A Newsletter for the Members of the Iowa Chapter - Spring 2021
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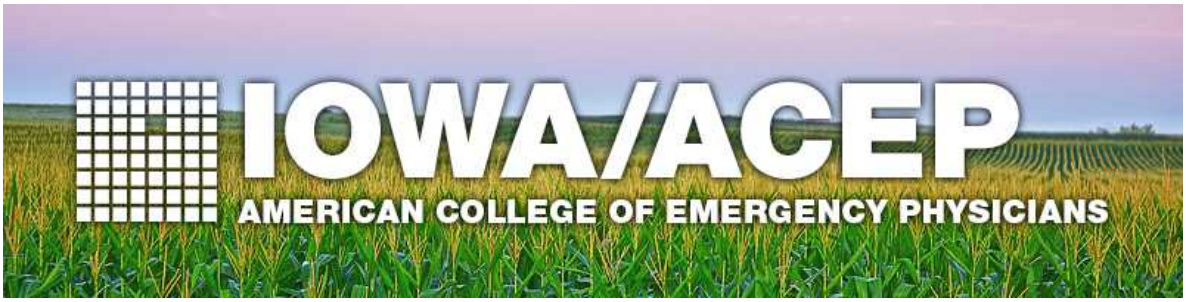

In this Edition

President's Message
A Year in to a Pandemic

Iowa ACEP Members,

So many things have changed in the past year. Life has changed. Our jobs have changed - from our daily workflow - to the future of Emergency Medicine career opportunities.

As Dr. Mark Rosenberg stated during the EM Workforce Webinar, there is now a supply: demand mismatch for EM trained physicians. If you have not had a chance to review the video, now is the time.

Most of us already knew the results of the study. We could see the writing on the wall. There are too many EM residency programs. Since I graduated residency the number of graduating residents has increased by approximately 1000 residents/year. Many states, for instance Florida where I completed residency, have new incentives for creating EM residencies. Many residencies have been started by for-profit hospitals and CMGs. There is an explosion of NPP practicing in ED's, including many with independent practice. The NP "mills" are pushing out new graduates at an alarming rate.

The slide that has gotten the most attention in this webinar shows that if nothing changes, in 2030, there will be a surplus of almost 10,000 EM trained physicians.

That assumes that NPP volumes do not continue to expand, that more states do not allow independent practice, and that more ED's do not hire "cheaper" labor. That assumes that no additional EM residencies are started. It assumes that those currently in practice with exit at a traditional time.

Training matters.

One of the suggestions during the workforce webinar was to increase EM training to 4 years. The suggestion that EM training be expanded while NPPs are graduating at record rates is mind-boggling. I do agree that the rigors of EM training, continuing to improve procedural competency, and across the board standardization is critical. Requiring NPPs to have specific emergency medicine training and standardization would also be a start, as was suggested, but "promoting" team-based care is a farcity in our current healthcare system. NPPs continually lobby for free practice authority in all states, preaching to our Congresspersons and Senators that they are equal, if not superior, to physicians.

Training matters. It matters today. It matters tomorrow.

This article is my opinion, and although discusses excerpts of the workforce study, is solely my opinion and not necessarily that of the College.

Upcoming Chapter Events

This year the Chapter Annual Meeting will be held in-person. To fulfill the goal of rotating cities in Iowa, the city that was chosen for the 2021 Chapter Annual Meeting is Cedar Rapids.

We will have a national ACEP Leader who will present a topic on The Value of Advocacy in Your Life & Career: If You Aren't at the Table, You are on the Menu and Dr. Cirillo will also provide a national ACEP Update. Come prepared to ask him questions and listen for any EM Workforce updates he may present.

An election will be held during the annual meeting, run for an open position. For more information, send the chapter an email. Register for the annual meeting & feel free to bring your spouse and significant other. The deadline to register to attend in-person is **Thursday, June 10th**.

