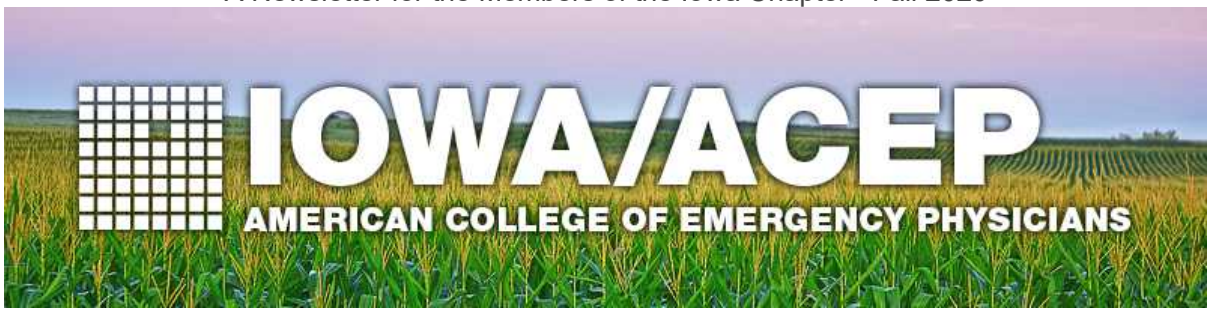
A Newsletter for the Members of the Iowa Chapter - Fall 2020

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**President**

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## In this Edition



## Medical Student Corner



## News from ACEP



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## President's Message
## A New Way to Council

Iowa ACEP Members,

This year continues to bring on the challenges, and the 2020 ACEP Council Meeting was no exception.

For the first time, the Council and all 400+ members, met virtually. Iowa was allotted three councilors, which is based on membership numbers. Drs. Kelly Douglas, Rachael Sokol, and I logged on to 16+ hours of virtual meetings. It was definitely different.

Resolutions were submitted ahead of time, as is typical, and this year testimony was asynchronous. There were SO MANY emails prior to, during, and following the two-day council meeting that I long since lost count. Resolutions were sent to Reference Committees, and then to the Council floor for debate.


Your Council voted to increase use of and access to telehealth, protect transparency in billing and coding, and continue to support EP's during the current pandemic. There was much discussion on CMG's and residency expansion. We discussed the use of the term "Resident" as well as physician-led care.

I would be amiss not to also mention the significant discussion regarding political issues and perceived political stance resolutions. This year more than I can ever recall (I have been a Councillor for many years), the tensions were high both via virtual debate and massive emails. Many resolutions were sent to the Board for further discussion prior to action; however, some were passed purely as "stance" type positions that have no "teeth" and cannot be enforced.

An easy example – Resolution 47 – Honoring Employment Contracts for Graduating Emergency Medicine Residents. It was Resolved that ACEP encourage employers to honor their contracts. I am speaking for myself only - of course ACEP should "encourage" contracts to be honored – but contracts are a legal vessel and we all should be aware of what we are signing. It is a pandemic, and many positions were terminated or postponed. This concept is not new, the massive number of residents that were affected at the same time is what is new. Having a resolution to encourage a continued employment relationship simply does not make sense to me and bogs us down in paperwork, needless discussion, and takes time that could spent elsewhere. Again, I am speaking only for myself in this position.

On the other hand, I am very happy that people are involved and active and passionate. A difference cannot be made without physicians willing to put forth the effort and LEAD. I write this on November 3rd, Election Day. I have always believed that people should not be allowed to complain about issues they are not willing to help resolve. I hope you all have voted. We need physician leaders. We need advocacy. Please also donate to NEMPAC. It does make a difference.

Finally, mark your calendars for February 16, 2021 for the Iowa Physician on the Hill Day in Des Moines. COVID pending of course, plan to make your voice heard and your face seen to those who are making decisions for us on the Iowa Hill.

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## Resident Corner
## Hyperbaric Season
## Brooke A. Dugdale, MD

In Minnesota, where I am from, the hyperbaric chamber had a seasonality to its life. There was the occasional summer scuba dive gone wrong and vascular issues run through the year, but by and large it is a winter affair. As fishermen drift to their ice houses and furnaces run for the first time each fall, carbon monoxide poisoning becomes a more frequent diagnosis. Unfortunately, hyperbaric season started a bit early this year in southeast Iowa, which turned to generator power in mid to late August, after the Derecho storm knocked out electricity for weeks.

