed respectfully, using their name, and when appropriate, title? What happens if words that diminish the value of others, and therefore their contributions, are not used, and microaggressions meant to reinforce a differential in power are insightfully avoided? The ability of a junior member of the team to question their senior, and also have their voice heard can clearly save lives. This is what has been learned and reinforced in the airline industry to avoid plane crashes. The team working and listening to each other together is better than any one voice alone. It may be that the junior resident is the only one in a crash situation who is in the position to recognize a dropping oxygenation in a patient, and if they have been trained to not share their voice, the patient can die.

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AND IF PEOPLE DON'T FEEL EMPOWERED in a discussion, eventually they may choose to leave the conversation and relationship altogether.

WOMEN IN EMERGENCY MEDICINE

Opening the conversation in a respectful way acknowledging the participation of the individuals involved leads to a more free and transparent exchange of information. This demonstrates a desire to hear the other person's words and shows value for their input. As an example, if it is a conversation between doctor and patient it allows for open discussion where a patient feels the value of their questions and equal participation in the ensuing discussion. The power differential between a doctor and patient can leave the patient intimidated if it is not clearly demonstrated that the patient is a valued part of the conversation. If they are intimidated, they might not ask the questions they need to ask to make sure that any disasters in their care might be avoided. Empowering patients to bring forward their point of view and questions, leaves all participants richer for the discussion.

So, in addition to "using their words" I found it important to teach my children to treat others respectfully and to listen carefully to others words. It was important to let everyone realize they had a voice and that

their voice is valuable. Many times, my children have brought up points in discussions that had escaped my consideration, but the respectful approach we used allowed those points to be considered in the discussion and issues that would have been of concern later in the process were avoided. I try to use this method with my residents and patients and have found it has opened discussions that might have otherwise been shut down, allowing patients to ask questions they might not otherwise have been comfortable asking. It is important for everyone's voice to be heard. ●

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Beyond the Sepsis Order Set

Michael L. Martino, MD FAAEM



Sepsis is the 7th leading cause of death in the US,¹ and a focus of early intervention and protocolized care by CMS and Emergency Departments

across the country. Our EMRs have pop-up “Sepsis Warnings,” and we must often explain to our EMR why we have not yet clicked on that wonderful sepsis order set. Are we so pressured to rapidly identify and treat sepsis that we might misdiagnose significant sepsis imitators? Couldn't we just click the boxes and call the hospitalist for admission?

Not All SIRS Is Sepsis

Systemic Inflammatory Response Syndrome (SIRS) often arises from noninfectious causes. Consider other immune targets such as autoimmune disorders, especially lupus, Graft Versus Host Disease, and vasculitides. Microangiopathic hemolytic anemia (TTP, HUS) often imitates sepsis, microvascular ischemia, organ dysfunction, and lactic acidemia. Let's not forget everyone's favorite clot in a blood vessel: pulmonary embolus. PE can cause fever, tachycardia, tachypnea, sepsis alert and even pulmonary infarct, with infiltrate on chest X-ray imitating pneumonia. PE may even arise from a DVT with associated cellulitis, giving us the old fake-out/not entirely relevant infectious source.

Adrenal crisis from Addison's Disease or from withdrawal of exogenous corticosteroids can certainly set the inflammatory cascade in motion, manifesting as SIRS and even shock. Tumor Lysis Syndrome (TLS) - especially in leukemia before or just after initial treatment - can produce an intense inflammatory response. Associated hyperkalemia, hyperphosphatemia, hypocalcemia and renal failure can be immediately life-threatening. Pancreatitis with SIRS can be septic (obstructive) or aseptic (alcohol, triglycerides, Bactrim, HCTZ, etc.). Even heavy metal fume disease (welders) and vaping can instigate severe febrile lung disease.

All of these disorders may produce EMR “Sepsis Warning,” and severe morbidity/mortality if we rush to the final diagnosis of sepsis while failing to treat the presenting disease process specifically.

Not All Fevers Are Even Inflammatory

Patients may have fever, tachycardia, etc., without primarily inflammatory causes. Heat exhaustion and heat stroke should not be overlooked in the right setting. Toxicologic etiology, e.g., salicylate poisoning, sympathomimetic ingestion (cocaine, methamphetamine), Neuroleptic Malignant Syndrome, Malignant Hyperthermia (seen in EDs from succinylcholine), and Serotonin Syndrome all require timely and specific therapy. Thyroid storm is another unique life-threatening process which may pop up that “Sepsis

Couldn't we
JUST CLICK THE
BOXES and call
the hospitalist for
admission?

Warning” in our minds and our EMRs.

Even Sepsis is Not Always Straightforward

If you were chosen for the reality TV show “American Ninja Doctor” and had one antibiotic to bring, what would it be? I would choose Zosyn. It's amazing. It covers Gram everything above and below the diaphragm, anaerobes and aerobes including Pseudomonas. It qualifies as sepsis “monotherapy.” I'm pretty sure it restores hair loss and increases self-esteem. Some people may be allergic, but hey, its reality TV and we have to think ratings...

Turning off the TV and returning to the ED, we quickly realize no one drug or cocktail will optimally address every septic patient. Recent cultures results may reveal MRSA, ESBL, or multi-drug resistant bacteria. Travel history may predispose to fungal agents (desert Southwest, Ohio River Valley), rickettsia (camping, hiking), Q fever or Anthrax (farm settings), or even malaria. These sorts of historical pearls should trigger ID consults from the ED. We wouldn't wait until the patient gets upstairs to start antibiotics; why wait to start the *right* antibiotics?

We treat more immunosuppressed patients than ever on chemotherapy, living with HIV, and managing autoimmune diseases with immunomodulating drugs. Serious opportunistic infections include PCP, fungi, tuberculosis, and parasites, in addition to all the more typical bacteria.

Finally, we have recently witnessed the SARS coronavirus and the annual flu epidemic producing extreme illness, often in otherwise healthy people.

Find the Pus and Drain It Early

Antibiotics and the immune system require a blood supply to reach a source of infection. Infections with poor blood supply (necrotic tissue, abscesses, empyema) need to be identified and drained/excised. Obtain CT scans to search for abscesses, perforation, or gas in the urinary bladder, gall bladder or in the skin (necrotizing fasciitis), impacted pyelonephritis behind a ureteral stone, ascending cholangitis behind a biliary stone, or toxic megacolon. Consider decubitus X-rays to distinguish empyema from effusions. Consult your interventional radiologists and surgeons to drain pus early and remove necrotic tissue. Transfer such patients if necessary. Don't wait and see how antibiotics work. Decompress urinary and bowel obstructions with Foleys and nasogastric tubes in the ED.

New heart block in IVDA and other endocarditis patients suggests purulent involvement of the conduction system, anatomically adjacent to



the aortic valve. Notify your CT surgeon and cardiologist about this possibility. MRSA or Strep pneumonia can cause devastating purulent pneumonia even in a previously healthy young person. Such suspicion should prompt consultation for early bronchoscopy, and the addition of Vancomycin to your treatment regimen.

