MCEP
ADVANCING EMERGENCY CARE

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In This Issue

Submissions to the May/June 2024 Newsletter should be received by the Chapter office no later than May 1, 2024.

FROM THE PRESIDENT

A few years ago, my wife and I bought a new truck. As we were signing the required paperwork, the dealer mentioned that as a perk of our purchase, we received Sirius XM satellite radio free for six months. Neither of us had ever had this feature on one of our vehicles before. So, being that it was free, we decided to listen to Sirius during our first trip in the new vehicle. After a few drives, we were amazed at all the various programming that Sirius had to offer! We were also excited that most of the programming was commercial free. A few months later, we received a letter in the mail stating we could extend our Sirius subscription for another six months if we paid two dollars. Thinking that was a good deal, we signed up for the additional six months. Once that trial membership expired, we began getting charged a monthly fee for our Sirius subscription. After paying the fee for a few months, my wife and I began to re-evaluate whether we needed this service in our vehicle. We realized that we could still listen to music while we drive on the free radio stations, and if we wanted to listen to commercial free music or an out of market talk show, we could just connect our phone to the truck speakers. We could no longer justify paying the monthly fee as we did not think we were getting any significant benefit, so we canceled our subscription.

The state of Michigan has many residency programs. This is reflected in our MCEP membership, as almost half of ACEP and MCEP members are resident physicians. However, only about 32% of physicians who complete a residency in Michigan continue their ACEP membership in their first year out of residency. After their first year of being an attending, only 69% of members renew for their second year.

Much like my Sirius radio subscription, MCEP dues increase once a physician graduates residency. However, unlike my Sirius radio subscription, the benefits of MCEP membership get better as physicians enter their first few years of practice. Our MCEP education committee puts forth high-quality CME opportunities at which members can earn category one ACEP and AOA CME credit for a relatively low cost. These conferences also allow for great networking opportunities and are typically held at family friendly locations. If you never have been to one of our excellent MCEP conferences, I encourage you to attend!

Michael Fill, DO, FACEP

For those physicians who are interested in leadership, MCEP offers a yearlong Leadership Development Program. The Leadership Development Program provide leadership foundation, leadership skill development, and supports program graduates' growth to leadership positions. In this program, young attendings attend MCEP Board meetings, develop relationships with State and National physician leaders. Although the program is geared towards developing college leadership, the skills developed during this program are applicable to physicians who aspire to be hospital leaders as well.

Our MCEP dues also allow us to retain the services of a lobbyist, Bret Marr with Muchmore, Harrington, Smalley & Associates, Inc., which helps to protect emergency medicine's interests in our state government. While our political activity does not guarantee we will always get what we want, collectively, we can work to educate legislators on our unique perspective of the healthcare system.

Many of our members have served on various MCEP committees, advancing the interest of Emergency Medicine in our state. The more members that we have, the more influence we can attain.

That being said, no organization is perfect. I would love to hear from our members, especially those resident members who may not want to renew their membership. It would be helpful to our organization to see how MCEP can evolve to become an organization where your membership has value. I would welcome the chance to have a conversation with any of our members or nonmember physicians - please use this link to leave your contact information and any additional information you might like to share. There is power in numbers, and the more members of MCEP we have, the more powerful and influential the College can be! §

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DÉJÀ VU

Have you ever experienced the feeling of déjà vu? I'm not talking about that sense of futility that many of us experience when we see a frequent flyer check in on the tracking board; that feeling is something that I imagine is unique to emergency medicine. What I'm talking about is a memory that we have done a similar thing before, and it strikes a sense of recollection about an experience, and a sense that you have been in a very similar place before.

I think political advocacy can evoke a similar feeling. Many of the issues and solutions are not quickly solved, and it seems necessary to advocate for much more often than a single effort can accomplish. At the 2024 ACEP Leadership and Advocacy conference, which took place a few weeks ago, political advocacy for emergency medicine was again advanced in a host of topics. Violence in the Emergency Department and Medicare reimbursement are two of the issues that often are in the forefront of interests for emergency medicine physicians, and sometimes efforts seem to be advancing slowly. In Michigan, we had some recent success getting efforts to translate to progress, but after years of advocacy and work, and it was a very welcome and great accomplishment by all those involved[1].

I think that continuing to tell our stories of violence will lead to further advancing efforts to help curb emergency department violence. ACEP has sent out surveys,[2] provided shared stories of violence,[3] as well as visual aids[4] to utilize if you find yourself speaking with political or administrative leaders such as the C-suite on this important topic. MCEP has asked members to reach out with stories to provide when speaking with our local legislators, and I would encourage anyone with a story to please reach out and share these, as stories have most often resonated well with those in political office[5]. Emergency Department boarding was also a highlight of advocacy efforts, which for many seems to be an issue we have seen before, but still are finding as relevant in our individual department's patient flow and throughput. Hopefully soon, this too will gain traction to finding solutions, so that our patients can get the care they need, in the places that it is best done.

This year LAC also had newer issues of advocacy such as ensuring proper due process rights for emergency physicians[6]. Diversity, Equality and Inclusion (DEI) had several lectures that highlighted the importance of having debate and discussion surrounding this important and timely issue. DEI certainly has been a topic of much political divide, and it was no different during the conference itself. However, despite the debate and controversial nature of this topic, it was well handled by ACEP President Dr. Aisha Terry, and in my opinion refreshing to see controversial topics discussion and debate, and well received to have very different opinions presented on the subject.

