COMMON SENSE

VOICE OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE
VOLUME 32, ISSUE 4
JULY/AUGUST 2025

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

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COMMONSENSE

Featured Articles

Suck It Up, Buttercup

Robert Frolichstein, MD FAAEM

A physician shall, while caring for a patient, regard responsibility to the patient as paramount. Paramount—more important than anything else. This is one of the nine AMA Principles of Medical Ethics. The vast majority of physicians that I have encountered take this principle as well as those expressed in the various forms of the Hippocratic Oath very seriously. I know I do. I have and continue to sacrifice because I was called to this noble profession. I am okay with that. It is what I signed up for. What I long for is contained in the last two sentences of a version of the Hippocratic Oath written by Louis Lasagna in 1964 based on the ancient text. The last two sentences read:

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Where is the respect? Where is the joy? I feel as though those have been taken from me. I don't think I am alone in those feelings.

I think the classic Hippocratic Oath maybe even said it better. It closes with:

If I faithfully observe this oath, may I thrive and prosper in my fortune and profession, and live in the estimation of posterity; or on breach thereof, may the reverse be my fate!

My interpretation of this is that I have committed to practicing medicine virtuously and therefore I hope for success in my practice and life as a result and that future generations will hold my work in high esteem. Are you thriving and prospering? I hope you are. Is your work held in high esteem? Many do hold our profession in high esteem. Many also see our profession as a means to their profit motive.

Wow! Pretty gloomy way to begin an article that I hope will be a bit encouraging. I start this way because it gives me an opportunity to highlight something that the Academy is involved in that may in some way address some of the struggles we face.

You, no doubt, have seen that we have become an investor in, and executive producer of a documentary that highlights myriad problems within our system and how it harms patients, physicians, and nurses. From the website suckitupbuttercupfilm.com:

Suck It Up, Buttercup is an investigative, emotional, solution-driven film featuring physicians, clinicians, patients, and other key stakeholders, exposing the frailties of the US healthcare system in terms of corporate greed, systemic bureaucratic failures, and a deteriorating work environment that's putting all of us at an ever-increasing risk. This is a close examination of health systems that have failed as well as systems that have succeeded and why.

I firmly believe that nothing will improve until most people genuinely comprehend the extent of the problems and recognize that the corporatization of our profession is a significant contributing factor. As a profession, physicians are likely more resilient than many, if not most other groups of

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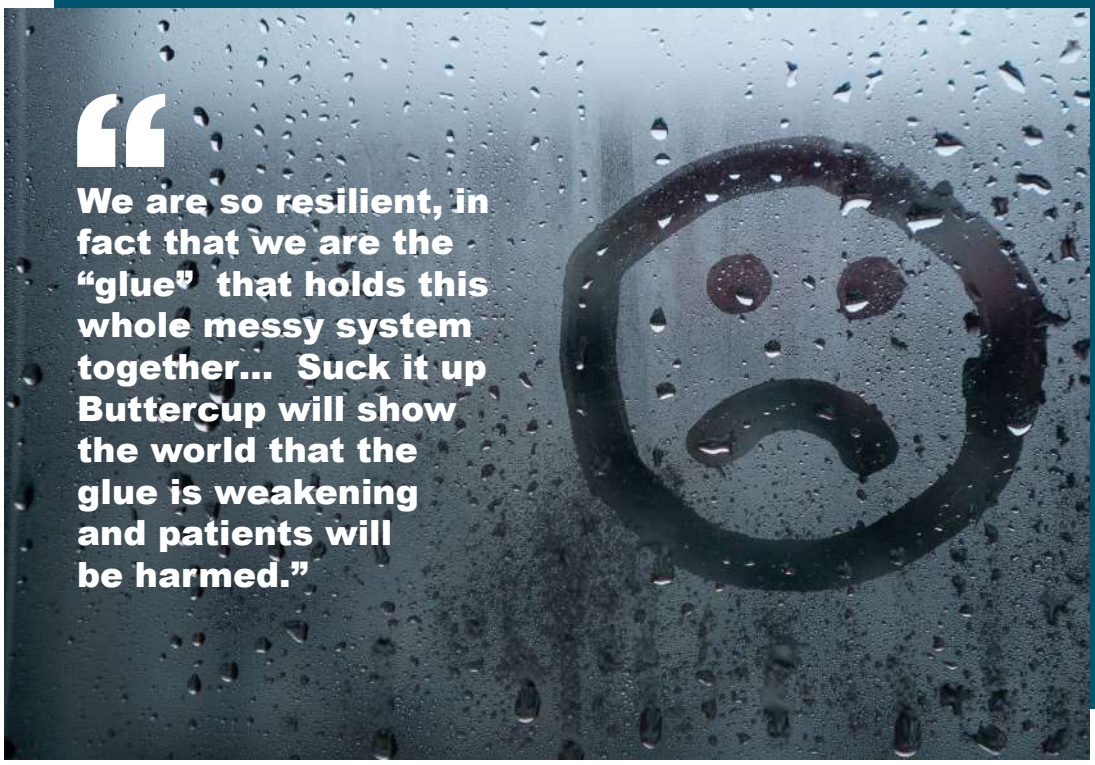


"By supporting this film, AAEM empowers us to tell our story, advocate for change, and remind society why we became physicians: to heal and serve."

people. We are so resilient, in fact that we are the "glue" that holds this whole messy system together. Everyone knows that. "They" count on it. We continue to be that glue because, well, that oath thing we can not, will not, forgo. *Suck it up Buttercup* will show the world that the glue is weakening and patients will be harmed.

This documentary has garnered significant interest from individuals who are well-versed in our system and are acutely aware of its challenges and the trajectory of its decline. There will be many physicians but also patients, physician family members, former healthcare executives, former insurance company executives, and other leaders in the healthcare arena. It is encouraging to me to see that so many people recognize the problems and want to expose the harm to patients and caregivers and offer some insight into solutions.

AAEM's involvement in this project appreciates emergency physicians battling burnout, moral injury, and a system that often prioritizes profits over people. By championing this documentary, AAEM is amplifying the voices of those who see the corporatization of medicine as a root cause of our profession's challenges.

For emergency physicians, AAEM's role in this documentary is a powerful acknowledgment of our struggles. It's a step toward reclaiming the respect and joy our oath promises. It fosters a broader understanding of the systemic issues we face, from crushing administrative burdens to the erosion of physician autonomy. By supporting this film, AAEM empowers us to tell our story, advocate for change, and remind society why we became physicians: to heal and serve. Much like treating a patient with acute lumbar strain, there's no quick fix for our system's woes. I've seen countless such patients, hoping for a magical cure. I, hopefully compassionately, explain there's no instant solution, only time, physical therapy, and perhaps some ibuprofen. Similarly, AAEM's work is like physical therapy for our profession—grueling, incremental, but vital. It's a call to action, a chance to heal our system, and a reminder that we're not alone in this fight to preserve the finest traditions of our calling. Like those patients with acute low back pain, the pain is excruciating. Perhaps dealing with the pain is a bit easier if we know we are doing something to make ourselves better. ■

My First International Emergency Medicine Conference

Yash Chavda, DO MBA FPD-AEMUS

Since becoming an attending, I've had some opportunities to present at local, regional, and national conferences. Through some luck, the Mediterranean Emergency Medicine Congress (MEMC25) happened to be held in Budapest, Hungary—a place I know well since my wife's family lives there. We were already planning our regular trip to visit family, and when one of my submissions was accepted for presentation, saying yes was easy. This was my first time attending an international emergency medicine conference, and what follows are some of my observations and recollections.

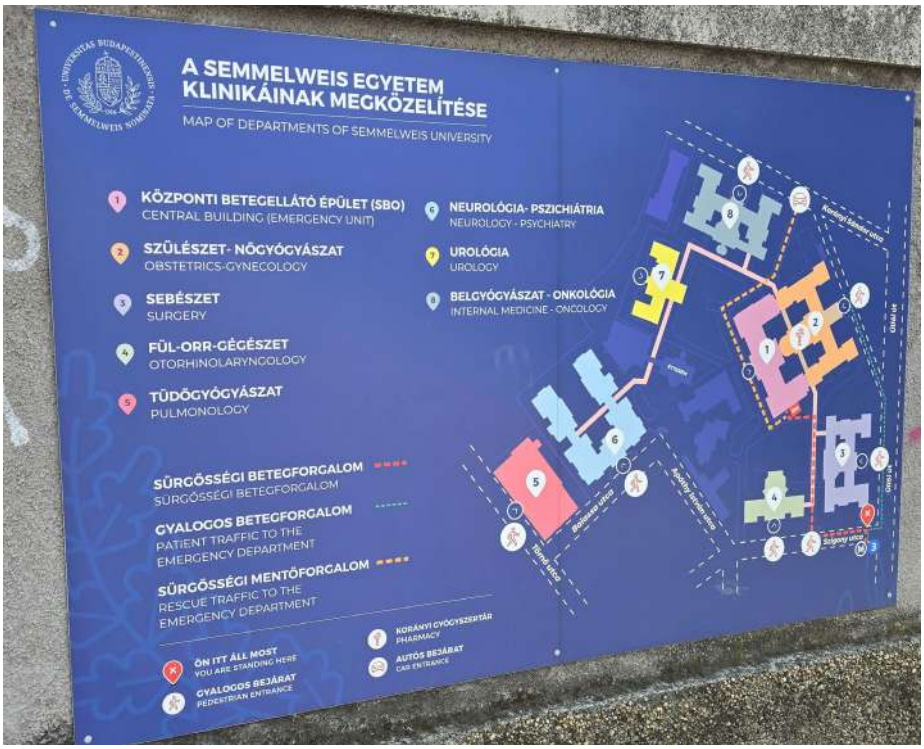
From the moment I arrived, the enthusiasm was palpable. Emergency physicians, trainees, and students from across the globe gathered with a shared purpose: to learn, to teach, and to advance our specialty. There were research posters and case reports from around the world. I've always been fascinated by how emergency medicine functions outside the United States. In some countries, the specialty I love does not yet exist, exists only in a limited capacity, or emergency departments are staffed by physicians from other disciplines, each managing only their own domain.

"[MEMC25] was a powerful reminder of why I chose emergency medicine: it is a field that crosses borders, tries to unite people, and, above all, makes a difference when it matters most."

What I Learned About EM in Hungary

Emergency medicine in Hungary is relatively new, but it has deep roots in prehospital care. In 1979, the field of Oxyology emerged—a system where physicians staffed ambulances to stabilize patients before and during transport. EM itself became recognized as a basic specialty in 2002, with a training duration of five years. Unlike the U.S., residency spots in Hungary are not fixed annually; some years a department may take two residents, other years five, depending on overall hospital positions and student interest. Hiring can occur at any time of year, but this is reportedly changing to a more standardized time. Trauma and medical emergencies remain largely separated, which can create challenges for trauma patients with significant medical comorbidities. Emergency physicians currently manage primarily non-traumatic patients. And yes, many of the physicians there have seen "The Pitt."

The Chair of Emergency Medicine at Semmelweis University, Dr. Bánk Gábor Fenyves, is a charismatic and visionary leader dedicated to strengthening the department.



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A 2015 graduate of Semmelweis University, he completed his EM specialization in 2022 and trained not only in Hungary but also in the United Kingdom, the United States, and Japan, with experience spanning emergency medicine, cardiology, and neurology. His academic path included PhD studies, a year-long research fellowship in Switzerland, and clinical research at Harvard and Massachusetts General Hospital during the COVID-19 pandemic. I had the honor of speaking with him and touring the University's emergency department. He has already spearheaded changes in departmental layout, increased the number of specialists (i.e., attending physicians), improved protocols, and launched research initiatives—all while working to build up EM.

EM POCUS is even newer to the landscape. Dr. László Békefi, the POCUS director, is leading this effort with great enthusiasm. He shared remarkable cases their department had diagnosed since adopting POCUS—such as a large pericardial effusion that made it to the OR in record time and an aortic dissection—powerful reminders of how useful EM POCUS can be, even in health systems where its role is still emerging. He also described the same struggles we face across the POCUS community: gaining recognition from other specialties, balancing teaching responsibilities with a busy clinical schedule, launching early research, and ensuring quality assurance in the absence of middleware.

