Vol. XLIII No. 3

Find us on: facebook

Follow us on twitter

May/June 2023

In This Issue

Contents

Submissions to the July/August 2023 Newsletter should be received by the Chapter office no later than August 1, 2023.

FROM THE PRESIDENT

I put my kids on a plane this morning. There were hugs and high-fives and bags triple-checked after last-minute runs to the store (yes, we still managed to forget something) and a delightful flight attendant, clutching her coffee cup, who still managed to smile and look benevolent after volunteering to manage a rather ragtag bunch of travelers.

Yes, I videoed the plane taxiing.
Yes, I waved frantically at the little face in the window in the last row, whether or not he could actually see me through the UV-protected glass at the end of the terminal.

Yes, I stared into the sky for a long minute after I could no longer actually see the plane.

And yes, I may have been transiently verklempt.

It's an act of faith to get onto an airplane at all, let alone to put your kids on one without you.

It's also an act of faith when our patients show up to the ED asking for care, trusting us to listen, to see, to evaluate, and, to the extent that our resources and the system and the circumstances permit, to heal.

As I reflect on how the practice of Emergency Medicine has changed over the last 50 years, and how it will surely change in the next 50, I ask myself how we can possibly be more resilient, more adaptive, more likely to thrive and grow into whatever the next half-decade brings. This year at MCEP, we've worked to clarify and update our internal processes, increase transparency for our membership, put our financial house in order, and set the stage for a bright future, one that is responsive to our membership's evolving needs and the challenges of the specialty. We've stood up in the courtroom to advocate against criminalization of EMTALA-mandated medical care. We've developed, supported, and testified on behalf of legislation to protect EM staff against violence in the workplace. We've nurtured another set of remarkable future leaders with our Leadership Development Program. We built an amazing team in the front office with Christy, Madey, and Allie, working together to further the mission of the College with dedication, enthusiasm, and grace.

Diana Nordlund, DO, JD, FACEP

As we look forward to time together on Mackinac Island this summer, it is with the confidence of a year well-spent and optimism for the future that I'll pass the gavel to Dr. Fill.

Thank you for the honor of serving as your President. §

TRANSITIONS

As June turns into July, emergency departments with residents and students prepare for transitions to the new academic year. Milestones are everywhere. Levelling up from medical school to residency. Adding another number to one's year of residency training. Upping your PGY number of years since graduation. A fresh cycle of aspiring medical students and soon-to-be residents are now preparing their applications and personal statements and eagerly seeking out letters of recommendation. New graduates from residency are moving and preparing for new jobs and new opportunities the country and the world over.

While transitions occur throughout the year, and milestones are not reserved for the unique change between June 30 and July 1, this is a prominent time of change for many. Although medical school graduation ceremonies are already a few weeks in the past, July 1 marks the first time many new graduates will introduce themselves by that familiar and yet foreign-sounding term (when used in front of their own last name), "Doctor." In Michigan, we are welcoming new graduates from all over the country and the world to the practice of emergency medicine in the state in which the specialty was founded.

Similarly, interns and junior residents are leveling up to more senior roles. For those of us in attending roles, think back to the first time that you were the resident "lead" on a shift. Remember when you first became the "senior" resident during a critical resuscitation. Those of us who teach residents still have the privilege of seeing these transitions and supporting our residents in the growth of their practice and their confidence. Nothing really changes except the month and their title, and yet everything changes in the perception of the role of the resident learner on shift. For those of you finishing up your internship, this is a time to welcome the new interns and to realize how much you've learned and how much you've grown in the course of the past year.

For senior residents, now is the time that the job hunt for next year is ramping up to full swing. If pursuing fellowship, you are working on your application. If looking for a job, your CV is likely polished, and you are putting out feelers across the country. For all, it remains a rite of passage to officially be the senior, the most seasoned emergency medicine trainee, not unlike being a senior in high school, a senior in college, or a fourth-year medical student. This is your time to put your stamp on your program and your hospital.

