

# common SENSE



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THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



## PRESIDENT'S MESSAGE

### The Seven Pillars of Emergency Medicine Excellence

by Tom Scaletta, MD FAAEM

During my tenure as President of AAEM, I would like to help move our specialty toward the development of a nationally recognized designation for excellence in emergency medicine. Some of us work at hospitals that have achieved such accolades for cardiovascular or orthopedics services. It is time to firm up measurable, universal criteria that define distinction in emergency medicine and to explore a manner of applying them to medical centers requesting consideration.

For those wondering if such a goal is really worthwhile, let me explain my rationale. First of all, I am confident this will happen whether or not professional societies take the lead. Publicizing quality markers is a direction the public, the government and regulatory agencies seem to be heading. We emergency physicians should actively participate in defining our future rather than having it foisted upon us. Secondly, process improvement efforts begin and succeed with performance measurement. This project may seem overly complex though it really represents a compilation of independent analyses of basic emergency medicine conditions.

AAEM position statements on a variety of topics can be promoted by incorporating them into this blueprint for excellence. For instance, it could be required that physicians are board certified (or prepared) in emergency medicine. Appropriate staffing levels could be mandated directly or indirectly such that average time to see a physician is under 30 minutes and time to disposition under 120 minutes. The number of hours that admitted patients board might need to be maintained below a certain threshold. The number of emergency department beds and type of equipment would have to be commensurate with the annual census. Radiology and laboratory services would need to be appropriately broad and turnaround times short. Basically, your current administrative wish list would need to be granted.

What could be more desirous to a hospital CEO or board member than to be nationally recognized? What could be more important to the public than to have a trusted destination for emergency services based on objective criteria? And, what could be more destructive to unfair profiteers than having to meet reasonable physician qualification and staffing benchmarks? How can this be anything but a good thing?

It will be important to set the bar sufficiently high. Perhaps only five percent of emergency departments would immediately meet the criteria with little or no improvement. However, every emergency department would have potential, no matter if community, academic, urban, suburban or rural. Unlike the percentile ranking system of certain satisfaction survey companies that create external competition, the struggle would be internal. The assessment will need to adapt to each institution rather than a one-size-fits-all approach. Clearly, the devil would be in the details.

I have devised a "Seven Pillars" model that defines distinct areas to assess when measuring the strength of an emergency department. These are listed in the side bar and not necessarily equal to one another in level of importance. Please consider this outline as a starting point in defining true Centers of Excellence in Emergency Medicine and send your feedback to [President@AAEM.org](mailto:President@AAEM.org).

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## THE SEVEN PILLARS OF EMERGENCY MEDICINE EXCELLENCE

### SAFETY

This Pillar is extremely important as it incorporates objective quality of care and outcomes. The work of the emergency department quality improvement committee as well as clinical practice and outcome measures assess the integrity of this Pillar.

### SATISFACTION

This Pillar relates patient perception of quality, which may or may not be technically accurate. This can be measured by third party surveyors or through timely callback systems.

### SOLVENCY

This Pillar addresses financial balance and survivability. It covers such areas as utilization management, optimal hospital subsidy (if necessary) and cost-efficiency.

### SPACE

This Pillar represents the functionality of the facility and equipment from the standpoint of both staff and patients/family.

### STAFF

This Pillar incorporates the quantity, quality, and ratios of physicians, nurses and technician/clerical staff. It encompasses education, experience, professional satisfaction (enjoyment) and retention.

### SUPPORT

This Pillar involves relationships with other departments, administration, expert resources and medical staff. Emergency departments are inter-dependent in a complex healthcare system and should work with the medical staff and hospital administration to assure that patients are well cared for when admission and specialty consultation or transfer is required.

### SYSTEMS

This Pillar involves all emergency department processes such as work systems, policies, guidelines and care pathways. This area most overlaps with technologic advances like implementing advanced information systems.



