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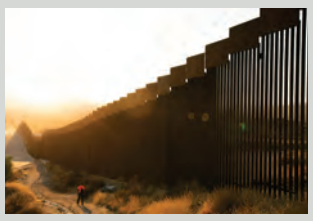

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Navigating the Sandwich Generation

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Another Failed Physician Management Company Leaves ED Staff Dangling

What happened and what, if anything, can be done

by LARRY BERESFORD

Late last year, the emergency department (ED) physician practice management company NES Health ceased operations, leaving hundreds of physicians and advanced practitioners at 35 hospitals nationwide scrambling.[1] This "difficult decision to wind down and cease operations" left these health care professionals uncertain if they will ever get paid for up to 2.5 months of work already performed, wondering who they would be working for next,

CONTINUED *on page 9*

Ramadan in the ED

Compassionate care for the fasting patient

by MOHAMED HAGAHMED, MD, FACEP; AND LAYLA ABUBSHAIT, MD, FACEP

Fasting during Ramadan—a time of profound spiritual journey for Muslims globally and a month dedicated to fasting, prayer, and deep introspection—involves abstaining from food, drink, medications, and other physical indulgences from dawn to sunset.[1] The Islamic lunar calendar shifts Ramadan 11 days earlier each year, causing fasting durations to vary by location and season, ranging from a few hours to more than 20 hours daily. In 2025, Ramadan was expected to begin on February 28 or March 1.[2]

Islamic teachings prioritize health and grant exemptions to those for whom fasting poses a risk, including travelers, pregnant or breastfeeding women, menstruating women, and individuals with acute or chronic illnesses.[3] Despite these allowances, many individuals with chronic conditions, such as diabetes or cardiovascular disease, choose to fast, often modifying medication regimens or delaying treatment, which can exacerbate health risks.

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NEWS FROM THE COLLEGE

UPDATES AND ALERTS FROM ACEP

ACEP-Supported Mental Health Bill Introduced in Congress

Bipartisan legislation introduced in the Senate would reauthorize funding for the law named in honor of the life and legacy of Dr. Lorna Breen, an emergency physician who died by suicide during the pandemic. ACEP was instrumental in the drafting and 2022 passage of this law, which has since provided $100 million for physician and care team mental health care.

"With strong ACEP support, the Dr. Lorna Breen Health Care Provider Protection Act became the first federal law focused on addressing the barriers preventing physicians and health care workers from receiving mental health care," said ACEP President Alison Haddock, MD, FACEP. "Emergency physicians face the highest rates of stress and burnout in medicine and there's no question, this law is saving lives and protecting livelihoods."

ACEP will continue working to restore physician autonomy and address the underlying issues fueling burnout. The College is committed to ensuring that physicians and health care workers have access to the mental health treatment and support services they need and deserve. If passed, the "Dr. Lorna Breen Health Care Provider Protection Reauthorization Act" would reauthorize the law for five years, providing grants for health care organizations, associations, schools and others to prioritize strategies to reduce burnout, peer-support programs, suicide prevention training, and mental and behavioral health treatment.

The bill, S. 266, also includes reauthorization for a national evidence-based education campaign.

ACEP is grateful to Sens. Tim Kaine (D-VA), Todd Young (R-IN), Jack Reed (D-RI), and Roger Marshall (R-KS), and allies across the country for prioritizing the mental health of the professionals on the frontlines.

"We fully endorse the reauthorization of this vital law honoring of the life and legacy of our emergency medicine colleague and strongly encourage its prompt passage," said Dr. Haddock.

Ohio ACEP is Protecting Emergency Physicians from Violence

A new Ohio law will help protect the state's emergency physicians and health care workers from violence.

Ohio ACEP advocacy supported the effort from start to finish. The new law aims to prevent hospital violence, enhance training, improve incident tracking and reporting, and strengthen security plans. In passionate testimony, Ohio ACEP leaders explained why laws that strength-

Inside

en protections for physicians and care teams are vital. They cited data from a 2024 ACEP member poll to emphasize that physical and verbal assaults are common across the country.

"Physical violence, intimidation, and threats are not accepted in any other workplace, and they should not be allowed or tolerated in a health care setting," said Ohio Past President Nicole Veitinger, DO, FACEP.

Additional comments from RJ Sontag, MD, FACEP, emphasized that emergency physicians must be able to concentrate on treating patients, without fearing for their personal safety.

"Emergency physicians and their care teams deserve a support system that prevents these incidents and protects us when they occur," said Dr. Sontag. "We need to bring awareness about these incidents to slow down the acceleration of violence in health care. Emergency departments should be a safe space where patients are guaranteed they have the full attention and dedication of their care team to treat their ailments."

What's the latest in your state? Check out ACEP's State Legislative Dashboard:

OHIO ACEP

Ohio ACEP's Government Affairs Chair, Dr. RJ Sontag, Workplace Violence Workgroup Chair, Dr. Nicole Veitinger, Executive Director Holly Dorr, and lobbyist Amanda Sines attend Governor DeWine's signing ceremony for H.B. 452, the Healthcare Workplace Safety Bill.

In Other News...

- Join ACEP Council Speaker Melissa W. Costello, MD, FACEP, and ACEP Council Vice Speaker Michael J. McCrea, MD, FACEP, next month to learn about how the ACEP Council works and how even a single member can make a big impact on the policy and direction of the College. The ACEP Council is a deliberative body that meets once a year for two days in conjunction with the College's annual Scientific Assembly. The Council votes on resolutions that guide the activities of the College. Learn how to craft your resolution and weigh in on the pressing issues in emergency medicine. This free virtual event is set for 2 p.m. (CST) on Thursday, April 10. acep.org/webinars

- Registration is open for ACEP's Leadership and Advocacy Conference. Both chambers are expected to be in session April 27-29 when ACEP members and volunteers learn crucial leadership skills and advocate for the specialty. Don't miss your chance to make a positive impact on your practice and your patients. acep.org/lac

- The deadline for nominating yourself or a colleague for ACEP's **Board of Directors, Council Speaker, and Council Vice Speaker** is March 17. Among other factors, the Nominating Committee will consider activity and involvement in the College, the Council and component bodies, leadership experience in other organizations or practicing institution, candidate diversity, and specific experiential needs of the organization when considering the slate of candidates. Elections for the Board of Directors and Council officers will take place on September 6, during the Council meeting in Salt Lake City. Learn more.

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CASE REPORT

Acute Kratom Withdrawal

by MARISELA DAVIS, MS, DO; DANA DARLING, DO; SAVANNA SCOTT PHARMD, BCEMP; AND AMANDA POLSINELLI, MD

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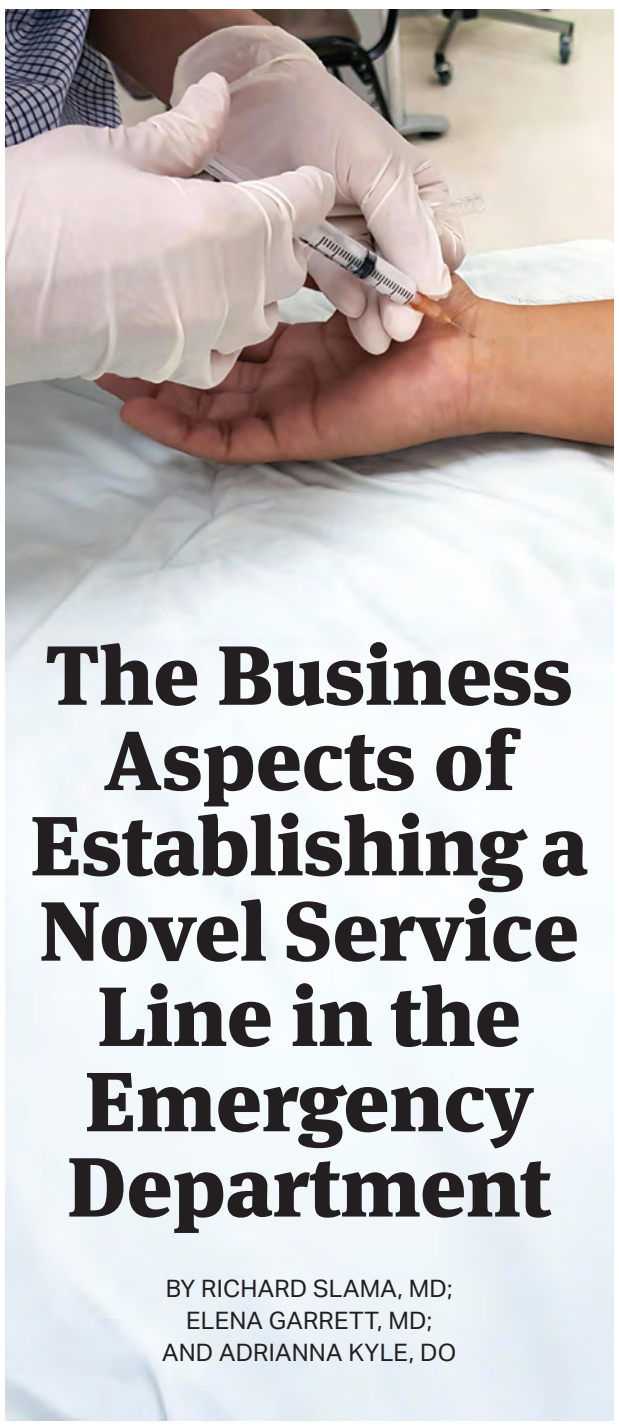

The Business Aspects of Establishing a Novel Service Line in the Emergency Department

BY RICHARD SLAMA, MD; ELENA GARRETT, MD; AND ADRIANNA KYLE, DO

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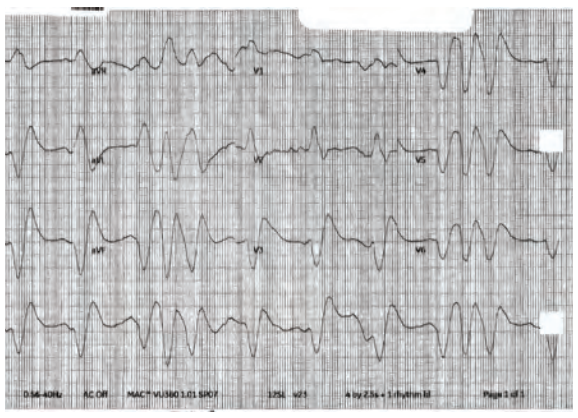
RESIDENCY SPOTLIGHT

