COMMON SENSE

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AAEM™
AMERICAN ACADEMY OF EMERGENCY MEDICINE
CHAMPION OF THE EMERGENCY PHYSICIAN

Welcome to Miami!

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AAEM ANTITRUST COMPLIANCE PLAN:

As part of AAEM's antitrust compliance plan, we invite all readers of Common Sense to report any AAEM publication or activity which may restrain trade or limit competition. You may confidentially file a report at info@aaem.org or by calling 800-884-AAEM.

Mission Statement

The American Academy of Emergency Medicine (AAEM) is the specialty society of emergency medicine. AAEM is a democratic organization committed to the following principles:

1. Every individual, regardless of race, ethnicity, sexual identity or orientation, religion, age, socioeconomic or immigration status, physical or mental disability must have unencumbered access to quality emergency care.
2. The practice of emergency medicine is best conducted by a physician who is board certified or eligible by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
3. The Academy is committed to the personal and professional well-being of every emergency physician which must include fair and equitable practice environments and due process.
4. The Academy supports residency programs and graduate medical education free of harassment or discrimination, which are essential to the continued enrichment of emergency medicine, and to ensure a high quality of care for the patient.
5. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.
6. The Academy supports the establishment and recognition of emergency medicine internationally as an independent specialty and is committed to its role in the advancement of emergency medicine worldwide.

Membership Information

Fellow and Full Voting Member (FAAEM): $525* (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)
Associate: $150 (Limited to graduates of an ACGME or AOA approved emergency medicine program within their first year out of residency) or $250 (Limited to graduates of an ACGME or AOA approved emergency medicine program more than one year out of residency)
Fellow-in-Training Member: $75 (Must be graduates of an ACGME or AOA approved emergency medicine program and be enrolled in a fellowship)
Emeritus Member: $250 (Please visit www.aaem.org for special eligibility criteria)
International Member: $150 (Non-voting status)
Resident Member: $60 (voting in AAEM/RSA elections only)
Transitional Member: $60 (voting in AAEM/RSA elections only)
International Resident Member: $30 (voting in AAEM/RSA elections only)
Student Member: $40 (voting in AAEM/RSA elections only)
International Student Member: $30 (voting in AAEM/RSA elections only)

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COMMONSENSE

Featured Articles

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President's Message: AAEM Elections: A True Vote of Confidence

Have you heard criticism that AAEM's Board of Directors election process is nothing more than a popularity contest? Dr. Frolichstein has and admits that in some ways, that's true. So, to better understand how AAEM's process compares to other professional organization, Dr. Frolichestein did the research and presents his findings.

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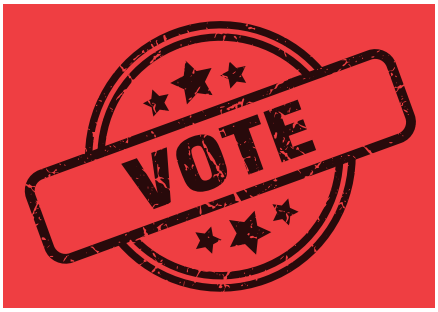
Board of Directors Election: Candidate Platform Statements



Voting for the AAEM Board of Directors is open now until April 8, 2025 at 11:59pm CT. Please review the candidate statements then exercise your democratic right to vote and make your voice heard.

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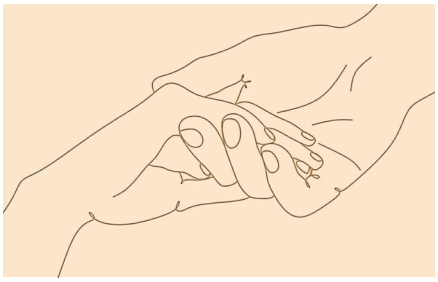
Editor's Message: Holding Lives, Holding My Own



Work-life balance is important in emergency medicine, but how do you balance it when our work touches so many lives beyond our own? Newly appointed *Common Sense* Assistant Editor, Dr. Yash Chavda, makes his editorial debut in this issue with his thoughts on his own work-life balance.

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AAEM25: The 31st Annual Scientific Assembly: Welcome to Miami!

Join AAEM for the 31st annual Scientific Assembly from April 6-10, 2025, in Miami, FL. We can't wait to see you there!

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Why Not Me?

After a fulfilling career spanning from junior faculty to directorship of a university ED, editing a medical journal to travelling the world on over 40 medical missions, Dr. Rutherford (or more accurately his wife) was looking for his next adventure as his retirement approached. His wife's search led him to Team Rubicon, a veteran led humanitarian organization that responds before, during, and after disasters and other crises though the US and around the world.

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Young Physicians Section: Physicians Are Unionizing: Who, What, Why? And Why Not...

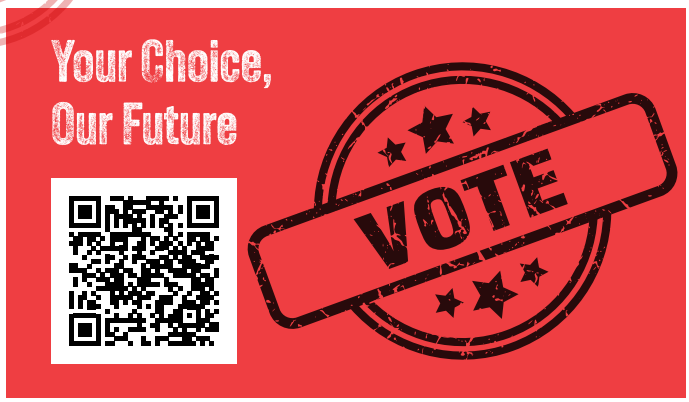
Emergency physicians are increasingly turning to unions due to a growing lack of control over their practice and working conditions. Simply put, emergency physicians are being asked with do more with less, and they have little control over it. Could collective bargaining give physicians a stronger voice? Dr. Rosenbaum explores the why and why not of physicians and unionization.

AAEM Elections: A True Vote of Confidence

Robert Frolichstein, MD FAAEM

This issue is packed with candidate statements for the three open AAEM Board of Directors seats. I know this is an exciting time for the candidates—at least, it certainly was for me when I first ran for the Board several years ago. I hope our members share in that excitement as they get to know those who aspire to help advance the Academy's mission for the benefit of our profession and, most importantly, our patients.

I've occasionally heard criticism that AAEM's election process is nothing more than a popularity contest. In some ways, that's true. To better understand how our process compares, I researched the election procedures of three other professional organizations outside of emergency medicine.



Comparison to Other Organizations

All three organizations I reviewed use nominating committees to control who appears on the final ballot. These committees, in turn, become highly influential bodies within their respective organizations. Below is a summary of how these committees are structured. (Table 1)

While these committees appear to be chosen through a fair and structured process, they ultimately decide who is nominated for the Board of Directors. (Table 2)

In each of these organizations, the **nominating committee determines** which candidates ultimately appear on the final ballot. (Table 3)

Society One allows for electronic voting before or during its annual meeting. Society Two votes on a slate presented by the nominating committee, essentially ratifying the choices made by a small group. Society Three is unique in that its Board ranks candidates before the election proceeds.

Table 1: Nominating Committee Composition

Society	One	Two	Three
Structure	Comprised of four members elected by active fellows. Immediate Past President serves as Chair.	Composed of selected members with a Chair who presents the slate to the Board.	Includes three Past Presidents (excluding Immediate Past President) and two at-large fellows.
Eligibility	Active fellows can serve once every five years.	Active members only, with attention to professional, geographic, and administrative diversity.	Past Presidents serve three years; at-large members serve four years.

Table 2: Nomination Procedures

Society	One	Two	Three
Nomination Sources	Members submit nominations electronically before the annual meeting.	Open nominations from membership. Candidates vetted by nominating committee.	Chair may solicit nominations from members, Board, and program directors.
Committee's Role	Reviews all nominations, adds nominees if needed, and confirms interest/qualifications.	Screens and evaluates based on qualifications and geographic representation.	Ranks nominees confidentially and selects final slate.
Qualifications to be on ballot	Active fellows in good standing with contributions to society activities and leadership roles.	Professional, scholarly, and administrative skills required.	Secretary-Treasurer nominees must have served on the Board.

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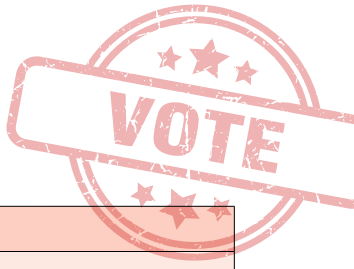


Taqble 3: Election Process

Society	One	Two	Three
Candidate Selection	Slate approved by the nominating committee and presented to membership at the business meeting.	Board reviews slate and members vote at the annual meeting.	Board reviews and ranks nominees; ballot sent to members before the annual meeting.
Membership Vote	Active fellows vote electronically and during the business meeting.	Membership votes on slate; additional nominations allowed if slate not approved.	Voting conducted online; ballot shared 90 days before annual meeting.
Results Implementation	Officers assume positions following the annual meeting.	Newly elected members assume roles immediately after approval at the annual meeting.	Officers assume positions immediately after the annual business meeting.

AAEM's Election Process

By comparison, AAEM's election process is straightforward and open. For at-large director seats, any full voting member can nominate another member or themselves. There is no pre-screening or vetting of candidates. While Board members and well-known AAEM members may endorse candidates, nominators and endorsers cannot support more candidates than there are open seats.

Once nominations are finalized, the slate is presented to all AAEM members, and Full-Voting and Emeritus members can cast their votes electronically as soon as they feel informed. Many wait until after the Candidates' Forum at the Scientific Assembly to make their decision. The votes are then tabulated, and the candidates receiving the most votes are elected. The newly elected Board members assume their roles immediately following the conclusion of the Scientific Assembly.

Board officer elections follow the same process, with one exception—a recent bylaw change now requires that candidates for President-Elect must have served as a director for at least one year.

Final Thoughts

So, is AAEM's election process a popularity contest? In some ways, yes—the candidates who receive the most votes win. But I don't see that as a problem or a weakness. My experience serving on the Board has shown me that this process works well. I've had the privilege of working with many Board members over the years, and I've seen firsthand the passion and expertise they bring to AAEM.

This year, we have three open at-large director seats and six highly qualified candidates. I'm grateful that our members—not a small nominating committee—will decide who joins our leadership. Voting ballots are only available online at aaem.org/about-us/leadership/elections. Voting is open now until April 8, 2025 at 11:59pm CT.

I encourage you to take the time to study the candidates. Pay attention to who nominated them. Read their statements on the next page. Watch their recorded videos online by scanning the QR code below. Attend the virtual and in-person candidate events.

Most importantly—VOTE. ■

Eric Brader, MD FAAEM

CANDIDATE FOR AT-LARGE BOARD MEMBER

Scan for candidate video

Current employer: Cleveland Clinic
Clinical EM practice employment type: Academic
Clinical hours in the ED per month: 144
Nominated/Endorsed by: James Keaney, MD MAAEM FAAEM; Vicki Norton, MD FAAEM; and Robert McNamara, MD MAAEM FAAEM
Membership: 1994 to present
Other leadership roles: Take Medicine Back - steering committee
Disclosure/Conflict of Interest Nothing to disclose.

AAEM Activities (past five years)

- Founding Member of Great Lakes Chapter, 2020 to present

AAEM Activities (five years+)

- Delaware Valley Chapter, Member, 2003 to present
- Emergency Ultrasound Section, Member, 2017 to present
- PAC member, 1997 to present

Statement

I am an AAEM founding member. I attended the founding meeting over 30 years ago. I am the Ohio rep to Great Lakes AAEM. I have served on various AAEM committees. I have fought and won personal battles against CMGs and am personally litigating against USACS. I advise EPs pro bono on fighting back against CMGs etc. I am a founder of Take Medicine Back and do pro bono work for them. I was research trained by Peter Safar, MD and did seminal benchtop work on my theories regarding resuscitative hypothermia. I also built the worlds first 24/7/365 EMS to cath lab for STEMI system (4/96). I was one of the first EPs do POCUS 4/86. I have trained over 400 EM residents.

Christopher Colbert, DO FAAEM

CANDIDATE FOR AT-LARGE BOARD MEMBER

Scan for candidate video

Current employer: University of Illinois at Chicago

Leadership role at current employer: Associate Program Director

Clinical EM practice employment type: I am an emergency medicine physician with over nine years of experience as an Assistant Program Director for the University of Illinois Emergency Medicine Residency Program. In addition to my role at the University of Illinois I am a dedicated Army Reservist with over eight medical deployments, demonstrating a deep commitment to both military service and global health. Passionate about medical education, I engage in teaching and mentoring at the local, national, and international levels, contributing to the advancement of emergency medicine and training the next generation of healthcare leaders.

Clinical hours in the ED per month: 88

Nominated/Endorsed by: Robert Frolichstein, MD FAAEM; Jonathan S. Jones, MD FAAEM; Lisa A. Moreno, MD MS MSCR FAAEM FIFEM

Membership: 2019 to present

Disclosure/Conflict of Interest: Nothing to disclose.

Other leadership roles: CME chair 2018 to present Illinois college of emergency physicians (ICEP); ACOEP CME chair 2016-2025 American college of osteopathic emergency physicians (ACOEP); Podcast anchor 2022-2025 "Virtual grand rounds" – ACOEP; MED TECH committee chair 2022 to present Council of residency Directors (CORD)

AAEM Activities (past five years)

- Education Committee, Member, 2020 to present
- Emergency Ultrasound Section, Member, 2021
- Great Lakes Chapter, Member, 2023-2024
- Justice, Equity, Diversity & Inclusion Committee-Member, 2023
- Scientific Assembly Planning Committee-Co-Chair, 2021-2024
- Scientific Assembly Planning Committee- Member, 2020-2022

Statement

It is an honor and privilege to contribute to the mission of the American Academy of Emergency Medicine. For over five years, I have had the opportunity to serve as an AAEM lecturer both nationally and internationally, sharing my expertise and learning from colleagues across the globe. Working alongside fellow educators and clinicians, I have witnessed firsthand the transformative power of education and the vital role AAEM plays in empowering emergency physicians.

One of the most rewarding aspects of my involvement with AAEM has been the opportunity to collaborate closely in the planning and execution of the Spring Assembly. This annual event brings together a diverse group of professionals, fostering an environment of intellectual exchange, innovation, and camaraderie. As a participant in AAEM subcommittees, I have worked alongside like-minded individuals who share a common vision: to amplify the message of AAEM and ensure that the academy continues to lead in advancing the practice of emergency medicine.

Beyond the Spring Assembly, my engagement with AAEM has allowed me to network with a wide array of professionals who are equally dedicated to the advancement of emergency medicine and patient advocacy. This exposure has shaped my own approach to teaching, mentorship, and advocacy, reinforcing the importance of inclusivity and global perspectives in the continued development of our field. I am continually inspired by the dedication and passion of my colleagues in AAEM, and I am committed to amplifying the mission of the organization through my own work and contributions.

Looking ahead, I am eager to contribute more directly to the future direction of AAEM as a member of the board. I firmly believe that the strength of our profession lies in the collective commitment to improving patient care, advocating for the well-being of our physicians, and advancing the education of the next generation of emergency medicine leaders. As a board member, I hope to bring my diverse experience, both as an educator and a practitioner, to help guide AAEM in its ongoing mission to promote excellence in emergency medicine.

