



SACTEM TIMES

SEP
2026

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CONCLAVE OF MEDICAL EMERGENCIES AND TRAUMA

INDIA'S LARGEST CONFERENCE ON EMERGENCY MEDICINE &
TRAUMA IS BACK FOR THE 2ND EDITION



THEME STRENGTHENING SYSTEMS – SAVING LIVES

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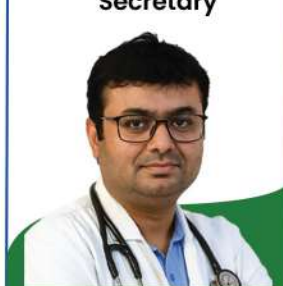
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SPECIAL ATTRACTIONS



A Medical Conclave with Spiritual Grace

Ram Mandir Darshan for the
delegates and faculties



From Conference Halls to the Sarayu River

Boat Ride with Light &
Sound Show

Meet the Chief Editor

DR. SREEJITH JAYACHANDRAN

MBBS, MD (Emergency Medicine - AIIMS Rishikesh,
Gold Medalist), DNB (Emergency Medicine)
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Dr. Sreejith Jayachandran brings a blend of academic excellence, clinical precision, and pedagogical leadership to this edition of our newsletter. An alumnus of Government Medical College, Trivandrum, he completed his MD in Emergency Medicine at the prestigious AIIMS Rishikesh, where he graduated with a Gold Medal, followed by obtaining his DNB in Emergency Medicine. He currently serves as a Senior Resident in the Department of Emergency Medicine at Amala Institute of Medical Sciences, Thrissur.

A dedicated educator and researcher, Dr. Sreejith has authored 12 peer-reviewed articles and co-authored two emergency medicine handbooks. His commitment to training the next generation of acute care providers is reflected in his roles as a certified BLS/ACLS trainer, ATLS instructor, and active convener of dedicated online lecture series for emergency medicine residents across the country.

His primary areas of clinical and academic interest include:

- Trauma Resuscitation & Critical Interventions
- Clinical Toxicology
- Disaster Medicine & Preparedness (pioneering and executing state-level disaster mock drills across Kerala)

Under his editorial guidance, this edition aims to spotlight the latest paradigms in acute care, bridging frontline emergency practice with rigorous evidence-based medicine.



ATAL BIHARI VAJPAYEE
MEDICAL UNIVERSITY
LUCKNOW



11th, 12th & 13th,
SEPTEMBER, 2026





SACTEM TIMES

Society of Acute Care, Trauma & Emergency Medicine

Building Resilient Emergency Response Systems in India



MISSION

Saving Lives Through Better Emergency Care

To improve the quality of acute care, trauma, and emergency medical services in India through education, advocacy, and collaboration—ultimately saving lives and reducing suffering.



VISION

Accessible Emergency Care for Every Citizen

A nation where every individual has access to timely, high-quality, and affordable emergency medical care delivered by well-trained and dedicated professionals.



OUR CORE VALUES



Patient-centered care: Placing the patient's needs and well-being at the heart of all decisions and actions.



Professionalism: Maintaining the highest ethical standards and continuously striving for excellence in clinical practice, education, and research.



Advocacy: Championing the needs of patients, doctors, and other healthcare providers involved in acute care, trauma, and emergency medicine.



Collaboration: Working in partnership with government agencies, medical institutions, professional organizations, and other stakeholders to improve the overall healthcare system.



Equity and access: Ensuring that all people in Uttar Pradesh, regardless of their socioeconomic background, have access to quality acute care, trauma, and emergency medical services.



WHO WE ARE

A Unified Force in Emergency Medicine

SACTEM is a multidisciplinary platform bringing together emergency physicians, trauma specialists, paramedics, nurses, first responders, educators, and public health professionals. We aim to build a unified ecosystem that promotes excellence, innovation, and ethical practices in emergency and trauma care across India.



WHAT WE ARE

In Emergencies, Preparedness is the Strongest Medicine

India faces a rising burden of trauma, cardiac arrests, and medical emergencies. SACTEM bridges this life-critical gap by:

- ✓ Standardizing training & protocols
- ✓ Enhancing emergency-response systems
- ✓ Empowering communities with life-saving skills
- ✓ Supporting research & innovation
- ✓ Giving emergency-care professionals a unified voice



WHAT WE DO

Training Today for the Emergencies of Tomorrow

We strengthen emergency care systems through:

- ✓ Research publications & academic resources
- ✓ Conferences, CME programs & expert panels
- ✓ Community outreach (CPR, road safety, disaster preparedness)
- ✓ Collaboration with healthcare institutions & first responders



KNOW THE FOUNDER AND THE PRESIDENT

My Childhood Dream

Since childhood, I've understood the importance of the pace of time and the significance of immediate response. The inception of the Society for Acute Care, Trauma, and Emergency Medicine was inspired by that ethos, where timely, thorough, and compassionate responses are paramount in every situation. I embarked on founding this organization with the purpose of enabling people worldwide to be vigilant in their responses, ensuring better care in critical situations. It is aligned with the vision of the institution, committed to achieving new heights in responsiveness, education, and research in modern healthcare. We embark on this journey with the belief that with each individual, we are ushering in a new era, where diversity in narratives and prosperity are being woven into the fabric of healthcare.



Dr. Lokendra Gupta FOUNDER & PRESIDENT

He is the founder and current President of SACTEM. With deep commitment and foresight, he launched the foundation to transform emergency medical care across India — striving to ensure timely, accessible, and high-quality trauma and emergency services for all.

- ✓ Dr Gupta serves as Director and Head of Emergency Medicine & Trauma Care at a major tertiary-care hospital.
- ✓ Under his leadership, SACTEM has initiated and driven multiple training, outreach, and public-health programs — with a special focus on equipping medical professionals and communities to act decisively in critical scenarios.



WHO ARE EMERGENCY MEDICINE DOCTORS?



DR JOHNNY SAXENA

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At a recent family function, a relative asked me which branch I specialized in. I replied, "Emergency Medicine," and as usual, he just nodded—understanding little beyond medicine, surgery, and cardiology. He then said, "Oh, so you see accident cases and trauma—sir, fata hua, haath kata hua, khoon beh raha?" I replied, "Yes, those cases—and any medical emergencies as well." His questioning continued: "How do you like seeing patients in such conditions?" I said I loved my job. Then came another question—first visible in his eyes, then spoken aloud: "Why? How can you like seeing people in trauma or in such bad condition?" At first, I hesitated. Then I explained that it's not only trauma—we are experts in acute medical conditions as well. I spoke about the golden window period, conditions like pulmonary edema and DKA, and concepts like the 1-hour bundle. He understood only part of it but appreciated the stressful work and busy nights. So here is what we do, in short—a busy ER shift

WE RECEIVED HANDOVER (DETAILS AND TREATMENT PLANS OF PREVIOUS SHIFT PATIENTS):



5 GREEN
PATIENTS



3 YELLOW
PATIENTS



1 RED
PATIENT

Thankfully, most were already stabilized.

1 THE FIRST CRITICAL CASE

- Suddenly, our hardworking EMT rushed in at full speed, pushing a stretcher. "Sir-swiating for 30 minutes, chest pain for 1 hour. Nurse, bega ECG bekut"
- Sometimes I wonder how efficient are because of such EMTs-SD experienced that they can triage and recognize early warning signs even without a degree.
- A gentleman in his 40s, from another state, had come for a 2-day work conference. developed chest pain during dinner and was lucky to reach the hospital within an hour.
- Vitals connected-BP 110/60, remaining were stable. short history was being taken when the bomb came: a 12-lead ECG showing classic ST elevation in II, III, and aVF.
- Everyone sprang into action-loading dose given, cardiology informed. PCI prepared, BP monitored every 5 minutes.
- The patient looked startled. I wondered was he thinking about his meeting, his family, his dreams, or just watching us rush around him placing cannulas, recording BP, and giving medications?
- We spoke to the attendant. No other family member was available. He asked, "It's gastritis, right? Nothing to worry?"
- We explained the risks and the need for urgent PCI. We spoke to his family over the phone in broken native language and planned for the cath lab.
- His second stroke of luck a working health insurance. Before shifting, he asked, "How are you? Maybe confirm once more? I feel better now... maybe it's not a heart attack?"
- "I understand your concern, sir. You fine. Don't worry your family is on the way. It is a mild heart attack, and we will make sure you are safe." Inside, I just hoped he remained stable during and after angiography.
- That is ER magic-within 40 minutes, a patient is on the cath table, while stable patients may wait for hours

**BLOOD ON MY HANDS.
SMILE ON MY FACE.
SWEAT ON MY FOREHEAD.**



realized this is what I will keep doing

This is my heaven

Helping people. Standing between life... and death.

An ER team saves families, yes, we lose sometimes but again we stand incoming with hope, hunger, sweats, personal disturbed sleep routine to triage, to stabilize, to diagnose and prevent life threatening causes and to make stable patient wait.

break Some duties do make us question. we might look chaotic but are organized following protocol with limited history, we might make long but you can be happy cause are not in our RED zone, are there for you 24*7 even when your family members are not around, in your worse days which you won't want to remember we will make sure you are treated rightly and your family is informed in the best possible way.

2 THE GREEN AND YELLOW ZONES

- CLWs and of course, leg pain for 6 months, headache for 3 months, numbness for 2 years. Interns were bravely managing patients one by one, finally feeling like doctors.
- Another young male in his 30s was triaged to red. His mother stood crying beside the stretcher.
- Blood-soaked T-shirt. Pate eyes. Yellow sclera. Hair loss. Distended abdomen. Within seconds, we suspected Gi bleed secondary to chronic liver disease. HR 130 bpm, BP 80/40 mmHg. Chaos began again two IV lines, fluids started, take blood samples; arrange for blood.
- Suddenly yellow zone had some loud noise, colleague is arguing with a father who was craming chaos, baby 2 year old examined and evaluated by previous shift team and pediatrics, diagnosed bronchiolitis advised nasal saline drops and suctioning, father wants nebulization and antibiotics by his AI acquired knowledge.
- It is difficult to explain to such "informed people that sometimes the correct treatment is patience and no drugs. I wonder how they would understand BRUE-or how giving antibiotics or nebulisation to his kid is just waste dangerous cause of resistance to antibiotics.

