

The Fast Track

Fall 2017 Issue

An Emergency Medicine Publication

**THE
BUSINESS OF
HEALTHCARE:
HOW PATIENT
SATISFACTION
PLAYS A ROLE**

**HAPPINESS
IN RESIDENCY
AND BEYOND**

**Q&A:
ACOEP'S NEW
RESIDENT
STUDENT
ORGANIZATION**



The Fast Track

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Letter from the Editor

Welcome back! The fall edition is here with an exciting line up of articles. From acute myocardial infarction, to physician burnout, to violence in the emergency department, *The Fast Track* covers a gamut of topics you want to be familiar with as a resident or student in emergency medicine.

Hopefully, you are reading this on our new website! If not, head on over to www.acoep-rso.org/the-fast-track and check it out! The complete fall edition is posted in PDF format on the website, and the individual articles are posted on our blog on the website as well. If you would like a print edition, come to Scientific Assembly in Denver, CO, on November 4-8, 2017, where you can get your own free copy and attend exclusive ACOEP Resident Student Organization events including private lectures from ZDoggMD and Dr K. Kay Moody!

Lastly, consider submitting your own article to our publication. The submission page on our new website makes uploading your article a breeze! And, our dedicated editors are excited to help make your article the best that it can be!

Best,

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PRESIDENTIAL MESSAGE

Welcome to *The Fast Track*!

This year has been a time of major shift here at ACOEP. As your resident and student leadership, we have been working to provide you with the most exciting and educational emergency medicine experience we can offer.

Many of you will be reading this letter from the comfort of your laptops and cellphones on our new dedicated RSO website! *The Fast Track* is now a digital publication allowing for more immediate connection and feedback with our readership. In the dynamic world of emergency medicine, we don't have the luxury to sit back and wait. We are excited to introduce real-time interaction on articles and events addressed by our authors. We will even be tracking which articles get the most #FOAMed love to print in our annual *The Fast Track Anthology*.

The RSO is now fully unified on social media. Whereas before the students and residents had their own accounts on Facebook and Twitter, the RSO has ushered in a new era of streamlined availability on social media. We, as your leadership, can keep you informed and you can reach out to us on multiple different platforms. If you aren't following us yet – what are you waiting for?!

This year's Scientific Assembly in Denver promises to be an unmissable event. If you are wondering about making the trip out to the Rocky Mountains, think no more. From airway competitions to one-on-one time with the ACOEP keynote speakers, career-relevant advice ranging from a student level to that of a senior resident – this year's fall conference promises to provide ample opportunity to instill the confidence you need to take the next step on your personal emergency medicine journey.

What organizational rebranding would be complete without some new apparel to represent us back home at your medical schools and residency programs? The RSO will be giving away shirts to every attendee in Denver! We also will be launching a new line of clothing with a resident/student budget and style in mind.

With all these great new changes, we have to take the time to thank the College for being behind us every step of the way! We are so grateful for the support of the parent chapter in helping us promote this new venture. Those of you that have been to ACOEP events before are well aware of the interest and support that the attending physicians show in us as both individuals, and also the future of the college as a whole. Their willingness to stand behind our endeavors is what allows us to face the future with certainty.

We hope to see you all in Denver!

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Happiness in Residency and Beyond

James Chapman, DO
Kent Hospital, Warwick, RI

Residency is full of tasks that make life busy. Working shifts, studying at home, preparing for weekly lectures, and attending journal club are all part of residency life. On top of this, you are encouraged to do research, travel and present at conferences, educate students, attend interview dinners, and many other responsibilities. With all of this going on, how do we find time for activities outside of work that we enjoy in order to lead a balanced life? I went into emergency medicine, because I enjoy the work environment and what I do. How are we supposed to be happy during residency and beyond?

Being happy in residency starts before you even match into a program. Getting into a residency where you will be happy should be one of your goals during medical school. Be sure to do well enough in school to be competitive so that a variety of programs take interest in you. When rotating through potential residency programs and throughout the interview process, take note of whether the residents are happy. I remember going to resident dinners the night before my interview and realizing that I would not be as happy at one program versus another. I was not the right personality fit for that program. Attending the interview dinners was a vital part of my interview process.

During interviews, ask how many shifts a month each program has, as well as the length of the shifts. Working a twelve-hour shift is much different than working an eight or nine-hour shift. When I get home from a nine-hour shift, I still have energy to accomplish other tasks or do something I enjoy. This can make a big difference in your quality of life during residency.

Another consideration is the length of a program. Many three-year programs require longer shifts and require a

greater number of shifts in the emergency department per month of residency. It makes financial sense to go the three-year route, but for me it is more important to be happy during my residency years than to finish earlier. Getting out of residency earlier will not necessarily make one happier. Making more money for one year is not that big of a difference in the long run in our field of work.

Another tip is to apply to locations where you can be happy. Some people will not be content living in a small town, while others do not want the hassle of a large city.

Emergency medicine is competitive, and sometimes you have to make a sacrifice to get into a residency. Finding out what is most valuable to you is a key part of applying to residency programs in emergency medicine.

Once you become a resident, it is easy to get caught up in the work and responsibilities of residency. It is key to remember what made you happy prior to starting residency. Make happiness a priority! Don't be a new person just because you are doing something new! It is imperative to take time each day for yourself.

Further, maintain relationships that you already have. If you are married or in a relationship, continue to spend time together. I try to set a time each week to go on a date with my wife. Sometimes with my schedule, this will be a morning date before a shift, but time together has made my relationship stronger and better. Your significant other is

FINDING OUT WHAT IS MOST VALUABLE TO YOU IS A KEY PART OF APPLYING TO RESIDENCY PROGRAMS IN EMERGENCY MEDICINE.

spending a large amount of time without you due to work commitments, and they deserve to have some time with you to improve the relationship. This applies to your children as well. Children need to have you in their lives. This is a period of time where you will miss some milestones, so it is vital to be there as often as possible with them.

We also need to take time out for our emotional well-being. Emergency departments are fast-paced and wear us down. Sometimes we need to step back and let our minds have a break. It is emotionally draining to see children die, families torn apart, or lives altered through injuries and addictions. This takes a toll on all of us, whether you realize it or not. Taking a break from the day-to-day tasks of residency to focus on your own well-being is important. Some people need time to meditate. Some enjoy spending time outdoors. Others exercise or do yoga. Whatever it is that is valuable to you, plan time to do it.

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Some people also find peace with religion. An attending physician I know was experiencing what we call "burnout" in medicine. He found ways to change his outlook on life. He found a church that helped him, and also started attending martial arts classes with his daughter. These two choices helped calm him and ease his mind. He is still in the same job at the same facility, but he is much happier due to finding joy and balance outside of work.

Making healthy choices contributes to a balanced life. In our field of work, many people are putting themselves second to patients. If you aren't taking care of yourself, how are you supposed to advise patients to make good decisions? Many times, I am so busy at work that I only have a few minutes to eat a snack, which tends to be unhealthy. We need to

consciously think about what we are putting into our bodies. Shift work is difficult, so our bodies need rest. It is vital to your health to get plenty of sleep. Sometimes people turn to alcohol to help them through hard times. Drinking alcohol excessively or turning to other addictive substances will make lives harder in the long run. Most residency programs have resources to go to if you find that you have developed an addiction.

Several points discussed here can make one think that residency is no fun at all. I can tell you that I am happier now in residency than I ever was in medical school. Why? It is because of the decisions I have made over the last five years or so. The interview process is central to finding a residency that fits your personality. It is my priority to keep a healthy work-life balance. It is critical for me to be part of a program where the residents are happy with their jobs. Going to a program where I have the time to do other activities is a sacrifice I am willing to make.

We are so lucky to be working in this field and to be where we are today! Make sure that you recognize this fact every day and do something that brings you happiness. Physician wellness is key. Make it a focus of your life each and every day!

Wellens Syndrome:

THE FORGOTTEN DIAGNOSIS

Frank Wheeler, OMS-IV
LECOM-Bradenton

Introduction

A middle-aged male complaining of resolved chest pain presents to the emergency department (ED). His physical examination is normal. His electrocardiogram (EKG) is seen in Figure 1 and cardiac enzymes were normal as well. The patient is determined to be low-risk for an adverse cardiac event and discharged home that night; however, two days later he returns to the ED. This time he arrives in cardiac arrest from a massive myocardial infarction. Reexamination of the EKG from two days prior reveals biphasic T waves in the precordial leads.

Background

This patient had Wellens syndrome. A syndrome that was incidentally found in 1982 by a group of cardiologists (including Dr. Wellens) who were studying the management

of patients with unstable angina. Among 145 patients, 26 had similar T wave changes within the precordial leads, negative cardiac enzymes, and poor outcomes with conservative management. Eight of the first nine patients went on to develop anterior myocardial infarctions and three died. Ninety percent who underwent cardiac catheterization and coronary angiography were found to have greater than 90% stenosis in the proximal LAD. It was found that untreated Wellens syndrome has a high risk of myocardial infarction and death. The average time for infarction following EKG changes was days 1 to 23; with an average of 8.5 days^[2].

In a second larger study, 180 out of 1260 unstable angina patients were found to have this syndrome. All were found to have at least 50% LAD blockage and 33 had complete occlusion. A number of these patients went on to develop anterior wall infarctions^[3]. Wellens syndrome is therefore a pre-occlusion stage whereby acute myocardial infarction is imminent.