Andrew Taylor, DO, FACEP

Emergency Medicine association with unionization has become a newer topic this year, even more relevant for Michigan with the recent strike on April 18th at Ascension St John Hospital in Detroit. MCEP and ACEP released a statement in support of those emergency medicine physicians affected by and involved in this strike[7]. Unionization and its association with emergency medicine will be a topic to watch as time progresses, and as the workforce of emergency medicine changes over time. So much has changed in the workforce since the specialty began in the basement of hospitals almost as an afterthought, to the robust specialty it is today.

Whatever your association with emergency medicine, whether as a front-line worker, educator, or administrator, (or as it seems a little of all of these for many of us), I think that LAC has something for everyone. Advocacy is simply an area that we cannot afford to stand on the sidelines of anymore, and it's great to see all of those who are able to contribute in this way. I encourage anyone considering attending LAC to strongly consider doing so, it's well worth it.

This issue welcomes back contributions from our President Dr Fill on membership and retention, as well as Don Powell on reimbursement in critical care, and Bret Marr with an update on the pollical advocacy efforts and relevant other updates from legislation. We welcome back again Dr. Brandtly Yakey and his toxicology section with an article on Rivastigmine and associated delirium. Our resident article comes from Dr Ahdi and Barish on Dextrocardia with unique EKG findings on STEMI. As noted in the article itself, Dr. Ahdi was also published this same month in the ACEP Now edition, we congratulate you on your success and well written piece. Finally, it is that time again to update the bylaws for MCEP and associated changes are included for review, with the last updates taking place prior in 2021. §

Andrew Taylor DO FACEP
Newsletter Co-Editor

www.mcep.org

1 https://www.mcep.org/2023/12/06/governor-whitmer-signs-ed-violence-bills/
2 https://www.acep.org/SysSiteAssets/new-pdfs/advocacy/acepmemberpoll-edviolencejan2024.pdf
3 https://www.acep.org/administration/ed-violence-stories/cover-page
4 https://www.emergencyphysicians.org/article/er101/preventing-violence-in-the-emergency-department?utm_source=emtoday&utm_medium=blurb&utm_campaign=lacrecap&utm_content=infographic
5 https://www.surveymonkey.com/r/ViolenceED
6 https://www.emergencyphysicians.org/issues
7 https://www.acep.org/news/acep-newsroom-articles/acep-stands-with-mcep-in-supporting-emergency-physicians

RIVASTIGMINE FOR ANTIMUSCARINIC DELIRIUM

Michigan Poison and Drug Information Center, Wayne State University School of Medicine; Henry Ford Health System, Department of Emergency Medicine.

Brandtly Yakey, DO

Anticholinergic toxicity, whether from unintentional or intentional overdose, is one of the most frequently observed toxidromes encountered in the emergency department. Although "anticholinergic" is commonly used, it's more appropriate to describe this toxidrome as "antimuscarinic", as these drugs do not antagonize nicotinic acetylcholine receptors. Central symptoms include agitation, delirium, incoherent ("mumbling") speech, and hallucinations[1]. Agitation and delirium are challenging to control and may result in severe sequelae including rhabdomyolysis, acidosis, aspiration, and psychological distress.

Intravenous physostigmine is the classic antidote used to treat central antimuscarinic toxicity. Its tertiary amine structure enables crossing of the blood-brain barrier and reversible inhibition of cholinesterase, ultimately overcoming muscarinic receptor blockade. Physostigmine was used frequently in 1970's for reversal of antimuscarinic delirium. Its popularity changed after a case series was published in 1980 describing detrimental complications after reception of physostigmine for TCA poisoning[2]. Since then, physostigmine has inappropriately been criticized, and many have avoided its use*. Physostigmine was vindicated in 2021 after a randomized controlled trial demonstrated superiority of physostigmine over lorazepam for treatment of central antimuscarinic delirium[1].

So why even have this discussion? Akorn, the sole manufacturer of physostigmine in the United States, has stopped production, and most hospitals have depleted their supplies. Due to this shortage, the FDA has allowed for temporary importation of Anticholium (physostigmine salicylate) from Germany[4], however stocking by hospitals is variable. It is worth mentioning that benzodiazepines, although often used for antimuscarinic delirium, do not address reversing the underlying muscarinic acetylcholine receptor blockade. Further, parenteral benzodiazepines can lead to over sedation, hypotension, respiratory depression, and induce delirium[1,5]. During this shortage, many Poison Control Centers have advocated for the use of rivastigmine. Rivastigmine is a long-acting cholinesterase inhibitor and is structurally similar to physostigmine. Its mechanism, structure, and pharmacokinetics make rivastigmine an attractive alternative to treating central antimuscarinic agitation and delirium.

**For further information on this topic, I invite you to read a fantastic article by Jon Cole, "Tox and Hound – The Physostigma.[3]"*

	Intravenous Physostigmine	Oral Rivastigmine	Dermal Rivastigmine
Time to Peak Concentration	2 minutes	1-2 hours	8 hours
Half-Life	22 minutes	2 hours	Continuous
Duration	45-60 minutes	8-10 hours	Continuous

Table 1: Pharmacokinetics of acetylcholinesterase inhibitor used for anticholinergic toxicity.