3 PSYCH ZONE-A DIFFERENT BATTLE

- Another trolley rolled in. This time, the EMT was smiling-as if he had achieved something.
- Suddenly, the patient head popped on elevated head end trolley and shouted, "Inquilab Zindabad!"
- Trolley moved to psych zone.
- A 45-year-old female, hearing voices of Gandhi ji and Bhagat Singh jis known schizophrenic. She abused everyone and resisted examination or even securing cannula Security was called. Her husband stood helpless with their 3-year-old child
- We thought of giving a try again and luck being our side with verbal de-escalation, she agreed to blood tests. The head nurse skillfully administered sedation along with sampling

4 TRAUMA-LIFE AND DEATH IN SECONDS

- to waste millisecond red zone doctors jumps with Ambu and intubation, patient wheeled in 20s young male head covered with dressing nose has blood no movement we understood, leads connected FLAT LINE, pupils dilated, multiple abrasion over stomach and bleeding from head, I asked for attenders for history and saw another patient getting wheeled in bleeding from right hand and pain right leg, moved to red. He cried, "How is my brother? Where is he?"
- Trauma survey done. EFAST negative, Patient Stabilized with analgesic, splint, iv fluids and bandage. CT and Xrays planned.
- But his question remained.
- We found a number in his wallet. Someone had to inform the family.
- I took a deep breath before calling. The worst part of ER-breaking bad news.
- and the other will need multiple surgeries soon.

5 THE LONG NIGHT CONTINUES

- adrenaline 1.2.3 last 10 2002 breaths check pulae hythm, asystole, continue.. the cycles kept going, ribs broke, intubation done, broken adrenaline vials kept increasing on crash cart but even after 40-45 minutes no pulse and another bed news to be explained, this time for a gir a i girl in 20s (age age younger than me, getting life experiences much than me) had got her father alcoholic for 35 years banding done 3 years back, drank again in a marriage function for 3 days and started bleeding again. She had her fingers crossed praying for last 40 minutes tears in eyes, support and here I am explaining her that he is not going to come back. one to
- glance at clock just 5 hours over and 7 still remaining, questioning about my existence this forever if I will be able to treat or be and if I will be able happy

6 THE MIRACLE - NEW LIFE

Ambu prepare for crash patient EMT kept running in maximum speed pushing the trolley and at same time stabilizing it. 19-year-old female active labor maybe husband was not grown up to know when to arrive, maybe she was young enough to recognize signs, maybe they lived very far, maybe they were referred from multiple hospitals. At that moment nothing mutters curtains drawn, labor kit opened and there it is hains. OS they reached just on time. Perineum supported, a new life came in seconds, active crying healthy fernate, sister give "oxy" give clamps take cord sample inform pediatric start uterine massage deliver placenta and noise continues me showing the baby girl to her mother and she smiled and then comes the father who almost cried looking at the new Princess in his life



THE WEIGHT OF RESUSCITATION



DR HIMANSHI BAID

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MRCEM Assistant Professor Emergency Medicine

MGMCH, Jaipur

Becoming an emergency physician is not a career choice in the conventional sense. It is a calling. You are, in some ways, chosen, to be the person who stands with people at the very worst moments of their lives. You will be the bearer of news that will shatter worlds. You will be, for some, the only barrier between life and death. You will hold that boundary with your hands, your training, your presence, and you will do it again the next day, and the day after that. It is an extraordinary privilege. And it carries an extraordinary weight.



Nobody tells you about the silence afterward.

They teach you the algorithm — airway, breathing, circulation. They walk you through the choreography of a code: who compresses, who pushes drugs, who calls time. In simulation labs, we rehearse it until our hands move without asking the brain for permission. We learn to be calm. We learn to lead. We learn, above all, to do.



But no one teaches you what to do with the silence that follows.

I have stood at the foot of many beds where everything that could be done, was done. Where every drug was pushed, every joule delivered, every airway secured with precision. Where the team worked in that wordless harmony that only emerges under pressure, a kind of grace that exists nowhere else in medicine. And then, at some point, the rhythm on the monitor stops changing. Someone looks at the clock. I say the words. The team disperses, gloves snapped off, notes updated, the resuscitation area turned around with quiet efficiency and the next patients are already waiting.

I think of a young intern who struggled with exactly this. She was bright, conscientious, the kind of person who remembered every patient's name. After a resuscitation we could not succeed, she followed me to the next bay almost in disbelief. Later, when there was a moment to breathe, she came and found me.

Don't you feel anything? she asked. Not accusingly. More like someone frightened by what she was witnessing, and more frightened still by what it might mean about her own future in this field. She had felt everything, the grief of the loss, the abruptness of the transition and had looked around the room and seen nothing reflected back. For a moment, she had wondered whether she was built for this. Whether her inability to switch off so quickly was a flaw, not a feature.

“

the weight of resuscitation does not disappear but carried together intentionally, across generations, it becomes lighter. and that, i think is also part of the work.

”

I told her: it is not that we don't feel anything. It is that there are other patients waiting, and no one else is going to see them

It was a true answer. But her question stayed with me. Because it taught me something I had not fully considered before. She was standing at the threshold of this calling, trying to understand how one carries the weight of it without being crushed. And in that moment, she needed more than an explanation. She needed what we instinctively know to give families after a resuscitation, she needed closure.

We choose our words carefully with grieving relatives. We sit with them. We allow them space to absorb an irreversible loss, because we know that without acknowledgment, grief becomes complicated and damaging. Closure is not optional, rather a part of the care we owe.

And yet we rarely extend the same instinct to the young doctors and medical students standing quietly at the edges of the room, perhaps witnessing their first failed code, processing something enormous entirely alone. They are watching how we respond. They are learning not just the clinical lessons, but the emotional ones. And if all we model is a seamless pivot to the next patient, we teach them that emotions have no place here, that they must be swallowed, that this is what professional looks like.



It is not. And the cost of that lesson compounds over a career.

They need closure too, and I have come to believe it must happen right there, before the room is cleared and the moment passes. When I have young interns or first year residents who have just run a long code and lost the patient, I do not move on immediately. I take a moment, right there at the bedside, to explain why it didn't work, what the underlying physiology was, what the odds were against us from the start, why every decision made was the right one given what we knew.

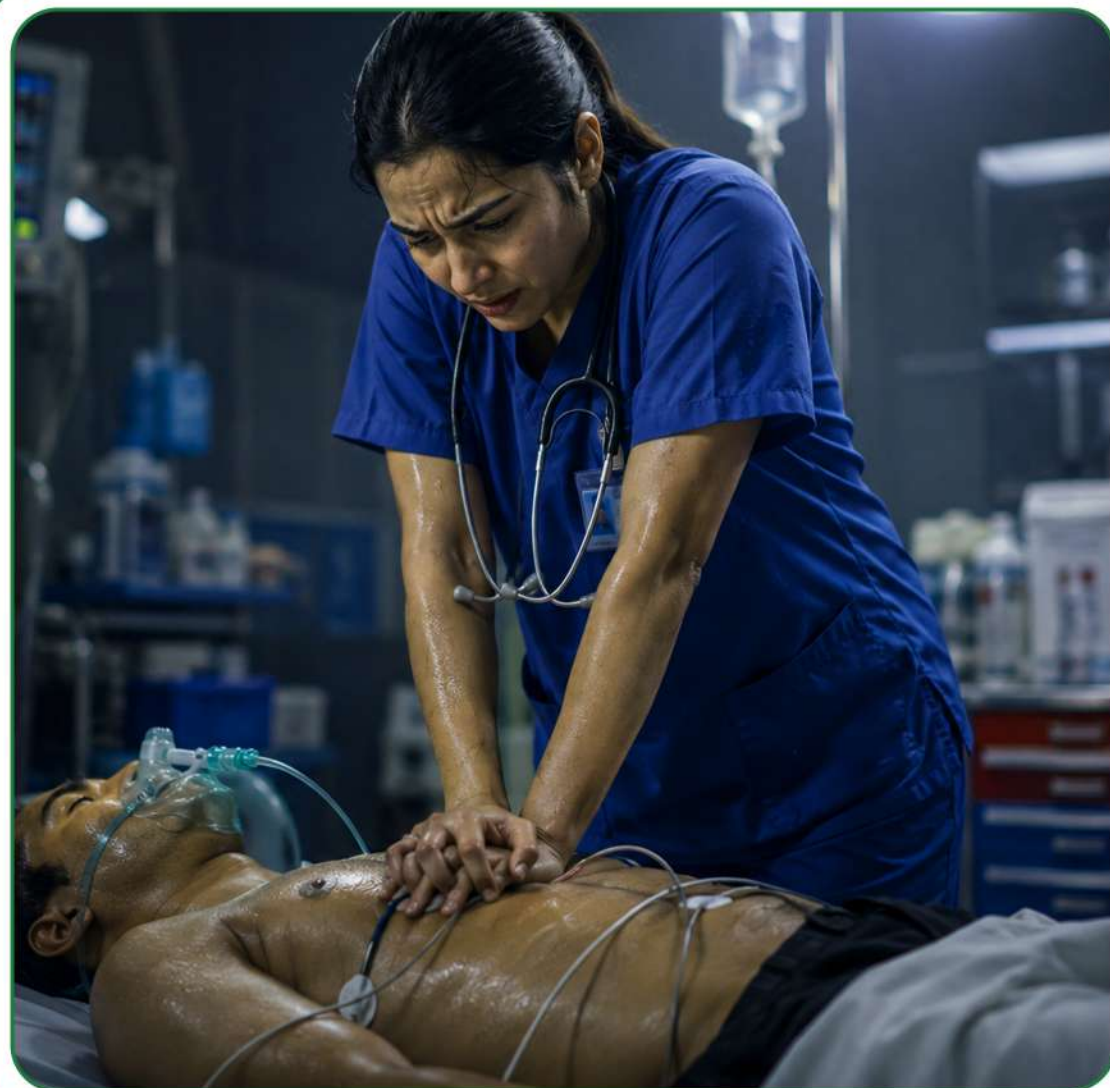
This is not a formal teaching session. It is two minutes of honesty that says: you did not fail. This is why. It closes the clinical loop and the emotional one simultaneously. It transforms a moment of helplessness into one of understanding. And understanding, I have found, is where healing begins.

Beyond the bedside, after particularly difficult shifts, I take my team out for coffee. We sit somewhere that is not the emergency department, and I let them talk. It is not a programme or a framework. It is just people who have been through something hard, given permission to say so.

Researchers call the accumulated emotional toll of this work, “moral residue” which means grief deferred, loss unacknowledged, weight carried silently across years. But I have come to think of debriefing as something larger than individual wellness. It is generational. If we offer closure to our trainees today, if we show them that pausing to feel and to understand is not weakness but wisdom, then when they become the seniors standing at the next bedside, they will do the same. And the residue, passed silently down through generations of clinicians, might finally begin to lessen.

The weight of resuscitation does not disappear. But carried together intentionally, across generations, it becomes lighter.

And that, I think, is also part of the work.



“



The weight of resuscitation does not disappear. But carried together intentionally, across generations, it becomes lighter.

And that, I think, is also part of the work.

”

THE TICKING CLOCK OF PREMATURITY: AN ED PERSPECTIVE

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The Ticking Clock of Prematurity: An ED Perspective

In emergency medicine, the concept of the "Golden Hour" is deeply ingrained in our trauma and stroke protocols. We understand that the interventions made in the first sixty minutes often dictate the patient's entire clinical trajectory. But what happens when the Golden Hour applies not to saving a life from trauma, but to sustaining a life that has arrived far too early?

