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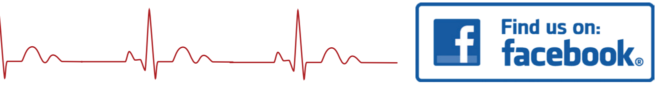

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Michael Fill, DO, FACEP

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Muchmore, Harrington, Smalley & Associates

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FROM THE PRESIDENT

Having just returned from our annual trip to Boyne for the Winter Symposium, my family and I have turned our attention to spring. In our house, signs of spring consist of driving to baseball/softball practice and awakening to the sounds of my youngest's insistence to practice her pitching in the basement before school! When I think of baseball season, I can't help but remember an article I read some years ago about Joe Maddon. For those of you who don't know, Joe Maddon was a Major League Baseball manager who managed several teams but is probably most famous for managing the Cubs to their first World Series title since 1908. In the article, Maddon talks about his upbringing in the small town of West Hazleton, Pennsylvania. He refers to his hometown as "a shot and a beer town." He explains that in his hometown, he learned that if you sit down with another individual, spending time with them while you each have a shot and a beer, you can learn a lot about the other individual's perspective and opinions.

As I reflected on this, I marveled at how great of a strategy this is. If I was able to sit down with someone in a relaxed atmosphere for the time it would take to have a few drinks, even if there was no alcohol involved, we could learn a lot from each other. This type of interaction would certainly promote the sharing of ideas!

We have these types of interactions with our legislators during the yearly ACEP Leadership and Advocacy Conference (LAC) in Washington D.C. During this conference, MCEP members meet with our representatives and senators to discuss hot button issues in Emergency Medicine. Those of you lucky enough to attend last year had the opportunity to sit with Senator Peters and his staff over appetizers and drinks to discuss issues such as workplace violence and ED boarding in an intimate setting. MCEP members who have attended the LAC have found it to be a valuable experience. If you have never attended LAC, or have not attended in some time, I recommend you consider attending this year!

Michael Fill, DO, FACEP

As the saying goes, "Time is money." I realize that given the 24/7/365 nature of our business, not all of us can go to Washington, D.C., in the spring. I also appreciate that the cost of conference registration, hotel, and flight can be taxing to many of us. In general, physicians tend to shy away from financial contributions to politicians. However, one of the most effective ways for our membership to get politicians to hear our concerns and give attention to issues facing Emergency Medicine is to contribute to the campaign of those representatives and senators who align with our values. At MCEP, our Political Action Committee, MEDPAC, does just that.

MCEP continually advocates for emergency physicians in the state of Michigan. Our state legislators have various experience and education when it comes to topics in the house of medicine. It is important that our state legislators hear our perspective on these issues, and although they may not always act in the way MCEP desires, MCEP ensures that they hear the voice of the emergency physician.

As I am finishing up this article, my bartender just produced my tab. My shot and a beer cost me $10. Maybe we all can't have a "shot and a beer" with our local politician, but we can probably all give $10 to the MCEP Political Action Committee. If every MCEP member was able to give at least that, MCEP could certainly effectively advocate for positive change in Emergency Medicine. §

Donating is easy at https://themedpac.org/ or via this QR code:

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FOR WHOM THE BELL TOLLS

December 14, 2023. The day started out like any other. I went to work. I spent some time with family at home. I turned on my computer to sign charts and to work on administrative tasks. Like many of us, I had a year-end list that was full of things to get done before the holidays.

Around the time my kids were going to sleep, I was on my computer, diligently checking items off my to-do list, when my husband came to me with a problem. He and his brother had received a call from an aunt who lives out of the country. The relative communicated that a Michigan hospital had called and said that their father was in the hospital. They had a possible name of a physician. The relative did not have any further information. My husband explained that they had immediately called the hospital, but their father was not listed as a patient. My father-in-law was not answering his phone. Everyone was worried.

As emergency physicians know, our world is small. We can find a connection to someone virtually anywhere in the medical world with only a few degrees of separation. I reached out to fellow MCEP Board Member Dr. Pamela Coffey, who works in the pediatric emergency department at Sparrow Hospital where my father-in-law would most likely have been taken. She promptly recognized the name of the physician as one of her hospital's emergency medicine residents. Within five minutes, I was speaking with Dr. Christopher Go. Unfortunately, he did not have good news. My father-in-law had collapsed outside of the hospital and died.

Time is weird. Grief is weird. Our jobs, with all of the compartmentalization that we learn to get through challenging cases, are weird. In no other job is a person routinely asked to deal with the heartbreaks of life, such as the horrific and unexpected diagnosis of cancer in a young person, the challenges of a complex pediatric resuscitation, or the notification of a family that their loved one has unexpectedly died, and then immediately move on to the next room, the next patient, the next note, all while making sure to smile, answer questions, and provide a positive experience for the family in front of you. That night, I was on the other side of the conversation. And yet, that night, after speaking with my husband, my first thought, above telling my children, calling other family, or starting to plan next steps, was to notify my bosses to figure out the next steps for my clinical schedule. As emergency physicians, we are conditioned to put others above ourselves, always.

