LUCAS - STUDIOLOCO-STOCK.ADOBE.COM

KIDS KORNER

## Volvulus and Ataxia

SEE PAGE 14

JOB MARKET

## 2024–25 Emergency Physician Compensation

SEE PAGE 18

PEARLS FROM THE EM LIT

## Neurologic Emergencies

SEE PAGE 19

WILEY

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# ACEP Now

The Official Voice of Emergency Medicine

2024 APEX® AWARDS FOR PUBLICATION EXCELLENCE

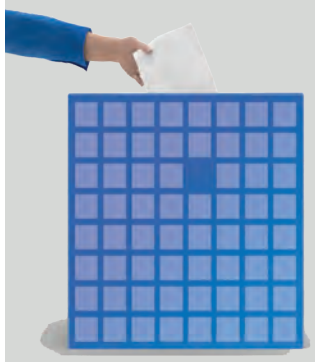
**SEPTEMBER 2024** Volume 43 Number 9 FACEBOOK/ACEPFAN INSTAGRAM/ACEPNATION X/ACEPNOW **ACEPNOW.COM**

**PLUS**

ACEP

**Checking In with President Terry**

SEE PAGE 7



ACEP ELECTION

**Board Candidates**

SEE PAGE 12

**FIND IT ONLINE**
For more clinical stories and practice trends, plus commentary and opinion pieces, go to:
**www.acepnow.com**

# Four Perfect Days *in* Las Vegas

## Things to do at ACEP24 in Las Vegas

*by* JUAN CARLOS JONES, MD, MBA

Certain places and experiences make this city famous, so when you're here, take advantage. Whether it's one of the night clubs, a steakhouse, the Fountains Show at Bellagio, a buffet or one of the shows like Cirque du Soleil, your conference and entire week will be so much better if you do something that's makes Vegas ... Vegas. I've lived here for five years, but I still look forward to spending time experiencing what Las Vegas has to offer.

**CONTINUED** *on page 9*

MARCHELLO74-STOCK.ADOBE.COM

# The ER Docs Strike Back

One-day strike in Detroit highlights concerns about private equity and emergency departments

*by* LARRY BERESFORD

A 24-hour labor strike, starting on the afternoon of April 18 and called by the union representing emergency physicians and advanced practitioners at Ascension St. John Hospital in Detroit, MI, did not resolve their concerns about working conditions, staffing levels, or patient safety. But emergency doctor Michelle Wiener, MD, president of the striking union, Greater Detroit Association of Emergency Physicians, said she quickly started to notice some changes around the hospital.

"All of a sudden, the ER is staffed (with nurses and other staff) at a higher level," she told *ACEP Now* after the walkout. "They've hired 16 new nurses in the last month. Bulletproof glass we had requested

**CONTINUED** *on page 11*

PERIODICAL

ACEP Now
The Official Voice of Emergency Medicine

WILEY PERIODICALS LLC
C/O THE SHERIDAN PRESS
PO BOX 465,
HANOVER, PA 17331
If you have changed your address or wish to contact us, please visit our website
*www.wileycustomerhelp.com*

ACEP Now
The Official Voice of Emergency Medicine




## INFORMATION FOR SUBSCRIBERS

Subscriptions are free for members of ACEP. Free access is also available online at www.acepnow.com. Paid subscriptions are available to all others for $348/year individual. To initiate a paid subscription, email cs-journals@WILEY.com or call (800) 835-6770. ACEP Now (ISSN: 2333-259X print; 2333-2603 digital) is published monthly on behalf of the American College of Emergency Physicians by Wiley Periodicals LLC, 111 River Street, Hoboken, NJ 07030-5774. Periodical postage paid at Hoboken, NJ, and additional offices. Postmaster: Send address changes to Wiley Periodicals LLC, c/o The Sheridan Press,PO Box 465, Hanover, PA 17331. Readers can email address changes and correspondence to acepnow@ACEP.org. Printed in the United States by Sheridan of Ohio (SOH), Brimfield, OH.

UPDATES AND ALERTS FROM ACEP

# NEWS FROM THE COLLEGE

## ACEP Applauds Adoption of CMS Age-Friendly Hospital Measure

ACEP strongly applauded the Centers for Medicare and Medicaid Services when it introduced the Age-Friendly Hospital Measure in August as part of the fiscal year 2025 Inpatient Prospective Payment System rule. This measure, developed by ACEP in partnership with the American College of Surgeons and the Institute for Healthcare Improvement, clarifies goals for those who work with older patients and incorporates important aspects of the ACEP Geriatric Emergency Department Accreditation (GEDA) framework into care delivery.

ACEP Geriatric Emergency Department Accreditation

"The Age-Friendly Hospital Measure reshapes the way we care for older patients," said Aisha Terry, MD, MPH, FACEP, President of ACEP. "ACEP is proud to collaborate with health care leaders at the highest levels to drive meaningful change that helps physicians, care teams and patients."

A hospital's score on the Age-Friendly Hospital measure is based on attestations across five domains. ACEP encouraged CMS to include attestations to reduce boarding in the emergency department and screen for risk factors related to social determinants of health, among others. The measure calls for hospitals to have protocols in place to move older patients out of the emergency department within eight hours of arrival or three hours of the decision to admit.

The ACEP GEDA program is informed by evidence-based best practices and recently accredited its 500th emergency department. The GEDA program is made possible through generous support from the John A. Hartford Foundation and West Health. A growing body of research links facilities in the ACEP GEDA program to lower costs, improve quality, and optimize patient experience.

Learn More About ACEP's Geriatric Emergency Department Accreditation

## ACEP Urges Senate to Pass the *SAVE Act*

ACEP and the American Hospital Association co-hosted a July Senate briefing in support of the bipartisan *Safety from Violence for Healthcare Employees (SAVE) Act*.

"There's a problem but we can fix it," said James Phillps, MD, FACEP, an emergency physician in Washington, D.C., speaking on behalf of ACEP. Dr. Phillips appeared alongside Mark Boucot, President and Chief Executive Officer, Potomac Valley Hospital, Keyser, W.V. and Garrett Regional Medical Center, Oakland, Maryland, and Rachel Culpepper, DNP, RN, CENP, General Medicine Service Line Director, Indiana University Health West Hospital, Avon, Ind.

Senator Joe Manchin (I-WV) joined the panelists as a featured speaker and lead Senate sponsor of the *SAVE Act*. "We're asking for the same protections workers in other industries have," said Sen. Manchin. "It's not too much to ask." Violence is not something anyone should have to tolerate as a health care professional, the panelists explained. On top of safety concerns, a steady barrage of assaults lowers morale, impacts recruitment and retention, and complicates care delivery.

The *SAVE Act* is a central component of ACEP advocacy this year. The legislation would make assaulting a health care worker a federal crime. The briefing marks the third in a series on preventing ED violence this year. ACEP advocacy makes sure that you are heard directly where your voice matters most. An ACEP poll found that 91 percent of emergency physicians said they or a colleague were threatened or attacked within the prior year. Emergency physicians are leading the call for solutions and sharing their troubling stories.

## ACEP24 Almost Here! Heather E. McGowan to Deliver Keynote

### Opening General Session

**Monday, Sept. 29 | 9-10:30 a.m.**

Future-of-work strategist Heather E. McGowan will deliver the Opening General Session keynote speech at ACEP24.

Emergency physicians deeply understand how the last few years have forever changed where we work, who works, how we work and measure work, what we do for work and, most importantly, why we work. McGowan helps leaders prepare their teams and organizations for the post-pandemic world of work. McGowan describes herself as a sense maker, a dot connector, a deep thinker, and a pattern matcher who sees things that others miss. She will translate that knowledge to the emergency medicine workforce during her opening session presentation.

In 2020, Ms. McGowan was recognized as one of the Top 50 female futurists in the world by Forbes. In 2019, she was appointed as a faculty member of the Swinburne University Centre For the New Workforce in Melbourne, Australia. In 2022, McGowan was awarded an honorary doctorate from Pennsylvania College of Art and Design, in addition to earning her MBA from Babson College and her BFA in Industrial Design from Rhode Island School of Design.

### OTHER CAN'T MISS SESSIONS

#### Up Next: Waiting Room Medicine

**James D. Mills Memorial Lecture**
**Monday, Sept. 30 | 12:30-1:20 p.m.**
***Speaker:*** *Diana Nordlund, DO, JD, FACEP*

No beds in your departments? Managing patients in the waiting room? Discuss risks and solutions.

#### Strike While the Iron Is Hot: How to Expand Your Independent Group

**Colin C. Rorrie, Jr., Lecture**
**Tuesday, Oct. 1 | 10-10:50 a.m.**
***Speaker:*** *Michael Granovsky, MD, FACEP and Thom Mayer, MD, FACEP*

There exists a generational opportunity for Independent Group growth. The current environment is unique and has not existed for decades. The clinical value of your local group is appreciated, but you need the financial insights and leadership culture to be successful.

## ACEP Submits Formal Comments to CMS on Proposed 2025 Medicare Physician Fee Schedule

ACEP urged the emergency medicine community to contact members of Congress over the past few months to let them know a fifth consecutive year of reductions in Medicare physician payments is unacceptable. ACEP has submitted comments to CMS on behalf of emergency physicians. The Proposed 2025 Medicare Physician Fee Schedule is expected to be released on or around November 1, 2024—with an effective date of January 1, 2025. Medicare physician reimbursements have failed to keep up with inflation for decades.

ACEP's advocacy to date has helped ensure that CMS included in this year's proposed rule a positive budget neutrality conversion factor update, but even with that, physicians will still face a 2.8 percent cut. More must be done so that Medicare reimbursement reflects the fair value of physician services.

The CMS proposal also suggests changes to the CMS Quality Payment Program, including the ACEP-developed Emergency Medicine Merit-Based Incentive Payment System (MIPS) Value Pathway, or the Emergency Medicine MVP. ACEP created and supported the implementation of this model as a strong option to encourage uniform reporting of emergency medical services, which helps MIPS performance scores.

# HAVE AN IDEA?

## Submit your story pitch to *ACEP Now*

If you have a story idea or drafted article, e-mail the word document file to Editor **Danielle Galian-Coologeorgen, MPS,** and Medical Editor in Chief **Cedric Dark, MD, MPH, FACEP**. We'll review your submission and update you on next steps.

To submit a story pitch, please send a 250 word summary along with bullet points of the following:

- Why our readers would value the story.
- How the story would influence the provision of emergency medicine.
- What you hope the reader would learn from your article.
- Potential outside experts or sources for the story.

The usual length of standard articles (departments, columns, one- to two-page articles) is about 800 words. The usual length of feature articles (two or more pages) is about 1,200 words. A reference list is also required to support researched material and the practice of evidence based medicine.

*Preference will be given to new voices.*

### Submit a Case Report

To be considered for publication, send your case presentation to Medical Editor in Chief **Cedric Dark, MD, MPH, FACEP**, with the following:

- 200-word introduction of the patient's presentation, followed by,
- 600 word description of the diagnosis and management of the case including up to three bulleted teaching points,
- 10 reference maximum.

*Rare, but not unusual, cases with clinical importance to emergency medicine will be considered. Those with clinical images preferred.*

### Interested in Joining ACEP Now's Medical Freelance Corps?

*ACEP Now* welcomes guest articles by physician writers. **Send us an email** with a brief writing sample to discuss opportunities.

# RESIDENCY SPOTLIGHT

## UNLV EMERGENCY MEDICINE

**Location:** Las Vegas, NV
**Year founded:** 2006
**Instagram:** @unlvemresidency
**Twitter/X:** @LasVegasEM
**Website:** www.lasvegasemr.com
**Number of residents:** 36
*(12 per year: 6 civilian and 6 military)*
**Program length:** 3 years

### What does your program offer that residents can't get anywhere else?

Our program's primary teaching site, University Medical Center (UMC) of Southern Nevada, is a high-volume tertiary care county facility, the largest civilian site for military training in the US, and the only Level 1 Trauma Center in the entire state—it serves as a safety net for a diverse and under-served patient population, in addition to more than 40 million tourists who visit Las Vegas each year. Our training program embraces early resident involvement with critically-ill patients, beginning with the very first ED shift as a PGY1 (although we start in the deep-end of the pool, we have 'floaties' on with tons of support and there's always a high level of supervision by our passionate and dedicated faculty). The program has a big focus on developing resuscitationists and team leaders—in addition to the large number of high-acuity patients we manage in the ED, our clinical curriculum includes five ICU rotations. We are one of four civilian EM programs with a significant Air Force affiliation—our civilian-military partnership affords numerous training and mentorship opportunities and ensures that our graduates are well-prepared to succeed in any practice location: academic, community, rural, military deployment, and highly austere environments.

UMC has the only 'free-standing' trauma center west of the Mississippi River—a separate Trauma Resuscitation Emergency Department with 11 resuscitation bays along with its own dedicated CT scanner and interventional radiology suite. With a census of more than 10,600 trauma patients last year (and a 38 percent admit rate with 27 percent ICU admissions), our residents gain extensive experience and comfort managing a complex and highly-traumatized patient population with varying multi-system injury mechanisms, including high-speed motor vehicle collisions and rollovers, motorcycle and all-terrain vehicle collisions, blunt sports-related injuries involving professionals and amateurs, professional boxers and mixed martial arts fighters, assault victims, rodeo riders, and falls from varying heights.

The program is very receptive to resident feedback, and embraces resident input and empowerment to effect change in the clinical and didactic curricula. Our residents share a very strong sense of camaraderie and mutual support of one another, and we consider ourselves a big family.

### What are some fun activities residents like to partake in or recently participated in?

Aside from top-notch training, our residents have a strong work-life balance and enjoy the numerous opportunities found only in Las Vegas. The entertainment available out here is never-ending: from concerts and music festivals comprised of renowned artists in every musical genre, to critically-acclaimed shows and performances of all kinds. Professional sports have taken off in Las Vegas in recent years with teams such as the NFL Raiders, WNBA Aces (2-time champions), NHL Golden Knights (2023 Stanley Cup winners), the Aviators, Formula 1 racing … and a Major League Baseball team (the Oakland Athletics) will be relocating here soon. Our pre-hospital and event medicine involvement creates outstanding opportunities for residents to participate and provide on-site medical coverage alongside attendings at mass-gathering events such as the Superbowl, the Las Vegas Grand Prix, Allegiant Stadium events (concerts, Raiders games, UNLV football games), Golden Knights games, frequent music festivals (including the Electric Daisy Carnival, one of the world's largest EDM festivals), the Rock 'n' Roll marathon, and the National Finals Rodeo championships, just to name a few.

KRISTEN PURCELL (INSTAGRAM @KRISTINEPURCHELL)

This year's annual wellness hike at Mt. Charleston.

Many of our residents spend their free time hiking in the local area and traveling to the various nearby National Parks. Within a 30-60 minute drive from the Las Vegas Strip, you can live the stereotypical EM lifestyle—the southern Nevada region offers outstanding opportunities for hiking, trail running, rock climbing, mountain biking, water skiing, and snowboarding/skiing (yes, really … at Mt. Charleston). One of our residents discovered a love of trail running during residency, completing multiple ultramarathons and the Boston Marathon, and another resident recently completed a Spartan Race. A recent graduate spent his days off at a local circus center practicing and perfecting trapeze and acrobatics, established the first EM conference dedicated to Circus Medicine, and now provides medical care to performance artists. Our program is full of foodies who take full advantage of the plethora of dining options available in Las Vegas – and for those who would rather spend a night in, we often host family get-togethers including cookie decorating, grilling, and pool parties. As a major airline hub, Las Vegas is also an easy flight away from just about anywhere in the world.

### How should potential applicants learn more about your program?

We would encourage you to check out our Instagram or our website (info above), and those interested in a potential rotation can email us at UNLVemrotation@gmail.com. Please reach out on any of these platforms for more information, or just to say hi!

*- Rebecca DiFabio, MD*

# THE BREAK ROOM

SEND YOUR THOUGHTS AND COMMENTS TO ACEPNOW@ACEP.ORG

## The Current Status of Continuous-Seizure Management (July 2024)

I appreciate this article, and this is by no means meant to be a personal attack or discrediting the validity of the information contained in the article. I consult for a pharma company and disclose it whenever I speak or write about something related to that work. In this case, the Open Payments website shows that one of the authors has received over 128,000 dollars from Ceribell, a company that makes a POC EEG system. I do not discourage this type of consulting, as I believe it is important for knowledgeable physicians to inform device manufacturers and pharma companies, but I respectfully request that *ACEP Now* include such disclosures within its articles so readers can be aware of potential biases.

