Vol. XLVI No. 1

January/February 2026

In This Issue

2 From the President

Michael Gratson, MD, MHSA, FACEP

"The Winter Symposium has come again and with it, cold weather, ski slopes, entertaining and informative lectures, and connecting with friends from around the state. Many thanks are owed to the course directors, Drs. Luke Saski and Abi Brackney, our amazing MCEP staff, Allie, Madey, and Christy, and the Boyne Mountain Resort."

3 From the Editor

Andrew Taylor, DO, FACEP

"What are your favorite types of workups? For some of us, it can be the organ system that provides us the most clinical excitement and favorite diagnostic and therapeutic treatments. Maybe for you it is the fast-paced nature of the traumatically injured patient. For others it may be the cardiac patient and the diagnostic challenge of interpreting EKG's and matching clinical history and unique physical exam findings, as well as the chance to use the stethoscope for more than simply ornamental purposes."

4 Kid's Korner

Pamela Coffey, MD, FACEP

"Autism is one of those words in a pediatric emergency department that holds a lot of space. I'm not actually sure what "holding space" means, but my teens tell me it's a way to describe things that are difficult to pin down to one specific thought or feeling. It's something that invokes many emotions, complex thoughts or confusing ideas. And in trying to define how autism is seen in an emergency department, holding space just seems fitting."

6 Legislative Column

Bret Marr, Lobbyist
Muchmore, Harrington, Smalley & Associates

"Late Fall of 2025, legislation allowing registered nurse practitioners to vastly broaden their scope of practice without the oversight of a physician was reported by the House Health Policy Committee. Michigan's current laws require nurse practitioners to be licensed under a supervising physician and work in the MCEP supported team approach."

8 MCEP Resident Case Report

Alex Ostman, MD and Sean McCormick, MD of Detroit Receiving Hospital, Detroit, MI

Submissions to the March/April 2026 Newsletter should be received by the Chapter office no later than April 1, 2026.

Contents

6 Calendar of Events
12 Medical Student Council Column
12 EMRAM President Column

FROM THE PRESIDENT

The Winter Symposium has come again and with it, cold weather, ski slopes, entertaining and informative lectures, and connecting with friends from around the state. Many thanks are owed to the course directors, Drs. Luke Saski and Abi Brackney, our amazing MCEP staff, Allie, Madey, and Christy, and the Boyne Mountain Resort.

One of the topics covered this year at the Winter Symposium was burnout. Drs. Michael Doyle and John DeVeau provided an excellent lecture of how their group was able to more effectively tackle this and the positive impacts it had on their group. I know, we have all had lectures, seminars, apps, and emails related to burnout over the year but one of the things really stuck with me. Connection. Connection can be our vaccine against burnout. It is all too easy while on shift to see all the ways how the medical system has failed our patients, has failed us, and to feel as if it is our responsibility to fix this mess on our own little island. Overburdened by trying to do more, with less, and still having enough to give to the next person. Connection offers us the sight that we are not alone, but rather all part of a greater group, all working toward the same ends. For many of us, the Michigan College of Emergency Physicians offers that venue for connection and the opportunity to effectuate change.

And effectuating change is what the college is committed to. Currently, the college is working with legislatures to resolve the reimbursement issues created by the Michigan No Surprises Act, expanding penalties against patients who willingly assault healthcare workers, and mandating that all emergency departments are staffed by emergency medicine capable physicians 24/7. The success of these efforts rests on our committed members working on the hill, in their communities, and in their shops. Through their and your efforts, we can begin to fix the broken medical system that often creates the conditions for burnout that we all face. If any or all of these issues speak to you or if you are looking for a stronger connection within emergency medicine, come join us for our board of directors meeting at the MCEP office in Lansing. Learn more about the college and what it can offer you. All are welcome.

Michael Gratson, MD, MHSA, FACEP

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS
WANT TO BE FEATURED ON OUR SOCIAL MEDIA?
Member Spotlight
Michael Gratson, MD, MHSA, FACEP
Where do you work?
When did you join MCEP?
What has been your proudest moment as an Emergency Physician?
What is your favorite part of being an MCEP member?
Favorite accomplishment outside of work?
MEMBER MONDAY
GET FEATURED

www.mcep.org

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

Executive Committee

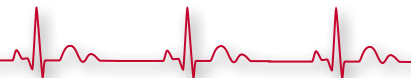
Michael Gratson, MD, MHSA, FACEP — *President*
president@mcep.org

Luke Saski, MD, FACEP — *President-Elect*
Andrew Taylor, DO, FACEP — *Treasurer*
Sara Chakel, MD, FACEP — *Secretary*
Therese Mead, DO, FACEP — *Immediate Past President*

Editor
Andrew Taylor, DO, FACEP
mcep@mcep.org

Executive Director
Christy K. Snitgen
csnitgen@mcep.org

Michigan Emergency Medicine News & Views is the official publication of the Michigan College of Emergency Physicians. Deadline for publication of all letters/articles is the 5th of the month prior. All correspondence should be addressed to MCEP News & Views, 6647 West St. Joseph Hwy., Lansing, MI 48917. Telephone (517) 327-5700, FAX (517) 327-7530, www.mcep.org. Opinions expressed within this newsletter do not necessarily reflect the College's point of view. While News & Views believes that the ads it accepts originate from reputable sources, it takes no responsibility for the consequences resulting from, or the responses generated by, any commercial or classified advertisement.