Initially, I really thought that I should be able to continue on with my list of things to get done before the holidays and before the end of the year. I kept a meeting with one of my mentees the following morning. I followed up on things via email. Ultimately, though, grief caught up. My group has a bereavement leave policy; although I was generally aware of this, I never gave it much thought as I had never had need for bereavement leave personally. Using this and the kindness of my colleagues, I was able to get a substantial amount of clinical time off in the next two weeks. My co-workers also assisted in helping me to clear my administrative calendar when I realized that my brain wasn't functioning in a useful capacity. Perhaps the most eye-opening part of my whole experience was seeing that the world did not come crashing down because of delayed meetings or because responsibilities were transferred to someone else to complete. Time kept moving forward. In the face of death, life moved on.

Sara Chakel, MD, FACEP

In reflecting on this experience, I keep coming back to John Donne's famous poem, "For Whom the Bell Tolls," in which Donne writes about the interconnectedness of humanity:

> *"No man is an island,*
> *Entire of itself.*
> *Each is a piece of the continent,*
> *A part of the main.*
> *If a clod be washed away by the sea,*
> *Europe is the less.*
> *As well as if a promontory were.*
> *As well as if a manor of thine own*
> *Or of thine friend's were.*
> *Each man's death diminishes me,*
> *For I am involved in mankind.*
> *Therefore, send not to know*
> *For whom the bell tolls,*
> *It tolls for thee."*

We are all connected as humans. We are people first, and our jobs and our roles and everything else second. I have to confess, I don't really remember any of the work-related things that I missed in the last two weeks of December and the early part of January, but I will always treasure the uninterrupted time that I had to spend with my husband, my children, and my extended family where we grieved together and where we celebrated my father-in-law's life together. When I was ready, I was able to return to my work duties, and it turns out that it was okay if things were behind schedule or if a meeting or task was skipped or missed, here or there.

My resolution for the New Year is to remember to have balance in life and to spend time with those who matter to me. I want to focus on things that I value and things that I love, and not just those things that are related to my job or to emergency medicine. I would encourage all of you to do the same. As Vladimir Nabokov eloquently stated, "Our existence is but a brief crack of life between two eternities of darkness." Live your life to the fullest in all facets, both on shift and outside work. §

In memory of Denis V. Soucy, December 10, 1946 – December 14, 2023

KID'S KORNER

THEY'RE BACK (PART 1)

Can you identify the following presentations?

1) Fever, rash, cough, coryza, conjunctivitis.
2) Dewdrop on a rose petal.
3) Tripoding, drooling, keep happy, call anesthesia.

You probably know these are 1) measles, 2) chicken pox, and 3) epiglottis due to H. Influenza. But how many of you have actually seen these clinically in the past 10 years or so? And those of you who are newer in the field, have you ever seen them? Well, get ready because modern news headlines are telling us they are coming back!

In 2000, measles was officially declared eliminated in the USA because there had not been a single positive case in the country for over a year. Fast forward to 2019, when there were 1300 cases reported over 31 states. Covid shut international travel down, so there were only 13 cases in 2020, 49 in 2021, 121 in 2022, and 58 in 2023. However, as of the first 25 days in 2024, there have already been 23 cases, including a daycare and multiple airport exposures. As per the CDC, almost every case was in a non-vaccinated child. The virus is contagious in the first few days when it resembles a common cold and lives for several hours on solid surfaces.

In 2022, a case of paralytic poliomyelitis was confirmed in an unvaccinated adult in NY. The virus was then isolated in the water supply extending out five counties from the source. Polio was considered eradicated in the USA by the World Health Organization (WHO) in 1994. As of 2023, it only exists in 2 countries, Afghanistan and Pakistan. As a refresher, to understand the potential of this illness, 1 in 200 infections lead to irreversible paralysis. And if even one case still exists, it can spread.

As most know, the first vaccine occurs at birth with the Hepatitis B vaccine. After that, they occur at 2 months, 4 months, 6 months, 13 months, 15 months, and then again before school starts around age 4. And vaccines work, right? Yes, if you are vaccinated. Current data from the Michigan Care Improvement Registry in June 2023 show that over 30% of kids aged 19-36 months are not fully vaccinated in 52 out of 83 counties in Michigan. Some of that is kids still catching up after Covid. Some of that is complete refusal to obtain the vaccines. All of these kids are fully vulnerable. Nationwide, the most current data shows that the number of kindergarteners fully vaccinated in the 2020-2021 school year was 94%. In 2021-2022, it was 93%. Michigan kindergarteners sat at 93.6% vaccinated in 2021-2022. Herd immunity requires rates at 95%. Looking at the rate of vaccinations of our current 3-year-olds, we have a lot of catching up to do to hit that number.