*—Scott Weiner, MD, MPH*

# FROM THE EDITOR

# A Question for You, Our Readers

*by* CEDRIC DARK, MD, MPH, FACEP

I wanted to respond to Dr. Weiner's concerns about the recent article on the management of status epilepticus by Drs. Marco and Kozak. I also want to use this opportunity to describe to the readers of *ACEP Now* the process by which we handle unsolicited submissions to our magazine, which the concept for this particular article originated.

When assuming the role of Medical Editor-in-Chief, I instituted a more formal process by which emergency physicians can submit articles and case reports to our magazine. No doubt you have seen our solicitations for these.

Many emergency physicians, especially researchers, have the support of industry when conducting their work. But our readers deserve to be educated on cutting edge technology and advances in medicine. While I eschew direct involvement with industry in writing pieces for our readers—for instance, I once rejected a pitch from an insurance company who wanted to describe their efforts in treating social determinants of health and instead offered them an interview (they ultimately rejected that offer)—I struggle to balance our reader's education on cutting edge technology while avoiding unwitting advertising of devices or pharmaceuticals.

**DR. DARK** is the medical editor in chief of *ACEP Now* and an associate professor of emergency medicine at Baylor College of Emergency Medicine.

In this specific case, I brought in our Associate Editor to review the broader topic of status epilepticus management, limiting discussion of the specific industry device to three sentences, and asked her to approach this issue with an independent and critical evaluation of the new technology.

As a news magazine, *ACEP Now* has asked for conflict of interest statements from our writers in the past. We remain watchful for the heavy hand of industry inside the pages of our magazine. My question to our readers is this…moving forward, should *ACEP Now* print authors' conflict of interest statements?

Just Released!

# EMC²

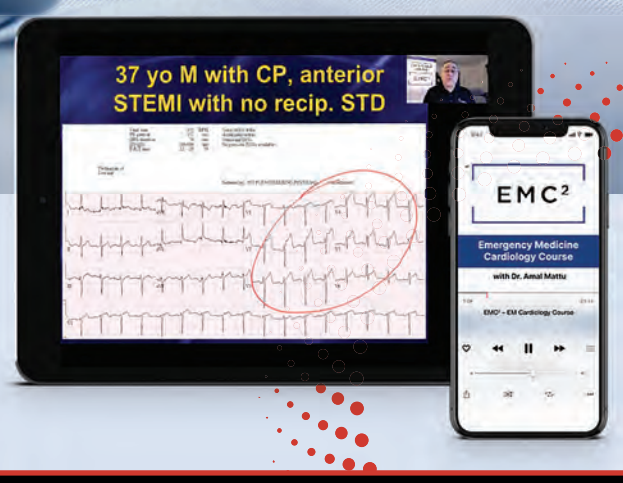
## Emergency Medicine Cardiology Course

with Amal Mattu, MD

*"This is the best CME course I have taken in 20 years of practice."*

*"An excellent course with an amazing teacher who maintains humility and humour. Thanks, Dr. Mattu!"*

*"Dr. Mattu has an incredible ability to demystify emergency cardiology. This is definitely worth the time."*




The all-new, 13-hour Emergency Medicine Cardiology Course (EMC²) is an online self-study program taught exclusively by Dr. Amal Mattu, a national authority on EM cardiology and an award-winning educator. Enhance your knowledge of ECG interpretation and ED-related cardiac presentations.

**1,500+ Participants | 13 CME Credits | 35 Topics**

*Sponsored by* The Center For Medical Education | CEME Center for Emergency Medical Education

Learn More at **www.CourseHost.org**
or Call 1-800-458-4779 (9-5 ET, M-F)

The Center for Emergency Medical Education (CEME) designates this enduring activity for a maximum of 13.00 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.


# MASTERING PEDIATRIC EMERGENCIES

FROM NEWBORN TO ADOLESCENCE

*"All of the presentations exceeded my expectations and I was blown away by the effectiveness of this conference."*

*"This course was exceptional, between the caliber of presenters to the review content."*

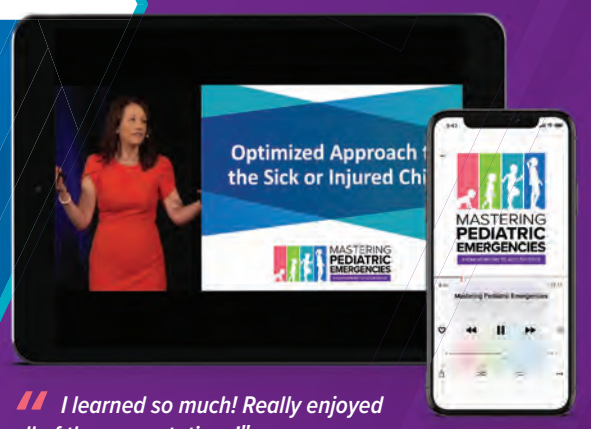
*"Very entertaining and engaging. More importantly, I learned a ton!"*

**Engage in the self-study course that provides an immersive educational experience designed to significantly boost your confidence in managing pediatric emergencies effectively.**

Produced by the developers of the **Emergency Medicine & Acute Care Courses**, **The National Emergency Medicine Board Review**, and the **EM Boot Camp Course Series**.

Whether you are EM board-certified or not, managing the acutely ill or injured child is one of the most challenging scenarios in emergency medicine – that's why the ***Mastering Pediatric Emergencies*** course was created.

- An intensive and comprehensive review covering newborn to adolescence.
- Taught by 9 energetic and knowledgeable peds/EM educators.
- A focus on data-driven, literature-based content.
- Incorporates the leading authoritative guidelines.
- A 21-hour, comprehensive course designed to renew your confidence in diagnosing and treating pediatric emergencies.




*"I learned so much! Really enjoyed all of the presentations!"*

*Sponsored by* The Center For Medical Education | CEME Center for Emergency Medical Education

Learn More at **www.pedsEMcourse.com**
or Call 1-800-458-4779 (9-5 ET, M-F)

The Center for Emergency Medical Education (CEME) designates this enduring activity for a maximum of 22.00 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Just Released!

# THE AIRWAY AND LUNG COURSE

**A Deep-Dive, 18-Hour Online Course into Airway Management and Lung Disorders**

Join nationally recognized airway expert **Richard Levitan, MD**, for an 11-hour deep dive into mastering emergency airway management.


Spend some high-yield time with our award-winning emergency physician duo, **Drs. Andrea Wu** and **Diane Birnbaumer**, as they deliver a 7-hour evidence-based update on all aspects of pulmonary emergencies.

*Sponsored by* The Center For Medical Education | CEME Center for Emergency Medical Education

Learn More at **www.CourseHost.org**
or Call 1-800-458-4779 (9-5 ET, M-F)

The Center for Emergency Medical Education (CEME) designates this enduring activity for a maximum of 18.00 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

# **ACEP4U:** State Legislative Roundup

ACEP state advocacy impacts the lives and careers of every emergency physician, every day. ACEP chapters continue to tally state legislative and policy wins by sharing their experience with public officials, and organizing bold campaigns on the issues that matter most.

The ACEP advantage is unmistakable. Chapters across the country are seeing success when they leverage the relationships and expertise that only ACEP can provide. Working together, physician advocates are making the case to protect physician leadership, address boarding, and strengthen on-the-job protections that you need and deserve. And that barely scratches the surface.

SHOCK - STOCK.ADOBE.COM

## California: Stopping Insurer Downcoding

Emergency physicians are standing up to insurance companies and demanding an end to bad behaviors. ACEP, alongside CalACEP and the California Medical Association, sent a letter in July to expose Aetna's bad behavior to the full California Congressional delegation. The letter outlined the insurer strategy to "downcode," or lower the severity of physician and facility claims for emergency services, for commercial, Medicare Advantage, and student health policies.

Aetna could not withstand the pressure and announced it would halt these dangerous and misguided policies in California. This is a major win for California's emergency physicians and patients, and a direct result of ACEP advocacy.

While the specific tactics mentioned in the letter are no longer a threat to practices or patients in California, Aetna has not committed to dropping these policies in any other states. The work is far from finished. ACEP will continue to expose insurers acting in bad faith and will never stop fighting for ACEP members.

## ACEP Needs to Hear From You

Are you experiencing insurance company behavior that puts you or your patients at risk? Your experience fuels ACEP advocacy across the country.

Share your story:

## Connecticut: Increasing Hospital Accountability to Address Boarding

Sometimes, impactful change happens because of emergency physicians' work behind the scenes. Connecticut ACEP members moved the levers of state government by participating in a boarding and crowding working group in January.

Emergency physicians helped compel the group to recommend that the Connecticut Department of Public Health develop and mandate publicly reported quality measures on emergency department boarding. The resulting metrics and dashboard are another major win for emergency physicians and patients.

This data collection and sharing will enhance efforts to increase transparency, inform public policy, and help drive the systemic solutions necessary to meaningfully address the crisis of boarding in emergency departments.

## Encouraging Collaboration and Growing Stronger Together

Each chapter success inspires another, and everyone benefits when the chapters work together. Oregon ACEP heard about the success in Connecticut. Additional discussions led to the development of model legislation that the Oregon chapter expects to strongly support during the 2025 legislative session.

Whenever possible, ACEP facilitates teamwork across chapters. These unique collaborative advocacy opportunities are changing emergency medicine for the better. The scope battles unfolding across the country offer additional examples.

## Indiana: ACEP-Developed Model Legislation Protects Emergency Physician Leadership

Back in 2023, Indiana's emergency physicians helped pass a state law requiring an emergency physician to be present and on duty in every emergency department. Relentless advocacy from Indiana ACEP reinforced how critical it is for emergency physicians to be the ones in charge of emergency care teams.

ACEP-developed model legislation was a big part of that victory. Today, emergency physicians in numerous states use the model language to champion policies that support physician leaders.

## Virginia: A Unique Approach to Scope of Practice

Emergency physicians are speaking out to mitigate risks that arise when nurse practitioners and physician assistants are permitted to expand their practice beyond their training. It makes all the difference when elected officials hear concerns directly from emergency physicians.

Virginia ACEP was able to strengthen the laws in its state by taking a strategic approach that they felt would resonate with their legislators. "We did not say it was about scope at all. We made it about fixing outdated legislation," Dr. Todd Parker said during the ACEP Leadership and Advocacy Conference.

Using the ACEP model legislation, VACEP worked to create and support a law that requires emergency departments in Virginia to have a physician onsite and responsible for managing the state's emergency departments. VACEP also utilized polling and tireless advocacy to push legislation across the finish line. The Virginia law goes into effect in July 2025. Chapters in Missouri, Ohio, and South Carolina are taking inspiration from Virginia, Indiana and others as they actively work on these same issues.

## Oregon and California: Mitigating Harm from the Corporate Practice of Medicine

ACEP policy strengthened in 2023 clearly states that "any practice structure that threatens physician autonomy, the patient physician relationship, or the ability of the physician to place the needs of patients over profits should be opposed."

ACEP firmly supports national and state efforts to address and limit consolidation and corporate investment in medicine. While ACEP continues to work with the Department of Justice, Federal Trade Commission and Congress, the battles continue on multiple levels and often land in state legislatures or courthouses.

In California, ACEP filed a brief in support of the lawsuit emergency physicians brought against Envision Healthcare and Envision Physician Services. Direct pressure from emergency physicians led to a settlement. In Oregon, ACEP supported the chapter's passionate efforts with a letter to the legislature supporting a bill that would limit corporate ownership of medical practices in the state.

## New ACEP State Legislative Dashboard Simplifies Issue Monitoring

To capture the full extent of ACEP state advocacy, a new members-only resource is available. The State Legislative Dashboard is a one-stop-shop to learn more about the issues and keep up with chapter priorities and accomplishments.

From coast to coast, ACEP chapters are indispensable allies. These battles will undoubtedly continue and ACEP will be there supporting individual emergency physicians every step of the way.

# Checking In with President Terry

## *ACEP Now* explores the pipeline, DEI, and work conditions with College leader

*by* CEDRIC DARK, MD, MPH, FACEP

Each year, the ACEP President sits down with *ACEP Now*'s Medical Editor in Chief to discuss issues of interest to members. This second interview, conducted toward the conclusion of Dr. Aisha Terry's tenure as President, reviews her goal of strengthening the leadership pipeline for the College and follows up on challenges that arose during the past 12 months. This interview has been edited for space and clarity.

**DR. DARK: Thanks Dr. Terry for joining us. When we last spoke and we had a good conversation near the beginning of your presidency, now we're kind of closing in on the home stretch. One of the things you wanted to accomplish was talking about the leadership pipeline for ACEP. What do you think you've been able to accomplish during your term so far?**

**DR. TERRY:** Well, first of all, thank you so much Dr. Dark. I appreciate the opportunity to share again and certainly a lot has happened since we last spoke. But in terms of the leadership pipeline efforts, we've definitely made some progress. As I mentioned before, my original plan was to first take a look at the landscape in terms of what leadership opportunities are out there currently, particularly relative to recruitment and succession planning. Those have been the key couple of areas that I've looked at in terms of leadership pipeline as well as highlighting those leaders in emergency medicine who are really outstanding examples of how to lead outside of the traditional kind of brick and mortar of practicing clinical medicine in the emergency department.

We've engaged the AAMC in terms of partnering when it comes to recruiting for our great specialty. We find ourselves needing to get back to the basics, of talking about why emergency medicine is an amazing specialty and why we are heroes, not just during COVID, not just during the pandemic, but in the job that we do in serving the health care safety net. We are taking that story on the road and sharing that particularly with medical students. We will be speaking at the AAMC again at their annual meeting in November. Again, just sharing the good word about what emergency physicians do and how we absolutely are looking for the cream of the crop when it comes to future generations of emergency physicians.

On the succession planning side of things, I am really focused on making sure that internally when it comes to ACEP operations and leadership operations, that there is a plan for the future.

There is a succession plan for all of the chairs of our committees and our sections as well as presidents of our chapters. There's a clear president-elect in the wings waiting to take the helm in terms of leadership.

We want there to also be a diversity of leaders who have an opportunity to serve. Mentoring and preparing future generations to lead is absolutely critical.

Finally, we spent this year really having conversations with and highlighting leaders in emergency medicine who are doing things outside of clinical practice. We've had the honor of speaking with Dr. David Callaway, who is one of the national presidential scholars and also an emergency physician. We've had conversations also with Dr. Brad Barth who is currently the Executive Director of Alpha Omega Alpha and an emergency physician. And finally, most recently I had discussions with Dr. Joneigh Khaldun, who is the Chief Equity Officer of CVS and an emergency physician. I truly believe that you can't be what you don't see. And so, this has been an opportunity to really highlight the vast opportunities that we have as emergency physicians.

Dr. Terry presenting a Congressional Leadership Award.

ACEP

**DR. DARK: I was looking back through our last interview, and you had said that only 39 percent of emergency physicians are women. Only 35 percent of emergency physicians are from minority backgrounds in terms of race and ethnicity. But over the past six months since we last spoke, we've seen DEI come under attack. You spoke with the Rep. Greg Murphy who introduced the *EDUCATE Act*, which we've mentioned a couple times in *ACEP Now*, and it's a bill that would've essentially defunded medical schools if they happen to even have a DEI office. I know that you've stated that it runs counter to ACEP's policies, but one thing that you did say, because I was sitting there at LAC, you said you're going to follow up with him. I want to know what kind of dialogue you have had?**

**DR. TERRY:** I really appreciate you holding me accountable to that. I'm so proud of the College for how we handled that situation. It really was a moment that gave us an opportunity to stand up with courage and to really shout about our policies when it comes to DEI. As you know, I did speak with Representative Murphy about the bill. First of all, it's pretty complex in that it has several components.

One of the components certainly speaks to defunding offices in schools of medicine that focus on DEI. There are all kinds of other pieces in there, but there are absolutely aspects of it that run counter to ACEP policy. My focus in having a conversation with him, which I thought was a reasonable dialogue—where we heard from him, he heard from us, and then we ended it with saying we're going to follow up to see what comes next relative to ensuring that our workforce is equipped to take care of all patients from all backgrounds relative to diversity, equity, and inclusion.

