Taming Complexity, Healing Moral Injury: The EM Mindset Shift Transcript

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Episode Introduction and Revisit

Welcome to a special Heartline Echoes episode where we revisit some of the most impactful conversations from Heartline changemaking in healthcare. This rerun isn't just a replay.

It's an opportunity to reflect, reconnect, and reignite the ideas that continue to shape the future of healthcare. Whether you're hearing this for the first time or returning for some fresh insights, let's dive back into this powerful discussion.

Enjoy. Welcome to Heartline, Changemaking in Healthcare. I'm your host, Dr. Andrea Austin, a board-certified emergency physician, physician development coach, and educator.

After years on the front lines, I've learned that real change in healthcare starts within. Each episode invites you to explore the inner work that unlocks clarity and bold leadership, because healing systems through changemaking begins with following our heartlines.

I'm really excited to have Dr. Shannon McNamara on our podcast today.

Host Welcome and Guest Introduction

I would say that I've been a fangirl of Dr. McNamara's from afar for a long time. We're both simulation educators and for better or for worse, I am on Twitter, I think mostly for better the way that I use it in medical education.

And I always really enjoy what she's posting. And I think she's a very innovative and forward thinking person in medicine. and simulation, and I had the distinct pleasure to meet her in person just a few weeks ago in Chicago at the High Performing Teams Summit.

And we clicked and I'm excited to have you on the podcast today. Andrea, thank you so much for having me. It was a very kind introduction and it was really, really fun to meet up in person in Chicago.

That was a great time. Yes, I'm just cherishing these in-person meetings so much more as we're still in the pandemic. Yes, it was my first trip. It was the first time I got on a plane since COVID.

And I was really pleased. I was able to hold all my COVID boundaries and still have a really great time and connect with folks. And I felt really good.

I'm really happy to hear that because we are going to talk a little bit about COVID today. I think that's a good message to get out to our audience because in-person conference attendance is still down across the board.

And my life is different than your life. And we had different approaches to masking and probably what was OK and not OK. I'm glad to hear that you felt it was a good experience and safe.

Yeah. I'm a high risk COVID person and I'm still getting over long COVID, which was not fun. So I mask at all times in public places and I only eat outside.

So flying was an experience, but I have a heavy stock of N95s and mask stuff and did my thing. And I just wore a mask the whole time and there was a nice outdoor eating space to where I could socialize with folks and the ventilation was really good.

So I had a great time. But it's been a huge adjustment to accepting this new reality that we're in and trying to figure out how things work.

Career Path and Transition Out of Emergency Medicine

Because there's something special about an in-person conference where, yeah, it's kind of an intangible, but it's a space where you can connect and learn and meet people in a way that it's really hard to do with distance.

So I was glad to have that opportunity. Absolutely. Well, let's back up. And for our listeners that maybe don't know you, could you tell us a little bit of your life story, where you're from, your profession, and what you're doing now?

Sure. So right now, I'm in New York City working in an urgent care as a physician. I've had a roundabout story. I grew up kind of all over the Midwest, Northeast, Chicago, Maryland, and a little bit of Germany as a kid.

So I was a nomadic child, then ended up going to med school in Jersey. And I was one of those folks in med school that loved everything. So I decided I wanted to be a generalist.

And I was trying to figure out, you know, do I want to be internal medicine, inpatient generalist, outpatient generalist, more like family medicine or emergency medicine.

And I absolutely fell in love with the emergency department with that. you know, those high acuity, undifferentiated patients. There's just so much going on.

We get to do such really cool procedures. There's always learning. It's always surprising, and I loved it. So I did residency in emergency medicine in Philadelphia.

and then moved to New York and did a simulation fellowship. And then I worked in emergency medicine in New York up until COVID. And I'm in this funky transition period where I was in a high-risk medical position when COVID started.

So I moved to telemedicine and then had some major conflicts in the world of academic emergency medicine in New York and decided to step away. That's a very long story, which we may or may not get to.

then kind of settled on urgent care as the best place for me right now as a board certified emergency physician. So that's where I'm at. Well, there's so much to unpack there.

We really founded this group, this company really grounded in stories like yours. And my story is different, but I also went through, well, Brene Brown would call it a midlife unraveling.

but kind of questioning my place in emergency medicine and also academics. I was always academically minded. I would say my third year of residency, I declared that I liked being in a learning institution and saw my career moving that way.