THE UNIVERSITY OF UTAH EMERGENCY MEDICINE PROGRAM

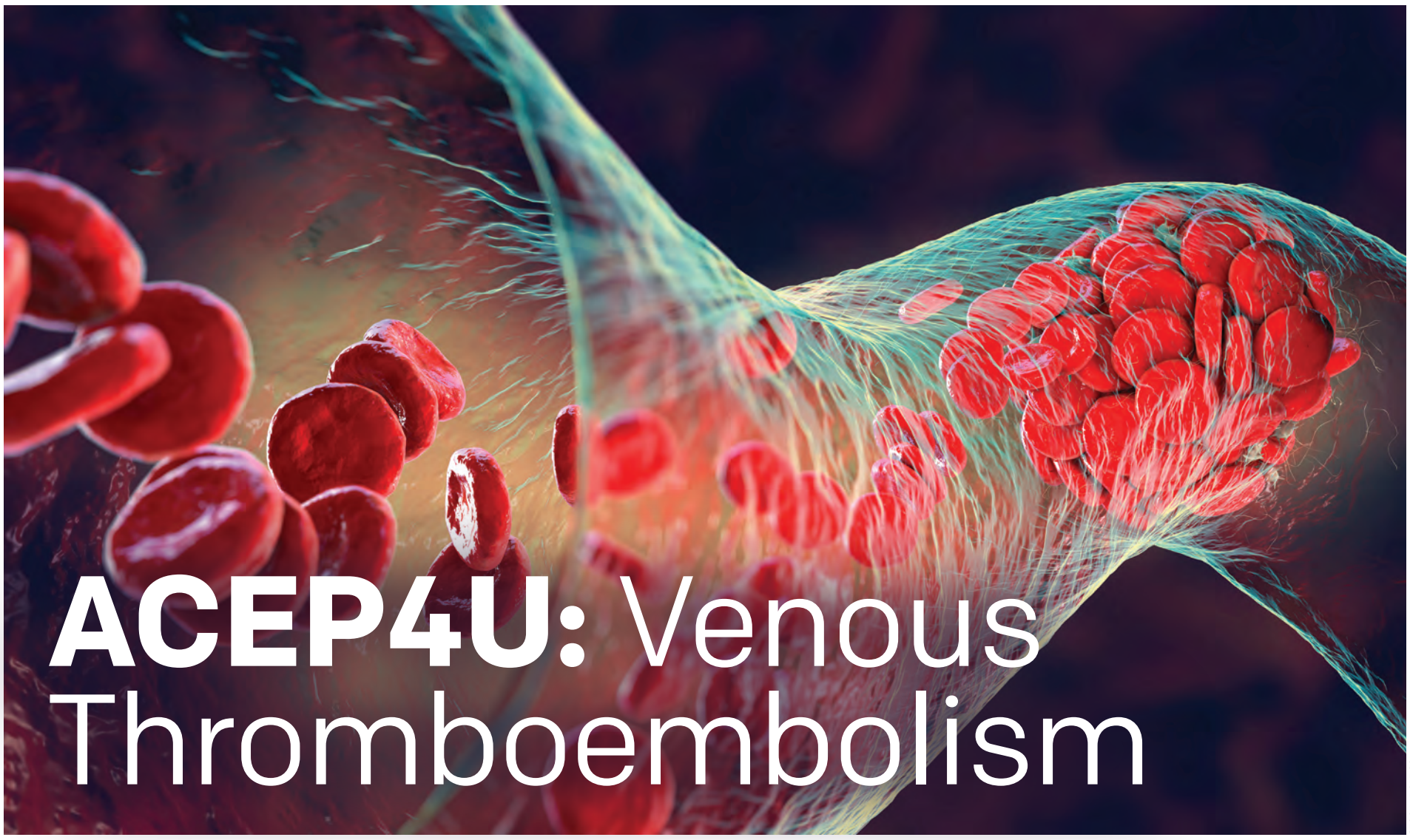
The University of Utah Emergency Medicine Program



CASE REPORT

Murine Typhus Presents as Severe Pneumonia & Sepsis

BY RYAN W. JOHNSON, MD, MPH, MA; AND JONATHON DYAL MD, MPH



ACEP4U: Venous Thromboembolism

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by MEGAN SAMBELL
AND DARRIN SCHEID, CAE

Emergency physician Kathleen J. Clem, MD, FACEP, is a firm believer in asking for help every now and then when it comes to patient care. That's why she's so proud of the recent Bristol-Meyers Squibb/Pfizer Alliance collaborative effort to improve care for patients with Venous Thromboembolism. VTE, she said, is a big problem in rural areas, and to increase awareness, improve treatment options, and ultimately save lives, it takes a village.

"I know the public is fearful of Big Pharma and its influence on physicians in how they prescribe and care for their patients," Dr. Clem said. "This was not the case in this project. The focus was on our patients and how to get the care they need—particularly in underserved areas. And it was under the big umbrella of expert emergency physicians providing the guidance."

The competitive grant program, "Improving the Outpatient Management of Emergency Department Patients with Venous Thromboembolism (VTE) in Rural Areas and Underserved Communities," launched last summer and asked for projects that promote the safe outpatient management of patients diagnosed with VTE. Applicants were asked to submit projects focused on clinical program development that overcome barriers to safe and evidence-based management, disposition, and follow up of this patient population.

The three chosen institutions—Corewell Health, Icahn School of Medicine at Mount Sinai, and Oklahoma State University Center for Health Sciences—are asked to describe the proposed clinical initiative's efficacy with outcome measures that demonstrate improved outpatient management of VTE patients, patient safety, physician satisfaction, and/or patient satisfaction.

Dr. Clem led a review board to choose the funded projects.

She said this project is crucial because of the growing challenges of patient care in certain areas of the country, and it's not exclusively in rural settings. Although the grant project is focused on those areas, patients and physicians everywhere will benefit.

"I don't think we have access to the testing that we need in real time across the entire country," she said. "Having a better understanding of why it matters will increase the accessibility and timeliness. We need a timely diagnosis of the patient to determine if the clot is there or not at all. And if they have one, is it progressing? And is it something we need to be even more concerned about? It's also crucial to get the patient into follow-up for someone who understands venous thromboembolism disease. Access is a challenge and timely follow up is difficult, even in places with high population density. More places have these challenges than ones who don't."

Dozens of submissions to win grant funding to combat these challenges came from across the country. Three stood out, and here are the core components of their submissions:

Corewell Health

- Tailor and implement an evidence-based PE clinical pathway that provides rural ED clinicians with clear criteria for screening PE patients for outpatient management, readily available clinical decision support tools, and a mechanism to ensure reliable expedited follow-up.
- Increase utilization of validated severity assessment tools among stable rural PE patients.
- Establish a virtual PE follow-up clinic using existing telehealth infrastructure to guarantee availability of follow-up for rural ED patients discharged with low-risk PE, proactively identify and address barriers to medication compliance, and bridge the transition back to a PCP.
- Utilize a recently established VACC to introduce a protocol-driven virtual follow up visit for PE patients within 72 hours of ED discharge to assess clinical stability, facilitate diagnostic testing, address barriers to medication compliance, and ensure subsequent PCP follow-up.
- Ensure rapid, consistent, follow-up care to PE patients discharged from rural EDs, reduce unnecessary return ED visits, eliminate interruptions in anticoagulation.

Icahn School of Medicine at Mount Sinai

- Develop and implement an interdisciplinary clinical pathway that includes an electronic medical record (EMR) order set and a discharge smart set to guide the management of low-risk VTE patients in the ED.
- Evaluate the impact of the pathway on key outcome measures, including: the reduction in admission rates for low-risk VTE patients, a decrease in ED return visit rates within 72 hours and 30 days, and an increase in the rate of initiation outpatient treatment and follow-up care, particularly for uninsured or underinsured patients.
- Enhance provider knowledge and adherence to evidence-based guidelines for the outpatient management of low-risk VTE through targeted education and clinical decision-support tools embedded within the EMR.
- Improve patient education and empowerment by developing and disseminating patient-centered educational materials that promote treatment adherence, self-management, and understanding of VTE.
- Foster collaboration and communication among interdisciplinary team members involved in the care of low-risk VTE patients, including emergency physicians, pharmacists, social workers, and case managers.
- Oklahoma State University Center for Health Sciences
- Develop and implement a comprehensive training program for interdisciplinary health care workers in rural EDs to enhance their ability to manage low-risk VTE patients safely on an outpatient basis.
- Increase the knowledge and application of evidence-based VTE management guidelines among health care professionals in targeted communities.
- Identify and evaluate barriers to safe, effective outpatient VTE care for low-risk patients in rural emergency medicine, focusing on health equity.
- Establish and implement system-based changes and procedures, guided by an interdisciplinary team, for identifying and treating low-risk VTE patients eligible for outpatient care across participating rural hospital EDs.
- Integrate virtual health through telehealth into outpatient care for low-risk VTE patients to enhance post-ED care access and improve adherence to provider recommendations.

Corewell, Mount Sinai, and Oklahoma State were notified of their grant funding in October. Each proposal included a timeline for completion.

"What I appreciated—just to put it in a short sentence—they got it." Dr. Clem said. "They understood why this mattered, and how this was going to work to improve their population of patients, not only in the here and now but as they progress in the future to improve the care of the diagnosis and treatment of patients with thromboembolic disease. I was so impressed and happy to work with our review team."

MS. MEGAN SAMBELL is a Quality Improvement Project Manager at ACEP.

MR. DARRIN SCHEID, CAE is Communication Director at ACEP.

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Waiting Room Medicine: The Ethical Conundrum

Emergency docs search for the needle in the haystack

by ELIZABETH P. CLAYBORNE, MD, MA, FACEP; PAUL BISSMEYER JR., DO, MA; NICK KLUESNER, MD, FACEP; NORINE A. MCGRATH, MD, FACEP; DEREK J. MARTINEZ, DO; AND LAURA VEARRIER, MD, DBE, FACEP

As hospital boarding, increased emergency department (ED) volumes, and complexity of patients have increased, so have wait times. Some physicians now coin themselves "waiting room medicine specialists" as departments schedule a physician in triage or attempt to evaluate patients in whatever spaces might be available. After years of training to fully undress a patient for an exam at ABEM General Hospital, patients may now routinely be treated in street clothes sitting in a hallway chair. Although this practice attempts to deliver care in a more timely and efficient manner, core aspects of care may be lost. A tension between the necessity and the compromises of "waiting room medicine" thus creates an ethical conundrum.

Privacy

Dating back to the Hippocratic oath, privacy is a core tenant of the profession of medicine.[1] When space is limited, patients' medical history is rarely protected from the vision or hearing of other patients and guests in the ED. The sensitivity of the details of an ankle sprain may seem minor. However, the history of a genitourinary complaint or the emotional impact of a miscarriage may be much more intimate. Attempting to obtain pertinent details and exams to allow appropriate and complete treatment may be compromised if care is conducted in the public space of a hallway or waiting room. A patient may not be willing to disclose a sensitive past medical history or events of an injury that they deem embarrassing and that could affect the differential diagnosis of a potentially otherwise benign complaint of pain or cough.

Waiting room medicine attempts to balance the ethical principles of beneficence and nonmaleficence. It is the response of an overwhelmed ED and health system attempting to provide the greatest good with inadequate resources, staffing, and space.[2] Focusing on the benefit of providing earlier testing and assessment, even under less-than-ideal conditions, will lead to more timely diagnosis, treatment, and disposition. However, this comes at the risk of potentially incomplete examination, missed details, and lack of privacy and sensitivity. Circumventing a traditional patient evaluation increases the risk for unnecessary testing or cost and risk for human error. There is also the recognized risk that a patient may undergo a partial evaluation and leave prior to full clinician assessment or results of tests initiated in triage. Struggling in the middle, emergency physicians balance what can be done versus doing nothing.

Harm to Physician Patient Relationship

Waiting room medicine is a component of ED crowding, which itself increases the length of stay for patients.[3] This affects the physician-patient relationship by prolonging the duration of the ED visit without increasing time spent face to face with a physician. The majority of patients will underestimate their anticipated ED length of stay, and will provide lower satisfaction scores as a result.[4] It also places a strain on the physician to provide optimal care for their patients while being constrained by space and time restrictions. Waiting room medicine results in significant strain on the physician-patient relationship and affects the ability for a patient to receive optimal care.

Liability Concerns

Many emergency physicians hesitate to evaluate patients from the ED waiting room because of liability concerns. Once a patient presents to the ED for evaluation, they are covered under EMTALA. The EMTALA law gives every patient the right to a medical screening exam in the ED and treatment until their emergent medical condition is stabilized.[5]

Does treating a patient in the waiting room establish liability for the patient? The answer is unclear. Perhaps a better way to frame the question is to consider if harm is being done to the patient. It may be that leaving patients unattended in the waiting room for prolonged periods of time may be more harmful than trying to treat with what little room and resources are available.

Solutions

Responses to the challenge of prolonged ED wait times and waiting room crowding center around reimagining the traditional ED workflow to deliver evaluations and treatments to patients asynchronously while they wait. A 2020 scoping review reported 38 interventions to improve patient care.[6] Common strategies include employing a nursing-driven standardized triage order sets or utilizing a physician-in-triage. Other interventions have included expanded point-of-care testing, frequent vitals, ED observation units, computerized clinical support systems, and activation of additional services such as scribes, mental health providers, and pharmacists.

These nontraditional care models all center around the reality that the alternative to the ED flexing its workflow is to provide no care to the waiting patients in a gridlock. Although such nontraditional care models may be scrutinized as they represent a deviation from the standard of care, it is a fallacy to reject these interventions, outright. Nontraditional care models may represent the "lesser of two evils" and the best standard of care within the context of crowded circumstances.

Call to action

The nation's EDs have continued to bend under the strain of waiting room crowding, principally a result of inpatient boarding in the ED, without any identifiable regulatory, financial, or altruistic motivations making a meaningful impact in this trajectory. For this reason, ACEP called for, and is participating in, a summit on ED boarding with the Centers for Medicare and Medicaid Services to seek pathways forward addressing the root of ED crowding. Although it is the ethical obligation of emergency physicians at the bedside to respond to the individual patient's needs seeking their best outcome and best interest, the swelling landscape of crowded ED waiting rooms and delayed ED care cannot be resolved at the bedside but at the federal level.