I was recently reminded of this time-critical imperative when a mother, 27+2 weeks pregnant, was rushed into our ED. The amniotic sac was presenting, and the baby was in the breech position. The delivery was precipitous, leaving no time for a transfer to the delivery suite.

The immediate moments following the delivery of an extremely premature infant are the definition of a golden hour. The fragility of a 27-week neonate means that hypoxia, hypoglycaemia, and hypothermia can cause irreversible damage within minutes. In the ED, we had to initiate the golden hour of neonatal care instantly.

Delivering the baby was only the first step. To see the newborn breathe was a moment of profound relief, but the clock was ticking. The immediate application of positive pressure support allowed her APGAR to reach 9 by the fifth minute. Simultaneously, the team executed a rapid sequence of critical interventions: securing IV access, initiating a dextrose infusion, and aggressively managing temperature control with a bedside incubator.

This scenario challenges emergency physicians to expand our definition of time-critical interventions. We must approach precipitous premature deliveries with the same urgency and protocol-driven mindset that we apply to a Level 1 trauma. The actions we take before the neonatologist arrives, including preventing heat loss, maintaining glucose levels, and supporting oxygenation, are the interventions that ensure the neonate survives to reach the neonatal intensive care unit.



When the handover finally occurred, the gratitude in the mother's eyes was profound. We had bridged the critical gap. For emergency care in India to continue advancing, we must recognise that the principles of the golden hour apply across all spectrums of life, requiring us to be as vigilant at the sudden beginning of life as we are in preserving it.

SACTEM AWARDS & RECOGNITIONS

Letter of Appreciation
Maha Kumbh 2025



Health ICON
of UP



Global POCT
Summit China



Community
Expansion Award



COUNCIL OF INTERNATIONAL ADVISORS



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Nepal



Dr. Tamer Farouk Al Shouha
United Arab Emirates

A SILENT PULSE -INTENTIONAL IVABRADINE OVERDOSE PRESENTING WITH LIFE THREATENING BRADYCARDIA



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CASE SCENARIO

A 42 years old female with no significant comorbidities, was wheeled in to ER with altered sensorium following suspected intentional drug overdose. A search of the patients belongings revealed four empty strips of Ivabradine (5mg tablets). The estimated ingestion was approximately 200mg,



INITIAL ASSESSMENT

- Patient drowsy, localising to pain,
- Hr-30 bpm
- Bp-80/60 mm of Hg
- Rr-10/min
- Spo2-94% RA
- GCS-E1V2M5

ECG demonstrated Marked Sinus Bradycardia with no atrioventricular block. There were no ischemic changes. Initial laboratory investigations, including electrolytes and ABG were within normal limits



MANAGEMENT AND CLINICAL COURSE

- Initial resuscitation followed standard protocols. Intravenous secured and fluid boluses were administered.
- Patient was initiated on gastric lavage and activated charcoal after clear aspirate and intubated in view of threatened airway and aspiration risk.
- Inj Atropine (1mg, 3 doses) were given but failed to produce a significant increase in heart rate.
- Due to persistent bradycardia and hypotension, Isoprenaline infusion was initiated at 5mcg/min resulting in partial improvement with Heart rate increasing to 50-55 bpm.
- After talking informed consent, patient was shifted to Cardiac Catheterization Lab for temporary pacemaker insertion.
- Patient was then shifted to ICU post procedure for close monitoring



OUTCOME AND FOLLOW UP

- In ICU, she remained hemodynamically stable, was gradually weaned off ventilatory support, and successfully extubated.
- TPI was later removed as she was not ventilator dependent.
- She made a full recovery with no residual cardiac dysfunction.
- She was evaluated by psychiatric team and discharged with appropriate follow up



DISCUSSION

- Ivabradine toxicity leads to profound sinus node suppression due to inhibition of IF current.
- Unlike beta blocker or CCB overdose, myocardial contractility and AV conduction are typically preserved.
- This pharmacological distinction explains the limited efficacy of Atropine, which primarily acts via vagolytic mechanisms.
- In contrast, Isoprenaline, a beta adrenargic agonist, can enhance heart rate by increasing sinus node automaticity, though response may be variable.
- In cases of severe or refractory bradycardia, temporary cardiac pacing remains the definitive intervention



TAKE HOME POINTS



Early recognition of drug specific toxidrome.



Limited role of Atropine in pure sinus node suppression



Isoprenaline as a pharmacologic bridge.



Early consideration of temporary pacing in Unstable patients.

INTRODUCING JACTEM (JOURNAL OF ACUTE CARE, TRAUMA & EMERGENCY MEDICINE)

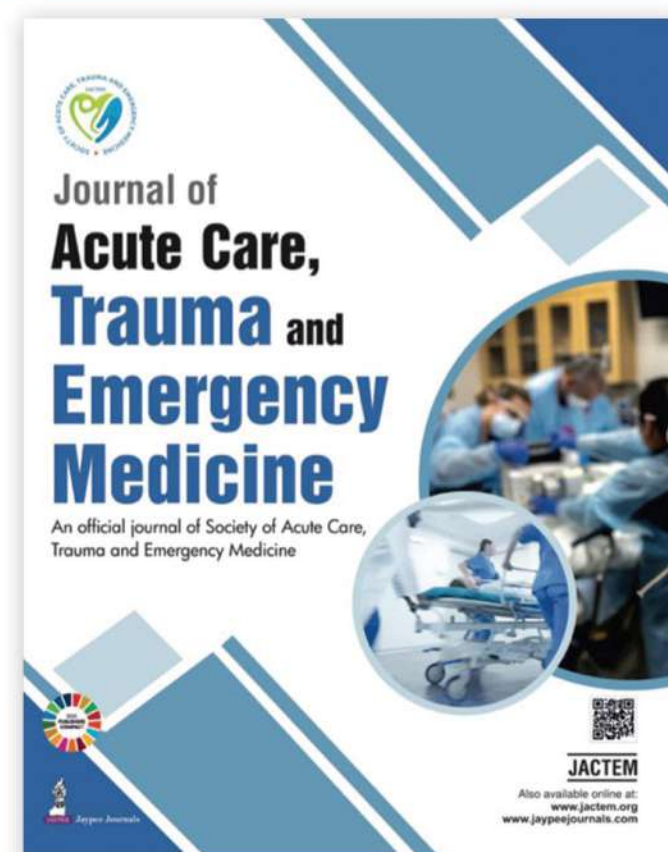
THE NEW ACADEMIC VOICE FOR EMERGENCY MEDICINE & TRAUMA CARE

JACTEM is more than a new journal — it marks a meaningful step toward strengthening the academic backbone of emergency and trauma care. Its launch reflects SACTEM's dedication to advancing emergency medical education, supporting high-quality research, and empowering the frontline professionals who save lives every day. It creates a unified space for sharing clinical insights, innovative ideas and real-world experiences. With JACTEM, SACTEM aims to inspire continuous learning and raise the standard of care across the emergency medicine community.

We at SACTEM are excited to unveil JACTEM, our newly launched peer-reviewed journal dedicated to advancing Emergency, Trauma and Acute Care Medicine — nationally and globally. This dynamic platform aims to bring together cutting-edge research, case reports, clinical protocols, simulation & education innovations, public-health and systems-based research, and expert commentary.

WHAT JACTEM OFFERS

- Covers a wide range of acute-care specialties including trauma, EMS, resuscitation, neurocritical care, disaster response and more.
- Ensures high academic standards through a rigorous double-blind peer review process.
- Supports young researchers with mentorship, simplified submissions and first-publication opportunities.
- Accepts multiple article types, including research papers, reviews, case reports, guidelines and educational innovations.



FROM UNREMARKABLE TO UNMISSABLE THE X-RAY THAT CHANGED THE CLINICAL PICTURE



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A 25-year-old lady who had previously been in good condition showed up at early morning at the emergency room with acute, sudden-onset epigastric discomfort that started while she was eating. She had severe discomfort that radiated to her back and did not go away despite changing positions. She denied having a cough, fever, dysuria, jaundice, vomiting, or dyspnea. There was no history of trauma, previous surgery, or comparable problems. She seemed uncomfortable but was hemodynamically stable upon inspection. An examination of the abdomen showed localized, guarding in the epigastric area with no rigidity. There were bowel sounds, but there were no obvious signs of ileus or obstruction. An early working diagnosis of acute pancreatitis was taken into consideration due to the type of pain.

Abdominal ultrasonography added to the enigma by showing no obvious pathology with normal amylase and lipase. Just for completion sake, an X-ray of the chest and abdomen was taken because the clinical picture was still unexplained. Surprisingly, it showed that the left thoracic cavity contained a sizable air-fluid level. The diagnostic trajectory was drastically altered by this discovery. Notably, there was no intervening history of trauma to account for this unexpected aberration, and a previous X-ray taken last week had been entirely normal delaying our speed to jump into an X ray.

A contrast-enhanced CT scan of the abdomen and chest was carried out showed large left posterior diaphragmatic defect with herniation of abdominal contents into the left hemi thorax – likely a Bochdalek hernia with no evidence of obstruction, strangulation or pneumoperitoneum discharged.

The herniated stomach was decompressed and the symptoms were partially relieved after a nasogastric tube was quickly placed. After the patient was stabilized, the diaphragmatic defect was surgically repaired. Her postoperative recovery was straightforward and was discharged.



Most importantly, during the perilous hours between midnight and dawn, it is far wiser to over investigate rather than under investigate. While excessive testing may invite public criticism, but the consequences of under investigation are far more severe can endanger lives and amount to medical negligence.



Discussion

This example demonstrates how an unexpected and potentially dangerous diagnosis can be hidden behind an apparently simple presentation of epigastric pain. The most prevalent causes of acute epigastric discomfort in young adults are pancreatitis, peptic ulcer disease, and gastritis. The patient's back-radiating discomfort strongly suggested pancreatitis, but early on, normal enzyme values and unimpressive ultrasonography cast doubt on this theory. The diagnostic turning point that a straightforward chest X-ray provides is what makes this case so strong. It was frequently regarded as a standard or even secondary inquiry in cases of stomach pain, but it turned out to be the key to the diagnosis.

Clinical thought quickly changed from intra-abdominal pathology to a structural problem involving the diaphragm as a result of the startling discovery of an air-fluid level within the thoracic cavity even missing the important point of auscultating the lungs focusing on bowel sounds in the lung cavity would have guided the diagnosis. Adult diaphragmatic hernias are rare and often disregarded, particularly when there is no trauma. Congenital abnormalities may not show symptoms for years, but when they do, they may appear suddenly and deceptively. There were no risk indicators for this patient, and the diagnostic uncertainty was increased by a previously normal X-ray. These situations serve as a reminder to medical professionals that "absence of history" does not imply "absence of disease." The absence of respiratory symptoms in spite of substantial thoracic involvement is another notable feature. When abdominal contents dominate the thoracic cavity, one could anticipate chest pain or dyspnea, but the patient's symptoms were exclusively abdominal. When clinical findings do not cleanly match first thoughts, this disconnect might delay detection and emphasize the need for caution. In this case, CT imaging played a crucial but confirming function. It guided surgical planning by defining the extent of herniation in addition to establishing the diagnosis. The prompt placement of a nasogastric tube, which offered instant decompression and symptomatic relief—showing how straightforward measures can stabilize patients even before definitive treatment—was equally crucial. In the end, this example supports a basic clinical medicine tenet: be receptive to new diagnoses. Instead than sticking to a single pathway, it is critical to expand the differential when preliminary examinations do not confirm the suspected diagnosis. The most illuminating discovery is frequently the "unexpected" one.