Rivastigmine may confer potential therapeutic benefits over physostigmine during this widespread shortage. These benefits include its slower rate of penetration into the CNS, longer duration of action thereby reducing dosing frequency, theoretical potential for less severe side effects, and multiple drug delivery formulations. Its pharmacokinetics make it a favorable treatment when prolonged delirium is expected, as is often the case in antimuscarinic delirium (Table 1). The transdermal formulations have a lower maximum concentration and longer time to reach this peak when compared to oral formulations, and recent publications have shown that oral rivastigmine allows for faster resolution of anticholinergic delirium than the transdermal patches (2h versus 5h, respectively)[6]. Another retrospective review showed 67% of patients demonstrating improvement within 4 hours after oral administration[7]. Depending on the degree of delirium, oral administration may not be feasible, and transdermal formulation may be the only available route of administration. Further, the transdermal rivastigmine formulation is an attractive option once acute delirium has been controlled with oral rivastigmine administration.

Patients qualifying for treatment should be delirious, agitated, with minimal response to benzodiazepines. They also should be tachycardic with no evidence of QRS prolongation on EKG (<110 ms). It is unknown whether therapeutic dosing of rivastigmine is sufficient to treat patients post-overdose. Much of the case report literature uses close to therapeutic dosing, with some using more aggressive and higher doses. There have not been any reported adverse effects of cholinergic phenomena in patients receiving rivastigmine for treatment of antimuscarinic delirium. Typical starting doses of rivastigmine based on age group are described

	Oral Rivastigmine	Transdermal Rivastigmine
Children (<10 years)	0.75 – 1.5 mg	4.6 mg
Adolescents/Teens (10-17 years)	1.5 – 3.0 mg	9.5 mg
Adults (18 +)	3 – 6 mg	13.3 mg

Table 2: Recommended initial rivastigmine dosing by age.

in Table 2. Depending on clinical response, repeat doses may be warranted, with a max dose of 12 mg per day in adults.

Rivastigmine can lead to marked improvement of the central antimuscarinic toxidrome. At the Michigan Poison and Drug Information Center, we have experienced success in effectively and safely treating antimuscarinic delirium at the bedside.

The next time you are managing a suspected antimuscarinic toxidrome, call the Michigan Poison and Drug Information Center at 1-800-222-1222 to discuss potential antidotal therapy with rivastigmine! §

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LEGISLATIVE COLUMN

SB 279 – LEGISLATION TO ALLOW NURSE PRACTITIONERS TO OPERATE INDEPENDENT OF PHYSICIANS

Legislation that would allow registered nurse practitioners to receive controlled substance prescription licenses and supervise registered and practical nurses without the oversight of a physician has received a committee hearing in the Senate Health Policy Committee. Michigan's current laws require nurse practitioners to be licensed under a supervising physician who fills prescriptions and orders certain treatments for the nurse practitioner's patients. SB 279 received significant testimony in March 2024 from numerous stakeholders on the bill and its potential impact. The bill is sponsored by Senator Jeff Irwin (D-Ann Arbor). No further action has been taken on the legislation since the committee hearing in March. MCEP put in a card of opposition to this legislation consistent with the College's guiding principles of supervision over prescribing authority in a health care facility.

FISCAL YEAR 2024-25 BUDGET UPDATE

Governor Whitmer presented her sixth budget in February to kick off the Fiscal Year 2024-25 budget cycle. Since early April, Appropriation Subcommittees in the House and Senate have begun reporting their respective departmental budgets to the full House and Senate Appropriations Committees. This process is still in the early stages with numerous steps remaining and further negotiations needed between the House, Senate and Governor. The Senate and House DHHS Appropriation Subcommittees both reported their budgets, which saw some differences from Governor Whitmer's executive budget recommendation. The Senate DHHS budget reported contains $37.71 billion, which is similar to the proposed funding by Governor Whitmer, but the programs contained in the Senate DHHS budget differ. The House DHHS budget reported contains $37.76 billion and is more aligned with the Governor's executive budget recommendation than the Senate. Budget negotiations are anticipated to ramp up following the May Consensus Revenue Estimating Conference, which provides the House, Senate and Governor's office with an accurate estimate of funds the state has to spend in the FY 2024-25 budget. The final budget is expected to be passed in June.

Bret Marr, Lobbyist
Muchmore, Harrington, Smalley & Associates

HOUSE BACK TO FULL STRENGTH

Following two special elections to fill vacancies in house seats where their prior members won Mayoral races, the House Democrats return to full strength and a 56-54 majority in the House. This will take place the week of April 29th and allow that chamber to begin session days in earnest. The House is expected to focus on the state budget and economic development issues over the next couple of months. §

CRITCAL CARE REVIEW 2024

Appropriately documenting critical care time can often be confusing for providers, which can lead to emergency medicine physicians to fail to adequately document and capture this important revenue stream. The 2024 revised Medicare conversion previously was $32.7442 in January 2024. and has changed as of March 9th 2024 to $33.2875. Depending on your practice environment, critical care time can often be 7-10% of the total ED volume, so failure to capture this should not be overlooked.