We Support You 100%: Aggressive IV Fluid Bolus

The 30 cc/kg crystalloid bolus for septic shock patients in the first three hours might be the most controversial part of this whole sepsis ordeal. We've gone from not wanting to drown old people to...drowning old people. Septic shock patients young and old who may be morbidly obese, have premorbid CHF, or ESRD on dialysis may not tolerate being connected to a fire hose. Then again, they may need it to survive.^{2,3} Opinion, recommendation and mandates are common, while we lack definitive data.² So, what do we do?

We can use noninvasive bedside testing for interim evaluations of fluid resuscitation,³ i.e., does passive leg raising still decrease tachycardia after the 10 cc/kg? After 20 cc/kg? Is the patient developing pulmonary edema? How is urine output? Capillary refill? For obese patients, we can dose our 30 cc/kg bolus on ideal body weight. Noninvasive ultrasound assessment of the internal jugular vein or IVC is another option. Consider ongoing invasive monitoring through a central line in these more complicated patients at special risk for over- and under-resuscitation. CVP 8 – 12 cm H₂O seems reasonable.⁴

Finally, what kind of crystalloid fluid should we use? Consider NSS is hypertonic and pH adjusted with HCl to as low as 4.5. Additionally, the Cl⁻ (154 mEq/L) contributes to hyperchloremic acidosis especially after infusion > 2 L. This acidosis promotes organ dysfunction and K⁺ entry into the extracellular space, contributing to hyperkalemia, especially in renal failure patients.

Alternatively, Lactated Ringers (LR) is isotonic (137 mEq Sodium/L), displays pH ~ 6.5, and avoids hyperchloremic acidosis is avoided by decreasing chloride administration (~109 mEq/L vs. 154 mEq/L). Depending on the metabolic

and redox state, the lactate (28 mEq/L) can enter the Krebs Cycle as pyruvate to produce ATP, or can be converted to our natural blood buffer, namely bicarbonate.

Contrary to urban legend, LR should not worsen sepsis nor cause elevated follow-up lactate. Remember that lactate is not the problem, but rather a marker of failed O₂ utilization by tissue due to local hypoxia and/or metabolic dysfunction. Lactate exhibits dynamic equilibrium with bicarbonate and the Krebs cycle, not simply accumulating in a bowl into which we pour our fluid.

Regarding concerns over potassium, LR's 4 mEq K⁺/L is physiologic. The 1/3 of administered crystalloid remaining intravascular would contribute 1.3 mEq to the average 5L blood volume = increase of 0.26 mEq/L. NSS-induced acidosis may promote increased K⁺, though it contains none itself, through acidosis-induced extracellular K⁺ migration from whole body stores. LR diminishes this phenomenon.

Other "physiologic" crystalloid solutions such as Plasmalyte, and its generic equivalent Normosol, use acetate and gluconate as anions, rather than lactate. The acetate seems to be helpful, in a way similar to lactate; we aren't sure what happens to gluconate,

especially in renal failure.

How about cost? NSS and LR cost about the same per liter, around \$1; Normosol ~\$6/L and Plasmalyte ~\$10/L. However, improved outcomes with more physiologic fluids should decrease overall cost of care, making NSS relatively expensive. LR is widely available, inexpensive and more physiologic than NSS.

A plethora of good literature now supports that aggressive resuscitation with LR in septic patients actually lowers lactate levels and improves clinical outcomes vs. NSS.^{3,5,6}

Pressing the Issue

Hypotension is so detrimental; consider administering inotropes/pressors simultaneously with the initial fluid bolus,^{7,8} i.e., hitting hemodynamic goals ASAP. You can always back down the inotrope/pressor if fluid response is robust. Choice of optimal pressor remains murky, although Surviving Sepsis Campaign Guidelines recommend Norepinephrine as first line.⁹ Recently criticized for inducing atrial fibrillation,¹⁰ Dopamine may well serve the patient with CAD and/or CHF who needs inotropy and may



not tolerate coronary vasoconstriction. If hypotension persists,

consider premorbid confounding factors, e.g., beta-blocker use, alpha-2 agonists, sympathetic neuropathy (age, diabetes), and adrenal insufficiency as factors preventing adequate resuscitation. Consider administering hydrocortisone, to increase sympathetic receptor expression and improve efficacy of the most common pressors and inotropes. Send off a baseline cortisol to guide later therapy upstairs about relative hypoadrenalism. If still ineffective, consider adding milrinone (inotrope) and/or vasopressin (pressor), independent of the sympathetic system.¹¹

You're So Sweet

Glycemic control has demonstrated improvement in septic patients, but is often overlooked. We shouldn't expect improved survivability if our septic patient with a glucose of 385 develops DKA before admission. Aim for glucose \leq 180 mg/dL, while avoiding hypoglycemia.⁹ Insulin puts all that glucose inside the cells where it can produce ATP so our pressors, inotropes and cellular machinery can work.

Feed Me, Seymour

In addition to fluid resuscitation, consider *metabolic* resuscitation. Cachectic, malnourished, alcoholic, and gastric bypass patients may require nutrients essential to energy production like Thiamine and other B vitamins. Numerous patients may have unexpected critical nutritional deficiencies: Hydralazine and Isoniazid promote Pyridoxine (B6) deficiency; Phenytoin causes Folate (B9) deficiency.

Single-dose Thiamine and MVI in the ED might be helpful in such patients. Avoid the vasodilatory Magnesium of the "Banana Bag"; instead order Thiamine and multivitamin IV/IM. Fun fact: Vitamin C, found in MVI, is actually required for humans' response to sepsis, including production of catecholamines, vasopressin, cortisol and interferon.^{12,13}

Now Breathe

That fluid overload and pulmonary edema you see in your declining patient on repeat CXR may actually represent ARDS. After all, septic shock means organ dysfunction, and ARDS

is what happens to failing lungs in this setting. For any septic shock patient requiring intubation, strongly consider ARDSNet settings for the ventilator.^{9,14} For alert septic shock patients with noticeable work of breathing but without respiratory failure, consider decreasing their metabolic expenditure by starting BIPAP.¹⁴

Sepsis Can Get Complicated

Be vigilant for *sudden* changes in status. This may indicate any number of complications, including respiratory failure in the nonintubated, or hypophosphatemia causing respiratory muscle weakness in DKA patients (after insulin administration and delayed admission to ICU). Other respiratory issues include right mainstem migration of the endotracheal tube with left lung atelectasis, mucus plug in lung or ET tube, air trapping, tension pneumothorax, and asynchrony with the ventilator. Cardiac issues include supervening arrhythmia, myocardial infarction, and AV node involvement in endocarditis. Finally, hollow viscus perforation or phlegmon erosion into a vascular structure can cause sudden collapse. With sudden changes, don't just order another liter of fluid or increase the pressor; go to the bedside and reassess the whole patient.

So Now What Do I Do on My Next Shift?