MOUSE AND COOKIE

What are your favorite types of workups? For some of us, it can be the organ system that provides us the most clinical excitement and favorite diagnostic and therapeutic treatments. Maybe for you it is the fast-paced nature of the traumatically injured patient. For others it may be the cardiac patient and the diagnostic challenge of interpreting EKG's and matching clinical history and unique physical exam findings, as well as the chance to use the stethoscope for more than simply ornamental purposes. Maybe the challenging airway or respiratory compromise can give the promise of an airway promptly secured and stabilized. Whatever the response is, I imagine that one of the more challenging patients is the pediatric patient.

Pediatric patients present multiple challenges to the non-pediatric trained emergency medicine physician. At least for those of us practicing in most community medicine departments, the pediatric patient presents multiple challenges that may not be present in other clinical encounters. Family dynamics and expectations can be difficult to navigate in the brief time that most clinical encounters present with, and occasionally the more tense dynamics can come to a head during stressful situations. Perhaps one of the more challenging aspects of pediatric encounters that I find is the mouse and cookie workup.

For those of us not familiar with the reference, I'm referring to the classic children's story *If You Give a Mouse A Cookie*, in which the book catalogues a series of events starting from a child initially giving into the request of mouse to give him a snack. Subsequently, the mouse has several related requests after initially receiving the cookie, leading to a stepwise series of events as the main characters finds out. As you can imagine, this book is silly and funny to both small children and adults reading the book alike, which is possibly the reason why it persists as a favorite among (at least my own) children as a story.

Sometimes I find myself thinking of this story when I look at my workups at the end of the shift. While it doesn't always exclusively happen in the pediatric patient, I do seem to notice it more often. I'm thinking of the patient that you think has a viral gastroenteritis and is having difficulty keeping anything sort of food down at home. Maybe it also happens in the traumatic patient that doesn't have any "hard signs" of trauma, and instead of advanced imaging is getting a series of abdominal exams and/or repeat FAST exams, as well as an oral challenge. I'm sure every practicing emergency medicine physician has their own set of expectations and memories of how these types of encounters have gone, both in their successes and failures. I recently even had a resident tell me that they heard something similar being called "ZO-PO and GO," to characterize symptomatic treatment with a popular anti-emetic as well as an oral challenge. I cannot claim any credit for coming up with this phrase, but whoever did, I admire the cleverness.

In the *Mouse and Cookie* story, you can get a sense of frustration with the time spent appeasing the mouse's requests, and (spoilers) you end up with the mouse again asking for a cookie in the end. The circular nature of the story ends I would imagine in frustration, and likely the lived experience of a toddler age child themselves. I think it would be natural to experience s sense of frustration with the experience n the clinical encounter, where one step leads to another, and often leads to a prolonged workup in a fast-paced environment in which speed always seems to be a goal that we strive for.

Instead, in my clinical experience with pediatric patients, the result is almost always a positive one. Slow and patient almost always seems to win this race, and the popsicles and prizes that find themselves along the way result in much more smiles than IV starts and imaging. I've even been offered the other half of a double popsicle as a prize, one of my most memorable encounters in the emergency department. Perhaps then there is something to be learned with *Mouse and Cookie* after all, and we should not be afraid to find ourselves being instead of looking at the clock to be looking at the patient instead. Maybe you will even be gifted a popsicle in return. §

Andrew Taylor, DO, FACEP

Stay Ahead of the Curve: Prep for the 2026 Certifying Exam

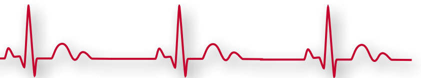
Immersive

Certifying Exam Preparation Course

A joint initiative between

Ohio ACEP + Agile Simulation

Approved for *AMA PRA Category 1 Credit*™.



HOLDING SPACE FOR AUTISM

Autism is one of those words in a pediatric emergency department that holds a lot of space. I'm not actually sure what "holding space" means, but my teens tell me it's a way to describe things that are difficult to pin down to one specific thought or feeling. It's something that invokes many emotions, complex thoughts or confusing ideas. And in trying to define how autism is seen in an emergency department, holding space just seems fitting. Because when we hear a patient has autism, so many complex and uncertain questions and emotions arise. Will this child need extra resources? Will we need sedation for a simple procedure? Will the child in the room next to them need to be moved? Will I be able to figure out what is wrong if they cannot tell me? Autism is a descriptive word that for me, used to invoke anxiety and angst. But then a patient with autism drew me a picture of his house.

The house was a typical drawing of a square with a door, two windows and a roof. When he handed it to me, he pointed to what looked like the door and said, "my window". Not understanding my current situation, I pointed to the same spot and said, "isn't that the door?" He became frustrated and upset and shouted "no, my window!" I looked over at the patient's mom because I had clearly upset him and was hoping she would help calm him down. She shrugged her shoulders and said, "he's autistic, he sees his world his way." I paused, looked down at the child who was now rocking back and forth on the bed. Without really thinking, I pointed to the door of the exam room and said, "my window." And he stopped rocking, sat up, nodded yes, then pointed to his drawing and said, "my window". That was the extent of our conversation, but he cooperated with me for the rest of the exam.

Pamela Coffey, MD, FACEP

I was intrigued by this and realized I had so much more to learn about autism. And as is usually the case, the more I learned the less I stressed about taking care of these patients. Now I find that our autistic patients are some of the most rewarding, interesting patients we see in the ED. So let me share what I've learned.