Friday, June 18th
Read more here

Workforce Projections
Nicholas H. Kluesner, MD
President-Elect

The workforce projections are concerning and have been significantly influenced by CMG-sponsored programs developed in dubiously oversupplied regions, in questionable training environments, and for likely self-serving motivations. The projections do include assumptions for continued ~4% annual growth of residency slots, which translates to over 80 per year. So, while a moratorium on residency growth is not necessary or appropriate, neither is zero response to the failed trial of lax academic requirements from the RRC that promoted this rapid expansion within the last decade. We should all support increasing the academic requirements of training programs - it should not be a lucrative endeavor for training

institutions. What is clear is that the ACGME will not (perhaps can not?) police this issue, out of concern for anti-trust violations; they are in the business of verifying programs meet the agreed upon standards. ABEM has been clear that it isn't the enforcer for this either; they're in the business of certifying physicians meet the board requirements. Who else is there? Us. We need to understand the situation and call for action everywhere and anywhere.

I believe states like Iowa are in a unique situation. We have only one, excellent training program in the state - my alma mater - UIHC. It celebrates a growing reputation as a nationally recognized academic institution, but there is no community-based program focused on training EM physicians for our Iowa communities. That is decidedly different than say, Florida, which has 20 programs! That is over 178 resident graduates a year. (Or ~1 doc per 120,000 citizens - as opposed to Iowa at 9 graduates, or ~1 doc per 344,000 citizens). It's impossible to make a wholesale judgment on the workforce supply with that degree of regional disparity.

One of the suggested responses to these challenges we face is working towards a certification or public-awareness campaign about the quality of EM-trained physician care: basically a 'gold star' certification-type endeavor similar to our trauma certification system. While our major cities and medical centers in Iowa have EM board-certified physicians, most hospitals in this state do not. And our patients, especially in rural Iowa, do not always recognize the significantly different types of care being provided in a rural critical access ED - which may be staffed by an APP alone. There can be an important, integral role for APP's in the ED - we have all worked with excellent APP's who provide quality medical care and provide that care in an appropriately supervised and cost-effective way. But we can do more to help our patients and our communities understand the continuum of expertise occurring under the same label of "Emergency Department" in our state. Without this public awareness and pressure, administrators and insurance companies are not likely to see past their spreadsheets. In this way we can meaningfully address the demand side of the mismatch we are seeing projected in a way that benefits our patients.

It is hard to make the case that EM physician training matters and in the same breath say we shouldn't train so many. Something must give unless we are to own a motivation that we want to keep this club exclusive and lucrative. Ultimately, we are wrestling with projections and economics theory these days, and we should do well to remember two things: we are each of us not above succumbing to our own biases and the influences of our self-interest, and we must continue to focus on the patient. At the end of the day, what is the best for our patients should and hopefully will prevail.

Resident Corner
Life-saving Trephination in the Emergency Department
Brooke A. Dugdale, MD

A recent case prompted my literature review of trephination in the ED. The transfer we received was from a very small and rural department where just such an intervention may be lifesaving. My reading revealed that patients with rapidly progressive epidural bleeds who 'talk and deteriorate' can have poor outcomes if they wait for hospital transfer prior to evacuation. Smith, et al culled records to find patients who were alert upon presentation, developed anisocoria and deteriorated despite medical therapies. They compared the outcomes for these patients who had pre-transfer trephination performed by emergency physicians in the outlying ED's to

those transferred without trephination. There were seven patients who underwent trephination at outlying hospitals and three had complete recovery, two had mild disability with good cognition, and two died. The mean time to pressure relief was 55 minutes in those who had intervention at the OSH vs. 207 minutes in those who transferred first. Interestingly, two patients identified with similar presentations, who were transferred without intervention, had similar neurologic outcomes in this study when evacuated after transfer.

The five patients involved in the study with good outcomes had epidural hematomas with GCS > 7 upon presentation. The two who died despite trephination had GCS of 3 and 4 initially. I suspect that with lower GCS, acute intervention is more necessary to preserve/salvage neurologic functioning and given that the alternative is death there is not much downside to an attempt.

A couple questions arise:

1) Are ED providers trained to perform this intervention? Largely, it seems that EM residents are not, as this procedure has been eliminated from the core curriculum. However, it is a simple procedure, that doesn't take much time to perform and may be lifesaving. This may be particularly relevant to providers in rural facilities located some distance from a neurosurgical center. In fact, a course taught to rural doctors, CALS (Comprehensive Advanced Life Support), does also teach the procedure to emergency providers.

2) Under what parameters should it be performed? Background information in their study highlighted other studies which showed epidural bleeds with anisocoria not drained within 70 minutes have poor outcomes (Cohen et al). The same paper recommended a guideline of evacuation 60-90 minutes within onset of anisocoria.