Pamela Coffey, MD, FACEP

When I first started putting this article together, I was planning on a clinical summary of these illnesses, as you might actually start seeing them. But I then went down the proverbial rabbit hole of why people refuse to have their kids vaccinated. Turns out, history does repeat itself over and over again. Here's what I found.

The first vaccine was created in the early 1800s when Edward Jenner created the smallpox vaccine. He presented an article to the Royal Society of London in 1796 detailing how he injected live material from the pustules of people infected with cowpox into 13 people and in doing so, made them immune to smallpox. Gross. But, wow. He called the

cowpox material vaccine from vacca, which is Latin for cow, and deemed the process vaccination. Critics say this process was already discovered by a farmer named Benjamin Jesty who injected his wife in the same way (she then lived to 84) and that Jenner was just politically savvier. But I digress.

According to references on the webpage https://historyofvaccines.org, oppositions to vaccines historically go back this far, with people claiming sanitary, religious, scientific, and political objections, particularly as legislation requiring these vaccines started in 1840. Leicester, England (ironically where many of my ancestors are from) was the site of the Leicester Demonstration March of 1885. This march, described as one of the most notorious anti-vaccination demonstrations in history, had 80,000-100,000 marchers protesting the 1853 Compulsory Vaccination Act, claiming it was a violation of their bodies as a form of political tyranny. Sound familiar? They succeeded, though, and in 1898, The Vaccination Act removed penalties for abstaining under a "conscientious objector" clause.

In the US, we also fought for our rights to decide if we should be vaccinated. As in England, several anti-vaccination societies were formed, and battles were fought. In 1902, the Cambridge, MA, Board of Health required all residents to be vaccinated against smallpox due an outbreak. Henning Jacobson refused based on the grounds that it violated his right to care for his own body. He went against the Supreme Court, but they ruled in the state's favor, saying the state had the right to protect the public during an outbreak.

Modern history tells of various concerns over the years with many vaccines. In the 1970s-80s there was concern that the Diphtheria, Tetanus and Pertussis (DTP) vaccine caused serious neurological conditions. This was disproved through actual research, but concerns lingered.

But the big one for our times, the famous Lancet article that linked the Measles, Mumps and Rubella (MMR) vaccine with autism, was published in 1998. In this study, AJ Wakefield et.al. described 12 children, ages 3-10 years, who presented to a GI clinic with concerns of recently developed GI and behavior issues. They took robust histories and concluded that along with some GI issues, the "onset of behavioural symptoms was associated, by the parents, with measles, mumps, and rubella vaccination in eight of the 12 children, with measles infection in one child, and otitis media in another." That's it. 12 children observed in a GI clinic changed the modern view on vaccines. Wakefield seized the opportunity for fame by stating that he felt the vaccines were not tested properly. Media grabbed it, and we've been chasing the truth ever since.

Wakefield was investigated and it was determined that he was paid by a law board to find out if there was evidence to support a case where the parents believed the vaccine had harmed their child, a "fatal conflict of interest." It was found that he falsified data and was trying to profit from his research. His license was revoked in England. The Lancet admitted to being wrong in publishing the article in 2004 but didn't formally retract it until 2010.

From here, the discussion gets dizzying. And because of online research, I am likely to get some new and interesting spam mail now. But in summary, the evidence that vaccines cause problems is lacking. Vaccines are supported by every major medical society. Are there side effects? Yes. Do bad things happen to kids in the period after receiving their vaccines? Yes. Is there a direct cause and effect to these bad events and the vaccines? None that have been proven. The only oppositions that I could find come from non-medical, self-proclaimed experts who are selling books and wellness material. So, I will spare you the details.

As a result, these illnesses are back. They make for great teaching moments and interesting rashes. More on this next month! §

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VIOLENCE IN EMERGENCY DEPARTMENTS UPDATE

Bret Marr, Lobbyist
Muchmore, Harrington, Smalley & Associates

In the past several issues, we have highlighted MCEP's success in passing legislation to increase penalties on assaults of healthcare workers in hospital settings. While the legislation did not accomplish everything we had asked from our legislators, we now have several lawmakers interested in pursuing new legislation to apply the stiffer penalties to patients and in parking lots. MCEP will continue to work with those legislators to more broadly apply those enhanced penalties, but we all must educate state policymakers on our environments in the hospital setting. Every chance you get to share your personal stories of abuse and violence in your daily setting helps to remind them of the hostile work environments you and your colleagues face every day.

