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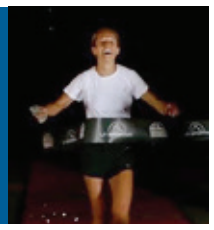

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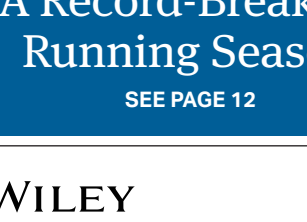

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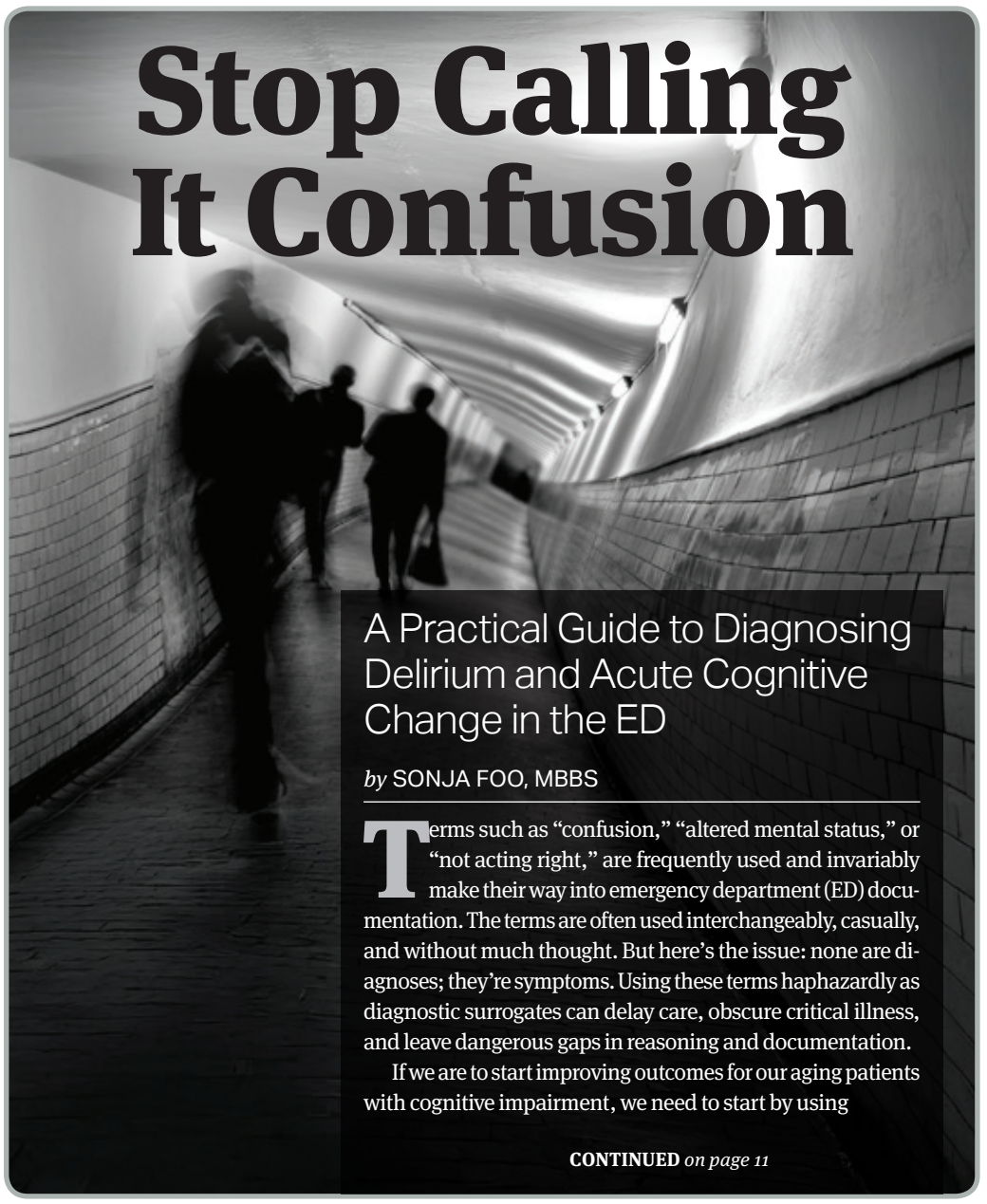

Stop Calling It Confusion

A Practical Guide to Diagnosing Delirium and Acute Cognitive Change in the ED

by SONJA FOO, MBBS

Terms such as "confusion," "altered mental status," or "not acting right," are frequently used and invariably make their way into emergency department (ED) documentation. The terms are often used interchangeably, casually, and without much thought. But here's the issue: none are diagnoses; they're symptoms. Using these terms haphazardly as diagnostic surrogates can delay care, obscure critical illness, and leave dangerous gaps in reasoning and documentation.

If we are to start improving outcomes for our aging patients with cognitive impairment, we need to start by using

CONTINUED *on page 11*

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Pediatric Torticollis: A Simple ED Approach

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

EM CASES

Torticollis in children is a posture rather than a diagnosis. Although most cases encountered in the emergency department represent a benign, self-limited muscular spasm of the sternocleidomastoid or trapezius and resolve over days, a meaningful subset heralds serious pathology involving the craniocervical junction, deep neck spaces, or posterior fossa.[1] An emergency department approach that is structured, risk-factor aware, and imaging-savvy can safely distinguish uncomplicated muscular torticollis from conditions requiring urgent specialty intervention.[2] This column offers a practical diagnostic and management framework so that you can pick up one of the often-elusive limb or life-threatening diagnoses on your next shift.

CONTINUED on page 15

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UPDATES AND ALERTS FROM ACEP

NEWS FROM THE COLLEGE

Statement on Changes in Hepatitis B Vaccination Recommendation for Newborns

ACEP joined leading physician and patient advocacy groups in opposing recommendations made by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) regarding hepatitis B virus (HBV) vaccination for newborns in the United States.

The joint statement signed by ACEP and more than 40 medical groups reaffirmed the vital role of vaccines in public health:

"ACIP's decision to downgrade the long-standing recommendation to vaccinate all newborns against hepatitis B at birth will lead to more childhood hepatitis B infections, will lead to more chronic infections that will follow patients into adulthood, and will complicate vaccine access for children. No new data [were] presented during the ACIP meeting to justify this change. The evidence remains clear: the hepatitis B birth dose is safe and an essential component in helping children develop immunity against a serious, potentially lifelong disease."

The joint statement aligns with ACEP's continued efforts to support evidence-based medicine and the importance of vaccines in public health.

In another recent statement, ACEP stood firmly behind the science, stating that decades of high-quality research show no link between vaccines and autism. ACEP also reaffirmed its strong support for the use of evidence-based vaccine schedules as an essential component of the emergency care safety net.

ACEP-Endorsed SUPPORT Act Is Reauthorized

The bipartisan Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Reauthorization Act of 2025 has been signed into law.

This ACEP-informed and -supported legislation renews and strengthens a range of critical federal programs designed to address the intersecting mental health, opioid/substance use disorder (OUD/SUD), and overdose crises affecting millions of patients and their families.

Emergency physicians see the toll that opioid and substance use disorder takes on our patients, their families, and our communities.

Ongoing efforts, many of which are made possible by the SUPPORT Act, are vital to the fight against the OUD/SUD epidemic and overdose crisis.

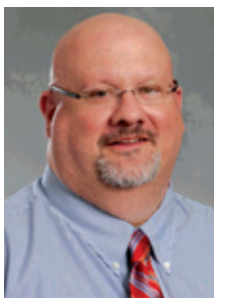
The reauthorization takes a narrower, more streamlined approach than the original SUPPORT Act that first passed in 2018. That law included several ACEP-led priorities, including the Alternatives to Opioids (ALTO) in the Emergency Department Act as a demonstration program to equip emergency physicians with the tools they need to help fight the opioid epidemic.

ACEP's successful advocacy ensured that ALTO was later reauthorized independently as a permanent program and received a boost in federal funding.

The reauthorized SUPPORT Act will improve access to evidence-based treatment and recovery programs, continue federal investment in overdose prevention and community-based recovery initiatives, preserve telehealth flexibilities for prescribing OUD/SUD medications, and enhance national data collection related to substance use and mental health services.

ACEP strongly applauds this reauthorization and recognizes that there's still much more to be done. We are proud to make sure that policymakers hear directly from you so that they can factor your expertise into policy solutions that save lives in the communities where you live and work.

CORRECTIONS



Our Forensic Facts column "*Patterns of Injury in Elder Abuse*," published in our November 2025 issue, inadvertently omitted the name of co-author Ralph Riviello, MD, FACEP. *ACEP Now* regrets the error.

ACEP4U: Pushing Back on New Anthem Out-of-Network Penalty and Calling Out Insurer Bad Behavior

by LEAH ENSER

ACEP is urging Anthem to withdraw a *new policy* that will penalize hospitals when care is delivered by an out-of-network clinician.

Effective January 1, 2026, facilities will see a 10 percent payment cut on claims involving an out-of-network physician. Anthem's new policy will affect plans in 11 states: Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, and Wisconsin. The insurer has also indicated that in time it may terminate hospitals from its network after continued use of out-of-network clinicians.

An Anthem spokesperson said in an interview that the policy is intended to streamline care. "This new policy encourages care to be delivered by in-network providers while visiting in-network facilities, which helps provide a smoother member experience, improve affordability and reduce unnecessary administrative complexity."

However, in a letter to Anthem leadership, ACEP joined the American Society of Anesthesiologists (ASA) and the American College of Radiology (ACR) in warning that the new policy will destabilize physician staffing and undermine patient access to care.

Although emergency services are technically exempt, the policy threatens emergency physician groups because it shifts the insurer's network adequacy obligations onto hospitals, holding them financially responsible for the contracting status of independent physician groups. As a result, emergency physicians and clinicians across other specialties will face increased pressure, contracting uncertainty, and potential disruptions in continuity of patient care.

ACEP and its partner societies raised concerns that hospitals facing the penalty will be incentivized to pressure contracted groups into joining Anthem's network, regardless of whether Anthem's terms are sustainable. This could threaten the viability of independent practices and democratic groups, or force sudden shifts in staffing arrangements.

"Hospitals will be forced to compel independent providers to join Anthem's network under unfavorable terms, leading to a risk of worsening financial instability and loss of clinicians. The need to reorganize or replace physician groups will jeopardize hospitals' continuity of care and patient access to essential services," the societies said in the joint letter.

ACEP was also part of another joint letter pushing back on the penalty. The letter underscored that Anthem's approach undercuts the intent of the federal No Surprises Act (NSA), which already provides a mechanism for resolving out-of-network payment issues.

"We are dismayed that Anthem is attempting to bypass the negotiated bipartisan policy under the No Surprises Act that protects patients from surprise medical bills when out-of-network care is provided at an in-network hospital. We find it very concerning that rather than working through the NSA, Anthem is choosing to implement a policy that essentially circumvents the statute," ACEP and its partner groups said in the letter.

ACEP is acting now in hopes of preventing disruption before the policy takes effect or sets a dangerous precedent for other payers.

A Larger Pattern of Insurer Bad Behavior

Emergency physicians know all too well that the effects of policies that narrow insurance networks land squarely on their shoulders, as they are legally required to treat all patients regardless of insurance status. The fight against Anthem's new policy is one battle in ACEP's broader campaign to hold insurers accountable when their proposals threaten the stability of emergency care.

As insurer maneuvering has continued to ramp up, ACEP has fought back at every turn. ACEP has continually applied pressure to compel insurance companies to roll back dangerous and frequently unlawful policies, including payment denials, downcoding, reimbursement delays, and other tactics putting emergency departments at financial risk.

Recently, ACEP strongly supported the No Surprises Enforcement Act, which will hold insurance companies accountable for continued and willful violations of the federal law.

The No Surprises Enforcement Act "takes critical steps to level the playing field and stop insurer bad practices," said Alison Haddock, MD, FACEP, immediate past president of ACEP. "Insurers consistently refuse to play by the rules, doing all they can to delay payments, or in some cases are outright failing to meet their obligations under current law. This bill will hold bad actors accountable and stop their dangerous, irresponsible abuse of the system."

ACEP remains committed to working with Congress and state and federal regulators to make sure insurance companies conduct business in good faith and in line with current law.

What Comes Next

It is not clear yet whether Anthem plans to revise or withdraw the penalty. ACEP continues to monitor the situation, and ACEP has met directly with Anthem leadership to discuss its concerns.