As emergency physicians and EDs develop innovative solutions to address the continual increase in ED crowding and wait times, it is imperative that emergency physicians do not accept this as fate, but continue to advocate for appropriate resources to care for patients. This less-than-ideal situation, however, does not negate the cornerstone of ACEP's Code of Ethics – to "embrace patient welfare as [our] primary professional responsibility." Nontraditional care models may be scrutinized as deviating from the typical standard care of

CONTINUED *on page 19*

Hypertensive Disorders in Pregnancy

In pregnancy, pay close attention to blood pressure

by RACHEL SOLNICK,MD, MSC, AND ALLISON WARREN

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You're working the night shift in a rural critical access hospital in the Midwest when a 36-year-old, 31-week primigravida patient with no known prior medical history presents with a mild headache. Initial vitals show a blood pressure (BP) of 170/115 mm Hg, which remains elevated 15 minutes later. You follow the recommended emergency department (ED) lab workup for hypertensive disorders of pregnancy, including urine protein/creatinine ratio, serum creatinine, platelet count, complete blood count, and renal liver function tests.

Fetal monitoring reveals normal fetal heart rate assessment. The physical exam is unrevealing, with no focal neurologic deficits or abdominal tenderness. A urine test reveals protein/creatinine ratio of less than 0.3; lab tests show no signs of end-organ dysfunction. Aiming to start treatment within the goal of the first 30 to 60 minutes of confirmed severe hypertension, you initiate an oral antihypertensive with immediate release oral nifedipine 10 mg and acetaminophen for her mild headache while the nurse works on intravenous (IV) access.

Once an IV is established, you first administer labetalol 20 mg IV because antihypertensive treatment is the priority, followed by magnesium sulfate 6 g IV over 20 minutes. Her headache abates after the acetaminophen. You advise the nurse to recheck the BP every 10 minutes with a target BP of 130-150/ 80-100 mm Hg and a plan to increase labetalol doses based on rechecks.

You call the nearest hospital, but because they don't have a neonatal intensive care unit (NICU), they advise you to call another one. You speak with the OB/GYN team at that hospital, and they recommend steroids for fetal lung maturation because the pregnancy is less than 34 weeks gestation. After a few more rounds of IV labetalol, BP is stabilized, and the patient, now diagnosed with severe gestational hypertension, is flown via air ambulance to the nearest hospital with a NICU.

Acute Hypertension in Pregnancy

Hypertensive disorders of pregnancy are the second leading cause of maternal morbidity and mortality and can also result in fetal complications. Maternal complications of this medical emergency include stroke, eclampsia, and HELLP—hemolysis, elevated liver enzymes, low platelet count—syndrome. Timely treatment can reduce these risks.

The consideration of delivery in severe gestational hypertension must balance risks for maternal and fetal complications, as immediate delivery can reduce maternal complications but can increase the risk for neonatal respiratory distress syndrome, particularly when performed before 37 weeks of gestation. Importantly, these conditions can appear up to six weeks postpartum, which is why it is essential for ED screening to include the question for reproductive age women: Are you pregnant or have you been pregnant in the last six weeks?

Patients with gestational hypertension are at increased risk for preeclampsia, HELLP syndrome, preterm birth, small-for-gestational-age infants, and placental abruption. Risk factors include obesity, use of assisted reproductive technology, prior preeclampsia, and multifetal gestation. Older maternal age and obesity contribute to increasing incidence. Close monitoring is essential to detect progression to severe hypertension or preeclampsia, particularly in those diagnosed before 34 weeks, those with systolic BP greater than 135 mm Hg, or those with a history of miscarriages.

Case Definitions[1,2]

Chronic hypertension: Hypertension (140/90 mm Hg or greater) presents before pregnancy or is diagnosed **before** the 20th week of gestation.

Superimposed preeclampsia: A patient with chronic hypertension who has passed after the 20th week of gestation AND develops new-onset proteinuria (p**rotein/creatinine 0.3 or greater; urine dipstick 2+ or greater**) or other signs of end-organ dysfunction such as:

Renal insufficiency: Creatinine levels greater than 1.1 mg/dL or a doubling of baseline creatinine

BP worsening: Typically, 160/110 mm Hg or greater, despite previously controlled chronic hypertension

Thrombocytopenia: Platelet count less than 100×10^9/L

Impaired liver function: Elevated AST/ALT [aspartate aminotransferase/alanine aminotransferase] twice the upper limit of normal, often associated with right upper quadrant or epigastric pain

Pulmonary edema: New-onset fluid accumulation in the lungs

Neurological symptoms: Persistent severe headache, vision changes, or altered mental status

Gestational hypertension: New-onset hypertension (140/90 mm Hg or greater) **after 20 weeks of pregnancy** in a previously normotensive patient. It differs from preeclampsia because it does **not** include proteinuria OR signs of end-organ dysfunction.

Severe gestational hypertension: BP at **severe levels** (160/110 mm Hg or greater), which remains elevated despite initial management efforts. Although the condition may lead to preeclampsia, it differs because it occurs without proteinuria or systemic findings of end-organ dysfunction.

Preeclampsia: Gestational hypertension AND either proteinuria OR systemic signs. Severe preeclampsia includes severe hypertension (systolic BP160 mm Hg or greater or diastolic BP 110 mm Hg or greater), significant proteinuria, and evidence of organ dysfunction). It can occur at any time after 20 weeks but is more common after 34 weeks.

HELLP syndrome: Serum aminotransferase levels 70 U/L or greater, platelet count less than 100×10^9/L, and LDH less than 600 U/L. HELLP affects less than 1 percent of pregnancies but has a seven percent to 70 percent perinatal mortality rate and a one percent to 24 percent maternal mortality rate.[3] Symptoms are nonspecific, including nausea, vomiting, and abdominal pain.

Management[4–7]

American College of Obstetricians and Gynecologists (ACOG) guide to Obstetric Emergencies in Nonobstetric Settings has issued the following guidance based on the Acute Hypertension in Pregnancy and Postpartum Algorithm regarding immediate treatment for severe hypertension (SBP greater than160 mm Hg, DBP greater than110 mmHg). Recommended antihypertensive drugs include labetalol, nifedipine, and hydralazine. According to ACOG guidelines, once BP is controlled (less than 160/110), it should be monitored every 10 minutes for an hour, every 15 minutes for the next hour, and every 30 minutes for the following hour.

Labetalol: An initial dose of 20 mg IV over two minutes is to be repeated at 10-minute intervals as needed, increasing to 40 mg and 80 mg on subsequent pushes, after which a switching agent is recommended. Avoid parenteral labetalol with active asthma, heart disease, or congestive heart failure; use with caution with a history of asthma.

Hydralazine: 5 mg to 10 mg IV over two minutes, to be repeated at 20-minute intervals as needed, increasing to 10 mg on a subsequent dose, after which switching agent is recommended. Maximum cumulative IV-administered doses should not exceed 25 mg in 24 hours. It may increase the risk for maternal hypotension.

Oral nifedipine: 10 mg capsules. Capsules should be administered orally, not punctured, or otherwise administered sublingually.

Antihypertensive treatment is the priority, followed by magnesium treatment for seizure prevention. The loading dose is four grams to six grams IV over 20 to 30 minutes, followed by a maintenance dose of one to two grams per hour. Contraindications to magnesium include myasthenia gravis, and caution should be used with renal failure or pulmonary edema. Magnesium can be administered as 10 g of a 50 percent solution IM (five grams in each buttock) without access.

Drugs to Avoid[8–10]

When treating pregnant patients for hypertension, avoid atenolol and propranolol because of reports of fetal growth restriction, angiotensin-converting enzyme (ACE) inhibitors, which may cause major congenital malformations, angiotensin II receptor blockers (ARBs) because of interference with fetal renal hemodynamics, and mineralocorticoid receptor antagonists (spironolactone, eplerenone, amiloride) and nitroprusside because of limited safety data available. Additionally, diuretics are not typically administered to pregnant patients.

Postpartum Risks

Hypertensive disorders of pregnancy significantly increase postpartum risks for preeclampsia and stroke. Patients should be educated on key symptoms to watch for, such as severe headache, visual disturbances, swelling, shortness of breath, chest pain, vomiting, or seizures. Early intervention is critical to preventing severe complications, and some may require prolonged antihypertensive treatment.

CONTINUED *on page 19*

Texas Hospitals Now Must Ask About Immigration Status

Executive order is an example of politics' impact on medicine

by LARA C. PULLEN, PHD

On August 8, 2024, Greg Abbott, Governor of Texas, issued an executive order directing the Texas Health and Human Services Commission "to assess costs to the Texas public hospital system imposed by the federal government's open-border policies."[1] The order directed hospitals to collect information on patients not lawfully present in the United States beginning November 1, 2024. The initial data submission was due to the Health and Human Services Commission no later than March 1. The data will then be reported to the Governor, the Lieutenant Governor, and the Speaker of the House on January 1, 2026, and annually thereafter.

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The U.S. and Mexico border.

Data Collection

"The executive order is really just trying to collect data," explained David Wampler, PhD, LP, FAEMS, San Antonio. He noted that undocumented immigrants have always passed through the area, and the federal Emergency Medical Treatment and Labor Act (EMTALA) compels Centers for Medicare & Medicaid Services (CMS) hospitals to care for all acutely ill or injured patients. However, this is the first time that hospitals have been explicitly directed to gather data on the number of patient discharges, emergency visits, and the cost of care provided to the patients. Dr. Wampler explained that this information is meant to help evaluate the financial burden on hospitals in the state.

Andrea Green, MD, FACEP, Past President of the Texas College of Emergency Physicians (TCEP) and an emergency physician in El Paso, Texas, explains that at registration, patients are given a form that has the patient's name, but no address or phone number. The form asks if the patient is a citizen or lawfully present in the United States. The patient can answer yes, answer that he or she is unlawfully present, or decline to answer. "I suspect most of the patients we are seeing are lawfully present or citizens," said Dr. Green. "We rarely get any decline to answer." She agrees that the process is primarily about data collection.

To the best of Dr. Wampler's knowledge, the hospitals report data that are not explicitly linkable to any individual patient but rather are surveillance in nature and address five main questions: 1) What is the cost of providing health care services, particularly to uninsured and Medicaid patients? 2) How many individuals are utilizing the public hospital system without corresponding payment? 3) How much reimbursement from Medicaid, the federal government, and other sources are public hospitals receiving compared with the total costs? 4) How much care is provided without reimbursement? 5) What are the overall operational expenditures of public hospitals?

Patient Care

Gov. Abbott stated in his executive order that "federal law contributes to the growth of uncompensated medical costs by requiring that any individual must be allowed to obtain emergency medical treatment regardless of that individual's immigration status, or willingness or ability to pay for such treatment." Dr. Wampler pointed out that this is important for emergency physicians because it reinforces that the executive order does not change the federal law requiring access to emergency medical treatment. As further reinforcement of this message, the executive order states that when the information is collected, hospitals should inform the patient that, as federal law requires, any response to the information request will not affect patient care.

"Operationally, it hasn't affected us that much," said Dr. Wampler. "Somebody's status doesn't really affect the medicine they receive … Emergency medicine has never performed a wallet biopsy. Emergency providers don't make clinical decisions based on whether or not someone has health insurance." Dr. Green agrees, explaining there was a little confusion when the question was first introduced, but now there is no pushback from patients responding to the questions.

Dr. Wampler also emphasized the separation between hospitals' admissions personnel and medical staff. "Health care staff don't ask those questions," he said. He does acknowledge, however, that the fact that the questions are being asked may be counterproductive to medical care if it causes people to delay seeking care. He noted that such delays may also affect health outcomes, especially with time-sensitive medical problems, making medical conditions more difficult and expensive to treat.

Merging of Politics with Medicine

"It's where politics meets medicine," explained Dr. Wampler. "This is not unusual for Texas." He noted Chapter 170A of the Texas Health & Safety Code, passed in 2022, which prohibits abortions in nearly all circumstances. Section 170A. prohibits a person from performing, inducing, or attempting an abortion. "The [Texas] abortion ban and access to emergency pain medications are examples of the intersection between medicine and politics," he says.

Gov. Abbott emphasizes this overlap in his executive order when he specifically identified the Biden-Harris administration as adopting open-border policies that invite mass illegal entry into Texas and other states. In the executive order, Abbott referred to a May 2021 disaster proclamation stating that the surge of individuals unlawfully crossing the Texas-Mexico border posed an ongoing and imminent threat of disaster for Texas.