I look forward to the opportunity to contribute to AAEM's continued success, and I am excited about the potential to work together with the board, leadership, and members to amplify the important work of the organization and the impact it has on our specialty, our patients, and our profession.

Jennifer Gemmill, MD FAAEM

CANDIDATE FOR AT-LARGE BOARD MEMBER

Scan for candidate video

Current employer: Silvertip Emergency Physicians
Leadership role at current employer: EMS Medical Director
Clinical EM practice employment type: I am currently working in a limited access location in NW Montana. My group staffs a level three trauma, community hospital that functions as a referral center for the central and Western half of the state. We do have some rotating Family Medicine Residents that we occasionally staff in the ED during their rotations.
Clinical hours in the ED per month: 100
Nominated/Endorsed by: Robert Frolichstein, MD FAAEM
Membership: 2017 to present
Disclosure/Conflict of Interest: Nothing to disclose.

AAEM Activities (past five years)

- Ethics Committee-Member, 2022-2023
- Leadership Academy Graduate, 2021

AAEM Activities (five years+)

- Texas Chapter-Member, 2018-2021

Statement

I have been a member of AAEM since 2017 after leaving the Air Force. I served four years on Active Duty as an EM physician and during that time staffed residents at the Joint Air Force/Army EM Residency Program in San Antonio. My time in the service, specifically my deployed time, allowed me a view a different aspect of EM. One that focused on resource utilization and the logistics of patient movement. Serving as Medical Director of our EM during my time overseas gave me my first insight into the intricacies of austere/rural medicine. Following military service, I joined a democratic practice in San Antonio and served four years as Medical Director for a large ED that saw 65,000 plus patients each year. As COVID began, I assumed the role of Co-Chair of the AAEM Ethics Committee and published a white paper and multiple editorials with that team. After spending five years practicing in the large urban, resource rich environment that San Antonio offered, my family moved to NW Montana. Transitioning to practice in my current area has been eye opening, but my past experience with the military has certainly helped me acknowledge the challenges that we face here. After a year with the group, I took over the EMS Medical Director position with our Air Ambulance service, A.L.E.R.T. We are the oldest rural Air EMS program in the country and we fly across multiple states to care and transport patients.

I feel my broad range of experience is conducive to a position on the Board. I have worked in single coverage EDs, academic centers, tertiary care facilities, community hospitals and the pre-hospital environment. I have been a prn employee, a teaching attending, a partner, and a Medical Director. I can offer a current voice to those EMPs practicing in rural environments. Thank you for your consideration.

Biosha Jones, MD FAAEM

CANDIDATE FOR AT-LARGE BOARD MEMBER

Scan for candidate video

Current employer: Basin Emergency Physicians
Clinical EM practice employment type: I work at two hospitals in West Texas. One hospital is a larger, 30 bed emergency room with high volumes and high acuity. The second is an eight bed, critical access hospital in rural west Texas.
Clinical hours in the ED per month: 150
Nominated/Endorsed by: Kimberly Brown, MD MPH FAAEM; and Jeffrey Pinnow, MD FAAEM
Membership: 2020 to Present
Other leadership roles: Prior EMRA Vice Chair of Diversity and Inclusion for two years
Disclosure/Conflict of Interest: Nothing to disclose.

AAEM Activities (past five years)

- Justice, Equity, Diversity & Inclusion Committee-Member, 2024 to present
- Texas Chapter, Member 2024 to present
- Young Physicians Council-Member, 2024 to present

Statement

Given that we care for people of all backgrounds, advocacy has always been at the heart of our speciality. In residency, I did a lot of work specifically in healthcare disparities and policy because I care deeply about these things. Since graduating residency, I have realized that advocacy is something that I'd like to be part of my long term career as an emergency medicine physician as well.

This was the original motivation behind my decision to go to the Health Policy in Emergency Medicine Symposium and Advocacy Day this past summer. The experience of educating myself about the most pressing issues in our specialty and then using my voice to advocate on our specialty's behalf was a special moment.

My experience was unparalleled. Being able to translate frustration into action is exactly what I did, and why I went. During my visit, I also got a rare opportunity to advocate directly to the Congressman of my own district which continued to exemplify the resounding importance of advocacy. I learned a lot and became even more clear in my longterm career goals outside of the hospital. That experience was only made possible because of AAEM.

Even the most recent events illustrate that this organization cares deeply about its members, our patients and our specialty. It has been impressive to watch AAEM help other doctors transition out of bad contracts, helping new attendings (like myself) transition into new attendinghood, and fighting against corporate medical groups. The recent victory against Envision exiting the state of California is huge, but is only a result of the consistent work of the organization. When reviewing the history of medicine, AAEM was one of the first (perhaps the first) doctor groups that opposed private equity. In all aspects, this organization has been a leader and a champion for us and for our patients. I believe that this organization aligns well with my own with my own values and hopes for emergency medicine.

Community is also a very important part of being sustained, and moving forward with this work even when things are difficult. Being able to bond with brilliant, down to earth and passionate leaders within our field during this trip reiterated my desire to continue working in advocacy, and to continue that work within AAEM. It inspires me deeply.

My future aspirations within emergency medicine are the same as the past ones—to advocate for our specialty, for the livelihoods of others and to use my voice for the greater good. Through advocacy, community and resourcefulness, I envision that future to be within AAEM as an at-Large Board Member.

Fred E. Kency, Jr., MD FAAEM

CANDIDATE FOR AT-LARGE BOARD MEMBER

Scan for candidate video

Current employer: Baptist Medical Center - Jackson
Clinical EM practice employment type: Community and Academia
Clinical hours in the ED per month: 160
Nominated/Endorsed by: William T. Durkin, Jr., MD MBA MAAEM FAAEM; Robert Frolichstein, MD FAAEM; and Vicki Norton, MD FAAEM
Membership: 2015 to present
Disclosure/Conflict of Interest: Nothing to disclose.
Attendance Record for AAEM BOD Meetings: 100%

AAEM Activities (past five years)

- AAEM Board of Directors, At-Large Member, 2024 - present
- AAEM Board of Directors-YPS Director, 2021-2024
- Clinical Practice Committee-Board Liaison, 2021-2022
- Justice, Equity, Diversity & Inclusion Committee-Member, 2017-2022
- Simulation Interest Group-Board Liaison, 2022-2023
- Membership Committee-Board Liaison, 2022-2024
- RSA Board of Directors-Board Liaison, 2024 to present
- Section Leadership Committee-Board Liaison, 2023-2024
- Young Physicians Council, Member, 2019-2020
- Young Physicians Council-YPS Director, 2021-2022
- Young Physicians Council-Board Liaison, 2021-2024

AAEM Activities (five years+)

- Justice, Equity, Diversity and Inclusion Committee, Member, 2017-2022
- Young Physicians Section Council, Councilor, 2019-2020

Statement

As a proud Board-Certified emergency physician from Jackson, Mississippi, and a US Navy military veteran, I am honored to seek re-election to the At-Large Board of Directors of the American Academy of Emergency Medicine (AAEM). Serving on the Board for the past four years has been a privilege, allowing me to contribute to advancing the values and mission of AAEM.

Throughout my career, advocacy, medical education, mentorship, and community service have been guiding principles. I believe in the transformative power of mentorship to shape the next generation of emergency physicians, fostering inclusivity and excellence in our field. My commitment to community involvement stems from a deep understanding of the importance of connecting with those we serve, both inside and outside the emergency department.

With a strong foundation in leadership, honed through military service and my tenure on the Board, I am dedicated to advocating for equity, professional growth, and the highest standards of patient care. I hope to continue leveraging my experiences to enhance AAEM's impact on our members and the communities we serve.

I would be honored to have your support as we work together to uphold the values that define our specialty and our organization.

Robert E. Suter, DO MHA FAAEM

CANDIDATE FOR AT-LARGE BOARD MEMBER

Scan for candidate video

Current employer: Sam Houston State University

Leadership role at current employer: Senior Associate Dean

Clinical EM practice employment type: Over the years, my EM practice has been a combination of experiences common to most emergeny physicians including urban, suburban, and rural practice in both community and academic settings. I have also practiced in military settings both on active duty and as a reservist. My non-clinical practice has been a combination of executive and academic leadership in a variety of settings. Currently I serve as a Senior Associate Dean while practicing clinically in everything from Freestanding Emergency Departments to busy urban Trauma Centers.

Clinical hours in the ED per month: 120

Nominated/Endorsed by: Jonathan S. Jones, MD FAAEM; Amin Kazzi, MD MAAEM FAAEM; and Mark Reiter, MD MBA MAAEM FAAEM

Membership: 2010 to present

Disclosure/Conflict of Interest: Nothing to disclose.

Attendance Record for AAEM BOD Meetings: 100%

Other leadership roles: Past President of ACEP, ACOEP, and the International Federation for Emergency Medicine (IFEM). Multi-year Delegate to the AMA and AOA, leader in both the Texas Medical Association and the Texas Osteopathic Medical Association as well as leader in Association of Military Surgeons of the US.

AAEM Activities (past five years)

- MEMC25 Executive Committee, 2024 – Present
- AAEM Representative to the International Federation for Emergency Medicine General Assembly, 2023 – Present
- MEMC23 Track Chair, 2023
- MEMC22 Track Chair, 2022

AAEM Activities (five years+)

- James Keaney Award, 2019
- MEMC19 Track Chair, 2019
- Uniformed Services Chapter, Member, 2019 – Present
- MEMC17 Executive Committee and Track Chair, 2017
- International Committee, Member, 2016 – Present
- Texas Chapter, Member, 2016 – Present
- AAEM Board of Directors, At-Large Member, 2015 – 2017
- Emergency Medical Service Council, Board Liaison, 2015 – 2017
- MEMC15 Executive Committee and Congress Co-Chair, 2015

Statement

As board certified emergency physicians advocating for our patients and our future, are potentially exposed to moral injury every day as a result of the many multidirectional assaults on our practice. The adverse impacts of private equity, non-physician corporations, and insurance companies can exhaust us. This is not ok. Why am I the person to fight these assaults for you? I have a clear track record as an experienced leader and warrior for the specialty of emergency medicine, committed to you and your patients. I pledge that when returned to the AAEM board I will bring all of my skills to bear in advancing your causes. My track record includes over 30 years of aggressively protecting the primacy of residency trained, board certified emergency physician practice, beginning with EMRA presidency and leading efforts to close ACEP membership to non-board certified doctors. This continued with international emergency medicine specialty development as the President of the International Federation, and serving in multiple roles supporting the past seven Mediterranean EM Conferences including as Co-Chair of the Rome Congress. All of this was in addition to having previously served on the AAEM Board prior to being deployed by the U.S. Army to be the Middle East Medical Commander, subsequently serving as a U.S. Army General leading COVID support to civilian hospitals and other disaster operations. I currently continue to practice clinically while serving in an academic leadership position with the full support of my medical school to serve on the AAEM Board. Please vote for me to return to the Board and allow me to use all of my relationships in organized medicine and DC to finish this work to benefit you, AAEM, and the causes you believe in. Thank you for your vote.

Holding Lives, Holding My Own

Yash Chavda, DO MBA FPD-AEMUS

I had my first daughter when I was a senior resident. I was working a Peds EM shift when my non-medical wife called to say her water had broken. She was heading home from work and then to the hospital. The ED was blowing up and I only had a few hours left so I asked my wife if it was okay if I finished my shift up, she said yes. I left at 4:00pm and made it to my wife in time. My daughter was not born until the next morning, just enough time for me to find coverage for my remaining few shifts before my vacation block that was coming up.

Unfortunately, I could not find coverage for one Peds EM shift that was coming up. As I worked that shift one of my first patients that day was a four-month-old girl that coded after an exhausted mom rolled over on her in bed. I intubated that baby and worked with my attending to attempt to resuscitate her. I heard the mom wail—we could not save her. I went home that day and looked at my wife and daughter and… compartmentalized my day. I couldn't bear to tell her what happened during my shift.

That same night, I noticed my daughter turning yellow, my wife crying trying to figure out what was going on. I looked at her—looking at me for answers as a physician, but at that moment I was also a dad. I went out and bought baby formula, and my wife gave it to the baby and her crying subsided. We took her to the pediatrician the next day and she had an elevated bilirubin, not enough to send to the hospital or for phototherapy but enough to be noticeable. Luckily the formula helped temper the breastfeeding jaundice she had, and my wife's milk came through.

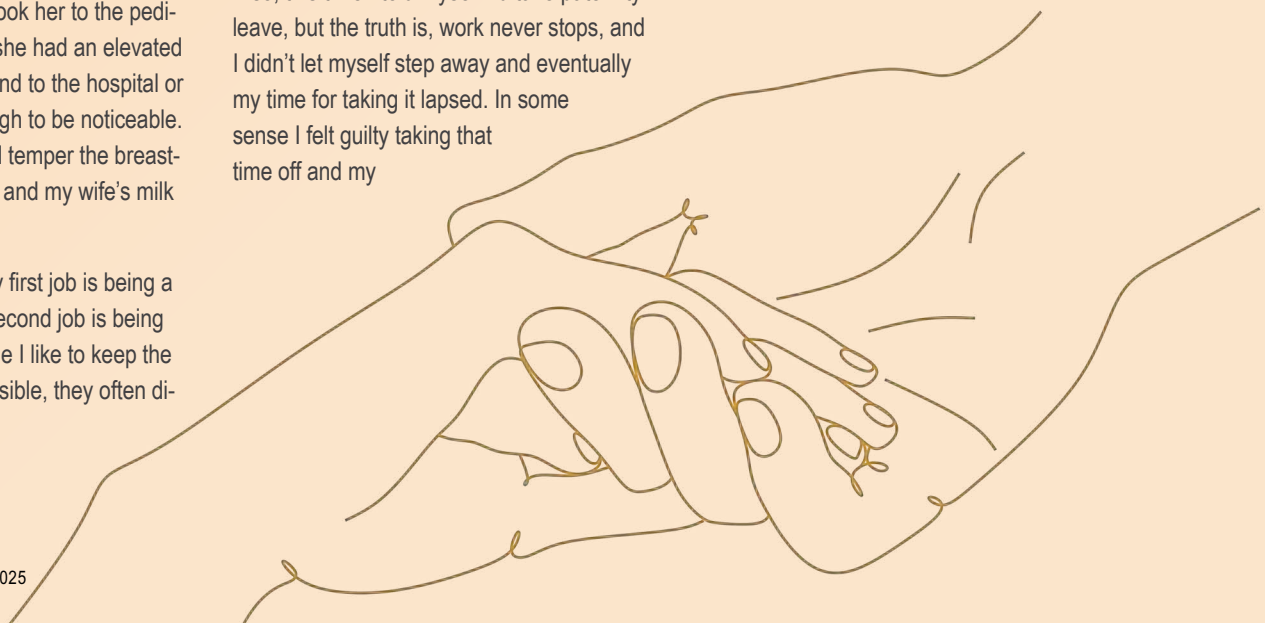
I joke with my wife that my first job is being a dad and a husband, my second job is being an EM physician, and while I like to keep the worlds as far apart as possible, they often directly impact each other.