And then when I left the military in 2020, which in retrospect, leaving a job during the pandemic is really hard and starting a new job during a pandemic is really hard.

So I entered an academic institution and I take responsibility that I probably didn't show up as my best self in that position because I don't think any of us were our best selves during the pandemic.

Or what I'd like to highlight is You said, what I'm doing now is best for me right now. And I think that's a really powerful message. And can you explain how you came to that conclusion and how you're okay with that right now?

Yeah, absolutely. I think, you know, I've been through many rounds of burnout for different reasons. And the pandemic hit me at a time where I was already struggling.

And there were just all these factors that made doing my chosen career path untenable. So in 2020, I was a simulation director at a big fancy academic center in New York City, working as an emergency physician.

I was really struggling before COVID hit with kind of academic politics and trying to do what they hired me to do. So that was in the mix of just, you know, I want to be really good at simulation.

I want to do really good science, really good education. I want to apply this tool and this environment to teach and to improve our performance. And that was very difficult due to the academic politics, which is really intense.

And then in the emergency department, things didn't work very well. So there's tons of boarding. There's a lot of conflict. There are not enough resources.

Staffing is an issue. And so getting through each shift was really difficult. and it felt like we could be doing a lot better. But then on the personal side, the night shifts were very difficult for me with my own health issues.

I think I've gotten hit with just kind of chronic illness after chronic illness, and I'll get one, get it under control, then get another one. Every two years I seem to get some new thing I get to deal with.

It's been really hard to manage my own health and do emergency medicine with night shifts, with the sensory milieu of the emergency department. I had chronic migraines for a while.

Every shift would give me a migraine. So I lived in migraine attack pretty much constantly, which was very unpleasant. So there was that sensory experience of working in the emergency department, the organizational experience of working in a dysfunctional work environment where things didn't really work.

the political, the experience of working in a political organization that was very toxic. And then COVID happened and I was like, I am so done with this.

I can't live like this. And I have two kids and a lovely spouse who I adore. And they are much more important to me than this idea of a career where I would be a successful woman in academic emergency medicine.

Like sure, that's nice, but It's not worth it to me if I'm miserable, my family's miserable, I'm sick all the time, and just living in this unfortunate state.

So when I left my last job, I decided not to look for another position in academic emergency medicine, which that was hard because I've run simulation fellowships for many years.

I've got folks that I trained scattered all around the city, and it's really lovely to see them thriving and running these great simulation programs. I love the learning environment of academics.

I love learning, I love teaching, I love working with residents and doing interprofessional sims in the department. It's so fun. But I decided that the priority was my wellness and my family.

We need to be okay before I can do anything else. So, urgent care has been a really good stepping stone for me right now, where I work two shifts a week, I don't do any nights, I make enough to pay my bills, and I have a good amount of autonomy.

I love undifferentiated acute complaints. And urgent care is like a microcosm of the ER in a lot of ways where I'm seeing lower acuity complaints, but I have a lot of autonomy.

And I work in a center where they're kind of like, all right, you see all the patients, here's your med cabinet, here's your suture stuff, here's your splinting stuff, here's an x-ray, go to town.

And I feel like I have the tools I need to do things the way I want to do them. And it's not perfect. And there are things I would love to improve or have more control over.

But it's enough for me right now. Like right now, I feel like I'm in a state of homeostasis, for lack of better terms. You know, I think I hear ballads and I think, is balance ever possible?

I don't know. But I'm okay. I'm able to be healthy enough. I'm able to spend enough time with my family. I'm able to get enough patient interaction, have enough autonomy.

And I really do miss the learning piece and the academic piece. And so right now I'm just writing on the side and I work on a newsletter that gives me something tangible to work on.

And just focusing on taking that energy that I was putting into designing simulations, running those, doing academic work, and just putting that into writing and speaking and having interviews like this, which are really fun.

Burnout, Moral Injury, and Dehumanizing Systems

Right. And that's one of the things that we talk a lot about is most of us were given one way to have an academic career or an academic outlet. And the truth is there's a ton of different ways for somebody that's intelligent and likes to use their brain.

There's so many different ways to get that outlet without the harm. And I think listening to your story, there was harm happening to you emotionally, physically.

And it's so bizarre to me when I tell some of these stories to people outside of medicine, they're just like, This would never happen in our workplace.