Characterization

Wellens syndrome can be identified most easily by its abnormal T wave findings in the precordial leads. These T wave abnormalities include either biphasic or inverted T waves. If one of these abnormalities are found, the patient must also have a history of anginal chest pain, but be pain free at the time of the EKG findings with

normal or slightly elevated serum cardiac enzymes. Other ECG criteria for this syndrome also include a normal R progression without Q waves and ST elevation present^[4].

Differential

Although T wave abnormalities are characteristic of Wellens syndrome, biphasic and inverted T waves can also be indicative of alternative diagnosis such as intracerebral hemorrhage, right bundle branch block, pulmonary embolism, hypokalemia, persistent juvenile T-wave inversion, or may be just a normal variant. Therefore, a finding of inverted or biphasic T waves can indicate a number of possible diagnosis and further history and clinical investigation is warranted to determine the cause.

Pathophysiology

Interestingly, the T wave abnormalities seen in Wellens syndrome are also seen in those who recently underwent reperfusion therapy following acute myocardial infarction^[5]. It is therefore hypothesized that Wellens is an incidental reperfusion following occlusion of the LAD. The reperfusion may be unstable and this vessel may re-occlude, causing further angina and ischemia. This cycle of occlusion and reperfusion will continue until the coronary blood supply can no longer be reestablished and an acute myocardial infarction occurs.

Type of Wellens Syndrome

Currently two types of electrocardiographic findings for Wellens exist. Type A involves biphasic T waves in the precordial leads that begin positive then become negative, as demonstrated in Figure 2. This type is found less frequently than type 2 in around 25% of cases. Type B, which occurs in around 75% of cases, demonstrates inverted T waves (Figure 3)^[6]. Throughout the cycle of occlusion and reperfusion that occurs over time, electrocardiographic findings will usually fluctuate through the different types of Wellens waves. However, if coronary supply is prone to worsen, EKG findings may show hyperacute T waves, indicating an anterior myocardial infarction. It is also important to note that Wellens syndrome does not always have to occur in the anterior leads but can also occur in other areas of the myocardium as well^[7].

Management and Treatment

Patients with Wellens syndrome are to be treated as unstable angina. This includes aspirin, nitroglycerin, and pain control, if needed. Patients should be admitted to the hospital where serial cardiac markers and electrocardiograms should be



Figure 2 displays a Type A Wellens waves.

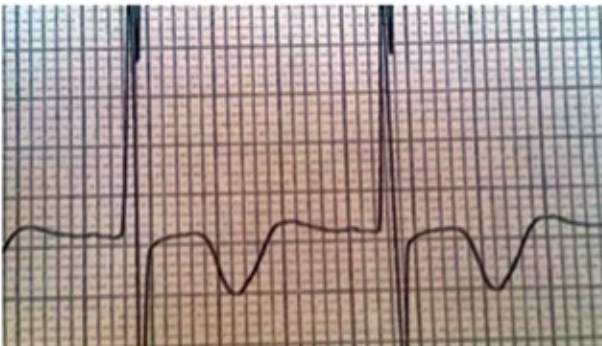


Figure 3 displays a Type B Wellens waves.

followed. Interventional cardiology should also be consulted as early cardiac catheterization and intervention is imperative in Wellens syndrome ^[3,8]. With early recognition and proper intervention, usually PCI, the prognosis for Wellens syndrome is good. It is also important to note that stress testing is contraindicated in Wellens syndrome as the increase in myocardial demand can exacerbate the limited blood supply to the myocardium and precipitate a myocardial infarction^[9].

Conclusion

Wellens syndrome is an important diagnosis to consider in a patient with T wave inversions or biphasic T waves and negative cardiac markers. Although these patients may be stable and pain free throughout their stay within the emergency room, a large number of patients will go on to experience anterior myocardial infarctions. With early recognition and intervention, significant morbidity and mortality can be avoided.

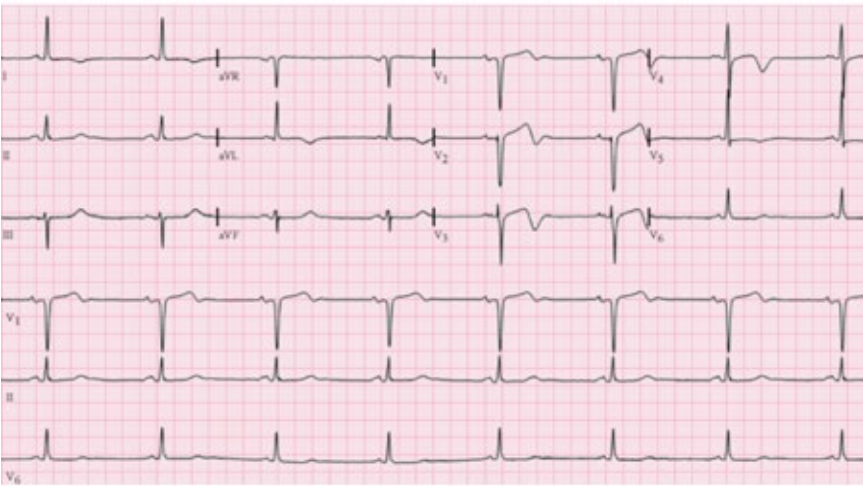


Figure 1 displays an electrocardiogram similar to this patient's ^[1].

THE BUSINESS OF HEALTHCARE:

How Patient Satisfaction Plays A Role

Alexander Torres, DO
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Patient satisfaction and its impact on healthcare and health outcomes dates back to the 1950s, where relationships between patients and healthcare providers were examined.¹ These relationships have become extremely complex as the healthcare industry has grown, and there is now legislation in the form of the Affordable Care Act (ACA) requiring that these relationships impact the business of healthcare in the form of reimbursement and consumerism. Operating as a service industry, healthcare has similarities to other firms whose goal is perfecting customer satisfaction and providing superior services or products. Fenton and associates² describe how high patient satisfaction is associated with high mortality, the opposite goal of the principles of healthcare. The purpose of this paper is to discuss how there has been a shift from the primary goal of medically treating patients to now treating them as consumers, and how patient satisfaction is changing the structure of healthcare.

Historical Background

In the early stages of examining patient satisfaction, the relationships between providers and patients were the main focus. It was found that patients experienced a lack of empathy, low levels of friendliness, and dissatisfaction from health services.¹ Since the initial investigations, there have been numerous studies looking to determine what affects patient satisfaction, eventually leading to the current mentality that patients are “consumers of healthcare,” and therefore the healthcare industry should shift towards a model of consumerism. Since the 1950s, several socioeconomic factors have become a reality and have changed patient-centered care. Factors such as rising patient expectations, demand for greater transparency, and demand for immediate access to imaging and pharmacotherapy have impacted the direction of healthcare as an industry.³ Senić and Marinković¹ found that the last service encounter experienced by a patient is usually the encounter on which they will rate their overall experience.

In 2002, the Baldrige National Quality Program began awarding businesses in healthcare. The Baldrige National Quality Program works to “identify and recognize role-model businesses, establish criteria for evaluating improvement efforts, and disseminate and share best practices.”⁴ These awards signify that a healthcare organization serves as a role model in its field based upon overall success. The award measures the success of patient care outcomes and processes, patient satisfaction, workforce satisfaction, and financial market performance, all of which lead to a successful organization.⁴

While patient satisfaction and patient-centered care have always been important, the passage of the Affordable Care Act by the federal government in 2010 set the stage for value-based purchasing; a system in which payments to healthcare organizations will be impacted by patient satisfaction scores.⁵ Patient satisfaction is measured in many ways, but the Hospital Consumer Assessment of

Healthcare Providers and Systems (HCAHPS) scores are the most influential, as they make up 30% of the overall performance score for value-based purchasing. The paradigm suggests that improving patient-centered care and improved patient satisfaction will lead to better health outcomes.⁶ This has had significant impact on the structure of healthcare and has led to changes in priorities, goals, and objectives of many healthcare organizations.

Impact of Patient Satisfaction on Healthcare Structure

The implementation of the Affordable Care Act imposed major changes on the healthcare industry. As medical coverage is extended to patients under the ACA, the number of patients entering the healthcare system is expected to reach 32 million, leading to difficulties for the current system to accommodate these new healthcare consumers.⁷ As patients make their way through the complex medical system, they will have a multitude of opportunities to complete surveys that will impact various organizations’ HCAHPS scores. They will rate categories including nurse communication, physician communication, responsiveness, pain management, medication communication, cleanliness, discharge information, overall rating, and likelihood to recommend. These scores based on patient experience will ultimately be tied to the reimbursement of physicians and healthcare organizations under a pay-for-performance model.⁸

With value-based purchasing becoming so important, multiple studies have examined the effects that it would have on healthcare organizations in regard to financial impact and business models. Cliff found that by improving the patient experience, institutions can experience positive financial results.⁵ It was found that hospitals that rank amongst the best inpatient satisfaction are also some of the most profitable and financially sound institutions. As with most businesses, anything that positively influences finances and payments is a strong motivator for success. With patient satisfaction being so closely tied to reimbursement and financial rewards, healthcare organizations have been motivated to improve the patient experience.

Using HCAHPS categories as a basis for areas in which to improve, the healthcare industry has seen a shift in priorities, goals, and objectives. With managers being educated in business, healthcare has seen a trend towards providing tangible services and goods aimed at improving the patient experience while, at times, losing sight of a primary objective of medicine which is to positively impact a patient’s health and well-being. This can lead to increased healthcare costs that do not directly impact a patient’s health outcome.