My older daughter asked me recently what I do for work, and although I told her multiple times that I am an 'emergency medicine doctor,' this time I gave her the simplest answer I could: I take care of people when they need me the most."

Years later, as an attending, I found myself in a different situation, but with the same urgency and responsibility. This time, I was at an EM conference in New Orleans when my wife's call came telling me she was having cramps, and she was going to the hospital. I had cleared the trip with my wife, but this daughter had her own timeline. I emergently bought a very expensive flight back the same morning and managed to make it to the hospital in time. My second daughter was more stubborn, an OP baby. She was not coming easy. Through the haze of medication, my wife looked at me for my medical opinion as the Ob/Gyn suggested vacuum-assisted delivery. I said yes. I held back the memory of the time I struggled during my training with my Ob/Gyn attending with a vacuum-assisted delivery. It went well and as I watched my daughter cry her first few cries, I compartmentalized the medical memories and statistics I knew.

Also, this time I told myself I'd take paternity leave, but the truth is, work never stops, and I didn't let myself step away and eventually my time for taking it lapsed. In some sense I felt guilty taking that time off and my guilt prevented me from doing so. I don't really regret it, my second daughter is growing up fine, but it makes me think more about work and life.

Work-life balance is important in emergency medicine, but our work touches so many lives beyond ours. I continue to try and improve this balance every day. My older daughter asked me recently what I do for work, and although I told her multiple times that I am an "emergency medicine doctor," this time I gave her the simplest answer I could: I take care of people when they need me the most. What I didn't say was that it means experiencing things most people never experience, making life-or-death decisions in seconds, and then somehow finding the strength to come home, push it all aside, and smile for her. One day, she'll understand the weight of it all, not that I would want her to; for now, she just needs her dad. ■

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Understanding Risk Tolerance: A Guide to Smarter Investing

Chris McNeil, MD

Risk tolerance refers to your ability and willingness to endure potential losses or uncertainty while striving to achieve your financial goals. It reflects a combination of emotional comfort with risk, financial capacity to absorb losses, and the time horizon for reaching your objectives. If you have a high risk tolerance, you may feel comfortable with significant uncertainty for the possibility of higher rewards. Conversely, a low risk tolerance often indicates a preference for stability and safer choices, even if it means potentially lower returns. Recognizing and understanding your risk tolerance is essential to creating a strategy that aligns with your objectives while avoiding undue stress or financial strain.

While risk tolerance is a fundamental concept, it is often overused and poorly understood in the world of finance and investing. Many of us have completed a risk tolerance survey or questionnaire—an industry-standard requirement for financial institutions to demonstrate regulatory compliance when providing investment advice. These surveys often fail to capture the nuances of how people behave during market fluctuations. For example, many investors consider themselves "growth-oriented" during market upswings but become "risk-averse" when their portfolios decline. This tendency to overestimate actual risk tolerance can lead to emotionally driven, poorly timed investment decisions.

To better apply risk tolerance in your financial journey, it's important to view it as a fluid and nuanced concept rather than a fixed, one-size-fits-all label. While risk tolerance can help guide your overall investment decisions, it should not dictate that every single investment follows the same level of risk. Instead, each investment or account should have a unique risk tolerance based on the specific goal assigned to it.

Here are some key considerations to help you determine your risk tolerance:

> **"[U]nderstanding risk tolerance is not just about numbers on a page—it's about building a foundation that helps you achieve your goals while feeling confident and at ease with your financial journey."**

Time Horizon

Time horizon is one of the most important factors in determining risk tolerance. In general, longer time horizons allow for higher risk tolerance, as there is more time to recover from market downturns. For example:

- If you need funds within the next 12 to 24 months, consider lower-risk investments to avoid the potential of withdrawing money during a market correction.
- Retirement accounts for individuals still in the workforce typically have a higher risk tolerance, while a savings account for a kitchen renovation next year should be more conservatively managed.

Financial Goals and Liquidity Needs

Each investment should serve a specific financial goal. For instance:

- A college savings plan with a goal just a few years away may require a more conservative allocation compared to a retirement account, which often has decades to grow.
- As the time horizon shortens for a particular goal, such as paying for tuition or a home purchase, rebalancing your portfolio to reduce risk becomes essential.

Emotional Comfort with Volatility

This is often called the "can you sleep at night" test. Everyone has a different level of comfort with the ups and downs of the market.

- Some individuals are more comfortable tolerating swings in the value of their investments, while others feel significant stress during periods of volatility.
- Your emotional comfort level is neither good nor bad—it's personal. What matters most is knowing yourself and aligning your strategy with your capacity to handle uncertainty.
- Remember: Your financial decisions are about your goals. Comparing your strategy to others is unnecessary, as they won't be paying your bills in retirement.

Partner or Spouse Considerations

If you have a spouse or partner, it's important to consider their feelings about risk and volatility as well. Often, couples have different levels of risk tolerance, which can lead to disagreements.

- Developing a plan that meets both partners' emotional needs while working toward shared financial goals is critical.
- Open communication and compromise can result in a strategy that benefits your partnership in both financial and emotional terms.

Continued on page 27 >>

When Your Inner Critic's Full of Haterade

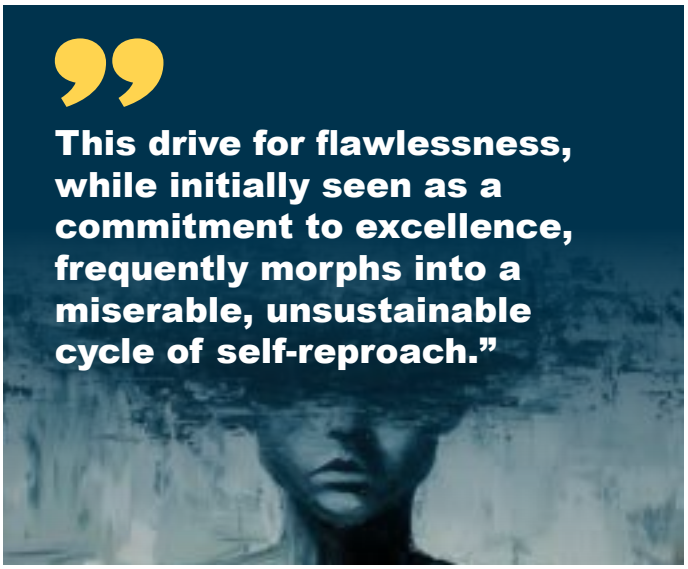
Amanda Dinsmore, MD, Kendra Morrison, DO, and Laura Cazier, MD

Many of us have a raging inner critic, significantly impeding our well-being. Our training stokes the fire of maladaptive perfectionism, of which self-criticism is a key component.[1] We go from being high achievers with an admirable drive to make the world a better place to morphing into perfection junkies, frantically avoiding negative judgments, especially from the voice in our heads. Having harsh inner critics makes our difficult job even more challenging, leading to second-guessing ourselves, anxiety, depression, imposter phenomenon, and burnout.

The Prevalence of Self-Criticism Among Physicians

Self-criticism is quite prevalent among physicians. We train for years to hold ourselves to extraordinarily high standards. Well-meaning people remind us our decisions have enormous impact. "Lives are at stake." Yeah, no kidding. Why do people say that? To add more pressure? I'm already on high alert, and this catapults me to DEFCON 1. It's as helpful as screaming, "Don't mess up!" during someone's golf backswing.

Our perfection-worship culture creates an internal dialogue where even minor errors are magnified. Research supports what many of us have long experienced. Nearly half of physicians report significant emotional exhaustion and depersonalization associated with a pattern of self-critical perfectionism.[2] This drive for flawlessness, while initially seen as a commitment to excellence, frequently morphs into a miserable, unsustainable cycle of self-reproach.



The Harms of Excessive Self-Criticism

Many rationalize self-criticism as necessary for exemplary performance. However, I gradually observed that excessive self-criticism did me more harm than good. The internal barrage of nitpicking intensified stress and deepened feelings of dread and borderline despair. I'd obsess about all the ways I could potentially mess up. Why? Because if I did, even slightly, *even if no one was harmed*, I'd be left to listen to vitriol from my inner critic repeatedly.

Studies consistently link these patterns to burnout, depression, and anxiety among healthcare professionals. Self-criticism triggers the threat-detection systems in our brain, meaning we're *en garde* against our greatest nemesis, ourselves.[3]

Where Does the Inner Critic Come From?

Jill Bolte Taylor, Ph.D., describes in "Whole Brain Living" how different brain regions shape our thoughts, emotions, and behaviors.[4] Four distinct "characters" live in the left and right hemispheres:

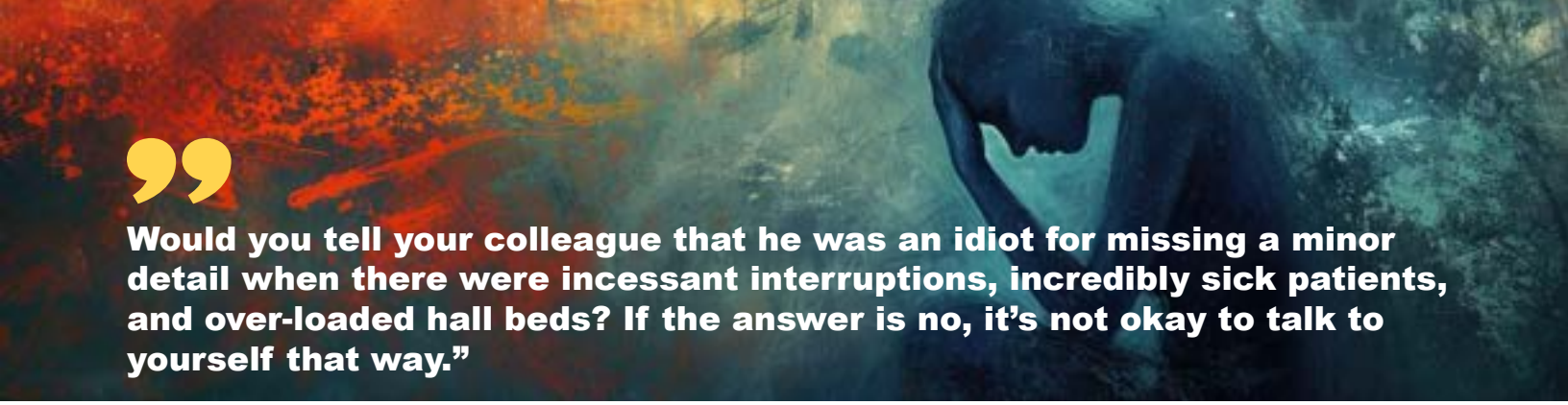
- **Left Brain Thinking (character one):** the logical, organized, and goal-oriented self
- **Left Brain Emotional (character two):** the inner critic, shaped by past experiences, fear, and self-judgment
- **Right Brain Emotional (character three):** the playful, creative, and spontaneous self
- **Right Brain Thinking (character four):** the deeply connected, peaceful, and expansive self

Inner criticism is primarily attributed to character two. This part of our brain holds past pain, fears, and limiting beliefs, often replaying critical or judgmental thoughts. It keeps track of perceived failures and maintains a sense of separation from others. Because of the nature of our work, I suspect many doctors have over-functioning characters one and two and under-functioning characters three and four.

Data on Self-Compassion: Insights from Kristin Neff's Research

To counterbalance our harsh inner critic, we can turn to the research on self-compassion from Kristin Neff, Ph.D. It conceptualizes self-compassion as comprising three core components: self-kindness, common humanity, and mindfulness.[5] According to her research, treating oneself with the same understanding and care we would offer a dear friend, rather than harsh self-judgment, can be a potent antidote to the relentless inner critic. Would you tell your colleague that he was an idiot for missing a minor detail when there were incessant interruptions, incredibly sick patients, and over-loaded hall beds? If the answer is no, it's not okay to talk to yourself that way.

In various studies, higher levels of self-compassion tend to be associated with lower levels of depression, anxiety, and stress. Also, individuals with



Would you tell your colleague that he was an idiot for missing a minor detail when there were incessant interruptions, incredibly sick patients, and over-loaded hall beds? If the answer is no, it's not okay to talk to yourself that way."

greater self-compassion show enhanced emotional resilience when faced with setbacks.[6] Self-compassion is not simply about feeling better at the moment—it is a sustainable, evidence-based approach to mitigating the pervasive harms of excessive self-criticism.

Self-compassion fosters a healthier, more balanced perspective on our imperfections. Rather than viewing mistakes as evidence of personal failure, it encourages us to see them as part of the human experience. This perspective is particularly valuable in emergency medicine, where the stakes are high, and errors are unfortunately inevitable. Embracing that we are talented, intelligent, hardworking, but universally imperfect humans doing our best in less-than-ideal circumstances makes it easier to persevere in this challenging field.

Strategies to Overcome Self-Criticism

Good news. Harsh self-criticism isn't a fixed trait. It's a changeable habitual thought pattern in your brain. Overcoming self-criticism is a gradual process, and several techniques can be beneficial:

- **Mindfulness Practices.** Mindfulness is observing the present moment without judgment.[7] You can reduce the emotional charge of harsh self-criticism by observing the thoughts as transient mental events rather than absolute truths.
- **Cognitive-Behavioral Approaches.** When spiraling into self-criticism, make a conscious effort to challenge its validity. Daniel Amen, MD, suggests identifying the thought and then asking five questions:[8]
  - Is it true?
  - Is it 100% true?
  - How do I feel when I have the thought?
  - Who would I be/how would I feel if I didn't have the thought?
  - What is the opposite of the original thought (and what's true about it)?
- **Cultivating Self-Compassion.** Start treating yourself with kindness and understanding, especially when experiencing failure or disappointment. Your mistakes do not define you, and self-forgiveness is essential for growth. If you're concerned you will suddenly become lazy and uncaring without your self-flagellation, think again. You've made it this far not because of your inner critic *but despite it.* Psychology generally agrees that positive reinforcement motivates "exceedingly better and faster" than punishment.[9]
- **Seeking Professional Support.** Discussing challenges with trusted colleagues, coaches, and mental health professionals helps. They provide external perspectives and practical strategies for coping with self-critical thoughts. Evidence suggests this collaboration significantly improves physician burnout.[10]

Conclusion

While self-criticism is deeply ingrained in our professional culture, it's not an inevitable byproduct of high standards. It is a modifiable behavior that, when left unchecked, can lead to adverse outcomes, both personally and professionally. By cultivating self-compassion, we can counterbalance the destructive effects of our inner critic.

Adopting mindfulness practices, challenging negative thought patterns, and embracing self-compassion can contribute to a more fulfilling career. In emergency medicine, such strategies are not just beneficial—they are essential.

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Welcome to Miami!

On behalf of the Scientific Assembly Planning Work Group of the American Academy of Emergency Medicine Education Committee, we are looking forward to welcoming you to AAEM25 Scientific Assembly and to Miami, Florida. This event is one of the most anticipated conferences of the year, with a focus on cutting edge clinical medicine and practical application to patient care. Whether you're looking for critical care, advocacy, tox, or ultrasound, emergency physicians from every state and practice setting will come away with new knowledge and skills that will change your practice of emergency medicine.

