

COMMON SENSE



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3. Emergency medicine is solely practiced by physicians who are board-certified or board-eligible through either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
4. Every emergency physician's personal and professional well-being is supported through fair and equitable practice environments and due process.
5. Residency programs and graduate medical education are free from harassment and discrimination.
6. The Academy continues to provide its members with high-quality, cutting-edge emergency medicine education.
7. The Academy supports the establishment and recognition of emergency medicine globally as an independent specialty.

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COMMON SENSE

Featured Articles

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President's Message: Corporate Practice of Medicine: A Fight Decades in the Making

The corporate practice of medicine has become one of the most discussed issues in healthcare, with more physicians speaking out and state legislatures strengthening laws against corporations and private equity firms. But for AAEM, this is not a new conflict. In this month's President's Message, Dr. Vicki Norton states every legal victory, legislative reform, and policy change against CPOM is only possible because physicians stand up and speak out. AAEM will continue to support physicians who challenge CPOM because the future of emergency medicine depends on it.



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Editor's Message: AI Will Not Replace Emergency Physicians: The Patient Is Not a Prompt



Hardly a week goes by now without a headline claiming the "ED missed something AI identified," or "AI is better than physicians." The claims are provocative, but are they justified? In this month's Editor's Message, Dr. Yash Chavda dives deeper into studies that make this claim. He concludes AI may become a useful instrument much like POCUS and computed tomography, but it will not replace the emergency physician.

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The Whole Physician: Ditch People Pleasing, Except These Two



Physicians are people-pleasers. Medicine rewards that. Our training selects for it. Medical culture reinforces it. And metrics make it an obligation. The message is consistent: your worth is determined by what others think of you, and it's always being measured. But what if you thought about what was best for the 8-year-old and 80-year-old you before you say "yes"? Those two people, the 8 and 80-year-old you, are the two people you shouldn't disappoint.

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The Tale of the 300 Club



Back by "popular demand" is Dr. Howard Rodenberg to share another tale of life as a physician practicing medicine in Antarctica. In this issue, Dr. Rodenberg shares "The Tale of the 300 Club," the worst kept secret in Antarctica, and begs you to remember "Nature always wins."

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The Patient I Couldn't Forget: Second Victim Syndrome and the Hidden Cost of Caring



Every emergency physician has a patient who stays with them. Not because of a rare diagnosis or dramatic save, but because the case burrowed into their psyche and challenged how they saw themselves as a doctor. Dr. Liz Paterek shares her "that patient" with us and discusses how Second Victim Syndrome affects all of us as emergency physicians.

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It's an Honor Being Part of Emergency Medicine



In this article, Dr. Lisa Moreno-Walton discusses growing up in diverse New York City and how that experience propelled her on the path towards becoming the emergency physician, and person, she is today. Past AAEM President Lisa Moreno-Walton, MD, MS, MSCR

Corporate Practice of Medicine: A Fight Decades in the Making

Vicki Norton, MD FAAEM



Today, corporate practice of medicine (CPOM) has become one of the most discussed issues in healthcare, with more physicians speaking out.

State legislatures are strengthening laws, and policymakers are beginning to recognize the dangers of allowing corporations and private equity firms to control medical practice.

For AAEM, however, this is not a new conflict.

Long before CPOM became a national topic, AAEM was the first professional organization to recognize the threat posed by corporate influence in medicine. For over three decades, our organization has stood alongside emergency physicians facing pressure from hospitals, contract management groups, and private equity-backed staffing companies seeking to place business interests above physician judgment.

Our position has remained unchanged: medical decisions should be made by physicians, and the patient-physician relationship must remain free from corporate interference.

Recent events in Eugene, Oregon demonstrate why this principle remains so important. For more than thirty years, Eugene Emergency Physicians staffed emergency departments in their community. Following Oregon's passage of strengthened CPOM legislation in 2025, PeaceHealth announced plans to replace the local physician-owned

group with a staffing arrangement involving ApolloMD. Eugene Emergency Physicians filed suit, alleging that the proposed arrangement violated Oregon's newly strengthened CPOM protections and undermined physician autonomy.

AAEM immediately recognized the national significance of the case. We publicly supported the physicians of Eugene and, through financial support from the AAEM Foundation, helped fund their legal efforts. We issued statements defending physician autonomy and opposing arrangements that threaten independent medical judgment. The case represents one of the first major tests of Oregon's strengthened CPOM laws and may influence how similar laws are implemented and enforced throughout the country.

The fight is not over.

AAEM is also closely following developments involving Valley Health in Virginia and the effective destruction of another physician-owned group, Emergency Medicine of Blue Ridge, which served its community for decades. Like Eugene, the situation raises fundamental questions about physician autonomy, local control, and the increasing influence of corporate interests in emergency medicine. Whether the challenge emerges in Oregon, Virginia, California, Texas, Minnesota, or elsewhere, our commitment remains the same. We will continue standing with emergency physicians and advocating for physician-led care.

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A Little History

AAEM's commitment to combating CPOM did not begin with Oregon.

For more than two decades, AAEM has consistently stood with physicians challenging corporate interference in medical practice.

In the early 2000s, AAEM became involved in disputes surrounding Catholic Healthcare West and the displacement of independent emergency physician groups. The Academy issued public statements, supported affiliated physicians, and participated in legal advocacy efforts designed to preserve physician control of medical practice. AAEM and the California Medical Association jointly supported legal challenges involving Catholic Healthcare West staffing arrangements. AAEM also issued open letters to emergency physicians affected by corporate takeovers and supported efforts to resist the replacement of physician-owned groups by corporate entities.

In 2003, AAEM supported affiliated Catholic Healthcare West physicians through amicus efforts and public advocacy surrounding emergency department staffing disputes. In 2004 and 2005, the Academy publicly opposed actions that threatened physician-owned emergency medicine groups and warned of the growing influence of corporate management structures.

In 2009, AAEM and Emergency Physicians Professional Association filed suit against EmCare in Minnesota, alleging violations of state corporate practice of medicine laws. The case represented one of the earliest direct legal challenges to the business model employed by large contract management groups.

In 2013, AAEM filed suit against TeamHealth in California, arguing that the company's business structure violated California's prohibition on the corporate practice of medicine. The Academy continued its efforts in Texas, supporting litigation against TeamHealth and Memorial Hermann Healthcare System and participating in related appellate actions, including amicus support in *Cassidy v. TeamHealth*.

AAEM has also participated in numerous amicus curiae briefs defending physician autonomy, including *Genova v. Banner Health* and other cases involving physician rights and corporate control of medical decision-making.

More recently, AAEM-PG launched what may be the most significant CPOM challenge in the Academy's history.

In December 2021, AAEM-PG filed suit against Envision Healthcare in California after Envision took over an emergency department contract at Placentia Linda Hospital. The lawsuit alleged that Envision's

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These actions share a common theme. The names, states, and corporate structures change, but the underlying issue remains the same: Who controls the practice of medicine? The answer should always be physicians.”

business model violated California's prohibition on the corporate practice of medicine by allowing a lay corporation to exercise control over medical practice.

The litigation survived multiple legal challenges and continued through Envision's bankruptcy proceedings. Then, in July 2024, Envision withdrew from all operations in California. While many factors contributed to that decision, the case represented a major victory for physicians seeking to preserve California's CPOM protections and demonstrated that large corporate entities can be held accountable when they attempt to circumvent laws designed to protect physician independence.



Moving Forward

These actions share a common theme. The names, states, and corporate structures change, but the underlying issue remains the same: Who controls the practice of medicine? The answer should always be physicians.

When corporations control staffing, contracts, scheduling, compensation, and clinical operations, physician autonomy erodes. When physician autonomy erodes, patient care suffers. CPOM laws exist because lawmakers understood that medicine is fundamentally different from other businesses. Physicians have ethical obligations to patients that cannot be subordinated to financial objectives.

Fortunately, momentum is building. States such as Oregon are strengthening CPOM protections. Lawmakers are paying greater

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AI Will Not Replace Emergency Physicians: The Patient Is Not a Prompt

Yash Chavda, DO MBA FPD-AEMUS



Hardly a week goes by now without a headline claiming that the “ED missed something

AI identified,” or “AI is better than physicians.” The claims are provocative: AI can triage emergency patients, reason like a physician, and manage complicated cases.

Take the recent New York Times article, “Doctors Thought It Was Asthma. A.I. Flagged a Serious Heart Problem.” A patient presented to the ED with hemoptysis and dyspnea. After an ECG, chest X-ray, and laboratory tests, he reported wildfire-smoke exposure and was discharged with an asthma inhaler. An AI system later flagged his ECG; he was subsequently found to have a low ejection fraction and ultimately required a heart transplant.

Many in the comment section thought this meant AI beat the physician and was better. This article only showed that an AI system identified something after one clinician’s evaluation had ended. Had the investigation continued—with POCUS, additional imaging, or other appropriate testing, this headline would not have existed at all. One missed diagnosis is not evidence that AI can outperform emergency physicians. Articles like this, whether they mean to or not, disparage the ED, promote the idea that AI is superior to emergency physicians, and sow public mistrust of emergency medicine.

Other harmful headlines include examples like: “Microsoft’s AI Is Better Than Doctors at Diagnosing Disease” (Time, 2025); “A.I. Chatbots Defeated Doctors at Diagnosing Illness” (The New York Times, 2024); “If A.I. Can Diagnose Patients, What Are Doctors For?” (The New Yorker, 2025); “Bill Gates Says AI Will Replace Doctors, Teachers and More in Next 10 Years, Making Humans Unnecessary ‘for Most Things’” (People, 2025); and “The Doctor Is Out, but It’s OK. ChatGPT Can Answer Your Questions” (Johns Hopkins, 2023).

It is not only the popular media. Researchers also compare AI with physicians and argue that it may surpass them. Emergency physicians should take these studies seriously; the technology is improving quickly. But we should be skeptical when performance on a retrospective exercise is presented as practicing emergency medicine.

Consider the recent Science study by Brodeur et al. (2026), which reported that an advanced large language model outperformed physician benchmarks across several clinical reasoning tasks. The experiment with the strongest connection to emergency medicine involved 76 ED cases.

Using written clinical information from three predefined points in each encounter, the model and two internal medicine attending physicians generated differential diagnoses, which were then scored by other physicians. The model did well. The authors concluded that “in all experiments, the LLM outperformed physician baselines and displayed continued improvement from prior generations of AI clinical decision support.”

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The [LLM] did not have to figure out what to ask. It did not examine the patient, call family for collateral, deal with agitation, argue with a consultant, or change course when the patient decompensated.”

Harvard Magazine went even further with the headline: “AI Outperforms Doctors in Emergency Room Tasks, New Harvard Study Shows.”

But that was not an AI system working in an ED. It was an AI system providing a text-based second opinion after clinicians had already gathered and documented the information, turning a messy clinical encounter into a clean block of text.

The model did not have to figure out what to ask. It did not examine the patient, call family for collateral, deal with agitation, argue with a consultant, or change course when the patient decompensated.

The ED portion of the study also compared the model with two internal medicine attendings—not with a representative group of practicing emergency physicians. Differential diagnoses were capped at five, and the measured outcome was similarity to the eventual diagnosis—not timely treatment, safe disposition, resource stewardship, rescue from deterioration, or patient outcomes. The authors described the experiment as a proof of concept and stated that “LLMs have eclipsed

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There is a fundamental asymmetry in these contests: the physician must discover the information. The machine is handed it...The model receives a curated block of text and produces another block of text.”

most benchmarks of clinical reasoning, motivating the urgent need for prospective trials.”

Another widely discussed study in JAMA Network Open by Williams et al. (2024) asked, can an LLM accurately assess clinical acuity in the ED? Investigators drew cases from a dataset of more than 250,000 ED visits and reported that GPT-4 identified the more acutely ill patient with 89% accuracy, comparable with a physician.