Fenton et al. describe the negative effects of achieving high patient satisfaction scores.² The implications of linking physician reimbursement to patient satisfaction have led to a change in the practice of medicine. In attempts to satisfy patients, physicians have begun to order unnecessary



testing (laboratory and imaging studies) simply to avoid negative impacts on reimbursement. This type of practice can quickly lead to an increase in overall healthcare costs, which is a major factor in the healthcare crisis currently being experienced in the United States. Greater patient satisfaction has been associated with increased utilization of healthcare resources and ultimately an increase in healthcare spending.⁵ Healthcare executives, in conjunction with physicians, must be wise to effectively and efficiently use resources to positively impact the patient experience while also containing costs.⁹ Physicians undergo extensive schooling and post-graduate training so that they will know what to investigate, how to investigate it, and when it should be investigated. By succumbing to patient requests for unnecessary testing, the physicians are compromising their ideals solely for the concern of decreased reimbursement as a result of dissatisfied patients.

Healthcare as a Service Industry

Service industries serve in the economy to provide services rather than tangible goods. These industries have become extremely focused on customer satisfaction to strengthen their places in competitive markets. Good customer service is extremely subjective, as each individual has their own idea of what is acceptable customer service. Service industries aim to provide individualized services, yet healthcare seems to be lagging by using generalizations from patient satisfaction surveys to provide for its customers.¹⁰ Healthcare is included in the service industry. Therefore, it is being treated as any other organization and is not seen as unique.

As the United States is seeing a shift in healthcare from treating patients to treating consumers, we are seeing an excessive amount of resources being used for advertising and marketing.¹¹ The market for healthcare providers is vast, therefore competition is increasing. When deciding on where to receive elective healthcare, patients tend to forget a hospital's clinical outcomes and seem to focus on the "window dressings" of free parking, food quality, guest internet access, and other amenities. These amenities aim to earn repeat business and recommendations from current patients.

It is unfair to compare healthcare services, such as life-saving emergency care, surgery, chemotherapy, etc., to other services such as haircuts, online video streaming, and package delivery. Consumers of healthcare typically do not seek services because they are having a good day. Very few, if any, patients begin their day of receiving healthcare services in a good mood. They are preparing themselves for long waits, potential for receiving bad news, receiving medications that may make them sick, having to endure a needle-stick to have laboratory work performed, and other unpleasant situations. There are few services where consumers do not expect

positive outcomes. Experiences like these make healthcare unique when it comes to its inclusion in the service industry of economics.

As consumerism is empowered in healthcare, the system is being placed under increasing pressure to conform to customer satisfaction practices, leading to shifts in the goals of providing patient care.¹² Healthcare providers are under significant stress with increasing demands from customers, payors, and government regulations; therefore, they are feeling that customer service is just one more thing added to their job requirements.¹³ Needham describes how patients, now considered consumers of healthcare, will begin to expect from healthcare what they expect from other service industries, such as value, convenience, and respect.¹⁴ Listening to customers for continuous feedback on their experiences is important for improving service quality, in both healthcare and traditional service industries.¹⁵ Healthcare leaders and management must have a strong foundation on which to improve patient satisfaction. This foundation should consist of empowering positive values and supporting change initiatives aimed at providing high-quality service.¹⁶

Patient Perceptions and Attitudes

Messina and associates describe how patients present to hospitals and clinics with their own agendas and expectations of what to expect with regarding service and care.¹⁷ This is true of consumers in many industries, and in some ways, healthcare is no different. Meeting service expectations and setting standards of behavior play a role in healthcare, but must be modified in certain situations.¹⁸

Many patients bring their own expectations to provider encounters. This includes demanding certain unnecessary testing, prescriptions, or other services. Patients tend to be more satisfied when physicians fulfill their expectations, regardless of whether the services are necessary.² This form of practice has led to inappropriate medication usage, increasing risk for adverse reactions to unnecessary interventions, and increasing healthcare expenditures all under the fear of decreased reimbursement. However, providing patient-centered visits where the provider has the time to discuss the patient's concerns could both improve patient satisfaction while being judicious in the use of resources. This requires longer patient-physician encounters, which is proving more difficult to find in today's healthcare system as the nation is currently experiencing a physician shortage. Satisfied patients are more likely to be compliant with their medical care plan, ultimately leading to improved outcomes and more efficient utilization of healthcare resources.¹⁹

With regards to the noncompliant patient, one can see the

issues regarding reimbursement being tied with patient satisfaction. Fontenot describes how a physician trying to improve a patient's health by empowering them to take a personal responsibility in their own care when that is not what they want to hear, will ultimately lead to a dissatisfied patient.⁶ These noncompliant patients' attitudes toward their healthcare is poor, and yet it is the healthcare provider that is financially penalized.

Patients seeking healthcare services have varying backgrounds ranging from excellent overall health to

AS CONSUMERISM IS EMPOWERED IN HEALTHCARE, THE SYSTEM IS BEING PLACED UNDER INCREASING PRESSURE TO CONFORM TO CUSTOMER SATISFACTION PRACTICES, LEADING TO SHIFTS IN THE GOALS OF PROVIDING PATIENT CARE.

extremely poor health with multiple chronic illnesses that require significant resources. The severity of patient illness impacts their perceptions of healthcare and the importance of various aspects. Otani et al describe how patients with serious illnesses see patient-physician interactions and physician care as most important.²⁰ As one might expect, patients that require frequent visits, procedures, and encounters with the healthcare system will have more opportunities to complete patient satisfaction surveys. As these patients are not regarded as being in good health, they are more likely to receive bad news, incur more healthcare debt, and require more resources all leading to a higher possibility of dissatisfaction with their experiences as well as the healthcare industry as a whole.

Satisfaction of Healthcare Employees

The healthcare industry would not be able to operate without cooperation between healthcare executives/administration, physicians, nurses, ancillary staff, and ultimately patients. The attitude of members of the healthcare team impacts sixty percent of patient experiences, as well as patient perception of quality care and service.¹² Ensuring employee satisfaction will likely indirectly increase patient satisfaction.

Physicians play a significant role in the healthcare system, especially in the care of patients with poor overall health. With an aging population seen in the "Baby Boomer" generation, chronically ill patients are becoming the norm. It should come as no surprise that empowering physicians and focusing on their satisfaction should be a top priority for healthcare management. From the beginning of their studies, and often before, physicians aim to provide a satisfying experience for their patients. This sentiment is often missed when discussing patient satisfaction. Handel detailed

how influencing physicians by honing in on their pride, professionalism, and natural problem-solving abilities can provide a positive impact on patient satisfaction.²¹

Medical education has become increasingly focused on patient communication due to the impact it has on the patient experience, and ultimately, patient satisfaction. Ossoff and Thomason¹¹ found that physicians' bedside manner, and the way in which they interact with patients, continues to be one of the most important factors in achieving high patient satisfaction scores. Improving bedside manner

involves improving how physicians listen to a patient, deliver information or bad news, allow patients and families to participate in medical decision making, and the respect they show towards patients. These traits can be applied to nursing and ancillary staff as well. By influencing all members of the healthcare team to positively impact the patient experience, patient satisfaction is likely to improve.

Shannon describes the impact of physician well-being on the patient experience. More satisfied physicians tend to have higher patient satisfaction scores; however, physician dissatisfaction and "burnout" are on the rise nationwide.²¹ A recent survey of currently practicing physicians demonstrated that nearly half of those surveyed would not choose medicine again as a career. Another worrisome statistic is that nearly 30 percent of practicing physicians are considering leaving the profession within the next two years due to "burnout." The factors leading to physician dissatisfaction are complex, but some of the most common issues faced by practicing physicians are issues with healthcare reform, some of which have been exacerbated by the passage of the Affordable Care Act. Physicians are concerned that they will face with reduced compensation and autonomy, along with worsening time constraints and increased pressures to complete administrative tasks all due to greater access to healthcare among patients that were previously not in the market for healthcare services.²¹ As value-based purchasing is becoming more prominent in the healthcare industry, it is imperative to focus on satisfied, engaged employees.

Discussion

As the information in this paper demonstrates, patient satisfaction is complex. There is no clear definition of patient satisfaction and the idea is highly subjective. Implementing a

standardized approach is not likely to be effective as patients are looking for individualized care. Patient satisfaction is not simply focused on the patient experience, but it has now become closely linked to reimbursement for physicians and healthcare organizations. At present, much of healthcare organizations are managed by business-minded individuals, as opposed to medically-trained personnel, leading to healthcare being run as a traditional service industry. The ability to realize that the healthcare industry is unique in its role to provide services is of utmost importance. Tailoring to the unique aspects of healthcare will allow for overall satisfaction, from patients to employees.

The healthcare system must not lose sight of its primary objective, providing world-class patient care to improve patient health and well-being in a safe manner. Tailoring patient care and amenities to provide positive patient experiences should also be considered important, but should not overshadow the importance of improving health outcomes. Unfortunately, patients who provide high patient satisfaction scores experience higher mortality.

Limitations of the Research

The research included in this paper is not without limitations. Patient satisfaction is highly subjective and is easily influenced. There are many confounding variables when discussing patient satisfaction, therefore increasing the complexity of research studies. A majority of the research involves patient surveys and questionnaires, which reflects the patient's personal views which are then applied to a generalized population. Human nature allows for patients to have a natural tendency to begin an experience with a predetermined expectation of how satisfying their encounter will be. Also, patient satisfaction surveys are conducted after each patient encounter, with a majority of visits being those patients with chronic medical conditions that are in poor health and often do not have good outcomes. The majority of the research studies referenced in this paper pertain to healthcare in the United States of America. It would be inappropriate to generalize these findings to healthcare around the world, as healthcare systems vary from country to country. Healthcare is changing on a daily basis; therefore, some data can quickly become outdated, increasing the importance of the need for ongoing research in patient satisfaction.