What is clear is that ACEP will continue to lead efforts to ensure payer policies support the delivery of timely, reliable emergency care. ACEP's engagement on this issue reflects its commitment to defending the stability of emergency medicine and to making sure emergency physicians have a strong, unified voice whenever insurer decisions threaten the care on which their patients rely.

ILLUSTRATION: CHRISTINA WHISSEN
PHOTOS TOMASZ & ELNUR - STOCK.ADOBE.COM

FAREWELL

Darrin Scheid left ACEP in November 2025 after more than a decade in multiple roles with *ACEP Now* and the ACEP Communications team. His latest feature for the magazine, on emergency physician and marathon runner, Dr. Anne Flower, appears on page 12. *ACEP Now* wishes him success in his new editorial role with Scouting America.

ACEP's New Executive Director

Michael Fraser addresses America's emergency physicians

It is an honor and a privilege to serve as ACEP's next Executive Director. Throughout the search process, I was deeply inspired by the passion of ACEP members and the vital role you play at the intersection of our nation's health care and public health systems. As I shared with the ACEP Council when we met in Salt Lake City, the emergency department is, quite literally, where health care access becomes real; where the system must work, and where you make a profound difference every single day. This is why I'm drawn to emergency medicine: You are on the front lines, seeing the impact of policy problems clearly and working tirelessly to solve them despite immense challenges. My career has been shaped by a commitment to supporting the conditions that assure optimal health for all, and to improving the systems that support health care professionals in their vital work.

I've spent more than two decades leading medical societies and public health associations through periods of significant transformation: Most recently, as CEO of the College of American Pathologists and before that, as CEO of the Association of State and Territorial Health Officials. Earlier in my career, I served as Executive Vice President and CEO of the Pennsylvania Medical Society (PAMED), where I gained invaluable experience working at the intersection of national and state medical society leadership. That role taught me how essential strong state chapter partnerships are to advancing a specialty's interests. State chapters are where advocacy becomes local, where member relationships are built, and where the national organization's mission comes to life in communities across the country.

Many experiences have taught me critical lessons about leadership during crisis, the importance of workforce well-being, and the need to support professionals who carry enormous burdens in service to their communities. I saw public health

ACEP

workers experience the same burnout, moral injury, and career frustration that so many of you face in emergency medicine today. I've made it a priority in my work to address workforce wellness, not as an afterthought, but as central to our mission. You cannot care for others if we don't care for you. I have also seen the power of effective staff and member partnerships in my previous roles. I am committed to supporting and helping our team grow as they contribute to ACEP's mission.

My priorities for the first year are engaging in conversations with our ACEP Board and with you. First and foremost, I will be listening and learning. I need to understand your experiences, your challenges, and your hopes for ACEP and the specialty. I'll be assessing our organizational capacity to ensure we have the people, policies, systems, and resources to serve you effectively. I want to create a clear member value proposition that speaks to why ACEP matters and what makes membership meaningful across different career stages and practice settings. We have so much to work with; that excites me.

Advocacy for the specialty and advancing the interests of emergency medicine are paramount. I'm committed to working with you and our team to address our key advocacy priorities: protecting physician autonomy, combating insurer tactics like downcoding and narrow networks, ensuring fair reimbursement, addressing violence in emergency departments, and tackling the boarding crisis. I look forward to new and innovative ways to amplify your voice in Washington, D.C., in state capitals with our chapter leaders, and in every venue where decisions are made that affect your practice and your patients. ACEP has a powerful voice, exceptional thought leadership, and a grassroots network that spans the entire country. Together, we can ensure that emergency physicians have the autonomy, support, and resources needed to provide the highest quality care.

A member of the Board shared with me that his measure of my first-year success will be whether the Board strongly agrees with the question: "Did we make the right decision hiring Mike, and does he fully understand our organization and the specialty?" That's the bar I've set for myself. I'm not here to have all the answers on day one. I'm here to learn from you, to work alongside you, and to build on ACEP's strong foundation to position our organization and the specialty for the future.

I look forward to meeting you in the months ahead. Please don't hesitate to reach out to share your thoughts, concerns, or ideas. This is your organization, and my job is to serve you and advance the specialty we all deeply care about.

With gratitude and commitment,
Michael Fraser, PhD, MS, CAE
Executive Director

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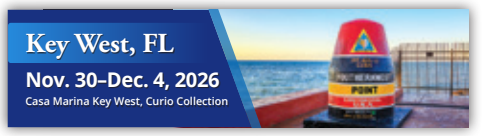

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Beyond Hypoxia: Other Causes of Low Pulse Oximetry

BY CATHERINE A. MARCO, MD, FACEP, AND ALAN P. MARCO, MD, MMM.

A 27-year-old woman presents with blue lips and fingers. She denies trauma, fever, chest pain, shortness of breath, or any systemic symptoms. She recently was treated for a urinary tract infection. On physical examination, she appears well with normal speech and mental status. Vital signs are: temperature 37.1 C; blood pressure 106/82; heart rate 78; respiratory rate 14, and peripheral oxygen saturation (SpO_2) 81 percent. Lungs are clear to auscultation. Cardiac exam shows regular rate and rhythm with no murmur or gallop. All digits, including fingers and toes, appear cyanotic, with good sensation and range of motion.

Discussion:

Pulse oximetry is a widely used point-of-care measurement of arterial oxygen saturation. The pulse oximeter transilluminates the skin using visible and infrared wavelengths and compares the absorption of wavelengths of oxygenated and deoxygenated hemoglobin.[1]

Common causes of low pulse oximetry measurements include hypoxemia and inadequate waveform detection from hypoperfusion, anemia, skin pigmentation, nail polish, or artifact (motion artifact, tachycardia, excessive ambient light, incorrect probe placement).[2,3,4,5]

Other less common causes of inaccurate pulse oximetry measurements include variant hemoglobins, or dyshemoglobinemias, such as methemoglobinemia or carboxyhemoglobin.[6,7] Methemoglobin and carboxyhemoglobin can falsely bias conventional pulse oximetry readings, although they are not typically detected by conventional pulse oximetry[8,9] . Methemoglobin typically results in a falsely low SpO2, while carboxyhemoglobin typically results in a falsely high measured SpO2.[10,11]

Case Discussion

The etiology of the measured low SpO_2 should be elucidated. True hypoxemia should be considered but is unlikely in this case of normal lung physiology. Other causes of low measured SpO_2 should be considered, including hypoperfusion, Raynaud's phenomenon, anemia, skin pigmentation, nail polish, variant hemoglobinopathies, methemoglobinemia, or carboxyhemoglobin. Hypoperfusion, anemia, skin pigmentation, and nail polish can be eliminated by physical examination and laboratory testing. Variant hemoglobinopathies cannot be ruled out in the emergency department setting. Methemoglobinemia and carboxyhemoglobin should be considered. Carboxyhemoglobin is less likely in this case without known exposure and with low pulse oximetry; it may be tested for using arterial blood gas measurement. Methemoglobinemia should be considered in this case as a likely cause of measured low SpO_2.

Methemoglobinemia can be caused by a variety of medications, including benzocaine, prilocaine, lidocaine, tetracaine, metoclopramide, sulfonamides, nitric oxide, nitroglycerine, nitroprusside, nitrates, nitrites, ibuprofen, phenazopyridine, acetaminophen, and others.[12] Phenazopyridine is the active ingredient in pyridium (AZO), an over-the-counter urinary tract pain relief medication.[13]

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

DR. ALAN P. MARCO is a professor in the department of anesthesiology and perioperative medicine at the Penn State Health-Milton S. Hershey Medical Center.

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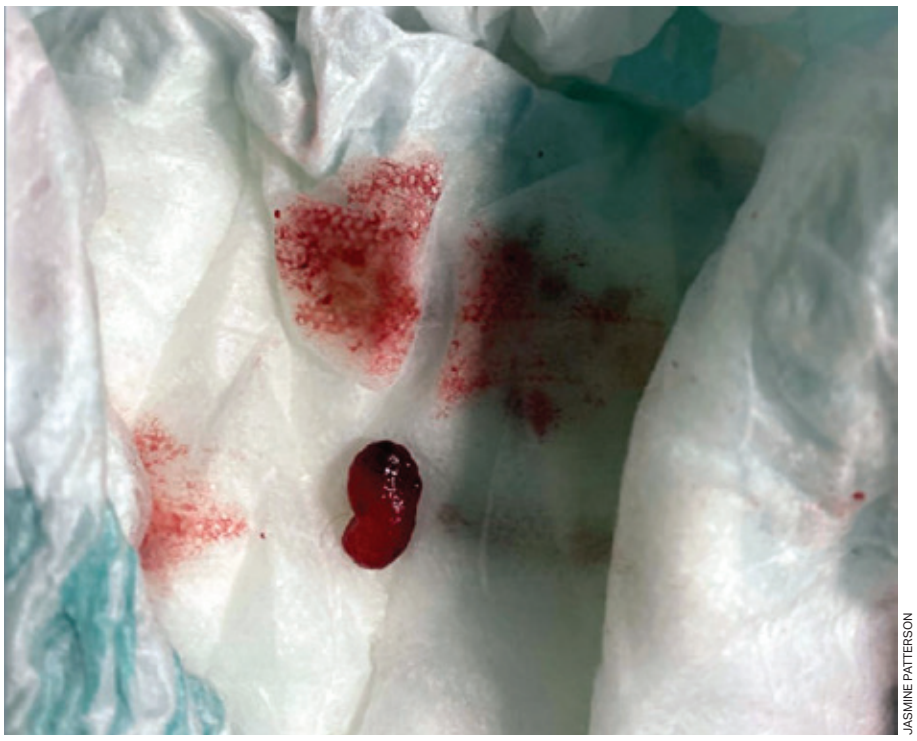
CASE REPORT

STORIES SHAPING THE PRACTICE OF EMERGENCY MEDICINE



JASMINE PATTERSON

Self Amputated Juvenile Polyp

Pediatric Amputated Juvenile Polyp

by SEAN EDEN, MD, PA-C, ALANNA CORNDER, MS4, AND JASMINE PATTERSON, MD

A 3-year-old female without past medical, surgical, or developmental history, and who is up to date on vaccines, presented with a chief complaint of "rectal prolapse" which occurred 20 minutes prior to arrival. She was in a normal state of health, eating and acting normally, until she attempted to have a bowel movement and developed abdominal and anal pain with a small amount of blood. The mother reported a protruding mass on wiping. The child was toilet training and had episodes of stool retention previously but had a formed bowel movement earlier in the day. There have been no recent illnesses or vaccinations, changes in diet, travel, sick contacts, fevers, upper respiratory symptoms, vomiting, diarrhea, or rashes. Her mother had a history of celiac disease, but denied family history of polyposis disorders, inflammatory bowel disease, or colon cancer. On arrival, the child's vital signs were normal, weight was in the 21st percentile (higher than one year prior), she was nontoxic appearing, and in no acute distress. She was holding her knees to her chest and appeared uncomfortable. Her abdomen was soft, nontender, nondistended, with active bowel sounds. Her external anal exam appeared normal, without fissures or hemorrhoids, but her diaper had a bean-shaped mass of mucosal tissue with streaks of blood.

Scan the QR code to read the full story online.