Gov. Abbott's assessment of the scope of the immigration problem also appears to be at odds with official data. (Gov. Abbott's office declined an interview with *ACEP Now*.) He wrote in the executive order that the number of individuals crossing the southern border had increased to 11 million people entering the country illegally in less than four years. (Factcheck.org places the number closer to 4.2 million.)[2] He also stated in the executive order that the Biden-Harris administration had taken steps to prevent states from addressing the crisis by destroying state barrier infrastructure and suing state officials. Moreover, he emphasized that since federal law requires emergency medical treatment, the State of Texas must absorb a large percentage of the cost for individuals not lawfully present in the United States. Texans must bear the costs of public financial support for the medical care of these individuals. Because EMTALA is an unfunded mandate, emergency physicians also bear a portion of this cost. Gov. Abbott further justified the executive order by stating that the increased expenditures for Texas hospitals impose burdens on the Texas health care system and increase the cost of medical care for all Texans.

On October 31, 2024, Tony Pastor, MD, a congenital cardiologist, posted a TikTok video, now viewed 28,100 times, informing the public of their right not to respond to the citizenship question on hospital intake forms.[3] Although Gov. Abbott stated this right explicitly in his executive order, on Nov. 24, he posted on X: "Hey Texas Children's Hospital & Baylor College of Medicine, this doctor is putting your Medicaid & Medicare funding at risk. You better think twice & have crystal clear records. There will be consequences for failing to follow the law in the Order."[4]

When asked for an interview on the topic, Texas Children's in Houston responded: "Texas Children's continues to prioritize patient care while also ensuring we are in full compliance with all laws and legal directives."

Texas physicians and hospitals have become familiar with the merging of medicine and politics. While federal law does not protect access to elective abortions, it does protect access to emergency medical care.

David Wampler, PhD, LP, FAEMS, is a professor in the Department of Emergency Health Sciences at UT Health San Antonio. While Dr. Wampler exercises his right to academic freedom, his views are expressed in an individual capacity and do not represent the views of the University of Texas Health Science Center at San Antonio or UT Health San Antonio.

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NES | CONTINUED FROM PAGE 1

and whether they would still have essential malpractice liability "tail" coverage.

In 2023 there were bankruptcies of two private equity-based ED companies, Envision Healthcare, which has since emerged from bankruptcy protection and continues to operate, and American Physician Partners, which closed that same year. In this new case, NES Health, based in Tiburon, Calif., was founded and owned by radiation oncologist Allan Rappaport, MD, JD. A September 2, 2024, blog post at the Emergency Medicine Workforce Newsletter listed NES Health as the country's 14th largest emergency department employer.[2]

The Timing

In September 2024, NES Health informed its contract physicians by email that their regular monthly payment would be delayed. Another delay in October was attributed to a transition to a new billing company. Then, in a November 22 email shared with *ACEP Now*, NES Health announced its intention to cease operations.

At press time, the NES Health website noted that the company "has experienced significant financial difficulties," leaving it with no funding or available cash to pay venders or contractors, or the premiums for its physicians' medical malpractice coverage.[1] *ACEP Now* was unable to reach anyone at NES Health for comment.

A December 13 "Dear Colleague" letter from ACEP President Alison Haddock, MD, FACEP, emphasized the College's commitment to help physicians affected by the NES closure to "find a way forward that works for them." She stated that "the expectation that emergency physicians would continue to treat patients absent contracted benefits and protections is unreasonable."[3]

ACEP has supported its members in a variety of ways, including a November Town Hall webinar discussion for affected physicians to share legal strategies for navigating the disruption.[3] ACEP also offered a hardship membership program for clinicians to join the College for free and thereby access resources, including tips for contract signing and a job board, among other tools and resources.[4]

But bigger questions remain: What legal recourse is there for doctors to pursue? How can the specialty prevent this from happening to other physicians at other hospitals?

Promises Made

Affected hospitals, now in need of a way to staff their EDs, have been making arrangements with other staffing entities to replace NES Health. Physicians contacted for this article said their hospitals have not been very supportive of the critical resource that their ED clinical staff represents.

An emergency physician who practices in hospitals in Pennsylvania, who asked not to be named for this article out of concern about how it might affect his relationship with his employers, said he didn't feel comfortable just walking away from scheduled shifts during the turmoil over NES Health's shutdown.

"Maybe I would have been better off, but like a lot of people, we're basically trying to decide what is our moral, ethical responsibility to keep working at this hospital when we know we're probably never going to get paid for all the work we've done," he said.

He and his fellow clinicians convened quickly after the troubles at NES Health were

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revealed, scrambling to find a lawyer who could answer, for example, "if we are allowed to walk out on a shift, and under what scenario?" The doctors are back at work now, employed by a Florida-based management firm. "But all of us have lost at least two months of pay. The hospital is not saying: 'We're going to make you whole,'" he said.

"We definitely, as a group, plan to file a lawsuit," he said. But most of the physicians he knows are planning to leave, cut hours, or otherwise hedge their bets regarding where they work. Experts encourage ACEP members to have working relationships with more than one hospital or employer, which would give them more flexibility and options in a crisis such as this.

Another emergency physician who asked not to be named, practicing at PeaceHealth Ketchikan Medical Center in a remote part of Southeast Alaska, described the experience of getting a last paycheck from NES Health on September 26, for work performed in August, and then finding out that his October check would not be forthcoming.

"Very quickly, our hospital rallied us together for a meeting, reassuring us that 'We'll make you whole. Your back pay and malpractice will be taken care of. Don't worry, just keep showing up. We deeply value the care you provide to our community,'" the doctor recalled.

A temporary relief contract agreement for ED staff to become hospital employees was offered by the hospital. Once that contract was signed, the idea of restoring lost back pay was dismissed as a "compliance issue," he said.

What has it been like to live through this work disruption? "It's been nonstop—communicating with the hospital, coordinating with my colleagues, consulting lawyers, engaging with ACEP, having meetings, researching and brainstorming solutions," he said.

"How do I feel? Gutted and overwhelmed. I feel like the hospital system and corporate greed have reduced me to a commodity rather than treating me as a human. They tell me I'm valued, but their actions say otherwise. And amidst this unnerving experience, I'm still showing up to care for patients—many at the most vulnerable moments of their lives."

Possible Responses

ACEP Board Member Diana Nordlund, DO, JD, FACEP, a corporate compliance lawyer and attending physician with Emergency Care Specialists in Grand Rapids, Mich., said the troubles with NES Health "are a very difficult position for physicians to find themselves in, where they have bound themselves to a contract and they've delivered what they promised to deliver pursuant to that contract."

There are several kinds of suits that physicians could pursue against companies that leave them high and dry, including a class action lawsuit for breach of contract. Affected physicians could file a claim in bankruptcy court for money owed to them by the corporation declaring bankruptcy, Dr. Nordlund said; although, that may not offer much chance of recovery if the defendant, like NES Health, truly has no resources.

"This has been an excellent argument for making sure that you have an air-tight employment contract the next time you sign one, and that you understand your contract clauses and termination clauses," Dr. Nordlund said. Start by developing a relationship with an attorney who practices in your state and does health care contracts.

ACEP is also trying to promote best models for employers and offers a master class for physicians looking to form their own physician-owned group. "We are also seeing some physicians move to a hospital system-employed model. There are pluses and minuses to all of these models," she said.

The NES Health closure "is another sign of how challenging our jobs are getting at all levels," ACEP President Dr. Haddock told *ACEP Now*. "We need more control in the hands of frontline physicians. Part of that is demanding more transparency from our employers, so we can understand what's happening to the money," Dr. Haddock said.

"Hospitals had a chance to be an advocate for their frontline employers. They have an important role here. Talk to your doctors. Find solutions. Make sure patients keep getting care," she added. "In the meantime, physicians need to look out for themselves. As a start, have a deep knowledge of your contract. That is important, now more than ever. Knowledge is power."

MR. BERESFORD is an Oakland, Calif.-based freelance medical journalist.

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FASTING | CONTINUED FROM PAGE 1

Islamic jurisprudence permits alternatives for those unable to fast, such as fasting later or feeding the needy:[4] "And anyone who is ill or on a journey should make up for the lost days by fasting on other days later. God wants ease for you, not hardship" (Quran 2:185). Recognizing these provisions helps emergency physicians respect patients' spiritual beliefs while ensuring appropriate care.

Common Emergency Presentations During Ramadan

Fasting can exacerbate chronic conditions or trigger acute medical emergencies. Common emergency department (ED) presentations include:

Dehydration and electrolyte imbalances

Glycemic emergencies: Altered medication regimens or dietary patterns may lead to hypoglycemia, hyperglycemia, diabetic ketoacidosis, or hyperosmolar hyperglycemic states.

Syncope and orthostatic hypotension: Reduced caloric and fluid intake can cause syncopal episodes, particularly in elderly or patients with cardiovascular compromise.

Exacerbation of chronic conditions: Patients with heart failure, chronic kidney disease, or other illnesses may experience worsening symptoms due to dietary and fluid restrictions.

Ethical Dilemmas

Critically ill patients may refuse interventions, such as intravenous fluids or emergency medications, to maintain their fast. Although Islamic teachings prioritize the preservation of life and permit breaking the fast in life-threatening situations, some patients view hardship as spiritually rewarding.

Emergency physicians can navigate these challenges by:

Engaging in compassionate dialogue: Use culturally sensitive language to explain the necessity of interventions and the religious permissibility of breaking the fast to protect health.

Involving family and religious leaders: Seek support from family members or spiritual advisors to reassure patients.

Providing alternatives: Emergency physicians can reassure fasting patients that certain medications and procedures do not invalidate fasting, including:[5,6]

Medications:

- sublingual medications or lozenges (excluding nicotine gum)
- topical medications, creams, and ointments
- oxygen supplementation
- vaccinations (excluding oral vaccines)
- metered-dose inhalers (excluding nebulizers)
- contrast dye for imaging (excluding oral contrast)
- injected medications (intramuscular, intravenous or subcutaneous; excluding fluids, glucose, or electrolytes)
- insulin therapy

Procedures:

- nasal packing
- pelvic exams
- foley catheter insertion
- endoscopy

Beyond Ramadan

Although Ramadan is the primary fasting period, many Muslims fast at other times, such as the six days of Shawwal (immediately after Ramadan), weekly fasts on Mondays and Thursdays, and specific religious occasions.[4] These practices mean fasting patients may present to the ED year-round. Maintaining cultural humility and applying empathetic care ensures consistent, high-quality care for Muslim patients at any time.[7]

Conclusion

Ramadan presents unique challenges and opportunities for emergency physicians to deliver culturally sensitive care. Key considerations include:

- Recognizing common health risks, such as dehydration, glycemic emergencies, and exacerbation of chronic conditions.
- Respecting patients' spiritual beliefs while prioritizing health and safety.
- Addressing ethical dilemmas with empathy, shared decision-making, and culturally appropriate communication.
- Preparing for year-round fasting practices among Muslim patients.

By integrating cultural humility into clinical practice, emergency physicians can enhance the quality of care for patients, fostering trust and promoting health equity.

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DR. ABUBSHAIT is a clinical assistant professor of emergency Medicine at Thomas Jefferson University in Philadelphia, Penn. She is also the Associate Program Director of the Emergency Medicine residency program at Jefferson Einstein Montgomery Hospital.

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ACEP Clinical Policy on Seizures

by MICHEAL D. SMITH, MD, MBA, FACEP

On April 17, 2024, the ACEP Board of Directors approved a clinical policy developed by the ACEP Clinical Policies Committee on the management of adult patients presenting to the emergency department with seizures. This clinical policy was published in the July 2024 issue of the *Annals of Emergency Medicine*, can be found on ACEP's website, www.acep.org/ClinicalPolicies, and will also be included in the ECRI Guidelines Trust, https://www.ecri.org/solutions/ecri-guidelines-trust, upon its acceptance.

Patients presenting with seizure account for about 1% of all emergency department patients. First-line treatment for recurrent seizures is the appropriate dosing of benzodiazepines with second-line treatment including agents such as phenytoin, levetiracetam, and valproic acid. This latest clinical policy from the ACEP Clinical Policies Committee readdresses the critical question from the 2014 clinical policy regarding appropriate second-line agents in patients with refractory seizures in the emergency department that have been appropriately dosed with benzodiazepines.