Future Research

Future research should be aimed at the comparison between healthcare systems and traditional service organizations. Also, as healthcare reform continues to be a major political and economic topic, the current healthcare system will likely

change. As value-based purchasing is a relatively new concept, extensive research will be needed on what the true impact on patient satisfaction and overall health outcomes is going to be. With a person's health being the true determinant of satisfaction with life, anything that can potentially have a positive impact on a person's health should be investigated thoroughly.

Summary

In summary, patient satisfaction has overtaken the structure of the healthcare system. There has been a shift in the paradigm in healthcare from providing excellent medical care to now providing services and/or goods focused on improving the patient satisfaction. This model of healthcare has the potential to have a negative impact on the healthcare system as evidenced by decreased physician satisfaction and increased burnout. The nation is already facing a physician shortage, and the concern for the future is that taking the focus away from providing medical care in order to focus on making customers happy will lead to more physicians, nurses, and ancillary staff leaving the healthcare industry.

The role of patient satisfaction in the healthcare system is not straightforward. It is quite complex. With the implementation of the Affordable Care Act and value-based purchasing, the structure of healthcare is in for a change. We are seeing the financial impact of patient satisfaction on healthcare organizations, which is driving the business of medicine to change as financial stability is a strong motivator of business. With patients being considered as consumers, healthcare is seeing a trend towards increased competition, and therefore we are seeing increased expenses for marketing and advertising while healthcare organizations are seeking a competitive advantage. Healthcare reform is a quite popular and complicated topic that is under the control of governmental agencies, nearly all of which are headed by non-medical personnel. This is likely contributing to a shift in medicine towards a business model focused on improving patient satisfaction. As healthcare reform evolves, there are likely to be significant changes to the healthcare experience.



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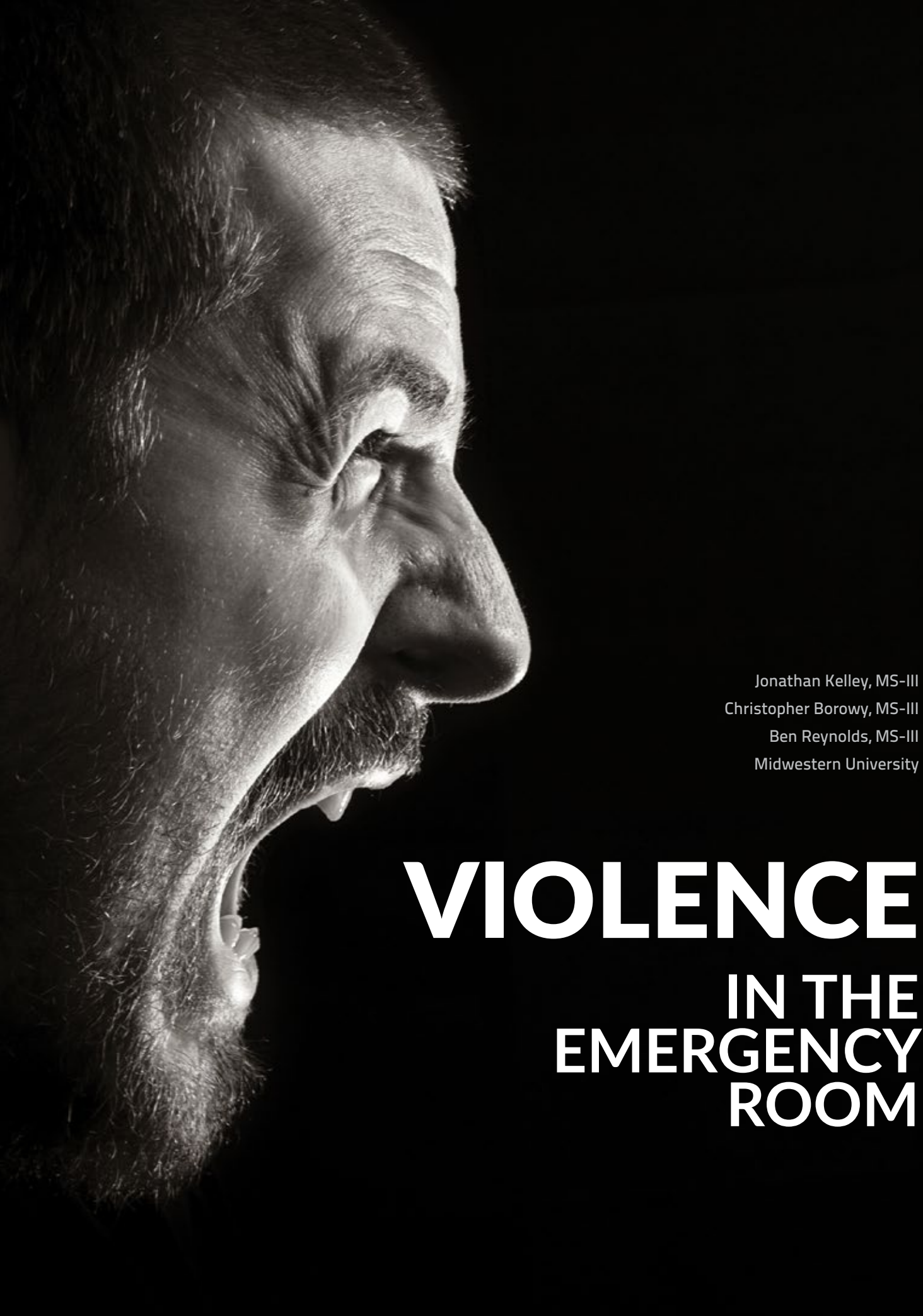
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Jonathan Kelley, MS-III
Christopher Borowy, MS-III
Ben Reynolds, MS-III
Midwestern University

VIOLENCE IN THE EMERGENCY ROOM

A 45-year-old man is brought to the emergency department (ED) by EMS with a head laceration after being found yelling in the street, threatening pedestrians, and destroying public property. Upon examination, you smell alcohol on his breath. Before your ED staff is able to get an IV in, the patient starts screaming and flailing his arms and legs, knocking one of your nurses to the ground. The nurse gets back up, says "I'm fine," and the team carries on treating the patient.

Sound familiar? I'm sure many of you reading this can relate, having personally experienced similar or worse incidents. In fact, most ED staff, in fact, wouldn't even think twice in this scenario before continuing on with their shift. Except, once you slow down and consider it, the nurse in this situation was just assaulted! In the real world it's likely that no one would even follow up and report such an incident. Some would probably say "It's just part of the job." But, should it be?

Why are ED staff so frequently exposed to violent patients?

It is no secret the ED can be stressful for patients. Long waits, crowded waiting rooms, and people who feel sick or scared are a recipe for increased emotions and agitation. Additionally, the ED is often on the front line of drug and alcohol abuse, which is an obvious contributor to violent behavior.

How common is violence in the ED?

The answer to that question is somewhat complicated, as violence comes in many different forms—physical assaults, verbal threats, confrontations, and even stalking. What we do know is that 46% of nurses reported some type of violence during their five most recent shifts. Even more alarming, one-third of that group reported that they had been physically assaulted⁽¹⁾. Another report claimed that 3 out of 4 emergency room physicians have had a violent encounter within a year,

SEVENTY-ONE PERCENT OF RESIDENTS REPORTED THAT THEY HAD NOT RECEIVED ANY TYPE OF TRAINING TO DEAL WITH VIOLENT PATIENTS.

and 1 out of 4 had more than one⁽²⁾. These are staggering numbers and should raise major concerns with health care providers, especially those working in emergency medicine.

What are we doing to mitigate violence in the ED?

Not enough! Seventy-one percent of residents reported that they had not received any type of training to deal with violent patients⁽¹⁾. Thankfully, there are residency programs that are beginning to recognize this as a serious problem and training their residents accordingly. One example is an Arizona-based emergency medicine residency program that has incorporated a training program called EVE (Escaping Violent Encounters) into their intern year.

Do physicians need self-defense training?

With the recent trend of increasing violent confrontations, it's hard to argue that basic self-defense training would be a bad idea. Physicians, at the very least, should have a baseline understanding about how to recognize a violent situation when it is approaching, how to defuse confrontations with potentially violent individuals, and how to employ fundamental self-defense and restraint maneuvers as a last resort. No, we don't want to encourage ED physicians to behave as if they've just stepped into the MMA octagon, but we do want them to have the knowledge and training they need to protect themselves and their coworkers as much as possible.

What can you do to help prevent workplace violence in the ED?

Raise awareness to all hospital staff, including administration, of the rising number of violent incidents in your workplace. Have open discussions, discourage passive dismissal of violent situations that occur where you work, and when time is available, follow up and report them. Educate patients and include them in prevention of future violence, because a violent patient can be a danger to everyone inside and outside of the hospital.

Q&A:

ACOEP's New Resident Student Organization

Lindsey Roden, ACOEP Staff
Gabriela Crowley, ACOEP Staff



With the recent merging of ACOEP's Resident and Student Chapters into the Resident Student Organization or RSO, comes many new and exciting changes! Below, ACOEP-RSO President Kaitlin Bowers, DO, and ACOEP-RSO Director of Student Affairs, Dominic Williams, OMS-IV, share what students and residents should look forward to with the Organization's new journey.

