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# Empire State EPIC



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**Matt Kaufman, MD**  
Emergency Medicine  
Staten Island, NY



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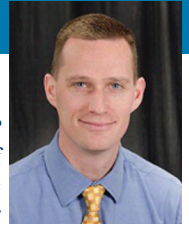
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# PRESIDENT'S MESSAGE



**Jeremy T. Cushman, MD MS FACEP**  
Associate Professor and Chief  
Division of Prehospital Medicine  
University of Rochester

## Marijuana Is Coming

Governor Cuomo recently offered his endorsement of legalizing marijuana for recreational use in New York and all signs point to him having the support necessary to pass such legislation. In response, the New York ACEP Government Affairs Committee has begun crafting our position. To be clear, we understand that we have members that support and members that oppose the legalization of recreational marijuana. Although we may be divided in that aspect, what I hope we have universally in common is an understanding and appreciation that the legalization of recreational marijuana will have both predictable and unanticipated effects on Emergency Departments (EDs) in New York.

Taking from the experiences of our colleagues in states around the country (and our northern Canadian friends) we know that there will be changes in ED utilization and care needs as a result of recreational marijuana legalization. Given these impacts, New York ACEP is offering the following recommendations as legislation is drafted:

Proponents have opined that benefits of legalization include decreases in synthetic cannabinoid and novel psychoactive substance use as well as decreases in opioid prescribing and opioid deaths, however, data to support these assertions are limited. Research is critically necessary to evaluate these assertions.

Given a common public perception that marijuana does not have greater health risks as other drugs, further research is needed on the short and long-term health effects of legalized marijuana. Additionally, that

research should focus on whether regulation increases use in adults and youth, and the effects increased marijuana availability may have on injury rates – motorized vehicle and otherwise.

There is significant concern that legalization will increase marijuana access to the pediatric community. Due to the increased availability, acceptability and potency of marijuana, we must reduce the incidence and severity of accidental child poisonings by efforts to prevent the unintended access and safety of packaging regulated marijuana products. Further, given the variety of

different routes of ingestion and concentration, we urge limits and research on the forms and concentrations of regulated marijuana.

Our broken mental health system is likely to undergo even more stress with

the legalization of marijuana as individuals with mental illness use marijuana at high rates and such use may contribute to worse functional outcomes. The effects of legalization on the mental health system must be closely followed and tax revenues are necessary to support increased mental health resources.

Lastly, based on experiences in other states, we can expect an increase in marijuana-related ED visits and tax revenues must offer some relief for uncompensated care related to regulated marijuana.

As emergency physicians we will no doubt bear the brunt of the mental and physical health burdens that legalization of marijuana will bring to New Yorkers. This

is why it is so critical we speak loudly of the need for adequate resources for uncompensated care, mental health services and preventive efforts for our patients and the research to guide the impact of legalization. The coming months will foretell much of the future impacts of this legislation and I hope you will join me as we advocate for our practice.

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## SOUND ROUNDS

Penelope C. Lema, MD RDMS FACEP

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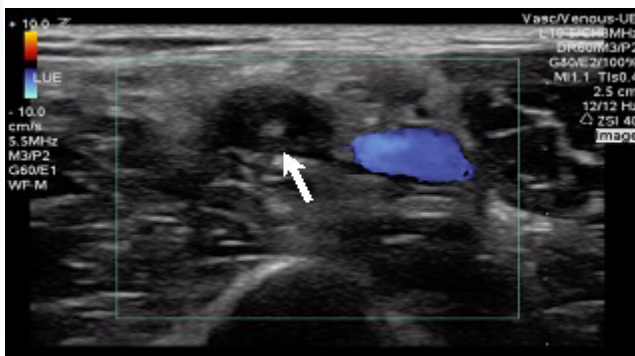
Director, Emergency Ultrasound

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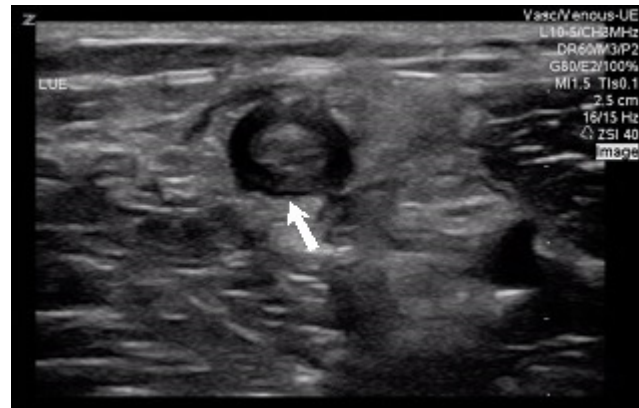
## Ultrasound Evaluation of Arm Pain and Swelling

**Guest Author:****Henry M. Bacher, MD**Emergency Medicine Faculty  
University at Buffalo, Jacobs School of Medicine  
and Biomedical Sciences**Guest Author:****Catherine DeGuzman, BS**Medical Student, MS4  
University at Buffalo, Jacobs School of Medicine  
and Biomedical Sciences**Case**

A 30-year-old male with no chronic medical conditions presented to the Emergency Department (ED) with two days of left arm pain. The patient reported a syncopal event five days prior. He was previously evaluated at an outside ED and discharged after a negative cardiac workup, including a normal EKG and basic labs. He complained of progressive left arm pain since his discharge. The patient's vital signs were within normal limits with blood pressure 128/87mmHg, heart rate of 81 bpm, respirations of 12 breaths per minute and SpO2 98% on room air. He was afebrile with a temperature of 37.1 C. Review of symptoms were positive for syncope and shortness of breath. Physical exam revealed circumferential swelling of the left upper arm with mild tenderness. The left hand was warm and well-perfused with normal radial pulse. Point-of-care ultrasound (POCUS) of the extremity was performed by an emergency physician. POCUS with a 10 MHz linear transducer (Zonare, Mountain View, CA) revealed extensive deep vein thrombosis (DVT) of the left upper extremity including the axillary and brachial veins (Figure 1) as well as superficial thrombophlebitis of the basilic vein (Figure 2) and antecubital veins. A computed tomography (CT) angiogram of the chest was then performed which revealed multiple acute pulmonary emboli, explaining his prior syncopal event and dyspnea. He was admitted to the hospital and additional workup revealed Factor V Leiden mutation.



**Figure 1.** Color flow Doppler ultrasound of the left brachial vessels demonstrating normal color flow in the artery (blue), but no color flow in the vein due to presence of a thrombus (white arrow).



**Figure 2.** Point-of-care vascular ultrasound of the left basilic vein with a high frequency linear transducer revealed a non-compressible, hyperechoic structure in the vessel lumen consistent with thrombus (white arrow).

**Discussion**

Deep vein thrombosis (DVT) with an annual incidence of 1/1,000 people is commonly diagnosed in the emergency department. However, it is easily misdiagnosed since classic physical exam findings are present in less than 50% of patients.<sup>1</sup> This can subsequently lead to a delay in treatment and increase the risk of complications including chronic limb pain, superior vena cava syndrome and pulmonary emboli.

Upper extremity DVT (UEDVT) has long been considered rare and is thus frequently not considered when evaluating upper extremity pain. Due to the increase in the use of chronic indwelling intravenous catheters and cardiac devices, the incidence of UEDVTs is rising. Current estimates indicate that UEDVT may comprise up to 18% of all cases of DVT. Additionally, it was once believed that UEDVT rarely results in pulmonary emboli, the most common significant complication of DVT. New data suggests that this rate may be as high as 17%.<sup>2</sup>

UEDVT can be divided into primary and secondary subtypes. Primary UEDVT occurs due to conditions such as thoracic outlet or Paget-Schroetter Syndrome. These conditions cause repetitive micro-trauma to the upper extremity vasculature as it exits the thoracic cavity via anatomic abnormalities resulting in thrombus formation. Secondary UEDVT occurs due to identifiable risk factors including venous stasis, direct trauma, hypercoagulability or vascular access devices such as



# SOUND ROUNDS

peripherally inserted central catheters (PICC) lines or cardiac device insertion.<sup>3</sup>

Compression ultrasonography is considered the gold standard for diagnosis of DVT. This involves scanning the upper extremity and neck vessels with B-mode ultrasound to test for venous compressibility as well as assessment with color and/or pulse wave Doppler to evaluate flow. Ultrasound is accurate, cost effective, non-invasive, painless and does not use ionizing radiation.

A comprehensive radiology ultrasound will typically be ordered when UEDVT is suspected. Data shows that with appropriate training, emergency physician performed POCUS is 95% sensitive and 96% specific for the identification of DVT.<sup>1</sup> Emergency physicians can quickly make the correct diagnosis with POCUS as well as identify possible alternate diagnoses. Many facilities have limited availability for comprehensive radiology ultrasonography to assess for DVT. Occasionally, patients may be empirically anticoagulated with instructions to return to the ED when formal vascular ultrasound is available. By performing POCUS, emergency physicians can decrease throughput time, decrease time to diagnosis, promptly initiate appropriate therapy, decrease unnecessary anticoagulation use and decrease the need for additional unnecessary testing.<sup>1</sup>

## Indications for Upper Extremity Ultrasound

- Pain
- Swelling
- Erythema

## Technique

- Position the patient's arm so the medial portion of the upper extremity can be easily scanned. This can be achieved with the arm overhead while the patient is supine or with the arm abducted while the patient is seated.
- Use a high frequency linear transducer.
- Scan the internal jugular, brachiocephalic and subclavian veins in the transverse plane as extensively as possible in B-mode.
- Scan the axillary, brachial, antecubital, radial and ulnar veins of the arm proximally to distally in B-mode.
- Though it not considered a deep vein, evaluate the basilic vein as it is large and a thrombus here can result in a pulmonary embolism.<sup>4</sup>
- Confirm vein compressibility at each site while scanning.
- When compressibility cannot be confirmed due to overlying bone (i.e. subclavian, brachiocephalic, proximal axillary veins), carefully evaluate for a thrombus and use color and

pulse wave Doppler to confirm normal blood flow in the vessel.

- DVT can be confirmed by direct visualization of a thrombus, lack of compressibility of the vein, lack of augmentation or lack of color or pulse wave Doppler signal within the vein and lack of respiratory variation.

## Tips

- Abnormal findings should be imaged in two planes.
- Placing the patient in trendelenburg position may distend the veins making them easier to visualize.<sup>5</sup>

## Pitfalls and Limitations

- Compression of the vein cannot be performed with overlying bone such as the clavicle. Additional sonographic techniques such as careful visualization of a thrombus, color flow and pulsed wave Doppler need to be implemented to evaluate the subclavian, brachiocephalic and proximal axillary veins.
- The exam may be limited in obese patients, as compressibility of a normal vein and necessary depth of imaging with the linear transducer may be difficult.
- Anatomic variability including duplicated veins and different orientations of artery and vein are common in the upper extremity.<sup>5</sup>

## References:

1. Baker M, dela Cruz J. Deep Vein Thrombosis, Ultrasound. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; Jan 2018.
2. Available from <https://www.ncbi.nlm.nih.gov/books/NBK470453/> Retrieved January 5, 2019.
3. Sartori M. and Cosmi B. Whole-Arm Ultrasound for Suspected Upper-Extremity Deep Venous Thrombosis in Outpatients—Reply. *JAMA Internal Medicine*. 2015 Nov; 175(11), 1871-2.
4. Badr S. Upper Extremity Deep Venous Thrombosis (UEDVT). *Intern Medicine* 5:206. 2015.
5. Rosen T, Chang B, Kaufman M, Soderman M and Riley DC. Emergency department diagnosis of upper extremity deep venous thrombosis using bedside ultrasonography. *Crit Ultrasound J*. 4(1): 4. 2012 Apr 16.
6. St. James E. "Vascular: Venous Thrombus Upper Extremities." *Practical Guide to Critical Ultrasound*. Edited by Lewiss R, Strony R and Jones R, Volume 1, American College of Emergency Physicians, 2018, pp. 145-151. <https://itunes.apple.com/us/book/practical-guide-to-critical-ultrasound-volume-1/id1439354416?mt=11>. Retrieved January 5, 2019.
7. Mintz A and Levy MS. Upper Extremity Deep Vein Thrombosis. American College of Cardiology. Nov 2017. <https://www.acc.org/latest-in-cardiology/articles/2017/11/09/13/30/upper-extremity-deep-vein-thrombosis>. Retrieved January 5, 2019.



## Careers in Emergency Medicine: A Medical Student Symposium

Wednesday  
April 10, 2019

Mount Sinai Beth Israel  
Medical Center

Register online at  
[www.nyacep.org](http://www.nyacep.org)

# PRACTICE MANAGEMENT



**Joseph Basile, MD MBA FACEP**  
 Director of Quality and Performance Improvement  
 Administrative Fellowship Director  
 Department of Emergency Medicine  
 Staten Island University Hospital, Northwell Health



**Guest Author:**  
**Teagan Lukacs, DO**  
 Emergency Medicine Resident  
 Good Samaritan Hospital Medical Center



**Guest Author:**  
**Christopher C. Raio, MD MBA FACEP**  
 Chairman, Emergency Medicine  
 Good Samaritan Hospital Medical Center  
 Chief, Emergency Medicine CHSLI

## Catholic Health Services (CHS) and Family and Children's Association (FCA) Sherpa Program

The misuse of and addiction to opioids including prescription pain killers, heroin and newer synthetic agents is a national crisis. Dependence on prescription opioids and heroin is a major public health issue that is affecting all socioeconomic classes. These patients often present to the Emergency Department (ED) for treatment of an acute overdose, intoxication, withdrawal, co-morbid medical and/or psychiatric condition or trauma. The nature of addiction often causes these patients to repeatedly present to the ED. These visits represent a critical opportunity to intervene. Many emergency medicine (EM) clinicians recognize these opportunities as a “call for help” but do not feel empowered to make a difference, typically given a lack of connection to resources outside the ED. The challenge from the EM perspective is that resources are often not aligned to continue treatment past the point of initial contact. While EM physicians might be very comfortable treating the acute phase of illness, the transition to outpatient care is something we typically have no control over. The standard is often to provide information for local addiction treatment services upon discharge. Unfortunately, the majority of addicted patients who are provided only referral information are not engaged in treatment 30 days after ED discharge.

Famed Nepali-Indian Sherpa mountaineer Tenzing Norgay once said “You do not climb a mountain like Everest by trying to race ahead on your own, or by competing with your comrades. You do it slowly and carefully, by unselfish teamwork.” It is this team approach that must be implemented to combat the opioid epidemic. While there are now greater options for initiating medical

treatment of opiate addiction in the ED, transitioning patients to appropriate longitudinal services is still crucial. Coordinated care for complex chronic conditions has shown positive influence on disease morbidity. As substance abuse is a chronic and relapsing medical condition, a coordinated transfer of care to the outpatient setting is important. However, EDs face substantial challenges in referring patients as many facilities are disconnected from the acute care system and few have structured, efficient referral processes accessible from the ED. While providers may be able to diagnose serious illness (in this case substance abuse and addiction) requiring specialty follow-up, many EDs do not have the mechanism or resources to ensure proper linkage to care. The increasing prevalence of opioid use disorders and the rate of overdose deaths accentuates the need to decrease barriers to addiction treatment and facilitate entry into appropriate outpatient treatment centers.

