COMMON SENSE

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CHAMPION OF THE EMERGENCY PHYSICIAN



A Full Moon, Friday the 13th, and Other Emergency Department Superstitions

pg 4

President's Message: 2
You Might Be a Leader Before You Know It

The Whole Physician: 12
The Soldier's Burden: What Emergency Physicians Carry Home

Aligned Incentives: 16
Building a Successful Physician-Owned Emergency Medicine Group

Young Physicians Section: 22
Disaster Medicine: A New Subspecialty

AAEM/RSA Editor's Message: 23
What I Found at the Bedside

Table of Contents

Foundation Contributions 7
AAEM PAC Contributions 10
LEAD-EM Contributions 10
Upcoming Events 11
The Whole Physician: The Soldier's Burden: What Emergency Physicians Carry Home 12
Aligned Incentives: Building a Successful Physician-Owned Emergency Medicine Group 16
Scoots: The Name Tag I Didn't Choose 21
Five Skin Findings That Should Change Your ED Management 24
…As Good As It Gets! 27
Justice, Equity, Diversity, and Inclusion Section: Caught Between Care and Custody: Human Trafficking, Immigration Enforcement, and the Emergency Department 29
Shiitake Dermatitis Presenting as a Flagellate Erythema in a Middle-Age Female: A Case Report 34
Young Physicians Section: ABEM Board Recertification 36
AAEM Job Bank 38

Correction: The YPS article "ABEM Board Recertification" which ran in the July/August 2026 issue of *Common Sense* contained errors regarding the ABEM board recertification process. In consultation with ABEM, these errors have been corrected. The corrected article is on page 36 of this issue. We apologize for this error and any confusion it may have caused.

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Featured Articles

2

President's Message: You Might Be a Leader Before You Know It



In this issue's President's Message, Dr. Vicki Norton describes her path to leadership. She never set out to be a leader in the beginning—balancing being a physician, a mother, and everything else that comes with life was hard enough. But other AAEM leaders encouraged her, challenged her, and put her name forward for opportunities she might have avoided. She concludes that sometimes, you have to trust the people who believe in you so you can believe in yourself.

4

Editor's Message: A Full Moon, Friday the 13th, and Other Emergency Department Superstitions



Emergency physicians are trained to practice evidence-based medicine. We rely on clinical decision rules, randomized controlled trials, and scientific literature to guide our decisions. But why, asks Dr. Yash Chavda, do we become a little superstitious when it comes to a full moon, Friday the 13th, or the dreaded Q-word? Read this issue's Editor's Message to find out.

14

American Medical Association House of Delegates: Report from AAEM's Delegates to the American Medical Association's 2026 Annual Meeting



The AMA House of Delegates met June 5-10, in Chicago, and AAEM was well represented. In this article, AAEM Delegate Dr. Gary Gaddis highlights the resolutions resulting from the meeting that have particular relevance to AAEM and its members.

18

She Came for Anxiety: Recognizing Postpartum Depression in the ED



Emergency physicians are trained to quickly identify potentially life-threatening postpartum complications—but postpartum depression can be more difficult to recognize. Instead, patients may present with a myriad of symptoms, may struggle to explain what is happening, or might not even recognize what they are experiencing is postpartum depression. The authors conclude that while a single ED visit may not treat postpartum depression, it may be the visit where someone finally recognizes it and actually listens.

22

Young Physicians Section: Disaster Medicine: A New Subspecialty



While disaster medicine is not a new topic for emergency medicine physicians since traditional emergency medicine residency programs already include training in key disaster medicine principles, as of March 2026, disaster medicine was formally approved as a new medical subspecialty. Dr. Leah Colucci states that while the decision to do fellowship is ultimately a personal one and depends on an individual's career goals, specialized training in disaster medicine can provide expertise that may lead to new and enhance a physician's competitiveness for leadership and academic positions.

23

AAEM/RSA Editor's Message: What I Found at the Bedside



What will we find when we go to the bedside? Will it be herpes zoster? Breast cancer? Anaphylaxis? An urgent toe amputation? Or lung cancer with bony metastases? Dr. Mel Ebeling doesn't know, but at the bedside is where they'll find it.

You Might Be a Leader Before You Know It

Vicki Norton, MD FAAEM



I never set out to be a leader. For a long time, I did not even see myself that way. I was willing to do the work, speak up when something mattered, and take responsibility when something needed to get done. But I never thought those things made me a leader, and I certainly never had a plan to pursue leadership positions in organized medicine.

Looking back, I realize that other people saw something in me that I did not see in myself.

My leadership journey started simply. I got involved. I attended meetings, volunteered for committees, asked questions, and voiced my opinion when I thought something needed to change. I was not trying to build a leadership resume. I was trying to contribute to emergency medicine. Over time, other leaders began to notice and recommend me for opportunities that I would never have pursued on my own.

One of those people was past AAEM President Mark Reiter. About a decade ago, I attended a Florida Chapter (FLAAEM) conference. I had recently joined the chapter board and had just had my second child. I was already trying to balance being a physician, a mother, and everything else that comes with life. Mark told me that one day I would be President of AAEM.

I laughed. The idea seemed ridiculous. I was newly elected to the chapter board, had two young children, and was not looking for another major responsibility. My immediate thought was, "Ain't nobody got time for that!"

Mark apparently saw things differently.

He was not alone. Loice Swisher, Robert McNamara, Bill Durkin, and David Farcy also played important roles in my develop-ment as a leader. They encouraged me, challenged me, and put my name forward for opportunities that I might otherwise have avoided. They were mentors, but they were also spon-sors. They did more than give me advice. They advocated for me when I was not in the room and opened doors I did not know were available.

At the time, I questioned whether I was ready. I worried about the time commitment, whether I was qualified, and whether I could balance leadership with clinical practice and family. I also worried about putting myself out there and failing. What I eventually learned was that you rarely feel completely prepared when an opportunity first appears. Sometimes you have to trust the people who believe in you before you are able to believe in yourself.

Eventually, I said yes. I am grateful that I did.

Leadership has changed me as a physician. It has made me more confident, taught me to listen to people who disagree with me, and pushed me to understand issues far beyond the clinical practice of emergency medicine. It has given me a better understanding of how healthcare decisions are made and, perhaps most importantly, shown

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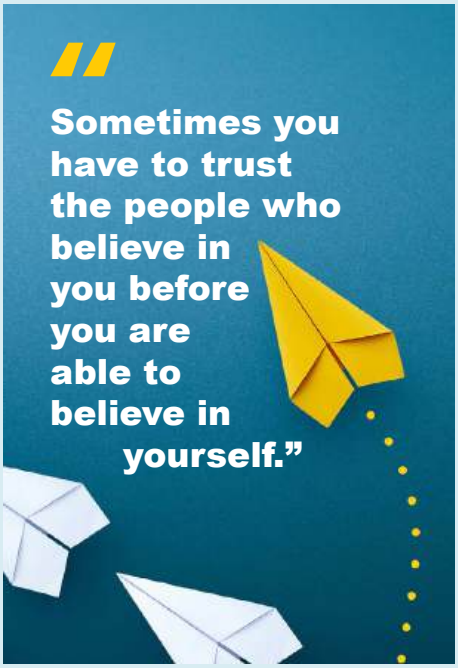
"I never set out to be a leader... Looking back, I realize that other people saw something in me that I did not see in myself."

me that our impact as physicians does not have to end when we leave the bedside.

There is real satisfaction in knowing that your work can improve the practice of emergency medicine for other physicians. Advocating for physician autonomy, fighting for due process, protecting patients, and helping shape policies that affect our specialty have given me a greater sense of purpose in medicine. Leadership has allowed me to work on some of the problems that frustrate emergency physicians every day rather than simply experiencing them myself.

My experience has also changed how I think about who becomes a leader.

We often picture leaders as people who actively seek out positions. They run for office, build networks, and intentionally pursue the next opportunity. That can certainly be one path, but many leaders emerge differently. They care about an issue, become involved, and gradually take on greater responsibility.



This is particularly important for emergency medicine. Our specialty faces significant challenges, from corporate control and private equity to boarding, workforce concerns, burnout, and threats to physician autonomy. We need physicians who are willing to engage beyond their individual shifts. They may serve on committees, participate in organized medicine, advocate for patients, or speak on behalf of their colleagues.

They may not initially think of themselves as leaders. They may simply be the physician who keeps asking why something is done a certain way, advocates for a colleague who is afraid to speak, or volunteers for a committee because someone needs to do the work. These are the people we should notice and encourage.

My own experience has made me more aware of the responsibility that comes with recognizing potential in others. The next generation of emergency medicine leaders may not be looking for a leadership position. They may have young children, demanding clinical schedules, or other responsibilities that make the timing seem impossible. They may even tell you they are not interested or do not think they are qualified.

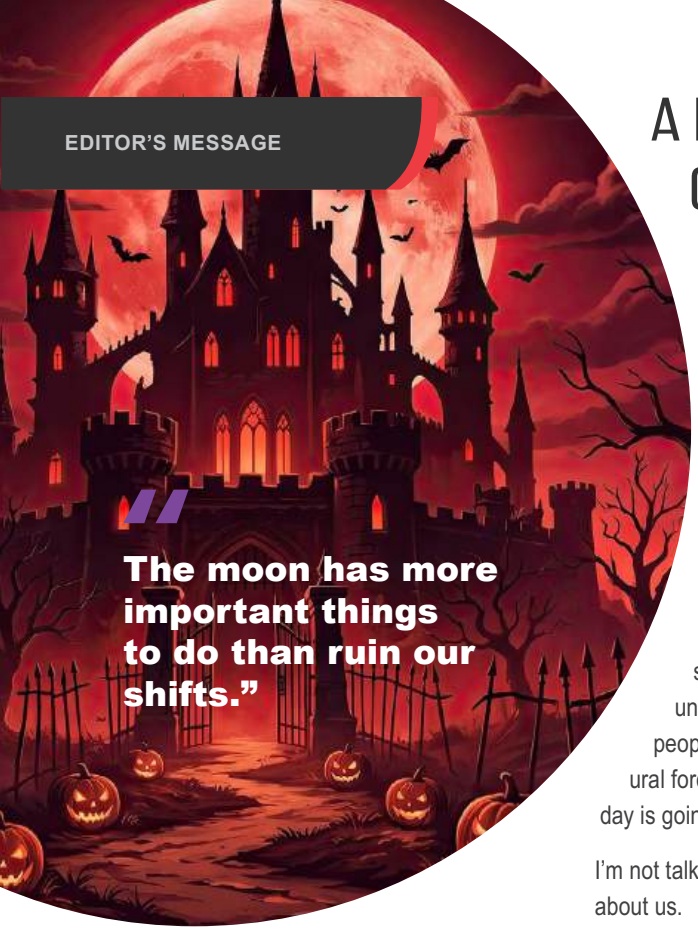
That should not necessarily be the end of the conversation.

A recommendation for a committee, an introduction to someone who can open a door, or an invitation to take on a project can change the trajectory of someone's career. Sometimes a physician simply needs someone they respect to say, "I think you should do this."

That is what my mentors and sponsors did for me. They saw potential before I did, pushed me beyond my comfort zone, and gave me opportunities to grow. I am grateful that they did not wait for me to decide I was ready.

About a decade ago, I laughed when Mark told me I would someday be President of AAEM. I was wrong about that being ridiculous. I just needed a few people to believe it before I did. ■





> **"The moon has more important things to do than ruin our shifts."**

A Full Moon, Friday the 13th, and Other Emergency Department Superstitions

Yash Chavda, DO MBA FPD-AEMUS



Halloween is just around the corner, and for most people, that means costumes, candy, haunted houses, and an evening spent with family and friends. For me, it means another shift in the emergency department.

As I write this, I can feel my wife glaring at me. Once again, I am scheduled to work on Halloween, and not just any shift, but the evening shift until midnight. That pretty much guarantees I will miss every Halloween activity with my family and friends. Halloween has never been a particularly important holiday to me, so I usually reserve my requests for other days, much to the ire of my wife.

I do remember one meaningful Halloween shift during my residency, working in a Bronx pediatric intensive care unit. I wanted to make sure that some extremely sick kids got to see a doctor wearing a costume and hopefully make their day a little better. I wore a cape and pretended to be a superhero, but I knew I was just a trainee trying to make a small impact. Even though I wasn't enjoying Halloween with my own family, I was still trying to make the holiday special for those kids.

Perhaps there is something fitting about spending Halloween in the hospital. Where else can you encounter so many things that seem to defy explanation, so many unexpected surprises, and so many people who genuinely believe supernatural forces are responsible for how their day is going?

I'm not talking about the patients. I'm talking about us.

Emergency physicians are trained to practice evidence-based medicine. We rely on clinical decision rules, randomized controlled trials, and scientific literature to guide our decisions. Yet somehow, when it comes to a full moon, Friday the 13th, or the dreaded Q-word, even the most scientifically minded among us can become a little superstitious.

The Curse of the Full Moon

During an extremely busy shift, I'm sure you've heard a colleague say, "Must be a full moon out there." Perhaps no superstition is more deeply embedded in emergency medicine than the belief that a full moon brings out the worst in people.

But does the full moon affect emergency department volume?

In 1996, Thompson and Adams published a study in the American Journal of Emergency Medicine examining 150,999 ED visits over four years, including 49 full moons. They found no significant differences in patient volume, ambulance arrivals, or hospital admissions on full-moon days.