As an ACOEP-RSO member, what do you find to be the most rewarding?

Dominic Williams, OMS IV: I think that as a student, the conferences and regional symposiums are incredibly rewarding. Not only is the programming an exceptional value financially, but the lectures tend to cover the exact issues students face as they work through the intricacies of the residency application process.

Kaitlin Bowers, PGY2: Being a smaller, tight-knit group allows for more one-on-one opportunities. I really enjoy that the RSO not only offers resident-specific activities, but also allows residents the opportunity to attend the main College lectures and the New Physicians in Practice Track. Between the lectures, research competitions, hands-on labs, committee meetings, and networking experiences there really is something for everyone!

What influenced you to join ACOEP's RSO?

D: I was looking for guidance. At the time, my school had no emergency medicine faculty, and I knew I was going to need some help. I was pretty certain that I was headed towards a career in emergency medicine, but I had no idea how to actually achieve that goal.

K: The people! I had gone to a couple of conferences and symposiums as a first-year medical student, and while I enjoyed all of them and learned a lot, none of them were quite like the feeling I got at ACOEP. As cheesy as it sounds, everyone really did seem like one big family.

How long have you been a member of the Organization?

K: Since the last time we were in Denver! In fall of 2012, I ran for a position on the student board at the time and have been involved ever since.

D: Since Spring 2015—just before my first conference in Ft. Lauderdale.

Throughout the years, what has influenced you to remain a member?

D: The ACOEP has been my home for much of my EM education. I have been fortunate to attend multiple conferences and events, and make connections and friendships that I'm sure will last a lifetime.

K: I would agree with Dominic. I haven't missed a conference in five years. ACOEP is a second family to me, and they have helped me get to where I am in my career today. The mentors and friends I have gained are invaluable.

What's something you can share that many may not know about ACOEP's RSO membership?

D: The new website has a ton of resources you may not even realize



exist! From podcast recommendations to advising resources, procedure videos to mobile app recommendations, the page is a great place to start for your EM materials. Membership for students is absolutely free and doesn't require AOA or AMA membership—just sign-up and get informed.

K: In addition, I would encourage residents to take advantage of the conference events we provide. Each year at Scientific Assembly, we have a Rapid Fire Madness lecture competition, Airway Shootout Competition, and multiple FOEM Research Competitions. A lot of these events are underutilized by residents and can provide great opportunities to present at the national level. Whether you are just trying to fulfill your research requirements for graduation or want to pursue a career in academics these are great events to be involved in. Outside of conferences, our publication *The Fast Track* has moved to a digital platform, this serves as a great opportunity to get published and put your name out in the FOAMed world.

What benefits would you say you utilize the most?

D: I'd say there are two types of

benefits with an ACOEP membership. The first is all of the practical wisdom provided in the official materials and scheduling. The second aspect is the copious number of connections and relationships that attending conferences and getting involved can provide. There aren't many places where this many emergency medicine physicians are so accessible at one time.

What opportunities and/or perks does ACOEP-RSO give to you that other organizations do not?

D: I feel that ACOEP is large enough to make a massive impact on the lives of students and residents, but intimate enough to create a friendly atmosphere. I have made so many friends over the course of my time as a member of ACOEP just by the virtue of standing next to somebody and striking up a conversation. It's that type of family.

K: I agree with Dominic, the relaxed family-like feel makes the attendings and college leaders much more approachable. In addition to networking, the smaller size allows for more hands-on labs with the opportunity for one-on-one time with cutting edge technology. It is also



very easy to get involved, whether it be giving a presentation, attending a committee meeting, running for an elected position or writing an article in *The Fast Track*.

How has your membership with ACOEP RSO benefited your professional career development?

K: I have been a member of the ACOEP since I was a second-year medical student. As a student, ACOEP gave me the education and resources I needed to ensure emergency medicine was the right career for me. The networking at conferences allowed me to meet residents from all over the country who helped me navigate the audition and match process. If it weren't for the great mentors I met along the way, I am certain I wouldn't have been lucky enough to join the residency program I did. After all of these years, my mentors have turned into co-residents, colleagues, and more importantly, some of my best friends.

As a resident, the RSO has given me the opportunity to give back to medical students through their mentoring process. I have also been fortunate enough to serve in various leadership



positions representing the resident voice on issues in emergency medicine. The experiences I have had over the past five years have been invaluable. I highly recommend looking in to all of the leadership opportunities the ACOEP has to offer!

What is one reason you would recommend a colleague to join ACOEP's RSO?

D: I believe ACOEP offers vital resources and opportunities to every medical student interested in emergency medicine. I want to share those with as many students as possible, there's a lot of room for us all to succeed.

K: ACOEP is all about supporting each and every resident along their journey to becoming a great emergency physician. I would encourage residents to sign up for a conference and come see for yourself what we are all about!

How would you describe the College's responsiveness to your professional needs?

D: Having sat on the Board over the past year, I have witnessed firsthand the willingness of leadership to invest time, money, and resources in us as students and residents. They truly see us as the future of the College and will do whatever is necessary to protect our ability to be at

the forefront of the profession.

What are your hopes for the future of ACOEP's RSO?

D: I feel that we are on an excellent trajectory as an organization. The RSO is continuing to synthesize available resources and to fill in the gaps of current information to provide the complete story with regards to a successful match into an emergency medicine residency and steps towards a long and successful career.

K: I agree that we have made great strides over the past couple of years. Having a more cohesive Resident Student Organization is going to make it even easier to provide quality educational opportunities for our membership. As far as the future, I would like to see *The Fast Track* blog gain popularity in the FOAMed world. I also hope that with the merger we are able to introduce allopathic residents to the ACOEP family!

Are there any major changes with the new RSO that residents and students should know about?

D: Yes, with the AOA and ACGME merger the RSO is opening its doors to both allopathic and osteopathic students. Moreover, any EM club with 20 ACOEP members that meets

the criteria for initial recognition will have a voting seat in the Congress of Residents and Students at the RSO National Membership Meeting each year at Scientific Assembly. If you don't have 19 friends to drag with you to your first ACOEP-RSO event (not that they all need to attend) then don't worry, we are sure you will find a warm welcome even if you show up alone!

K: From the resident side, we too will be opening our doors to allopathic residents. Any residency program with 1/2 of their residents as ACOEP members will be given a voting seat in the Congress of Residents and Students. We also ask that a Residency Representative be appointed from these programs to serve as a liaison between the program and RSO throughout the year. Additionally, we will no longer be having resident-specific events at Spring Seminar. Instead, residents are encouraged to attend main college lectures and participate in the FOEM Research Competitions. Other exciting changes to be on the lookout for include: our new digital platform of *The Fast Track*, big name speakers each year at Scientific Assembly, and a more robust career fair!

AN ODE TO OSLER: A Physician Profile

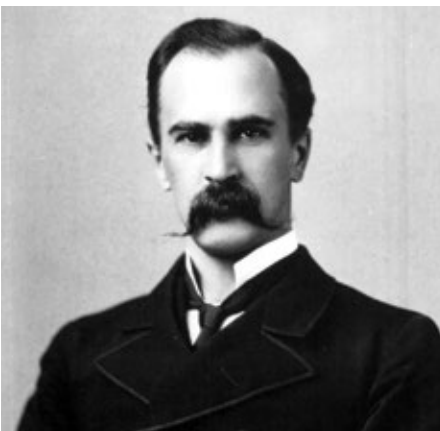
Dominic Williams,
OMS-IV LECOM - Bradenton

"MEDICINE IS A SCIENCE OF UNCERTAINTY AND AN ART OF PROBABILITY."

Have you ever wondered why, as a third-year medical student, you're cast out into the hospital to fend for yourself among patients? Have you ever stopped to think about which creative genius came up with the idea of years of torture post medical school? Ever wondered about the man behind the painful nodes of endocarditis? Well, wonder no more. In this brief article, we will take a whirlwind tour through the life of one of the physicians credited with birthing modern medicine from the classroom to the clinic—Sir William Osler.

William Osler, fondly referred to as "Willie," was born on the 12th of July in 1849, about 40 miles north of Toronto in a frontier village called Bond Head. As one of nine children born to a reverend and his wife, his childhood was split between traveling with his father and tending the small farm attached to the parsonage. As Reverend Osler's career progressed, the family moved to a larger parish in Dundas when William Osler was a mere eight years old.

Allegedly, as quite a mischievous young man, Osler decided to enter the theological field after taking his antics too far and deciding he must atone for his wrongdoing. Thankfully for the field of modern medicine, at Trinity College School in 1866, Reverend William Arthur Johnson set young Osler's life on a trajectory quite different from the one he'd planned. Through Reverend Johnson's introduction to the field of science, Osler awoke to the joy of understanding how things worked, and was no longer stuck in the monotony of translating classic texts from their original Greek and Latin. This newfound interest drove him to make the transition from "the study of nature to the study of man" and ended up working with a new mentor Dr. James Bovell, a faculty member at the Toronto School of Medicine. Osler transferred schools to complete his medical training at McGill University Faculty of Medicine in Montreal where he graduated as both an MD and CM—a medical doctor and a master of surgery. At this point, Osler sought clinical experience at that time not available in North America. So off he went to England and Germany where he worked with names such as John Burdon Sanderson, and perhaps the more well-known, Rudolf Virchow (of triad fame). Returning to Montreal in 1874 Osler swiftly took on the title of professor and became an active member in the scientific community. At this time, Osler became interested in the reformation of medical education. And after being inspired by his time in Europe and his visits



Source: Courtesy of Wikimedia Commons

"Listen to your patient, he is telling you the diagnosis."