Look more closely at the data, however, and the study is not very good.

The model was not asked to triage an arriving patient. It was shown two physician-written histories from visits with different ESI scores and asked which patient had the higher-acuity presentation. Identical scores were excluded, and the dataset gave equal weight to all pairings, including obvious comparisons such as ESI 1 versus ESI 5. When weighted to reflect the natural distribution of ESI pairings, accuracy fell to 83%.

The human comparison was primarily one resident with two years of postgraduate training; an attending emergency physician reviewed only 10% of the sample. The model also received information from emergency physician notes written after triage, which the authors acknowledged may have included

information unavailable when the original ESI score was assigned.

Asking which of two completed charts describes the sicker patient is an interesting language-processing task. It is not the same as looking across a crowded waiting room and deciding who needs to be seen urgently.

A 2024 study in the Journal of Medical Internet Research by Hoppe et al. carried the provocative title, “ChatGPT With GPT-4 Outperforms Emergency Department Physicians in Diagnostic Accuracy: Retrospective Analysis.”

The study included 100 adults admitted with internal medicine conditions at one institution; discharged patients and those with trauma, surgical, pediatric, or psychiatric presentations were excluded. The model received the documented ED history, medications, laboratory results, and diagnostic findings and was graded against the final hospital discharge diagnosis, as was the resident physician's ED diagnosis.

Once again, the model was solving a retrospective chart problem after emergency clinicians had already obtained, selected, and documented the relevant information. It was rewarded for matching the final inpatient diagnosis. The emergency physician had been responsible for making safe decisions before that diagnosis was fully known.

There is a fundamental asymmetry in these contests: the physician must discover the information. The machine is handed it.

The physician determines whether the history is reliable, whether the vital signs make sense, whether the examination contradicts the story, and whether an apparently reassuring patient is about to become critically ill. The model receives a curated block of text and produces another block of text.

Emergency medicine is filled with situations in which the final diagnosis is less important than the actions taken under uncertainty. We resuscitate shock before every cause is known. We treat hyperkalemia before the laboratory results return based on the clinical picture and ECG findings. We act while the information is incomplete and accept the consequences of those decisions.

A system that names a disease after receiving a polished clinical summary has not demonstrated the diagnostic capability required to practice emergency medicine. It has not demonstrated the ability to do our job.

But AI is useful as an assistant, right? We should use it clinically to improve efficiency, some argue. Maybe. In another study published in JAMA Network Open by Goh et al., a randomized trial involving 50 physicians from internal medicine, family medicine, and

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emergency medicine found that access to GPT-4 did not significantly improve diagnostic reasoning compared with conventional resources. The physicians using the model were not significantly faster, either. More broadly, the problem with AI as an assistant is this: humans may overtrust it, underuse it, anchor on its first suggestion, or spend additional time checking a confident but incorrect answer.

For very focused questions, AI can be incredibly useful. AI systems are already showing promise in ECG occlusive myocardial infarction interpretation, a narrow and structured task. I know firsthand how many ECGs I interpret during a shift and having AI help with that would reduce burden. But it cannot replace the physician who must act on the ECG, treat the STEMI, manage the shock, recognize emergent POCUS findings, and integrate the tracing with the patient in front of them.

AI scribes can also be useful for documenting an HPI, but even then, their work must be checked thoroughly. I can think of multiple times when an AI system misinterpreted conversations coming from another patient's room across the curtain and inserted them into my encounter. The medical decision-making sections are often hollow and not particularly useful, and they require thoughtful editing.



A system that names a disease after receiving a polished clinical summary has not demonstrated the diagnostic capability required to practice emergency medicine. It has not demonstrated the ability to do our job.”

Any note AI produces should be verified by a human.

We must also be alert to how these studies may be used. The immediate threat is that corporate leaders will misinterpret these benchmarks. They may use AI to justify thinning physician staffing, shifting care to less costly clinicians, and piling greater supervision liabilities onto the remaining doctors under the flawed assumption that technology has stripped the complexity from emergency medicine.

It has not.

Before an AI system is integrated into emergency care, it should demonstrate improved patient-centered outcomes in prospective, diverse, real-world trials. It should be helpful without being intrusive or contributing to alarm fatigue. Its errors, biases, failure modes, and data sources should be transparent.

Emergency physicians should lead its implementation, monitor its performance, and retain the authority to disregard it. Responsibility cannot remain with the physician while control migrates to an algorithm—or to the company selling it.

Artificial intelligence may become a useful instrument. So did point-of-care ultrasound and computed tomography. Neither replaced the emergency physician. They expanded what a well-trained emergency physician could see and do.

A language model may know every disease on the differential. It cannot hold the hand of a person receiving terrible news. It cannot lead a team through a failed airway. AI will likely change our work. Used well, it may make us more efficient in certain areas. But it will not replace the physician who deals with significant uncertainty, makes sense of the person in front of them, and accepts responsibility for what happens next.

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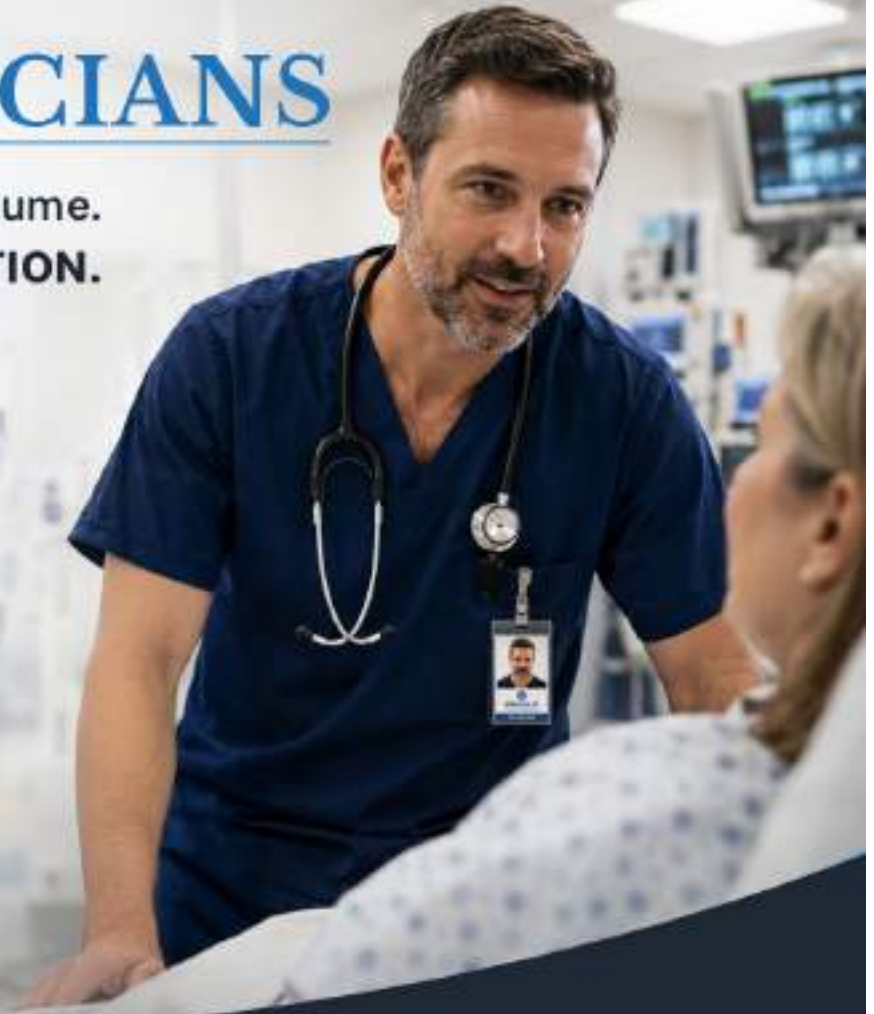
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Ditch People Pleasing, Except These Two

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



Physicians are (many of us, anyway) active or recovering people-pleasers. Medicine rewards that. Our training selects for it. Medical culture reinforces it. And metrics make it an obligation. The message is consistent: your worth is determined by what others think of you, and it's always being measured.

One day, somewhere between a committee meeting you attend because nobody else would do it and a shift you picked up because you felt guilty, it hits you. You've given so much time and effort to get others' subtle nods of approval that you've lost yourself along the way.

The solution isn't to stop caring what people think. Most of us couldn't manage that if we tried (plus, some of our colleagues who have stopped caring aren't that fun to work with). The solution is to choose better people to please.

David Perell, a writer and podcaster, has a suggestion: "Make two people proud: Your 8-year-old self and your 80-year-old self." This framework serves as a guidepost, because it's not about doing less or lowering your standards. It's about recalibrating around the standards that matter most: the ones that matter to you.

Why External Validation Is a Losing Game

Psychology literature suggests relying on external validation has negative consequences. Deci and Ryan's self-determination theory distinguishes between intrinsic motivation, doing something because it is inherently meaningful or enjoyable, and extrinsic motivation, doing something for reward or approval from outside of oneself.¹ Decades of research confirm that when extrinsic motivators become the primary driver of behavior, intrinsic motivation fades. Performance may persist, but meaning doesn't. Engagement erodes. The work that once felt like a calling starts to feel like a transaction.

For physicians, it looks like this. We enter medicine with some version of intrinsic motivation: desire to make a difference, love of learning, the thrill of a challenge. Then, external metrics systemically get

“The solution isn't to stop caring what people think. Most of us couldn't manage that if we tried... The solution is to choose better people to please.”



layered on top of that: grades, board scores, evaluations, certifications. By the time we're in practice, many of us have forgotten how to want something that isn't being judged.

The cost is high. Physicians operating primarily on external validation are at higher risk for burnout, emotional exhaustion, and depersonalization.² The machinery is still running, but the person inside it is fading away.

The 8-Year-Old You

The younger version of you didn't know about RVUs or door-to-doc times (maybe the current version of you doesn't either). Know what you did know? What made you laugh. What interested you. Without a blink of an eye, you tried new things, fell on your face, got up, and kept going. It didn't matter if you were always seen as competent because your job was to learn and experience what life has to offer.

Research on intrinsic motivation reveals that play, novelty, and autonomy are necessary for humans to function well.³ It helps a physician preserve their sense of wonder while remaining genuinely interested in a curious case. A doctor who has something outside medicine that engages them for its own sake is more resilient, not less dedicated.

When was the last time you did something purely for fun? Something new? Not because it checked a box, but just because. Fun is not an indulgence. It's necessary for career sustainability.

Delight the 8-year-old version of you and protect what was great about them. Make them glad they grew up to be you.

The 80-Year-Old You

This version of you doesn't care about the nonsense. Your colleague's metrics compared to yours. In the end, who gives a rip? The shift that needs coverage even though you're not responsible for the staffing shortage and are already exhausted, 80-year-old you is interested in you staying healthy and not crashing your car. The patient complaint filed because a turkey sandwich wasn't savory enough, not a second thought (other than maybe trying one yourself to see if they're right).

“

Being in this job means we inevitably disappoint people; just don't let it be the two people who matter most.”

What you care about are the real things: relationships, presence, health, meaning. You care about whether you were there for the ones you care about. Whether you were fully present in those moments versus only there physically but checked out mentally. You care about if you let yourself be loved and if you loved back.

Research on end-of-life reflection consistently identifies a similar set of regrets.⁴ Literally zero of them involve wanting to spend more of their life charting. The regrets center on time, presence, and the things that were deprioritized amid decades of busyness. The 80-year-old version of you already knows what matters in the end. The question for now is if you're willing to listen to them and do something about it.

A Decision Framework for the 8- and 80-year-old You

Time is the most important, non-renewable resource you have. Every “yes” to something that doesn't serve either version of you is a “no” to something that does. When a new obligation appears, and they appear constantly, try running it through these questions before you respond.

Will this make the 8-year-old version of me smile?

Will it let the 80-year-old version of me rest easier?