The critical question was based on feedback from ACEP membership. A systematic review of the evidence was conducted, and the committee made recommendations (Level A, B, or C) based on the strength of evidence available. This clinical policy underwent internal and external review expert review and was available for review by ACEP membership during an open comment period. Responses received were used to refine and enhance the final policy.

CRITICAL QUESTION

In emergency department patients with generalized convulsive status epilepticus who continue to have seizures despite receiving optimal dosing of benzodiazepine, which agent or agents should be administered next to terminate seizures?

Patient Management Recommendations

Level A recommendations. Emergency physicians should treat seizures refractory to appropriately dosed benzodiazepines with a second-line agent. Fosphenytoin, levetiracetam, or valproate may be used with similar efficacy.

Level B recommendations. None specified.

Level C recommendations. None specified.

Translation of Classes of Evidence to Recommendation Levels

Based on the strength of evidence for the critical question, the subcommittee drafted the recommendations and supporting text synthesizing the evidence using the following guidelines:

Level A recommendations. Generally accepted principles for patient care that reflect a high degree of scientific certainty (eg, based on evidence from one or more Class of Evidence I or multiple Class of Evidence II studies that demonstrate consistent effects or estimates).

Level B recommendations. Recommendations for patient care that may identify a particular strategy or range of strategies that reflect moderate scientific certainty (eg, based on evidence from one or more Class of Evidence II studies or multiple Class of Evidence III studies that demonstrate consistent effects or estimates).

Level C recommendations. Recommendations for patient care that are based on evidence from Class of Evidence III studies or, in the absence of adequate published literature, based on expert consensus. In instances where consensus recommendations are made, "consensus" is placed in parentheses at the end of the recommendation.

DR. SMITH was born, raised, and trained in Ohio, and relocated to the heat and constant party of New Orleans, Louisiana. His academic interests are simulation and student and resident education. He has been active in organized emergency medicine including many ACEP committees and is the past president of the Ohio Chapter of ACEP, the Louisiana Chapter of ACEP, and the Simulation Academy of SAEM.

DOING THE MATH TO BENEFIT OUR SPECIALTY

EQUITY EQUATION

DR. KENDALL is the chief of clinician engagement at US Acute Care Solutions and has 15 years of emergency department leadership experience. She is the chair of the USACS diversity, equity, and inclusion committee, the social issues and equity in medicine committee co-chair, and leads physician leadership development for USACS.

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Navigating the Sandwich Generation

Challenges and support for emergency physicians caring for the old and the young

by JAYNE KENDALL, MD, MBA, FACEP, CPE

My good friend and colleague, Dr. Sydney De Angelis, gave a great talk at the American Association of Women Emergency Physicians meeting at ACEP24. The talk was about the "sandwich generation" and how it affects physicians, particularly female physicians, which inspired me to write this article.

For those unfamiliar, the term "sandwich generation" encompasses people typically in their 30s to 50s, who will most likely be "sandwiched" between raising their kids and helping support aging parents.[1] Sometimes, particularly with physicians, this generation stretches even into our 60s and beyond, as many physicians delay starting their families until after residency or later. One study conducted by a team from the University of Michigan estimated that there are at least 2.5 million caregivers in the United States that fall into the sandwich generation, with nearly 25 percent of adults caring for at least one parent older than 65 while also looking after at least one child younger than 18.[2]

For many emergency physicians in this situation, the dual role of caregiver presents unique challenges that can affect their careers and family life as they deal with increased stress because of competing demands. Given the intense work and demanding hours of an emergency medicine career, physicians may have additional stressors that increase feeling overwhelmed, making it essential for health care organizations to recognize and identify these caregivers to provide needed support. In an age of growing discussions on wellness and how to avoid burnout, understanding the emotional and logistical burdens emergency physicians face in the sandwich generation is key to helping medical organizations implement better support systems that promote well-being and resilience, ultimately benefiting caregivers and patients.[1,3]

As we all know, emergency medicine is a demanding specialty with many high pressure situations where physicians must quickly diagnose and treat patients with potentially life-threatening conditions. This fast-paced environment requires rapid actions and decision-making skills while still having the ability to remain calm under stress. Further compounding these challenges are our profession's irregular hours and shift work.[4] These demands create time pressures that can disturb family functioning, parental sense of connectedness, and emotional wellness in physicians navigating the complexities of their roles as partners and parents alongside work obligations.[5]

Juggling Act

These demands and challenges for emergency physicians in the sandwich generation are magnified as they juggle caregiving responsibilities for their children, aging parents, and a high-pressure career. As they wear both hats, these physicians experience considerable emotional, psychological, and even financial burdens associated with higher levels of stress and burnout in this group.[3] Many physicians in this situation feel guilty and inadequate and question their ability to meet their families' needs and demanding jobs.[2]

Deep-seated gender norm expectations add another layer of complexity. Across cultures, women in medicine often feel pressure to "do it all," balancing physician and caregiver roles.[5] This is only exacerbated by the disparities in gender representation and the responsibilities of domestic care, with two out of every three caregivers being female; this added pressure makes life even more difficult for female emergency physicians, and it leads to higher attrition rates among women in the workplace.[6] This raises the importance of health care organizations focusing on multi-layered support systems that recognize these distinctive pressures to create a healthier work-life balance for all sandwich-generation emergency physicians.[7]

Solutions

Emergency physicians in the sandwich generation can use different coping strategies and solutions to help navigate the complexities of balancing work and home life. Time management and prioritizing are critical skills that help these physicians create a more manageable schedule. It is also essential to set clear boundaries between work and home life for quality time

CONTINUED *on page 20*

BE A MEDICAL DETECTIVE—BONE UP ON YOUR FORENSIC SKILLS

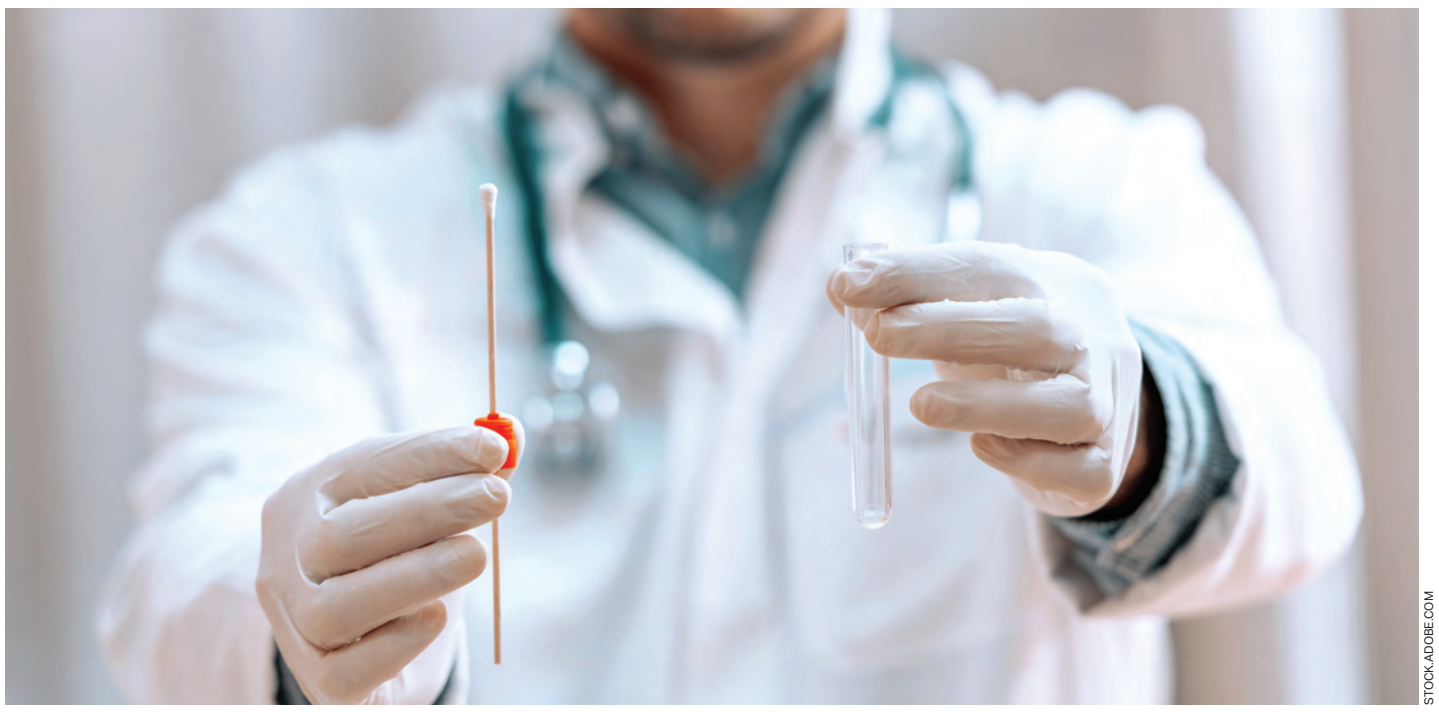
FORENSIC FACTS

DR. ROZZI is an emergency physician, medical director of the Forensic Examiner Team at WellSpan York Hospital in York, Pennsylvania, and secretary of ACEP's Forensic Section.

DR. RIVIELLO is chair of emergency medicine at Crozer-Keystone Health System and medical director of the Philadelphia Sexual Assault Response Center.

Do You Want to be a SANE Medical Director?

by RALPH J. RIVIELLO, MD, MS, FACEP; AND HEATHER V. ROZZI, MD, FACEP



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You work as the medical director at a suburban, community emergency department (ED). At your monthly meeting with the chief medical officer (CMO) and chief nursing officer (CNO), they inform you of the hospital's plan to start a Sexual Assault Nurse Examiner (SANE) Program. They ask you if you would be willing to serve as the team's medical director. As expected, you have several questions. Do you know what you need to know to make an informed decision?

Discussion

SANE programs started in the early 1970s to provide medical forensic examinations to patients after sexual assault. There are approximately 1,000 current SANE programs in the United States.[1] There are many program models including ED-based, non-ED hospital-based, hospital, and community-based programs. Regardless of the type of program, one key to the success of the program is its management team. The program is typically led by a nursing program director and a medical director.

A SANE program medical director is generally responsible for several aspects of the program including developing policies and protocols, mentoring and educating the team by providing guidance and assistance, helping to develop and implement quality initiatives, championing the program and sharing the program's mission and values, and developing high-quality, cost-effective care for victims of sexual violence.

Because of the close relationship with emergency medicine and SANE programs, emergency physicians often serve in the role of SANE medical director. Often, the role and responsibilities are added to the ED medical director job description, though other specialists including family practitioners, obstetricians and gynecologists, and pediatrics may serve as medical directors. For pediatric programs, it is preferred that the medical director be trained as a child abuse pediatrician.

The medical director's actual responsibilities can vary by program, but may include:

- Signing and developing care protocols, especially those for care of the pregnant sexually assaulted patient, sexually transmitted infections, and HIV prophylaxis
- Medication standing orders
- Protocol development regarding provider involvement, medical screening examination, and strangulation
- Ordering tests
- Participating in patient care issues and care questions
- Participating in quality assurance and improvement processes
- Participating in staff clinical education
- Participating in administrative aspects of the program
- Participating in strategic planning and benchmarking processes
- Assisting with clinical expansion and implementation of new programs
- Serving as a liaison to other providers in the ED, hospital, or community

What makes a good SANE medical director? Program managers should look for someone who is enthusiastic about the work, has excellent collaboration skills, especially with nursing staff, and has a passion for teaching. The medical director should share the mission and values of the program and understand the importance of trauma-informed, victim-centered care. Other typical standards include board certification or eligibility and experience and knowledge of the medical forensic examination. Some states may require the medical director to be an accredited forensic examiner or to have additional training and knowledge in sexual assault care. In some instances, an advanced practice provider may fulfill the medical director role. A sample job description can be found at: https://illinoisattorneygeneral.gov/Page-Attachments/GuidetoEstablishingaSexualAssaultNurseExaminerProgram.pdf

What important questions should one ask before accepting the role? A prospective medical director should have good understanding of the program itself, program leadership and reporting structure, job expectations and responsibilities, time commitment, and, of course, compensation (amount and model [hourly, stipend, CME allotment]). Establishing a new program or expanding a current program may have more of a time commitment, especially early in the process, than taking over an established program. Another consideration is any specific training or course work you may need to better prepare to take over the role. Although not typical, a medical director may be asked to participate in staff hiring and recruitment, as well as fiscal management of the program. There may also be external meeting requirements such as participation in the region's Sexual Assault Response Team or multidisciplinary team meetings.