The interval between discharge from the ED and the initiation of outpatient care is a high-risk time period for patients. Systematic barriers and difficulty navigating through these issues put patients at risk for both acute opioid withdrawal and relapse. In an effort to combat this epidemic, Good Samaritan Hospital Medical Center in West Islip, NY has piloted a program, in partnership with Family and Children's Association (FCA), to help Long Island's affected patients access appropriate long-term treatment. The Sherpa Program, named after the mountain guides of the Himalayas, consists of peer recovery coaches trained to meet with overdose survivors and their families at the bedside in the ED. The Sherpas are contacted by the clinical or social work team

from the ED and meet with the patient and/or family at the bedside or contact them the following day if they are not able to get to the ED before the patient is discharged. The peer coaches are individuals who have been through the recovery process themselves and are able to better connect with patients in the hectic ED environment. Patients often find trust in these mentors. Family, friends and loved ones are also offered the services of Sherpas to assist them in coping and managing the patient's illness. The Sherpa team at FCA is equipped to connect patients to in-patient or out-patient treatment facilities, guide them through the system, provide harm reduction strategies and peer and family counseling and encourage continued engagement every step of the way, at no charge to the patient or family. The program is supported by legislative funding, an OASAS Family Support Navigator Grant and the Long Island Community Foundation. The peer mentors are well-connected with system resources and are proficient at maintaining individual survivors engaged in the treatment process. The FCA attempts to tackle addiction from every angle and provides individual and family counseling alongside other treatment options. A multidisciplinary approach is necessary to keep patients focused on their recovery.

This program of peer support and recovery coaching provides the necessary link between ED treatment and longitudinal management. It fills the role of the “warm handoff” between acute and ongoing care. Warm handoffs include direct communication between a treating physician and a provider that will be initiating continued care, ideally involving the patient and their family in the conversation. Having a direct discussion with the outpatient team who



# PRACTICE MANAGEMENT

will be receiving the patient may help alleviate some of the barriers in care and constructs a more streamlined process. This helps prevent repeated assessments, gaps in medication-assisted therapy and relapse. The Sherpas have relationships with the outpatient teams and have adequate time to provide a secure handoff. This relieves some of the frustration for EM physicians who may not have the time or information necessary to connect the patient with further treatment. Sherpas are well versed and connected to the addiction treatment infrastructure of Long Island and follow with the patient for several months post ED discharge. Preliminary data has shown that approximately 61% of cases identified present with alcohol as the primary substance of choice, 21% heroin and another 9% prescription opiates. The program is also tracking engagement with the peer navigator and participation in treatment over time. To date, 73% of patients connected to a Sherpa accepted an initial treatment referral, with over 50% of those attending their first appointment.

Sherpas provide support, system navigation and a strategy to rebuilding full, healthy lives to our patients struggling with addiction. While this is a tremendous step in the right direction, it is not the sole solution to this crisis. Catholic Health Services of Long Island (CHSLI) has also implemented Emergency Medicine Opioid Prescribing Guidelines, tracks

individual provider prescription rates, initiated a multitude of educational programs for clinicians, offers free Narcan packs and training for patients and their support systems and has also started an ED initiated medication assisted treatment project. The opioid epidemic represents a major focus not only for emergency medicine but for CHSLI as a whole. The Sherpa program has been well supported by CHSLI leadership including Executive Vice President and Chief Medical Officer Dr. Patrick O'Shaughnessy, an emergency medicine physician himself. Plans to expand the program to other CHSLI EDs are well underway.

1. [Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial.](#)  
D'Onofrio G, O'Connor PG, Pantalon MV, Chawarski MC, Busch SH, Owens PH, Bernstein SL, Fiellin DA. JAMA. 2015 Apr 28;313(16):1636-44. doi: 10.1001/jama.2015.3474.
2. [Identification, Management, and Transition of Care for Patients With Opioid Use Disorder in the Emergency Department.](#)  
Duber HC, Barata IA, Cioè-Peña E, Liang SY, Ketcham E, Macias-Konstantopoulos W, Ryan SA, Stavros M, Whiteside LK. Ann Emerg Med. 2018 Oct;72(4):420-431. doi: 10.1016/j.annemergmed.2018.04.007. Epub 2018 Jun 5. Review

## Calendar

### March 2019

- 5 Lobby Day, 10:30 am-4:00 pm
- 13 Education Committee Conference Call, 2:45 pm
- 13 Professional Development Conference Call, 3:30 pm
- 14 Practice Management Conference Call, 1:00 pm
- 20 Government Affairs Conference Call, 11:00 am
- 20 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 20 Research Committee Conference Call, 3:00 pm
- 21 EMS Committee Conference Call, 2:30 pm

### April 2019

- 10 Education Committee Conference Call, 2:45 pm
- 10 Professional Development Conference Call, 3:30 pm
- 10 Medical Student Symposium, 5:30-9:30 pm, Mt. Sinai Beth Israel
- 11 Practice Management Conference Call, 1:00 pm
- 17 Government Affairs Conference Call, 11:00 am
- 17 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 17 Research Committee Conference Call, 3:00 pm
- 18 EMS Committee Conference Call, 2:30 pm
- 25 Board of Directors Meeting, 1:30-5:30 pm, New York City
- 26 ED Director Forum, 8:00 am-4 pm, New York Academy of Medicine

### May 2019

- 8 Education Committee Conference Call, 2:45 pm
- 8 Professional Development Conference Call, 3:30 pm
- 9 Practice Management Conference Call, 1:00 pm
- 15 Government Affairs Conference Call, 11:00 am
- 15 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 15 Research Committee Conference Call, 3:00 pm
- 16 EMS Committee Conference Call, 2:30 pm

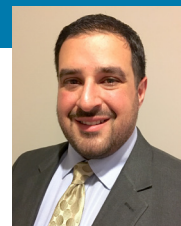
### June 2019

- 12 Education Committee Conference Call, 2:45 pm
- 12 Professional Development Conference Call, 3:30 pm
- 13 Practice Management Conference Call, 1:00 pm
- 19 Government Affairs Conference Call, 11:00 am
- 19 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 19 Research Committee Conference Call, 3:00 pm
- 20 EMS Committee Conference Call, 2:30 pm

### July 2019

- 9-11 Scientific Assembly, Sagamore Hotel, Bolton Landing, NY
- 9 Board of Directors Meeting, 11 am-12 pm, Sagamore Hotel
- 10 Annual Membership Meeting, 12:45 pm-1:45 pm, Sagamore Hotel
- 10 Committee Meetings, 1:45 pm-2:15 pm, Sagamore Hotel
- 10 Annual Resident Volleyball Tournament, 3 pm, Sagamore Hotel
- 11 Board of Directors Meeting, 7am-8am, Sagamore Hotel

# ASK THE EXPERTS



**Robert M. Bramante, MD RDMS FACEP**  
Associate Chair, Emergency Medicine  
Director, Emergency Ultrasound  
Good Samaritan Hospital Medical Center



**Interview With:**  
**Joel R. Gernsheimer, MD FACEP**  
Senior Education Faculty  
SUNY Downstate/Kings County Hospital  
Visiting Associate Professor,  
SUNY-Downstate College of Medicine



**Interviewed By:**  
**Muhammad Waseem, MD FACEP**  
Associate Professor, Emergency Medicine in Clinical  
Pediatrics; Attending Physician and Research  
Director, Department of Emergency Medicine,  
Lincoln Medical Center

## Advancing Your Career in Academic Emergency Medicine

### Introduction

Dr. Joel Gernsheimer has been practicing and teaching emergency medicine since 1976. Dr. Gernsheimer helped establish the emergency medicine residency training program at the Lincoln Medical and Mental Health Center in the Bronx in 1981. Dr. Gernsheimer was the emergency medicine program director there for 20 years and also served as the director of emergency services there for nine years. Dr. Gernsheimer has been a visiting associate professor of emergency medicine, senior educational faculty and attending physician at SUNY Downstate Medical Center and Kings County Hospital Center in Brooklyn since 2007.

Dr. Gernsheimer has received numerous awards for his teaching and his contributions to the practice of emergency medicine, including Teacher of the Year and Physician of the Year from the Lincoln Medical and Mental Health Center, Emergency Medicine Teacher of the Year from SUNY Downstate, the Albert Einstein College of Medicine Lifetime Achievement, the New York ACEP Physician of the Year and was named a Hero of Emergency Medicine by ACEP. Dr. Gernsheimer has helped train many of the current leaders of emergency medicine and is firmly committed to help train the next generation of emergency medicine physicians.

### **How did you initially become involved in academic emergency medicine?**

When I initially completed my residency and started working as an attending physician in the Emergency Department (ED) at Lincoln Hospital, I just wanted to take care of as many patients as possible that needed emergency care. However, I soon realized that in the long run I could help more patients by teaching and training more emergency physicians. We started the emergency medicine training program at Lincoln Hospital, because we saw the great need to have more emergency physicians, who were dedicated to providing competent and compassionate acute care to patients on their “worst days”.

### **What do you find most rewarding in being an emergency medicine educator?**

What I find most rewarding is seeing residents and students that I have trained and taught become very competent and caring emergency physicians. Also, witnessing emergency physicians that I have helped train become leaders in emergency medicine has been very rewarding.

### **What do you find most challenging about your role as an educator?**

Keeping up with the latest developments in emergency medicine can be very challenging. It is very important that your clinical practice, when you are supervising and working with residents and students in the ED, is current and competent. Also, when you are teaching them in conferences, the information that you are giving them must be consistent with current guidelines and practice.

### **During their training, what can emergency medicine residents and fellows do to best prepare themselves for a career in academic emergency medicine?**

Obviously, the most important thing is to become a very competent emergency physician, who can then pass the necessary clinical skills and knowledge on to others. In addition, there are several ways for residents and fellows to further prepare themselves for a career in academic emergency medicine. One way is to get involved in teaching students and junior residents at an early stage during your training by volunteering to give lectures to them and supervising them in the ED. It is also important to hone your teaching skills by reading about and taking courses on how to teach, such as the ACEP Teaching Fellowship. It is also very helpful to find a niche, such as ultrasound, research, pediatric emergency medicine, wilderness medicine, medical education, etc., during your training in emergency medicine, and to have a mentor with expertise in that area. At SUNY Downstate we offer “Mini-Fellowships” to our residents who are interested in an academic career. After completion of residency training, one can then do a formal fellowship in that subspecialty. Also doing scholastic projects, such as blogs, publications and presentations during your training is a good way to start getting some name recognition in academic emergency medicine.

### **What are the different ways to advance your career in academic emergency medicine?**

You can advance your career by teaching and supervising medical students, residents, fellows and mid-level providers. You can give conferences at your institution, at a local level, at a national level and even at an international level. You can get involved helping with the administration of the residency program at your institution. You can do research, and do presentations, posters and publications. You can join and get involved with the academic activities of emergency medicine organizations, such as ACEP, SAEM and AAEM. It is important to build a portfolio with all your academic accomplishments.



**What special advice would you give to your emergency medicine colleagues who want to change their role in our field from a clinical to a more academic role?**

One often hears that it is very hard to go from a purely clinical job in a community hospital to an academic position, but that is not necessarily true, and I have known emergency physicians who have successfully done so. You have to really want to do it and be willing to sacrifice some money, as academic positions usually pay less, and time, as you may have to spend some of your free time preparing lectures, doing research and writing publications. One can “start slow” by doing shift work at a hospital where there is an emergency medicine training program and impress the residents and staff there with your skills, knowledge and efficiency. You can volunteer to give conferences and help with administration of the residency program. At our institution we have had several “moonlighters” who were so impressive that they were offered full-time positions with “protected time”.

**How did you choose a mentor, and how did you become a mentor and role model for students, residents and junior colleagues who were interested in becoming academic emergency physicians?**

I was very fortunate to have several mentors that were wonderful role models during my residency training and when I was a junior attending. I chose mentors that were very competent, compassionate and caring towards the patients. I also chose mentors that really wanted to teach me and help me further my career in emergency medicine. I have tried to be a good mentor and role model by “not just talking the talk, but by walking the walk”, that is by being competent, working hard, being nice and being enthusiastic about taking care of patients and teaching students and residents. It is also very important to be accessible to your mentees, and being willing to go the “extra mile” for them.

**How can an academic emergency physician best achieve promotion in our field?**

First, you have to know the criteria for promotion in your department in your institution. Most institutions have several tracks, for example clinical, research, teaching or service. You need to know what the criteria for promotion for the different levels, such as assistant professor, associate professor and professor for each track is. You can then work towards meeting the promotion criteria for the track and level you believe that you are most qualified for. Your chairman and/or your department’s representative to your institution’s promotion committee should help you with this decision and with the promotion process.

**How did you avoid burnout during your long career in academic emergency medicine?**

Doing something that you really like helps prevent burnout and I really like doing and teaching emergency medicine. I also believe that doing different things, such as seeing patients, supervising residents and students in the emergency department, giving conferences to residents, students and mid-level providers, assisting with the administration of the residency programs and especially doing research and publications, have helped me avoid burnout. It is also very important to have a very strong support system both in and out of emergency medicine, which for me have been my family, friends, colleagues and patients.

**New York ACEP  
New Speaker Forum**

**Open to Attendings  
Deadline: March 11, 2019**

**Presentation Date  
Tuesday, July 9 at 4:30 pm**



**2018 New Speaker Forum Winner**  
*Sally Bogoch, MD*

If you are considering professional speaking and would like to gain experience, this forum was designed for you. New York ACEP will showcase members who are dynamic lecturers, but may be new to presenting at the state or regional level.

Speakers must be attending physicians, who are New York ACEP members, and have never presented at the national level.

The topic for the New Speaker Forum is “Best Practices in Emergency Medicine.” The Forum will be held Tuesday, July 9 at 4:30 pm-5:30 pm at the Sagamore Resort on Lake George. Applicants will be selected to give a 15 minute presentation on this topic.

Candidates interested in presenting at New York ACEP’s New Speaker Forum need to apply by 11:59 pm, March 11, 2019.

 *New York*  
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**Joshua Lynch, DO FACEP**  
Assistant Professor of Emergency Medicine  
University at Buffalo, Jacobs School of Medicine  
and Biomedical Sciences

## A Practical Response to the Opioid Crisis: The Buffalo Experience

Traditionally, emergency departments have had few options when addressing patients who present with sequelae of Opioid Use Disorder (OUD). Obstacles to effective treatment have been numerous while inpatient “detox” beds and outpatient clinic appointments rarely meet the demand. Often patients do not meet admission criteria even if inpatient beds are available. The encouraging results of an emergency department (ED)-initiated buprenorphine project at Yale in 2015<sup>1</sup> sparked interest in this approach to treatment across the emergency medicine community including here in Buffalo.

Like too many other regions in the country, we had watched opioid overdose death rates climb. The arrest of a prominent local pain management physician on charges related to opioid prescribing practices in 2016 was a turning point in our community. In the wake of the arrest, thousands of patients sought care at other facilities, including local emergency departments. This event led to unprecedented collaboration between healthcare systems, urgent care centers, and local public health agencies in an effort to meet the needs of the displaced chronic pain patients. Partially, but not exclusively in response to this event, consensus documents were developed by the University at Buffalo Department of Emergency Medicine (UBMDEM). The consensus documents were intended to help guide emergency physicians<sup>2</sup> on responsible prescribing of controlled substances for chronic pain patients and to educate patients<sup>3</sup> on what they should expect when seeking treatment in the emergency department.

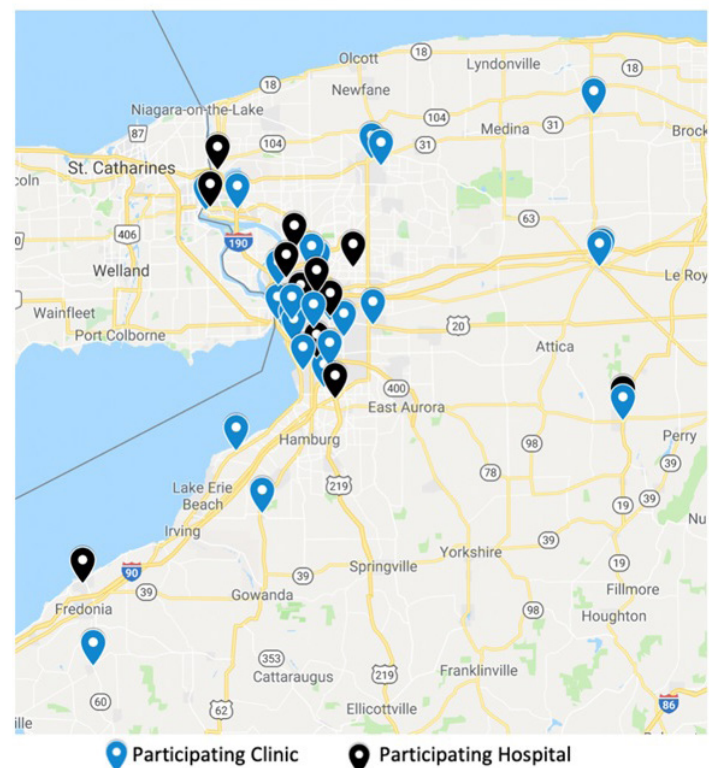
In Buffalo, we knew we had to do something different. We set out with three goals: decrease inappropriate prescribing of opioids, expand access to buprenorphine in the emergency departments and provide rapid access to treatment clinics across the greater Buffalo region.

