Letters to the Editor

Emergency Medicine News welcomes letters to the editor about any subject related to emergency medicine. Please limit your letter to 250 words, and include your full name, credentials, and city and state of residence or practice.

Letters may be edited for content, length, and grammar. Submission of a letter constitutes the author's permission to publish on all media, including print, online, and social media, but does not guarantee publication. Letters express the views of the authors and do not necessarily reflect those of *Emergency Medicine News* and Wolters Kluwer.

Letters to the editor may be sent to emn@lww.com.

Online Tantrums Not the Right Response to the NRA

Editor:

The NRA responded in a predictable but bumbling fashion to new American College of Physicians recommendations on reducing firearm-related deaths and injuries. The policy was ripe for dissension from Second Amendment supporters, and included some recommendations based on dubious evidence.

The response from the online medical community was swift and fierce, but quickly degenerated into name-calling, insults, and ad hominem attacks. Others included emotional and graphic clinical stories of victims of gun violence. The hashtag #ThisIsOurLane exploded. Truly, hell hath no fury like a doctor's ego threatened.

Unfortunately, fervent emotion does not always confer expertise or correlate with wise public policy. To move forward, we must carve out an intelligent communal space that will help us address the problems of firearm-related deaths. We can start by tackling pressing issues such as research into the best practices of mass shooting response training or firearm restrictions to domestic abusers.

The question is can physicians go it alone? We will have no other choice if we cling to emotional responses, online temper tantrums, and our worst impulses. Twitter is not built to engender harmony with its 280-character limit. It is necessary to set aside these impulses knowing they will lead nowhere beneficial. Such behavior is more likely to be injurious to your own soul than persuasive to anonymous Twitter users.

Luckily, we physicians already possess amazing skills that can help us broaden our base of support. Every day patients present to us with distasteful biases, aggressive behaviors, and even racist or sexist attitudes. But we do not lash out at them. We have nuanced techniques to calm agitated patients and assuage those with misplaced ideals so that they partner with us on their health care.

We should employ these skills in the public forum as well by avoiding unnecessary conflict, derisive language, and accusatory statements. We should encourage all to partner with groups occupying the space of common agreement, such as the AFFIRM research group (https://affirmresearch.org/).

There is a path forward on these issues. Physicians can be the leaders, but it cannot be through deliberate exaggeration and snarky commentary. The way forward must be claimed by thoughtfulness, understanding, and compromise. This is where our lane exists if we are willing to stay in it.

Kevin L Taylor, MD
Jupiter, FL

The Roots of Suicide and the Culture of Medicine

Editor:

I found the recent article by Janae Sharp examining suicide in EPs to be insightful and informative. ("Preventing Physician Suicide Starts with Radical Honesty," *EMN* 2018;40[9]:18; http://bit.ly/2CsMcuD.) I know physicians who have considered suicide and one who succeeded.

A recent article examined the frequency of burnout symptoms among second-year residents. (*Fam Pract Res J* 1994;14[3]:213.) Burnout, even this early in their career, was common among 53.6 percent in emergency medicine. More than 11 percent experienced career choice regret. Few of my colleagues cited the practice as the source of their dissatisfaction; rather, it was the administration of the practice. Other issues that make the practice of medicine increasingly frustrating are administrative domination, malpractice threats, and the total lack of control that physicians have over their professional lives. It has been well documented that burnout is associated with poor medical practice (*JAMA Intern Med* 2018;178[10]:1317), so not only are the practitioners at risk, their patients are as well.

Suicide is just a more tragic exit, but the truth is the realities of the practice of medicine, particularly emergency medicine, are driving good practitioners to take desperate steps to exit the specialty. Those who stay do so with near heroic personal sacrifice of their own well-being and happiness. It is the culture in which we are forced to practice that drives us away. The roots of suicide do not originate in the practice but in what we must tolerate to practice what is truly a most noble art and science.

Paul Janson,MD
Lawrence, MA

Treat EPs as Administrators Would be Treated

Editor:

Edwin Leap, MD, brings up an important concept in his column, which is also ancient: "Treat others as you would be treated." ("Ban on Food and Water in the ED a Cruel Policy," *EMN* 2018;40[10]:8; http://bit.ly/2Pbt06j.)