For our newest attendings, those who graduated residency this month and who are leaving for your first jobs, rest assured that you are well-trained and that you are ready. Just as you thought critically the first time you signed an order as an intern (even for something so simple as acetaminophen for a fever), most of us had some measure of anxiety the first time that we were working truly independently, without the safety net of our attendings to validate and confirm our clinical instincts and our plans. Remember that you are never without support. You can always reach out to your residency mentors and support system, but more importantly, at the local level, you can contact specialists or PCPs or even run a challenging case by a colleague. In our field, you are never a lone wolf, and you are never truly alone.

For those of us who have been in practice, summer is often a time for transition as well. If moving jobs or location, summertime is ideal to minimize disruption of the school year. If returning to fellowship, we make the same jump on July 1 as the rest of medical learners. While retirements can happen at any time of the year, the beginning of summer seems like a natural time to move on to the next phase of life. MCEP also celebrates its outgoing board members at the end of July at the Michigan Emergency Medicine Assembly and elects new board members who bring fresh ideas to the leadership of the College. In addition, I will be starting my transition of editorial duties for the News and Views newsletter, and I warmly welcome Dr. Andrew Taylor as my co-editor for the upcoming year, starting with our next issue.

Sara Chakel, MD, FACEP

In closing, as we celebrate these transitions, let's all push back at any ill-founded humor directed towards our learners that suggests that patients are less safe in July. Many studies show that there are not increased adverse outcomes in July compared to the rest of the year. If we hear negative comments, let's remind the naysayers that we were all July 1 interns and that each of these new emergency physicians has literally spent a lifetime studying and thousands of supervised clinical hours in preparation for this day. With appropriate guidance, our new interns are ready to enter the emergency medical world. Let's inspire them with our leadership and work to teach them, as we were once taught by those who came before us.

July 1 is a day of transitions. May you all enjoy a beautiful Michigan summer. May you enjoy the next stage of your career and your life, no matter where it takes you. §

2023 MPFS CODING GUIDELINE CHANGES:

Don Powell, DO, FACEP

We are now nearing nearly six months of experience with the 2023 Medicare Physician Fee Schedule (MPFS) documentation guideline changes. By now, providers have likely started to receive feedback, even at a macro level, on compliance and acuity shifts from their corporate Revenue Cycle Management (RCM) entities. It was well known entering this monumental documentation change that the educational arm was to be two-fold, with one arm aimed at clinicians and the other aimed at coders.

The acuity shifts that are playing out were largely anticipated. 99283 (level 3) and 99285 (level 5) are both down as they have both propagated into an increased volume of 99284 (level 4) E&M levels. The resulting overall acuity is rising compared to the historical data for most groups. That may not result in overall increased revenue, however. While the increased RVUs from the shift of 99283 to 99284 (+1.5 RVU) is helpful, the larger loss of RVUs from 99285 to 99284 (-1.65 RVU) continues to remain a concern. It is paramount that both arms (clinicians and coders) continue to regularly communicate to try to negate confusion and to capture appropriate levels of care.

All clinicians should continue to keep regular lines of communication open with their coding/RCM teams. Many aspects, terms, and documentation styles that clinicians use may be confusing to our largely non-medically trained colleagues. If the complexity of care is not clear to the coding teams, then it likely will not be captured on the acuity side!

In initial discussions with coders, several themes seem to be fairly common:

1. Complexity of problems addressed (COPA) is a very subjective area that many coders struggle with. Recall that for a high COPA, one of two scenarios need to be met:
   - One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment, or
   - One acute or chronic illness or injury that poses a threat to life or bodily function.
   - To help alleviate some of the confusion in this area, *a differential diagnosis in the MDM is of great help to explain the mindset and decision-making process of the clinician, and this can often justify a high level of COPA.*
2. Clarity in individual interpretations of radiology studies, EKGs, rhythm strips, and other data is another area of potential confusion. Was this clearly an "independent interpretation"?
   - Recall that per CMS guidelines, "A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test."
   - It's *recommended that very straightforward statements be documented, e.g., "I personally reviewed and interpreted as ...."*

As more information is collected over the next few months, we will continue to see patterns that need to be fine-tuned. Remember, however, that this is a two-pronged approach, and we need to be on the same page as our coding team.