In early 2017, several emergency physicians from UBMDEM became Drug Addiction Treatment Act (DATA) 2000 waived to prescribe buprenorphine in the ED. Working with a few colleagues at addictions’ clinics, sporadic emergency department initiation of buprenorphine began in Buffalo. On a case-by-case basis, patients were inducted, and clinics were called to arrange appointments. This process was inefficient and 24/7 coverage for clinic appointment scheduling was not available to the EDs. It was quickly evident that the creation of a network of community clinics willing to accept patients from the EDs was necessary. With grant support from the John R. Oishei Foundation, aggressive efforts to provide buprenorphine waiver training to emergency physicians began and a rapid referral network expanded.

After initial success with a few ED physicians providing buprenorphine in the ED, the Buffalo MATTERS (Medication Assisted Treatment and Emergency Referrals) Network was created in mid-2018 in an attempt to unite the hospitals and community clinics of Western New York around a common mission, vision, and set of values.<sup>4</sup> A consensus document was created and vetted by the UBMDEM clinical excellence committee. The goal was to ensure that patients accessing

care at any participating hospital would receive a similar approach to the management of opioid use disorder. The Western New York region is home to 23 hospitals affiliated with several parent organizations. Seven of these hospitals are staffed by faculty from the UBMDEM. This group employs over 125 board certified emergency physicians, physician assistants and nurse practitioners. Two of the hospitals have on site chemical dependency resources and one has affiliated outpatient chemical dependency clinics. Currently, 14 hospitals across Western New York are referring patients into the network.

Community based chemical dependency clinics offering MAT were approached and asked to provide treatment “slots” for patients referred from network hospitals. Beginning with three clinic locations, the network has grown to 29 clinics representing 11 different health care organizations. Initially, some clinics had differing policies on their approach to polysubstance abuse and buprenorphine, pregnant patients, uninsured patients and patients who had previously been discharged from their practice. Over time, every clinic has agreed to our common mission, vision, and values. This ensures that patients receive care regardless of medical or substance use comorbidities, insurance status or previous interactions with any particular clinic. Today, we are proud to offer 74 weekly appointments for hospital-based referrals.

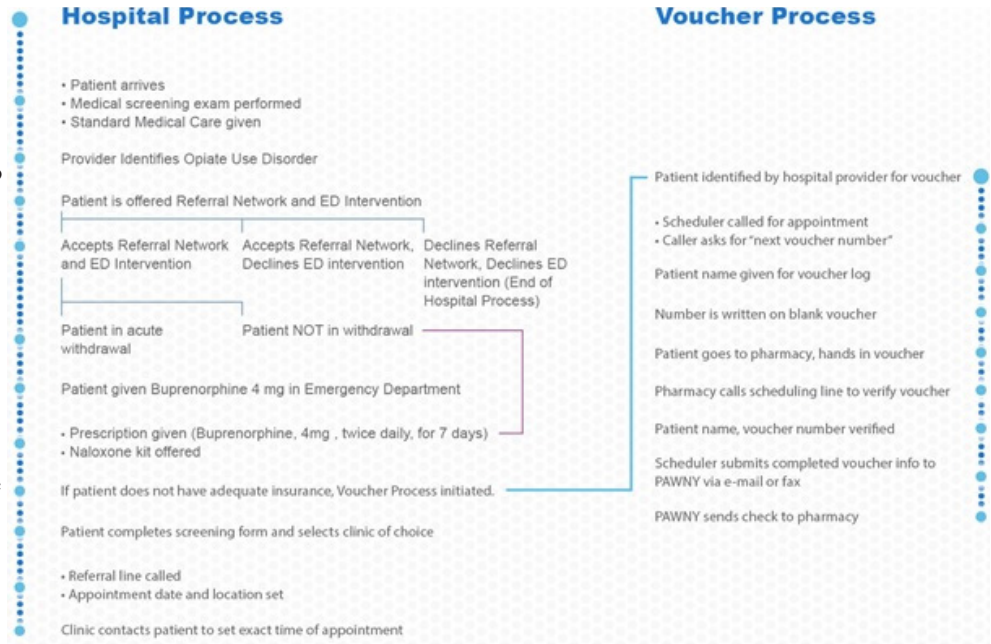




With input from several addiction experts, leadership from the University at Buffalo Jacobs School of Medicine and Biomedical Sciences and the UBMDM clinical excellence committee, we developed an emergency department protocol<sup>5</sup> for use within the Buffalo MATTERS network. Our protocol calls for a standard dose of 4mg/1mg buprenorphine/naloxone twice daily for seven days. Patients presenting in opioid withdrawal receive a dose of 4mg of buprenorphine/naloxone in the ED followed by a prescription. Patients presenting after an overdose and those not in opioid withdrawal are offered a prescription and home induction instructions. Both groups receive hospital-initiated buprenorphine specific discharge instructions.<sup>6</sup> We developed our protocol with efficiency in mind. No specific laboratory or toxicology tests are mandatory (including liver function studies or urine drug screens).

ED-initiated buprenorphine is available only when a DATA 2000 waived provider is available in the ED. When eligible patients agree to community referral and buprenorphine initiation, they complete a demographic form.<sup>5</sup> We provide patients with a list of participating clinics and ask them to pick their top two choices for community follow-up. The information is reviewed and a member of the hospital team contacts our 24/7 referral hotline staffed by a local EMS organization. The EMS organization provides the referral service as an in-kind donation to the program. An EMS dispatcher confirms appointment availability, enters the patient's information into a HIPPA compliant database and electronically transmits the information to the respective clinic. The clinic then contacts the patient to set a time mutually acceptable to the patient and clinic. Most patients referred into this network are seen at their first choice clinic within 48 hours of ED discharge.

Future goals of the network include focusing on areas of referral and treatment where barriers still exist. This includes patients not being able to afford their first seven-day prescription of buprenorphine, those living in rural areas with no access to a MAT provider and those who do not follow-up with their first scheduled appointment. In our experience, most patients were enrolled in Medicaid or a managed Medicaid product, but often they were in an inactive status with Medicaid. With support from a private corporate donor and in partnership with the Pharmacists Association of Western New York, we have created a voucher system that covers the cost of the first week of buprenorphine. The majority of our clinic partners have on site or immediate access to facilitated enrollers to assist patients in navigating the insurance process. Linking patients from the rural regions of Western New York with MAT providers has proven difficult. While in its infancy, we are establishing a telemedicine addictions treatment network to connect patients with MAT providers currently participating in our treatment network. Our goal is to provide patients with evidence-based treatment regardless of their geographic location. Peer networks are engaged and patients are offered peer linkage prior to discharge from the emergency department. Peer navigators will meet with the patient and provide guidance and encouragement during the period between the emergency department visit and the patient's first clinic appointment.



While the process of constructing an ED-initiated buprenorphine program may sound overwhelming, taking a stepwise approach makes it significantly more feasible. We suggest the following steps to success:

- Develop relationships with your pharmacy team to allow for buprenorphine distribution in the ED
- Educate hospital leadership on the lifesaving benefits of ED initiated buprenorphine
- Establish relationships with local outpatient treatment facilities that will see ED patients you refer
- Depending on the timeframe of referrals, determine the need to obtain DATA 2000 waiver training for ED providers (if so, consider the half-and-half training format)
- Develop an easy to understand protocol for the initiation of buprenorphine in the ED or instructions for home induction
- Utilize peers to assist patients between their ED visit and outpatient clinic appointment

Please visit [www.buffalomatters.org](http://www.buffalomatters.org) for links to obtain your DATA 2000 waiver, to setup a training, find resources for patients/providers and more information on our network.

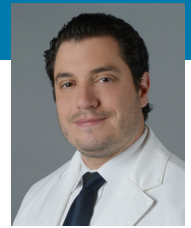
## References:

1. D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. *JAMA*. 2015;313:1636-1644.
2. Buffalo MATTERS Website <https://buffalomatters.org/wp-content/uploads/2018/10/Opioid-and-Sedative-Prescribing-Guidelines-October-2018.pdf>
3. Buffalo MATTERS Website <https://buffalomatters.org/wp-content/uploads/2018/10/Opioid-and-Sedative-Patient-Handout-October-2018.pdf>
4. Buffalo MATTERS Website <https://buffalomatters.org/wp-content/uploads/2019/01/ED-Bupe-MVV-FINAL.pdf>
5. Buffalo MATTERS Website <https://buffalomatters.org/wp-content/uploads/2018/11/Referral-Packet.pdf>
6. Buffalo MATTERS Website <https://buffalomatters.org/wp-content/uploads/2018/11/Buprenorphine-Discharge-Instructions.pdf>

## EMS



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## Why Did EMS Bring the Patient Here?

You give your patient their discharge papers and follow-up instructions and grab your late night snack; it is 2:00 AM and you just sent your last patient home. Feeling elated, you can finally catch-up on paperwork while working the overnight shift at the free-standing Emergency Department (ED), the strobe lights of the local EMS distract your attention back to reality as they pull into your driveway. Seconds later they are whisking in a middle aged male on the stretcher, C-collar in place, copious amounts of blood on his clothing, being ventilated with an ambu bag as their monitors alarm.

You look at them, the patient, and in your head wonder why they brought this disaster of a patient to your ED when 20 minutes down the road is an ED with more staffing and capabilities than your standalone institution.

In New York, EMS agencies all operate under a standing set of protocols developed by a council of physicians, EMTs, and public health officers. Slight differences in protocols exist due to logistics involving geographical concerns, availability of responders and medical directors' practices. To help with these differences New York State EMS is divided into eighteen different regions; each region is responsible for their own protocols to help tailor to what is more suitable/needed for the region.

Within these protocols are guidelines for treatments, medication dosages allowed and directions for when to contact medical control for guidance/further recommendations. They also help to direct providers as to where to transport specific types of patients, such as stroke patients, trauma patients, burns, etc.. These are determined by the region's hospital capabilities and are constantly evolving.

While these protocols exist and most time providers follow them without an issue, situations may arise which force them to deviate. Below are a series of situations to help you better appreciate why these patients show up to some EDs when you would expect them to go elsewhere.

### Trauma

Trauma can and does occur anywhere. EMS agencies are typically well versed and prepared for these situations with this being the foundation for development of today's EMS systems. In 1966, the National Academy of Sciences published a paper titled "Accidental Death and Disability: The Neglected Disease of Modern Society" (also called The White Paper). It demonstrated in one year there were 52 million accidental injuries resulting in 107,000 deaths, over 10 million disabled

and 400,000 permanently impaired. This cost society approximately \$18 billion then (\$140 billion today). This paper led to the creation of government agencies focused on accident prevention and the development of on scene medical care. Using data from battle field medicine noting improving survival rates from WWI to the Vietnam war, it helped create the foundations for our EMS agencies today.

Today, our trauma system has designations for hospitals based on their capabilities with nomenclature stating their preparedness levels (i.e. 24 hour in-house surgical coverage in multiple specialties). The EMS regions have their designated trauma centers as well as indications for when they should utilize them. There are situations though that can force these providers to deviate from their protocol destination:

*Hemodynamic instability* – While non-trauma hospitals may not have the ability to care for these patients long term, they can help in acute care stabilization. A 30 minute transportation time with a profound hypotensive traumatic patient is a deadly proposition. These non-trauma centers can help by giving blood and blood products, gaining direct control of vascular injuries, even surgically repair with intended transfer after the patient stabilizes for final care.

*Airway concerns* – Trauma airways are some of the more difficult airways providers manage. Mangled anatomy, severe hemorrhage, sedation/paralytic issues coupled with an unstable patient makes a definitive airway a major concern for even the most experienced provider. Ventilating a patient without a definitive airway on a long transport to a trauma center (sometimes with only one provider in the back of an ambulance) is not realistic. These patients may show up to a local non-trauma designated facility needing emergent airway management.

### Burns

Burn management can range from simple ointment applications to skin grafts and amputations for more complicated chemical burns. Initial management of these burns focuses on stopping the burning process via removal of contaminated clothing, irrigation with copious water and beginning the fluid resuscitation process. EMS protocols will help delineate which patients should go direct to burn centers and which can go to any ED. Some of the stipulations are body surface area that has suffered second degree or greater burns, locations of burns, type of burn and if any burns are circumferential. EMTs and paramedics are typically pretty good about following these guidelines, but some issues can arise which can cause them to deviate:

*Airway involvement* - We all know rule #1 of burns; If you see soot in



the airway, hear a raspy voice, stridor or the patient tells you they feel as if their voice is different, RUN, do not walk to control that airway before it becomes surgical. This is ingrained in us as emergency physicians as well as our EMS colleagues. They should divert to your facility for airway management.

*Circumferential burns* - These are best managed in burn centers, however, the injury may already be severe enough to cause constrictive injury; from ischemia due to loss of blood supply to airway and breathing issues surrounding the chest. EMS is not trained in escharotomy and may rush to your facility for this limb and life sparing procedure.

*Incorrect BSA calculation* - This is not an exact science and takes some finesse. We look at a burn and calculate the BSA, however, after cleaning and debridement, we realize most of it is a lower severity burn or the total area is less. EMS is doing this without the aid of cleaning or debridement or even good lighting and spare hands to assist.

### **STEMI/Cardiac Arrests**

EMS is aware of the hospitals that have cardiac catheterization labs and know that if they have a patient who is having a STEMI to aim for this facility with pre-notification, if possible. However, sometimes this is not always possible.

Your freestanding ED may not be attached to an interventional catheterization lab, however, it will have more resources than an ambulance and may be why some of these patients roll into your ED.

*Instability* - Injured and stunned myocardium does not pump as effective as we would like. Bypassing one or more emergency departments to get to a STEMI Center may put these patients at higher risk for poor outcomes. Stabilization and possibly giving tPA may be the best alternative in a crashing patient.

*Incorrect EKG Identification* - Each of us has held up a 12 lead EKG at one point and questioned if a patient was in fact having a STEMI. Now imagine doing this without being able to compare old EKGs or time to do serial EKGs. Sometimes EMS providers are unable to see the nuances of EKGs we have been trained in and sometimes EKG changes occur while they are transporting these patients. Keep this in mind when you are questioning why this patient has rolled into your ED.

### **CVA**

Stroke identification is fraught with its own difficulties and we are blessed with the benefit of labs, CTs and MRI. EMS must identify and decide where they need to transfer. Sometimes there may not be a regional stroke center within a reasonable transportation timeframe, therefore, they may end up on your doorstep. There are also many changes in stroke center designation occurring across the state, be on the lookout for further information in the near future.

*Time of Onset* - This can be a tricky scenario, if the patient lives alone, nobody is able to give a good story as to when they last saw them well or even if they can give an adequate time last known well they could end up in your department if they will fall outside of the window for treatment if transported to the stroke center. The thought is your institution can initiate tPA and give the patient more time to go for more definitive treatment (catheter directed treatment or embolectomy).