SACTEM'S COLLABORATIONS

SACTEM X RAPIDO



वर्ल्ड इमरजेंसी डे कल: सड़क पर चल रहे दुर्घटनों को दमिग देगी सेक्टर दुर्घटना के बाद अहम है पहला घंटा



YOGI सरकार Rapido के वाइक टैक्सी केटन को देगी सीपीआर और फर्स्ट एड प्रशिक्षण



रेपिडो केटन बनेगे जीवन रक्षक, योगी सरकार देगी CPR और फर्स्ट एड की ट्रेनिंग, आपातकाल में बचावों दूसरे की जिंदगी - RAPIDO CAPTAIN BECOME LIFESAVER



World Emergency Medicine Day | Drive on CPR, first-aid training today: Govt

Disaster Medicine
Institute (DMI) USA



MAHAKUMBH 2025 EMERGENCY PREPAREDNESS



CTM-E SEMPER
SCIENTES





TOO EARLY, TOO LATE NEVER JUST RIGHT



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Navigating Expectations, Hierarchy, and Reality While Building Emergency Medicine

Building an emergency department is not about constructing walls—it is about reconstructing mindsets. I walked into a place that had everything on paper: beds, monitors, infrastructure. It looked complete. In reality, it felt like a fully equipped kitchen where nobody quite knew how to cook.

Coming from established institutes, I expected systems to fall into place. They didn't. The real challenge wasn't patients—it was people. Especially postgraduate students (PGs) who had grown used to a system where emergency medicine didn't function as a structured authority. To them, it felt like freedom. To me, it looked like controlled chaos.

Training them became the foundation. I started with reasoning—explaining mistakes calmly. It works... until it doesn't. Sometimes, the "old-school" approach still gets results. Emergency medicine teaches you quickly: diplomacy is useful, but clarity is essential. And over time, I realized something simple but powerful—sometimes, teaching happens better over chai than in classrooms. Those short, informal discussions after rounds often achieve more than structured lectures ever can.

One of the early operational challenges was balancing expectations between departments. Senior faculty often expected early handover after basic interventions, while younger faculty—trained in systems with established emergency medicine—expected more complete stabilization before transfer. In practice, this became a constant balancing act. Calling too early felt inadequate to one group, while calling too late seemed like unnecessary delay to another. Over time, the solution was not choosing one side, but building a shared understanding through repeated discussions and consistent clinical reasoning.

Take septic shock as an example. For some, initiating fluids and vasopressors was enough to involve the next team. For others, stabilization meant achieving and maintaining hemodynamic targets. These differences were not theoretical—they shaped real-time decisions. Learning to navigate this without friction became an essential skill.

Complaints were inevitable. When you are building a new system, every gap becomes visible. As the only person anchoring the department, everything flowed inward—academic concerns, administrative pressures, interdepartmental disagreements. Reacting emotionally was never going to help. A strategy was necessary.

I followed what I would call a defensively offensive approach. I often noticed mistakes in patient management from other departments, but I deliberately avoided escalating them to HODs or management. Instead, I corrected their PGs quietly at the ground level. The intention was not to prove superiority, but to build trust. However, when complaints were raised against my department—which happened frequently—I accepted our mistakes openly. At the same time, I would point out similar mistakes made by their PGs and explain how I had already corrected them then and there without escalation. This shifted the focus from blame to accountability and reinforced the idea that correction is more important than complaint. The goal was never to win arguments—it was to build credibility.

One lesson stood above all: if you want to be heard, don't raise your voice—raise your knowledge. Academic strength is the only authority that sustains itself. People may ignore opinions, but they rarely ignore consistent, sound clinical reasoning.

Defining responsibility was another evolving challenge. Ideally, the patient remains under emergency care until physically shifted. In reality, this depends on mutual understanding and gradual system maturity. Communication helps, but consistency builds trust.

Communication itself is a paradox. "Why didn't you call earlier?" and "Why did you call so early?"—both questions exist, often on the same day. There is no perfect timing, only context-based judgment refined through experience.

Relationships, however, are non-negotiable. Interestingly, nursing staff and non-medical staff often adapt to change faster than doctors. They don't carry the burden of losing cases or the anxiety of patient outcomes in the same way. They are less influenced by hierarchy and more open to change. In many ways, they become the earliest supporters of a new system—quietly stabilizing the transition while others are still debating it.

One hard truth defines the early phase: there is almost zero margin for error. Building a department is like launching a new product—trust is fragile, and a single mistake can undo weeks of effort. This demands close supervision, continuous teaching, and a strong sense of ownership.

At the same time, the people you train are not machines. Emergency medicine carries double stress—critically ill patients and constant decision-making. If you don't give them space to decompress, the system cracks. Sometimes, the best support you give is simply being available—not as a superior, but as a mentor.



Looking back, I am still learning. My experience is limited, and my views may evolve. But one thing is clear:
An emergency department is not built by protocols alone— it is built by consistency, credibility, and the ability to correct without conflict.
And if I had to summarize the journey in one line:
It feels less like running a department and more like walking a tightrope— where calling too early or too late can both be wrong, but standing still is never an option.

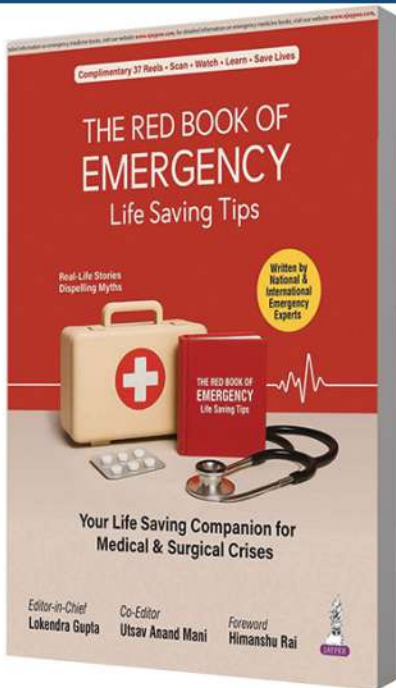


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ISBN
9789372022643



Pages
206



Edition & Year
1st Edition, 2026



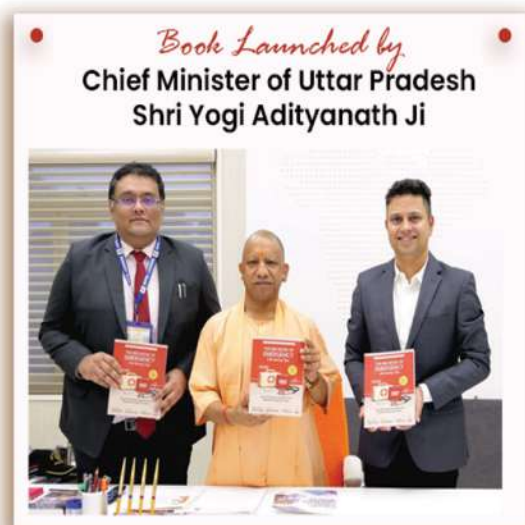
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AT THE CROSSROADS OF CARE AND LAW



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In the modern healthcare landscape, the intersection of clinical practice and legal obligation has become increasingly complex. In 2025 alone, India's healthcare sector saw 65,000 medical negligence cases filed across High Courts, the Supreme Court, and the National Consumer Disputes Redressal Commission (NCDRC). This sharp rise in litigation underscores the critical need for medical professionals to understand their legal duties as thoroughly as their clinical ones

1 Defining the Medico-Legal Case (MLC)

A Medico-Legal Case is any case of injury or ailment where the attending doctor, after taking a history and examining the patient, considers that some investigation by law enforcement is essential.

Statutory Categories

Certain scenarios are legally mandated to be treated as MLCs:

- Road Traffic Accidents (RTAs)
- Assault and Sexual Assault
- Burns and Poisoning
- Hanging or Suicide attempts
- "Brought Dead" cases (these are MLCs by default)

The "Grey" Area: Doctors must also exercise professional judgment to register an MLC in any case where they suspect foul play or "unnatural" circumstances.

2 The Supreme Duty to Treat: "Treat First, Comply Later"

The landmark Supreme Court judgment in Pt. Parmanand Katara vs. Union of India (1989) established that the preservation of life is paramount.



Fundamental Right: Access to medical aid is a fundamental right.



No Refusal: No hospital, whether Government or Private, can refuse an emergency patient.



Priority of Care: Legal formalities and police reporting must never delay life-saving treatment.



Obligations: While treatment comes first, the registration of an MLC and subsequent police intimation remain mandatory statutory obligations.

3 The New Legal Landscape: BNS vs. IPC

As of 2024, the transition to the Bharatiya Nyaya Sanhita (BNS) has updated the legal framework for medical practice.

BNS Section	Corresponding Old IPC	Description
Section 106	Section 304A	Death by negligence; requires "Gross Negligence" for criminal charges.
Sections 114-117	Sections 319-320	Defines "Hurt" and "Grievous Hurt," essential for wound certificates.
Section 238	Section 201	Penalty for disappearing evidence; emphasizes the need for a strict "Chain of Custody".

The Bolam Test and Jacob Mathew Ruling

Negligence is not established if a doctor acts in accordance with accepted medical practice supported by a responsible body of medical professionals

- **Clinical Pressure:** The Bolam Test protects doctors making decisions under time pressure or when choosing between multiple acceptable treatment options.
- **Protection from Prosecution:** The Jacob Mathew vs. State of Punjab (2005) case protects doctors from frivolous prosecution, stipulating that criminal negligence requires proof of "gross" negligence.

Good Samaritan Law

Following Savelife Foundation vs. Union of India (2016), bystanders who assist accident victims are protected:

- **Liability:** There is no civil or criminal liability for injury or death resulting from assistance provided in good faith.
- **Police Interaction:** Police cannot harass, detain, or repeatedly question a Good Samaritan.
- **Hospital Duties:** Hospitals are obligated to provide immediate care and cannot detain a bystander for paperwork or payment.

The Bolam Test and the Jacob Mathew vs. State of Punjab (2005) judgment provide essential safeguards:



Bolam Test: A doctor is not negligent if their action is supported by a responsible body of medical professionals, even if other doctors would have acted differently.



Gross Negligence: Criminal prosecution requires proof of "gross" negligence, not just routine errors or lapses in judgment.