Since then, we have had some conversations. We do know that some of the co-sponsors on that bill had staffers that were part of that LAC session and actually went back to their bosses, to say, 'Hey, maybe we should take another look at this bill. Maybe we should reconsider.' And so, for me, the whole point of that is that change comes in all kinds of packages. You don't know exactly how it may be delivered. You don't know who you're going to impact and how it will come to fruition. But we do believe that what we did that day on that stage at LAC and having a dialogue and talking to Representative Murphy changed and impacted some minds.

Unfortunately, Representative Murphy has had some health issues of late and so certainly being very respectful of his time of healing and recovering. But rest assured, more to come about the ongoing dialogue on that bill.

**DR. DARK: Let's talk about a piece of bipartisan legislation, the *Physician and Patient Safety Act* (H.R.8325). It was formerly introduced by an emergency physician Raul Ruiz in the House of Representatives and has a couple of co-sponsors, one of which I believe includes Representative Murphy as well. This bill would ensure that emergency physicians are afforded due process protections under medical staff bylaws before a third-party employer can make any decision affecting our employment status. What can you tell us about that bill?**

**DR. TERRY:** We're really excited about having played an instrumental role in even having that bill introduced this year. It was one of our focus areas at Leadership and Advocacy Conference in terms of promoting due process for emergency physicians. When we say due process, what we mean is you cannot be terminated by your employer without having the opportunity to go through the process of defending yourself and to ensure that all of the policies are being adhered to appropriately. There tends to be a two-tiered system when it comes to some hospitals and how physicians are treated relative to due process. We want to make sure that emergency physicians, like any other physician in the hospital, is able to undergo appropriate processes when it comes to potential termination. We're really proud of having championed this topic. It's actually a topic that we have been championing for many years, but like many things, COVID and the pandemic really amplified the need to codify and clarify what the protections would be for emergency physicians when it comes to not having to deal with retaliation or retribution for speaking up when it comes to quality and fair and equitable patient care. We've connected also with AAEM, as well as the American Hospital Association around this bill with the hope of making sure that all stakeholders and partners are at the table to ensure the success of moving forward and getting this bill across the finish line.

**DR. DARK: I wanted to bring up the contentious issue between EMTALA and the Supreme Court and how that interacts with Idaho's abortion statute. The Supreme Court essentially dismissed the case, which means that emergency physicians are still unclear what we're supposed to follow—whether it's the state law or EMTALA when a patient presents with a medical need for an abortion. What is ACEP's updated position on this specific issue?**

**CONTINUED** *on page 8*

**DR. TERRY:** ACEP's position on this is still clear. EMTALA is a federal mandate that we adhere to and that we proudly have adhered to for the entire existence of our specialty. We should be protected as emergency physicians from being criminalized from simply adhering to EMTALA and the mandate that we have been called to perform when it comes to ensuring that all patients, including women who happen to be pregnant. We have fought from day one relative to ensuring that those protections remain in place.

It's not about really the ethics or the morality around it as much as it is about not criminalizing physicians for simply doing their job. ACEP has actually signed on to a handful of various amicus briefs and we continue to pursue various advocacy efforts even in the wake of the Supreme Court's decision. Medicine can be complex. That is why it really should be left in the hands of medical people, physicians who are trained to understand the nuance of providing health care to patients.

**DR. DARK: Unionization is probably more relevant to your average emergency doctor that's working right now on shift. There was a group in Detroit that did a 24-hour strike back in April. Do you think that unionization is the next appropriate step for emergency physicians to regain their authority in a system that seems to have declining respect for physicians? And, if so, should ACEP be the one doing this organizing nationally?**

**DR. TERRY:** We know that unfortunately we are finding that work conditions are not what they should be. That we're having patients languish, there's boarding and crowding in the emergency department like never before. We know workplace violence is ravaging our emergency departments across the country. All of these issues, due process, boarding, workplace violence, having to worry about maintaining and keeping your job, whistleblower protections and the like are really, really coming down on us all at once. Not to mention reimbursement issues. ACEP believes that unionization is a potential solution to some of these issues. We want to educate our members around the various facets of unionization, specifically for emergency physicians.

Like most issues there can certainly be unintended consequences and those are the blind spots that we want to absolutely make sure that our members are aware of as they decide to pursue whatever decision makes the most sense for them and their particular practice. ACEP does strongly believe in collective bargaining but not at the expense of patient care. At the end of the day, whatever solutions we pursue, there should always be those pieces in place to ensure that patients still receive the care that they need in a timely fashion.

**DR. DARK: What's your pitch to younger members as to why they should join ACEP or even some of those members that are on the fence as to why they should remain members of ACEP?**

**DR. TERRY:** I can tell you that when I was in medical school, that is when I realized that I wanted to impact change on a large scale. That I really wanted to impact the masses through policy and not just at the bedside clinically. And what I understood was that to do that, health policy and public health would be my vehicle. When I was elected president of EMRA, I realized that organized medicine is the vehicle we need to create change on large scale. Perhaps, to your point, younger generations aren't joiners, but I believe there is a sense of wanting to belong. There is an absolute sense of wanting to create change in a meaningful way.

Our newer and younger generations absolutely want to fight for rights and they want to fight for equity and they want to fight for better and improved outcomes. Organized medicine is the perfect vehicle by which to do that. Because the change that we need is hard. And it takes years and years of relationship building and resources and expertise. Organized medicine allows you to have all of those things in a nutshell. ACEP has been working hard in terms of advocacy for emergency physicians and our patients for many years. Through those years of expertise and experience that we find ourselves supporting things like the due process bill, we find ourselves in circles where influence matters. I can tell you that about a month ago I was in a room on Capitol Hill filled with congressmen and women who are in health care, who are physicians. Later that day, I had dinner with the Surgeon General, and those opportunities were only afforded to me due to my connection through ACEP, not because I'm special. So again, I really just want younger generations to realize that the change they want to see, that equity that they want implemented can oftentimes come through vehicles that are tried and true, such as EMRA and ACEP. Your membership dollars matter tremendously. Because it's only through those membership dollars that we're able to continue to have these advocacy efforts and for them to be impactful and influential.

That doesn't mean that you're going to agree with every single thing that the organization promotes. But you certainly can get behind the general sense that we're promoting the highest level of quality emergency care for our patients and that we are advocates for emergency physicians.

**DR. DARK: Thank you for joining us.**

**DR. TERRY:** Super excited about Vegas '24. We are really looking forward to launching a brand-new format and approach to ACEP '24 that really facilitates more engagement.

JUAN CARLOS JONES

Dr. Jones enjoys a night in Las Vegas with his wife, Mayra Jones-Betancourt, MD.

## LAS VEGAS | CONTINUED FROM PAGE 1

### DAY ONE

I'm coming in from my house because I live here, but if I'm staying at the hotel, I'll go to the fitness center and start my day with a quick workout. Once I'm dressed and ready, I look for a nice cup of coffee at the hotel. Then, it's off to the conference to get a lay of the land.

As I walk around the venue, I'll familiarize myself with the layout and hope to bump into someone I know. It's always nice to catch up with colleagues and perhaps link up with someone who's interested in attending the same sessions. Next, it's off to the General Session, "Future of Work in Emergency Medicine" at 9 a.m. with Heather McGowan. ACEP does a terrific job of vetting the quality of speakers, so I'm confident that it will be good.

When the General Session ends, I'll probably head to the Exhibit Hall. It is one of my favorite parts of the conference. I enjoy browsing through the different booths, talking to vendors, and reconnecting with people I might see. I like the energy in there, and I find myself looking forward to the latest innovations and products.

Since I've lived in Vegas for several years, I have some favorite spots for lunch. I might head north on the Strip to Tacos El Gordo, which is known for its delicious street tacos. You line up to order by the type of meat you want. The lines can get long, but it's worth the wait. If I'm in the mood for a more sit-down experience, I might go to Javier's in the Aria Resort for authentic Mexican cuisine and their signature margaritas. The food is great, and the atmosphere is upscale and eye-catching. Javier's is the perfect spot for a relaxing lunch.

Once back from lunch, I will stop by and see some of the Game On! Competitions, particularly the one on dermatology at 12:30 p.m. I'm not going to compete, but it would be fun to watch and learn.

After a few more courses, it's time to start thinking about where to get drinks and dinner. One of my favorite social spots is the Chandelier Bar at the Cosmopolitan Hotel. It's kind of a trendy spot and has a famous three-story crystal chandelier. Another great spot is Top Golf by the MGM Grand, where you can enjoy hitting some golf balls, eating good food, and hanging out with friends while a DJ spins the latest hits.

### DAY TWO

I'm probably going to hit a couple of early sessions, but this might be the day that you grab brunch and try to squeeze in one of the famous buffets.

My favorites are the Wynn Buffet (at the Wynn Hotel) and the Wicked Spoon Buffet at the Cosmopolitan. I love these buffets because

**CONTINUED** *on page 10*

they offer variety, from Asian to Latin to traditional American breakfast and lunch dishes. I take my time exploring the different stations, trying a bit of everything from fresh fruit and pastries to breakfast meats and omelets.

Vegas is known for its buffets, so it would be a shame to come here and not experience that.

After that, it's back to the conference. I'll try my best to make it back in time for the Mills Lecture, "Up Next: Waiting Room Medicine," with Dr. Diana Nordlund. I will have planned the rest of my day in advance when it comes to education sessions because I don't like to wing it. The Coffee House chats look interesting, so if I'm in the Exhibit Hall, you will probably catch me there.

If I can get a spot, I'm going to catch a session from Dr. Amal Mattu. He has one at 1:45 p.m. called "From Paper to Patient" that talks about Advances in ECGs. I've read his books, "ECGs for the Emergency Physician Vols 1 and 2." I listen to his EMcast podcast, so I know there is a lot to learn in that session.

Now it's time for dinner and Vegas is known for its high-quality steakhouses. My favorites include the SW Steakhouse at the Wynn, which features prime aged steaks and a selection of Japanese and domestic Wagyu. Make sure you get a table in order to view the water show. Another favorite is the STK steakhouse at Cosmo which features high end cuts in a bustling energetic environment. After dinner it's time for a show. I highly recommend Cirque du Soleil or the Blue Man Group. Vegas is known for it's shows, so plan an evening with your friends and book your tickets in advance.

After the show, I'll explore more of the Vegas nightlife. Some of my favorite clubs are Hakkasan at the MGM, Marquee at the Cosmo, Jewel at the Aria, Omnia at Caesars Palace, or XS at Encore. Bottle service is pricey, so residents make sure you take your attendings, and attendings make sure you take the department chair or better yet, the hospital CEO. They owe us!

## DAY THREE

I'll get up early and grab my coffee to prepare for an early session. Between sessions, there's time to connect with some friends who I've been meaning to catch up with. When it gets close to lunch, I know it might be tough because of time, but I'd hope to take in the Fremont Street Experience in Downtown Vegas. Fremont street is a pedestrian district featuring retro and revived casinos, open air bars, a zip line, and live music. And don't forget to check out the Heart Attack Grill where you don a hospital gown upon entry, "nurses" take your order (try the infamous Bypass Burger), and you get spanked if you don't finish your food.

Dinner on Day Three might be a little fancy. Nobu in Caesars Palace is phenomenal. They have a mix of traditional Japanese dishes with a modern twist. I'm not usually a raw seafood person, but the dishes here are so good they just melt in your mouth. The experience is unforgettable, from the ambiance to the impeccable service.

Make sure to try some of Nobu's signature dishes, like the black cod with miso and the yellowtail jalapeño. After dinner, I make sure to walk by the Bellagio to watch the famous fountain show. It's a must-see Vegas staple, with the water show synchronized to music. It's a beautiful and mesmerizing experience, perfect for a night out on the Strip.

This is the night when I'll meet up with old friends from University of Chicago residency at our annual ACEP program alumni event. It's such a great time catching up with the folks I battled in the trenches with and seeing what they've been up to since graduating.

## DAY FOUR

By day four, I'm usually exhausted. I can't keep up like I used to, but I'll still make the most of it. I start with a half-day of conference sessions, making sure to catch any final topics I might have missed earlier. After the conference, I'll take it easy and spend some time exploring.

This is a great time to visit the Red Rock Canyon. It's a natural area just a short drive from the Strip. Even if it's too hot to hike, driving through the park offers views of the red rock formations and desert landscape. In the afternoon, I might visit some of the attractions like the Neon Museum, also known as the Neon Boneyard. Before heading out, I'm going to have one more great meal. There are so many incredible restaurants in Vegas that it's hard to choose just one. But if I'm in the mood for something different, I might try Lotus of Siam, a Thai restaurant that's popular with tourists and locals. You also have options for day clubs and pool parties if you aren't too tired and still want to have a good time.

Hopefully, you're staying an extra day or two at the end or coming in early because there's so much to do, and there's so much you don't want to miss at the conference. It's a good idea to tack on some extra time.

**DR. JONES** is an emergency physician in Las Vegas. He graduated from the David Geffen School of Medicine at UCLA and trained at the University of Chicago.

## ED STRIKE | CONTINUED FROM PAGE 1

for the ED registration area is now up." Dr. Wiener suggested that the union's action may yet prove to be a catalyst for change for the hospital.

More recently, Ascension notified TeamHealth that it will not be renewing their contract for ED staffing, set to expire August 31 for St. John and five other hospital sites in Detroit. TeamHealth, which is a physician staffing and contract management company owned since 2010 by the private equity firm Blackstone, has managed the emergency department at Ascension St. John Hospital since 2015, when it acquired ownership of the hospital's ED physician group, St. John's Emergency Services, PC.

Ascension, which did not respond to *ACEP Now*'s request for comment on the transition away from TeamHealth, wasn't forthcoming to its ER staff, either, Dr. Wiener said. But the doctors have heard from Independent Emergency Physicians (IEP), a small, physician-owned medical group based in Farmington Hills, MI, that IEP will be taking over the contract with Ascension for emergency medicine staffing when the TeamHealth contract expires August 31.

It remains to be seen how this will affect the local union's status, Dr. Wiener said. But much of IEP's leadership trained or worked at Ascension St. John and thus is familiar with its culture. "We think it's going to be a good thing. So far, they are communicating well. It feels like progress."


JIM WEST/ALAMY LIVE NEWS

Doctors in the emergency department at Ascension St. John Hospital began a one-day strike to protest understaffing and unsafe conditions. The 43 emergency doctors, physician assistants, and nurse practitioners organized the Greater Detroit Association of Emergency Physicians nearly a year ago.

### Forming a Union

Clinicians from St. John's emergency department, including about 43 doctors, nurse practitioners, and physician assistants not working as supervisors or residents, nearly unanimously voted to form a union in 2023. Organizing was a challenge, Dr. Wiener said. It was hard to find an established union to take them on, so they formed their own. "We meet and vote on almost everything. There's a lot of government paperwork and reporting required," she said.

When negotiations for their first contract stalled, that's when they voted to strike—an "unfair labor practice" strike giving 10-days' notice. "The strike was called to bring attention to the issues, including emergency department wait times of up to 17 hours," Dr. Wiener told *ACEP Now*. "It was successful at that, without having to harm patients." With plenty of warning from the union, TeamHealth and the hospital implemented contingency staffing plans to keep the ED fully operational.

In a prepared statement shared with Detroit media at the time of the strike, TeamHealth asserted that the emergency department at Ascension was "fully staffed" while median wait times in the ED were going down. "We have negotiated in good faith with the union and any statement to the contrary is false."

In a more recent statement issued in June, TeamHealth stated that it had been in discussions with Ascension St. John to continue their contract for emergency services. While TeamHealth expressed disappointment in losing the contract, its "top priorities have always centered on delivering high-quality patient care and supporting our frontline clinicians."

### Zeroing in on Private Equity

The one-day walkout in one emergency department in Detroit put a magnifying glass to issues its emergency physicians had not been able to get the hospital or TeamHealth to respond to. But it has also highlighted growing attention nationally to the impact on health care from private equity firms—which today employ clinicians at one-third of U.S. hospitals. The Federal Trade Commission, Department of Justice, and Department of Health and Human Services launched a joint inquiry in April into the increasing dominance of private equity in the U.S. health care system.