Like HR would be down there. People would be fired. They would be in programs. We would never allow working conditions in which the volume was so loud or all the myriad of different things that we deal with.

So maybe panning out for just a minute. I mean, what bothers me so much is I love physicians and I especially love emergency physicians because we're really smart.

We have so much grit. We are such problem solvers. How did we end up working in systems and conditions that are so dehumanizing to us? I know that's a really broad, weird question, but I'm just curious now that you've had some time away from it, How did we get here?

That's a million-dollar question. When you talk about dehumanizing working conditions, I think that's really what sticks out to me as the issue. So I think simulation has been my strategy for humanizing medicine and humanizing teaching, and I've loved it as a practice.

And once I brought that back to work, and said, oh, wow, if I'm taking what I'm using in simulation to teach and improve and bring it to our department, we really have to address these dehumanizing conditions.

This is out of control. And it's boarding being one example, showing up to work and having just patients lining the hallways and admitted for over 24 hours and miserable.

And I feel like walking into the ER, there's just this wave of suffering that hits you. And then another wave of powerlessness because I can't fix it.

I'm the face of the hospital, and people come in and are like, doctor, I'm hungry. Doctor, I'm in pain. Doctor, I'm throwing up. Help me, help me, help me.

And I give everything I can when I show up, and yet I alleviate that suffering. And I think that's that moral injury piece that comes through. What I've found scientifically that's helping me have some hope is science around complexity, which is what I talked about at the high-performing team summit.

And ultimately, I think the hospitals are so dehumanizing because they've become so industrial and they're so big and they don't acknowledge the complexity of our realities.

And one of the reasons I love emergency physicians is because our whole job is dealing with reality. We don't get

to pick our patients. We don't get to say, oh, sorry, you're fired, go away.

Or like, I'm only going to see patients with renal disease who meet my intake criteria and have this insurance. No, you get everybody. And you're confronted with what's going on in the world and how it works, and you don't get to run away from it, and you deal with it.

And emergency physicians, I think, are amazing at managing complexity and dealing with it. But then when we turn around and look at the hospital as an organization, that's not what's happening.

And where the finances and the resources and the power and how our organizations are set up are not set up to help us thrive in the complex world that we live in.

And I think there's a lot of reasons for that. I've worked in a lot of old, old hospitals. These hospitals were built when women didn't have the right to vote and people of color weren't allowed to be citizens.

And we were still dealing with this or also didn't have the right to vote. But thinking about who gets to have a say in this? Who is this hospital for?

Who are we building this for? Now we live in a world where we're trying to look at power differently and value every person equally. And the systems that were built in a world where that wasn't true are still active today.

So for a concrete example, working at an academic center that had a private hospital and a public hospital and really segregated care and then showing up and saying, wow, the level of segregation that's still inherent in our clinical practices, yes, America was segregated when these hospitals were built.

It's not anymore, why is our practice still like this? It's making us bad at medicine. We need to fix this. And having the system shrug and say, well, this is how it is.

And that being infuriating. So you asked a million dollar question. I don't have one answer. It's a deep tapestry that we have to unravel and look at together.

But we're in a really tough spot right now. I think emergency medicine is at a breaking point. Healthcare in the US and around the world is at a breaking point.

And I think a big piece of that is that our ability to do medicine has evolved faster than our ability to deliver medicine. We have failed to integrate complexity into our processes.

So I had the benefit of hearing your lecture on complexity at our recent conference. So somebody listening, they're driving maybe to their emergency medicine shift right now, and they're hearing what you say, it resonates.

Is there anything that they can do on shift or at their staff meeting to start to bring in some of your ideas and work on complexity in healthcare? Some basic stuff that we've learned works really well in simulation, works really well because it integrates complexity.

So things like regular huddles, debriefs, pre-briefs, you know, team conversations to talk about what's happening, what our goal is, and talking about how things work.

Those are a really powerful tool that are pretty simple, and when you do them regularly, they make a huge difference. One of the challenges in working in a complex environment like an emergency department is that no one person has a complete and current understanding of how things work at any time.

Because things are constantly changing. Resources are constantly limited. We're always having to make trade-offs to make things work. You show up to your shift and they say, oh, we're short on nurses.

There's no IV morphine. There was a monkey pox case down the street a few days ago. So keep an eye out for

that. There's two new COVID variants. And EMS is 10 minutes out with an unstable trauma patient.