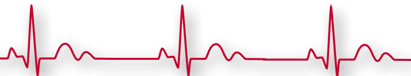
Autism is generally defined as a neurologically based disability that affects a child's social skills, communication and behavior. The American Academy of Pediatrics describes Autism or autism spectrum disorder (ASD) as "a developmental disability that affects a child's social skills, including how they interact and communicate with others. The term *spectrum* refers to the wide range of symptoms and degree to which children may be affected. For example, some children with ASD can talk, while others cannot; some children with ASD may be able to learn at the same pace as their peers with little or no assistance, while others may need assistance; and some children with ASD may be able to live on their own as adults, while others may not."[1] The CDC states that 1/31 children and 1/45 adults are affected by ASD. It's generally diagnosed by age 5, but signs often appear by age 2-3 years. Its diagnosed more frequently in boys.[2]

The DSM-5 criteria divide autism into 3 levels based on the amount of support a person might need. Level 1 autism requires some support.

REGISTRATION DEADLINE APRIL 1, 2026
PLEASE CONTACT THE EMRAM/MCEP OFFICE AT ALLIEP@MCEP.ORG TO
REGISTER YOUR TEAM OR WITH ANY QUESTIONS.

Find out more here:

April 15, 2026 - Central Michigan University Sim Lab
1632 Stone St Saginaw, MI 48602



These are kids who communicate but may appear disinterested or awkward. They may have repetitive behavior or difficulty with organizing and planning. Level 2 autism requires a higher level of support as these people likely have some level of significant verbal deficits. They may only use a few words at a time and are uncomfortable in social situations. They may be inflexible with their behavior. Level 3 autism requires a substantial amount of support. These patients have severe deficits in communication and are often categorized as non-verbal. They struggle to cope, particularly in unfamiliar situations. Their behaviors interfere with functioning daily.[3]

The communication behaviors exemplified by kids with ASD include [4]:

- Delayed speech and language skills
- Flat or sing-song voice
- Reverse pronouns
- Repeating words
- Avoid eye contact
- Difficulty relating or interacting with others
- May avoid physical contact, or may want excessive contact
- May engage in self-stimulating or repetitive behavior
- May have meltdowns

In addition to communication difficulties, kids with ASD have sensory and stimulation issues. As such, the Emergency Department (ED) can be a stressful environment for patients with autism. ED's are full of bright lights, constant motion, unfamiliar noises, unusual smells and lots of people talking at once. A child with autism will likely withdraw, become agitated, cry or become aggressive. This can mask their illness and lead to incorrectly attributing symptoms to autism instead of an underlying medical problem. Having a plan such as this one from the ACEP toolkit[4] for taking care of these patients is important to prevent this from happening.

1) Approach the patient slowly, use the persons first name and speak in a calm voice.
2) Try to establish a rapport.
3) Ask simple yes/no questions, avoid the need for complex responses.
4) Use family/caregiver for information to get history.
5) Allow time for the patient to respond.
6) Tell the patient what you are going to do before you examine the patient.
7) Demonstrate on a caregiver or yourself if it will help.
8) Go slowly and be flexible, may need to modify your regular exam process.

If the patient becomes agitated it's important to have methods to de-escalate as quickly as possible. Often the best resource is their caretaker, be sure to ask what works for them at home. Weighted blankets, dim lights and music are often effective. Don't underestimate hunger as a reason for agitation, especially if they have been waiting for a prolonged time in the waiting room. Carter Kits (Carterkits.org) are a fantastic resource of items known to comfort kids with ASD and are available on their website. And, if need be, use pharmacological agents to prevent harm to the patient or staff, but keep in mind this may mask a medical concern.

There is a multitude of online resources both from Michigan and nationally to help with understanding how you and your ED can approach and care for the autistic child. Some of my favorites to search for are:

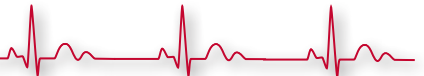
- Michigan Department of Health and Human Services Autism program
- Autism Alliance of Michigan
- Autism Speaks
- Autism Alliance of Michigan – welcome kits
- American Academy of Pediatrics
- ACEP Autism Spectrum Disorder Toolkit

All these resources can be used to develop a plan that best serves your department, which will hopefully help alleviate the stress and anxiety for you, your staff and your patients. I strongly encourage you to at least form your own plan for how you will approach these kids. For me, it has made a big difference in how I practice.

And with that, I will leave you with one last anecdote. In addition to medical resources, as an attempt to understand the human nature side of autism, I often will read online social media discussions and non-medical websites to learn about how parents care for their autistic kids. In doing so, I once came across information that said that autistic kids often connect with their hands. So, I started holding my hands out to the kids. I do this while I'm standing next to them, before I start asking questions or examining them. I put one hand, palm up, next to them as I'm talking to the caretaker. More often than not, the child will put their hand in mine, then I cover their hand with my other hand. I hold space for them for a few seconds until they make the next move. Occasionally they pull away. Sometimes they just relax. But sometimes they reach out and give me a hug. It's my way of trying to show them that I want to see the world the way they see it. And every now and then, I think it works. §

1. https://publications.aap.org/patiented/article-abstract/doi/10.1542/ppe_document143/503/ASD-What-Is-Autism-Spectrum-Disorder?redirectedFrom=fulltext?autologincheck=redirected
2. https://www.cdc.gov/mmwr/volumes/74/ss/ss7402a1.htm
3. https://www.autismspeaks.org/levels-of-autism
4. https://poctools.acep.org/POCTool/AutismSpectrumDisorder/2ce91825-5d88-48ed-b662-b8657fc1cc0f/

LEGISLATIVE COLUMN



HB 4399 – LEGISLATION TO ALLOW NURSE PRACTITIONERS TO OPERATE INDEPENDENT OF PHYSICIANS

Late Fall of 2025, legislation allowing registered nurse practitioners to vastly broaden their scope of practice without the oversight of a physician was reported by the House Health Policy Committee. Michigan's current laws require nurse practitioners to be licensed under a supervising physician and work in the MCEP supported team approach. As previously reported, MCEP Board member, Dr. Pam Coffey, testified on the need to retain this team approach and not pit nurses against physicians in the workplace.