A 2026 study examining 69,764 psychiatric emergency consultations in France similarly found no significant association between lunar phases and consultation or admission volume.

The moon has more important things to do than ruin our shifts.

Nevertheless, I remember a story from one of my colleagues who managed a cardiac arrest. Despite her best efforts, there was no pulse or cardiac activity on ultrasound. Resuscitation was stopped and she informed the family. But then, unexpectedly, the patient began spontaneously breathing again, right in front of them.

My colleague had just witnessed the Lazarus phenomenon, a rare occurrence of spontaneous return of circulation after resuscitation has ended. The patient was admitted to the ICU, where they survived for approximately another 12 hours before ultimately dying.

I can only imagine what my colleague and the family must have been thinking.

I think I remember her asking me if there was a full moon outside that day...

Friday the 13th: Really a Bad Friday?

If a full moon isn't enough to make an emergency physician nervous, perhaps it's Friday the 13th.

Researchers have investigated this superstition as well. A 2012 study published in the American Journal of Emergency Medicine examined 49,094 patient encounters across six emergency departments. Investigators found no overall increase in ED visits on Friday the 13th. Interestingly, penetrating trauma was more frequent, although it was the only one of 13 conditions examined that showed a statistically significant increase.

Before you start requesting every Friday the 13th off, I wouldn't interpret that single finding as proof that the day is cursed. Still, it's easy to see how one intriguing result can

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"Of all the superstitions in emergency medicine, however, there is one that I suspect carries more weight than the full moon and Friday the 13th combined. The Q-word."

perpetuate a superstition, even when the overall evidence suggests that Friday the 13th is just another day.

Fortunately, for those of us working Halloween this year, October 31 falls on a Saturday, not Friday the 13th.

One less thing to worry about…

A Dangerous Word in Emergency Medicine

Of all the superstitions in emergency medicine, however, there is one that I suspect carries more weight than the full moon and Friday the 13th combined.

The Q-word.

Imagine this: It's 2:00am The waiting room is slowly winding down, it's never really empty… your patients are getting dispositioned, and you think you might finally enjoy some coffee. A colleague walks by, looks around, and says, "Wow, it's really quiet tonight."

Suddenly, heads in the department turn. Someone tells them to knock on wood. A nurse gives them a look of absolute horror. Another physician reminds them that they've just doomed the rest of the shift.

Even though we all know that saying the word "quiet" cannot possibly influence how many ambulances will arrive in the next hour, a small part of us wonders whether we should start preparing for the inevitable disaster.

I still remember the time an intern mentioned how quiet the ED had been recently, around 3:00am on a Saturday night. Within minutes, a Level 1 trauma, a cardiac arrest, and multiple intoxicated patients arrived.

As it turned out, a driver had suffered a cardiac arrest, struck a pedestrian, and crashed into a nearby bar.

It certainly wasn't a quiet night. Of course, it was just a coincidence, but it's one I remember much more clearly than all the times someone said "quiet" and absolutely nothing happened.

As ridiculous as this superstition may seem, researchers have conducted randomized controlled trials to investigate it.

A 2025 systematic review published in Emergency Medicine Journal examined eight randomized trials evaluating whether saying the Q-word affected clinical workload. Seven found no significant difference in objective workload measures. The remaining study reported an increase in overnight orthopedic admissions but had important methodological limitations.

Yup, an actual systematic review examining whether saying "quiet" makes a hospital busier.

Despite the evidence, I suspect most of us still aren't willing to casually announce that we're having a quiet shift.

Especially not at 6:30am, thirty minutes before sign-out.

Why Do We Still Believe?

Why do these superstitions persist in a profession grounded in science?

Perhaps it's because emergency medicine is inherently unpredictable. We can prepare for almost anything, but we can never know exactly what the next patient will bring through our doors.

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Maybe our superstitions provide a little humor in the face of that uncertainty. Or perhaps they have simply become part of the shared culture of emergency medicine.

We may not agree on every clinical decision, hospital policy, or approach to patient care, but we can probably all agree that the person who says the Q-word during a perfectly good shift deserves at least a few dirty looks.

As Halloween approaches, I hope you have an opportunity to enjoy the holiday with your family, dress up, hand out some candy, and experience a few scares that don't involve a crashing patient or an overflowing waiting room.

I'll be spending another Halloween in the emergency department, hopefully enjoying some candy brought in by everyone working and trying to make it home before midnight.

My wife may not be particularly thrilled about that arrangement, but at least I can reassure her that the full moon isn't going to make my shift any worse.

Of course, I won't be making any promises about how quiet it will be.

Happy Halloween, everyone!

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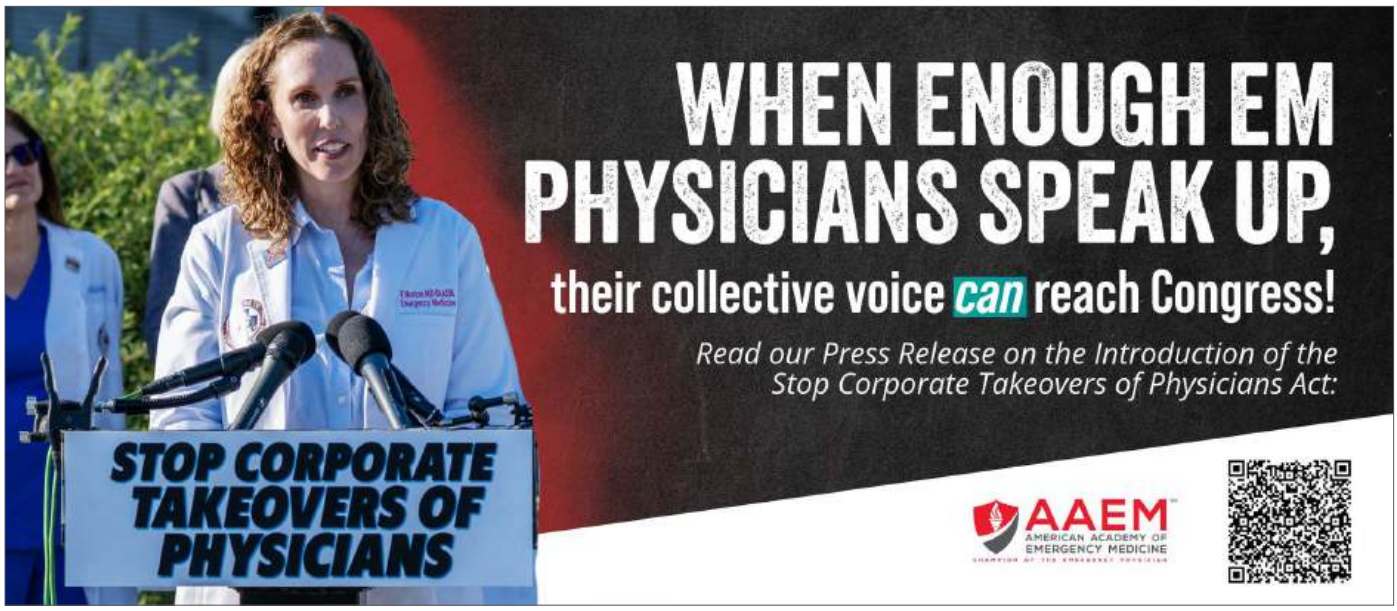
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The AAEM Institute for Leadership, Education & Advancement in the Development of Emergency Medicine, Inc. (LEAD-EM) was established after the tragic and unexpected death of AAEM president, Dr. Kevin G. Rodgers.

The Kevin G. Rodgers Fund and the Institute will LEAD-EM just like Dr. Rodgers did. The funds will support important projects such as development of leadership qualities, and clinical and operational knowledge of emergency physicians with a view toward improving and advancing the quality of medical care in emergency medicine, and public health, safety and well-being overall. LEAD-EM would like to thank the individuals below who contributed from **9/1/2025 to 9/1/2026.**

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Introducing the AAEM and AAEM/RSA Events Calendar — your go-to source for conferences, webinars, workshops, and more. Explore the latest opportunities to connect, learn, and grow in emergency medicine by scanning the QR code.

AAEM Events

AAEM/RSA Medical Student Symposium – South
October 10, 2026 – Hybrid – aaem.org/events-calendar/aaem-rsa-medical-student-symposium-south-2

Emergency Medicine Western Regional Conference
October 17, 2026 (San Diego, CA) – Hosted by Cal/AAEM and the EMS Club of UCSD

14th Annual FLAAEM (Florida Chapter of AAEM) Scientific Assembly
November 13-14 (Sarasota, FL)

33rd Annual Scientific Assembly
April 25-29, 2027 (San Antonio, TX)

Recommended Education

21st Annual Emergency Medicine Update: Hot Topics 2026
October 20-24, 2026 (Kauai, HI) - https://health.ucdavis.edu/emergency/education/Continuing%20Med%20ED/CME-index.html

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

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Explore AAEM CME Online, where we understand the fast-paced nature of emergency medicine (EM) and the need for concise, accessible education. This platform is designed to provide members of the American Academy of Emergency Medicine (AAEM) and AAEM Resident and Student Association (AAEM/RSA) with top-tier continuing medical education (CME) resources right at their fingertips. Access today!

The Soldier's Burden: What Emergency Physicians Carry Home

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





One of the strangest things about emergency medicine is how quickly we are expected to go from crisis to normal life.

One minute you are telling a family their person is dead. Or intubating a child. Or holding pressure on something that should definitely not be bleeding that much. Or trying to find an ICU bed that does not exist.

Then your shift ends.

You get in your car, drive home, and are expected to rejoin normal civilization.

For years, I sometimes made it all the way home and still could not make myself go inside. I would sit in my car in the driveway for an hour. Sometimes two. Occasionally close to three.

I loved my family. I wanted to be with them.

I just could not seem to cross the last twenty feet.

At the time, I assumed I was exhausted. But lately I have wondered whether there was more to it.

My body had come home. Some part of me had not.

I recently started reading about the psychological burden carried by soldiers, particularly moral injury, reintegration, and an emerging concept called cognitive immobility. While I realize that working in an emergency department is not combat, there are some useful parallels. I am not equating the experiences, but as I read about soldiers, I kept recognizing us.

There are things human beings are simply not accustomed to seeing. BAFERDs see them all the time.

We see bodies broken in ways bodies are not supposed to break. We see children die. We see violence, cruelty, neglect, addiction, suicide, grief, and the exact moment somebody's ordinary Tuesday becomes the worst day of their life.

And then we move on to room 12.

Sometimes room 12 wants a work note. Or to complain about how long they've had to wait to get their ingrown toenail seen about.

That ability to move on is part of the job. We compartmentalize because we have to. We learn to make decisions while other people are panicking. We become comfortable with blood, screaming, uncertainty, and the possibility that somebody may die if we get something wrong.

> **"For years...I would sit in my car in the driveway for an hour. Sometimes two. Occasionally close to three...I just could not seem to cross the last twenty feet... My body had come home. Some part of me had not."**

We develop dark humor that would horrify most normal people.

And sometimes it is funny.

Military psychology has long recognized that exposure to extreme circumstances can leave wounds that are not captured completely by classic PTSD. One of those concepts is moral injury: the distress that can follow witnessing, participating in, or being unable to prevent events that violate deeply held moral beliefs.[1]

Emergency medicine has plenty of opportunities for that.[2]

We know the patient needs an ICU bed. There isn't one.

We know the psychiatric patient needs treatment. There is nowhere to send them.

We know the ninety-year-old boarding in a hallway deserves dignity, privacy, and time. Meanwhile, EMS is bringing three more patients and the waiting room has become its own small municipality.

We know what good medicine should look like. Sometimes we cannot deliver it.

That is different from simply being busy.

There is another idea I find interesting: cognitive immobility. Researcher Ezenwa Olumba used the term to describe people who have physically left a place but remain psychologically anchored there.[3] The concept arose from migration rather than medicine, and it is not a psychiatric diagnosis. But when I read about it, I thought about my driveway.

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"For years, I sat in my driveway because I could not make myself walk those last twenty feet. I thought I was tired. Now I wonder what I was carrying."

I had left the ER.

Why couldn't I leave the ER?

Veterans returning from deployment can describe difficulty moving between military and civilian cultures.[4] The rules are different. The identity is different. The people around you may love you and still have very little idea what you have just experienced.

BAFERDs make a smaller version of that trip several times a week.

At 6:52 p.m., you may be running a code.

At 7:15, you are driving home.

At 7:32, somebody wants to know whether you remembered the cilantro.

In the department, hypervigilance is useful. Emotional containment is useful. Rapid decision-making is useful. You may suppress your reaction to something awful because five other people still need you.

Then you walk through your front door, where the desired skill set is almost the opposite: patience, presence, softness, curiosity, emotional availability.

Apparently the nervous system did not get the memo about shift change.

There is also the strange loneliness of this work. Other emergency physicians understand things that are difficult to explain outside medicine. We tell our families the shift was "busy." That may mean we saw thirty patients. It may also mean a stranger died with our hand on their chest, a child was abused, somebody threatened to kill us, and then we spent fifteen minutes arguing with the hospitalist whether an admission was indicated.

"Busy" covers a lot of ground.

Maybe that is part of why BAFERDs tend to find one another. There is comfort in being around people who do not require the footnotes.

