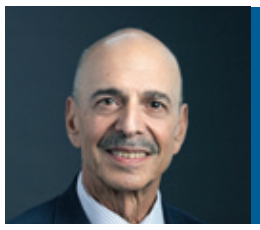

PROFILE

Can't Put Away the Advocacy

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Patient Offload Delays

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Emergency Physicians Volunteer to Deliver Care

Free, mobile clinics throughout the country bring health care to those in need

by DARRIN SCHEID, CAE

After a long Thursday shift at Loyola University Medical Center in Chicago, emergency physician Theresa Nguyen, MD, FACEP, heads to the train station. It's late, but she's not going home.

Dr. Nguyen and several volunteers meet at the end of the Chicago Transit Authority Blue Line, the Forest Park Station, where patients without access to care, health insurance, or anywhere else to turn, are waiting. Health care professionals, social workers, and students from area universities stay until midnight treating wounds and bruises. They deliver medical care while their community partner The Night Ministry offers information on housing and warm meals.

There's even a mobile shower unit, something Dr. Nguyen said is a key part of their wound care.

"Our motto is simple: Go to the people," Dr.

CONTINUED *on page 16*

JORDAN VAUGHN, MD

ACEP Chapter Roundup: Highlights and Updates from 2024

by ACEP NOW

As we close out 2024, ACEP's chapters were invited to share news from the past year and preview what's to come. Chapters have been busy advocating for physician autonomy, hosting educational events, and continuing to support their members on a variety of practice issues.

ACEP Now did not receive content from Alaska, Delaware, Mississippi, North Dakota, and Wyoming before our print deadline.

Alabama

The Alabama Chapter appointed Benjamin Von Schweinitz, MD, FACEP, to the Statewide Trauma and Health System Advisory Council, and Julie Brown, MD, to the Birmingham Regional Emergency Medical Services System. ALACEP's ability to appoint board-certified emergency physicians to these positions is important to ensure that emergent patient care standards are maintained.

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UPDATES AND ALERTS FROM ACEP

NEWS FROM THE COLLEGE

Annals *of* Emergency Medicine
An International Journal

Annals Study Details Cost of Boarding

A study in the October issue of *Annals of Emergency Medicine* is the first of its kind to detail the daily costs of boarding for a hospital.

"Our analysis found that caring for patients who are boarding in the emergency department nearly doubled the daily cost of care for the hospital," said lead study author Maureen M. Canellas, MD, MBA, FACEP, assistant professor of emergency medicine at the University of Massachusetts T.H. Chan School of Medicine, and associate chief medical officer at the University of Massachusetts Medical Center. "Boarding is a systemic problem that requires collaborative solutions. This cost data should give hospital leaders a new perspective when addressing the boarding crisis."

The total daily cost per patient was $1,856 for those boarding, which is nearly double the $993 for those receiving inpatient care. The daily cost of boarding intensive care patients in the emergency department was $2,267 compared with $2,165 for those being treated in the intensive care unit. The authors examined the cost of care for 25 patients who had a stroke and then boarded in the emergency department for a combined 563 hours at a large, urban, academic comprehensive stroke center hospital. The study used time-driven activity-based costing to quantify the care cycle by calculating daily resource use, salary data, and operating costs. This research was supported by the Emergency Medicine Foundation and Emergency Medicine Policy Institute's Health Policy Research Scholar Award.

Boarding is more costly than inpatient care and the overall costs of boarding are likely higher than reported, the authors noted. The study did not factor in other costs associated with prolonged hospital stays, including occupied beds unavailable for evaluation and treatment of new patients, staff inefficiencies, or the potential for malpractice lawsuits.

Although this analysis focused on hospital costs, the dangers for patients are well established. Nearly 70 studies have shown that boarding was associated with elevated health and safety risks, prolonged delays in treatment, and increased likelihood of death. These dangerous bottlenecks are also associated with ambulance diversion, preventable medical errors, violent episodes, and care team burnout.

ACEP Continues to Lead the Call for Accountability, Solutions to the Boarding Crisis

ACEP met with the Biden Administration in late October to discuss its proposal to require hospitals to have plans in place for when they reach capacity. ACEP President Alison J. Haddock, MD, FACEP, urged the White House Office of Management and Budget to adopt an ACEP-developed standard that would require hospitals to create and implement protocol to move admitted patients out of the emergency department when the hospital reaches a specific capacity threshold. ACEP's comprehensive multiyear efforts to address the root causes of boarding include alerting the White House, sounding the alarm through hundreds of troubling stories directly from the frontlines, and tying boarding-related attestations to hospital performance measures, among other initiatives.

ACEP efforts culminated in an October stakeholder summit convened by the Agency for Healthcare Research and Quality. ACEP is making sure that emergency physicians have a prominent seat at the table for critical conversations that impact you and your patients.

ACEP-Supported Bill Introduced to Stop Medicare Payment Cuts, Provide Inflationary Update

On October 29, the ACEP-supported bipartisan Medicare Patient Access and Practice Stabilization Act of 2024 (H.R.10073) was introduced in the House of Representatives by congressional physician champions and physician allies. Now, it needs emergency physician support to help enact it into law. This bill addresses the impending 2.8 percent Medicare Physician Fee Schedule (PFS) cuts scheduled to go into effect on Jan. 1, 2025, and provides a temporary update to the PFS via a one-year inflationary update of half the 2025 Medicare Economic Index (MEI), a proposal similar to recommendations that the Medicare Payment Advisory Commission (MedPAC) recently shared with Congress.

This bill is a vital stopgap to fully prevent the imminent cuts facing emergency physicians at year-end, establish an important precedent of reflecting inflationary pressures in the Medicare physician payment system, and provide the physician community and Congress additional time to collaborate on long-term physician payment reform. ACEP and 130 organizations representing physicians, health care providers, hospitals, and other organizations support passing this bill into law.

ACEP Vermont Chapter Voices Strong Opposition to Hospital Conversion Plan

A recommendation by Vermont's Green Mountain Care Board (GMCB) to convert four hospitals into standalone emergency departments staffed by nonphysicians is being met with strong opposition from ACEP's Vermont Chapter.

"Emergency medicine is a complex and demanding specialty that requires comprehensive training and expertise," said Vermont ACEP President Niki Thran, MD, FACEP. "Every Vermonter deserves access to a fully qualified emergency physician when they arrive at an emergency department."

The chapter's letter to the GMCB outlined concerns about care quality and patient safety, emphasizing that nurse practitioners (NPs) and physician assistants are indispensable members of the care team; however, they simply do not have the training or education of an emergency physician. The letter explained that unsupervised nonphysician care can lead to:

- **Increased costs**: NPs delivering care without supervision increased lengths of stay by 11 percent and raised 30-day preventable hospitalizations by 20 percent compared with emergency physicians.
- **Increased resource utilization**: Multiple studies have demonstrated higher diagnostic test utilization, longer length of stay, and reduced clinical efficiency in non-emergency physician-led staffing models.
- **Lower patient satisfaction**: Ninety-five percent of voters said it is important to them for a physician to be involved in their diagnosis and treatment, and 62 percent said patients are most likely to be harmed from scope of practice changes.
- **Increased medico-legal risk**: More than 85 percent of malpractice claims against NPs are because of errors in diagnosis, treatment, and medication.
- **Increased inappropriate prescribing**: Compared with physicians, nonphysicians are more likely to prescribe antibiotics when they are not needed and overprescribe opioids.

ACEP strongly supports state and national efforts to prioritize physician leadership. There is no substitute for a licensed, trained, and board-certified emergency physician.

In Case You Missed It

- **ACEP Announces New Migraine Point-of-Care Tool:** ACEP's new Migraine in the ED point-of-care tool is now available. This tool aims to help emergency physicians better diagnose and treat patients who present with this common complaint. Visit poctools.acep.org.
- **ACEP Releases Clinical Policy on Thrombolytics for Acute Ischemic Stroke:** The recently approved Clinical Policy on Thrombolytics for Acute Ischemic Stroke will be published in the December issue of *Annals of Emergency Medicine*. The latest policy is an update of the 2015 Clinical Policy: Use of Intravenous Tissue Plasminogen Activator for the Management of Acute Ischemic Stroke in the Emergency Department, and seeks to evaluate the outcomes for patients who present with an acute stroke from a large vessel occlusion who have received endovascular therapy with or without intravenous thrombolysis.

ACEP ACCELERATE

- **Don't Miss ACEP Accelerate in Orlando Jan. 18-23:** There will be multiple meetings in one fantastic location.
  - » **AAWEP Power Up: Women in Leadership** - Jan. 18
  - » **Observation Medicine Science and Solutions** - Jan. 18-19
  - » **ACEP/CORD Teaching Fellowship Phase 1** - Jan. 18-22
  - » **ED Directors Academy: Leadership Essentials** - Jan. 19-23
  - » **ED Directors Academy Small Group Masterclass** - Jan. 19-22
  - » **ED Directors Academy Team Strategies and Applied Management** - Jan. 20-23
  - » **Pediatric Emergency Medicine Assembly** - Jan. 20-22
  - » **Reimbursement & Coding** - Jan. 20-22

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Corrections

In "2024–2025 Emergency Physician Compensation Report" (*ACEP Now*, September 2024, p. 18), the sidebar detailing the Midwest incorrectly abbreviated Iowa as IO instead of IA, and the sidebar detailing the West/Southwest incorrectly abbreviated Hawaii as HA instead of HI.

In "Leadership Column" (*ACEP Now*, October 2024, p. 20), Dr. Aisha Terry's bio should have identified her as Immediate Past President of ACEP.

ACEP Now Shifts to Hybrid Format in 2025

by CEDRIC DARK, MD, MPH, FACEP

Egon Spengler, PhD, famously quipped, "Print is dead!" in the 1984 film *Ghostbusters*. As a man who spent his evenings chasing down ethereal forms of the deceased, perhaps he knew of the demise of the print medium before the rest of us.

Data from the Pew Research Center during the past 40 years confirm Spengler's assertion.[1] In 1984, the estimated circulation of daily newspapers in America was more than 63 million. Since that time, print circulation has dwindled such that by 2020, circulation was roughly one-third its 1980s peak.

Why the shift? Television has outpaced newspapers as a source of information. Digital platforms now surpass all others for news distribution. The 65-plus age demographic obtains its news from print more than all other age groups; however, only one in five seniors in America read a newspaper daily.[2] For Gen Z, less than 10 percent of their daily news consumption comes in print. About half arrives via social media.[3] With those headwinds in mind, it is no surprise that print publications, including *ACEP Now*, face similar threats.

DR. DARK (@RealCedricDark) is associate professor of emergency medicine at Baylor College of Medicine and the Medical Editor-in-Chief of *ACEP Now*.

ACEP News was created in January 1982 "to provide more timely and in depth news than was possible in the news pages of *Annals*."[4] Originally launched as a bi-monthly publication, *ACEP News*, later rebranded *ACEP Now*, evolved to reach more than 40,000 emergency physicians throughout the U.S. in print, with more than one million annual online visits.

Annals of Emergency Medicine, another ACEP publication, recently went fully digital, abandoning print and citing publication costs as a large consideration. Declining advertising dollars, a readership that continues to drift to digital, and a costly supply chain made this unfortunate transition inevitable.

Facing similar pressures, *ACEP Now* is shifting to a hybrid format in 2025. Instead of the typical 12 issues, you will receive just six print issues in your mailbox next year. However, we remain dedicated to providing content every month, alternating digital and print releases, and will continue to notify you of new material in our eNow edition.

You can expect to see online-only features, many of which will be interesting patient cases from readers like you, each Sunday in the eNow newsletter.

ACEP Now will continue to focus on four main areas: 1) updates from the College, 2) topical news stories relevant to emergency physicians, 3) clinical updates and medical education, and 4) opinions from emergency physicians around the globe.

We have invested heavily in expanding our online content during the past few years. Many of our Opinion pieces (formerly "New Spin") and Case Reports (a new feature introduced in recent years) are now primarily online. We have also been able to publish breaking news online weeks or months before our magazine reaches your mailbox—for instance, emergency medicine's rebound in the Match and the immediate reaction to the *Dobbs v. Jackson* Supreme Court decision).[4,5]

Although I personally hate to see the physical copy of *ACEP Now* reducing in frequency, I understand the challenge we face. Our publication must transition into something that emergency physicians will want to consume in the format of their choice. If you're like me, that choice remains flipping through those pages by hand; nothing beats the texture of paper on my fingertips. For others, the preference might be our podcast "ACEP Nowcast" hosted by Dr. Amy Faith Ho. Others prefer digital—email or the web. One thing I know is that to meet the changing demographics where the readers are, *ACEP Now* must fully leverage digital and social media to reach them.

As we work to build a multifaceted, multimedia experience for our readers, you have my continuing commitment that *ACEP Now* will represent "multiple viewpoints and address myriad concerns," as I wrote in my first Letter from the Editor.[6] Every emergency physician, whether they "practice in a community or academic setting, a rural or urban environment, whether you live in a blue state or red, and regardless of whether you are a member of ACEP or not, you can expect an editorially independent perspective."

Although *ACEP Now* is an official publication of ACEP, our journalism will remain free to explore stories of interest to readers and our opinion pages will continue to represent physicians who wish to express their ideas in the public forum. For me, as Medical Editor-in-Chief, it is imperative that *ACEP Now* lives up to its the moniker, "the Official Voice of Emergency Medicine."

References

1. Pew Research Center. Newspapers Fact Sheet. https://www.pewresearch.org/journalism/fact-sheet/newspapers/. Published November 10, 2023. Accessed November 11, 2024.
2. Watson A. Frequency of using newspapers as a source of news among adults in the United States as of February 2022, by age group. Statista. https://www.statista.com/statistics/1251242/newspaper-usage-frequency-by-age/. Published January 2, 2024. Accessed November 11, 2024.
3. Watson A. Frequency of using selected news sources among Generation Z in the United States as of August 2022. Statista. https://www.statista.com/statistics/1124119/gen-z-news-consumption-us/. Published January 4, 2023. Accessed November 11, 2024.
4. ACEP Board Minutes. June 1982.
5. Kiemeny M, Fisher J, Calaway N, et al. Emergency medicine shows rebound in 2024 residency match. *ACEP Now*. https://www.acepnow.com/article/2024-match-week/. Published March 11, 2024. Accessed November 11, 2024.
6. Koyama A, Paulk L, Quinley K, et al. The emergency department after the fall of Roe: are you prepared? *ACEP Now*. https://www.acepnow.com/article/the-emergency-department-after-the-fall-of-roe-are-you-prepared/. Published June 24, 2022. Accessed November 11, 2024.
7. Dark C. Dr. Cedric Dark: an unexpected journey to medical editor in chief. *ACEP Now*. https://www.acepnow.com/article/faust-after-dark-an-unexpected-journey-to-medical-editor-in-chief/. Published July 28, 2021. Accessed November 11, 2024.

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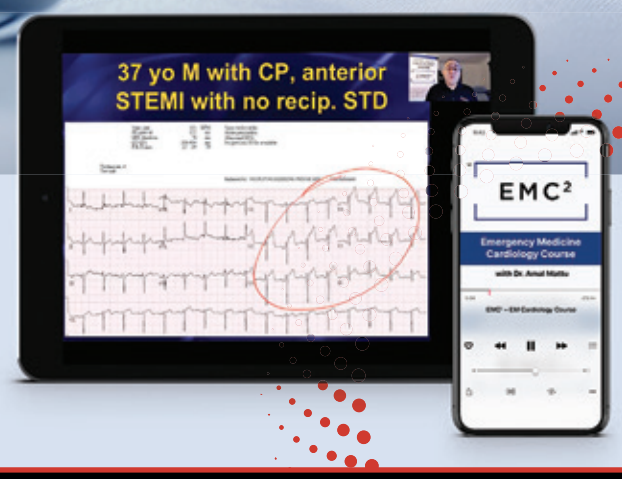

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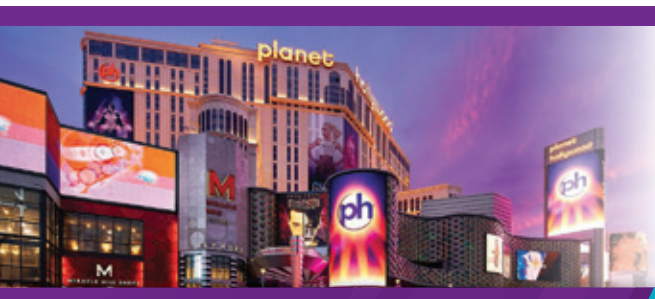

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JENNIFER LUK

George Washington University OB/GYN and emergency medicine residents came together to advocate for patients and EMTALA at the Supreme Court building.

Advocating for Patients

Medical emergencies in pregnant women should not be falsely equated with expanding access to elective or induced abortion

by CORTNEY S. DRAPER, MD

Misinformation about health care and abortion abounds in the media today. It would be reasonable to believe that physicians are better educated on these subjects than the average layperson in the United States. However, it was disappointing to read a recent article in *ACEP Now* entitled "Advocating for Patients," which contained numerous inaccurate and false statements regarding current laws in America, as they pertain directly to patient care.