3) How is it done? Skull trephination does not require extensive training and results in few complications. It should only be performed in the temporal region in ED's and be CT-guided. To perform: 1) Cut a 4cm vertical incision down to the periosteum. 2) Expose the skull. 3) Apply the trephine with pressure and back-and-forth rotating motion until the skull is penetrated. 4) Gently suction to evacuate clot (Smith et al).

4) What is the equipment needed? The Galt trephine was the recommended model due to being able to extrude clot at lower pressures. Per google, it costs $391.

5) Is it effective? Nelson performed a literature review and found that a single burr hole does tend to be adequate at relieving sufficient pressure, though that it is effective in improving outcomes (2011). In fact, the Royal Australasian College of Surgeons recommends that country doctors in Australia and New Zealand, perform this procedure if transit time is greater than two hours.

I certainly learned from this case and was excited when our rare procedures conference day this year included trephination, as instructed by our neurosurgery colleagues. I can attest that it was not a difficult procedure and depending on your setting, learning it may be well worth while - even lifesaving!

References

Smith, S., Clark, M., Nelson, J., Heegaard, W., Lufkin, K. and Ruiz, E. (2010). Emergency Department Skull Trephination for Epidural Hematoma in Patients Who Are Awake But Deteriorate Rapidly. The Journal of Emergency Medicine, 39(3), pp.377-383.

Cohen, J.E., Montero, A. and Israel, Z. (1996) Prognosis and clinical relevance of anisocoria-craniotomy latency for epidural hematoma in comatose patients. J Trauma, 41:120-22.

Nelson, J. (2011). Local Skull Trephination Before Transfer is Associated with Favorable Outcomes in Cerebral Herniation from Epidural Hematoma. Academic Emergency Medicine

Medical Student Corner
How Taking a Course in Improvisation Will Make Me a Better Emergency Medicine Doctor
Annee Rempel, M3 (UICCM)

During the month of April, I took an elective course titled Improvisation: A Life Skill. The class is offered through the University of Iowa Carver College of Medicine and taught by a theatre department faculty member at the University. As I reflect on a month spent learning about improvisational theory and practice, as they relate to both medicine and everyday life, I have come to appreciate the myriad ways improvisation (improv for short) will inform and complement my future practice as an emergency medicine physician.

Through course instruction and readings, I learned the central tenets of improv and ways to better understand and communicate with patients as well as fellow healthcare providers. At its core, improv is the act of making or doing something that has not been pre-planned. In theatrical terms, improv describes a spontaneous performance that occurs among actors supporting each other without a script. One of the main principles of successful improv is encompassed by the phrase: “Yes, and…” For example, when acting out an improvised scene, if someone says, “Look how hard it’s raining!” One way to reply would be: “Yes, and I’m so glad I decided to put on my rainboots this morning!” One should not reply “What are you talking about? It is not raining. I’m getting fried by the sun!” No matter how firmly someone believes the developing scene takes place on a sunny day, improv requires the internal flexibility to agree and add to whatever is offered by surrounding improvisors. By doing so, actors build trust, improve communication, and generate more interesting scenes. I hope to incorporate this “Yes, and…” mentality into my future rotations and practice as an emergency medicine provider as it will allow me to approach situations with flexibility and through a positive lens. While there are certainly dangerous circumstances where saying no is imperative, particularly in an emergency setting, I can imagine innumerable situations where applying “Yes, and…” to a patient’s request or to an attending’s feedback has the potential to not only improve communication but also build a sense of connection and maybe even make the work more enjoyable.

By reading the work of Patsy Rodenburg, I learned the ways body language, word choice, posture, tone, and even breathing can influence the way we are able to connect and communicate with others (1). She argues that to effectively communicate, listen, and learn; we must be present in what Rodenburg describes as “second circle.” In her framework, there are three circles. A quiet medical student who is seemingly trying to take up as little space as possible, with shoulders rounded forward, and a voice so soft that an attending must ask them to repeat what they have just said would be considered in “first circle.” A macho senior resident who speaks loudly, has their hands on their hips to take up space, and interrupts a patient when they feel the patient is no longer offering valuable information would be considered in “third circle.” To be truly present with patients and effective at communicating with all members of the medical team – from first year student to senior attending - Rodenburg argues that people must be in “second circle,” a state of being where one is relaxed and confident with an energy that fosters human connection. While more nuanced than what I have described here, I found value in thinking about my physical and mental presence in a hospital setting and the ways in which I may be able to better understand and connect with others.