If it's yes to both, it's a high priority. If it's yes to one, it belongs on the list, weighed against what it costs the other. If the answer is no to both, it belongs on the “oh h&ll no” list. Not every obligation needs to be accepted. Not every gap needs to be filled by you.

Using this framework is not about doing less. It's a framework for doing the right things, the ones that will still matter when the

metrics have changed, and the scoreboard no longer applies.

A Note on Regret

This exercise will, for some, raise regrets. It's worth acknowledging. Regret is useful when it points toward something actionable: a habit to start, a relationship to repair, a boundary to set. It becomes pointless rumination when it loops without purpose.⁵ If this reflection brings up discomfort about who you've spent your time pleasing, let that discomfort be inspiring, not punishing. The 8-year-old you fell off the bike and hopped right back on. The 80-year-old you isn't keeping score. They're just hoping you figure it out in time to enjoy some of it.

You can start now. Protect one evening for yourself. Send the text you've been composing in your head. Leave work at work. Do something playful for no justifiable reason.

Being in this job means we inevitably disappoint people; just don't let it be the two people who matter most.

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The Tale of the 300 Club

Howard Rodenberg, MD MPH



Dear AAEM,

I promised last time I wrote that in the event of popular demand, I might share another tale of life at the South Pole. When I said that, I'll admit I wasn't exactly sure what I meant by "popular demand." Perhaps I had some delusion that, after reading the prior work, the leadership of your august organization would swoop down upon my doorstep and entreat me with candy and cash to shine just that tiny ray of light into their forlorn existence that only my prose could provide.

But of course that's not how it works. "Popular demand" in this context means a note from the Editor saying, "I need pages. What have you got for 1200 words?"

So let me share with you "The Tale of The 300 Club."

The 300 Club is the worst kept secret in Antarctica. The Club is named for the change in temperature undergone by members in their initiation rites. You find a night when the outside temperature is less than -100°F, sit for a few minutes in a sauna set to 200° degrees, then run outside to South Pole, get your picture taken, and run back inside. Nude, except for boots, gloves, and goggles. It's worse than Fight Club, because no one who spends four months in total darkness exhibits the kind of admirable nudity of a Patrick Swayze.

Before we delve more into The 300 Club, I must again harken back to my dinosaur philosophies of ER care. As I approach the completion of PGY-37, I've recognized 90% of the practice of emergency medicine is some variation of saying, "Don't do that." Punch a wall and get a boxer's fracture? Don't do that. Go outside without your walker and fall? Don't do that. Get so drunk at a college party you think the ER doc who could be your grandfather if he hadn't used birth control in college is actually the President of the fraternity who found you curled up on the grass holding a funnel? Don't do that, either.

(Admittedly, this theory only works if you're also comfortable with the terribly ungrammatical double negative. So you could say "Don't **not** follow-up with your own doctor," or "Don't **not** take your medications as prescribed," or "For God's sake, please don't **not** ever see a dentist... ever" and still be consistent. As the proud owner of a T-shirt that proclaims "Grammar Police: To Serve and Correct" this pains me deeply, but is nonetheless true.)

Here's another practice tidbit: "Nature always wins." You know the telephone pole or the retaining wall you hit with your car? They used

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As I approach the completion of PGY-37, I've recognized 90% of the practice of emergency medicine is some variation of saying, 'Don't do that.'"

to be trees and rocks.

Between you and it, guess which one's still standing? Same thing goes for any injury involving gravity, ice, snow, the sun, and anything involving a wild animal.

You can now begin to see why, as a person of somewhat later than middle age, I declined the opportunity to join the Club with an alacrity that would put the Golden Age Flash to shame. I'm at the point in life where I'm putting three extra blankets and perhaps a warm dog on the bed just to stop my knee from aching when a cold front drops in. And while the younger me would have been proud to be photographed, by now there has been so much—well, "shrinkage," as George Costanza might say—that what had been a mighty oak would now appear as a wizened old twig. Nobody wants to see that. Best to live in the past. So I opted out of membership, and I advised my colleagues accordingly.

"Don't do that," I said, "because nature will win. You'll get frostbite, and depending on where it is I will not be the one applying Aloe Vera." But I did ask them to let me know when they were making their Door Dash, because I would rather be awake and know in advance rather than get a radio call at 3:00am letting me know that someone lost their glasses and fell on the ice and now nobody can find him.

About 1:30 on a July morning I got the notice. There were seven to go, six men and one woman, and it had hit -101.4°. My job was to hold the door. The way to the Pole is through the Beer Can, which is a set of steps inside a corrugated metal cylinder that goes from the top floor of the station down to the tunnels under the ice that lead to the power plant, storage areas, and industrial shops. It's thirteen flights of

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steps both ways, and the door to the outside is about halfway down. It's technically "inside" but unheated, so it stays a toasty -45° or so all year long.

(The skewed perception of temperature takes a while to resolve once you get back home. My beloved Dental Empress still doesn't understand how six weeks after my return, we stayed in an unheated Florida barn in 50° weather under an electric blanket and I wanted to die. I tell her the difference is the Pole is a "dry cold." She calls me a wuss.)

I don't recall that much about the actual run. I stood there holding the door from the Beer Can open, and a series of pink blurs flashed by me in one direction, and a second set did so again the opposite way a few minutes later. You would think it would be a voyeurs' dream, but it's all so fast—it's so cold that nobody cares to linger and pose—that there's really nothing to see. (And, to be honest, we weren't exactly a picturesque crew even in our parkas). All accounted for and tucked back into the sauna to thaw out, it was back to bed for me. No harm done! Or so I thought.

Six weeks later, one of the new club members—a genuine astrophysicist, who understands the workings of the universe in intimate detail—a

guy whom Yogi would say is "Smarter than the averrrrrrage bear!" pulled me aside.

(Since I've been at the Pole, and commingled with real scientists, I've learned to be very careful in describing my colleague's fields of study. This is because I used to use the term "rocket scientist" with impunity in the ED. Now enlightened, I may note that an individual patient may not be a "bright spark." But I still can't help thinking that some shifts clearly overlap with Academy of Rocket Science Alumni Reunion.)

"I just thought you should know," he said confidentially. "I did get frostbite."

"Why didn't you say something?" I asked, genuinely worried that I would have to file an incident report under the category of "Missing Digits."

"Well," he admitted. "It was on one of those places you said you weren't going to touch."

Finally, a patient who listened to me.

I have the honor to remain, your most humble and obedient servant,

Howard Rodenberg, MD MPH ■

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All accounted for and tucked back into the sauna to thaw out, it was back to bed for me. No harm done! Or so I thought.”

AAEM PRESIDENT'S MESSAGE

Continued from page 3 >>

attention to healthcare consolidation and private equity involvement in medicine. Physicians are increasingly willing to speak out about the consequences of corporate control.

That momentum is not limited to state legislatures and the courts. It is occurring within organized medicine as well.

AAEM has long been a leading voice against corporate practice of medicine, and we are beginning to see those efforts reflected in national policy. Within just one year of AAEM obtaining representation in the American Medical Association House of Delegates, significant progress has been made. This year, the AMA adopted policy supporting federal legislation to prohibit violations of corporate practice of medicine principles. The AMA also strengthened its corporate investor policy by recognizing and addressing loopholes that have allowed corporations to exert control through arrangements such as "friendly physician" models and management services agreements.

These changes are important. For years, corporations have relied on increasingly sophisticated legal structures to create the appearance of physician ownership while maintaining substantial control over medical practices. By modernizing its policies, the AMA has acknowledged the reality that corporate influence often operates through in ement matters. When physicians organize, advocate, and persist, even longstanding policies can evolve. The conversation around CPOM is changing, and AAEM has helped lead that change. But progress does not happen on its own.

Every legal victory, legislative reform, and policy change begins with physicians willing to stand up and speak out. AAEM has been fighting this battle for decades, and we will continue supporting physicians who challenge corporate interference with medical practice. The future of emergency medicine depends on it. ■



It's Time to Take Back Control: Why Emergency Physicians Must Lead Their Own Groups

Daniel Nelson, MD FAAEM – Chief Operating Officer, Emergency Physicians Associates

Emergency physicians across the country, and particularly here in California, are at a crossroads in emergency medicine. The recent departure of a major corporate contract group from our state should serve as a wake-up call. Now is the time for emergency physicians to reclaim control of their own groups and redefine how care is delivered.

For too long, commercial contract management groups (CMGs) have inserted themselves as middlemen, diverting revenue away from frontline physicians under the guise of administrative efficiency and corporate stability. The reality has been bloated overhead, opaque decision-making, and a steady erosion of professional autonomy. Most tragically, the patients suffer when continuity, quality, and morale decline.

Meanwhile, Medicare reimbursements continue to drop, and Medicaid reimbursements hang in the balance, threatened by federal and state budget fluctuations and systemic underfunding. Every cent matters, and when margins are thin, there is simply no justification for siphoning dollars to corporate shareholders,

excessive layers of middle management, or subsidizing unrelated specialties as the new cost of doing business or securing a contract. Emergency medicine dollars should stay in emergency medicine, supporting the clinicians who are delivering 24/7 care on the front lines.

The recent departure of a large national group from California emergency departments is not a crisis. It is an opportunity. It reveals the fragility of these corporate models and their inability to commit to communities for the long haul. At the first sign of decreased margins, they are out, or they cut your pay, or bring in a lower-cost alternative. This moment is a call to action for physician leaders across the state to step forward and build sustainable, locally governed practices.

Independent, physician-led groups not only keep decision-making close to the bedside, they also create a natural alignment of incentives between physicians and hospitals. When both sides share the same goals, delivering high-quality, efficient, patient-centered care, the partnership is stronger and built for long-term success.

Physician-led groups like EPA have done just that and continue to thrive. We have assumed contracts, built leadership from within, and returned control to the bedside. More importantly, we have shown that when the physicians in the trenches hold the reins, patients receive better care, and the workforce feels invested in their work again.

This is not just about finances or politics. It is about ownership, accountability, and dignity. Our patients deserve emergency departments led by doctors who are empowered to make decisions. Doctors who are not bound by corporate directives, inflexible staffing models, or outsourced operations.

Our colleagues deserve to see the value of their work reflected in their compensation, their schedules, and their ability to shape the future of their department. And our trainees, the future of emergency medicine, deserve to enter a profession where clinical excellence and leadership are not mutually exclusive.

If you are part of a hospital or health system exploring a new model, or a group of

Continued on page 23 >>

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This is not just about finances or politics. It is about ownership, accountability, and dignity.”

The Unwritten Curriculum of Mentorship: A Medical Student Perspective

Adrienne Chang, BA – Medical Student



If there is one word to describe the first year of medical school, it is “adjustment.” For the first time in my student-life, I was being asked to learn, retain, and synthesize information faster than ever before all within the backdrop of moving to a new city, making friends, and deciding when I would have time to exercise and call my family. Much to my surprise, these adjustments fell quickly into place, and I was feeling grateful and happy to make UC Irvine my new home for the next four years. My new primary goal of MS1-year became to find an attending mentor. Prior to medical school, I was lucky to have great mentors who invested in my career and personal aspirations, and I attribute much of their support to where I am today. I didn’t think “finding a mentor” would fall into that bucket of adjustment. Yet as a newly minted MS2 reflecting back on my first year, I realize that finding a mentor in medical school has been my biggest adjustment so far.

“What kind of doctor do you want to be?” This is a question that your typical medical student will receive from family, friends, and strangers alike. For being only my first year, this question was a reminder of how fast four years of medical school will fly by, which motivated me to want to try to start carving my path in medicine early. Especially with the erasure of pre-clinical grades and USMLE Step 1 transitioning to Pass-Fail in 2022, there is a new challenge of trying to discover specialty interest early and build meaningful experiences. When I would ask upperclassmen on advice they had for finding their path, answers would commonly come back to “having supportive mentors.” But how do I go about finding these mentors? Those answers were a bit more elusive. When asking my peers about their perspectives of mentorship, many have agreed that mentorship feels uncomfortable. Some of it stems from embarrassment to ask for help, the great unknown of how to find a mentor, the expectations that

come with maintaining mentorship, and the vagueness associated with having a “mentor.” While our curriculum may neatly outline the areas of physiology, pathology, and anatomy that we need to know to advance in our training, very little guidance exists to help us answer the other aspect of that question, “What kind of doctor do I want to *become*?”