AAEM25 will feature popular sessions like the seven-minute "short and sweet" Breve Dulce lectures and Small Group Clinic workshops. We heard your feedback and have added some longer concurrent sessions to delve deep into important topics. You will see talented new speakers take the plenary stage, as well as returning favorites. We are especially looking forward to our keynote speaker, Dr. Stuart Swadron, who will help you rediscover your passion for emergency medicine.

Networking opportunities are plentiful. Join us at the Opening Reception and the engagEM! Social on Tuesday, where you can learn about AAEM and earn free drink tickets. Many AAEM groups are hosting educational and social events with opportunities to meet new colleagues and catch up with friends.

The Scientific Assembly Planning Work Group has invested significant time and thought to ensure that every participant has an educational, enjoyable, and safe experience in Miami. We look forward to sharing these amazing topics and engaging presenters with you.

See you in Miami!

Co-Chair
Zachary Repanshek, MD FAAEM

Co-Chair
Julie Vieth, MD FAAEM

Vice Chair
Harman S. Gill, MD FAAEM

Breve Dulce

These ever-popular "short and sweet" sessions are seven-minute overviews and 25 slides packed full of information! Plan to catch a variety of Breve Dulce topics at AAEM25 to round out your educational experience.

Small Group Clinics

These sessions provide personal and hands-on education on procedures, ultrasound skills, communication skills, and more! All workshops will be filled on a first-come, first-served basis. Sign up is available at 7:30am ET beginning the day before the workshop.

Scan the code to learn more about small group clinics.

Visit the AAEM25 website for full educational details including the scientific program, hotel and travel information, and more!

Keynote Speaker

Re-discover your passion for emergency medicine at the keynote address, An EM Doc's Education, presented by Dr. Stuart Swadron.

Competitions

The spirit of competition is alive at AAEM25.

- NEW at AAEM25: FLAAEM Games - the ultimate platform for emergency medicine residency programs to showcase their mastery!
- Sim Sono Sleuthing Case Challenge
- Open Mic Competition – Onsite sign-ups available!
- CCMS-AAEM Breviloquent Competition

Learn more about competitions by scanning the code.

Abstracts

Browse the poster displays or attend abstract presentations at AAEM25.

- Photo Competition – The Guided Top Poster Tour is back! Embark on a journey with an expert tour guide to hear presentations on the 24 top-rated case reports.
- AAEM and *Journal of Emergency Medicine* Resident and Student Research Abstracts
- AAEM/RSA & *Western Journal of Emergency Medicine* Population Health Research Abstracts
- AAEM Young Physicians Section (YPS) Research Abstracts

Scan the code to learn more about abstracts at AAEM25.

Boost your CME by signing up for an add-on course (formerly known as a pre-conference course) before AAEM25.

Collaborate and network with colleagues from around the world.

AAEM/RSA Track at AAEM25

April 9, 2025 | 8:00am – 5:25pm ET

The AAEM/RSA Track programming is selected by residents, for residents. The sessions are designed to equip emergency medicine residents with essential knowledge and skills as they transition from residency to the next phase of their careers. Through a series of expert-led presentations, participants will explore key topics that range from administrative skills and professional development, to personal well-being and patient care.

See all Resident and Student AAEM25 highlights by scanning the code.

Network at Social Events

Join AAEM for networking and other fun activities throughout the Assembly. Kick off AAEM25 at our Opening Reception. Enjoy light hors d'oeurves and drinks while networking with colleagues and exhibitors. Get a taste of what AAEM groups have to offer at the Social Media Bar, the Palliative Care Tea and Cookies session, and many other events. Explore opportunities to get involved in AAEM with the engagEM! Social. Attend Curbside: EM Stories by EM Docs for an evening that promises to showcase the great range of human experience and suggest ways to overcome the challenges we all face each day.

Learn more about all the networking opportunities at AAEM25 by scanning the code.

Take time to celebrate and recharge at socials hosted by AAEM's committees, sections, and chapter divisions throughout AAEM25.

Keynote Speaker

Keynote Address:
An EM Doc's Education
Tuesday, April 8, 2025 • 8:55 AM – 9:40 AM ET

Stuart P. Swadron, MD FRCPC

Plenary Speakers

Plenary I—Emergency Cardiology Literature Update: The Articles You've Got to Know!
Monday, April 7, 2025 • 1:45 PM - 2:30 PM ET

Amal Mattu, MD FAAEM

Plenary II—Recent Critical Care and Resuscitation Articles You've Got to Know!
Monday, April 7, 2025 • 2:40 PM - 3:25 PM ET

Mike Winters, MD MBA FAAEM

Skyler Lentz, MD FAAEM

Plenary Speakers, continued.

Plenary III— Did You Ask About Intimate Partner Violence?
Tuesday, April 8, 2025 • 8:00 AM - 8:45 AM ET

Joelle C. Borhart, MD FAAEM

Plenary IV—Pediatric Emergency Medicine: Cutting-edge Updates and Essential Insights
Tuesday, April 8, 2025 • 3:15 PM - 4:00 PM ET

Mimi Lu, MD FAAEM

Ilene Claudius, MD FAAEM

Plenary V—Battle of the Ages: A Discussion on Geriatric Emergency Medicine Controversies
Wednesday, April 9, 2025 • 9:00 AM - 9:45 AM ET

Danya Khoujah, MBBS MEHP FAAEM

Phillip D. Magidson, MD MPH FAAEM

Plenary VI— Excited Delirium: Fact or Fiction?
Wednesday, April 9, 2025 • 2:30 PM - 3:15 PM ET

Valerie A. Pierre, MD FAAEM

Cortlyn Brown, MD FAAEM

Italo M. Brown, MD MPH FAAEM

Kelli Robinson, MD FAAEM

Plenary VII—When Minutes Count - Updates in Emergency Neurology
Thursday, April 10, 2025 • 8:10 AM - 8:55 AM ET

Wan-Tsu W. Chang, MD FAAEM

Plenary VIII—The Success of Failure: Dealing with Adverse Outcomes
Thursday, April 10, 2025 • 10:00 AM - 10:45 AM ET

George Willis, MD FAAEM FACEP

AAEM25 Speakers

Scan the code to browse speakers.

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Thank you to all AAEM25 speakers for your invaluable contributions, enriching our conference with knowledge, innovation, and inspiration. Your expertise has truly made a difference. Thank you!

Thanks to our 2025 Industry Partners

AAEM extends its thanks and appreciation to the following industry partners who have funded activities at the 2025 AAEM Scientific Assembly.

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BRONZE SPONSOR – Up to $4,999 SUPPORT LEVEL

- ConsensioHealth
- QMACS

Visit the Exhibit Hall to make new connections – exhibiting and sponsorship opportunities are still available.

AAEM25 Exhibitors – Thank You

Plan your visit to the exhibit hall in Miami to network with these exhibitors:

- Abbott
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- ApolloMD
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- Auburn University - Physicians Executive MBA Program
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- Kansas Emergency Physicians
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Wellness Committee's Know Before You Go: Can't Miss Events for SA25 in Miami, FL!

Neha Bhatnagar, MD,* Janae Hohbein, DO,† and Jennifer Kanapicki Comer, MD FAAEM‡



The Wellness Committee is excited to announce our numerous events at the upcoming AAEM Scientific Assembly happening April 6-10, 2025, in Miami, FL!

To kick it all off, we will have our **New Attendee Welcome** on Monday April 7 at 11:30am ET in the Trianon Room just before the Opening Remarks. Come say hello to old friends and meet new ones over snacks. This is a great event for any solo travelers or first-time attendees to AAEM.

Later on Monday afternoon, we will have our **Wellness Committee Meet and Greet** at 5:00pm ET in the Alhambra Room. Anyone who is interested in Wellness is welcome to join us! You do not have to have any prior experience or involvement in our committee. We are eager to meet you and hear your ideas and perspective.

We are thrilled to bring back our **Wellness 5k Fun Run/Walk** which will take place early Tuesday April 8 morning at 6:30-8:00 am ET. We will meet up in the InterContinental hotel lobby and head over to Bayfront Park together. The cost of registration gets you a slick "Light EM Up!" t-shirt! Any activity level is welcome: whether you walk, run, or salsa down the route, come join us for some fresh oceanfront air and physical wellbeing!

Our most popular event is back again this year with a new name: **CURBSIDE: EM Stories by EM Docs!** Formerly known as Airways, this beloved gathering showcases real stories from your fellow emergency medicine colleagues, offering an unfiltered glimpse into the highs and lows of life in EM. Join us on Tuesday evening from 6:30pm-8:30pm ET in the Gusman/Tuttle room for an evening of joy, heartbreak, intrigue, and hilarity at this must-attend event! No PowerPoints, no projectors, no CME—just pure connection. It's about you, your peers, and the shared experiences that unite us all. Grab a drink (if you like), bring a friend, and settle in to commiserate, laugh, and bond over stories that resonate far beyond the department. And no, the stories aren't all about airway patients—contrary to popular belief from past years!

On Wednesday April 9 at 6:00pm ET in the Michelangelo Room, we will have our second annual **Mental Health Action Plan** workshop: a small group discussion sharing the strategies one may use for maintaining and improving your mental health, whether you find yourself having a good (green), neutral (yellow), or difficult (red) day. We will share what works for each of us and together make our own individual plans that can be referenced in the future whenever we need them.

Immediately after that at 7:00pm ET Tuesday evening, stick around in the Michelangelo Room for the **Paint 'N' Sip** event: come express your creativity by painting with friends and colleagues while sipping wine and laughing together. There will be a Miami themed painting for those who want to participate, but as always feel free to create your own art instead! The cost of registration covers the art supplies.

Join us for one of our **F3 Meals: Friendship, Fun, and Food!** These are small group gatherings intended to foster meaningful connection and conversation over delicious food at a local restaurant. The event itself is free, but each participant pays for their own meal/drinks. We will have a few options for dates and times, so be sure to sign up during the registration process if you're interested so we can coordinate together!

The Wellness Committee looks forward to seeing you in sunny Miami this spring!


References

*Wellness Committee Co-Chair; Guthrie Medical Group, Corning, NY
†University of Illinois
‡Wellness Committee Co-Chair ■

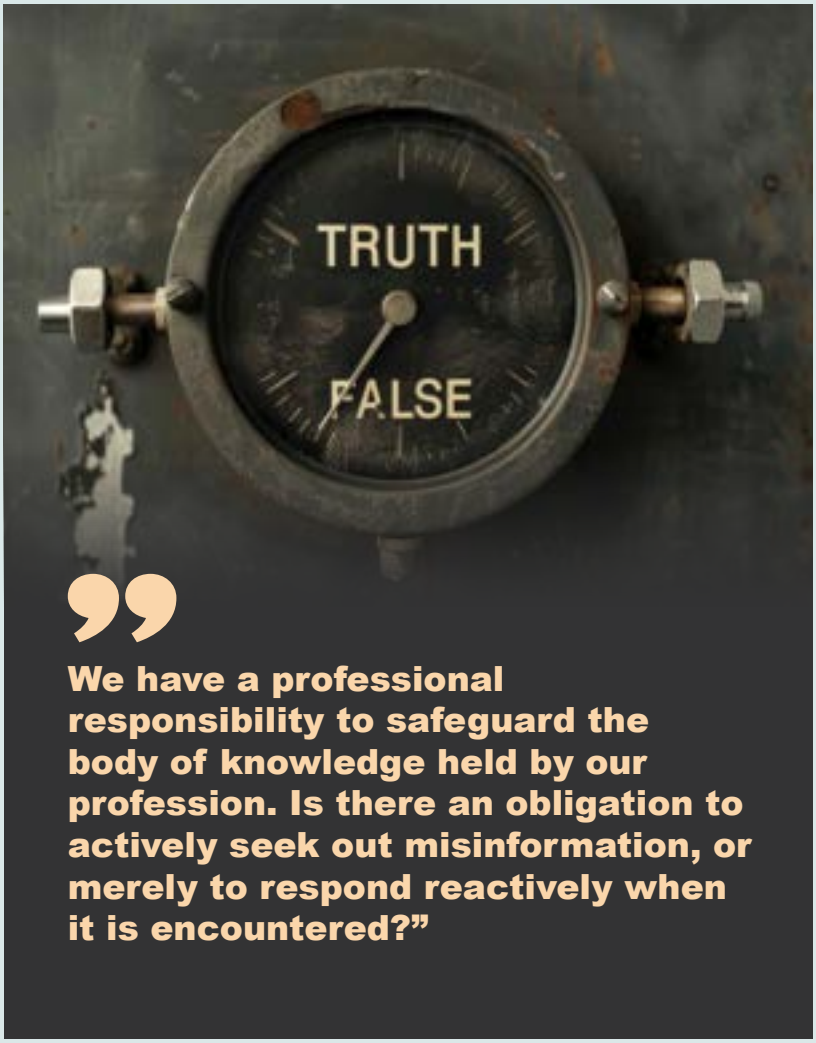
The Ethics of Combating Misinformation in the Digital Age

Melissa Myers, MD FAAEM and Ben Wedro, MD FAAEM

Misinformation is defined as false or inaccurate information, which is deliberately intended to deceive. We live in an age where unfiltered access to the internet allows misinformation to be disseminated unchecked. This is especially harmful to people who seek to understand their own medical conditions, or the conditions of loved ones, and may not have a good way to validate the information they are receiving. Patient encounters with their physician have become increasingly brief and there may be roadblocks to access medical care in a timely manner. Access to information online is readily available but it is not curated or reviewed. Misinformation abounds, from content creators who are merely misinformed themselves through those who actively intend to deceive to profit themselves.

What are the responsibilities of professional societies and their individual physician members regarding this misinformation? We have a professional responsibility to safeguard the body of knowledge held by our profession. Is there an obligation to actively seek out misinformation, or merely to respond reactively when it is encountered? Certainly, we encounter misinformation routinely in our roles as physicians. Many of us have cared for patients in the emergency department who request treatments with minimal or no evidence, such as Vitamin C for sepsis. In this case, a physician-patient relationship exists and there is a duty to provide accurate information regarding the disease and the validity of available treatments.

There are times when a physician may decide to avoid directly confronting misinformation to avoid disruption to patient care. Take the case of a child with moderate respiratory distress who is diagnosed with pneumonia and requires admission for respiratory support. The parents are hesitant to agree to admission, and during conversation with the emergency physician report that the child is not vaccinated. In this case, the obligation to advocate for widespread vaccination and public protection is weighed against the immediate need to ensure that the child is cared for. We argue that in this case, there is no positive duty to discuss vaccination with the parents, but the duty remains if possible in other circumstances.



We have a professional responsibility to safeguard the body of knowledge held by our profession. Is there an obligation to actively seek out misinformation, or merely to respond reactively when it is encountered?"