One sunny August morning, CO poisoning from a generator used indoors brought in multiple patients by ambulance to our local ED. The patients had slept through the night but awoke in a state of confusion. There were complaints of severe headaches and difficulty moving the upper and lower extremities. Some patients were found particularly difficult to awaken and "limp" per by-standers. EMS found one patient was mumbling only a few words and two had been incontinent of urine. There were degrees in those affected, as some had difficulty moving, while others ambulated, moving outdoors without difficulty. CO levels were measured at 500ppm in the residential structure.

The patients were immediately treated with 100% FiO2 via non-breather facemask and cleared appropriately in the emergency department, but the case brought us to a rather nebulous area of medicine. I read several articles on CO poisoning and indications for treatment, gleaning the following:

- The elimination half-life of CO with normobaric 100% O2 is 74 minutes vs. 320 minutes on room air, so a 30% CO level could drop to about 10% in two hours of treatment (as was observed with these patients), but…
- Treatment with hyperbaric oxygen (HBO) is mostly to ameliorate long-term neurologic symptoms including impaired memory, cognitive dysfunction, depression, anxiety, and vestibular/motor deficits.
- Treatment with HBO should be considered if patient has LOC, neurologic deficits, metabolic acidosis (pH< 7.2 has significant mortality) or CO level greater than 25%.-Weaver et al (2002) did show significant improvement in long-term neurologic/cognitive symptoms following HBO treatment versus not (46% vs 25%).
- Significant cardiac injury can result from CO poisoning as well. About 1/3 have significant cardiac dysfunction and ~50% show left ventricular reduced functioning.
- CO mechanism of injury is binding of intracellular proteins, lipid peroxidation, free radical generation and mitochondrial oxidative stress.

We did consult with hyperbaric medicine at the University of Iowa and it was recommended that the patients be transferred for a series of treatments in the hyperbaric chamber over the next 24 hours to allay possible delayed neurologic sequelae of CO poisoning. This was due to the neurologic deficits reported by EMS and initial levels over 25.

**Sources**

1. Rose, J.J, Wang, L., Xu, Q. et al. “Carbon Monoxide Poisoning: Pathogenesis, Management, and Future Directions of Therapy.” Am J of Respiratory and Critical Care Medicine. Vol 195: 5. March 2017.
2. Hampson, N.B, Plantadosi, C.A, Thom, S.R. and Weaver, L.K. “Practice Recommendations in the Diagnosis, Management, and Prevention of Carbon Monoxide Poisoning.” Am J Respir Crit Care Med. Vol 186, Iss. 11, Dec 2012.
3. Weaver, L.K. “Carbon Monoxide Poisoning.” New England Journal of Medicine. 2009.

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## Medical Student Corner
## The Clashes of Medical Education against a Pandemic
## Kierstyn Sandwell, OMS-III

Beginning my clinical education was not as smooth as I and three of my fellow classmates had intended. Three weeks before our official first day of third year, the hospital we were supposed to rotate at for the year denied students from rotating entirely, without explanation. As you can imagine, three of us had already moved across Iowa for our rotation site. Fortunately, I had procrastinated signing a lease due to studying for boards and avoided that financial mess. At that moment it became possible my clinical year would be replaced with online education, however, our clinical coordinators were hopeful that we could string together new sites. My greatest fear was sacrificing my training for online simulations, which is what some of my classmates have been forced to do. Again, I was fortunate enough that it took only a week for the school to land me rotations where I could begin on time. Now fast forward to September, less than two months later, and I have all my rotations scheduled. My schedule is not faultless—most of my rotations are outpatient, and the pandemic has prevented me from experiencing emergency medicine this year. Considering the challenges of a pandemic, the gratitude I have for physicians jumping to assist students like me is immeasurable.

There are several other students in similar or worse situations that will undoubtedly impact their skills as future providers. More specifically, a classmate of mine drove an hour every day for a psychiatric rotation that was entirely telemedicine. Even more frustrating, their interaction with their preceptor was limited to communicating through the telemedicine appointments or email. It may be a small step above online simulations, but mental illness will be found in any specialty and efficiently managing it will not be a skill acquired from a textbook or telemedicine.

