

Friday Night (under the) Lights...

2022

Happy Friday...

Happy Friday...

Happy Friday. There! Sorry – I was on mute ... (“on Mute” – Get it??? OK – give me a break – a little residual Covid humor in print form...)

So, it’s been a while. A long while.

Seems like a million years ago that I sat down to say hello on a Friday. I miss doing these. It’s always been a good way for me to reflect on the week, pass along interesting info, highlight stellar people and cool events and selfishly – *connect*. Plus, I get to go look for the best humor “epilogue” of the week.

I hope tonight finds you, and all the people you care about, healthy, happy & sane.... (I initially typed “rested” but realized I’d probably lose half of you on that one).

Here comes Captain Obvious. There’s certainly no question that we’ve all been navigating some rough waters in our profession over the past couple of years. It’s been *really* hard. Frankly, it’s *still* pretty tough. It’s not the same challenges today as we had almost 30 months ago, but there are clearly some new stressors in all of our personal and professional lives.

Personally, I don’t think I’ve experienced this much change in medicine in my entire career. It’s not just managing that pesky new infection, it’s how to take care of people when all the “norms” have changed.

Disruptive changes just like having to snap a pic of the QR code at a restaurant to get a menu.

Or experiencing longer waits for just about everything because staffing has been such a challenge for everyone. And even though you wait longer, you pay more. Regardless of what it is.

Or it may be trying to navigate the everchanging Covid guidelines for masking, testing and vaccines. Or wondering if you should be worried about Monkeypox. Or Polio.

Or experiencing new (sometimes intense) feelings about each other based on whether we have a mask on, who we voted for, what we believe in, how we look or who we associate with...

Or something totally bizarre – like a Russian war...



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I could go on and on, but I think this sums it up better.

Some days it feels like it's just another...



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Seriously – I personally think a lot about all the changes and I think about how different things are right now – In medicine, in EMS, in *life* all the way around... No lie – it's unsettling.

So, I want to share something with you that a friend of mine passed along. It gave me some much needed perspective.

I'm sure you're familiar with the landmark work of Dr. Elizabeth Kubler-Ross on the stages of death and dying.

Essentially, she and her colleagues described what they believe are the critical stages of dealing with something significant – in this case death & dying (I know you're probably asking yourself whether you want to read any further, but bear with me...).

The Five Stages they describe (not necessarily experienced in order) are:

- Denial
- Anger
- Bargaining
- Depression
- Acceptance

They found that individuals would pass through these various stages when faced with not only death & dying, but anything significant that substantially disrupted their lives.

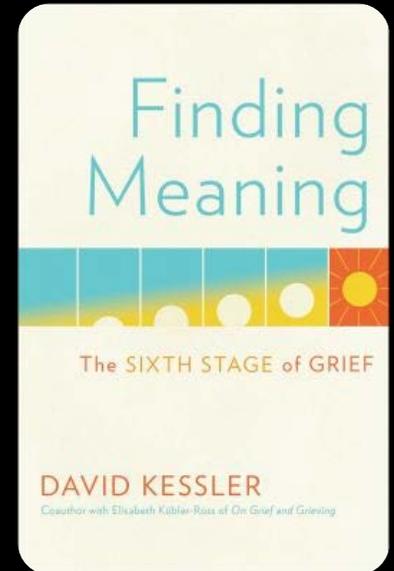
Of note, in the original papers, the "final" stage was always believed to be "Acceptance". Sort of the behavioral equivalent of "it is what it is...".

Well, two years ago, David Kessler, part of the original work, published his findings on a new *SIXTH* stage of grief. In his book he describes the importance of not just acceptance (the old final stage), but a new end point.

Finding meaning. Meaning in whatever the disruptive, grief producing issue or circumstances had caused.

It makes sense that some of what I am (we are) feeling right now is this sense of grief that life is harder. Much of the stuff that seemed predictable, is all of a sudden not. Relationships are evolving. Our expectation of our profession is changing. Principles of medicine we held near and dear have evolved based on experience (look at the lower O₂ saturations we tolerated in the sick Covid patient).

And not to make it dramatically worse – But the price on Costco's Chicken Bake WENT UP BY \$1.00...



When we're faced with so much change and deviation from what was comfortable, it can sometimes create a sense of loss of purpose.

Enter Kessler's work on meaning.

In his book he says the brain can be like Teflon when it comes to positive memories. It can be like Velcro when it comes to the tough stuff. Makes some sense. It's one of the reasons we don't tend to touch a hot stove twice, we are more careful with our belongings if we get a backpack stolen and for some of you – You smell your milk or cheese before you eat or drink...