Unlike our preclerkship courses, there is no handbook for specialty exploration, making connections between faculty physicians and medical students especially valuable to not only gaining insights into careers and boosting research productivity, but receiving honest feedback and genuine investment into our development into the physicians we aspire to be. Mentorship serves as a critical scaffold for facilitating this personal development. Mentoring is universally accepted as a key

component of medical education, with quality mentorship improving medical school satisfaction, career development, and research productivity.¹ However, finding and maintaining relationships with faculty are frequently cited challenges for medical students, with barriers to having meaningful mentorship relationships including perceived time constraints, lack of formal structures, and difficulty finding available mentors.¹

There has been some push to implement formal mentorship programs to provide early exposure especially in specialties not typically included in core clerkships.²⁻⁴ But, informal mentors tend to feel more meaningful than those gained in formal programs; highlighting that quality matters more than just having a mentor.⁵ These results resonate with me as I don’t want to simply inherit a

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But how do I go about finding these mentors? Those answers were a bit more elusive.”

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research project, but rather I'm seeking mentors that actually know my name and interests. Mentorship workshops and toolkits exist for faculty, emphasizing the growing popularity of the mentee-driven relationship and supporting students underrepresented in medicine.⁶⁻⁸ This surprised me, as minimal formal structures exist for mentees to guide these "mentee-driven" relationships. It seems a bit counterintuitive to have formalized structures to facilitate informal mentorship relationships that feel authentic. But medical students who want to form these meaningful relationships can benefit from guidance on unspoken mentorship expectations.

I used to think that I would find an attending who would guide me through all my career questions, research aspirations, and professional development. However, I realized the benefits don't lie in the hands of a *single* mentor, but rather *multiple* mentors will shape different areas of my journey to becoming a physician. What kind of rapport

and relationships do I want to build with my patients? Which communities do I hope to interact with and impact? Does having a career of profound service to others mean that I need to sacrifice parts of my personal aspirations?

Personal contemplations that are not specific to one specialty. Prior to medical school, I had mentors in a wide range of fields and expertise, but the common thread was their genuine investment in me as a person. But unlike college or professional mentors, finding a mentor outside of your institution can feel out of reach without formal structures in place. Organizations like AAEM that are promoting connections between medical students and physicians outside their institutions, whether it be a community doctor or a physician at a different academic center, are a great first step in addressing some of that void. For medical students seeking mentorship from someone who truly mirrors where they hope to go, having an organized network of physicians who have already raised their hands to invest

in the next generation of trainees addresses some of the gap in a way that neither a formal program nor cold email can fully replicate. As I continue to navigate the unwritten rules of medical training, I look forward to meeting many great mentors and taking lessons from each to shape the physician that I hope to be. Ultimately, effective mentorship encompasses advice stemming from a place of personalization and care.

In an era of medical training with rapidly emerging technologies and new information to guide clinical practice, mentorship remains important for developing the soft skills of physicianship and elucidating the many uncertainties that medical students face about our future careers. I contend a lot of my clinical knowledge will be derived from lectures, clinical experiences, and thousands of Anki cards. Yet, my future in medicine will depend on not only what I'm taught in the classroom and on rounds, but also on those that are willing to guide me. ■

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THE AAEM ACTION REPORT



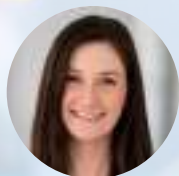
An advocacy report designed to keep you informed on the critical developments affecting emergency medicine.

LATEST ISSUE



AI Scribes in the Emergency Department: New Tool or New Burden?

Robert Darzynkiewicz, MD and Madison Idso, BA



Our community emergency medicine group recently started the process of utilizing an artificial intelligence (AI) powered large language model (LLM) documentation tool for charting and I became curious: will this tool make us better emergency physicians? Specifically, will it measurably improve quality, efficiency, our experience and our patients' experience? Or will it just be another add on to an already demanding day?

To compare the difference, I ran my own informal experiment. I overlapped my regular scribes with the AI scribe for a month to get direct feedback. One senior scribe summed it up as "It is pretty darn good." He was impressed at the history of present illness, how it processed the history into a concise note and even produced an appropriate medical decision making section. For several years I worked with this scribe. We built trust and a successful workflow that allowed me more time to focus on the patient. I became both hopeful for AI scribes and saddened for the likely future of human scribes.

I then read a recent JAMA article on how LLM improved efficiency in clinics¹ and the May 2026 Annals of Emergency Medicine journal featuring AI. Is there enough literature out there to prove this technology works?

Quality

When polling my partners on what a high-quality chart looks like, one partner said, "I know it when I read it." A subjective measurement for a subjective document. I wondered if that is the best way to measure a chart?

In the emergency department (ED) pilot article on AI scribes versus human scribes featured in Annals, charts were measured that way.

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So, if the quality may appear acceptable, then my next question is will I get home earlier after my shift?”

Physicians compared the quality of 100 AI-generated charts (with physician editing) to human scribe charts using the Physician Documentation Quality Instrument (PDQI-9). It rates charts on nine dimensions that include thoroughness, accuracy, usefulness, organization, and internal consistency among others. Chart quality was comparable in adults and slightly lower in pediatrics, though the authors themselves noted the difference was "not likely meaningful."² It was also interesting to listen to an EM:RAP podcast about this article and hear how one speaker felt optimistic as the scores for both human and AI scribes were high overall and noted it as a promising sign for something so new.

Efficiency

So, if the quality may appear acceptable, then my next question is will I get home earlier after my shift?

In the previously mentioned ED specific pilot, AI scribe users spent slightly more time in the EHR overall compared to human scribe users, a difference that fell within the 95% confidence interval.² However, in a separate retrospective observational study in the ED of adult encounters found AI was associated with a "28% reduction in on-shift documentation time." The visits skewed more towards lower emergency severity index patients (ESI). Many of which were via telemedicine and/or "vertical care" (chair based ambulatory care).³ One large JAMA multisite outpatient study found a 13.4 minute reduction in EHR time and a 16 minute reduction in documentation time per shift with AI adoption.¹ Residents and high frequency users saw much greater gains. Not surprising, given how quickly younger clinicians are more immersed in technology and are possibly early and frequent adopters.

I found these results both promising and interesting. Do clinicians save time for just simpler cases? Or is it because they feel the risk of a "lower quality chart" is acceptable?

Physician Experience

And so how will I feel once I leave my shift? Exhausted or energized? In using AI scribes, I must admit I do feel better after my shift. What will be the best way to measure that going forward?

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Pointed survey questions in one study showed improvement in work-life balance perceptions and reduced energy drain from charting. However, clinicians still did not think AI was ready to “make a positive impact on my workflow.” Interestingly, the responses were notably more negative about chart quality. Moreover, net promoter score (NPS), for the technology was neutral.⁴ So it helped, but overall people appear to not be advocating its use. In a separate study, physicians showed modest burnout improvement but more meaningful gains in cognitive load scores specifically.⁵ And yet when asked if they could see more patients, the response was favorable for urgent visits but not regular visits. This makes sense as less mental time charting may allow us more time or energy for medical decision making. But it may not be what gives us enough bandwidth to see more patients on a scheduled clinic day (unless it is urgent).

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Patient Experience

Searching for articles on this topic was very challenging as most studies addressed chatbots and patient experience instead of emergency medicine visits and charting. Patient experience is a very important metric to measure. And for many of us in practice, we already have patient experience data that is brought to us through survey dashboards. As we move forward with AI scribes will we see changes in these surveys? Will they be for the better or for worse?

Conclusion

Recent evidence suggests that with AI scribes chart quality may not be significantly different. It may improve our efficiency and clinician cognitive load. And perhaps in the future will have patient surveys that compare experience before and after AI scribe implementation.

I think of AI/LLM documentation the way I think of video-assisted laryngoscopy (VAL). When it first was proposed as an alternative

way to intubate it required proper research, training and clear outcome measures to determine it was superior to direct laryngoscopy. It then became the new standard of care. I hope AI/LLM adoption will follow the same pathway. I worry that without clinician driven research, measurement and development it may not be used to its full potential.

I also believe burnout is more than just charting. Yet if this innovation starts the process and discussion of how to simplify our work and return back to the bedside, I believe it will be worth the journey.

Robert Darzynkiewicz, MD, is an emergency physician in community practice in Reno, Nevada. He was a co-founder of a school-based telemedicine practice that provides urgent care and mental health care. He is also an elected board member of the Tahoe Forest Hospital District. Madison Idso, BA, is a premedical student and medical assistant at a pain management clinic with prior experience in molecular biology research. She is interested in patient advocacy and the thoughtful integration of emerging technologies into clinical care. ■

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emergency physicians ready to take the leap, you do not have to do it alone. Many of us have walked this road. EPA has done it and continues to do it. We have weathered contract transitions, navigated billing challenges, and proven that clinical quality, operational stability, and financial sustainability can coexist in an independent physician-owned model.

Editor's Note:

AAEM is committed to promoting independent, physician-owned emergency medicine practices and highlighting successful democratic

groups as examples of what is possible and optimal within our specialty. These articles are shared to illustrate principles of democratic practice, transparency, and physician autonomy that AAEM supports.

Groups attest to the following:

- 100% physician ownership
- Equal ownership for all partners, or a democratically developed, transparent alternative
- Unencumbered access to all financial records for all owners
- Fair, transparent, and consistent path to ownership
- Physician control of clinical and operational decision-making
- Local governance with participatory voting rights
- All revenue produced is distributed to administrative costs and compensation in a transparent manner decided upon by the group ■

Naloxone in the Emergency Department: A Common–Sense Standard of Care

Garret Vincent, OMS-IV



Emergency physicians are problem solvers. We intubate when patients cannot breathe. We defibrillate when hearts stop. When hypoglycemia threatens neurologic injury, we administer dextrose. When opioids suppress respiratory drive, naloxone is given without hesitation.

Despite our comfort using naloxone during active resuscitation, we are far less consistent about ensuring our patients have access to naloxone after discharge. In the current overdose landscape, that gap is no longer acceptable. Naloxone distribution from the emergency department is not controversial, political, or experimental. It is a common-sense emergency medicine practice.

Evidence

Naloxone is one of the safest and most effective medications used in emergency care. It rapidly reverses opioid-induced respiratory depression, has no misuse potential, and no intrinsic psychoactive properties. From an emergency medicine standpoint, it represents a low risk, high yield intervention with extraordinary mortality benefit. Few medications in our practice offer such a favorable risk benefit profile.

Community based naloxone distribution programs have repeatedly demonstrated reductions in overdose mortality and opioid related harm. Implementation of overdose education and naloxone distribution programs was associated with significantly decreased opioid overdose death rates.¹ Additionally, naloxone coprescribing programs have been associated with reductions in opioid-related emergency department visits among patients receiving long-term opioid therapy.²

Importantly, concerns that broader naloxone access may encourage riskier substance use behaviors have not been supported by evidence. Studies evaluating take-home naloxone programs have shown no increase in opioid consumption, heroin use, or compensatory risk-taking behaviors following naloxone access or training.³ Recent longitudinal data similarly demonstrated no increase in injection drug use frequency after naloxone training and distribution.⁴ Naloxone does not encourage substance use; it prevents overdose and death.