*Incorrect Identification* - Stroke mimics are plentiful and can even challenge a seasoned emergency physician. Hypoglycemia, seizures, sepsis, migraines, even masses can all be mistaken for a stroke. Misinformation, mistakes and narrow differential can cause EMS providers and even us to mistake them for a CVA.

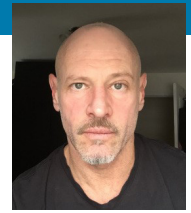
### **Psych**

The agitated and aggressive patient can be a resource and attention hog in your ED. Now imagine doing it while bumping down the road and alone in the back of an ambulance. This can be a recipe for a bad outcome and while your local facility may not have a designated Comprehensive Psychiatric Emergency Program, these patients may present to you not so much for evaluation but more for help with situational control. EMS protocols can be limited to the medications available in an agitated patient as well as how many times they can administer it. With limited options, they may detour to your facility for assistance.

Many of us went into emergency medicine for the variety, the constantly changing array of illness, injuries, and scenarios which require us to not just react, but to think how to best treat these patients. And while some of us may function at one of the specialty facilities with numerous specialties at our fingertips, many of us may not. It may seem almost unbelievable that EMS would bring one of these cases to your department if the proper site is just across town. Please keep in mind that being on the road and working as an EMT is also full of its challenges and sometimes spur of the moment decisions have to be made. Patient preference also plays heavily in the transportation decisions and a patient may desire to go where their primary care doctor can follow them, even after explaining the need for specialty services and care.

Finally, when one of these cases show up at your facility, talk to EMS after the patient is stabilized. If they are able to transport the patient to the more appropriate destination after stabilization then follow-up with them afterwards. These are great cases for learning for both of the teams involved. We as emergency physicians can understand their decision making, as well as offer guidance when a similar situation may occur.

# EDUCATION



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## Difficult Conversations

A few months ago, we had the opportunity to send a select number of residents to an international conference in New York City. We decided to send our senior residents given it would be one of their last opportunities for development in the program. As the conference was drawing to an end, I learned that one of my residents had decided to skip the whole event.

The news shocked me – I had not seen it coming. He was one of our top residents and someone with whom I had developed a strong working and personal relationship over the last two years. Not only was I surprised, but I was also extremely frustrated and, frankly, disappointed. We had paid for his attendance, given him the time off and denied other interested residents the opportunity. As the new Assistant Program Director and the resident point person for this conference, I knew that it was my responsibility to address this.

I had no idea where to begin. I am a generally conflict-avoidant person and the upcoming uncomfortable conversation loomed over me as I hesitated over what I needed to say. I also saw myself more as a friend to the residents rather than a disciplinarian and I found the whole situation utterly awkward. But I knew I needed to learn how to have this type of conversation, as it would probably not be the last one. I quickly realized that I had to be prepared for the conversation if I wanted a productive outcome. So I started doing my research. Here are the 10 best and most effective tactics I learned.

### 1. Be Prepared

It is important to think about how we want to show up for these conversations. Do not wing it. Do your homework in advance - be organized with concrete examples and data if possible. If you know the person well, think about how he or she may respond and play out the proceeding conversation in your mind. Invest the time to be as thoughtful as possible. Similar to how we do procedures, if you practice and have a step-by-step plan, you give yourself the best chance of success.

### 2. Present a United Front

Confirm that you have the full support of the program leadership before the conversation. You do not want the resident receiving different information from different people. Ensure that if any disciplinary action might be taken, everyone is in agreement. The absence of this alignment severely undermines your authority and credibility.

### 3. Deliver Information Clearly

The point of the conversation is not to make the other person feel better, but to discuss the information and situation clearly and openly in order to resolve it. Stick to the facts.

### 4. Reframe the Situation

We defuse angry patient situations like this all the time with no issues because we really do not care whether or not we are “liked” by most of our patients. With residents we do care, so our own personal reputation feels like it is on the line. Reframe the conversation to be in the best interest of the resident rather than as a personal conflict between two people.

### 5. Remove Emotion From the Conversation

If the resident is getting defensive, upset or worked up, do not indulge them. The conversation should be objective and professional. It is perfectly okay to take a short break to regroup if you think that would help defuse a potentially heated discussion. You can also end the conversation and come back to it in a day or two once he/she has had time to process. If the situation feels too out of hand, have another member of leadership in the room with you.

### 6. Try Role Reversals

If the resident still cannot understand where you might be coming from, pose the question “how would you handle the situation if you were in my position?” This might be a way to engage the resident differently. It is also helpful to put yourself in their shoes in order to understand his/her thought process.

### 7. Remember the “Why”

Why are we having these unpleasant conversations? Because we care about the residents. We do it because we want to give them the best chance to grow and succeed. Ensure the resident knows your concern comes from a place of caring.

### 8. Avoid Assumptions

Instead of coming into the conversation with preconceived notions, do your best to remain open-minded and objective the whole way through. This can be made easier by allowing the resident to describe the situation in his/her own words.



### 9. Always Believe There is Good Intention

The last point leads to this one. Oftentimes prior to such conversations, a resident's position can be easily characterized based on preconceived notion. Usually, there is not a simple explanation for perceived misbehavior. So, this compels us to believe that there was likely good intention until proven otherwise. We may be naïve in this practice, but it is easier to overcome naivety than cynicism.

### 10. Not Everyone Will Like You, and That is OKAY

Likeability is subjective; people tend to gravitate towards those who have similar interests, morals and values. As a leader, it is nice to be both liked and respected, but it is more important that your residents respect you as a physician and as part of their leadership team rather than someone they would choose to go to dinner with. Having the difficult conversations may affect your likeability, but being able to have this conversation in a professional manner using the tactics above will show the resident that you are both authentic and trustworthy. These are qualities of a good leader and will allow you to form a relationship of mutual trust and respect.

I do not have a perfect answer on how to deal with having the difficult conversations. But deliberate practice helps with this just like any other skill. Using the advice I received helped me to have my first successful difficult conversation with a resident.

*A special thanks to Drs. Ben Osborne (Baystate Medical Center), Arlene Chung (Maimonides Medical Center), & David Saloum (Maimonides Medical Center) for their continued guidance and support.*

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### References:

1. Berglas, Steven. "Five Reasons Leaders Should Strive For Respect, Not The Liking Of Followers." *Forbes*, Forbes Magazine, 21 Apr. 2012, www.forbes.com/sites/stevenberglas/2012/04/18/the-top-5-reasons-leaders-should-strive-for-respect-not-the-liking-of-followers/#75676df87e95.
2. Matthew Alexander, Vanessa McPherson, and Mary Nolan Hall (2013) The "Hateful Resident". *Journal of Graduate Medical Education*: December 2013, Vol. 5, No. 4, pp. 547-549. <https://doi.org/10.4300/JGME-D-12-00371.1>
3. Su, Amy Jen, et al. "How to Give Feedback to People Who Cry, Yell, or Get Defensive." *Harvard Business Review*, 21 Apr. 2017, hbr.org/2016/09/how-to-give-feedback-to-people-who-cry-yell-or-get-defensive?autocomplete=true.
4. Weeks, Holly. "How to Give Feedback to Someone Who Gets Crazy Defensive." *Harvard Business Review*, 12 Aug. 2015, hbr.org/2015/08/how-to-give-feedback-to-someone-who-gets-crazy-defensive.

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## NEW YORK STATE OF MIND



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### Standardized Video Interviews Do Not Correlate to United States Medical Licensing Examination Step 1 and Step 2 Scores.

*Egan DJ, Husain A, Bond MC, Caputo W, Cygan L, et al; Columbia University Vagelos College of Physicians and Surgeons, Department of Emergency Medicine, New York; West J Emerg Med. 2019 Jan;20(1):87-91.*

**INTRODUCTION:** In 2017, the Standardized Video Interview (SVI) was required for applicants to emergency medicine (EM). The SVI contains six questions highlighting professionalism and interpersonal communication skills. The responses were scored (6-30). As it is a new metric, no information is available on correlation between SVI scores and other application data. This study was to determine if a correlation exists between applicants' United States Medical Licensing Examination (USMLE) and SVI scores. We hypothesized that numeric USMLE Step 1 and Step 2 Clinical Knowledge (CK) scores would not correlate with the SVI score, but that performance on the Step 2 Clinical Skills (CS) portion may correlate with the SVI since both test communication skills.

**METHODS:** Nine EM residency sites participated in the study with data exported from an Electronic Residency Application Service (ERAS®) report. All applicants with both SVI and USMLE scores were included. We studied the correlation between SVI scores and USMLE scores. Predetermined subgroup analysis was performed based on applicants' USMLE Step 1 and Step 2 CK scores as follows: ( $\geq 200$ , 201-220, 221-240, 241-260,  $>260$ ). We used linear regression, the Kruskal-Wallis test and Mann-Whitney U test for statistical analyses.

**RESULTS:** 1,325 applicants had both Step 1 and SVI scores available, with no correlation between the overall scores ( $p=0.58$ ) and no correlation between the scores across all Step 1 score ranges, ( $p=0.29$ ). Both Step 2 CK and SVI scores were available for 1,275 applicants, with no correlation between the overall scores ( $p=0.56$ ) and no correlation across all ranges, ( $p=0.10$ ). The USMLE Step 2 CS and SVI scores were available for 1,000

applicants. Four applicants failed the CS test without any correlation to the SVI score ( $p=0.08$ ).

**CONCLUSION:** We found no correlation between the scores on any portion of the USMLE and the SVI; therefore, the SVI provides new information to application screeners.

### A Review of Natural Language Processing in Medical Education.

*Chary M, Parikh S, Manini AF, Boyer EW, Radeos M; New York-Presbyterian/Queens, Department of Emergency Medicine, Flushing; West J Emerg Med. 2019 Jan;20(1):78-86.*

Natural language processing (NLP) aims to program machines to interpret human language as humans do. It could quantify aspects of medical education that were previously amenable only to qualitative methods. The application of NLP to medical education has been accelerating over the past several years. This article has three aims. First, we introduce the reader to NLP. Second, we discuss the potential of NLP to help integrate FOAM (Free Open Access Medical Education) resources with more traditional curricular elements. Finally, we present the results of a systematic review. We identified 30 articles indexed by PubMed as relating to medical education and NLP, 14 of which were of sufficient quality to include in this review. We close by discussing potential future work using NLP to advance the field of medical education in emergency medicine.

### Changes in Pain Score Associated with Clinically Meaningful Outcomes in Children with Acute Pain.

*Tsze DS, Hirschfeld G, von Baeyer CL, Suarez L, Dayan PS; Department of Emergency Medicine, Division of Pediatric Emergency Medicine, Columbia University College of Physicians and Surgeons, New York; Acad Emerg Med. 2019 Jan 13.*

**BACKGROUND:** Identifying changes in pain score associated with clinically meaningful outcomes is necessary when using self-report measures to assess pain in children.

We aimed to determine the changes in pain score associated with a minimum clinically significant difference (MCS D), ideal clinically significant difference (ICS D), and patient-perceived adequate analgesia (PPAA), and to evaluate for differences based on initial pain intensity and patient characteristics.

**METHODS:** Cross-sectional study of children 6-17 and 4-17 years old who were assessed using the Verbal Numerical Rating Scale (VNRS) and Faces Pain Scale-Revised (FPS-R), respectively. Children qualitatively described any endorsed change in pain score; those who received an analgesic were asked if they wanted additional analgesics to decrease their pain intensity. We used a receiver operating characteristic curve-based methodology to identify changes in pain score associated with "a little less" and "much less" pain (MCS D and ICS D, respectively) and patients declining additional analgesics because of adequate analgesia (PPAA).

**RESULTS:** We enrolled 431 children with painful conditions. For the VNRS, raw change and percent reductions in pain scores associated with MCS D, ICS D, and PPAA were 2/10 and 20%, 3/10 and 44%, and 2/10 and 29%, respectively; for the FPS-R, 2/10 and 33%, 4/10 and 60%, and 4/10 and 40%, respectively. Raw change in pain scores increased with increasing initial pain intensity, but percent reductions remained stable. There were no significant differences based on patient characteristics such as age, sex, and race/ethnicity. **CONCLUSION:** Our findings provide patient-centered outcomes in children that are suitable for designing trials and are generalizable across patient characteristics.

### Aggressive Imaging Protocol for Hanging Patients Yields No Significant Findings: Over-Imaging of Hanging Injuries.

*Schuberg S(1), Gupta N(2), Shah K(3); Department of Emergency Medicine, Icahn School of Medicine at Mount Sinai, New York; Am J Emerg Med. 2019 Jan 4.*

**BACKGROUND:** Despite rising rates of hanging injuries, few high-quality data and no national trauma guidelines are available to



# NEW YORK STATE OF MIND

standardize the evaluation of these patients. We sought to identify the yield of imaging hanging patients at our institution.

**METHODS:** This is a retrospective study at an urban Level I Trauma Center. Charts for patients diagnosed with “Hanging, Strangulation, or Asphyxiation” (ICD-9 E93.0) from February 2008 to March 2014 were reviewed. Frequency of imaging orders and their results were recorded. Logistic regression analyses were done to determine factors associated with increased rates of imaging.

**RESULTS:** 78 patients met inclusion criteria. The average age was 34 years, 86% were male, and 65% were witnessed hangings. In total, 195 CT scans and 67 X-rays were done. Frequency of imaging in our cohort: 77% received CT of the head (CTH); 88% CT of the neck; 85% CT angiography (CTA) of the neck; 86% chest X-ray. Highest-level trauma activation occurred in 76% of patients and was associated with an increased rate of imaging, with the likelihood of CTH being increased by 31% ( $p < 0.01$ ), CT of the neck without contrast by 19% ( $p < 0.01$ ), CTA of the neck by 25% ( $p < 0.01$ ), and chest X-ray by 25% ( $p < 0.01$ ). Of the 78 patients, none had significant findings that required intervention.

**CONCLUSIONS:** In this study, the highest-level trauma activation was associated with increased rates of imaging, but did not alter patient care. A more selective approach in the evaluation of hanging injuries should be considered.

## Use of Capnography and Cardiopulmonary Resuscitation Feedback Devices Among Prehospital Advanced Life Support Providers.

*Sahyoun C, Siliciano C, Kessler D; Division of Pediatric Emergency Medicine, Morgan Stanley Children's Hospital of New York, Columbia University Medical Center, New York; Pediatr Emerg Care. 2018 Dec 27.*

**BACKGROUND:** Capnography and cardiopulmonary resuscitation (CPR) feedback devices have been shown to improve resuscitation outcomes, with the American Heart Association recommending their use during advanced life support (ALS). Little is known about the availability of these devices, their protocol use, and the attitudes toward them in the prehospital setting.

**OBJECTIVES:** The objectives of this study were to assess the availability of capnography and CPR feedback devices among prehospital ALS agencies in New York State (NYS), to describe the protocol use of these devices, and to evaluate the attitudes of providers toward the use of these devices.

**METHODS:** Prehospital agencies that provide ALS services in NYS were identified using an online registry. Managers in these agencies were contacted by electronic mail and asked to complete a questionnaire regarding their agency's experience with capnography and CPR feedback devices. The questionnaire included questions on the availability of capnography and CPR feedback devices, the existence of clinical protocols for using capnography, and provider opinion on the utility of capnography and CPR feedback devices for improving pediatric resuscitation.

**RESULTS:** Of 710 ALS agencies, 238 (33.5%) completed the survey. Ninety-five percent and 24% of agencies reported having capnography and CPR feedback devices available aboard ambulances, respectively. Ninety-seven percent of agencies reported having capnography clinical protocols for endotracheal intubation, 63% for return of spontaneous circulation, and 54% for guiding CPR. Forty-seven percent agreed that capnography improves outcomes in the resuscitation of pediatric patients, whereas 51% of providers were neutral and 2% disagreed.