Familiar Despite Being Different

The Hungarian hosts brought warmth and hospitality, and the lecture halls were filled with people eager to exchange ideas, compare experiences, and push the boundaries of what EM can be. What struck me most was not our differences but our similarities. The challenges we face in the U.S.—earning respect from other specialties, recruitment, fighting burnout, developing curricula, balancing patient volumes against staffing, and dealing with boarding—are echoed worldwide.

In Greece, for example, EM is still only a subspecialty requiring two extra years after five years of prior training. This is reportedly changing though. Many EDs are not continuously open, and lowest salaries in Europe often push trained physicians abroad. Meanwhile, in the U.S., although we benefit from a stronger specialty, rural areas continue to struggle with physician shortages as many emergency physicians gravitate toward urban or higher-paying settings.

What We Do Matters

The sessions I attended—whether clinical pearls, research updates, or discussions about system barriers—were more than just academic. They were reminders that emergency medicine thrives when we learn from each other. At its core, EM is about being there when patients need us most: distinguishing sick from not sick, resuscitating, stabilizing, and dispositioning those in crisis. There is no physician I would rather have at the bedside in those first critical hours than an emergency physician.

A big thank you to the congress presidents—Dr. Amin Antoine Kazzi, Dr. Robert Frolichstein, and Dr. Béla Merkely—as well as all those involved in planning and moderating the meeting for delivering such a meaningful conference.

Leaving MEMC25, I felt thought of our shared challenges—but also the strength of a global community determined to face them together. Our problems are real, but so is our passion.

For me, this first international conference was a powerful reminder of why I chose emergency medicine: it is a field that crosses borders, tries to unite people, and, above all, makes a difference when it matters most.

■

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AAEM established its Foundation for the purposes of (1) studying and providing education relating to the access and availability of emergency medical care and (2) defending the rights of patients to receive such care and emergency physicians to provide such care. The latter purpose may include providing financial support for litigation to further these objectives. The Foundation will limit financial support to cases involving physician practice rights and cases involving a broad public interest. Contributions to the Foundation are tax deductible.

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The AAEM Institute for Leadership, Education & Advancement in the Development of Emergency Medicine, Inc. (LEAD-EM) was established after the tragic and unexpected death of AAEM president, Dr. Kevin G. Rodgers.

The Kevin G. Rodgers Fund and the Institute will LEAD-EM just like Dr. Rodgers did. The funds will support important projects such as development of leadership qualities, and clinical and operational knowledge of emergency physicians with a view toward improving and advancing the quality of medical care in emergency medicine, and public health, safety and well-being overall. LEAD-EM would like to thank the individuals below who contributed from **1/1/25 to 8/15/25.**

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2025 Oral Board Review Courses
Early Fall Course Dates: September 16, September 18, September 24 - Late Fall Course Dates: November 18, November 19, November 25 - aaem.org/education/oral-boards/

13th Annual FLAAEM Scientific Assembly
November 21-22, 2025

32nd Annual Scientific Assembly
April 11-15, 2026 (Seattle, Washington)

Re-Occurring Monthly
Spanish Education Series*
Jointly provided by the AAEM International Committee
https://www.aaem.org/committees/international/spanish-education-series/ (*CME not provided)

Recommended

Online CME
Rapid Response to Adverse Events of Bispecific Antibodies: Follicular Lymphoma and Diffuse Large B-Cell Lymphoma Emergency Medicine Strategies - staging.medscape.org/viewarticle/1001569

Online CME
Recognizing Life-Threatening Emergencies in People with VEDS
thesullivangroup.com/TSG_UG/VEDSAAEM/

The Difficult Airway Course: Emergency™
September 19 - 21, 2025 (Denver, CO); November 14-16, 2025 (San Diego, CA)
theairwaysite.com/a-course/the-difficult-airway-course-emergency/

20th Annual Conference Emergency Medicine Update: Hot Topics
October 20, 2025 – October 24, 2025
https://na.eventscloud.com/ereg/index.php?eventid=822782&

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For Serenity Now, Mind Your Business

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



One of my [AD] favorite memes is Seinfeld's character, Frank Constanza, screaming at the top of his lungs, "Serenity Now!" I've thought about screaming the exact same thing as traumas, wild psych patients, and malodorous GI bleeds have poured in simultaneously during shifts…if only it would work.

But here is something that might help reclaim a bit of clarity and peace: a simple mindset shifts about what's actually *your business*—and what's not.

What does it mean to "Mind Your Business"?

Byron Katie, in her book "Loving What Is," outlines a simple but effective framework.[1] She says there are only three kinds of "business" in life:

- **Your business**—your thoughts, choices, feelings, and behaviors.
- **Someone else's business**—another person's opinions, mindset, and actions.
- **God's business**—everything outside human control: the weather, random tragedy, or whether a patient survives despite your best efforts.

When you're mentally in any other business other than your own, you're no longer grounded in your own agency. And that's often where stress, anxiety, and moral distress creep in.

What's *Your* Business in the Emergency Department?

You can control how you show up. You can control if you perform a thorough exam in a patient with abdominal pain. You can control the way you explain test results to a worried patient and if you take a calming breath before walking into a trauma bay. You can own your tone, your teamwork, your curiosity, and your decisions.

Now, think about a recent shift. Did you find yourself ruminating on how a consultant responded rudely? Wishing a nurse would prioritize tasks differently? Get frustrated with a patient who made bad choices? That's stepping into someone else's business.

And maybe you've stayed awake worrying about whether a patient with a massive head bleed will survive the night in the ICU. You gave the best possible care with the information and resources you had. But the outcome? That's "God's business."

Letting go of what's not your business frees up the emotional bandwidth you need for what is.

Circles of Control, Influence, and Concern

Ancient Stoic philosophers felt the way to live a more fulfilling and peaceful life is to focus your attention on what you can control.[2] Psychologists expanded this idea to include the gray zone in between what's in our control and what's out of our control by adding a "sphere of influence." Steven Covey explains it in "The 7 Habits of Highly Effective People."[3] He described three "circles":

- **Circle of Control:** things you directly manage—your own behavior, reactions, judgments, decisions.
- **Circle of Influence:** the gray zone of indirect impact—speaking up about how your department handles issues, voting in elections, voicing your concerns to management.
- **Circle of Concern:** things you care about but are totally beyond your control—the economy, other people's actions, the weather.

If you focus your energy on what you can control, and gradually expand your influence, you stay empowered. But if you spend too much time in the Circle of Concern, where you care deeply but have no leverage, you risk feeling disempowered and frustrated. (Westerners reportedly have a tendency to overestimate their circles of control and influence—an internal control fallacy.[4])

> **"You care. Of course you do. But caring doesn't mean that you have to carry it all. In fact, knowing what's not yours to carry may be the most compassionate thing you can do, for yourself and your patients."**

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Let's Put This Into Practice

Imagine you're treating a patient with severe sepsis. You've gotten access, started antibiotics, and started coordinating admission to the ICU. But the patient and family are demanding alternative treatment based on misinformation. You can feel your jaw tighten.

Pause here.

Ask yourself:

- **What's in my control?** Your communication. Your empathy. Your decision to pause and clarify the risks. Your tone.
- **What's in my influence?** You might print a summary of the latest data for them. You might involve social work or the chaplain. You can attempt to establish rapport to increase their trust.
- **What's outside both?** Whether they ultimately agree with your plan. Whether the patient responds to antibiotics.

You can let go of what's not yours while staying firmly committed to what is.

Increasing Your Circle of Influence

You might be thinking, "But what about the bigger stuff? Like the broken medical system, the bed shortages, moral injury?"

That's fair. This goal is to grow your influence. It won't happen overnight, but it can expand steadily. Start by grounding yourself in your Circle of Control. Then work on your influence. Maybe you decide to talk to your team about gaps in communication. Maybe you mentor a young colleague who is experiencing imposter syndrome. Over time, those actions ripple.

You might ultimately find you've created a better workflow, or influenced the culture of well-being in your department. That's expanding your Circle of Influence which changes things bit by bit, from the inside out.

What Happens When You Don't Mind Your Business?

Let's be real: it's easy to get sucked into every concern and everyone else's business. You overhear a colleague ranting about administration and want to jump in. You ruminate for hours over an unexpected but unchangeable poor outcome. You carry home the emotional load of the things you had no control over.

That emotional "residue" builds. It weighs you down shift after shift. And it doesn't make you a better physician. It just drains your ability to think clearly, care as deeply, and adequately recharge between shifts.

But when you start asking, "Is this my business?" or "Is this in my circle of control or influence?" you give yourself permission to refocus and focus your energy. You allow yourself to breathe and come back to the present moment, where you do have agency and power.

You care. Of course you do. But caring doesn't mean that you have to carry it all. In fact, knowing what's not yours to carry may be the most compassionate thing you can do, for yourself and your patients.

You didn't choose emergency medicine because it was easy. You chose it because you wanted to help people in their worst moments. That's noble. But it doesn't require martyrdom.

Next time you're knee-deep in stress and chaos, ask yourself:
"Is this my business?"
"Is this something I can control or influence?"
If the answer is yes, lean in.
If not, breathe, let it go, and return your focus to where it makes a difference.

You're not in this alone. Medicine is a team-sport. The weight of the world is not solely yours to carry. Thanks for being part of the force for good that is emergency medicine.

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Resilience

Amy Walsh, MD MDP

Author's Note: Content Warning: This article opens with a discussion of suicide. If you're not up for that today, either skip this article or the first paragraph. If you need support, reach out to the national mental health hotline at 988 or 988lifeline.org.

On April 9, 2020, Dr. Lorna Breen called her sister.[1] She couldn't get out of her chair because she was nearly catatonic. She hadn't slept in a week. She had been working well past the 12 hours she was scheduled to work because critically ill patients just kept coming. There wasn't enough PPE, oxygen, beds, or help. She, herself, had just had COVID and quarantined for 10 days. Despite returning home to Virginia and seeking psychiatric care, seventeen days later, she died by suicide. We know her story because her sister and brother-in-law have started an organization to change laws that increase doctors' fears that they will lose their medical license and/or credentials if they seek mental health treatment. However, even before the pandemic, 400 physicians died by suicide each year. A former colleague of mine died by suicide during the pandemic as well.

Doctors (and all healthcare staff) more than demonstrated their resilience during the pandemic. If individual strength was all it took to overcome adversity, doctors would have done it. Our training, while sometimes damaging, was effective at creating mental toughness, grit, and the ability to endure difficult circumstances.

However, my work in healthcare has left me heartbroken. I know I am far from alone. Many of us were burned out before COVID started, but psychological disconnection, frustration, compromised decision making, and working under pressure were cited as additional causes of the deterioration of mental health during the COVID pandemic.[2]

Research indicates that I was not alone in feeling that institutional support services usually lacked "commitment, rigor, and sustainability."[3] Unfortunately, isolation and loneliness are amongst the most damaging feelings when one is struggling as we need physical contact and presence to heal from stressful situations. As Soraya Chemaly put it in her book, The Resilience Myth, "If resilience has an opposite, it's not weakness or dependence, it's loneliness."[4] Chemaly argues, effectively, that our ability to withstand the many challenges we face today has much less to do with our individual toughness and perseverance than our connections to others and our ability to provide and receive mutual care when we, inevitably, face setback, failure, or loss.

When I think back on my experience during the pandemic, it is a feeling of abandonment that stings the most. We were called "healthcare heroes." As Soraya Chemaly put it, this "normalized demands of superhuman performance" rather than inspiring government, healthcare organizations, or even many friends or neighbors to provide meaningful support. Resilience is considered a universal good. Certainly, bouncing back from adversity is a necessary skill. None of us live friction-free lives. However, every skill and gift has its dark side. Our current emphasis on a very narrow form of resilience, both in medical training and societally, reduces our capacity for human connection and our ability to challenge dysfunctional and harmful systems.