Duties to the patient are clear when a physician-patient relationship exists, but determining when to combat misinformation on social media presents a greater challenge. It is indisputable that misinformation surrounding medical therapies is rampant on social media. One anti-vaccination post was shared 812,000 times between February 1 and March 16, 2021.[1] In general, no physician-patient relationship exists on social media, and it could be said that there is then no obligation to confront this misinformation. However, this information can lead to clear patient harm. Websites advocating that patients with cancer avoid chemotherapy in favor of baking soda result in clear harm to patients.[2] Similarly, misinformation surrounding alternative and unproven treatments for COVID-19, such as hydroxychloroquine resulted in patient harm before the initial papers were withdrawn.[3]

We argue that a duty exists for the individual physician to speak and to educate the public, even one patient at a time. But there is a demarcation that should be drawn for that duty. On one's private social media account, there is no duty to respond to misinformation

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Maybe Drugs Aren't the Problem

Mahan Naeim, MD

As emergency medicine (EM) physicians, we have an intimate and complex relationship with drugs, whether or not we are aware of it. Our emergency departments (EDs) care for patients who use illicit substances and, frankly, employ crucial members of our teams who use drugs personally. The difference between the patients and the clinicians in the ED is less likely to be the drugs but more likely the privilege, socioeconomic, and professional status. The patient who is apneic with pinpoint pupils or tachycardic, anxious, and picking at their skin is all too familiar to us. Clinicians are often quick to make judgments on these patients, labeling them "abusers" and "users." Assumptions about their backgrounds, motivations, and ability to adhere to medical treatment are often made because of the substances they choose to use. But what if it's not the heroin, the methamphetamine, the drugs that are the root of the problem? What if it is the structures, systems, and drug policies of the United States that are the true cause of harm?

"For many thousands of years, in every known culture, there has been some percentage of the population—usually the shamans, the curanderos, the medicine men—which has used this or that plant to achieve a transformation in its state of consciousness."
Alexander and Ann Shulgin (PIHKAL)

Using drugs is not outside of the norm for the human condition; rather, anthropology has shown that this is the norm. Almost ubiquitously, cultures share traditions of consuming ethanol or another drug as a form of community building. We have found evidence of cannabis consumption more than 2,500 years ago in China and 1,000-year-old pouches that contain ayahuasca and coca in Bolivia.[1,2] Human beings use drugs. Human beings will always use drugs. This realization is key to providing empathetic and patient-centered care in the emergency department.

Medication-assisted treatment (MAT) within the ED is a fantastic example of the care and progress we can make when accepting that human beings will use drugs. MAT with buprenorphine has saved countless lives in the midst of the opioid epidemic and should expand with fervor. However, MAT falls short in caring for, acknowledging, and accepting the people who wish to continue using their drug of choice. Not all drug use is chaotic or problematic. Stopping all drug use would not benefit every patient's life. The more interactions I have had with patients who do not want to stop using, the more I increasingly find highly rational, practical, and irrefutable reasons for why they wish to continue to use their drug(s): opioids to help secure sleep, solace, and a sense of warmth in the unsheltered and harsh outdoors; amphetamines to stay vigilant and productive in a world that is unkind and demanding of physically taxing labor in order to afford food.

The War on Drugs (WOD) policy, which in large part has influenced and shaped international policy, has been one of intense criminalization and brutality to supposedly stop the flow of illicit drugs to the populace. This policy of incarceration and military expansion in the pursuit of total illicit drug prohibition has defined the modern era of drug laws. However, once it is accepted that human beings will forever ingest psychoactive substances, the futility of the WOD is inescapable. Unfortunately, futility would have been the best outcome of the WOD policy, as what we witness in our EDs is the catastrophe of this policy. The War on Drugs is the biggest problem.

Crackdowns on illicit drugs in demand inevitably lead to the rise of adulterants and other substances we know less about and therefore can treat less effectively. We have witnessed the rise of street fentanyl, xylazine-laced fentanyl, MDMA that is actually methylone, stimulants laced with opioids—the list is endless. This is the direct product of a criminalized, unregulated drug market that has allowed profit-driven motives to supply the demand that remains after a drug of choice becomes more scarce. As a second-year resident, I feel confident about a few things, but I am confident that currently and for the rest of my career, I would take better care of a patient with a single known drug overdose than a patient with a poly-drug ingestion of unknown and unstudied chemicals.

The nature of the WOD problem must include an indictment of its policy as the most significant contributor to systemic racism through mass incarceration in the United States. Our country is roughly five percent of the world's population with approximately 25 percent of the world's incarcerated population.[3] Of that population, 77 percent of people incarcerated in federal prisons for drug offenses are Black or Latino. Black and Latino folks make up roughly 30 percent of the United States population.[4] Drugs have also been used as scapegoats in instances of state violence. The world watched as George Floyd was murdered with a police officer's weight on his neck. The defense for the officers and some in the media raised the question of fentanyl playing a driving role in his death. As EM physicians, we know firsthand that people dying from opioid overdoses do not say, "I can't breathe."

"Penalties against possession of a drug should not be more damaging to an individual than the use of the drug itself; and where they are, they should be changed." *Jimmy Carter*

What can we do? Let's understand that drugs are a part of people's lives and not always a problem in their lives. Let's accept that some can use opioids in a way that mirrors our morning cups of coffee. Let's admit that some can use MDMA responsibly to build community and celebrate life without having a diagnosis of PTSD to validate their ingestion. While holding these truths, we can continue to pursue and provide medication-assisted treatment to those who have found their drug use to be problematic and would like to change. To those who are not ready to stop their use, do not want to stop, or can't stop, let's provide harm reduction supplies, from clean needles to band-aids. Fentanyl does not spread HIV—shared needles do. Methamphetamine does not cause endocarditis—dirty and unsterile injections do. Let's work towards a world where laws and policy protect our patients and allow for their use to be safer. Let's contend that drugs aren't the problem, it is the ***war*** on them that is the principal problem.

People always have and always will use drugs. MAT is a beautiful and valid option. For some, using drugs is an equally valid option that should be met with respect, understanding, and harm reduction.

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3. Roy Walmsley, *World Population List, 10th Ed.* (London: International Centre for Prison Studies, 2013); National Research Council, *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (Washington, D.C.: The National Academies Press, 2014).
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Continued from page 15

Finding the Right Balance

By thoughtfully evaluating these factors—time horizon, financial goals, emotional comfort, and partner considerations—you can refine your investment strategy to balance growth potential with effective risk management. Self-awareness and careful planning will empower you to make informed decisions that align with your financial needs and personal comfort level.

In the end, understanding risk tolerance is not just about numbers on a page—it's about building a foundation that helps you achieve your goals while feeling confident and at ease with your financial journey.

Dr. Chris McNeil, the author of this explanation, is an emergency physician and former emergency medicine residency program director who transitioned his career to finance. He owns a registered investment advisory firm, VitalStone Financial, LLC, and specializes in financial planning for physicians. ■

Fear: The Unseen ED Visitor

Gary M. Gaddis, MD PhD FIFEM MAAEM FAAEM FACEP

Dr. Edwin Leap's column, "Listening Skills," offered in the November/December 2024 *Common Sense*, has inspired me, a late-career emergency physician, to offer observations about listening for patients' fears. This is done toward helping your patients be more likely to feel heard, and toward helping you increase your job satisfaction, a step that can help mitigate the feelings of burnout that are so pervasive in our specialty.

The good Dr. Leap noted the importance of listening to our patients. He quoted Sir William Osler, who famously said, "Listen to your patient, he is telling you the diagnosis."

Why did the esteemed Dr. Osler say this? Isn't it obvious? Physicians are quite adept at interrupting our patients. This is an ageless phenomenon. And these interruptions can keep us from learning what the patient really hopes we can do for them.

Not only must we listen to our patients, but I think we need to do a better job *finding and addressing* our patients' *fears*. Nobody taught me this, but in my experience, most of the patients whom we see are in our EDs are accompanied by a fear of something. It's almost as if any patient room contains two persons, the patient themselves, and Mr. Fear or Ms. Fear.

Why do I assert fear is pervasive? Consider that:

- Many patients with a twisted ankle fear having a fracture.
- Many with chest pain fear they are having a heart attack.
- Many with abdominal pain fear having a surgical condition such as appendicitis, a severe ulcer, or gallstones.
- Many with weakness or numbness fear they are having a stroke.

With such fears in mind, I have learned to approach all of my patients with three goals:

- Seek their fear by giving the patient permission to share it.
- Find their fear by having the patient state it.
- Address their fear, alleviating it when possible, by applying your training and clinical skills.

> **Patients who feel heard, even if you have to give them bad news, are usually satisfied."**

Thus, the three steps I suggest, regarding fear include:

Seek Their Fear

Once I meet a patient and note what the electronic health record says is their chief complaint, I first address whether that written data is true. (Often, it is not.) When I make it clear that I want the patient to share their fear while I am confirming their chief complaint, I know that I can often find their fear by asking them what they hope I as a doctor or we as a medical team can do for them. If I get an unclear answer, I just ask point blank, "Is there something specific that you are afraid might be wrong with you?" This ask communicates caring, shows that you prioritize the patient and their concerns, and gives permission to the patient to name their fear or fears.

Find the Fear

Usually, a patient's history and physical findings align with our abilities, as highly-trained emergency medicine specialists, to decide whether or not the patient has reason to fear. Sometimes, a history and physical alone is sufficient. An example, our ability to diagnose Zoster on sight, so we can tell the patient what to expect. Most patients will take you at your word in such scenarios. Doctors are still, generally, highly respected by patients. If you are not sure if you are addressing the patient's fear(s), just ask them if they feel like there is something being overlooked. Sometimes, your patient will surprise you and lead you to explore further, toward determining their fears.

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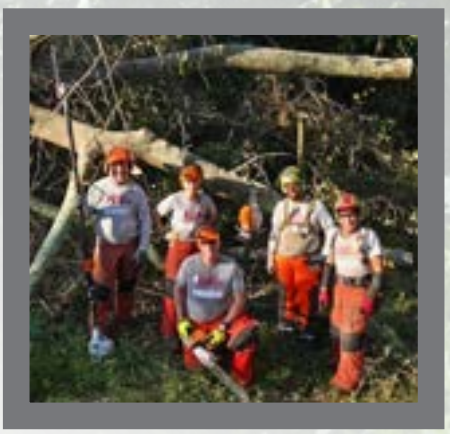
Why Not Me?

William Rutherford, MD



My ship had pulled into Hong Kong for R&R after several weeks on the line off Vietnam, and my shoes were being "spit-shined" by an old Chinese man. As he buffed furiously, a huge lipoma wobbled back and forth on his forearm. I was mesmerized by the oscillations, thinking, "Someone should do something about that…" which was followed immediately by the most important question I've ever asked myself, "Why not me?"

Most, if not all of us have asked ourselves this question in various forms, "What can I do?", "What's my purpose?", etc. A medical career offers several "bright, shiny objects" such as intellectual fulfillment, prestige, income, etc. Such altruism may wane or even disappear as what was once fascinating becomes mundane with familiarity, as we're called out of bed at the most unholy hours, or as we are unable to save patients and accumulate what we refuse to recognize as PTSD. Worse still, some may reach a place where the business aspect so adulterates and obscures the art, science and compassion of medicine to the point that these attributes are no longer sufficiently fulfilling. For those of us fortunate enough to withstand such onslaughts plus our own medical fragility, the final blow may well be retirement. Like the athlete who has only known near perfect physical performance but who can no longer achieve it, we can face an abyss of lack of purpose.

I'm beyond fortunate with my career, fulfilled in many ways. While a fellow in the ICU, I had stopped to look at a beautiful sunset in a brief moment of peace, shared by the attending who had joined me. He counseled me with, "Your job for the rest of your life is to bring order out of chaos." My immediate response to him, "That means you have to go to the chaos." As Teddy Roosevelt said in his famous 1910 Paris speech, I knew I had to be "actually in the arena." What followed over the next four decades was more training, and I achieved board certification in internal medicine, emergency medicine, and critical care. I was privileged to work with great institutions and even greater mentors, colleagues, and allied healthcare partners. Junior faculty positions led to medical directorships of a university emergency department and air medical and ground EM services, a position as editor of a medical journal, and the opportunity to travel the world with over 40 medical missions and responses to international disasters including the 2010 Haiti earthquake.

As my retirement approached two years ago, my wife was searching desperately for something to keep me occupied, likely as much for her own self-preservation as mine since I've been described as "a flea on a hot skillet." She led me to Team Rubicon, a veteran led humanitarian organization that responds before, during, and after disasters and other crises though the United States and around the world. Though a large portion of our volunteers are veterans, we also benefit from the training, experience, wisdom, and discipline

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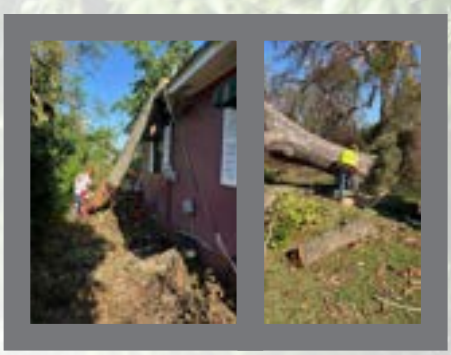
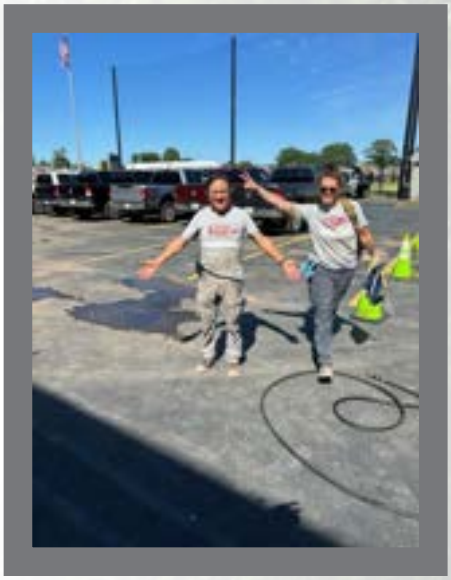
"With each leaky roof we tarp or home we clean and make safe, we watch hope flow back into their faces, just like patients whose day is made better by medical servants of mercy."

The day may start with tears, but often ends with intense gratitude, smiles, and even laughter—and I've never received a paycheck worth nearly as much."





of first-responders—nurses, medics, doctors, fire and law enforcement personnel, as well as "kick-ass" civilians ranging from stay-at-home parents to CEOs. Growing out of a handful of veterans who felt compelled to serve following the 2010 earthquake in Haiti, we now have approximately 180,000 "Greyshirts" in the US, as well as affiliated organizations in Canada and other countries.

Team Rubicon responds when requested by local, state, and federal emergency operations centers and authorities. Our 15th year has been particularly busy from the very beginning—floods and tornados in Texas and the Southeast, fires in Hawaii and California, and oh yes, a few "small rain storms." Hurricanes Helene and Milton required the deployment of 300 Greyshirts a week for most of October through December, from the tip of Florida through Georgia, the Carolinas and eastern Tennessee. We still have ongoing operations that will extend well into 2025. Through just the first 10 months of 2024 we provided over 200,000 hours of labor, serving in excess of 2.9 million individuals and 700 plus communities.

At a "FOB" (forward operating base), Greyshirts start early, get dirty, finish late, and often sleep on cots in a church basement or community hall in what is euphemistically referred to as an austere environment. Those we serve are often devastated, showing the classic "thousand-yard stare," mirroring patients faced with medical calamity. We tarp roofs that have been breached, muck out moldy drywall, carpet, and ruined possessions from flooded homes, remove downed and hazardous trees, open roads with chainsaws (my personal "specialty") and heavy equipment, and much more. With each leaky roof we tarp or home we clean and make safe, we watch hope flow back into their faces, just like patients whose day is made better by medical servants of mercy.