So, how do we find meaning in what we do today?

One of the most powerful approaches is to take a look back at things that were impactful before all this happened.

I'll take a stab on a few:

- We, as an organization, managed more Covid patients than any other single EMS Agency. Easy? No. Fun? No. Meaningful – Damn right.
- As I type, our colleagues in CrowdRx are taking care of almost 50,000 people in the desert outside Reno Nevada. Complete with Rampart (the treatment center) physicians, nurses, medics, communications staff, support staff, aircraft, and flight crews.
- We've developed a new "GMR Bridge" located in Lewisville, TX Integrated Communications Center to monitor evolving conditions (weather, wildfires, civil unrest, active shooters, etc) and escalate notification and resources to effectively "jump start" our responses.
- This past year, under the phenomenal leadership of the Office of Emergency Management Leadership Team, GMR was awarded (that word should really be "earned") a five year federal contract to manage all four US FEMA regions.
- This past year, our colleagues in AirMed developed and managed a flight for an ECMO patient from the US to Dubai (managing an ECMO patient in an ICU is hard enough. Add the challenges of moving them across the globe, all the math equations required to make sure the flight times / distances were appropriate – O₂ calculations... The team was successful in completing the longest ECMO patient flight on record.
- Our national GMR Therapy Dog program is now being used by our colleagues at ATT as part of their employee support (please feel free to write to ATT and let them know the GMR CMO doesn't have a dog yet 😞)
- All of the 2:38 in the morning successful resuscitations, delivering babies, managing MCIs, responding to Active Shooters and even the simplest transport that made someone who was scared feel safe and secure...

I could literally go on & on. It's who EMS is. It's who we are. We step in and create order out of other people's chaos.

We can do this for each other too.

What a gift it is to be able to help others get through their own Sierra² (if you're really good, you know exactly what that is...). I honestly believe now is the time for each of us, in our own way, with our own style, in our own words – To start communicating the importance of meaning.

- “Meaning” is different from me to you...

I know I’m running the risk of being all soft and squishy here (the Friday Night Hallmark Channel email)... Hear me out.

What’s important (has meaning) for me, may be different than what has meaning for you (please see Costco Chicken Bake concern above). When people with different skill sets and drive come together for a common purpose – the results are magical. We can rally around those things we make a difference in. Even though they may not be identical efforts...

For example, this Letter to the Editor in the New England Journal of Medicine that popped into my inbox today, doesn’t really float my particular boat (like how I made an analogy that could pertain to the article??). But the impact of a collaborative effort from people that DO want to make a difference in this problem is substantial...

Letters

RESEARCH LETTER

Trends in Urinary Catheter Use by Indication in US Emergency Departments, 2002-2019

In 2015, an estimated 62 700 catheter-associated urinary tract infections occurred in the US,¹ costing approximately \$864 million.² Emergency departments (EDs) are major sources of urinary catheters, with over 2.6 million placed in 2010,³ making them crucial targets in reducing health care-associated infections.

Supplemental content

For more than a decade, hospital-, state-, and national-level initiatives have aimed to standardize urinary catheter use, especially the 2009 Centers for Disease Control and Prevention (CDC) guidelines⁴ and the Choosing Wisely initiative in 2013.⁵ This study examined trends in urinary catheter use in US EDs between 2002 and 2019.

Methods | We analyzed the 2002-2019 National Hospital Ambulatory Medical Care Survey (NHAMCS), an annual survey of US hospital-based ED visits (eMethods in the Supplement). This analysis was exempted from review by the Mass General Brigham institutional review board.

The main outcome was urinary catheter use among ED patients with and without CDC indications (such as perineal wound, urinary retention, or other conditions potentially requiring urinary catheters),⁴ defined with ED visit diagnoses and

dispositions (eTable and eMethods in the Supplement).³ We calculated biannual rates (percentage of ED visits) of urinary catheter use, separating by catheters with and without CDC indications, among ED visits by adults and the subset of these ED visits leading to hospitalizations, including observation and inpatient admissions. Annual trends in ED visit rates were examined using least squares regression with inverse variance weights. All analyses used survey procedures in Stata version 15.0/MP, incorporating complex survey designs and weights. Significance was defined at $P < .01$ with 2-sided tests, as recommended by the National Center for Health Statistics.⁶

Results | Between 2002 and 2019, NHAMCS sampled 407 588 adult ED visits, from 59 016 (11 037 hospitalized; 2798 with CDC indication) in 2002-2003 to 30 726 (5696 hospitalized; 2636 with CDC indication) in 2018-2019. The 2002-2003 and 2018-2019 hospitalization rates remained similar, whereas ED visits with CDC indications, including those who did and did not receive a catheter, increased overall (5.0% to 9.0%; annual trend, 0.15% [95% CI, 0.08%-0.22%]; $P < .001$) and among hospitalized ED visits (16.1% to 33.2%; annual trend, 0.87% [95% CI, 0.66%-1.07%]; $P < .001$) (Table).