Have a good day. That is the reality, unfortunately, for a lot of us. And, you know, what do we do with that? How do we cope with that? Well, we cope by adapting.

So we're constantly making trade-offs. Because things are changing constantly, no one has a fixed full picture of what's happening. So communicating about what's happening with your team regularly.

is a really important way for coping with complexity where, you know, before EMS comes in with a patient, if we can do a quick pre-brief. Hi, I'm Shannon.

I'm the attending. We have a patient coming cardiac arrest. Our priorities are CPR defibrillation, who have everybody go around, okay, I'm so-and-so, I'm the documenting nurse, I'm the med nurse, or I'm on the defibrillator today, I can do airway, those kinds of things.

Very, very simple. It's like painfully simple, and it makes a huge difference. because we're always operating with a limited view of what's happening.

And the more we can widen that lens and say, here's what's going on right now, the better. When I was working in the emergency department, the things that helped me the most were regular team huddles or even just huddling with a nurse to talk through their patients and make sure we're on the same page and share our perspectives on what was happening, share our goals.

Debriefing after resuscitations and pre-briefing resuscitations that we knew were coming in made a huge difference. as a simulationist, also a big fan of the pre-brief, debrief, and huddles.

Complexity, Huddles, and Team Communication

The other reason I really enjoy these huddles is Whether we like it or not, most of us, unless I don't think we have any sociopaths listening to our podcast, I think we've selected those folks out.

But we are wired for connection. Most of us got into emergency medicine because we like talking with other people or communicators. It's so fascinating when you worked at a lot of different emergency departments.

I have one emergency department that there are no huddles and it's weird. We sit together, but we work very separately. And I think it's how the dynamics of revenue generation work that kind of drives the way people act.

I worked at several other places that had a huddle culture and It just made your day better because you felt like you were working together as a team and connecting and sometimes have a moment of chit chat.

It's fascinating when you talk to people that work in offices, there's the water cooler culture catching up, chit chat in the halls. I don't really have that in emergency medicine.

And the huddle is like a very small way to introduce basic human conversation. Yeah, it's the contrast that you talk about between the structure of revenue generation and how that shapes our behavior.

It reminds me of when we're talking about dehumanization. Industrialized healthcare is very dehumanizing because it treats all the people like widgets.

I'm a big nerd. So I dig into the science on like, where do these management practices come from? These are all from factory days. A lot of folks are using science that's 100 years old on how to manage a factory and work with widgets that are very mechanical objects that have no feelings.

And we're working in a complex environment where that doesn't apply. And when you try to apply it, it's miserable. And so a thing I love about strategies that focus on thriving and complexity is they feel good.

because we're acknowledging our reality. We're social people. We want to interact with one another. And in fact, our work depends on us interacting with one another.

When we acknowledge how interdependent we are, we all do better. We do better work. We feel better. Things work better. It's a win-win. I'm guessing there's a few people listening to this podcast that are experiencing similar feelings to what you and I both had.

And you ended up pivoting to urgent care. When I left my academic job in 2021, I pivoted to doing some veteran disability work. And I taught some online courses.

And then I slowly added emergency medicine back in very deliberately on where I would work. When you made that leap, Did you do any deliberate work on values?

That's one of our concepts here that values are really what drive meaning in our lives. And when we get clear on our values. usually that begins to unlock a period of transformation and excitement or I don't know, what's your reaction to that?

Was that a deliberate process for you or pieced it together? It sort of happened how it happened, but values are always a part of it. I think some big values with me, one of the reasons I went into emergency medicine was that it was a take all commerce situation.

And EMTALA says we have to see everybody that shows up. And a conflict with those values is I would see the kind of bills we would send out after those visits, which were, rough.

We're sending out $10,000 bills to people who don't have insurance. And I wanted to do something that I need to pay my bills and get my health insurance, but I don't want to be exploiting patients in doing that.

And it's hard to find the right balance of that in our current system. Nothing's perfect. Working in an urgent care where there's a pretty low bar to entry.

We take most public insurances. So I'm seeing a lot of patients who can't get into most private medical offices based on their Medicaid coverage and our group will see them, which that was important to me.

And if someone's uninsured, they do have to pay out of pocket for the visit. But there's a lot that I can do. I feel like I can be a good doctor there and take care of the folks in my neighborhood and provide quality medicine.