LEGISLATURE BEGINS 2024 SESSION AND GOVERNOR'S 2024 STATE OF THE STATE

Governor Whitmer kicked off the 2024 legislative session with her sixth State of the State Address on Wednesday, January 24th. The Governor highlighted the many accomplishments of legislative Democrats during the 2023 session. She also proposed multiple education-focused bills and budget requests for the coming year. Her sixth budget will be presented on Wednesday, February 7th to a joint hearing of the House and Senate Appropriations Committees. We already know she will have a focus on behavioral health issues to help the state better manage the demand on those services at all ages. This budget presentation starts off the budgeting process that will end by the end of June 2024.

MCEP PURSUES MICHIGAN MEDICAID REIMBURSEMENT INCREASE

MCEP Leadership, led by Health Finance Committee Chair Dr. Michael Gratson, has 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 (DHHS). MCEP will keep members posted as these discussions progress over the coming months. §

2024 BOARD ELECTIONS

All active members of the Michigan College of Emergency Physicians interested in serving on the Board of Directors are encouraged to submit their names to the 2024 Board Nominating Committee for consideration as the Committee develops the slate of candidates.

New Board members will be selected by the membership during the Annual Meeting that takes place at the Michigan Emergency Medicine Assembly to be held in beautiful northern Michigan at The Highlands in Harbor Springs at the end of July. Four 3-year positions on the Board are open for election this year.

Those interested in Board service should e-mail their notice of intention to the Chapter office, mcep@mcep.org, no later than March 1, 2024. Please include with your notice a brief biographical sketch, a copy of your curriculum vitae, current photo, and your preferred contact information. Additional information can be found on our website here. Any questions regarding Board service and expectations should also be directed to the Chapter office. Thank you! §

MCEP CALENDAR OF EVENTS

March 6, 2024
Board of Directors
Chapter Office
Lansing, Michigan

March 21, 2024
Critical Care in the ED Conference
Virtual Zoom Meeting

April 10, 2024
EMRAM SIMWARS
Central Michigan University SIM LAB
Saginaw, Michigan

April 14 – April 16, 2024
ACEP Leadership & Advocacy Conference
Washington, DC

May 1, 2024
Board of Directors
Chapter Office
Lansing, Michigan

May 10, 2024
Mock Oral Board Review Course
Virtual Zoom Meeting

May 16, 2024
MCEP Legislative Day w/ LDP
Capitol Building
Lansing, Michigan

July 28-31, 2024
Michigan EM Assembly
Boyne Highlands
Harbor Springs, Michigan

July 29, 2024
Annual Membership Meeting & Board of Directors
Boyne Highlands
Harbor Springs, Michigan

August 15, 2024
EM Career Planning: Life After Residency
Somerset Inn
Troy, Michigan

September 4, 2024
Board of Directors
Chapter Office
Lansing, Michigan

September 13, 2024
Observation Medicine Conference
Virtual Zoom Meeting

September 17, 2024
MCEP Councillor Meeting
Chapter Office
Lansing, Michigan

September 27-28, 2024
ACEP Council Meeting
Las Vegas, Nevada

September 29-October 2, 2024
ACEP Scientific Assembly
Las Vegas, Nevada

December 4, 2024
Board of Directors
Chapter Office
Lansing, Michigan

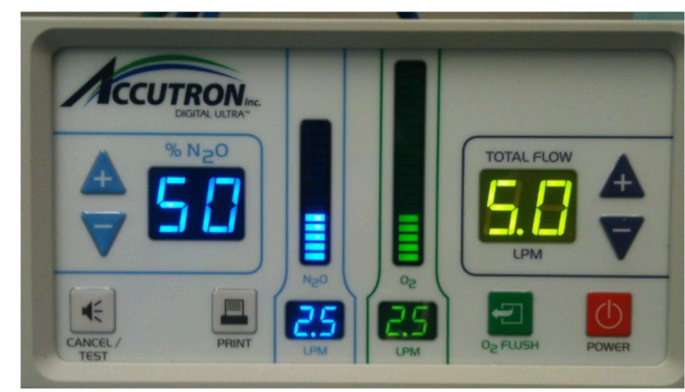
December 10, 2024
$traight Talk Reimbursement Course
Virtual Zoom Meeting

Want to Learn About Nitrous Oxide Sedation?

Nitrous Oxide (N2O) offers rapid on and offset that is unmatched by any other sedative. The use of nitrous oxide can decrease length of stay, increase throughput and has an excellent safety profile. It can be used for pediatric and adult patients, for procedures from laceration repair to fracture reduction.

Come to our state-of-the-art Simulation Center and use real nitrous oxide machines on live simulated patients.

- Complete five sedation cases and get checklists for using nitrous oxide.
- Learn how to set up a nitrous machine and what to avoid when setting up a N2O sedation program.
- Get literature to support a nitrous program at your hospital.
- Taught by experts in nitrous use.



When: Monday, March 25, 2024
Where: Western Michigan University Homer Stryker M.D. School of Medicine Simulation Center, 300 Portage Street, Kalamazoo, MI, 49008
Time: 9 a.m. – 4 p.m.
Cost: $1,100.00
Register by email at linda.bunting@wmed.edu.