Beyond mortality reduction, naloxone distribution programs are also cost effective. A systematic review of economic evaluations found

that community naloxone distribution consistently provides favorable cost-effectiveness outcomes due to reductions in overdose morbidity and mortality.⁵

Finally, engagement with harm reduction strategies such as naloxone distribution programs may serve as an important bridge to treatment. Patients participating in harm reduction initiatives are often more likely to subsequently engage in treatment for opioid use disorder compared with individuals not connected to these services. Rather than enabling addiction, naloxone programs create opportunities for continued health-care engagement, recovery, and long-term treatment access.⁴

Naloxone Remains Underutilized

Despite national recommendations and overwhelming evidence, naloxone is significantly underprescribed and underdispensed across the United States.⁶ Even among patients treated in the ED for nonfatal overdose, a minority leave with naloxone in hand or even a prescription.

Currently, naloxone is only co-dispensed at a 0.9% rate for all prescriptions and a 1.3% rate for high-risk opioid prescriptions.⁷

The emergency department is often the only healthcare touchpoint for patients with opioid use disorder (OUD) or high risk polysubstance use. If we do not intervene, there may not be another opportunity.

We would not discharge a patient with anaphylaxis without epinephrine or a patient with severe asthma without an inhaler. Naloxone should be viewed similarly: as essential harm reduction equipment for patients at risk of opioid toxicity.

Dispensing Is Superior to Prescribing

While prescribing naloxone is appropriate, direct dispensing from the emergency department is a more effective means, as only 2% of prescriptions for low-cost intranasal naloxone kits are filled.⁸ Prescriptions introduce barriers, especially to those with OUD. These barriers can include transportation challenges, cost variability, pharmacy access limitations, stigma, and understanding of naloxone's role.

When patients leave with naloxone in their possession, the intervention is complete. When they leave with a prescription, the patient may still face many barriers to obtaining this life-saving medication. Emergency medicine is about removing friction between intervention

“Naloxone distribution from the emergency department is not controversial, political, or experimental. It is a common-sense emergency medicine practice.”

and outcome. Direct ED dispensing, whether via take-home kits, standing orders, or nurse driven protocols, aligns with our specialty's propensity toward action.

Access and Regulatory Considerations

Naloxone is now widely available in the United States as an over-the-counter product, including intranasal formulations available at retail pharmacies. Many states have standing orders and good samaritan protections that allow bystanders to administer naloxone in good faith during an overdose emergency.

However, widespread access does not equal practical access. Cost can remain prohibitive for some patients. Pharmacy stigma and misinformation may discourage purchase. Some patients are unaware that naloxone is available without a prescription. Others may not prioritize obtaining it after discharge or have a negative association with its use.

For these reasons, relying solely on community availability is insufficient. With pharmacy availability varying from 23.5% to 96.1% depending on location.⁹ Emergency departments are uniquely positioned to bridge that gap by prescribing and dispensing naloxone directly and providing brief education on recognition of overdose and administration technique.

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Who Should Receive Naloxone at Discharge?

Naloxone should be offered to any patient at risk of opioid exposure or overdose. This includes:

- Patients with diagnosed or suspected opioid use disorder.
- Patients presenting after opioid overdose.
- Individuals using non-prescribed opioids such as heroin or fentanyl.
- Individuals using substances that may be contaminated with opioids (ie, cocaine or street benzodiazepines)
- Patients prescribed chronic opioid treatment
- Family members, friends, or any close contacts of anyone at risk of opioid exposure/toxicity

There is little downside to offering naloxone and substantial potential benefit. Better to err on the side of over dispensing than under.

A Common-Sense Standard

Naloxone distribution is a natural extension of the emergency physician's mission to prevent sudden death. It is not an endorsement of substance use. On the contrary, it is an evidence based harm reduction strategy that saves lives while we continue addressing the underlying disease of opioid use disorder (reference the AAEM white paper for support). Naloxone should be included as part of that treatment approach.

When a patient at elevated risk of opioid exposure leaves the emergency department without naloxone, we may have missed an opportunity to prevent a future death. In a field defined by decisive action, ensuring access to naloxone is simply common sense.



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The Patient I Couldn't Forget: Second Victim Syndrome and the Hidden Cost of Caring

Liz Paterek, MD FAAEM



Every emergency physician has a patient who stays with them. Not because of a rare diagnosis or dramatic save, but because the case burrowed into their psyche and challenged how they saw themselves as a doctor. For me, that patient was a woman in her 30s whom I cared for during my second year of residency.

She presented with leg pain and swelling. She was in a hallway bed. Her only abnormal vital sign was mild tachycardia. A history of deep vein thrombosis was the only item documented in her past medical history. I evaluated her, ordered laboratory studies and an ultrasound, and moved on to the next patient. Before labs could be drawn, she was whisked away to ultrasound. When she returned, everything had changed. She was pale, clammy, and visibly ill. She was found to be hypoglycemic. My attending quickly recognized what I had not fully appreciated: septic shock. A key piece of history that was missed in the chart, a prior splenectomy, suddenly transformed the clinical picture.

From there, she spiraled. She developed disseminated intravascular coagulation from meningococcal bacteremia. Over the course of my shift, I watched a previously healthy,

active woman crash before my eyes. Needless to say, she didn't survive.

The guilt was immediate. I replayed every decision repeatedly. What if I had recognized the severity sooner? What if I had noticed the splenectomy? What if I had insisted on obtaining labs before the ultrasound? What if my clinical instincts had been better?

The questions became relentless. Did I take her seriously enough? Was I at my best that day? Am I too stupid to do this job?

The images haunted me. The regret lingered. Years after the shift ended, the case remained alive in my mind.

Years later, I learned there was a name for what I was experiencing: **Second Victim Syndrome (SVS)**. Second victim syndrome describes the emotional, cognitive, and psychological distress we experience after a medical mistake, adverse patient event, or poor patient outcome. While patients and their families are the "first victims," clinicians can become affected by the event as well.

The experience is remarkably common. A systematic review involving more than 11,000 healthcare professionals found that troubling

memories occurred in 81% of those affected by SVS. Anxiety affected 76%, self-directed anger 75%, regret and remorse 72%, distress 70%, and guilt more than half. Sleep disturbances, fear of future errors, and embarrassment were also common.¹

Reading those numbers felt validating. The emotions I had carried for years were not unique. They were characteristic.

Emergency medicine is particularly vulnerable to SVS. We work in uncertainty. We make high-stakes decisions with incomplete information. We care for critically ill patients under relentless time pressure. Not surprisingly, approximately one-quarter of emergency physicians report severe and pervasive distress after traumatic patient-care events.²

The hardest part of being a physician is not the medicine. It is the story we tell ourselves afterward. Research has identified several stages physicians often experience following an adverse event. First, the chaos of the event itself. Then the intrusive reflections. Endless mental replaying of decisions, conversations, and missed clues. We fear rejection and judgment from colleagues while simultaneously seeking reassurance that we are competent physicians. And worse, adverse outcomes lead to institutional reviews, quality investigations, or legal scrutiny often without mental or emotional support.³

When I look back, I can clearly see myself moving through these stages.

The intrusive reflections lasted far longer than I expected. I replayed the encounter repeatedly, searching for the exact moment where a different decision might have changed the outcome. I worried that my attending, my peers, or future employers would discover what I already feared: that I was not good enough.

What strikes me now is how many women physicians may experience these feelings even more intensely. A

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The questions became relentless. Did I take her seriously enough? Was I at my best that day? Am I too stupid to do this job?”



2025 review examining gender differences in second victim syndrome found that female healthcare professionals reported more severe anxiety responses following adverse events than their male counterparts. The review also highlighted how gender-based discrimination in training and practice can amplify the emotional burden women carry after medical errors or poor outcomes.⁴ Many women physicians are already navigating perfectionism, imposter syndrome, and the pressure to prove their competence. When an adverse event occurs, these vulnerabilities can magnify self-blame and self-doubt.

Instead of asking, "What can I learn from this?" we may find ourselves asking, "What

does this say about me?" That distinction matters. The good news is that support systems can make a profound difference.

A three-tiered approach exists to support clinicians after traumatic events⁵. The first and most immediate intervention is emotional first aid from a trusted colleague or mentor. This is not about solving the problem or dissecting the case. It is about being heard. It is about creating a private space where a physician can acknowledge what they are feeling without fear of judgment. The second level involves trained peer supporters who follow up over days and weeks. The third level provides access to mental health professionals when symptoms persist or begin affecting personal and professional functioning.

Clinicians often need connection,
not advice. Someone to
say, "I've been there."
Someone willing to sit with

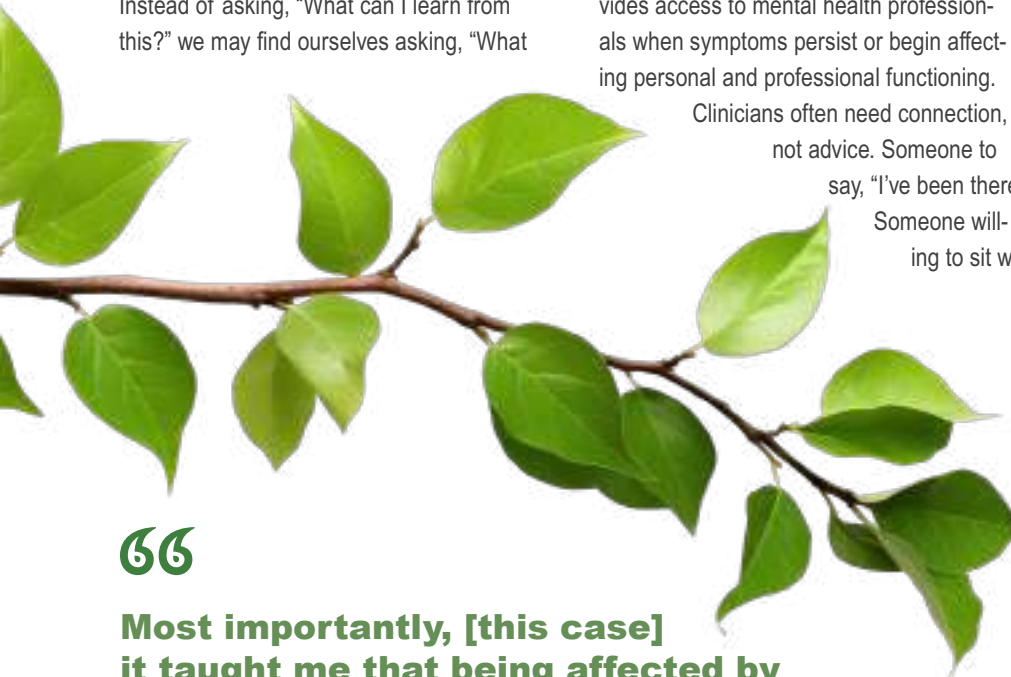
uncertainty, grief, and regret without rushing to fix them. Someone who understands that caring deeply is both our greatest strength and our greatest vulnerability.

Not every physician reaches the same destination after a second victim event. Some leave clinical medicine entirely. Some remain haunted by the experience for years. Others ultimately find ways to transform their suffering into growth. The literature describes these outcomes as "drop out," "survive," or "thrive."^{3,5}

It's been almost 15 years and I still remember that patient. I still wish I had recognized her illness sooner, whether it would have made a difference or not. But with time, I have come to understand that carrying the memory is different from carrying the blame.

The case taught me to look harder for hidden clues. It sharpened my clinical awareness. It deepened my empathy for trainees struggling with difficult outcomes. Most importantly, it taught me that being affected by a patient's outcome does not mean you are weak. It means you cared.

As physicians in emergency medicine, we often extend endless compassion to our patients and colleagues while withholding it from ourselves. It is time we offered ourselves the same grace. Because the patient you cannot forget may always stay with you but you can use them to make you a better clinician.



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Most importantly, [this case] it taught me that being affected by a patient's outcome does not mean you are weak. It means you cared."