Continue to keep regular communication lines open and facilitate discussions to alleviate any confusion. Just as our clinical team is a group effort, so should be the RCM component. §

Don H Powell, DO, FACEP
Emergency Care Specialists
President- Medical Management Specialists

HOUSE VOTES TO INCREASE PENALTIES FOR VIOLENCE IN MICHIGAN'S EMERGENCY DEPARTMENTS!

On Tuesday, June 27, 2023, the Michigan House voted 97-11 on House Bill 4520 and 99-9 on House Bill 4521 to increase penalties on assaults on health professionals and volunteers in emergency departments. MCEP has long advocated for these increased penalties and worked to pass legislation last session in the House that died in the 2022 Lame Duck session. MCEP Executive Director Christy Snitgen and Board President-Elect Dr. Michael Fill testified with several ED nurses from around the state in early June at the House Criminal Justice Committee hearing on the legislation.

The bills now go to the Senate for consideration. The Senate will refer the bill to the Senate Civil Rights, Judiciary and Public Safety Committee. The Committee consists of the following members:

Senator Stephanie Chang, Chair, D-Detroit
Senator Sue Shink, Vice Chair, D-Ann Arbor
Senator Paul Wojno, D-Warren
Senator Jeff Irwin, D-Ann Arbor
Senator Sylvia Santana, D-Detroit
Senator Jim Runestad, Minority Vice Chair, R-White Lake
Senator Ruth Johnson, R-Groveland Township

We expect a hearing on the bill in September after the Legislature returns from its summer recess. MCEP will call on all members to contact their state senator toward the end of the summer to encourage them to support the legislation and adopt this legislation. We appreciate all the calls and emails that members sent to House leaders the past several months. Also, many thanks to MCEP's Leadership Development Team that spent a day in April lobbying legislators in Lansing!

Bret Marr, Lobbyist
Muchmore, Harrington, Smalley & Associates

MCEP PURSUES MICHIGAN MEDICAL REIMBURSEMENT INCREASE

MCEP Leadership, led by Health Finance Committee Chair Dr. Michael Gratson, have begun the process of pushing for an increase in Medicaid reimbursement for visits to emergency departments. Some in the college may recall that MCEP pursued a similar effort in the mid-2000s. This is a multi-year process, but it starts with conversations with the state's Medical Services Administration (MSA), which is part of the Department of Health and Human Services. MCEP will keep members posted as these discussion progress over the coming months.

STATE BUDGET FINALIZED AND SUMMER LEGISLATIVE RECESS

The last week of June traditionally signifies the final process of the state budget being passed. The state's fiscal year doesn't start until October 1st of each year, but it has been a tradition to get the budget done several months prior to the start so local units of government and other state stakeholders can prepare for the coming year. The FY 2023-24 budget has significant focus on health issues, mainly on the behavioral health crisis in our state. With final passage of the budget, the legislature will be at recess for the month of July and limited days in August. As mentioned earlier, the fall session starts after Labor Day and traditionally runs into the holiday season. §

MCEP President-Elect Michael Fill, DO, FACEP and Christy Snitgen, MCEP Executive Director, testifying at the House Criminal Justice Committee.

A CASE OF NITROUS OXIDE-INDUCED SUBACUTE COMBINED DEGENERATION

Jacob Hirschl, M.D. and Joel Krauss, M.D., of the University of Michigan, Ann Arbor

INTRODUCTION:

Nitrous oxide (N2O), commonly known as laughing gas, is a widely used inhaled anesthetic. It is easily available in whipped cream chargers for a low cost. It is also widely used recreationally for its euphoric properties. In fact, data from the 2014 Global Drug Survey suggests that 29.4% of U.S. survey respondents had used N2O in their life [1]. Excessive use of N2O is known to cause neurological injury by vitamin B12 deficiency with the most frequent symptoms being paresthesia (80%), unsteady gait (58%), and weakness (43%) [2].