Now for my first rotation in internal medicine, the outpatient clinics were unable to see ill patients with symptoms such as fever, dyspnea, or cough. Where does that leave the COPD or heart failure patients with acute or worsening chronic dyspnea? Are they supposed to lie when filling out the questionnaire before their appointment? Forms do not provide a box to explain nonspecific symptoms, let alone the ones that coincide with COVID-19. Physicians are strained in a position hoping their patients with serious chronic conditions are stable, yet if the patient’s status were to decline, then there is a question of where they can go to seek treatment or be evaluated. If they have dyspnea, then their PCP in the outpatient setting cannot see them and urgent care is not capable managing chronic cardiac or pulmonary diseases. The only option remaining is the emergency department, which can stabilize and work up a patient’s complaint, but they also are not the providers to manage long-term diseases. Whether or not patients have COVID-19, they are being left behind to have their disease managed by emergency providers because clinics only allow “healthy” patients to be seen. The decision to deny

unhealthy patients limits our education to routine wellness checks and eliminates our exposure to these common diseases when they become uncontrolled. Clearly, this leads to less opportunities for us to assess these patients and understand the approach to management as well.

Medical education during the COVID-19 pandemic has created numerous unprecedented challenges for students and future providers alike. Despite how quickly I was thrown a blank schedule, I am still hopeful that this year will be a valuable experience, even if I must miss out on emergency medicine for the time being. In the mix of “what ifs”, I believe it is guaranteed that online rotations will hold back our capability to create a physician-patient bond and understand how complex patient care can truly be. The pandemic has greatly affected my classmates and myself, now only time will tell which benefits we gain. We may use this pandemic to boost preventive medicine (washing hands, vaccines, etc.), become experts at developing telemedicine technology, or become greater advocates of public health. Regardless of the unforeseen and current obstacles, I trust that over time our education will normalize again, and this viral storm has given us beneficial lessons along the way.

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## Medical Student Corner
## Can students safely share opinions on politics and medicine while applying for residency?

**Destinee Soubannarath Gwee, MS4**
**University of Iowa Carver College of Medicine**

It is mid-November and 4th year medical students around the country are interviewing for residency positions. This year, unlike previous years, we are being interviewed over virtual platforms rather than traveling to program sites and meeting in person. Applicants are relying more heavily on program websites and social media accounts to build connections and form opinions to make decisions about where to apply this fall and ultimately how we will rank programs in the spring. I wrote an article for the Daily Iowan on this topic entitled “The Doctor Is In: Medical trainees view medicine as activism. Do programs?” Is it safe to assume programs are similarly using online interactions and personal social media accounts to form opinions on applicants? Given that we cannot interact in person, are programs paying more attention to applicant social media accounts compared to previous years? And if so, should students be more cautious when sharing opinions on politics and the practice of medicine?

In recent years, questions of science, humanity, and equity have become increasingly politicized. As a future healthcare provider, is it wrong for me to publicly share my opinions on these issues?

As a person with strong opinions on what is just and what is not, these are questions I ask myself daily. It is difficult to challenging authority and the status quo and not fear negative consequences. And what does challenging authority even mean? Just as there are varied views within the applicant pool, there must certainly be a range of views within residency admissions committees.

I have had friends and family ask whether I should consider sharing my views less frequently on social media. I know that these questions come from a place of love and concern. They want to make sure I do not sabotage my own chances of getting into residency. If one person on the admissions committee does not agree with my views, it is completely possible that this will impact where I end up on a program’s rank list.

On the other hand, as someone who believes strongly that medicine and politics cannot be separated, and who is actively searching for a program that will help me further develop skills to advocate for my patients and communities, do I really want to end up at a program that might have disqualified me based on my dedication to humanity and justice?

I know I am not the only medical student publicly voicing my opinions on social media. Do we need to be more careful about what we share? Medicine is not apolitical, has never been apolitical, and will never be apolitical. The way that we care for patients will always be shaped by politics. Over this past year we have seen how a government's response to a pandemic can impact the health of its people. As future physicians, why should it be controversial to share views on politics that will impact the health of our patients?

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PCSS Providers Clinical Support System

# *Emergency Medicine Medications for Addiction Treatment*

## Waiver Training Course

*Register for the updated EM-focused MAT Waiver Training required to apply to the Drug Enforcement Agency for a waiver to prescribe buprenorphine*

This is your chance to complete the updated Emergency Medicine Focused MAT training required to apply to the Drug Enforcement Agency for a waiver to prescribe buprenorphine.

This is one of three medications, (buprenorphine, naltrexone, and methadone), approved by the FDA for the treatment of Opioid Use Disorder. Research demonstrates that MAT is effective in the treatment of Opioid Use Disorders and can help some people sustain recovery.