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Operationalizing Psychological Trauma in Blast Injury Doctrine: The Case for a Senary Classification

Mel Ebeling, MD



In the midst of the second World War, Lord Solly Zuckerman, a British zoologist, anatomist, and scientific advisor to the Allies, published a groundbreaking article in the *Proceedings of the Royal Society of Medicine*, “Discussion on the Problem of Blast Injuries.”¹ Here, Zuckerman detailed the first classification of blast injuries, which included primary through quaternary effects. This framework persisted until the early 2000s, when the U.S. Department of Defense transposed the definitions for secondary and tertiary blast injuries and codified a quinary type of blast injury.

This modern, standard classification of blast injuries is as follows:

- **Primary:** effects due to being impacted by overpressure (shock) wave
- **Secondary:** injuries caused by the being thrown against a hard surface
- **Tertiary:** injuries sustained from secondary projectiles (e.g., flying debris) or from being buried or crushed by debris or collapse of a shelter
- **Quaternary:** effects from carbon monoxide poisoning, burns, asphyxiation
- **Quinary:** consequences of contaminants (e.g., bacteria, radiation, and tissue reactions to fuel and metals)

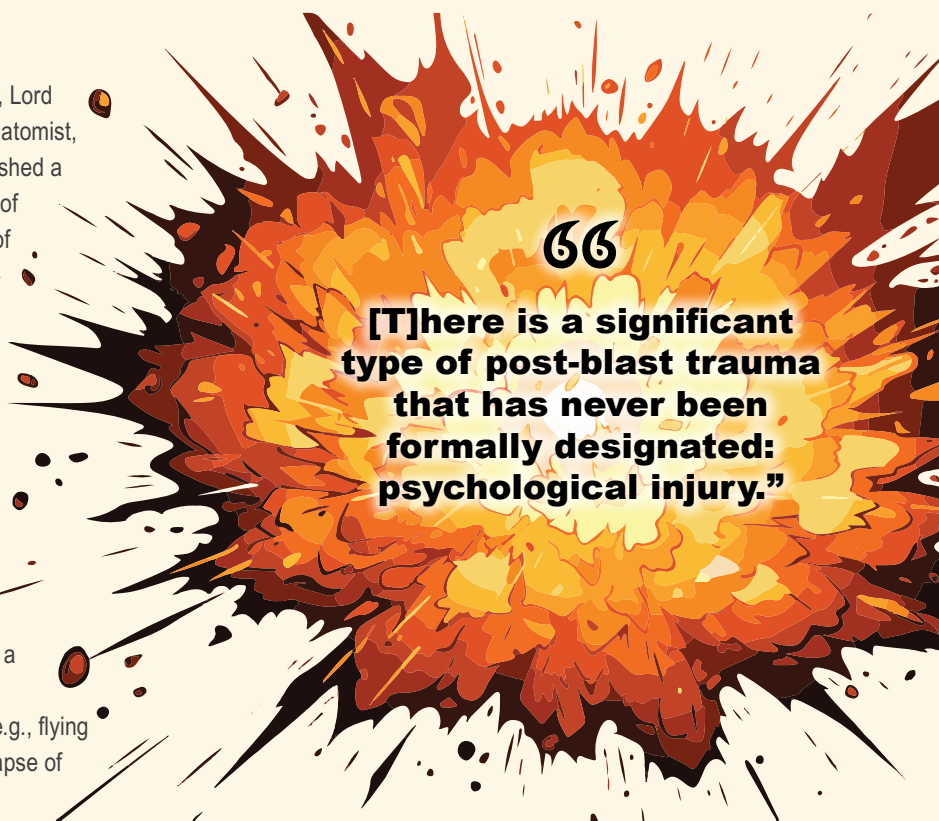
Outside of the minor modifications made by the U.S. Department of Defense, the overall classification of blast injuries has otherwise largely remained unchanged over the past 85 years, sufficiently capturing the wide breadth of physical injury after an explosion. Nevertheless, there is a significant type of post-blast trauma that has never been formally designated: psychological injury.

Explosions can occur under a variety of civilian contexts (e.g., industrial accidents, acts of terrorism, and residential gas leaks), in addition to those experienced by military personnel under wartime conditions. It is well-known that post-traumatic stress disorder (PTSD), anxiety, depression, and substance misuse can follow survival of a blast and are associated with significant morbidity and mortality.^{3,4} Following the Beirut explosion in 2020, an increase in the incidence of PTSD was naturally observed, and within the military context, advances in resuscitation science and body armor have increased survival after combat injury leaving more soldiers to contend with the psychological consequences from trauma exposure.^{5,6} Previous estimates have demonstrated that the treatment of post-deployment PTSD and depression

costs upwards of \$6.2 billion USD in the first two years following deployment.⁷

As a medical community, we have much to gain by incorporating psychological trauma into blast injury doctrine. By legitimizing it as a senary classification, we foremost validate the devastating psychological effects experienced by many blast survivors. Secondly, acknowledging this consequence officially—adding it to our own mental schema of post-blast injuries—will likely allow for the initiation of early involvement of mental health resources and treatment, as we are more primed to think about it in the acute period when intervention may be particularly helpful (e.g., addressing symptoms of acute stress disorder early before it evolves into PTSD). Similarly, in more resource-challenged environments, endorsement of this classification may push not only for more education on this topic but strengthen the case for expanding funding for more robust psychiatric and psychological services.

While it may be argued that our framework for organizing blast injuries should remain limited to those potentially life-threatening physical injuries sustained immediately during an explosion, psychopathology can equally lead to bodily harm, the most severe of which being suicide. Moreover, the complex relationship between post-blast traumatic



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The Physiologically Difficult Airway: A One–Size–Fits–All Pitfall

Rachael S. Hamm, MD, Michael A. Newton, MD, and Lane M. Smith, MD PhD

Rapid sequence intubation (RSI) is the near-simultaneous administration of an anesthetic and neuromuscular blocking agent to facilitate endotracheal (ET) tube placement.¹ It remains the default strategy for emergency department (ED) and intensive care unit (ICU) intubation since it increases first attempt success and reduces complications compared to laryngoscopy without paralysis.^{2,3} Traditional RSI emphasizes pre-oxygenation without positive pressure ventilation (PPV) prior to ET tube placement to reduce aspiration risk.^{1,4}

However, RSI can be harmful in a subset of patients. Peri-intubation cardiovascular collapse complicates up to 5% of emergent intubation attempts.^{5,6} Similar to the anatomically difficult airway, a minority of patients exhibit severe physiologic derangements, collectively termed the physiologically difficult airway, who benefit from modification or avoidance of traditional RSI.⁷ These patients broadly fall into contrasting groups: those with severe respiratory decompensation who benefit from PPV before laryngoscopy, and those with severe circulatory dysfunction who risk deterioration from anesthetic induction and PPV.

Patients Benefitting from PPV

Among ED patients who benefit from PPV before laryngoscopy, those with severe hypoxic respiratory failure are best studied.^{5,6} PPV prevents peri-intubation hypoxia by

delivering 100% inspired oxygen and increasing mean airway pressure that recruits alveoli, increasing functional residual capacity (FRC), and improving shunt fraction. While simple facemasks can increase inspired oxygen and high flow nasal cannula marginally increase mean airway pressure, neither of these methods deliver the combined benefits of 100% oxygen delivery and high mean airway pressures afforded with PPV. The benefits of PPV are most profound in populations with poor pulmonary compliance from severe lung disease or conditions such as obesity that result in high pleural pressures that reduce FRC and the safe apnea time.⁸

Early support for PPV during RSI came from the PreVent Trial where ICU patients treated with PPV between induction and laryngoscopy suffered less hypoxia than those given standard pre-oxygenation.⁹ This was followed by trials in ED and ICU populations including PREOXI and FLORALI-2 demonstrating the effectiveness of longer periods of PPV exposure during pre-oxygenation, through induction, and until laryngoscopy.^{10,11} Importantly, no trial detected harm from aspiration or cardiovascular collapse after exposure to PPV.⁹⁻¹¹ Moreover, 60% of the patients in the PREOXI Trial had acute alterations in mental status suggesting that brief PPV is safe in this population.¹¹

While the evidence for PPV in preventing peri-intubation hypoxia is compelling, patients with severe acid-base disturbances are unstudied populations likely to benefit from PPV. These patients rely on respiratory compensation and are at risk for deterioration during the apneic period due to sudden decreases in pH. PPV helps reduce work of breathing and provides estimations of the high minute ventilation that will be needed once the patient is intubated. Continuing PPV during the apneic period at a high set respiratory rate (more than 24 breaths per minute) allows for maximal alveolar ventilation and prevents dangerous drops in pH before laryngoscopy.

Use of PPV during pre-oxygenation has practical considerations and requires careful planning. First, many non-invasive ventilatory devices cannot double as invasive ventilators. Coordination with respiratory therapy is needed when intubation is anticipated in patients already receiving non-invasive PPV. Second, patients with respiratory failure often have air hunger and intolerance of facemasks. Use of low-dose anesthetics such as ketamine facilitates mask tolerance while maintaining airway reflexes in what is known as delayed sequence intubation. Finally, PPV use during pre-oxygenation represents a paradigm shift for many team members who are accustomed to traditional RSI making clear communication and pre-planning necessary for team comfort.

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Patients Harmed by PPV

Patients with severe cardiovascular compromise represent a population that may be harmed by RSI. High intrathoracic pressure generated by mechanical ventilation both decreases right ventricular (RV) venous return and increases pulmonary vascular resistance. When coupled with the hemodynamic depressant effects of anesthetics, the sudden decrease in RV preload and increase in afterload reduces stroke volume and may lead to cardiovascular collapse. Certain populations are particularly vulnerable including those with right-sided heart failure, cardiac tamponade, hypovolemia, and aortic stenosis.^{7,12} Notably, 25% of patients with acute pulmonary embolism who undergo intubation experience peri-intubation cardiac arrest.¹³

Early identification of patients with circulatory dysfunction who may be harmed by PPV is important, and intubation should be delayed or avoided in favor of treating the underlying cardiovascular physiology whenever feasible. Respiratory support through non-invasive means is preferable as most of these vulnerable patients experience cardiovascular rather than respiratory deterioration. In centers capable of advanced circulatory support such as ECMO, this means avoiding intubation until such technology is immediately available. Delaying intubation in patients with cardiovascular extremis represents an important but necessary paradigm shift for emergency physicians who have been traditionally tasked with securing the airway.

In situations where intubation cannot be avoided, modifications to RSI help prevent cardiovascular collapse. First, establish adequate hemodynamic monitoring with an

arterial catheter whenever practical. Second, premedicate patients to maintain systemic vascular resistance with medications having favorable RV hemodynamic profiles such as epinephrine, vasopressin, and norepinephrine; avoid medications such as phenylephrine that increase RV afterload.¹² Apart from hypovolemic shock, the PREPARE II Trial found no benefit to intravenous crystalloid boluses in preventing peri-intubation instability, and this practice should be avoided.¹⁴ Regarding induction agents, the RSI trial found no mor-

emergency medicine training and rarely performed in EDs.¹⁷ While potentially lifesaving, awake techniques require early resource mobilization, familiarity with topical anesthetics, and frequent practice to maintain proficiency that are not always practical for emergency physicians. While awake intubation is within the scope of practice for emergency physicians, it is reasonable for those unfamiliar with the technique to call upon expert consultation rather than default to RSI for these patients.

Excessive intrathoracic pressures and high levels of sedation should be avoided post-intubation. Prioritize analgesia for ET tube tolerance while minimizing the dose of anesthetics. Ideally, these patients should be allowed to breathe spontaneously in pressure support modes to minimize airway pressures. Although PEEP improves oxygenation, it can reduce cardiac output, particularly when it exceeds 15cm H₂O in preload-dependent states.¹⁸ For patients with severe RV dysfunction or hypovolemia, maintain PEEP less than 10cm H₂O.