This article purported that the state of Idaho (and at least 14 other states) would not allow for appropriate emergency care of a spontaneous abortion (i.e., miscarriage), in a hypothetical patient with hemorrhagic shock. The authors claim that "abortion bans" such as Idaho's would not allow for treatment of this patient, despite her nonviable pregnancy.

To start reviewing this topic, let us examine the definition of "abortion." Per Idaho ID 18-604, "abortion means the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child." It explicitly excludes "the removal of a dead unborn child" from its definition, or the removal of an ectopic or molar pregnancy.

These exclusions clearly contradict the article's claim that Idaho's law restricts the use of dilation and curettage (D and C) to treat a miscarriage.

My home state of South Carolina is similar. SC Section 44-41-610 defines "abortion" almost identically to Idaho, including the exclusion of "an action to remove a dead unborn child."

So at least in these two states, the article is incorrect in asserting that this patient, suffering a miscarriage, would be legally restricted from receiving appropriate medical care.

A more difficult example would involve a patient with complications from an induced abortion, such as the much-cited case of Ms. Amber Thurman, who, according to news outlets, died days after taking abortion pills. Notably, she died on the operating table after waiting 20 hours in the ICU for a D and C to treat her diagnosis of sepsis and retained products of conception.

Many have wondered: Could she have survived if a D and C had been provided earlier? Why did her hospital wait so long? Was there any legitimate legal concern that performing a D and C could be considered illegal in Georgia?

Both Idaho and South Carolina clearly state that "abortion" does not include action to remove a dead unborn child, which means that Ms. Thurman could have been treated there without hesitation. Georgia's law is a bit different. Although the state's definition of "abortion" similarly allows for miscarriage management, the specific language excludes "removing a dead unborn child *caused by spontaneous abortion*." Ms. Thurman's physicians may have known that she was facing complications of an induced abortion, not miscarriage from a spontaneous abortion, and been hesitant to provide lifesaving medical care for her because of how this law is worded.

However, Georgia law defines abortion as an action with "purpose to terminate a pregnancy with knowledge that termination will...

CONTINUED *on page 7*

Collateral damage of restrictive laws continues to be the death and injury of pregnant patients

by KAREN HOU CHUNG, MD; NEHA GUPTA, MD; BREANNE JACOBS, MD; DARA KASS, MD; AND KIMI CHERNOBY, MD, JD

Our recent *ACEP Now* article on attending a Supreme Court rally during EMTALA and abortion ban arguments prompted many responses. In her letter, Dr. Draper argues that abortion bans are clear and do not hinder the provision of standard medical care. This could not be further from the truth.

States with restrictive abortion bans are seeing an increase in maternal morbidity and mortality.[1] These laws, written by legislators with little or no physician input, are vaguely written, using non-medical terms such as "dead unborn baby" to describe exceptions. These poorly written laws are causing delays or denials of care and increasing pregnancy complications—even when indicated care would have been allowed by the letter of the law. Proponents claim that the exceptions typically contained within abortion bans are clear enough for effective care, but real-life outcomes tell a different story.

For example, "medical emergency" exceptions are often poorly defined, forcing doctors to interpret vague laws during urgent clinical situations. In Texas, Josseli Barnica presented to a hospital 17 weeks pregnant with a miscarriage in progress. Because of the state's abortion ban, doctors waited 40 hours until fetal cardiac activity ceased before inducing a delivery. She died three days later from an infection, most likely caused by the prolonged time her cervix was dilated. In a state without an abortion ban, Barnica could have been offered an induction of labor or dilation and evacuation sooner, which could have saved her life.

Furthermore, many pregnancy situations, like preterm premature rupture of membranes (PPROM) before fetal viability, do not fit within the narrow exceptions defined by "medical emergency" exception laws. In these cases, terminating the pregnancy is often necessary to protect the patient's health and future fertility, and waiting until there is no fetal cardiac activity only prolongs risk to the patient. Denying timely emergency abortion care, as was shown in the case of Mylissa Farmer, violates EMTALA; she was denied care in both Missouri and Kansas after experiencing PPROM at 18 weeks.

Dr. Draper, despite asserting legal clarity, spends much of her response discussing the case of Amber Thurman, a woman who died in Georgia from complications after using legally obtained abortion medication from another state. Georgia law permits treatment for spontaneous miscarriages but lacks clear guidance for induced cases, complicating decisions about treating retained products after an induced abortion. Dr. Draper herself acknowledges that ambiguity around the cause of Amber's retained products of conception may have contributed to delays in her care and her death, yet she shifts responsibility to doctors to manage within these vague constraints. We wholeheartedly agree that it should be the physician's responsibility to decide what is the safest and most effective medical treatment for his or her patients. However, this case, and many others, show that the laws as currently written are not providing physicians the needed autonomy to make these critical and timely decisions to provide lifesaving care.

CONTINUED *on page 7*

POINT | CONTINUED FROM PAGE 6

cause the death of an unborn child." By the time she presented to the emergency department, she was at least a few days post-ingestion of the abortion pill regimen. Treating her condition likely would not cause the death of her unborn child or even terminate her pregnancy. In addition, the Georgia law, like all U.S. state laws, clearly contains a "medical emergency" clause, requiring only that a physician determine, in reasonable medical judgment, that a medical emergency exists.

As physicians, we are responsible to advocate for our patients and their health. There is an obligation to understand the laws that directly affect our medical practice. The claim in the *ACEP Now* article that "pregnant people experiencing medical complications remain in a precarious position, as their doctors are kept in the dark about what the law requires," indicates a lack of ownership over our medical practice on the part of physicians. This is shameful, and we physicians should hold ourselves accountable to be better prepared and educated in caring for our patients.

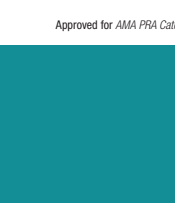
If your state's laws are ambiguous or poorly worded, please get involved in improving them! Treatment of pregnant women with medical emergencies should not be falsely equated with the desire for expanding access to elective or induced abortion. This confusion of definitions is clearly contributing to preventable patient deaths. It is our responsibility as physicians to be leaders, providing accurate medical information and optimal treatment of our patients.

DR. DRAPER is an emergency medicine attending physician with Lowcountry Emergency Physicians in Charleston, S.C.

COUNTERPOINT | CONTINUED FROM PAGE 6

Dr. Draper concludes by suggesting that physicians should advocate for clearer laws if they find them ambiguous. We applaud Dr. Draper's optimism that physician input would inspire lawmakers to clarify the life-threatening impacts of their laws, but in fact the real world has shown us the opposite. Take *Zurawski v. State of Texas*,[2] where women who were denied abortions despite medical necessity sought clarification on Texas's "medical emergency" exception. They asked the State of Texas for clarification on the "medical emergency" exception, arguing that the laws contained conflicting language and nonmedical terminology, making it unclear when physicians are permitted to provide care. In their decision, the Texas Supreme Court failed to offer additional clarification on what care is permissible, despite physicians asking for it, which does not help improve care for women like Josseli Barnica.

The collateral damage of these restrictive laws continues to be the death and injury of pregnant patients and their babies. Dr. Draper and others argue that treating pregnancy emergencies shouldn't be conflated with expanding access to elective abortion. We agree that this is not the forum to advocate for protecting or expanding abortion access in violation of state law. But to ignore the fact that our patients, and their families, are experiencing harm due to these bans seems to be both willfully ignorant and factually insincere. As physicians committed to saving lives, we hope to work together to protect pregnant people in our emergency departments, regardless of the post-*Roe* restrictions imposed by state governments.



DR. CHUNG is a PGY-4 resident in emergency medicine at George Washington University in Washington, D.C.

DR. GUPTA is a PGY-2 resident in emergency medicine at George Washington University in Washington, D.C.

DR. JACOBS is assistant clinical professor of emergency medicine at the George Washington University School of Medicine. She is an ACEP Ethics Committee member.

DR. KASS is an emergency physician in New York City and the clinical lead for Access Bridge.

DR. CHERNOBY is an assistant clinical professor of emergency medicine at George Washington University in Washington, D.C., and a reproductive rights lawyer.

References

1. Nambiar A, Patel S, Santiago-Munoz P, et al. Maternal morbidity and fetal outcomes among pregnant women at 22 weeks' gestation or less with complications in 2 Texas hospitals after legislation on abortion. *Am J Obstet Gynecol*. 2022;227(4):648-650.e1.
2. *State v. Zurawski*, 690 S.W.3d 644 (Tex. 2024) Court: Supreme Court of Texas. https://www.txcourts.gov/media/1458610/230629.pdf. Published May 31, 2024. Accessed November 12, 2024.

ACEP4U: NEMPAC Creates Opportunities, Results for Emergency Medicine and Patients

ACEP MEMBERS ACROSS THE COUNTRY SPEAK OUT ON WHY EMERGENCY PHYSICIANS NEED STRONG POLITICAL ADVOCACY

by DARRIN SCHEID, CAE

As voters across the country braced for uncertainty heading into Election Day 2024, emergency physicians could rest assured that the National Emergency Medicine Political Action Committee (NEMPAC) was looking out for their best interests.

Although ACEP members have differing opinions on issues that drove voters to the polls, most agree on the pressing challenges facing emergency medicine—patient boarding, workplace violence, defending emergency medicine against insurer bad practices, and creating an appealing workplace and opportunities for the next generation of emergency physicians.

Many may question whether to get involved in advocacy amidst a myriad of professional pressures. However, decisions that affect how we take care of our patients are regularly being made by nonphysicians. NEMPAC gives us a seat at the table among thousands of competing interests in Washington, D.C.

ACEP asked several emergency physician advocates across the country to tell us why they got involved with NEMPAC, and why NEMPAC is important to the future of emergency medicine.

Money Buys Access

"It's not enough to rest on our white coats and initials. Instead, we need to fight fire with fire and open our wallets in order to heal and fix health care in our country."

— Damian E. Caraballo, MD, FACEP | Florida

Damian E. Caraballo, MD, FACEP, said that during the past decade multiple legislators on both the federal and state level have told him that money is the lifeblood of politics. He said the reality of American politics is that money buys access, access leads to influence, and influence results in laws leading to change. Physicians are outspent by Big Pharma, hospitals, and health insurers, but wonder why they are always first on the chopping block fiscally or in legislation. Meanwhile, Dr. Carabello said, emergency physicians are outspent by optometrists, who are wise enough to understand that PAC money directly affects their bottom line and existential survival.

If emergency physicians and physicians in general want to take back medicine and the doctor–patient relationship, Dr. Carabello said, it is not enough to rest on our white coats and initials. Instead, emergency physicians need to fight fire with fire and open up their wallets in order to heal and fix health care in the U.S.

"If you want to make a difference, give your time," Dr. Carabello said. "If you really want to make a difference, give your money. If you want to make change, you're going to have to give both."

Lobbying Is Essential

"Without a strong PAC, we have no chance, and our patients and practices will continue to suffer."

— John R. Corker, MD, FACEP | Ohio

John R. Corker, MD, FACEP, pointed out that every day, decisions are made by nonphysicians that directly affect the ability of emergency physicians to care for patients. NEMPAC, he said, gives physicians a seat at these decision-making tables—whether it's legislation or executive action, Medicare physician payment, or insulin price caps. Elected officials and their decisions have a big effect on patients and practices every day.

Dr. Corker said he still has friends on the Hill from his time as a policy fellow.

"When I asked them how it's possible that physicians' salaries account for less than eight percent of total health care costs yet remain the only sector of health care that has their payment cut by Medicare every year (hurts us and patients, doesn't help the budget), their only response was 'the insurance companies and hospitals lobby better,'" Dr. Corker said. "That's it, that's the answer. Without a strong PAC, we have no chance, and our patients and practices will continue to suffer."

Dr. Corker said it should be recognized that NEMPAC supports a bipartisan group of elected officials who have either proven or promised to support the issues important to our patients and practices. He understands that no candidate is perfect, and rarely does everybody agree on all issues. That is why NEMPAC's support is revisited each cycle in case new candidates emerge or others don't live up to their promises.

"That said, NEMPAC is also transparent, and we welcome all questions, concerns, and feedback regarding candidates we've supported," Dr. Corker said. "Get involved and help us make a difference!"

Opportunities for Interaction

"I support NEMPAC … and hope you will too."

— Kristin M. Donaldson, MD, MPH, FACEP | Illinois

Kristin M. Donaldson, MD, MPH, FACEP, said NEMPAC has provided opportunities for leaders in Illinois to interact with national and state level legislators during the past year. These interactions led to discussions about issues facing emergency physicians, including boarding, violence, and reimbursement.

"NEMPAC has provided these opportunities to educate legislators about important issues impacting emergency medicine and patients," she said.

Openness to Collaboration

"I feel lucky to have a resource like NEMPAC…"

— Lisa Maurer, MD, FACEP | Wisconsin

Lisa Maurer, MD, FACEP, cited how NEMPAC's influence and reputation on Capitol Hill has made a positive impact on the No Surprises Act legislation, regulation, and subsequent legal action, "without which we could be facing disastrous market forces for my independent democratic group."

She noted how NEMPAC supports candidates on both sides of the aisle based on policy positions and openness to collaboration, and heavily considers input from local docs.

"Leaders in my state have been asked often about our personal experience and opinions regarding federal candidates," Dr. Maurer said. "Frankly, I feel lucky to have a resource like NEMPAC where staff and docs on the Board of Directors use my hard-earned dollars to support the expert opinion and research that I don't have the experience or time to do myself."

MR. SCHEID is ACEP's Communications Director.

NEMPAC 2024 Election Recap

In the recent election cycle, NEMPAC supported 177 candidates for the House of Representatives and 20 candidates for Senate. Here's a look at NEMPAC's work and results from the Nov. 5 elections:

- ACEP members donated $1.7 million to NEMPAC in the 2024 election cycle (2023 and 2024). NEMPAC spent $1.78 million for federal candidates, committees, and bipartisan funds that supported the election of physicians to Congress. In 2022, NEMPAC spent $1.6 of $1.75 million raised. NEMPAC's record high in donations is $2.1 million, raised in 2010.
- NEMPAC reaches more than 200 lawmakers each cycle. It only supports federal congressional candidates and committees.
- NEMPAC is bipartisan, donating 53.4 percent of funds to Democrats, 45.4 percent to Republicans, and 1.2 percent to Independents in this election.
- NEMPAC supported 24 physicians and dentists, including five emergency physicians; two were ACEP members.
- As of press time, 17 NEMPAC-supported candidates won their Senate races and three lost.
- As of press time, in the House, 164 NEMPAC-supported candidates won their elections and one race was in recount.

Emergency Physician Election Results

- Raul Garcia, DO, FACEP, a Republican challenger candidate, lost his election to incumbent Sen. Maria Cantwell (D) in Washington.
- Rep. Mark Green, MD, (R-TN-7) defeated Megan Barry (D-TN-7) and Shaune Greene (I-TN-7).
- Rep. Ronny Jackson, MD, (R-TX-13) was unopposed.
- Rep. Rich McCormick, MD, (R-GA-07) defeated Bob Christian (D-GA-07).
- Tim Peck, MD, (D-IN-09), a challenger, lost to incumbent Rep. Erin Houchin (R-IN-09).
- Rep. Raul Ruiz, MD, (D-CA-25) defeated Ian Weeks (R-CA-25)
- Amish Shah, MD, FACEP, (D-AZ-01), a challenger, lost to incumbent David Schweikert (R-AZ-01).

Can't Put Away the Advocacy

Retired Maryland emergency physician still in the fight

by DARRIN SCHEID, CAE

By some definitions, you could call former Maryland state legislator Dan Morhaim, MD, FACEP, a retired emergency physician. He thinks of it as "re-deployed."

Dr. Morhaim spent more than two decades in the Maryland House of Delegates, fighting for legislation to protect health care workers and patients before his final legislative term ended in 2019. His health care focus included hospital efficiency, physician and patient satisfaction, and emergency department (ED) wait times, as well as a host of nonhealth issues.

Today, Dr. Morhaim is donating his time to a recently established Maryland commission focused on ED wait times.

The ED Wait Time Reduction Commission took effect in July and will spend three years developing relevant strategies and initiatives to recommend to state and local agencies, hospitals, and health care professionals. Recommendations should address factors throughout the health care system that contribute to increased ED wait times.

Dr. Morhaim is also serving a four-year term on the Maryland Behavioral Health Advisory Council, a group that works to enhance behavioral health services statewide.

"Maryland, like most states, has an ER wait time problem," Dr. Morhaim said. "We've had kids and adolescents, often with mental health issues, spending days or even weeks in an ER waiting for placement. There was a work group a couple of years ago that didn't accomplish much, so the legislature enacted legislation creating this commission. There are two ER doctors, and 11 other people are involved. We have a fair amount of power to demand data that could lead to real solutions—instead of working with Band-Aid fixes."