**CONCLUSIONS:** Capnography is available in most NYS ALS agencies surveyed. Cardiopulmonary resuscitation feedback devices are less common. Protocols for the use of capnography mainly focused on endotracheal intubation and less for the recognition of return of spontaneous circulation and for guiding CPR. Half of the providers surveyed were neutral on whether capnography improves outcomes in the resuscitation of pediatric patients.

## Hospital Observation Upon Reversal (HOUR) With Naloxone: A Prospective Clinical Prediction Rule Validation Study.

*Clemency BM, Eggleston W, Shaw EW, et al; Department of Emergency Medicine, Jacobs School of Medicine and Biomedical Sciences, University at Buffalo, Buffalo; Acad Emerg Med. 2018 Dec 28.*

**OBJECTIVE:** St. Paul's Early Discharge Rule was derived to determine which patients could be safely discharged from the emer-

gency department after a 1-hour observation period following naloxone administration for opiate overdose. The rule suggested that patients could be safely discharged if they could mobilize as usual and had a normal oxygen saturation, respiratory rate, temperature, heart rate, and Glasgow Coma Scale score. Validation of the St. Paul's Early Discharge Rule is necessary to ensure that these criteria are appropriate to apply to patients presenting after an unintentional presumed opioid overdose in the context of emerging synthetic opioids and expanded naloxone access.

**METHODS:** In this prospective, observational validation study, emergency medicine providers assessed patients 1 hour after administration of prehospital naloxone. Unlike in the derivation study the threshold for normal oxygen saturation was set at 95% and patients were not immediately discharged after a normal 1-hour evaluation. Patients were judged to have a normal 1-hour evaluation if all six criteria of the rule were met. Patients were judged to have an adverse event (AE) if they had one or more of the preestablished AEs.

**RESULTS:** A total of 538 patients received at least one administration of prehospital naloxone, were transported to the study hospital, and had a 1-hour evaluation performed by a provider. AEs occurred in 82 (15.4%) patients. The rule exhibited a sensitivity of 84.1% (95% confidence interval [CI] = 76.2%-92.1%), a specificity of 62.1% (95% CI = 57.6%-66.5%), and a negative predictive value of 95.6% (95% CI = 93.3%-97.9%). Only one patient with a normal 1-hour evaluation subsequently received additional naloxone following a presumed heroin overdose.

**CONCLUSION:** This rule may be used to risk stratify patients for early discharge following naloxone administration for suspected opioid overdose.

## The Challenges of a Vertical Evacuation Drill.

*Salway RJR, Adler Z, Williams T, Nwoke F, Roblin P, Arquilla B; Department of Emergency Medicine, SUNY Downstate Medical Center, Brooklyn; Prehosp Disaster Med. 2018 Dec 27:1-5.*

**INTRODUCTION:** Recent natural and infrastructural disasters, such as Hurricanes Sandy (2012) and Katrina (2005) and the Northeastern power outage of 2003, have emphasized the need for hospital staff to be

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trained in disaster management and response. Even an internal hospital disaster may require the safe and efficient evacuation and transfer of patients with varying medical conditions and complications. A notably susceptible population is renal transplant patients, including those with post-transplant complications.

**HYPOTHESIS:** This descriptive study evaluated staff performance of a vertical evacuation drill of renal transplant patients at State University of New York (SUNY) Downstate Medical Center - University Hospital Brooklyn (UHB; Brooklyn, New York USA).

**METHODS:** Thirteen standardized patients, 12 of whom received a renal transplant, with varying medical histories, ambulatory ability, and mental status were vertically evacuated by the transplant staff from the eighth floor to the ambulance entrance on the ground floor. Non-ambulatory patients were transported on portable evacuation sleds.

**RESULTS:** All patients were evacuated successfully within 3.5 hours. On a post-drill evaluation form, drill participants self-reported largely positive results concerning their own role in the drill and the evacuation drill itself. Drill evaluators observed very different results, including staff reticence, poor training retention, and lack of leadership.

**CONCLUSION:** Despite encouraging post-drill evaluation results from the participants, the evacuation drill highlighted several immediate deficiencies. It also demonstrated a significant discrepancy in performance perception between the drill participants and the drill evaluators.

## Missed Opportunities: Integrating Palliative Care Into the Emergency Department for Older Adults Presenting As Level I Triage Priority From Long-Term Care Facilities.

*Mogul AS(1), Cline DM(2), Gabbard J(3), Bryant C(4); Department of Emergency Medicine, Stony Brook Medicine, Stony Brook; J Emerg Med. 2018 Dec 6.*

**BACKGROUND:** Early integration of palliative care from the emergency department (ED) is an underutilized care modality with potential benefits, but few studies have identified who is appropriate for such care.

**OBJECTIVE:** Our hypothesis is that patients aged 65 years or older who present to the ED as level I Emergency Severity Index from a long-term care (LTC) facility have high

resource utilization and mortality and may benefit from early palliative care involvement.

**METHODS:** We performed a retrospective chart review of patients aged 65 years or older who arrived in the ED of an academic suburban southeastern level I trauma center from an LTC facility and triaged as level I priority. The ED course, hospital course, and final outcomes were analyzed.

**RESULTS:** Of the 198 patients studied, 54% were deceased 30 days after discharge, with only 29.8% alive at 12 months. Admitted patients had a median hospital length of stay of 5 days and 73% required intensive care. Formal palliative care intervention was provided in 40.4%, occurring a median of 4 days into hospitalization and leading to 85% downgrading their advanced directive wishes, and discharge occurring a median of 1 day later. Few formal palliative care interventions occurred in the ED (9.1%).

**CONCLUSIONS:** Elderly patients from LTC facilities presenting with severe acute illness have high mortality and seldom receive early palliative care. Introduction of palliative care has the ability to change the course of treatment in this vulnerable population and should be considered early in the hospitalization and, where available, be initiated in the ED.

## Bundled HIV and Hepatitis C Testing in the Emergency Department: A Randomized Controlled Trial.

*Cowan E, Herman HS, Rahman S, Zahn J, Leider J, Calderon Y; Mount Sinai Beth Israel, Department of Emergency Medicine, New York; West J Emerg Med. 2018 Nov;19(6):1049-1056.*

**INTRODUCTION:** An estimated 25% of the 1.2 million individuals living with human immunodeficiency virus (HIV) in the U.S. are co-infected with hepatitis C (HCV). The Centers for Disease Control and Prevention recommends HCV testing for high-risk groups. Our goal was to measure the impact of bundled HIV and HCV testing vs. HIV testing alone on test acceptance and identification of HCV and HIV.

**METHODS:** We conducted a two-armed, randomized controlled trial on a convenience sample of 478 adult patients in the Jacobi Medical Center emergency department from December 2012 to May 2013. Participants were randomized to receive either an offer of bundled HIV/HCV testing or HIV testing alone. We compared the primary outcome,

HIV test acceptance, between the two groups. Secondary outcomes included HIV and HCV prevalence, and HCV test acceptance, refusal, risk, and knowledge.

**RESULTS:** We found no significant difference in HIV test acceptance between the bundled HCV/HIV (91.8%) and HIV-only (90.6%) groups ( $p=0.642$ ). There were also no significant differences in test acceptance based on gender, race, or ethnicity. A majority of participants (76.6%) reported at least one HCV risk factor. No participants tested positive for HIV, and one (0.5%) tested positive for HCV.

**CONCLUSION:** Integrating bundled, rapid HCV/HIV testing into an established HIV testing program did not significantly impact HIV test acceptance. Future screening efforts for HCV could be integrated into current HIV testing models to target high-risk cohorts.

## Analgesic Administration for Patients With Renal Colic in the Emergency Department Before and After Implementation of an Opioid Reduction Initiative.

*Motov S, Drapkin J, Butt M, Thorson A, Likourezos A, Flom P, Marshall J; Maimonides Medical Center, Department of Emergency Medicine, Brooklyn; West J Emerg Med. 2018 Nov;19(6):1028-1035.*

**INTRODUCTION:** We aimed to evaluate the patterns of analgesic prescribing for emergency department (ED) patients suffering from pain of renal colic before, during, and after implementation of an opioid reduction initiative. We hypothesized that this initiative based on the concept of channels/enzymes/receptors-targeted analgesia would result in overall decrease in opioid utilization in the ED and at discharge.

**METHODS:** We performed a retrospective analysis of ED electronic medical record of patients presenting with renal colic who received analgesics in the ED and at discharge over a five-year period. Patients were divided into three groups based on the following periods: 2012-2014 (pre-implementation phase); 2014-2015 (implementation phase); and 2015-2017 (post-implementation).

**RESULTS:** A total of 4,490 patients presented to the ED with renal colic over a five-year study period. Analgesics were administered to 3,793 ED patients of whom 1,704 received opioids and 2,675 received non-opioid anal-



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gesics. A total of 3,533 ED patients received a prescription for analgesic(s) upon discharge from the ED: 2,692 patients received opioids, and 2,228 received non-opioids. We observed a 12.7% overall decrease from the pre-implementation to post-implementation time period in opioid prescribing in the ED and a 25.5% decrease in opioid prescribing at discharge, which translated into 432 and 768 fewer patients receiving opioids, respectively.

**CONCLUSION:** Implementation of an opioid-reduction initiative based on patient-specific, pain syndrome-targeted opioid alternative protocols resulted in a reduction in opioid administration in the ED by 12.7% and at prescriptions at discharge by 25.5%. Adoption of similar ED initiatives nationwide has the potential to foster effective non-opioid analgesic practices for ED patients presenting with renal colic and to reduce physicians' reliance on administering and prescribing opioids.

## Characteristics of Prior Emergency Department Visits Associated With Subsequent Opioid Overdose.

*Youssef E, Gao HT, Russell C, Hassan S, Ardolic B, Hahn B; Department of Emergency Medicine, Staten Island University Hospital, Northwell Health, Staten Island; J Opioid Manag. 2018 Sep/Oct;14(5):327-333.*

**OBJECTIVES:** In this study, we aim to identify and discuss the clinical and demographic characteristics of previous emergency department (ED) patient visits, at one of the only two medical centers in Staten Island, the epicenter of the opioid epidemic within Staten Island, who subsequently present to the ED with an opioid overdose.

**DESIGN:** This was a retrospective, observational study of all patients presenting to the emergency ED between July 1, 2010 and December 31, 2015.

**SETTING:** The study was conducted at Staten Island University Hospital. The ED has a census of 120,000 patient visits per year.

**PATIENTS:** All adult patients  $\geq 18$  years of age, with an ICD-9 code consistent with opioid intoxication and a history of intentional or unintentional overdose were included.

**MAIN OUTCOME MEASURE:** Clinical and demographic characteristics of previous ED patient visits who subsequently presented to the ED with an opioid overdose.

**RESULTS:** One hundred and twenty-four

subjects with a median age of 30 years [interquartile range, 24-40] were reviewed. Eighty-seven (70 percent) were males. Fifty-five subjects were admitted, 68 discharged, and one death. Patients were not more likely to present at any specific time of day. The most common past medical history was anxiety (21 percent), depression (20 percent), back pain (15 percent), hypertension (14 percent), and seizure disorder (11 percent). The most common past surgical history was a prior orthopedic procedure (11 percent).

**CONCLUSIONS:** This study identified clinical and demographic characteristics of previous ED patient visits who subsequently present to the ED with an opioid overdose. These characteristics will be vital toward an increased understanding of subjects who subsequently experience an opioid overdose.

## A Novel Emergency Department-Based Telemedicine Program: How Do Older Patients Fare?

*Greenwald PW, Stern M, Clark S, Hafeez B, Gogia K, Hsu H, Mulcare M, Sharma R; Department of Emergency Medicine, NewYork-Presbyterian Hospital/Weill Cornell Medical Center, New York; Telemed J E Health. 2018 Oct 24.*

**INTRODUCTION:** When we started using telemedicine to treat low acuity patients in the emergency department (ED), we assumed that this voluntary treatment pathway would primarily be used by younger patients. We were surprised to find that a significant portion of patients evaluated by telemedicine were older adults.

**MATERIALS AND METHODS:** We conducted a retrospective cohort study of quality assurance data. Adult ED patients at an urban academic medical center who had their care provided by telemedicine from July 2016 to September 2017 were included. We measured demographic characteristics, ED length of stay (LOS), triage severity score, X-ray orders placed, ED revisit within 72h, need for change in treatment plan or admission on 72-h return, and patient satisfaction.

**RESULTS:** Of 1,592 patients evaluated, 18% were age 65 and older. Older patients were more likely to be evaluated for wound care and less likely to be evaluated for nontraumatic connective tissue illnesses. Older patients also had shorter median LOS (59 min vs. 63 min). Unplanned 72-h return (2% vs. 2%),

likelihood to have a change in treatment on return (1% vs. 0.2%), and patient satisfaction were similar between age groups. The percentage of patients who returned in 72 hrs requiring admission were similar between age groups (0.4% vs. 0.1%  $p=0.325$ ). Sensitivity analysis with an age threshold at 75 years did not change primary results.

**CONCLUSION:** These findings suggest that among low acuity patients there are groups of older adults for whom an ED telemedicine evaluation can provide safe and effective medical care that is satisfactory to patients.

## Approach to Buprenorphine Use for Opioid Withdrawal Treatment in the Emergency Setting.

*Cisewski DH, Santos C, Koyfman A, Long B; The Icahn School of Medicine at Mount Sinai, Department of Emergency Medicine, New York; Am J Emerg Med. 2019 Jan;37(1):143-150.*

**INTRODUCTION:** Opioid use disorder (OUD) is increasing in prevalence throughout the world, with approximately three million individuals in the United States affected. Buprenorphine is a medication designed, researched, and effectively used to assist in OUD recovery.

**OBJECTIVE:** This narrative review discusses an approach to initiating buprenorphine in the emergency department (ED) for opioid-abuse recovery.

**DISCUSSION:** Buprenorphine is a partial mu-opioid receptor agonist with high affinity and low intrinsic activity. Buprenorphine's long half-life, high potency, and 'ceiling effect' for both euphoric sensation and adverse effects make it an optimal treatment alternative for patients presenting to the ED with opioid withdrawal. While most commonly provided as a sublingual film or tablet, buprenorphine can also be delivered via transbuccal, transdermal, subdermal (implant), subcutaneous, and parenteral routes. Prior to ED administration, caution is recommended to avoid precipitation of buprenorphine-induced opioid withdrawal. Following the evaluation of common opioid withdrawal symptoms, a step-by-step approach to buprenorphine can be utilized to reach a sustained withdrawal relief. A multimodal medication-assisted treatment (MAT) plan involving pharmacologic treatment, as well as counseling and behavioral therapy, is essential to maintaining opioid

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remission. Patients may be safely discharged with safe-use counseling, close outpatient follow-up, and return precautions for continued management of their OUD. Establishing a buprenorphine program in the ED involves a multifactorial approach to establish a pro-buprenorphine culture.

**CONCLUSIONS:** Buprenorphine is an evidence-based, safe, effective treatment option for OUD in an ED-setting. Though successfully utilized by many ED-based treatment programs, the stigma of ‘replacing one opioid with another’ remains a barrier. Evidence-based discussions on the safety and benefits of buprenorphine are essential to promoting a culture of acceptance and optimizing ED OUD treatment.

## Does Initial Temperature in the Emergency Department Predict Outcomes in Patients Admitted for Sepsis?

*Khodorovsky B, Youssef E, Adamakos F, Cina T, Falco A, LaMura L, Marion A, Nathan S, Hahn B; Department of Emergency Medicine, Staten Island University Hospital, Northwell Health, Staten Island; J Emerg Med. 2018 Sep;55(3):372-377.*

**BACKGROUND:** Sepsis is a leading cause of morbidity and mortality in hospitalized patients. Prompt recognition and early treatment has been shown to improve mortality. Both low and high temperature are among the four elements of systemic inflammatory response required for the diagnosis of sepsis. We hypothesized that initial temperature has an effect on the identification, treatment, and outcomes of septic patients.