The bill was referred to the House Rules Committee where it has received comments to committee members over the past month. MSMS has led the effort for meetings with House Rules Committee members and MCEP has supported along the way. MCEP has also worked with the bill sponsor, Rep Dave Prestin (R-Escanaba), to educate him on the EMTALA environment in our hospitals and the need for a team approach in those locations. He has explained the EDs are not the target of the scope expansion.

The House Rules Committee has not held a hearing yet on HB 4399 this year. While a hearing would be the next logical step in the process, we understand that there are certain procedures some House Republicans want to exempt from NPs performing (genetic counseling, transgender services and abortion related procedures). This has slowed down the progress of the bill and given MCEP more time to talk to members about our EMTALA care related concerns.

STATE BUDGET UPDATE

Last year, the Legislature passed by its statutory deadline to adopt a budget. After a one-week extension, the budget was passed with few changes to health care spending. This year, the state budget is on shakier ground and federal spending for Medicaid and SNAP are starting to drop back. Governor Whitmer proposed her FY 26-27 budget on February 11th. This is the official kick off of the budget process.

Bret Marr, Lobbyist
Muchmore, Harrington, Smalley & Associates

The Governor's budget is very dependent on the passage of almost $1B in new tax increases to prop up Medicaid and SNAP spending. The House has already indicated their reluctance to pass any new taxes, especially after passing a Marihuana and gas tax increase last year to support local roads. MHSA expects a prolonged budget process this year again that might carry over into the fall.

2026 LEGISLATIVE PREVIEW

Governor Whitmer gave her eight and final State of the State on Wednesday, February 25th to a joint House/Senate session. She focused on the need to address declining reading literacy scores for the state's 3rd and 4th graders. She also emphasized keeping and locking into statute the health care programs that she expanded during her time as Governor. MCEP and MHSA will continue to advocate for newer penalties for assaulting health care workers as part of the 2026 calendar. MCEP is also working on a long term push to address the unintended consequences of No Surprises Act legislation from 2020. §

MCEP CALENDAR OF EVENTS 2026

April 15, 2026
EMRAM SIMWARS
Central Michigan University
SIM LAB
Saginaw, Michigan

April 26-28, 2026
ACEP Leadership & Advocacy Conference
Washington, DC

May 6, 2026
Board of Directors
Chapter Office
Lansing, Michigan

May 29, 2026
Mini Mock Cert Course
Virtual Zoom Meeting

July 26-29, 2026
Michigan EM Assembly
The Grand Hotel
Mackinac Island, Michigan

July 27, 2026
Annual Membership Meeting & Board of Directors
The Grand Hotel
Mackinac Island, Michigan

August 20, 2026
EM Career Planning
Somerset Inn
Troy, Michigan

September 2, 2026
Board of Directors
Chapter Office
Lansing, Michigan

September 10, 2026
Pediatric EM Conference
Somerset Inn
Troy, Michigan

September 23, 2026
MCEP Council Meeting
Chapter Office
Lansing, Michigan

October 3-4, 2026
ACEP Council Meeting
Chicago, Illinois

October 5-8, 2026
ACEP Scientific Assembly
Chicago, Illinois

December 2, 2026
Board of Directors
Chapter Office
Lansing, Michigan

December 8, 2026
$traight Talk Reimbursement Course
Virtual Zoom Meeting

January 28 – 31, 2027
Midwest Winter Symposium
Mountain Grand Lodge
Boyne Mountain, Michigan

January 30, 2027
Board of Directors
Mountain Grand Lodge
Boyne Mountain, Michigan

February TBD, 2027
ITE Review Course
Virtual Zoom Meeting

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

Can’t Miss:

PEDIATRIC EMERGENCY MEDICINE CONFERENCE

September 10, 2026

This will be a dynamic and essential learning experience you won’t want to miss!

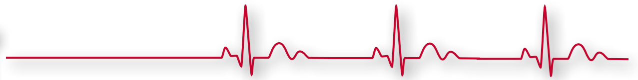
Our agenda is packed with hot topics in pediatric emergency medicine, presented by a lineup of renowned local experts who are leaders in the field. Topics covered will equip you with the critical knowledge and skills to confidently navigate high-stakes pediatric EM situations.

- **Approved for *AMA PRA Category 1 Credit*™**
- **AOA Category 1-A credits to be offered**

www.mcep.org

Somerset Inn, Troy, MI

MCEP RESIDENT CASE REPORT



POST PARTUM ENIGMA: A CASE OF SEPTIC PELVIC THROMBOPHLEBITIS

Alex Ostman, MD [1], Sean McCormick, MD [1]

AFFILIATIONS

Department of Emergency Medicine Wayne State University
Detroit Michigan USA.