While much of our visible work is intensely physical, other Greyshirts provide the necessary logistical and administrative support so critical to accomplishing our task. Team Rubicon will help anyone in need but prioritizes those with little or no financial or physical capacity to help themselves. Our service is provided without any cost to those we assist. When not deployed to a disaster, Greyshirts train constantly to accomplish our mission while maximizing the cost-effectiveness of our donated funds. The day may start with tears, but often ends with intense gratitude, smiles, and even laughter—and I've never received a paycheck worth nearly as much.

The United States Navy taught me several valuable principles—accountability, discipline, how to lead, and how to follow, but perhaps the greatest lesson was that the more important word in "Armed Services" is service. Team Rubicon is but one of thousands of opportunities to serve others, from similar organizations restoring infrastructure to volunteer tutoring, from handing out food and clothing at shelters to providing rides to medical appointments. It's simply not so much how you serve, but that you serve.

Should you wish to know more about Team Rubicon, please visit teamrubiconusa.org or search Roku TV and YouTube.

Editor's Note: Dr. Rutherford is happy to answer any questions you may have. Please reach out to info@aaem.org with the subject line "Team Rubicon" and we will be happy to forward your email to him. ■

Physicians Are Unionizing: Who, What, Why? And Why Not...

Jennifer Rosenbaum, MD FAAEM

Let's Start With the Why

Emergency physicians are increasingly turning to unions due to a growing lack of control over their practice and working conditions. Collective bargaining gives physicians a stronger voice. A recent study published in JAMA characterized physicians' motivation for union campaigns and concluded that most were non-compensation concerns. More than 80 percent of petitions cited working conditions and lack of voice in management as a motivation for unionizing.[1]

Healthcare has shifted from small independent practices to larger corporate healthcare systems, often with private equity backing. Emergency physicians have amongst the lowest rate of practice ownership compared to other specialties. According to some estimates, private equity owned firms staff nearly 25 percent of all EDs.[2] With less physician partnership, practices may see cuts in labor force and increased use of non-physician practitioners. They may notice shrinking supplies and poor maintenance of facilities and equipment. Emergency physicians have had the highest compensation decrease amongst medical specialists over the past five years and yet increasingly healthcare systems rely on emergency physicians to provide more inpatient care.[3] Simply put—emergency physicians feel they are being asked with do more with less, and they have little control over it. These conditions have contributed to physician moral injury and burnout in our specialty.

Who Is Unionizing?

Residents have led the charge of physician unionizing efforts. About 20 percent of all residents are union members. The Committee of Interns and Residents (CIR) boasts over 34,000 resident members, making it the largest house staff union in the country.

Historically, attending physicians work models were physician-owned, independent practices which excluded them from protections from the National Labor Relations Act (NLRA). Now nearly three quarters of all physicians are employees, which could make them eligible for union membership.[4] Attending physicians have started to organize. In a landmark event, physicians at Christiana Hospital in Delaware recently voted to unionizing marking the largest union of private sector physicians.

It is important to realize that not all physicians can unionize in their current roles. Physicians who are partners in a democratic group or work as independent contractors as defined by the National Labor Relations Board cannot unionize. However, this line is subject to some legal scrutiny. Some interpretations of the law suggest that emergency physicians with long-term contracts could be union eligible. Managers and supervisors are also generally not eligible to unionize (though there is some nuance in the law here too).

What Unions Are Emergency Physician Joining?

Some physicians are joining pre-existing unions including the Doctors Council (SEIU), the Union of American Physicians and Dentists, and the American Federation of Teachers (AFT). Others are forming their own.

Why Not Unionize?

Many emergency physicians see unionization as a solution to improve their workplace conditions and maintain quality patient care. However, there are some areas of caution to consider. First and foremost, most labor unions have the right to strike and consider this a negotiation tactic. By law, healthcare workers can strike if giving 10 days' notice. But ethically, most emergency physicians could not imagine a full strike in patient care. The decision to strike is complicated for physicians and therefore limits the power of the threat. There have been very few physician strikes, with most strikes occurring with resident employees. Physicians are more likely to consider adjusting their workflow in a way that would not harm patients but could affect their employer, like neglecting documentation, hence preventing effective billing.

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> **Simply put—emergency physicians feel they are being asked with do more with less, and they have little control over it."**

Additionally, forming a union comes with some financial costs. These costs are not always easy to estimate ahead of time. There may be costs in labor attorneys and labor dues after contract formation. Forming a union can take a long time and negotiating a contract may take even longer. Lastly, some worry that there is a stigma associated with unions that may make the standing of physicians seem less professional. Still when surveyed, over 80 percent of emergency physicians report interest.[5] With high levels of union curiosity and the growth of resident union members entering the attending workforce, I'd keep an eye on this trend.

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Continued from page 25

encountered while viewing other profiles. This lack of obligation is similar to avoiding a person who chooses to confront you in a nonprofessional setting. There is no duty to engage in discourse, aside from perhaps agreeing to disagree. But when the physician is using social media in their professional sphere, like writing a medical blog, promoting their practice, or interacting with governmental and private organizations, an obligation exists to promote and protect accurate information and counter misinformation that is being spread.

In the world of medical liability, the act of omission is as culpable as the act of commission should it result in patient harm. In an age where patients receive information, from a variety of sources, much of which is not evidence based, researched, may be harmful to the individual, and sometimes to society as a whole, there is an obligation for the physician to positively step forward to combat misinformation when encountered in their professional sphere, and not presume that the responsibility belongs to others. This is the same duty required of those physicians who have chosen to engage in social media, podcasting, or other methods of engagement with the public at large. It should be the same duty for every physician whenever the opportunity presents itself.

Author's Note: The opinions and assertions expressed herein are those of the author(s) and do not reflect the official policy or position of the Uniformed Services University of the Health Sciences or the Department of Defense.

The authors would like to thank Dr. Kaveh Hoda from the "House of Pod" podcast, whose recent episode on medical misinformation sparked the idea for this article.

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Transgender Health Emergencies: A Primer for Physicians

Mel Ebeling, BS and Erin Carriker, MD MS

Over the past two decades, there has been a considerable increase in the amount of education provided on LGBTQ+ health in both the graduate and undergraduate medical education spheres, as evidenced primarily through the increase in number of publications on educational interventions introduced in this space.[1-3] Still, there remains a large gap between actual and optimal amounts of education provided on LGBTQ+ health, and as it relates to transgender-specific content in particular, there is significant room for growth.[1,2]

Caring for LGBTQ+ patients, particularly those who are transgender, surpasses using correct pronouns and inclusive sexual history-taking. Rather, it also involves recognizing urgencies and emergencies related to gender-affirming medical and surgical interventions. When transgender patients "pass" (i.e., when they are readily perceived as cisgender—the gender they identify with—as opposed to their sex assigned at birth), the unique health concerns of transgender individuals may be overlooked, especially if these patients do not disclose their transgender identity due to the gender euphoria from passing. When assumptions are made based on physical characteristics alone, they can negatively impact risk assessment for various conditions. In emergency situations, this can have devastating consequences.

> **"Caring for LGBTQ+ patients, particularly those who are transgender, surpasses using correct pronouns and inclusive sexual history-taking."**

Given that recently developed content on LGBTQ+ health has likely only reached our newest and upcoming physicians, we acknowledge the importance of providing an overview of transgender health emergencies for all physicians. We hope that this synopsis will be a helpful introduction to the potential complications of gender-affirming care that may be seen in emergency departments.

Urgencies and Emergencies in the Transgender Woman

In both transgender men and women, urgencies and emergencies associated with gender-affirming care can be generally categorized as stemming from either hormonal therapy or surgical/cosmetic procedures.

For transgender women taking estrogen, physicians should be cognizant of the increased thrombotic risk associated with this therapy, especially when evaluating patients complaining of chest pain, shortness of breath, and limb pain/edema, as they may be experiencing a deep vein thrombosis or pulmonary embolism.[4,5]

Feminization of body parts can also be achieved more rapidly through certain plastic surgery procedures, such as dermal fillers and breast augmentation via silicone implants. Similar to this procedure being performed by a trained medical professional on a cisgender woman, breast augmentation does come with a risk of implant rupture, causing silicone migration and inflammation. A patient with an implant rupture may present with chest/breast pain or tenderness with breast asymmetry.[6] However, rapid feminization of the breasts, in addition to the face, hips, and buttocks, can also be performed via illicit "silicone" injections which come the risk of more severe, even potentially fatal, complications. The dangers of these injections are multifaceted. Often these injections are marketed as medical-grade silicone fillers when they may actually consist of industrial silicone, petroleum, or tire sealant, to name a few.[7,8] They are then typically administered by unlicensed, non-medical practitioners at gatherings known as "pumping parties," which have traditionally allowed transgender women the ability to receive a gender-affirming care at a fraction of the cost and with greater accessibility than standard procedures performed by licensed physicians (albeit at the expense of safety).[7] Complications associated with these "silicone" injections range from skin manifestations, such as cellulitis and granulomatosis, to fatal pulmonary conditions (i.e., silicone embolization syndrome).[9,10]

With gender-affirming "bottom" surgery (i.e., vaginoplasty) for transgender women, emergent complications to be aware of in the emergency department include vaginal stenosis, acute vaginal prolapse and graft loss, and rectovaginal and urethrovaginal fistulas.[11]

Urgencies and Emergencies in the Transgender Man

There are also several hormonal and surgical complications associated with gender-affirming interventions for transgender men. Akin to estrogen therapy for transgender women, testosterone therapy for transgender men comes with an increased risk for thrombosis secondary to polycythemia.[12,13] While ordered as a "basic lab" in many practices, it would behoove any physician to consider obtaining a complete blood count when treating a transgender man, especially if there is a concern for venous thromboembolism.

Gender-affirming "top" surgery (i.e., bilateral mastectomy with or without free nipple grafts) comes with its own unique complications. Hematomas and seromas may present as tender areas of localized swelling under the skin in the days to weeks following surgery despite the placement of Jackson-Pratt drains; depending on the size of the fluid collection and

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its associated symptoms, and surgical evacuation may be warranted.[14] Perhaps even more emergent is graft failure, evidenced by necrosis of the nipple-areolar complex, which should be differentiated from normal scabbing during the initial graft healing process.[14,15]

"Bottom" surgery (i.e., phalloplasty) is associated with high rates of complications.[16] For the transgender male presenting with a genital or urologic concern, the emergency physician should consider and assess for partial flap loss (necrosis), in addition to urethral strictures and fistulas.[17-19]

Conclusion

Care of the transgender patient presenting with an emergency secondary to a gender-affirming care intervention ultimately revolves around the recognition and acute stabilization of that complication. Many of these risks are the same as those associated with similar procedures in cisgender persons as well (breast augmentation, filler complications), however the recognition may be more difficult. For complications of a surgical procedure, it is necessary to communicate with the performing surgeon for further inpatient management or outpatient follow-up. If unavailable, consulting the appropriate service (likely plastic surgery or urology, depending on the nature of the procedure) for further guidance is essential. Finally, it is important to be mindful of "trans broken arm syndrome" (gender-related medical misattribution and invasive questioning) when treating the transgender patient.[20] While complications of gender-affirming interventions *can* be the etiology of an emergency, it is entirely possible (and perhaps even more likely) that a patient's gender identity has nothing to do with their chief concern—be cautious to avoid pigeonholing in these situations.

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Student Mentorship for the Community Doc: Part One

Molly Estes, MD and Kaitlin Bowers, DO

For community physicians, mentoring medical students is often a rewarding, one-on-one experience. Without residents or other learners on shift, you get the rare chance to work closely with students, teaching them the ropes of emergency medicine in a more personal setting. This level of access not only helps them gain confidence and skills but also positions you as a key figure in their journey into the specialty.

The EM residency landscape has shifted significantly in recent years, making the path to a successful match much different than what we experienced. Being a community-based physician, you might feel somewhat removed from the academic side and the latest in residency trends. But your perspective, experience, and practical knowledge are immensely valuable to these students. You can guide them on what it truly means to work in EM, how to balance personal and professional life, and what to expect from a career that is both demanding and deeply rewarding.

This article is the first in a series of two that will cover the essentials you need to know to become a supportive mentor for a student interested in EM. From an overview of the latest changes in the match process to standardized letters of recommendation and resources, you'll find helpful information to make a lasting impact on a future colleague.

> **By blending practical advice with genuine support, you equip students not only to succeed in the match but to thrive in their careers."**

How to be a Good Mentor

So, the good news is that you don't have to have extensive experience to be a good mentor. A mentor is someone who can share their journey and experience with someone else. So, congratulations! You are a mentor! To ensure your mentoring meetings with your student are as effective as they can possibly be, consider setting SMART (specific, measurable, achievable, relevant, time-based) goals with your student. Be responsive to their outreaches when they have questions or need advice. However, no matter how good of a mentor you are, your student likely needs an advisor in addition to your mentorship. An adviser knows all the latest and greatest hard data about the match process, especially over the last few years. This data changes annually. Your job as a mentor is to ensure your student also has an advisor (see resources below), one who is an EM-trained physician.

Match Updates

So, although you may not be filling the adviser role, your student will likely ask you some very specific advising questions. You are not expected to be the expert (that's their advisor's job), but here are some broad strokes of information that may come up:

- The timeline for the application season begins in the spring of the third year. Students should complete their sub-intern (acting intern) rotations beginning in April/May and ending in October/November. Electronic Residency Application Service (ERAS) applications are released to programs at the end of September. Students can expect to receive interview invitations and complete them from October through the winter months and sometimes as late as the end of January. Students are aiming to have 10 to 12 interviews in order to maximize their rank list chances of successfully matching; completing more than 12 interviews (and ranking more than 12 programs) does not benefit their match chances in any way and takes an interview spot from another student who might need it. **Caveat!** Emergency

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medicine is moving to a new application system. Although we will continue to say "ERAS" be aware that there will soon be a new name used for this process.

- There is **one** single application pathway for residencies through the ACGME. Both MD and DO students use this process.
- The ERAS application now limits students to only list their top 10 experiences from medical school or before. No more laundry lists of every single volunteer experience, so encourage your student to do some soul searching about the experiences that have meant the most to them and define them as an individual and future physician.
- There are new sections in ERAS for students to select a geographic region or practice setting preference. These are hidden from programs where they don't apply (e.g. a West Coast program will not be able to see if a student selected an East Coast preference). Students should use these options **if** they have a true preference, and then explain why they do. Encourage them to be honest; programs want to know why you are choosing their location to spend the next three to four years of your life.
- Students currently have five "signals" they can use to send to a program indicating they are very, **very** interested in that program. This can be for any variety of reasons, but it is most helpful to indicate that a student is genuinely interested in a place and not just blanket applying. Students should **not** signal any program where they did a sub-intern rotation or are already guaranteed an interview for a different reason. Research has shown that signaling a program does help in getting an interview at that program, although it does not necessarily increase a student's likelihood of matching at that program.[1] That being said, you cannot match at a program unless you have interviewed, so this is a useful tool as part of the application process.
- The vast majority of residency programs are still completing interviews virtually, but there is a slow trickle of programs heading toward a return to in-person interviews. Students should be aware of this, and when scheduling their interviews, make sure to account for the time and finances of travel if interviewing in person. Many programs also now offer an in-person second-look experience after the conclusion of their interviews. These are designed to benefit the students and give them a chance to see the program firsthand. There is an agreement amongst most programs that whether a student comes to a second-look that it will not be used as a reason to move them on the rank list. **Caveat!** Students should remember to be on their best behavior. Egregious or unprofessional behavior will likely move them down the program's rank list.