I don't think emergency physicians need to start thinking of ourselves as soldiers, but I do wonder whether military psychology has language for experiences medicine has been too quick to sweep into the enormous bucket labeled burnout.

We ask emergency physicians to repeatedly enter a world most people never see, adapt ourselves to function well inside it, witness things human beings are not designed to witness, make life-or-death decisions with incomplete information and inadequate resources, and then drive home.

Twenty minutes later, we are supposed to be completely back.

For years, I sat in my driveway because I could not make myself walk those last twenty feet.

I thought I was tired.

Now I wonder what I was carrying.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Report from AAEM's Delegates to the American Medical Association's 2026 Annual Meeting

Gary M. Gaddis, MD PhD FIFEM MAAEM



The American Medical Association (AMA) 2026 Annual House of Delegates (HOD) met June 5-10, in Chicago. Many matters of relevance to AAEM, to physicians in general, to our patients and to our health care systems were debated. A total of 247 resolutions and reports were considered.

Although no AMA actions have the force of law, the AMA is the largest policy-making physician organization in the United States. Thus, its voice is considerable. Therefore, representation of our American Academy of Emergency Medicine (AAEM) in the HOD is important and valuable.

AAEM was directly represented by Delegates Robert McNamara, MD MAAEM FAAEM, Jonathan Jones, MD FAAEM, and Gary Gaddis, MD PhD MAAEM FAAEM FIFEM, and Alternate Delegates Scott Rineer, MD MPH FAAEM, Leah Colucci, MD MS, and Fred Kency, MD FAAEM FACEP. AAEM Past RSA President Katy Wyszynski, DO served an Alternate Delegate from the Resident and Fellows Section, sponsored by AAEM. AAEM President Vicki Norton, MD FAAEM provided a stellar role, as described below, serving as a Delegate for the Florida Medical Association. AAEM member Debbie Fletcher, MD FAAEM served as an Alternate Delegate for the Louisiana Medical Society.

This was the third AMA HOD meeting at which AAEM participated. AAEM was initially seated as an official delegation at the Annual AMA HOD in 2025. If you wish to learn more about how the AMA HOD functions, and why our presence is important, see "AAEM Joins the AMA House of Delegates (and Why It Matters)" in the July/August 2025 issue of *Common Sense*.[1]

> **Our biggest two wins included markedly strengthening two AMA policies opposing various aspects of CPOM…AMA press releases issued just two days after the meeting's end cited these policy changes as some of the most important developments from the meeting.**

Our biggest two wins included markedly strengthening two AMA policies opposing various aspects of the Corporate Practice of Medicine (CPOM). Our President, Dr. Vicki Norton, had a huge and ongoing hand in these wins. She now has offered wording for two anti-CPOM resolutions, one at last fall's Interim AMA meeting that led directly to a Board of Trustees report adopted this June, and another adopted at this June's Annual Meeting. Both resolutions contained very detailed, point-by-point suggestions to revise and strengthen two existing AMA policies regarding CPOM. The changes that Dr. Norton led brought the AMA into closer alignment with long-held AAEM positions. AMA press releases issued just two days after the meeting's end cited these policy changes as some of the most important developments from the meeting.[2]

Taken together, these AMA actions place America's largest physician organization on-record as fully supporting specific anti CPOM policies for which AAEM has long advocated. Now, when our lobbyists encounter congressional members or staff who wonder "What does the AMA have to say about the CPOM?", we can say that AMA is fully aligned with AAEM goals, and we can cite those two AMA policies.

Resolution 002 was introduced both by the Florida Medical Association (FMA) delegation and by AAEM. Dr. Norton was again the principal author, with assistance from Dr. Jones. The resolution concerned physician workload issues as impacted by employers' staffing decisions. Thus, this resolution was, at its core, another anti-Corporate Practice of Medicine statement. Many of us have or have had corporate employers that systematically understaff emergency departments in the interest of cost savings. This harms patient safety and that detracts from the quality of our workplaces. Resolution 002 was adopted after a few slight but useful amendments, handing the FMA and AAEM another victory. There were suggestions to refer the matter for further study, but fortunately, the HOD did not kick the can down the road.

Resolution 240 addressed the financial practice of Dividend Re-capitalization (Div ReCap). The resolution was authored by Dr. Gaddis, and adopted after minimal amendment by the HOD. It advocates that the practice of Div ReCap must be abolished from private equity (PE) acquisitions of health care enterprises.

Div ReCap is a pernicious PE practice. If you could not define just what Div ReCap is, or

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why it works against physicians' and patients' interests, you would not be alone. Indeed, many AAEM members probably believe that PE ownership of health care enterprises is a bad thing, but would find it difficult to articulate why. This resolution gets at part of the why.

Div ReCap is the practice by which a PE firm that acquires a goods or services-producing corporation, then pays an immediate dividend to that PE company's shareholders, immediately upon purchasing that newly-acquired corporation. The source of funds for that dividend is a loan from commercial loan markets. That loan must be repaid. Under Div ReCap, the repayment becomes the responsibility of the corporation that the PE firm acquired!

That's conceptually equivalent to forcing a home seller to repay the bank loan that the purchaser used to complete the home purchase from the seller! Div ReCap is not only unjust, it saddles the acquired corporation with a new debt that did not previously exist on its balance sheet. This is not the way capitalism is supposed to work. Dividends in a capitalist economy typically follow the generation of profit, and do not precede operations conducted in pursuit of profit. The new debt imposed by the PE practice of Div ReCap leads to service and quality cutbacks consequent to Div ReCap's impact on the corporate balance sheet. Thus, Div ReCap brings harms to patients and to the quality of the workplace, which contributes directly to health care worker burnout.

Resolution 714, concerning case log portability, is another example of AAEM providing leadership at the AMA HOD, as it was written as an AAEM Leadership Academy exercise

> **"Now, when our lobbyists encounter congressional members or staff who wonder 'What does the AMA have to say about the CPOM?', we can say that AMA is fully aligned with AAEM goals, and we can cite those two AMA policies."**

by Saba Rizvi, MD FAAEM, then sponsored by our AAEM delegation. This resolution, also adopted by the HOD, supports a mandate for prompt and timely communication of case log data from employers to physicians who may need such logs for purposes such as credentialing or recredentialing. Given that many emergency physicians work for numerous employers during their careers, this matter is an important concern to us. It was a win that the HOD adopted this resolution, because too many physicians have encountered unreasonable delays obtaining their case logs from a prior employer when new employment is sought.

The only resolution we offered that was not met with success was resolution 242. It offered a new approach to ameliorate ED boarding and crowding (EDB&C) by advocating for financial penalties to be assessed upon poorly-performing hospitals. We are unaware of such suggestions by any group or organization in the past. We were unable to persuade the HOD to adopt our suggestion for financial penalties. Several HOD members testified that they agreed EDB&C is an important problem, and it is a hospital issue, and not simply an ED Issue. However, several who testified opined that the matter is complicated by numerous factors for which a hospital cannot itself be responsible. We may have under-estimated reluctance on the part of HOD members to support financially penalizing hospitals for system-level problems that are not fully their fault. The other is that many delegates seem to have acquired a learned helplessness view of the problem. The attitude of the HOD seemed to be that it agreed EDB&C is a bad thing, but they don't believe that highly impactful changes are feasible. Perhaps these people are too enamored by the writings of psychologist Jean Piaget!

From the testimonies and insights offered in the HOD, we plan to address the issue of EDB&C further, with new approaches at the Interim Meeting of the AMA in November.

If you have suggestions for a new resolution that may be both aligned with AAEM objectives and likely to be received favorably by physicians from many other specialties, you may reach out to Dr. Gaddis at info@aaem.org.

Together, we are stronger!

References

1. *Common Sense* 32.4. AAEM Joins the AMA House of Delegates (and Why It Matters). July/August 2025. https://issuu.com/aaeminfo/docs/july_august_2025_common_sense/17.
2. More details about these anti-CPOM policies can be found here: search for 2026 AMA Board of Trustees Report 25, adopted by the AMA HOD this June to update AMA Policy H-215.981, and for Resolution 241-A-26 ("Resolution 241" of the 2026 Annual Meeting), which updated AMA Policy H-160.891. One can search the "AMA Policy Finder" to read the updated versions of these policies that resulted after Dr. Norton's advocacy. ■

Aligned Incentives: Building a Successful Physician–Owned Emergency Medicine Group

Daniel Nelson, MD FAAEM*

In my previous article[1], I argued that emergency physicians should reclaim ownership of their practices. A natural question followed: *How do you actually build a successful physician-owned emergency medicine group?*

There is no single formula, but I believe the answer comes down to one principle: aligned incentives.

Everything in the organization should encourage physicians, hospital partners, and leadership to work toward the same goals. When incentives are aligned, better decisions follow.

That philosophy has guided Emergency Physicians Associates (EPA) for decades.

Our physicians are compensated entirely based on their clinical productivity. We have no base salaries and no guaranteed income. Physicians are paid for the work they perform. That creates accountability while naturally aligning physician incentives with those of our hospital partners.

When physicians are rewarded for providing efficient, high quality care, hospitals benefit from improved operational performance, physicians are fairly compensated for their efforts, and patients receive better care. Everyone succeeds together.

That alignment extends beyond compensation. Because every physician shares in the success of the practice, there is a collective commitment to improving operations, supporting colleagues, solving problems, and strengthening the organization. Decisions are made with a long-term perspective because everyone has a stake in the outcome.

Our compensation model has also made our group exceptionally competitive in recruiting physicians. Talented emergency physicians want transparency. They want ownership. They want to know they will be rewarded for the value they create.



"Just as importantly, our leaders continue to practice emergency medicine… Decisions are informed by firsthand clinical experience, not just financial reports."

Another important aligned incentive is keeping resources focused where they belong. Too often, emergency medicine dollars are diverted to layers of corporate administration, shareholder returns, or unrelated business operations. Every dollar spent supporting unnecessary bureaucracy is a dollar that cannot be invested in physicians, patients, or improving emergency care.

Our group has deliberately chosen a different approach. We keep nearly every major business function in house. We negotiate our own contracts. We oversee budgeting, finances, physician compensation, payroll, and tax planning. We manage governance, shareholder relations, legal and regulatory compliance, credentialing, physician recruitment, onboarding, scheduling, technology, cybersecurity, operational planning, quality improvement, clinical program development, and oversight of our billing partners. We work directly with hospital executives, nursing leadership, EMS agencies, consultants, attorneys, regulators, technology vendors, and community partners.

Running a modern physician organization is extraordinarily complex. Groups do not run themselves. One of the greatest strengths of our organization is that our board of directors and shareholders have always understood that physician leadership requires meaningful time and investment. They recognize that leadership is not overhead. It is one of the highest-value investments a physician group can make.

Every day our physician leaders are solving operational problems, negotiating contracts, developing strategy, recruiting physicians, managing finances, improving quality, implementing technology, responding to regulatory changes, strengthening hospital relationships, and planning for the future. Those responsibilities cannot simply be squeezed in between clinical shifts. Because our partnership has consistently invested in physician leadership, we have been able to build a sophisticated organization without creating an expensive corporate bureaucracy.

Just as importantly, our leaders continue to practice emergency medicine. They experience overcrowding, boarding, staffing shortages, and the daily challenges of emergency care alongside their colleagues.

Decisions are informed by firsthand clinical experience, not just financial reports. Leadership remains accountable to the physicians it represents, and our hospital partners know they are

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working directly with physicians who understand both clinical care and operations.

None of this suggests physician-owned groups have an easier path. In many ways, they have a harder one. Every contract, every budget, every staffing decision, every regulatory challenge, and every operational problem ultimately belongs to the physicians themselves. There is no distant corporate office to solve those problems.

The stakes are also deeply personal. Fortunately, EPA has never lost a hospital contract, but if we did, it would not simply be a line on a corporate balance sheet. It would affect the livelihoods of friends, partners, and colleagues who have invested years building relationships with their hospitals and communities. The physicians making difficult decisions are the same physicians who would live with the consequences. That creates a level of accountability that is difficult to replicate in any other model.

Ultimately, EPA's success is not the result of any single compensation plan or leadership philosophy. It is the result of consistently aligning incentives. Physicians are rewarded for creating value. Leadership remains accountable to practicing physicians. Resources stay in emergency medicine instead of supporting unnecessary bureaucracy. Our shareholders understand the importance of investing in physician leadership while remaining disciplined about overhead.

Aligned incentives have allowed our group to grow, remain independent, and build lasting partnerships with the hospitals we serve. More importantly, they have created an organization where physicians, hospitals, and patients all benefit together.

References

1. * Chief Operating Officer, Emergency Physicians Associates and Chair, Department of Emergency Medicine, Santa Clara Valley Medical Center
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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 within our specialty. The inclusion of any individual group in Common Sense does not constitute endorsement of that group, its business model, or its leadership. Rather, these articles are shared to illustrate principles of democratic practice, transparency, and physician autonomy that AAEM supports. Opinions expressed are those of the author and do not necessarily represent the views of AAEM or Common Sense.