VERTEBRAL ARTERY DISSECTION AFTER FREE DIVING

Jake M. Vinton, DO and Anthony T. Lagina III, MD, FACEP, of Detroit Receiving Hospital, Detroit, MI

INTRODUCTION:

Vertebral artery dissection (VAD) is a rare yet well-described etiology for ischemic stroke in young to middle-aged adults. This condition usually occurs in the setting of recent neck trauma, including hyper-rotation injuries from chiropractic manipulation, yoga, and sports [7]. This case describes VAD in the setting of free diving. It is essential to recognize that VAD may be the etiology for post-diving neurologic insults and may not be related to decompression illness or arterial gas embolism (AGE). Distinguishing the difference with proper neuroimaging is crucial as the treatment and clinical course differ. The pathophysiology, diagnostic testing, and treatment of this condition are discussed as we report a case of VAD in a 32-year-old male who presented with neurologic symptoms after free diving.

CASE REPORT:

The patient is a 32-year-old male who presents with a five-day history of nausea, dizziness, slurred speech, and disequilibrium that started after free diving and snorkeling in the Pacific Ocean. The patient had resurfaced from a 20-foot free dive shortly before symptom onset. The dive was uncomplicated, and he exhaled fully on ascent. When swimming back and ambulating on land, he started tracking to his right, feeling disequilibrium punctuated with episodes of nausea and vomiting. He denied tinnitus, ear pain, or headache; the symptoms did not change during the flight home. At the outside hospital, CT head demonstrated a right cerebellar stroke. The patient was then transferred to our facility for hyperbaric oxygen therapy as there was concern for AGE. On arrival to the ED, vital signs were significant for hypertension to 155/95; otherwise, they were unremarkable. NIHSS was 1 for mild dysarthria. Laboratory studies were unremarkable other than mild hyperlipidemia. CT of the head and neck demonstrated moderate-sized recent infarction in the right cerebellar hemisphere involving the right superior cerebellar artery territory (Figure 1). CTA demonstrated an eccentric filling defect in the lateral aspect of the right vertebral artery at the level of C6 extending along a 1.6 cm segment with subintimal thrombus, resulting in moderate segmental stenosis (Figure 2). MRI demonstrated moderate-sized subacute infarction in the right cerebellum. A diagnostic angiogram revealed a right vertebral pseudoaneurysm. The patient was initiated on dual-antiplatelet therapy with clopidogrel 75 mg and aspirin 81 mg daily for three months. The patient was discharged on hospital day two from the NICU and was instructed to follow up in three months for repeat digital subtraction angiography (DSA).

DISCUSSION:

Vertebral artery dissection is the etiology of approximately 2% of all ischemic strokes. However, in young to middle-aged adults, it is believed to cause as high as 25% of cases [3]. In scuba diving, the incidence of arterial gas embolism is rare and estimated to be approximately 7 per 100,000 dives [1]. Typically, if divers develop neurologic symptoms within minutes of surfacing, AGE should be highly suspected. However, in our case, other etiologies were at play. We suspect hyper-extension or hyper-rotation of the cervical spine may have been the precipitating insult.

There are four segments of the vertebral artery. In our case, the patient had a dissection of the V2 segment - the intraforaminal segment from C6 to C2 [2]. Dissection occurs when the intimal layer of the arterial wall is damaged. Arterial blood dissects between the tunica intima and tunica media, creating hematoma formation, platelet aggregation, and fibrin clots [3]. The resulting stenosis of arterial blood flow then leads to decreased distal perfusion and, ultimately, ischemic infarction. Common symptoms include dizziness, which can be accompanied by cerebellar signs such as vertigo, nystagmus, and gait ataxia [4].

Accurate diagnosis is vital to target therapeutic interventions appropriately. VAD and AGE can both cause cerebellar symptoms, and

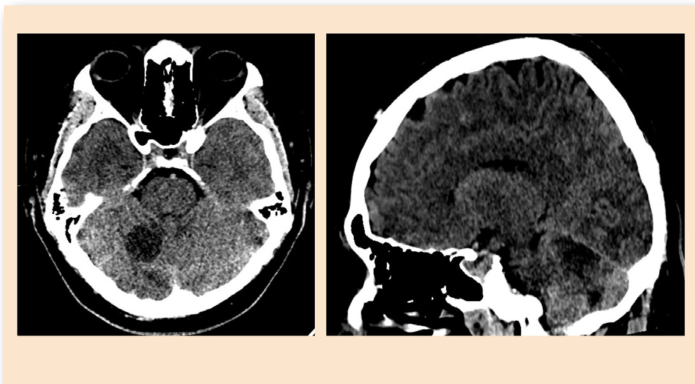
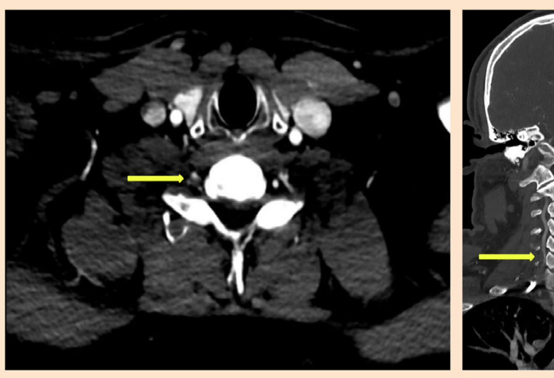