Being mindful of equity and who can get in the door, being mindful of my ability to do good medicine, those are both important to me. Being in my neighborhood, I take the bus to work and I live near where I work and I feel like I'm part of the community.

But I'll be honest, it's been a struggle to look at what other options are out there that are in line with my values. Thought about lots of different things and struggling with that.

I think LGBT health has always been really important to me. And I've thought about ways to get involved doing more queer medicine work and gender affirming healthcare.

Ways to do that, that financially align with my values as well is challenging. But that's another area where I'm interested to explore more. Yeah, so that's really wonderful to hear.

So what I heard from that is justice, equity, and then family. Yeah. Your family. And we think Brene Brown says two values, we kind of stick to like three, I kind of like my four top values.

But I think having those as Susan Davids, a psychologist I really enjoy, talks about how these are guideposts to our lives. So There's lots of different, and that's the other message I want people to understand is again, when you go to residency, whether you're emergency medicine listening or internal medicine, you're only shown a very small

fraction of what you're actually able to do as a doctor.

And once you start laying out what your values are and then what your boundaries are, you know, like you said, I Don't like working night shifts. It makes me feel sick and it just doesn't work for me anymore.

Where there was a time in your life where it may have worked. Okay. It wasn't as much of an issue as it was later. And that's how I'm feeling now too.

And I'm surprised. I'm like, wow. Like in my late thirties, but the night shifts are hitting me harder than I anticipated.

Values, Boundaries, and Choosing Urgent Care

And I think it's okay for us to change. It's okay that. Things were acceptable to me in my 20s. There's a lot of stuff that was acceptable to me in my 20s that now is Not okay.

Yes, there's a lot there. We're human people. We have human bodies. And I'm in my late 30s. And we're going to have to reckon with this as a specialty in emergency medicine because no one has done a full career in emergency medicine with what it looks like right now.

You know, the people that trained me that were nearing retirement, like in their 50s and 60s, They started when medicine was a different beast. And now the degree of volume, the type of expectations, the extra layer of complexity you get with electronic records, emergency medicine is hard.

It's physically difficult work. It's physically, mentally, emotionally taxing. I'm at the point where I'm in my late thirties and I can't do it anymore.

Acknowledging that limitation is really tough. And I wonder, will I be able to do it again? Maybe. I don't know. But I'm trying to create a world for my family and myself where I don't have to go back to the ER for us to be financially well.

That's tough. Like I was a chief resident. I was a great emergency physician. I barely got 10 years out of that gig. I was a D1 athlete in college. I've done a lot of stuff.

I've run some marathons. I'm somebody who's physically quite active, but emergency medicine as a career is something that I physically could not do for more than 10 years.

I'm not that special. I'm not that unique. What does that mean for us as a workforce if our environment is so toxic that people are going to get sick if they keep doing this work?

And what does that mean for our patient? I have a feeling this conversation is going to keep coming up over the next 10 years as more folks like myself deal with that kind of burnout.

That's not just, wow, I'm emotionally taxed by this environment, but oh, I'm dealing with a degree of disability or a degree of occupation-related disability that keeps me from doing emergency medicine.

It's very frustrating. Yeah, I really do think we need a whole shift on how we look at what we're exposed to as emergency physicians. You know, if you just basic compare an emergency physician's shift to an emergency nurse's shift, and I'm not saying this to be mean or condescending, quite the opposite.

Hats off to the nurses. They unionized in California. We got nursing unions. Their pay has gone up tremendously. They have breaks. They have protections.

I watch nurses have boundaries all day about what they will and will not do. They have career mobility. So what I see with my colleagues who are PAs and nurses is that when they are done with emergency medicine, they do something else.

The way we've set it up as emergency physicians is that we train in our residencies, we're board-certified emergency physicians, and then we're supposed to do emergency medicine for 30 years.

And the off-ramps or like the career branches are not very visible or talked about. I did simulation thinking, because people would say, oh, you can't do, this is a really hard job, so you have to have other parts of it.

I trained in simulation so that I could do both. And I was always doing part-time clinical, part-time academic with simulation work. And now that I'm shifting more towards urgent care clinically, which is a good option, I think there's some shame around saying, I can't do this anymore.

And that's a big statement. I've dealt with a lot of grief around that, saying, wow, I can't do emergency medicine anymore. There's a ton of grief around that.