Aggressive LR resuscitation, well-considered broad-spectrum antibiotics and "sepsis workup" seem prudent and necessary in patients with suspected sepsis. Further therapy should be guided by the presence of hypotension and/or lactate; consider early pressors/inotropes. Savvy clinicians will utilize frequent reassessment, EMR evaluation, and historical risk factors to confirm sepsis, atypical sepsis, or sepsis masquerader.

We should re-open our decision-making if a septic source cannot be found or if the patient is not responding as expected. Is there a source of pus to drain? Is there possibly an unusual infectious agent? Do we need to obtain cerebrospinal fluid? Could we address

significant comorbidities - malnutrition, medication effect, hyperglycemia or organ failure? Has a critical complication developed that requires immediate action? Have we considered other processes like heat exposure, toxic ingestion or PE? Could vascular, endocrine or autoimmune disease be masquerading as sepsis, requiring a different tailored clinical response? These are the clinical challenges we must face beyond the Sepsis Order Set. ●

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We've gone from NOT WANTING TO DROWN
OLD people to, well, drowning old people.

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Follow the QR code for a Critical Care Hacks solution to make rewarming a little easier

Passively rewarm

- Remove cold/wet clothing
- Give warm blankets
- Rewarm at 1.5 degrees Celsius/hour

Mild
(32-35C)
Shivering

Moderate
(28-32C)
AMS
No shivering

Actively rewarm externally, minimally invasive methods

- Warm IVF
- Bare hugger
- Be cautious with movement, myocardium prone to arrhythmias, *if central access needed, only femoral lines

Accidental Hypothermia



Invasive measures + Modified ACLS

- Airway: standard ACLS (warm air if possible), try to avoid depolarizing paralytics
- Breathing: no changes
- Circulation: consider ultrasound assistance
 - Vtach/Vfib shock x 1, at most x 3 then no shocks until > 30 degrees Celsius
 - European guidelines: Epi only if T > 30 with double the interval i.e. 6-10 min between doses (US no clear guideline)
- Active rewarming (IV fluids, bladder irrigation), bilateral chest tubes (high anterior/low posterior), peritoneal lavage, ECMO
- Time of death when warm and dead, i.e. >30 degrees (vague guideline)

Pulseless

Severe
<28C
Unconscious

Invasive measures

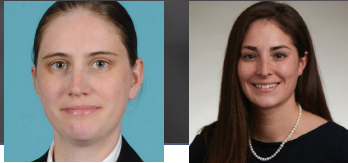
- IVF
- Bladder lavage
- Chest tubes, right sided only to avoid myocardium stimulation
- Peritoneal lavage
- ECMO

*Likely futile efforts if K >12, T <14C

*Consider broad etiology, hypoglycemia, sepsis, drugs/EtOH, other toxic/metabolic

Development of a Focused Designation of Clinical Practice in Ultrasound

Melissa Myers, MD FAAEM and Alexis Salerno, MD



Emergency physicians have been an essential part of the development of Point-of-Care Ultrasound (POCUS). In the 1970s, POCUS started as part of the trauma resuscitation. Since then, emergency physicians have expanded the boundaries of POCUS to evaluate and treat a wide range of medical conditions. As early as 1988, emergency physicians began publishing on the use of bedside ultrasound in the emergency department. Within a few years, in 1991, both the American College of Emergency Physicians (ACEP) and the Society of Academic Emergency Medicine (SAEM) published policy statements regarding the utility of bedside ultrasound in the emergency department.¹

Emergency physicians have also led the way in developing curriculum. The first published curriculum in 1994 by Mateer et al has led to multiple well-developed curriculums based in educational research. Today, POCUS is considered an essential skill and was recognized as such in the 2013 Model of the Clinical Practice of Emergency Medicine. Modern emergency medicine residencies include rigorous and extensive training in POCUS with graduates performing a wide array of POCUS skills to diagnosis and treat their patients.

Some emergency physicians choose to pursue ultrasound training beyond that required during residency, by completing an emergency ultrasound fellowship. During one or two year fellowships, these physicians become experts in advanced ultrasound modalities and ultrasound education. The presence of ultrasound fellowship trained faculty at residency sites correlates with a higher number of faculty credentialed to perform ultrasound and may assist with quality assurance for ultrasound performed in the ED.² Fellowship trained emergency physicians also continue to develop new ways to improve the use of POCUS and to study best practices for use on shift.

The Society for Clinical Ultrasound Fellowships (SCUF) currently lists 50 fellowships, though this list is not exhaustive, and does not include the military programs. Until recently, there has been no established way to recognize physicians who choose to pursue this extra training or to credential these fellowships. While some have chosen to pursue recognition through the exams offered by the American Registry for Diagnostic Medical Sonography or other similar organizations, these exams were not developed by emergency physicians and do not reflect the use of POCUS in the emergency department. As noted by Dr. Gibbons in the

May/June 2019 edition of *Common Sense*, emergency physicians do not need these merit badges to legitimize our training.³

Following an extended debate and vote, members of these fellowships and ultrasound societies nationwide felt that attempting to establish a subspecialty board could have unintended consequences for the practice of POCUS by those who did not choose to pursue a fellowship. The alternative chosen was a "Focused Practice Designation (FPD)."

The FPD, which is approved by the American Board of Medical Specialties, "recognizes physicians who devote a substantial portion of their practice to a specific area of a specialty."⁴ This will hope to recognize emergency physicians with expertise in emergency ultrasound beyond the requirements for ABEM certification. It will be a recognition developed by emergency physicians which will be specific to the requirements of our specialty. There will be three pathways to obtain this designation, the fellowship training pathway, the training-plus-practice, and the practice-only pathway.⁵

In the fellowship training pathway, physicians will complete an Advanced Emergency Medicine Ultrasound (AEMUS) fellowship accredited by the Emergency Ultrasound Fellowship Accreditation Council (EUFAC). The Society of Clinical Ultrasound Fellowships (SCUF) will be charged with the creation of this council. For those who do not know, the current SCUF website helps potential fellows compare various ultrasound fellowships and complete fellowship applications. In the future, the EUFAC will release regulations to obtain fellowship accreditation and a curriculum for the fellows. The curriculum will expand on the basic emergency medicine ultrasound knowledge by including advanced measurements and views. Although the curriculum has not been released yet, potential topics may include muscular tendon assessment, arterial doppler assessment or even cardiac diastology. The curriculum will most likely also cover administrative topics such as billing and workflow solutions.



Fellowship trained emergency physicians also continue to develop new ways to improve the use of POCUS and to study best practices for use on shift.

EMERGENCY ULTRASOUND

In the training-plus-practice pathway, physicians must complete an acceptable non-EUFAC accredited fellowship. This pathway will most likely be for recent emergency ultrasound fellows who graduated prior to the date of the first accredited fellowship. The physician must also demonstrate 24 months of AEMUS practice including performing or supervising 300 studies per year and reviewing for quality assurance 500 studies per year. This pathway will only be available to physicians for five years from the date of the first EUFAC-accredited AEMUS fellowship. Those who are considering applying for this pathway, may wish to start logging ultrasound scans and QA'ed studies.