With the current 2024 RVU's of critical care CPT codes 99291/99292 of 6.31/3.18 respectively, this translates into Medicare payments of $210.04/$315.89. This compares to a typical level 5 (99285) payment of $173.10.

WHAT IS CONSIDERED CRITICAL CARE?

CPT/CMS definition:
"An illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition."

A practical approach to consider critical care would be to ask the three following questions:

1. Is at least one organ system acutely impaired?
2. Is there a high probability of imminent, life-threatening deterioration?
3. Did you intervene to prevent further deterioration of the patient's condition?

TIME REQUIREMENTS

The duration of critical care time is based on the providers total time spent evaluating, managing, providing care to the patient, as well as the time spent documenting. This is an accrued total time.

Examples of allowable time elements include:

Time spent at bedside, reviewing test results, discussing the case with staff, documentation, time spent with family/DPOA discussing patient management when patient is incapacitated or unable to make own decisions.

What's NOT considered allowed time? Teaching time to residents or other QHP's, procedures (billed separately) Common examples to include are CPR, intubation, patients with procedures such as central line/pacing/transvenous pacing, cardioversion.

Time increments-
At least 30 minutes of total time required to meet requirements. Be specific and list appropriate cumulative times in minutes.

- 99291- 30-74minutes
- 99292- 75-104 minutes, however recent 2023 CY 2023 CMS requirements state that 99292 can only be reported when the full 30 minutes of cc time has been provided.

Thus 74 minutes plus 30 minutes = >104 minutes. Additional 99292 codes can be added for every completed 30 minute increments thereafter.

Can time be requested with split services with an APP? Yes. Time spent separately by a physician and APP may be combined. However, the time counted should not be duplicative. It is helpful to document which provider spent greater than 50% of time caring for the patient. As always, best practice is for the attending to provide a robust addendum or note detailing their involvement and indications for required cc time.

Don H. Powell, DO, FACEP
President - Medical Management Specialists

FINAL THOUGHTS

We often overlook critical care time in our day-to-day practice largely because it's not in our mindset or it seems to fall in the category of a typical ED shift and patient presentations. Take time to prioritize proper documentation and capture of appropriate critical care time which can improve your overall reimbursement. §

ACUTE PROXIMAL LAD MYOCARDIAL INFARCTION IN A PATIENT WITH DEXTROCARDIA: A CASE REPORT*

Heaveen Ahdi, MD and Patrice Barish, MD of Corewell Health William Beaumont University Hospital, Royal Oak, MI and Oakland University William Beaumont School of Medicine, Rochester, MI.

INTRODUCTION:

Dextrocardia is a rare congenital anomaly where the heart is intrinsically positioned in the right hemithorax with the apex pointing towards the right caudal position[1]. It has a prevalence of 0.01%[1] Dextrocardia can be associated with an overall situs inversus, where all internal organs are in the reversed position or be limited to situs ambiguous, where only some organs are in the reversed[1].

During the first month of fetal development, the primitive heart loop may loop towards the right or the left, resulting in the apex of the heart migrating from the right to left or from the left to right[1]. Most commonly, dextrocardia occurs as a L-bulboventricular loop, with the apex migrating from the left to the right at the end of the first month of development[1]. The second most common form of dextrocardia is the failure of rotation of the apex [1].

Despite the rarity of dextrocardia, coronary artery disease may occur with a similar frequency to that of the general population[3]. Dextrocardia can present with unique findings on a traditional left-sided EKG that raise suspicion for this anomaly. However, there may be diagnostic dilemmas if these findings are not immediately recognized. This delay in recognition can result in the inadvertent underdiagnosis of STEMI using traditional left sided EKG. Thus, it is important to recognize dextrocardia and adjust our diagnostic tools appropriately. In this case report, we describe a proximal LAD STEMI in a patient with dextrocardia and sinus inversus.

CASE PRESENTATION:

A 59-year-old male with a past medical history of a repaired VSD, dextrocardia, hypertension, hyperlipidemia, and current smoker presented to the emergency department. This patient had known CAD and previously required drug eluting stents to obtuse marginal and diagonal arteries. The patient's current presentation was prompted by epigastric pain, nausea, and fatigue followed by non-exertional, constant right-sided chest pain with radiation to his right arm.

The patient initially presented to an outside emergency department and subsequently transferred to our facility for continuity of care. Patient had stable vital signs with an oral temperature of 36.4 °C, heart rate of 91, blood pressure of 118/76, respiratory rate of 23, and pulse ox of 96% on room air. He was in no acute distress and remained asymptomatic upon presentation.

Initially, a traditional, left-sided EKG was obtained, which demonstrated inverted P waves in lead I, deep Q waves in lead V1, negative QRS complex in V1, and RBBB (Fig. 1). It was found that the patient had dextrocardia from previous records, and an EKG for dextrocardia was obtained, which was concerning for STEMI in the precordial leads (Fig. 2). The patient's first and second troponins from the outside hospital were <0.01 ng/mL. The third troponin at our facility resulted as >50.00 ng/mL. The patient was started on IV heparin and immediately taken for cardiac catheterization by the cardiology team. In the cath lab, the patient was found to have evidence of a proximal thrombus and significant stenosis of the LAD. Patient underwent successful revascularization and stenting of the proximal to mid LAD.