Expert Opinion: Police must obtain an independent medical expert's opinion before prosecuting a doctor.

4 Understanding Medical Negligence: The 4Ds

To establish medical negligence in court, four specific elements must be proven:

1. **Duty of Care:** A doctor-patient relationship must exist.
2. **Dereliction of Duty:** The doctor failed to follow the accepted standard of care that a reasonably competent peer would have provided.
3. **Direct Causation:** The breach of duty—not the underlying illness—must be the direct cause of the injury.
4. **Damages:** The patient must have suffered actual harm, such as physical injury, death, or financial loss.

Protection for Doctors and Good Samaritans

The legal system provides specific protections for both medical professionals and bystanders acting in good faith.

5 Consent and the Emergency Exception

Consent is the bedrock of the doctor-patient relationship.

- **Implied Consent:** For routine assessments like pulse checks or blood pressure measurements.
- **Informed Consent:** Required for invasive procedures (e.g., chest tubes) or high-risk drugs (e.g., thrombolytics). Doctors must explain risks, benefits, and alternatives.
- **The Emergency Exception (Section 92 IPC/BNS Equivalent):** If a patient is unconscious or delirious and no guardian is present, doctors can perform life-saving interventions without formal consent. Documentation must explicitly state: "Life-saving intervention done under emergency exception".

6 Challenging Scenarios: LAMA, DAMA, and Absconding

LAMA (Left Against Medical Advice)

LAMA carries significant legal risk. To protect against litigation (as seen in Tarlok Chand Mattu vs. Vasal Hospital), doctors should use the "5-Point Shield":

- 1. **Mental Capacity:** Assess if the patient is "fit of mind" to make the decision.
- 2. **Specific Risk Disclosure:** Document specific risks (e.g., "Explained risk of sudden cardiac arrest") rather than vague terms.
- 3. **Neutral Witness:** Get a signature from a staff member or security guard if relatives refuse to sign.
- 4. **Documentation of Care:** Record all stabilization efforts provided before departure.
- 5. **Police Intimation:** Mandatory for MLCs.
- **Respect Autonomy:** You cannot legally stop a patient from leaving, even in Medico-Legal Cases (MLC), as doing so constitutes "Wrongful Confinement" under BNS Section 127.
- **Sample Integrity:** Any forensic samples collected (blood, clothing) must be sealed and handed to the police to maintain the "Chain of Custody".
- **Provide Records:** Never withhold medical reports as leverage; this is considered a "Deficiency in Service". Provide a copy of all treatment administered up to the point of departure.
- **Consent Refusal:** If a patient refuses to sign the LAMA form, do not force them. Instead, document the refusal and have it witnessed by two staff members.

Absconding

Absconding is often viewed more severely by courts as it may suggest poor hospital security or monitoring.

- **Immediate Action:** Search the grounds and inform hospital security.
- **Police Notification:** Send an "Absconding Memo" to the police station for all MLCs. Failure to do so in RTA or assault cases could lead to charges of "concealing evidence" under BNS Section 238.

7 Conclusion: Documentation as Defense

In the eyes of the law, "If it isn't written, it didn't happen". Medical records are admissible evidence; they must be contemporaneous, factual, and legible. While 55.2% of Supreme Court decisions from 2012–2021 favored healthcare providers, proper documentation remains the strongest shield against frivolous litigation.

The core takeaway for any emergency physician is clear: **Life-saving care has absolute legal priority, but thorough documentation and awareness of the law are what ensure the caregiver remains protected.**



8 Protocol for "Brought Dead" Cases

In the Emergency Department, the rule is "Declare, Don't Certify".

- **No Death Certificate:** Do not issue a Medical Certificate of Cause of Death (MCCD) for a "Brought Dead" (BD) case. This avoids liability under BNS Section 238 for potentially concealing an unnatural death.
- **Documentation:** Record arrival time, two identification marks, and the "Alleged History" in quotes.
- **Body Custody:** The body must be shifted to the mortuary for police procedures and not handed to relatives. Do not clean the body or remove clothing, as these are forensic evidence.

SACTEM Training Programs



BEYOND THE CARINA RECOGNIZING CONGENITAL AIRWAY ANOMALIES IN ACUTE CARE



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ABSTRACT

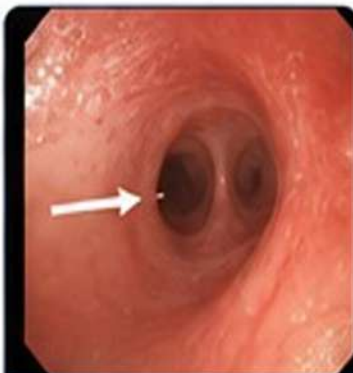
Tracheal bronchus is a rare congenital airway anomaly characterized by an aberrant bronchus arising directly from the trachea, most commonly supplying the right upper lobe. Although typically asymptomatic and incidentally detected, it may assume clinical significance during airway interventions. We report a case of a 24-year-old male trauma patient who developed right upper lobe collapse following endotracheal intubation. Subsequent evaluation using bronchoscopy and HRCT revealed a tracheal bronchus. This case highlights the importance of recognizing anatomical airway variants in critically ill patients.

Case Presentation

- A 24-year-old male presented following a road traffic accident with reduced GCS suggestive of traumatic brain injury. He was intubated for airway protection.
- Post-intubation chest X-ray showed right upper lobe collapse. Tube repositioning resulted in resolution of collapse.
- Bronchoscopy revealed an aberrant bronchus arising proximal to the carina.
- HRCT confirmed a tracheal bronchus supplying the right upper lobe.
- The patient remained stable with optimized ventilation and no recurrence of collapse.



Chest X-ray
Showing right
upper lobe collapse



Bronchoscopy
showing tracheal
bronchus



HRCT showing
tracheal bronchus
arising from trachea

INTRODUCTION

A tracheal bronchus is an uncommon congenital anomaly in which an accessory bronchus originates directly from the trachea, usually above the carina. Its incidence ranges from 0.1% to 2%, with predilection for the right side^{1,2}. It is often detected incidentally during imaging or bronchoscopy³. Improper endotracheal tube positioning may lead to exclusion of the bronchus, resulting in lobar collapse^{2,4}.

DISCUSSION

Tracheal bronchus includes displaced and supernumerary variants, commonly supplying the right upper lobe^{1,3}. Some patients present with recurrent infections or bronchiectasis⁵. During intubation, distal tube placement may exclude ventilation to this segment causing atelectasis or hypoxia^{2,4,6}. Diagnosis is confirmed using bronchoscopy and HRCT^{4,7}.

Conclusion



Tracheal bronchus is a rare but clinically significant anomaly in airway management. Awareness and early recognition can prevent complications such as lobar collapse. Bronchoscopy and HRCT are essential for diagnosis.

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SACTEM’S INITIATIVE

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Overview

- Hosted by: Society for Acute Care, Trauma, and Emergency Medicine (SACTEM)
- Event: First official national conference - Conclave of Medical Emergencies and Trauma (COMET 2025)
- Dates & Venue: 11-13 April 2025 at Indira Gandhi Pratisthan, Gomti Nagar, Lucknow
- Theme: Golden Hour, COMET Power - emphasizing critical early moments in emergency care
- Attendees: More than 800 Delegates and 200+ national and international faculties

Impact

- COMET is fast becoming the premier national forum for emergency care thought leadership.
- Continues to advance education, training, and policy dialogue in emergency medicine in India.





APPLICATION OF LVOT VTI IN EMERGENCY



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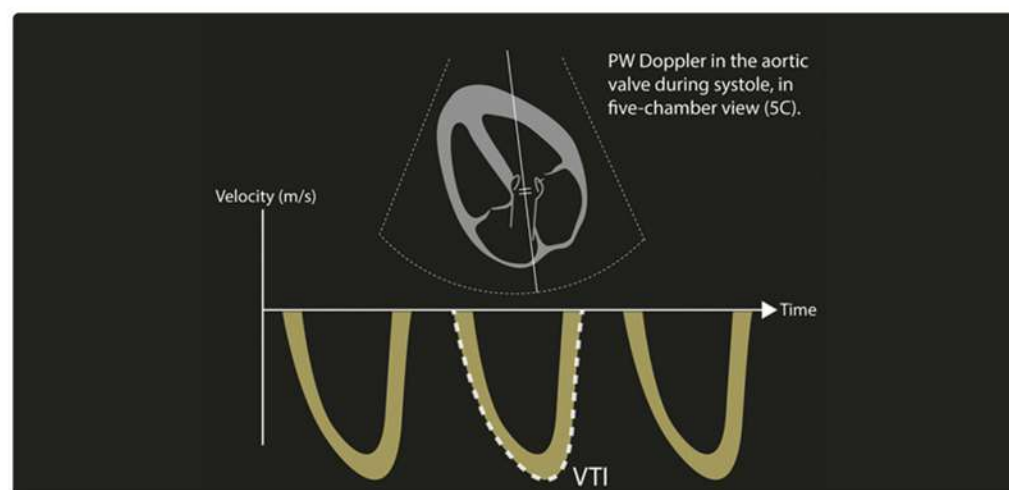
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Velocity Time Integral (VTI) is a clinical doppler ultrasound measurement of blood flow, measured by the area under the velocity time curve and is equivalent to the distance blood travel in a one cardiac cycle.[1] The VTI helps in measuring the Stroke Volume (SV) and Cardiac Output (CO) indirectly and thus helps in identifying the treatment response by doing serial measurement.[2]

Method:

To obtain LVOT VTI use the apical five- or three- chamber view. Select pulse-wave doppler (PWD). Keep the sample volume placed within the LVOT, approximately at 1 cm distance to the aortic valve. Then trace the envelope of the doppler spectrum of LVOT systolic flow.[2] VTI is considered optimal when alignment of the PWD sample volume is parallel to the subaortic flow and obtained with minimal spectral broadening.[2]



VTI Normal Range:

When HR is within the normal range, mean LVOT VTI values are 20 ± 3 cm (17–23 cm)

- If HR <55 bpm: VTI must be higher than 18cm:
Or else indicates a low SV and CO
- If HR >95 bpm: VTI must be lower than 22 cm:
Or else indicates a high SV and CO

More than an isolated value of VTI, change of VTI in response to treatment is more important. An increase in the VTI value to >15% from the first VTI, after a treatment indicates a concrete response to the therapy and if no increase is seen, it suggests the futility of the treatment.[2]



Limitations of LVOT VTI

VTI is not reliable in the following conditions:[2]

- Moderate to severe aortic regurgitation (AR)
- Subaortic obstruction
 - Fixed LVOTO
 - Dynamic LVOTO
 - Extreme hypovolemia
 - Asymmetric left ventricular septal hypertrophy
 - Anterior myocardial infarctions with compensatory hyperdynamic basal segments of the interventricular septum
 - Takotsubo syndrome