As a future emergency medicine practitioner, I anticipate needing to swiftly connect with patients, to communicate concisely with consulting providers, and to have the

flexibility to say “Yes, and…” to whatever unexpected, critical situation rolls through the ED doors. I now firmly believe that transposing the skills I learned reading and discussing improv theory and even while playing improv games with fellow medical school classmates will help me to become a more grounded yet flexible doctor. While taking an improv course is certainly not feasible for all medical students going into emergency medicine, I am grateful that the Carver College of Medicine values the humanistic and artistic dimensions of medical education and provided me with the opportunity to spend a month creatively honing my communication and improvisation skills as I know it will help make me a better emergency medicine physician.

Reference
(1) Rodenburg, Patsy. (2017). Second Circle: Using Positive Energy for Success in Every Situation. New York City: W. W. Norton & Company.

Social Media

Did you know that there are many valuable benefits to social media for a non-profit organization such as the Iowa ACEP Chapter?

A list of a few of the benefits are the following:

- The ability to uncover industry trends in real-time.
- Provide better customer service.
- State the chapters position over legislative issues that affect emergency medicine across the state.
- Build a better search engine presence for the chapter.
- Appeal to younger, social-savvy potential members.
- Social media platforms allow organizations to tell their story.
- Messages can help engage supporters, increase awareness, and promote fundraising initiatives.
- Facilitates the sharing of ideas, thoughts, and information through the building of virtual networks and communities.

Why is it important to know this? The chapter is looking to fill a Social Media Ambassador position.

What is the role, responsabilities, and terms of this position? Read details here.

Where will you get the content to keep the chapter Facebook page active? Adriana our Chapter Executive Director will be providing you with most of the content. However, it will also be your responsibility to watch for important content at the local level that should be shared immediately via social media - to get the word out. For example, you may hear about something at your local hospital that could potentially affect all emergency departments and emergency physicians in Iowa.

If you are interested in this position, please reach out. Additionally, if you have social media, please follow us on Facebook and like our posts so that we can build a better search engine presence for the chapter.

We need your support!

2021 ACEP/EMRA National Award Recipient

Join us in recognizing the winner of the 2021 ACEP/EMRA National Oustanding Medical Student Award:

Joyce Wahba (UICCM)

This award was announced via national ACEP social media channels and in ACEP*Now*.

Welcome New Members!

A special welcome to the new members of the Iowa Chapter and to those that renewed their membership with the chapter. We are excited to have you.

Anna White
Anthony J Camodeca, DO
Conner Michael Willson
Dustin Nguyen
Everett Axel Williams
Hunter Christian Hayes
Jacob Nelson
Jaron Ken Fowers
Jimmy Luu
Kai William Corwin Friesen
Katherine Aneta Marciniec
Kristina E Damisch
Lisa Dillon Bell
Michael Jared Foster
Savannah Mayer
Skyler Hill-Norby
Tavi Madden-LeDuc, DO

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.

Other Chapter Events

The DC ACEP Chapter has extended an invitation to all ACEP State Chapters to attend the EM Workforce Town Hall that they will host.

Tuesday, June 8th
6:00PM EST

The Panelist are Dr. Aisha Terry and Mr. Salsberg the Primary Investigator of the EM Workforce Study. Read more details here. See the flyer here. Register for the Town Hall here.

Any questions for the panelist should be submitted via email to the DC ACEP Chapter by Monday, June 1st @ 5:00PM EST.

FROM NATIONAL ACEP

Featured News

EM Physician Workforce of the Future:

- The Workforce Solutions infographic outlines ACEP's next steps. (May 5, 2021)
- Workforce Considerations: ACEP's Commitment to You and Emergency Medicine (ACEP *Now* - April 21, 2021)

National EMS Week is here! ACEP is proud to partner with NAEMT to feature National EMS Week as a year-round initiative to create significantly greater visibility of EMS among health professions and communities. ACEP thanks the generous organizations that are supporting this year's initiatives.