Among all ED visits, overall urinary catheter use decreased from 3.1% in 2002-2003 to 1.6% in 2018-2019 (annual trend, -0.12% [95% CI, -0.14% to -0.10%]; $P < .001$) (Figure; Table). In these periods, among all ED visits, catheter use without CDC indications decreased from 2.1% to 0.8%

Table. Urinary Catheter Use Among ED Visits (Total and Those Leading to Hospitalization) in 2002-2003 and 2018-2019*

	2002-2003		2018-2019		Annual trend % (95% CI)	P value ^b
	Unweighted No.	Weighted % (95% CI)	Unweighted No.	Weighted % (95% CI)		
Overall ED visits	59 016		30 726			
Has CDC indication ^c	2798	5.0 (4.7 to 5.3)	2632	9.0 (8.2 to 9.9)	0.15 (0.08 to 0.22)	<.001
Urinary catheter						
Any	1662	3.1 (2.8 to 3.5)	465	1.6 (1.3 to 1.8)	-0.12 (-0.14 to -0.10)	<.001
Without indication	1096	2.1 (1.8 to 2.4)	250	0.8 (0.7 to 1.0)	-0.09 (-0.11 to -0.07)	<.001
With indication	566	1.1 (0.9 to 1.2)	215	0.7 (0.6 to 0.9)	-0.02 (-0.03 to -0.02)	<.001
ED visits leading to hospitalization ^d	11 037	18.7 (17.7 to 19.8)	5696	18.4 (17.0 to 19.8)	-0.13 (-0.27 to 0.02)	.08
Has CDC indication ^c	1637	16.1 (14.9 to 17.4)	1777	33.2 (29.7 to 37.0)	0.87 (0.66 to 1.07)	<.001
Urinary catheter						
Any	943	9.6 (8.5 to 10.9)	239	4.2 (3.4 to 5.1)	-0.33 (-0.41 to -0.26)	<.001
Without indication	607	6.0 (5.3 to 6.9)	101	1.6 (1.2 to 2.1)	-0.27 (-0.30 to -0.24)	<.001
With indication	336	3.6 (3.1 to 4.3)	138	2.6 (2.0 to 3.3)	-0.06 (-0.10 to -0.03)	.002

Abbreviations: CDC, Centers for Disease Control and Prevention; ED, emergency department.

^a All estimates, CIs, and P values, except unweighted counts, incorporated survey weights and complex sample design of the National Hospital Ambulatory Medical Care Survey.

^b Significance of annual linear trend in ED visit rates estimated with least squares regression with inverse variance weights.

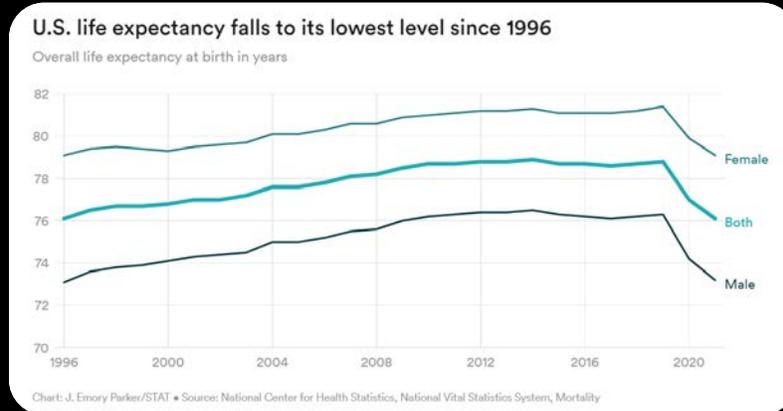
^c The proportion of ED visits with CDC indication for urinary catheter use

(including patients who did and did not receive a catheter), as defined with ED diagnoses and patient disposition (eTable and eMethods in the Supplement).