Beat to beat VTI variability is seen in presence of arrhythmias like atrial fibrillation and frequent extrasystoles. To obtain a more accurate VTI value, take the average of at least five VTIs.[7]

Conclusion

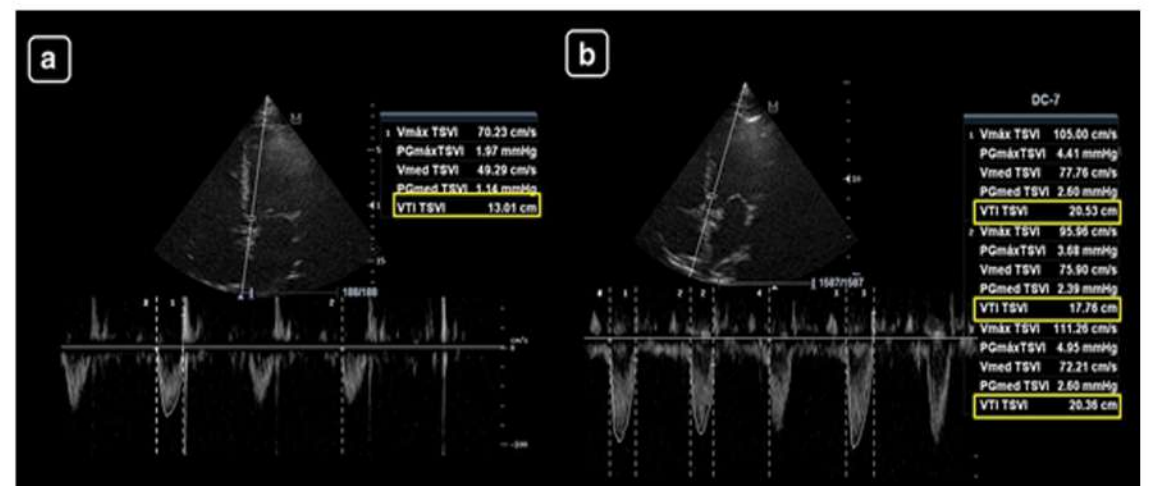


LVOT VTI is a reliable doppler measurement that can be assessed in Emergency department to know the SV and CO status of a patient and to tailor the treatment for that particular patient. Serial monitoring of VTI will help in assessing the response to treatment.



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Practical use of VTI

1. Assessing fluid responsiveness

A increase of >12% in the VTI after a Passive Leg Raising (PLR) has demonstrated a good accuracy for differentiating fluid responders from non-responders[2,3]

2. Predicting poor outcome in Heart failure patient

Extremely low VTI (<10cm) strongly predicts poor outcome and identifies patients who may benefit most from advanced heart failure therapies like Left ventricular Assist Devices (LVAD)[2,4]

3. Predicting poor outcome in Pulmonary Embolism

A low VTI (<15 cm) was associated with cardiac arrest, shock or need for reperfusion.[2,5]

4. Guiding initiation of inotrope in Acute Decompensated Heart Failure (ADHF)

A LVOT VTI of 13.9 cm predicts Low Cardiac Output syndrome (LOS) signs in ADHF and a VTI of 12.3 cm is an indication for starting inotrope support.[2,6]

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ETHICAL DILEMMA



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It started as a hectic evening shift, as always. My Junior Resident (JR) and I were reassessing our patient; 70-year-old male, known case of carcinoma lung. He had presented with chief complaints of progressive shortness of breath and cough since the last 2 weeks. On arrival, he was hypoxic and tachypneic. We had evaluated the patient and came to a conclusion that this was most likely due to the progressive nature of the disease, unlikely to improve with any interventions and his time had probably come to say goodbye to this mortal world. Right now, he was still tachypneic and was very sick looking despite being on HFNC support. The primary treating team had also reviewed the patient by this point of time and had their impression on the diagnosis as “Lymphangitic Carcinomatosis” and suggested their next line of management as “best supportive care”.

Now comes the difficult part. The patient’s son after being informed his current status and hearing all the options left in front of him, wants intubation and cardiac resuscitative measures. Multiple small counselling sessions later, his initial decision remains the same. And we intubate.

At this point, my JR comes up to me and says, “We could have counselled the patient’s son better. I feel bad for the patient.” The patient’s son comes up to me and says, “Sir, aap mere se naaraaz tho nahi he na? Kya bathaaun sir, ye mere paapa he.” (Sir, I hope you are not upset with me? What to say, sir, he is my father after all.) Now, I am hurt, my JR is hurt.

At this point, my JR comes up to me and says, “We could have counselled the patient’s son better. I feel bad for the patient.” The patient’s son comes up to me and says, “Sir, aap mere se naaraaz tho nahi he na? Kya bathaaun sir, ye mere paapa he.” (Sir, I hope you are not upset with me? What to say, sir, he is my father after all.) Now, I am hurt, my JR is hurt.

How do I address the harm done to the treatment team when we are forced to perform intensive care on a clearly futile case to satisfy family demands? This feeling that we as medical professionals go through is termed as moral distress. This has been recognized since many years.

In 2010, Temel et al, found that early palliative care for metastatic non-small cell lung cancer patients resulted in less aggressive end of life care among other significant findings. A few things that we can try in our emergency department is mentioned below. A trial of intensive care, where a compromise is reached between the treating team and patient relatives. Here, we provide intensive care for a prefixed time period (eg: 24-72 hours). If no clinical improvement (based on prefixed outcomes) occurs, we de-escalate intensive care to comfort care, and this includes extubating the patient as well. This gives relatives more time to accept their loved one’s fate and makes them understand the “futility” of the treatment given if the patient does not recover. We have the law backing us to de-escalate treatment as well, if the relatives agree.



Shared joy is a double joy; shared sorrow is half a sorrow.

Debriefing sessions (hot or cold) after such difficult cases helps the staff to better process their feelings, and this has shown to reduce the long-term psychological impact of moral distress.



“The pause” is a practice that was introduced in the mid 2010s

This is performed immediately after a code where death is announced. And one of us say, “Could we take a moment just to pause and honour this person in the bed. This was someone who was alive and now has passed away. They were someone who loved and was loved. They were someone’s friend and family member. In our way and in silence, let us stand and take a moment to honour both this person in the bed and all the valiant efforts that were made on their behalf.” This is followed by 45 to 60 seconds of silence.



In a recent study done by Kraus et al

the burnout rate among emergency attending physicians was 52.7%. The patient load in ED is less likely to reduce for the next few years. One of the ways to reduce this high burnout rate is to bring in policies at the administrative level. While this will take more time to form and implement, we need to talk more about it, read more about it, and practice mental well-being into our day-to-day duties. As the old saying goes, “Shared joy is a double joy; shared sorrow is half a sorrow.”

SACTEM’S INITIATIVE

QUARTERLY NEWSPAPER

(Connecting emergency physicians across India, share clinical insights, and highlight activities of the Society)





CREATING SAFE SPACES IN EMERGENCY MEDICINE – EM DAY 2026



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Emergency medicine is defined by unpredictability. Emergency departments function in high-pressure environments where clinical uncertainty, time-critical decisions, and emotional stress intersect daily. From resuscitating critically ill patients to counseling distressed families, emergency physicians constantly navigate complex clinical and emotional challenge

While patient safety has long been emphasized, the concept of a “safe space” for emergency medicine teams is increasingly recognized as fundamental to both provider well-being and optimal patient outcomes



Physical Safety-The most visible layer

Most emergency departments have protocols for pharmacological management of agitation. But are we truly staffed and prepared to safely restrain a violent patient or respond to an aggressive mob? If so, repeated assaults on healthcare workers—including the tragic death of a young intern doctor in Kerala—would not continue to occur. Ensuring physical safety requires a structured, systems-based approach focused not only on managing violence, but also on prevention, early recognition, and effective de-escalation

Environmental and Systems-Level Measures

The physical layout of the emergency department plays a major role in safety. Essential measures include controlled access points, visible security personnel, CCTV surveillance, panic alarms, and designated de-escalation areas.

A common challenge in many EDs is the accumulation of patients in lower-acuity zones (e.g., green or yellow areas) while critical care areas remain occupied. Deploying a dedicated team member for rapid initial assessment—providing early symptomatic relief and initiating essential investigations—can significantly reduce patient anxiety, improve perceived care, and prevent escalation

De-escalation as the First-Line Approach

Verbal de-escalation is the cornerstone of managing potential violence in the emergency department and can often prevent the need for physical or pharmacological restraint. Key principles include maintaining a calm tone, using clear and simple communication, acknowledging emotions, keeping a safe distance, and ensuring an exit route for staff.

De-escalation is a learned skill that requires formal training and regular practice. Effective strategies include speaking slowly and softly, using short sentences, calmly repeating key messages, addressing patients by name, and using purposeful silence when needed

Team-Based Response and Role Clarity

Managing violence in the emergency department requires a coordinated team-based approach rather than relying on an individual clinician. Institutions should establish code-based response systems, clearly define team roles, and conduct regular simulation drills to improve preparedness and coordination.

A structured and rehearsed response reduces chaos, improves role clarity, and helps prevent unnecessary escalation

Managing Bystanders and Attenders

In many emergency settings, violence from bystanders and attendants can be as significant as patient-related aggression. Preventive measures include limiting attendants, providing clear and regular updates, assigning staff for family communication during critical events, and maintaining separate waiting areas to reduce overcrowding. Transparent, timely, and empathetic communication is one of the most effective ways to prevent escalation and preserve trust.

Post-Incident Protocols and Prevention of Recurrence

Every violent incident in the emergency department should be viewed as a learning opportunity through structured reporting, staff debriefing, psychological support, and root cause analysis of system gaps such as delays, communication failures, or inadequate staffing. A non-punitive culture is essential to encourage reporting and continuous improvement.

Long-term change also requires strong institutional support, including zero tolerance policies for workplace violence, legal protection for staff, regular training programs, and collaboration with law enforcement when needed.



Psychological Safety: The Core

While physical safety addresses visible threats, psychological safety shapes the invisible culture within emergency teams. It is the assurance that team members can speak up, ask questions, raise concerns, and admit mistakes without fear of blame or humiliation



Why Psychological Safety Matters in Emergency Medicine

- Emergency care depends on effective teamwork, where unvoiced concerns or hesitation can directly affect patient outcomes. Psychological safety allows junior doctors to question decisions, nurses to escalate concerns, and team members to admit uncertainty or errors early—enabling timely correction and safer care
- In its absence, silence, rigid hierarchies, and fear of speaking up can delay error recognition and compromise patient safety.

Building Psychological Safety in the Emergency Department

1

Leadership and Role Modeling

Leaders set the tone. Simple behaviors—inviting input, acknowledging uncertainty, and responding respectfully—can significantly influence team culture. When senior clinicians demonstrate openness, it normalizes speaking up across all levels.

2

Flattening Hierarchy

While clinical hierarchy is essential for decision-making, communication hierarchy should be minimized. Simple prompts such as “Does anyone have concerns?” or “What am I missing?” encourage participation, reduce barriers to speaking up, and promote a culture of shared responsibility.