DISCUSSION:

Dextrocardia with STEMI is a rare clinical presentation that presents with both diagnostic and technical challenges. Our literature search through PubMed yielded less than 80 case reports of this presentation. Further, patients with dextrocardia may have atypical presentations of STEMIs. Dextrocardia can have features of right axis deviation, positive

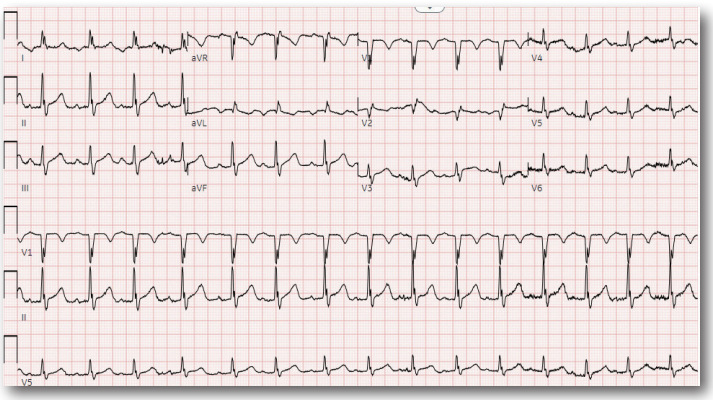

Figure 1: Traditional, Left sided EKG

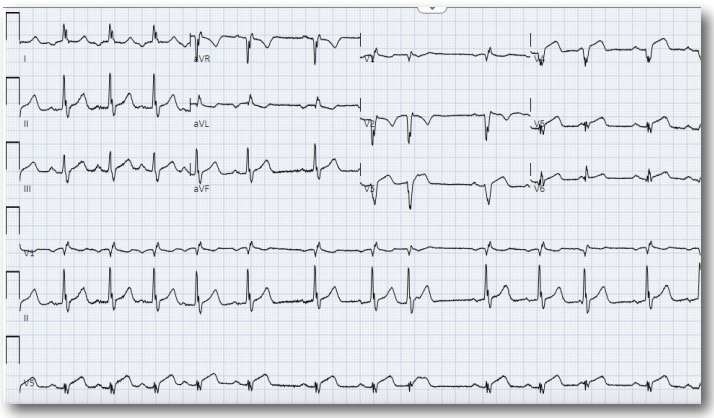

Figure 2: EKG for Dextrocardia (right sided EKG with limb lead reversal)

QRS complexes (upright P and T waves) in aVR, negative P and T waves and QRS complexes in lead I, and absent R wave progression in the precordial leads with dominant S waves[4]. In cases of dextrocardia, precordial leads should be placed in a mirror image on the right side of the chest, as is done for a right-sided EKG, with the additional reversal of the right and left limb leads[4].

Symptoms of acute coronary syndrome classically present on the left chest wall, however, our patient's pain was all localized to the right side of the chest, which has been described with other cases of dextrocardia[5]. The patient's initial left-sided EKG did not demonstrate concerning ST segment changes. However, the patient had known dextrocardia based on documented medical history and was confirmed with a recent chest x-ray. Upon the prompt reversal of EKG leads for dextrocardia, the patient was found to have an obvious STEMI in the precordial leads. The patient was then emergently taken for cardiac catheterization. It is important to discern cardiac anomalies, such as dextrocardia, early in a patient's clinical presentation, as it can significantly impact the timely interpretation of EKGs and the appropriate management of the patient's care. §

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Editor's Note: This article was submitted and published to the April 2024 edition of ACEP Now Volume 43 No 4, having been already accepted for publication for March/April MCEP News and Views.

MCEP CALENDAR OF EVENTS

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

November 21, 2024
Expert Witness Course
Virtual Zoom Meeting

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

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

PROPOSED AMENDMENTS TO THE MICHIGAN COLLEGE BYLAWS

In its recent review of the Michigan College of Emergency Physician Bylaws (last revised in July 2021), the ACEP Bylaws Committee made several recommendations. While many of these changes are "housekeeping" changes to maintain consistency with recent changes in the ACEP's Model Chapter Bylaws, a few warrant specific mention: The first is a provision giving the Michigan College Medical Student Council the option to select a non-voting medical student representative to serve on the MCEP Board of Directors (the Board) (Article VI, Section 2). The term of office for this position would be one year, with a maximum of two consecutive terms (Article VI, Section 4). Additional changes include clarification of how the College handles Councillor resignation and the filling of Councillor vacancies (Article VIII, Sections 7-8), as well as language explicitly stating that a quorum (i.e. a majority) of Executive Committee members have the authority to act on behalf of the Board of Directors (Article IX, Section 2), provided all actions taken are ratified at the next Board meeting. Finally, Article XIV (Ethics) was removed, as it was felt to be adequately covered by the ACEP Bylaws and therefore not requiring specific mention in the Michigan Chapter Bylaws. These Bylaws amendments will be presented to the membership for approval vote at the upcoming annual meeting (July 29, 2024) as an amendment by substitution. §

EMRAM PRESIDENT COLUMN

YEARLY RECAP

It has been my pleasure serving as the EMRAM Treasurer and then President over the past two years. I would like to thank this year's EMRAM officers (Lindsay Davis, Daniel Dunaske and Brittany Garza) for all their hard work. Additionally, I would like to thank Christy Snitgen, Madey Costello, Allie Perttunen, and Dr. Therese Mead for all their hours of diligent work to make EMRAM possible and successful. Over the past year EMRAM has been involved with numerous events. Please see below for the yearly recap and upcoming events.