KEY POINTS

- Important cause of rectal bleeding in children.
- In rare cases such as this, the polyp may self-strangulate, causing passage of tissue and bleeding that may self-resolve or require intervention for hemorrhage.
- Clinicians should maintain a high index of suspicion when patients present with persistent rectal prolapse, as timely recognition and polypectomy can both resolve symptoms and prevent recurrence

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The First National Congress on Emergency Medical Care in Ukraine

by JOHN QUINN, MD, MPH, PHD, EMT-P, AND TIM BONGARTZ, MD, MS, CTROPMED

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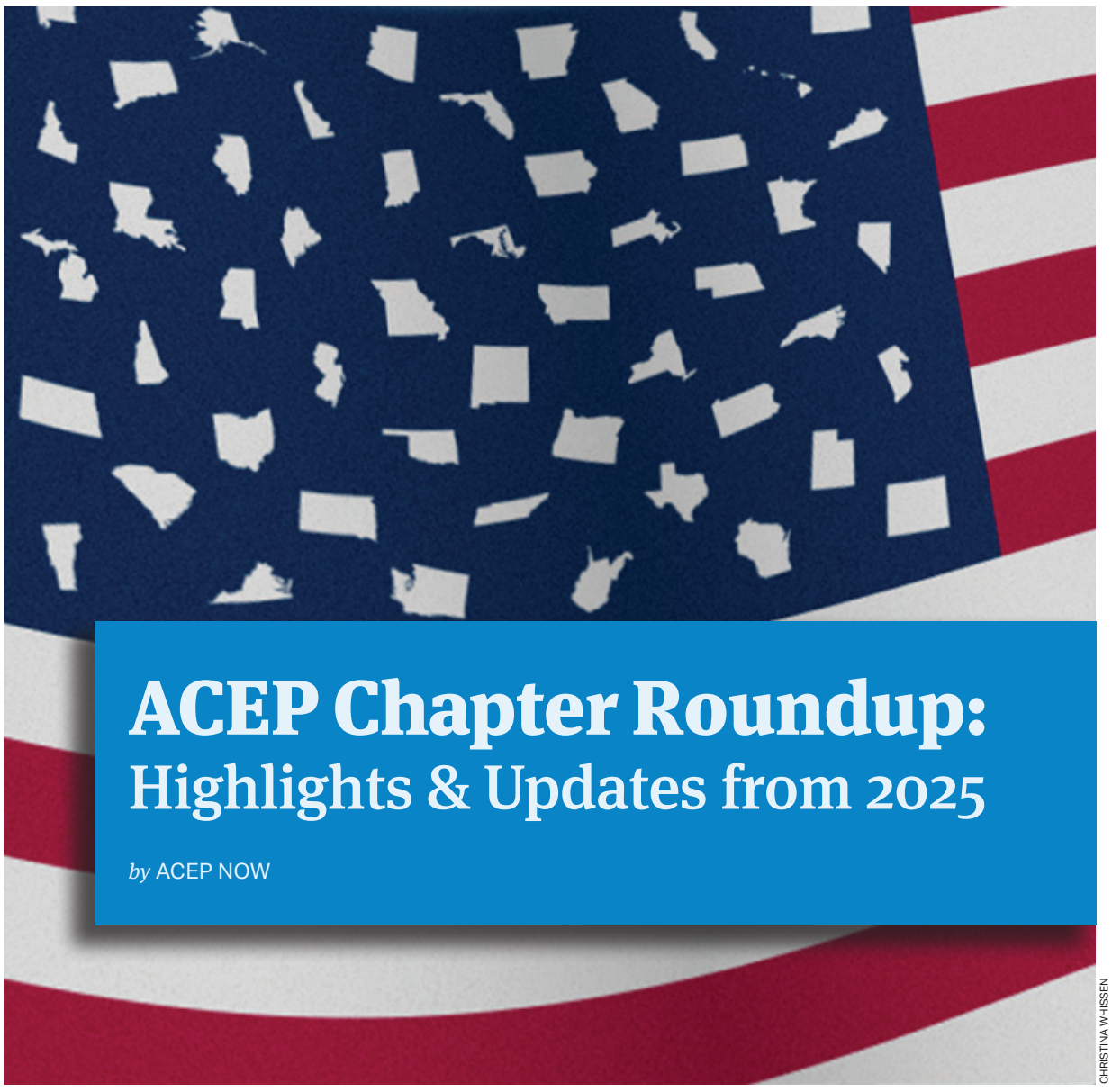

ACEP Chapter Roundup: Highlights & Updates from 2025

by ACEP NOW

CHRISTINA WHISSEN

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TOP FIVE ARTICLES

by CEDRIC DARK, MD, MPH, FACEP

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Why the Nonrebreather Should be Abandoned

by PAUL JANSSON, MD, MS, FACEP

DR. PAUL JANSSON

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"No Surprises?" Insurer Tactics Reshape Emergency Medicine Reimbursement

by LEONA SCOTT

A new RAND Corporation report, funded by the Emergency Medicine Policy Institute, confirms what many emergency physicians feel daily: payments are falling, administrative burdens are rising, and the No Surprises Act (NSA) has tilted the playing field toward insurers. This article explores the report's findings on Independent Dispute Resolution (IDR), how insurers are using the NSA to cut payments, and what emergency physician leaders see as the path forward for fair reimbursement and sustainable emergency care.

A System Built on a Crumbling Business Model

Emergency physicians are accustomed to practicing in crisis mode. But the RAND report, "Strategies for Sustaining Emergency Care in the United States," concludes that the system of emergency care itself is now in crisis, mainly because of how it is funded.

The data are stark. Between 2018 and 2022, real (inflation-adjusted) payments per emergency department (ED) visit fell by 3.8 percent for both Medicare and Medicaid, while commercial payments dropped by 10.9 percent for in-network visits, and by a staggering 47.7 percent for out-of-network visits. At the same time, roughly 20 percent of allowed amounts across all payers were never actually paid — about $5.9 billion annually in unpaid professional services for ED clinicians.

Facility and professional payments are also diverging. RAND's national analysis found that from 2018 to 2022, ED facility-allowed amounts increased 18.65 percent in real terms, while professional-allowed amounts for emergency physicians fell 7.42 percent. Hospitals are increasingly paid more for keeping the doors open, while the clinicians providing the care are paid less.

For ACEP President L. Anthony Cirillo, MD, FACEP, the big-picture message from the RAND report comes down to three points. "The three things that everybody should know about the RAND report are, number one, they [report authors] basically said, 'Wake up, America.' The system of emergency care that we're all going to need and rely on someday is failing."

He added that the current financing model is fundamentally flawed. "The second lesson was that the current construct of financing emergency care, particularly on the physician side, is flawed and has been flawed since it was created. And it's just that the system of payment is getting worse."

Finally, federal and state policies have steadily expanded the responsibilities of emergency departments without expanding how those services are funded. The third message from Dr. Cirillo is that "We've been asked or told by the federal government to do many, many more things beyond what the original fee schedules were paying us to do, and we have to think outside of the traditional fee schedule box if we're going to make the system sustainable."

The No Surprises Act: Protection for Patients, Pressure on Physicians

The NSA was designed with a straightforward goal: protect patients from balance billing (also called "surprise billing") in situations where they cannot choose their clinicians, particularly in emergencies. By that narrow metric, it has primarily worked. Patients are far less likely to receive large out-of-network emergency bills.

But the RAND report, along with interviews with emergency physician leaders, shows that the law has had profound, often unintended, downstream effects on physician reimbursement and contract negotiations.

Mahshid Abir, MD, MSc, the report's lead author and an emergency physician and health policy expert, noted that the NSA created an Independent Dispute Resolution process to settle payment disputes between insurers and out-of-network physicians, but the combination of a low qualifying payment amount (QPA) from insurers, high IDR fees, complex rules, and lack of enforcement has shifted leverage decisively to payers.

Dr. Abir

From the physician side, Andrea Brault, MD, MMM, FACEP, CEDC, president and CEO of Brault Practice Solutions, said she believes that the QPA became a key inflection point. "Once payers had that tool, sanctified in rulemaking, it allowed them to artificially devalue emergency medicine services," she explained. Insurers began sending letters telling long-standing in-network groups that their contracts would be canceled unless they accepted double-digit rate cuts.

Dr. Brault

Seth Bleier, MD, FACEP, vice president of finance for Wake Emergency Physicians PA, has watched those dynamics play out in real time. One insurer told his group it would need to accept a roughly 40 percent decrease in a long-standing commercial contract to remain in network. Groups that refused often found themselves pushed out of network, with initial payments far below prior rates — and a complicated, slow IDR process as the only avenue for relief.

Dr. Bleier

Inside IDR: "Even When You Win, You Lose"

In theory, IDR under the NSA was supposed to be a quick, balanced way to resolve disputes when physicians believed commercial payments were too low. In practice, emergency physicians described a system that is expensive, slow, and easy for large payers to exploit.

Dr. Bleier identified several pain points:

- High administrative burden and cost. For small and mid-sized independent groups, IDR fees and staff time can be prohibitive.
- Delays that crush cash flow. Many groups report an average six-month delay from date of service to payment — if payment comes at all.
- Non-compliance with arbiters' decisions. Even when physicians "win" an IDR case, insurers sometimes pay partially, pay late, or do not pay the full awarded amount.

"The law created a process that, on paper, looks fair," Dr. Bleier said. "But if there are no penalties for not following it, insurers can drag their feet indefinitely. That's what we're seeing."

Dr. Brault agrees that implementation — not the core idea of the NSA — is the problem. Emergency physicians are winning a large majority of IDR disputes — about 80 to 85 percent by many accounts — because their offers more closely reflect the real cost of care. Yet insurers still rarely come back to the table for meaningful contract negotiations.

Dr. Cirillo framed it as "insurer math." Because fewer than 10 percent of underpaid out-of-network claims go to IDR, even losing 85–90 percent of arbitrations still leaves insurers ahead financially. Underpaying the other 90 percent more than offsets arbitration losses.

Dr. Abir noted that current regulations also make it difficult for groups to batch related claims, adding cost and complexity. "[Physicians] need mechanisms to reduce the cost of IDR, speed up processing, including batching, and create real consequences when insurers don't pay correctly or on time," she said.

When Facility Fees Rise and Professional Fees Fall

The RAND analysis quantifies something emergency physicians have sensed for years: The financial benefits of emergency care are increasingly flowing to hospital facilities, not to the clinicians delivering the care.

From 2018 to 2022, commercial-facility-allowed amounts for ED services increased by nearly 19 percent, while professional-allowed amounts fell by more than 7 percent. Nationwide,

CONTINUED *on page 10*

insurance claims reviewed in the report showed that although facility charges have always exceeded professional fees, the gap widened substantially over the study period. Facility charges totaled $8.7 billion compared with $1.4 billion for emergency physician services — underscoring RAND's finding that professional reimbursement is becoming a shrinking share of overall emergency care payments.

Dr. Abir described a "pretty overwhelming consensus" that emergency medicine has undersold its value. Communities and policymakers often see only the cost, not the broader benefits of emergency departments, from public health surveillance to disaster response. When an emergency department closes, nearby hospitals and communities feel the shock. Yet the clinicians who keep those doors open are seeing their professional payments erode over time.

Dr. Brault said she believes that the facility-professional gap reinforces the need to rethink advocacy. "We've tended to look at payment one claim at a time," she says. "The RAND report pushes us to think more broadly about how society funds a system that everyone relies on, often unexpectedly."

The Next Policy Battleground: NSA Enforcement

Given the misalignment between IDR's intent and real-world performance, emergency medicine groups are pushing for stronger enforcement. A key example is H.R. 9572, the proposed No Surprises Act Enforcement Act, introduced by a bipartisan group of physicians in Congress in September 2024. The bill would require insurers that fail to pay IDR awards on time to pay interest and penalties on overdue amounts.

"Insurers consistently refuse to play by the rules, doing all they can to delay payments, or in some cases are outright failing to meet their obligations under current law. This bill will hold bad actors accountable and stop their dangerous, irresponsible abuse of the system," said Alison Haddock, MD, FACEP, immediate past president of ACEP.

Organizations including the Emergency Department Practice Management Association (EDPMA) have also endorsed the measure, arguing that enforcement is critical to preserve independent emergency physician practices.

The RAND report also recommends:

- Securing dedicated funding for EMTALA-mandated care for uninsured and underinsured patients,
- Strengthening penalties for unlawful insurer behavior such as chronic underpayment, delays, and improper denials, and,
- Exploring state-level funding models, such as local or employer-based support, for surge capacity and public health preparedness.

Dr. Abir said she believes many promising solutions may emerge at the state level, where policymakers are closer to the real-world impact of ED instability.

Practical Steps for Groups Navigating NSA and IDR Now

While larger reforms play out, emergency physician groups need strategies to survive today's environment. Interviewees highlighted several steps:

1. **Know Your Data — Deeply** Dr. Bleier stressed the importance of robust revenue cycle reporting and analytics. Track denials, downcoding patterns, and partial payments by payer; identify where claims are being underpaid; and use public price-transparency data to understand what nearby hospitals are paid.
2. **Take IDR Seriously — or Find a Partner** For groups pushed out of network or receiving low initial payments, IDR may be the only route back to fair reimbursement. Brault encourages groups to audit the impact of the NSA, assess which payers are most appropriate for IDR, and consider third-party assistance if in-house capacity is limited.
3. **Strengthen Relationhips With Hospitals** Drs. Bleier and Brault noted that in some markets, payers negotiate directly with hospitals and offer improved facility terms if hospitals pressure physician groups to accept lower professional rates. That makes close alignment with the C-suite essential.
4. **Engage in Advocacy — Local, State, and National** Dr. Abir emphasized pairing quantitative data from the RAND study with local ED stories. Dr. Cirillo noted that ACEP is pushing on multiple fronts, from Medicare cuts to longer-term physician fee schedule reform. Emergency physicians can get involved through state chapters, legislative meetings, and clear messaging about what the phrase "percent of Medicare" actually means in real dollars.