Figure 1. CT non-contrast: moderate-sized subacute infarction in the right cerebellar hemisphere involving the right superior cerebellar artery territory.



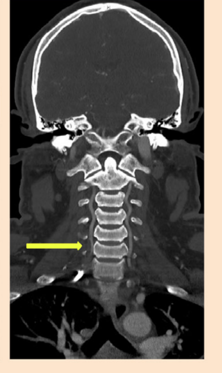


Figure 2. CTA: eccentric filling defect in the lateral aspect of the right vertebral artery at the level of C6 extending along a 1.6 cm segment with subintimal thrombus, resulting in moderate segmental stenosis.

neuroimaging studies, including CTA, MRI, and DSA, should be utilized to distinguish the difference. Treatment goals in AGE are based on terminating the source of air and decreasing the size of the gas embolism. The mainstay of treatment includes administering 100% FiO2 and early hyperbaric oxygen therapy [5]. On the other hand, treatment of VAD is based on decreasing the propagation of intraluminal clot formation. This is accomplished by antiplatelet or anticoagulation medication. Our patient was treated with dual antiplatelet therapy and did not require systemic anticoagulation or endovascular intervention. §

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MOVING INTO THE FUTURE:
ABEM WILL LAUNCH A NEW CERTIFYING EXAM IN 2026

NEW

OPPORTUNITIES TO LEARN MORE

- ABEM WEBINAR FOR PROGRAM DIRECTORS AND CORE FACULTY
MARCH 11, 2024, AT 3 P.M. EST
- CORD ACADEMIC ASSEMBLY
MARCH 27, 2024 | NEW ORLEANS
- AAEM SCIENTIFIC ASSEMBLY
APRIL 27 - MAY 1, 2024 | AUSTIN, TEXAS
- REQUEST AN ABEM SPEAKER!

More info

AMERICAN BOARD OF EMERGENCY MEDICINE

PASSING THE BATON: SENIORS MENTORING JUNIOR RESIDENTS

Laura Schroeder, MD, MS

As the last few months of the residency year count down, senior residents may be struggling to combat "senioritis." A good way to help prevent this is by creating personal and professional goals. This is also a great time to think of ways to help your fellow residents grow. Senior residents can compose lists of previous experiences, including tips and tricks, which they can pass down to the next generation of residents. Below are numerous ways that senior residents can help further motivate and mentor junior residents:

1. **SUPERVISED INDEPENDENCE:** This is the time to allow junior residents the ability to step up. Empower them to take charge of trauma and medical resuscitations. Senor residents can act as "whispering angels," offering guidance when junior residents are unsure or are missing essential steps. This will allow junior residents to gain confidence and turn into leaders.
2. **BE A LIFEGUARD:** Push junior residents out of their comfort zones. To help junior residents increase their patient volumes, I continuously monitor their progression throughout their shifts. I can tell when there is a slower period in their shift, such as between dispositioning patients and waiting for test results to return. I will often encourage them to pick up an extra patient or two during this time. It's good to push them until they feel like they are almost drowning; however, be there to thrown them a life raft when they need help or get too overwhelmed.
3. **BE AVAILABLE:** Let your junior residents know that you are available to talk. Give them the opportunity to reach out for advice or mentorship. As senior residents, you have a lot of knowledge to impart due to previous experiences, both good and bad. Therefore, you can give them good advice about things to do as well as things not to do. Let them learn from both your mistakes and triumphs.
4. **PROCEDURAL PROFICENCY:** At this point in the year, junior residents are becoming more comfortable performing a variety of procedures. This is the time to help them trouble shoot when procedures do not go exactly as planned. If the patient is stable, but your junior residents encounter an issue, do not automatically jump in and take over. Teach them to be adaptive and discuss a variety of techniques during difficult procedures. Furthermore, you can also help them to be more efficient and to minimize unnecessary delays in their procedures by prepping their set up to optimize the space or by foreseeing potential complications before they arise.
5. **POSITIVE PERSONA:** Do not let feelings of senioritis set in. Remain positive and helpful to the junior residents and staff. A bad attitude or lack of motivation can be projected onto other staff members and negatively impact everyone. Continue to act professional and create a good example for others. Challenge yourself to give 100% effort and feel accomplished at the end of every shift.
6. **POWERFUL ALUMNI NETWORK:** After graduating, you will be part of an alumni network. In order for programs to have strong alumni networks, you must stay engaged with your residency program. Be available for current residents to reach out for questions. Additionally, you should pass along information regarding good opportunities for away rotations or career connections.