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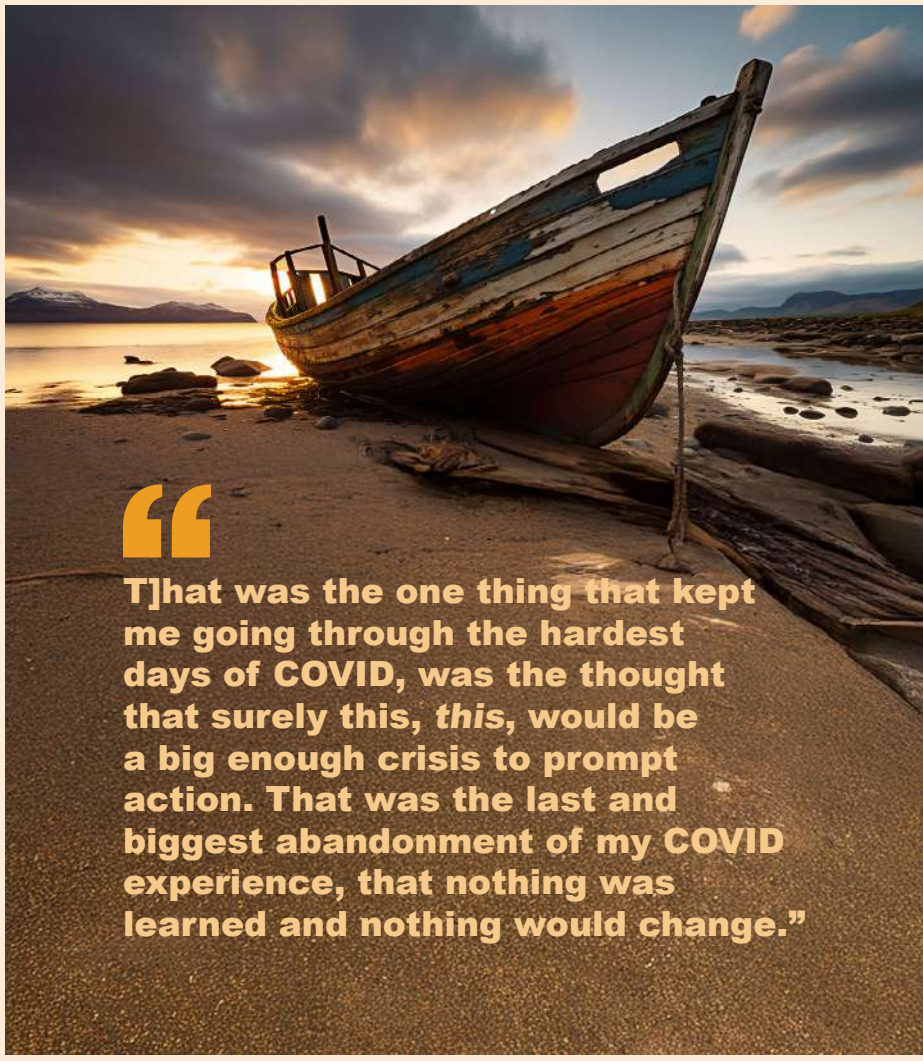

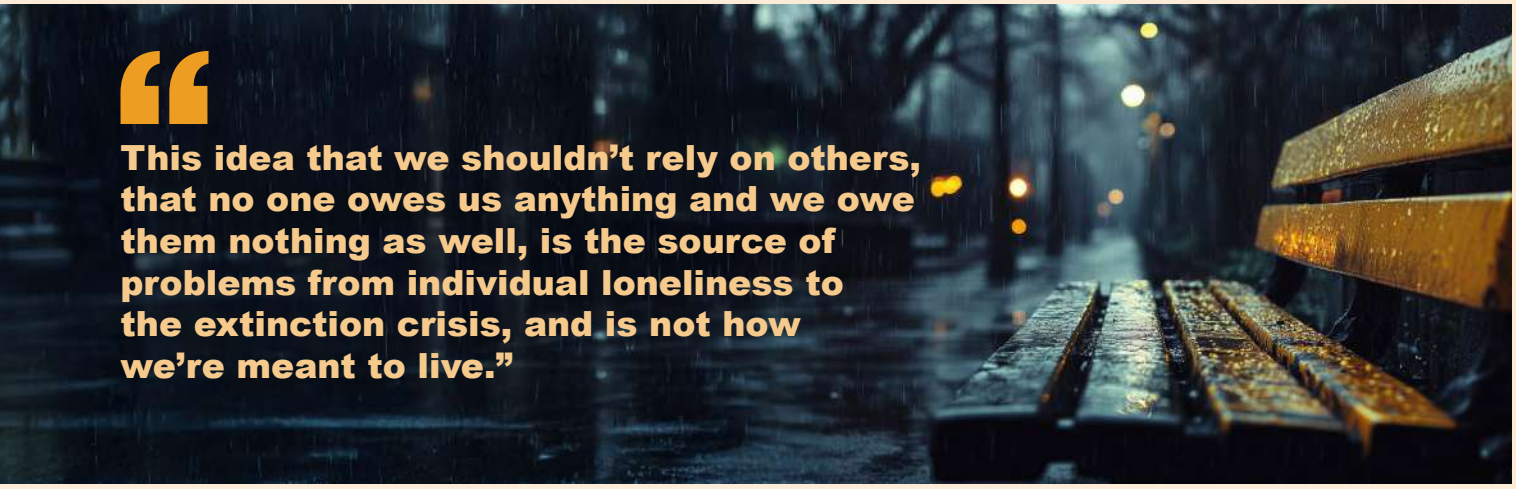

“This idea that we shouldn’t rely on others, that no one owes us anything and we owe them nothing as well, is the source of problems from individual loneliness to the extinction crisis, and is not how we’re meant to live.”

Mind Over Matter

In medical school and residency, we learn to “soldier on,” to power through your body’s physical and emotional needs. There is value in this. There are times when lives depend on our ability to focus and perform one’s best even though she is hungry, tired, grieving, or overwhelmed. However, ignoring one’s body and pushing past those needs persists even in situations where we are just regular busy, which is nearly always. Chemaly explains, “An essential element of any mental toughness program is learning to ignore physical pain and emotional distress. People who don’t, won’t, or can’t do this are somehow inferior.”

We all understand that though we can ignore our physical and emotional needs in the short-term, we do so long-term at our peril. Many physical and mental health problems follow. I don’t think we realize how this interferes with our ability to empathize with others. A system that rewards “self-sufficiency, limitless positivity, and individual strength” diminishes the experience of those who are struggling.

In a patient care setting, when we don’t recognize the advantages we have and think that we have gotten where we are through “mind over matter,” it can leave us feeling rather merciless toward those who were dealt a different set of cards. In a field where care for the ill and disabled is, well, basically the whole point, Chemaly explains, “Mind-over-matter resilience is replete with scorn for ‘unfit’ bodies, quickly making ableism foundational. This framework creates a fundamental structural problem for resilience: systematized cultural disdain for bodies, their needs, and the people who care for them. This makes it easier to subject bodies to brutalization and to minimize our material needs: food, water, care, and time to heal.”

The Resilience to Tolerate the Intolerable

One sneaky way that the promotion of resilience as a virtue serves the powers that be is through the strong linkage between resilience and productivity that has developed. Often, hospital wellness programs look like “we want you to feel good enough that you can continue to produce for us.” Similarly, our current iteration of resilience often assumes the goal is to get back to normal. Chemaly shares the story of two children who were at Uvalde during the school shooting. One returned to Uvalde for school and the other went to a different school. The first was portrayed as resilient, whereas the second was not. However, that one data point tells us very little about which child will successfully overcome adversity.

Teens and young adults often show their resilience in ways that make even my generation, older millennials, uncomfortable. They are faced with many crises that their elders were unwilling or unable to deal with. Rather than tolerating the intolerable, they call attention to these problems and show their feelings of “loud despair, emotionality, and rejection of norms is that their way of being resilient is having a specific effect: it makes them ungovernable.”

This is what the healthcare system needs from physicians now. It needs us to become emotional, to become ungovernable. It is not natural for us to do this. We are champions of stiff upper lips, grinning and bearing it, but there are few things less tolerable than interacting with our healthcare system now for patient or doctor. For patients, the cost is exorbitant, the results are often unimpressive, and many leave feeling their concerns were dismissed. For doctors, the task list is impossible, the administrative burden is absurd, and the emotional cost is gutting. If we had arrived in our current state of healthcare suddenly, we would be protesting in the streets. In fact, that was the one thing that kept me going through the hardest days of COVID, was the thought that surely this, *this*, would be a big enough crisis to prompt action. That was the last and biggest abandonment of my COVID experience, that nothing was learned and nothing would change.

Real Resilience

Physicians have learned the same lessons everyone else has, that we always need to be self-sufficient, strong, mentally tough, and positive. However, these traits don’t arise from a place of health, rather, “They are ultimately based on the belief that you cannot trust or rely on anyone else, certainly not your society to nurture and care for you” as Chemaly points out. Our current view of resilience “makes no demands on anyone,

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erases social context, and absolves us of the responsibility to care for one another." This idea that we shouldn't rely on others, that no one owes us anything and we owe them nothing as well, is the source of problems from individual loneliness to the extinction crisis, and is not how we're meant to live.

The research bears this out. Angela Duckworth, who is the researcher who pioneered the concept of "grit," takes issue with how it is commonly portrayed in the media and in educational programming. "Gritty people are more dependent on other people, not less. They rely more on their coaches, mentors, and teachers. They are more likely to ask for help. They are more likely to ask for feedback." Chemaly echoes this, saying, "Being resilient in healthy and positive ways means accepting that resilience can coexist with wanting and needing care, affection, respect, and love."

This feels so foreign to how we relate to each other in medicine, where the implicit, if not explicit messages tell you that you need to be perfect and invulnerable. I recently listened to a webinar about clinician wellbeing during COVID.[5] During the meeting, one idea nearly brought me to tears. It is so simple, sometimes the agenda of a meeting may need to change to address people's emotional lives and stress rather than simply the next quarter's work schedule or policies and procedures. This both helps employees feel seen and heard and gives leaders a more accurate view of the challenges staff are facing so they can be addressed. This fits with what Chemaly found as well, "When you allow yourself and others to be pessimistic, to grieve or be sad, you build pivotal resilience tools for you and those around you. When you validate a person's pragmatic pessimism, you show that you are listening and care deeply about the person's well-being."

Chemaly notes that research indicates that most people are inherently resilient, "The question isn't how we can help children learn to be resilient but what are we doing, as a society, to undermine their well-being and innate ability to adapt." Of course, this doesn't apply only to children. How can we stop undermining the well-being of all who interact with the healthcare system, patients and doctors alike? The entire healthcare system rests on the resilience of healthcare staff who have been continually asked to do more with less for the entirety of my twenty year career and likely much longer. The irony is that nurturing relationships that we have been told we are too busy for or don't need are exactly what leads to a sense of self-worth and purpose that allows us to take risks and truly confront the challenges we face rather than avoiding them or playing small.

Sharing our stories is the first step of building beyond self-care and toward true community care. Chemaly says, "...sharing our personal stories helps to diffuse anxiety, stress, and fear because we aren't bearing the burden of hardship alone. But the purpose of personal narratives isn't simply to make us feel good about ourselves. It's also to communicate with others, form strong bonds, and, ultimately, cultivate empathy, cooperation, a shared knowledge. When we listen to or watch sympathetic stories, oxytocin, the hormone of love, compassion, and empathy, surges in us."

I can speak to this from experience. Last year, I went on a wilderness fast, both before and after we sat in council, sharing our stories without interruption, without advice, and with a little reflection from our group leaders. At the beginning of the event, there were a few people who I either felt I had little in common with or even felt annoyed by. By the end of the week, after having come to understand each person and their struggles as thoroughly as you can in a week and a half, I hold them all with love in my heart.

Self-care is necessary for those who cannot get their needs met through community care, but now we must re-establish community care where it has been lost. Steph Beecher, the basic needs coordinator at the University of Iowa describes community care like this, "Community care transcends the realm of individual acts of kindness. It embodies a culture of empathy, solidarity, and mutual support within our neighborhoods, our academic institutions like the UI and our social circles." How do we bring community care back into our daily lives?[6]

Active listening. Listen to others without judgment. It can be helpful to ask directly if people would like advice or simply a listening ear. Asking thoughtful questions helps to build connections. Unsolicited advice often lands as criticism.