In December U.S. Senators Chuck Grassley (R-IA) and Sheldon Whitehouse (D-RI) launched a bipartisan investigation into powerful private equity firms' involvement in the nation's health care. On April 3, Sen. Edward J. Markey (D-Mass.) chaired the Senate Health, Education, Labor, and Pensions (HELP) Subcommittee on Primary Health and Retirement Security's field hearing, held in Boston and titled, "When Health Care Becomes Wealth Care: How Corporate Greed Puts Patient Care and Health Workers at Risk."

More recently, Sen. Gary Peters (D-MI), Chair of the Senate Homeland Security Committee, is leading an investigation into whether private equity's control over hospital emergency departments is compromising patient care and potentially putting emergency preparedness at risk. Sen. Peters, who said more than 40 emergency physicians across the country have raised substantial concerns with his staff about private equity, patient safety, and emergency department staffing, recently sent letters to Blackstone, TeamHealth and other private equity firms asking them to answer questions and to plan to attend a meeting at the Senate.

On the surface, private equity-owned firms in emergency medicine seem to be having their problems these days. One, American Physician Partners closed entirely on July 31, 2023 (see *ACEP Now*, Sept. 12, 2023), while Envision Healthcare filed for Chapter 11 bankruptcy in May of the same year and TeamHealth faced debt restructuring.[1]

### Strikes and ED Doctors

"Nobody goes to medical school intending to learn how to go on strike," Dr. Wiener noted. "But we needed some way to ensure that we have the resources to do our jobs." Those include safe staffing ratios for the clinicians and for nurses and other staff, with a cap on the number of beds a single emergency physician needs to cover. "We also have no paid vacation or sick time, no maternity leave, no night shift differential, no paid time for the hour we stay for shift overlap," she said.

"I live six miles from this hospital. My kids were born there," Dr. Wiener said. "Most of us have worked here for 15 or 20 years. We don't want to leave this hospital. We just want things to change, to go back to what it was like to practice emergency medicine here before TeamHealth came."

### Crisis in Emergency Medicine

Harry Severance, MD, FACEP, a workforce advocate and consultant, has written widely about the growing trend toward unionization in medicine. "Many physicians have become progressively frustrated with the critical worsening and degradation of their increasingly unsafe, overburdened and understaffed clinical workplaces and many seeing little if any interest or support from an overall health care system that they see as increasingly moving toward corporate mega-system 'profit above all' mentality," he said in an email to *ACEP Now*.

Physicians are turning to unionization as one of the few remaining pathways they see available to them to effect change and improve patient outcomes. "Will unionization prove to be a 'panacea' for addressing many of the ills of the health care workplace—or something else? Only time will tell," he says.

Nurses are often leading the drive toward unionization of health professionals, but there is huge dissatisfaction among doctors—and future doctors, Dr. Severance noted. His article in *MedPage Today* last year cites support for unionization from an unlikely source, a frustrated hospital administrator.[2]

ACEP President Aisha Terry, MD, MPH, FACEP, says the field is coming to a greater realization of the understaffing, hospital system overload, and other conditions that put emergency department patients in harm's way while adding to the moral injury of their physicians.

"We are proud to staff the health care safety net in this country 24 hours a day. But we're fed up with conditions that are not amenable to fully utilize, in a quality manner, the training we have as emergency physicians." The unionization trend speaks to growing recognition of this multi-factorial crisis, said Dr. Terry, who referred readers to ACEP's new unionization resource page. She also acknowledged that in many settings, emergency medicine residents are out ahead on the issues.

On the day of the strike in Detroit, the Michigan College of Emergency Physicians issued a statement saying, "MCEP stands with our emergency physician members and colleagues as they fight to ensure that emergency physicians have the necessary resources to serve their patients."

MCEP President Michael Fill, DO, FACEP, said the problems of emergency medicine include not having enough nursing staff, leading to closed beds on the hospital floors and lack of throughput, with accompanying hospital overcrowding, boarding of hospitalized patients in the ED and extended waiting times. Add to that the crisis in mental health services, where these patients can't be transferred quickly to another facility.

He said for doctors to organize or even strike is another tool in their toolbox. "The take-home message for doctors is to realize how much of a crisis emergency departments—and the whole U.S. health care system—are facing," Dr. Fill said. "These physicians [in Detroit] thought their only action was to form a union and strike. That says these people were so frustrated and felt they were unable to have open, productive conversations with their employer or their hospital system."

"We are an important part of this hospital," Dr. Wiener said, adding that doctors are starting to fight back against the private equity business model. "The problem is a real fear that when you get rid of these bigger groups, then what? There's a real need for advocacy, and that's where groups like ACEP come in."

Dr. Wiener said what she has learned from the whole unionization experience, besides a lot of labor law, "is that if physicians stand together, we have a voice that is loud enough to bring about a positive change for our patients and our colleagues."

### References

1. Beresford L. American Physician Partners' closing raises questions. https://www.acepnow.com/article/american-physican-partners-closing-raises-questions/. Published September 12, 2023. Accessed August 25, 2024.
2. Severance H. A manager's perspective on healthcare unionization. https://www.medpagetoday.com/opinion/second-opinions/104932?trw=no. Published June 11, 2023. Accessed August 25, 2024.

# MEET THE BOARD OF DIRECTORS CANDIDATES

Each year, ACEP's Council elects new leaders for the College at its meeting. The Council, which represents all 53 chapters, 40 sections of membership, the Association of Academic Chairs of Emergency Medicine, the Council of Emergency Medicine Residency Directors, the Emergency Medicine Residents' Association, and the Society for Academic Emergency Medicine, will elect four members to the ACEP Board of Directors when it meets in September, along with a new President-Elect.

The candidates for President-Elect, and an overview of the election process, were featured in the August 2023 issue of *ACEP Now*.

**Board of Directors Candidates**







## ACEP BOARD OF DIRECTORS

*Candidates for ACEP Board of Directors responded to this prompt:*

What innovative strategies would you use to recruit and retain membership?

### Jennifer J. Casaleto, MD, FACEP
(North Carolina)

**Current Professional Positions:** Emergency Medicine Physician, CirrusMD and Mid-Atlantic Emergency Medical Associates (MEMA); Adjunct Clinical Faculty Physician, Atrium Health's Carolinas Medical Center

**Internships and Residency:** Emergency Medicine Residency, Carolinas Medical Center (2003)

**Medical Degree:** MD, Vanderbilt University School of Medicine (2000)

**Response**

Similar to most member organizations, ACEP experienced membership decline associated with the COVID pandemic. However, unlike 80 percent of U.S. membership organizations, whose membership challenges were related to the cancellation of their annual meeting and a lack of organizational activity, ACEP brought our emergency physician community together with ACEP Unconventional and continued to support emergency physician practice through efforts such as facilitating information-sharing via engagED, developing the Field Guide to COVID-19, advocating for our safety lobbying Congress for PPE, working with the TJC to support physicians wearing their own PPE, and partnering with Amazon to get institution-level access for ACEP members. While ACEP was doing what EPs do best, identifying and caring for the most emergent member needs, ACEP wasn't doing what the one-quarter of U.S. member associations who saw membership growth during this time were doing ... continuing membership recruitment efforts.

Recruitment requires providing a compelling value proposition and innovating to meet members' changing needs. In addition to offering practice support, advocacy, career development, and networking, ACEP must listen to needs of graduating residents and new attendings. With elimination of CME funding in many of our hospitals and groups, it is crucial to continue to add value and communicate that value to residents before graduation. Our state chapter members and leaders are uniquely positioned to follow EMRA's lead in partnering with local EM residency programs to improve communication of ACEP's value to EM-bound medical students and EM residents by hosting residency visits or local events relevant to our shared mission. In addition to outreach, we must further develop chapter-level engagement opportunities for residents and newly graduated attendings, providing a sense of belonging to our new members, and a leadership pipeline for the chapters' future.

Retaining members requires maintaining trust and demonstrating continued value. Effective, timely, and personally relevant communication is required to achieve these goals. Creation of an accurate database of emergency physicians living and working within a state, as well as a network of each states' EM groups and ED medical directors would help chapter leaders disseminate relevant information, strengthen advocacy efforts, and plan regional solutions summits to focus on unique challenges. Opening lines of communication with chapter leaders allows member and non-member emergency physicians to reach out with questions and concerns.

By integrating these innovative recruitment and retention strategies, ACEP can effectively showcase the value of membership and foster a supportive and influential professional community dedicated to advancing emergency medicine.

### Steven B. Kailes, MD, MPH, FACEP
(Florida)

**Current Professional Positions:** Emergency Physicians and Director, Governmental Relations, Emergency Resources Group (ERG), Jacksonville, FL

**Internships and Residency:** Emergency Medicine Residency, Naval Medical Center (2004); Surgery Internship, Naval Medical Center (1999)

**Medical Degree:** MD, Tufts University School of Medicine (1998)

**Response**

ACEP's value is not reaching all emergency physicians but, with early education, medical students and residents can better grasp "the why." This knowledge must start early and ACEP must do better explaining what ACEP provides for our careers. ACEP should seek greater partnerships with residency directors and programs to ensure practicing physicians see the many products of ACEP's efforts. While some issues are handled locally, many issues cannot be solved in our emergency department or hospital. We must have a community of like-minded individuals working towards shared goals.

As a community "pit doctor," I believe I have a good understanding of the needs of emergency physicians. We need more practical education on how we get reimbursed to make independent groups stronger and to make everyday doctors' lives easier. ACEP must collaborate with other organizations to unify and multiply our efforts in areas of common interest. We must educate everyone in emergency medicine about the important role ACEP and affiliated state chapters play in our professional lives, such as being the only emergency medicine representative at the AMA's RUC or Relative-Value Scale Update

Committee. A recent success by the ACEP was averting a decrease of our reimbursement for our 99284 E&M codes, saving an estimated $200 million for emergency physicians in 2023.

If ACEP is already doing this, why be a member? ACEP has a voice for all, but its reach is limited by resources. More members translate to more resources. More resources allow better advocacy and influence. With greater resources, ACEP can satisfy the emergency medicine interests and education emergency physicians desire, as well as offering greater practice support and career guidance.

Our physician profession has lost sight of itself as a community. Too many feel like they just need to take care of themselves and they cannot be a catalyst for change. We have difficult jobs that can be spiritually and emotionally draining, along with debt and responsibilities outside of the workplace. ACEP is a community of physicians working together to make changes. We sometimes disagree on issues but ultimately, we all share similar goals – good pay (with raises) and a safe working environment with the resources we need to care for our patients and ourselves. ACEP must start early to connect and resonate with the needs of emergency physicians.

## C. Ryan Keay, MD, FACEP
(Washington)

**Current Professional Positions:** Emergency Physician, North Sound Emergency Physicians, Providence Regional Medical Center Everett and Puget Sound Physicians, Snoqualmie Valley Hospital
**Internships and Residency:** Emergency Medicine Residency, Denver Health Medical Center, University of Colorado (2009); Chief Resident (2008-2009)
**Medical Degree:** MD, University of Washington School of Medicine (2005)
**Response**

The answer to this question is simple – it is not an easy fix. It is a multi-phase process, and we have to listen to the voices of our membership. The themes that are evident today are not new or unexpected. Most organizations through history experience a disconnect between older, "seasoned" membership, and the younger, vigorous parts of our organizations. In ACEP, we have not yet ascertained what drives different demographics to join, and stay, a part of a larger organization. Unless you have information to inform strategy, then you are stabbing in the dark. The longest-serving members of the College are rightly proud of the institution that they were part of creating and shaping. The rising generation, however, may be interested in transformative disruption of the status quo, a longer-term vision of the future, and most importantly in having their voices heard. Those in mid-career may simply be trying to prevent drowning in the burden of compliance, decreasing reimbursement, and harmonizing a life with their careers.

So, with this potential paradigm, I would pose the following questions as the framework for three pillars of work. 1. What is essential to ACEP and cannot be changed? 2. What needs to be disrupted and remade? 3. And finally, what needs to be added to make us whole? When we understand those three pillars, then we can begin phase two of the process. Listening sessions with key stakeholders will help us to understand for each demographic within ACEP what falls into those three buckets. Phase three will be to then take the summary of that information to the other teams – to dialogue around the needs and fears, and truly understand the barriers to implementing change. Finally, phase four is implementation – and we have to get this right.

This will be uncomfortable, and the conclusions could be radical. However, to stay static in today's world is to fade into irrelevance and our country and our membership needs the voice and presence of emergency medicine.

## Heidi C. Knowles, MD, FACEP
(Incumbent, Texas)

**Current Professional Positions:** Medical Director, Chief of Operations and Vice Chair for the Department of EM at John Peter Smith Hospital (Fort Worth, TX) with Integrative Emergency Services
**Internships and Residency:** Emergency Medicine Residency, University of Texas Health Science Center at Houston, Memorial Hermann Hospital (2006)
**Medical Degree:** MD, University of Texas Health Science Center at Houston (2003)
**Response**

Recruitment and retention strategies are crucial for any membership organization. To do this, we must assess and address the needs and desires of both our current and potential members. These needs could include the following:

Education: Enhancing ACEP's educational offerings, including the Scientific Assembly, is essential for providing cutting-edge education. Developing unique opportunities like the Indy Master Class, which caters to EM physicians interested in the business and management aspects of the field, and offering ample networking opportunities for physicians to connect are key.

Community: Creating public awareness campaigns that highlight our work and the stories of individual emergency physicians can foster a sense of community and pride within the profession.

Leadership development: Developing future leaders should involve AI-driven personalized development plans, gamified learning experiences, and a digital mentorship platform with ACEP leaders to provide real-time advice and role modeling.

Recognition: Enhancing the recognition of emergency physicians through digital badges/certificates, an interactive recognition platform, and a peer-nomination system can bolster morale and professional pride.

Career longevity: Addressing moral injury and burnout in medicine requires advanced strategies and technologies, including digital wellness platforms with guided meditation and virtual counseling, AI-driven personalized wellness plans, and telehealth peer support networks. Interactive webinars, advocacy campaigns, and innovative recognition programs further promote well-being.

Communication: Effective communication is *essential* for sharing the abundance of work that ACEP is doing daily. Leveraging the latest technologies and platforms, including data analytics and virtual reality, can personalize and enhance our messaging. Clear and consistent communication ensures everyone knows the available resources and ACEP's ongoing efforts to support professional growth and well-being.

By focusing on these areas, we can strengthen our organization, recruit new members, and retain current ones.

## Diana B. Nordlund, DO, JD, FACEP
(Michigan)

**Current Professional Positions: Corporate Compliance Officer, Partner and Attending Physician, Emergency Care Specialists**
**Internships and Residency:** Emergency Medicine Residency, Metro Health, Grand Rapids, MI (2010)
**Medical Degree:** DO, Kirksville College of Osteopathic Medicine/Andrew Taylor Still University, Kirksville, MO (2006)
**Response**

Building trust, strengthening community, and communicating value.

Building trust requires transparency, communication, and responsiveness. This requires direct-line interactions to understand the needs of members in a variety of practice environments to best serve the membership's needs. Communicating with chapters prior to impactful decisions whenever possible to gauge priorities, needs, and foresee potential problems is essential. A membership that feels heard, trusts and sees value in its organization, and freely shares that truth with others is an effective vehicle to retain and recruit.

Strengthening community requires connection. EPs face a variety of challenges that require real-time answers. Increasing the accessibility of College expertise and the ease with which members with similar interests and needs can connect with each other builds value and community. Facilitating follow-up to these connections at in-person meetings further develops community. When ACEP is the go-to for speedy answers to tough problems, whether learning from others who have already been through similar situations or solving problems together, we build strength, efficiency, and purpose and demonstrate unique and indispensable value. We are stronger together – with our wealth of diverse opinions and experiences – working effectively toward common goals, benefitting from lessons learned, and recognizing the excellent work being done in all corners of the profession.

Communicating requires the right channels. ACEP needs to clearly communicate its values and value to members. Personally, I'm grateful to find a service or product that improves my quality of life in a manner consistent with my values, while providing value proportional to the investment. Great gains have been achieved by our leadership, members, and staff that are not always known to general and potential membership, in part because our inboxes and notification queues are already overflowing. For EPs to determine for themselves if ACEP's values are consistent with their own and if ACEP provides value commensurate with the investment, the relevant information must be provided via channels that are already part of their routine or easily become part of their routine. Clarity of our organizational values so that they are easily identified and used as a consistent lens through which to view organizational decisions is of utmost importance. In-person connection, such as between colleagues working side-by-side in the ED, at the state level in leadership and advocacy, and professional community building at all levels may be key to communicating a richer dimension of value.