INTRODUCTION

Deep septic pelvic thrombophlebitis (SPT) is an uncommon postpartum presentation affecting 1 in 3000 pregnancies [1]. Risk of occurrence is furthermore associated with cesarean section as 1 in 800 of these cases have occurrence of SPT compared to 1 in 9000 vaginal deliveries [1]. It is not a pathology unique to a peripartum complication, though, and has also been associated with endometritis, pelvic abscess, vaginal lacerations, and urinary tract infections [4]. Typical treatment consists of antibiotics combined with anticoagulation; however, the following represents a case in which there was resolution without any significant anticoagulation treatment.

CASE

A 38 year-old G4P4 female patient presented 10 days after a spontaneous vaginal delivery complaining of abdominal pain for the last 1 week. Her vital signs at triage were temperature 38.5, blood pressure 107/70, heart rate 109, respiratory rate 18 and oxygen saturation 96% on room air. On physical exam, the patient had fundal tenderness and bilateral adnexal tenderness. The patient's laboratory tests were concerning for a leukocytosis of 23 K/CUMM. A transvaginal ultrasound was concerning for possible endometritis. OB/GYN was consulted and recommended initiation of intravenous (IV) gentamicin by pharmacy dosing protocol, IV ampicillin 2g and oral metronidazole 500 mg. The following day, the patient's pain did not improve so a Computed Tomography (CT) scan of the abdomen and pelvis with intravenous contrast was ordered. It revealed a 4.8 x 3.8 cm fluid collection concerning for abscess as well as pelvic septic thrombophlebitis of the left arcuate vessel. The patient was started on enoxaparin 80 mg subcutaneously twice daily. The patient improved and was discharged on hospital day 3 with a prescription to complete a 14 day course of enoxaparin. However, secondary to insurance reasons, the patient was not able to acquire the medication in the outpatient setting. The patient did return to the hospital 1 year later to deliver her fifth child without complication or any residual effects from the previous bout of pelvic septic thrombophlebitis.

DISCUSSION

Septic Pelvic Thrombophlebitis can be subdivided into deep septic pelvic thrombophlebitis and ovarian vein thrombophlebitis although pathogenesis for each is believed to be the same. It involves Virchow' triad, with endothelial damage to the pelvic veins caused by an infection, endotoxins, or minor trauma like delivery or surgery, along with a hypercoagulable state and venous stasis, which are both established conditions present during pregnancy and postpartum [8]. As for the infectious component, the bacteria most commonly associated with SPT are Streptococcus spp., Enterobacteriaceae, and Anaerobes with MRSA also being attributed in some case reports [6].

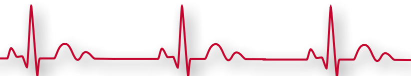
The two subtypes also have similarities in symptomatic presentation although ovarian vein thrombophlebitis tends to have a more toxic appearance. Typical symptoms include noncolicky, constant abdominal or flank pain with radiation to the groin or upper abdomen [4]. Tachypnea and dyspnea can be seen as well and are frequently mistaken for pulmonary embolism [4]. Fever is another hallmark symptom and is sometimes referred to as "enigmatic fever" given that it will fail to respond to antibiotics [5]. These symptoms are non-specific and high clinical suspicion based on patient risk factors needs to be maintained to reach diagnosis. In terms of physical exam there are reports of palpating a rope or sausage like mass in the abdomen but this is uncommon [7].

Prior to the advent of CT and MRI, diagnosis was purely clinical and based on a postpartum patient having fever that failed to respond to antibiotics after 72 hours. Currently, CT and MRI are commonly used in diagnosis of SPT. Both have excellent sensitivity and specificity but CT with contrast is preferred due to being more readily available and having slightly higher sensitivity compared to MRI (100% vs 92% respectively) [4]. Ultrasound is not beneficial in making the diagnosis but is often used to rule out other likely diagnoses [2]. Laboratory work up is not particularly beneficial as the literature states ranges for positive blood cultures between 3% and 20% only [1,6]. Leukocytosis too is not present in the majority of cases.

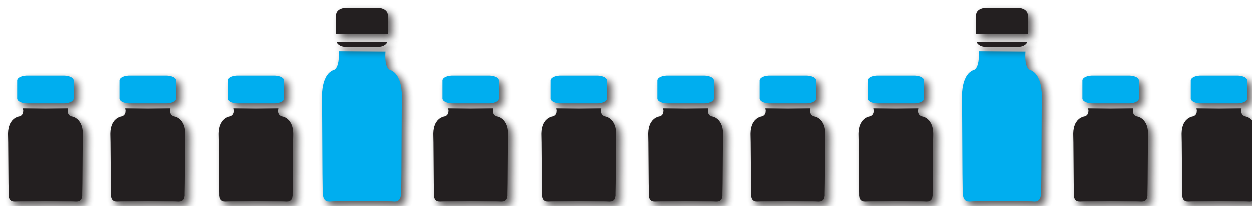
The cornerstone of treatment for SPT has been broad spectrum antibiotics. Recommendations for anticoagulation were later added. Anticoagulation's role is to prevent the progression of thrombosis, prevent embolization, and reduce the extension of the septic emboli [2]. It should be noted though that there have never been any controlled studies to confirm its suspected benefits [5]. In fact, in the Brown et al study, there was found to be no change in duration of fever or hospital stay between antibiotics alone and antibiotics combined with anticoagulation [3]. There are not currently any guidelines to assist clinicians in anticoagulation therapy. In summary, considering the non-specific presentation of this potentially life-threatening pathology, high clinical suspicion for septic pelvic thrombophlebitis must be maintained when evaluating postpartum patients with abdominal pain and fever. §