Reclaiming the Narrative: Emergency Care as A Public Good

Across interviews with physicians and RAND findings, a consistent theme emerged: Emergency medicine has been framed primarily as a cost center rather than a public good. Yet emergency departments are one of the few parts of the health care system that reliably say "yes" to everyone, 24/7/365, regardless of insurance or ability to pay. Emergency physicians are at the front line for pandemics, disasters, behavioral health crises, and routine emergencies alike.

Dr. Abir called emergency departments a "national treasure" whose value is underappreciated. Dr. Cirillo noted: "Times have never been easy, but we fought our way through, and we'll continue to fight to make sure emergency medicine stays a viable practice."

Where We Go from Here

For emergency physicians, the RAND report offers both validation and a roadmap. It quantifies what many have experienced anecdotally. Professional payments are falling while facility payments rise.

Insurers are using their leverage, and the NSA framework, to manipulate rates downward and delay or avoid payment.

The current funding model of emergency medicine is unsustainable without new approaches and real enforcement.

At the same time, the report highlights opportunities including strong IDR outcomes when claims are well-prepared, emerging bipartisan support for enforcement measures such as the No Surprises Act Enforcement Act exists and, new state-level models might be needed to fund surge capacity and public health roles that emergency departments already fulfill.

For ACEP members, the path forward involves both practice-level tactics and collective advocacy. It means knowing your numbers, engaging IDR strategically, strengthening hospital partnerships, and ensuring lawmakers understand that this is not just about physician reimbursement — it is about whether emergency care will be there the next time someone calls 911.

Editor's note: ACEP Now *reached out to UnitedHealthcare for comment on IDR implementation and NSA enforcement but did not receive a response in time for our publication deadline.*

ED Boarding Earns Most Votes as Key RAND Report Topic to Cover

by ACEP NOW

When asked in November to select from a list of topics in the RAND report on emergency medicine that you'd most like to see covered as the final installment of *ACEP Now's* series on RAND, a plurality of ACEP members chose the federal response to emergency department boarding, which received 45 percent of the total 47 votes cast.

The topic of EMTALA's unfunded mandate earned 40 percent of members' votes, making it a solid second choice among emergency physicians. The other topics suggested were the emergency department as a community's resilience/infrastructure, which garnered nine percent of the votes; and the emergency medicine nursing workforce, which earned six percent of your total votes.

ACEP Now plans to cover six topics from the RAND report in 2026, including this issue's focus on Independent Dispute Resolution, starting on page 9. Watch our upcoming issues for more coverage on the RAND report and ED boarding.

ACEP Now RAND Report Poll Results

FEDERAL RESPONSE TO BOARDING:
(21 votes, 45%)

EMTALA'S UNFUNDED MANDATE
(19 votes, 40%)

EM NURSING WORKFORCE
(3 votes, 6%)

THE ED AS A COMMUNITY'S RESILIENCE/INFRASTRUCTURE
(4 votes, 9%)

the right vocabulary. Delirium is not just another way of saying "confused." It's a well-defined clinical syndrome characterized by acute onset, a fluctuating course, impaired attention, and disturbed awareness that arises from an underlying physiological insult.[1] Delirium is identifiable, screenable, and often reversible.

By contrast, encephalopathy is a pathobiological process, referring to diffuse brain dysfunction caused by metabolic, toxic, infectious, or other systemic disturbances.[1] Encephalopathy has a broad pathogenesis, and delirium is what the culmination of that pathogenesis might look like clinically. Recognizing this distinction isn't purely academic — it's actionable. Once we name it delirium (not just confusion), we can screen for it, work it up, and treat it.

Delirium in the ED

Delirium affects as much as 15 percent of older adults in the ED.[2,3] Despite this, emergency physicians do not recognize delirium in about half or more of cases. One prospective study of about 1,500 patients aged 65 or older found that nurses missed delirium in 55 percent of cases, and physicians in about 50 percent.[4]

Sending patients home with delirium unrecognized is not a minor oversight and comes with serious consequences. A recent retrospective study of 22,940 ED visits showed that patients discharged with delirium experienced nearly three times the 30-day mortality rate (adjusted relative risk 2.86) and significantly higher rates of return ED visits compared with those discharged without delirium.[5] Beyond mortality, unrecognized delirium is linked to prolonged hospital stays, increased risk for institutionalization, and long-term functional decline.[3,6]

Efficient Screening

Once delirium is suspected, we need a validated, rapid tool to screen for it. The 4AT rapid clinical test is ideal as it assesses alertness, attention, acute change/fluctuation, and cognition.[7] The test takes less than two minutes, is training-free, and demonstrates approximately 88 percent sensitivity/specificity in adults.[8,9] The tool also outperforms Confusion Assessment Method-based screens in ED environments.[10] A score of four or greater indicates delirium; a score of one to three suggests cognitive impairment and a potential need for further observation.[7]

A Structured Workup Matters

When a patient presents to the ED with an acute change in mental status, it's our job as emergency physicians to uncover whether the etiology is treatable or life-threatening. A structured framework can help identify reversible causes and those who require escalation. The distinction between toxic-metabolic encephalopathy, focal neurologic deficit, and psychiatric dysfunction is more than just semantics — it's a determinant of treatment and outcomes. Early clarity improves decision making, speeds treatment, and enhances safe disposition planning.

Structured Workup: Reversible Causes

When delirium is identified — or even strongly suspected — it's crucial to search for a cause. Here's a simple framework:

Documentation: A Legal and Clinical Shield

Documenting that a patient is simply "confused" without further detail is not just medically inadequate; it could leave you legally exposed. Confusion is a symptom, not a diagnosis, and failing to clarify its nature, severity, and cause can expose physicians to significant liability, particularly when issues of competence and decision-making capacity arise.[11-14] Courts have repeatedly identified gaps in documentation of altered mental status as evidence of substandard care, especially in cases involving unsafe discharges, failure to obtain informed consent, or missed diagnoses like sepsis, hypoxia, or toxic-metabolic encephalopathy.[15]

Instead of vague descriptors, clinicians should clearly articulate:

- Baseline versus current mental status (with collateral when possible)
- Objective findings (e.g., inattention, fluctuating alertness, or disorganized thinking)
- Clinical decision tools (e.g., 4AT score and interpretation) to anchor your exam in a validated framework
- Suspected etiology (e.g., infection, medications, or organ dysfunction)
- Disposition and treatment plan (e.g., acute interventions, consults, and decisions around admission versus outpatient follow-up)

A clear documentation of mental status changes reinforces clinical reasoning, supports safe care, protects legally, and ensures billing compliance. How you document influences how you deliver care and how that care is judged.

Future Directions

The ED is chaotic. We're pressed for time, faced with frequent interruptions, and often lack baseline context (especially overnight). This is precisely why and where structure matters most. A brief screening checklist shouldn't be a burden but instead a safeguard. Integrating 4AT into triage or nursing workflows, prompting collateral questions (if available), and adopting the DELIRIUMS mnemonic in electronic health record smart phrases are low-cost yet high-impact strategies. Better structure results in better care with minimal workflow disruption.

Conclusion

We're no strangers to the nuances of detecting delirium in the chaotic, fast-paced setting of the ED. Just the other day, a 78-year-old woman presented to my ED with a chief complaint of "confusion." Upon evaluation, she was alert, oriented, and perfectly conversational. She insisted she felt fine and had only come because her daughter was worried. However, it was the collateral history that told the real story: the night before, she'd been disoriented, wandering her own home, convinced she was somewhere unfamiliar. Her workup revealed a urinary tract infection that I was able to quickly identify and treat.

Delirium isn't a harmless observation — it's a red flag of serious underlying pathology. And although encephalopathy may underlie it, naming the process isn't enough. Treat delirium as a syndrome that demands the question: What prompted this and what can we do about it? Use 4AT. Use structured frameworks. Document thoroughly. Protect patients and your practice.

Let's stop calling it "confusion." Let's start recognizing it as what it might be — delirium — and manage it accordingly. Our patients deserve nothing less. ➕

DR. SONJA FOO is a board-certified emergency medicine critical care physician completing her Neurocritical Care Fellowship at the Massachusetts General Hospital, Brigham and Women's Hospital, and Harvard Medical School Training Program.

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1 ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	**0**
Mild sleepiness for <10 seconds after waking, then normal	0
Clearly abnormal	**4**

2 AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	**0**
1 mistake	**1**
2 or more mistakes/untestable	**2**

3 ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

MONTHS OF THE YEAR BACKWARDS

Achieves 7 months or more correctly	**0**
Starts but scores <7 months / refuses to start	**1**
Untestable (cannot start because unwell, drowsy, inattentive)	**2**

4 ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	**0**
Yes	**4**

➕ SCORING

4 OR ABOVE: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if ➍ information incomplete)

4AT SCORE _____

ACEP Member Dr. Anne Flower Completes Record-Breaking Running Season

PHOTOS: ANNE FLOWER

ABOVE: Dr. Flower keeps pace along the Leadville Trail 100 Run in Leadville, Colo. in August 2025.

RIGHT: Dr. Flower set a new speed record when she finished the Leadville Trail 100 Run in less than 18 hours last summer.

by DARRIN SCHEID

When emergency physician Anne Flower, DO, set out to run a 100-mile race in Colorado, she didn't expect it would turn her into something of a local celebrity.

But the result was so impressive that her story has been featured in numerous running publications, newspapers, and websites. Dr. Flower, an attending physician at UCHealth Memorial Hospital Central in Colorado Springs, didn't just finish first in her age division at the Leadville Trail 100 Run. She set a new course record with a time of 17 hours, 58 minutes, and 19 seconds in the August 2025 event.

A few weeks later at the Tunnel Hill State Trail run in Vienna, Ill., Dr. Flower set a world record with a time of 5:18:57 in 50 miles.

Dr. Flower's journey to long-distance running started well before the Colorado race, though not in the typical way of lifelong competitive runners. In fact, she explained that for most of her early life, running wasn't her passion at all.

"I did high school cross country, maybe two years," she said. "But it just wasn't great for me. I wanted to play soccer with my friends."

In college, she gravitated toward hiking, biking, and climbing. She skied a lot. Running didn't become an important part of her routine until medical school, where the limited free time made it an ideal and efficient escape.

"There wasn't that much else to do with my free time," she said.

That's when Dr. Flower started to realize that she's not just a runner. She's an elite runner. By residency, she qualified for the Olympic marathon trials. Still, medicine was her priority. Running was second. Her emergency medicine schedule, however, provided exactly the right kind of flexibility for an endurance athlete.

"Nowhere in my sphere did it seem like running was going to be anything that I would either want to do or be good enough to do more than as a hobby," she said. "But as you know, with emergency medicine, I have random time off. It's better for me to have a weekend off where I can go run a race than try to go on a Fourth of July vacation."

Those unstructured pockets of time became opportunities.

The Colorado 100-mile race that kicked off a fall filled with interviews and attention overlapped with her emergency medicine training, Dr. Flower said. The same mental focus needed for a successful shift in the emergency department is like the mindset required to excel at a long-distance run.

"It's the mentality of just being okay with things not being perfect," she said. "During a 100-miler, you are constantly encountering problems, you are problem solving, but you're taking it as it goes. I think that's exactly what you need to be able to be an ER doctor and be able to run 100 miles."

Just as in the emergency department, she focuses on what she can control.

"Me being upset or scared by it is not going to make it better," she said.

Instead, she zeroes in on what she calls the essentials: assessing the situation and moving forward. What Dr. Flower did not expect was the volume of attention her Colorado performance received, especially from colleagues. She's also proud to have inspired others around her to start training, or at the very least, start running. Since the 100-mile race that turned Dr. Flower into a local celebrity, several friends and coworkers have told her they're planning to start training for a half marathon or a 10K. Some have just said they plan to start running.

"It has really become a vehicle for connection," she said.

Despite her accomplishment, Dr. Flower is not someone who walks around broadcasting her athletic feats. "I try not to," she laughed, adding that her non-running family trained her early to avoid becoming the person who monologues about their mileage. "People are not that interested to hear about what you did with your running life that day unless it's a funny story or something cool."

Dr. Flower, interviewed after the 100-mile run in Colorado and before the Tunnel Hill race, was asked what's next for her.

"I'm actually running a 50-mile race called Tunnel Hill," she said.