Offer support without prompting. If you know someone is dealing with a health crisis, a death in the family, mental health struggles, or just a general rough time. Don't leave it open ended, "Let me know if you need anything." Show up with what you would want in that situation, use one of your unique gifts to brighten their day, or just ask if they would like you to simply be present without expectation.

Engage in acts of kindness. In my neck of the woods a random snow shoveling is sure to brighten someone's day.

Participate in community projects. What's important to you? Animal welfare, environmental stewardship, food insecurity, supporting the unhoused? People in your area are probably already working on these issues. How can you join in? Most of us are feeling overwhelmed these days, so start small and simple.

Create supportive spaces to share thoughts, feelings, and struggles without judgment.

Cultivate empathy. As noted above, sharing personal stories helps build understanding.

Celebrate achievements. Recognize the contributions and successes of community members. It feels good and helps us realize when we are making an impact.

Prioritize well-being over productivity. Can you even imagine a healthcare industry or society that does this?

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So, You've Cannulated for ECMO in the ED... Now What?

Matthew Carvey, MD EMT-P and Allyson M. Hynes, MD FAAEM FACEP

"While the initiation of ECMO in the ED is a significant feat, the subsequent management of these critically ill patients is equally crucial."

Extracorporeal membrane oxygenation (ECMO) has become an increasingly vital tool in emergency departments (EDs) for patients experiencing severe, reversible cardiopulmonary failure. While the initiation of ECMO in the ED is a significant feat, the subsequent management of these critically ill patients is equally crucial. This article outlines an evidence-based step-by-step guideline for managing ECMO patient's post-cannulation in the ED, emphasizing early stabilization, neurological monitoring, anticoagulation management, and addressing complications that can occur prior to intensive care unit (ICU) admission.

Immediate Post-cannulation Stabilization

Following ECMO cannulation, the primary goal is to achieve hemodynamic stability. Generally, for veno-arterial (VA) ECMO, target flows should be between 2.2–2.5 L/min/m², with a mean arterial pressure (MAP) exceeding 65 mmHg and continuous mixed venous oxygen saturation above 70%. Left ventricular (LV) distension is a recognized complication of VA-ECMO and may necessitate LV venting to prevent pulmonary edema, thrombus formation, and impaired myocardial recovery.[1,2] In veno-venous (VV) ECMO, ensure adequate oxygenation and ventilation while minimizing ventilator settings to reduce ventilator-induced lung injury. Regular monitoring of lactate levels can guide resuscitation efforts and indicate tissue perfusion adequacy.[3,7]

Neurological Monitoring and Management

Neurological complications, including acute brain injury (ABI), are prevalent in ECMO patients, particularly those on VA ECMO or undergoing extracorporeal cardiopulmonary resuscitation (ECPR), with devastating complications being intracranial hemorrhage and seizures. A consensus guideline from the Extracorporeal Life Support Organization (ELSO) recommends routine neurological assessments using tools like the Richmond Agitation-Sedation Scale and the Glasgow Coma Scale. Early identification of ABI is critical, as it significantly impacts morbidity and mortality. Management strategies include optimizing cerebral perfusion, controlling intracranial pressure, careful management of anticoagulation and promptly correcting thrombocytopenia, and renal failure, and considering neuroprotective interventions.[5]

Anticoagulation and Hemostasis

Anticoagulation is essential to prevent thromboembolic complications in ECMO circuits. However, balancing anticoagulation to prevent bleeding is challenging. Monitoring parameters such as activated clotting time (ACT) and anti-Xa levels is recommended. In cases of heparin-induced thrombocytopenia (HIT), alternative anticoagulants like bivalirudin should be considered. Regular assessment of platelet counts and coagulation profiles is necessary to adjust anticoagulation therapy appropriately.[4,8]

Fluid and Electrolyte Management

Patients on ECMO often present with fluid overload. Aggressive diuresis is typically initiated once the patient is stable. Ultrafiltration can be incorporated into the ECMO circuit to facilitate fluid removal. However, caution is advised, as excessive fluid removal can lead to hypotension and reduced organ perfusion. Continuous monitoring of hemodynamic status and urine output is essential to guide fluid management.[3]

Transfer and Ongoing Care

Once stabilized, ECMO patients should be transferred to an intensive care unit (ICU) or specialized ECMO center for ongoing management. Prior to transfer, ensure that all necessary documentation, including patient history, cannulation details, and current treatment protocols, are communicated effectively.[1,2]

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Complications and How To Address Them

Chatter

- Cause: Chatter, characterized by intermittent oscillations or interruptions in the ECMO circuit flow, is often due to inadequate venous drainage. This phenomenon typically results from hypovolemia, malposition of the venous cannula, or excessive negative pressure in the drainage limb of the circuit, leading to vessel collapse.
- Management:
  - Assess volume status and administer intravenous fluids to correct hypovolemia.
  - Reposition the patient or cannula, optimize ECMO pump speed, or use echocardiographic guidance can help restore consistent flow.
  - Continuous monitoring and collaboration with the ECMO team are essential to prevent circuit thrombosis or hemodynamic compromise.[13]

Air Embolism

- Cause: Air embolism is a rare but potentially fatal complication of ECMO, most often resulting from a breach in circuit integrity such as a tubing fracture, loose connection, or compromised cannula site. The entrainment of air into the ECMO circuit can lead to systemic air embolism, causing cerebral, coronary, or pulmonary vascular obstruction.
- Management:
  - Immediate recognition is critical.
  - Clamp the circuit proximally to the air entry site to prevent further air migration.
  - Reduce pump speed to minimize circuit pressure.
  - Place the patient in the left lateral decubitus and Trendelenburg position to limit cerebral embolization.
  - 100% oxygen should be administered to promote nitrogen washout.
  - Emergency consultation with the ECMO team is warranted to facilitate circuit inspection, air evacuation, and possible circuit exchange.[14]
  - Real-time monitoring with bubble detectors and circuit pressure alarms can aid early detection and prevention of catastrophic outcomes.[14]

Vascular Injury (e.g., arterial or venous perforation, dissection, perforation of the posterior wall, arteriovenous fistula, pseudoaneurysm)

- Cause: Misplacement of cannula, fragile vessels, guidewire placement, vessel dilation, or difficult anatomy.
- Management:
  - Use ultrasound guidance for cannulation to reduce risk.[6]
  - Immediate recognition via ultrasound or hemodynamic instability.
  - Apply manual pressure, obtain surgical or interventional radiology consultation, and utilize endovascular stabilization techniques (e.g., balloon tamponade).[6]

Bleeding/Hemorrhage

- Cause: Anticoagulation (e.g., heparin), small vessel injury, platelet dysfunction due to shear stress, thrombocytopenia, coagulopathy.
- Management:
  - Apply direct pressure to slowly oozing sites, redress or re-suture, and correct coagulopathies.
  - Reassess correct positioning of the ECMO cannula.
  - Use lowest effective anticoagulation dose, monitor ACT, aPTT, PT, platelet count and TEG/ROTEM.
  - Be prepared with blood products (PRBCs, FFP, platelets).
  - Achieve adequate hematocrit levels for perfusion.
  - Meticulous management of hemostasis and thrombosis.
  - Use topical hemostatic agents or consider surgical control for localized bleeding.[8]

Limb Ischemia (commonly in femoral VA ECMO)

- Cause: Occlusion of femoral artery by large arterial cannula.
- Management:
  - Prophylactically place a distal perfusion catheter to perfuse the leg.[9]
  - Monitor limb perfusion with Doppler or near-infrared spectroscopy (NIRS).[10,14]
  - If ischemia develops, adjust cannula size/position or consider surgical consultation.[9]

Cannula Malposition

- Cause: Misplacement into incorrect vessel or poor positioning.
- Management:
  - Confirm placement with ultrasound, fluoroscopy (if available), or X-ray.
  - Monitor ECMO circuit performance (e.g., low flows or high pressures may indicate malposition).
  - Reposition or replace cannula with image guidance.[11]

Continuous Education and Training

Given the complexity of ECMO management, continuous education and training for ED personnel are vital. Regular simulation exercises, workshops, and review of current literature help maintain proficiency and readiness for ECMO initiation and management. Engaging in collaborative learning with other institutions can provide valuable insights and enhance the overall quality of care.[1,2]

Conclusion

Initiating ECMO in the ED is a critical intervention for patients with severe, reversible cardiopulmonary failure. However, the success of ECMO therapy hinges on meticulous post-cannulation management, including stabilization, neurological monitoring, anticoagulation, and addressing complications that can arise. By adhering to evidence-based protocols and fostering a collaborative approach, ED physicians can significantly improve patient outcomes in this high-stakes setting.

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AAEM Joins the AMA House of Delegates (And Why It Matters)

Gary Gaddis, MD PhD FIFEM MAAEM

On June 9, at the Annual Meeting of the American Medical Association (AMA), three American Academy of Emergency Medicine (AAEM) members were seated as new delegates to the AMA's House of Delegates (HOD). This was a very important development, because for the first time, via gaining these delegates, AAEM can now participate in decision-making and policy-making functions within the AMA. In other words, AAEM now has direct access to the AMA's "voice," a voice much bigger than AAEM alone could ever have.

Regarding that access, once our concerns developed through AAEM can be shared within the AMA, if its HOD delegates vote to support our positions, ideas, and suggestions, these also become AMA positions. The AMA is America's largest physician organization—every member of Congress has at least heard of the AMA. Not so for our AAEM. Our new access matters!

Our three AAEM delegates have now joined the nine delegates from the American College of Emergency Physicians who have previously been the only representatives of our specialty within the AMA HOD. With the addition of AAEM's additional three delegates, the AMA's HOD now totals 733 Delegates.

More than 1500 AAEM members are also AMA members, and this enabled our HOD seating. AMA Bylaws allow one seat in its HOD for every 500 members of any state or specialty organization's medical societies. So, a heartfelt thank you is due to all AAEM members who are also AMA members.

A recent example illustrates how access to the voice of the AMA has benefitted all emergency physicians, even before our AAEM delegates became seated. Consider waiver of due process (WODP) clauses, which exist in many of our employment agreements. Most of us believe these clauses, often demanded by an employer, have no legitimate place in physicians' employment agreements. A contract that waives due process muzzles the physician. Emergency physicians need to be free of WODP clauses in their employment agreements, so that they are free to speak up when they must, in the interests of their patients or co-workers, even in cases where such advocacy might well anger their employers and/or those in the C-suite of their facilities.

Consider the example of emergency physician Dr. Ming Lin of Bellingham, Washington. He learned the hard way about the WODP clause in his employment contract in the winter of 2020. He advocated within his hospital to procure much more personal protective equipment (PPE) early in the COVID pandemic, because he and his colleagues were working with inadequate PPE supplies. His pleas were met by deaf ears. After being repeatedly ignored within his hospital organization, he reluctantly took his concerns to social media. When his hospital's administrators learned of this, Dr. Lin's advocacy quickly led to his being summarily terminated from the physician duty schedule. If Dr. Lin's employment agreement did not have a WODP clause, his access to employment at the hospital at which he had long served would not have been so rapidly crushed.

> **"AAEM now has direct access to the AMA's 'voice,' a voice much bigger than AAEM alone could ever have."**

Similarly, a doctor whose name cannot be revealed here, (due to a confidentiality agreement), was terminated by a private equity-owned employer after expressing concerns that an unacceptable number of sentinel events had been occurring, shortly following a decrease of the number of emergency physician hours provided per day by that employer at that site. The doctor felt a moral duty to speak up for the well-being of their patients. Once that doctor informed the administration of their concerns, the administrator asked representatives of that employer if the doctor's concerns were reasonable. The employer, arguably motivated by profit considerations,

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quickly terminated that employee, who had unfortunately waived due process protections in their employment agreement. This forced a doctor whose children were soon to matriculate to college to scramble for new employment in a new and inconvenient location.

The common thread in these terminations was an egregious WODP clause in these doctors' employment agreements. The logical reaction was advocacy by proposed resolutions against WODP clauses in physicians' employment agreements, throughout 2022, initiated by AAEM member Dr. Gary Gaddis. The first anti-WODP resolution Dr. Gaddis wrote was adopted by his state medical society, which then offered the AMA a nearly identical resolution. The AMA adopted that resolution in 2022, giving its national voice to this matter. Both resolutions advocated that WODP clauses should become illegal in physician employment agreements, and void where they currently exist. Subsequently, the AMA has developed model state legislation on the matter.