UPCOMING EVENTS (details online at https://www.mcep.org):

- **EMRAM Teaching Award**: Nominations open February 1-March 15. This award recognizes emergency medicine faculty who have outstanding contributions to resident education.
- **EMRAM E-Board Elections:** Nominations open March 1-April 1. This is great opportunity to get involved and advocate for your fellow Michigan emergency residents. Positions available include President, Vice President, Secretary, and Treasurer.
- **SIMWARS:** April 10 at Saginaw. This is an interactive simulation competition that allows resident teams to compete against each other.
- **Mock Oral Board Review:** May 10 (virtual). There are three sessions throughout the day to run simulated oral cases and prepare you to ace your oral boards.
- **EMRAM Annual Meeting:** May 23 (virtual). This is the yearly recap of all EMRAM events. Plans for next year will also be discussed. All residents are welcome to join, network, and share their ideas.
- **EMRAM Inspired – Rapid Fire Talks:** Submission deadline March 1. The Michigan Emergency Medicine Foundation (MEMF) is sponsoring three scholarships of $1200 to attend the Michigan Emergency Medicine Assembly at Boyne Highlands from July 28-July 31 and to present a talk at the conference on July 29. §

Thank you for all that you do!

To all of our frontline workers

From all of us at MCEP

MEDICAID BASE PAY RATE INCREASE

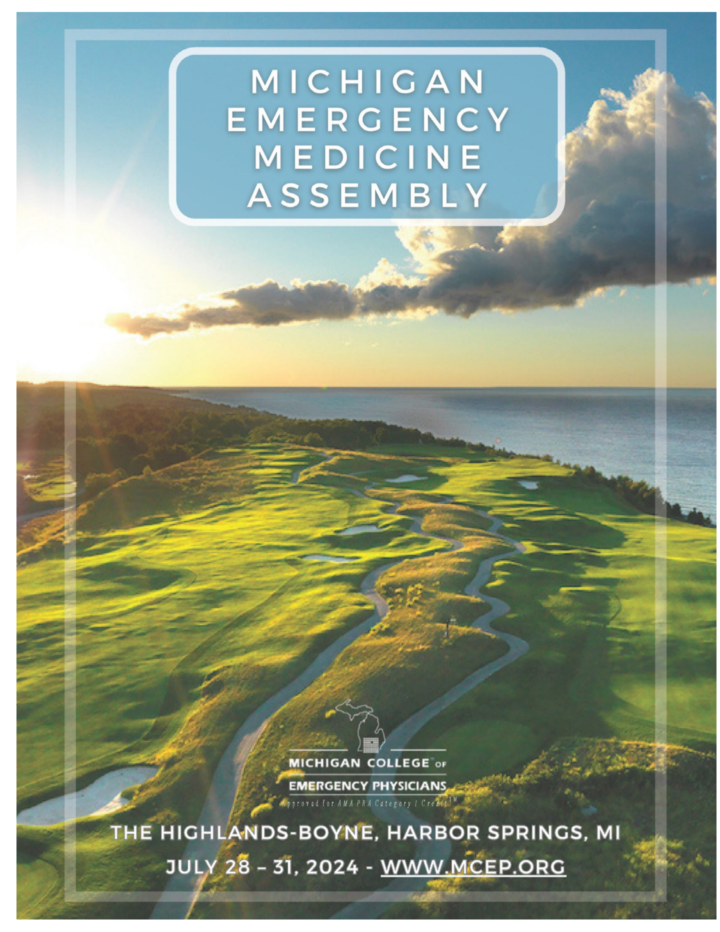
Dear Membership,

Last year, the Health-Finance Committee, along with the College at large, continued our commitment to fighting for fair pay and reimbursement for emergency medicine services provided by our members. That is why we focused on successfully lobbying the State for an increase to our Medicaid base pay rate.

Late summer, the Michigan College of Emergency Physicians (MCEP) and Muchmore Harrington Smalley & Associates (MHSA) met with Meghan Groen, State Medicaid Director, and explained the unique challenges that emergency medicine physicians face in reimbursement, along with the value that we provide to the patients and communities we serve. Our message was heard, and we received a significant increase of 7% to our Medicaid base pay rate, which was well above the rate of inflation of 3.1%. Although we are pleased with this increase, we know there is more work to be done. We must continue to fight for true payor parity between the rates paid for Medicaid to Medicare. We must continue to fight for a change to the Michigan No Surprises Act, which allows for private insurers to have unfair leverage in contract renegotiations.