2023 EMRAM EXCELLENCE IN TEACHING AWARD: Dr. Benjamin Schoener, MD, FACEP from Central Michigan University was the recipient of this award. Dr. Schoener received this award for his enthusiasm for furthering resident and student education, compassion towards patients and being an excellent resident advisor.

2023 MICHIGAN EMERGENCY MEDICINE SUMMER ASSEMBLY: This multiple day conference took place at the Mackinac Island Grand. At this event, there are several educational sessions which provide simulating emergency medicine topics and legal updates. During the conference there was time to explore Mackinac Island, play golf, horseback ride and sample fudge from the numerous shops.

2023 SONOW.A.R. (ULTRASOUND WILDERNESS ADVENTURE RACE): EMRAM became a new sponsor for this event. This fun filled event allowed emergency medicine residency programs across Michigan to travel to Belle Isle. Teams hiked approximately 4 miles around the island to find hidden stations, which challenged their ultrasound and wilderness medicine skills.

2023 EMERGENCY MEDICINE CAREER PLANNING LIFE AFTER RESIDENCY: This daylong event was held at Somerset Inn in Troy. There were numerous speakers who educated residents on financial planning, litigation, work-life balance, and offered job networking.

Laura Schroeder, MD, MS

2024 MIDWEST WINTER SYMPOSIUM: This excellent multiple day conference took place at Mountain Grand Lodge in Boyne Falls. There were several speakers who provided cutting edge information on emergency medicine hot topics. There were also numerous opportunities for social networking, job networking and medical student engagement.

2024 ITE REVIEW COURSE: EMRAM was happy to bring back the ITE review course this year. It was in virtual platform this year, making it easily assemble to emergency medicine residents state wide. There were a large variety of speakers from around the state, who delivered high yield content in a rapid review format.

2024 LEADERSHIP AND ADVOCACY CONFERENCE SCHOLARSHIP: Each year EMRAM sponsors a scholarship for a resident to attend ACEP Leadership and Advocacy Conference in Washington D.C. From this opportunity residents learned to better advocate EM topics, heard about current medical policies and developed relationships with policymakers. This year's EMRAM LAC scholarship recipient was Brianne Howerton, DO, MSBE from Corewell Health East.

2024 SIMWARS: Teams from ten Michigan emergency medicine residency programs competed at Central Michigan University in numerous simulated medical cases. The two finalists were Central Michigan University and Trinity Health Muskegon. Congrats to Trinity Health Muskegon who were the overall winners.

2024 EMRAM EXCELLENCE IN TEACHING AWARD: Dr. Christopher Moore, DO, FACEP from Ascension Genesys was the recipient of this award. Dr. Moore received this award for his exceptional leadership, passion for imparting pearls of wisdom, and patient empathy.

NEW EMRAM OFFICERS MEMBERS:

- President: Brittany Garza, DO from Central Michigan University
- Vice President: Tara Knisely, MD, MPH from Ascension Genesys Hospital
- Treasurer: Philip Stone, MD, MBA from Ascension Genesys Hospital
- Secretary: Sarah Baribeau, DO from Trinity Health Muskegon

UPCOMING EVENTS:

- **MOCK ORAL BOARD REVIEW:** May10th (Virtual). There are three sessions throughout the day to run simulated oral cases and prepare you to ace your oral boards. You may register at https://www.mcep.org/emram/mock-oral-board-review/
- **EMRAM ANNUAL MEETING:** May 23rd (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 EXCELLENCE IN TEACHING AWARD

CHRISTOPHER MOORE, FACEP

The Emergency Medicine Residents' Association of Michigan (EMRAM) announces the recipient for its 32nd Annual Excellence in Teaching Award is Dr. Christopher Moore of Ascension Genesys. This award is given to recognize faculty members who have made outstanding contributions to emergency medicine resident education. The award will be presented at the Michigan Emergency Medicine Assembly President's Banquet scheduled for Tuesday, July 30, 2024, at the Highlands - Boyne in Harbor Springs, MI.

Remembering

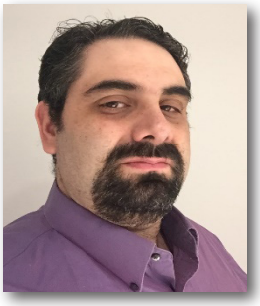
Gregory L. Walker, MD, FACEP

December 15, 1958 – March 26, 2024

MCEP Past President (1998-1999)