3

Structured Communication

Using tools such as closed-loop communication and standardized handover formats ensures clarity and inclusivity, particularly in high pressure situations.

4

Non-Punitive Approach to Errors

Errors should be viewed as opportunities for learning rather than blame. Morbidity and mortality discussions should emphasize system factors, encouraging openness, reflection, and continuous improvement

5

Debriefing Culture

Even brief, structured debriefs can significantly enhance psychological safety

“In emergency medicine, we are trained to create safety for patients during the most critical moments of their lives. But true excellence begins when we extend that commitment to our own teams. A safe emergency department is defined not only by protocols or infrastructure, but by a culture where every voice is valued, every concern is heard, and every team member feels supported

**As we mark Emergency Medicine Day 2026,
the message is clear: safer teams create safer patients.**

**Building safe spaces is not an aspiration—
it is a responsibility**



FROM CLASSROOMS TO FIRST RESPONDERS: INDIA NEEDS CPR TRAINING IN SCHOOLS NOW



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It began as a routine training session. A group of senior school students sat in a classroom, curious but uncertain. For most of them, this was their first exposure to anything resembling emergency care. The idea of “saving a life” belonged to doctors, ambulances, and hospitals—not to them. Within 20 minutes, that belief had changed. Hands that had never performed a clinical task were now confidently delivering chest compressions. Voices counted rhythms in unison. Questions emerged—not from textbooks, but from lived realities:

- “
- What if this happens at home
 - What should we do before the ambulance arrives
- ”

In that moment, the classroom transformed into something much larger—a potential first-response network.



The Silent Gap in India’s Health System

India carries a high burden of cardiovascular diseases, with a substantial proportion of deaths occurring outside hospital settings. Survival in such situations is not determined by advanced technology, but by time-sensitive basic interventions, especially early cardiopulmonary resuscitation (CPR).

Global evidence consistently shows that early bystander CPR can double or even triple survival rates in cardiac arrest. Yet in India, bystander CPR rates remain extremely low. This is not merely a knowledge gap. It is a systems gap.

We have invested in tertiary care expansion, emergency transport, and critical care infrastructure. But the first link in the chain of survival—the community—remains underprepared.



School Health Services: An Underutilized Opportunity

Bharat has created a wide-reaching structure with access to millions of adolescents. However, the current implementation remains heavily oriented toward: Screening, Reporting and Health awareness sessions. While these are important, they often fail to translate into actionable capability. There is a critical difference between: Knowing what to do and Being able to do it under pressure

The American Heart Association, in partnership with institutions across India including AIIMS Rishikesh, is actively working to build a nation of CPR-trained lifesavers

The logic of starting with schools is straightforward. Adolescents can physically perform effective compressions. They learn quickly. And unlike adults who may attend a workshop and never share what they learned, a trained teenager goes home into a family, a neighbourhood, a community. The knowledge travels. Training students in life-saving skills transforms them from passive recipients of health messages into active participants in health systems.



Why Hands-On Training Matters

One of the most striking observations from the session was the speed of skill acquisition. Students with no prior exposure now understood the concept within minutes. They performed compressions with acceptable technique and retained procedural memory through repetition. This reinforces an important principle in public health training: Skill-based learning is more durable and actionable than information-based learning.

In resource-constrained settings, interventions that are low-cost, scalable and skill-oriented offer the highest return on investment. CPR training checks all three boxes.

Traditionally, emergency medicine and community medicine are seen as distinct domains: One operates in high-intensity hospital settings, the other focuses on prevention, population health, and systems but CPR training in schools represents a powerful convergence of the two. It brings emergency response into the community. This is where community medicine moves beyond epidemiology and program design—to building resilience at the grassroots level.



The Quiet Thing I Took Home

The Quiet Thing I Took Home

At the end of one session, a student came up to me — quiet, hadn’t spoken much during the class. He said his grandfather had collapsed at home two years ago. The family had stood around him, panicked, waiting for an ambulance that arrived too late.

He asked: “If we had known this, would it have helped?”. I stood there for a moment with that weight, gathered my thoughts and then we had a discussion on how we might never know answer to this but how this scenario let’s us know that being calm and prompt at decision making in such scenario might give us the best chance at saving a life.

That is what the 1.3% statistic actually means. It means rooms full of families who did not know what to do. It means preventable silences



Teaching Hands-Only CPR in schools will not solve everything. But it will ensure that the next time someone collapses in a home in Rishikesh — or Patna, or Bengaluru, or a hundred other places — there is at least a chance that someone nearby knows exactly what to do, and is not afraid to do it. That chance is worth every session, every manikin, every classroom.

BOLUSES THAT BUY TIME: PUSH DOSE VASOPRESSORS IN EMERGENCY MEDICINE



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Introduction

In many ways, the essence of Emergency Medicine is not to provide the final cure immediately — it is to buy time. Time for the blood and oxygen to reach the brain, time for antibiotics to start working, time for the cardiologist to open the artery in the cath lab, time for the surgeon to stop the bleeding, time for the ICU to continue definitive care. Every intervention in the emergency department is essentially a battle against the clock.

For many years, bolus administration of pressor agents are used in the operating room by anaesthesiologists, but this practice is not yet very popular in standard emergency medicine practice.

A patient in shock does not die instantly from the underlying disease; they die because vital organs are deprived of perfusion before definitive treatment can reverse the pathology.

Push-dose vasopressors (PDP) embody this philosophy perfectly. They are not definitive therapy, but rather a temporary hemodynamic bridge — a rapid intervention that preserves cerebral and coronary perfusion during the most vulnerable moments of resuscitation.



Real-time experiences in ED

The concept of push dose pressors was initially introduced to us during our rotation postings in the operating room. It was successfully used to tackle the transient hypotension episodes, especially during the induction of anaesthesia, blood loss, positive pressure ventilation, etc.

In the ER, many times it was a tough challenge to manage hypotension cases, especially the ones that were not responsive to fluids and single inotropic agents like Noradrenaline. Before the action of the pressor agent takes over, the patients used to have cardiac arrest and succumb in front of our eyes. This phenomenon was very common in post-CPR, where patients used to have a repeat cardiac arrest.

We were thinking in terms of something that will buy us some time for the action of the vasopressor agents to take over and stabilise, and some agents that will buy time for us to insert a central venous catheter to deliver the pressor support in the manner it should be done. It is that time we searched for articles related to this and found out the concept of push dose pressors in the ED.

Nowadays, these agents are successfully used to tackle septic shock, post ROSC hypotension, peri intubation hypotension, etc.

In the literature, it says that ketamine and etomidate are hemodynamically stable agents that won't cause hypotension.

But in real-life scenarios, we have encountered cases where drugs like ketamine and etomidate have caused post-intubation hypotension especially in patients with septic shock, prolonged critical illness due to the direct myocardial depressant effect of ketamine which may predominate and also due to the initiation of positive pressure ventilation.

So, it is important to optimise the vitals before intubation and post-intubation in all cases.



Clinical Indications

The most accepted indication for PDP is transient hypotension expected to improve rapidly or while awaiting definitive therapy.

Common ED scenarios include :

- Peri-intubation hypotension
- Septic shock awaiting vasopressor infusion
- Post-intubation vasodilatory collapse
- Post-return of spontaneous circulation (ROSC) hypotension
- Procedural sedation-associated hypotension



Challenges in ED

- Dosing errors from bedside dilution
- Extravasation risk
- Tachyarrhythmias
- Severe hypertension
- Masking of ongoing shock
- Vigorous usage by untrained personnel:

Always, vasopressor agents should be tapered and stopped gradually because abrupt discontinuation can cause rebound hypotension, organ hypoperfusion and cardiovascular collapse due to multiple reasons like unmasking of ongoing shock, receptor downregulation and dependence, etc.

So, it is always important to note that in these patients, there should be continuous blood pressure monitoring and continued pressor support despite using bolus doses.



Commonly Used Agents

1) Phenylephrine:

Pure alpha-1 agonist causing arterial and venous vasoconstriction. It increases systemic vascular resistance without direct inotropic effects. Dose: 50–200 µg intravenously (IV) every 1–5 minutes as needed. (Take 1ml which contains 10mg (10,000 mcg), add 99ml normal saline to make it 100mcg per mL) Onset: <1 minute Duration: 5–20 minutes Phenylephrine is preferred in patients with tachycardia because it may produce reflex bradycardia. However, excessive vasoconstriction may reduce stroke volume and cardiac output, especially in cardiogenic shock.

2) Epinephrine

It has both alpha- and beta-adrenergic activity, improving vascular tone and cardiac contractility. Dose: 5–20 µg IV every 1–5 minutes as needed. (Take 1ml of cardiac epinephrine (1:10000) which contains 100mcg, add to 9ml NS and make it 10mcg per mL) Duration: Approximately 5–10 minutes Epinephrine may be advantageous in peri-arrest states, bradycardia, or mixed shock. Adverse effects include tachyarrhythmias, hypertension, and myocardial ischemia.

3) Norepinephrine

It provides potent alpha activity with modest beta-1 stimulation. Dose: 5–20 µg IV bolus every 1–5 minutes as needed (Take 1ml norepinephrine (1000mcg), add to 99ml NS so that final concentration is 10mcg/ml)



Conclusion

Push-dose vasopressors represent a valuable resuscitative adjunct in emergency medicine, particularly for peri-intubation hypotension and transient hemodynamic instability.

Phenylephrine and epinephrine remain the most commonly used agents, while push-dose norepinephrine is an emerging alternative. Current evidence supports short-term hemodynamic improvement, but high-quality prospective studies are still lacking. Until stronger data become available, PDPs should be used cautiously, with standardized preparation methods and close monitoring, as a bridge rather than a substitute for definitive shock management.



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MD EMERGENCY MEDICINE FINALS: SOMEWHERE BETWEEN SURVIVAL AND BECOMING



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“I didn’t feel ready. I just showed up anyway.”

The strange thing about finishing MD Emergency Medicine is this: the day the finals end, nothing magical happens. No sudden enlightenment, no cinematic relief. Just a quiet realization—you survived something intense, and somewhere in the process, you changed. Preparing for finals at AIIMS Rishikesh was never a neat, well-planned journey. It was chaotic, inconsistent, exhausting—and very real.

The Myth of the Perfect Schedule

I started with a plan. Color-coded timetable, topic-wise targets, revision cycles—the usual optimism. It lasted exactly three days. Emergency Medicine doesn’t respect timetables. Patients don’t wait because you planned to revise shock that evening. Some days I would plan to study toxicology and end up managing a real poisoning case instead. Eventually, I stopped fighting it. Studying became opportunistic:

- 20 minutes between cases
- Revising ABGs after actually seeing one
- Reading airway just after struggling with one

Thesis during finals felt like that one patient who keeps coming back just when things seem under control. Ignoring it wasn’t an option—so it was managed in small, strategic bursts.