## Bing S. Pao, MD, FACEP
(California)

**Current Professional Positions:** General Partner and Senior Director of Provider Relations, Vituity
**Internships and Residency:** Emergency Medicine Residency, University of California San Diego (1996); Internal Medicine Internship, University of Colorado Health Science Center (1993)
**Medical Degree:** MD, Duke University (1992)
**Response**

Increasing membership involves a strategic approach that focuses on attracting new members while also retaining current ones. Here are several strategies the College could consider:

1. **Targeted Outreach:** Tailor outreach efforts to residents, young emergency physicians, and recent graduates. Additionally, ACEP should perform a gap analysis by soliciting feedback from current and prospective members to understand their needs, preferences, and challenges. Use this feedback to continuously improve membership offerings, communication strategies, and member engagement initiatives. ACEP needs to effectively communicate with **non-members** on how ACEP membership can benefit individual emergency physicians. Highlight the value of membership, such as access to educational resources like board preparation material, networking opportunities, advocacy successes and professional development. Illustrate how ACEP membership can (1) improve reimbursement (2) protect emergency physicians' rights, for example, banning non-competes and preserving due process (3) help advocacy efforts to reduce overcrowding (4) provide advocacy and leadership training (5) teach practice management skills (6) allow members to participate in research, and (7) assist with career development. Consider direct outreach through phone calls, texts, e-mails or social media. Offer new members incentives, including credit or free subscriptions to educational material like ACEP Anytime and/or registration to ACEP conferences. As a condition of the incentive offer, prospective members could be required to meet with Officers, Board Members and/or ACEP staff at ACEP meetings to talk about the benefits of membership. In-person marketing is a proven method for convincing prospective members to join.
2. **Referral Program:** Allow current members to receive discounts or benefits when referring prospective members or emergency physician groups that eventually join ACEP. The referral program could allow a member to bring a friend for free or at a discount to an ACEP-sponsored event. By attending networking events, conferences, and regional meetings, prospective members will have the opportunity to connect with other emergency physicians, share best practices, and collaborate on research or quality improvement projects. Emergency physicians that seek a network of colleagues may be inclined to join ACEP.
3. **Member Benefits and Discounts:** Offer a range of member benefits, such as discounts on conferences, publications, and educational resources to new members. Group discounts could also include packages that include advertisement or registration at ACEP-sponsored events. ACEP should also consider offering new members more free benefits or discounts for multi-year memberships.

By implementing a combination of these strategies, the College could effectively increase membership and strengthen its community of emergency medicine professionals.

Q&A ABOUT OUR LITTLEST PATIENTS

# KIDS KORNER

**DR. JONES** is associate professor at the department of emergency medicine & pediatrics and the program director of pediatric emergency medicine fellowship at the University of Kentucky in Lexington, Kentucky.

**DR. CANTOR** is the emeritus medical director for the Central New York Poison Control Center and professor of emergency medicine and pediatrics in Syracuse, New York.

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


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

# Ultrasound for Detecting Volvulus in Infants

## Question 1: "What Is the Sensitivity of Ultrasound for Detecting Volvulus in Infants When Compared to An Upper GI Study?"

Most of us do not work in a location that has ready access to obtain an upper GI study in infants to evaluate for malrotation with midgut volvulus. While surgical evaluation is the true gold standard for identifying midgut volvulus, the diagnostic study of choice for many surgeons tends to be the upper GI study. But what about ultrasound? In cases where the clinical suspicion is lower for a midgut volvulus, but you feel it still needs to be explored, can ultrasound help?

Interestingly, upper GI studies have a wide range of sensitivities and specificities for diagnosing malrotation with midgut volvulus. The sensitivity for the diagnosis of malrotation, alone, ranges from 40-100 percent.[1,2] The diagnosis of malrotation with midgut volvulus is lower.[2]

Regarding ultrasound's ability to diagnose malrotation, a prospective study by Zhou et al included 70 children with suspected malrotation with ages ranging from 2 days to 13 years (median 31 days).[1] These children with suspected malrotation were included based upon their clinical exams and had symptoms of bilious vomiting, repeated upper abdominal pain with vomiting, or upper abdominal distention. Of these 70 children, 23 were confirmed to have malrotation by surgery. Regarding these 23 patients with malrotation, all 23 patients were found to have inversion of the superior mesenteric artery (SMA) and superior mesenteric vein (SMV) and 22 had the ultrasound "whirlpool" sign. Thirteen of the 23 children were noted to have a transverse duodenum in front of the mesenteric artery. The transverse duodenum should be behind the superior mesenteric artery and the "whirlpool" sign—which is indicative of volvulus—occurs when bowel rotates around its mesentery leading to whirls of mesenteric vessels. All cases of malrotation demonstrated inversion of the SMA and SMV and there was a single false positive, yielding a sensitivity and specificity of 100 percent and 97.6 percent, respectively. For the whirlpool sign, the sensitivity was 95.6 percent and specificity was 95.7 percent, respectively. These findings suggest that ultrasound is an excellent tool to evaluate for malrotation with volvulus.

A 2021 systematic review and meta-analysis also explored the diagnosis of malrotation and midgut volvulus via ultrasound.[3] Inclusion criteria were ages 0-21 years who had suspected malrotation with/without volvulus, the presence of a reference standard for comparison, and reported results. Reference standards did vary by study and included surgical identification, upper GI study, CT, MRI, clinical follow up, or any combination of these as a composite reference. Seventeen studies were identified and included in the systematic review. Included studies evaluated the relationship between the SMA/SMV, whirlpool sign, or duodenal position in relationship to the SMA. Not all studies included all of these ultrasound signs. The pooled data (n=2,257 patients) for malrotation with or without midgut volvulus yielded a sensitivity of 94 percent (95 percent CI 89-97 percent) and specificity of 100 percent (95 percent CI 97-100 percent). This demonstrated a positive likelihood ratio of 317 and a negative likelihood ratio of 0.06, which are both excellent tests for malrotation and suggest that ultrasound can be used to effectively evaluate for malrotation with or without volvulus.

A separate systematic review and meta-analysis looked at the role of the whirlpool sign, alone, in diagnosing midgut volvulus.[4] So not just malrotation, but malrotation with midgut volvulus. The authors included 16 studies with 1,640 patients and found a pooled sensitivity and specificity of 87.42 percent (95 percent CI 81.05-92.25 percent) and 98.63 percent (95 percent CI 97.88-99.18 percent), respectively. While the whirlpool sign itself is not as sensitive for midgut volvulus, its overall ability to diagnose malrotation with midgut volvulus is very good and it appears to be a reasonable diagnostic option, especially when working in a setting without the ability to obtain an upper GI study. Furthermore, the ability to evaluate for the correct SMA/SMV

STUDIOLOCO - STUDIOLOCO-STOCK.ADOBE.COM

orientation adds a significant amount of value to the study.

## Summary

If you work in a setting with the ability to evaluate potential malrotation with or without volvulus via ultrasound, it appears to be a very good diagnostic tool to help with clinical decision-making. It is important to evaluate for both the position of the SMA in relationship to the SMV as well as for the "whirlpool" sign. With the ability to evaluate these two parameters, the sensitivity and specificity approximate 95 percent and 100 percent, respectively.

# Common Causes of Ataxia

### Question 2: "In Children Presenting to the ED, What Is the Most Common Cause of Ataxia?"

Ataxia in children can be fear-inducing for parents. Sometimes the child develops an acutely abnormal gait; sometimes the child manifests ataxia simply as the refusal to ambulate. Either way, ataxia in children can often be difficult to assess because children have a wide range of gaits considered normal. When a child does develop ataxia, what are the most likely causes? A recent 11-year retrospective study performed at a tertiary-care outpatient Pediatric Neurology clinic identified 120 children with acute ataxia.[5] Acute ataxia was defined as ataxia less than or equal to 4 weeks and the authors excluded children with underlying neurological diagnoses that could explain the ataxia. The study identified 120 children with ataxia and 82 percent were 1 to 6 years in age and 16 percent were older than 6 years of age. Acute post-infectious cerebellar ataxia was the most common diagnosis (59.2 percent; 71/120 patients), followed by drug intoxication (8.3 percent; 10/120 patients), and opsoclonus myoclonus ataxia (8.3 percent; 10/120 patients). Other less common causes included cerebellar stroke (1.7 percent) and acute disseminated encephalomyelitis (1.7 percent). Another retrospective outpatient Pediatric Neurology clinic study demonstrated similar etiologic results with acute post-infectious cerebellar ataxia identified again as the most common cause (51.2 percent) of acute ataxia.[6] It's important to note, though, that the practice settings in these studies were outpatient neurology clinics, so the causes of presentation may not reflect our ED setting.

Specific to the ED setting, there's some data on this topic but not a ton. A multi-center retrospective study of 11 Italian pediatric emergency departments identified 509 children with acute ataxia over an 8-year period.[7] The median age was 4.4 years. Like the above studies, the most common identified cause of acute ataxia in this study was also acute post-infectious cerebellar ataxia (33.6 percent; 171 cases), followed by CNS tumors (11.2 percent; 57 cases), and migraine disorders (8.3 percent; 42 cases). Only 35 cases (6.9 percent) were secondary to drug overdose or substance abuse. Another 2019 retrospective study demonstrated a similar incidence of acute post-infectious cerebellar ataxia (36.2 percent), but ingestion accounted for a larger percentage of the cases (15.6 percent).[8]

A separate pediatric ED study retrospectively identified 88 patients aged 1 to 18 years with ataxia over a three year period.[9] The authors included children with ataxic symptoms less than 30 days and divided the patients into two groups: clinically urgent neurological pathology (CUNP; n=37) and patients who were not clinically urgent (No CUNP; n=51). Children with previously-known diseases associated with ataxia were excluded. Clinically urgent neurological pathology (CUNP) was defined as any nervous system disorder requiring early diagnosis and prompt medical or surgical treatment such as neoplastic, cerebrovascular, and infectious central nervous system disorders, demyelinating disease, acute neuropathies, and CNS malformations. The median age was 5 years and the majority of patients (58 percent) were categorized in the "No CUNP" group which included post-infectious/parainfectious cerebellitis (i.e., post-infectious cerebellar ataxia). The most common overall cause of ataxia, again, was post-infectious/parainfectious cerebellitis (45.5 percent), followed by acute cerebellitis (10.2 percent), and Guillain-Barre (9 percent). While other urgent causes of ataxia within the CUNP group included things like encephalomyelitis, stroke, tumors, and AV malformations, these were uncommon and the authors make little mention of the duration of ataxia and the association with clinically urgent pathology—compared to non-urgent pathology.

## Summary

The most common cause of acute ataxia in children is post-infectious cerebellar ataxia and accounts for approximately half of the cases of acute ataxia.

## References


1. Zhou L, Li S, Wang W, et al. Usefulness of sonography in evaluating children suspected of malrotation: comparison with an upper gastrointestinal contrast study. *J Ultrasound Med.* 2015;34(10):1825-1832.
2. Mohamad Burhan MS, Hamid HA, Zaki FM, et al. The performance of ultrasound and upper gastrointestinal study in diagnosing malrotation in children, with or without volvulus. *Emerg Radiol.* 2024;31(2):151-165.
3. Nguyen HN, Kulkarni M, Jose J, et al. Ultrasound for the diagnosis of malrotation and volvulus in children and adolescents: a systematic review and meta-analysis. *Arch Dis Child.* 2021;106(12):1171-1178.
4. Enyuma COA, Adam A, Aigbodion SJ, et al. Role of the ultrasonographic "whirlpool sign" in intestinal volvulus: a systematic review and meta-analysis. *ANZ J Surg.* 2018; 88(11):1108-1116.
5. Thakkar K, Maricich SM, Alper G. Acute ataxia in childhood: 11-year experience at a major pediatric neurology referral center. *J Child Neurol.* 2016;31(9):1156-1160.
6. Kirik S, Aslan M, Ozgor B, et al. Acute ataxia in childhood: clinical presentation, etiology, and prognosis of single-center experience. *Pediatr Emerg Care.* 2021;37(3):e97-e99.
7. Garone G, Reale A, Vanacore N, et al. Acute ataxia in paediatric emergency departments: a multicentre Italian study. *Arch Dis Child.* 2019;104(8):768-774.
8. Luetje M, Kannikeswaran N, Arora R, et al. Utility of neuroimaging in children presenting to a pediatric emergency department with ataxia. *Pediatr Emerg Care.* 2019;35(5):335-340.
9. Yaradilmiş RM, Güngör A, Bodur I, et al. Evaluation of acute ataxia in the pediatric emergency department: etiologies and red flags. *Pediatr Neurol.* 2023;139:1-6.

**DR. LEE** is a second-year resident in emergency medicine at Highland Hospital in her hometown of Oakland, California. Her primary interests are in ultrasound, machine learning, and health justice.

# The Private Equity Wave in Health Care

## A swell of investment and rough seas for early-career emergency physicians

*by* CARMEN LEE, MD, MAS

MILA103 - AI GENERATED - STOCK.ADOBE.COM

Hahnemann University Hospital in Philadelphia closed in 2019, a year and a half after it was acquired along with St. Christopher's Hospital for Children by private equity (PE) firm Paladin Healthcare Capital for 170 million dollars. Of that total, 120 million dollars were new loans taken out against the assets of the hospitals with interest rates around 10 percent.[1] Immediately after the purchase, the real estate holdings of the hospitals were spun off into a separate company owned by Paladin and other PE investors.[2] Former employees and administrators described the period that followed as chaos: it included diminished staffing levels, delayed equipment and building maintenance, closures of entire departments, and a hastily-executed emergency department renovation designed to increase volume that quickly stalled due to poor design and a failure to obtain permits.[1,3]

Executives had been persuaded not to close the residency and fellowship programs at the hospital, only to have the program's 550 training spots liquidated for 55 million dollars in bankruptcy proceedings.[4] St. Christopher's was able to find a buyer prior to bankruptcy but Hahnemann could not. Its real estate, exempt from bankruptcy filings and valued around 120 million dollars, remains held separately by the original private equity investors, who have sought buyers for the valuable downtown property.

Prior to its closure, Hahnemann had served primarily low-income patients from the surrounding Philadelphia community and had struggled to break even under the ownership of the for-profit Tenet Healthcare Corporation. This story has become increasingly common in the health care industry, as hospitals and physician groups flounder in an increasingly complex reimbursement environment and private equity firms have stepped in to infuse capital.

Private equity investment in health care has increased more than 20-fold since 2000, with 70 percent of this activity since 2010. From 200 billion dollars that year, the firms that make up the Healthcare Private Equity Association now have over 2 trillion dollars in assets under management.[2] While widespread, these investments have also begun to saturate local markets: a recent study found that, through physician group acquisitions, the majority of physician market share is controlled by a single private equity firm in 13 percent of metropolitan markets.[5]

Private equity follows a fundamentally different business model from other forms of investment, such as publicly-traded or privately-owned companies. PE firms manage funds in which only large-scale institutional investors and high-net-worth individuals accredited by the Securities and Exchange Commission may invest. These funds are permitted to use high levels of debt to purchase companies in leveraged buyouts in which typically 60 percent to 80 percent of the purchase price comes from new loans against the value or assets of the acquisition. Between 2 to 10 percent comes from the private equity firm itself; the remainder comes from the fund's investors including accredited individuals, endowments, and pension funds.[2,6] As with Hahnemann, the PE firm and its investors do not remain liable for debts incurred during the purchase. These stakeholders are similarly shielded in court when adverse patient outcomes, such as negligent deaths, occur under their management or when the bought-out companies are challenged for anticompetitive business practices overseen by the PE firm.[7-9]

The PE model then aims to sell acquired businesses for a profit within three to six years. To do this, firms must dramatically increase the market value of their portfolio to produce the return on investment sought by the industry, typically around 20 percent, all while also paying off large levels of debt needed to finance the acquisition.[2,6] At the same time, most PE firms engage in common practices that increase costs and overhead for acquired companies beyond the debt incurred in the acquisition. PE firms typically pay the firm and its investors first, often by borrowing additional money in a strategy called dividend recapitalization.[10] Secondly, PE firms also charge the entities that they own for the oversight they provide in the form of management fees.[2,6] Companies acquired with these high debt burdens and saddled with increased costs and are later at a much higher risk for bankruptcy: 20 percent compared with 2 percent for propensity-matched companies with similar size and risk that were not acquired.[11]

The playbook to quickly grow margins enough to meet these new financial obligations can start to feel familiar, according to emergency physician Ellana Stinson, MD. In her congressional testimony this year, she described working for PE-owned and publicly traded entities including Envision, TeamHealth, Steward Health System, and Tenant as following a familiar script. "I began to realize how resources were being dwindled down and pulled from each facility ... and Quincy Hospital was taken down to bare bones before its ultimate closure. Not having blood products, respiratory therapy on certain days, or certain specialty services no longer felt like I was able to provide safe or quality care."[12]

A common first move is often staffing cuts, since labor amounts to more than half of costs for many health care companies.[13] Cost cutting may also include, as in the case of Hahnemann, postponing maintenance on existing equipment, decreasing inventory or cost of supplies, and shuttering departments. It also frequently includes substituting the physician labor force with advanced practice practitioners (APPs) such as physician assistants and nurse practitioners. Studies have found that while both physician and non-physician staffing turnover occurs at significantly higher rates at PE-owned firms, APPs are also hired at much higher rates, implying replacement of physicians with other types of clinicians.[14]

Dr. Stinson remembers what it was like to work for a PE-owned hospital early in her career. "I walked into a hospital and [the APP] was fresh out of nurse practitioner school, had never worked in the ER before as the primary caregiver of a patient, had no training or anything, they just threw her out there. It was my first week in the facility, and I'm still trying to just figure out where the bathroom is, and I'm like 'This can't be safe that we're the only two people here!' But they needed bodies, and they're putting NPs and PAs also in very challenging positions."