**OBJECTIVE:** Our aim was to determine the prognostic and diagnostic utility of the initial recorded body temperature in patients presenting to the emergency department (ED) with sepsis.

**METHODS:** This retrospective cohort study was conducted in the ED of a single facility during the study period of January 1, 2014 through December 31, 2014. Inclusion criteria were adult subjects 18 years of age and older who were admitted to the hospital from the ED with a diagnosis of sepsis.

**RESULTS:** Hypothermia on presentation was associated with a longer time to antibiotics treatment of 338.6 min ( $p=0.002$ ), longer length of stay of 14.5 days ( $p<0.001$ ), higher rate of intensive care unit (ICU) admission of 32.7% ( $p=0.003$ ), and higher mortality rate of

30.8% ( $p<0.001$ ).

**CONCLUSIONS:** In this study of adult patients diagnosed in the ED with sepsis, hypothermia correlated with increased time to initial antibiotics, length of stay, rate of ICU admission, and mortality. Therefore, hypothermia in the setting of sepsis requires early and aggressive intervention to prevent adverse outcomes and delays in care.

## Early Point-of-Care Testing at Triage Reduces Care Time in Stable Adult Emergency Department Patients.

*Singer AJ, Taylor M, LeBlanc D, Meyers K, Perez K, Thode HC Jr, Pines JM; Department of Emergency Medicine, Stony Brook University, Stony Brook; J Emerg Med. 2018 Aug;55(2):172-178.*

**BACKGROUND:** Core laboratory testing may increase length of stay and delay care.

**OBJECTIVES:** We compared length of emergency department (ED) care in patients receiving point-of-care testing (POCT) at triage vs. traditional core laboratory testing.

**METHODS:** We conducted a prospective, case-controlled trial of adult patients with prespecified conditions requiring laboratory testing and had POCT performed by a nurse after triage for: a basic metabolic panel, troponin I, lactate, INR (i-STAT System), urinalysis (Beckman Coulter Icon), or urine pregnancy test. Study patients were matched with controls based on clinical condition, gender, age, and time to be seen. Groups were compared with Wilcoxon rank-sum or Fisher’s exact tests.

**RESULTS:** We matched 52 POCT study patients with 52 controls. Groups were similar in age, gender, clinical condition, time to be seen by a physician (3.3h, 95% confidence interval [CI] 2.2-4.4, vs. 3.1h, 95% CI 2.2-4.5h, in POCT and control patients, respectively;  $p=0.84$ ), use of imaging, and disposition. Of 52 study patients, 3 (5.8%, 95% CI 2.0-15.9) were immediately transferred to the critical care area to be urgently seen by an emergency physician. POCT patients had a significantly shorter median (interquartile range [IQR]) ED care time than matched controls (7.6, 95% CI 5.1-9.5 vs. 8.5, 6.2-11.3h, respectively;  $p=0.015$ ). Median [IQR] ED length of stay was similar in study patients and controls (9.6, 95% CI 7.9-14.5 vs. 12.5, 8.2-21.2h, respectively;  $p=0.15$ ).

**CONCLUSIONS:** Among stable adult patients presenting to the ED with one of the

prespecified conditions, early POCT at triage, compared with traditional core laboratory testing after evaluation by an ED provider, reduced ED care time by approximately 1h.

## Evaluation of Fixed-Dose Four-Factor Prothrombin Complex Concentrate for Emergent Warfarin Reversal in Patients With Intracranial Hemorrhage.

*Scott R, Kersten B, Basior J, Nadler M; Buffalo General Medical Center, Buffalo; J Emerg Med. 2018 Jun;54(6):861-866.*

**BACKGROUND:** Different strategies exist for dosing four-factor prothrombin complex concentrate (PCC4) for international normalized ratio (INR) reversal in the setting of life-threatening bleeding. Fixed doses ranging from 1000 IU to 1750 IU have demonstrated efficacy similar to weight-based dosing, however, few studies look exclusively at intracranial hemorrhage (ICH).

**OBJECTIVE:** Our aim was to evaluate whether a fixed dose of 1000 IU of PCC4 achieves INR reversal similar to weight-based dosing in patients with ICH who were anticoagulated with warfarin.

**METHODS:** We compared a weight-based dose vs. 1000 IU PCC4 between January 2014 and January 2017. The primary end point was achieving an INR  $< 1.5$ . Secondary end points included in-hospital mortality, patient disposition, and reversal defined by INR  $< 1.6$ .

**RESULTS:** A total of 31 patients were included in the weight-based group and 30 were included in the fixed-dose group, with baseline INRs of 2.98 and 2.84, respectively ( $p=0.39$ ). Twenty-two patients (71%) achieved an INR  $< 1.5$  in the weight-based group vs. 16 (53%) in the fixed-dose group ( $p=0.15$ ), while 25 (81%) achieved an INR  $< 1.6$  in the weight-based group vs. 22 (73%) in the fixed-dose group ( $p=0.49$ ). There was no difference in the number of patients discharged to home (19% vs. 20%;  $p=0.95$ ) or in-hospital mortality (26% vs. 27%;  $p=0.93$ ).

**CONCLUSIONS:** We found a non-statistically significant difference in warfarin reversal to an INR goal of  $< 1.5$  when comparing a fixed dose of 1000 IU PCC4 and a weight-based dose for ICH. Further studies correlating clinical outcomes with INR reversal are needed.



# TOXICOLOGY



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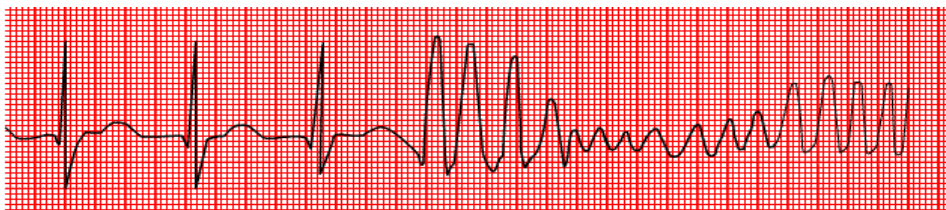
## Syncope and Dysrhythmia

### Case

35-year-old male with a past medical history of opioid abuse presents to the Emergency Department (ED) accompanied by his girlfriend after a witnessed syncopal episode at home while on his couch watching TV. On arrival to the ED his vitals were: BP 128/78 mm Hg; HR, 70 beats/min; RR, 18 breaths/minute; T, 36.6° C (rectal); O2 Sat, 100%, FSG, 120 mg/dL. IV access was obtained and he was placed on a telemetry monitor. ECG revealed normal sinus rhythm, normal axis, QRS 100ms and prolonged QTc of 505 ms. His physical exam was unremarkable, without any appreciable toxidrome or withdrawal syndrome present.

The patient attributed his syncopal episode to fatigue with no similar prior episodes and no family history of sudden death. He had no prodromal symptoms, including chest pain, palpitations or lightheadedness prior to the loss of consciousness. He denied prescription, over-the-counter, or herbal medication use; he endorsed occasional ethanol use, but no tobacco or recent illicit drug use. He endorsed a long history of IV heroin abuse, resulting in two prior drug detox/rehab admissions, with the last use over one year ago. He was never put on medication assisted therapies (MAT), such as methadone or buprenorphine maintenance. Initial labs were unremarkable, including potassium and magnesium.

One hour into his ED stay, the patient suffered another syncopal episode, with pulselessness and apnea. Standard ACLS protocol was initiated. His telemetry recording demonstrated the following rhythm:



He was defibrillated (200 J) with immediate return of spontaneous circulation and gradual return of mental status within minutes. Shortly thereafter, he complained of weakness and palpitations followed by a sustained polymorphic dysrhythmia (with a pulse) which responded to two grams of magnesium IV. He was then placed on a lidocaine drip for continued ventricular ectopy. Collateral from his girlfriend revealed that the patient was self-medicating his opioid addiction with an “anti-diarrheal” medication, and the patient disclosed that he had been consuming escalating doses of Imodium (loperamide), reaching up to 100-150 mg daily over the past year. An examination of the patient’s belongings revealed dozens of 2mg loperamide blister-packs in his possession. The ectopy and episodic runs of torsades de pointes spontaneously resolved after placing the patient on 1:1 constant bedside observation.

### Discussion

Loperamide is an anti-motility agent indicated for the treatment of diarrhea. It also happens to be a synthetic phenylpiperidine opioid mu-receptor agonist. Over the last 15 years, there has been an uptrend in both overdose and abuse. This phenomena is attributed to its use as a means to curb the symptoms of acute opioid withdrawal and as a self-administered maintenance strategy. Additionally, it has been abused at higher doses for its euphoric properties. Easy access (over the counter), cheap cost compared to street/illicit opioids, and lack of regulation, has created a dangerous recipe during our current opioid crisis. While loperamide has

minimal toxicity and abuse potential at therapeutic dosing, significant morbidity and mortality has resulted from both overdose and abuse.

Outside the typical opioid toxidrome, monomorphic and/or polymorphic ventricular dysrhythmias are the most life-threatening toxicities from loperamide abuse. It exhibits sodium and potassium channel blocking properties that can result in a widened QRS and/or prolonged QTc. This places patients at risk for developing lethal dysrhythmias, in particular torsades de pointes (TdP), as was seen in our vignette. Loperamide-induced TdP should be treated with standard ACLS protocol including defibrillation and IV magnesium. Electrical or chemical overdrive pacing can also be employed in certain clinical situations. It is also important to note, that patients may develop ventricular arrhythmias days after cessation of loperamide misuse; therefore, close cardiac monitoring is warranted throughout the hospital stay. There is no defined role for extracorporeal removal at this time.

### Case Conclusion

The patient underwent serial ECGs and electrolyte repletion in the ICU. He did not exhibit any further cardiac sequelae during the remainder of his hospital course. However, he developed signs and symptoms of opioid withdrawal 24 hours after admission, which was managed with clonidine and anti-emetics. Medication assisted therapy using buprenorphine-naloxone (Suboxone) maintenance was initiated in the hospital with plans set in place for further outpatient support.

### Summary

Large loperamide ingestions can achieve an opioid-like effect, while simultaneously exerting cardiotoxicity that can manifest as syncope, lethal dysrhythmias, and/or TdP.

*references continued on page 28*

# PEDIATRICS



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## Understanding and Addressing Bullying: Guidance for Pediatric Emergency Departments

Bullying is a widespread and significant public health concern. It affects 21-35% of youth aged 12-18 in the United States, and is associated with significant morbidity and mortality, including depression, anxiety, substance use and suicide.<sup>1-3</sup> In recent years, the media and general public—and clinicians and researchers as well—have become more aware of the long-lasting issues bullying may cause. This attention is primarily because of suicides associated with bullying and because an increased number of children and adolescents are visiting emergency departments (EDs) with suicidal ideation. The American Academy of Pediatrics recommends that physicians introduce the concept of bullying to parents and guardians during the six-year-old well-child examination.<sup>4</sup>

### What Is Bullying?

Bullying is defined as repeated, negative behavior with the intention of causing harm. It necessarily involves a power imbalance between the bully and the victim.

A child can be involved in bullying as a “perpetrator” (enacting bullying behavior) or as a “victim” (being the target of bullying). There is a third category of bullying behavior that involves both perpetration and victimization, and a youth involved in this kind of behavior is labeled a “bully-victim.” Often bully-victims are at the highest risk of psychosocial maladjustment, both as children and later as adults.<sup>5</sup>

Bullying may take on numerous forms. The U.S. Department of Health and Human Services identifies two modes of bullying (direct and indirect) and four broad types of bullying (physical, verbal, relational and damager of property). Direct bullying involves actions taken in the presence of the targeted youth, while indirect bullying may be less explicit (i.e. spreading rumors). Bullying behavior ranges from violent assault to more subtle relational approaches that aim to harm the victims’ reputations or relationships. Cyberbullying is another growing concern, with verbal and relational offenses amplified through social media, digital communications, and other contexts enabled by changing technologies.<sup>6</sup>

Stigma-based bullying is another pervasive form of negative behavior that affects particularly high-risk youth: those “living with socially devalued identities, characteristics, and attributes,” such as racial minority, LGBTQ, disabled, low socioeconomic status, or overweight youth, or other such populations.<sup>7</sup> These cases should be handled with

attention to multicultural treatments and approaches.

There are no significant differences in prevalence of bullying based upon gender,<sup>5</sup> but research does link physical bullying more strongly with boys, while girls are more prone to verbal or relational bullying.<sup>8,9</sup>

### How Does Bullying Affect Children and Adolescents?

Children who experience bullying are at higher risk for developing behavioral difficulties, physical health problems, and suicidal ideation.<sup>1-3</sup> These consequences extend not just to those who are victims of bullying but also to those who perpetrate and witness it too.<sup>10-14</sup>

Moreover, the psychological and physical consequences of bullying behavior often last well into adulthood. Data from a large longitudinal study of 7,000 adults who were frequently bullied in childhood showed that victims of bullying had higher rates of depression, anxiety and suicidality; worse general health; and less social support in different stages of adulthood, even after adjusting for known correlates of bullying victimization.<sup>13</sup> Perpetration of bullying also predicts negative long-term outcomes, including but not limited to criminality,<sup>16</sup> intimate partner and sexual violence perpetration,<sup>17,18</sup> as well as significant mental health issues, including depression, anxiety and suicidality.<sup>19</sup>

### Why Do Children Engage in Bullying and What Are Risk Factors for Bullying?

Bullying—both victimization and perpetration—is a complex behavior that is not easily explained. However, identifying risk factors is important in preventing and in identifying children in need of further intervention.

Risk factors for bullying perpetration, victimization and bully-victimization should be viewed from both the individual level and the contextual level. A 2010 meta-analysis pooling data from 153 previous studies scrutinized the strengths of 13 predictors, ranging from gender to cognition to home environment.<sup>20</sup> The results of this meta-analysis are generally consistent with findings from other large studies,<sup>5,21</sup> and provide a concise summary of the risk factors associated with bullying.

**Individual Factors That Predict Bullying Involvement:** Cook, et al. found a significant correlation between bullying perpetration and high externalizing behavior, or a tendency to direct antisocial, aggressive

# PEDIATRICS

behavior toward others or the environment, as well as, a low ability to perform other-related cognitions (i.e. low empathy and perspective-taking). Meanwhile, children who were low in status and social competence were more likely to be victims of bullying. Bully-victims showed both externalizing and internalizing behaviors. They tended to have low self-esteem and, similar to pure bullies, exhibited less ability to consider others' perspectives and to show empathy. In addition, they scored lower on social competence measurements.<sup>20</sup>

While some studies posit that bullies are deficient in both self-esteem and social skills, other studies have suggested that they can be quite functionally and socially adept, and employ bullying as a calculated adaptive behavior.<sup>5</sup> Current research is only beginning to uncover how heterogeneous bullying behaviors can be. Thus, further study is required to add nuance and complexity to our understanding of these issues.

**Contextual Factors That Predict Bullying Involvement:** Factors such as poor peer relationships, negative family or home environment and adverse community environment (e.g., low socioeconomic indicators, violence, crime) heighten the risks for all three forms of bullying involvement.<sup>20</sup> In particular, bully-victims often come from the most challenging homes and show significant difficulties in adjusting socially with their peers.<sup>5</sup>

In summary, a wide range of factors influence children's involvement in bullying, as perpetrators, victims, or bully-victims. In all cases, bullying is correlated with psychosocial issues and challenging environmental contexts. These factors are also related to long-term physical and mental health outcomes and can influence future behavioral issues well into adulthood.

## Why Is Bullying Relevant to the Emergency Department?

Although many youths with behavioral issues presenting to the emergency department (ED) have been found to report bullying during their ED interview, bullying is still not generally viewed as an emergency medicine issue. In fact, caretakers and ED physicians may play a crucial role in identifying significant risk factors for serious long-term health risks, such as depression, anxiety, substance abuse and suicide,<sup>1-3</sup> by actually screening for bullying involvement. Data from the National Center for Education Statistics suggests that less than half of youth who experience bullying at school reported it to an adult (40%), and only 26% of youth who experienced cyberbullying told an adult.<sup>22</sup> Because children may be reluctant to report bullying, making detection difficult, emergency physicians can help elucidate these issues and to help intervene and plot a clear course of action.