Mentoring medical students as community physicians offers a unique opportunity to shape the next generation of emergency medicine physicians. By sharing your real-world experiences and providing hands-on guidance, you play an essential role in helping students understand the demands and rewards of a career in EM. While navigating the complexities of the modern match process may seem challenging, your mentorship can make a significant impact, especially when combined with access to knowledgeable advisors who stay current on match trends.

As you encourage your mentee to set meaningful goals and approach each step with intentionality, remember that your insight is invaluable. By blending practical advice with genuine support, you equip students not only to succeed in the match but to thrive in their careers. Your investment in their growth helps ensure a bright future for both them and the field of emergency medicine.

Check back for part two in this series, where we'll cover key aspects of writing letters of recommendation, advising special populations of students, and essential resources to support both you and your mentee on their journey into emergency medicine.

Resources

- AAEM RSA Road to Match: https://www.aaemrsa.org/education/road-to-match/
- EMRA Student Mentorship: https://www.emra.org/students/advising-resources/student-resident-mentorship-program

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Responding to ICE in Emergency Departments: Protecting Patients and Navigating Legal Obligations

Nicole E. Exeni McAmis, MD

Hospitals and emergency departments have long been considered places of refuge, where individuals can access medical care without fear of discrimination or interference, regardless of their immigration status. However, recent changes in immigration enforcement policies, including the recission of 2011 Sensitive Locations Memorandum, have heightened concerns about how physicians and non-physician practitioners should respond to Immigration and Customs Enforcement (ICE) agents visiting hospitals. This shift has significant implications for patients, physicians and non-physician practitioners, and hospital operations, especially in emergency settings where patient trust and safety are paramount.

Historically, ICE was discouraged from conducting enforcement actions—such as arrests or interrogations—in certain locations, including hospitals, schools, and places of worship. The intent of this policy was to ensure individuals could access essential services without fear of deportation. However, recent policy changes have diminished these protections, permitting ICE to conduct enforcement actions in hospitals under certain conditions.[1] This policy shift has raised alarm within the medical community, particularly in emergency departments where vulnerable populations frequently seek care.

This shift could deter undocumented individuals from seeking medical care, placing physicians and non-physician practitioners in the challenging position of balancing legal compliance with their ethical duty to care for all patients. Emergency departments (EDs) must adopt detailed protocols and training to ensure patient privacy and safety while adhering to federal laws such as the Health Insurance Portability and Accountability Act (HIPAA).[2,3]

To navigate these changes, ED staff must be prepared with clear protocols and thorough training to manage ICE interactions. This article combines a comprehensive hospital policy with step-by-step instructions to equip ED staff with the knowledge and tools necessary to handle ICE interactions effectively and ethically.

The Impact on Patients and Emergency Care

Patient Fear and Avoidance of Care

Undocumented individuals may delay or avoid seeking medical care due to fear of deportation or detention. Studies show that increased ICE activity near sensitive locations correlates with decreased healthcare utilization among immigrant communities.[4] This avoidance can lead to worsening health conditions, delays in treatment, increased emergency department visits for preventable issues, and public health risks.

> **ED staff must be prepared with clear protocols and thorough training to manage ICE interactions."**

Disruption of Emergency Services

ICE activity in emergency settings can create chaos, disrupt patient care, and increase stress for both patients and staff. The presence of law enforcement agents may escalate tensions, particularly for vulnerable populations already experiencing trauma.[3]

Ethical and Legal Considerations

Physicians and non-physician practitioners have an ethical obligation to treat all patients equitably, regardless of their immigration status.[5] Simultaneously, HIPAA mandates the protection of patient information and limits when and how it can be disclosed, even to law enforcement.[2]

Editor's Note: Examples of a hospital policy on how to manage ICE interactions in the ED and a step-by-step guide for ED staff appear on the next pages.

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Hospital Policy: Managing ICE Interactions in Emergency Departments

Purpose: To establish clear procedures for responding to ICE agents in a manner that prioritizes patient safety, respects legal obligations, and maintains the hospital's commitment to equitable care.

Scope: This policy applies to all employees, medical staff, contractors, and volunteers at the hospital.

POLICY STATEMENT

- The hospital is a safe space for all patients seeking medical care, regardless of immigration status.
- ICE agents are not allowed access to patient areas or information without a valid judicial warrant.
- All staff are expected to prioritize patient care and privacy in every situation.

PROCEDURES

ICE Arrival at the Hospital

Initial Interaction

- ICE agents must identify themselves and state the purpose of their visit.[1]
- Staff should request identification and any supporting documentation, such as a warrant.

Notification

- Immediately notify the designated Point of Contact (POC), such as the hospital administrator or legal counsel.[6]
- Security personnel should be informed and positioned to monitor the situation without escalating tensions.

Verification of Warrant

- Determine if the warrant is judicial (signed by a judge) or administrative (issued by ICE). Judicial warrants allow access under specific conditions, while administrative warrants do not grant access to private areas.[3]

Patient Privacy and Safety

Access to Patients

- ICE agents may not interview, detain, or remove patients without a valid judicial warrant.
- Do not allow ICE agents to access restricted areas such as patient rooms or operating areas.

HIPAA Compliance

- Never disclose patient information without a valid judicial warrant or explicit patient consent.[2]
- Ensure that medical records do not document immigration status unless medically relevant.[3]

Informing Patients

If ICE agents request to interview or detain a patient, inform the patient (if medically appropriate) and explain their rights:

- The right to remain silent.
- The option to decline speaking to ICE agents without an attorney present.[5]

Offer the patient contact information for legal aid organizations specializing in immigration law.[7]

Training and Education

Provide comprehensive training for staff on the hospital's policy, including:

- Recognizing valid warrants.
- HIPAA compliance.
- De-escalation techniques when interacting with law enforcement.[6]

Conduct annual policy refreshers and simulate scenarios to reinforce procedures.

Documentation

Record the details of any ICE interaction, including:

- Names and badge numbers of agents.
- Date, time, and reason for the visit.
- Actions taken by staff and outcomes.[6]

Submit the documentation to the POC and legal counsel for review.

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Detailed Step-by-Step Guide for ED Staff:

Understand Legal Protections and Responsibilities

- All staff must understand that patient information, including immigration status, is protected under HIPAA. Information can only be disclosed with patient consent or a valid court order.
- Train staff to differentiate between a **judicial warrant** (signed by a judge and legally binding) and an **administrative warrant** (issued by ICE and not sufficient for access).[2]
- Train staff on how to handle ICE interactions respectfully and lawfully.[3]
- Patients have the right to decline speaking with ICE agents and may request legal representation before interacting with them.

Prepare a Response Plan

- Assign a Point of Contact (POC) to manage ICE inquiries and coordinate staff responses.[6]
- Develop clear protocols for documenting ICE interactions and preserving patient confidentiality.

Address ICE Agents Professionally

- Greet ICE agents professionally and ask for identification and the purpose of their visit.
- Request a **judicial warrant** to confirm the legal basis for their actions. If ICE agents present an administrative warrant, explain that it does not authorize access.[3]
- Direct ICE agents to a non-patient area and ensure they are accompanied by authorized personnel at all times.
- Avoid confrontations or escalating tensions.

Focus on Patient Safety

- Shield patients from ICE activity as much as possible.
- Ensure patient care continues uninterrupted.
- Do not disclose any patient information, including location or medical records, without a valid judicial warrant.[2]
- Focus medical records on clinical care only. Avoid noting immigration status unless it is medically relevant.

Advocate for Patients

- If ICE requests to detain or speak with a patient, inform the patient of their rights to refuse to speak with ICE agents and provide support if they wish to contact legal counsel.[7]
- If the patient is critically ill or in an unstable condition, explain that medical care takes precedence over enforcement actions.
- Offer contact information for local immigration legal aid organizations or advocacy groups.
- Reassure patients and families that the hospital is committed to providing care regardless of immigration status.

Document the Incident

- Record key details, including: names and badge numbers of ICE agents; time, date, and purpose of the visit; copies or descriptions of any warrants or documents presented; actions taken by staff.
- Submit an internal incident report to hospital administration and legal counsel.

Conduct Post-Incident Review

- Debrief staff and review actions taken during the incident.
- Update policies and training materials as needed to address any identified gaps.

WHY THIS MATTERS

The presence of ICE agents in emergency departments can erode trust in healthcare systems, especially among immigrant populations. Patients may avoid seeking care, leading to worsened health outcomes and further disparities. By implementing clear protocols and maintaining a commitment to equitable care, physicians and non-physician practitioners can protect vulnerable patients while navigating this complex legal landscape.

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Brain Injury Guidelines, Can They Help?

Christopher Tanner, MD FAAEM

A 40-year-old falls down a series of stairs and hits their head. Bystanders report loss of consciousness and CT imaging reveals a trace subdural hematoma with no skull fracture. Your facility has no neurosurgical coverage. The patient and family are wondering what benefit transfer to a higher level of care will provide if their injury is considered nonoperative. Nursing pressures you for a disposition.

Critical access and rural hospitals are increasingly affected by the boarding crisis with facilities increasingly handling more complex patients. The aim of this series is to highlight common challenges our facilities face and how to implement change. In this article we will address uncomplicated head injuries in low risk patients that do not benefit from transfer to higher levels of care. Additionally reviewing the thought process and way to get buy-in from involved parties will be an important consideration.

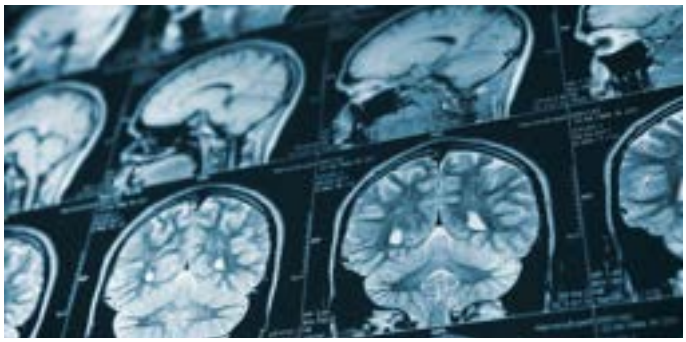
The Brain Injury Guidelines (BIG) provide an algorithm for patients with head injuries. The goal is to reduce hospital admission/transfers, repeat imaging, and neurosurgical consultation. Decreased length of stay, improved resource utilization, and patient satisfaction are all factors both administration and hospital systems value. The obvious parallel to this is the HEART score used by us and cardiology.

This multi-site review was done with 269 patients being put into different categories based on severity. This was graded based on the size of the largest area of bleeding. Bleeds less than 4mm in size were considered low risk (BIG 1) and between 4-7mm were intermediate (BIG 2). High risk bleeds were those greater than 7mm or those with intraventricular hemorrhage. Skull fractures also put the patient in the intermediate and high-risk categories. Lastly, anticoagulation or antiplatelet therapy put the patient in the high-risk category (BIG 3).

For low-risk patients in the BIG 1 category they recommend discharge from a neurosurgical standpoint after six-hour observation with no repeat imaging or consultation with neurosurgery if the patient had no other concerning features such as altered mental status or GCS less than 15. For BIG 2 moderate risk they recommended admission to a trauma service without need for repeat head CT or neurosurgical consultation. BIG 3 high risk patients are recommended full consultation and routine standard of care.

To summarize, our objective is to improve resource utilization. To have any proposal be successful we must first get buy-in and understand the perspective of the applicable parties.

For patients and families keeping their loved ones closer to home by avoiding transfers at critical access facilities is ideal. Many families and patients will have questions if they are admitted to the hospital. Speaking with neurosurgery offering remote telehealth evaluation and consultation is ideal to answer questions and offer expert guidance. Speaking with nursing, offering observation status will provide clear disposition recommendations and help reduce boarding in the emergency department by opening up the ability to admit low risk patients at facilities without neurosurgery. High risk categories agreed upon with trauma centers associated with facilities offers guidelines for justifying the need for higher level of care.



BIG 1: SDH≤4 mm, EDH≤4 mm, IPH≤4 mm, SAH-trace, no skull fracture, no anticoagulation/antiplatelet therapy, or no intraventricular hemorrhage (IVH).

BIG 2: SDH 4 to 7mm, EDH 4 to 7mm, IPH 4 to 7mm, SAH-localized, non-displaced skull fracture, no anticoagulation/antiplatelet therapy, or no IVH.

BIG 3: SDH≥8 mm, EDH ≥8 mm, IPH≥8 mm, SAH-scattered, displaced skull fracture, on anticoagulation/antiplatelet therapy, or an IVH.

Figure 1: BIG Criteria definitions. Subdural hematoma (SDH), Epidural hematoma (EDH), Intraparenchymal hematoma (IPH), Subarachnoid hemorrhage (SAH)

From a neurosurgical standpoint they support such initiatives as these to help reduce unnecessary nighttime calls and automate the process for obvious disposition questions. Having buy-in for any telehealth programs started is best discussed with administration to offer incentives such as RVU or on-call responsibilities outlined clearly. Additionally, guidelines on repeat imaging and consultation recommendations should be discussed based on distance from a facility as well as ease of transfer to higher level of care if needed.