CASE REPORT

A 46-year-old woman with past medical history of vitamin B12 deficiency presented to the emergency department with bilateral foot numbness for the past five months which had worsened in the preceding week, spreading superiorly to her hips. She also complained of severe lower back pain and bilateral leg weakness with multiple falls over the past week. Physical exam showed reduced sensation of bilateral shins, bilateral patellar and Achilles hyperreflexia, and an unstable, wobbly gait. Laboratory workup was significant for vitamin B12 deficiency (130 pcg/mL; reference range 180-914 pcg/mL). She was not anemic (hemoglobin 12.9 g/dL; MCV 94.1). MRI was obtained and showed subacute combined degeneration (SCD) of the thoracic spinal cord with demyelination of dorsal columns. Upon obtaining further history after this finding, the patient admitted to using nitrous inhalants on weekends for the past year and a half.

DISCUSSION

This patient's previously diagnosed vitamin B12 deficiency may have been due to her N2O use, which had not yet been disclosed. She exhibited all three of the most common symptoms associated with N2O-associated SCD: Limb numbness, limb weakness, and gait disturbance. Additionally, N2O abuse may cause psychiatric symptoms such as hallucinations, delusions, or disordered speech as well as hematologic sequelae due to vitamin B12 deficiency [3]. The mechanism of how N2O causes the above symptoms is unclear, but animal studies suggest that the pathophysiology is due to a deficiency of a methyl group due to homocysteine methyltransferase dysfunction. N2O inactivates vitamin B12 by oxidizing the cobalt in cobalamin, causing impaired activity of methionine synthase and resulting in reduced production of methionine.