In the practice-only pathway, physicians must demonstrate 36 months of AEMUS practice with 300 performed or supervised studies and 500 reviewed studies. In addition, physicians will have to demonstrate additional knowledge in the area by prior work in leadership administration, publications, or teaching. This pathway will most likely be for more senior faculty that continue to have a strong interest in ultrasound. And just as in the training-plus-practice pathway, this will only be available to physicians for five years from the date of the first EUFAC-accredited AEMUS fellowship.

Physicians who meet the eligibility criteria will also need an appropriate verifier who can confirm the physician has the hand-eye-motor coordination to perform ultrasound tasks. Finally, physicians will be able to take a multiple-choice examination to gain FPD. The first exam is scheduled to be offered in 2022.

Through these pathways, emergency physicians who devoted significant time and attention to practicing point-of-care ultrasound will be able to obtain recognition of their expertise. This exciting development will likely continue to evolve over the next few years as ultrasound societies nationwide work together to develop the exam and fellowship credentialing guidelines. To keep updated on the progress of the AEMUS FPD check out the SCUF website at eusfellowships.com and don't forget to check out EUS-AAEM newsletter, the *POCUS Report*. ●

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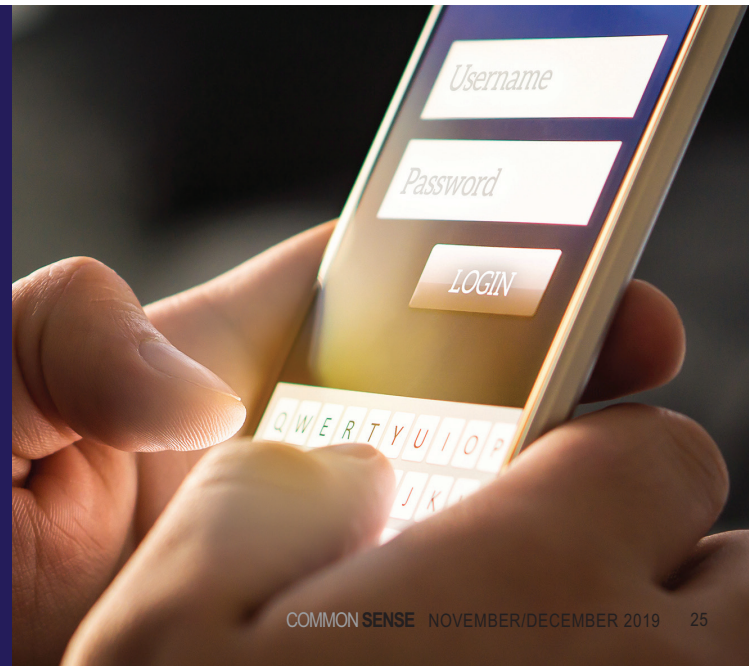
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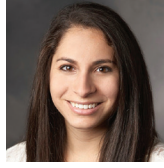
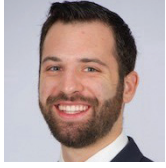
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The Empathy Emergency

Danielle Goodrich, MD FAAEM and Reed B. Wise



After waiting a number of hours to be seen in the Emergency Department, a patient is brought into a treatment area. Filled with anxiety over what could be wrong with

them, fearful about the potential ramifications of illness, and filled with uncertainty about the costs and time that could be lost, the patient jolts up as you walk into the room. At this moment, you – a busy physician with many other patients to see – must set the tone of the visit and the relationship you will have with the patient.

You can remain standing, or you can take a seat and show the patient you are present and engaged. You can develop good eye contact, or you can avoid the patient's nonverbal cues.

You might cut the patient off while talking to save time, or you can engage in a partnership with the patient, asking their thoughts on your current theory, opening up honest communication and showing a genuine interest in creating a comfortable environment for patient to be treated.

It may seem obvious that these empathetic approaches will lead to better outcomes, however in the fast-paced emergency department environment, empathy is often abandoned for the sake of efficiency. It cannot be

overstated that *empathy is a vital aspect of our care we provide our patients.*

Even more than making the patient feel more comfortable, research suggests that the effects of empathy are far reaching for both the patient and the physician. In a literature review by Derksen et al, seven separate studies found that effective physician empathy improves patient

satisfaction, and adherence to treatment plans, decreases anxiety and distress, leads to better diagnostic and clinical outcomes, and creates a higher level of patient enablement.¹ One such study found a positive relationship between diabetic patients' perceived level of empathy by the physician and those patients' improved A1c levels and LDL levels.² The study suggests that effective empathy in the physician-patient relationship increases trust and mutual-understanding that leads to increased diagnostic accuracy and more focused treatment plans.

In addition, patients are not the only ones to benefit from the improved doctor-patient relationship. Research shows that increased empathy in patient interactions is associated with fewer mistakes by physicians,

fewer occurrences of malpractice, and increased patient satisfaction. Not to mention that we benefit on an emotional level; recent studies have shown that by taking the time to connect on a deeper level with our patients, we can provide meaning to our jobs, increase professional satisfaction, and reduce burn out.³

It is clear that empathy is important for both the patient and physician, but what exactly is empathy and how does someone practice it? Empathy can be de-

scribed in many different ways, but most simply, empathy is the capacity to place oneself in another's position. However, empathy, especially in medicine, is more complex. In 1992, *Morse et al* divided empathy into four distinct components, breaking empathy up into a set of skills rather than an innate abstract trait or just an emotional experience.⁴ The components include the emotive, moral, cognitive, and behavioral aspects that together make up an empathetic professional interaction.

The emotive component is the ability to subjectively experience another's feelings, while the cognitive component addresses the provider's intellectual skills to identify and understand others' feelings, perspectives, beliefs, and experiences. Moreover, the moral component is the underlying force that motivates the provider to empathize and engender altruism for the benefit of optimal patient care.

Finally, this definition of empathy is incomplete without the most important component, the behavioral component, defined by the ability to communicate your understanding of others' feelings. Where we as providers can do a better job serving our patients is this final concept, the communication of empathy to our patients.

One of the most effective ways to convey empathy to your patients and to develop a therapeutic relationship is through active communication. Start early in the visit by thanking your patient for their patience if there has been a long wait.⁵ Nonverbal cues such as sitting down and developing good eye contact have been proven to increase the patient's perception of the time the physician spent talking with them. In essence, displaying full attentiveness and genuine interest will facilitate your patients to talk more openly.⁶

It cannot be overstated that
**EMPATHY IS A VITAL ASPECT OF
OUR CARE WE PROVIDE OUR
PATIENTS.**



YOUNG PHYSICIANS
SECTION NEWS

To convey empathy, “affiliative behavior” (nodding and showing genuine interest) is proven to be far more effective than “controlling behavior” (ordering lifestyle changes or interrupting the patient).⁵ The American Medical Association highlights that active listening and affiliative behavior is the best way to engage the patient in a more collaborative conversation. Try using phrases like “tell me more,” “what do you think about,” and “what is important to you,” to encourage the patient to be forthcoming and expansive.