Because the AMA, contrary to Dr. Gaddis' intent, did not also make WODP clauses a national issue, a similar resolution to extend advocacy nationally was sent to the AMA via the MSMA in 2024, and those resolutions were also adopted. To have the AMA on our side in this issue, rather than keeping our concerns within AAEM, increases our chances for favorable changes on this matter. In fact (and not wholly by coincidence), one proposed bill before the United States Senate, the Physician and Patient Safety Act (S. 1767), introduced again in the 119th Congress (2025-2026), after failing to gain a committee hearing in two prior Congresses, aims to ensure due process protections for all physicians. Doctors employed by third-party contract management groups deserve the protections this act would confer. By our AMA having adopted by resolution advocacy for this position, when our AMA lobbyists speak in Washington in favor of S. 1767, they can unambiguously assert that S. 1767 is concordant not only with the wishes of AAEM, but also concordant with the wishes of AMA.

Vicki Norton, MD FAAEM, AAEM President-Elect, has also brought AAEM concerns to the AMA HOD via her strong record of activity with the Florida Medical Association (FMA), for which she serves as an Alternate Delegate to the AMA HOD. She is also active within the AMA's Organized Medical Staff Section (OMSS). In 2024, she brought a resolution through the FMA addressing the need for proper emergency department staffing and supervision of Non-Physician Practitioners (NPPs) in the emergency department. That our AAEM aligns with this position regarding NPPs should not come as a surprise. Dr. Norton's resolution was adopted by the HOD. This year, Dr. Norton has successfully offered Resolution 712, addressing the need for transparency in billings and collections for the services we render. If our employers would adopt the suggestions in the resolution, we would be entitled to a periodic inspection of billings sent in our name for services which we have rendered, without fear of intimidation or sanction by our employers for daring to ask to gain access to this important data. Resolution 712 was adopted by the AMA HOD this year.

The above examples also illustrate advantages of joining your state's medical society. Each state's medical society is also represented in the AMA HOD, with proportional representation based upon its number of AMA members. By being a member of your state's society, you can gain access to others in your state but outside of our specialty, who may share our opinions and join in collaborative advocacy. In addition to Dr. Norton and Dr. Gaddis, Jonathan Jones, MD FAAEM, AAEM Immediate Past President, is active within the Mississippi Medical Society, and Debbie Fletcher, MD FAAEM, AAEM member, is similarly a long-term member of the Louisiana State Medical Society (LSMS). She is one of the LSMS' alternate delegates to the AMA HOD.

In closing, Dr. Jones and Robert McNamara, MD MAAEM FAAEM, former AAEM President, as well as Dr. Gaddis, have been selected as AAEM's first three delegates, and Scott Rineer, MD MPH FAAEM, AAEM member, Dr. Fletcher, and Leah Colucci, MD MS, former AAEM/RSA Past President, are our alternate delegates. Dr. Rineer served as a delegate this June, as Dr. McNamara was not able to attend due to a prior conflict. All of us look forward to continuing to represent AAEM's interests within the AMA, the "House of Medicine", next at the November interim meeting of the AMA HOD, and then beyond! We will keep you informed of relevant developments.

Author's Note: Dr. Gaddis wishes to thank the contributions and editorial comments to drafts of this column that he received from Drs. Jones, Rineer, Colucci, Norton, Fletcher, all of whom were in attendance at the AMA House of Delegates meeting, June 6-11, 2025, in Chicago. ■

A Tale of Two Systems: Comparing Emergency Department Models in the United States and Europe

Nick Hakes, Mphil and Mel Ebeling, MD

Emergency departments (EDs), referred to as accident and emergency departments (A&Es) in much of Europe, sit at the crossroads of emergency care, public health, and public policy. The "front door" of the hospital offers insight into how healthcare systems regulate patient access, manage clinical flow, and allocate scarce resources. In the United States, EDs function within a fragmented, largely privatized system that lacks universal coverage, often leaving EDs to absorb the downstream effects of unmet outpatient needs. In Europe, most A&Es operate within publicly funded universal health care systems that emphasize integration and primary care coordination. From a broad systems perspective, there exists two dominant models for the provision of emergency medical care: the Anglo-American model and the Franco-German model. The Anglo-American model prioritizes hospital-based care delivered by emergency physicians and is exemplified by the United Kingdom and United States, whereas the Franco-German model initiates treatment earlier through physician-led prehospital services and is exemplified by France and Germany. Ultimately, how EDs function reflects the design of the broader emergency care system, highlighting opportunities to compare, adapt, and improve models of care. Here we seek to provide a basic introduction to the similarities and differences between these two models.

> **"In the United States, EDs function within a fragmented, largely privatized system that lacks universal coverage, often leaving EDs to absorb the downstream effects of unmet outpatient needs."**

Systemic Context and Volume

The American emergency care system is governed by the Emergency Medical Treatment and Labor Act (EMTALA), which mandates that EDs treat all patients regardless of ability to pay. This has made EDs de facto safety nets, particularly for those without reliable access to primary care. In 2022, 155 million people visited an ED, equating to 47 per 100 people.[1]

Like the United States, access to emergency care is guaranteed as a right regardless of ability to pay. The primary difference is that European A&Es operate within systems of universal health coverage. To combat wait times and overcrowding, many countries use primary care gatekeeping and coordinated triage systems to redirect non-urgent cases to more appropriate settings. Primary care gatekeeping is a system where patients must first consult a general practitioner before accessing specialist or hospital care. Unlike the American 911 system, which focuses on emergency dispatch and ED transport, European coordinated triage systems assess urgency through integrated call centers and clinical pathways to redirect non-urgent cases to general practitioners or community care. For example, in the Netherlands, general practitioners handle nearly 90% of after-hours care, referring to A&E only if necessary.[2] As a result, visit rates vary. The European mean is 30 per 100 people, though in some countries, such as the Czech Republic, the rate is as low as 0.7 per 100 people.[3,4]

Structure and Staffing

American EDs vary in size from rural freestanding EDs to urban trauma centers and are usually staffed 24/7 by board-certified emergency physicians; although, advanced practice practitioners (i.e., physician assistants and nurse practitioners) are managing a growing share of patients.[5] Emergency medicine in the United States is a well-established specialty with over 50 years of dedicated training and certification.

In Europe, however, recognition of emergency medicine as a specialty is relatively recent and uneven. As of 2023, only 33 of 54 (61%) European countries recognize emergency medicine as primary specialty.[6] Countries like the United Kingdom and Ireland have robust training and staffing models for consultant-level

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emergency physicians, equivalent to the attending emergency physician in the United States. Others, including Germany and Sweden, have historically relied on rotating physicians from other specialties, though this is changing over time.[7]

A notable European innovation is the consultant in triage model. For instance, in the United Kingdom, consultants conduct rapid assessments alongside triage nurses, initiating care early and reducing unnecessary delays. This model has been shown to decrease A&E length of stay and the number of patients who leave without being seen.[8] Some American EDs have adopted a similar triage approach, but widespread implementation remains limited by staffing costs.

Throughput and Flow

ED crowding is a shared transatlantic challenge. In the United States, boarding of admitted patients, caused by a shortage of available inpatient beds, remains a primary driver of delays. The United Kingdom faces similar issues, with over 12,000 patients medically fit for discharge remaining in hospital beds daily, causing delays in the A&E.[9]

Both systems have responded by developing fast track zones for minor injuries and clinical decision units for short-term observation and treatment. These units reduce unnecessary admissions and allow EDs to focus on higher acuity cases. One study using queuing theory and mathematical modelling found that establishing a fast track reduced average waiting times by up to 35%.[10]

Triage systems are now standardized across regions. The United States uses the Emergency Severity Index (ESI), while the United Kingdom and parts of Europe use the Manchester Triage System or adaptations of the Canadian Triage and Acuity Scale. Despite different names, all follow a five-level structure to prioritize patients by urgency and resource needs.

Compared to the United States, Europe makes greater use of co-located primary care. For example, in the Netherlands, urgent general practitioner clinics are located adjacent to A&E to reduce self-referrals and inappropriate use of emergency resources. Research supports a resulting reduction in A&E attendance and wait times alongside an increase in patient satisfaction.[11]

Systemic coordination also differs. Countries like the United Kingdom maintain national A&E dashboards that track patient flow and capacity in real time. This enables central authorities to redirect ambulance traffic and redistribute internal resources. Due to the fragmented nature of the American healthcare system, where hospitals minimally communicate with each other and ambulance dispatch is operated at the local or regional level, the lack of an equivalent national integration limits situational awareness across institutions and regions.

Toward an Ideal Model

As pressures mount on emergency departments worldwide, the path forward is unlikely to be found in any single system. Instead, the most resilient models will emerge from combining the best of both sides of the Atlantic. From the United States: strong in-hospital specialty integration, attending-level staffing, and operational innovation. From Europe: early and experienced decision-making from a consultant in triage, real-time coordination, and upstream care integration that reduces preventable attendance.

For the United States, policy change must target structural integration. Co-locating urgent care and general practitioner services within ED campuses would create lower acuity offramps and ease overcrowding. Incentivizing consultant-in-triage models during peak hours would accelerate clinical decision-making, reduce time to disposition, and improve patient flow. Most critically, federal investment in a national emergency care data infrastructure could enable real-time monitoring, cross-institutional coordination, and dynamic resource allocation, transforming emergency care from reactive to anticipatory. These changes require not only funding, but regulatory frameworks that facilitate intersystem communication and accountability.

> **"In Europe, most A&Es operate within publicly funded universal health care systems that emphasize integration and primary care coordination."**

Ultimately, emergency medicine policy should move beyond throughput metrics to prioritize systemwide alignment around access, equity, and continuity of care. Fragmentation remains the greatest threat to progress. By embedding emergency care within a broader, integrated health strategy—one where EDs are supported rather than siloed—policymakers can help EDs not only absorb acute crises but avert them, creating a more agile and equitable emergency care system.

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CRITICAL CARE MEDICINE SECTION

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EM–Bound Medical Student Becomes AAEM/RSA Medical Student Ambassador

Loressa Lara, MS4

Why I Applied to Become a Medical Student Ambassador

Attending the AAEM Scientific Assembly was my first opportunity to connect with emergency medicine professionals from all areas of the country. Being a Florida native, having the AAEM scientific assembly in Miami was an opportunity that could not be missed. It was important to me that I connect with like-minded individuals with similar goals and passions.

As an ambassador, we were assigned specific sessions to help monitor the session, count attendance, and provide directions. I was glad to have this assigned schedule because if I attended on my own, I would have no idea where to start!

This role connected me with a supportive community of third- and fourth-year medical students to help navigate the waters during the AAEM Scientific Assembly. It opened the door to meaningful networking and gave me invaluable insights as I prepare for the 2026 Match cycle.

Another advantage of being a medical student ambassador is being matched with a mentor based on our educational interests and geographic preferences. Having a mentor as a third and fourth year EM bound medical student can help alleviate many questions and concerns, promoting success during application season.

What It Was Like Attending My First AAEM Scientific Assembly

Exciting! Nervous! All the feelings!

I can truly say it was an amazing experience. Also, having the experience in Miami, FL, made the experience just that much more enjoyable. I say this with some bias, as I currently live in South Florida while completing my clinical rotations.

I enjoyed the variety of topics presented, and one of my personal favorites was the mini lectures, also known as "Breve Dulce," which is Latin for "short and sweet." These were quick topics or EM pearls to help learners use in their everyday practice.

Another important aspect of attending AAEM Scientific Assembly is the opportunity to sign up for specific sessions or courses. I personally completed the AAEM/RSA Introduction to Critical Care in Emergency Medicine Course. This course primarily had third and fourth year medical students looking to scratch the surface of critical care in emergency medicine. This was another wonderful networking opportunity in addition to the vast amount of knowledge that I learned in a short time with this course.

How I Plan to Stay Connected and Involved

One of the easiest ways I stay connected is through social media. Instagram is my go-to, and following @AAEM_RSA and @AAEMinfo keeps me posted on current, relevant information.