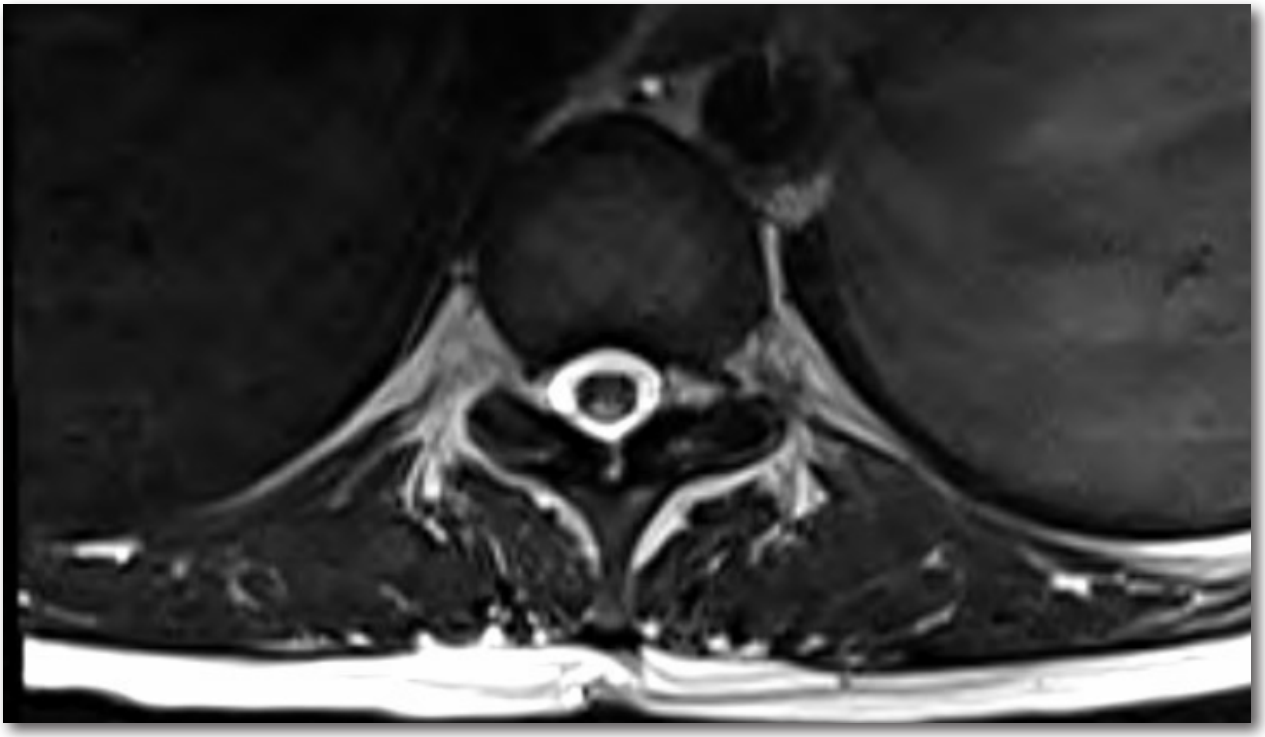

Figure 1: MRI of thoracic spine at T9 level showing increased attenuation of the dorsal spinal cord (arrow). Read showed abnormal patchy hyperintensity in the dorsal aspect of the spinal cord extending from the cervicothoracic junction to the distal spinal cord just above the conus medullaris at L1, with patchy linear gadolinium enhancement involving the dorsal spinal cord at the mid-thoracic levels, particularly from approximately T5 through T7-T8.

Ultimately, this leads to failure of myelin maintenance with spinal cord and axonal degeneration [4].

When N2O abuse is suspected, workup should include not only vitamin B12 levels and a complete blood count to assess for megaloblastic anemia, but also methylmalonic acid (MMA) and homocysteine, which will be elevated. Of note, vitamin B12 levels are often within normal limits; thus, MMA and homocysteine levels are key to diagnosis. MRI can also be done if SCD is suspected, as in this case. Most patients with SCD show no abnormalities on MRI, however [4,5].

This condition is treated with vitamin B12 supplementation and cessation of N2O use. Specifically, for severe neurological deficits, patients should be given 1,000 mcg vitamin B12 daily for one week, then weekly for one month, followed by maintenance therapy with 1,000 mcg monthly. Vitamin B12 and MMA levels should be closely monitored during this period [4]. With adequate treatment, the neurological deficits from N2O-induced SCD have a good prognosis [3,6]. However, N2O abstinence is of critical importance as illustrated by a case series in which four patients who continued to use N2O were receiving vitamin B12 supplementation and still developed progressive N2O-induced SCD. N2O cessation must thus be stressed in addition to B12 supplementation [7]. Independent ambulatory function at time of SCD diagnosis is a prognostic factor which predicts complete restoration of ambulatory function; over 88.9% of patients walking unsupported at time of diagnosis made a complete recovery, regardless of etiology of their SCD [6]. This case report illustrates that N2O-induced SCD should be considered in patients with new neurological deficits who may be using this widely used substance. §

REFERENCES:

1. Kaar SJ, Ferris J, Waldron J, Devaney M, Ramsey J, Winstock AR. Up: The rise of nitrous oxide abuse. An international survey of contemporary nitrous oxide use. Journal of Psychopharmacology. 2016;30(4):395-401. doi:10.1177/0269881116632375
2. Oussalah A, Julien M, Levy J, Hajjar O, Franczak C, Stephan C, Laugel E, Wandzel M, Filhine-Tresarrieu P, Green R, Guéant JL. Global Burden Related to Nitrous Oxide Exposure in Medical and Recreational Settings: A Systematic Review and Individual Patient Data Meta-Analysis. J Clin Med. 2019 Apr 23;8(4):551. doi: 10.3390/jcm8040551. PMID: 31018613; PMCID: PMC6518054.
3. Yu M, Qiao Y, Li W, Fang X, Gao H, Zheng D, Ma Y. Analysis of clinical characteristics and prognostic factors in 110 patients with nitrous oxide abuse. Brain Behav. 2022 Apr;12(4):e2533. doi: 10.1002/brb3.2533. Epub 2022 Mar 20. PMID: 35307992; PMCID: PMC9015005.
4. Omotosho YB, Ying GW, Orji R, Patel H. Recreational Nitrous Oxide-Induced Subacute Combined Degeneration. Cureus. 2022 Mar 22;14(3):e23409. doi: 10.7759/cureus.23409. PMID: 35475085; PMCID: PMC9023326.
5. Temple C, Horowitz BZ. Nitrous Oxide "Whippet" Induced Subacute Combined Degeneration of the Spinal Cord. J Emerg Med. 2022 Mar;62(3):e83-e84. doi: 10.1016/j.jemermed.2021.10.045. Epub 2022 Jan 20. PMID: 35065869.
6. Jhunjhnuwala D, Tanglay O, Briggs NE, Yuen MTY, Huynh W. Prognostic indicators of subacute combined degeneration from B12 deficiency: A systematic review. PM R. 2022 Apr;14(4):504-514. doi: 10.1002/pmrj.12600. Epub 2021 May 19. PMID: 33780172.
7. Temple C, Horowitz BZ. Nitrous oxide abuse induced subacute combined degeneration despite patient initiated B12 supplementation. Clin Toxicol (Phila). 2022 Jul;60(7):872-875. doi: 10.1080/15563650.2022.2046772. Epub 2022 Mar 7. PMID: 35253567.

www.mcep.org

ABOUT THE OBSERVATION MEDICINE COMMITTEE

The Observation Medicine Committee consists of Observation Unit (OU) medical directors and physicians who have an interest in Observation Medicine across Michigan. We meet quarterly and work together to assist EM physicians starting or thinking about starting an OU in Michigan. We provide a collaborative platform to brainstorm and discuss issues OU directors may be facing and how best to inform and educate EM physicians and residents about Observation Medicine. Visit our webpage at: https://www.mcep.org/about-us/committees/obstoc/ to learn more and to find information on:

- Protocols, pathways, and other tools for management of an Observation Unit
- Educational Observation Medicine content
- Observation Medicine educational opportunities such as medical student and resident elective rotations and OM fellowships
- Information about our yearly *Observation Medicine - Science and Solutions* conference. Save the Date for our 2023 virtual conference on *September 15, 2023!*

Please contact me at margarita.pena@ascension.org if you are interested in joining our committee.

Margarita E. Pena, MD, FACEP
Chair, Observation Medicine Committee

Michigan Emergency Doctors
Political Action Committee
6647 West St. Joseph Highway
Lansing, Michigan 48917
(517) 327-5700

Dear Doctor:

As members of MCEP, ACEP, and the health care community, we dedicate ourselves to advancing quality emergency care. Increasingly, key decisions affecting our ability to fulfill this mission are made by elected officials—few of whom are medically trained and even fewer of whom are emergency physicians—in Lansing and in Washington, DC.

Emergency physicians face myriad challenges in emergency departments, not the least of which is violence in the workplace. A long-existing barrier to delivery of quality care, ED violence has steadily increased at a rate greater than four times the rate for workers in the private sector overall. MCEP is coordinating efforts to introduce a group of bills in Michigan legislature to address these concerns, and the momentum is promising.

I strongly encourage you to contact your legislator, so they understand the fundamental role that emergency physicians play in safeguarding and advancing the health of our communities as well as how violence in the ED affects quality patient care. Supporting MEDPAC this year is one of the most important ways you can become involved in transforming these bills into laws. A contribution of any amount will make it more likely that ED physicians and the rest of the ED team can benefit from heightened protections against violence in the ED.

You have an opportunity to strengthen our voice in Congress. Supporting MEDPAC allows our message to reach our legislators: A safe environment for both patients and health care providers in the ED is imperative to quality care. It strengthens our voice on this issue and future issues that impact our care, our patients, and our profession.

Your donation can be a one-time only donation or broken into quarterly or monthly payments. A link to MEDPAC can be found here: **https://themedpac.org/**.