"Observe, record, tabulate, communicate. Use your five senses. Learn to see, learn to hear, learn to feel, learn to smell, and know that by practice alone you can become expert."

The above quotes are a couple favorites among clinical faculty everywhere. Osler believed that the vast majority of diagnoses could come from a thorough history and physical. Although I stand by his statement, I feel that in this era of medicine even Osler would recognize that the armory of tests we have available far exceeds his arsenal at that time. This quote should still be an encouragement to us all to actively listen to the nuances of a patient's history. Our testing should be to confirm and support, not simply because we "don't know."

“While medicine is to be your vocation, or calling, see to it that you have also an avocation—some intellectual pastime which may serve to keep you in touch with the world of art, of science, or of letters.”

It is impressive to me that nearly a century before all our wellness seminars and life/work balance advice that Dr. Osler recognized the importance of preventing losing touch with the rest of life for the sake of medicine.

“The good physician treats the disease; the great physician treats the patient who has the disease.”

Here, Osler shows his genial personality in his approach to treating patients. This theory seems positively Osteopathic in its foundation and I can’t think of a better physician to share a philosophy with.

“There is no disease more conducive to clinical humility than aneurysm of the aorta.”

This quote resonates with us all I’m sure. Despite the advances of modern medicine, some conditions remain heart-wrenchingly lethal.

to the United States, Osler introduced new classes at the medical school, altered the format of exams, and campaigned to promote greater clinical experience for students.

Osler’s full-time American adventure began in Pennsylvania, enticed by the clinical opportunities he could provide to his students there. He was famed for his fascinating autopsies and sharing the joy of learning with his students. He also became a regular public speaker in the medical profession and questioned the current medical school curriculum and the discrimination of women in medicine. Perhaps Osler’s more famous appointment came in 1889 when he became Physician in Chief of a medical school that even the average layperson recognizes—Johns Hopkins Hospital in Baltimore. In this position, he was given the freedom to structure his own course curriculum which he based on his time in Europe. Third-year students began in outpatient clinics and fourth-years were sent into the hospital under the supervision of the residents. Osler would also round on patients and gained a reputation for both his intricate exploration of each presentation and his superb rapport with patients and students. During this time Osler married Grace Revere Gross, the widow of a famous surgeon, and published his seminal work *The Principles and Practice of Medicine*, a conglomerate of his clinical experience and the most up-to-date information he could gather in the newer fields of medicine such as microbiology. A huge success, the book was a popular work for many years after printing.

In his mid-50s Osler’s commitments were beginning to overwhelm him and he accepted a job at Oxford University as the Regius Professor of Medicine. His family made the move to the United Kingdom and he swiftly settled into life there. Despite working clinically and

Continued on page 29

Osler embraced humor in all aspects of his work; he used the pseudonym Egerton Yorrick Davis to help publish his musings. Once he tricked the Philadelphia Medical News into publishing a report on penis captivus (one I’ll leave you to Google on your own time). He took on this alter-ego and used it to sign into conferences and hotels.

Osler’s literary works caught the eye of the Rockefeller family and resulted in their founding of the Rockefeller Institute of Medical Research.

Osler’s home in Oxford was known as the “Open Arms” due to all the visitors he and his wife would receive. This is a delightful play on words as many public houses in the UK are the _____ Arms, and his home was a constant hive of activity and hospitality.

Dr. Harvey Cushing, yes, that Cushing, wrote Osler’s biography “The Life of Sir William Osler” and published it in 1925.

LEAD FROM THE FRONT

Christina Powell, OMS-III
LECOM-Bradenton

In the past, a sentiment existed among some emergency physicians that arriving on time and covering the shift with 100% effort was sufficient for success. However, in the face of increasing competition in the field, changing insurance models, and expanding expectations, physicians are being called to a higher level of leadership, with a unique set of both clinical skill and professional management. Many emerging leaders start their careers in healthcare or transition to a new role in the department without the leadership skills to succeed. Developing and cultivating interpersonal skills needed to listen to and lead multiple strong personalities is no simple task. These skills are acquired over time by trial and error, or through personal mistakes that cost the department down the line. It is the aim of this article to focus on the leadership responsibilities involved with preserving psychological health in our emergency departments, leading to positive outcomes and an overall improved work environment. An engaged, proactive, solid physician leader creates a more resilient team focused on improving patient care.

In general, being a good leader boils down to trust and respect. To maintain trust with your staff, hospital administrators, and the IT guy down the hall, one must a) care, b) be optimistic, and c) continuously and actively develop the art of leadership. Below are some leadership behaviors that build trust.

CARE

Behavior #1: Know Your Staff

When you first meet a new staff member, what do you talk about? Expectations for your department? Do’s and Don’ts of the specific ED they are entering? Despite the time constraints you may face at that instance, resist the temptation to go directly to practical questions. Instead, let them tell you a little bit about themselves. Listen to their

story. What brought them here? What goals do they hope to achieve? Where do they see themselves in ten years? Details aren’t as important as themes. Some personal life details you may want to avoid completely; however, the main point is to demonstrate that the new member of your team is respected and valued as a person. Once these questions are asked, the key is to actually listen to the response. Write down significant facts if needed, to remind yourself of what that new relationship uncovered. Know your staff and the administrators. Build the relationship.

Behavior #2: Be Visible

When you are not concealed behind a computer screen completing charts, or interviewing a patient, it is important to spend quality time in the nurse station. If you are taking a

coffee break, or the patient volume is slow, arise from the blue light of the workstation and be visible to the staff. Devoting time is the ultimate expression of respect. Ask your staff how you can assist them—how can you inspire them, challenge them to grow, and mentor them as a health care provider? You may not be afforded the time to do this often, but this is a great way to find out what is really going on. A quick visit down the hall holds more value and gains more insight than hours of emails. Another benefit of maintaining visibility and transparency with your staff is decreasing intimidation in the workplace. If your staff is intimidated by you, they won't be honest with you. There is an increased risk of mishaps and cover-ups when staff members are intimidated by those they report to. It is important for your staff to trust you both during times of excellence and times of challenge.

Behavior #3: Show Dignity and Respect

A Harvard Business Review article in 2015 polled over 20,000 employees asking which leadership behavior was the most important for garnering commitment and engagement in the

“BEING TREATED WITH RESPECT WAS MORE IMPORTANT TO EMPLOYEES THAN RECOGNITION AND APPRECIATION, COMMUNICATING AN INSPIRING VISION, PROVIDING USEFUL FEEDBACK—OR EVEN OPPORTUNITIES FOR LEARNING, GROWTH, AND DEVELOPMENT.”

workplace. The #1 leadership behavior was to be treated with respect. “Being treated with respect was more important to employees than recognition and appreciation, communicating an inspiring vision, providing useful feedback—or even opportunities for learning, growth, and development.”¹ How often do we focus on maintaining respect in the department?

Ask yourself this question: how do I react to bad news? We dedicated countless hours training medical students and residents how to give bad news tactfully, but not as much training on how to respond to bad news within our emergency department. Do you react with anger? Judgement? Condescension? Emotional lability? Fear? The first goal, when bad news arises, is to resist the urge to shoot the messenger, as tempting as it may be to use anger as your primary leadership tool. Responding inappropriately devalues the relationship you’ve been building with your staff by decreasing trust and increasing intimidation. Give each staff member respect despite the circumstances. When bad news is brought to your attention, show neither shock nor anger—or the bad news will stop coming, and you’ll find out the hard

way. The culture you create is dictated by your behavior as a leader. Build dignity and respect into your department.

Behavior #4: Don’t Ignore Good or Poor Performance

Always set expectations. Expectations for medical students. Expectations for residents. Expectations for nursing staff. Expectations for the attendings. Defining “what is excellence” is key to helping your team achieve it. If they meet the standard for excellence, tell them! Especially praise their performance in front of others. This will not only reinforce their admirable performance, but also encourage others to seek a higher level of achievement. Set a department culture of improvement and affirmation. Taking time to say “thank you,” both verbally and in notes or by sharing positive patient reviews are excellent ways to show appreciation. If there is poor performance, do not ignore it! Seek first to understand. “Can you help me understand why you are making these mistakes?” Where do you think the problem lies? Is it a lack of training? A lack of sleep? Maybe a simple solution exists.

Carefully assess and take action. The goal, as always, is to maintain respect in the workplace.

OPTIMISM

Colin Powell described the importance of enthusiasm and optimism, and how this can be an emotional contagion with his phrase: “perpetual optimism is a force multiplier.” Powell circulated lessons on how to demonstrate leadership, and how optimism will drive your followers (or in our case, staff and peers) to share the positive attitude. Optimism is not a prediction of success or some view of an unknown reality to attain—rather it is how you forge forward in the face of difficulty, maintaining the belief in your purpose and goal. Alternatively, a pessimistic leader can cause as much harm as an absent leader. If we mope around the ED, complaining about the slow triage tracker, or how no one informed the doc that there was a hard stick in bed⁵ and it has been 30 minutes since the blood cultures were ordered, the tone of the department declines overall. Fear is also the ugly sister to pessimism. Fear can easily paralyze us as students, residents, and physicians. Fear can prevent clear and rational analysis

“OPTIMISM IS NOT A PREDICTION OF SUCCESS OR SOME VIEW OF AN UNKNOWN REALITY TO ATTAIN—RATHER IT IS HOW YOU FORGE FORWARD IN THE FACE OF DIFFICULTY, MAINTAINING THE BELIEF IN YOUR PURPOSE AND GOAL.”

of the conundrum in front of us. If we do not learn to control and prevent fear, we cannot effectively lead others to do the same.