^d The proportion of overall ED visits in which the patient was hospitalized, including both inpatient and observation stays.

^e The proportion of hospitalized ED visits with CDC indication for urinary catheter use (including patients who did and did not receive a catheter), as defined with ED diagnoses and patient disposition (eTable and eMethods in the Supplement).

- Here's one that does land in our wheelhouse...



The recently released American Life Expectancy data just released shows life expectancy dropped for the second year in a row – It's lowest level since 1996. If you were born in 2021, you would live (on average) until 76.1 years (and you wouldn't be reading this right now).

But here's what's interesting.

The cause?

About half is Covid related (not unexpected). But the other half is mainly an increase in Unintentional Injuries (accidents) and overdoses (particularly narcotic).

The EMS literature has clearly identified successful interventions impacting both of these.

Meaning?

We have one of the nation's leading EMS authorities on narcotic overdose mitigation strategies in the GMR family.

Chris Stawasz in New Hampshire.



Given the national life expectancy data and the expertise and experience of what Chris and his colleagues are doing, I'm betting we can start to take a swing at some of these problems in a more systemic way.

This kind of stuff is all around us.

Meaning.

- I'd love to write a bit more, but...

So - A recent study in the European Health Journal evaluated the impact of bedtime on mortality...

The study found that going to bed between the hours of 10 p.m. and 11 p.m., you may lower your risk of developing significant cardiovascular disease.

As part of the study, researchers looked at more than 88,000 individuals between 2006 and 2010. Study participants used a wrist-worn accelerometer to gather data about sleep onset and waking time in participants.

Following up an average of 5.7 years later, it was found 3,172 participants had developed cardiovascular disease. Among those participants, the incidence of heart disease was highest for those who fell asleep at midnight or later and lowest for those who hit the sack from 10 p.m. to 10:59 p.m.

Researchers found that compared with falling asleep between 10 p.m. and 10:59 p.m., there was:

A 25% greater risk of cardiovascular disease for those going to sleep at midnight or later

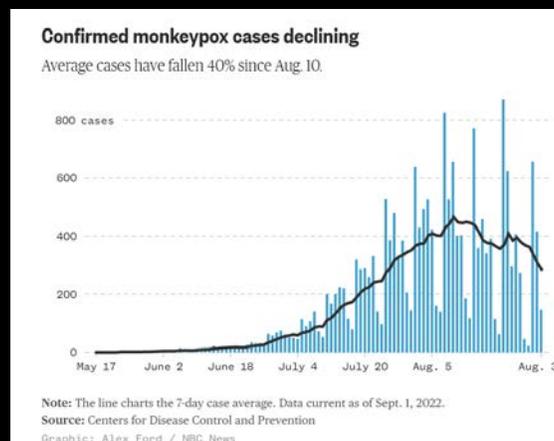
A 12% greater risk with sleep starting between 11 p.m. to 11:59 p.m.

A 24% greater risk with sleep starting before 10 p.m.

That said, based on the data – You don't want to hit the sack TOO early....

Damn.

- Good news chart 😊



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- **GMR Pride...**

Looking after Artemis 1. Our colleagues from AirMed. (Thanks, Amber...)



- **Epilogue...**

A married man was having an affair with his office mate.

One day, their passions overcame them in the office and they took off for her house. Exhausted from the afternoon's activities, they fell asleep and awoke at around 8 p.m.

As the man threw on his clothes, he told the woman to take his shoes outside and rub them through the grass and dirt. Confused, she nonetheless complied and he slipped into his shoes and drove home.

"Where have you been?" demanded his wife when he entered the house.

"Darling," replied the man, "I can't lie to you. I've been having an affair with my colleague. I fell asleep in her bed and didn't wake up until eight o'clock.

"The wife glanced down at his shoes and said, "You liar! You've been playing golf!"

So, that's it from my World. *Happy Friday.*

I have to tell you. It feels good typing this out. I love our profession, this organization and the people we get to work with.

It sounds really cliché, but what you do to take care of people that are sick, injured or just scared is such a great opportunity to change their lives for the better. And we get tremendous support from our non-clinical colleagues that allows clinicians to do what they do best.

And what you (we) do to take care of each other, makes our individual personal world's better (particularly if you're heading into the Emergency Department and someone wants to put a catheter in you *just to be sure*).

That friends, is meaning.

Thanks for what you do, and how you do it...

Enjoy your Labor Day however & whenever you can...

I'm grateful to be your colleague...

Ed

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