MCEP 2024 BOARD OF DIRECTORS CANDIDATES

BRAM DOLCOURT, MD, FACEP



- Graduate, Brandeis University, Waltham, Massachusetts, 1999
- Graduate, New York Medical College, Valhalla, New York, 2004
- Residency, Emergency Medicine, Henry Ford Hospital, Detroit, Michigan, 2007
- Fellowship, Medical Toxicology, Children's Hospital of Michigan, Detroit, Michigan, 2009
- Attending Emergency Physician, Medical Center Emergency Services, PC, Detroit, Michigan, 2007–present
- Assistant Professor, Emergency Medicine, Wayne State University, Detroit, Michigan, 2009-2022
- Associate Professor, Emergency Medicine, Wayne State University, Detroit, Michigan, 2023–present
- Clinical Consultant, Children's Hospital of Michigan Regional Poison Control Center/Michigan Poison and Drug Information Center, Detroit, Michigan, 2009–present
- Assistant/Associate Program Director, Sinai Grace Residency in Emergency Medicine, Detroit, Michigan, 2010
- Member, MCEP Leadership Development Program, 2013
- Course Director, MCEP Mock Oral, 2018–present
- Member, ACEP Academic Affairs Committee, 2016-present
- Chair, ACEP Academic Affairs Sub Committee, 2023
- Fellow, American College of Emergency Physicians
- Member, Society of Academic Emergency Medicine
- Diplomate, American Board of Emergency Medicine
- Diplomate, American Board of Emergency Medicine, Medical Toxicology sub board
- Diplomate, American Board of Preventative Medicine, Addiction Medicine sub board

Dr. Dolcourt has served in residency leadership since 2010. He became active in MCEP since joining the LDP class in 2013. Dr. Dolcourt has been a frequent lecturer for MCEP educational programs and has lectured yearly for the Winter Symposium since 2015. Nationally, Dr. Dolcourt has been involved in ACEP's Academic Affairs Committee since 2016 and was recently a sub chair for a committee objective. In addition to the practice of Emergency Medicine in an Urban teaching hospital, Dr. Dolcourt is a Clinical Consultant for the Michigan Drug and Information Center and recently has expanded his practice to include inpatient Addiction Medicine.

MICHAEL DOYLE, DO

- Graduate, Michigan State university College of Osteopathic Medicine, Lansing, Michigan, 2017
- Residency, Emergency Medicine, Henry Ford Jackson, Jackson, Michigan, 2021
- Attending Emergency Physician, Emergency Care Specialists, Corewell Health West, Grand Rapids, Michigan, 2021-present
- Attending Emergency Physician, Southwestern Michigan Emergency Services, Bronson Healthcare, Kalamazoo, Michigan, 2021-2022
- Urgent Care Physician, IHA (Trinity/St. Joseph Mercy Health System), Ann Arbor, Michigan, 2019-2021
- Chief Resident, Henry Ford Jackson, Jackson, Michigan, 2020-2021
- Laboratory Teaching Assistant, Gross Anatomy Course, MSU Colleges of Osteopathic and
- Human Medicine, East Lansing, Michigan, 2014
- Clerical Office Assistant, Henry Ford Jackson Digestive Health, Jackson, Michigan, 2011-2013
- Chemical Laboratory Assistant, Jackson Community College, Jackson, Michigan, 2010-2011
- Member, Leadership Development Program, Michigan College of Emergency Medicine, 2023
- Chief Resident, Henry Ford Jackson ED Residency, Jackson, Michigan, 2020-2021
- Task Force Member, LGBTQA Issues and Quality of Care: Task Force, Henry Ford Jackson, Jackson, Michigan, 2019-2021
- Committee Member, Annual Residency Program Review, Henry Ford Jackson, Jackson, Michigan 2018-2021
- Committee, Member, Blood Utilization, Henry Ford Jackson, Jackson, Michigan 2018-2021
- Committee, Pharmacy and Therapeutics, Henry Ford Jackson, Jackson, Michigan 2018-2021

Dr. Doyle was born and raised in Michigan and has remained loyal to the lower peninsula even after having completed his undergraduate, medical studies and residency with chief year, all within state. Dr. Doyle first became engaged with MCEP during a Winter Symposium in medical school at Michigan State, which helped solidify his interest in emergency medicine. He has been an active member of both MCEP and ACEP since 2016. Dr. Doyle recently completed the Leadership Development Program in 2023 and served as an Alternate Councilor at the Council Meeting during ACEP's 2023 Scientific Assembly. Dr. Doyle was recognized by his peers and recently awarded the 2023 Physician Rising Star Award, by demonstrating high quality patient care, efficiency, collegiality and professionalism within his physician owned and governed ED group. Since graduating residency, he's had a diverse experience in clinical practice working at 10 various EDs throughout 9 counties across West Michigan, including two Level 1 trauma centers, multiple community-based hospitals and 3 registered critical access hospitals.

Dr. Doyle lives and works in beautiful West Michigan, appreciates Lake Michigan in the summer as well as the picturesque lake effect snowfall in the winter. Professionally, he has a passion for differences and making connections, caring for persons living with disabilities, identifying disparities and the challenges those create with the delivery of healthcare. Outside of his career in medicine, he enjoys staying physically active, trying different cuisine and traveling.