Maintaining an optimistic attitude can become difficult depending on the situation at hand, but the downstream effects of one attitude adjustment can exponentially change the emotional effect of those surrounding the situation. Optimism and pessimism can easily produce the same outcome. As Yvon Chouinard stated: “There’s no difference between a pessimist who says, “Oh, it’s hopeless, so don’t bother doing anything,” and an optimist who says, “Don’t bother doing anything, it’s going to turn out fine anyway.” Either way, nothing happens.” If you have read the book *Good to Great* by Jim Collins, you may have come across the idea called the Stockdale Paradox. The Stockdale Paradox is named after Admiral Jim Stockdale, who was held as a prisoner of war in Vietnam for eight years. He interestingly commented on how it was the most optimistic of captives that failed to make it out of the situation alive—they held such blind optimism that when their timetable for freedom came and left, they died of “a broken heart.” The Stockdale paradox demonstrates a specific type of optimism, one that can easily be applied to the emergency department, where the outcomes are not always as desired and self-delusion is fatal. Optimism in this sense is 1) maintaining strength that you will prevail in the end, regardless of the difficulties, while also 2) confronting the nature of your current reality with brutal honesty. The first half of the Paradox is easy; it is the second half that we must apply in our practice of medicine: combining optimism with admitting the truth of the current situation and a willingness to act. Admiral Stockdale knew his situation was grave, but instead of succumbing to defeat,

he stepped up and did all that he could to improve the morale and prolong the lives of his fellow comrades.

CONTINUED LEARNING

In medicine, we are lifelong learners. While we spend hours on pre-clinical or clinical medical education and CME credits, we do not dedicate as much time to process of professional development and the art of leadership. I would challenge each of you to add a book or podcast to your yearly list to cultivate personal and professional development as a leader.

The leadership behaviors presented here can be applied to any area of life. The principles may seem simple, but they are easily forgotten during times of severe stress and limited resources. Do not ignore their value and I implore you to remind yourself of them daily. Your emergency department will benefit from continuously cultivating the art of leadership. Regardless of which stage of the journey you reside in, as a medical student, a resident, or an established physician, professional and personal development should never cease. As health care providers, we must always rise to new challenges, not only as they relate to clinical knowledge or expertise, but as they relate to individuals working together towards a common goal. Be reminded to always lead from the front. Be the first person to make a change in the culture of the department, and see the productivity and overall outlook transform.

Portions of this article were inspired by Ret. USN CAPT Mark Brouker of Brouker Leadership Solutions and Assistant Professor of Leadership Studies at Chapman University. Visit CAPT Brouker’s website at www.Brokerleadersolutions.com.

SUGGESTED BOOKS

Good to Great
Jim Collins

Touch Points
Douglas R. Conant and Mette Norgaard

Mastering Civility: A Manifesto for the Workplace
Christine Porath

First, Break All the Rules
Marcus Buckingham

The Art of Medical Leadership
Suzan Oran and Scott Conard

7 Habits of Highly Effective People
Stephen R. Covey

Primal leadership
Daniel Goleman

The Leadership Secrets of Colin Powell
Oren Harari

Fatigue and Poor Appetite IN AN ELDERLY FEMALE

Dhimitri Nikolla, DO
AHN Saint Vincent Hospital, Erie, PA

CASE

An 86-year-old female with a past medical history of chronic congestive heart failure with a dual-chamber pacemaker, hypertension, severe mitral regurgitation, and dementia was sent to the emergency department (ED) by family via ambulance with reports of confusion, hallucinations, and poor appetite for one week. The patient was a poor historian and family was not present initially to provide further history. On examination, her vital signs were normal. She was alert but confused without a focal motor or sensory deficit. She had a systolic ejection murmur with some bibasilar crackles, but no peripheral edema. Her electrocardiogram (ECG), as well as previous, is displayed in Figure 1.

Her initial troponin in the ED was 6.20 ng/ml. She was given aspirin, nitroglycerin, and heparin in the ED. Just prior to admission her family arrived and confirmed the history from EMS as well as described marked weakness in that the patient was having more difficulty ambulating. They denied the patient experiencing any chest pain or shortness of breath.

DISCUSSION

Patients often present to the ED with nonspecific symptoms making a focused evaluation nearly impossible. Since the classic description of cardiac chest pain is not sensitive nor predictive of acute myocardial infarction (AMI)⁽¹⁾, most adult patients presenting to the ED with any chest pain will likely

be evaluated for AMI. Unfortunately, many patients may not even experience chest pain at all in the setting of AMI, particularly women and the elderly. Women with AMI are more likely than men to present without chest pain and carry a higher mortality⁽²⁻³⁾. Similarly, elderly patients can present with a variety of symptoms; one study of elderly patients with STEMI found chief complaints of presyncope or fall 15.7% of the time, gastrointestinal symptoms 9.8%, impaired condition 6.7%, and delirium 5.0%⁽⁴⁾. Emergency providers should have a high suspicion for AMI in women and the elderly despite a lack of chest pain.

Similarly, an underlying paced rhythm can make interpretation of the ECG difficult. *The rule of appropriate discordance* describes the expected discordance of the ST segment one would expect to see in a bundle branch block or paced rhythm⁽⁵⁾. There is no definitive rule or method to differentiate between ST segment changes from an underlying paced rhythm and possible AMI. However, the following ST changes are highly suspicious for AMI⁽⁶⁾:

- $\geq 5\text{mm}$ of ST segment elevation in leads with a generally negative deflection (*Excessive Discordance*).
- $\geq 1\text{mm}$ of ST segment elevation in a lead with a generally positive deflection (*Concordance*).
- $\geq 1\text{mm}$ of ST segment depression in a leads V1-V3 or leads with a generally negative deflection (*Concordance*).

What is concordance vs discordance on an electrocardiogram?

- *Concordance*: $\geq 1\text{mm}$ of ST segment elevation or depression in the **same** direction of the general deflection of the QRS.
- *Discordance*: $\geq 1\text{mm}$ of ST segment elevation or depression in the **opposite** direction of the general deflection of the QRS.

CASE CONCLUSION

The patient was admitted to the intensive care unit. Due to her multiple comorbidities, medical therapy alone was recommended by the cardiology team. She had an echocardiogram that revealed an ejection fraction of $<30\%$ with diffuse hypokinesis. Although, clinically, she did not appear to be in heart failure. Her subsequent troponin levels gradually declined. She was continued on heparin for three days and was discharged to a rehabilitation facility seven days later with prescriptions to continue her aspirin, carvedilol, and atorvastatin.