At my medical school, staying involved in our emergency medicine interest group has also been a great way to build community. Many of us help each other connect across the country. This year, a large group of us were able to attend the RSA party to network. If you attended, you may recall a group of individuals wearing cool color block jackets to Havana night.

AAEM also offers a wide variety of options to be able to stay connected, such as committees, chapter divisions, interest groups, and sections. These resources make it easy to continue learning and contributing beyond the conference.

I am truly grateful for the opportunity to be a Medical Student Ambassador for the 2025 AAEM Scientific Assembly. I hope to be able to continue to serve as an advocate and supporter of peer learners growing during our emergency medicine journey. ■

"What was it like attending my first AAEM Scientific Assembly? Exciting! Nervous! All the feelings!"

Echoes That Stay: Reflections on Patients Through the Lens of Ultrasound

Yash Chavda, DO MBA FPD-AEMUS

The use of point-of-care ultrasound (POCUS) in emergency medicine is typically framed through the lens of rapid diagnostics, procedural guidance, and immediate clinical decisions. For me, beyond its clinical utility, POCUS holds a deeper significance. Each scan is not just a clinical tool; it captures a fleeting moment of a patient's life, often becoming an indelible memory that I carry with me.

Certain scans remain vividly etched into my memory, beyond the hundreds of scans that blur into the daily workflow. I clearly recall the young teenager brought in by ambulance after a high-speed motor vehicle collision every time I look at those FAST exam clips. Or the patient with a gunshot wound who had a pericardial effusion and required a thoracotomy after losing pulses. They died, but the POCUS clips remain. The patient's name fades, but the rhythm of that heartbeat, captured mere moments before life slipped away, persists clearly in my memory.

Then there are other scans, brief and quiet moments of immense vulnerability. An abortion in progress, unmistakably visualized on the screen. The fetus that had a heartbeat two days ago and now doesn't. The sick pediatric patient whose heart I captured on my ultrasound, and whom I later learned passed away. I still can't look at that clip without thinking of that child asking for her mommy. These clips carry with them a heaviness and solemnity that words can scarcely capture. More than just medical confirmation, these clips embody loss, grief, and human fragility.

"While POCUS can save lives, guide interventions, and sharpen clinical decision-making, perhaps its deeper, less tangible value lies in reminding us continually of the humanity at the heart of medicine."

While all physicians carry memories of their patients, the dynamic nature of ultrasound clips—the unmistakable rhythm of a heartbeat, the subtle movements—offers tangible, objective proof of their existence. These images linger long after the patient's physical presence has vanished from our lives.

Carrying these echoes comes with an emotional toll, but also profound privilege. They remind us of the fragility inherent in life and the role we briefly play in the stories of countless strangers. Reflecting on these echoes, the ghosts of their former owners, fosters humility, compassion, and resilience, grounding us firmly in our mission to care, heal, and bear witness.

Sometimes, when I use these de-identified clips for teaching, there's a feeling that the patient continues to share their world with us. They teach us, remind us, and help us learn, even through the memories we have. In sharing these reflections openly, we acknowledge the emotional complexity of our work. While POCUS can save lives, guide interventions, and sharpen clinical decision-making, perhaps its deeper, less tangible value lies in reminding us continually of the humanity at the heart of medicine. These echoes, while emotionally taxing, form the very essence of what it means to be a physician—carrying our patients' stories forward, gently yet firmly etched into memory. ■

"The Internal Conflict": A Narrative Medicine Piece Encompassing the Emotional Battle Faced During Residency Training

Kristina Awan, MD

I still remember the pit in my stomach. Walking into the designated quiet space in the middle of a loud, busy ED waiting room with a social worker to tell a woman I've never met that her 27-year-old husband died for an unknown reason.

EMS reported that she found him passed out at home…so many unanswered questions. I don't see a history of dysrhythmias or substance use in his chart, he seems healthy? None of this makes sense.

Okay, it's finished. She knows that he died and took it way better than I would have. It's time to move on but I'm having a hard time with the fact that the patient's death didn't really seem to affect me—it's always witnessing the reaction of their loved ones. I wanted her to know that he didn't die alone but I started to choke up and I wanted to maintain a brave face.

How is this a normal part of my job? Can I do this forever? Why wasn't I sad when I called time of death? It's hard to explain but I can actively feel my emotional, soft side of my personality harden. But I know this is necessary. I have other patients that I need to disposition so I can get home to my husband and hug him a little tighter tonight. ■

"How is this a normal part of my job?"

THE NETTLE WITCH, MD
Continued from page 12 >>

The era in which we can expect individuals to cover for failing systems through sheer willpower is long past. Solving the crises we face requires us to weave ourselves together again, to rely on each other. We need to change the stories we tell ourselves about asking for help and about who succeeds at overcoming adversity. Who is more resilient? The doctor who grits her teeth continues in medicine or the doctor who steps into the unknown? The doctor who continues to work in a field that breaks her heart for a secure income or the doctor who relies on others for financial help? How do we break out of a resilience that is isolating, constricting, and fragile into a resilience that is interconnected, difficult to control, and won't tolerate the intolerable?

Editor's Note: To read more of Dr. Walsh's writing about healthcare and herbalism, please visit The Nettle Witch, MD at thenettlewitchmd.substack.com

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Selected Highlights of the Annual Meeting of the AMA House of Delegates 2025

Gary Gaddis, MD PhD FIFEM MAAEM

As noted elsewhere in this issue of Common Sense, AAEM for the first time became represented on the floor of the House of Delegates (HOD) of the American Medical Association (AMA), at its recent HOD Annual Meeting in Chicago, June 6-11, 2025.

HOD delegates considered and debated more than 175 resolutions and reports at this assembly. Some resolutions that became adopted are of clear interest to AAEM members, and these are summarized and profiled below.

But before reviewing some of these actions of the HOD, those who read this column deserve to know that the AMA follows very well-delineated deliberative process as it considers the various matters of business before it. Those processes mimic certain functions of the United States Senate or House of Representatives.

In Congress, before any bill can become law, it first must be proposed, then heard before a committee, then voted out of that committee, and forwarded to the entire chamber for consideration by that chamber as a whole. Similarly, any report or resolution to be considered by the AMA HOD first makes its way through a committee hearing process, in what are called "reference committees," where a resolution is first considered (and often amended). Each reference committee centers on a theme, such as medical education, science and technology, public health, and numerous others. It is only after due consideration by a reference committee that any vote is made by the HOD as a whole regarding any resolution. In the interest of brevity, those processes will not be fully outlined here.

Here are a few issues considered by the AMA HOD that I believe will interest our AAEM members.

Emergency Resolution 1001

While the HOD meeting was ongoing, HHS Secretary Robert F. Kennedy Jr. dismissed the 17 current members of the Advisory Committee on Immunization Practices (ACIP), shortly before its planned June 25 meeting. This action prompted AMA to formally request reversal of the Secretary's directive, and further, to ask the Senate's Health, Education, Labor, and Pensions Committee to investigate Secretary Kennedy's actions. At the meeting, there clearly was a majority sentiment that AMA must speak up firmly and clearly to defend important matters of science, because if AMA were to maintain silence on controversial matters of science, such silence could be mistaken as assent. One can anticipate that AMA will also lend its future voice to support other matters that concern the implementation of science-based actions by governmental agencies.

Unionization of Physicians

A sizable majority of physicians are now employees of non-physician-owned organizations, such as hospitals, medical school multispecialty groups, insurance companies, or other employers. As such, physicians have suffered progressively decreased power for self-determination in the workplace, imposed by employers as conditions of employment. In response, a growing portion of physicians are becoming unionized. Indeed, physician unionization has been gaining increasing attention within AMA. Toward this end, the HOD considered Council for Ethical and Judicial Affairs (CEJA) Report 02, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization." The HOD voted to refer this proposed report for refinement, due to reasonable concerns that some of the well-considered and well-intended language in the report could be weaponized against activist doctors. Thus, this report will be reconsidered at AMA's interim meeting of its HOD in November. However, rest assured that at that meeting, one can anticipate that AMA will adopt strong language supportive of protecting doctors' rights to unionize, so long as patients' interests and access to care will not be compromised.

> **"Some resolutions that became adopted [by AMA] are of clear interest to AAEM members, and these are summarized and profiled below."**

Resolution 712, re Billing Transparency

This resolution was brought to the HOD by Vicki Norton, MD FAAEM, AAEM President-Elect, through her activity and advocacy within the Organized Medical Staff Section. When bills for the medical care we have

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rendered are sent for reimbursement, whether by Medicaid, Medicare, or a commercial insurer, we as physicians are ultimately responsible for the accuracy of the bills (and level of service implied therein). When Medicare or Medicaid are being billed, the Federal False Claims Act serves as a deterrent to fraudulent billings, because the penalty for systematically fraudulent billing is triple the damages estimated to have occurred because of that fraudulent billing. Further, some physician employers don't permit the employed physician to learn what portion of collected fees are allocated to the physicians who provided the care that led to those fees, and what portion can be attributed to management fees. This resolution, "Billing and Collections Transparency", speaks to these matters, and advocates that each physician for whom an employer bills and collects fees should have access to detailed, itemized statements of such billings, at least biannually, and more often upon request. It also supports that physicians shall not be asked to waive access to this information. This is an important advance for employed physicians. Numerous emergency physicians have been intimidated or penalized by their employers for seeking such information about the bills being sent in their name, and for which they have a legal responsibility. This resolution seeks to provide grounding for subsequent advocacy to gain physicians appropriate access to data regarding the bills sent in their name.

Corporate Practice of Medicine

The HOD adopted the Council on Medical Service (CMS) Report Three, which addressed the issue of "Corporate Practice of Medicine" (CPOM). Many of us have encountered at least some of the various ways by which corporate rules and influences can impair our ability to deliver quality care to our valued patients. Having adopted this CMS report, AMA's position regarding CPOM now aligns with the policies of both AAEM and the American College of Emergency Physicians (ACEP). Both of those policies have strong advocacy, inspired in large part by new AMA delegate Robert McNamara, MD MAAEM FAAEM, former AAEM President. It also merits a reminder that when AMA policies align with AAEM objectives, the voice of AAEM becomes magnified through the AMA.

Protections for Physicians Who Engage in Contracts to Deliver Healthcare

The HOD considered and then adopted "CEJA Report Five", which addressed this topic. The Council of Ethical and Judicial Affairs (CEJA) is the AMA's Council that speaks to ethical matters. That council's report recognized that contracted physicians are at risk of being asked to sign employment agreements that contain provisions that threaten or interfere with their professional autonomy. This report underscored that it is doctors who need to be in charge of the delivery of medical care, not corporations. It also underscored that the corporate practice of medicine should be prohibited, and that nothing in an employment contract should force the physician to compromise their professional obligations to their patients. This CEJA report is also strongly aligned with core principles of AAEM, and we welcome its adoption by the HOD.

Pregnancy-Related Emergencies

The Ethics and Bylaws Reference Committee also considered Late Resolution 014, "Protecting Access to Emergency Abortion Care Under EMTALA." This is highly relevant to any emergency physician who practices in a state that constrains abortion access, such as my home state of Missouri. In Missouri, and in some other states, it is a felony criminal offense to end a pregnancy in which fetal cardiac activity can be demonstrated. Missouri law does not provide clear guidance to medical teams for emergency pregnancy-related medical conditions in which the fetus is doomed and cannot be delivered alive and successfully, such as (but not limited to) pre-term premature rupture of membranes (PPROM) or ectopic pregnancies (EP). Further, this problem is not limited to Missouri. Indeed, the states of Texas and Idaho have asserted that the Supremacy Clause of the United States Constitution does not supervene, and that their state laws on the matter should take precedence over EMTALA, which has been the law of the land since 1986.

Some may recall that the United States Supreme Court (SCOTUS) failed to fully support EMTALA, as most emergency physicians understand it, during 2024. In May of that year, SCOTUS dismissed the case of Moyle v. United States, which involved the conflict between Idaho's abortion ban and EMTALA, without ruling on the merits of the Idaho law. This dismissal action effectively left in place, at least for the current time, a lower court ruling that effectively blocks Idaho from enforcing its abortion ban to the extent it conflicts with EMTALA. To block Idaho's law is a position that most emergency physicians would probably favor. However, because SCOTUS did not make a final ruling on the matter, there is reason to fear that a future finding by SCOTUS that would favor states' rights would place women with pregnancy-related emergencies and the medical teams that provide their care into an untenable position.