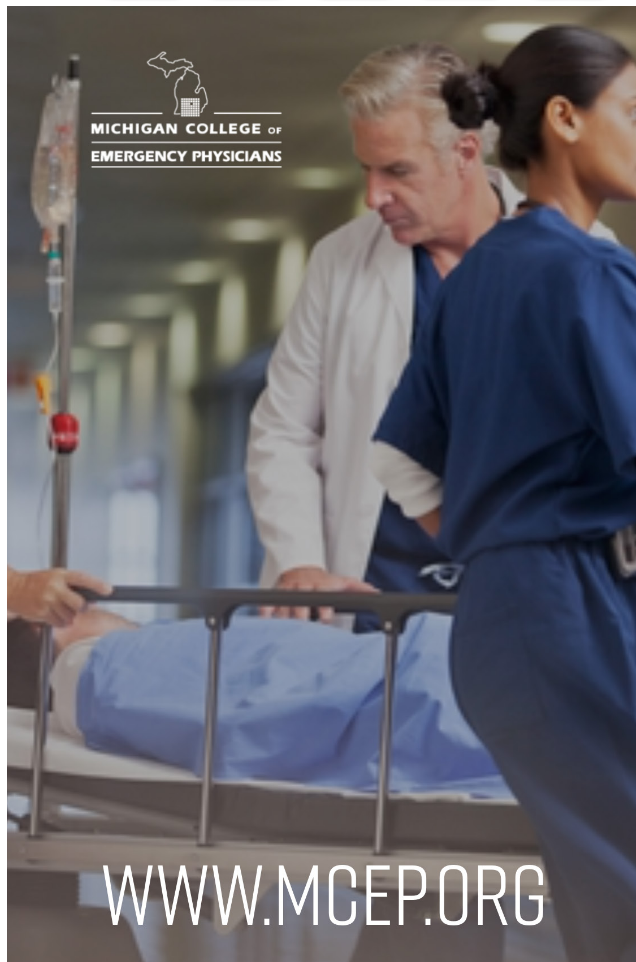
REFERENCES

1. Barnes AV, Noman R, Shakfeh S. Beyond Postpartum Fever: Case Report Uncovering Deep Septic Pelvic Thrombophlebitis. Cureus. 2023 Aug 6;15(8):e43034. doi: 10.7759/cureus.43034. PMID: 37692680; PMCID: PMC10491858.



2. Akbari EA, Majdalawi R, Harb DK, Hazari K, Abdelkareem W, Ammar A. Postpartum Septic Pelvic Thrombophlebitis in a Tertiary Maternity Hospital in Dubai, UAE. Cureus. 2023 Mar 21;15(3):e36452. doi: 10.7759/cureus.36452. PMID: 37090405; PMCID: PMC10116435.
3. Garcia J, Aboujaoude R, Apuzzio J, Alvarez JR. Septic pelvic thrombophlebitis: diagnosis and management. Infect Dis Obstet Gynecol. 2006;2006:15614. doi: 10.1155/IDOG/2006/15614. PMID: 17485796; PMCID: PMC1581461.
4. Kozar S, Šavc H. DEEP SEPTIC PELVIC THROMBOPHLEBITIS - A LIFE-THREATENING CONDITION IN POSTPARTUM PERIOD. Acta Clin Croat. 2021 Dec;60(4):773-776. doi: 10.20471/acc.2021.60.04.27. PMID: 35734504; PMCID: PMC9196213.
5. Lipe DN, Afzal M, King KC. Septic Thrombophlebitis. 2023 Jul 4. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan–. PMID: 28613482.
6. Miyamori D, Shigemoto N, Une K, Kinoshita H, Harimoto S, Sakashita T, Ito M. Delayed onset septic pelvic thrombophlebitis treated by tissue-plasminogen activator following initial treatment for massive right ovarian vein thrombosis and methicillin-resistant Staphylococcus aureus bacteremia: A case report. J Obstet Gynaecol Res. 2024 Aug;50(8):1408-1414. doi: 10.1111/jog.15991. Epub 2024 May 28. PMID: 38807344.
7. Shi Q, Gandi DS, Hua Y, Zhu Y, Yao J, Yang X, Xu Y, Zhang Y. Postpartum septic pelvic thrombophlebitis and ovarian vein thrombosis after caesarean section: a rare case report. BMC Pregnancy Childbirth. 2021 Aug 17;21(1):561. doi: 10.1186/s12884-021-04037-4. PMID: 34404357; PMCID: PMC8369649.
8. Roepke RML, de Campos FPF, Lovisolo SM, Santos EHS. Septic pelvic thrombophlebitis of unknown origin: an ever threatening entity. Autops Case Rep. 2014 Sep 30;4(3):39-46. doi: 10.4322/acr.2014.027. PMID: 28573117; PMCID: PMC5444397.





EMERGENCY MEDICINE CAREER PLANNING:

LIFE AFTER RESIDENCY

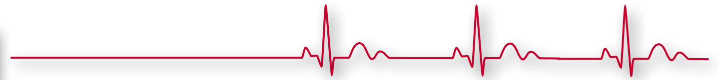
SOMERSET INN - TROY, MI | AUGUST 20, 2026

THIS CONFERENCE IS INTENDED FOR SECOND AND THIRD YEAR EMERGENCY MEDICINE RESIDENTS TO LEARN WHAT LIFE WILL BE LIKE OUTSIDE OF RESIDENCY.