Conclusion

You take a few days to research the role and formulate your questions. You meet with the SANE program manager to understand their expectations of your role and relationship. You then meet again with the CNO and CMO who answer all your questions and inform you that there is additional compensation for the role. You accept the position.

KEY POINTS

- A medical director is a necessary part of a sustainable SANE program.
- An invested and dedicated medical director who interacts with the SANE program manager and team is crucial.
- It is important for the SANE medical director to act as a champion for the program.
- Emergency physicians are often the logical choice for SANE program medical director.
- Key functions of the SANE medical director include treatment and medication protocol development, SANE mentoring and education, developing quality initiatives, and liaising with the medical staff and community partners.

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REAL STORIES, REAL REMEDIES

ART OF HEALING

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BY ALEX KOO, MD, FACEP

Satonofuji Hisashi has been a career sumo wrestler since 1996. He is no champion wrestler—in fact, he is far from it. His highest attained rank was in the Makushita division in 2005, the third highest of six sumo divisions. Traditionally, the most elite wrestlers sat in a curtained area at the arena—makushita did not and the name thus translates to "below the curtain." The current salary of makushita is about $800 U.S. per month.[1] If you enter the Isegahama stable today, you might find Satonofuji diligently training, but you will also find him performing lower-ranked sumo duties such as simmering chanko nabe or "sumo stew" for others, sweeping the communal living areas, cleaning the bathrooms, or carrying the higher ranked sekitori sumo's belongings during tournament days. Now 47, he is currently ranked Jonokuchi, the lowest division, and unlikely to ever achieve Makushita again.

One may ask, "Why doesn't he retire?" or think, "Clearly, he chose the wrong profession…" However, Satonofuji continues because he has uncovered his ikigai in sumo.

Ikigai is a Japanese concept of "reason to being." It can be defined by an overlap of four pillars:[2,3]

- **Passion -** what makes you excited
- **Mission –** what makes a difference in the world
- **Profession –** what you can make a living on
- **Vocation –** what you're good at

Another broader definition of ikigai is a "sense of purpose" or "what we wake up in the morning for" or "makes the time fly by." It is as narrowly or broadly as we define it.

Satonofuji found his ikigai in sumo, but even more specifically, in the yumitori-shiki, or bow-twirling ceremony. He performs this short ritual, spinning, twirling, and sweeping a six-foot bamboo bow artfully above his head, across his body, and toward his feet. This custom is at the end of all the day's sumo matches, oftentimes to an emptying stadium echoing the shuffling feet and distracted chatter of leaving spectators. But it's no bother to Satonofuji. He's "in the zone," looking upwards to the sky or down toward the ground and without regard for a lack of an audience. His ikigai in the yumitori-shiki is not dependent on the spectators or what others define as a "good" sumo wrestler, but moreso on his own derivations of significance. In a 2022 interview about his performance of the yumitori-shiki, Satonofuji said, "Every single gesture has a meaning, so I put my heart into it."

Why Ikigai Can Be Important to Us?

Ikigai is associated with improved quality and quantity of lifespan. Who wouldn't want to live longer and better? In large, longitudinal studies, those with self-reported ikigai had lower rates of functional disability, dementia, and cardiovascular disease, ranging from a 20 percent to 30 percent decrease compared with those without.[4-6]

Additionally, in the health care environment where burnout is prevalent, particularly emergency medicine, we search for meaning in a landscape that has increasing boarding, violence against health care workers, loss of autonomy, and depersonalization. A sense of purpose is an integral part of well-being.[7,8] In a national survey of emergency medicine residents, finding meaningfulness in clinical work had the strongest positive association with professional fulfillment.[9] Furthermore, meaningful work is a cornerstone in the longevity of career academic physicians.[10] For us to continue in dedicated service to our patients and specialty, it's important to have a sustained sense of meaning in our work.

Ikigai in Emergency Medicine

Ikigai is inherently within us but needs to be *deliberately uncovered and identified*. Although it is unlikely one finds the whole of emergency medicine to be their ikigai, there are portions of the practice that are. So how does one uncover their ikigai in the craft of emergency medicine?

Start with the pillars and go with the flow. Reflect on an activity where a) your focus is dedicated, b) mind is on the present moment, and/or c) you are doing the task for the sheer sake of doing it. That's flow. Now—with the context of the four pillars, what makes time flow by?

Reflecting on the pillar of vocation, perhaps you're an excellent proceduralist or a "productivity" speed demon—the one colleagues ask as backup for a difficult intubation or lumbar puncture, or the one that colleagues breathe a sigh of relief seeing you come on shift when there are 10-hour wait times, respectively. For the pillar of mission, you feel a sense of calling to your community when rendering care to your patient and neighbor in room 14. Or perhaps you express a deep passion in women's health or resident education. Within these pillars, are there patterns of flow that you uncover?

Embrace the whole of ikigai. An important point is that ikigai is not what is easy to do nor what makes you happy. Struggle, and at times distress, are necessary components of ikigai. Troubleshooting a challenging transvenous pacer that intermittently captures, dealing with a frustrating transfer conundrum, navigating your patient's complex home health needs, or mentoring a struggling resident ultimately adds deep meaning to those aspects. That sense of accomplishment to "get to the next level," the gratification of learning something new, the curiosity to dig a little deeper, or even outright failure drives ikigai. Accepting this reality of fulfillment reframes seeing the negative experiences and feelings in a broader light.

Experiment consciously. Augmenting your ikigai means either 1) rooting it deeper in a pil-

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ANSWERING CLINICAL QUESTIONS

PROBLEM SOLVERS

DR. MARCO is professor of emergency medicine at Penn State Health-Milton S. Hershey Medical Center and associate editor of ACEP Now.

Can This Patient Leave Against Medical Advice?

by CATHERINE A. MARCO, MD, FACEP

A 28-year-old man presented with agitation. He was brought in by police and was restrained because of threats of biting and hitting police. The patient refused any additional medical care and stated, "I know my rights! You can't hold me against my will." When the emergency physician recommended vital signs, a history, and physical examination, the patient began hitting and biting staff, yelling obscenities, and threatening legal action. Should this patient be allowed to leave against medical advice (AMA)?

Leaving AMA

Informed consent and informed refusal of care are important components of patient autonomy, or self-determination, in medical decision making.[1,2] Approximately 2 percent of emergency department (ED) patients in the United States leave prior to evaluation or AMA.[3] Certain patient factors are associated with higher incidence of leaving AMA, including male gender, younger age, alcohol use, illicit substance use, weekend treatment, Medicaid insurance, and lack of medical insurance.[4-6] Patients cite a variety of reasons for leaving AMA, including wait time, unmet expectations, anger, drug or alcohol use, family responsibilities, financial concerns, and negative interactions with staff.[7,8]

ACEP has summarized these issues in its Code of Ethics: "Emergency physicians shall communicate truthfully with patients and secure their informed consent for treatment, unless the urgency of the patient's conditions demands an immediate response."[9] Patients with appropriate decisional capacity have the right to participate in the informed consent process and also have the right to refuse medical care. Informed consent and informed refusal are a process, not merely a signature on a form. Some erroneously believe that merely documenting a patient leaving AMA, using an "AMA form," is sufficient to meet legal and ethical standards. The process of refusal of care, including leaving AMA, should include determination of decisional capacity, delivery of relevant information, including risks of refusing treatment, alternative treatments, and documentation of these elements. When a patient refuses medical treatment, care should specifically be taken to ensure that the patient understands the consequences, and that the physician expressed a willingness to treat the patient, including providing reasonable alternative treatments, and providing appropriate discharge instructions and follow-up recommendations (see table 1).

Patient Assessment

Assessment of capacity is an essential element of informed consent for treatment or informed refusal of care (see table 2).[10,11] Multiple clinical conditions may impair capacity, such as cognitive disorders, neurologic disorders, medication effects, alcohol intoxication, substance abuse, psychosis, pain, anxiety, or any other condition that impairs ability to make an authentic choice.

Assessment tools may be helpful in the assessment of decisional capacity, particularly in high-risk settings. There is no evidence to establish a single tool as a valid gold standard for assessment of capacity, and the utilization of any of these assessment tools represents only one part of the clinical assessment of capacity.[12-14] Examples of assessment tools that may be utilized as a part of the assessment of capacity include: Mini Mental State Examination (MMSE); Montreal Cognitive Assessment (MoCA), the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), Competency Interview Schedule, Structured Interview for Competency and Incompetency Assessment Testing and Ranking Inventory, Hopkins Competency Assessment (HCAT), the Mini-Cog, Aid to Capacity Evaluation, and the Capacity Assessment Tool (CAT).[15-18]

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Table 1. Essential Elements of Informed Refusal of Medical Care

1. Assessment of decisional capacity
2. Delivery of information, including risks, benefits, and alternatives to the proposed therapy
3. Delivery of the standard of medical care, or best possible under the circumstances, according to patient wishes
4. Recommendations for follow-up care
5. Documentation

Table 2. Determination of Decisional Capacity

Ensure the patient's ability to communicate.
Correct any reversible environmental, metabolic, mental and physical challenges to capacity.
Utilize standardized tests of capacity, if indicated.
Assess patient goals and values using open-ended questions about the choices (including risks and benefits), alternatives (including the option not to treat), and consequences.
Communicate with the patient and their health care advocates, if appropriate, about the decision and its ramifications.
Document essential elements of capacity, or its impairment in the medical record.

Patient Management

The appropriate management of a patient who wishes to refuse medical care includes the following elements: determination of decision-making capacity, assessment of the reasons for refusal of care, delivery of information including risks and benefits of the proposed therapy, discharge planning, including the best treatment alternative, and documentation. Proper documentation of AMA is essential to documentation, and also can confer medicolegal protection.[19,20]

Ensuring the safety of staff and other patients is an important concern when treating patients who may refuse medical care. Some patients may require physical or chemical restraints to assure safety of other patients or the treatment team. Physical restraints should be limited to use in cases where the safety of the patient, other patients, or staff is threatened, or to prevent elopement when the patient must be treated despite refusal. ACEP has stated in policy that, "restraints should be individualized and afford as much dignity to the patient as the situation allows" and "any restraints should be humanely and professionally administered." The policy also states that pro-

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PUTTING RESEARCH TO WORK FOR YOU

PRACTICE CHANGERS

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Anticoagulant Selection is a Cornerstone to PE Treatment

It is time to embrace alternatives to unfractionated heparin

by LAUREN WESTAFER, DO, MPH, MS, FACEP

MONIKA WISNIEWSKA AMAVIAEL-STOCK.ADOBE.COM

The treatment of patients with pulmonary embolism (PE) has evolved substantially over the past few decades. Many patients with PE can be discharged directly from the emergency department (ED). Advanced therapies such as catheter-directed treatments (CDT) are now available in many centers, and anticoagulants such as low-molecular–weight heparins (LMWH) and direct oral anticoagulants (DOACs) have been developed, which obviate the need for frequent laboratory monitoring and dose titration in many patients. Anticoagulant selection may seem much less important and exciting than the decision to administer thrombolytics or send a patient for thrombectomy; however, it is the cornerstone of PE treatment—and we are getting it wrong in a fair number of patients.

Although intravenous unfractionated heparin (UFH) was the first anticoagulant developed and routinely used in venous thromboembolism (VTE), the pharmacokinetics are wild. UFH has a variable half-life, extensive protein binding, and two-phased elimination requiring patients to undergo frequent bloodwork to ensure levels fall within a narrow therapeutic range. Despite nursing or pharmacy-driven protocols to adjusted doses based on activated partial thromboplastin (aPTT) or anti-factor Xa levels, a minority of patients anticoagulated with UFH for PE sustain therapeutic values across timepoints in the first couple of days.[1] Further, a Cochrane review found that LMWH is associated with improved outcomes compared with UFH including reduced incidence of major hemorrhage (odds ratio [OR]=0.69; 95 percent CI, 0.50-0.95) and recurrent VTE during initial treatment up to 15 days (OR=0.69; 95 percent CI, 0.49-0.98). As a result, professional society guidelines have recommended alternatives to UFH such as LMWH or DOACs for most patients with PE for more than a decade.[2-4]

A study in *Annals of Emergency Medicine* of almost 300,000 patients hospitalized with acute PE between 2011-2020 found that the use of UFH increased from 41.9 percent to 56.[3] percent despite guideline recommendations. During the same period, there was no sign that patients were sicker (i.e., no increase in vasopressor use, mechanical ventilation, admission to an intensive care unit, in-hospital mortality).[5] The opposite trend in UFH use exists in countries outside the United States, where UFH use steadily decreased to less than 10 percent of patients.[6] The question is: Why? What is driving this gap?