Another common tactic is the sale-leaseback strategy, in which an acquired entity's real estate is sold off to a third party who then charges it rent to use the land and facilities with the proceeds from the sale funneling back to the PE firm. In the widely publicized example of Steward Health Care, a PE-acquired hospital network with 30 hospitals across multiple states currently facing bankruptcy, sales of its real estate to Medical Properties Trust covered the entire purchase price for the PE owner Cerberus and created 800 million dollars in additional profit. Cerberus then sold the heavily

indebted entity back to a group of its own doctors, and Steward is now failing to meet both rent and debt obligations.[15]

The same playbook seen across many industries with PE investment can have especially negative effects on the health care workforce. "Private equity is generally highly leveraged, profit focused, and has a short-term mindset," explains Jim Dahle, MD of the White Coat Investor. "Good docs tend to be driven elsewhere, burnout levels tend to increase, and capital is used for profit rather than investing in the long-term viability of the business. Undercapitalized hospitals don't pay their vendors, don't maintain and purchase needed equipment and supplies, and run overly lean staffing models." Indeed, when 156 private equity-acquired hospitals were compared to 1,560 matched controls, they lost 24 percent of their capital assets over the first two years after acquisition.[16]

Proponents of the private equity model argue that it can be used to identify and increase economies of scale, yet a growing body of evidence finds that both hospital and physician costs increase after private equity acquisition, and that these costs are typically passed on to the patient.[6,17-18] In a 2023 systematic review, no studies showed decreased costs to patients or payors, and the effect of PE ownership on quality of care measures was "mixed to harmful," a pattern that has continued in subsequent studies.[19,20] The more granular effects of acquisitions on physician pay, for example, can be hard to quantify, as contracts, business practices, and revenues are often shrouded in secrecy.

A statement from Envision argued that their internal data shows that Envision clinicians exceed national quality benchmarks. "Our physician-led teams are guided by the delivery of high-quality, clinically-appropriate evidence-based care," the Envision statement said. "They make hiring decisions locally in partnership with hospitals based on communities' needs. All clinicians—no matter the stage of their career—undergo a rigorous screening process and are hired by local physician leaders if they and the clinician believe it's a fit."

The saga surrounding balance billing in emergency medicine illustrates the influence of private equity on the specialty. During the legislative fight to pass the federal *No Surprises Act* of 2020, it was asserted that most balance billing in the U.S. was due to two large physician groups, TeamHealth and Envision. Both groups, with a collective employment of nearly 90,000 physicians, had recently been acquired by private equity firms and are alleged to have instituted the balance billing strategy to enhance profitability.[2]

In the case of Envision, balance billing was reported to be such a fundamental part of its plan for increased revenue and meeting debt obligations that the passage of the *No Surprises Act* and subsequent disputes with insurers resulted in multiple downgrades of the quality of its corporate bonds. This was cited as a cause for its eventual bankruptcy.[2,5,18] Envision had been acquired for 9.9 billion dollars in one of the largest leveraged buyouts since the 2008 financial crisis, of which over 7 billion dollars was new debt obligation.[18] Two months after Envision's bankruptcy, PE-owned American Physician Partners (APP) also folded under the weight of its 630 million dollars in debt despite consistently rising revenues .[21,22]

TeamHealth Chief Medical Officer and emergency physician Jody Crane, MD argues that blame for any increased cost or perceived impact on quality should be placed on insurance companies, referring to long-running legal battles with private insurers over payments for its services. "The harsh reality is that physician groups, regardless of ownership model, have very little control over reimbursement," Dr. Crane said. "While scale can improve a physician practice's ability to negotiate with insurers and hold them accountable for fair payment, at the end of the day healthcare premiums continue to increase year over year and physician reimbursements continue to decline. Insurers leverage laws, like EMTALA or the *No Surprises Act*, to drive down payments .... This is not about private equity driving up costs, this is about unchecked insurer fraud and abuse."

Still, this wave of private equity acquisitions in emergency medicine has come crashing down on the heads of many early-career physicians. As of 2022, 1 in 4 emergency departments in the United States were staffed by a private equity-owned physician group.[23] The emphasis on lower-cost labor results in heavy recruitment of recent graduates to place downward pressure on wages. Dr. Stinson said, "There have been [PE] facilities where I worked where a third to a half of the staff are all new residents. Usually, they'll get two or three every now and then, but if everybody is fresh, who's teaching who?" While secrecy surrounds the operations of many PE-owned groups, Envision serves as a case study. During the pandemic they "cut pay and benefits for emergency room doctors and other medical workers" while "continuing to spend millions on political ads" to counter the *No Surprises Act*, according to reporting from ProPublica.[18,24]

When reached for comment, TeamHealth and Envision both said their companies now have a policy against balance billing. "Envision fully supports the patient protections under the *No Surprises Act* and, before it was passed, had a policy prohibiting balance billing," the Envision statement said. "Meanwhile, some health insurers improperly deny and underpay claims for care provided to their members. The 2023 ruling by an independent arbitration panel stating UnitedHealthcare owes Envision more than 91 million dollars for underpayment of essential medical care is a clear example of this." At the same time, there is evidence that declining reimbursements by insurers, including UnitedHealthcare, may also be a strategy driven by private equity investment.[25]

Wesley Barnett had heard disturbing stories about the firm staffing his hometown critical-access ED as he was nearing the end of residency at the University of Kentucky, so he founded an independent physician group to try to take back the contract. He was shocked when the hospital CEO took him up on it, but a year later, volumes increased 30 percent with his emphasis on quality rather than cost-cutting. He explained what he feels is the trap set for early career physicians this way: "Say you're paying 200 dollars an hour to a physician to see 2 patients an hour. If that number is now 4 patients an hour, instead of keeping safe staffing models, we'll give you incentive pay, making 300 dollars an hour. Before they were paying you 100 dollars a chart, now they're paying you 75 dollars a chart, and you just got had. You've taken on the additional liability and more money for more pain." Because young physicians are often walking into these situations fresh, he says, "They're just happy they're making more than in residency."

Amid high-profile failures of hospitals and physician groups, legislatures are looking to limit private equity investment in health care. In California, a recent bill has been introduced and has sparked a lobbying battle pitting physicians' and nurses' associations against PE-funded groups.[26] In the United States Senate, Senator Elizabeth Warren (D-MA) has introduced legislation that would make it easier to hold PE firms and health care executives accountable for the negative consequences of leveraged buyouts, including criminal liability for the wrongful deaths of patients.[27]

Private equity acquisitions tend to target hospitals and physician groups financially struggling to survive and those with a significant proportion of government-insured patients. Dr. Stinson is concerned about the potential to exacerbate disparities. "Most of these private equity firms are in lower-income, under-resourced places already because they come in with a promise to turn the books around. But maybe that was never the intention," she speculates. "They leave the area deprived of access." Low Medicaid and Medicare reimbursement, which according to the American Medical Association have "declined greatly between 2001 and 2023 after adjusting for inflation in practice costs," increase the financial strain on providers of health care including both hospitals and physicians. The AMA found that administrative burden of reimbursement and low rates were the most frequent factors in physicians' decisions to sell their practices.[28]

Dr. Crane sees acquisitions as a way to help physician practices survive: "The singular focus the house of emergency medicine in America, big or small and regardless of ownership model, should rally around is fair reimbursement." Yet the advice may differ for newer physicians versus more seasoned ones. In a cautionary tale for young physicians, Dr. Dahle warns, "The only benefit I see to any private equity involvement is for a doctor at the end of her career to have an additional buyer for a practice."

*This article contains additional reporting from Medical Editor-in-Chief Cedric Dark, MD, MPH, FACEP, and ACEP staff.* ACEP Now *reached out to Paladin, the Healthcare Private Equity Association, Cerberus, Steward Health System, and Tenant for comment but did not receive any in time for press. The views expressed in this article do not represent an official position of the American College of Emergency Physicians."*

## References


1. Pomorski C. The death of Hahnemann Hospital. The New Yorker. https://www.newyorker. com/magazine/2021/06/07/the-death-of-hahnemann-hospital. Published May 31, 2021. Accessed August 25, 2024.
2. Appelbaum E, Batt R. Private equity buyouts in healthcare: who wins, who loses? Center for Economic and Policy Research (CEPR). https://cepr.net/report/private-equity-buyouts-in-healthcare-who-wins-who-loses/. Published March 15, 2020. Accessed August, 2024.
3. D'Mello K. Hahneman's closure as a lesson in private equity healthcare. J Hosp Med. 2020;15(5):318-320.
4. Barrish C. Bankruptcy judge approves 55 million sale of Hahnemann residency program. WHYY. https://whyy.org/articles/bankruptcy-judge-approves-55-million-sale-of-hahnemann-residency-program/. Published September 5, 2019. Accessed August 25, 2024.
5. Sheffler RM, Alexander L, Fulton BD, et al.Monetizing medicine: private equity and competition in physician practice markets. American Antitrust Institute (AAI). https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf. Published July 10, 2023. Accessed August 25, 2024.
6. Cai C, Song Z. Private equity in Health Care: Prevalence, Impact, and Policy Options for California and the U.S. California Health Care Foundation (CHCF). https://www.chcf.org/publication/private-equity-in-health-care-prevalence-impact-and-policy-options-for-california-and-the-u-s/. Published May 7, 2024. Accessed August 25, 2024.
7. Justia. Filing 45. Salley et al v. Heartland-Charleston of Hanahan SC LLC et al. https://law.justia.com/cases/federal/district-courts/south-carolina/scdce/2:2010cv00791/173842/45/. Accessed August 25, 2024.
8. Stempniak M. Private equity firm, accused of trying to build a monopoly in radiology, dismissed as defendant in FTC lawsuit. Radiology Business. https://radiology-business.com/topics/healthcare-management/legal-news/private-equity-firm-accused-trying-build-monopoly-radiology-dismissed-defendant-ftc-lawsuit. Published May 15, 2024. Accessed August 25, 2024.
9. Herman B. Private equity escapes FTC in court, but anesthesia group doesn't. STAT. https://www.statnews.com/2024/05/20/welsh-carson-private-equity-escapes-ftc-antitrust/. Published May 20, 2024. Accessed August 25, 2024.
10. Dubner SJ. Are private equity firms plundering the U.S. economy? Freakonomics Radio. https://freakonomics.com/podcast/are-private-equity-firms-plundering-the-u-s-economy/. Published November 15, 2023. Accessed August 25, 2024.
11. Ayash B, Rastad M. Leveraged buyouts and financial distress. Finance research letters, forthcoming. SSRN. https://ssrn.com/abstract=3423290. Published July 22, 2019. Accessed August 25, 2024.
12. United States Senate. When health care becomes wealth care. Subcommittee Field Hearing of the U.S. Senate Committee on Health, Education, Labor andPensions. https://www.help.senate.gov/hearings/when-health-care-becomes-wealth-care-how-corporate-greed-puts-patient-care-and-health-workers-at-risk. Published Apr il 3, 2024. Accessed August 25, 2024.
13. Coleman-Lochner L, Church S. Private equity is no longer a reliable last resort for troubled hospitals. Bloomberg. https://www. bloomberg.com/news/articles/2023-09-12/troubled-pennsylvania-hospital-reveals-failure-of-private-equity-deals. Published September 12 2023. Accessed August 25, 2024.
14. Bruch JD, Foot C, Singh Y, et al. Workforce composition in private equity-acquired versus non-private equity-acquired physician practices. Health Aff (Millwood). 2023;42(1):121-129.
15. Schooley M, Hager C, Kaplan M. Steward Health Care files for Chapter 11 bankruptcy. CBS Boston. https://www.cbsnews.com/boston/news/steward-health-care-bankruptcy/. Published May 7, 2024. Accessed August 25, 2024.
16. Schrier E, Schwartz HEM, Himmelstein DU, et al. Hospital assets before and after private equity acquisition [published online ahead of print July 30, 2024]. JAMA.
17. Singh Y, Song Z, Polsky D, et al. Association of private equity acquisition of physician practices with changes in health care spending and utilization. *JAMA Health Forum*. 2022:3(9):e222886.
18. Bugbee M. Envision Healthcare: a private equity case study. Private Equity Stakeholder Project (PESP). https://pestakeholder.org/reports/envision-healthcare-a-private-equity-case-study/. Published December 14, 2022. Accessed August 24, 2025.
19. Borsa A, Bejarano G, Ellen M, et al. Evaluating trends in private equity ownership and impacts on health outcomes, costs and quality: systematic review. *BMJ*. 2023;382:e075244.
20. Kannan S, Bruch JD, Song Z. Changes in hospital adverse events and patient outcomes associated with private equity acquisition. JAMA. 2023;330(24):2365-2375.
21. Yerak B. American Physician Partners files for bankruptcy after shutdown. The Wall Street Journal. https://www.wsj.com/articles/american-physician-partners-files-for-bankruptcy-after-shutdown-5792e23c. Published September 19, 2023. Accessed August 25, 2024.
22. Muoio D. Hospital, ED staffer American Physician Partners files for Chapter 11 bankruptcy. Fierce Healthcare. https://www.fiercehealthcare.com/providers/hospital-ed-staffer-american-physician-partners-files-chapter-11-bankruptcy. Published September 20, 2023. Accessed August 25, 2024.
23. Adelman L. 2023 State of the Emergency Medicine Employer Market. Ivy Clinicians. https://assets.ivyclinicians.io/content/2023%20State%20of%20the%20EM%20Employer%20Market_Ivy%20Clinicians.pdf. Published February 2023. Accessed August 25, 2024.
24. Arnsdorf I. Medical staffing companies cut doctors' pay while spending millions on political ads. ProPublica. https://www.propublica.org/article/medical-staffing-companies-cut-doctors-pay-while-spending-millions-on-political-ads. Published April 20, 2020. Accessed August 25, 2024.
25. Hamby C. In battle over health care costs, private equity plays both sides. The New York Times. https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills-private-equity.html. Published April 7, 2024. Accessed August 25, 2024.
26. Sabalow R. Doctors vs. hospitals: a bid to regulate hedge funds is dividing California medical groups. Cal Matters. https://calmatters.org/health/2024/04/health-care-private-equity/. Published April 30, 2024. Accessed August 25, 2024.
27. Lannan K. Warren seeks consequences for 'corporate crimes' in health care. WGBH. https://www.wgbh.org/news/politics/2024-06-11/warren-seeks-consequences-for-corporate-crimes-in-health-care. Published June 11, 2024. Accessed August 25, 2024.
28. Kane CK. Changes in physician practice arrangements: shifts away from private practice and towards larger practice size continue through 2022. American Medical Association (AMA). Physician Practice Benchmark Survey. Published May 16, 2024. Accessed August 25, 2024.