JOIN US FOR AN UPDATED AND INNOVATIVE DECK OF TOPICS AND SPEAKERS THAT YOU WON'T WANT TO MISS! MORE DETAILS TO FOLLOW.

FIND OUT MORE HERE:

MEDICAL STUDENT COLUMN



GAME DAY MEDICINE: UMMS EMIG'S BIG HOUSE SHADOWING PROGRAM

By Mackenzie Kay, M.Phil, MS2; University of Michigan Medical School

OVERVIEW AND HISTORY:

Each fall, more than 100,000 fans fill the University of Michigan's Big House to watch the Wolverines take the field for Saturday home football games. From late-summer heat to crisp autumn evenings and frigid winter matchups, Michigan fans arrive prepared to cheer on the Wolverines in all conditions. Ensuring the safety of this massive and dynamic crowd is a complex undertaking that relies on a long-standing partnership between the University of Michigan Medical School's Department of Emergency Medicine and Huron Valley Ambulance (HVA).

For the last two football seasons, medical students at the University of Michigan Medical School have had the unique opportunity to observe this operation firsthand through a structured shadowing experience hosted by the Emergency Medicine Interest Group, gaining firsthand exposure to the realities of large-scale event medicine.

Huron Valley Ambulance has provided comprehensive emergency medical coverage for Michigan football games for more than 45 years. Each game day, HVA deploys between 65 and 100 EMTs, paramedics, and nurses dedicated exclusively to first response, extrication, treatment and transport of patients. Coverage includes on-foot response teams stationed throughout the stands or towers, as well as field response teams operating custom all-wheel-drive ATVs ("gators") equipped with stretchers and extrication equipment. These teams patrol the stadium perimeter and facilitate rapid transport to either the on-site Medical Center or directly to a waiting ambulance when indicated.

HVA Supervisors and EMS Fellows (emergency physicians completing additional training at Michigan Medicine in EMS operations and prehospital care) provide additional oversight and support throughout the stadium. While University of Michigan athletes are cared for by a dedicated sports medicine team, two paramedic teams remain on the sidelines prepared to quickly and safely transport injured players safely and efficiently to the hospital if needed.

The second cornerstone of game day medical coverage is the Michigan Stadium Medical Station. Prior to 1993, the station was staffed by a moonlighting non-emergency medicine resident. Recognizing both a care gap and an opportunity for meaningful resident education, responsibility for the station transitioned to the University of Michigan Department of Emergency Medicine in 1993.

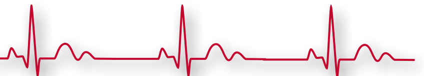
In 2010, a medical station was built on the north end of the stadium. The station includes a 10-chair rapid treatment area and an 18 bed semi-open ward, providing care to walk-in and patients brought by gator transport. Each game, the station is staffed by an attending physician with expertise in EMS and event medicine, four emergency medicine residents, and two EMS fellows from Michigan Medicine's Department of Emergency Medicine, working alongside with the four nurses and two paramedics from HVA.

Patient volume varies widely depending on weather, kickoff time, and opponent, ranging from approximately 20 to more than 200 patients per game. Hospital transports may range from two to as many as 30. Warmer weather and evening games are consistently associated with higher patient volumes.

The overarching goal of the medical station is to provide timely, high-quality care while minimizing the impact on surrounding community medical resources. This steady partnership models the excellence that is required to support a high-profile football program and a devoted fan base.

EMIG AT UMMS'S BIG HOUSE SMHADOWING PROGRAM:

Building on this robust infrastructure, the Emergency Medicine Interest Group (EMIG) at the University of Michigan Medical School (UMMS)



launched the Big House Shadowing Program last year, offering medical students interested in emergency medicine a rare opportunity to observe game day operations from the inside. Due to strong student interest and positive feedback, the program continued this season, with plans for ongoing expansion.

Two medical students are selected for each game. Participants arrive approximately two hours before kickoff and typically remain until two hours after the game concludes. Upon arrival, students are provided with a meal and orientation before joining the physicians or teams they will shadow for the day.

While the experience is primarily observational, students are often invited to participate at an appropriate level. Pre-clinical students may practice focused histories and physical exams, while clinical students can assist with assessment and management planning under direct physician supervision in this unique setting.

Inside the Medical Station, resources are similar to what is typically found in a paramedics ambulance, at scale, with no access to imaging or laboratory testing. One of the physicians himself described the station as a "slightly-better-equipped ambulance." In this setting, providers rely heavily on focused history taking, physical examination, and clinical judgment to make real time treatment and disposition decisions. Space constraints necessitate efficiency, with target length of stay under 15 minutes; it is uncommon for a patient to stay longer than one hour. This experience offers students at all levels a powerful introduction to the fundamentals of emergency medicine and the unique demands of event medicine.

FINAL THOUGHTS

Managing medical care for more than 100,000 spectators requires meticulous planning, rapid decision-making, and seamless communication across prehospital and hospital-based teams. The scale and complexity of Michigan football game-day operations highlights the strength of the partnership between Huron Valley Ambulance and Michigan Medicine's Department of Emergency Medicine.