If you would like to donate quarterly or monthly, please contact our office at 517-327-5700 or email madeyv@mcep.org.

Please join me in supporting the Michigan Emergency Doctor Political Action Committee!

Sincerely,

Diana Nordlund, DO, JD, FACEP
President, Michigan College of Emergency Physicians
Chair, Michigan Emergency Doctors' PAC Board of Trustees

EMRAM: A YEAR IN REVIEW

Krishna Patel, DO

EMRAM has been dedicated to supporting and empowering emergency medicine residents across the state. Here's a recap of all the exciting things EMRAM has been involved with this year.

MCEP kicked off the academic year with its annual Summer Assembly at Mackinaw Island, featuring resident presenters who were awarded scholarships to attend. The Summer Assembly proved to be a fantastic platform for residents to showcase their expertise and knowledge.

Focusing upon the importance of career guidance for residents nearing the end of their training, the annual "Life After Residency" event in Troy was a success. This gathering provided valuable insights into the job market, interview preparation, and networking opportunities. Residents received unbiased advice on essential tasks to complete before graduation, such as disability insurance and financial planning.

The Midwest Winter Symposium proved to be a popular event for medical students and residents interested in emergency medicine. Held at the Boyne Mountain Resort, this symposium offered a range of activities, including skills workshops, toxicology updates, and concise presentations on relevant topics. Attendees also enjoyed time on the slopes, creating a perfect blend of education and recreation.

SIMWARS was a highly successful event, with ten teams participating. SIMWARS was hosted by Western Michigan University this year. Trinity Health Muskegon emerged as the winners, followed by Central Michigan University in second place. With plans to switch locations annually, SIMWARS aims to facilitate ease of travel across the state and provide exciting opportunities for emergency medicine residents to showcase their skills and teamwork.

SONOWARS was held on June 1st. This was a "wilderness medicine meets bedside ultrasound" competition held at Belle Isle. This event has always been a hit in the Metro Detroit area, and this year, for the first time since partnering with MCEP, we've been able to expand to all residency programs in the state. We hope to continue to offer this statewide event for years to come.

Recognizing the importance of hearing from its membership and understanding how to better serve emergency medicine residents in Michigan, EMRAM initiated a resident representative program. Each residency program has a liaison to the EMRAM board, providing a platform to convey ideas, concerns, and feedback. This ongoing initiative aims to facilitate stronger connections and ensure that resident voices are heard and addressed effectively. If your program does not have a representative identified, please reach out to our incoming EMRAM leadership board so we can better serve you!

EMRAM's commitment to fostering growth, education, and camaraderie among emergency medicine residents in Michigan has resulted in a series of impactful events and initiatives. By providing valuable opportunities for learning, networking, and career development, EMRAM continues to take part in shaping the future of emergency medicine.

In closing, I want to take a moment to congratulate all of our graduating seniors. After having medical school graduations and celebratory milestones canceled due to Covid-19, you embarked on your journey to become an emergency physician during a global crisis. You stood side by side with your frontline colleagues to help your communities' most vulnerable populations. You worked in pop-up ICUs all over the hospital to help the healthcare system in anyway you could. You survived a second global pandemic scare with monkeypox. You dealt with "RSV 2.0" filing pediatric units to the brim and trying to find open beds for your patients so they could get the care they needed. You practiced medicine during a time when law and scope of practice came to the forefront after Roe v. Wade was overturned. You dealt with staff shortages, overrun ERs, and bed holds. Through all of that, you survived. You made it. You finally made it! Congratulations!

And with that, this concludes my last "EMRAM President's Corner." It has been my great pleasure and honor to serve the EM residents of Michigan over the past couple of years. I wish you all the very best in your next chapter, whether it's surviving intern year or finishing residency! §

Michigan Emergency Medicine News & Views is the official publication of the Michigan College of Emergency Physicians. Deadline for publication of all letters/articles is the 5th of the month prior. All correspondence should be addressed to MCEP News & Views, 6647 West St. Joseph Hwy., Lansing, MI 48917. Telephone (517) 327-5700, FAX (517) 327-7530, www.mcep.org. Opinions expressed within this newsletter do not necessarily reflect the College's point of view. While News & Views believes that the ads it accepts originate from reputable sources, it takes no responsibility for the consequences resulting from, or the responses generated by, any commercial or classified advertisement.