That was not what I expected when I was a chief resident. I thought I would do this for 30 years. But we don't have the same career mobility. And looking at what other options are out there in outpatient medicine for acute care as an emergency physician, You know, we're not trained in the other facets of outpatient medicine that maybe a family physician would do where some family physicians get really niched into like reproductive health care or gender affirming health care or other things, addiction medicine.

And you can go do a fellowship and do something else. But that's another big investment of your time and energy. And emergency physicians are extremely well-trained.

We are incredibly capable people. And I'm imagining a world where there are going to be a lot of emergency physicians who say, I want to do clinical medicine outside the emergency department, whether as a complement or as an alternative.

And we need to talk more about what we're good at and what we can do and identify those opportunities because there's not a good system for this. The need is there.

Like emergency physicians can prescribe suboxone, but there's not a clear route to that. Or we can do gender-affirming health care, there's not a clear route to that.

We can do reproductive health care, but there's a lot we can do and there's not a clear path to get there. Yeah, I think this ties in wonderfully with the EM workforce report that was released.

And so the tagline from that workforce report is that it's projected that we're going to have 10,000 too many emergency doctors 10 years from now. Now I will tell you my gut that's not.

In the evidence of the paper this my podcast i can swear there's no fucking way there's going to be too many emergency positions in ten years i just refuse to believe it the demand signal just keeps going up and up and up for emergency medicine and people like you and me.

I don't see myself doing emergency medicine in 10 years. I'm not even sure if I'll be doing it in five. So you're going to lose people like you and me.

And I also think the younger generation, they're going to have less of a tolerance for the current working conditions than you and I had. So that's number one.

But number two is, again, I think we're just victims of the way the world is instead of what it could be. And I think as emergency medicine physicians, we need to take that back.

understand the healthcare system probably better than almost any other physician. That's why so many emergency physicians do end up doing administration, but that's a problem too because administration's not saving us.

There's different ways to deliver healthcare, whether it's gender-affirming care, reproductive care, teaching our

future physicians and our current physicians how you can open your own medical practice, your own telemedicine practice, get your own malpractice insurance, which isn't as expensive or scary.

as people have made it out to be. I think as emergency medicine physicians, our malpractice has always been tied to the hospital or the group we're working for.

So we haven't really been clear on what is a premium, what does it cover. So increasing the literacy, which by the way, and I'm totally pulling for my friend, Naomi Lawrence Reed, who is on the podcast.

a few episodes ago, that's probably by design. You know, hospitals and groups want us, we are the money makers. So they want us to stay linked to the system.

So if they start to teach us how we could start our own businesses and have our own malpractice and work outside the system, that's not benefiting them.

There are so many problems in healthcare that people like us going out and doing different things, starting our own functional medicine practice or your own ketamine clinic, that is serving a need.

And most of the patients I see in the emergency department right now, they don't want to be there.

Emergency Medicine Beyond the ED

They really, really don't want to be there. And they're really frustrated with not only the care they're getting in the emergency department, They're almost always frustrated with the care or lack of care they're getting outside the emergency department.

So I think more of us need to, you know, pulling from Brene Brown again. Stop, you get frustrated pulling babies out of the river every fricking shift.

We need to go upstream and we have to start creating our own practices and ways of doing things, especially when it's not safe for us to work in the emergency department anymore.

Yeah, it's been really great to work in an urgent care near emergency departments I used to work in. So I'm the one sending people in. And when I was on the other side, people would roll their eyes and say, oh, this again, like they're sending them in.

These urgent care people don't do anything. And I send in one or two people to the ER a day, but it's so amazing to see what I can do before that. So if I'm sending somebody into the ER, I'm going to try to help them go to the right ER that has what they need.

Don't go to that one, go to this one. They have the specialist you need on call that, you know, I kind of know the system because I worked in four or five of the ERs around me and I can send people to the right place.

Or, you know, let me do this workup for you. We're going to do a pregnancy test. We're going to put it on this piece of paper, highlight it. You're going to hand it to the triage nurse and then you won't wait for an hour and a half to get seen because they need that negative pregnancy test before someone will touch you for your abdominal pain.

like trying to go upstream and make things better. And I can do a lot in like, I'm the, you know, we talk about the dock in the box. I'm a dock in a box and I have some great supplies in my box and I do a lot of stuff there.