Vetting Process Information Required:

- *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*
- *No corporate layers siphoning revenue away from frontline clinicians*
- *Alignment of incentives between physicians, patients, and hospitals* ■



She Came for Anxiety: Recognizing Postpartum Depression in the ED

Kirstie Marice M. Venegas, MD* and Nicole E. Exeni McAmis, MD†

A 29-year-old woman presents to the emergency department eight weeks after giving birth. Her chief complaint is "anxiety." She reports sleeping very little, feeling increasingly overwhelmed, and crying almost every day. Her baby is healthy and she loves being a mother, but admits she has started wondering whether her family would be better off without her. When asked directly about suicide, she acknowledges these thoughts but denies any intent or plan to harm herself. She asks if she can go home.

Her physical examination is reassuring. She has no fever, hypertension, focal neurologic deficits, or other findings to suggest an acute postpartum medical emergency.

Emergency physicians are trained to quickly identify potentially life-threatening postpartum complications including: hemorrhage, infection, pulmonary embolism, hypertensive emergencies, and postoperative complications. Postpartum depression can be more difficult to recognize because it rarely presents as the chief complaint. Instead, patients may present with anxiety, insomnia, headache, abdominal pain, difficulty coping, or simply feeling like they are "not themselves." Often, the patient struggles to explain what is happening.

Most importantly, patients may not even recognize what they are experiencing as postpartum depression or even have the language to describe it in that way.[1]

For some, the emergency department may be the first place they feel comfortable talking about these symptoms. Recognizing postpartum depression, even when the patient never uses those words, is an important part of emergency care.

Common and Unrecognized

Postpartum depression can go beyond the expected fatigue and emotional changes that can come with having a newborn. Symptoms can significantly affect a patient's ability to function, maintain relationships, and care for herself and her infant.[1,2]

> **"The question is not whether postpartum depression belongs in emergency medicine. The question is what the emergency physician can do about it."**

The reported prevalence varies considerably depending on how depression is defined and measured. A meta-analysis using diagnostic interviews estimated that 12.1% of women experience a depressive disorder during the first year postpartum, with 7% meeting criteria for major depression. The highest rates occur during the first six months after delivery.[3]

More recent evidence suggests postpartum mental health concerns do not necessarily end after the first year. A 2024 systematic review identified depression prevalence estimates ranging from 6.6% to 41.4% between one and twelve years after childbirth.[4] In other words, the patient who presents to the emergency department four months, eight months, or even years after delivery may still have depression or anxiety associated with the postpartum period and should not be dismissed simply because substantial time has passed since childbirth.[4]

The question is not whether postpartum depression belongs in emergency medicine. The question is what the emergency physician can do about it.

Recognize the Presentation

Once postpartum depression is on the differential, the next step is recognizing symptoms that may otherwise be attributed to the normal stress and adjustment of caring for a newborn.[1,2]

Symptoms that should raise concern include:[1,2]

- Persistent sadness or emptiness
- Loss of interest or pleasure
- Excessive guilt
- Feelings of worthlessness
- Irritability
- Anxiety
- Poor concentration
- Sleep disturbance beyond what can be explained by infant care
- Difficulty bonding with the infant
- Feeling overwhelmed or unable to cope
- Thoughts of death or suicide

Most patients will not volunteer these symptoms on their own. A simple, open-ended question can help the patient open up: "How have you been doing since the baby was born?"

Baby Blues Versus Postpartum Depression

One of the first steps is distinguishing the expected postpartum experience from postpartum depression. The "baby blues" are common and typically begin within the first several days after delivery. Symptoms are usually mild, peak within the first week, and resolve within one to two weeks without treatment.[5]

In contrast, postpartum depression persists beyond two weeks, interferes with daily functioning, and may be accompanied by hopelessness, suicidal thoughts, or significant

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anxiety.[1,5] Distinguishing between the two is important because postpartum depression requires further evaluation and treatment.

Maternal mental health also affects infant health. A 2024 systematic review and meta-analysis found an association between perinatal depression and adverse infant and toddler neurodevelopmental outcomes.[6] Recognizing and treating postpartum depression is important not only for the mother, but also for the health and well-being of her child.

Screen

The Edinburgh Postnatal Depression Scale (EPDS) and Patient Health Questionnaire-9 (PHQ-9) are commonly used validated instruments for perinatal depression.[1] The American College of Obstetricians and Gynecologists (ACOG) recommends screening for depression and anxiety during pregnancy and throughout the postpartum period, with systems in place for assessment, treatment, and follow-up.[1]

The EPDS is a 10-question, self-reported screening tool specifically designed to identify depressive symptoms during pregnancy and the postpartum period. It asks about symptoms such as sadness, anxiety, guilt, sleep disturbance, and thoughts of self-harm. The EPDS takes only a few minutes to complete and is particularly useful in the postpartum population.[1]

The PHQ-9 is a nine-question depression screening tool based on DSM criteria. It assesses depressive symptoms over the preceding two weeks and provides a severity score that can help identify patients who warrant further evaluation.[1]

While screening is only the beginning, these tools should support, not replace a conversation with the patient or clinical judgment. A score is not a diagnosis, and a reassuring screening result should never outweigh a concerning history. If a patient's story raises concern for postpartum depression, further evaluation is warranted regardless of the screening score.

If a patient screens positive or the history raises concern, key questions include:

- *What symptoms have you been experiencing?*
- *When did they start?*
- *How are they affecting your daily life?*
- *Do you feel safe at home?*
- *Are you having thoughts of hurting yourself?*
- *Are you having thoughts of hurting your baby?*
- *Do you feel like you are losing touch with reality?*

Suicide Risk Assessment

While postpartum depression exists on a spectrum, suicidal thoughts should always prompt a separate suicide risk assessment. ACOG recommends that an affirmative response to a self-harm or suicide question trigger an immediate suicide risk assessment and risk-tailored management.[1] This assessment should address intent, a plan, access to lethal means, prior attempts, preparatory behavior, substance use, psychosis or mania, protective factors, and whether the patient can safely return to her current environment.

Patients with active suicidal intent, a plan, or an inability to maintain their own safety require immediate psychiatric evaluation.

The EPDS and PHQ-9 can help identify patients who require further evaluation, but they should not be used to determine disposition.[1]

Ask About the Baby

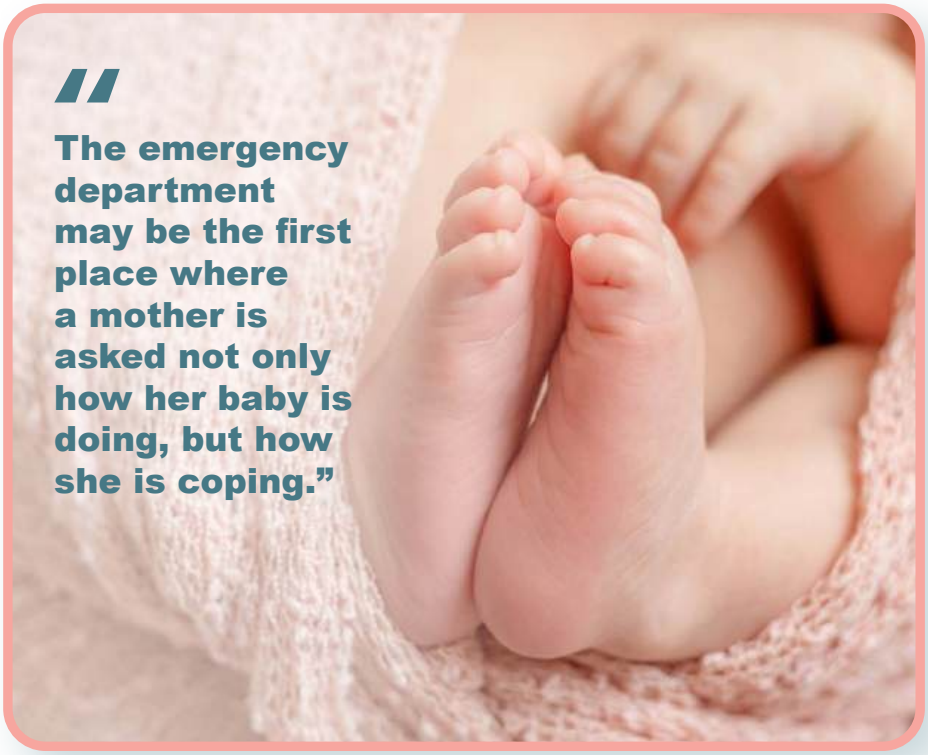
Asking about thoughts of harming the infant can feel uncomfortable, but it is an important part of the evaluation. Patients may experience intrusive thoughts that are distressing and unwanted, and these thoughts do not necessarily indicate psychosis or an intent to act.[1]

Consider asking:

- *Have you had thoughts about something bad happening to your baby?*
- *Do these thoughts feel unwanted or frightening to you?*
- *Do you think you might act on these thoughts?*
- *Do you believe these thoughts are coming from somewhere outside of yourself?*

Studies have found that patients who are frightened by intrusive thoughts and have

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no desire or intent to act on them are clinically different from those experiencing command hallucinations, fixed delusions, or the belief that harming their infant is necessary.[1] Distinguishing between these presentations is critical because their management and level of risk are very different.

Postpartum Psychosis ≠ Postpartum Depression

Postpartum psychosis is a psychiatric emergency and should not be confused with postpartum depression. Patients may present with hallucinations, delusions, paranoia, severe agitation, disorganization, mania, confusion, or rapidly changing mental status.[7] Unlike postpartum depression, postpartum psychosis requires immediate psychiatric evaluation, and many patients require inpatient psychiatric hospitalization because of the risk of harm to both the mother and infant.[1,7]

Do Not Forget Bipolar Disorder

Not every patient who presents with postpartum depression has unipolar depression. ACOG recommends screening for bipolar disorder before initiating pharmacotherapy for depression or anxiety if it has not already been assessed.[2] Approximately one in five patients who screen positive for depression may have bipolar disorder.[2] In these patients, antidepressant monotherapy can worsen symptoms and may precipitate mania, psychosis, or suicidality.[2]

When evaluating a patient with suspected postpartum depression, ask about:

- Prior episodes of mania or hypomania
- Decreased need for sleep
- Periods of unusually elevated or irritable mood
- Racing thoughts
- Impulsive or high-risk behavior
- Previous psychiatric diagnoses
- Previous psychiatric medications

Identifying bipolar disorder is important because it may change both treatment recommendations and the need for psychiatric consultation.[2]

Next Steps

Once postpartum depression has been identified, priorities include identifying immediate safety concerns, evaluating medical contributors, initiating appropriate care, and establishing a safe transition to outpatient follow-up.



Rule Out Medical Contributors – Consider postpartum thyroid disease, anemia, infection, electrolyte abnormalities, medication effects, substance use, hypertensive disorders, neurologic disease, and other postpartum complications.

Screen Appropriately – The EPDS and PHQ-9 are useful screening tools to identify patients who require further assessment but should support, not replace clinical judgment.[1]

Ask Directly About Suicide – If the patient endorses suicidal thoughts, perform an appropriate suicide risk assessment and determine the safest disposition.[1]

Assess for Psychosis and Mania – While postpartum depression is common, postpartum psychosis is uncommon but represents a psychiatric emergency. The two should not be managed interchangeably.[1,7]

Involve Psychiatry When Indicated – Patients with active suicidal intent, psychosis, mania, severe functional impairment, inability to care for themselves or their infant, or inadequate safety planning may require psychiatric consultation and inpatient treatment.[1,7]

Build a Safe Discharge Plan – Following up with OB alone is not a discharge plan. Before discharge, consider:

- Who will provide follow-up care?
- When will the patient be seen?
- Does the patient have access to behavioral health services?
- Does the patient have transportation?
- Does the patient have safe housing?
- Does the patient have adequate social support?
- Are childcare responsibilities creating barriers to treatment?
- Does the patient know when to return if symptoms worsen?

ACOG emphasizes that screening should be paired with systems that ensure timely assessment, treatment, and monitoring.[1]

Treatment is Changing

Traditional antidepressants and psychotherapy remain the foundation of treatment for postpartum depression, but newer therapies are expanding treatment options for selected patients.[2]

In 2023, the FDA approved zuranolone, an oral neuroactive steroid, for the treatment of postpartum depression. In a phase three randomized trial, patients treated with zuranolone experienced greater improvement in depressive symptoms than those receiving placebo, with improvement evident as early as day three.[8] A subsequent systematic review and meta-analysis similarly demonstrated rapid antidepressant effects, although adverse effects such as somnolence, dizziness, and sedation remain important considerations.[9]

Continued on page 33>>

Scoots: The Name Tag I Didn't Choose

Lauren Rosenfeld, MD



I earned the nickname "Scoots" in residency, after my first broken bone, my first laceration, and my first trauma resuscitation. All of them were mine.

I was coming off shift when a foreign diplomat hit me on a roundabout. I went up onto his windshield and then twenty feet off of it. I woke up—helmet on—to an ambulance staged less than a hundred feet from the GW bay I had just walked out of. The mechanism and the diffuse injuries should have triggered a trauma activation. Instead I was quietly swept into a room, where I was found to have a tibial plateau fracture, a distal radius fracture, and a clavicle fracture. I was admitted for surgery, discharged home later that week, and spent months in rehab and physical therapy.

I came back a little ahead of schedule, on a different kind of scooter, rolling around the ICU at the end of my PGY-2 year. That is where I earned the nickname "Scoots," and I wore it as a badge of honor long after I was walking on two stable feet again.