RYAN REECE, MD, NRP, FACEP

- Graduate, Michigan State University, College of Human Medicine, East Lansing, Michigan, 2010
- Residency in Emergency Medicine, Michigan State University/Sparrow Health System/McLaren Health Care, Lansing, Michigan, 2018
- Assistant Professor, Clinical Track, University of Michigan, Ann Arbor, Michigan, 2022-present
- Adjunct Assistant Professor, Michigan State University, College of Human Medicine, Lansing, Michigan, 2019-present
- Course Director, Michigan State University, College of Human Medicine, Lansing, Michigan, 2023-present
- Medical Team Manager, Michigan Task Force 1, Urban Search and Rescue Team, Holly, Michigan, 2023-present
- Physician Medical Officer, National Disaster Medical System, United States Department of Health and Human Services, 2023-present
- Medical Director of EMS Education, CPR and Aquatics Community Education Consortium LLC, Caro, Michigan, 2023-present
- Medical Director, EMT-B Training Program, Genesee Intermediate School District, Flint, Michigan, 2021-present
- Medical Director/Sheriff Deputy, Paramedic Division, Genesee County Sheriff's Office, Flint, Michigan, 2020-present
- Attending Physician, Detroit Medical Center, Sinai Grace Hospital, Detroit, Michigan, 2022-2023
- Member, Standards and Practice Committee, National Association of EMS Physicians, Atlanta, GA, 2023-present
- Member, EMS Committee, ACEP, Irving, TX, 2023-present
- Member, Board of Directors, New Paths, Inc., Flint, MI, 2023-present
- Chair, Education Committee, Genesee County Medical Control Authority, Flint, MI, 2022-present
- Member, Emergency Medicine, Medical Control Authority Subcommittee, Emergency Medical, Services Coordinating Committee, Department of Health and Human Services, State of Michigan, 2022-present
- Member, EMS Committee, Michigan College of Emergency Physicians, Lansing, MI, 2021-present

Dr. Ryan J. Reece, MD, NRP, FACEP is an assistant professor of emergency medicine at the University of Michigan. He received his medical degree from Michigan State University College of Human Medicine, completed his emergency medicine residency at the Michigan State University / Sparrow program in Lansing and an EMS fellowship at the Wayne State University / Detroit Medical Center program in Detroit.

For the last several years, Ryan has been practicing in the Flint area at Hurley Medical Center. He is triple board certified in emergency medicine, addiction medicine and EMS/Prehospital Medicine. He is working to improve care for patients with substance use disorders in the emergency department and in the prehospital environment. He is involved in EMS in Genesee County as the medical director of a few EMS education programs, the medical director of the Genesee County Sheriff's Office Paramedic Division and chairs the education committee within the local medical control authority. He is also active within the State serving on EMS, medical control and trauma system committees. He is currently involved in out-of-hospital cardiac arrest research with the goal of improving survival outcomes.

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MCEP 2024 BOARD OF DIRECTORS CANDIDATES *(Continued from Page 13)*

ANDREW TAYLOR, DO, MA, FACEP

- Graduate, Michigan State University, College of Osteopathic Medicine, East Lansing, Michigan, 2014
- Residency in Emergency Medicine, MSUCOM/Henry Ford Allegiance Health, Jackson, Michigan, 2018
- Attending Physician, Henry Fors Allegiance Health, Jackson, Michigan, 2019-present
- Attending Physician, Sparrow Health Systems, Lansing, Michigan, 2018-2019
- MSUCOM Clinical Faculty, Henry Ford Allegiance Health Emergency Medicine Residency, 2014-present
- Chair, MCEP Membership Committee, 2022-present
- Co-Editor, MCEP Newsletter, 2023-present
- Council Member, ACEP, 2021-present
- IEP APP Mentor, IEP Mentoring Committee
- Member, IEP Quality Improvement Committee
- Physician Representative, Henry Ford Allegiance Healthy Complex Patient Committee
- Speaker, MCEP In Service Review Course (ITE), 2020
- Member, MCEP Leadership Development Program, 2018-2019
- Physician Champion, Henry Ford Allegiance Health, MEDIC Conference, 2019
- Member, MCEP Board of Directors, 2021-present
- Chief Resident, Henry Ford Allegiance Health, Jackson, Michigan, 2017-2018

Dr. Andrew Taylor has been an active member of the Michigan Council of Emergency Physicians and the American College of Emergency Physicians since 2014.

Dr. Taylor graduated from Henry Ford Allegiance Health in Jackson, Michigan in 2018. After residency he accepted a position with Emergency Physicians Medical Group at Sparrow Hospital System in Lansing, Michigan. There he worked at both their level one trauma center as well as their critical access hospital in Ionia. He then decided to return to Henry Ford Allegiance Health in Jackson to pursue more of a teaching role in both the residency and medical school level, which has always been a passion of his. Currently he is a core faculty member for the residency program.

Dr. Taylor has been actively involved in quality improvement initiatives through Henry Ford Allegiance Health Complex Patient Committee, Independent Emergency Physicians Quality Improvement Committee, and also was a representative to Michigan Emergency Department Improvement Collaborative (MEDIC) from Henry Ford Allegiance.

Dr. Taylor completed the MCEP Leadership Development program in 2019. Through this leadership program, he gained a desire to continue in advocacy for the medical profession. This has furthered his interest in continuing his involvement in MCEP and ACEP. Dr. Taylor also has an interest in the bioethical aspects of medicine and completed a Master of Arts in philosophy with a bioethics concentration at Michigan State University.

Dr. Taylor hopes to take his past experiences and the knowledge he has gained to advocate for the future of emergency medicine and the patients he cares for. He would be very honored to have the opportunity to serve on the MCEP board of directors and help lead the future of emergency medicine.