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Further, on June 3, 2025, the Trump Administration rescinded the July 2022 Centers for Medicare & Medicaid Services (CMS) guidance regarding EMTALA enforcement, stating those interpretations and policies clarified under the Biden Administration "do not reflect the policy of this Administration." Most AMA delegates did not find this recission to be reasonable and many did not understand exactly what became rescinded, and whether or not the current administration would support EMTALA as most emergency physicians understand it.

In response, the AMA HOD adopted language that advocates for "reinstatement of federal guidance affirming hospitals' obligations under EMTALA to provide emergency pregnancy-related medical care… irrespective of state-level abortion restrictions." In other words, AMA has our backs when it comes to the dilemma that will inevitably arise when a pregnant woman with a newly-diagnosed pregnancy-related emergency involving a fetus with cardiac activity presents for care, well before the mother has developed the inevitable decline of her vital signs that will ensue as a consequence of that emergency condition.

I believe that few would want the United States to adopt the practice of physicians such as those in El Salvador, where women with diagnosed advanced ectopic pregnancies are hospitalized with frequent assessment, and are allowed by law to be taken to the operating room only when they demonstrate clear evidence that the ectopic gestation has ruptured.

Firearm Storage Diagnosis Counseling Reimbursement

The HOD adopted Resolution 108, which if followed by legislation or policies concordant with the resolution, would allow billing for counseling patients regarding proper firearm storage, if such counseling is done for a patient during their ED care. Many of us do this when we ask about firearms access by patients with suicidal ideation, or for families in which a gun-related tragedy has brought a patient to our ED for care. This public health action that many of us perform may in the future be a billable service.

Non-emergency Medical Transportation

Resolution 508 asked AMA to adopt a policy that non-EMS vehicles that transport patients to or from a hospital should have at least some basic life support capabilities, in order to be able to transport patients to or from medical appointments or to and from an emergency department. Testimony on this was mixed; many pointed out that such a new requirement may lead some non-EMS service providers to withdraw from providing this service, for which the need for any life support services is probably vanishingly rare. In other words, there was concern regarding the law of unintended consequences. This resolution was referred for further study, before AMA adopts any position on this matter. This proposed resolution was included in this discussion to demonstrate how not all idealistic or well-intended resolutions become adopted, and how many that merit further study and consideration before any final consideration shows how AMA engages in due diligence on matters it considers.

Fix Prior Authorization

Many patients have care delayed or denied due to insurers' or Medicare Advantage requirements for prior authorization, before payment can be assured for the provision of medical procedures or medications. Eventually, some of those patients avoidably end up in our emergency departments, as a clear downstream consequence of these delays and denials. Be assured that to fix prior authorization is one of the five chief priorities of AMA, and several resolutions addressed various issues related to the needless complications induced by prior authorization practices. We in emergency medicine can be thankful that we do not need (at least yet) to obtain prior authorization for the tests and treatments we order, but this pain is borne by almost all other medical specialties.

Thank you for reading this summary, which has attempted to highlight the items of business that our members would find to be relevant. Your delegates and alternate delegates to the AMA House of Delegates look forward to continuing to represent you and our Academy at upcoming meetings of the AMA HOD, and we pledge to report back to let you know of future developments that derive from our collaboration with AMA.

Finally, if you have ideas for resolutions that you believe should be offered by AAEM to the AMA House of Delegates for its consideration, please feel free to reach out to me at info@aaem.org with Attn: Dr. Gaddis – AMAHOD in the subject line. ■

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.

Section I: Positions listed in Section I are in compliance with elements AAEM deems essential to advertising in our job bank. Fairness practices include democratic and equitable work environments, due process, no post contractual restrictions, no lay ownership, and no restrictions on residency training and have been given the AAEM Certificate of Workplace Fairness.

Section II: Positions listed in Section II are in compliance with elements AAEM deems essential to advertising in our job bank. Fairness practices include democratic and equitable work environments, due process, no post contractual restrictions, no lay ownership, and no restrictions on residency training but have not been given the AAEM Certificate of Workplace Fairness.

Section III: Positions listed in Section III are hospital, non-profit or medical school employed positions, military/government employed positions, or an independent contractor position and therefore cannot be in complete compliance with AAEM workplace fairness practices.

SECTION I: POSITIONS RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK CRITERIA AND GIVEN THE AAEM CERTIFICATE OF WORKPLACE FAIRNESS

COLORADO

Southern Colorado Emergency Medical Associates (SCEMA) is hiring full and part time emergency physicians. SCEMA is a democratic group that began in 1979 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 Physician 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 pre-partnership rate of $200/hour. Part time positions also available with time spent eligible to count towards partnership. Partners average annual total compensation is $491k per year including profit sharing, 401k plan, and a SCEMA funded cash balance plan. 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. Learn more about our group online at www.scema.info. Please email our VP of Recruiting Dr. Mary Russo at mary.russo@uchealth.org if interested in joining us. Also feel free to reach out to our Medical Director Dr. Tyler Keller at tyler.keller@uchealth.org with any further questions. (PA 2160)
Email: mary.russo@uchealth.org

FLORIDA

Join Our Democratic Group in St. Petersburg, Florida: A Unique Opportunity for Emergency Physicians We are seeking dedicated Board Eligible/Board Certified Emergency Physicians to join our democratic group in beautiful St. Petersburg, Florida. This is an extraordinary opportunity to be part of a transparent, accountable organization that prioritizes collaboration and excellence. As a member of the American Academy of Emergency Medicine (AAEM), we adhere to the highest standards of accountability and transparency of a Democratic Group, ensuring that our physicians are empowered and supported in their roles. Why Join Us? This is not just another job; it's a chance to help shape the future of emergency medicine in our community. You will have the unique opportunity to open a brand new 24-bed community hospital and two freestanding emergency departments in Wesley Chapel, anticipated to begin operations in Spring/Summer 2026. The physicians we hire will form the foundation for the development and growth of the Emergency Department, setting the culture and expectations from day one. Key Highlights of Our Group: - Democratic Structure: Our group operates on democratic principles, fostering an environment where every physician has a voice and is held accountable for our commitment to transparency. Partnership track available after 3 years of employment, working a minimum of 140hrs/month during those 3 years - New Facilities: Be part of a state-of-the-art 24-bed facility with an expected volume of 40-45K visits annually, including approximately 10% pediatric cases. - Anticipated to be an accredited Stroke and STEMI center - Work-Life Balance: We emphasize a lifestyle-focused approach, allowing for balanced schedules to ensure you have ample time to enjoy the stunning world-renowned beaches, beautiful weather, and numerous outdoor activities that Tampa/St. Pete has to offer. - Flexible Scheduling: Prior to partnership, full-time hours average 140 hours per month. Once partnered, full-time is approximately 110 hours per month or more if you choose. - Compensation: $230-240/hr with the following breakdown: $200/hour as a W-2 employee along with a comprehensive benefits package that includes health and 401(k) plan with employer match, profit sharing, holiday bonuses, and a CME budget. Partnership includes RVU pay structure, a more robust CME allowance as well as quarterly dividends and meeting compensation. - Supportive Environment: APP coverage will be provided as volume demands. We are a physician heavy group and utilize our APPs primarily in low acuity/fast track. - EMR: Our facilities utilize Epic for EMR, Dragon for dictation, and Shiftadmin.com for scheduling to ensure streamlined operations. - Hospital Partnership: Our hospital system is a unique partnership with Orlando Health and Florida Medical Clinic, providing robust support and resources. If you are a passionate Emergency Physician looking to join a democratic group that values transparency, accountability, and work-life balance, we invite you to consider this exceptional opportunity. Help us shape the future of emergency care in our community and be a part of something truly special. Please see our website which offers a link to apply: https://www.epspbayfront.com (PA 2155)
Email: krystal.mendoza@epspbayfront.com
Website: https://www.epspbayfront.com/

SASKATCHEWAN, CANADA

The Saskatchewan Health Authority (SHA) and the University of Saskatchewan are seeking a full-time or part-time Pediatric Emergency Physician (0.50 FTE - 1.0 FTE) to join their team in Saskatoon. The successful candidate will provide pediatric emergency services at the Jim Pattison Children's Hospital, a state-of-the-art facility located on the University of Saskatchewan campus. This academic position includes an assistant professorship with the University. Responsibilities include providing clinical care in the Pediatric Emergency Department, teaching trainees, and participating in research with the Department of Pediatrics. There are opportunities for academic and clinical advancement, as well as involvement in research initiatives. Compensation is through an Alternate Payment Plan (APP), with the opportunity for financial benefits as an independent contractor. Physician benefits are the responsibility of the individual. Qualifications: MD degree Pediatric Emergency Medicine Fellowship Certification or Emergency Medicine Certification Eligible for licensure with the College of Physicians and Surgeons of Saskatchewan Benefits: Physician responsibility Location: Saskatoon, Saskatchewan Language of Work: English To Apply: Please submit your letter of interest and CV to Amanda Lee, Specialist Recruitment and Retention, at amanda.lee@saskhealthauthority.ca. Candidates selected for an interview will be asked for three reference letters, including one from the Fellowship Program Director for recent graduates. SHA is committed to diversity and encourages applications from individuals who contribute to the diversity of our community. Priority will be given to Canadian citizens and permanent residents. (PA 2134)
Email: amanda.lee@saskhealthauthority.ca
Website: https://www.saskhealthauthority.ca/

SECTION II: POSITIONS RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK CRITERIA

ARKANSAS

Job Title: Emergency Medicine Physician – Ultrasound Director/ Core Faculty Position Overview: Washington Regional Medical System is seeking a passionate, dedicated, and experienced individual to join our team as an Ultrasound Director and Core Faculty for a newly accredited Emergency Medicine Residency welcoming residents in June 2026. This is an exciting opportunity to make an impact in a community-focused setting while contributing to both patient care and medical education. We invite you to come build the Ultrasound program you have always wanted! The EM Ultrasound Director will play a critical role in the education and training of residents, in the use of point-of-care ultrasound (POCUS) across a variety of specialties and clinical settings. This individual will be responsible for developing, leading, and delivering ultrasound curriculum, advancing ultrasound education, and actively participating in clinical care. Key Responsibilities • Responsibilities include the practice of emergency medicine, and the provision of care to critically ill and injured patients. • Education and mentorship of residents in emergency ultrasound techniques, enhancing overall training • Create effective curricula and provide hands-on training for students, residents, and attending physicians in POCUS. • Guide residents through clinical cases involving ultrasound, ensuring competence in both technical skills and clinical decision-making. • Participate in the clinical practice of emergency medicine, utilizing ultrasound as a diagnostic and procedural tool. • Provide quality assurance feedback on both patient care and educational POCUS exams. • Participate in ultrasound-related quality improvement projects within the clinical setting to enhance patient care outcomes. • Maintain up-to-date knowledge on advancements in ultrasound technology and best practices in education and clinical care. Required Experience and Competencies • MD or DO degree with board certification in Emergency Medicine • Fellowship training in an EUFAC-accredited fellowship program or Advanced Emergency Medicine with Ultrasonography (AEMUS) Focused Practice Designation or Eligibility • Experience in implementation of ED Ultrasound Billing • Strong commitment to education with proven experience teaching medical students, residents, and/or fellows. • Evidence of scholarly activity, including publications and presentations, in the field of ultrasound is highly desirable. • Proficient in ultrasound-guided procedures, diagnostic applications, and advanced imaging techniques. • Strong clinical skills and the ability to perform in a high-pressure emergency setting. • Excellent communication, leadership, and organizational skills. • Experience with curriculum development, ultrasound administration, and education research preferred. • Licensed or eligible for licensure to practice medicine in Arkansas. Washington Regional Medical Center – Fayetteville, Arkansas • A community and teaching hospital with a 3-year EM Residency Program affiliated with the University of Arkansas Medical Sciences (UAMS) • Our mission has always been to improve the health of people in the communities we serve. In recent years, we've worked to fulfill that mission by: • Being the area's only Level II Trauma Center • Starting three new residencies to ensure care for the future • Maintaining the area's only Comprehensive Stroke Center • TJC's Gold Seal of Approval for Advance Certification in Spine Surgery • TJC's Gold Seal of Approval for Hip and Knee Replacement • US News & World Report – Named as the state's only High Performing Hospital for Maternity Care (PA 2154)
Email: jfarmer@wregional.com
Website: https://www.wregional.com