THE IMPORTANCE OF DISABILITY INSURANCE FOR DOCTORS DURING

Residency is a crucial stage in a doctor's career that demands immense dedication, hard work, and countless hours of training. During this period, physicians are exposed to numerous physical and mental stressors, making them vulnerable to potential injuries or illnesses that could jeopardize their ability to practice medicine. Therefore, it is essential for doctors in residency to consider investing in disability insurance to protect their financial well-being and future livelihood. In this article, we will explore the reasons why doctors should prioritize acquiring disability insurance during their residency.

Residency is typically a time of limited financial resources, with medical trainees often facing significant student loan debt. If a resident becomes disabled due to injury or illness, they may lose the ability to earn income and meet their financial obligations. Disability insurance acts as a safety net, providing a regular income stream to cover living expenses, loan repayments, and other financial responsibilities during the period of disability. This protection ensures that doctors can maintain their financial stability and focus on their recovery without the added stress of financial burdens.

Disability insurance policies offer different types of coverage, including short-term and long-term disability benefits. Short-term disability insurance provides coverage for temporary disabilities, such as recovery from surgery or injuries. Long-term disability insurance, on the other hand, provides coverage for prolonged disabilities that could last for several months or even years. By investing in both types of coverage, doctors can safeguard their financial well-being against a wide range of potential disabilities.

A disability can disrupt a doctor's career trajectory, especially during residency. The loss of income and absence from work can delay career progression and opportunities for professional advancement. Disability insurance not only provides financial support but also helps doctors maintain their standing in their specialty by ensuring they have the resources to continue their education, attend conferences, and participate in research activities, even if they are temporarily unable to practice medicine.

Obtaining disability insurance during residency often comes with certain advantages. Premiums tend to be lower for younger, healthier individuals, making it an opportune time to secure coverage at a more affordable rate. As physicians progress in their careers and their income increases, the cost of disability insurance may also rise. By purchasing insurance during residency, doctors can lock in lower premiums, providing long-term cost savings.

Purchasing disability insurance during residency is a wise investment for doctors to protect their income, financial stability, and career aspirations. By securing comprehensive coverage at an early stage, physicians can ensure that they are prepared for unforeseen circumstances that may impact their ability to practice medicine. With disability insurance, doctors can focus on their professional development, patient care, and overall well-being, knowing that they have a safety net to rely on in times of need. It is a decision

that demonstrates foresight and responsible financial planning, providing a solid foundation for a successful medical career. §

Editor's note: When obtaining disability insurance, whether in residency or as an attending, look for true own occupation insurance and always consult with a trusted insurance agent.

The BattDouglas Financial Group
Michael Douglas, CFP
Allison Batt, MS
216-470-2728
Allison@BattDouglas.com
www.BattDouglas.com

MCEP CALENDAR OF EVENTS 2023

July 30 – August 2, 2023
Michigan EM Assembly
Grand Hotel
Mackinac Island, Michigan

July 31, 2023
Annual Membership Meeting &
Board of Directors
Grand Hotel
Mackinac Island, Michigan

August 16, 2023
EM Career Planning:
Life After Residency
Somerset Inn
Troy, Michigan

September 6, 2023
Board of Directors
Chapter Office
Lansing, Michigan

September 15, 2023
Observation Medicine Conference
Virtual Zoom Meeting

September 26, 2023
MCEP Councillor Meeting
Chapter Office
Lansing, Michigan

October 7-8, 2023
ACEP Council Meeting
Philadelphia, Pennsylvania

October 9-12, 2023
ACEP Scientific Assembly
Philadelphia, Pennsylvania

November 14, 2023
$traight Talk
Reimbursement Course
Somerset Inn
Troy, Michigan