And it's really affirming to just have those human interactions with patients again. You know, in academics, I've gotten to the point where I'm supervising so many people.

My role was more on team management and running the ED team than individual patient care. And now when I was doing telemedicine, it was just that total shift back to just one-on-one individual patient care.

And I loved it. Just talking to people about how to deal with the acute issue they were having. and helping people navigate this super complex healthcare system that we're working in.

And emergency physicians are great at that. We see everybody and we see what happens on the inpatient side. We know what's going on the outpatient side where we have a huge capacity to help people navigate the system and not waste their time and use our knowledge for good.

And, you know, the US is going through some rough stuff with healthcare right now. We've got a lot of people with long COVID. We've got some major issues with the opiate epidemic and other addiction challenges.

Reproductive healthcare is legally under tremendous threat, and I think having more providers available from either the contraceptive side or the abortion side is huge.

And emergency physicians have capacity to do some of that work. I'm reading the jobs report. It's so narrow. I'm thinking about 10,000 extra emergency physicians.

It's only looking at the ED, and it's not looking at us as clinicians who can do a lot more than that. is also not talking to all the folks that I am texting with who are talking about quitting.

I've got a lot of friends who are coping with the realities of what it means to be somebody in their 30s or their 40s with a family or with a life trying to be an emergency physician.

And it's really hard. And a lot of people are working as little as possible to pay their bills, and that's it, and looking for other careers. So I'm hopeful that we can find high yield things that we can do that can really add value to our communities and help people get care outside the emergency department.

A hundred percent. We have to start changing the paradigm. And I wrote a blog post about we have to go from where emergency department physicians to where emergency medicine trained.

And we had this thing in the Navy that when I was at Navy Trauma Training Center, I was training teams to sometimes operate in hotel rooms or in tents or in a compartment of a ship.

And my trauma surgeon would always say that trauma is a mindset, not a location. And I love that. And I've adapted that to emergency medicine is you were trained to be a pit doc.

You're trained to work in typical emergency department. We are way more than that. I'm really excited actually that I think we can, like you said, add value to our communities and fill these tremendous needs with our unique skill sets.

I love that. You sent me the essay you wrote about the emergency mindset. And I've been going through some really intense grief around not going back to the emergency department.

And what does that mean for my professional identity? And just what you said, emergency medicine is a mindset, not a place. We're not emergency department physicians.

We're emergency medicine trained physicians. That's huge because I'm always going to be that. I have this wealth of experience and I want to make use of it and I don't have to keep working in the emergency department to do that.

Oh, and one other thing I've been thinking about is the medical training system for physicians is that we do a minimum of three years of residency training.

Many of us do for an emergency medicine, which is fantastic. That is when you look at how impeccably trained, how many hours, I mean, most of us are well beyond 10,000 hours.

by the time some of us hit that probably halfway through our residency. And then you look at other people that work in medicine and nurse practitioners, physician assistants, they move between specialties all the time.

You can be an orthopa, or then move to emergency medicine, then move to some family medicine, practice and as physicians, we're very reticent to doing that and with some good reason behind that.

But on the flip side, are we really saying that a physician that's board certified in a specialty is less capable of learning a new skillset than somebody that had, let's be honest, a very small percentage of the training that we had?

There's so much there. I got into the accreditation wars around sim fellowships, where a sim fellowship is an unaccredited fellowship. You work part-time, or it has been, you work part-time clinically and then you get academic enrichment.

And I designed some fellowships. I ran them. I tried to make it an amazing experience for fellows. And I think they really did learn a lot and get a tangible skill they could go forth and use.

But they also got a little bit taken advantage of sometimes, and I say this as a former SEM Fellow, where they're getting paid part-time clinical and they're not getting paid for that training.

So the way it gets funded is a little funky. And we were having these conversations about accreditation and as a national society, like should we accredit some fellowships?

On the one hand, you want quality control, like you don't want people doing stuff that they don't know how to do or saying, oh, I know how to do that.

And they don't know how to do that. But on the other hand, there's this whole separate economic system that thrives off accreditation, where people are extracting value from the accreditation process.

And it's a complete waste. And I was trying to avoid that. I don't want to be spinning my wheels doing all this paperwork and paying someone $2,000 a year to accredit my fellowship when it was perfectly fine to begin with and you're not adding any value.