Radiology considerations include reducing the need for repeat or unnecessary imaging studies. Another important aspect is making sure they can document the imaging guidelines. Our group made the decision to simply ensure size of lesions were documented. Similar to a lab reporting

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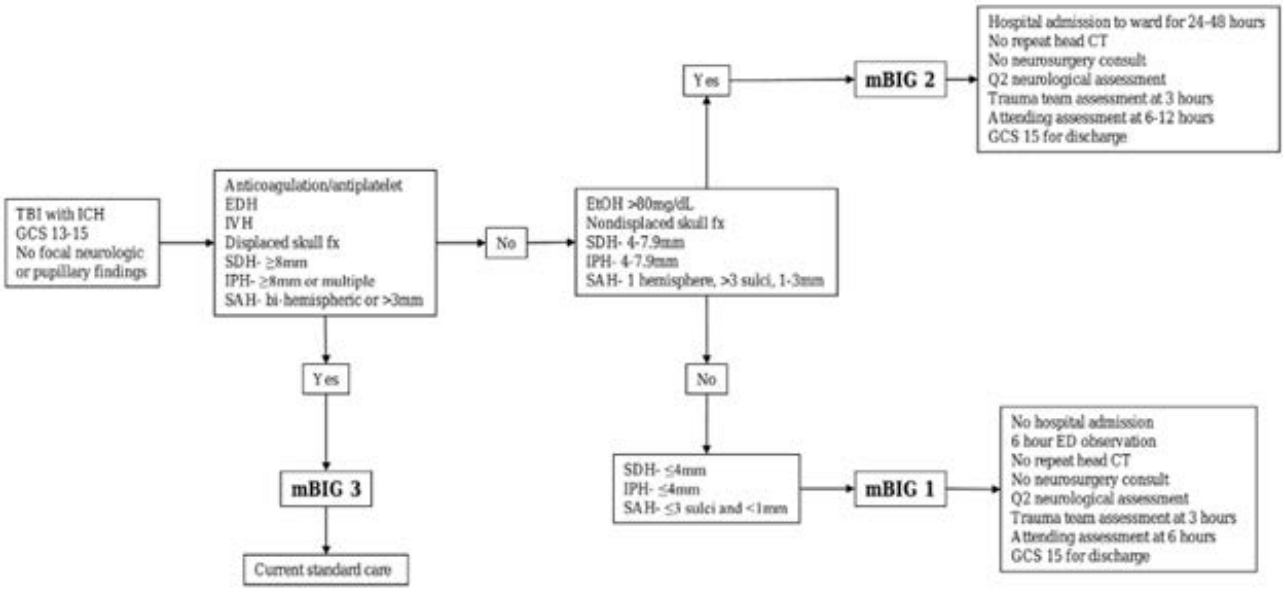

Figure 2 Modified Brain Injury Guidelines. BIG, Brain Injury Guidelines; ED, emergency department; EDH, epidural hematoma; EtOH, blood alcohol level; fx, fracture; GCS, Glasgow Coma Scale score; ICH, intracranial hemorrhage; IPH, intraparenchymal hematoma; IVH, intraventricular hemorrhage; mBIG, modified BIG; SAH, subarachnoid hemorrhage; SDH, subdural hematoma; TBI, traumatic brain injury.

a troponin, the interpretation of the study ultimately falls on the decision maker of the emergency physician.

From administration and system wide level improved utilization will help with availability for hospital transfers as well as decreased length of stay. Additionally increasing the use of telehealth utilization and RVU capture can help community and critical access hospitals expand their scope of practice.

From my experience, different neurosurgical groups will have opinions on these recommendations and adjustments will be important. Sites without neurosurgery will have different needs than higher level trauma centers. Discussion with our neurosurgeons revealed a preference for repeat imaging at six hours to ensure stability before making disposition recommendations. For those nervous about adoption of clinical guidelines, further studies continue to validate this approach with 2,432 patients being studied in a prospective multi-institutional trial.

Other important considerations are the role of a reliable neurological exam in patients. Alcohol and other mind altering substances can be a frequent confounder in patient assessments. The Q2 hour clinical assessments are critically important in a busy ED and should be emphasized when making disposition decisions. Lengthening and discussing with both trauma and neurosurgical services can help refine the applications of these rules to suit the needs of the department and patient.

Based on your discussion you return to the family of the 40-year-old that suffered an uncomplicated 2mm SDH with no skull fracture, GCS 15, and no anticoagulation use. After six hours their condition remains stable. Using shared medical decision making you review with them the guidelines laid out by your neurosurgeons and trauma team. After discussion they request a repeat head scan which shows no progression. They are given strict return guidelines and are subsequently discharged home with outpatient follow-up and a glowing Press Ganey score.

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AAEM Job Bank

Promote Your Open Position

To place an ad in the Job Bank:

Equitable positions consistent with the Mission Statement of the American Academy of Emergency Medicine and absent of restrictive covenants, will be published (upon approval). All ads run for a six month period or until canceled and will appear in the AAEM member magazine *Common Sense* and online. For pricing and more information visit www.aaem.org/membership/benefits/job-bank.

Complete a Job Bank registration form, along with the Criteria for Advertising Section, and submit payment. If you are an outside recruiting agent, the Job Bank Criteria for Advertising must be downloaded and completed by a representative from the recruiting hospital/group.

Direct all inquiries to: www.aaem.org/membership/benefits/job-bank or email info@aaem.org.

Positions Available

For further information on a particular listing, please use the contact information listed.

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COLORADO

Southern Colorado Emergency Medical Associates (SCEMA) is hiring full and part time emergency physicians. SCEMA is a democratic group of over 30 years based in Southern Colorado staffing UCHealth Parkview Medical Center in Pueblo, CO and UCHealth Parkview Pueblo West Hospital in Pueblo West, CO. SCEMA holds an AAEM Certificate of Workplace Fairness and is an AAEM practice group member. Come live and work in the beautiful Front Range of Colorado. We offer a superior financial package with a 2-year partnership track and subsequent income as a partner based upon productivity. Receive a competitive hourly rate pre-partnership with an average annual compensation of $250k. Alternative non-partnership track, part-time hourly rate available. Partners average annual compensation is $470k per year including profit sharing, 401k plan, and a SCEMA funded cash balance plan. Additional benefits include health insurance, CME, malpractice insurance, compensation for licensing examinations and travel, medical and DEA licensing fees, as well as relocation expenses coverage. Full time status is approximately 13-14 shifts per month with 8-10 hour shifts. Must be BE/BC in emergency medicine. Please email Dr. Mary Russo at mary.russo@uchealth.org or Dr. Tyler Keller at tyler.keller@uchealth.org if interested. (PA 2104)
Email: mary.russo@uchealth.org

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Email: svemgcareers@gmail.com
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MARYLAND

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Email: thaagdespa@gmail.com

NEW YORK

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Email: slameira@summithealth.com
Website: https://www.citymd.com

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Email: amanda.lee@saskhealthauthority.ca
Website: https://www.saskhealthauthority.ca/

WISCONSIN

Fox Valley Emergency Medicine in Neenah, WI is recruiting to hire a full time doc. We are a single democratic group of 8 docs. We staff a single hospital with stable contract for last 20 years. Highlights: Hospital- Thedacare in Neenah WI, trauma level II & comprehensive stroke center Patients per hour - 1.5 to 1.7 avg Compensation- 1st year: W2 rate of $250/hr, 144 hrs per month. 1 year partnership track and partners made $375+/hr. Shifts: 10 hour shifts, with a full time nocturnist. 54 hours of coverage per day. (PA 2109)
Email: srikarkaranam@gmail.com
JanFeb, MarApr, MayJun

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Email: dhowe@TrinityHealthofNE.org
Website: https://www.jointrinityne.org/Physicians

DELAWARE

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Email: megan.hopkins@christianacare.org
Website: https://careers.christianacare.org/posting/JR74677/?page=1

INDIANA

The Department of Emergency Medicine at Indiana University School of Medicine and Riley Children's Health invites applications for the Chief, Division of Pediatric Emergency Medicine and Vice-Chair, Pediatric Emergency Medicine, Department of Emergency Medicine. We seek a visionary leader dedicated to improving children's health. The division is supported by a comprehensive system-wide commitment to building a nationally pre-eminent program. Candidates must possess: • MD, MD/PhD or equivalent degree • Board certified or board eligible in Pediatric Emergency Medicine or both EM and Pediatrics • Eligible for an unrestricted medical license in Indiana • Academic credentials for appointment at associate or full professor level (PA 2094)
Email: kerry@careerphysician.com
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Email: jerry.price@owensborohealth.org
Website: https://www.owensborohealth.org/

MASSACHUSETTS

Emergency Physician Opening! Pittsfield, MA. Berkshire Health Systems Berkshire Health Systems is seeking a passionate and skilled Emergency Room Physician to join our team at Berkshire Medical Center. With an annual patient volume of 55,000, we are a regional referral center and trauma center committed to providing exceptional care to our community. Collaborative Environment: Join a very stable and collaborative group of professionals who share a commitment to high-quality patient care. Comprehensive Support: Work alongside seasoned Hospitalists, along with a team of Inpatient Psychiatrists, and various other specialists. Clinical Teaching Opportunities: Engage in periodic clinical teaching with medical students and off-service residents, enhancing the training of the next generation of healthcare providers. No Single Coverage: Enjoy the benefits of a team based approach to patient care, with no single coverage responsibilities. Comprehensive Benefits: • Competitive Sign on Bonus • Professional Liability Insurance • 403(b) & 457(b) Pension Plans • 12 weeks PTO • Short Term and Long Term Disability at no cost to you! • Life and AD&D Insurance at no cost to you! All Interested candidates may apply online at www.berkshirehealthsystems.org or reach out directly to Cody Emond at cemond@bhs1.org. (PA 2105)
Email: cemond@bhs1.org
Website: https://www.berkshirehealthsystems.org/

MISSOURI

Mercy Emergency Medicine is currently seeking multiple BC/BE Emergency Medicine or Family Medicine Physicians to join our practices in Cape Girardeau, Dexter, Lincoln, and Perryville, Missouri. These positions offer: • Competitive, shift-based model • Comprehensive, day one benefits including health, dental, vision and CME. • System-wide Epic EMR • As a not-for-profit system, Mercy qualifies for Public Service Loan Forgiveness (PSLF) • These locations are eligible for J1 and H-1B sponsorship. Find us at: Facebook | LinkedIn | Instagram | mercy.net | Mercy Careers For more information, contact: Camryn Rivenburgh, Physician Recruiter Phone: 573-902-2676 Camryn.Rivenburgh@Mercy.net | Providers - Mercy Careers AA/EEO/Minorities/Females/Disabled/Veterans (PA 2123)
Email: sandra.jones@mercy.net

MISSOURI

Mercy is recruiting emergency physicians for Springfield Missouri, an 886-bed, level I, tertiary hospital for four states. • 90,000 annual visits • 9-hour shifts - 7 for patient care and 2 for cleanup • 13 physician shifts each day • 80-bed ED • 600 employed physicians • 24/7 in-house stroke, trauma, hospitalists, intensivists, OBGYN • Epic EMR • Excellent culture – low physician turnover, stable, employed • $100,000 recruitment bonus plus paid relocation • Springfield is the third largest city in MO with multiple fortune-500 companies, universities, national airport, and wonderful access to National Forest and Ozark Mountains Todd Vandewalker, MHA, CPRP, Senior Physician Recruiter Todd.Vandewalker@mercy.net 417-820-3606 AA/EEO/Minorities/Females/Disabled/Veterans (PA 2125)
Email: Todd.Vandewalker@mercy.net

MISSOURI

Mercy Hospital South in St. Louis, Missouri is currently seeking BC/BE Emergency Medicine or Family Medicine Physicians to join our practice. These positions offer: • Competitive, shift-based model • Comprehensive, day one benefits including health, dental, vision and CME. • System-wide Epic EMR • As a not-for-profit system, Mercy qualifies for Public Service Loan Forgiveness (PSLF) • Annual incentive Find us at: Facebook | LinkedIn | Instagram | mercy.net | Mercy Careers For more information, contact: Joan Humphries, Director of Physician Recruitment Phone: 314-364-3821 Joan.Humphries@Mercy.net | Providers - Mercy Careers AA/EEO/Minorities/Females/Disabled/Veterans (PA 2126)
Email: sandra.jones@mercy.net
Website: https://careers.mercy.net/jobs?categories=Physician

NORTH CAROLINA

Brody School of Medicine at East Carolina University is seeking to hire a full-time Associate Dean of Clinical Simulation to lead its Interprofessional Clinical Simulation Program. Responsibilities include leadership and oversight to all activities including; Teaching/Instruction, Administration, Strategic Planning, and Research/Creative Activity. The current program is 10,000 sq. ft with 24-rooms in addition to a 44-foot specialized vehicle that provides simulation education throughout the region, and an MV-22 Osprey Military Transport Simulator. A new 30,000 sq ft Simulation Center will begin construction in spring 2025. (opening Fall 2027). https://apptrkr.com/5634863 (PA 2097)
Website: https://apptrkr.com/5634863

PENNSYLVANIA

Penn State Health Holy Spirit Hospital and Hampden Medical Center is seeking an experienced Emergency Medicine physician to join our team to rotate shifts between these two facilities located in the metro Harrisburg, PA region. This is an excellent opportunity for physicians who wish to enjoy a high-quality of life while providing care within a community setting employed by the Penn State Health system. What we're offering: • Competitive Salary & Sign-On bonus • Commitment to patient safety in a team approach model • Experienced colleagues and collaborative leadership • Comprehensive benefit and retirement package What we're seeking: • M.D., D.O., or foreign equivalent • Completion of accredited training program • BC/BE in emergency medicine • Ability to acquire a license to practice in the State of Pennsylvania • Must be able to obtain valid federal and state narcotics certificates About Us: Penn State Health is a multi-hospital health system serving patients and communities across 29 counties in central Pennsylvania. Located in a safe family-friendly setting, Hershey, PA, our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. We're conveniently located within a short distance to major cities such as Philadelphia, Pittsburgh, NYC, Baltimore, and Washington

DC. We're proud of our community involvement and encourage you to learn more about Penn State Health and our values. Penn State Health is fundamentally committed to the diversity of our faculty and staff. We believe diversity is unapologetically expressing itself through every person's perspectives and lived experiences. We are an equal opportunity and affirmative action employer. All qualified applicants will receive consideration for employment without regard to age, color, disability, gender identity or expression, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, and family medical or genetic information. (PA 2106)
Email: hpeffley@pennstatehealth.psu.edu
Website: https://www.pennstatehealth.org/careers/job-opportunities/physicians

PENNSYLVANIA

Temple Health is accepting applications from BC/BE emergency medicine physicians interested in joining the team as faculty. Our EM faculty covers three distinct clinical sites: Temple University Hospital (TUH) – Main Campus, a level 1 Trauma Center; the busy inner city emergency department at TUH - Episcopal Campus; and TUH - Jeanes Campus located in the northern suburbs of Philadelphia. All sites are part of the EM residency program and medical student experience so candidates should have a strong interest in clinical teaching. Clinical time distribution will be matched to the candidate's interest and qualifications in regards to staffing needs at each. The department prides itself on transparency and equitable treatment of faculty. For additional information and/or to apply, please visit: https://bit.ly/3C4pgAY Lewis Katz School of Medicine at Temple University is an Affirmative Action/Equal Opportunity Employer and strongly encourages applications from women, minorities, veterans, and persons with disabilities. (PA 2108)
Email: Francis.Gallagher@tuhs.temple.edu

AGING WELL IN EMERGENCY MEDICINE INTEREST GROUP

Continued from page 28

Address the Fear (And Alleviate It, When That Is Possible)

Usually, to address our patients' fears, we must obtain lab and radiographic studies. With results obtained, I interpret them for the patient in terms that make clear that I am attentive to the patient's fears. For instance, when a patient's high-sensitivity troponins are all non-elevated and not significantly rising, I explain why this, plus a non-ischemic EKG, clearly indicate that a heart attack is not going on. When a radiograph is negative, as expected, I tell the patient that they need not worry about having broken their ankle, but that they still face a period of recovery. You get the idea.

Closing

When I evaluate patients using the paradigm of "seek their fear, find their fear, address or alleviate their fear," only rarely do I find that a patient will tell me that they did not feel heard. (If I am unsure, I will straight-up ask the patient, "Did you feel heard by me today?") Patients who feel heard, even if you have to give them bad news, are usually satisfied. Such patients who will often thank you personally before they are discharged or admitted. And to be thanked repeatedly during a shift lets one go home knowing that you did something good and useful for numerous people. This helps us see that we are serving a higher purpose, toward alleviating burnout. Aren't these all things we all hope we can do for our patients and for ourselves, while we are directing their care? ■

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