There, she set a new world record.

OPINIONS FROM EMERGENCY MEDICINE

OPINION

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The Rejection of a Divided People

Emergency physicians witness the universal truth of humanity

BY DAVID BENARON, MD

If you were to judge the state of our union solely by the headlines or the latest data from *The New York Times*/Siena College polls, you would see a nation fractured by ideology.[1,2] However, I believe we are not actually divided by these beliefs as much as we are being influenced by an echo chamber that distorts our reality. Algorithms and isolated feeds convince us that our values are radically different from one another, painting our neighbors as aliens or enemies. My experience as an emergency physician rejects this division and supports a different reality. When political noise is stripped away, we share the same longing for the safety of our families and the health of our communities, just as we share the pain of loss and injury.

As emergency physicians, every day we witness pain, fear, love, and mortality as the great equalizers, exposing the universality of our human experience when faced with life's most stressful and challenging crises. When a mother weeps in the anguish of losing a child, or when a family gathers around a loved one broken by a car accident, the ideological hostility that dominates our airwaves is fundamentally disarmed. In these moments of raw vulnerability, I have seen that most, if not all, Americans are fundamentally united in their suffering and support of each other.

We are far more similar and connected than we believe ourselves to be.

This unique perspective is not just a byproduct of our job. It is rooted in the ethical framework of our specialty. ACEP has long held the position that emergency medical care is a fundamental right. ACEP's principles on health care reform emphasize that care must be provided based on the urgency of the medical condition, not on the patient's social status, ability to pay, or personal beliefs. This nonnegotiable mandate of universal care creates a sanctuary of neutrality.

A core clinical discipline of emergency medicine is separating ideology from the person. As emergency physicians, we are trained to walk into a room and treat an individual marked with gang-related tattoos with the exact same dedication and clinical rigor as we would a celebrated community leader. We focus solely on the human crisis at hand, not the offensive symbol or the fringe belief. This is a profound ethical stance that is woven carefully into the core of what it means to be an emergency physician.

This stance acts as the crux of the lesson we can offer society, grounded in our profound understanding of the human condition. In the emergency department, we have the privilege of engaging with humanity in its rawest reality, stripping away the social and political veneers to see the person underneath. We meet every conceivable type of person, yet time and time again, we discover that when the defenses are down, every individual possesses an inherent dignity that demands our respect. By translating the medical imperative of unconditional care into a demonstration of unconditional human worth, we model what civic reconciliation should look like. We demonstrate that disagreement must never escalate into contempt.

In 2014, Dr. Catherine Thomasson wrote regarding "Physicians' Social Responsibility," arguing that our duty extends beyond the biological management of disease.[3] We have a responsibility for the health of society itself. Today, that responsibility requires us to act as intermediaries in an ideologically polarized world. We possess wisdom gained by our understanding of the universal human condition. We know, because we have seen it in the eyes of our patients, that the "united American" core still exists beneath the current political noise.

Therefore, this is a call to action for emergency physicians to voice this reality. We cannot remain silent observers of this false narrative of division. We are uniquely positioned to be a voice of unity in our hospitals and communities and a tool to combat the tribalism that has hurt our greater society and democracy. We must remind our communities that despite what the polls say, we are not "at war with each other."

We must take the moral high ground we occupy, the ground of unconditional care, and use it to heal more than just injured bodies. We must help heal our broken civic trust. We have evidence that when the pretenses are stripped away, people bleed the same, cry the same tears, and care deeply for one another. It is time we share that evidence with a world desperate for unity and a path forward.

Let us lead by example, showing that while we may vote differently, we survive together. In the end, what divides us pales in comparison to what unites us.

DR. DAVID BENARON is assistant professor and vice chair of the Department of Emergency Medicine at the University of Nevada, Reno.

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THE CALL OF EMERGENCY MEDICINE

Despite some drawbacks, emergency medicine is still a great specialty

by RENÉE BACHER

It was a seemingly ordinary drive through Texas that changed John Prescott, MD's, life and made him realize that emergency medicine was his calling.

As a young U.S. Army physician contemplating flight surgery, he was driving on a deserted highway between San Antonio and Fort Hood when a convertible with its top down and a passenger with her feet on the dashboard sped past his four-cylinder Toyota Corolla, which was barely going 55 mph. A couple of miles down the road, he came upon this car flipped over on the median. "I thought, 'Oh my God, what am I going to do?'" he said.


Dr. Prescott

The ground was littered with beer cans, the driver was dead, and the passenger — pregnant and critically injured — had been ejected from the vehicle but survived, although the fetus would not. Armed with only basic medical knowledge and aided by a nurse anesthetist who had been passing by, and then a paramedic in another car with a bag full of equipment, the three worked to save the surviving victim until help arrived.

"That's the day I decided I was going to go into emergency medicine," said the now-retired Dr. Prescott, professor emeritus with the West Virginia University department of emergency medicine, where he was one of its founding members. "I never wanted to be in a position again where I could not take care of a patient or assess the situation and take definitive action."

This desire to be prepared for anything draws many physicians to emergency medicine. For Jennifer Oman, MD, who initially considered trauma surgery, it was the ability to practice comprehensive care that attracted her. "I like being able to take care of all ages," she said. "There's a little bit of ortho and a little bit of cardiology and a little bit of pediatrics. There's not really anything you don't see."


Dr. Oman

Dr. Oman, a board-certified emergency physician in Orange County, California, said her specialty-defining moment was one morning at 3 a.m. on her surgery rotation when she was called to the emergency department for a consult. "It was super fun and there was a lot going on. I loved it, but all of the surgeons were complaining about how they hated the emergency department and how tired they were," she said. As soon as it was decided the patient needed to go to the operating room, the surgeons were suddenly wide awake and happy, whereas Dr. Oman said she couldn't keep her eyes open and all she wanted was to go back to the emergency department.

Gabor Kelen, MD, chair of emergency medicine at Johns Hopkins University in Baltimore, also found his calling in the specialty's fast-paced environment. "I love the adrenaline rush. I still like it," he said. "When you're in a stressful environment with people, there's a certain joy to the relationships that you have in being on the front lines." For Dr. Kelen, running a resuscitation is like conducting an orchestra — a complex choreography requiring both technical expertise and leadership skills.


Dr. Kelen

The Evolution of a Specialty

Emergency medicine has grown dramatically since its early days. "In 1976, it literally was a room," said Dr. Oman. Today's emergency departments have become sophisticated operations with dozens of beds, managing everything from minor injuries to major traumas. The specialty has earned respect through decades of proving its value, with emergency physicians increasingly taking leadership roles in health care systems.

"Emergency physicians are known for getting stuff done," said Dr. Prescott, who also served as chief academic officer for the Association of American Medical Colleges. He pointed to the growing number of emergency physicians who have become deans of medical schools or health care system leaders. Adaptability and efficiency have become hallmarks of the specialty.

Freedom to Practice

One of emergency medicine's greatest strengths is its flexibility. "There are so many different ways you can be an emergency physician," Dr. Oman said. "There's rural emergency medicine, academic institutions, community hospitals, urgent cares, cruise ship medicine, and locum tenens, where you can go to different parts of the country."

This variety allows physicians to find their ideal practice setting. "That's the best part about emergency medicine — you're not stuck," Dr. Oman said. "If you're miserable, you can go somewhere else. You don't even have to move, depending on where you are."

The specialty also offers the satisfaction of immediate impact. "What part of medicine can you practice where your skill set has to be at such a high level for so many different things, and you get to see the impact of your work on the same shift?" Dr. Kelen said. This immediate feedback and the ability to make a difference in critical moments continues to attract physicians to the field.

Meeting Modern Challenges

Emergency medicine faces significant challenges, including corporate consolidation, hospital boarding, high levels of burnout, and workplace violence. According to recent surveys, more than 90 percent of emergency physicians have experienced some form of violence in the workplace. "There's no way you can get through an eight-hour shift that somewhere in the department there aren't up to 10 instances of violence," said Dr. Kelen. Long wait times and boarding exacerbate the problem. "People lose their tempers if they've been hungry without food and water for 20 hours," Dr. Kelen noted. "It's not just patients; it's often their families."

But despite the challenges, emergency physicians continue to find deep meaning in their work. At Johns Hopkins, many doctors choose to work in the emergency department specifically because they want to work with underserved populations and provide them with world-class care, Dr. Kelen said.

For Dr. Oman, the rewards come from helping patients navigate an increasingly complex health care system. "Actually being able to get the person the right kind of help that they need, trying to find resources for people, trying to get them where they need to be, that's challenging, but at the end of the day, it is also rewarding."

The Corporate Challenge

With roughly one-quarter of emergency medicine visits now staffed by private equity-controlled groups and some companies staffing hundreds of emergency departments nationwide, emergency physicians face new pressures from corporate employment models. Contract arrangements can make it difficult for physicians to advocate for better patient care, and hospital sales or mergers can leave entire physician groups suddenly seeking new positions. However, the specialty's inherent flexibility helps mitigate these risks, as physicians can often find new opportunities that better align with their values.

Innovation and Adaptation

Emergency physicians have consistently demonstrated their ability to adapt to changing health care needs. During the COVID-19 pandemic, emergency departments quickly reorganized to handle patient surges, setting up tents and creating new care areas. This adaptability extends to embracing new technologies and care models while maintaining the core mission of providing immediate, high-quality care to anyone who needs it.

The specialty continues to innovate in areas like EM research, out-of-hospital care, and disaster preparedness. Dr. Prescott noted how emergency physicians have been instrumental in developing programs like the American College of Surgeons' "Stop the Bleed," which has made a major difference on a national level.

Looking Forward

Despite challenges in the field, leaders remain optimistic about emergency medicine's future.

The key, according to Dr. Kelen, may be reconnecting with the specialty's core mission while adapting to modern health care realities. "If we all got together and started trying to reach real solutions to these many issues, that other part — the heroic part and the nobility of what we do — will shine through," Dr. Kelen said.

Although emergency medicine is not an easy job and one never knows who is going to walk into their department, for medical students considering the specialty, Dr. Oman's message is clear: "It's still the best specialty, even with all its drawbacks and challenges, because you can make it into almost anything you want."

RENÉE BACHER is a freelance medical writer located in Baton Rouge, La. She is a frequent contributor to Wiley medical trade publications including *ENTtoday*, *ACEP Now*, and *The Rheumatologist*.


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Differential Diagnosis Anchored to Clinical Risk

Three "can't-miss" categories warrant deliberate consideration. Atlantoaxial subluxation/atlanto-axial rotatory fixation (AAS/AARF) arises from ligamentous laxity or osseous anomalies and may follow minor trauma, congenital connective-tissue disorders, or postoperative inflammatory states (Grisel syndrome).[3] Children with trisomy 21 (Down syndrome), Marfan syndrome, juvenile idiopathic arthritis, or rarer syndromes (e.g., Klippel-Feil, Morquio) carry elevated risk.[4] A careful history that elicits recent ENT surgery and a focused screen for myelopathic symptoms is essential.