Anticoagulant Misconceptions

Misconceptions regarding anticoagulant pharmacology and contraindications are common. First, UFH is often perceived as "stronger" than alternatives, partially owing to the intravenous route of administration.[7] Although UFH begins working immediately, studies demonstrate it takes a median of six to 15 hours to achieve therapeutic aPTT or anti-Xa levels.[1,8] In contrast, the peak effect for LMWH and DOACs such as rivaroxaban and apixaban are much quicker (three to four hours and one to four hours, respectively). The pervasive maxim "quick on, quick off" for UFH doesn't hold up as well as touted.

Second, a nearly ubiquitous belief exists that anticoagulation is withheld or reversed for CDT.[7] In fact, anticoagulation is continued during CDT and can include LMWH.[9,10] Similarly, use of LMWH does not preclude salvage thrombolytic use. The TOPCOAT trial, evaluating tenecteplase for intermediate-risk PE, protocolized the use of LMWH prior to thrombolysis, switching patients started on UFH to a LMWH.[11] Most patients hospitalized with PE undergo neither CDT nor thrombolysis and, even if they do, administration of LMWH is not a contraindication. Although we may worry about the potential for decompensation and don't want to preclude advanced therapies, this fear should not motivate us to choose UFH over a LMWH for most patients.

In addition, a circular pattern of deference of anticoagulant choice exists within the hospital spectrum of care. In the qualitative study, emergency physicians revealed choosing UFH over LMWH not only because this is how they were trained and the inertia of their practice pattern, but also to allow more flexibility to the inpatient team. Hospital medicine clinicians revealed that even if they preferred an alternative to UFH, they were unlikely to change the anticoagulant until preparation for discharge. Hospitalists cited not wanting to "second guess" the emergency physician and the hassle of multiple changes in anticoagulation regimens as reasons they continued UFH use in these cases.[7]

Unfractionated heparin has a role in a select minority of patients with acute PE, largely in patients on vasopressors who may have impaired subcutaneous absorption of LMWH, those who are actively bleeding or are imminently undergoing invasive surgical procedures, and those with severe renal dysfunction in whom renally dosed LMWH or DOACs are contraindicated. However, these exceptions account for a minority of patients hospitalized with PE. It's time to dispel the myths associated with UFH and embrace alternatives as the default, reserving UFH for a much narrower subset of patients with PE.

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BRINGING YOU CANADA'S BRIGHTEST MINDS IN EM

EM CASES

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Eating Disorders in the ED

Assessment of eating disorders, an underrecognized high-risk diagnosis

by ANTON HELMAN, MD, CCFP(EM), FCFP

A 16-year-old male presents to the emergency department (ED) with his mother with the chief complaint of intermittent abdominal pain and constipation for several weeks. There are no red flag symptoms for an underlying surgical cause and review of systems is otherwise unremarkable. Vital signs include a heart rate of 50, blood pressure 85/40, temperature of 35.9 ˚C (96.6˚ F). Blood work is ordered, and it shows a mildly low potassium at 3.2 mEq/L, a mildly low hemoglobin at 11g/dl, and normal liver enzymes.

The patient is discharged from the ED with the diagnosis of low-risk nonspecific abdominal pain with a recommendation to follow-up with their primary care physician and instructions to return for list of red flag symptoms. This case represents the miss of a potentially life-threatening diagnosis that emergency physicians have little knowledge of. In this *ACEP Now* column, I outline some of the salient features of eating disorders to improve our knowledge, recognition, and management of them in the ED.

Common, Deadly, Elusive

Eating disorders, which include anorexia nervosa, bulimia nervosa, binge eating disorder and avoidant/restrictive food intake disorder (ARFID), are common with increasing prevalence, increasing visits to EDs, and the highest mortality of any psychiatric illness.[1-3] The lifetime prevalence rates of anorexia nervosa are as high as four percent among females and is increasing among males.[3] In young females, the mortality rate of eating disorders is estimated to be as high as 10 percent.[4]

In a recent study, after a five-year follow-up the mortality rate of anorexia nervosa in admitted patients was found to be as high as 16 percent.[5] Despite these disorders being common and deadly, eating disorders are often elusive diagnoses with only 27 percent of women with eating disorders receiving treatment, suggesting a significant portion remain undiagnosed or untreated.[6] They are often missed in the ED for a variety of reasons including lack of physician education, vague presenting symptoms, patient factors such as lack of insight or denial, and atypical phenotype. In one study, only one out of 246 patients who screened positive for an eating disorder at ED triage had a chief complaint that specifically mentioned eating disorders.[2] Eating disorders affect all organ systems and present with a myriad of vague symptoms.

Identification

A range of medical conditions can mimic the symptoms of eating disorders—hence the description of "the great masquerader." There is a lack of education on eating disorders in residency programs in the United States. A survey that looked at 637 residency programs including pediatric, family, and internal medicine in 2014 found that only 42 programs offered formal training in eating disorders.[7] A more recent study surveyed emergency physicians' knowledge and training and found that of 1.9 percent of 162 emergency physicians who completed a psychiatry rotation in residency, 93 percent were unfamiliar with the American Psychiatric Association practice guidelines on eating disorders.[8]

Another reason we miss these diagnoses is that patients often do not fit the stereotypical phenotype of an eating disorder as eating disorders are seen in all genders, racial/ethnic identities, and socioeconomic backgrounds. Additionally, many patients with eating disorders have a normal body mass index (BMI) and may not appear underweight, especially male patients who may appear muscular due to excessive weightlifting (a common manifestation of anorexia nervosa in males). Finally, many patients with eating disorders have a lack of insight and/or denial, similar to patients with schizophrenia and dementia, and may deny feeling sick when they present to the ED with their parents.

It is important that we identify eating disorders in the ED, as the earlier treatment is started, the better the long-term outcomes (similar to schizophrenia), the lower the mortality rate, and the less likely they are to develop serious medical complications.[4] With eating disorders missed often in the ED, and the importance of early recognition and treatment, there is an argument for universal screening at emergency triage with a quick screening tool such as the SCOFF questionnaire.[9]

The hallmark of anorexia nervosa is an inability or refusal to maintain a body weight at or above 85 percent of the expected weight based on age-appropriate BMI charts. Individuals with anorexia often engage in severe caloric restriction or excessive exercise as a means to cope with emotional distress or psychological pain, accompanied by an intense fear of gaining weight or becoming overweight. Bulimia is defined by episodes of uncontrollable binge eating, often followed by compensatory purging behaviors such as self-induced vomiting or the misuse of laxatives. Individuals with the binge-eating/purging subtype of anorexia may also engage in similar binge and purge cycles. Those with bulimia can present at a normal weight, but they may also be underweight or overweight.

It is imperative that when assessing youth with vague physical symptoms or any psychiatric symptoms in the ED, physicians ask the patient and their parent(s) a few simple questions to screen for eating disorders: What is your highest ever weight and what is your weight currently? Do you make yourself sick because you feel uncomfortably full? Do you believe yourself to be fat when others say you are too thin? Tell me what you eat in a day. When was your last menstrual period?

If there is any suspicion for a possible eating disorder based on these questions, risk factors should be explored, investigations to screen for medical complications should be ordered, and specialist consultation or referral should be arranged. Risk factors for eating disorders include family history (as twin studies suggest that they are 60 percent to 70 percent heritable), personality type of high achieving perfectionism with a pronounced fear of failure, impulsive personality, participation in sports that rely on a lean and/or muscular body type, chronic medical conditions such as diabetes, and transgender youth.[10,11] It is a

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misconception that parents are the cause of eating disorders. Parental blame is counter-therapeutic and should be avoided.

A Medical and Psychiatric Disorder

Common ED presentations of eating disorders include vague gastrointestinal complaints, palpitations, dizziness and syncope. Complications of eating disorders include life-threatening conditions in all body systems. Cardiac complications include severe bradycardia, Torsades de Pointes, and heart failure. Metabolic complications include hypokalemia, hypophosphatemia, and hypoglycemia. Gastrointestinal complications include gastric perforation because of acute gastric dilatation impeding venous return leading to necrosis, esophageal rupture, pancreatitis, and superior mesenteric artery syndrome. Pulmonary complications include pneumothorax and pneumomediastinum. Musculoskeletal complications include osteopenia with increased risk for long bone fractures. Finally, hematologic and neurologic complications include pancytopenia and intracranial hemorrhage related to severe thrombocytopenia.[12]

Physical exam may provide important clues to the presence of an eating disorders. Bradycardia is very common and may be erroneously dismissed in athletic patients.[13] Although a resting heart rate of 48 may be normal in an adult elite athlete, bradycardia is almost never normal in an adolescent and needs to be investigated. Normal triage vitals should not be reassuring as patients with eating disorders who are bradycardic at baseline may be especially anxious when presenting to the ED. For this reason, vital signs should be repeated after 10 minutes of rest with the patient supine and should include orthostatic vitals. A "blind" weight should be obtained post-void with the patient in a hospital gown only (to prevent hidden weights), and the patient's back to the weight display.

The skin may provide clues to the presence of an eating disorder. Skin findings may include dryness, loss of subcutaneous fat, the presence of lanugo (fine body hair), and hypercarotenemia, characterized by an orange discoloration of the palms and soles because of excessive carrot consumption. Patients who engage in self-induced vomiting may exhibit calluses on the dorsum of the dominant hand and erosion of dental enamel.[14] Enlargement of the salivary glands is another notable indicator of purging behaviors.[12] Expose the patient's back. Bruising or erythema over the spinous processes suggests excessive sit-ups or crunches. However, many patients may have a completely normal physical examination, particularly in the early stages of the disorder.

Laboratory investigations should be ordered in the ED for all patients with any suspicion of an eating disorder after clinical assessment is completed, as they may reveal clues to a diagnosis, potentially life-threatening metabolic conditions and help to guide disposition. I recommend an order set that includes ECG, glucose, creatinine, liver enzymes, lipase, amylase, electrolytes including calcium, magnesium, and phosphate ketones, and urinalysis. Some laboratory findings suggestive of an eating disorder and/or that can be clues to a specify eating disorder features include urine pH greater than eight suggesting active catabolism, a low urine specific gravity, which is suspicious for water loading, urine ketones suggestive of starvation, hypoglycemia, and hypokalemia, which suggests repetitive vomiting or diuretic use.[16] An elevated amylase suggests repetitive vomiting as well. Serum phosphate should be obtained in all patients with eating disorders as hypophosphatemia is suggestive of refeeding syndrome, which can be fatal.[16] Refeeding syndrome occurs when feeding is started after a period of prolonged deprivation. The sudden influx of carbohydrates stimulates insulin release, causing a rapid intracellular shift of phosphate, potassium, and magnesium. This metabolic disturbance can result in life-threatening complications, including cardiac arrhythmias, respiratory failure, and multiorgan dysfunction. A common cause of unexplained weight loss and vague gastrointestinal symptoms in young people is inflammatory bowel disease. Consider obtaining erythrocyte sedimentation rate and C-reactive protein to screen for this diagnosis. These tests are almost always normal in patients with eating disorders.[17]

Treatment

When it comes to ED treatment of patients with eating disorders, besides addressing immediate life-threatening complications, there should be no specific treatment initiated. It may be tempting to administer crystalloid boluses to patients with eating disorders who appear to be dehydrated in the ED; however, this should be avoided because a common cardiac complication is heart failure. It also might be tempting to administer dextrose in the ED; however, this should also be avoided as it increases the risk for refeeding syndrome.