# 2024–2025 EMERGENCY PHYSICIAN COMPENSATION REPORT

*by* BARB KATZ

As I sit here in early August contemplating my retirement at the end of the year and writing up my final jobs report, I am plagued by one very important and all-encompassing question:

Will Paris ever be allowed to host the Olympics again?

From the controversial opening ceremonies to an Olympic village with lousy food, no real air conditioning and cardboard beds, to swimming in a toxic river, the future looks a bit dicey! I mean, who puts Simone Biles in a cardboard bed? There were definite expectations—the athletes expected a village and venues that gave comfort and safety, but the organizers expected a thumbs-up for a "green" environment. Expectations—a slippery slope! It takes me back to my early days in the emergency medicine arena 34 years ago, and I can't help but be nostalgic.

In 1990, residency programs in emergency medicine were only in existence for about 15 years. Those programs graduated less than 400 residents a year. Emergency departments (EDs) were primarily staffed with area primary care docs, many of whom had been working exclusively in the ER for years. Emergency docs were the real cowboys of medicine—they did a lot of locums work, and many of them had their own airplanes, flying themselves to gigs around the country. Hospitals didn't have Emergency Departments per se, they had ERs under the department of Surgery. Even most residency programs operated under the surgical umbrella. There were no mid-level providers. There were no scribes. The gold standard job was with a democratic private group with partnership opportunities.

There was no sign-on bonus, loan forgiveness, stipends or other front money. Docs were lucky to get basic relocation funds from a new employer. But with all of that, emergency physicians lived to work. They wanted to work as many shifts as they could—2,080 clinical hours a year was the norm. Earning $150 an hour was high income, and their primary expectations were to work hard and make a difference.

Thirty-four years later, we are graduating more than 2,200 emergency physicians a year whose job search expectations have become more like entitlements, even though there are just 1,700 jobs available and 33 percent of those jobs are open to primary care boarded physicians. There is no balance in residency program location or physician compensation on a national basis. Large, national contract groups run 68 percent of the EDs in the country and sign-on bonuses reach as high as $150K for a 3-year contract. There is even an opportunity being advertised for a "casual emergency physician with occasional sitting and standing."

It has been my pleasure to serve the emergency medicine specialty in so many ways for the past 35 years. I will be continuing some consulting work for the next few years, and hope to pop up at a Scientific Assembly in the near future!

**BARBARA KATZ** is president of The Katz Company EMC, a member of ACEP's Workforce and Career sections, and a frequent speaker and faculty at conferences and residency programs. She can be reached at katzco@cox.net.

**The Southeast provides 34 percent of the country's jobs this season, 71 percent with a National Contract Group (NCG) and 64 percent open to primary care (PC) boards; regional salary average is $390K.**

**FL:** 40 percent NCG/28 percent PC Average: $400K, High: $510K Heavy HCA & TeamHealth openings

**NC:** 54 percent NCG/56 percent PC Average: $385K, no real highs, but a low of $312K in Charlotte

**KY:** 88 percent NCG/79 percent PC Average: $390K, High: $410K

**TN:** 92 percent NCG/72 percent PC Average: $410K, High: $375 hour for locum, heavy TeamHealth jobs

**VA:** 86 percent NCG/31 percent PC Average: $390K, High: $450K a few jobs in the DC area

**LA:** 97 percent NCG/ 96 percent PC Average: $380K, SCP is the primary employer

**GA:** 81 percent NCG/ 81 percent PC Average: $380K, High: $462K a few openings in Atlanta area

**WV:** 42 percent NCG/ 38 percent PC Average: $360K, WVU Health is the primary employer

**AR:** 86 percent NCG/ 86 percent PC Average: $365K

**AL:** 100 percent NCG/100 percent PC Average: $400K

**SC:** 7 percent NCG/7 percent PC Average: $365K

**MS:** 81 percent NCG/ 90 percent PC no financial information available

**The states of the West/Southwest provide 24 percent of the US jobs, 61 percent with NCG employers and 32 percent open to PC boarded physicians; regional salary average is $397K.**

**TX:** 66 percent NCG/40 percent PC Average: $468K, High: $353 Hour in Odessa

**CA:** 66 percent NCG/15 percent PC Average: $430K, High: $330 an hour in Stockton

**AZ:** 76 percent NCG/ 35 percent PC Average: $414K, lots of opportunity in the Phoenix area

**OK:** 88 percent NCG/42 percent PC Average: $425K

**NV:** 89 percent NCG/39 percent PC Average: $369K, lots of opportunity in Las Vegas

**NM:** 47 percent NCG/41 percent PC Average: $350K, High: $500K with group in Deming

**CO:** 91 percent NCG/50 percent PC Average: $320K

**HA:** 25 percent NCG/25 percent PC Average: $280K

**UT:** no NCG or PC, no financial information available; 3 positions in academics

**Figure 1. States and Cities Offering the Best Opportunity**

**Top 10 States for Opportunity**

1. Texas
2. Florida
3. California
4. New York
5. Ohio
6. North Carolina
7. Pennsylvania
8. Illinois
9. Kentucky
10. Tennessee

**Top 10 Cities for Opportunity**

1. San Antonio, TX
2. Phoenix, AZ
3. New York City, NY
4. Baltimore, MD
5. Houston, TX
6. Knoxville, TN
7. Dallas, TX
8. Boston, MA
9. Las Vegas, NV
10. Pittsburgh, PA

**The Midwest represents 21 percent of the current job openings, 43 percent with NCGs and 28 percent open to PC-boarded physicians; regional salary average is $370K.**

**OH:** 74 percent NCG/32 percent PC Average: $380, primary employer is USACS

**IL:** 60 percent NCG/38 percent PC Average: $400K, a scattering of opportunities in Chicago

**IN:** 93 percent NCG/43 percent PC Average: $420K, High: $460K, sign-on bonuses found up to $150K

**MO:** 44 percent NCG/33 percent PC Average: $380K

**IO:** 60 percent NCG/82 percent PC Average: $340K

**MN:** 56 percent NCG/6 percent PC Average: $390K

**MI:** 56 percent NCG/44 percent PC Average: $320K

**KS:** 40 percent NCG/6 percent PC Average: $360K

**WI:** 31 percent NCG/8 percent PC Average: 380K

**ND:** no NCG/40 percent PC Average:$360K, major employer is the Indian Health Service

**NE:** no NCG or PC, Average: $360K, High: $315 hour in Omaha

**SD:** no NCH or PC, Average: $348K, all openings are with the Indian Health Service

**The Northeast provides 9 percent of available US jobs, 38 percent with NCG employers and 21 percent open to PC boarded physicians; regional salary average is $345K.**

**NY:** 44 percent NCG/24 percent PC Average: $365K, High: $480K in the Finger Lakes region; Heavy NYC jobs

**MA:** 6 percent NCG/no PC Average: $380K, High: 518K with a private group

**ME:** 29 percent NCG/50 percent PC Average: $300K, $150K sign-on with a group

**CT:** 50 percent NCG/50 percent PC Average: $385K, High: $425K at Teed Co Agency client

**NH:** 22 percent NCG/22 percent PC Average: $330K, High: $380K in Lancaster

**VT:** no NCG or PC openings Average: $330K

**RI:** 100 percent NCG/no PC Average: $325K

**The Middle Atlantic brings 8 percent of national openings, 45 percent with NCGs and 10 percent open to PC boarded physicians; regional salary average is $359K.**

**PA:** 63 percent NCG/17 percent PC Average: $372K

**MD:** 68 percent NCG/6 percent PC Average: $380K, primary employer is USACS, heavy in Baltimore

**NJ:** 63 percent NCG/26 percent PC Average: $325K

**DE:** 63 percent NCG/no PC no financial information available

**DC:** no NCG/PC openings and no financial information available; 1 academic opening

**Bringing up the rear, the six states of the Pacific Northwest gives 4 percent of U.S. jobs, 27 percent with NCG employers and 40 percent open to PC boarded physicians; regional salary average of $360K.**

**WA:** 42 percent NCG/38 percent PC Average: $410K, heavy urgent care openings in the Seattle area

**MT:** no NCG/50 percent PC Average: $350K, 50 percent rural ERs, 50 percent Indian Health Service

**OR:** no NCG or PC openings Average: $355K

**ID:** no NCG/100 percent PC no financial information available, all rural openings

**AK:** 50 percent NCG/50 percent PC Average: not enough info available; $350K with group in Fairbanks

**WY:** no NCG or PC Average: $350K

EM LITERATURE OF NOTE

# PEARLS FROM THE MEDICAL LITERATURE

**DR. RADECKI** (@emlitofnote) is an emergency physician and informatician with Christchurch Hospital in Christchurch, New Zealand. He is the *Annals of Emergency Medicine* podcast co-host and Journal Club editor.

# Latest in Neurologic Emergencies

## The science of stroke marches on!

*by* RYAN RADECKI, MD, MS, FACEP

You may have mastered all the latest changes affecting management of sepsis, STEMI, and opiate-use disorder, but there's no stopping the relentless revisions to our approach to neurologic emergencies.

The first bit of news is good news, however: a "negative" study in which no change in practice is needed. This comes out of INTERACT-4, a trial testing the efficacy of blood pressure reduction in undifferentiated acute stroke syndromes.[1] Our prior INTERACT family of trials are those whose results have influenced our current practice of blood pressure control following intracranial hemorrhage, demonstrating reductions in hematoma size associated with prompt blood pressure control. The hypothesis tested in INTERACT-4 is whether antihypertensive treatment might be started even earlier, in the pre-hospital setting, reducing any time-dependent negative effects.

In this trial conducted in China, the antihypertensive of choice was urapidil, primarily an alpha-1 receptor antagonist, and provided by the trial sponsor. Without delving into too much detail, approximately half of the over 2,300 patients in the trial suffered ischemic stroke, and the remainder hemorrhagic stroke. The intervention was, indeed, successful at lowering blood pressure in those randomized. However, the overall trial itself was "negative" in that there was no overall difference between groups. Looking more closely, there is a very clear demarcation within these results in which the intensive blood pressure control harmed those patients suffering ischemic stroke, but benefitted those suffering hemorrhagic stroke. These results suggest there is yet no role for prehospital antihypertensives until the specific stroke syndrome is diagnosed, as with one of the mobile CT scanners.

The next question addressed in recent trials continues to be refinement of the thrombolytic of choice. The last few years have been consistently spotlighting tenecteplase as superior to alteplase, both with respect to efficacy and safety. This is not unwelcome in the slightest, as tenecteplase administration in stroke is more straightforward than the bolus-plus-infusion requirement for alteplase. The most recent spotlight for tenecteplase is whether it can be used in extended time windows up to 24 hours. Two recent trials have looked at this same question: TIMELESS and TRACE-III.[2,3]

These trials lend themselves to discussion in the same breath because they have, effectively, the same study concept. Each trial enrolled patients presenting with acute ischemic stroke in a large-vessel territory and favorable perfusion imaging. Each trial included patients in the 4.5 to 24 hour treatment window, outside of traditional indications for thrombolysis. How these trials differ, however, is important.

TIMELESS enrolled patients with the expectation they would receive endovascular intervention following enrollment, 77 percent of whom ultimately underwent thrombectomy. TRACE-III, on the other hand, enrolled patients without access to endovascular intervention, testing the idea that tenecteplase may be suitable as an alternative in such cases. This distinction represents the crux of their differing results.

**CONTINUED** *on page 20*

The foundation of the paradigm for endovascular intervention lies in the established observation intravenous thrombolysis is grossly ineffective at dissolving large vessel occlusions. Therefore, in TIMELESS, a trial where the overwhelming majority receive thrombectomy per the standard of care, all clots are expunged, irrespective of the pre-intervention treatment with tenecteplase. There are a few clots teneteplase dissolves prior to endovascular intervention. However, the sorts of patients who have salvageable tissue in late time windows turn out to be those whose "time is brain" clock is running the slowest, already, due to strong collateral perfusion. Therefore, TIMELESS is a "negative" trial, showing no advantage to tenecteplase when subsequent endovascular intervention is expected.

In contrast, TRACE-III does not have the endovascular backstop following intravenous thrombolysis. In this case, because outcomes are so dismal already from large-vessel occlusions, there is some benefit to treatment with tenecteplase, 33 percent versus 24 percent advantage for good or excellent functional outcomes. The authors report an excess bleeding events in the tenecteplase cohort, likely leading to the neutral effect on overall survival. It is reasonable to consider the use of tenecteplase in extended time windows, then, in systems of care where endovascular intervention is not readily available.

Now, just when you've gotten used to the idea of tenecteplase replacing alteplase as your preferred agent, should we be reconsidering reteplase? Reteplase is not "new" by any stretch of the imagination. It should sound familiar from its use in the early days for STEMI. However, in those trials, it was associated with higher rates of bleeding than alteplase and tenecteplase, and thusly it fell into disfavor. The RAISE trial in China tested reteplase versus alteplase in, generally, mild strokes with a median NIHSS of 6.[4] Overall, good or excellent outcomes were seen in 79 percent of the reteplase cohort versus 70 percent of those receiving alteplase. Unfortunately, consistent with other trials, excess bleeding events were seen with reteplase, leading to increased mortality and other extra-cranial complications. Further evaluation and replication of these results will be necessary to even begin reconsideration of reteplase in the coming years.

Finally, we have the ongoing saga of Andexxa, properly known as "coagulation factor Xa [recombinant], inactivated-zhzo". The conditional approval for Andexxa in the United States hinged upon single-arm studies and apparent hemostatic efficacy. However, prior to the availability of this specific reversal agent for factor Xa inhibitors, clinicians have been utilizing prothrombin concentrate complexes to treat major bleeding events. The ANNEXA-I trial aimed to compare this PCC-based stopgap "standard of care" against Andexxa for the treatment of intracerebral hemorrhage.[5]

As is the fate of many trials whose procedures, enrollment, and reporting is orchestrated by pharmaceutical companies, the topline results are misleading. Looking narrowly at their primary outcome of hemostatic efficacy, defined primarily by change in intracerebral hematoma volume, the trial favors Andexxa. However, a full 15 percent of those in the "standard of care" cohort were not treated with PCCs and an excess of patients in the Andexxa cohort were lower-risk types of intracerebral bleeding such as subdural hematomas. More troubling, however, were the poor patient-oriented outcomes observed in the trial. Patients in the Andexxa cohort suffered a substantially greater number of thrombotic events, including ischemic stroke and myocardial infarction, and the mortality in patients receiving Andexxa was actually higher at 30 days. A greater number of patients randomized to "standard of care" attained modified Rankin scores of 0 to 3 than the Andexxa cohort, as well. It may be the case Andexxa clearly reduces factor Xa inhibition and attenuates hematoma growth, but the primacy of patient-oriented outcomes clearly ought to caution clinicians about its use.

In summary, continue to expect further permutations for potential treatment in extended time windows. The march towards tenecteplase continues unabated, while reteplase has re-emerged for further investigation. Prehospital blood pressure control in undifferentiated stroke syndromes should not be considered. Finally, the Andexxa marketing push continues, but it's clear harms cannot be ignored.

## References


1. Li G, Lin Y, Yang J, et al. Intensive ambulance-delivered blood-pressure reduction in hyperacute stroke. *N Engl J Med*. 2024;390(20):1862-1872.
2. Albers GW, Jumaa M, Purdon B, et al. Tenecteplase for stroke at 4. 5 to 24 hours with perfusion-imaging selection. *N Engl J Med*. 2024;390(8):701- 711.
3. Xiong Y, Campbell BCV, Schwamm LH, et al. Tenecteplase for ischemic stroke at 4.5 to 24 hours without thrombectomy. *N Engl J Med*. 2024;391(3):203-212.
4. Li S, Gu HQ, Li H, et al. Reteplase versus alteplase for acute ischemic stroke. *N Engl J Med*. 2024;390(24):2264-2273.
5. Connolly SJ, Sharma M, Cohen AT, et al. Andexanet for factor xa inhibitor–associated acute intracerebral hemorrhage. *N Engl J Med*. 2024;390(19):1745-1755.