In summary, traditional RSI has served emergency physicians well for decades and is often the best method to intubate ED patients. However, a minority of patients with complex respiratory and cardiovascular disease are challenging a single approach to airway management in the ED. A new paradigm is emerging—one that emphasizes patients likely to be harmed by traditional RSI, incorporates selective use of PPV, and culminates in tailored intubation methods based on physiology. This means continued evolution of our understanding of intubation best practices and refinement of techniques is needed to best care for these complex patients. ■

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**However, RSI
can be harmful
in a subset of
patients.”**

ality difference among etomidate or ketamine, although etomidate caused less cardiovascular instability.¹⁵ Dose reductions when using ketamine or etomidate and avoidance of propofol may blunt adverse cardiovascular effects.⁶

Perhaps the most significant departure from traditional RSI is the selective use of awake intubation techniques that minimize anesthetic dosage, obviate the need for neuromuscular blockade, and avoid exposure to high intrathoracic pressures.¹⁶ Use of flexible laryngoscopy for emergent intubation is not always taught in

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The Calm Patient

Ahmed Nadeem, DO MS MS FAAEM



I am having lunch in the doctor's room in the back of the ER when the nurse calls, "Doc to room seven." As I head there, the intercom rings out, "Respiratory STAT to ER." In the room, a calm middle-aged woman looks at me and says her tongue has been swelling for the past hour. "I feel it in the back of my throat."

I review her medications; an ACE inhibitor is on the list. In a hoarse voice, she says, "I took them two hours ago." Her bedside vitals are normal except for mildly elevated blood pressure. On exam, her tongue is swollen. I hear no stridor. Her lungs are clear. No crackles, no wheeze, no rales. "I might need to put a tube in your throat to help you breathe, but don't worry, we'll work through this together," I say. I order subcutaneous epinephrine, diphenhydramine, and methylprednisolone, in case this is an allergic reaction, and start preparing for a difficult airway. I prep for a delayed sequence intubation and get the GlideScope.

We don't have an ICU, so I page surgery, anesthesia, and pulmonary over the intercom in case I need help securing the airway. It's 2:37 p.m. They might still be in-house. I call the closest tertiary care center, fifteen minutes away. I call the pharmacy in the chance the swelling is from a different pathway and an intubation might be avoided with different meds.

"Do you have Cinryze or Berinert?"

"Never heard of them," says the pharmacist.

"A C1 esterase inhibitor," I explain.

"I'll have to check."

The patient receives the anaphylactic cocktail. I wait to hear back from the pharmacy.

When I return to the room, her tongue fills her oral cavity and sticks out of her mouth. I won't get an ET tube in, GlideScope or not. She is unable to speak, and her face is swollen. There is still no noisy breathing. It has been about fifteen minutes since she arrived.

I consider attempting an awake nasotracheal intubation with a 6.0 ET tube. There's scant blood in her nose. I'm not sure why, but she's breathing through it well. I don't want to go through the nose blindly. I don't know what's happening in the turbinates, and there's no time to investigate. I grab my cricothyrotomy kit.

Anesthesia calls back: "We're not in-house and won't be there for another hour and half." The surgery attending comes bedside and



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I tell her to give me a thumbs-down if she feels worse. She gives me a thumbs-up.”

says, "Look at her, she has no neck. Ahmed. I'm not traching her, it'll be a bloody mess."

I palpate her neck. I can't feel the cricothyroid membrane. "Hang in there, I'm figuring things out." I tell her to give me a thumbs-down if she feels worse. She gives me a thumbs-up. I remember patients just like her. They looked calm and were talking. Thirteen years ago, a young child came in short of breath; she died despite everything we did. I cried with her mother that night. Three years ago, a middle-aged man walked into my ER; he died under my care from fungemia sepsis. And now this patient, like the others before her, is calm, talking, and trusting me.

The airway courses always say: If you can't intubate, trach. I've seen angioedema before, but this is worse than the pictures in journals, and this is not going in the right direction. I feel nauseated and sick to my stomach. I refocus, tell myself, "She will not die on my watch."

"How do you feel?" I ask her. Thumbs-up. I lay her flat. She tolerates it. God is on my side. I open the introducer and prepare to anesthetize her neck. The nurse calls out to say the tertiary care center is calling back. They usually don't accept patients.

"Is the patient stable?" the accepting physician asks.

"She has no stridor," I say. "She'll need ENT at the bedside."

A pause.

"We'll be ready. Send her over."

God again.

Blood pools at the corners of her mouth where her teeth cut into her swollen tongue. "Are you okay?" I ask. She nods. "I'm sending you to

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another hospital." She has mild stridor now. Her breathing rate has increased. Do I have time? She looks at me and gives a thumbs-up.

An ambulance arrives for another patient. "Take this patient instead, look at her," I say.

"We need permission from central," says the paramedic.

I grab his arm and bring him to the bedside. "She doesn't have time. I have an accepting physician, we need to go now. Can you get there in fifteen minutes? Yes or no?"

He looks at her. With wide-open eyes, he says, "Let's go, doc."

The ride takes thirteen minutes—the longest ride of my life.

At the tertiary center, triage stops us. "We have no beds."



"She's an angioedema transfer," I say. "The ER knows we're coming."

The nurse looks at me, looks at the patient, and finds a bed.

I sit with the patient, holding her hand. "You'll be fine," I say.

Thumbs-up. Blood drips from the corners of her mouth. Her breathing is louder, harsher. She is diaphoretic. A resident walks in, looks at her, "Wow," and leaves.

Overhead: "STAT anesthesia. STAT ENT." I step aside and watch an army of residents, nurses, respiratory therapists, anesthesiologists, ER and ENT attendings struggle for over an hour to secure her airway. When it's all over, she's intubated, sedated, stable. I say a prayer and leave.

Back at my ER, the hallways are full. I go to the doctor's room and try to decompress for a couple of minutes, then return to the floor and thank everyone. Pulmonology returns my call; they're not in-house. I thank them anyway. I never hear back from pharmacy.

Back home, I talk with my wife about the close call and let my tears flow. For the next couple of days, I think about the patient. Should I have used TXA, FFP? Should I have intubated her right away? Should I have been a better patient advocate, insisted surgery do the cric? Were they able to extubate her? Was she hypoxic at any point and now has anoxic encephalopathy? Is she alive? I can call the hospital and find out how she is doing. Do I really want to know? I usually call, but this time I don't.

Three weeks later, I'm called to the waiting room. A visitor wants to see me. She's wearing a bandanna; I don't recognize her. She looks at me, smiles, and gives me a thumbs-up. ■

AAEM/RSA EDITOR'S MESSAGE

Continued from page 29 >>

brain injury and the subsequent development of psychiatric illness further blurs the distinction between psychical and psychological consequences of explosions. With the ever-increasing body of literature acknowledging the significant impact of disorders like depression and PTSD on the health of both civilian and military populations, it is time to consider expanding the scope of what is considered a blast injury. If blast injury doctrine is intended to capture the full spectrum of harm caused by explosions, then the psychological wounds sustained by survivors deserve recognition too. ■

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It's an Honor Being Part of Emergency Medicine

Lisa Moreno-Walton, MD, MS, MSCR



In spring of 2026 I was inducted into Sigma Xi—The Scientific Research Honor Society. I join the ranks of Albert Einstein, Sally Ride, James Watson and Francis Crick, Jennifer Doudna, Linus Pauling, Alexis Carrel, Enrico Fermi. Membership is by invitation only, after nomination by two members who are anonymous to the candidate, and full vetting by the Board of Directors. This is a tremendous honor, and it has allowed me to reflect on what brought me to this position and how far emergency medicine has come.

Mrs. Joyce Kahn started me on my public speaking career, and I guess some would rue her. She was my music teacher in fifth grade, and yes, we had music classes in New York public schools; and art, and physical education, library, and health. And New York City public schools were rated among the best in the nation. Mrs. Kahn chose me to read the words of Emma Lazarus' poem, "The New Colossus," whose final lines are engraved on the base of the Statue of Liberty at Ellis Island in New York Harbor at the school's annual spring concert following the chorus' musical rendition of the sonnet. Mrs. Kahn had a master's degree in music education, and Mr. Kahn had a master's degree in physical therapy and his own private practice. In another city, in another country, the Kahn's daughter, Judy, would not have become friends with the child of a single parent family whose mother graduated only high school and whose father was a high school dropout who was forced to join the military in lieu of a second incarceration in juvenile detention. But Mrs. Kahn knew a little bit about liberty and freedom and second chances. Her mother had barely survived incarceration in Ravensbrück, the notorious women's concentration camp of the Third Reich.

The Kahn's family history was a story often repeated in various ethnic versions throughout New York, and Judy and I were part of a group of children whose families all had stories. Mary Tierney's and Tim Connolly's people had come to escape starvation during the Irish potato famine. Jesus Guerrero's parents had brought him from Mexico so that his father could

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Mrs. Joyce Kahn started me on my public speaking career, and I guess some would rue her.”

find employment. Fatima Ali's family had come from Lebanon during their civil war, and her mom wore a hijab. Louann Hague's family was from Lithuania and descended from Leif Eriksen. Frank Abadie's ancestors were part of the Huguenots who left France for Canada and then migrated down to the US, his mother's family a few generations before his father's. Filomena and Jean Paul's families took dangerous boat trips from Cuba and Haiti respectively. Tamra's parents came from Armenia and Lydia's aunt was a nun in Senegal. Sophie's folks came from Greece. Her dad worked night shift in the Greek diner, and the first time I ever saw black out shades was in their apartment, where we had to be quiet during the day while he slept. Paulie's parents were born in Italy, and his dad was a renowned mason in our community.

I spent my youth not only going to Holy Communion, Confirmation, and Quinceanera parties, but to Bat and Bar Mitzvah's, baby brothers' brises, seders, iftar dinners, Eid al Fitr, Holi and Diwali celebrations, and attending services in mosques, temples, and churches of all denominations. I learned why Mrs. Markowitz wore a wig and Mrs. Al Hitali wore a hijab. Girls' sleepovers not only consisted of trying to stay up all night and gossiping about boys. They were also occasions on which sari clad moms made us curries, abaya clad moms made us hummus and falafel, Latino moms made pernil and arroz con gandules, and Eastern European moms made stuffed cabbage. And we begged for these foods, just as we begged for the moms to tell us how to say "you're cute" and "I like you" in their native languages so that we could run up to boys the next day at school, saying the words and running away laughing. And we were all Americans. And we accommodated each other's differences without fuss. When the sleepover was at Sharon's, who

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No fuss, no sighs, no judgements. We were friends, people, Americans.”

like most of us, had one bathroom, she announced, “And Fatima, my dad, and brother will be away on a camping trip for the weekend, so all good.” When Ron handed me the invitation to his Bar Mitzvah, he said, “You’re the same size as my sister Fagey, and she says come over tomorrow to pick an outfit to borrow for the Bar Mitzvah.”

No fuss, no sighs, no judgements. We were friends, people, Americans.

This was my life in New York, and so I never realized that life could be any different; I never realized how rich my life was made by exposure to diversity and inclusion. I was 20 years old before I went west of Pennsylvania or south of Washington DC, but I had the microcosm of the world in my hometown, and it never crossed my mind that someone could “not belong.” As my grandmother said, “Everyone is from somewhere else, unless you’re Native American.” And that historical reality was taught to us in school. We learned about both slavery and the abolitionist movement. We learned about both the Japanese internment camps and the United States’ participation in the liberation of countries under the rule of the Third Reich during World War II. We learned about the colonization of Europe by the Mongol Empire and the Ottomans and then the colonization of Africa and the Americas by the Europeans. I never had the impression that our teachers had an agenda. Both the good and the bad, the shameful and the proud, were part of the history of our nation, the history of the world, and the history of being human. These were the facts and there was no discussion about whether they were divisive or portrayed some particular group “badly.” Mr. Curry told us in social studies, “this is what happened.” Mrs. Blythe told us in English class that “a good journalist reports the facts and an educated public form their own opinions.” Well-meaning people wrote the Constitution. They loved liberty and would die for freedom. They denied women the vote and said that a Black person was three-fifths of a human being. Those are the facts. This is America, in all her glory and with all her faults.