Remember, physician empathy is not an innate trait. It’s a practiced skill. Just as we spend years refining and perfecting our techniques,

One of the most effective ways to convey empathy to your patients and to develop a therapeutic relationship is through **ACTIVE COMMUNICATION.**

effectively conveying empathy to our patients takes time and a great deal of practice. When you arrive at your next shift, take a seat next to your patient, put your past cases out of your mind, engage the patient to be a part of the process, and take the first step toward improving the patient-provider relationship. ●

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Who is in Control of Our Specialty? Hint: It's not the President of ACEP or AAEM

The AAEM Resident and Student Association

Most of you who are reading this are here because you live, breathe, and bleed emergency medicine. EM offers the perfect mix of medicine, procedures, and adrenaline. Unfortunately, not all parties involved do it for the love of emergency medicine. While EM may be one of the youngest specialties, its short history is rife with conflict pitting hospitals against emergency medicine physicians in the form of lay entities incorporated to manage emergency departments even though there are statutes against this practice in many states, and some even run residency programs.¹ A lay entity means that a non-physician owns and operates the emergency department. For an excellent history lesson as told by James Keane, MD MPH FAAEM, the first president of AAEM, we highly suggest that every medical student and resident interested in EM read *The Rape of Emergency Medicine*.²

Although the book was published 25+ years ago, the threat of lay corporations fighting to take control of emergency departments away from EM docs is ongoing. One unfortunate route to controlling EM reimbursement is through graduate medical education. A growing number of emergency medicine residency programs and fellowships are operated by incorporated lay entities. According to state law in 38 states, lay entities are prohibited from owning or operating medical practices.³ State laws vary in restrictions, however, several state laws, including Texas and Florida directly prohibit corporations from employing physicians to provide medical services.³ When a lay entity signs a contract to staff an emergency department, that contract, in many cases, is a clear violation of the state statute. Unfortunately, many of the entities have utilized loopholes and lobbying to work around state law. Lay entities who manage emergency departments and residency programs can be found nationwide with at least 30 residency programs and many many more coming.

Furthermore, there has been a push from some lay corporations for family medicine



Most of you who are reading this are here because you
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practitioners to complete one-year EM fellowships. We believe that patients are best treated by emergency medicine board prepared and trained physicians, and not those who complete a one-year fellowship. There is a long history of filling emergency departments with non-EM trained physicians as outlined in Dr. Keane's book.

Another consideration regarding lay corporations managing emergency medicine departments is their ability to undercut emergency physicians by paying lower than fair market wages and often distributing excess fees for services rendered away from EM physicians.^{4,6} In some cases, as much as 22% of potential fees for service are being diverted from physicians. Essentially, one out of every four shifts, or every fourth hour as an attending working for one of these entities will be on the house.

Who do you want running your residency program?

AAEM/RSA urges all students to strongly consider where they apply. Applicants and residents should be well aware of their future and current employers and the motives that drive the program. We recommend that students applying to residency do their due diligence and consider their role in supporting lay entities whose mission to increase their profits at the cost of the individual physician, and most importantly at the cost of patient safety.

Corporate-owned programs exist in Florida, Georgia, Pennsylvania, Ohio, Michigan, West Virginia, Illinois, Nevada, Texas, and Oklahoma.

The official AAEM/RSA policy regarding corporate management groups running residency programs can be found here: <http://www.aaemrsa.org/about/position-statements/cmgs-running-residencies>. ●



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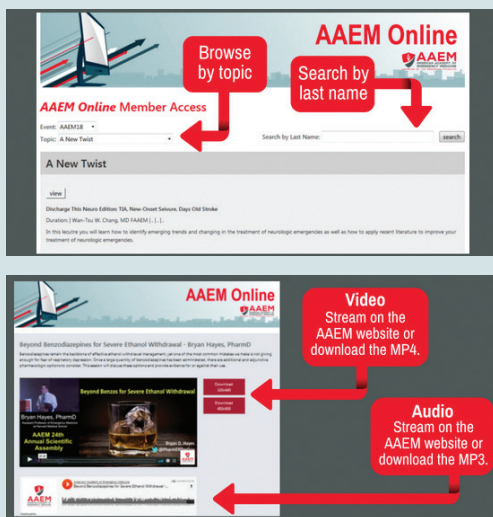


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Ways To Ace Residency

Adriana Coleska, MD — AAEM/RSA Board of Directors



My name is Adriana and I am one of the AAEM/RSA Board Members and your liaison to the Publications and Social Media Committee. As I transition into my role as the senior resident, I thought I would share with you a few tips that have helped me enjoy my time in residency and make the most out of the learning opportunities.

1. Save the numbers of all of your co-residents in your phone!

Your co-residents are your lifeline. You should always be able to count on them for advice, shift swaps, check-ins, and that occasional “sorry I’m running late” text. You don’t want to be fumbling around looking for numbers in a time of need.

2. Find a “failure buddy”

This is your person to share your deepest, darkest failures with. It’s the person you can talk to about the missed diagnosis, the hard intubation, the emotional toll of taking care of trauma patients. The failure buddy is the one you can safely talk to about anything that’s weighing on your mind to keep you moving forward, learning, and saving lives.

3. Talk to your family and your friends outside of residency

Our job is hard and we see and hear things that are not ordinary. Use your connections outside of the hospital to keep you grounded and understand how lucky you are to have the job you have, but also how unusual the challenges you face on a daily bases are.

4. Become best friends with your pharmacist

You don’t know struggle until you try to run a code without a pharmacist... Trust me, get to know them, asked them questions, you will not regret it.

5. Immerse yourself in the off-service rotations

I know that you didn’t go into EM to titrate a beta-blocker or write progress notes, but your off-service rotations are your chance to learn from the specialists. Ask them how they would deal with emergencies in their field and remember those pearls when you have that patient in your ED.

6. Make friends with your off-service coworkers, they will be your future consultants

Asking for a borderline admission is much easier when talking to a friend. Personalize your consults, be polite, and enjoy the social aspect of EM.



THE FAILURE BUDDY is the one you can safely talk to about anything that’s weighing on your mind to keep you moving forward, learning, and saving lives.

7. Engage your nursing and tech staff in the care of your patients

This collaborative approach allows for everyone to have skin in the game. The workup goes much smoother if everyone is on the same page. Talking the plan through can also help bridge gaps in the care and catch potential mistakes before they become a problem.

8. Bring snacks and drinks to your shift

Don’t become hangry, enough said.

9. Take wellness walks!!

Take 5 minutes during your shift to walk around the emergency department, say hi to your coworkers, check in on how their day is going, and stretch your legs. This lets you reset and remember that you signed up for this for a reason. Wellness walks have been a huge hit for our residency, try it in yours!