Deep neck space infection — most notably retropharyngeal abscess (RPA) — often presents between ages two and four, with prominent unwillingness to move the neck and limitation of extension, frequently accompanied by fever, dysphagia, odynophagia, drooling, or stridor in more advanced cases.[5] Osteomyelitis/discitis of the cervical spine is rarer but should be considered when midline bony tenderness is present. Lemierre syndrome (septic thrombophlebitis of the internal jugular vein after oropharyngeal infection) is uncommon but important; look for focal tenderness, swelling, or induration along the jugular chain in a toxic-appearing child.[6]

Central nervous system lesions involving the posterior fossa or high cervical cord can initially manifest with a painless head tilt. Approximately half of pediatric brain tumors arise in the posterior fossa. Torticollis may precede other neurologic signs in a non-trivial proportion, with contemporary series and expert synthesis citing up to 20 percent of posterior fossa tumors presenting with torticollis.[7] A normal passive range of cervical motion and lack of neck tenderness must not reassure when other posterior fossa symptoms or subtle cranial nerve deficits are present.[8]

Bedside Discriminators: History and Focused Examination

Risk stratification begins with three targeted lines of inquiry. First, screen for AAS risk: trauma (often minor), congenital hypermobility or inflammatory conditions, and recent head/neck surgery.[4] Second, elicit infectious red flags including fever, odynophagia, drooling, stridor, and focal jugular-chain tenderness.[5] Third, probe neurologic symptoms — headache (especially morning predominant headache), vomiting, gait disturbance, ataxia, and focal deficits or cranial nerve palsies.[9] On examination, a key clinical clue is that in uncomplicated muscular torticollis, the head typically tilts toward the spastic sternocleidomastoid (SCM) with the chin rotated contralaterally, whereas in AAS/AARF the head frequently tilts away from the affected side; the contralateral SCM (on the chin side) may be tighter and tender as it "attempts" to correct the deformity.[4] This bedside sign should heighten concern for craniocervical instability and lower the threshold for immobilization and advanced imaging.[10]

Painless torticollis demands particular caution. When the head tilt is not painful and passive range of motion is relatively preserved, prioritize a central nervous system (CNS) search rather than a muscular diagnosis. Incorporate a complete neurologic exam, including ocular alignment and cranial nerves IV and VI, as head tilt can be a compensatory posture for diplopia.[9]

Imaging Strategy: When Plain Films Suffice and When CT or MRI Is Required

For children with low pretest probability of AAS, antero-posterior (AP) open-mouth odontoid and lateral cervical radiographs can serve as a first-line screen. The atlantodental interval (ADI) — the distance between the anterior arch of C1 and the odontoid — should not exceed roughly 4-5 mm in young children, acknowledging technique dependence and increased laxity with flexion. Values above this range are suspicious for transverse ligament injury.[11] However, radiographs may be normal in rotatory malalignment. When clinical suspicion is moderate to high, or when neurologic findings, significant risk factors, or equivocal films are present, CT is the diagnostic gold standard for AARF/AAS and should not be delayed. Dynamic CT in maximal rotation can characterize chronic fixation.[11] MRI adds value when there is concern for cord compression, ligamental disruption, or associated infection.[12]

For suspected retropharyngeal abscess, a lateral neck radiograph may show prevertebral soft-tissue widening and can be a useful screen; contrast-enhanced CT of the neck is typically definitive, delineates collections, and expedites operative planning with ENT.[12] For suspected posterior fossa or high cervical cord pathology, MRI of brain and cervical spine is preferred; if MRI is not immediately accessible in a deteriorating child, CT is an acceptable bridge while arranging definitive imaging .[11] Throughout any AAS work-up, maintain gentle immobilization and avoid forced rotation or range-of-motion testing until stability is clarified.[3]

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Management Pathways Tailored to Etiology

Children with uncomplicated muscular torticollis generally respond to oral analgesia, local heat application, and gradual return to comfort-guided range of motion. A brief period in a soft collar can be used for comfort but should not delay reassessment. Persistent symptoms beyond one week, or clinical non-response to supportive measures, argues against a benign muscular etiology and should trigger re-evaluation and imaging.[2]

For AAS/AARF, treat the neck as potentially unstable. Employ gentle immobilization, consult pediatric spine/neurosurgery early, and obtain a CT. Many patients without neurologic deficit improve with traction, anti-inflammatory measures, and collar immobilization. Refractory, recurrent, or neurologically complicated cases may require reduction under anesthesia or operative stabilization.[3] Children with trisomy 21 merit special vigilance: routine screening radiographs are no longer recommended by the American Academy of Pediatrics, but clinicians and families should be counseled to monitor for symptoms and signs of myelopathy (neck pain, torticollis, loss of motor skills, gait change, or bowel/bladder dysfunction) and to seek prompt evaluation when present.[12]

Management of RPA and related deep neck infections begins with airway assessment and early ENT involvement. Initiate broad-spectrum intravenous antibiotics according to local antimicrobiogram, maintain a low threshold for contrast CT to define deep collections, and arrange timely drainage when indicated.[13] In Lemierre syndrome, cover Fusobacterium necrophorum and gram-negative organisms empirically, image the neck veins (ultrasound or CT venography), and admit for intravenous therapy and monitoring. Be attentive to pulmonary septic emboli.[14]

For suspected CNS lesions, do not be reassured by a comfortable neck. Expedite neuroimaging and neurosurgical consultation when torticollis is painless or accompanied by posterior fossa symptoms, ocular misalignment, or gait disturbance. Recognize that torticollis may precede more obvious neurologic findings.[15]

Disposition and Follow-Up

Well-appearing children with improving muscular torticollis, reliable caregivers, and no red flags can be discharged safely with clear instructions regarding analgesia, gentle mobility, and specific return precautions: especially fever, drooling, stridor, progressive vomiting or headache, gait change, focal weakness, or persistence beyond one week. Admission is appropriate for suspected or confirmed AAS/AARF, any neurologic deficit, signs of airway compromise or confirmed deep neck space infection, or when diagnostic imaging or specialist consultation cannot be completed safely as an outpatient.[16]

Key Take-Home Points

A risk-factor-anchored approach improves diagnostic yield and reduces unnecessary imaging. The "tilt away" sign is a useful discriminator for AAS/AARF at the bedside. The atlantodental interval provides a radiographic clue but cannot exclude rotatory malalignment. CT remains the emergency department gold standard when suspicion is meaningful. RPA typically affects young children and limits neck extension, contrast CT guides surgical drainage. Painless torticollis should default to a CNS search. Above all, persistence beyond one week or failure to respond to supportive measures warrants re-evaluation. With these key points in mind, the next time you are faced with child who presents with torticollis, you will have the tools to sort through the differential diagnosis, make imaging, treatment and disposition decisions, and potentially save the life or limb of a child.

Many thanks to Dr. Deborah Schonfeld, the guest expert on the EM Cases podcast that inspired this column.

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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.

Addressing Period Poverty to Promote Health Equity

by JAYNE KENDALL, MD, MBA, FACEP, CDE, CPE

OLGA YASTREMSKA, NEW AFRICA, AFRICA STUDIO-STOCK.ADOBE.COM

My daughter, Claire, has dedicated several years to founding and leading a local school chapter of Liv & Cur, a nonprofit organization run by high school students that raises funds and sources sanitary products and other women's necessities for schools, women's shelters, and orphanages.[1] Witnessing her tireless efforts, including advocating at the North Carolina State General Assembly, has prompted me to reflect on the issue of period poverty. As emergency physicians, we likely encounter this problem daily, often without realizing its prevalence and impact on our patients.

Many of us believe that period poverty is a problem limited to distant Asian or African regions. However, a report from Procter & Gamble reveals that around one in five girls in the United States has missed school due to a lack of access to menstrual products.[2] Due to feelings of shame and stigma, girls often don't talk about this issue openly. Instead, they talk about this natural biological process in euphemisms like "Bloody Mary," "Shark Week," "Aunt Flo," and my personal favorite, "The Curse."[2]

This lack of open dialogue contributes to a widespread misunderstanding of period poverty as a critical public health issue that impacts millions of girls and women worldwide, particularly those in low-income communities. Period poverty encompasses the lack of access to menstrual hygiene products, education, and safe facilities for managing menstruation. This issue not only undermines the health and dignity of those affected but also exacerbates existing health disparities. The consequences can be severe, leading to increased absenteeism from school or work, a heightened risk of infections, and detrimental effects on mental health.[3]

It may come as a surprise to some that period poverty is not just a distant issue affecting women in developing regions, but a reality that also exists in our own communities. For example, menstruators in some regions of sub-Saharan Africa will use impromptu types of items, such as paper, rags, leaves, or bits of cotton and wool, rather than sanitary pads and tampons.[4] Deprived of the availability of appropriate menstrual hygiene materials, these girls are at risk of health problems, missed educational opportunities, and compromised well-being.[4] But the problem of period poverty is not only happening in distant lands. There are millions of girls and women similarly situated here in the United States.[5] I had friends when I was in school using old clothes or toilet paper for their period because they could not afford to buy sanitary pads or tampons. This underscores the fact that period poverty can affect anyone, regardless of their location or socioeconomic status. The stigma surrounding menstruation often prevents open discussions about these types of challenges, leaving many to suffer in silence.

Complicating this is the "pink tax" — the additional amount women pay for items marketed specifically to them, which can include state sales tax on menstrual products.[6] This monetary burden makes it even harder for those already financially struggling to access necessary items. The pink tax isn't just limited to menstruation products. It can be found across various products and services targeted at women, deepening these economic gender gaps.[5] Some examples include razors, shampoo, and body wash, which are often priced higher than men's razors and shampoo even when they have same ingredients and functionality. By addressing period poverty, we can also challenge the systemic inequities that contribute to the pink tax, working to ensure that all essential health products are fairly priced and accessible.

As emergency physicians, we are in a great place to help combat period poverty and advocate for solutions that address health disparities and improve the lives of people in our communities. Given the significant impact of period poverty, it is crucial to recognize that this issue disproportionately affects marginalized groups, including low-income individuals, people of color, and those experiencing homelessness.[2] These disparities highlight the critical need for targeted interventions and advocacy to make sure that every single person has what they need to menstruate with dignity.

Role of Emergency Physicians

Emergency physicians commonly serve at the interface where we meet patients from different backgrounds who present with a range of health conditions. Here are some of the ways we can help end period poverty:

1. **Awareness and Education:** Emergency physicians can play a vital role in raising awareness about period poverty within our communities.[4] By discussing this issue with patients and colleagues, we can help reduce the stigma around menstruation and encourage more open discussions about menstrual health. By providing patient literature in waiting areas or when meeting with patients, we can give patients permission to access help and resources.
2. **Advocacy for Access to Products:** Emergency departments can be important access points for menstrual products. We can be of immediate assistance to those in need by keeping our sites supplied with menstrual hygiene products (specifically in the bathrooms where women might collect urine for testing). Physicians can encourage policies that permit free distribution of menstrual products in public areas, schools, and community centers that will mitigate access barriers.
3. **Collaboration with Local Organizations:** Partnering with local nonprofits and community organizations can amplify our efforts to combat period poverty. We can work with those groups pushing for menstrual health and hygiene to find out what our communities need, and ome up with effective solutions together. This may include organizing donation drives for menstrual products or supporting initiatives that provide education on menstrual health.
4. **Incorporating Menstrual Health into Patient Care:** As part of holistic patient care, emergency physicians should consider menstrual health when evaluating patients. This encompasses inquiring about the menstrual life history, examining concerns around any related health issues, and offering resources. By including menstrual health in our evaluations, we can provide high-quality care that meets the individual needs of patients.
5. **Research and Policy Advocacy:** Research into period poverty can produce evidence of how period poverty can affect health outcomes and inform policy reform.[4] Emergency physicians can advocate for policies that promote menstrual health equity, such as funding for menstrual product distribution programs and education initiatives. By contributing to the evidence base, we can help shape policies that prioritize the health and dignity of all individuals.

In conclusion, period poverty is a significant public health issue that requires urgent attention and action. As emergency physicians, we are well situated to address this need by raising awareness, advocating for access to menstrual products, partnering with local organizations, and including menstrual health as part of our patient care. By taking these steps, we can help dismantle the barriers that perpetuate period poverty and promote health equity for all individuals. Together, we can ensure that everyone has the resources they need to manage their menstrual health with dignity and respect.

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THE NEXT GENERATION OF EMERGENCY MEDICINE

RESIDENT VOICE

DR. ZVONAR is a third-year resident at The Mount Sinai-Elmhurst Emergency Residency Program in New York City. Her interests include medical education, immigrant and refugee health, and global health

C heyenne River Health Center

PHOTOS: VANYA ZVONAR

TOP: Clouds gather as the sun sets over the Cheyenne River Health Center on the Cheyenne River Reservation in Eagle Butte, South Dakota.

RIGHT: The Cheyenne River Health Center is part of the Indian Health Service network of hospitals, clinics and health stations on or near American Indian reservations.

LEFT MIDDLE: A landing pad near the health center allows for small plane landings and takeoffs to transport patients to larger health care facilities.

LEFT BOTTOM: The view from the Cheyenne River Health Center.

by VANYA ZVONAR, MD

"Vanya, the plane is here for the patient in room three if you want to ride out to the airstrip with the EMS crew."

It is dark outside as we step out under the star-studded South Dakota sky. I hop in the passenger seat of the ambulance, and we drive a few minutes away where there is a tiny green fixed-wing plane waiting in the darkness, lights flashing. I watch, buzzing with excitement, as the pilot and flight crew load the patient onto the plane, then quickly take off to fly to Sioux Falls for what would have been a five-hour transport by ground. We watch them leave and then head back to the Cheyenne River Health Center to finish our night shift.