In a study of 909 anonymous surveys obtained at an ED, approximately 79% of youth reported exposure to bullying, whether as a witness, perpetrator or victim. Roughly one-third of the total reported being both a witness and a victim; this group was the largest, with witness-only participants being the second largest. The third largest group included youth who were involved as witnesses, victims and bullies (128 individuals).<sup>23</sup> In another study, 55% of patients reporting recent bullying victimization at three EDs across the U.S., were also at risk for suicide.<sup>22</sup> The high incidence of bullying exposure in pediatric patients reporting to EDs, in conjunction with high suicide risk, calls for greater awareness of these issues among emergency physicians and increased

screening efforts.

## How Can Emergency Physicians and Staff Help Youth Involved in Bullying?

Identifying youth who are at risk for bullying involvement or who are already involved in bullying, is not always straightforward. The table below details some common indicators of bullying involvement.

Indicators of bullying victimization	Indicators of bullying perpetration
<ul style="list-style-type: none"> <li>• Receives injuries with no plausible, or consistent explanation</li> <li>• Frequent loss of belongings</li> <li>• Somatic symptoms, such as headaches and stomach aches</li> <li>• Frequent nightmares, change in sleep patterns</li> <li>• Reluctance to go to school, or to riding the bus to school</li> <li>• Running away from home, self-injuring behaviors, suicidal ideation or hurting others</li> </ul>	<ul style="list-style-type: none"> <li>• Engaging in physical or verbal fights</li> <li>• Associating with others who bully</li> <li>• Behaving aggressively</li> <li>• School administering disciplinary measures against him/her</li> <li>• Possessing extra money or new belongings without explanation</li> <li>• Blaming others for his/her problems</li> <li>• Not accepting responsibility for his/her actions</li> <li>• Being excessively concerned with his/her reputation or popularity</li> <li>• Intimidating or being excessively physical with siblings or other peers</li> </ul>

Table adapted from Waseem, et al. 2017<sup>25</sup>

If physicians have reason to believe a pediatric patient has been involved in bullying, they should proceed with further screening for identifying risk factors. Sometimes, asking youth direct questions about bullying can be a good way to gather the necessary information (i.e. "Have you ever been bullied?" "How often were you bullied?"). However, because youth may be unforthcoming with reporting bullying or other psychosocial issues and identifying perpetration may be harder than identifying victimization, physicians may elect to perform more general assessments.

One popular and effective psychosocial assessment is named "HEADSS." This set of comprehensive questions surveying adolescent systems has more recently expanded to HEEADSSS, or HE<sup>2</sup>ADS<sup>3</sup>, standing for Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression and Safety from injury and violence (the last of which explicitly includes bullying). Further information and a list of suggested probes can be found online.<sup>26</sup> While not every question suggested by HE<sup>2</sup>ADS<sup>3</sup> is feasible to ask in an ED setting, given the time and resource constraints, this assessment can act as a guide in mapping out a patient's psychosocial well-being.

A 2017 paper by Waseem, et al. outlines suggested steps that ED staff can take to address issues caused by bullying involvement once such an involvement has been confirmed.

### Step 1: Establish Rapport

It is imperative all ED personnel provide a sense of safety and to be nonjudgmental.<sup>25</sup> Youth are often reluctant to disclose cases of bullying due to a number of factors, such as shame, self-blame, fear of retaliation or concern about being a "tattletale."<sup>25</sup> Therefore, physicians should engage youth with a warm and open demeanor, ask for privacy from parents (whose presence may make them less likely to disclose) and stress the confidential nature of their conversation.<sup>26</sup>

### Step 2: Stabilization

Address any immediate physical or psychological health concerns.

*continued on page 23*



### Step 3: Screen for Psychological Conditions and Assess Risk for Aggressive Behavior

Physicians may screen for risk of suicide and other psychological issues such as depression and anxiety, using assessments such as the ASQ (Ask Suicide-Screening Questions).<sup>26</sup>

### Step 4: Identify Resources and Develop a Plan

Developing a plan with the youth and his or her family while they are in the ED is an important step in preventing or ending bullying involvement. Provide mental health care from trained medical staff as needed and suggest parental involvement in continuing care and engaging any other necessary parties, such as teachers, school officials or community liaisons. Emphasize nonjudgmental attitudes and refrain from criticizing or blaming the youth.

### Step 5: Provide Resources for Bullying Intervention

Provide referrals for counseling and treatment when necessary. Encourage the ED to serve as a resource for the community.<sup>25</sup> Bullying prevention programs can have moderate, but significant results in reducing harm in the school setting.

In summary, emergency physicians can play a crucial role in interrupting cycles of violence. Youth who witness or are targets of abuse and bullying, in their neighborhood, at home or in school, are more likely to become bullies themselves.<sup>20,29,30</sup> They are also at higher risk for perpetrating violence as adults.<sup>17</sup> Engaging with at-risk pediatric patients in the ED can have life-long effects not only for that patient, but also for their peers, their loved ones and members of their communities.

### References:

- Williams K, Chambers M, Logan S, Robinson D. Association of common health symptoms with bullying in primary school children. *BMJ*. 1996;313(7048):17-19.
- Arseneault L, Walsh E, Trzesniewski K, Newcombe R, Caspi A, Moffitt T. Bullying Victimization Uniquely Contributes to Adjustment Problems in Young Children: A Nationally Representative Cohort Study. *Pediatrics*. 2006;118(1):130-138. doi:10.1542/peds.2005-2388
- Kim Y, Leventhal B, Koh Y, Hubbard A, Boyce W. School Bullying and Youth Violence. *Arch Gen Psychiatry*. 2006;63(9):1035. doi:10.1001/archpsyc.63.9.1035
- Lyznicki, J, McCaffree, M, & Robinowitz, C. Childhood bullying: implications for physicians. *American Family Physician*. 2004;70(9).
- Menesini E, Salmivalli C. Bullying in schools: the state of knowledge and effective interventions. *Psychol Health Med*. 2017;22(sup1):240-253.
- Facts About Bullying. StopBullying.gov. <https://www.stopbullying.gov/media/facts/index.html>. Published 2018. Accessed September 29, 2018
- Earnshaw V, Reisner S, Menino D et al. Stigma-based bullying interventions: A systematic review. *Developmental Review*. 2018; 48:178-200
- Besag V. *Understanding Girls' Friendships, Fights And Feuds: A Practical Approach To Girls' Bullying*. Maidenhead, England: Open University Press; 2006
- Crick N, Grotpeter J. Relational Aggression, Gender, and Social-Psychological Adjustment. *Child Development*. 1995;66(3):710
- Wolke D, Lereya S. Long-term effects of bullying. *Arch Dis Child*. 2015;100(9):879-885. doi:10.1136/archdischild-2014-306667
- Moore S, Norman R, Suetani S, Thomas H, Sly P, Scott J. Consequences of bullying victimization in childhood and adolescence: A systematic review and meta-analysis. *World J Psychiatry*. 2017;7(1):60
- Klomek A, Kleinman M, Altschuler E, Marrocco F, Amakawa L, Gould M. Suicidal Adolescents' Experiences with Bullying Perpetration and Victimization during High School as Risk Factors for Later Depression and Suicidality. *Journal of Adolescent Health*. 2013;53(1):S37-S42
- Rivers I, Poteat V, Noret N, Ashurst N. Observing bullying at school: The mental health implications of witness status. *School Psychology Quarterly*. 2009;24(4):211-223
- Janosz M, Archambault I, Pagani L, Pascal S, Morin A, Bowen F. Are There Detrimental Effects of Witnessing School Violence in Early Adolescence? *Journal of Adolescent Health*. 2008;43(6):600-608
- Takizawa R, Maughan B, Arseneault L. Adult Health Outcomes of Childhood Bullying Victimization: Evidence from a Five-Decade Longitudinal British Birth Cohort. *American Journal of Psychiatry*. 2014;171(7):777-784
- Ttofi MM, Farrington DP, Lösel F, Loeber R. The predictive efficiency of school bullying versus later offending: A systematic/meta-analytic review of longitudinal studies. *Criminal Behaviour and Mental Health*. 2011;21(2):80-89. doi:10.1002/cbm.808
- Falb KL. School Bullying Perpetration and Other Childhood Risk Factors as Predictors of Adult Intimate Partner Violence Perpetration. *Archives of Pediatrics & Adolescent Medicine*. 2011;165(10):890. doi:10.1001/archpediatrics.2011.91
- Espelage DL, Basile KC, Hamburger ME. Bullying Perpetration and Subsequent Sexual Violence Perpetration Among Middle School Students. *Journal of Adolescent Health*. 2012;50(1):60-65
- Gibb SJ, Horwood LJ, Fergusson DM. Bullying victimization/perpetration in childhood and later adjustment: findings from a 30-year longitudinal study. *Journal of Aggression, Conflict and Peace Research*. 2011;3(2):82-88.
- Cook CR, Williams KR, Guerra NG, Kim TE, Sadek S. Predictors of bullying and victimization in childhood and adolescence: A meta-analytic investigation. *School Psychology Quarterly*. 2010;25(2):65-83
- Thomas HJ, Connor JP, Scott JG. Why do children and adolescents bully their peers? A critical review of key theoretical frameworks. *Social Psychiatry and Psychiatric Epidemiology*. 2017;53(5):437-451
- Robers, S, Kemp, J, & Truman, J. Indicators of School Crime and Safety: 2012. NCES 2013-036/NCJ 241446. National Center for Education Statistics. 2013.
- Seltzer M, Menoch M, Chen C. Opportunistic Screening for Exposure to Bullying in the Pediatric Emergency Department. *Global Pediatric Health*. 2017;4.
- Stanley IH, Horowitz LM, Bridge JA, Wharff EA, Pao M, Teach SJ. Bullying and Suicide Risk Among Pediatric Emergency Department Patients. *Pediatric Emergency Care*. 2016;32(6):347-351
- Waseem M, Paul A, Schwartz G, et al. Role of Pediatric Emergency Physicians in Identifying Bullying. *The Journal of Emergency Medicine*. 2017;52(2):246-252.
- Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemporary Pediatrics*. January 2004.
- Carr-Gregg, M & Manocha, R. Bullying: Effects, prevalence and strategies for detection. *Australian family physician*. 2011; 40(3), 98
- Ask Suicide-Screening Questions (ASQ) Toolkit. National Institute of Mental Health. <https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/index.shtml>. Accessed September 30, 2018.
- Go EJ, Kong JW, Kim KE. A Meta-analysis of the Correlation between Maltreatment, Witnessing Domestic Violence, and Bullying among Youths in South Korea. *Social Work in Public Health*. 2017;33(1):17-30
- Choi B, Park S. Who Becomes a Bullying Perpetrator After the Experience of Bullying Victimization? The Moderating Role of Self-esteem. *Journal of Youth and Adolescence*. November 2018.



## Call for Board and Councillor Nominations

### Councillor Nominations

Active members of New York ACEP interested in serving as a New York ACEP Councillor are encouraged to submit their nominations to the 2019 Nominating Committee for consideration as the committee develops the slate of candidates.

### Councillors with Terms Ending in 2020

Theodore Albright, MD (Resident)  
 Nicole Berwald, MD FACEP  
 Robert M. Bramante, MD RDMS FACEP  
 Jeremy T. Cushman, MD FACEP  
 Mathew Foley, MD FACEP  
 Abbas Husain, MD FACEP  
 Stuart G. Kessler, MD FACEP  
 Laura D. Melville, MD

Joshua B. Moskovitz, MD MBA MPH FACEP  
 Nestor B. Nestor, MD FACEP  
 Salvatore R. Pardo, MD MBA FACEP  
 Jeffrey S. Rabrich, DO FACEP FAEMS  
 Christopher C. Raio, MD MBA FACEP  
 Peter Viccellio, MD FACEP  
 Joseph A. Zito, MD MHA FACEP

### Councillors With Terms Ending in 2019

Brahim Ardolic, MD FACEP  
 Michael W. Dailey, MD FACEP  
 Sanjey Gupta, MD FACEP  
 Marc P. Kanter, MD FACEP  
 Penelope C. Lema, MD FACEP  
 Mary McLean, MD (resident)  
 William F. Paolo, Jr., MD FACEP

Mikhail Podlog, DO (Resident)  
 Louise A. Prince, MD FACEP  
 Jennifer L. Pugh, MD MBA FACEP  
 Gary S. Rudolph, MD FACEP  
 Livia M. Santiago-Rosado, MD FACEP  
 L. Carlos Zapata, MD FACEP

The Board of Directors will elect Councillors at the Thursday, July 11, 2019 Board meeting at the Sagamore Resort. Members interested in representing New York ACEP at the ACEP Annual Council Meeting (October 25-26, 2019 in Denver, CO) should submit a nomination form and their CV to New York ACEP. New York ACEP will be represented by 29 Councillors at the 2019 ACEP Council meeting.

### Board Nominations

Active members of New York ACEP who meet the criteria and are interested in serving on the Board of Directors are encouraged to submit their nominations to the 2019 Nominating Committee for considerations as the Committee develops the slate of candidates.

Four directors will be elected by the membership through a proxy ballot distributed at least 30 days prior to the annual membership meeting. The annual membership meeting will be held Wednesday, July 10, 2019 at the Sagamore Resort on Lake George.

### Board Members with Terms Ending in 2019

Open Board Position  
 Nicole Berwald, MD FACEP

Frank L. Dimase, MD FACEP  
 Laura D. Melville, MD

Interested candidates should review the Criteria for New York ACEP Board Nomination, Board Member Duties and Responsibilities and send a completed nomination form along with a copy of their CV to New York ACEP by April 1, 2019. Self nomination and nominations of colleagues are accepted. To request the policies and nomination form, contact New York ACEP at (585) 872-2417 or by email at nyacep@nyacep.org.

Successful nominees will be notified by May 13, 2019. Board candidates are required to submit background information on their professional career, a photograph and answer questions posed to all board candidates. Candidates will have approximately two weeks to submit material.

**Nomination Deadline: April 1, 2019**





**Arlene S. Chung, MD MACM**  
Residency Director  
Maimonides Medical Center

## Work Life Balance and Other Fairy Tales

This July I had the privilege of being elected to the New York ACEP Board of Directors. It has been a tremendously fulfilling opportunity to represent and serve my fellow emergency physicians in New York State over the past several months. This year I also became the Chair of the national ACEP Well-Being Committee and the Program Director of the Maimonides Medical Center Emergency Medicine Residency, a large and well-established training program in Brooklyn. While I am proud of these accomplishments and grateful to the mentors who helped me along the way, my professional life has certainly not become any less hectic with the addition of these new responsibilities. I have built a career on advocating for physician wellness and for every long day that I spend racing around the Emergency Department (ED), trapped in meeting rooms, or typing maniacally away on my computer into the small hours of the night, I am acutely aware of my own personal struggle with work life balance.

I once presented a Grand Rounds lecture a few years ago entitled, “Achieving a Perfect Work Life Balance and Other Fairy Tales.” During my talk, I advocated strongly for the adoption of the phrase “work life integration” rather than “work life balance.” I reasoned that a need for “balance” implies that life is good and work is bad.<sup>1</sup> Instead, we should be aiming to integrate professional engagement and personal fulfillment such that we feel complete in all aspects of our lives. Work can be good too. At the time, I thought I had stumbled on a rather profound conclusion and vigorously tried to incorporate it into my own day-to-day practice. In reality, however, I found that justifying my round-the-clock work schedule in the name of personal fulfillment became increasingly difficult, no matter how engaged I felt in my career.