10. Finally, celebrate the victories, and learn from the mistakes.

I hope these pearls help you in your upcoming years in residency. ●

Diagnosis and Treatment of Cellulitis in the Emergency Department

Authors: Taylor M. Douglas, MD; Taylor Conrad, MD; Ted Segarra, MD; Rithvik Balakrishnan, MD; and Christianna Sim, MD MPH

Editors: Kelly Maurelus, MD FAAEM and Kami Hu, MD FAAEM

Skin and soft tissue infections (SSTIs) result in over two million visits to the emergency department (ED) every year. While this term encompasses infections ranging from erysipelas to necrotizing fasciitis, this article focuses on superficial cellulitis. Due to the lack of good data, there is no true consensus in the medical community regarding standard of care, i.e. whether intravenous (IV) antibiotics are required or what clinical presentations mandate admission. The Infectious Disease Society of America (IDSA) makes recommendations for treatment duration (five days), when to cover methicillin-resistant *Staphylococcus aureus* (MRSA) [penetrating wounds, intravenous drug use, systemic inflammatory response syndrome (SIRS), nasal colonization, evidence of other MRSA infection] and outpatient management (for those without SIRS, altered mental status, or hemodynamic instability).¹ Most of these guidelines, however, are based on retrospective studies. Studies in the surgical field have attempted to identify grading systems to help guide management without success.² Without consensus, emergency physicians are left with the following questions on how to best treat and disposition our patients with cellulitis to ensure their infection resolves.

1. What is the evidence behind treatment of cellulitis with IV antibiotics and which patients should receive them?
2. What risk factors have been identified to predict outpatient failure and the need for inpatient treatment of cellulitis?

Peterson D, McLeod S, Woolfrey K, McRae A. Predictors of failure of empiric outpatient antibiotic therapy in emergency department patients with uncomplicated cellulitis. *Acad Emerg Med.* 2014;21(5):526-31. doi: 10.1111/acem.12371.

Peterson et al. aimed to identify risk factors that predict failure of initial outpatient antibiotic therapy in patients presenting to the ED with uncomplicated cellulitis. They performed a prospective cohort study conducted at two academic tertiary care center EDs in London, Ontario over an 18-month period, including adults 18 years or older who were diagnosed with cellulitis in the ED. They designed a multivariate, logistic regression model including variables based on the known epidemiology of cellulitis as well as the hypothesized relationship between potential risk factors and treatment failure. Exclusion criteria included hospital admission, current or recent treatment for cellulitis prior to ED presentation, and abscess without concomitant cellulitis. The primary outcome – treatment failure – was defined as a required change in antibiotic therapy or subsequent hospitalization for cellulitis within two weeks after initial presentation.

The study enrolled 598 patients; 52 were excluded and 49 were lost to follow-up. Of the 497 included in the final analysis, 102 (20.5%) had treatment failure but only 21.6% of these required subsequent hospitalization. Failure rates were similar in those treated with oral (38.2%, 95%

CI 29.4-47.9%) and IV (40.2%, 95% CI 31.2-49.9%) antibiotics, but lower in those who had received both (21.6%, 95% CI 14.7-30.5%). Five covariates were identified as statistically significant predictors of failure of empiric outpatient antibiotic therapy:

1. fever at triage >38°C (odds ratio [OR] 4.3, 95% CI = 1.6-11.7)
2. chronic leg ulcers (OR 2.5, 95% CI = 1.1-5.2)
3. chronic edema or lymphedema (OR 2.5, 95% CI = 1.5-4.2)
4. prior cellulitis in same area (OR 2.1, 95% CI = 1.3-3.5)
5. cellulitis at a wound site (OR 1.9, 95% CI = 1.2-3.0)

Covariates included in the study found NOT to have a significant association with treatment failure were heart rate at triage > 90 beats/min, diabetes mellitus, smoking and obesity.

Abetz JW, Adams NG, Mitra B. Skin and soft tissue infection management failure in the emergency department observation unit: a systematic review. *Emerg Med J.* 2018;35(1):56-61. doi: 10.1136/emmermed-2016-205950.

The past twenty years have seen a dramatic rise in the number of observation or short-stay units designated for patients who are not necessarily sick enough to require inpatient admission but will require fewer than 24 or 48 hours of observation and management prior to discharge. SSTIs are one of the common diagnoses that warrant placement in an ED observation unit (EDOU). Abetz et al. conducted a systematic review to quantify the rate of and identify patient risk factors for management failure.

The authors searched for manuscripts using the outcome of management failure (inpatient admission, stay >28 hours, or death). Studies were excluded if patients were observed on an outpatient basis, if management failure was defined as ED revisits or re-presentation, or if the studies did not differentiate between SSTIs and other conditions in the observation unit. All of the studies that met eligibility criteria reported management failure rates (15%-38%) higher than generally accepted ED OU failure rates (15%), with higher failure rates in the later studies than in the earlier studies. The most commonly identified risk factors for treatment failure in the separate studies were MRSA infection (OR 4.2, 95% CI 1.4-12.3) or exposure (OR 1.9, 95% CI 1.1-3.4), subjective fever (OR 3.02, 95% CI 1.41-6.43), history of fever (OR 2.3, 95% CI 1.7-3.1), or measured fever with temperature >38°C (OR 2.5, 95% CI 1.1-5.5, and WBC count >15,000 (OR 4.06, 95% CI 1.53-10.74).

Limitations of the study include the fact that only one study reported outcome blinding, and the vast majority of the patient population (206,000 patients) came from a single study by Venkatesh et al. The overall level of evidence was low; three of the 10 studies were rated as NHMRC (National Health and Medical Research Council) evidence Level II, and

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the remaining seven were Level III-C (including the Venkatesh study) or lower. Only two of the ten studies commented on culture-positive MRSA infection, three on the number of purulent SSTIs, three on SSTI anatomic location, and one on antibiotic choice. This contributed to the marked inter-study heterogeneity ($I^2 = 93.9\%$, $p < 0.01$) which, combined with the low levels of evidence among the identified studies, limits any definitive conclusions that can be taken from the analysis.

Aboltins CA, Hutchinson AF, Sinnappu RN, et al. Oral versus parenteral antimicrobials for the treatment of cellulitis: a randomized non-inferiority trial. *J Antimicrob Chemother.* 2015;70(2):581-6.

While some institutions have outpatient IV infusion clinics, these are not common; a big decision point in determining the disposition for patients with cellulitis is the need for IV antibiotics. Perceived severity of disease is often a factor in the decision, along with patient comorbidities or the character of the SSTI, but no consensus exists on which patients are safe to discharge on oral antibiotics. A Cochrane study in 2010 confirmed that data was limited in this area.³

In this prospective, randomized, open-label, non-inferiority single center study out of Australia, patients with cellulitis who had been determined by treating providers to require IV antibiotic therapy were randomized to either IV cefazolin or oral cephalexin. The diagnosis of cellulitis was defined as characteristic skin findings present for < 5 days with pain, temperature $\geq 37.88^\circ\text{C}$, heart rate > 90 beats/min, systemic symptoms, or elevated inflammatory markers. Patients were excluded if the cellulitis was mild, if they had complicated or severe disease (bullous disease, severe sepsis, presence of abscesses, necrotizing fasciitis), or if it was associated with trauma, patient immunosuppression, or was periorbital. Patients who had already received antibiotics prior to randomization were included if oral therapy was < 48 hours or IV therapy was < 12 hours. If a patient was allergic to penicillin, clindamycin was used instead. The primary outcome was the duration of time until no advancement of the area of cellulitis, at which point patients on IV therapy were transitioned to oral. Secondary outcomes included failure of treatment (defined as requiring a change in or prolonged course of antibiotics, readmission to the hospital, or abscess drainage), pain, complications, and patient satisfaction.