Passion for Policy

Dr. Morhaim said he never would have predicted such a lengthy career in public policy after serving clinically from 1981 to 1994 as chair of the Department of Emergency Medicine at Franklin Square Hospital in Baltimore. But then, he never really saw himself becoming an ED doctor either. That changed when, as a college student, he joined a friend on a volunteer shift at Highland Hospital in Oakland, Calif. That shift led to medical school, and that led to board certification in emergency medicine and internal medicine.

His passion for policy stems from his clinical work and seeing numerous social issues in the patients he treated. Much of what Dr. Morhaim encountered in the ED, from end-of-life crises to preventable health conditions, was exacerbated by social factors like poverty, addiction, and lack of preventative care.

His path toward state legislative work was set. Dr. Morhaim ran for and won a seat in the Maryland House of Delegates. He campaigned with humor and creativity, handing out Band-Aid packs and likening himself to "George Clooney making a house call" when introducing himself as an ED doctor at voters' doorsteps. He got to be known as "Dr. Dan."

The effort paid off. Dr. Morhaim was elected for six terms, giving him 24 years to advocate for policy reforms that addressed the systemic issues he observed in the ED.

Citizen Legislator

Maryland, like most states, is a citizen legislature. Dr. Morhaim was a full-time legislator during the annual legislative session from January to early April, then returned to doing ED shifts for the rest of the year. What he saw in those ED months helped shape part of his legislative agenda for the upcoming session.

In his legislative role, Dr. Morhaim was a champion for drug treatment programs, health equity, and safety measures. He also worked on bills aimed at improving quality of life for seniors and environmental sustainability initiatives such as recycling. Dr. Morhaim has continued to write and advocate on health care issues, publishing books and articles on topics like end-of-life care. His clinical role continues as a medical director for ambulance companies, a volunteer physician with Remote Area Medical, and as faculty at George Washington University.

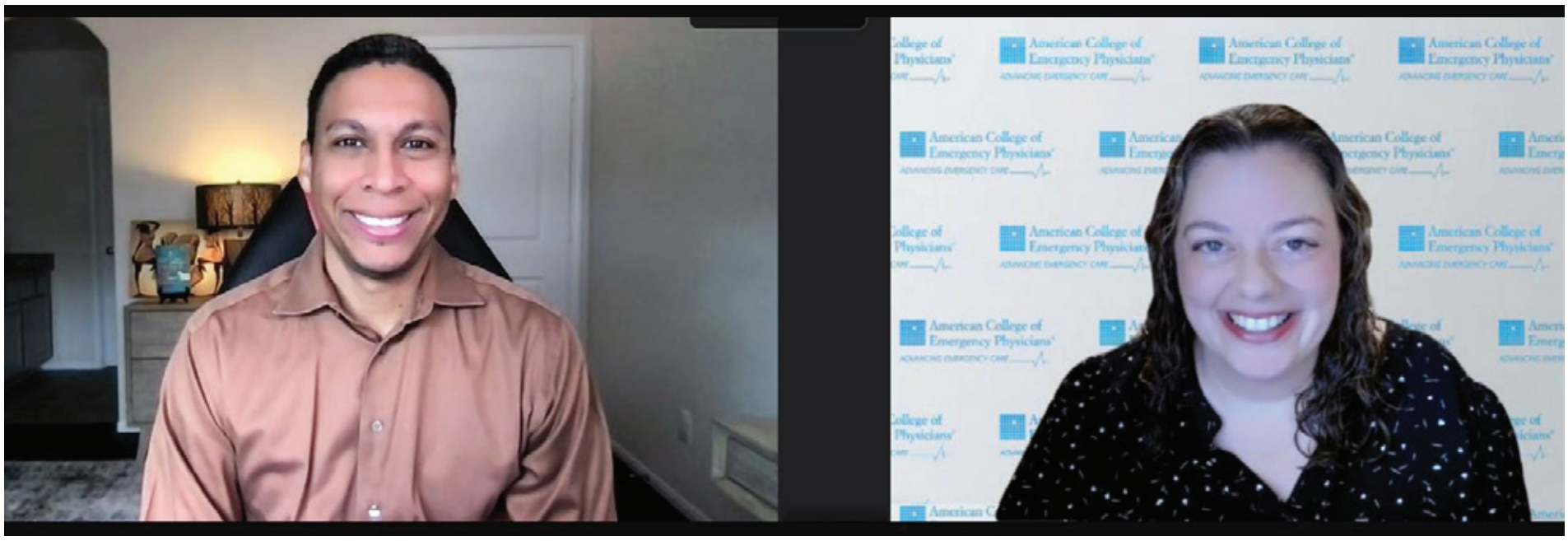
"People spend a lot of time paying attention to national politics, but it's state legislatures that decide most health care policy, such as whether states participate in Medicaid expansion, for example," Dr. Morhaim said. "Issues include scope of practice, payment, insurance, regulation, let alone education, traffic, public safety—states are really where the action is and where you can make a difference."

MR. SCHEID is ACEP's Communications Director.

Dan Morhaim, MD, FACEP

DAN MORHAIM

Dan Morhaim, MD, FACEP, speaks at a meeting of the Maryland House of Delegates. Dr. Morhaim has been assigned to a state commission to address emergency department wait times.



ACEP

ACEP Now Medical Editor-in-Chief Cedric Dark, MD, MPH, FACEP, interviews ACEP President Alison Haddock, MD, FACEP, about issues relevant to the College and emergency physicians.

A Conversation with ACEP President Dr. Alison Haddock

by CEDRIC DARK, MD, MPH, FACEP

Twice a year, the Medical Editor-in-Chief of *ACEP Now* sits down with the ACEP President to discuss issues relevant to the College and important to emergency physicians. The questions asked are based on feedback from readers and ACEP24 attendees, as well as the ACEP Council Meeting. This article is an excerpt of the conversation I had with Alison Haddock, MD, FACEP; it has been edited for length and clarity.

Dr. Cedric Dark: I was there when you made your remarks as President at the ACEP Council meeting in Las Vegas, and you mentioned to attendees that you wanted to focus on physician autonomy this year. What does physician autonomy mean to you?

Dr. Alison Haddock: When I look at what's happening in emergency medicine right now and I try and connect the threads of all the stressors that we're experiencing, a common thread appears. We are physicians. We are experts. We are incredibly well trained. We are ready to take on anything, but we are not being given the resources and the choices that we need to take excellent care of our patients. That boils down to a lack of autonomy.

If we have access to what we need, we can take better care of our patients. That means having access to insurance coverage for things like discharging someone to a skilled nursing facility. That means access to all the medications we need and not having to face drug shortages. It means having a say in how our workplaces are staffed and what the expectations are. I really think it's that loss of autonomy that's causing the distress and burnout that we're seeing in emergency medicine right now.

Dr. Dark: That's what I wanted to talk about next. Multiple surveys from Medscape over the past three years indicated that emergency physicians have led all physicians in burnout. What is the College doing to address that?

Dr. Haddock: The cause is the lack of autonomy. We have less autonomy than all the other specialists in medicine. Other [physicians] have different resources and different abilities to have their own practice and choose their own style. If you're a neurologist, you can go set up your own neurology practice, hire your own staff, decide what kinds of insurance you're going to take. We just can't make [these decisions] in emergency medicine because of the systems and because we've tied ourselves predominantly to working in a hospital.

There are some freestanding emergency departments that have been privately owned and have flipped that on its head a little bit. There are advantages and disadvantages to that. It's important to investigate the autonomy that they offer us as physicians to own our own space and control those factors that are otherwise outside of our control. But in my opinion, the core of improving [our situation] is greater autonomy, greater control over our schedules, and greater control over our lives.

Dr. Dark: We published a piece in *ACEP Now* about the role of private equity in health care in September, and according to Ivy Clinicians, about 25 percent of emergency physicians work at private-equity owned firms. Do you think that private equity needs to get out of the business of emergency medicine?[1]

Dr. Haddock: It's a difficult question because there are some well-run hospitals that may have some degree of private equity involvement, and there are some poorly run small democratic groups that aren't necessarily treated well by their hospital and able to offer what they want. However, broadly speaking, private equity is not holding the interests of patients or the interests of physicians at the top of mind.

The business model of private equity is to briefly invest in something, extract as much profit as you can during that brief investment, and then get out. That's not a model that's patient focused or physician focused. It's only about extracting dollars. I don't think that model is well suited for health care. Health care should be about putting patients first and putting the caretakers of patients second. That's not what private equity is doing. Honestly, it's not what most insurance companies are doing either. That's why we're seeing burnout. That's why we're seeing patients who are so dissatisfied with the health care system.

Dr. Dark: On a related note, a lot of emergency physicians seem to be growing frustrated with so-called contract management groups [CMGs], which are larger organizations that are trying to run the business practice of emergency medicine across multiple hospitals, sometimes multiple states. Do you agree with these frustrations and, if so, what do you think ACEP can do about that?

Dr. Haddock: I think that there is a lot of frustration with a variety of physician employers. That's why ACEP is working to increase transparency in this space and restore physician autonomy. The reason why people are frustrated with employers is because they're not being given the autonomy they need. They don't feel compensated. They don't feel like schedules are fair. They don't feel like they have control over the resources they need. What's driving the dissatisfaction with physician employers is the lack of autonomy.

I think we need to pressure all kinds of employers to offer more autonomy. CMGs are part of the problem, but so are giant, giant, giant academic groups where you just have such huge group size that the power is not localized at all. It's all centralized. The folks on the ground, who are living the life and seeing the patients, aren't able to talk to the folks who are making the decisions.

It's important for ACEP to help be that voice for those physicians, and to encourage employers of all kinds to offer transparency about how they do their business, and how they follow ACEP policies or don't. That's one of the drivers of ACEP Open Book—to have a place where you can go when you're looking for a job to say, "Does this site [or] this employer adhere to ACEP policies that are intended to protect the emergency physician?"

Dr. Dark: Like you said, academic groups sometimes can be like these large mega groups. Even still, physician-owned groups are not immune to these kinds of difficulties. One of the major things breaking in the news cycle now is that a [physician-owned] group, NES Health, has had some difficulties with financial pressure paying their employees. What do you think is the outlook for the business of emergency medicine when we're seeing these disruptions happening all the way from larger groups to even the physician-owned groups?

Dr. Haddock: What happened with American Physician Partners (APP) was unacceptable, where people were left without malpractice tail coverage due to group transitions. I just hope that we don't see that same thing happen with NES. It does show that this is happening across models of providers of emergency medicine services, because those have two different business models, with APP having more private equity involvement and NES being more individual physician-led.

Part of what's driving all of this is consolidation in the health care industry overall, which means consolidation of hospitals and consolidation of insurance companies. A lot of what's driving consolidation of [physician] employers is the fact that to be able to fairly position yourself and negotiate with these mega conglomerate insurance companies, you need to have a group of a certain size. I believe we need to be looking at consolidation across health care because it's having negative consequences on multiple levels—not just the insurance company level, not just the physician group level, but all these levels. They're decreasing the amount of choice that patients have, and they are leading to imbalances in the marketplace.

We already face a dysfunctional marketplace because of EMTALA, which means that we will see everyone who comes through the door, regardless of their insurance coverage. You

CONTINUED *on page 11*

RESIDENCY SPOTLIGHT

CHRISTIANACARE EMERGENCY MEDICINE RESIDENCY PROGRAM

Social media: @christianacareemed

Location: Newark, Del.

Year founded: 1980

Number of residents: 12 categorical EM residents, three EM/FM, and three to four EM/IM residents per class

Program length: three years for categorical, five years for combined residencies

WAIT STAFF AT MAKER'S ALLEY

Match Day 2024 celebration

What does your program offer that residents can't get anywhere else?

We see a high volume of critically ill patients within our department (approximately 210,000 visits per year). Our catchment area is extensive, including all of Delaware and portions of Maryland, New Jersey, and Pennsylvania. Our three campuses that we work at are within 35 minutes of each other and provide a diverse patient population. We offer a one-month long paid orientation that allows interns to acclimate to the hospital, form bonds with their classmates, and refresh medical knowledge concepts. We have an unopposed residency. Our pay is extremely competitive with additional educational funds that cover the cost of ACLS/ATLS/PALS/NRP, Step 3, a new phone or laptop once during residency, and conference attendance, along with, EMRA and ACEP memberships paid for while in residency. We work eight-hour shifts while on service in the ED, with a one to two shift per month reduction each year. There are amazing moonlighting opportunities starting your second year in the ED, CICU, and NCCU. We have faculty who are great teachers on shift, a well-established program of informal and formal feedback, and a group of co-residents who quickly become family.

What is the work–life balance like? What are some fun activities residents like to partake in or recently participated in?

While on service in the ED, residents work eight-hour shifts at our three different locations. This allows for time with family and friends. Some residents are part of a club soccer team (no experience required) that consists of residents of different specialties, as well as ancillary staff like pharmacists and nurses. There is weekly Wednesday night trivia. Friendsgiving happens each year and all classes are invited. We have easy access to Philadelphia and often go to Phillies, Union, and Sixers games, head in for date nights at some of the nicer restaurants, or study at coffee shops. There are plenty of parks and wildlife within 15 minutes of Newark and Wilmington, Del. The Delaware beaches are only 1.5 hours away.

How should potential applicants learn more about your program?

You can visit our website at https://residency.christianacare.org/em and/or email tempestt.melton@christianacare.org (Program Coordinator) or dannielle.allen@christianacare.org (Social Recruitment Chief, 2024-2025).

HADDOCK | CONTINUED FROM PAGE 10

can't set up an emergency department and say, "Hey, we don't take Medicare and Medicaid in a hospital." Hospitals have to participate in Medicare. They have to accept these kinds of insurance. There are some EMTALA mandates and those mandates are important to protect our patients. I think they're a driver for a lot of us to go into emergency medicine, but they also create a very unusual negotiating environment in terms of the free marketplace that we generally try to have in America.

Dr. Dark: I've known you for a long time now and in our conversations, you've always stressed to me your concern about membership of the College. I often will talk to people that aren't ACEP members but are emergency physicians, and one of the things that they ask me is, "What is ACEP doing for me?" What would be your answer to them?

Dr. Haddock: We are constantly trying to empower our members, protect our members, and make the practice of emergency medicine better. There is such a huge spectrum of things that we're doing. Some of our most important work right now is around the Open Book project and creating policies that define what a good workplace looks like for emergency physicians. The reimbursement work that we do is critically important. We're representing you at the [RVS Update Committee] and trying to make sure that the RVUs for the services that we provide in emergency medicine are fair.

It's also going to Congress and having conversations about balance billing and the dispute resolution process. It's also, at a more individual level, looking at how we can make each individual emergency department better for both patients and physicians. Now we're looking at the next level. Can we accredit emergency departments broadly and have even better requirements in terms of what it requires the workplace to offer you as a physician—and offer you in terms of resources for your patients?

The last point I will make is boarding. Boarding is crushing us all in emergency medicine right now. It is absolutely an example of that lack of resources that don't let you be the kind of doctor that you went into emergency medicine to be. We're doing critical work now advocating with the [Agency for Healthcare Research and Quality] and the federal government, trying to act on boarding so hospitals are under more pressure to solve boarding. We know it's not an emergency department problem. It's a health system overload problem that needs to be solved on a higher level. That kind of advocacy is something that you can't get anywhere else other than ACEP. I hope folks will recognize that, and I hope they become members so that they can participate in that and get a better workplace for themselves and their patients.

Dr. Dark: One of the difficulties with membership is this concept called the "tragedy of the commons" where people benefit from things ACEP members are paying for, even if they haven't paid for it themselves. How do you counter that mentality of people who want to stay outside of the organization because they feel like they'll get those benefits anyway, as opposed to people that want to stay dedicated and continue to contribute to the organization?

Dr. Haddock: I ask them to join and be part of the solution, not just let the solution happen to them. There are tons of ways to have your voice heard within ACEP as well. You can participate on a committee, you can participate in a section, you can become a Councillor. There are ways that you can not only sit back and watch those good things happen, but you can participate in implementing them and prioritizing them.

Dr. Dark: We're recording this the Friday after the presidential election, and our country right now seems divided. I've seen a lot of the opinions put forth by ACEP members on multiple issues, whether it's reproductive health care, diversity, equity, inclusion, or other broader societal issues. Those opinions seem to differ drastically. We receive letters to the editor, we get opinions, and sometimes they represent various poles. How do you, as ACEP President, plan to navigate these issues that pit some members of the College in opposite camps from one another?

Dr. Haddock: These are challenging spaces for us to be in, but I think we need to focus on putting our patients and our practices first. There can be a variety of opinions on an issue, and maybe it doesn't really touch us in emergency medicine. We need to look at the spaces where it does engage us as emergency physicians and how we can make sure that physicians are protected, making sure they have the resources that they need to provide quality care. For example, Medicaid expansion can be a somewhat politically polarizing issue. However, when you look at reimbursement for emergency physicians, it's generally expected to improve with Medicaid expansion, so we offer resources to states and we have a policy in support of Medicaid expansion because that seems to get better compensation for our emergency physicians and offer better coverage for our patients.

Dr. Dark: Thank you, Dr. Haddock.

Dr. Haddock: Thanks so much. Great to see you today.

Scan the QR Code to watch a video of the full interview.