Boundaries are a good thing. Our professional goals (work) and personal values (life) are no exception to this rule. Neglecting one aspect of ourselves in sacrifice to another is not the path to happiness. Research clearly demonstrates that physicians who care for themselves provide better care to the patients they serve.<sup>2,3</sup> I believe that it is possible to have an incredibly engaging career but still suffer from burnout if we chronically neglect our sleep, physical health, spiritual growth, or friends and family. However, carving out the time for balance is a challenge for all of us. The easy solution to this problem of course would be to create more than 24 hours in each day. Or to clone ourselves. But in the absence of such technology, I have found the following pieces of advice to be useful in my own day-to-day struggle. I hope they may be useful in yours:

**Schedule regular time away from work and stick to it.** One of the unintended consequences of the advancement of technology has been the development of a 24/7 work culture. Emergency medicine has always been a 24/7 specialty, but now there is frequently an expectation to engage in what I call “low level administrative work” at all hours of the day. I used to spend my clinical time off sitting on the couch at home typing away on my computer with the television blaring in the background. But without regular breaks away from work, I never felt fully present for my loved ones and only worked at half-speed the majority of the time. In response, I began to schedule dedicated breaks of personal time for

friends, family and self-care and explicitly gave myself permission to do so. Unless I am scheduled for a clinical shift, I close my computer every Friday evening and try to leave it closed until Monday morning. Practically this means that anything due Monday must be completed the Friday before and that I cannot bank on the 48 hours of the weekend to catch up on any major projects. Alternatively, I have colleagues who take time off between 6:00 pm and 9:00 pm every evening or select different days off depending on their schedules.

**Schedule regular time to get work done and stick to it.** “Flow” is defined as a mental state of being fully immersed in an activity. We become incredibly engaged and productive and it is an ideal time to finish large tasks requiring a significant amount of cognitive effort (e.g. manuscript writing). But flow cannot be achieved in 10-minute increments between meetings or subway transfers or email responses. Scheduling regular blocks of time helps to achieve a flow state during which tasks can be more efficiently accomplished.<sup>4</sup>

**Resist checking email first thing in the morning.** Do not fall into the trap of confusing busyness with productivity. Checking email rarely results in significant progress on any task and can easily lead into a time warp sinkhole. I try to accomplish at least one task in the day before launching into my inbox. (Although truthfully, I am successful only about 50% of the time. Setting priorities can help with this.

**Set priorities.** Although rapid task switching is an essential skill in the practice of emergency medicine, it can be distracting and inefficient when applied to non-clinical tasks. Taking time to write down the priorities for the day or for the week can be an effective way to ensure that the most essential tasks are completed on time. Tasks should not be simply limited to professional duties either. Going to the gym, attending a child’s music recital, or finding time to connect with a friend can all be important priorities. One of my mentors is fond of using the phrase, “the institution will never love you back.” I usually take her to mean that decades from now when I am old and gray, the various leadership titles held in my youth will probably not come to bring me flowers or joy in my sunset years. Keeping that advice in mind can help to release any resentment or conflicting feelings about prioritizing family, friends and loved ones over the decision to take on a new role or project.

### References:

1. Schwingshacki A. The Fallacy of Chasing After Work-Life Balance. *Front Pediatr.* 2014;2:26.
2. Tawfik DS, Profit J, Morgenthaler TI, et al. Physician Burnout, Well-Being, and Work Unit Safety Grades in Relationship to Reported Medical Errors. *Mayo Clin Proc.* 2018;93(11):1571-1580.
3. Wallace JE, Lemaire JB, Ghali WA. Physician Wellness: A Missing Quality Indicator. *Lancet.* 2009;374:1714-21.
4. Newport C. *Deep Work: Rules for Focused Success in a Distracted World.* New York, NY: Hachette Book Group; 2016.

## Announcing New York ACEP 2019 Research Forum Call for Abstracts



The New York American College of Emergency Physicians is now accepting abstracts for review for oral and poster presentation at the 2019 Scientific Assembly, July 9-11, at the Sagamore Resort on Lake George in Bolton Landing, New York.

The **Research Forum**, including both oral and poster presentations, will be held Tuesday, July 9 at 1:30 pm. This forum is designed to feature and foster resident and faculty research. Topics may address the broad range of emergency medicine practice and educational development. Preference will be given to work completed at the time of submission. **Authors and institutions should not be identified in any way on the page containing the abstract.**

Abstract submissions must be in electronic format (Microsoft Word) and must include the following subsections, Title, Objectives, Methods (include design, setting, type of participants), Results and Conclusion. The abstract should be written in complete sentences using grammatically correct English. Spell out all abbreviations on first usage. Abstracts are limited to 3,000 characters (excluding spaces). Accepted abstracts will be published as received; no copy editing will be done. Send abstracts by e-mail to nyacep@nyacep.org. Use abstract title in subject line.

Illustrations are discouraged; however, if critical, one (1) small table may be included. Figures, tables and photos must be black and white with a resolution of at least 300 dpi. Note: tables, figures and illustrations will be considerably reduced when published causing loss of detail. Please consider this when determining whether to include these.

Including the following information on the submission form for each abstract:

1. title of the abstract;
2. author(s) and affiliations;
3. IRB approval or exemption;
4. contact person's mailing address, phone/fax numbers and e-mail address;
5. information regarding previous presentations or publication;
6. potential conflicts by author;
7. if accepted, indicate who will present the abstract July 9, 2019 and their role in the project; and state preference for oral or poster presentation (or no preference).
9. identification of resident if s/he will likely be first or second author on manuscript.

Although we are interested in original work, consideration will be given to abstracts presented at other conferences (SAEM, ACEP).

Oral presentations will be allocated 10 minutes followed by 5 minutes of Q&A. Twenty-four poster presentations will be allocated 5 minutes followed by 3 minutes of Q&A. Other poster submissions will be selected for display. All presenters (oral or poster) are expected to have had a significant role in the execution and report preparation of the project being presented.

**About the Process:** There will be a blind review of all abstracts. Notification letters will be sent April 22, 2019. We regret we cannot give notification information by telephone.

deadline  
**April 1, 2019**  
**11:59 pm Eastern**

Coming Soon



2019 Scientific  
Assembly



at the  
Sagamore  
Resort





# ALBANY UPDATE



## 2018 Statewide Elections

Last Fall, Democrats swept all of the statewide elections. Democratic Governor Andrew Cuomo defeated Republican challenger Marc Molinaro, former New York City Public Advocate Letitia James is the first elected female Attorney General following her win over Republican Keith Wofford and incumbent Democratic State Comptroller Tom DiNapoli easily prevailed over his Republican opponent Johnathan Trichter, a former investment banker.

## Senate and Assembly

In the State Senate, Democrats took control of the chamber. Since 2011, 31 Republicans have held a one-seat majority in the 63-member house with the help of Brooklyn Democrat, Senator Simcha Felder, who caucused and voted with the Republicans. On November 6, Democrats beat eight Republican incumbents giving them a 40 seat majority over 23 Republican members. Defeated Republican incumbents include long-time Health Committee Chairman Kemp Hannon, who held that post for the last 24 years.

The Assembly Democratic Majority currently stands at 107 members, the minority has 43 Republicans. This increases the Assembly's "super majority" by 3 seats.

## 2019 Committee and Leadership Posts

In the Assembly, Assemblywoman Crystal Peoples-Stokes (Eric County) was named to the post of Majority Leader vacated by Joe Morelle who successfully won New York's 25<sup>th</sup> Congressional District. Carl Heastie remains the Speaker. Committee posts of relevance to New York ACEP did not change in the Assembly.

The new Senate leadership and committee posts are as follows:

- Senate Majority Leader: Andrea Stewart Cousins (Westchester)
- Chair, Democratic Caucus: Michael Gianaris (Queens)

## Reid, McNally & Savage

### New York ACEP Legislative & Regulatory Representatives

- Senate Health Committee: Gustavo J. Rivera (Bronx)
- Senate Higher Education Committee: Toby Ann Stavisky (Queens)
- Senate Insurance Committee: Neil Breslin (Albany & Rensselaer)
- Senate Judiciary Committee: Brad Hoylman (Manhattan)
- Senate Finance Committee: Liz Krueger (Manhattan)

## 2019-20 State Budget Released

The Legislature returned to Albany for the 2019 Legislative Session January 9 and is scheduled to recess June 19, 2019. On January 15, Governor Andrew M. Cuomo released his proposed Executive Budget. Of interest to New York ACEP members, the plan includes a proposal to legalize the sale of recreational marijuana to persons over the age of 21, eliminate the exemption in a hospital emergency department to check the Prescription Monitoring Program (PMP) if a controlled substance prescription is written for a 5-day supply or less and other items impacting emergency medicine as outlined below.

## Excess Medical Malpractice Program

The Governor proposes to extend the Excess Medical Malpractice program for one year through June 30, 2020 and includes level funding of \$127.4 million.

## Emergency Department PMP Exemption

The proposed State Budget eliminates the exemption in a hospital emergency department to check the PMP if a controlled substance prescription is written for a 5-day supply or less. Numerous studies, including a 2015 and 2018 study in the *Annals of Emergency Medicine*, demonstrate that hospital emergency departments are not a major source of opioid prescriptions. In addition, New York ACEP has gathered data from a geographical cross

section of large, medium-size, and smaller hospitals in the State which show a significant downward trend in patients leaving emergency departments with opioid prescriptions since the enactment of the I-STOP law.

New York ACEP strongly supports integrating PMP information into the patient Electronic Medical Record (EMR) which would streamline the process for consulting it and increase quality of care for patients.

## Hospital/Emergency Department Medication Assisted-Treatment (MAT)

The Governor's budget includes a proposal to require hospital emergency departments to have policies and procedures in place for providing medication assisted-treatment (MAT) prior to patient discharge. This includes policies and procedures and treatment protocols for the appropriate use of buprenorphine, prior to discharge, or referral protocols for evaluation of medication-assisted treatment when initiation in an emergency department is not feasible.

## Adult Regulated Cannabis Program

As expected, the Governor's budget proposes to legalize the purchase of marijuana by adults age 21 and over. The budget bill establishes the Office of Cannabis Management within the Division of Alcohol Beverage Control to regulate adult recreational and medical use marijuana and industrial hemp. The proposal requires separate licensing for growers, distributors and retailers, with a ban on growers opening retail shops. Large municipalities such as counties and cities may ban marijuana sales within their boundaries.

Last year, New York ACEP developed a statement on the legalization of recreational marijuana which will be shared with the Governor's Office and all state legislators. The paper examines the "**Potential Effects of the Legalization of Recreational Marijuana Upon Hospital Emergency Departments.**" Some of the recommendations in the report include but are not limited to the following:

- Further research is needed on the short-and-long term health effects of legalized marijuana and tax revenues should support these research projects.

- New York ACEP anticipates an increase of marijuana related emergency department visits and tax revenues should offer some relief for uncompensated care.
- New York ACEP urges limits and research on the forms and concentration of regulated marijuana.
- New York ACEP supports further research regarding the effect on motor vehicle injury rates; and
- New York ACEP believes that further study is needed to show the actual effect of marijuana use on opioid deaths and prescribing because the Department of Health's study presumes a decrease.

### New York ACEP Lobby Day, March 5, 2019

On Tuesday, March 5 members of the New York ACEP Board and their colleagues will travel to Albany for the annual lobby day to meet with key legislators and staff on New York ACEP's 2019 legislative priorities including opposition to the elimination of the emergency department exemption for consulting the PMP before prescribing opioids, integration of the PMP in the EMR and support for initiatives that preserve the emergency health care safety net.

We will continue to keep members apprised of activities in Albany as they relate to New York ACEP's government affairs goals. You will soon be receiving Action Alerts and other calls for grassroots activities to advance your priorities. We greatly appreciate all of your local efforts which are critical to New York ACEP's success.

*Toxicology column references from page 20*

#### References:

1. Vincent R. Lee, Ariel Vera, Andreia Alexander, Bruce Ruck, Lewis S. Nelson, Paul Wax, Sharan Campleman, Jeffrey Brent & Diane P. Calello (2018) Loperamide misuse to avoid opioid withdrawal and to achieve a euphoric effect: high doses and high risk, *Clinical Toxicology*, DOI: [10.1080/15563650.2018.1510128](https://doi.org/10.1080/15563650.2018.1510128)
2. Eggleston, W., Clark, K.H., and Marraffa, J.M. Loperamide abuse associated with cardiac dysrhythmia and death. *Ann Emerg Med.* 2017; 69: 83–86
3. Eggleston, W., Nacca, N., and Marraffa, J.M. Loperamide toxicokinetics: serum concentrations in the overdose setting. *Clin Toxicol (Phila).* 2015; 53: 495–496
4. Spinner, H.L., Lonardo, N.W., Mulamalla, R. et al. Ventricular tachycardia associated with high-dose chronic loperamide use. *Pharmacotherapy.* 2015; 35: 234–238

**Save the Date**

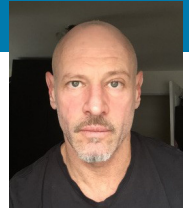
**2019 ED Director Forum**  
**Friday April 26, 2019**  
 New York Academy of Medicine  
 8:00 am - 4:00 pm  
 Register online at [www.nyacep.org](http://www.nyacep.org)

This activity has been approved for *AMA PRA Category 1 Credit(s)™*

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# THE OPENING



**Joshua Schiller MD**  
Assistant Program Director  
Department of Emergency Medicine  
Maimonides Medical Center

## My Relationship with Art and Medicine

I have been an attending emergency medicine (EM) physician since 2008. Since then, I have attempted to promote a balance to the resident lifestyle by incorporating influences of art and culture into the practice of medicine. By finding like-minded colleagues, innovative programming can be developed both institutionally and across the EM community.

The trajectory into medicine in general, and EM specifically, takes a normal person from looking at the world as a large macrocosm to the microcosms of pathophysiology and the often claustrophobic environment of the emergency department (ED). While making that transition myself, I found myself naturally drawn to art and literature, mostly for inspiration and calm as I was growing up and trying to figure things out.

But as I progressed through medical school and residency, I found the path fraught with loneliness and isolation. I suspected at the time I was not alone, and when I started in medical education, I realized that residents exist in an almost perpetual state of isolation.

Exposure to books, paintings, music and movies can give what is sorely lacking in carrying out our work—perspective, context, and insight. When we experience the expressions that are essential to our humanity, we understand better how we, as doctors, fit into society. And in doing so, we add that most precious aspect to our work: meaning.

Much of the artwork that may be consistent with the ED experience reflects the everyday—drawing beauty from the experience on a daily

basis, turning the mundane into the extraordinary. There is a long line of artists who draw from this type of inspiration, from the French Realists in the 1800s (i.e., Daumier) with Impressionism (i.e., Degas) developing at the turn of that century. Over the past 100 years, increased awareness of common pressures across societies have yielded social realism in the depression (i.e., Wood) and given way to photorealism and more subversive works in the current age (i.e., Banksy).

In turn, art provides a lens through which to view life in the ED, and how to put the work we

do into context of the larger world. And we may very well need it. It should go without saying that the ED attracts much of the unpleasant-ries of life—the sick, incarcerated, addicted, poor,

etc. It is an uncomfortable environment for most. Yet it can provide us with a unique perspective into life's rarely seen conditions, both the joys and heartbreak, that push the human condition towards inspiring a reckoning of what we can and cannot control. This view is challenging, but also beautiful, to observe the resilience of society to the inevitable and amoral ills of the world. This beauty exists in a space where bad things happen to perfectly good people, where questions about why someone may live while someone with the same disease may die.

As much as we would like to not think about it, there are limits to our clinical understanding, beyond which art and literature can guide us how we accommodate for this in our practice.

**Let's celebrate together**  
**Share a piece of writing, art or music at**  
**"The Opening" July 9, 2019**  
**5:30 pm – 6:30 pm**  
**2019 New York ACEP Scientific Assembly**

We fight the good fight.



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