Of the 47 patients enrolled, one patient in the parenteral treatment arm was lost to follow-up and one patient in the oral arm received clindamycin due to development of a rash. There was no statistically significant difference between IV and oral therapy the primary outcome, suggesting oral treatment was non-inferior to parental therapy. A large portion of patients (43%) had received antibiotic therapy prior to enrollment, but seeing as the cutoff was 48 hours, this likely represents a different cohort than those who received antibiotics prior to ED presentation. The inclusion of patients with signs of systemic illness who were slated to receive IV therapy is a strength of this study. Major weaknesses of this study are its very small size and that the primary outcome was non-progression of disease, rather than treatment failure, which is arguably more important to providers in decision-making. Interestingly, although the study was not

powered for treatment failure, it trended towards favoring oral therapy. Lastly, the authors note in the discussion that their community does not have a high rate of community-acquired MRSA, which may affect overall generalizability as many communities in the U.S. do have a high prevalence of MRSA. This study emphasizes the need for larger validation studies that can help guide the use of oral antibiotics for cellulitis, even in those with signs of systemic disease, but does suggest that many patients likely can be safely treated with oral therapy.

Yarbrough PM, Kukhareva PV, Spivak ES, et al. Evidence-based care pathway for cellulitis improves process, clinical, and cost outcomes. *J Hosp Med.* 2015;10(12):780-6. doi: 10.1002/jhm.2433. Epub 2015 Jul 28.

In order to address the wide variation in antibiotic choices for cellulitis and overuse of broad-spectrum antibiotics and advanced imaging, Yarbrough et al. designed and implemented an EMR-based care pathway for the management of cellulitis with the goal of improving clinical, logistical, and economic outcomes.

The pathway (shown below) was primarily based on guidelines from the IDSA for the management of SSTIs and infections caused by MRSA. It focuses heavily on antibiotic selection, indications for obtaining blood cultures and advanced imaging, and frequently overlooked patient care principles (i.e. elevation of the affected limb). Similar to the 2014 IDSA updates, the pathway made clear distinctions between purulent and non-purulent cellulitis in an attempt to distinguish between staphylococcal and streptococcal infections. It additionally excluded patients with more complicated infections, including those with neutropenia, osteomyelitis, diabetic foot ulcerations, cellulitis of the hand, perineum, or periorbital region, surgical site infections, and human or animal bites. Use of the pathway was not mandatory, but all providers were repeatedly educated regarding the pathophysiology and management of cellulitis, the IDSA guidelines, and the availability of the pathway order set.

The authors designed a single-center, retrospective, observational, pre/post-intervention study at a 500-bed academic center in Salt Lake City, Utah. They included all patients over the age of 18 who were either admitted or placed on observation with a diagnosis of cellulitis over a 2½ year period. Exclusion criteria were discharge from the ED and diagnosis other than cellulitis. The primary outcome was use of a broad spectrum antibiotic (vancomycin, piperacillin/tazobactam, or meropenem). Secondary outcomes included computed tomography (CT) or magnetic resonance imaging (MRI) use, length of stay (LOS), 30-day readmission (excluding visits for diagnoses other than SSTI), and pharmacy, lab, imaging, and total facility costs. A total of 677 visits met inclusion criteria, of which 370 (54.6%) employed the use of the order sets and 307 (45.3%) did not.

The authors noted a significant hospital-wide decrease in the odds of ordering broad spectrum antibiotics (59% decrease, $P < 0.001$) and decrease in pharmacy costs (23% decrease, $P = 0.002$). Overall total facility costs were also significantly decreased (13% decrease, $P = 0.006$), but this decrease was actually driven by the non-intervention group (in which order sets were not used), rather than by the intervention group.



In the subpopulation of patients in whom the order sets were employed, the authors noted

statistically significant reductions in the odds of using broad spectrum antibiotics (75% decrease, $P < 0.001$), pharmacy costs (25% decrease, $P = 0.074$), and clinical LOS (13% decrease, $P = 0.041$). However, the absolute differences in LOS were minimal and had notable overlap between groups (2.0 +/- 2.1 days vs 1.7 +/- 1.6 days). Results were similar between those patients who were admitted and those placed on observation.

The authors concluded that implementing a care pathway along with education, pathway-compliant electronic order sets, and audit and feedback can reduce costs and improve the quality of care, without increasing readmission rates. They further hypothesized that the reduction in broad spectrum antibiotic use could potentially reduce rates of *Clostridium difficile*, but admit that this outcome was not studied in their analysis. Nevertheless, the paper has several limitations in addition to those typically found in retrospective, observational studies. Most notably, there was an ongoing parallel trial during the post-intervention period aimed at reducing laboratory use, and this important confounder unfortunately invalidates any pre-/post-intervention laboratory use comparisons, and likely invalidates the pre-post/intervention total facility costs comparison as well. Overall, this was a fairly well-designed retrospective study, and demonstrates a role for care-pathways to reduce broad spectrum antibiotic use, but its broader applicability and clinical implications are limited by its inherent flaws and confounders.

Conclusion

The studies highlighted above demonstrate the need for further research into the management and disposition of patients with cellulitis. Based on the current guidelines as well as the designs and results of the reviewed studies, consideration of patient-based risk factors such as chronic skin conditions and comorbidities should factor into the treatment of SSTIs. Interestingly, most papers reported cefazolin and ceftriaxone (IV) and cephalexin (PO) as the most common antibiotics used, with clindamycin

as a second line agent in patients with allergies. The use of antibiotics that cover MRSA should be made based on local prevalence and susceptibility trends, but are likely unnecessary in simple non-purulent cellulitis. Regardless of treatment choice, the IDSA recommends reassessment for treatment failure 48 to 72 hours after initiating treatment¹, so close primary care or consideration of scheduled ED follow-up may play a role in outpatient management.

Now we return to the questions posed in the introduction:

1. *What is the evidence behind treatment of cellulitis with IV antibiotics and which patients should receive them?*

There is no clear evidence indicating which patients should receive IV antibiotics, however even patients demonstrating systemic symptoms may do well with oral therapy.

2. *What risk factors have been identified to predict outpatient failure and the need for inpatient treatment of cellulitis?*

Predictors of failed outpatient therapy include fever at triage, chronic leg ulcers, edema or lymphedema, prior cellulitis at the same site, and cellulitis at a wound site, while fever, MRSA infection or exposure, and leukocytosis $> 15,000$ are the most commonly identified factors predicting treatment failure in ED observation units. ●

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2020-2021 AAEM/RSA Board of Directors Elections

AND

2020-2021 Medical Student Council Nominations

Nominations: **November 1, 2019-December 1, 2019**
Elections: **December 15, 2019-January 15, 2020**

Competitiveness in Emergency Medicine

David Fine — Medical Student Council President



I was recently discussing emergency medicine with a surgical resident who said, “Oh! Emergency, I hear that’s getting much more competitive.” This conversation has really stuck with me, so I wanted to take this opportunity to look at this information objectively rather than rumors and word of mouth.