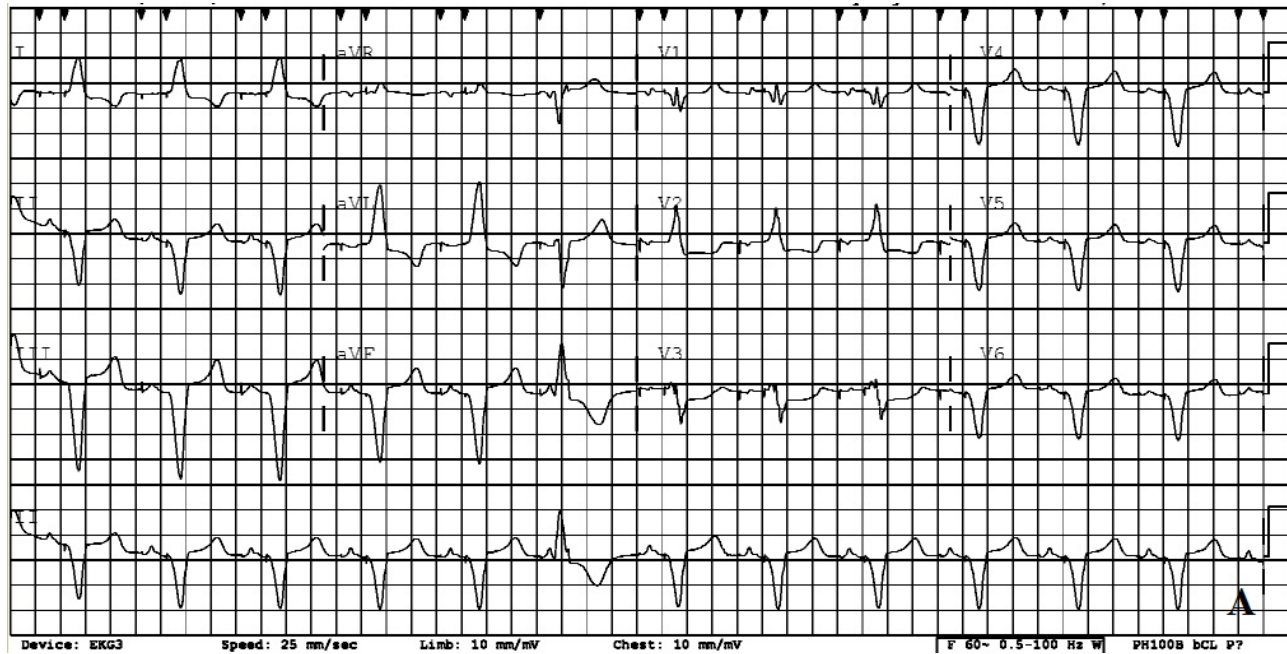
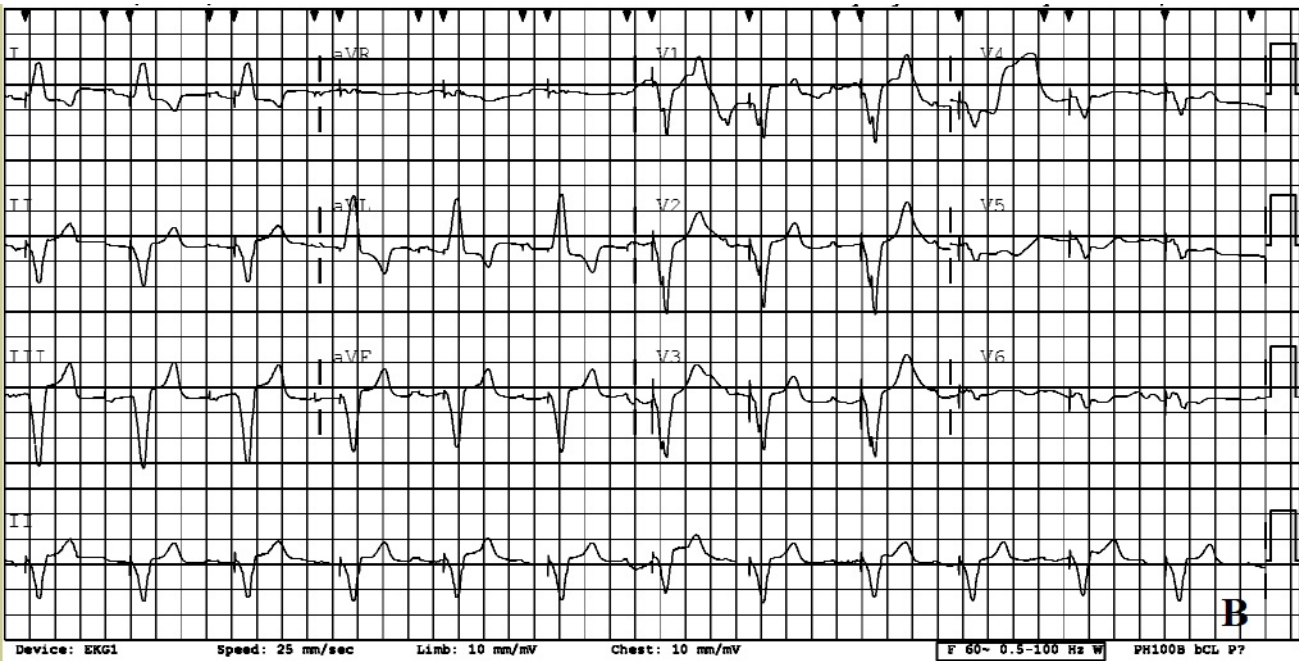


Figure 1 displays the patient's electrocardiogram (A) at presentation to the emergency department with a paced rhythm at 75bpm in a right bundle branch block pattern with a PVC and appropriately discordant ST segments except for lead V3 where there is new concordant ST segment depression compared to the previous electrocardiogram (B).



WHAT'S NEW IN EMERGENCY MEDICINE?

Aadil Vora, OMS-IV
NSUCOM

The Pediatric Sedation State Scale to assess pediatric procedural sedation (July 2017)

Scales that seek to describe the level of sedation achieved during procedural sedation focus largely on physiologic depth, primarily airway and cardiovascular impairment. But a new tool called the Pediatric Sedation State Scale (PSSS) seeks to incorporate patient behavior along with physiologic parameters. The PSSS is a simple scale that monitors pain, anxiety, movement, and adverse side effects of sedation on a scale from zero to five where zero is over-sedation requiring an acute intervention (ie. BVM ventilations) and five is under-sedation with movement impeding the procedure (ie. requires forceful immobilization). Researchers at Boston Children's Hospital created videos of children undergoing a laceration repair with sedation, and had 20 providers from various specialties grade the stages of sedation they saw using the PSSS. The tool has demonstrated a 96% correlation to the Observational Scale of Behavioral Distress-revised scale, which was an arduous tool that was difficult to use in the clinical setting. Moreover, it is the first objective tool with strong inter and intra-observer reliability, healthcare providers such as Anesthesiologists and Emergency Medicine Physicians used the scale to grade videos of children undergoing various invasive procedures, and demonstrated a 99.4% consensus. Providers used the scale again six months later to assess more videos, and the interrater reliability was 98.6%. Since the PSSS includes the full extent of pediatric patient presentations from over to under-sedation, the scale can be used to evaluate various types of procedural sedation, including the non-pharmacologic such as distraction and verbal persuasion. The authors further suggest that this tool should be used in the pediatric EM community to develop new methods of pediatric procedural sedation that can be described by the objectivity of the PSSS.

Cravero JP, Askins N, Sriswasdi P, et al. Validation of the Pediatric Sedation State Scale. *Pediatrics*. 2017 May;139(5). pii: e20162897.

Antibiotic therapy for skin abscess (July 2017)

An antibiotic course in conjunction with incision and drainage is recommended for treating an abscess with surrounding cellulitis, systemic signs of toxicity, risk factors for MRSA, or size over 2cm. The perception that cure rates of skin abscesses requiring incision and drainage do not improve with antibiotics was propagated by smaller trials and expert opinion, but has been challenged by larger trials such as Talan et al and a new large multicenter trial investigating the 7-10 day clinical outcome of an abscesses less than 5cm in size treated with incision and drainage and either Clindamycin, TMP-SMX, or placebo. Cure rates were 82% and 83% respectively for clindamycin and TMP-SMX as compared to 69% for placebo. Secondary analysis showed that Clindamycin was particularly more effective in treating abscesses among children. Clindamycin had a lower abscess recurrence rate at the 1 month visit than TMP-SMX, 6.8% vs 13.5% respectively. However, Clindamycin had a higher rate of side effects, with diarrhea being the most common complaint. Interestingly, none of the cases were associated with *C. difficile*.

Daum RS, Miller LG, Immergluck L, et al. A Placebo-Controlled Trial of Antibiotics for Smaller Skin Abscesses. *N Engl J Med*. 2017;376(26):2545

Talan DA, Mower WR, Krishnadasan A, et al. Trimethoprim-sulfamethoxazole versus placebo for uncomplicated skin abscess. *N Engl J Med* 2016;374:823-832

ACC/AHA/HRS guideline for the evaluation and management of syncope (July 2017)

The American College of Cardiology, American Heart Association, and the Heart Rhythm Association, have published new syncope guidelines. Major points from the new guidelines include an emphasis on the initial evaluation, which includes a detailed history and physical examination along with an ECG. The history should focus on the frequency and duration

of episodes, onset, position of the patient, provocative factors, associated symptoms preceding and following the syncopal event, witnessed signs, preexisting medical conditions, and family history of early cardiac death and disease or seizure disorders. The physical exam should focus on vital signs, cardiovascular, and neurologic systems. Routine and comprehensive laboratory evaluation is not useful in the evaluation of syncope, as well as neurologic imaging, and electroencephalography in routine evaluation of the syncopal patient without focal neurologic deficits. Prevalence of syncope is reported to be as high as 41%, with vasovagal syncope as the most common type. Reasonable treatment includes beta blockers and ICDs for adult patients with long QT syndrome and suspected arrhythmic syncope. In patients with moderate or severe atherosclerotic coronary heart disease and unexplained syncope, it is reasonable to conduct electrophysiological studies. Additionally, syncopal patients with neurodegenerative disease may benefit from autonomic evaluation.

Shen WK, Sheldon RS, Benditt DG, et al. 2017 ACC/AHA/HRS Guideline for the Evaluation and Management of Patients With Syncope: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines, and the Heart Rhythm Society. *J Am Coll Cardiol*. 2017 Aug 1;70(5):e39-e110.

Continued from page 22

academically, Osler also found time to build his literary collection and further explore medical history. In 1911, thanks to King George V, and due to his outstanding contributions to medicine, Dr. William Osler became Sir William Osler. As with many other retirees, the First World War brought many physicians out of retirement and into the forefront of their field again. As a Canadian by birth he helped organize many of the foreign military hospitals in the Oxford region, and opened his home to the vast number of displaced individuals that suffered as a result of the war. The war brought great tragedy to Sir William and his wife Lady Grace. Their only son to survive into adulthood (one was torn from them soon after birth) was killed in the fighting in Ypres, Belgium, the summer of 1917.

Osler battled respiratory issues, quite possibly undiagnosed bronchiectasis, much of his adult life. A short time after turning 70, Sir William Osler suffered from pneumonia, likely a complication of the Spanish influenza. He died in late December of 1919. Osler himself referred to pneumonia as "the old man's friend," in his writings and was controversially known to have joked about the swift downhill slide of the aging man. In death, as in life it seems, Osler embraced the science that he had founded his career upon.

"Too many men slip early out of the habit of studious reading, and yet that is essential."

"By far the most dangerous foe we have to fight is apathy—indifference from whatever cause, not from a lack of knowledge, but from carelessness, from absorption in other pursuits, from a contempt bred of self-satisfaction."

"No human being is constituted to know the truth, the whole truth and nothing but the truth; and even the best of men must be content with fragments, with partial glimpses, never the full fruition."

Osler's attitude to education and lifelong learning is one that I trust inspires us all. In our field, burgeoning with new and exciting information in more creative formats than ever before, we can continue to peak our own curiosity and better our patient care.

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