**Earn a maximum of 8.0 *AMA PRA Category 1 Credits*™**

**8.0 CME**

**January 5, 2021**

**10:00AM-7:00PM CST**

**Virtual**

**Hosted by the Iowa Chapter of American College of Emergency Physicians**

**Register Here**

*Funding for this initiative was made possible (in part) by grant no. 5U79T1026556-03 from SAMHSA. The policies of the Department of Health and Human Services; nor does mention of trade names, views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official, commercial practices, or organizations imply endorsement by the U.S. Government*

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American College of Emergency Physicians, the Iowa Chapter of Emergency Physicians, and the Providers Clinical Support System. The American College of Emergency Physicians is accredited by the ACCME to provide continuing medical education for physicians.

The American College of Emergency Physicians designates this live activity for a maximum of 8.0 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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**New FACEP Designation!**

Congratulations to:

Kelly M. Douglas, MD, FACEP

See the *ACEP20* Awards Brochure here.

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## Welcome New Members!

A special welcome to the new members of the Iowa Chapter. We are excited to have you.

Agustin Aguilar, Jr, MD
Ankit Chopra
Annee Rempel
Ashley Borden, DO
Ashley Danielle Guinn, MD
Benjamin Michael Wilkinson
Cassandra Barbara Moylan
Cassandra Hardy
Clint Hawthorne, MD, FACEP
Connor Christian Fraser
Daniel John Ritter, MD
Danielle S Pohl
David L Junkins, MD
Derrick D Creighton, MD
Destinee Gwee
Douglas Augustin Hernandez
Emily Ann Willmann
Haley Maree Spector
Hannah Rose Porter
Holly Kristen Conger
Ivan Lazar
Jacob Joseph Dirkman
Jacob W Bennick
Jamie Lynn Miller
Katherine Plotzke
Kristina Judith Sousou
Lakshmi Karuparthy
Lauren Elizabeth Harter
Megan Pearl Horne
Michael J Foggia, III
Michael Russell Klemme, BS
Michael Slattery
Midhad Mrvoljak
Morgan Elizabeth McKinney
Nicholas James Lepa, DO
Omar Gaber Shaban
Samantha Powell
Sukhvir Singh, MD

You may wonder if you should get involved with Iowa ACEP or EMRA or at the national level? We encourage you to please get involved!

If you are unsure about how to get involved, feel free to contact the chapter directly.

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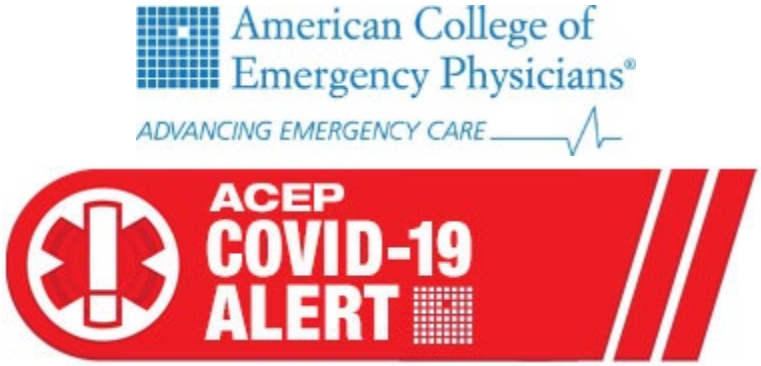
# FROM NATIONAL ACEP




ACEP continues to update its COVID resources regularly to reflect the latest information. Visit the COVID-19 Center for access to all COVID content, including the following most popular tools from the past few months:

COVID-19 Field Guide | COVID-19 Communication Hub (engagED Forum) | Wellness/Counseling | COVID-19 Severity Classification Tool | Elemeno/ACEP Tool | Literature Library | ACEP Statements on PPE & Other Physician Protections

**NEW Resource**: Monoclonal Antibody Toolkit

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## Federal Regulatory News

- Catch up on the latest federal regulatory news with Regs & Eggs. Latest blog post: The Holiday Gift-giving Season (of Regulations) is Here!
- On November 17, the FDA issued an Emergency Use Authorization to Lucira Health for its COVID-19 All-In-One Test Kit for prescription home use.
- On November 10 and 11, the Medicare Payment Advisory Commission (MedPAC) held a public meeting covering a variety of pertinent Medicare policy topics, including the advanced use of telehealth and access to care in rural areas.
- For more information on ACEP's recent advocacy efforts, watch the **Capital (30) Minutes video** from November 18. It looks at election results and what they mean for emergency medicine. Other topics include the latest legislative and regulatory updates, potential COVID-19 relief package and more.