The value that our members provide to their patients and communities must be recognized. MCEP will continue this fight until these goals are met. §

Sincerely,
Michael Gratson, MD, MHSA, FACEP
Chair, MCEP Health-Finance Committee
Treasurer, MCEP Board of Directors



2023 — WHERE ARE THEY GOING?

RECENT GRADS BEGIN CAREERS ACROSS COUNTRY

With a total of 26 (allopathic and osteopathic) emergency medicine residencies, Michigan sends many of its newly trained emergency medicine physicians all over the United States and the globe. In this issue, we list where the 2023 graduates will be practicing.

FROM ASCENSION GENESYS

David Carroll, MD	Toxicology Fellowship, Detroit Medical Center, Detroit, MI
Cameron Douglas, DO	Concord Hospital, Laconia/Franklin/Concord, NH
Rosalee Gammell, DO	Tacoma Emergency Care Physicians, Tacoma, WA
Brice Guy, DO	US Acute Care Solutions, Regional Travel, FL
Alison Ralston, MD	US Acute Care Solutions, Ascension Genesys Hospital, Grand Blanc, MI
Adeel Saqib, MD	Reston Hospital Center, Reston, VA
Kaitlyn Takach, MD	US Acute Care Solutions, Regional Travel, FL

FROM HENRY FORD MACOMB

Michael Cole, DO	Adventist Shady Grove in Rockville, MD
Nicola Colucci, DO	ER One, Henry Ford Macomb Hospital, Clinton Township, MI
Amanda Connolly, DO	McLaren Greater Lansing Hospital, Lansing, MI
Richard Grenn, DO	Atrium Health, Atrium Pineville, Charlotte, NC
Nadia Khan, DO	Accension Health, Michigan
Alan Rupp, DO	La Palma Intercommunity Hospital, La Palma, CA EMA Leadership Development Program
Brooke Sherman, DO	Henry Ford Medical Group, Henry Ford Health, West Bloomfield, MI

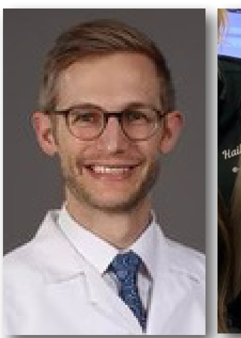
FROM MCLAREN MACOMB

Nawal Elbashir, MD	Lawnwood Regional Medical Center, Fort Pierce, FL
Laura Hintze, DO	Ascension St. Vincent, Indianapolis, IN
David Tawney, DO	Beaumont Lenox, Lenox, MI
Emily Torgerson, DO	Northwestern Medicine Huntly Hospital, Huntly, IL
Michael Van Tiem, DO	Riverside Regional Medical Center, Newport News, VA
Carlos Yeelot, DO	Baylor College of Medicine, Houston, TX

MCEP MEMBERS SAVE A LIFE AT WINTER SYMPOSIUM

On the first day of the 2024 Midwest Winter Symposium at Boyne Mountain, three attendees of the MCEP conference jumped into action after a young man dropped to the floor, immediately recognizing pulselessness, initiating chest compressions and calling loudly for an AED. An AED was available and brought to the patient quickly. A shockable rhythm was detected and defibrillation with return of spontaneous circulation was obtained. Following defibrillation, the patient was fully alert and taken to the local hospital. Minutes matter and our emergency experts made the difference for this patient, providing expert care to the visitors at Boyne Mountain Ski Resort.

MICHAEL JULE, DO of Fenton, MI, **AUSTIN JULE, MD** of Kalamazoo, MI and **CARLA POTTER, PA** of Dearborn, MI attended to the patient, working together to save this young man's life. MCEP would like to recognize them as heroes. We had multiple talks about cardiac arrest at the conference and their actions showed how Basic Life Support works! Dr. A. Jule described the encounter as a "Wild evolution of the scenario of an otherwise healthy patient with syncope vs seizure vs arrhythmia." Whether on a flight, a ski resort or in a restaurant, emergency physicians and advanced practice providers save lives. "Kudos to the Boyne staff as well for knowing the location of their AED!" We're proud to be a part of this amazing specialty. §



Austin Jule, MD

Carla Potter, PA

Michael Jule, DO

SENATE BILL 249 OPPOSITION

Recently, the Michigan Senate passed Senate Bill 249, which is meant to increase the Paramedic workforce. However, this bill aims to increase the workforce by creating a state certification pathway, which effectively lowers the standards for pre-hospital emergency care. Both the MCEP EMS Committee and the MCEP Board of Directors have expressed their concern regarding this legislation, and we are asking membership to consider contacting your state representative by sending the linked letter below detailing our opposition. Our aim is to show the House of Representatives a unified front in this issue. You are welcome to edit the letter to make it more personal.

We at the College thank you for your support in this matter.

Michael Fill, DO, FACEP
MCEP President

SB 249 Letter