In the May 19th edition of ***Capital (30) Minutes***, ACEP's advocacy team provides a legislative update on new legislation and recent hearings, a regulatory update on Buprenorphine practice guidelines and Surprise Medical Billing, and an advocacy update on Scope of Practice coalition and LAC in July. Watch the recap.

ACEP's COVID-19 ED Management Tool was updated this week and is now available on the MDCalc website and in their app. (May 14, 2021)

ACEP Responds to Regulation that Proposes Modifications to HIPAA (Regs & Eggs Blog - May 14, 2021)

Problem Solving: It's What We Do. In her new post on ACEP Lately, Executive Director Sue Sedory provides **updates on EM workforce, sepsis, ultrasound, advocacy and more.** (April 30, 2021)

Early Outcomes of Bivalirudin Therapy for Thrombotic Thrombocytopenia and Cerebral Venous Sinus Thrombosis after Ad26.COV2.S Vaccination: A Case Report (*Annals of EM* - April 28, 2021)

Physician on Trial: What to Expect (ACEP *Now* - April 23, 2021)

AAP, ACEP and ENA Call For Improving Emergency Care for Children in Joint Policy Statement (ACEP Newsroom - April 21, 2021)

New/Revised Policies
ACEP's new and revised policies allow you to bill more for your bottom line, makes sure you are entitled to fair and equitable compensation and are provided contractual transparency.

- Compensation Arrangements for Emergency Physicians - Revised April 2021
- Emergency Physician Compensation Transparency - Approved October 2020
- Emergency Physician Contractual Relationships - Revised April 2021

- Emergency Physician Rights and Responsibilities - Revised April 2021

Upcoming ACEP Events and Deadlines

May 17-21: EMS Week
May 25: How to Get Started: Introduction to Healthcare Quality Improvement
June 8: 988-The Future of Suicide Prevention and Crisis Care
July 25-27: Leadership & Advocacy Conference (Washington, DC) - Register Today
October 25-28: ACEP21 (Boston, MA) - Book your hotel

ACEP Member Benefit

Career Resources: The job market is tumultuous right now. Whether you're actively looking for a position or just want to be a better advocate for yourself with your current employer, ACEP's resources can help. Check out the ACEP Career Center for information on vetted EM job opportunities, contracts, compensation reports, policy statements and more!

ACEP Member Advantage: Whether on shift or at home, your ACEP Membership provides perks and discounts from a variety of businesses wanting to support you.

Wellness & Assistance Program: Did you know your ACEP membership comes with three **free** counseling or coaching sessions available through phone, text or online chat? And for a small extra fee, you can add on **financial and/or legal assistance**. Learn more about this free member benefit.

Clinical Tools:
- ACEP's Point-of-Care tools are transforming care at the bedside.
- Feel confident in your ultrasound ability with the re-designed, easy to-use Sonoguide.

Latest Podcasts:
- ***Annals of EM****:* Hypertension in the ED, ultrasound for COVID, Prediction models for sepsis, and chest pain decision tools in the ED.
- **ACEP Frontline**: House Call - Brining EM to the Home with Remote Symptom Monitoring + Medical Clearance- Psych And EM On The Same Page?
- **Critical Decisions in EM**: Drs. Danya Khoujah and Wendy Chang take on the great outdoors and discuss the various forms of high-altitude illness + presentation and management of several tick- and mosquito-borne illnesses, such as Lyme disease and West Nile virus, which often go overlooked.

Pain and Addiction Care in the ED (PACEP) Accreditation

More than 83,000 people in the U.S. are thought to have died of drug overdoses in the 12-month period ending June, a record-breaking number according to the most recent data available from the CDC. Emergency Physicians can help by being part of the solution. ACEP's Pain and Addiction Care in the Emergency Department (PACED) accreditation program provides emergency departments with the tools to elevate the quality of patient care with innovative treatments, alternative modalities, and impactful risk reduction strategies, resulting in positive outcomes for patients, families, providers, and communities. Find out more today – www.acep.org/PACED - and be a leader. Use your unique position to help fight this epidemic at the point of care.

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Be Prepared When Disaster Strikes

From the Emergency Medicine Foundation

- Bidding is open for The World of Travel and Art EMF Online Auction. The proceeds will benefit the EM Wellness Grant, and FUJIFILM Sonosite will match any donations and bids.
- EMF has a new Health Policy Scholar Grant opportunity! Apply by June 11.

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