In June 2026, I graduated and moved to Houston—new city, new faculty appointment, new plans to build a career in medical education. I was trying to stay active and actually see the place. One of those attempts was White Linen Night in the Heights with a new colleague. I stumbled. We both watched the tendon snake up my calf, a hematoma blooming behind it.

I will admit to self-diagnosing. In my defense, I had an EM colleague at my informal sidewalk bedside, and he agreed with me. One "step" at a time. I Ubered home with my husband, who promptly bought knee scooter number two. I splinted myself in equinus and had an orthopedist on the calendar within 24 hours. Surgery was 48 hours after that. I was back at work on POD5, because I already knew the path.

Here is what I have been turning over since.

I have never had any trouble calling a tibial plateau fracture a hardship. I have enormous trouble calling residency one. Long shifts, back-to-back ICU blocks, the conversations in the family room, the patients who stay with you—I will describe all of it as *training*, or *formative*, or, if I am feeling generous with myself, *hard*. I will not call it a hardship, because hardship implies I needed something, and needing something implies I was not strong enough on my own.

> **"We are not short on grit… Resilience was never the missing ingredient. What we are short on is permission."**



That instinct is not a personal quirk. It is the water we swim in, and the data are not subtle about it.

We are not short on grit. In a national survey of more than 5,000 physicians, physicians scored higher on resilience than the general U.S. working population, and yet 29% of those who scored the highest possible resilience score were still burned out.[1] Resilience was never the missing ingredient.

What we are short on is permission. At one large children's hospital, 83% of attending physicians and advanced practice clinicians reported working while sick in the past year, even though 95% of them believed doing so could endanger patients.[2] Their reasons had nothing to do with not knowing better: not wanting to let colleagues down, not wanting to let patients down, staffing, and fear of being ostracized for calling out.

And when the need is formal and legally protected, we still do not ask. Among first-year residents with disabilities who reported needing accommodations, roughly half never requested them, and the single most common reason was fear of stigma or bias.[3]

Half. Of people who needed something, knew they needed it, and were entitled to it.

Which brings me back to the scooter.

The knee scooter is an ID badge I did not choose and cannot take off. It walks into the room before I do. I cannot round in it and

Continued on page 26 >>

Disaster Medicine: A New Subspecialty

Leah Colucci, MD, MS



Disaster medicine is not a new topic for emergency medicine physicians. Traditional emergency medicine residency programs already include training in key disaster medicine principles such as mass casualty triage, personal protective equipment (PPE), surge capacity planning, and disaster response. However, in March 2026, disaster medicine was formally approved as a new medical subspecialty. As the frequency of both natural and human-made disasters continues to increase, so does the need for physicians who are specifically trained to provide care in environments where standard protocols cannot be followed and critical resources are limited.

There are already 14 disaster medicine fellowships in the United States. Currently, there is no standardization among the fellowships, and they vary considerably in structure and duration, ranging from one to two years of training beyond residency. Educational experiences also differ among programs. Some emphasize hands-on disaster response and field deployment, while others rely primarily on virtual learning and simulation.

Because disaster medicine has historically been closely associated with emergency medicine, it is often assumed that fellowship training is limited to emergency physicians. Most existing programs are housed within emergency medicine departments. However, the development of the subspecialty was a collaborative effort between emergency medicine, surgery, and preventive medicine, and all three boards will be hosting certification. Physicians who complete residency training in anesthesiology, internal medicine, neurological surgery, obstetrics and gynecology, ophthalmology, orthopaedic surgery, pathology, pediatrics, physical medicine and rehabilitation, preventive medicine, psychiatry, neurology, radiology, or surgery are eligible to pursue disaster medicine fellowship training. The American Board of Preventive Medicine currently oversees the standards, assessment, and certification processes for the subspecialty, as it does for aerospace medicine, undersea, and hyperbaric medicine.

The establishment of disaster medicine as a formal subspecialty is intended to standardize fellowship curricula, create consistent educational and training expectations, and establish uniform standards for competency assessment and board certification. These efforts aim to ensure that physicians entering the field possess a consistent foundation of knowledge and skills regardless of where they complete their fellowship training.

The decision to do fellowship is ultimately a personal one, and depends on an individual's career goals, as everyone may receive a different benefit from the additional years of training. Specialized training in disaster medicine can provide expertise that may lead to career opportunities in emergency management, disaster preparedness, public health, humanitarian response, and academic medicine. Fellowship training may also enhance a physician's competitiveness for leadership and academic positions. Although many positions in disaster medicine currently do not require fellowship training, the formal recognition of the specialty may increase employer expectations for specialized training and board certification in the future.

Resources

1. https://www.acep.org/disastermedicine/resources/disaster-medicine-fellowships-and-other-training-programs
2. https://www.theabpm.org/a-new-subspecialty-in-disaster-medicine-approved-by-the-american-board-of-medical-specialties-abms/
3. https://www.abem.org/news/certification-in-disaster-medicine-coming-soon-for-physicians/ ■



What I Found at the Bedside

Mel Ebeling, MD



When I went to the bedside, I thought I would find a 56-year-old woman clutching her chest, diaphoretic, and nauseous. Someone with a history of a couple of stents, a new two-liter oxygen requirement, or maybe a pair of edematous legs concerning for congestive heart failure. The pending labs and imaging ordered out in triage—a CBC, BMP, BNP, troponin, chest x-ray, ECG—all suggested a concern for some precarious cause of chest pain. Instead, I found a relatively healthy-appearing, unbothered older woman intermittently reaching up to scratch her left breast. Below three layers of clothing...ah-hah! The beginnings of a vesicular rash. The source of this patient's chest pain was nothing more than herpes zoster.

I made my way back to the bedside again. This time I thought I found a "fall on thinners," at least that's what I heard in passing as the paramedic crew bustled down the hall. *Guess who just bought themselves a CT head?* A disgruntled 73-year-old woman sat before me; a beat-up old rollator with a tattered seat hid in the corner. Everything hurt, yet nothing hurt at all. The hematoma on her head told only part of the story. An unusual, firm mass over the right arm led me proximally to the chest wall, where a textbook peau d'orange appearance of the right breast informed a new diagnosis of inflammatory breast cancer.

Once more, I went to the bedside. I thought I found a heart failure exacerbation—I swear it was just supposed to be a heart failure exacerbation—at least that's what the patient's story led everyone to believe. An obese 60-year-old man with crackles in his lungs, a dilated IVC, and pitting edema to the thighs had run out of his diuretics. He just wanted some fluid pulled off. Then the shoes came off, underneath was a wet, gangrenous toe with exposed bone. He was ultimately admitted for an urgent amputation with podiatry.

So I went to the bedside across the hall, where I thought I found the perfect scenario for Haldol and Versed. A young woman with a history of…well, who knows—save for a history of psychiatric illness and substance use, guaranteed by the police officer—was grunting, kicking, and thrashing around on the stretcher. But something wasn't right. The tongue looked a little too big, and the neck a little too firm. Within a minute, the tongue was a little bit bigger, the neck a little firmer. One tube later, the ICU found themselves managing one hell of a case of anaphylaxis.



"Tomorrow I'll go back to the bedside. I don't know what I'll find, but I know that's where I'll find it."

I went to the bedside one last time that day, and I thought I found someone who was going to be okay. A healthy 40-year-old man with the contours of lean, muscular build under a ribbed white tank-top had chest pain. He got "the works" before I saw him—all normal. The HEART score was low risk. S2 followed S1, as expected. Pulses equal and symmetric throughout. Not a single wheeze auscultated. I wanted to send him home, until I palpated his chest. The right eighth rib was far too tender to be a costochondritis. The CT results brought devastating news—lung cancer with bony metastases.

Tomorrow I'll go back to the bedside. I don't know what I'll find, but I know that's where I'll find it.■

Five Skin Findings That Should Change Your ED Management

Kenechi Iwelumo, MD



When the Skin Warrants a Second Look

Emergency physicians routinely make high-stakes decisions before a definitive diagnosis is available. In this setting, the skin can provide an important, yet sometimes underused, source of diagnostic information. Findings such as erythema, edema, purpura, bullae, and necrosis are common and have broad differentials, but certain morphologic patterns may offer clues that warrant a second look or a broader differential.

A practical understanding of a few high-risk cutaneous findings can help emergency physicians recognize when the skin may provide an important clue and inform decisions about further evaluation, consultation, or treatment.

Five such findings are particularly useful to recognize in the emergency setting.

> **"Sometimes, the skin provides the clue that helps point the rest of the evaluation in the right direction."**

1 Pain out of proportion to the skin examination: Think beyond cellulitis

Necrotizing soft-tissue infection (NSTI) may initially resemble cellulitis, with erythema, warmth, edema, and tenderness. Severe pain that appears disproportionate to the visible examination, particularly when accompanied by rapid progression or systemic toxicity, should raise concern for deeper infection. Other concerning findings include bullae, ecchymosis, anesthesia, crepitus, woody induration, and edema extending beyond the area of erythema.[1,2]

Importantly, the absence of necrosis, bullae, or crepitus does not exclude NSTI. Laboratory testing, imaging, and scoring systems may support clinical suspicion but should not delay surgical evaluation when concern is high. A contemporary US surgical review emphasizes that the diagnosis ultimately remains clinical, while the Eastern Association for the Surgery of Trauma recommends early operative debridement once NSTI is suspected.[1,2]

What changes in the ED?

- Reassess the depth and rate of progression.
- Look specifically for anesthesia, bullae, ecchymosis, crepitus, and induration.
- Use imaging when it will aid decision-making without delaying definitive care.
- Obtain early surgical consultation when NSTI remains clinically plausible.
- Initiate appropriate empiric antimicrobial therapy when indicated.

The key lesson is that a benign-appearing surface does not guarantee a benign process underneath it.

2 Retiform purpura: Think vascular occlusion, not simply "vasculitis"

Not all purpura is equivalent. Retiform purpura is a branching, angulated, or stellate pattern produced by compromised cutaneous blood flow and downstream ischemia.[3] In an acutely ill patient, this morphology can signal disseminated intravascular coagulation, purpura fulminans, thrombotic vasculopathy, antiphospholipid syndrome, calciphylaxis, cholesterol embolization, infection-associated vascular occlusion, or other processes.[3]

This distinction matters because vasculitis and vasculopathy are not synonymous. Vasculitis primarily involves inflammatory injury to the vessel wall, whereas vasculopathy emphasizes vascular occlusion and ischemia. The distinction can substantially alter the diagnostic evaluation and treatment.[3]

What changes in the ED?

- When retiform purpura is identified, ask: "What is compromising blood flow to the skin?"

The answer may require evaluation for coagulopathy, thrombosis, infection, embolization, autoimmune disease, or medication-associated vascular injury. The patient's overall clinical context should determine the laboratory and imaging evaluation. Dermatology consultation and appropriately performed skin biopsy can subsequently help distinguish vasculitis from occlusive vasculopathy.

For emergency physicians, the important point is that retiform purpura may be a visible marker of systemic vascular disease.

3 Dusky, painful skin with mucosal involvement or sloughing of epidermis: Think SJS/TEN

Stevens-Johnson syndrome and toxic epidermal necrolysis (SJS/TEN) are severe cutaneous adverse reactions, usually drug-induced, characterized by epidermal injury and prominent mucosal disease. Early manifestations may be nonspecific, but skin pain, dusky erythema, blistering or epidermal detachment, and mucosal erosions should prompt consideration of epidermal necrolysis, particularly with a compatible medication exposure.[4,5]

US Society of Dermatology Hospitalists guidance emphasizes immediate multidisciplinary

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involvement and meticulous supportive care, including wound, ocular, oral, urogenital, airway, fluid, nutritional, and pain management.[4] A large US inpatient analysis found substantial mortality among hospitalized patients with SJS/TEN, reinforcing that this is not a benign drug eruption.[5]

What changes in the ED?

- Stop nonessential suspected culprit medications.
- Assess oral, ocular, genital, and other mucosal involvement.
- Evaluate the extent and progression of epidermal loss.
- Involve dermatology early.
- Determine whether ICU or specialized burn-level supportive care is warranted.
- Provide appropriate fluid, electrolyte, nutritional, analgesic, wound, and ocular support.

Not every blistering eruption is SJS/TEN; important mimics include erythema multiforme, bullous fixed drug eruption, autoimmune blistering disease, burns, and staphylococcal scalded skin syndrome. Nevertheless, painful dusky skin plus mucosal disease should be treated as a diagnostic emergency until appropriately evaluated.

4 Fever, diffuse eruption, and facial edema after a new medication: think DRESS

Drug reaction with eosinophilia and systemic symptoms (DRESS) is particularly easy to miss in the emergency setting because it can resemble sepsis or another systemic inflammatory illness. Typical features include fever, diffuse eruption, facial edema, lymphadenopathy, hematologic abnormalities, and internal-organ involvement, particularly hepatic involvement.[6]

A 2024 US-authored JAAD review emphasizes that DRESS commonly develops two to six weeks after exposure and may involve the liver, kidneys, lungs, heart, or other organs.[6] The emergency-medicine insight is that the skin should trigger a search for extracutaneous disease.

What changes in the ED?

- Construct a medication timeline rather than simply documenting "new medications."
- Identify potentially causative agents.
- Obtain CBC with differential, hepatic and renal testing, and additional organ-specific evaluation when indicated.
- Discontinue the suspected culprit medication when appropriate.
- Arrange early dermatologic and inpatient evaluation when systemic involvement is suspected.