References

1. Lee C. The private equity wave in health care. *ACEP Now.* https://www.acepnow.com/article/the-private-equity-wave-in-health-care/. Published September 3, 2024. Accessed November 12, 2024.

Arizona

AzCEP supports emergency department-based clinical research and emergency medicine residents, medical students, and fellows as they work toward their future careers. For the past 13 years and with $20,000 in grant dollars, we have made it a priority to support emergency medicine training programs throughout Arizona.

Arkansas

Several Arkansas ACEP officers attended ACEP24 in Las Vegas, where they shared ideas and strategies to strengthen the chapter's work. Arkansas ACEP is also planning a residency visit to Unity Health–White County Medical Center. Looking ahead to the chapter's annual meeting in December, the chapter leaders will hold officer elections and recognize the hard work and dedication of its members.

California

The chapter secured $200 million annually for Medicaid increases for emergency physicians—the first increase in 20 years. The increase was approved in 2023, but the governor proposed to take it to backfill the state's deficit in 2024. Emergency physicians were the only ones to get funding restored. The chapter also championed AB-977, which will increase penalties for emergency department violence.

Colorado

COACEP, together with other specialty societies, hospitals, and insurers, formed a coalition called Coloradans Protecting Patient Access (CPPA) to fight the proposed removal of medical malpractice caps and an attack on peer review protections. The governor's office helped broker a deal between the lawyers' association and CPPA to maintain the sanctity of peer review, while increasing medical malpractice caps a reasonable amount.

Connecticut

Connecticut ACEP members successfully advocated for state accountability on emergency department boarding. By leading a working group, they helped secure legislation requiring hospitals to report metrics on boarding. They are continuing to work to institute quality measures and other recommendations to help address boarding and improve patient care.

District of Columbia

The DCACEP Chapter submitted two resolutions that were passed by the ACEP Council in October 2024—Workplace Violence and the first resolution of support for the Well Workplace policy statement. The DCACEP Chapter also collaborated with the Medical Society of the District of Columbia (MSDC) on licensing and renewals in Washington, D.C.

Florida

The Florida Chapter focused on leadership development through clear expectations and open communication; expanded influence through strategic engagement and strengthening external communications with legislators, the public, and others; prioritized membership engagement and set record attendance at FCEP's Symposium by the Sea; and relocated to a new headquarters, eliminating the chapter's mortgage obligation.

Georgia

In December, GCEP hosts its Leadership and Advocacy Conference with a record number of Georgia General Assembly guests. For 2025, GCEP plans a medical liability reform push, partnering with the Medical Association of Georgia (MAG) and other specialty societies. GCEP is well positioned to lead the fight, with the chapter's members chairing MAG's Council on Legislation and its Tort Relief Taskforce.

Government Services

In 2024, GSACEP hosted its largest Government Services Symposium, welcoming more than 150 participants. The chapter selected Capt. Mike Ramirez, MD, MS, as the second COL (Dr.) Dave Barry Leadership Development fellow. GSACEP also continued its research efforts to assess military health care readiness and ensure access to mental health resources.

Hawaii

Hawaii ACEP bid aloha mid-term to a wonderful president, Beth England, MD, and welcomed Mark Baker, MD, FACEP, in serving his third presidential term. HI-ACEP advocated at Leadership and Advocacy Conference for solutions to emergency department boarding, mental health, and physician safety. The chapter's annual conference was a wonderful event with members, and bylaws revisions were approved. Jobs are available in paradise for anyone interested!

Idaho

Idaho ACEP worked with national ACEP to release a statement following the SCOTUS decision to allow emergency abortions in Idaho. The chapter remains hopeful that more states will lift restrictions to vital emergency care, a position outlined in amicus briefs filed in Texas and Idaho by ACEP, defending physician autonomy.

Illinois

ICEP's Patient and Physician Advocacy Committee has been working with the Illinois Political Action Committee to provide campaign donations and make in-person visits to political events for candidates who support emergency medicine access and safety. ICEP is working with aligned professional societies to pass patient safety legislation, ensuring patients' access to physician-directed care and freedom from workplace violence.

Indiana

The Indiana Chapter has fought for fair reimbursement for emergency department services during the past year. The chapter had meetings with emergency medicine groups, insurance companies, and state legislative agencies, and will continue to work toward fair reimbursement during the state's upcoming legislative session.

Iowa

The chapter strengthened member engagement, networking, and educational opportunities through a successful annual meeting with more than 30 members and guests, development of a new joint educational series with the two Iowa residencies featuring a live podcast event, and hosting a dedicated reception at ACEP24.

Kansas

In 2024, the chapter had a record turnout and engagement at the ACEP Council Meeting. Additionally, we had the privilege of hosting ACEP Immediate Past President Aisha Terry, MD, FACEP, for Grand Rounds at the University of Kansas emergency residency program.

Kentucky

In 2024, Kentucky ACEP focused on physician billing and coding, and engaging with state leadership. Kentucky's annual state chapter meeting was another success. The University of Kentucky and the University of Louisville emergency medicine resident programs continued their annual "Battle of the Bluegrass," competing in knowledge and procedural events in a fun, spirited contest.

Louisiana

The LAACEP chapter authored the chapter council allocation resolution, and it was passed. Chapter councillor allocation will now be calculated based on the average for the year, instead of the final number on December 31. Phillip LeBas, MD, FACEP, received the ACEP Council Curmudgeon Award.

Maine

This year the Maine Chapter updated their bylaws and worked with the state of Maine to address the boarding of pediatric behavioral health patients.

Maryland

In April 2024, Maryland ACEP hosted its annual Educational Conference and Annual Meeting, attracting more than 150 attendees. Chapter leaders participated in the HSCRC ED Flow Committee, advocating for emergency physicians throughout Maryland. The yearly Legislative Reception in Annapolis welcomed many key legislators and staff, who engaged with chapter members advocating for emergency medicine in the state.

Massachusetts

In June 2024, MACEP held a successful advocacy day at the State House and prioritized strengthening safety protections for health care; overhauling the involuntary commitment landscape for individuals grappling with alcohol and substance use disorders; and stressing deteriorating health care conditions, including the boarding crisis leading to poor patient outcomes, avoidable deaths, physician burnout, and a worsening workforce shortage.

Michigan

The Michigan Chapter celebrated the election of MCEP Past President, Diana Nordlund, DO, FACEP, to the ACEP Board of Directors. Rami Khoury, MD, FACEP, completed his term on the ACEP Board. Earl Reisdorff, MD, FACEP, received the 2024 James D. Mills Outstanding Contribution to Emergency Medicine Award. Advocacy efforts included conversations with state leaders about Medicaid reimbursement increases, as well as additional protections for emergency department workers from workplace violence.

Minnesota

During the past year, the Minnesota Chapter focused on addressing legislative efforts and increasing member engagement. The chapter rebuilt its Legislative and Advocacy Task Force to educate members on the state's legislative process, inform the board on priority issues, and create an alert system for members to contact state officials.

Missouri

During the 2024 legislative session, MOCEP protected Missouri's scope of practice boundaries. The chapter supported expanded prescription drug discounts and federal reim-

bursements to offset Missouri's health care budget. MOCEP's 2025 priorities are scope of practice, physicians in every emergency department, workplace violence, down coding, and protecting physician reimbursement.

Montana

MT ACEP started a chapter of The Naloxone Project, a national effort to directly distribute free naloxone from emergency departments statewide. Additionally, two large grants are under consideration that would distribute free naloxone from all 66 emergency departments in the state. Montana teamed up with Idaho and Wyoming and will host a Northwestern Ski Symposium Feb. 6, 2025, in Sun Valley, Idaho.

Nebraska

Nebraska ACEP has been successful in strengthening the chapter. It held a highly attended annual meeting in late summer, participated in the state medical association's Advocacy Breakfast, where chapter leaders connected with state legislators, and advocated for emergency medicine during the legislative session.

Nevada

NV ACEP focused on enhancing its engagement with emergency medicine residents this year. At ACEP24 in Las Vegas, the chapter organized a mixer that drew an excellent turnout of residents, and our board members are hopeful it could lead them to become more involved with ACEP.

New Hampshire

To boost engagement and offer greater value to our members, the NH chapter proudly hosted Ski Day in February and a beautiful lake cruise in September. Although there was a nominal fee for Ski Day, the lake cruise was complimentary for our members, and family members were welcomed.

New Jersey

New Jersey ACEP, through the Access to Care Coalition, met with state representatives to continue to advocate for patient protection by standing firmly against removing physicians from the front lines. The chapter continues to focus on growing membership from the ground up and visited with every medical school in the state.

New Mexico

NM ACEP worked with Sen. Martin Heinrich this year to support legislation allowing patients with opioid use disorder greater access to buprenorphine. The chapter added a medical student to its board to hear and understand the issues that are most important to the next generation of emergency physicians.

New York

New York ACEP is working to advance legislation addressing emergency department violence. The chapter also defeated physician assistant independent practice and maintained the physician-led team; supported the expanded ability for first response services to administer blood transfusions; and supported insurance coverage and cost ceilings on epinephrine.

North Carolina

In 2024, NCCEP was proud to have a second member, Jennifer Casaletto, MD, FACEP, elected to the ACEP Board of Directors in as many years. The chapter successfully lobbied BCBSNC to rescind an inappropriate policy regarding evaluation and management codes. The chapter also banded together to recover from Hurricane Helene, which devastated western North Carolina, affecting the state's local communities and national IV fluid supplies.

Ohio

The Residents' Assembly and Medical Student Symposium had a record attendance of 450. Ohio ACEP's Advocacy Day spurred House Bill 452, addressing hospital violence, which is now advancing to the Senate. At the ACEP Council, Ohio members held leadership roles, and at ACEP24, the newly edited *Carol Rivers' Emergency Medicine* textbook was showcased. The chapter also offered ultrasound, oral board, and emergent delivery sim courses.

Oklahoma

The Oklahoma College of Emergency Medicine Physicians unveiled a new website in 2024, featuring member spotlights, advocacy updates, and a searchable database for statewide emergency department resources. OCEP leaders are making resident outreach visits to promote College activities and benefits of membership. Priorities for 2025 include member engagement and retention, leadership development, and state advocacy efforts.

Oregon

OR-ACEP's greatest success this year was lobbying in support of an EMS modernization bill that will strengthen statewide EMS coordination and ensure timely access to trauma, cardiac, stroke, critical care, and behavioral health specialty care. OR-ACEP worked with state agencies and legislators to address the boarding crisis and improve health system capacity by implementing a statewide transfer coordination center.

Pennsylvania

The chapter's biggest victory was the successful passage of legislation to limit health care noncompete agreements to one year. This landmark law was signed by Gov. Josh Shapiro in July and will take effect Jan. 1, 2025. The chapter leaders extend special thanks to Rep. Dan Frankel and Rep. Arvind Venkat, MD, (an ACEP member) for their instrumental roles in achieving this outcome.

Puerto Rico

In May 2024, Puerto Rico ACEP hosted its annual Caribbean Congress in San Juan, attracting more than 250 attendees. Additionally, the chapter hosted two virtual discussions on managing critically ill patients and resuscitating poisoned patients. Dedicated to emergency medicine's future, Puerto Rico ACEP provided mentorship and support to residents attending ACEP's Leadership and Advocacy Conference and other chapter events.

Rhode Island

The chapter supported the Health Care Provider Shield Act with successful passage and testified on numerous malpractice bills.

South Carolina

This year, the chapter concluded the two-year legislative session, and with the help of the South Carolina Medical Association, South Carolina ACEP successfully held off a broad scope expansion bill that would have granted unsupervised practice to nonphysicians. The chapter plans to introduce a "physician onsite" bill in 2025 to ensure physician-led care in all emergency departments.

South Dakota

The South Dakota Chapter is using 2025 to begin re-engaging the SD ACEP chapter members and working to get its yearly educational conference back up and running.

Tennessee

TNCEP addressed key issues, including opposing a bill that would have overturned Tennessee's Corporate Practice of Medicine Act, which prohibits most instances of direct employment of emergency physicians by hospitals; supporting the requirement that physician assistants collaborate with a physician; supporting increased penalties for health care facility assaults; and supporting a bill to limit emergency department boarding (although it failed to pass).

Texas

TCEP played a significant role in overturning the *Marsillo v. Dunnick* (snakebite) case, ensuring that plaintiffs must prove willful and wanton treatment in emergency malpractice cases. TCEP also led efforts to prevent the closure of the CHRISTUS Spohn Emergency Medicine Residency program by educating hospital administrators on the program's importance to patients in the community.

Utah

The chapter held its annual Utah Emergency Medicine Physician Summit, which this year featured ACEP Immediate Past President Aisha Terry, MD, FACEP; Don Stader, MD, FACEP; Amal Mattu, MD, FACEP; and other esteemed speakers. The chapter also advocated for minimum standards for freestanding emergency departments, because services and staffing are in danger of being scaled back as the number of facilities continues to increase.

Vermont

Vermont ACEP is advocating for physician-led emergency care and opposing a proposal for standalone emergency departments staffed by nonphysicians. Through a detailed letter to the Green Mountain Care Board, the chapter highlighted the essential role of emergency physicians in ensuring patient safety, care quality, and efficiency, reinforcing the value of physician-led emergency department teams.

Virginia

Chapter leaders successfully advocated for a law requiring a physician be physically present in emergency departments starting in July 2025. Another new law allows family access to patients under Emergency Custody Order/Temporary Detention Order in the emergency department unless the physician deems it unsafe. Opposed by Virginia ACEP, a bill reduced training for nurse practitioner independent practice from five to three years.

Washington

Washington ACEP successfully defeated inappropriate scope of practice proposals in 2024. A current statewide priority is cardiac and stroke system legislation. PAC activities led to early support of the state's new insurance commissioner—the chapter hopes to be a resource for her going forward. The chapter continues to engage membership through events and its annual conference.

West Virginia

WVACEP developed a new five-year strategic plan. The strategic pillars are advocacy, membership, value, education, and sustainability. These strategic pillars will guide the organization's work during the next five years. The Emergency Medicine Summit 2024 took place on Sept. 19, 2024. WVACEP will celebrate its 50th anniversary in October 2025.

Wisconsin

The Wisconsin Chapter remains dedicated to enhancing Medicaid reimbursement rates for emergency codes and advocates for staffing emergency departments with qualified physicians to address crucial scope of practice issues. Along with state residency programs, WI-ACEP hosted the Annual Wisconsin Emergency Medicine Research Forum. The chapter is committed to fostering greater member engagement and expanding support for those in the state's rural areas.

Scan a QR Code below to access the full story.

Coronary Vasospasm-Induced Cardiac Arrest

Refractory ventricular fibrillation arrest abated with IV nitroglycerin in the ED

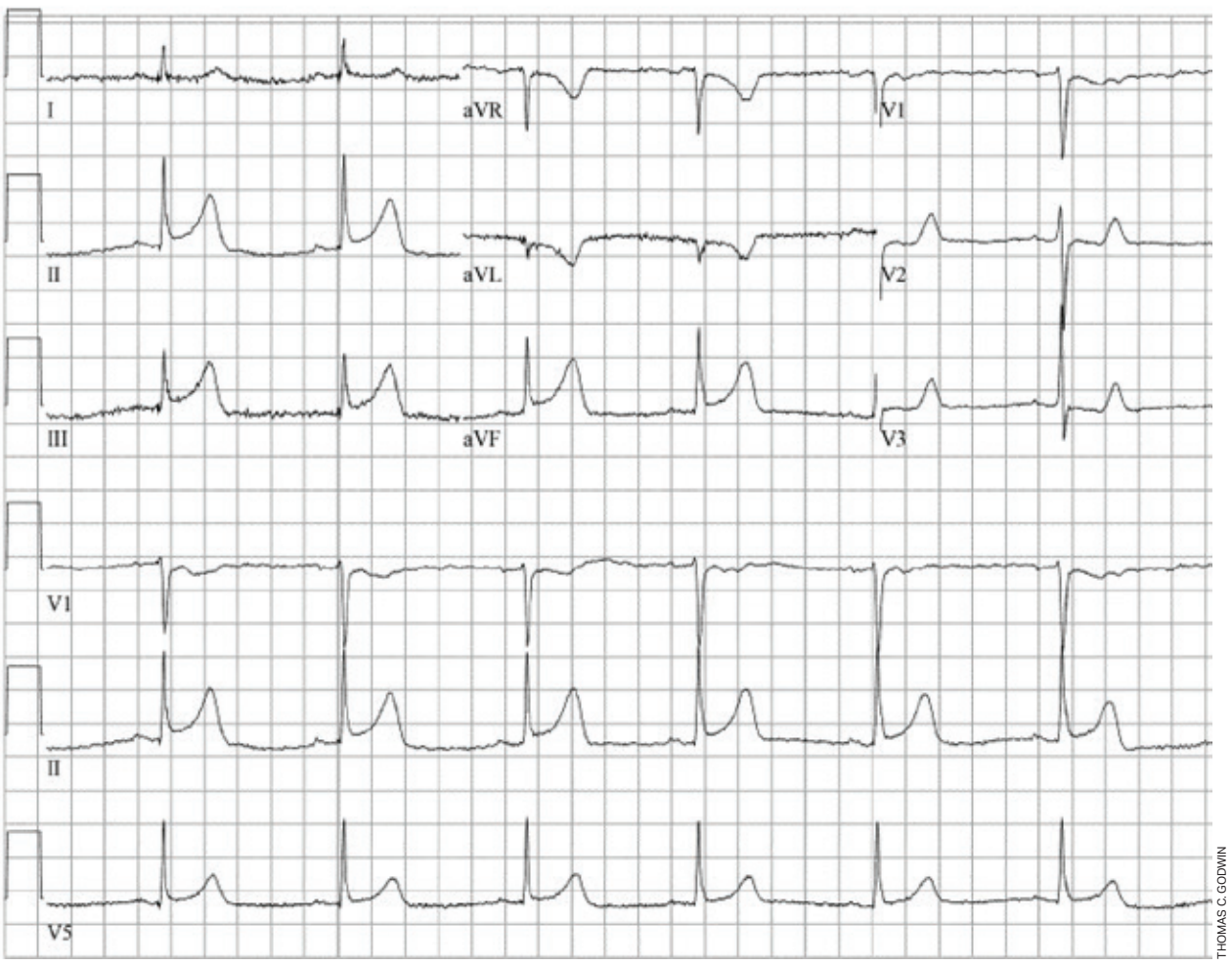
by THOMAS C. GODWIN, MD; DANY ACCILIEN, MD; AND JAHAN RAD, MD

A 45-year-old male with a history of chronic obstructive pulmonary disease (COPD), asthma, amphetamine and tetrahydrocannabinol (THC) use, and coronary vasospasm presented to triage with chest pain. During initial assessment, an ECG was obtained and revealed ST-segment elevation (STE) in the inferior leads with ST depression anteriorly.