Theory: Writing What I Would Actually Do

At some point, I realized I was still writing like an undergraduate—long answers, definitions, classifications. That had to change. I started writing answers the way I think in the ER: First 10 minutes—Primary survey—Immediate stabilization—Then diagnosis. Flowcharts replaced paragraphs. Headings replaced storytelling. And honestly, the biggest shift was mental: I stopped trying to impress the examiner and started trying to be a safe doctor on paper.



Long Case: Trying to Look Calm While Internally Panicking

The long case felt like real life compressed into an exam. I remember standing there, aware of every movement, every word, every pause. The patient in front of me, the examiner watching, and that constant inner voice: Don’t miss anything.

But what helped was pretending it wasn’t an exam. Just another patient. Another shift. I followed the same structure I had practiced for years: History. Examination. Think aloud. Prioritize. And one important lesson stayed with me: Even if something is missed, how I think matters more than what I missed.

Short Cases: Brutally Short, Surprisingly Stressful

Short cases were oddly exhausting. You get a minute or two. Just enough time to either sound confident or completely lost.

I learned to simplify: See → Pick key finding → Say diagnosis → Stop.

No over-explaining. No unnecessary details. Confidence carried more weight than perfection.



OSCE: When Simple Things Become Complicated

OSCEs were uncomfortable. Not because they were difficult, but because they were being watched so closely. Intubation I had done multiple times suddenly required step-by-step narration like I was recording a tutorial. It felt unnatural at first. But repetition helped. Saying things out loud. Slowing down. And accepting that it’s okay to pause and think.

ACLS Code Run: Heart Rate Higher Than the Patient’s

This one felt real. Standing there, leading a code—even a simulated one—triggered something familiar. That mix of urgency and focus. For a moment, it didn’t feel like an exam. Just another resuscitation. I stuck to the algorithm. Spoke clearly. Assigned roles. My hands were steady. My mind—slightly less. But that’s Emergency Medicine, isn’t it? Functioning despite the adrenaline.

Grand viva prep wasn’t about mugging answers—it was more like training my brain to survive politely under pressure. I practiced thinking out loud, structuring answers, and buying time without sounding lost.



The Part No One Talks About Enough

The hardest part wasn’t the syllabus. It was everything around it. Post-night duty exhaustion. Sitting with a book and not remembering what I just read. Watching others revise more and feeling behind. There were days I did nothing. Days I doubted everything. But somehow, the next day, I showed up again. And that mattered more than any perfect study plan. After it was all over, I tried to think about what really prepared me. It wasn’t the last month of studying. It was:

- Every chaotic night duty
- Every difficult airway
- Every mistake that stayed in my head longer than I liked.

And maybe that’s what this exam is really about. Not proving how much, I know. But showing who I’ve become.

“ In the end, I didn’t walk into the exam as a perfectly prepared candidate. I walked in as an Emergency Medicine resident who had learned to think, adapt, and stay calm. ”



And lastly—
Still learning—but no longer lost.



YOUR HEALTHY ER PHYSICIAN: CARING FOR THE CAREGIVER



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Step into the emergency department, and you'll feel it instantly: the hum of urgency, the shuffle of footsteps, the sharp beeps of monitors, and the weight of decisions made in seconds. ER physicians live in this rhythm daily. We stand for hours, walk miles within the hospital walls, and juggle dozens of cases—each demanding precision, empathy, and speed.

We are expected to be tireless, unshakable, and endlessly compassionate. But beneath the white coat lies a human being whose health is often stretched thin. The question we rarely ask is: How does the ER physician stay healthy while caring for everyone else?

Here are ten powerful strategies to keep the healers themselves strong, sane, and sustainable.

3 Protect Sleep Fiercely

Shift work disrupts circadian rhythms, but sleep remains non-negotiable. Blackout curtains, earplugs, and disciplined routines on off-days help restore rest. Prioritizing sleep is not selfish—it's the foundation of safe practice.

7 Mindfulness in Micro-Doses

Mindfulness doesn't require long sessions. A few deep breaths before entering a patient's room or a 30-second grounding exercise can calm the nervous system. These micro-moments build resilience drop by drop.

4 Fitness as Armor

Standing and walking for hours strains the body. Regular exercise, especially core strengthening and stretching, prevents musculoskeletal injuries. Fitness builds stamina and resilience, shielding us from the physical toll of the ER.

8 Smooth Shift Handovers

Handovers are more than routine—they're safety nets. Taking a few minutes to organize thoughts and summarize cases clearly prevents errors and allows us to mentally detach from the shift.

1 Pause to Power Up

Short breaks are not indulgences—they're essential. Even a two-minute pause to stretch, hydrate, or breathe deeply can reset focus and reduce fatigue. Think of these micro-breaks as the fuel that keeps us sharp through long shifts.

5 Guard Emotional Boundaries

We encounter grief, anger, and relief daily. Without boundaries, emotions seep in and overwhelm. Mindfulness, journaling, or counseling can help process the weight. Protecting emotional sanity is a mark of strength, not weakness.

9 Life Beyond the ER

Our identity should not be consumed by medicine alone. Pursuing hobbies—music, sports, travel, or creative arts—restores balance and joy. A healthy life outside the hospital fuels strength inside it.

2 Eat Smart, Hydrate Often

Skipping meals or relying on vending snacks drains energy. Keeping healthy options—nuts, fruit, protein bars—within reach stabilizes blood sugar and concentration. Hydration is equally vital; even mild dehydration impairs judgment.

6 Invest in Team Dynamics

No ER physician works alone. Respectful communication, mutual support, and shared responsibility make the difference between chaos and calm. A strong team is the best medicine for stress and burnout.

10 Lean on Your Tribe

Family, friends, mentors, and colleagues are anchors. Sharing experiences, venting frustrations, or simply laughing together lightens the load. No one should carry the ER alone—we all need support.



The emergency department will always be demanding. Patients will arrive in crisis, families will bring raw emotions, and teams will need to perform under pressure. But the health of the ER physician is not optional—it is essential.



A physician who is physically fit, emotionally balanced, and supported by a strong team is better equipped to deliver safe, compassionate care. "Your Healthy ER Physician" is not just a phrase—it's a reminder that caring for ourselves is part of caring for others.



By embracing these strategies, we can continue to stand tall in the storm—not as exhausted warriors, but as resilient healers who thrive while saving lives.

SACTEM'S INITIATIVE

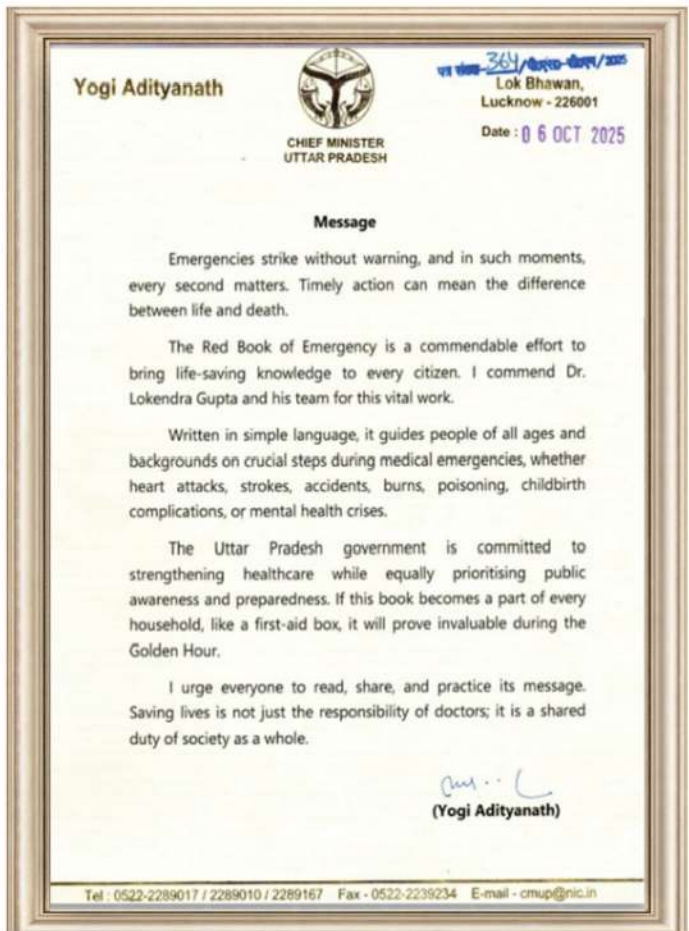
THE GOLDEN HOUR OF LIFE



Timely intervention in the first few minutes of an emergency can:

- Increase survival rates significantly
- Reduce long-term disability
- Lower healthcare system burden
- Improve community resilience

Investment in emergency preparedness generates measurable social impact.



WHAT WE HAVE DONE SO FAR

Rabies Prevention and Management



SACTEM launched with successful Rabies Awareness Program at Hotel Sky Hilton, attended by many doctors!



Ambulance Meet



The first Ambulance Meet at Medanta Hospital, Lucknow featured a Health Talk & BLS training. with Dr Samir Mishra as Chief Guest and Dr S. S. Tripathi as Guest Speaker.



World Emergency Day



Conducted multiple awareness programs across Lucknow with doctors from top institutes like Hind, Era, and SGPG. Dr Lokendra led a medical emergency session for 100 bureaucrats.



IACC Varanasi



SACTEM, represented by Dr Lokendra, actively participated in the Advancing Health & Wellness Conference at Taj Ganges, Varanasi, where he was a Guest Speaker.



Excise Office Prayagraj



Medanta Hospital & SACTEM held a Health Talk at Excise Office, Prayagraj, with 100+ staff attending.



Lucknow Bar Association



Medanta Hospital & SACTEM conducted a Health Talk on Medical Emergencies at Lucknow Bar Association, drawing a large audience.



Shock Unveiled



A CME on Septic Shock Management marked a milestone, driving society expansion and a booming membership drive.



Ambulance Meet



The 2nd Ambulance Meet at Medanta Hospital, Lucknow trained 70-80 drivers & technicians on the Golden Hour & CPR. Dr Rajeev Kumar Gupta was the Chief Guest.



Neurological Emergencies



Highlights: Talk by Dr Dinkar Kulshreshta, first Community Expansion Award, and 120+ members attending the CME.



Ayushman Head Office UP



Medanta Hospital & SACTEM held a Health Talk at Ayushman Head Office, UP, engaging 60-70 staff, led by Dr Lokendra Gupta.



Tourism & Forest Department, Varanasi



Medanta Hospital & SACTEM held a Health Talk & CPR Training on 23rd Aug at Tourism & Forest Dept., Varanasi, for 150+ staff, with Dr Lokendra Gupta as Chief Guest.



Labour Commissioner HO



Medanta Hospital & SACTEM conducted a Health Talk & BLS Training at Labour Commissioner Head Office, Kanpur, led by Dr Lokendra Gupta, with a large staff turnout.



SACTEM MEDIA COVERAGE



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