Eosinophilia is an important clue but should not be treated as an absolute prerequisite early in the disease course. Conversely, eosinophilia alone does not establish DRESS. The diagnosis remains clinical and requires assessment of the overall pattern and organ involvement.[6]

The important distinction is: A patient with a drug eruption may have a skin problem. A patient with DRESS has a systemic drug reaction that happens to be visible on the skin.

5 Acral discoloration or necrosis in a patient receiving vasopressors: Think potential ischemia

In the critically ill patient, the skin can also reveal the consequences of treatment. Vasopressor-associated peripheral ischemia results from profound vasoconstriction superimposed on the microcirculatory dysfunction of critical illness and can progress from cool, discolored digits to irreversible necrosis.[7]

However, attributing all acral ischemia to vasopressors can itself become a form of anchoring bias. Arterial thrombosis, embolization, line-related vascular injury, disseminated intravascular coagulation, and other vascular processes may produce similar findings.

What changes in the ED or ICU?

Document:

- temperature and color of the extremity;
- capillary refill;
- palpable and Doppler-detectable pulses;
- symmetry of involvement;
- sensory and motor function;
- progression over time; and
- temporal relationship to vasopressor initiation or dose escalation.

The key question is not "Is this from norepinephrine?"

It is "Is this tissue ischemia, and what is causing it?"

A practical approach: Recognize the "STOP signs"

These five findings can be remembered as a series of STOP signs:

- **Severe pain** ➔ Consider necrotizing infection.
- **Targetoid or dusky epidermis with mucosal disease** ➔ Consider SJS/TEN.
- **Occlusive morphology such as retiform purpura** ➔ Evaluate for vascular occlusion or coagulopathy.
- **Peculiar drug eruption with fever, facial edema, or organ abnormalities** ➔ Consider DRESS or another severe cutaneous adverse reaction.
- **Peripheral ischemia** ➔ Assess perfusion and distinguish vasopressor effect from thrombosis, embolization, or systemic vasculopathy.

This framework is not a diagnostic algorithm because morphology overlaps, multiple processes can coexist, and definitive diagnosis may require biopsy, imaging, laboratory testing, or consultation. Instead, the framework serves as a cognitive tool: when one of these findings is present, pause before anchoring on the initial diagnosis.

Conclusion

Emergency physicians encounter a wide range of cutaneous findings, often in patients whose diagnosis is still evolving. A practical familiarity with a few high-risk patterns can help clinicians recognize when the skin may offer an important clue and when a finding warrants a broader differential or a closer look.

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A painful red extremity may be cellulitis or NSTI. Retiform purpura may represent a localized skin process or disseminated vascular occlusion. A "drug rash" may be benign or the beginning of epidermal necrolysis or DRESS. Acral discoloration in a patient receiving vasopressors may be an expected consequence of shock or evidence of a separate vascular catastrophe.

Sometimes, the skin provides the clue that helps point the rest of the evaluation in the right direction.

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Continued from page 21 >>

"Showing up to work with a temporary disability is just the legible version of what all of us are already doing...The difference between them and me is not magnitude. It is whether anyone can see it."

simultaneously perform at 100%, which is precisely what I spent residency trying to do, and precisely what most of my colleagues are doing on any given shift. My disclosure was made for me.

What surprised me is what came back. The scooter has produced more conversation, more connection, and more disclosure from other people than anything I have ever said about myself on purpose. Patients tell me about their surgeries. Nurses tell me about their kids. Residents tell me things they would not otherwise volunteer to a faculty member, because I have visibly stopped pretending.

Showing up to work with a temporary disability is just the legible version of what all of us are already doing. Someone is here with a sick kid at home. Someone is here after a fight that is not resolved. Someone is here after a resuscitation that did not go the way it should have, or four hours of sleep, or a truly terrible cup of coffee. The difference between them and me is not magnitude. It is whether anyone can see it.

So what is the lesson, and how do we teach it?

I do not think the answer is another resilience module. I think it is smaller and harder than that. It is an attending saying out loud, in front of learners, that today is a rough one. It is asking "what do you need" instead of "are you okay," because the second question has only one socially acceptable answer. It is knowing your program's accommodation process before somebody needs it, and saying so before they have to ask.

Losing the choice about whether to share my story has made me much more deliberate about the times when I do have a choice. Not everyone gets a name tag. Most of us have to say it out loud.

Author Note: Shoutout to Dr. David Yamane for the original nickname and Dr. Masood Mohammed for his curbside consultation.

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...As Good As It Gets!

Dan Mayer, MD FACEP FAAEM



So, emergency medicine is a great field. We are frequently "saving lives and stamping out disease" and we all have lots of memorable cases of having saved lives on a regular basis. But EM is more than that, and we don't always get to find out that we've done something truly miraculous. This was one of those times.

This episode happened over 20 years ago. I was working at a major tertiary trauma center in upstate New York as an ED attending. With kids in college, I needed to do some moonlighting to make tuition a reality. I moonlighted in several rural hospitals in nearby communities. It was at one of these moonlighting shifts, an overnight shift in a small local community hospital, that I had what would become a truly remarkable experience.

It was an overnight shift on a Saturday night in the depths of an upstate New York winter. This community hospital ED was not usually very busy after midnight, but as usual, the evening had been fairly busy. Then as if on cue, at about 1:00am it all stopped. I was hoping to get a nap when the triage nurse informed me that EMS was bringing in a man who had been in a bar fight and was "pretty cut up." OK, another cup of coffee and I'll take care of him.

The medics brought in a middle-aged man, his face and clothes covered in blood and with many obviously deep cuts on his face. Well, that doesn't really give the full flavor of what he had. There were over a dozen deep lacerations, all of them over an inch long, and most of them now just oozing. Well, I didn't really think that this would be much of a challenge as we had a plastic surgeon on call. I hoped they would be able to come in and repair these in a timely manner.

The patient was able to speak and had full recollection of the evening. He told me his name was Harry* and that after drinking too much he got into a fight with another bar patron. The other guy broke a bottle on the furniture. Harry assured me that it was not broken on his head, and in corroboration, there were no injuries on his head, save for the multiple lacerations only on his face. He remembered the whole incident, which although I couldn't verify, was totally consistent with the EMS report. I did my trauma evaluation and found no other injuries, just the way too many cuts on his face. My next call was to the plastic surgeon to ask him to come in to repair them.

> **"I...offered to transfer him. He gave a way too loud and drunken response while pointing his index finger at my face, saying 'I don't want no plastic surgeon, Doc, I want you!"**



He called back quickly and notified me that he was not able to come in to repair this man's face due to the fact that he had been at a party and had been drinking that evening. As if to make sure that I wouldn't call him again for a "cut up drunk," he added that even if he hadn't been drinking, he was not going to come in to take care of this "drunk." And if I couldn't fix his lacerations, I should send him to the local trauma center, where there were plastic surgery residents who could do that repair. Oh well, I thought, just my luck.

I gave this information to the patient and offered to transfer him. He gave a way too loud and drunken response while pointing his index finger at my face, saying **"I don't want no plastic surgeon, Doc, I want you!"**

After a discussion with the nurses, we agreed that I'd start working on him and see how many of his lacerations I could repair until we got busy again. After all, I could always transfer him in the morning. And, I enjoyed doing plastic closures, challenging myself to make them as unobtrusive or invisible, as possible.

I sat down and started cleaning up his lacerations, which were mostly irregular and deep. After getting started, I made small talk, basically trying to fill up the time while repairing his face.

I thought back to my residency training in family medicine and reflected on what I had learned about communicating with alcoholics. We had rotations on the detox unit of the hospital, which was run by a wonderful man, a Penobscot Indian who had been an alcoholic and really understood (grokked) the issues involved in helping other alcoholics into recovery. He taught me what it took to really communicate with alcoholics, and by the time I left residency, I was pretty good at it.

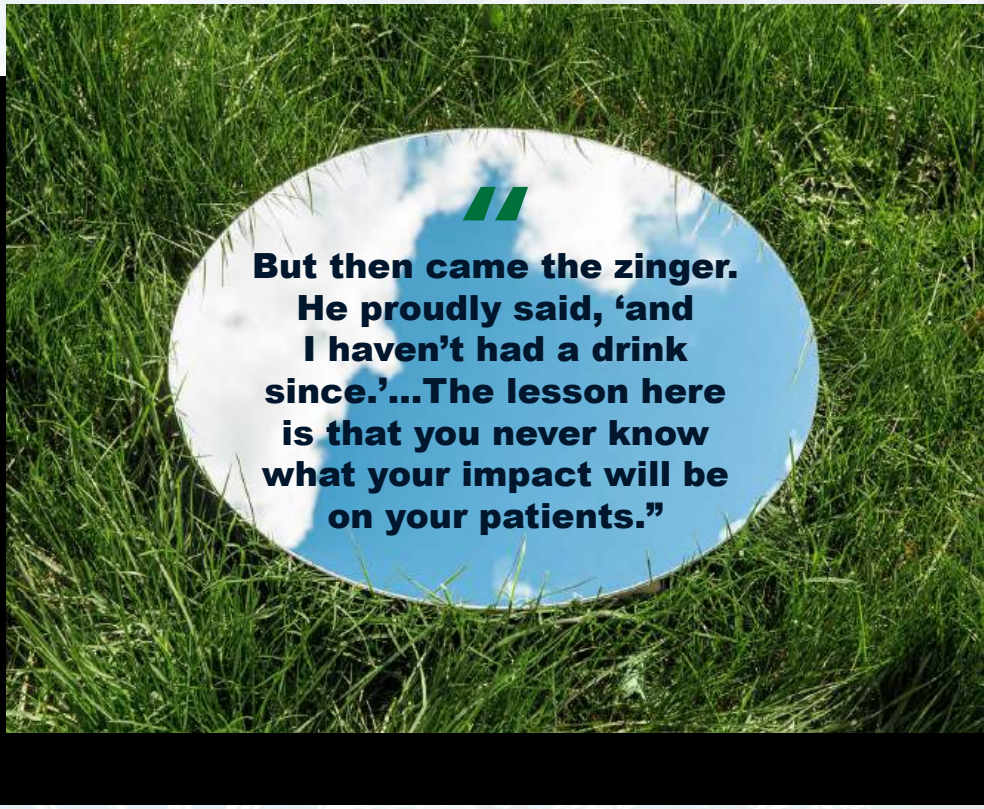
Harry was married with a couple of kids and a good job. He liked to drink and told me that he was a regular drinker, usually going to the local bar a couple of nights a week. Of course, he knew that he drank too much, a feeling that I quietly reinforced. I asked him whether he knew the dangers of excessive

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drinking, that is, his drinking. He did and told me that he wasn't ready to stop yet. After all, he assured me that he was definitely not an alcoholic. Of course, I didn't buy it, and not just because he scored four out of four positives on the CAGE questions.

I kept coming back to the fact that he was, in fact, an alcoholic and all his denial wouldn't change that. I repeatedly pointed out the contradictions between his actions and his story. He drank every day and was almost proud of that fact. And he was sure that his family was not concerned, a presumption that I disabused him of. I also pointed out that his drinking was making him become sicker and sicker, which he also denied, but heard me say it over and over. He didn't have much to say about the cost of drinking, a theme to which I regularly returned. There is really nothing like a captive audience. After a while of mostly me talking about how he was an alcoholic no matter what he thought or say, parrying his denials, and telling him the dangers of alcoholism, he continued to come up with excuses for continuing to drink, I gave him permission to do whatever he wanted, which of course, he didn't disagree with. After about three hours, I finished my suture job. His face looked much better with my well-executed layered closure of his wounds and although covered with lacerations, they were all carefully closed and met my high expectations of what they should look like. I let him sleep it off for a few hours and I discharged him to his wife's care as my shift ended.

Fast forward to six months later. I was back at the same ED for another moonlighting shift. I was caring for a middle-aged woman with chest pain and making the arrangements to get her admitted to cardiology to be ruled out for an MI. I was at her bedside discussing the plan when a man walked up to me. He immediately asked, "Doc, do you remember me?" I had to admit that I see so many patients and that I really didn't remember having seen him before. He then reminded me that six months earlier, I had sutured up a whole lot of facial lacerations. As I looked over his face, seeing a few almost invisible scars, I was very proud of my work.



But then came the zinger.

He proudly said, "and I haven't had a drink since."

Some days are way better than others.

The lesson here is that you never know what your impact will be on your patients. No matter who you think they are when you first see them, and no matter how much you don't like their choices, you have the ability to make a real difference in their lives. Treating all patients with the utmost respect and educating them in ways that they can understand, goes a long way to help them to "conquer" their demons, whether it is drinking alcohol to excess, smoking, using drugs, or just feeling that they can control their health care.

And yes, sometimes it feels like "this is as good as it gets."

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Caught Between Care and Custody: Human Trafficking, Immigration Enforcement, and the Emergency Department

Nicole E. Exeni McAmis, MD*



Emergency departments are designed to be a safe haven for individuals seeking medical care without fear of discrimination or interference. Clinicians are taught to identify and help victims of human trafficking. But there is a new factor to consider: What happens when a patient fears that seeking care could expose them to immigration enforcement? What happens when a patient is already in ICE custody?