As I got older, and I began to travel, I often told people that one of the things I love so much about my country is that you can stand on the street corner and yell that the President is an idiot, and no one would arrest you or try to shut you down. You could even say that you think that homosexuals should go to hell or that slavery was justified. I might find your ideas despicable, but I will defend your right to express them. I love America and I love the First Amendment. I saw many other people who love America, who themselves or their forebears chose America, taking the stand that sometimes we can be better. Just as our children might sometimes behave in ways that are not worthy of themselves and our desire to correct them is born of love for our children, so it is with our patriotism. Acknowledging that sometimes our nation behaves in ways that are not worthy of our democracy and asking that we make a course correction back to our commitment to equal opportunity, liberty, or freedom is not an act of hatred of America. It is an act of love and commitment.

And so my fifth grade self walked onto the stage in my first store bought dress ever, a pink A-line, and I said these words:

*Not like the brazen giant of Greek fame,
With conquering limbs astride from land to land;
Here at our sea-washed, sunset gates shall stand
A mighty woman with a torch, whose flame
Is the imprisoned lightning, and her name
Mother of Exiles. From her beacon-hand
Glow world-wide welcome; her mild eyes command
The air-bridged harbor that twin cities frame.
“Keep, ancient lands, your storied pomp!” cries she
With silent lips. “Give me your tired, your poor,
Your huddled masses yearning to breathe free,
The wretched refuse of your teeming shore.
Send these, the homeless, tempest-tost to me,
I lift my lamp beside the golden door!”*

I went into a trance when I said it, I had practiced so many times. I was stunned back to reality when I heard the applause, and I realized I had finished the sonnet. I can still recite those words by heart—indeed, by heart. Because I know now what I knew then: that America is built by immigrants; some who chose to come and some who were brought on slave ships, but all who share the destiny of this nation and who want to live in a place we help to build and a place we can be proud of. That indeed she is a mighty woman, the Mother of Exiles, indeed her eyes command, indeed she lifts her lamp in welcome. And if we love her, we will not behave like the crowds in “The Emperor’s New Clothes,” who see her error and remain silent so as to gain the approval of others. Rather, when we see the need for a course correction, we will speak truth to power, because that power is what makes America great, that from acknowledging our imperfection we create the opportunity to be better every day.

I grew up in an environment where no one in the room had the exact same color skin, where no one’s parents spoke with the same accent, where no one’s kitchen smelled the same, where some people had clothes from Bloomingdales and some from the Salvation Army thrift store, where some went to Yale and others to jail. I grew up knowing that we are all Americans, all “created equal...endowed by their Creator with certain unalienable rights, that among these are life, liberty and the pursuit of happiness.”

Thank you to all who have supported your colleagues in emergency medicine. You are what helps make America great for future generations!

Author’s Note: These ideas do not represent the Past Presidents’ Council, AAEM, the University of South Alabama, or any entity. They are proudly my own. ■

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OHIO

Position Overview IEP is seeking a Board-Certified or Board-Eligible Emergency Medicine Physician to join our team at Magruder Hospital in Port Clinton, Ohio. This position offers the opportunity to practice in a collaborative, community-focused emergency department with strong support from APPs, nursing, and hospital leadership. Ideal candidates are clinically strong, adaptable, and committed to delivering patient-centered care in a fast-paced environment. Please review the full posting here: <https://talent.paylocity.com/Talent/Jobs/Details/4152185> (PA 2209)
Email: mdemand@iep-pc.com
Website: <http://www.iep-pc.com>

OREGON

Eugene Emergency Physicians (EEP) is seeking an Emergency Medicine trained BC/BE physician to join us in the Pacific Northwest. We are a longstanding, stable democratic group currently staffing two emergency departments in the Eugene area. Following a recent landmark legal action affirming physician employment by independent medical groups, EEP is expanding recruitment and welcoming physicians interested in practicing with a group who stands for preserving physician leadership, clinical autonomy, and community accountability. Limited Time Opportunity for physicians with three years' experience and EM board certified • \$36,000 Sign-on bonus • 20% employer contribution to retirement from Day 1 • Paid like full partner from Day 1 • Partner Vote at 1 Year • 13 Shift Minimum for First Year Perks: Flexible scheduling, nocturnist program with night differential, month-long sabbatical program, strong collaboration & shift support. Eugene, Oregon is a vibrant college town (University of Oregon) with easy access to: • Incredible biking & hiking • Snow sports • Golf • Whitewater rafting RiverBend Medical Center • Level 2 Trauma Center & regional referral center • 87,000+ visits/year • 8-hour physician shifts, 96 hours/day total MD coverage • 3 PAs for fast track & lower acuity • Scribes available • Epic EMR & full subspecialty coverage Cottage Grove Medical Center • Critical access hospital, 20 mins from Eugene • Single doc coverage + 10 hours PA coverage • 11-hour day, 13-hour night shifts • Small inpatient unit, most admissions transfer to RiverBend For more information: Contact Beth Anderson, EEP Office Manager 541-344-8757 eugeneemergency@comcast.net (PA 2212)
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MASSACHUSETTS

Salem Hospital, a proud member of Mass General Brigham (MGB), is seeking an accomplished, Board-Certified Emergency Medicine physician to serve as Chair of the Department of Emergency Medicine. This is a unique leadership opportunity for a visionary clinical leader to guide a high-volume, community-based emergency department while leveraging the resources, stability, and academic connections of one of the nation's leading integrated healthcare systems. About Salem Hospital Salem Hospital is a 371-bed community hospital located north of Boston and is the largest healthcare provider on the Massachusetts North Shore. The hospital is a Level III Trauma Center, an American Heart Association Stroke Gold Plus hospital, and a recognized leader in community-based care and innovation. Through its integration with Mass General Brigham—founded by Massachusetts General Hospital and Brigham and Women's Hospital—Salem Hospital delivers world-class care while remaining deeply rooted in its local mission. Position Overview The Chair of Emergency Medicine provides clinical, operational, strategic, and administrative leadership for all Emergency Medicine services at Salem Hospital. The Chair reports to the President & Chief Operating Officer of Salem Hospital, the Salem Hospital Board of Trustees, and the Chief of Mass General Brigham Enterprise Emergency Medicine. Department Highlights • State-of-the-art Emergency Department fully renovated in 2019 • More than 75,000 annual emergency visits serving adult and pediatric patients • 65 private patient bays • Dedicated behavioral health treatment area with on-site psychiatry consultation • 9-bay Pediatric Emergency Department pod staffed 24/7 • Newly opened 16-bed Observation Unit (January 2025) Key Responsibilities • Provide leadership and direction for Emergency Department physicians, Advanced Practice Providers, and staff • Ensure the highest standards of clinical quality, patient safety, and patient experience • Lead initiatives to optimize patient flow, throughput, and access to emergency services • Develop and execute a strategic vision aligned with Salem Hospital and Mass General Brigham priorities • Represent Salem Hospital within the Mass General Brigham Emergency Medicine Enterprise Service Group • Recruit, retain, mentor, and develop a high-performing clinical team • Advance quality, safety, health equity, and evidence-based care initiatives • Support medical education, continuing education, and scholarly activity Qualifications • MD or DO from an accredited medical school • Board Certification in Emergency Medicine • Eligibility for unrestricted Massachusetts medical licensure • Minimum of 8–10 years of progressive clinical leadership experience strongly preferred • Demonstrated success in quality improvement,

operations, and physician leadership Interested candidates should submit a CV and letter of interest to Jeff Maloney at JMaloney9@mgb.org. Applications will be reviewed on a rolling basis through March 30, 2026. (PA 2194)

Email: kaltobello@mgb.org

Website: https://massgeneralbrigham.wd1.myworkdayjobs.com/MGBExternal/job/Salem-MA/Chair-of-Emergency-Medicine--MGB-Salem-Hospital_RQ4048606

MASSACHUSETTS

Pediatric Emergency Medicine Physician. Salem Hospital | Mass General Brigham | Salem, Massachusetts. Mass General Brigham Salem Hospital is seeking a Board Certified or Board Eligible Pediatric Emergency Medicine Physician to join our Pediatric Emergency Department. We offer flexible full-time and part-time opportunities in our state-of-the-art Pediatric Emergency Department and Pediatric Observation Unit. Our department cares for more than 15,000 children annually and is the only 24/7 pediatric emergency department on Massachusetts' North Shore. Physicians also have the opportunity to obtain joint credentialing with Massachusetts General Hospital. Position Highlights: Provide comprehensive emergency care in a modern Pediatric Emergency Department. Collaborate with experienced pediatric hospitalists, specialists, nurses, and support staff in a team-based environment. Practice in a facility equipped with advanced imaging, electronic monitoring, and leading infection prevention technology. Participate in bi-weekly academic conferences through Mass General for Children. Access research, teaching, and professional development opportunities throughout the Mass General Brigham system. What We Offer: Competitive compensation. Comprehensive benefits, including health, retirement, and malpractice coverage. Flexible full-time and part-time scheduling options. Eligibility for the Public Service Loan Forgiveness (PSLF) Program. Opportunities for academic collaboration and career advancement across the Mass General Brigham network. About Salem: Located on Massachusetts' scenic North Shore, Salem offers an exceptional quality of life with coastal beauty, rich history, a vibrant downtown, waterfront recreation, acclaimed restaurants, museums, year-round community events, excellent schools, and convenient commuter rail access to Boston. To Apply: For more information or to apply, please contact Jeff Maloney at jmaloney9@mgb.org (PA 2215) Email: kmldiaz@mgb.org Website: https://massgeneralbrigham.wd1.myworkdayjobs.com/MGBExternal/job/Salem-MA/Pediatric-Emergency-Medicine-Physician-MGB---Salem_RQ4070561

OHIO

The Department of Emergency Medicine at Cleveland Clinic Main Campus seeks an Assistant Program Director to support the development, launch, and ACGME application process of a proposed new Emergency Medicine residency training program at the Cleveland Clinic. This is a unique leadership opportunity to help design and implement a high-quality, academically rigorous residency program at one of the nation's premier academic medical centers. The Cleveland Clinic Main Campus ED is a high-acuity, state-of-the-art facility, 24/7 adult and pediatric ED treating over 61,000 patients annually. Care is provided to a diverse patient population with complex medical and surgical presentations, making it an excellent environment for resident education. Key Responsibilities: • Support program design, curriculum development, and preparation of ACGME accreditation materials • Assist in establishing educational systems, and resident assessment frameworks • Help recruit qualified faculty and future residents • Participate in resident teaching, mentorship, and evaluation Required: • MD or DO degree • Board-certified or board-eligible in Emergency Medicine • Eligible for medical licensure in Ohio • Demonstrated interest in GME and academic medicine • Strong organizational, communication, and leadership skills Interested candidates should submit their cover letter and CV online. <https://www.practicematch.com/physicians/job-details.cfm/1111070> Applications accepted until Friday, February 6th, 2026 (PA 2192) Email: kosturm@ccf.org

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OHIO

University of Toledo Emergency Medicine seeks an enthusiastic, mission-driven Associate Program Director to join our growing academic program. This is an outstanding opportunity for an emergency physician passionate about resident and student education, faculty development, curriculum innovation and mentorship—while allowing you to remain clinically active with residents across our multi-site emergency department system. Protected administrative time and strong institutional support are provided. Prior leadership experience is welcome but not required; we value passion for education, collaboration, and a commitment to training the next generation of emergency physicians. The ideal candidate has long-term aspirations in GME leadership. (PA 2200) Email: matthew.graber2@utoledo.edu Website: <https://careers.utoledo.edu/en-us/job/500547/associate-program-director-apd-emergency-medicine>

CRITICAL CARE MEDICINE SECTION

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