With sources such as the National Resident Matching Program (NRMP) match statistics we can see if there is truth to the perception.¹⁻⁴

	Positions Offered	Matched US Seniors	US Senior Applicants
2019	2488	1617	1823
2017	2047	1601	1845
2015	1821	1438	1613
2010	1556	1182	1340

These statistics show that it is true that there has been an increase in the number of US emergency medicine applicants over the past decade. That being said, the number of positions offered has vastly increased. Even if we only look at the number of matched US seniors we can see that there have been 435 positions added in less than a decade.

This small snapshot of US positions is an incomplete picture. One reason is that the 2020 application cycle brings a DO-MD merger, and the table above does not discuss the additional 648 osteopathic positions. Another reason is that even combining these two groups does not account for the total number of positions available. Lastly, we should be asking where these new programs are coming from.

There has been a rise in corporation-run residency programs. The Accreditation Council for Graduate Medical Education (ACGME) must accredit all residency programs, which ensures the quality of residency training. Despite this, a 2012 *Common Sense* article by Dr. Howard Blumstein discusses the potential drawbacks of these programs including working conditions and fairness of resident expectations.⁵ What this means to medical students is that you should undoubtedly do your research on the programs that you apply to and understand the pros and cons of the environment you will be training in.

My goal with this article is not to bring a fresh take to the raw data, but rather to reduce some students’ anxiety about the process. Hopefully, this expands your understanding of the data, the context, and the environment that students will be applying to in just a few short weeks. These are certainly exciting times for those interested in emergency medicine. ●

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What this means to medical students is that you should **UNDOUBTEDLY DO YOUR RESEARCH** on the programs that you apply to and understand the pros and cons of the environment you will be training in.



An Approach to Vulnerable Populations in Medical Education

Miriam Asher; Cortlyn Brown, MD; and Faith Quenzer, DO



It was in my second year of medical school and I was sitting in a room with nine of my classmates and a physician during our case-based learning class. The case presented

that day was of a young man with a sore throat and fever. He recently returned from a business trip to South America and was in a committed, exclusive relationship with his boyfriend.

After reading the opening statement about the patient, we began the usual task of developing differential diagnosis. Infections, of course, were a significant subsection of our differential list. These question stems of theoretical patients are designed to lead us in a certain direction unlike

However, I do not need to use my imagination to discover whether HIV would take such a prominent place on our differential list if we did not know about this patient's sexuality. HIV is only mentioned as a differential for patients who are men who have sex with men, regardless of their relationship status, and in sex workers and IV drug users. If the patient presented above was in a committed relationship with a woman, everything else being equal, likely no one in our group would have even mentioned HIV.

Let us break down the assumptions we are taught to make in medicine. First, men who have sex with men have sex with many men, even if this



Let us **BREAK DOWN THE ASSUMPTIONS** we are taught to make in medicine.

means cheating on their partner. Second, men who have sex with men regularly have unprotected sex regardless of what they claim. Finally, any sex between two men has a high chance of spreading HIV.

The first two assumptions are blatantly homophobic, though they are defended in the

medical community by saying that we never actually believe any patients are telling the truth about their sexual activity. The pros and cons of this undercurrent of distrust in medicine are debatable and not the topic of this piece. The ways in which this distrust is applied to different populations, especially vulnerable populations, is the bigger issue here.

The final assumption is largely inaccurate. According to the Centers for Disease Control and Prevention (CDC), the riskiest thing one can do to contract HIV is to receive a blood transfusion contaminated by the virus, with a greater than 90% chance of transmission.¹ Comparably, everything else the CDC has listed as "risky behavior" for contracting HIV is unlikely to happen. Receptive anal intercourse has the highest likelihood of the remaining behaviors at 138 per 10,000 exposures, or about a 1.4% chance per sexual encounter without protection with an HIV positive partner.¹ This is likely the statistic people will point to as proof that men who have sex with men are more likely to contract HIV. This argument ignores the simple and unavoidable fact that men who have sex with men do not

real patients who present with both relevant and irrelevant details. To the average medical student studying their "high-yield medical pearls," the most obvious primary differential in a young man who has sex with men is Human Immunodeficiency Virus (HIV). Even if the patient is not sick at all, we are taught to suspect HIV because we are supposed to assume that men who have sex with men have sex with multiple partners (regardless of their relationship status) and do not practice safe sex.

Now some may protest at this point. They may point out that the prevalence of HIV in this population is high, so it is reasonable for HIV to be at the top of our differential diagnosis. They might stress that we are taught to have a healthy level of suspicion with all patients, especially when it comes to stigmatized behaviors like sexual intercourse, drug use, and so on. They might insist that providing the best care for our patients includes not ignoring the possibility of a disease just because it might offend the patient.

And I agree, these are all valid points.



The ways in which this **DISTRUST IS APPLIED** to different populations, especially vulnerable populations, is the bigger issue here.

exclusively engage in and are not the only people who engage in anal sex. Furthermore, a 1% chance that something will happen is less of a guarantee and more of a minor risk that can and should be mitigated, but not condemned.

Generalizations like these about our patients are taught in our classes, tested on in our exams, and often modeled in our clinical experiences. To the credit of my medical school, who wrote this particular case, the patient ended up having mononucleosis, not HIV. The written case made a point of explaining that we should never assume HIV in a man who has sex with men. On the other hand, this case came after two prior example cases of men who cheated on their wives with men while on overseas business trips and now needed HIV testing. In a way, then, our biases and assumptions were reinforced rather than countered.

Our medical education is littered with contradictions such as this. The ethicists tell us one thing while our mentors and future colleagues show us something different. Which of these discrepancies we encounter and how we navigate them shape what kinds of doctors we will become. Will our practice be driven by norms, which are based on generalizations of statistics most people hardly understand? Or will we rise above these norms, maintaining strict ethical integrity, but creating friction in our workplace and possibly endangering our careers? It is a difficult line to walk

and the way we traverse it has significant, and possibly severe, implications for ourselves, our colleagues, and our patients.

It is an ambitious task to address this discordance in medicine as it is embedded in the very heart of our medical culture. One way to begin shifting cultural norms is to start with the newest members of the group, students. The case presented to us on that day attempted to defy one of the concerning assumptions the medical community tends to make regarding an underprivileged population. However, its well-intentioned point was overshadowed by the rest of the curriculum which drove home the very assumptions it was trying to contradict. A more targeted overhaul of medical education is required, and it must include our textbooks, our standardized tests, and our teachers. Though complex and daunting, this effort is worth the price for more open-minded medical professionals who practice better, safer medicine. ●

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