An 18-year-old female presents to the emergency department with a chief complaint of abdominal pain. She is accompanied by an older man, who identifies himself as her boyfriend. As the history begins, he answers most of the questions for her. When she does answer, she looks to him for reassurance when answering them. The physician asks to complete the evaluation and examination privately. When alone, the patient begins to describe her living situation, her work situation, her immigration status, and her financial situation. She repeatedly expresses fear about what will happen if she discloses her situation.

This is where human trafficking and immigration enforcement intersect in a way that directly affects emergency care. Emergency physicians often approach human trafficking and immigration as separate issues. However, they can intersect in ways that directly affect whether a patient feels safe enough to seek care, disclose exploitation, or accept help.

For patients experiencing trafficking, fear is already a primary mechanism of control. For undocumented patients, fear of immigration consequences adds another layer of uncertainty. Even when immigration enforcement is not directly involved in the patient's care, the belief that seeking help could expose them or their family may influence what they are willing to disclose.

This creates an important challenge for emergency clinicians: how can trafficking be recognized and addressed while preserving patient safety, autonomy, and trust?

The Emergency Department: A Critical Point of Contact

The Trafficking Victims Protection Act of 2000 defines severe forms of human trafficking to include:

- Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age; or
- The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.[1]

Human trafficking occurs in communities across the country and frequently goes unrecognized. Many victims interact with the healthcare system while still being controlled or exploited, making the healthcare setting an important opportunity to identify potential indicators of trafficking, including physical or sexual abuse, coercion, restricted freedom or movement, psychological control, untreated medical needs, or an

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> **"For survivors of human trafficking who are undocumented or otherwise fearful of immigration enforcement, that fear may be another barrier to disclosure."**

A patient's immigration status does not change the emergency physician's obligation to provide appropriate medical care."

accompanying individual who appears to control the patient's communication or decision-making. Recognizing these indicators can allow clinicians to offer support and connect patients with appropriate resources.

In one study of survivors of human trafficking, 88% reported seeking medical care in a variety of healthcare settings during their exploitation, with the emergency department being the most common point of contact (63.3%).[2,3] A separate study of an emergency department screening program found that 69 of 557 patients (12.4%) assessed over 12 months screened positive for trafficking risk. Of those patients, 56.5% accepted trafficking-specific referrals and 87% accepted some type of resource referral.[4]

These findings highlight an important opportunity for emergency physicians: identification does not necessarily require a dramatic disclosure. Sometimes, it begins with recognizing that something about the patient's circumstances does not fit.

Immigration Fears: Another Point of Control

Survivors are often fearful of their trafficker, law enforcement, loss of housing or employment, or retaliation against family members.[2] For patients who are undocumented, there is a new level of fear: immigration enforcement. Given this new layer of fear, patients do not necessarily know what will happen to the information they share, causing further uncertainty.

For survivors of human trafficking who are undocumented or otherwise fearful of immigration enforcement, that fear may be another barrier to disclosure.

In one study, 12% of undocumented Latino immigrants presenting to two California emergency departments reported fear of seeking care due to concerns about immigration discovery and deportation.[5] Another study showed that undocumented Latino immigrants reported fear of reporting crimes to law enforcement in San Francisco and Oakland because of concerns related to immigration enforcement.[6]

While these studies are not specific to victims of human trafficking, they illustrate a new problem for emergency physicians: fear of immigration consequences can influence whether an undocumented patient feels comfortable visiting the healthcare system designed to protect them. Traffickers may use immigration-related threats as another means of maintaining control. The threat of deportation, arrest, separation from family, or immigration consequences may be enough to discourage a patient from seeking medical care or disclosing exploitation.

Direct research examining the effect of immigration enforcement on trafficking disclosure in the emergency department remains limited. However, these findings highlight an important concern: a patient may be physically safe enough to speak, but may not feel safe enough to state why they need help.

What About ICE?

ICE has a complex role in this discussion. Homeland Security Investigators, a division of ICE, investigates human trafficking and other transnational crimes. Law enforcement investigations can play an important role in identifying trafficking networks and holding traffickers accountable. At the same time, immigration enforcement may be a source of fear for immigrant patients. Law enforcement involvement and patient safety are not always perceived as the same thing by the patient.

A patient's immigration status does not change the emergency physician's obligation to provide appropriate medical care. Under the Emergency Medical Treatment and Labor Act (EMTALA), emergency departments must provide an appropriate medical screening examination to individuals who present requesting examination or treatment for an emergency medical condition, regardless of their ability to pay.[8]

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule also protects patients' protected health information (PHI) and generally does not permit disclosure to law enforcement simply because information is requested. Disclosure may be permitted under specific circumstances outlined in the Privacy Rule, including certain judicial warrants, court orders, subpoenas, and legally authorized administrative requests.[8,9]

An immigration enforcement request does not, by itself, authorize access to a patient's medical information or non-public areas of the hospital. Emergency physicians should understand the distinction between a judicial warrant, which is issued or signed by a judge or magistrate and may carry legal authority to compel access or disclosure, and an administrative immigration warrant, which is issued by immigration authorities and does not, by itself, provide the same authority.[9,10] Physicians should not be expected to independently determine the legal validity or scope of an enforcement document.

If immigration or other law enforcement personnel request patient information or access to a patient care area, physicians should follow their institution's established protocol and immediately involve the designated privacy officer, hospital leadership, risk management, or legal counsel. The physician should avoid independently releasing PHI or

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> **"Above all, give the patient something the trafficker may have taken away: a choice. Restoring even small elements of autonomy can help establish trust and reinforce that the patient's voice and preferences matter."**

consenting to access while the request is being reviewed. Any disclosure should be limited to what is legally permitted and required. The circumstances surrounding the request and the response should also be documented in accordance with institutional policy.

These situations should be addressed before they occur. Emergency departments and health systems should have a written policy outlining how staff should respond to immigration enforcement activity, including who should be contacted, who is authorized to review warrants or other legal documents, how requests for PHI should be handled, and who can provide legal guidance when questions arise. A designated 24-hour contact or escalation pathway can help ensure that clinicians are not left to interpret complex legal requests while simultaneously caring for patients.

Emergency physicians must be prepared to recognize trafficking while ensuring that the emergency department does not become another environment in which a patient feels unsafe.

Red Flags of Human Trafficking

Human trafficking is a profound violation of human rights and a pressing local, national, and global health problem. Victims are reduced to objects for commerce. There is no single presentation that identifies a survivor of human trafficking. Instead, physicians must search for patterns of control, coercion, and fear. Potential red flags include:

- Someone else is speaking for the patient and refuses to let the patient have privacy
- Exhibits fear, anxiety, submission, or tension
- Reluctance to explain injuries or a scripted or inconsistent history
- Signs of physical or sexual abuse
- Reports an unusually high number of sexual partners, STIs, pregnancies, miscarriages, or termination
- Altered mental status or disorientation (e.g., inability to identify location, date, or time)
- Someone else controls the patient's identification documents, money, or phone

While none of these findings independently establish trafficking, they should prompt a closer assessment of the patient's safety and circumstances. The role of the emergency department is to recognize concerning circumstances, provide medical care, assess immediate safety, and connect patients with appropriate resources.

A Step-by-Step Approach to Identification and Response

Step One: Create a Private, Safe Environment

Interviewing the patient privately and using a professional interpreter when needed are important steps in creating an environment where disclosure is possible. Victims of human trafficking often experience deep mistrust due to exploitation by authority figures or caregivers.

It is important to normalize the conversation rather than make the patient feel as though they are being investigated:

- *I ask these questions of many of my patients because I want to make sure everyone is safe and supported*
- *I want to give you an opportunity to speak with me privately*
- *I ask these questions to better understand your situation and connect you with any resource you might need*
- *You don't have to answer anything you're uncomfortable with, but I am here to listen and help if I can.*

It is important to remember mandatory reporting requirements or other legal exceptions that may apply. These vary depending on age, jurisdiction, and circumstance.

Step Two: Assess Safety

Before beginning an interview, consider performing a safety check:

- *Is it safe for you to talk with me right now?*
- *Do you feel safe right now?*
- *Do you feel like you are in any kind of danger for speaking with me?*

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Questions should focus on establishing the patient's circumstances and safety:

- *Do you feel safe where you are living?*
- *Can you leave your job or living situation if you want to?*
- *Has anyone threatened you or your family?*
- *Does anyone control your identification documents?*
- *Are you being forced to work or perform sexual acts?*
- *Has anyone forced you to do something you did not want to do?*

If immigration concerns arise, ask about them directly:

- *Has anyone prevented you from getting medical care?*
- *Has anyone threatened to report you to immigration?*
- *Are you afraid that getting medical care could cause problems with your immigration status?*
- *Has anyone told you that you will be deported if you leave?*
- *Are you worried about what could happen to your family if you tell someone?*

Immigration status should not be used as a proxy for trafficking risk, and trafficking should not be assumed based on immigration status.

Patients should not be pressured by healthcare personnel to voluntarily disclose information to law enforcement, and questions about their legal rights should be referred to appropriate legal counsel.

Step Three: Address Immediate Medical Needs

The immediate medical needs of the patient come first. If the patient is critically ill or medically unstable, prioritize stabilization and emergency medical care. The medical consequences can be extensive, including physical trauma, sexual and reproductive health concerns, infectious disease, mental health conditions, and substance use. Be sure to involve social work, trafficking resources, and legal resources when appropriate.

Step Four: Offer Options and Resources

Trauma-informed care recognizes the widespread impact of trauma and actively avoids re-traumatization by creating a secure environment, maintaining transparency in decision-making, and respecting patient autonomy. This shifts the question from "What's wrong?" to "What happened?"[7]

Patients who have experienced exploitation may have already lost significant control over their lives. Provide the patient with autonomy and respect their rights. It is important to recognize that not every patient will want to report, will want to leave, or will be ready to accept help. The physician may not hear the entire story during the encounter, but a supportive interaction can communicate that help is available if the patient is ready to seek it. Avoid pressuring the patient to disclose more than they are comfortable sharing, and respect their decisions about what happens next.

Above all, give the patient something the trafficker may have taken away: a choice. Restoring even small elements of autonomy can help establish trust and reinforce that the patient's voice and preferences matter.

Available resources for patients include:

- National Human Trafficking Hotline: 1-888-373-7888 or text HELP/INFO to BeFree (233733)
- Local hospital social work/case management
- Immigration attorneys and Department of Justice-accredited representatives can help patients understand their eligibility and available options.

Step Five: Document Objectively

Documentation is particularly important when caring for victims of human trafficking, particularly when law enforcement or immigration authorities become involved. It is important to objectively and clinically report the facts provided and distinguish patient statements from clinical observations. Record the following:

- Patient statements, safety concerns, and objective findings
- Relevant injuries and medical findings
- Consultations and referrals offered or accepted
- If law enforcement requests information, document the request, the identity of the requesting individual when available, and the process followed according to institutional policy
- Document any legal documents presented according to hospital policy
- Avoid unnecessary documentation of immigration status unless it is clinically relevant or necessary for the patient's care

Caring for Patients Caught Between Exploitation and Enforcement

Human trafficking and immigration enforcement may seem like separate issues, but for some patients, they are closely connected. Emergency physicians are in a unique position to recognize how fear, coercion, and uncertainty may affect a patient's ability to seek care and disclose what they are experiencing. Creating a private, supportive environment and connecting patients with appropriate resources can make a meaningful difference, even when the circumstances surrounding the patient's care are beyond the physician's control.

Emergency physicians may not be able to determine what happens after a patient leaves the emergency department, and they may not be able to prevent an enforcement action. They can, however, determine how they care for the patient in front of them: whether the patient is treated with dignity, whether privacy is protected within the limits of the law, whether choices are respected, and whether the patient is offered an opportunity to access support.

For patients caught between exploitation and fear of immigration consequences, that distinction matters. The emergency department should be a place where patients can receive medical care, speak without coercion, and understand that support is available regardless of immigration status. Providing that space may be the first step toward helping a patient recognize their options and access safety and support.

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Continued from page 20 >>

If medication initiation or referral is being considered, breastfeeding, potential drug interactions, sedation, access, cost, and coordination with the patient's obstetric and psychiatric clinicians should all be considered. ACOG's treatment guideline provides recommendations regarding pharmacologic management during pregnancy and the postpartum period, including lactation considerations.[2]

Social History is Medical History

Postpartum depression rarely occurs in isolation. Understanding a patient's social situation is an important part of the emergency department evaluation because it may influence immediate safety, disposition, and the ability to follow through with treatment.

Important factors to assess include:

- Partner support
- Intimate partner violence
- Food insecurity
- Housing instability
- Financial stress
- Immigration concerns
- Social isolation
- Lack of transportation
- Infant medical problems
- Breastfeeding difficulties
- Sleep deprivation
- Recent trauma or loss

ACOG specifically recognizes lack of support and stressful life events as important contributors to postpartum depression.[5]

The Baby Matters—But So Does the Mother

In medicine, it is easy for the focus to shift entirely to the newborn after delivery. In the process, the mother's health can be overlooked. The postpartum period can be physically exhausting, emotionally overwhelming, and medically complicated. Depression and anxiety can make an already difficult transition feel impossible.

The emergency department may be the first place where a mother is asked not only how her baby is doing, but how she is coping. While a single ED visit may not treat postpartum depression, it may be the visit where someone finally recognizes it and actually listens.