Through the EMIG Big House Shadowing Program, medical students gain an unparalleled view of this collaboration in action, observing how coordinated systems deliver efficient, high-quality care in the largest sporting venue in the country. The Emergency Medicine Interest Group at the University of Michigan Medical School hopes this opportunity will continue to inspire and educate future emergency physicians for years to come. §

ACKNOWLEDGEMENTS:

Mark J. Lowell, MD; Clinical Associate Professor Emeritus of Emergency Medicine

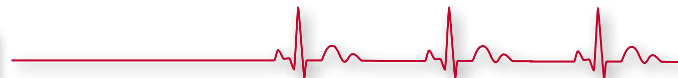
Karl Rock; Vice President of Huron Valley Ambulance

Nathaniel R. Hunt, MD; Director of Emergency Medical Services Fellowship Program, Medical Director of Survival Flight, Deputy Medical Director of Washtenaw/Livingston Medical Control Authority, Clinical Assistant Professor of Emergency Medicine

Nathan Louras, MD; Clinical Assistant Professor of Emergency Medicine

Stephen Dowker, MS2; University of Michigan Medical School

EMRAM PRESIDENT COLUMN



A FRESH START FOR 2026

With the arrival of 2026 comes a natural moment to pause, reflect, and reset. This point in the academic calendar is an ideal time to check in with yourself—acknowledging how far you've come while making sure your personal and professional goals still align with where you want to go. Below are a few realistic, high-impact areas residents can focus on to make meaningful progress in the year ahead.

1. PRIORITIZE YOUR MENTAL HEALTH

Life as a resident is demanding and, at times, overwhelming. Seeking mental health support is not a sign of crisis—it's an investment in prevention and long-term well-being. Many residency programs offer confidential counseling services or access to therapists at low or no cost. Establishing care before stress feels unmanageable can help you build effective coping tools and maintain balance throughout training and beyond.

2. STAY AHEAD OF BURNOUT

Burnout rarely happens all at once—it builds gradually. Being proactive is key. Make time for activities outside of medicine that help you recharge, whether that's gardening, cooking, exercising, or exploring a creative hobby. Stay connected with family and friends, as well as lean on your support system when things feel heavy. Remember that your PTO exists for a reason—use it. Even small daily habits, such as stepping away for a few quiet moments or practicing mindfulness, can make a meaningful difference.

Tara Stone, MD, MPH

3. START EXPLORING FUTURE CAREER OPTIONS

It's never too early to begin learning about potential attending positions—even for PGY1s and PGY2s. Conferences offer valuable opportunities to bring your CV, meet recruiters, and ask questions about different practice settings. Online job boards from professional organizations and hospital systems can also provide insight into current trends and opportunities. Talk with attendings in your program about their career paths and consider setting up a virtual or in-person conversation with a recruiter or medical director. Early exploration allows time to understand different employment models, practice environments, and what matters most to you as you plan for life after training.

4. BUILD A FINANCIAL PLAN AND LOAN REPAYMENT STRATEGY

Financial well-being matters at every stage of your career. Taking time now to understand disability insurance, life insurance, and student loan repayment options can pay dividends later. Meeting with a financial planner can help you develop a strategy that supports both your current needs and long-term goals. When possible, paying down debt earlier can reduce interest costs and increase future flexibility. Be sure to explore Public Service Loan Forgiveness (PSLF). While this is often not an option for traditional emergency medicine attending positions, those employed directly by non-profit hospitals may qualify—making it worth a closer look.

As we move through 2026, remember that progress doesn't need to be perfect to be meaningful. Small, intentional steps taken now can set the foundation for a healthier, more sustainable career. §

UPCOMING EMRAM EVENTS

- **2026–2027 EMRAM Officer Elections – Join our team!**
  March 1 – April 1, 2026

- **EMRAM SIMWARS – Central Michigan University, Saginaw, MI**
  April 15, 2026
  **Resident social event to follow!*

- **EMRAM Officer Meeting**
  June 10, 2026 | 2:00 PM

Michigan Emergency Doctors' Political Action Committee

6647 West St. Joseph Highway Lansing, Michigan 48917 (517) 327-5700

Dear Doctor:

As members of MCEP, ACEP, and the health care community, we dedicate ourselves to advancing quality emergency care. Increasingly, key decisions affecting our ability to fulfill this mission are made by elected officials—few of whom are medically trained and even fewer of whom are emergency physicians—in Lansing and in Washington, D.C.

Emergency physicians face myriad challenges in emergency departments, not the least of which is violence in the workplace. A long-existing barrier to the delivery of quality care, ED violence has steadily increased at a rate greater than four times the rate for workers in the private sector overall. MCEP, with the support of MEDPAC, backed a group of bills in the Michigan legislature to address these concerns, culminating in the passage and enactment of the bipartisan House Bills 4520 and 4521 in 2023. With your support, we will keep the momentum going and build on these wins in the upcoming year.

In addition, we continue to work at the state level to support the interests of Michigan emergency physicians, including limiting scope creep, addressing reimbursement challenges resulting from the implementation of Michigan's Surprise Billing Law, and improving access to psychiatric care. Your support helps us to highlight these and other issues to legislators in Lansing.

I strongly encourage you to contact your legislators in Lansing and in Congress to explain the fundamental role that emergency physicians play in safeguarding and advancing the health of our communities. Your support of MEDPAC allows our message to reach elected officials and helps to strengthen our voice on issues that impact our care, our patients, and our profession.

Please join me in supporting the Michigan Emergency Doctor Political Action Committee! Your donation can be a one-time only donation or broken into quarterly or monthly payments. A link to MEDPAC can be found here: **https://themedpac.org/**. If you would like to donate quarterly or monthly, please contact our office at 517-327-5700 or email madeyv@mcep.org.

Sincerely,

Sara Chakel, MD

Sara Chakel, MD, FACEP
Chair, Michigan Emergency Doctors' PAC Board of Trustees