During assessment, the patient reported that a left heart catheterization six months prior indicated "spasms" but no coronary artery disease. Before nitroglycerin (NTG) could be administered, the patient became unresponsive and was transferred to the resuscitation bay, where the monitor revealed a ventricular fibrillation arrest. Advanced cardiac life support protocol was initiated, and the patient was intubated. During this time, a comprehensive chart review was conducted that revealed the patient had experienced two prior ventricular fibrillation arrests, both resolved with intracoronary NTG during left heart catheterization, showing severe dominant circumflex spasm resulting in 99 percent occlusion, which abated with intracoronary NTG.

The patient was deemed to be in refractory fibrillation.

What would you do next? ⊕

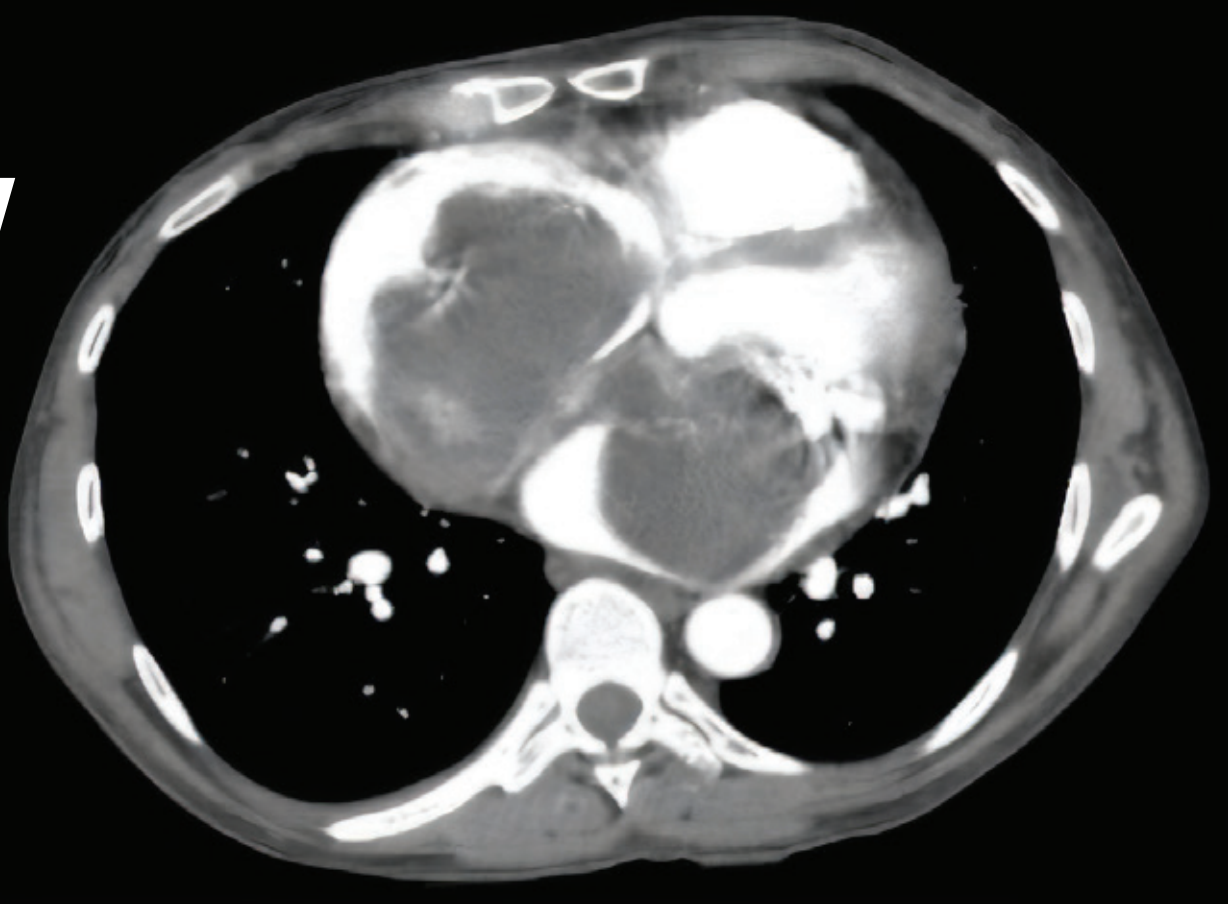


THOMAS C. GODWIN

Butterfly in the Sky

by NANAKWAME A. DARKWA, MD; AVINASH RAM, DO; AND KAZI SUMON, MD

A 46-year-old female with a prior medical history of asthma presented to the emergency department with shortness of breath and wheezing. After three DuoNeb treatments and 16 mg of dexamethasone, her wheezing improved; however, she continued to report shortness of breath on exertion. Given the persistent symptoms, a cardiac point-of-care ultrasound was obtained. ⊕



NANAKWAME A. DARKWA

Moving Beyond Controversy to Comprehensive Care

Advancing emergency stroke care

by KORI ZACHRISON, MD, MSC, FACEP; BRUCE LO, MD, MBA, RDMS, FACEP; ED JAUCH, MD, MS; AND ARJUN VENKATESH MD, MBA, MHS, FACEP

The use of thrombolytics for acute ischemic stroke may be one of the most controversial topics in emergency medicine during the last several decades. This debate recurs in multiple forums including many previous pieces in *ACEP Now*.[1] The reason is understandable—thrombolytics in stroke is a high-risk, higher-reward treatment. If the potential for harm were absent, or if the benefit of thrombolytics was only marginal, there would be no controversy. Because both real risk and very real reward are at play, the debate persists.

However, like any topic—including the optimal medications for rapid sequence intubation or whether Pepsi is better than Coke—these discussions largely live in a stratosphere far above our daily clinical practice. In the setting of regular patient care, the debate is over. There continues to be consistent evidence favoring treatment. Professional organization guidelines universally support the use of thrombolytics, including the American Heart Association and ACEP.[2,3] Hospital policies and stroke protocols include thrombolytic administration for eligible patients as a rule. Systems of care have evolved to better support emergency physicians in overall stroke care and, specifically, decisions on giving thrombolytics. Because of the increased availability of neurology consultation, expansion of telestroke, and clear hospital protocol, emergency physicians are less alone in deciding when to give thrombolytics. Another argument is also there—emergency physicians don't want to be sued; data consistently show that medical malpractice risk is much greater for undertreatment of stroke. When we care for eligible patients with ischemic stroke in the emergency department (ED), there is no debate: We administer thrombolytics when the opportunity presents.

Acceptance of thrombolytics in stroke is exemplified in the results from a survey of EDs participating in ACEP's Emergency Quality Network (E-QUAL) Stroke Collaborative. This learning network engages community EDs, regardless of setting or size, that are interested in improving stroke care. As part of the collaborative, we performed a capabilities assessment to understand the resources of participating sites. Last year's assessment demonstrated widespread adoption of thrombolytics for stroke among emergency physicians (see Figure 1).

Figure 1. Attitudes toward thrombolytic therapy in stroke among physician groups in E-QUAL participating community EDs

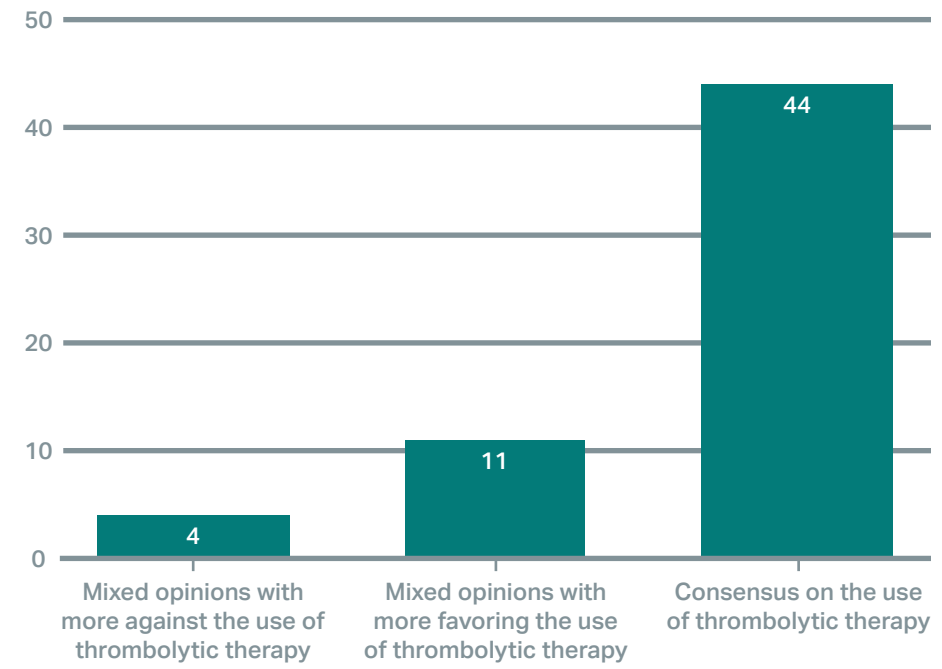
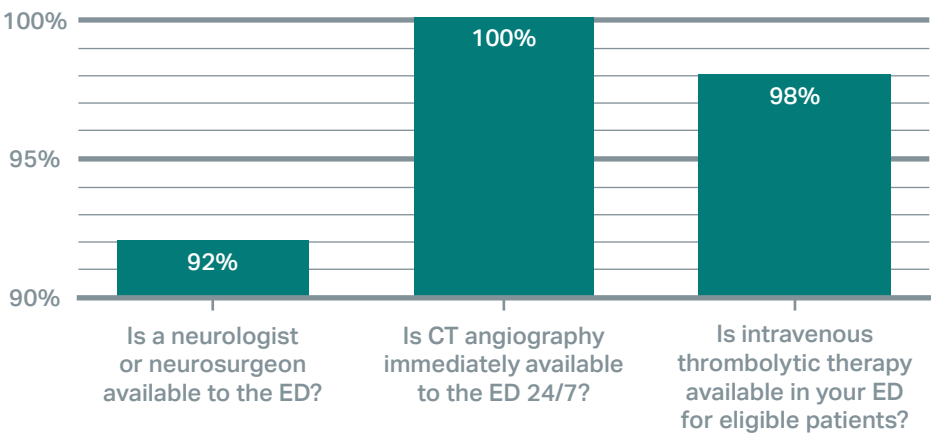


Figure 2. Availability of stroke care resources among community EDs in E-QUAL



Diagnostic Efficiency

Moving past the debate of whether to administer thrombolytics enables us to engage in a new set of conversations related to stroke care in the ED.

First, we are now operating in a paradigm in which the ED can provide tremendous diagnostic efficiency for acute stroke. Nearly all community EDs reported having access to CT angiography, thrombolytics, and even neurology (see Figure 2). Many (71 percent in our sample) even had access to perfusion imaging, whether through MRI or CT perfusion.

Today, the integrated stroke system of care is far advanced from when the initial research in this space was performed. We are equipped to rapidly identify eligible patients and, in most cases, have the ability to make specialist-supported treatment decisions. In fact, although they may not have an official stroke certification, data from E-QUAL showed that many U.S. hospitals are already well equipped to function as Acute Stroke Ready Hospitals. These sites have the necessary structure to receive patients with acute ischemic stroke, administer timely thrombolytics, and identify those who require transfer for thrombectomy or a higher level of care. In areas where stroke center certification does not provide a prehospital triage advantage, such as remote and rural settings, hospitals may not invest in these official designations. Nevertheless, these sites are increasingly demonstrating that they have the necessary structures to function as an Acute Stroke Ready Hospital with the right processes and resources in place.

Stroke Identification

Second, emergency physicians have a broad skillset and are particularly suited for identification of patients who will benefit from all types of treatments—from extracorporeal membrane oxygenation to lithotripsy. We combine data related to the patient's profile, physical examination, onset of timing, and imaging results to form the complete clinical picture. Our role is no longer to decide whether thrombolytics work or not, but to identify and treat patients who will benefit. The latest research underscored that there is more nuance to treatment than a simple "yes" or "no" for thrombolytics, and that our skillset, along with our consultants, can help drive the best outcomes for our patients.[4]

For example, in the prehospital setting, we must consider how potential stroke is identified and which patients should be diverted to thrombectomy-capable and comprehensive stroke centers to ensure timely treatments, while avoiding overwhelming already-full tertiary care centers. In the ED, how do we create efficient and effective stroke protocols that include optimal imaging strategies, the selection of the best thrombolytic agent, and the management of wake-up strokes? And in stroke systems of care, how do we determine who to transfer, when to transfer, and how to transfer patients with stroke in a timely manner, particularly in the era of severe hospital crowding, significant ED boarding, and critical health care workforce shortages (EMS, nursing, techs, and board-certified emergency physicians)?

Like other practices, we will need learning networks like E-QUAL and other systems of care with well-developed protocols including engaging our consultants to support treatment decisions. As we recognize the growing strength of our systems for acute stroke care, we have the tools and resources to provide optimal care for our patients. It is now imperative to push the conversations in our specialty to the next level, ensuring high quality care delivery and the best outcomes for our patients.

The authors would like to acknowledge ACEP staff members Megan Sambell, Prateek Sharma, Sam Shahid, and Yale University statistician and E-QUAL data analyst Craig Rothenberg for their support and contributions to this work.

DR. ZACHRISON is an associate professor of emergency medicine at Massachusetts General Hospital and Harvard Medical School and Chief of the Division of Health Services Research for Mass General Brigham Emergency Medicine.

DR. LO is the chief of emergency medicine at Sentara Norfolk General and professor at Eastern Virginia Medical School in Norfolk, Va. He is a partner with Emergency Physicians of Tidewater, a local private, democratic group, and chaired the ACEP clinical policy subcommittee on stroke thrombolytics.

DR. JAUCH is chair of the Department of Program Evaluation and Research at the University of North Carolina Health Sciences at MAHEC.

DR. VENKATESH is professor and chair of emergency medicine at Yale School of Medicine and chief of emergency medicine at Yale New Haven Hospital.

References

1. Radecki RP. Is the tPA-for-stroke debate over? *ACEP Now*. 2018;37(6).
2. Power WJ, Rabinstein AA, Ackerson T, et al. Guidelines for the Early Management of Patients with Acute Ischemic Stroke: 2019 update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. [published correction appears in *Stroke*. 2019 Dec;50(12):e440-e441]. *Stroke*. 2019;50(12):e344-e418.
3. ACEP. Thrombolytics for the management of acute ischemic stroke. https://www.acep.org/patient-care/clinical-policies/thrombolytics-for-the-management-of-acute-ischemic-stroke. Accessed November 4, 2024.
4. Radecki RP. The latest research in neurologic emergencies. *ACEP Now*. 2024;43(9).

Nguyen said. "I love coming out here, listening to people's stories, and building relationships with individuals who are often neglected by the health care system. It's actually a great way to unwind after a busy shift."

The Chicago Street Medicine program is just one example of ACEP members delivering care to underserved populations outside of the traditional emergency department (ED). Volunteers with free time and board certification in emergency medicine work in clinics where all that is required to get blood pressure medication is a diagnosis of high blood pressure. Volunteers work in mobile clinics, where converted vans and buses move where the need is greatest. An increasing number of emergency physicians are working in street medicine programs, removing most of the barriers to health care access.