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Shiitake Dermatitis Presenting as a Flagellate Erythema in a Middle–Age Female: A Case Report

Adriana Kiz*, Cameron Blanchard*, Meghan Etsey*, Javier Martinez, MD†, and Lilliam Alvarez, MD‡

Abstract

Shiitake dermatitis is an overlooked toxicoderma that appears as a visibly distinct cutaneous reaction. The reaction is characterized by an intensely pruritic urticarial reaction that appears in a flagellate or "whip-like" pattern. The rash appears after the consumption of raw shiitake mushrooms (Lentinula edodes) that contain the thermolabile polysaccharide lentinan. When cooked at inadequate temperatures the toxin remains biologically active and has the potential to trigger this severely uncomfortable reaction. This condition has the potential to last weeks and therefore warrants more awareness as it can be easily avoided through proper cooking. Known to be self-limiting and have a good prognosis, Shiitake dermatitis has a higher known prevalence in countries such as Japan and China due to differences in diet. With globalization, more widespread knowledge of this condition is necessary to avoid this reaction. This would be of particular benefit in urgent care or emergency department settings where quick recognition of this condition relieves concerns of a more serious etiology.

Keywords: Shiitake Dermatitis, Flagellate Erythema, Lentinan, Pruritus, Toxicoderma

Introduction

Shiitake dermatitis is an acute dermatological condition that presents as a distinct generalized rash. It appears as erythematous pruritic streaks often described as "whip-like" that occur after the ingestion of undercooked shiitake mushrooms, *Lentinula edodes.*[1] The underlying pathogenesis involves a hypersensitivity reaction to the toxin lentinan that remains stable unless subjected to a high enough temperature. Otherwise, the cutaneous reaction occurs on average 48 hours after consumption, followed by a persistent inflammatory phase.[2] While most cases are self-limiting and last under two weeks, clinical duration has been documented to last up to 40 days.[2] Shiitake dermatitis only occurs in an estimated 1.8-2.0% of individuals who have ingested the toxin, therefore it is poorly understood and is most likely heavily under-reported in the current literature.[3]

Evidence suggests variable host sensitivity due to differences in genetic predispositions, immune status[1], prior sensitization[4], as well as the fact that it causes effects in a dose dependent manner.[5] This being said, some people may not even appreciate a noticeable effect.[4] On visual appearance this rash seems quite distinguishable, however it appears strikingly similar to a few other dermatological conditions, potentially contributing to it being underreported. Examples of such conditions include; dermographism or the Koebner phenomenon (self-inflicted cutaneous reactions that are the result of trauma or scratching of the skin[6], jellyfish stings[7], and bleomycin-induced flaggellate erythema.[8]

This article was previously presented at a poster presentation at the Lincoln Memorial University at the 10th Annual Essential of Clinical Medicine Conference and Poster Competition on June 12, 2026 and June 13, 2026.

Case Report

A 56-year-old female of Chinese descent with a documented history of allergic rhinitis and no known drug or food hypersensitivities presented to an acute care setting with a 48 hour history of an intensely pruritic, cutaneous rash. The patient remained afebrile, and denied any constitutional symptoms, respiratory distress, genitourinary or gastrointestinal symptoms. Physical examination was remarkable for erythematous, linear streaks in a flagellate configuration across the entire body that the patient insists is not due to scratching (figure 1). The rash seemed to cover the entire body except the palms of the hands, soles of the feet and majority of the face (although it did seem to spread over the scalp and around the circumference of the face).

While the patient reported an uneventful personal and family history of similar reactions or known allergies, her husband reported a subclinical and attenuated rash that was barely noticeable around the same time frame. She and her partner live in the same household and share many of the same meals. The patient noted that they had not used any new soaps/skincare products/laundry detergents or cleaning products—substances known to precipitate unknown allergic reactions. After discussion of what they had eaten in the past two to three days, it was discovered that they had cooked shiitake mushrooms for dinner two days prior to the onset of the reaction. One tablet of loratadine each morning for one week was recommended. After one week of follow up, the patient noted the rash began to subside.

Discussion

Given that the reaction to lentinan is likely dose-dependent and subject to variable host susceptibility, it is probable that the true population incidence remains significantly underestimated and under-reported in current literature.[4] Broader clinical awareness of the condition would be beneficial for several reasons. First off, the easiest and most effective "treatment" for this condition appears to be prevention. Knowledge of the condition and following the proper cooking techniques precludes any costly workups, allergy testing or unnecessary systemic corticosteroid regimens that carry their own iatrogenic risks. Another benefit of clinical awareness is the expedited symptom management for a condition that has the potential to last up to 40 days.[2]

From a psychosocial standpoint, a skin condition of this temporal duration has the potential to impact occupational productivity, cause symptoms of acute body dysmorphia and anxiety, impact sleep hygiene and lead to symptoms of depression.[9] Thus this reaction is not a minor inconvenience, it is a chronic inflammatory state causing a multitude of effects. Embarrassment due to the rash being perceived as something potentially contagious or reflecting poor personal hygiene as it has been known to lead to social withdrawal and

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avoidance of public spaces including ones' work environment, therefore affecting occupational productivity.[9] Severely pruritic cutaneous reactions are also known to negatively impact sleep hygiene. Sleep deprivation and chronic fatigue are therefore serious sequelae to consider in a reaction that has the potential to last this long. Current research suggests that chronic inflammation triggered by long term release of cytokines can also cause feelings of anxiety and depression, exacerbating the clinical picture.[10] Ultimately, the effects of shiitake dermatitis would be easily avoided by more widespread knowledge of the condition. Japan and China have historically had a much higher recorded prevalence of the condition most likely due to dietary habits[11]; however, more widespread knowledge of shiitake dermatitis is necessary with globalization and the spread of diet and culture. With this globalization, quick recognition of the condition relieves concerns of a more serious etiology, particularly in an urgent care or emergency department setting.

Conclusion

Shiitake dermatitis is a distinctive yet under-recognized toxicoderma caused by ingestion of raw or undercooked shiitake mushrooms containing lentinan. This case underscores the importance of recognizing its characteristic flagellate rash to avoid unnecessary diagnostic workups and inappropriate treatments. Increased clinical awareness can facilitate timely diagnosis, guide supportive care, and mitigate the physical and psychosocial burden associated with prolonged pruritic eruptions. Given its dose-dependent and variable presentation, clinicians should maintain a high index of suspicion in patients with compatible dietary history. Ultimately, proper cooking of shiitake mushrooms remains a simple and highly effective strategy for prevention.

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Figure 1: Clinical presentation of shiitake dermatitis on the torso, posterior trunk, and back of the neck. Note the linear, non-confluent streaks that were apparent 48 hours following the ingestion of undercooked shiitake mushrooms.

ABEM Board Recertification

Nicholas Boyko, DO FAAEM – AAEM Young Physician Section Chair



If you became board certified or recertified in 2021 or later, you are on ABEM's new five-year continuing certification cycle. Here is what you need to do to recertify through the American Board of Emergency Medicine (abem.org) continuing certification program:



1

Complete four MyEMCert Modules

- Open-book, online modules
- For physicians in a 5-year certification cycle, the modules have no fee, as they are included in your annual fee (if you wish to get CME for the module, there is a $30 fee paid directly to the CME provider; AAEM or ACEP)
- The intended pace is one per year
- This replaced the old 10-year ConCert exam

2

Complete one Practice Improvement (PI) Activity such as a QI project, departmental metrics initiative, or patient care/process improvement work.

3

Maintain Professional Standing. You must maintain an active, unrestricted medical license and adhere to ABEM professionalism policies.

4

Pay Annual ABEM Fees. Instead of large exam fees, there is now an annual fee. As of May 2026, the annual fee is $330 and is subject to change.

What you do **not** need to do:

- There is no longer a 10-year Continuation Certification (ConCert) exam.
- Lifelong Learning and Self-Assessment (LLSA) activities if you are in a 5-year certification cycle. LLSAs will retire after 2027, and are only available for physicians finishing out the former 10-year certification cycle during the transition.

If you became ABEM board certified prior to 2021 and have not already transitioned to the above model, you may need to complete your 10-year recertification requirements and will transition to the five-year model afterwards. ConCert is no longer offered. Those with a 10-year certification have LLSA requirements in the first five years and MyEMCert requirements in the last five years of their certification. By 2030, all ABEM-certified physicians will have transitioned to the new Continuing Certification process outlined above.

Editor's Note: The original version of this article which ran in the July/August 2026 issue of Common Sense contained errors regarding the ABEM board recertification process. In consultation with ABEM, these errors have been corrected in this version. We apologize for this error and any confusion it may have caused.

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

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

Positions Available

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

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

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

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

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

COLORADO

Southern Colorado Emergency Medical Associates (SCEMA) is hiring full and part time emergency physicians. SCEMA is a democratic group that began in 1979 based in Southern Colorado staffing UCHealth Parkview Medical Center in Pueblo, CO and UCHealth Parkview Pueblo West Hospital in Pueblo West, CO. SCEMA holds an AAEM Certificate of Workplace Fairness and is an AAEM Physician Group member. Come live and work in the beautiful Front Range of Colorado. We offer a superior financial package consisting of a short, 2-year partnership track that receives a competitive hourly rate of $200/hour and then subsequent exceptional income as a partner based upon productivity. Part time positions also available with time spent eligible to count towards partnership. Benefits include a traditional 401(k) retirement plan available at 12 months from hire plus a SCEMA funded Cash Balance Plan available upon partnership. Additional benefits include health insurance, CME, malpractice insurance, compensation for licensing examinations and travel, medical and DEA licensing fees, relocation expenses coverage, night shift differential with a dedicated nocturnist group, and holiday pay. Full time status is approximately 13-14 shifts per month with 8-10 hour shifts. Must be BE/BC in Emergency Medicine. Learn more about our group online at www.scema.info. Please email our VP of Recruiting Dr. Mary Russo at mary.russo@uchealth.org if interested in joining us. Also feel free to reach out to our Medical Director Dr. Tyler Keller at tyler.keller@uchealth.org with any further questions. The above is informational only, and in no way constitutes a binding offer or guarantee of terms. (PA 2229)
Email: Mary.Russo@uchealth.org
Website: http://www.scema.info

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

COLORADO

Join EMSPC, a thriving democratic, physician owned EM group with 40+ years of excellence in the Colorado Springs region. We staff 4 hospitals and 4 Free Standing EDs, including the area's only Level I Trauma Center, giving you the clinical variety and acuity you want - without sacrificing autonomy or lifestyle. We offer an average starting rate of $200/hour for both partnership and non-partner tracks, along with a partnership pathway that includes productivity based income and profit sharing. Our partners average $416K annually before benefits and distributions, working approximately 130 hours per month. Employees can access comprehensive health benefits, malpractice coverage, CME and licensing reimbursements, and flexible scheduling. Outside the ED, Colorado's Front Range delivers unbeatable living - mountain trails, world class skiing, and a vibrant, growing community. If you're looking for a career that rewards your skill and a location that elevates your life, this is it. (PA 2202)
Email: andriagraversen@vitalsignsrm.com
Website: https://coloradoemspc.com/career-ops/

FLORIDA

Emergency Medicine Physician Opportunities – Central Florida East Coast Come for the Job. Stay for the Lifestyle. Emergency Medicine Professionals, P.A. (EMPros) is seeking board-certified/board-eligible Emergency Medicine physicians to join our physician-led, physician-owned group along central Florida's beautiful east coast. This is more than a job—it's a long-term career path with flexibility, strong compensation, and a lifestyle that's hard to match. Choose the Path That Fits Your Goals Partner Track • $185/hour base + $10/hour quality bonus • RVU bonus up to $25/hour • Full benefits package • Equitable partnership opportunity after 36 months • Nominal buy-in • Post-partnership earnings: additional $5/hour + shareholder bonuses 1099 Independent Contractor • $250/hour (day) | $270/hour (night) • RVU bonus up to $25/hour • Flexible independent contractor structure Other non-partner and W2 options also available Why EMPros? • Physician-led & physician-owned • Flexible scheduling options • Supportive, collegial team environment • Clear growth and partnership opportunities Why This Location? • Coastal living with year-round sunshine • Easy access to Orlando, St. Augustine, and Jacksonville • Excellent schools and family-friendly communities • Ideal balance of professional fulfillment and personal lifestyle Let's Connect! Email: Recruitment@EMProsOnline.com Website: www.EMProsOnline.com Phone: 386-310-3519 Instagram: @empros1976 (PA 2205)
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KENTUCKY

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Email: kayla.osborne@pikevillehospital.org
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SECTION II: POSITIONS RECOGNIZED AS BEING IN FULL COMPLIANCE WITH AAEM'S JOB BANK CRITERIA

MARYLAND

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Email: jennifer.ha@som.umaryland.edu
Website: https://www.medschool.umaryland.edu/em/

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)
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Website: http://www.iep-pc.com

OREGON

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

CALIFORNIA

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CALIFORNIA

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Website: https://bit.ly/SCPMG-EMLA

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: kmdiaz@mgb.org
Website: https://massgeneralbrigham.wd1.myworkdayjobs.com/MGBExternal/job/Salem-MA/Pediatric-Emergency-Medicine-Physician-MGB---Salem_RQ4070561

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


AAEM
AMERICAN ACADEMY OF EMERGENCY MEDICINE
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