I get back to my desk in the emergency department, an 11-bed unit and check in with the team. Our night crew consists of several nurses, one physician assistant, and one attending physician. There is one radiology tech covering the X-ray and CT machines in the hallway adjacent to the department. Past radiology, the hall leads to the eight-bed inpatient unit where there are currently four admitted patients. The rest of the complex is quiet, waiting for daybreak when the outpatient offices start stirring. I take some time to wander the silent hallways, passing by plaques written in both English and the Lakota language, stopping in to see the traditional healing room where family members can burn sage when a loved one dies.

The hospital, which was reconstructed in 2012, is part of the Indian Health Service (IHS). The IHS provides care to some 2.8 million American Indians and Alaska Natives in 574 federally recognized tribes.[1] It includes over 600 hospitals, clinics, and health stations on or near American Indian reservations. The Cheyenne River Health Center is in Eagle Butte, South Dakota, home to around 1,500 people, 85 percent of whom are Native American.[2] It lies on the Cheyenne River Reservation, home to the Cheyenne River Sioux Tribe. The IHS mission statement hangs on a wall at the front of the hospital: "To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level."

Back in the emergency department, I reflect on everything I have seen and done during my week here. I have been handed a fetal heart tracing to look at, something I have not done since my obstetrics/gynecology (OB/GYN) rotation in medical school. I have called the transfer center countless times to discuss cases with hospitalists and specialists. I have taken care of a mother and her son in the same week during two different visits and learned how close knit this community is. I have cared for a stroke patient who received tenecteplase

CONTINUED *on page 21*

DR. WESTAFER (@LWESTAFER) is an assistant professor in the departments of emergency medicine and healthcare delivery and population science at UMass Chan Medical School, Baystate, and co-host of FOAMcast.

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Peritonsillar Abscess Management

Time to put the scalpels down

by LAUREN WESTAFER, DO, MPH, MS, FACEP

Most emergency physicians recall hearing something along the lines of "the solution to pollution is dilution," and "the answer to pus is a scalpel," or "if there's pus, let it out," at some point during their training. Source control through drainage by any number of methods depending on the location and size — needle aspiration, incision and drainage (I&D), or loop-drainage — is a key principle in abscess management. Historically, the treatment of patients with peritonsillar abscesses has been no different.

Over time, however, the treatment of peritonsillar abscess has become increasingly less invasive. Initially, tonsillectomy (called quinsy tonsillectomy in this case) was once typical care for peritonsillar abscess. Although some individuals with recurrent infections may require tonsillectomy, in the urgent setting, this surgical procedure has largely been replaced by I&D. More recently, needle aspiration, even less invasive than a traditional I&D, has shown comparable outcomes with I&D and may be associated with less discomfort. However, a significant amount of recent observational data has challenged the necessity of any surgical treatment for many patients with peritonsillar abscess.[1–4] Lately, many have questioned the need for initial surgical treatment. Medical therapy, generally consisting of an antibiotic (either clindamycin, amoxicillin/clavulanate, or ampicillin/sulbactam) and steroids, is increasingly embraced for this disease.

Why the shift? Needle aspiration and I&D not only take additional physician time and resources, but also are associated with increased morbidity, pain, and missed days of work.[3] Additionally, the occurrence of "dry taps" is frustrating for clinicians and patients. It is not infrequent, occurring in up to 50 percent of cases, that an aspiration or I&D attempt fails to obtain pus. It can be difficult to clinically differentiate where patients fall on the spectrum of peritonsillar abscess versus phlegmon. Even the addition of point-of-care intra-oral ultrasound is imperfect, with a sensitivity of approximately 91 percent (95% CI: 82%–95%) and a specificity of 75 percent (95% CI: 63%–84%).[5]

A study from an integrated health care delivery system compared outcomes from 12 centers that had adopted medical treatment as first-line with seven sites that continued with surgical drainage. Consistent with prior studies, similar failure and complication rates occurred in patients treated with medical and surgical therapy. However, the medical treatment group had a reduced number of opioid prescriptions, missed days of work, and fewer sore throat days.[3] In this study, not all patients received imaging, and some might argue that these patients could have had peritonsillar cellulitis rather than frank abscess.

What If There Is Definitive Abscess?

A retrospective study assessed outcomes among 214 emergency eepartment (ED) patients who underwent CT imaging demonstrating a definitive peritonsillar abscess at one of three EDs. Overall, the mean abscess size was 2.0 cm. The study found treatment failure (defined as return visit with need for surgical treatment within 30 days), was similar between groups treated with medical therapy (8.0 percent) or surgical therapy (7.9 percent).

As expected in non-randomized data, there were some differences between groups. Individuals selected for medical treatment alone were, on average, older, less likely to be febrile, and had smaller abscess size (1.69 cm versus 2.32 cm). In a secondary analysis of outcomes based on abscess size, there was no difference in treatment failure between medical therapy (5.3 percent) and surgical treatment (5.0 percent); however, in those with an abscess >2.0 cm, there was a non-significant trend towards treatment failure in the medical therapy alone group (13.3 percent vs 9.2 percent). Interestingly, when the definition of treatment failure included return ED visits for pain without subsequent surgical intervention, the failure rate in the surgical group jumped to 18.4 percent, making medical treatment alone appear more appealing.[1]

In most patients, the initial treatment of peritonsillar abscess is perfect for informed, shared decision making. The evidence clearly demonstrates that 5 to 15 percent of patients with peritonsillar abscess will have treatment failure/recurrence, regardless of whether the abscess was drained on the initial visit. Patients should receive counseling that regardless of initial treatment approach, there is a decent chance they may need a subsequent procedure and that drainage is more painful. While initial drainage is certainly necessary in ill-appearing patients and probably preferable for large abscesses, in others, an initial approach of antibiotics and steroids is in line with the best available evidence.

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ED PHARMACIST QUICK TIPS

PHARMED OUT

DR. WATTS is an emergency medicine pharmacy specialist at Carolinas Medical Center in Charlotte, NC.

DR. GIBBS is the chair of the department of emergency medicine at Carolinas Medical Center in Charlotte, NC.

Subcutaneous Insulin for Diabetic Ketoacidosis in Adults

by ALYSSA WATTS, PHARMD, BCPS, BCEMP; MICHAEL GIBBS, MD, FACEP, FAAEM

Case Vignette

SI is a 35-year-old woman with past medical history significant for type 1 diabetes mellitus who has been out of insulin for two days and now presents to the emergency department in mild diabetic ketoacidosis (DKA). The Intensive Care Unit (ICU) is at capacity, and the team is discussing treatment options that could be initiated and would not require admission to the ICU.

When?

Subcutaneous rapid-acting insulin, such as insulin lispro, is a reasonable alternative to intravenous insulin and can be considered in patients with mild-to-moderate DKA, often defined as blood glucose level (BGL) >250 mg/dL, pH >7.0, HCO_3 >10 mmol, positive ketones, and an anion gap >12.

Why?

Available literature indicates that insulin therapy is effective for treatment of DKA regardless of the route of administration (intravenous versus intramuscular versus subcutaneous). Traditionally, intravenous insulin has been the preferred treatment method for DKA given concerns about delayed response to subcutaneous insulin. However, with the development of rapid-acting insulin, the subcutaneous route has provided an attractive alternative to treatment of mild-to-moderate DKA, with potential cost savings.

How?

- **Dose:** The optimal dose in DKA has not yet been established, but initial doses of insulin lispro 0.1-0.3 units/kg subcutaneously have been studied and shown to be effective in this patient population.
- **Onset:** <15 minutes
- **Peak effect:** 0.5-1.5 hours
- **Duration:** 3.5 hours
- **Adverse Effects:** hypoglycemia, hypokalemia, injection site reactions

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DR. ANYANWU is an emergency medicine physician in Houston with an MPH in epidemiology and fellowship training in leadership and advocacy. She serves on the *ACEP Now* Editorial Advisory Board.

The Chilling Effect of ICE Raids

BY CHINWE ANYANWU, DO, MPH

When I walk into the chaos of the emergency department (ED), I expect traumas, cardiac arrests, and acute strokes. What I don't expect is the eerie sense that some patients walked in the door more afraid of being deported than of their own medical emergency. Recent data has shown an alarming increase in [federal] Immigration and Customs Enforcement (ICE) detentions and arrests under the Trump administration, driven by racial/ethnic profiling and $45 billion in funding courtesy of the reconciliation bill signed into law by President Trump in summer 2025, resulting in a nearly 40 percent increase in detainments.[1,2]

Although news of raids in cities such as Chicago, New York City, Los Angeles, Charlotte, North Carolina, and elsewhere around the country is publicized, the injuries to patients are not always reported. Data regarding the surge in injuries related to ICE raids have been poorly tracked. From a strictly data-driven standpoint, there lies a dangerous gap in information. Currently there is no trackable national database showing a clear increase in ED visits for injuries sustained during ICE agent enforcement. Some regional reporting hints at increases in trauma: A Chicago alderwoman said agents brought injured people to the hospital from a raid; one man "broke his leg running from the agents."[3] Another report from California described doctors seeing detained patients with injuries after raids and agents embedded in hospital rooms. Some reports stated that "hospital administrators are allowing federal immigration agents to interfere in medical decisions and block doctors from properly treating detainees who need emergency care."[4] But no robust epidemiologic study has yet quantified the rise in injuries and ED visits as a consequence of ICE actions.

Emergency physicians are aware of the risk . An article intended for ED staff warns that when ICE enforcement moves into once-protected "sensitive locations," such as hospitals, the consequences include disruptions of care, increased stress for staff and patients, and secondary injuries from delayed care.[5] So while we can't definitively say that ED visits for ICE enforcement-related injuries increased by a certain percentage, we can say the risk is real, and the institutional impact is apparent.

Here's where the data get clearer, and scarier for us as emergency physicians. Research consistently shows that enforcement activity by ICE and the surrounding deportation rhetoric creates a chilling effect on health-seeking behavior in immigrant populations. For example, a study found that after raids or legislation targeting immigrants, visits to county public-health clinics dropped about 25 percent among Latino adults.[6] A recent article reported that many patients have said that they've "hesitated or waited too long to come in for health care" because of fear of ICE [agents] in hospitals.[7] In New York, a federally qualified health-center doctor said that one shelter stopped receiving patients altogether because "almost no one was showing up for care" after rumors that ICE was operating nearby.[8] In another story, a woman reportedly avoided prenatal care because she feared her partner's deportation. Her baby suffered complications as a result.[9] So, no, we may not have a neat ICD-10 code for this yet, but we have real stories of delay, avoidance, and the medical sequelae that follows. It likely leads to more advanced presentations, more preventable complications, more cost, and worse outcomes.

Why Does This Hit So Hard in the ED?

As an emergency physician with a public health lens, I want you to imagine this scenario: a man showing up at 3 a.m., shirt still stained from drywall dust. He's been hiding a deep cut from a power tool for several days because he heard ICE raided the job site next door. By the time he comes in, the wound is swollen, streaked with infection, and his hand barely moves. He's now septic with an untreated open fracture. He tells you — through an interpreter — that he'd rather lose a limb than be deported. But now, he requires emergent surgery.

That's the avoidable burden that I have seen.

In the emergency department, we are trained that time equals tissue. Whether that tissue is myocardium or bacteremic bone — delay costs. And when avoidance is driven not just by lack of resources but also by fear of deportation, we're facing a social determinant of health in real-time. Moreover, when ICE agents show up in health care spaces (or are perceived to), trust evaporates. One hospital reported agents entering patient care areas without warrants, refusing to identify themselves, restraining detainees in cuffs while medical decisions were being made, and preventing doctors from contacting families.[4] That undermines confidentiality, trust, and physician-patient autonomy — everything we rely on for safe, high-quality care.

This is no longer just an immigration issue. It is a public health issue. The rippling effects impact all of us. A study in New York reported that patients who feared ICE were three times more likely to delay care for tuberculosis (TB), even though untreated TB threatens the broader public.[10] When fear prevents community members from seeking care, communicable diseases spread, ED volumes grow, hospitals' resources become strained, and patient outcomes worsen.

We should call for hospital-level data surveillance linking enforcement events with care avoidance and injury trends, including use of force by law enforcement. We need hospital staff training and policies to handle these interactions ethically, in a way that protects all patients regardless of immigration status. And we must demand that agents should not be allowed to undermine physician treatment or patients' access to care. Because, as much as I love the drama of a trauma bay, the quiet ones scare me more — the person who avoided coming in until it was too late, the parent who skipped their child's follow-up appointment because ICE might show up at the clinic, the hospital corridor where patients glance over their shoulder and wonder if someone in uniform will step through the door.