# EM ALLIANCE

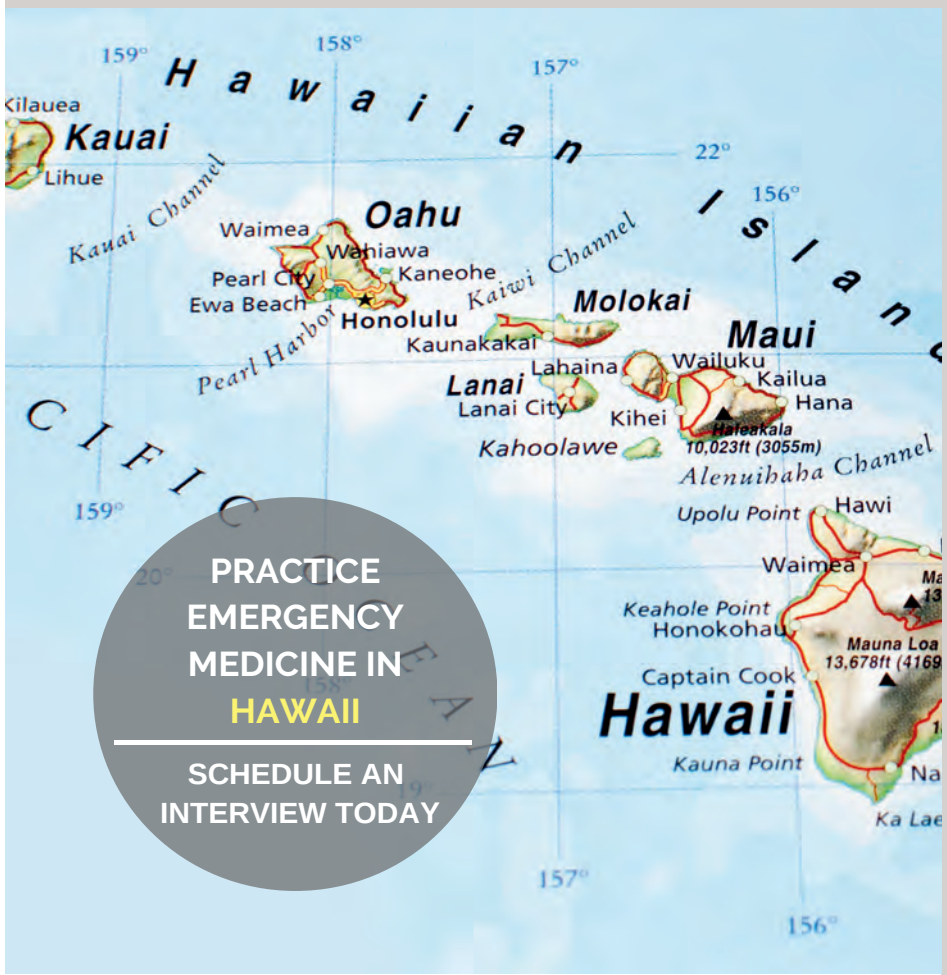
## Join a Team Where Physicians Come First

As other contract groups have faced bankruptcy and dissolution, leaving many emergency providers without a practice, EM Alliance has remained strong. Our providers remained united and upheld our hospital agreements, creating a stable and secure team environment.

Owned and led by Emergency Physicians, EM Alliance is driven by a clear mission: to provide exceptional clinical care in a patient-centered setting. We stand apart as a refreshing alternative to private equity-backed contract groups, with our focus dedicated to supporting our physicians and delivering the best possible care to our patients.

**Scan for More Info**

**11 Locations in Florida and California**
**Stop by ACEP Booth #4408**




**PRACTICE EMERGENCY MEDICINE IN HAWAII**

**SCHEDULE AN INTERVIEW TODAY**

HEPA
HAWAII EMERGENCY PHYSICIANS ASSOCIATED

**As Hawaii's oldest and largest ED physician group,** we are dedicated to nurturing the next generation of quality emergency physicians and meeting the ever-changing healthcare challenges.

**Send CV to HEPA@EMrecruits.com**

**Meet our Leadership at Booth #4408 in Las Vegas**

GSEP
EMERGENCY MEDICINE

## San Antonio, Texas Metro Locations

Our new physicians work the same number of shifts as our shareholders, have access to revenue, expenses, and productivity - and eligible for partnership after 2,000 hours.

**Interested in Interviewing?**
**Send your CV to GSEP@EMrecruits.com**

- Work in the #1 ranked hospital system in San Antonio
- Live in a Metropolitan City with a Low Cost of Living
- Enjoy Great Neighbors and Award Winning Schools

**Visit ACEP Booth #4408 in Las Vegas**

Commonwealth
EMERGENCY PHYSICIANS

## Virginia - Loudoun & Fairfax Counties

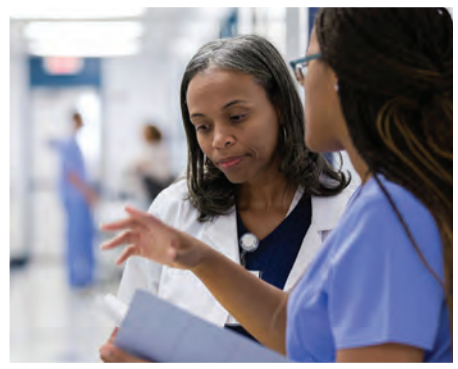
Commonwealth Emergency Physicians is a physician owned and managed Emergency Medicine group in Northern Virginia offering a unique and attractive career opportunity.

We are seeking EM Physicians who have a broad experience with high acuity and share our philosophy to provide progressive, compassionate, emergency medicine care.

**- Stable, Private, Democratic Group - Employed**
**- Medical Benefits, Retirement Plan, Paid Malpractice**

From Alexandria in the east to Loudoun County in the west, communities have adopted elements of both urban and suburban lifestyles allowing young families to live in communities with great schools, fine dining, and stocked with amenities.

**Send CV to CEP@EMrecruits.com**
**Visit ACEP Booth #4408 in Las Vegas**

# Penn State Health Emergency Medicine

**About Us:** Penn State Health is a multi-hospital health system serving patients and communities across central Pennsylvania. We are the only medical facility in Pennsylvania to be accredited as a Level I pediatric trauma center and Level I adult trauma center. The system includes Penn State Health Milton S. Hershey Medical Center, Penn State Health Children's Hospital and Penn State Cancer Institute based in Hershey, Pa.; Penn State Health Hampden Medical Center in Enola, Pa.; Penn State Health Holy Spirit Medical Center in Camp Hill, Pa.; Penn State Health Lancaster Medical Center in Lancaster, Pa.; Penn State Health St. Joseph Medical Center in Reading, Pa.; Pennsylvania Psychiatric Institute, a specialty provider of inpatient and outpatient behavioral health services, in Harrisburg, Pa.; and 2,450+ physicians and direct care providers at 225 outpatient practices. Additionally, the system jointly operates various healthcare providers, including Penn State Health Rehabilitation Hospital, Hershey Outpatient Surgery Center and Hershey Endoscopy Center.

We foster a collaborative environment rich with diversity, share a passion for patient care, and have a space for those who share our spark of innovative research interests. Our health system is expanding and we have opportunities in both academic hospital as well community hospital settings.

**Benefit highlights include:**
- Competitive salary with sign-on bonus
- Comprehensive benefits and retirement package
- Relocation assistance & CME allowance
- Attractive neighborhoods in scenic central Pa.

**FOR MORE INFORMATION PLEASE CONTACT:**

Heather Peffley, PHR CPRP - Penn State Health Lead Physician Recruiter
**hpeffley@pennstatehealth.psu.edu**

PennState Health

Penn State Health is fundamentally committed to the diversity of our faculty and staff. We believe diversity is unapologetically expressing itself through every person's perspectives and lived experiences. We are an equal opportunity and affirmative action employer. All qualified applicants will receive consideration for employment without regard to age, color, disability, gender identity or expression, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, and family medical or genetic information.

EPT | Emergency Physicians OF TIDEWATER

www.ept911.com

## Private Democratic Group in Norfolk/Virginia Beach

***Up to $50,000 Signing Bonus!***

Since 1972, Emergency Physicians of Tidewater has been providing exceptional patient care via several Emergency Departments in Southeastern Virginia. Our physicians enjoy their choice of practice settings from an academic Level 1, Quaternary Referral Center to a community-based practice. EPT leads the longest running Emergency Medicine Residency program in Virginia as well as multiple fellowships. EPT physicians enjoy coastal living in Virginia Beach and Norfolk, with history-rich areas like Colonial Williamsburg and the Blue Ridge Mountains within a short drive.

### Opportunities:

*Apply Now:*

- **EQUITY/OWNERSHIP**: Accelerated two-year partnership track
- **LEADERSHIP**: Governing Board/Committee appointments
- **TEACH**: Faculty appointment at Eastern Virginia Medical School
- **COLLABORATE**: With a highly-cohesive, LOCALLY-governed group
- **EARN**: Rich Benefits & Top-Ranked Retirement Plan

Practice Variety • Democratic Group • Partnership • Leadership • Teaching

The Henry JN Taub Department of Emergency Medicine at Baylor College of Medicine seeks a Vice Chair of Research to oversee research operations for the department.

Baylor College of Medicine (www.bcm.edu) is recognized as one of the nation's premier academic health science centers and is known for excellence in education, research, healthcare and community service. Located in the heart of the world's largest medical center (Texas Medical Center), Baylor is affiliated with multiple educational, healthcare and research affiliates (Baylor Affiliates).

Salary, rank, and tenure status are contingent upon candidate qualifications. The rank and tenure status awarded will be based upon qualifications in alignment with Baylor College of Medicine's promotion and tenure policy.

Qualified applicants are expected to have a research record with significant extramural funding and leadership skills to develop a strong multidisciplinary collaborative Emergency Medicine research program and continue to grow current departmental research efforts. In addition to the above responsibilities, other duties may be assigned by the Chair.

Please include a cover letter and current curriculum vitae to your application.

This position is open until filled. For more information about the position, please contact Dick Kuo, MD via email [dckuo@bcm.edu].

MINIMUM REQUIREMENTS
Education: M.D. or D.O. degree
Experience: Research Fellowship not required for application
Licensure: Must be currently boarded in Emergency Medicine and eligible for licensure in state of Texas.

# EM ALLIANCE

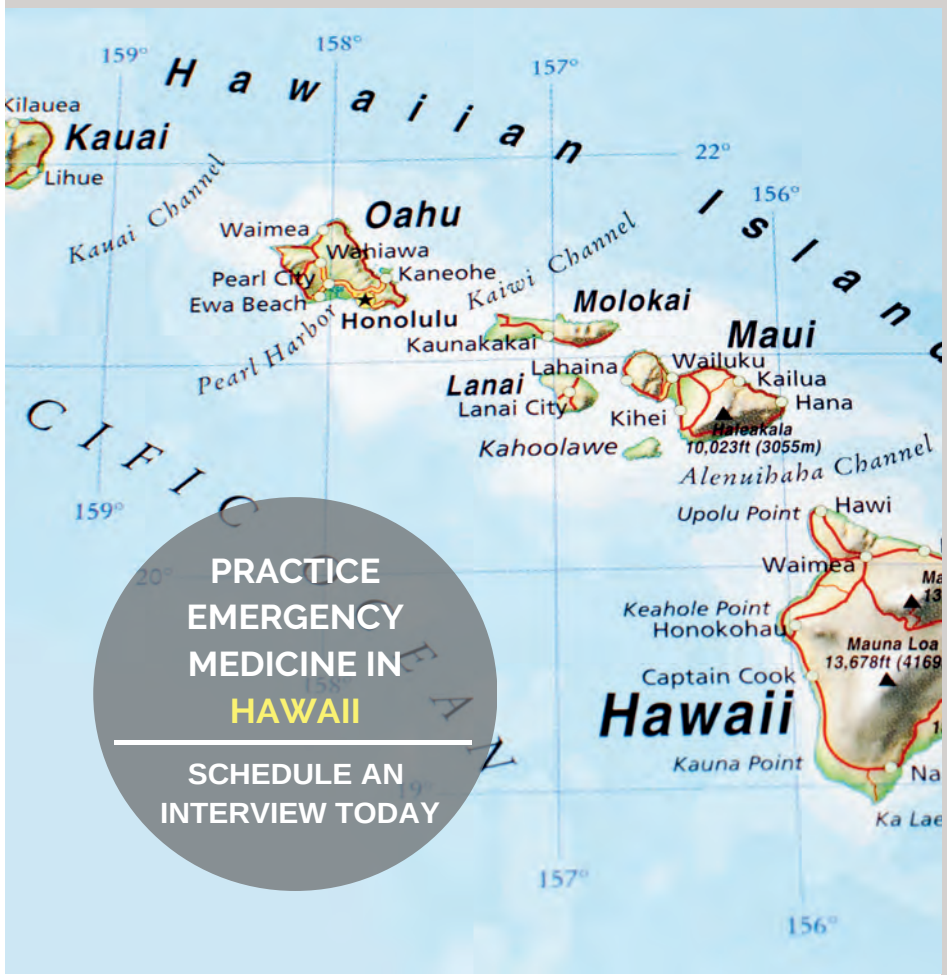
## Join a Team Where Physicians Come First

As other contract groups have faced bankruptcy and dissolution, leaving many emergency providers without a practice, EM Alliance has remained strong. Our providers remained united and upheld our hospital agreements, creating a stable and secure team environment.

Owned and led by Emergency Physicians, EM Alliance is driven by a clear mission: to provide exceptional clinical care in a patient-centered setting. We stand apart as a refreshing alternative to private equity-backed contract groups, with our focus dedicated to supporting our physicians and delivering the best possible care to our patients.

**Scan for More Info**

**11 Locations in Florida and California**
**Stop by ACEP Booth #4408**




**PRACTICE EMERGENCY MEDICINE IN HAWAII**

**SCHEDULE AN INTERVIEW TODAY**

HEPA
HAWAII EMERGENCY PHYSICIANS ASSOCIATED

**As Hawaii's oldest and largest ED physician group,** we are dedicated to nurturing the next generation of quality emergency physicians and meeting the ever-changing healthcare challenges.

**Send CV to HEPA@EMrecruits.com**

**Meet our Leadership at Booth #4408 in Las Vegas**

GSEP
EMERGENCY MEDICINE

## San Antonio, Texas Metro Locations

Our new physicians work the same number of shifts as our shareholders, have access to revenue, expenses, and productivity - and eligible for partnership after 2,000 hours.

**Interested in Interviewing?**
**Send your CV to GSEP@EMrecruits.com**

- Work in the #1 ranked hospital system in San Antonio
- Live in a Metropolitan City with a Low Cost of Living
- Enjoy Great Neighbors and Award Winning Schools

**Visit ACEP Booth #4408 in Las Vegas**

Commonwealth
EMERGENCY PHYSICIANS

## Virginia - Loudoun & Fairfax Counties

Commonwealth Emergency Physicians is a physician owned and managed Emergency Medicine group in Northern Virginia offering a unique and attractive career opportunity.

We are seeking EM Physicians who have a broad experience with high acuity and share our philosophy to provide progressive, compassionate, emergency medicine care.

**- Stable, Private, Democratic Group - Employed**
**- Medical Benefits, Retirement Plan, Paid Malpractice**

From Alexandria in the east to Loudoun County in the west, communities have adopted elements of both urban and suburban lifestyles allowing young families to live in communities with great schools, fine dining, and stocked with amenities.

**Send CV to CEP@EMrecruits.com**
**Visit ACEP Booth #4408 in Las Vegas**

US Acute Care Solutions

# STABILITY MEETS OPPORTUNITY

With US Acute Care Solutions, you don't have to choose between stability and opportunity. Our commitment to honoring your seniority allows you to confidently explore new career paths across our nationwide network of hospitals, from fast-paced urban centers to tranquil rural communities.

SCAN TO VIEW OUR NATIONWIDE **CAREERS**


**Bobby Missaghi, MD**
**EM Residency:** The University of California, Los Angeles – Harbor Medical Center, 2017
**Emergency Physician**

**Misty Nguyen, DO**
**EM Residency:** Southwest Medical Center, 2021
**Emergency Physician**

**Calen Hart, MD**
**EM Residency:** Vanderbilt University School of Medicine, 2022
**Emergency Physician**

**Erin Fenoff, DO**
**EM Residency:** Ohio University Heritage College of Osteopathic Medicine, 2018
**Emergency Physician**

**Dan Kelly, MD**
**EM Residency:** The University of Texas Medical School, 2011
**Emergency Physician**