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## Urge Your U.S. Senators to Take Action to Halt Impending Medicare Cuts

Negotiations continue in Congress on how to address the impending Medicare cuts that many physicians will face in 2021. Emergency physicians will face a 6% cut unless Congress acts. Although you may have already contacted your U.S. House member on this issue, your two U.S. Senators need to hear from you now about the importance of halting the cuts and the impact they would have on access for patients to emergency care. **Please click here to urge your U.S. Senators to take action that will ensure that any year-end legislation includes language to halt these harmful cuts.**

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## EMF Grant Available

The EMF/NIDA Mentor-Facilitated Training Award in Substance Use Disorders Science Dissemination Solicitation is due November 30, 2020. The purpose of the

award is to enhance a resident/trainee's knowledge of SUD treatment research and the dissemination and adoption of evidence-based SUD treatment practices. **Apply here**.

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## Address Pressing EM Issues with the Theater of War

After rave reviews of the Theater of War event at ACEP20, another FREE performance has been scheduled for the EM community on 12/2 from 7-9pm. The actors will present scenes from Sophocles' Ajax to create a vocabulary for discussing themes such as burnout, betrayal, personal risk, loss, moral distress, suicide, depression, shame, and working in a complex hierarchy. It's free, but registration is required.

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## Opioid Webinar Series Continues Dec. 3

Part five of the six-part webinar series on opioid use disorder and federal, state and regulatory considerations examines New York's I-Stop program and other state initiatives to curb the opioid epidemic. Led by Dr. Keith Grams, this free webinar is 2 p.m. EST on Dec. 3. Register today.

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## ACEP20 Access Continues, New Option Available for Non-Attendees

If you participated in ACEP20, remember that you continue to have access to the education, Research Forum, exhibit showcase and more. This content will remain on the ACEP20 platform for 90 days post-conference before moving to the ACEP Online Learning Collaborative for the remainder of your three-year access period. This is how you claim CME.

Those who were unable to attend can still can still get the education you missed from ACEP20 Unconventional and earn up to 276 CME hours for three years with the Virtual ACEP20 component. One new element of Virtual ACEP20 compared to previous years is that it includes highlights from Research Forum, including State of the Art and Plenary presentations.

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## Podcast: COVID-19 and Stroke

With stroke being one of the top three causes of death in the nation, timing is everything. Join the conversation between host Dr. Ryan Stanton and Dr. Aisha Terry as they discuss the different factors that affect the presentations of stroke in the emergency department due to COVID-19 and how you can advocate for improved care for stroke patients. Listen now.

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## ACEP Leadership and Excellence Awards

The program provides an opportunity to recognize all members for significant professional contributions as well as service to the College. Nominations will open in December and be accepted until March 1, 2021. Some of the newest awards include the Community Emergency Medicine Excellence Awward, the Innovative Change in Practice Management Award, the Pamela P. Bensen Trailblazer Award and the Policy Pioneer Award. Check out all Leadership and Excellence Awards.

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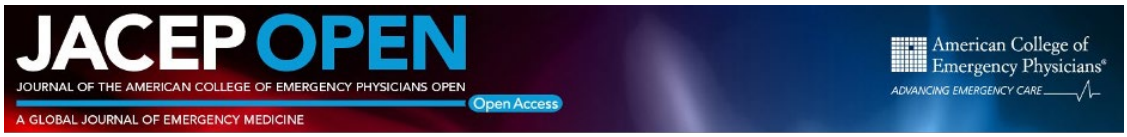


*JACEP Open* is the official Open Access journal of the American College of Emergency Physicians (ACEP). Complementing ACEP's flagship journal, *Annals of Emergency Medicine*, *JACEP Open* welcomes high quality reports representing the full spectrum of emergency care.

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## EMRA Opportunities for Residents and Medical Students

EMRA Committee Leadership applications are due December 1 for Chair Elect and Vice Chair positions for EMRA's 19 Committees.

EMRA Medical Student Council applications are due December 1 to lead our medical student efforts.

Applications are due for the Class of 2022 for the EMRA/ACEP Leadership Academy on December 31. The EMRA and ACEP Leadership Academy is a leadership/professional development program and virtual community for emerging leaders in emergency medicine.

EMRA Winter Awards Deadline: January 10.  Awards and scholarships include a travel scholarship for ACEP21, Resident of the Year, Fellow of the Year, Medical Student of the  Year, Chair of the Year, Residency Director of the Year, APD of the Year, Residency Coordinator of the Year and more.

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