If we believe in emergency medicine as a universal safety net, we must reckon with the fact that enforcement-driven fear is ripping holes in that net. And, yes, if you are a physician, a nurse, a hospital administrator, or a public-health advocate, you are part of the solution. Because when we lose trust, we don't just lose access for undocumented patients, we lose access for everyone.

Without reform, this will only be the tip of the ICE-berg.

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and was whisked away in an ambulance. I treated a trauma victim who needed blood, something that exists in very limited supply here. I have seen countless patients suffering from alcoholism and depression, conditions that are unfortunately very common in the community. I have taken care of a 9-day old infant who had not received any care since birth. This is the privilege of learning what it is like to work at a critical access IHS hospital dedicated to the survival of its community.

My time there was much too brief, as part of an established rotation residents at my residency program can join, accompanying attendings who work out at Eagle Butte one week at a time throughout the year.

Yeisabeth Jimenez, MD, the acting emergency department director, told me about her vision for visiting residents and the value of the rotation. Dr. Jimenez emphasized the importance of being exposed to medicine at an IHS hospital and understanding the mission to provide excellent care to Native American communities. "You may see Native American patients at your hospital, but if you do not come to the reservation, you will not see and understand challenges they face daily: transportation issues, socioeconomic issues, children who cannot be fed at home, parents under the influence of drugs with a neglected child, grandparents taking care of kids."

Teresa Bormann, MD, the clinical director, echoed this sentiment. "The system you are working within is much different than a private health system," she told me as she discussed the value of being immersed in a different health system. "There are different rules about [the] care you give and how you go about giving that care."

Dr. Bormann reinforced the value of residents seeing rural medicine and how the emergency department functions with limited resources. "The biggest thing is how to care for patients when you do not have all the specialty services around you. There is a different decision making skillset [that] you develop."

Dr. Jimenez agreed that in this type of environment, "You need to know, and you need to be prepared....We do not have surgery; we do not have respiratory therapy. In the case of trauma, be ready to stabilize your patient and transfer them. You might not expect your biggest challenge of the day to be finding an accepting hospital that is not on diversion."

Dr. Bormann stressed the fact that exposing residents to rural medicine is key as it can change career paths and where they choose to practice. "Having residents come [here] is very helpful as they get to understand what it is like to live and work in a rural environment. Learners who come to a location are more likely to return to work there in the future. They might consider working for IHS later in their career."

Dr. Bormann also discussed the educational value that residents add to the hospital. "When learners are in an environment it elevates the level of scholarship in that facility. The people who are teaching have to be up to date on their knowledge and have the ability to teach. That drives the infrastructure around scholarship for everybody."

Before coming to Eagle Butte, Dr. Jimenez stressed that physicians need to have cultural sensitivity and awareness. "You have to consider the respect we have to provide to our patients. You are coming as a foreigner to their land and must think about how to present yourself for them to trust you."

Dr. Bormann suggested that "residents should at least have done some reading on cultural humility. When you come into our environment, you get a sense for people's beliefs. For example, there is a certain subset of patients who do not prefer to engage in Western medicine and take care of themselves through Lakota spirituality and ceremony. Respecting those choices is a different mindset. We can see them as noncompliant, but they are not a bad patient. They just have a different belief system."

Dr. Bormann and Dr. Jimenez's words and advice perfectly summarize the incredible exposure this rotation offers to residents like me for the experience of working in a rural setting and at an IHS site. It was a pleasure to learn from them and the community, and I hope to return in the coming years.

I would like to thank the staff at the Cheyenne River Health Center for welcoming me into their hospital. It was a privilege to visit and work in the emergency department and learn from the staff and the patients. I would also like to thank Dr. John Rozehnal, who leads the Mount Sinai Hospital partnership, for allowing me to accompany him during his week of shifts and providing me with an abundance of knowledge outside of our usual New York City home.

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Preparing For and Surviving the Next Bear Market

by JAMES M. DAHLE, MD, FACEP

Q I am very worried that the AI bubble is going to crash soon. What should I do?

A A bear market in stocks is generally defined as a 20 percent drop in value from the peak. On average, bear markets occur about every three years, last for 10 months, and require two and a half years to recover. As I write this in November 2025, our last bear markets were January to October 2022 (a 27 percent drop in U.S. stock prices) and February to March 2020 (a 34 percent drop in U.S. stock prices). A knowledge of financial history arms an investor with the means to control the most important factor in their investment returns and financial security: their own behavior.

After exceptional returns, particularly among U.S. large-growth tech companies, (aka artificial intelligence (AI) stocks), for the last three years, many investors are worried about a bubble. While bubbles, and particularly the date they'll burst, are challenging to identify in advance, we are sure to have another bear market at some point in the future. A wise investor prepares in advance for bear markets and controls their own behavior throughout the bear market to avoid serious financial setbacks.

Preparing for a bear market is critical. Perhaps the most important thing is to educate yourself about stock market history in advance, then incorporate that knowledge into a written investment plan that you can follow in the throes of a bear market. A solid written plan will dictate what you invest in and how you behave during a bear market. Then all you have to do when the bear market actually occurs is keep your commitment to yourself by following the plan.

A solid investing plan is diversified, both between and within asset classes (or types of investments). For example, my personal long-term asset allocation (mix of investments) dictates that I will have 40 percent of my money invested in U.S. stocks, 20 percent in international stocks, 20 percent in bonds, and 20 percent in real estate. If U.S. stocks have a bad year, my new investment money will go toward those stocks to bring the portfolio back into balance. If things get really bad, I might even have to sell some of those other assets to buy more U.S. stocks. Although it doesn't feel very good to buy something that has recently gone down in price, history informs us that these purchases usually have the best long-term returns. Using broadly diversified investments such as index funds, rather than a few individual stocks, also allows us to have confidence in the eventual recovery of money lost in a bear market.

Additional preparation includes keeping a reasonable amount of money in cash, or at least, very safe investments. Money you expect to spend in the next few years doesn't belong in the stock market, much less next quarter's estimated tax payment or a down payment for an upcoming home purchase.

A good plan not only tells you what to do in a bear market (stay the course, rebalance, continue to invest), it tells you what not to do. It will tell you to avoid changing your asset allocation, panic selling, market timing, stock picking, using actively managed mutual funds, and other activities that have been shown to decrease long-term returns.

Once you are in a bear market, all you have to do is follow your previously written plan. Lots of investors don't realize they need a written plan, so a bear market often provides the impetus to do some real financial planning. Here are some other useful things you can do in a bear market.

No. 1: Do Nothing Major

The most important consideration, assum-

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ing you have a reasonable mix of diversified investments like index funds, is to make no major changes. "Stay the course!" Jack Bogle, founder of The Vanguard Group Inc., famously said. Some people find it easier to stay the course if they are not frequently reminded about poor performance. They avoid financial news like the plague, turning off CNBC and avoiding investment magazines. While no long-term investor needs to check their investments every day or even every month, if you know your plan is reasonable and your portfolio is diversified, you may find it better not to look at investment statements until the bear market is over in a few months, or even a couple of years.

No. 2: Tax Loss Harvest

While it's no fun to lose money, at least in a taxable account Uncle Sam will share your pain. When recently purchased shares of an index fund go down in value during a bear market, you can swap them for shares of a similar, but not "substantially identical" (in the words of the IRS), index fund. Without significantly changing your asset allocation, you have booked a capital loss that you can use against future capital gains and even $3,000 worth of ordinary income each year.

No. 3: Rebalance the Portfolio

When you set up your portfolio, you choose to take on a reasonable amount of risk, often defined by a ratio of stocks to bonds or other safe investments. In a bear market, that ratio is likely significantly changed. It's time to rebalance the portfolio back to the original ratio, essentially forcing yourself to sell high and buy low.

No. 4: Evaluate Your Risk Tolerance

Your first bear market or two is a great time to get to know yourself as an investor. Are you lying awake at night worrying about your money? Or are you wishing you could pile even more money into the market and buy shares "on sale?" If the former, you might want to decrease your long-term stock to bond ratio (after the market recovery, of course). If the latter, you might want to increase that ratio — again after you've seen the bear market through.

No. 5: Consider Putting Off Major Purchases

Bear markets are a great time to invest more money, since you can purchase more shares with any given amount of money due to the lower prices. Conversely, bear markets are a rough time to sell shares in order to get more money to spend. This might be a good time to defer a major purchase. This may allow you to pick up shares at a discount, or at least avoid selling them low.

You can learn a lot about yourself in a bear market, but it's most critical to avoid big mistakes, like panic selling.

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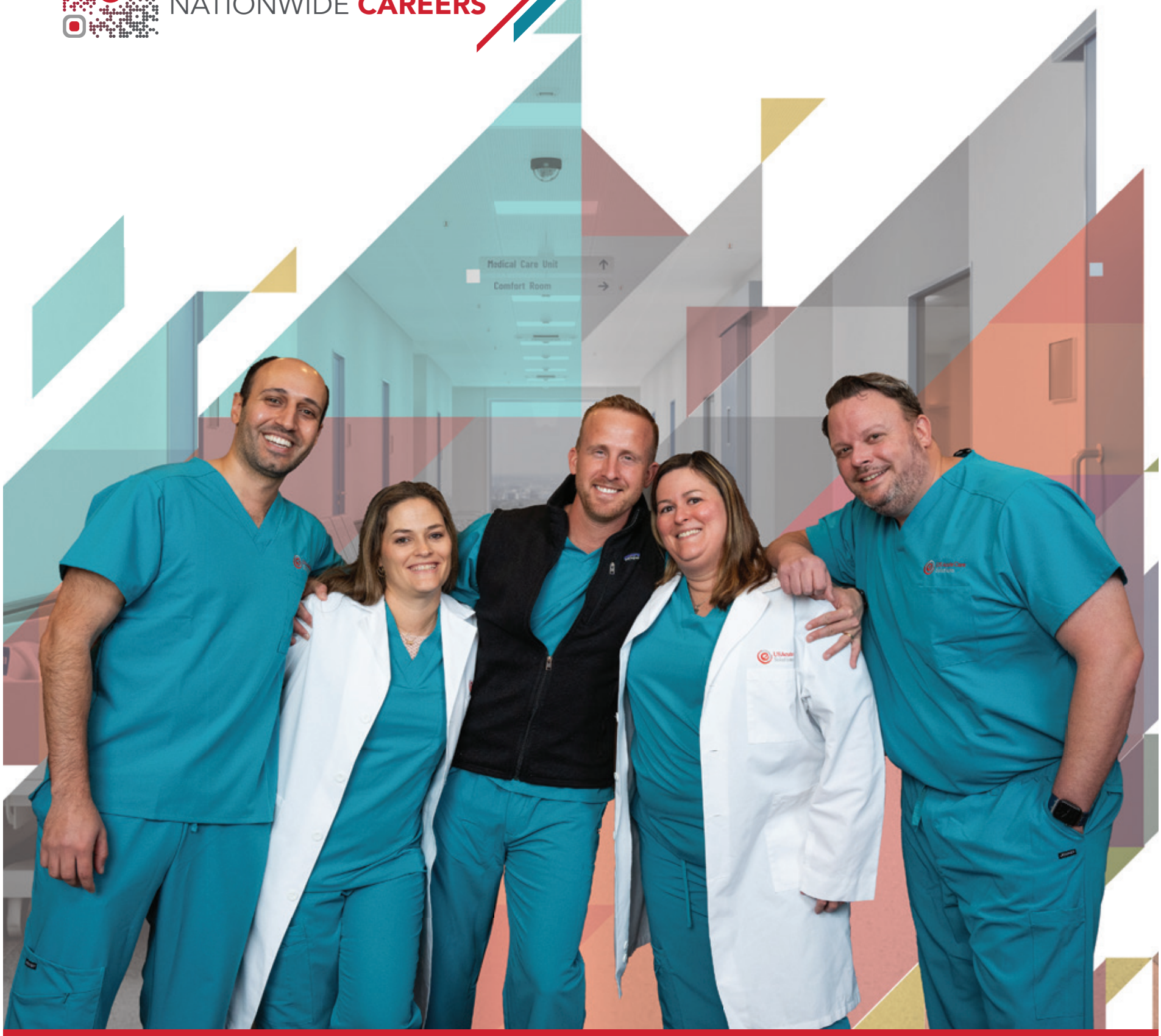

Bobby Missaghi, MD
EM Residency: The University of California, Los Angeles – Harbor Medical Center, 2017
Emergency Physician

Misty Nguyen, DO
EM Residency: Southwest Medical Center, 2021
Emergency Physician

Calen Hart, MD
EM Residency: Vanderbilt University School of Medicine, 2022
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