And I think that's a microcosm of what we're dealing with medical training where You know, what I've been looking at, what can I train in? Like I can learn stuff, like teach me how to do ketamine or suboxone or reproductive health care, gender affirming health care, this kind of stuff.

Like I can learn that. No problem. Who's going to teach me that? Well, you could do a year long fellowship that's H-U-G-M-E accredited and make $70,000 a year and work full time.

Well, that doesn't sound great. Or you can basically take a CME course online for a couple hundred bucks, set up your own shop and do it. We're a little too focused on the formal accreditation, probably because there are these huge organizations extracting value from that process.

And there's other ways that we can learn this stuff and do this stuff.

Grounding, Joy, and How to Connect

And yes, we should be qualified and trained and supervised in doing something new that we don't know how to do. And we need systems to account for that.

But the current systems aren't set up to help us learn new things and actually do it, if that makes sense. It 100% makes sense. Well, this has been just a complete joy.

And I could do this all day. But you and I probably have a few other things we have to do. This is a delight. Thank

you so much for having me. Yes. So just a few, we like to do our rapid fire questions.

We didn't even scratch the surface on some of the things I wanted to cover, but one of the questions we ask a lot of our guests is this moment in the world, in America, in medicine, emergency medicine, there's just so much turmoil and mass shootings and monkeypox and all of it.

How are you staying somewhat grounded or what advice do you have to somebody that's like, their hands are gripping the steering wheel so tight right now and they just don't even know how they're gonna make it through their next shift with everything going on.

Oof, I feel that. The grief of the world is enormous. The things that are happening right now that are terrible and awful are terrible and awful than they are.

There is still room for joy and connection and community and growth and good things to happen. Both things are true. Things that are helping me right now are being honest with myself about what's happening and what my capacity is.

Communicating a lot in my family around how we're dealing with this present moment in ways that we're going to pivot as a family. We're looking at this post-COVID world, looking at our capacity, looking at our kids and what they need and what we need and thinking, where do we want to point our family?

And really being mindful about our values and our boundaries. you know, talking out what that looks like in this really tough reality and then finding routines that work for us.

So right now I live near a beautiful park. I try to take my little one to the park and go for a walk every day. I love the trees. It's good for me. It's good for the little one.

And that routine has been something that's given me so much joy amidst all the trouble. And I do check up on the news and I do stay current, but I've really stepped away from Twitter and other news sources that I use just because the barrage is so much.

And really trying to cultivate what I take in, not in a way to avoid our reality. Like, yes, I know it's bad. I'm not trying to hide under a rock, but I am trying to be mindful of when I take in that information and what I do about it and put limits because the doom scrolling can be really disabling and cause just like that despair.

So for me, it's trees. I love trees. Gotta go hang out with some trees. And I think everybody's got things that give them joy and nourishment and help kind of spark that thing inside that you that helps you feel alive and like a person that's grounded on this planet.

This is tough. It's a tough time. Well, thank you again for sharing your time with us today. How can our listeners connect with you? So I have a newsletter.

It's called Plus Delta. It's on a site called Review. That's R-E-V-U-E. If you Google it, it'll show up. I can send you the link. I am on Twitter at Shannon Omak, though I've set it to private to limit the abilities to be trolled, which is very nice.

So if you send me a friend request and you look like a person that's not a robot, then I will accept it. But yeah, that's where I'm at. Well, awesome.

I've got your website up right now and I'm a subscriber. to the Plus Delta newsletter, which anybody who's not a simulationist, Plus Delta is from the simulation world.

If you learned one thing today, it's something you can take to your shift. It's a way to debrief. You know, what went well? What could have went better?

That's the Plus Delta. So it's such a clever name. I love that. Thank you. Oh, well, thank you again, Shannon. And we should definitely do this again.

And I'm also feeling like we need to put in a proposal to ASAP to do a talk on beyond the typical. So whether the emergency medicine community is ready for this or not, work will not be the same 10 years from now.

And there has to be a few canaries in the coal mine. like us and hey, guess what? We're actually not in a coal mine. I think the lives that we're carving out are pretty cool and awesome.

So I think there's a way to bring our creativity and intelligence and make things better for us and our patients. We're making lives better for physicians and that makes lives better for patients.

We gotta go for the win-win. Yes. All right. Well, awesome. Great to see you, Andrea. Thanks for listening to Heartline, Changemaking, and Healthcare.

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