"Street medicine goes beyond medical care," said Dr. Nguyen, co-founder of the Loyola Street Medicine program and director at the Center for Community and Global Health at Loyola's Stritch School of Medicine. "It's about understanding the full picture of a patient's circumstances. We're addressing the roots of their needs, which go far beyond their medical symptoms."

JORDAN VAUGHN, MD

Volunteers and the organization "Freestanding Communities", which provides medical triage and patient screenings, prepare a street medicine clinic in New Orleans. ACEP member Jordan N. Vaughn works with Louisiana State University, volunteers, and other city services to provide care to underserved populations.

Street Medicine Movement

Street medicine is rooted in a movement that began in the 1990s, pioneered by physician James S. Withers, MD, who went into Pittsburgh's homeless campsites to provide care and gain insight into the lives of people living on the streets. Today, that movement has expanded globally. According to the Street Medicine Institute, more than 140 cities have street medicine programs, serving the unsheltered in 27 countries and six continents.

Volunteers said street medicine demands adaptability and a deep understanding of patients' lives. To develop this understanding, Dr. Nguyen created a "street medicine inpatient consult service" at her hospital.

This initiative supports homeless patients admitted to the hospital, ensuring continuity of care and safe discharge plans. The program is designed to offer a holistic care experience, building long-term relationships with patients that stretch from the streets into the hospital.

Chicago Street Medicine works with medical schools throughout the city, creating a network of chapters led by students from the University of Illinois Chicago, Northwestern University, the University of Chicago, and Loyola. This organizational structure allows street medicine to be flexible and responsive to the unique needs of each neighborhood.

A Rewarding Learning Experience

For Qi Charles Zhang, MD, MPH, attending physician at Humboldt Park Health, Chicago, delivering health care is about reaching people the system can miss. Until recently, Dr. Zhang was the medical director of the Chicago Street Medicine program. He learned about street medicine working with Dr. Withers in Pittsburgh as a visiting student for a program called Operation Safety Net, and then helped grow street medicine while in medical school at Tulane University and as resident at Louisiana State University (LSU), before moving to Chicago.

Dr. Zhang said many underserved patients face barriers to accessing clinics or simply don't feel welcome in conventional health care settings. Street medicine, in contrast, brings a clinic to them—backpacks filled with wound care supplies, antibiotics, and over-the-counter medications, along with essentials like snacks, socks, and water.

For the medical students and residents participating in these street runs, the work is eye-opening and rewarding.

"It's an important opportunity for these students to really see what it is that these patients go through," Dr. Zhang said, adding that it fosters a deeper understanding of the barriers faced by underserved populations. Dr. Zhang said this experience is essential, regardless of the specialty students choose later.

"A lot of the things we used to blame patients for—being noncompliant, signing out against medical advice—are so much more complicated," he said.

Delivering More Than Medicine

Emergency physician Jordan N. Vaughn, MD, clinical assistant professor at the LSU School of Medicine and public health clinical director for the New Orleans Health Department, helps deliver critical health care services to New Orleans' most vulnerable populations and is keenly aware of Dr. Zhang's legacy.

Through a partnership with LSU's Street Medicine Program and the city's initiatives to improve housing opportunities, Dr. Vaughn and her team bring health care directly to those living on the streets, filling gaps in access, and addressing the complex needs of these communities.

The LSU Street Medicine Program, primarily a mobile health outreach initiative, engages medical students in providing health services to people who are unhoused or facing extreme poverty.

Services are extensive and go beyond traditional medicine, including distributing essentials like toiletries, clothing, snacks, and vitamins, and providing guidance on obtaining identification or filling out paperwork for housing and health care.

"This is a patient population that's frequently misunderstood," Dr. Vaughn said. "One decision or one life event can put somebody in this situation. These programs and the outreach we do remind me of why I went into medicine and why, as emergency physicians, we do what we do."

Partnering with the Mayor's Office of Homeless Services and Strategy, Dr. Vaughn's team also coordinates care and resources for residents of New Orleans' encampments, areas designated for the homeless. The effort is both strategic and empathetic, as they map out high-priority encampments using 911 and EMS data and spend the first two weeks establishing rapport.

"Each encampment, especially in New Orleans, has its own flavor of needs," Dr. Vaughn said. "A lot of time is just spent introducing myself with 'Hey, I'm Dr. Vaughn, and I'm coming out every morning.' You wear them down a little bit because they're like, 'Okay, this is familiar. She keeps showing up.'"

Once trust is established, the team works on individualized plans to overcome barriers to housing and health care. Some struggle with addiction. Others face challenges related to disabilities. In cases where it wouldn't be safe to place a person in independent housing, the team arranges for long-term care. By the end of their outreach period, they've created a name list, identified barriers, and coordinated with case workers to ensure everyone receives appropriate support.

In addition to housing and outreach, Dr. Vaughn's team delivers a range of medical services on the street, meeting many residents' primary care needs.

"A lot of it is chronic ailments—high blood pressure, diabetes," she said. "'I lost my meds, or they were stolen, or I couldn't fill my medications.'"

Making a Street Run

At the University of South Florida, Enola Okonkwo, MD, participates in a student-driven Tampa Bay Street Medicine program, delivering care to Tampa's homeless population. Through the program, Dr. Okonkwo and a team of medical students, residents, and faculty embark on "street runs" along a central downtown route frequented by the unhoused community. The team goes out in small groups, carrying backpacks loaded with basic medical supplies and dressed in matching, recognizable green shirts. They don't provide prescription medications, but they have a "mini pharmacy" of over-the-counter medicine, wound care items, insect repellent, hygiene kits, and Narcan.

"Sometimes, patients just need someone to help them understand when a problem might require an ER visit," Dr. Okonkwo said. "One patient came to us with a severe hand infection. We got him to Tampa General for IV antibiotics before it became life-threatening."

For Dr. Okonkwo, whose regular job is serving as associate program director for University of South Florida's emergency residency program, one of the most impactful aspects of street medicine is the opportunity to connect with patients on their own terms; the population has a totally different demeanor on the street.

"They know we're there only to help them," she said. "It's a different level of trust, without the metrics or pressure typical in the ER. The informal, nonclinical setting helps ease the stigma and guardedness these individuals often feel in traditional health care environments, and it lets us focus on simple medicine and essential care."

Beyond street medicine, the Tampa program also provides a student-led continuity clinic and a specialized refugee clinic, both of which are commonly staffed by emergency physicians. The continuity clinic operates out of Tampa Hope, a structured shelter with semi-permanent mini-cottages funded by Catholic Charities, and offers a stable location for ongoing care. Volunteers can prescribe medications and provide a primary care bridge to reduce ED visits. For Dr. Okonkwo, it's this more consistent care model that makes a lasting difference.

"We're helping to fill the primary care gap, which is essential for avoiding preventable complications in vulnerable populations," she said.

The student-led refugee clinic, Dr. Okonkwo's "passion project," delivers free health care to refugees resettling in Florida. She describes this as "a unique practice where I can incorporate global health training to address specific needs, ranging from preventive medicine to conditions such as parasitic infections and complex nutritional issues, often seen among newcomers who have spent extended time in transition." Recently, the clin-

ENOLA OKONKWO, MD

QI CHARLES ZHANG, MD, MPH

ABOVE: Volunteers with the University of South Florida Tampa Bay Street Medicine team head out to deliver care to underserved residents in Tampa, Fla.

RIGHT: The Loyola Street Medicine team at Loyola University Medical Center, Chicago, includes ACEP members Theresa Nguyen, MD, FACEP, (first from left) and Qi Charles Zhang, MD, MPH, (middle).

ic acquired an ultrasound machine, thanks to grant funding, which allows them to provide real-time diagnostics and reduce the need to refer patients for costly imaging. EM ultrasound faculty regularly volunteer in the clinic, which has been incredibly valuable for patients and medical students to learn alongside the faculty.

Funding for these clinics is a constant challenge, Dr. Okonkwo said, and is sustained primarily by donations, grants, and the support of the University of South Florida faculty who volunteer time and resources.

"Our medical students play a huge role in fundraising, applying for grants, and seeking support," Dr. Okonkwo said, noting that the dedication of students and residents has been essential to the program's sustainability.

Accidental Volunteer

When he's not working his regular job at an urgent care in Columbia, S.C., David Baehren, MD, FACEP, volunteers about two days per week at a free clinic in Beaufort, S.C. Dr. Baehren not only provides care at the Good Neighbor Medical Clinic, but also serves as its medical director. The free clinic serves as a medical home for around 700 patients who would otherwise face challenges in accessing health care; it provides primary care and coordinates specialty care, lab services, imaging, and medications at no cost to patients.

Dr. Baehren was asked to lead the Good Neighbor Medical Clinic when the previous director became ill. He was reluctant. He wasn't sure an ED background fully prepared a physician for so much primary care. He found that adapting to this new role was a natural extension of his experience.

"If you're practicing emergency medicine, you have a lot of skills," Dr. Baehren said. "There are a few things you need to brush up on … but it's worth it. Our patients get just as good care as somebody who has insurance, and I get to spend more time with them, building connections that can be rare in the ED. A new patient gets an hour of my time."

The clinic operates with significant support from a network of dedicated volunteers and Beaufort Memorial Hospital. Patients aren't financially responsible for labs, imaging, or specialty referrals. Paid staff includes an executive director, clinical director, and volunteer coordinator. A shared hourly position and volunteer nurses and nursing students round out most of the team, along with a volunteer dietitian. One volunteer is a physician in his 70s who used to have a family practice in the building where the clinic is located.

Two Years Turned into 22

Dr. Baehren said the need for more access to affordable medical care is enormous in South Carolina, and emergency physician M. Todd Crump, MD, agreed. Dr. Crump is the medical director at The Free Medical Clinic in Columbia, S.C.

The Free Medical Clinic isn't just part of a broader network of more than 40 free clinics in the state; it's one of the largest and operates as close to an ED as possible. With most of its patients typically living at or below the federal poverty line, Dr. Crump said the clinic supports individuals who often face the impossible choice between buying food or essential medications.

The clinic provides comprehensive services, including primary care, specialty care, and medication distribution, all free of charge. Patients visit a doctor, and prescriptions are prepared at an in-house pharmacy, allowing them to leave with everything they need.

"We dispense over $2 million worth of medications each year," Dr. Crump said, noting that partnerships with drug companies and community support make this possible.

The clinic operates a first-come, first-served model to ensure fairness and accommodate the unpredictable schedules and transportation challenges many patients face. Clinic staff posts a daily patient limit on the door, giving patients clarity about their waiting time. Although most services are primary care, specialty visits are also provided with dermatologists, cardiologists, neurologists, and gynecologists—all scheduled in advance. Beyond providing immediate care, the clinic emphasizes preventive health services, a crucial component in reducing long-term health care costs and avoiding ED visits.

Dr. Crump recalled a 52-year-old patient who arrived for a routine checkup with no symptoms but had never had a colonoscopy. He talked her into one. Doctors found a large tumor, which was removed with surgery with no need for chemotherapy or radiation.

Dr. Crump's journey to the clinic began nearly three decades ago when he was a medical student who enjoyed volunteering. He was asked to become The Free Medical Clinic medical director and agreed to do it for two years. That was 22 years ago.

"I work every other weekend in the ER, but I always make time for the clinic," he said. "This work is too important."

Driving Access to Health Care

On oppositive sides of the country, ACEP Washington Chapter Immediate Past President and ACEP Public Health Committee Chair Herbert C. Duber, MD, MPH, FACEP, and New Hampshire emergency physician Deepak Vatti, MD, FACEP, volunteer for the delivery of care that involves driving it to where it's most needed.

Dr. Duber helped grow the Harborview/UW Medicine Mobile Health Outreach Program, has served as a preceptor for years, and still volunteers when the converted van cranks up for a run. Funded by donations, the program provides a free clinic—staffed mostly by student volunteers, but with clinician help—focusing on residents of several Seattle Tiny House Villages just outside the boundaries of the University of Washington.

Dr. Duber, professor and section head for population health at the department of emergency medicine at UW Medicine, said the van is well-equipped to care for most of what volunteers will see. There's even a curtain for private conversations.

"We're very fortunate to have a community that cares about people, and we have amazing student leaders who want to help however they can," Dr. Duber said.

At the St. Joseph Hospital Mobile Health Clinic in Southern New Hampshire, Dr. Vatti and his team have celebrated some huge victories since declaring the converted rock-band-tour-size bus fully operational about five years ago. One victory was in his neighborhood.

Law enforcement informed him that a park-and-ride lot in the area was where some unhoused people were temporarily sleeping in their cars. They felt safe with security cameras and lighting in place, and the lot offered access to restrooms. Police asked Dr. Vatti if the bus could swing by and see if they needed medical care.

"A lot of people park there and take the train into Boston, so it's always busy," Dr. Vatti said. "But I had no idea this was going on, and it's three miles from my house. We took the bus out there and connected with multiple individuals, provided immediate care where we could, and referred them to long-term resources."

After deciding to start a mobile clinic, the bus sat still for a couple of years because of financial challenges and difficulty getting it fully equipped to serve in the capacity St. Joseph's wanted. Today, it's fully licensed to offer non-urgent, walk-in health care services. The mobile clinic is staffed with nurse practitioners, midwives, nurses, and patient service representatives; it has internet capability, and a staff interpreter is available.

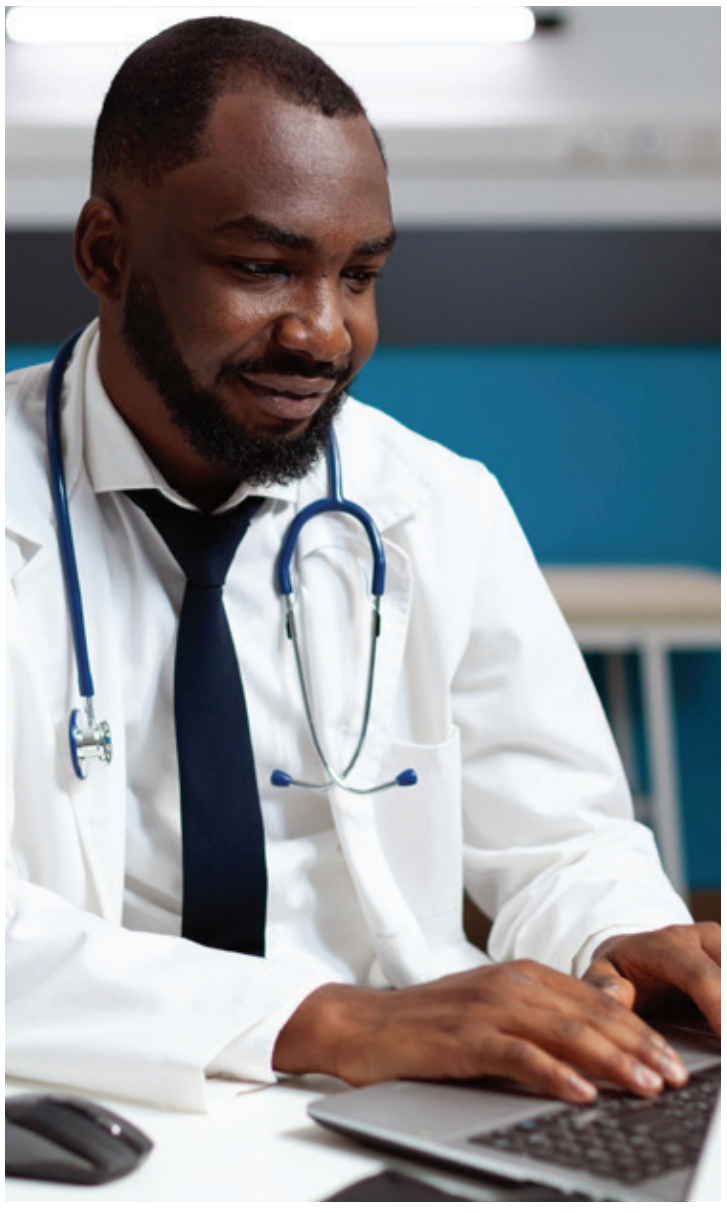
The clinic brings free care to those without insurance and, although it's a small percentage, a billing system is set up for those with coverage.

The next mobile outreach project is a challenge, said Dr. Vatti.

Immigrants in the area, mostly students around age 20, need to be seen by a physician to maintain their visa status, but they don't know how to start receiving care and don't speak much English. The U.S. Public Health Service reached out to St. Joseph's to ask for help. Its Mobile Health Clinic came to the rescue. The first clinic, Dr. Vatti said, was inefficient and only saw two patients because of state and federal government paperwork.

"We're going to figure it out; there's some infrastructure to build," Dr. Vatti said. "The patients were lovely; they're just falling through the cracks. It's a challenge, but we're going to get these people taken care of."

MR. SCHEID is ACEP's Communications Director.