If this simple precept were to be observed by people with the authority to create an environment of care for the caregiver, a lot of burnout problems would vanish. This job is tough enough; when leadership doesn't have your back, it's that much more of a load to carry.

Tom Benzoni, DO
Des Moines

Best Evidence on Clean-Catch Urine Samples

Editor:

We read the article, "The Myth of Midstream Clean-Catch Urine Samples" (*EMN* 2018;40[10]:43; http://bit.ly/2yRWTm7) with great interest because asymptomatic bacteriuria and urine specimen collection are significant areas of interest for our emergency department antibiotic stewardship program. (*J Emerg Med* 2016;51[1]:25.) We agree with the authors' overall message, but the article misses the mark on three important points.

First, clean-catch urine collection may not reduce culture contamination rates, but the diagnostic performance of urinalysis degrades rapidly in the presence of squamous epithelial cells, which are associated with an increased rate of pyuria (WBCs in the UA). (*Acad Emerg Med* 2016;23[3]:323.) UTIs in the ED are primarily diagnosed using UA results, so pyuria may bias clinicians toward the presence of infection and result in unnecessary antibiotics. Rather than abandon the mid-

Continued on page 23

Continued from page 15

stream clean-catch, we advocate implementation research aimed at mitigating factors that result in poor patient compliance with the technique. (*J Emerg Med* 2017;52[5]:639; *J Clin Pathol* 2016;69[10]:921; *Am J Emerg Med* 2018;36[1]:61.)

Second, visual inspection of urine clarity is misleading in diagnosing UTI because it is more likely related to hydration status or the quantity of urea in the sample. The positive predictive value of cloudy urine for UTI has been reported at only 40%. (*J Am Board Fam Med* 2011;24[4]:474.)

Finally, the literature does not support diagnosing UTI based on "typical" symptoms without a UA. The probability of UTI in women presenting with urinary complaints is only 50 percent. (*JAMA* 2002;287[20]:2701; *Ann Emerg Med* 2007;49[1]:106.) To reduce overuse of antibiotics and the associated patient safety and public health implications, UTI should be diagnosed only after consideration of symptoms, physical examination findings, and the UA.

Robert S. Redwood, MD, MPH
Portage, WI
Barry Fox, MD, &
Michael S. Pulia, MD
Madison, WI

Better Outcome in OHCA if Epinephrine Given Earlier

Editor:

Regarding the review by Rory Spiegel, MD, of the PARAMEDIC2 trial, I would like to offer another interpretation of the study. ("No Benefit of Epinephrine in OHCA," *EMN* 2018;40[10]:1; http://bit.ly/2NfBWWs.)

The study shows that epinephrine in OHCA will likely not improve neuro-intact survival if your EMS agency does not give the drug earlier than a median of 14.8 minutes after arrival and if your EMS agency has a very low overall survival rate for OHCA, one-fifth that of the great state of Oregon, according to 2017 CARES data. (*Resuscitation* 2017;120:5; http://bit.ly/2K2H3cs.)

Repeating this study in the United States with EMS agencies with a CPR fraction greater than 90 percent and who give epi early (less than 10 minutes after EMS arrival) would help better define the utility of this drug in OHCA.

William J. Reed, MD
Bend, OR

The Benefits of EM Still Worth the Costs

Editor:

I agree with every single point Alex Mohseni, MD, articulated in his article. ("Why I Quit Emergency Medicine," *EMN* 2018;40[10]:1; http://bit.ly/2Pc0ktQ.) The work of an EP is nitpicky, cumbersome at times, emotionally exhausting, litigious, and, frankly, hard. The merit badges we are required to maintain, including ACLS, PALS, and ATLS, an up-to-date flu vaccination, and endless hospital compliance modules, require an Excel spreadsheet to keep up. I will, however, take them any day over what our primary care colleagues have to carry: disability forms, insurance company fights, and preapproved MRIs, to name a few. My wife, who works in corporate America, has struggles that sometimes make ours seem far more tolerable.

I was told coming through the medical education pipeline that emergency medicine was a "young man's game" and that the average life cycle of an EP is 10 years. I am six years out of residency now. I still have not found an area of medicine that offers the equivalent intensity, diversity, and income

Continued on page 25