The American Academy of Pediatrics admission criteria for adolescents with an eating disorder include: less than 75 percent median BMI for age and sex, dehydration, electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia), ECG abnormalities (severe bradycardia or prolonged QTc), heart rate less than50 beats per minute daytime or less than 45 beats per minute at night, blood pressure less than 90/45, temperature less than 96, orthostatic pulse increase greater than 20 beats per minute or decrease in blood pressure greater than20 systolic or greater than 10 diastolic, arrested growth and development, failure of outpatient treatment, acute food refusal, uncontrollable binge eating and purging, acute medical complications of malnutrition (syncope, seizures, heart failure, pancreatitis, etc.), and comorbid condition that prohibits or limits appropriate outpatient treatment (severe depression, suicidal ideation, obsessive compulsive disorder, Type 1 diabetes).[18]

A common pitfall is reassuring a patient with an eating disorder that they have a normal physical exam and investigations. Both physical exam and lab findings may be normal in patients with severe eating disorders. This false reassurance reinforces the common perception by the patient that they do not have an eating disorder and is counterproductive to initiation and maintenance of treatment. Do not minimize the illness.

Have a low threshold to consult pediatrics, internal medicine, or psychiatry, and/or refer to the local outpatient eating disorder program for a multidisciplinary assessment. Timely follow-up in a clinic with experience managing patients with eating disorders is essential. Generally, primary care physicians are not equipped to manage eating disorders alone and should not be the sole follow-up care provided.

Next time you are faced with a young person who presents to the ED with vague symptoms, it is imperative to consider eating disorders. Ask a few simple screening questions. Obtain repeat resting vital signs including orthostatic vitals. Perform a focused physical exam looking for clues of eating disorders. Order appropriate investigations, and have a low threshold for consultation or timely referral to a clinic familiar with eating disorders management. With these principles in mind you are more likely to pick up these often elusive diagnoses, get them on the road to early initiation of treatment, prevent chronic relapsing disease, and, potentially, save another life!

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WAITING ROOM | CONTINUED FROM PAGE 6

patients, but should also be lauded and protected as a commitment to beneficence and nonmaleficence.

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Conclusion

Hypertensive disorders in pregnancy, particularly severe gestational hypertension and preeclampsia, pose significant risks to both mother and fetus. As emergent obstetric resources across the United States become more limited, the ED plays a critical role in improving maternal and fetal outcomes for both pregnant and recently pregnant patients in early detection, close monitoring, and timely treatment.

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with their children and aging parents without feeling overwhelmed.[8,9] Finally, creating a solid social support system is critical, as your family, friends, and peers can offer emotional and practical support. Professional resources, including mentorship, counseling, and even executive coaching, can also guide stress and wellness management.[8,10]

On a broader scale, health care organizations can support emergency physicians in excelling at work and feeling satisfied with their lives outside of work by creating a culture that understands the sandwich generation.[8] In August 2024, U.S. Surgeon General Dr. Vivek Murthy released an advisory highlighting parents' and caregivers' mental health and well-being. In the report, he noted that this group is "struggling" and called for workplace policy improvements and employer programs that support caregivers.[11]

One suggestion is to have employers offer "paid parental, medical, and sick leave, flexible and equitable work schedules, and access to childcare (either in the community or onsite)" for their employees. Additionally, Dr. Murthy recommended that employers implement training programs for managers focusing on stress management and work-life balance. This training should help managers recognize indications of stress and mental health challenges among caregivers and provide strategies for promoting work-life integration.[11]

Other ways to create a supportive organizational culture would be offering comprehensive and affordable mental health resources such as therapy and support groups, providing financial planning assistance, and training emergency department chairs and directors to understand the unique needs of these physicians.[8,11]

Ultimately, the issues important to emergency physicians in the sandwich generation are complex and require a multifaceted approach to support and promote well-being. As these professionals balance their medical careers with caregiving roles for children and aging parents, hospitals and health care organizations must recognize and address their unique needs.

Emergency physicians can thrive in their personal and professional lives with appropriate coping strategies, robust support systems within the workforce, and organizational advocacy for work-life balance. In the end, caring for these caregivers will have a ripple effect: improving their quality of life, eventually reflecting on better care at the bedside. Therefore, we must continue raising awareness about the sandwich generation's challenges and work collectively towards solutions that empower emergency physicians to achieve a healthier balance in their demanding lives.

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lar and/or 2) expanding into other pillars. Start small and expand, if you find it meaningful with continued flow. Perhaps you find flow in performing certain procedures. Learning the paramedian approach for a lumbar puncture or new shoulder reduction technique increases your vocation. Or, if you thrive on moving the department, perhaps joining a working group to create a physician-in-triage model may be in the cards. Dedication to your community may expand into areas of passion and/or vocation as you create CPR education workshops for your community's daycares and schools. Passion for women's health may lead one to research and advocate for more effective emergency contraceptive options in your department. Starting with small increments ensures that the new task is not overwhelming and allows for an attainable, more concrete objective.

Leverage trustworthy contacts. If you struggle with finding ikigai, talk with a peer, friend, or mentor. Sometimes having the perspective of a trusted individual or talking it out to a conscientious listener can help identify areas of interest. Although no one can truly identify your ikigai but yourself, others may identify talents or focus points that you may not be aware of. They can also elucidate avenues for experimentation. Reflect on others' opinions and see if those areas are places where you either find flow or would continue to do regardless of any attention from others. Perhaps you feel tedious with interdepartmental conciliation, but in speaking with a mentor, they see you're a highly effective and involved department chief in conflict mitigation. In further reflection, you uncover the flow is actually in the creative brainstorming of logistical solutions that occurs with the conflict.

Closing Thoughts on Ikigai

Ikigai is not for everyone, nor should it be. It's simply just one concept of many, like one type of laryngoscope blade, whether Mac, Miller, or D-blade. There is not a 'best' blade, but depends on the physician and situation. No one needs ikigai to feel fulfilled and our sense of fulfilment itself can be fluid. There are many competent, fulfilled emergency physicians that don't need to have deep purpose or marry all "four pillars" in their practice. One's work can sincerely be and remain a profession alone—perhaps so one's efforts can be placed in other areas, whether it's community, family, travel, or other interests. That choice and outlook should be respected.

Although the conception of ikigai into the four pillars is easy to digest, it may be myopic at times. It may constrain ikigai to external validation from others or societal/cultural norms. Per pillars of vocation or profession, Satonofuji was not very good by sumo wrestling standards (i.e., wins, division rank), but he derived ikigai in sumo by the yumitori-shiki. Again, ikigai can only be defined by our own selves and is inherent within. No one can tell you what is "worthwhile" and, thus, if your ikigai doesn't "fit" into a pillar, that's perfectly fine. Instead, we should simply recognize, support, and celebrate others' ikigai, regardless of whether it aligns with others' or our own. Those that know of Satonofuji's ikigai come to the tournament, sitting patiently after the matches conclude, to watch the yumitori-shiki. They may not recognize the intricacies of the tradition, but they recognize an individual who has found meaning. They celebrate his sense of ikigai.

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tocols should ensure appropriate observation, treatment, assessments, and documentation of medical care.[21]

Case Discussion

In this case, assessment of decisional capacity is essential prior to the consideration of leaving AMA. It is reasonable to detain a patient who lacks decisional capacity until they regain decisional capacity or a safe disposition is determined. If there is any question regarding capacity, a standardized test, such as the MMSE, may be helpful. After the determination of appropriate decisional capacity, the physician should conduct an informed refusal discussion with the patient, including risks and benefits of the proposed tests and treatments, and risks of refusal. Alternatives to the recommended treatment should also be discussed and implemented when appropriate. Necessary follow-up care should be arranged, and the discussion and interactions should be documented.

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Assistant Medical Director - Emergency Medicine

Salary Range: Assistant Professor: $261,630 - $325,983 per year; Associate Professor: $283,653 - $346,121 per year

The University of Chicago's Department of Medicine, Section of Emergency Medicine, is searching for a full-time faculty member, at Assistant Professor or Associate Professor rank, on the School of Medicine track, to serve as Assistant Medical Director for UChicago Medicine's (UCM) Adult Emergency Department (ED). The appointee is expected to assist the ED Administrative Team in all aspects of ED clinical operations and quality oversight, and work with other medical center clinical operations directors to promote an outstanding patient experience. Clinical responsibilities include evaluating and treating patients who present to the ED. Other duties will include teaching and supervision of trainees and students, and scholarly activity. Academic rank and compensation are dependent upon qualifications. For information on benefits, please consult the University of Chicago Benefits Guide: https://mybenefits.nfp.com/UChicago/benefits-guide/.

The Section's academic faculty are responsible for the education of Pritzker School of Medicine students and 54 residents in our Emergency Medicine Residency Program (established in 1972 and one of the oldest programs in the country), five fellowship training programs, and off-service rotating residents. They are active in bench and clinical research, medical education, simulation, EM ultrasound, Administration, Global Emergency Medicine, EMS services, and air-medical transport. UChicago Medicine is a Level 1 Adult and Pediatric Trauma Center, a receiving hospital for ST-Segment Elevation Myocardial Infarction (STEMI), a Comprehensive Stroke Center, a Burn Center, and a Chicago South EMS regional resource hospital. The Adult ED has an annual volume of 75,000; EM faculty have the option to also work in the Comer Pediatric ED which has an annual volume of around 35,000.

Prior to the start of employment, qualified applicants must: 1) have a medical doctorate or equivalent, 2) hold or be eligible for medical licensure in the State of Illinois, and 3) be Board Certified/Eligible in Emergency Medicine.

We especially welcome applicants with fellowship training in addition to prior experience in data science and analytics and/or an active research program in the field of Clinical Operations.

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Salary Range: $143,897 - $179,290 a year

The University of Chicago's Department of Medicine, Section of Emergency Medicine, seeks Clinical Associates at 50% effort for a renewable term of up to three years. The appointees will have responsibilities in patient care and clinical operations. The University of Chicago Medicine is a STEMI-receiving hospital, a Comprehensive Stroke Center, a Burn Center, and a Chicago South EMS regional resource hospital. The Adult ED has an annual volume of 75,000 and we are a Level 1 Adult and Pediatric Trauma Center. Compensation is dependent on qualifications. For information on benefits, please consult the University of Chicago Benefits Guide: https://mybenefits.nfp.com/UChicago/benefits-guide/.

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Clinical Associates – Emergency Medicine Nocturnists

The University of Chicago's Department of Medicine, Section of Emergency Medicine, is seeking full-time emergency department (ED) nocturnists for appointment as Clinical Associates for renewable terms of up to two years. The appointees will have responsibilities in patient care and clinical operations. These positions do not require teaching or scholarly activity. Compensation (including a generous package of fringe benefits) is dependent on qualifications.

The University of Chicago Medicine is a ST-Segment Elevation Myocardial Infarction (STEMI) receiving hospital, a Comprehensive Stroke Center, a Burn Center, and a Chicago South EMS regional resource hospital. The Adult ED has an annual volume of 75,000 and we are a Level 1 Adult and Pediatric Trauma Center.

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Ultrasound Director - Emergency Medicine

The University of Chicago's Department of Medicine, Section of Emergency Medicine, is seeking a full-time faculty member at the Associate Professor rank to serve as Ultrasound Director. Responsibilities include ultrasound operations, quality oversight, medical student and resident education, participation in our EM Ultrasound Fellowship Program, and participation in scholarly activity. Compensation (including a generous package of fringe benefits) is dependent upon qualifications.

The University of Chicago Emergency Medicine residency program, established in 1972, has a rich history as one of the oldest emergency medicine programs in the country. The appointee will join an academic faculty who are active in research, medical education, simulation, international medicine, EMS/prehospital medicine and air-medical transport. The University of Chicago Medicine is a STEMI receiving hospital, a comprehensive Stroke Center, a Burn Center, an Adult and Pediatric Trauma Center, and one of the Chicago South EMS regional resource hospitals. The Adult ED has an annual volume of over 65,000 patients and our Pediatric ED has a volume of 30,000 patients per year.

Prior to the start of employment, qualified applicants must: 1) have a medical doctorate or equivalent, 2) hold or be eligible for medical licensure in the State of Illinois, 3) be board certified or eligible in Emergency Medicine, and 4) be ultrasound fellowship trained.
We welcome applicants who possess leadership skills and a commitment to excellence in patient care, clinical operations, and education. This position provides the opportunity to join committed faculty members and outstanding residents who are dedicated to academic excellence.

To be considered, those interested must apply through The University of Chicago's Academic Recruitment job board, which uses Interfolio to accept applications: http://apply.interfolio.com/157546. Applicants must upload a CV including bibliography and cover letter. Review of applications ends when the position is filled.

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Emergency Physician

Erin Fenoff, DO
EM Residency: Ohio University Heritage College of Osteopathic Medicine, 2018
Emergency Physician

Dan Kelly, MD
EM Residency: The University of Texas Medical School, 2011
Emergency Physician