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OPINIONS FROM EMERGENCY MEDICINE

OPINION

TOMASZ-WYSZOLMIRSKI-DABARTI-STOCK.ADOBE.COM

Ambulance Patient Offload Delays

Holding ambulances is a dysfunctional response to hospital boarding and emergency department overcrowding

by MARC GAUTREAU, MD, MBA, AND CLAYTON KAZAN, MD

As emergency departments (EDs) have become the focus of bottlenecks in the entire health care system—from insufficient inpatient beds leading to hospital boarding to dwindling access to primary care—a siege atmosphere has developed. Although EDs offer around-the-clock access to highly trained physicians and a full suite of imaging and laboratory services, their very success has led to tremendous overcrowding and enormous strains on staff. The combination of a lack of health care access, an impatience for outpatient workups of nonemergent conditions, and an aging population with a growing complexity of health issues has resulted in packed EDs, prolonged wait times, and overwhelmed ED staff with no relief in sight.

Simultaneously, the EMS system has also experienced a huge increase in call volume, and, because of the COVID-19 pandemic, has now experienced a critical loss of paramedics and EMTs, leaving those who remain to deal with the strain of overwork, stagnant wages, and, in many cases, forced overtime. This leads to a vicious circle of more and more professionals exiting the EMS workforce.

Unfortunately, ED staff are faced with an ever-difficult game of Tetris to shuffle patients through, and this has led to a strategy of holding EMS patients on ambulance stretchers, often for hours at a time, in an effort to relieve some of the strain. The domino effect resulting from holding ambulances is hugely impactful to EMS operations, yet wholly sight unseen to most ED staff. EMS resources, like ED beds, are not limitless, and the resulting reduction in available ambulance response can cost lives. In Los Angeles County, major trauma patients have been held on scene with their call queued because there was no available ambulance to even assign to the call. Critically ill and injured patients have been transported in fire engines when they could not wait for an ambulance response. We have also experienced paramedic crews calling their base hospital for medical control for a deteriorating patient *while in the ED of a different hospital*. Patients endure long hours on a narrow stretcher with poor access to bathrooms or food, no privacy, and in the care of EMS personnel whose very authority to treat inside a hospital is under question.

Strategies to Reduce Delays

It doesn't have to be this way. A number of strategies may be employed to significantly reduce or even eliminate delays in the offload of ambulance patients. The majority do not require any additional resources on the part of the ED. Some are so obvious that the fact that they have not been employed already in some hospitals is, frankly, mind boggling. We will outline a few that have long been tested and employed by some EDs already.

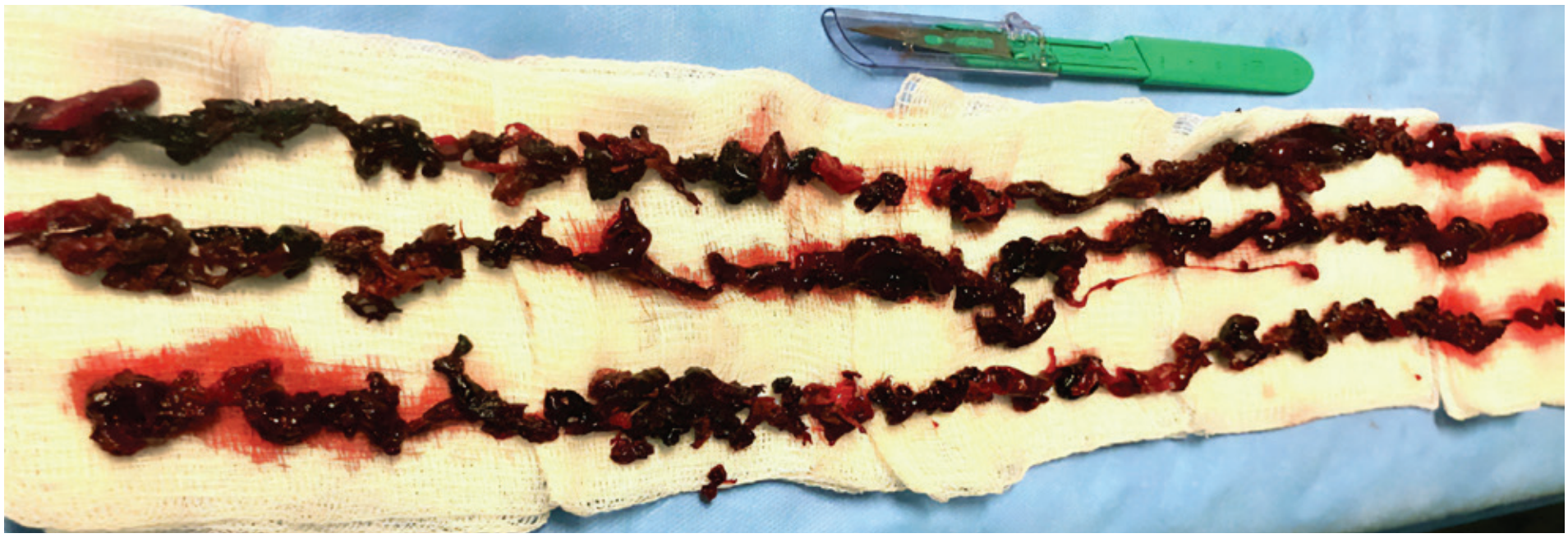
- Just because the patient arrives by ambulance does not mean that they require an immediate ED bed. Many such patients can safely be taken to the waiting room and triaged along with the patients who arrive on their own. Mode of arrival is not a triage category.
- Patients awaiting an inpatient bed should be sent to an upstairs hallway as soon as their bed is assigned, and they should not be made to wait in the ED for housekeeping to clean their room. Once the previous patient has been discharged, the unit has capacity for a new patient, whether or not their room is ready for them.
- Assign a physician or advanced practice provider to the waiting room to conduct rapid medical screening exams and to manage the volume of low-acuity patients that can be safely discharged without ever occupying an ED bed. Simple tests such as urinalysis, chest X-ray, or extremity X-rays can be ordered, completed, and interpreted with the disposition made from the waiting room.
- Many ED patients who require a bed for part of their stay do not require a bed for their entire stay. Patients with low-acuity conditions such as abdominal pain or flank pain, for instance, can be examined, have labs drawn, be medicated, and have tests performed. Once they have clinically improved or their evaluation is completed, they can be moved to a discharge lounge or waiting room to await their results, their paperwork, a social work consult, or their ride home without continuously occupying an ED bed.
- Create an ambulance–patient waiting area for those patients who cannot go to the main ED waiting room. Staff it with hospital staff who are, unlike EMS workers, credentialed to observe patients in the hospital, and release the EMS personnel back to the community.
- Lastly, a hospital that is so overwhelmed that it must hold ambulances for hours at a time and has exhausted all other options, should be activating its disaster plan.

Some EMS systems have employed EMTs and paramedics to "mind" EMS patients in the ED. This is a poor solution, costing the EMS system money and personnel better deployed responding to calls. If EMS-employed EMTs can watch a patient, then hospital-employed EMTs (or staff such as certified nursing assistants and licensed vocational nurses, among others) can watch a patient. Techniques like these allow one very busy, high-acuity ED of 65 beds seeing around 100,000 patients per year to never hold ambulances.

Holding ambulances is almost always an unnecessary and dysfunctional response to hospital boarding and ED overcrowding that has tragically become normalized. EMS represents a shared community resource that must remain available and accessible, at all times, to respond to critically ill and injured residents. We cannot allow the dysfunction of hospital boarding to consume the EMS system and flow out into the streets.

DR. GAUTREAU is clinical professor of emergency medicine, director of pre-hospital care, director of EMS Fellowship at Stanford University School of Medicine, and medical director at the San Jose Fire Department.

DR. KAZAN is assistant clinical professor of emergency medicine at the David Geffen School of Medicine at UCLA, Charles Drew University, and medical director at the Los Angeles County Fire Department.



INARI MEDICAL

A clot removed from a patient's lung with a mechanical thrombectomy system.

A Peek into EKOS and the Inari FlowTriever System

Treatment of acute pulmonary embolism with targeted clot busting and retrieval

by GHIDA GHANIM, MD; AND ROBERT MCARTHUR, MD

Approximately 60,000 to 100,000 patients die from pulmonary embolism (PE) each year in the United States, and PE is the third leading cause of cardiovascular mortality.[1]

A wide spectrum of severity exists in PE presentations, ranging from mild shortness of breath to cardiac arrest. A PE is classified into one of three categories: low risk, submassive, and massive. Low-risk and submassive PEs do not have hemodynamic compromise (i.e., no hypotension). A submassive PE does not result in hypotension but does result in right ventricular (RV) dysfunction (as evidenced by CT or ECG) and/or signs of myocardial injury, such as elevated B-type natriuretic peptide, elevated troponin, or new ECG changes. A massive PE, the most severe, causes hemodynamic instability and carries the most morbidity and mortality.[2] With varying clinical pictures, unique patient profiles, and risk factors, the treatment of PE provides complex challenges.

Thrombolysis

Although systemic thrombolysis has been the standard treatment for submassive and massive PEs, its risk of major bleeding and intracranial hemorrhage continues to raise concern, particularly in older patients with comorbidities.[3] Use of systemic thrombolysis carries a 20 percent risk for major bleeding, including a two to three percent risk for intracranial bleeding.[3] Therefore, new interventions using catheter-based or mechanical removal strategies are becoming increasingly more common for the treatment of PE causing hemodynamic instability, myocardial injury, or severe hypoxia.[3,4] In addition, for patients with contraindications or those who have failed thrombolysis, catheter-directed thrombolysis and surgical thrombectomy are useful treatment modalities that are associated with low major complication rates and improved patient outcomes.[5]

As opposed to systemic therapy, catheter-directed thrombolysis is a minimally invasive technique that delivers targeted lytic therapy locally to the clot using catheterization. Ekosonic Endovascular System (EKOS), a form of pharmacomechanical thrombolysis, uses a catheter to deliver thrombolytics directly to the target pulmonary artery in combination with high-frequency ultrasound to enhance lytic penetration and encourage thrombus fragmentation.[6,7] Moreover, as the risk for bleeding with systemic thrombolytic therapy is dose-dependent, catheter-directed thrombolysis (CDT) allows for use of lower doses, making its use appropriate even for patients with relative contraindications.[8] The prospective SEATTLE II trial demonstrated that this unique approach to thrombolysis therapy reduced clot burden, improved RV function, and reduced pulmonary hypertension, all while minimizing occurrence of intracranial hemorrhage in patients with massive and submassive PE.[6]

The second common catheter-directed approach is mechanical thrombectomy. This approach may be used as monotherapy or in combination with lytic therapy based on the clinical picture. The Inari FlowTriever System treats PE without the use of thrombolytics by using a large lumen catheter and large-bore syringe to mechanically remove large volumes of clots via aspiration.[4,9] The FLARE study, a prospective multicenter trial, demonstrated that implementation of Inari FlowTriever in management of PE provided rapid thrombus removal allowing for faster improvement of pulmonary artery pressures and SpO_2 without the presence of thrombolytic complications.[10] Using this approach to eliminate systemic lytic exposure from the equation provides an alternative treatment option for patients with absolute contraindications to thrombolysis. In addition to the reduced risk for major bleeding, use of mechanical thrombectomy techniques has been shown to decrease hospital costs by reducing the need for post-procedural critical care following intervention.[10,11]

Complications, Limitations

Although some studies have shown promising safety profiles for these interventions, more robust trials are needed as these techniques still carry complications such as access site bleeding, arrhythmias, pulmonary artery dissection, and tamponade.[12] In addition to complications, limitations to the implementation of EKOS and Inari FlowTriever include the fact that use requires technical expertise to navigate pulmonary vasculature and resources that not every facility is equipped with.[7] Aside from equipment and device costs, use of these therapies usually requires multidisciplinary involvement from specialties like pulmonology, interventional cardiology, vascular surgery, interventional radiology, and more, to which smaller institutions may not have access.

The clinical presentation and effect of acute PE are highly variable and make management decisions, which include weighing risks and benefits of certain interventions, difficult and complex. How and whether to perform a catheter-based intervention is a multidisciplinary decision initiated in the emergency department, which factors in the patients' clinical picture, bleeding risk, available personnel, expertise, and devices. Targeted approaches such as EKOS and Inari FlowTriever, appear promising because they reduce bleeding complications by lowering or eliminating the overall systemic dose of the thrombolytic delivered.

Given the rapid ability to restore favorable hemodynamics with catheter-directed intervention for PE, patients who display signs of RV dysfunction, myocardial injury, severe hypoxia, or hemodynamic instability are now considered for early intervention using these methods. Furthermore, these techniques provide a useful alternative in patients who fail systemic thrombolysis or those with relative or absolute contraindications to thrombolysis. Although the popularity of these techniques has grown, limitations of their clinical use must still be considered. With more devices and techniques being developed and approved for use in managing PE, it remains important to continue exploring their efficacy, accessibility, and safety profiles.

DR. GHANIM is a third-year emergency medicine resident physician at the Baylor College of Medicine in Houston, Texas.

DR. MCARTHUR is a board-certified emergency medicine physician and assistant professor at the Baylor College of Medicine in Houston, Texas.

References

1. Silver MJ, Giri J, Duffy Á, et al. Incidence of mortality and complications in high-risk pulmonary embolism: a systematic review and meta-analysis. *J Soc Cardiovasc Angiogr Interv.* 2023;2(1):100548.
2. Shah IK, Merfeld JM, Chun J, et al. Pathophysiology and management of pulmonary embolism. *Int J Angiol.* 2022;31(3):143-149.
3. Meyer G, Vicaut E, Danays T, et al. Fibrinolysis for patients with intermediate-risk pulmonary embolism. *N Engl J Med.* 2014;370(15):1402-1411.
4. Mathbout MF, Al Hennawi H, Khedr A, et al. Inari large-bore mechanical thrombectomy in intermediate-high risk submassive PE patients: case series and literature review. *Glob Cardiol Sci Pract.* 2022;2022(1-2):e202208.
5. Bloomer TL, El-Hayek GE, McDaniel MC, et al. Safety of catheter-directed thrombolysis for massive and submassive pulmonary embolism: results of a multicenter registry and meta-analysis. *Catheter Cardiovasc Interv.* 2017;89(4):754-760.
6. Piazza G, Hohlfelder B, Jaff MR, et al. A prospective, single-arm, multicenter trial of ultrasound-facilitated, catheter-directed, low-dose fibrinolysis for acute massive and submassive pulmonary embolism: the SEATTLE II study. *JACC Cardiovasc Interv.* 2015;8(10):1382-1392.
7. Khan K, Yamamura D, Vargas C, et al. The role of EkoSonic Endovascular System or EKOS® in pulmonary embolism. *Cureus*. 2019;11(12):e6380.
8. Wang C, Zhai Z, Yang Y, et al. Efficacy and safety of low dose recombinant tissue-type plasminogen activator for the treatment of acute pulmonary thromboembolism: a randomized, multicenter, controlled trial. *Chest*. 2010;137(2):254-262.
9. Capanegro J, Quinn E, Arndt M, et al. Successful removal of a life-threatening PE using the INARI flow triever device. *Radiol Case Rep*. 2021;16(7):1878-1881.
10. Tu T, Toma C, Tapson VF, et al. A prospective, single-arm, multicenter trial of catheter-directed mechanical thrombectomy for intermediate-risk acute pulmonary embolism: the FLARE study. *JACC Cardiovasc Interv.* 2019;12(9):859-869.
11. Callese TE, Moriarty JM, Maehara C, et al. Cost drivers in endovascular pulmonary embolism interventions. *Clin Radiol*. 2023;78(2):e143-e149.
12. Mostafa A, Briasoulis A, Telila T, et al. Treatment of massive or submassive acute pulmonary embolism with catheter-directed thrombolysis. *Am J Cardiol.* 2016;117(6):1014-1020.

BE A MEDICAL DETECTIVE—BONE UP ON YOUR FORENSIC SKILLS

FORENSIC FACTS

DR. ROZZI is an emergency physician, director of the Forensic Examiner Team at WellSpan York Hospital in York, Pa., and chair of the Forensic Section of ACEP.

DR. RIVIELLO is chair and professor of emergency medicine at the University of Texas Health Science Center at San Antonio.

Employ a Trauma-Informed Approach to Care

This approach includes an awareness of the effect of trauma on the individual

by RALPH RIVIELLO, MD, FACEP, AND HEATHER ROZZI, MD, FACEP

A 28-year-old female is brought to the emergency department (ED) by police after a sexual assault. She is visibly anxious and tearful. The police officer is waiting for the sexual assault evidence kit. What is the trauma-informed approach to care for this patient?

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[1] A significant number of patients present to the ED with concerns related to traumatic experiences. These concerns may be a direct result of trauma (e.g., injuries following an assault), or an indirect result of trauma (e.g., substance abuse as a coping mechanism following traumatic events).

Patients' subsequent experiences in the ED may be retraumatizing or trigger memories from past experiences.[2] The chaos of the ED, lack of privacy, fear, pain, physical touch, and invasive history questions may provoke a trauma response. Patients may be anxious, hypervigilant, and even combative. Conversely, they may respond to real or perceived threats by "shutting down" and not participating in their care, even refusing certain aspects of care or procedures. Trauma responses in the ED present a challenge to ED staff and may prevent the optimal provision of care. Given the prevalence of trauma among ED patients, clinicians should assume that all patients would benefit from a trauma-informed approach to care.