CALIFORNIA

Emergency Medicine Residency Program Director with Kaiser Permanente in the California Central Valley The Permanente Medical Group, Inc. (TPMG – Kaiser Permanente Northern California) has an opening to lead our 3-year Residency Program comprised of 8 residents/class for a total of 24 residents, while overseeing 3 assistant PDs, multiple fellowship trained faculty, and GME Program support staff. Must be BC in Emergency Medicine with 5 years as a core faculty member in an ACGME-accredited residency program. View salary and apply at: https://northerncalifornia.permanente.org/jobs/title/emergency-medicine-residency-program-director-in-modesto-ca/mod-ac-2500168. Or contact: Roy Hernandez at (510) 410-5813 or Roy.B.Hernandez@kp.org. We are an EOE/AA/M/F/D/V Employer. VEVRAA Federal Contractor. (PA 2136)
Email: Roy.B.Hernandez@kp.org
Website: https://northerncalifornia.permanente.org/jobs/title/emergency-medicine-residency-program-director-in-modesto-ca/mod-ac-2500168

CALIFORNIA

Hello! Eden Emergency Medical Group is a small independent group that staffs a single small hospital in the Bay Area - Eden Medical Center in Castro Valley. Some quick points about our group and hospital below: - We offer resident education: we have a resident from Highland Hospital most days with a single PGY3 or PGY4 resident shift - Comprehensive stroke center - Level 2 trauma center - High acuity patient population - Services on call: Pediatrics, OB/GYN, General Surgery/ Trauma, Orthopedics, Hand, Urology, GI, Cardiology, Neurology, Neurosurgery, ID, Heme/Onc, Renal, Podiatry, Vascular Surgery, ENT, Ophthalmology, Palliative - Hourly rate: $230/hr + $20/hr bonus for overnight shift, +$20/hr bonus for weekend shift - We offer a productivity bonus & holiday bonus - We offer a 2-year Junior Partnership track - We are a collegial and down-to-earth group of doctors, a lot of us close friends outside of work - We have strong queer and women in medicine representation within our group - We have had our contract with our hospital for > 3 decades We are currently looking for either a FT or PT employee at this time. Please reach out if you are interested! (PA 2145)
Email: alexei.adan@gmail.com

CALIFORNIA

Full and Part Time Positions Available in Downtown Los Angeles IEMG is a fully democratic, physician-owned emergency medicine group that has been serving the greater Los Angeles Area for over 40 years. We are looking for part time or full time BC/BE EM physicians to help launch our new site in the heart of downtown Los Angeles at PIH Good Samaritan. There are also opportunities to work in our other region in the Whittier/ Downey area at PIH Whittier and PIH Downey. - 50,000 annual volume - Designations: Primary Stroke and STEMI Receiving Center - Shifts: 8–12 hours with 24/7 APP support - Competitive compensation: $250/hr plus generous night differential - Malpractice coverage with tail - A physician-led, collaborative culture - Physician leadership that values clinical excellence and work-life balance - Shift equity with nights, weekends and holidays (PA 2152)
Email: iemgcareers@gmail.com

NORTH CAROLINA

Raleigh Emergency Medicine Associates (REMA) is recruiting a partnership track EM trained physician to join our outstanding group. REMA is a stable, independent, twenty-nine physician, democratic emergency medicine group that currently employs ten APPs. - UNC Rex Raleigh , 70,000 visits/yr. - UNC Rex Holly Springs, 35,000 visits/yr. REMA offers a competitive hourly rate and RVU productivity bonus with an excellent benefits package including full medical, disability, and retirement funding. Partner physicians enjoy a full fee-for-service reimbursement structure. The area offers a temperate climate, close to beaches and mountains, several major universities/medical centers, cultural activities, college and professional sports. (PA 2148)
Email: Careers@rema-em.com
Website: https://www.rema-em.com/

SECTION III: POSITIONS NOT RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK ADVERTISING CRITERIA

CALIFORNIA

The San Francisco VA Health Care System (SFVAHCS) is recruiting a Chief for its Emergency Medicine Section at the SFVA Medical Center. This leadership role oversees a team of approximately 12 physicians and 2 advanced practice providers, plays a key role in clinical care, education, and research. The EM section is part of the Department of Medicine and maintains a strong academic affiliation with the University of California, San Francisco (UCSF). Ideal candidates will have a record of clinical excellence, leadership, teaching, and/or scholarship. For more information, apply online: https://apptrkr.com/6162325 Contact: daniel.wheeler@ucsf.edu or josue.zapata@ucsf.edu (PA 2143)
Email: daniel.wheeler@ucsf.edu
Website: https://apptrkr.com/6162325

KENTUCKY

Join our team of 14 physicians and 8 advanced practice clinicians who welcome an average of 65,000 annual ED visits at Owensboro Health Regional Hospital in Owensboro, KY. Our 40-bed, level 3 trauma unit is located in a cutting-edge facility licensed for 477 beds, where patient experience and quality care drive every decision for the 500,000+ population we serve. • $409,500 Average Annual Base Compensation • $50,000 Potential Engagement Bonus Compensation • $75,000 Upfront Bonus • Up to $100K in student loan forgiveness ($25K/year for 4 years) • Full Benefit and retirement packages • Certified sepsis, stroke, and ACS verified trauma center (Level III) (PA 2122)
Email: jerry.price@owensborohealth.org
Website: https://www.owensborohealth.org/

KENTUCKY

We are honored with the American Psychiatric Association's Gold Achievement Award and recognized by the National Alliance on Mental Illness for excellence in psychiatric education, top-tier clinical services, and impactful community outreach. About the Role: Primary Responsibilities: Lead as the Medical Director for both Eastern State Hospital and the EmPATH unit, providing high-quality psychiatric care to adult patients. The EmPATH (Emergency Psychiatric Assessment, Treatment, and Healing) unit is a crisis intervention center that offers a therapeutic alternative to emergency departments for behavioral health crises. Clinical & Teaching Excellence: As part of our faculty, you will engage in a robust mix of clinical care, teaching, and research within UKHC's state-of-the-art facilities. You'll mentor medical students, residents, and other healthcare professionals, contributing to the continued growth of our respected psychiatric program. Our Facilities: Eastern State Hospital: A 239-bed facility with a mission of recovery-focused care, delivering inpatient mental health services across 50 counties. EmPATH Unit: A specialized, 24/7 crisis intervention unit with a welcoming environment for behavioral health, providing rapid assessment and stabilization within a dedicated space. Core Requirements: BE/BC Submit your CV and cover letter to: Sonali Patel, Senior Physician Recruiter UK HealthCare sonali.patel@uky.edu 908-938-0764 (PA 2138)
Email: sonali.patel@uky.edu
Website: https://www.uky.edu/

KENTUCKY

Pediatric Emergency Medicine Physician/Faculty Role Join the University of Kentucky Pediatric Emergency Department Are you passionate about providing exceptional emergency care to children? The University of Kentucky Pediatric Emergency Department is a leading referral center for Central and Eastern Kentucky, serving as one of only two tertiary pediatric centers in the state. As a Trauma Center with over 32,000 annual pediatric ED visits, we are committed to delivering top-tier emergency care to children in need. State-of-the-Art Facilities and Comprehensive Support Our 31-bed department, with additional treatment spaces, is set to expand with a brand-new, state-of-the-art Pediatric ED in the coming years. We offer comprehensive support with 24/7 respiratory therapists, pharmacists, social workers, and dedicated Pediatric ED child life specialists. In-person interpreter services ensure that we provide comprehensive, patient-centered care. Submit your CV to: Karen Kuehn, Sr. Physician Recruiter UK Healthcare Karen.Kuehn@uky.edu 859-323-0198 (PA 2149)
Email: karen.kuehn@uky.edu
Website: https://ukhealthcare.uky.edu/kentucky-childrens-hospital

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

ONTARIO, CANADA

Located in beautiful Windsor, Ontario, Canada, our client, Windsor Regional Hospital (WRH), is situated directly across the border from Detroit, Michigan. WRH is the regional provider of advanced care in complex trauma, renal dialysis, cardiac care, stroke and neurosurgery, and intensive care. WRH is seeking full-time or part-time Emergency Medicine Physicians to contribute to the top tier care provided in the Department of Emergency Medicine. Pathway licensure is easily available for US Board Certified Physicians through WRH and the College of Physicians of Ontario without requirement for supervision. Please forward a CV in confidence to: Robb Callaghan, E-mail: rcallaghan@medfall.com (PA 2159)
Email: rcallaghan@medfall.com
Website: https://www.medfall.com/

PENNSYLVANIA

Penn State Health is a multi-hospital non-profit health system serving patients and communities across 15 counties in central Pennsylvania. We are seeking exceptional BC/BE Emergency Medicine Physician to join our expanding emergency medicine teams at various locations within our health system. Opportunities available for applicants with ultrasound focus, observation experience, or interest in leadership positions. Opportunities available at Penn State Health Milton S. Hershey Medical Center, the only Level 1 Adult and Pediatric Trauma Center in PA as well as additional opportunities at our state-of-the-art regional medical centers Penn State Health Holy Spirit and Hampden Medical Centers and Penn State Health Lancaster Medical Center - all providing exceptional care to our communities. What We're Offering: • Competitive Salary & Sign-On Bonus • Comprehensive Total Rewards package with robust retirement options • Relocation Assistance & CME • Work among highly qualified, friendly colleagues • Leadership opportunities What We're Seeking: • MD, DO or foreign equivalent • BE/BC by ABEM or ABOEM • Completion of ACGME accredited Emergency Medicine Residency Program • Ability to acquire medical license in the state of Pennsylvania • Observation experience or interest in ultrasound a plus What the Area Offers: Located in a safe family-friendly setting, 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. Our community is rich in history and offers an abundant range of indoor and outdoor activities, arts, and diverse experiences. We're conveniently located within a short distance to major cities such as Philadelphia, Pittsburgh, NYC, Baltimore, and Washington DC. 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 perspective 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 2128)
Email: hpeffley@pennstatehealth.psu.edu
Website: http://www.pennstatehealth.org

TEXAS

Baylor Scott & White Health is seeking an ABEM/AOBEM board certified or eligible Emergency Medicine physician to join an outstanding employment model multispecialty group practice providing direct patient care. The ideal candidate is a hard-working team player with a favorable work and/or training history. Location/Facility: Greater Austin Region including 6 sites Specialty/Department/Practice: Emergency Medicine Shift/Schedule: Fulltime- 132 hours per month As the largest not-for-profit healthcare system in Texas and one of the largest in the United States, Baylor Scott & White Health includes 52 hospitals, more than 1,300 health system care sites, more than 7,200 active physicians, over 57,000 employees and the Scott and White Health Plan. At Baylor Scott & White, you'll be joining a team that's committed to better.?Because better never settles. And neither should you.? QUALIFICATIONS: • Doctorate Degree in Medicine • Licensed to Practice Medicine in the state of Texas by the Texas Medical Board • The perspective employee shall be board certified in emergency medicine or demonstrate active pursuit of board certification as defined by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine. For additional information, contact: Tara Moore, Physician Recruiter, at Tara.Moore@BSWHealth.org (PA 2150)
Email: Tara.Moore@BSWHealth.org
Website: https://jobs.bswhealth.com/us/en/

ByteBloc Software

Scheduling Emergency Providers Since 1989

- ✓ Highly flexible
- ✓ Automates scheduling
- ✓ Saves time and money
- ✓ Mobile & web support
- ✓ Trade, split, and give away shifts
- ✓ Extensive reporting & payroll support
- ✓ Track requests, vacations, and worked hours
- ✓ And many more…

For a free trial, visit us at www.bytebloc.com


32nd Annual
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AAEM
26
April 11-15, 2026
Seattle, WA
SAVE THE DATE