Trauma-informed care (TIC) is an approach to the delivery of care that includes an understanding of trauma and an awareness of the effect it may have on the individual or patient. Use of the principles of TIC improves the medical care of the patient, improves patient experience, helps survivors of trauma rebuild a sense of empowerment, and may prevent violence against ED staff.

According to SAMHSA, for an organization to provide TIC, it must abide by four principles:[1]

- **Realization** of the widespread effect of trauma and understanding of potential paths for recovery;
- **Recognition** of the signs and symptoms of trauma in patients, families, staff, and others involved in the system;
- **Response** by fully integrating knowledge about trauma into policies, procedures, and practices; and,
- Active **resistance** against retraumatization.

TIC is based on six principles: 1) safety; 2) trustworthiness and transparency; 3) peer support; 4) collaboration and mutuality; 5) empowerment, voice, and choice; and 6) cultural, historical, and gender issues.[1] There are a multitude of ways to incorporate TIC throughout the ED encounter.[3,4]

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History

During the initial evaluation of the patient, the physician should establish the ED as a safe space for the patient. Simple actions such as knocking and asking permission to enter the room may provide reassurance to the patient that their preferences will be taken into consideration. Clinicians should confirm the pronunciation of the patient's name, use their preferred pronouns, and use an interpreter, if necessary. Ask whether the patient wants others (friends or family members) in the room during the history and examination. The patient may not feel empowered to ask visitors to leave, so this should be addressed by the clinician. Conversely, the patient may feel safer with friends or family members present in the room or on speaker phone.

Physical Examination

Clinicians should describe the steps of the physical examination so that the patient knows what to expect and should ask for consent to do the examination, especially of sensitive areas of the body. Stress to the patient that they can refuse any or all parts of the medical forensic examination. The patient should be offered as much privacy as possible during the examination. This may mean moving a patient from a hallway bed into an examination room or using adequate draping techniques. The clinician should also ask questions such as, "Is there a part of the examination that is worrisome to you? Is there anything we can do to make you more comfortable?"

Procedures

Procedures, including necessary equipment, should be explained in as much detail as the patient would like. After obtaining consent, the clinician should provide as much pain relief as possible prior to the procedure. Ask the patient about preferences regarding position of comfort and whether they want a support person present. Give the patient as much control as possible. The speculum or pelvic exam can be triggering to a patient with a past history of sexual abuse or assault; therefore, patients may prefer to self-insert a speculum or to self-swab the genitals. If the patient needs a break during the procedure, this should be provided if possible.

Disposition

Shared decision making is key to empowering patients in their own medical care. If the patient is being discharged, ensure appropriate referral and community resources. Because many ED patients are experiencing stress, which may interfere with comprehension and retention of instructions, methods such as teach-back should be used. Patients should be asked what questions they have, and resources should be provided in case they have questions following disposition.

Case Conclusion

You sit down at the patient's level, confirm name and preferred pronouns, and introduce yourself. You ask if she would like to have a friend, family member, or the rape crisis advocate present during the ED encounter. After obtaining a history, you describe the physical examination and evidence collection. The patient is anxious about the speculum examination and genital swabs, so you show her the equipment and answer her questions. After obtaining consent for the examination, you do the exam and evidence collection, talking through each step, and providing draping for the patient's privacy. You confirm that she does wish to have evidence turned over to the police. You engage the patient in decisions regarding post-exposure prophylaxis and post-coital contraception. All her questions are answered, and she is discharged with outpatient resources, including contact information for the rape crisis center.

References

1. SAMHSA's Concept of Trauma and Guidance for a Trauma-informed Approach. https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf. Published July 2014. Accessed November 3, 2024.
2. Purkey E, Davison C, MacKenzie M, et al. Experience of emergency department use among persons with a history of adverse childhood experiences. *BMC Health Serv Res*. 2020;20(1):455.
3. Ashworth H, Lewis-O'Connor A, Grossman S, et al. Trauma-informed care (TIC) best practices for improving patient care in the emergency department. *Int J Emerg Med*. 2023;16(1):38.
4. Greenwald A, Kelly A, Thomas L. Trauma-informed care in the emergency department: concepts and recommendations for integrating practices into emergency medicine [published correction appears in *Med Educ Online*. 2023 Dec;28(1):2206681]. *Med Educ Online*. 2023;28(1):2178366.

KEY POINTS

- Survivors of acute and past traumas often seek care in the ED.
- A patient's past experiences may shape how they perceive health care or their ED visit and may affect the care they receive.
- Given the prevalence of traumatic experiences among ED patients, assume that all patients would benefit from a trauma-informed approach to care.
- Trauma-informed care improves the medical care of the patient, improves the patient's experience, helps survivors of trauma rebuild a sense of empowerment, and may prevent violence against ED staff.

BRINGING DATA TO THE BEDSIDE

BENCHMARKING ALLIANCE

DR. AUGUSTINE is a member of the *ACEP Now* Editorial Board, clinical professor of emergency medicine at Wright State University in Dayton, Ohio, and vice president of the Emergency Department Benchmarking Alliance.

The Invisible Hand of the Patient

ED volumes continue upward pace as patients demand acute, unscheduled care

by JAMES AUGUSTINE, MD, FACEP

The Centers for Disease Control and Prevention (CDC) estimates of emergency department (ED) visits for 2022 were recently released.[1] It was the highest volume ever reported by the CDC, at 155.4 million visits, with an all-time high utilization rate of 473 visits per 1,000 populations. This visit rate puts American EDs back on the data line it has followed since World War II.

For quick comparison, ED visits in 2012 were about 131 million, which was 424 visits per 1,000 population. ED visit estimates and utilization rates for 2018 to 2022 are shown in Figure 1.

The CDC data are the oldest consistent data source for the United States, but the estimates of total ED visits remain different among the national data sources. This explanation has been published.[2]

Why the Increase?

Why are ED visits increasing? One significant driver of the increase is the aging population. Persons aged 75 and older had 660 visits per 1,000 population in 2021. In line with the aging U.S. demographics, EDs have provided excellent service to larger numbers of senior patients. Older patients typically have higher acuity than younger patients, which often means more diagnostics and treatment. Because older patients are admitted to the hospital more often, they disproportionately affect ED staff time and work.

The reality is that visits to EDs are the result of excellent service access. The patients and the community like the service provided in the ED, the availability of a wide range of diagnostic services, the immediate entrée to hospital admission, and the unfettered 24 hours a day/365 days per year availability. Almost half of ED visits are made between 5 p.m. and 8 a.m.[3] In fact, when weekends are included, about 60 percent of ED visits are made outside of traditional business hours, which is becoming even more compressed in the post-pandemic years.

The ED is clearly perceived as serving the needs of patients and as the "front door to the hospital." There is continuing growth in the percentage of overall hospital admissions presenting through the ED. The Emergency Department Benchmarking Alliance (EDBA) data survey found that about 69 percent of hospital inpatients are processed through the ED.[4] The efficient ED processing of sick and injured patients, sorting the ones that would benefit from inpatient care, is a hallmark of high quality emergency care. But that efficiency is impeded by patient boarding.[5]

ED surveys done by the EDBA and the CDC report that there were more high acuity visits, senior patients, ambulance arrivals, diagnostic tests, and patients with mental health issues. Injury visits, which continue to decrease, now represent only 26 percent of visits.

Financial factors are stacked against patients getting service in the ED. Insurance companies have placed more and more financial penalties on patients who come to the ED, and charges by both hospitals and emergency physicians have escalated to produce high bills for these services. Nonetheless, the patients are still coming in higher numbers.

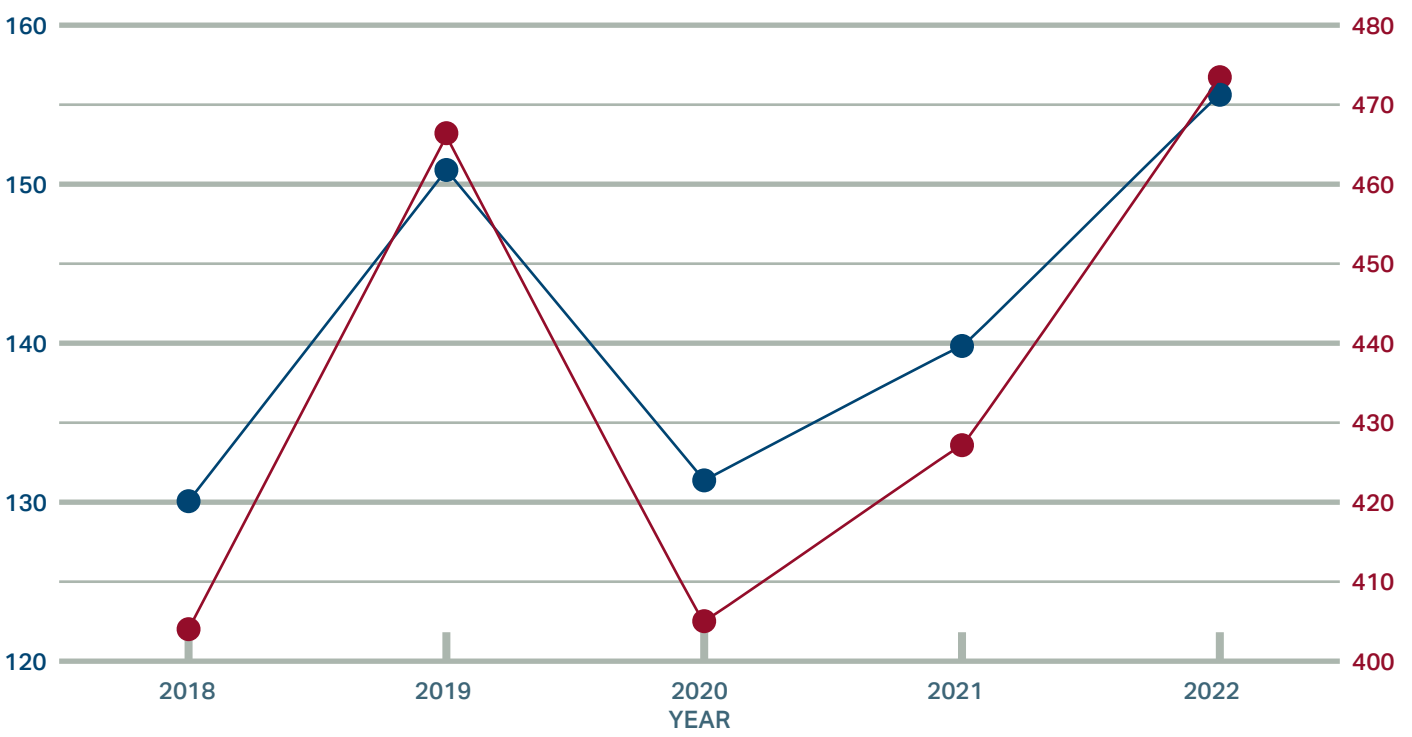
Quit Fighting the Market

A sensible approach would be to quit fighting the market—the many patients, families, and communities that want the ED to serve their acute, unscheduled care needs.

First, let's work with hospital leaders to improve the efficiency of admitting patients and eliminate the boarding problems for patients admitted to the hospital. Let's restore timely and patient-friendly patient transfer systems.[6] Let's develop a rational set of charges for care that match acuity and service delivered.

A critical need is for private insurance companies and government payers to follow payment policies that fairly pay emergency physicians. These policies should not be punitive to patients, with "no surprises" to the patient regarding their coverage for emergency services. Finally, service in the ED needs to be high quality and friendly to the 155 million patients and families—and growing—that sought us out in 2022.

Figure 1. Emergency Department Visits and Utilization, 2018-2022

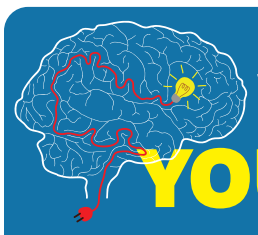


TALKING POINTS *from CDC Survey Data*

- Per CDC data (1992–2022), there was a 2.2 percent growth rate for ED visits per year. The pandemic created a two-year decrease in visits, which has now ended.
- More ED patient visits are related to medical illnesses than injuries.
- More ED patient visits are by the elderly, and most arrive by EMS.
- The CDC estimates that only 2.5 percent of ED visits were non-urgent, with the highest rates of these visits for patients younger than 15.

References

1. Centers for Disease Control and Prevention. National Center for Health Statistics. Estimates of Emergency Department Visits in the United States, 2016-2022. https://www.cdc.gov/nchs/dhcs/ed-visits/index.htm#print Generated August 14, 2024. Accessed November 3, 2024.
2. Augustine JJ. Emergency department patient challenges to come. *ACEP Now.* 2022;41(11):15.
3. Coalition to Strengthen America's Healthcare. 24/7 Access Makes the Difference: After-Hours Access to Emergency Departments Is Critical for Supporting Patients and Communities. https://strengthenhealthcare.org/emergency-department-report/. Published July 29, 2024. Accessed October 31, 2024.
4. Augustine JJ. Latest data reveal the ED's role as hospital admission gatekeeper. *ACEP Now.* 2019;38(12):26.
5. Augustine JJ. Long emergency department boarding times drive walkaways, revenue losses. *ACEP Now.* 2016;33(7):16.
6. Augustine JJ. Interhospital transfer capabilities still pose major issues. *ACEP Now.* 2024;43(6):21.



WHAT ARE YOU THINKING?

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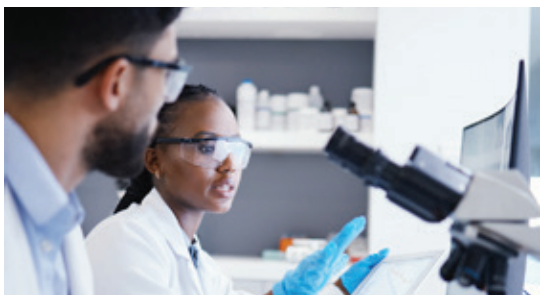

NOW HIRING

Emergency Medicine Residency Program Director

The Henry JN Taub Department of Emergency Medicine at Baylor College of Medicine (BCM) is looking for outstanding applicants for the position of Emergency Medicine Program Director. Applicants should have a strong background in medical education with a career path directed towards graduate medical education. We are seeking an applicant with at least three years of experience as a core faculty member that meets requisite ACGME qualifications. This applicant will embody our residency values of service, education and leadership. Applicants will be able to embrace the lived experiences of our residents while encouraging their growth and development into phenomenal emergency medicine physicians.

We are looking for an outstanding candidate with the following attributes:

- Holds current board certification in Emergency Medicine through ABEM or ABEOM
- Exhibits strong leadership and educational experience
- Advocates for resident well-being, personal and professional growth
- Provides outstanding clinical care to a diverse patient population
- Communicates in a collaborative and effective manner
- Creates a positive learning and work environment

Those interested in the position or further information may contact Dr. Sarah Bezek via email at bezek@bcm.edu or by phone at 713-873-6549. Please send a CV and cover letter expressing your experience and interest.

NOW HIRING

Vice Chair of Research

The Henry JN Taub Department of Emergency Medicine at Baylor College of Medicine (BCM) seeks a Vice Chair of Research to oversee research operations for the department. Salary, rank and tenure status are contingent upon candidate qualifications. The rank and tenure status awarded will be based upon qualifications in alignment with Baylor College of Medicine's promotion and tenure policy.

We are looking for an outstanding candidate with the following attributes:

- Education: M.D. or D.O. degree
- Experience: Research Fellowship not required
- Licensure: Must be currently boarded in Emergency Medicine and eligible for licensure in state of Texas.

Qualified applicants are expected to have a research record with significant extramural funding and leadership skills to develop a strong multidisciplinary collaborative Emergency Medicine research program and continue to grow current departmental research efforts. In addition to the above responsibilities, other duties may be assigned by the Chair.

Please include a cover letter and current curriculum vitae with your application. This position is open until filled.

For more information about the position, please contact Dick Kuo, M.D. via email at dckuo@bcm.edu.

NOW HIRING

Academic Faculty Openings including Ultrasound and Nocturnist

The Henry JN Taub Department of Emergency Medicine at Baylor College of Medicine (BCM) is looking for Faculty of all levels who are interested in a career in Academic Emergency Medicine. We are also hiring faculty of all ranks and seeking applicants who have demonstrated a strong interest and background in a variety of areas such as ultrasound, research or operations. Clinical opportunities including nocturnist positions are available at our affiliated hospitals. Our Ultrasound team is currently seeking an Assistant Director of US to support current educational, clinical and research elements of the program while also creating growth opportunities in our department.

We are looking for an outstanding candidate with the following attributes:

- Education: M.D. or D.O. degree
- Experience: Previous experience in an academic area of expertise preferred but not required
- Licensure: Must be currently boarded or board eligible in Emergency Medicine and eligible for licensure in Texas.

Those interested in a position or further information may contact Dr. Dick Kuo via email at dckuo@bcm.edu. Please send a CV and cover letter with your past experience and interests.

Baylor College of Medicine