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#### AAEM Mission Statement

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

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.
2. The practice of emergency medicine is best conducted by a specialist in emergency medicine.
3. A specialist in emergency medicine is a physician who has achieved, through personal dedication and sacrifice, certification by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
4. The personal and professional welfare of the individual specialist in emergency medicine is a primary concern to the AAEM.
5. The Academy supports fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care. Such an environment includes provisions for due process and the absence of restrictive covenants.
6. The Academy supports residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine, and to ensure a high quality of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.

#### Membership Information

Fellow and Full Voting Member: \$365 (Must be ABEM or AOBEM certified in EM or Pediatric EM)

\*Associate Member: \$250 (Associate-voting status)

Emeritus Member: \$250 (Must be 65 years old and a full voting member in good standing for 3 years)

International Member: \$125

AAEM/RSA Member: \$50 (Non-voting status)

Student Member: \$50 (Non-voting status)

\*Associate membership is limited to graduates of an ACGME or AOA approved Emergency Medicine Program

**Send check or money order to : AAEM, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202, Tel: (800) 884-2236, Fax (414) 276-3349, Email: [info@aaem.org](mailto:info@aaem.org) AAEM is a non-profit, professional organization. Our mailing list is private.**



## EDITOR'S LETTER

## “Do Your Duty”

by David Kramer, MD FAAEM

It's election time. As you might have noted, the candidate statements are included in this issue of *Common Sense*. This is your opportunity to have a say - to have an influence on the future direction of our organization. It is impossible to overstate the impact that leadership has on the activities and direction of any organization. If you are planning to attend the Scientific Assembly, you may want to wait for the candidate forum during the business meeting to place your bet, I mean cast your ballot. However, I know that many of you will be unable to join us at our Scientific Assembly in Las Vegas. Nevertheless, each of you can and should still make your voice heard. Take the opportunity to study the candidates' statements so that you can do your best to have your interests represented. Don't drop the ball. Every vote counts.

By now all of you are aware that the AAEM Scientific Assembly is fast approaching. The conference schedule is on our website. The first thing I noted is that once again we have a slate of great speakers presenting on interesting and intellectually stimulating topics. The speaker list looks like a “Who's Who” of great presenters in emergency medicine. The only problem I foresee is the inability of each of us to be in more than one place at a time. In addition, the price is right. Talk about bang for your buck and value for your dollar! As you know, each of you is entitled to a refund of the \$100 fee for the conference. I would like to encourage you to strongly consider donating that money to the AAEM Foundation. Remember that “having the back” of the individual practicing emergency physician is one of the main tenets of our organization. Your continued financial support helps maintain all of AAEM's activities. Keep in mind that there will be plenty of time and options for fun in Las Vegas. Having recently been there, I strongly advise you to secure both entertainment and dinner reservations prior to your trip there. The hotels have an extremely high occupancy rate year round, and as a result, shows and restaurants tend to book early also.

While you are looking through this issue of *Common Sense*, be sure to read the provocative articles from our AAEM president and the president of the Young Physicians Section (YPS). While one contains new ideas and the other tried and true ideas, both are thought provoking and worthy of your time. Many of you may be wondering if joining the YPS is worthwhile. I believe that if you read the three articles originating from that section your answer will be an unqualified “Yes.”

I want to wish everyone a Happy New Year (belated). Speaking about New Year's resolutions, consider how you might get more involved with AAEM. That's one idea that just might pay huge dividends.

I look forward to seeing everyone in Las Vegas!



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October 23, 2006

The Honorable Daniel R. Levinson, Esq.  
Inspector General  
Department of Health and Human Services  
Room 5250, Wilbur J. Cohen Building  
330 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Mr. Levinson,

The American Academy of Emergency Medicine (AAEM) is a national specialty society of board certified Emergency Medicine physicians, a democratic organization with over 5,000 members. It is our understanding that, according to the Office of the Inspector General (OIG) in Opinion 98-4, when a contract management company is paid a percentage of the physician fees, the OIG has determined that such an arrangement may be in violation of the anti-kickback statute contained in the Social Security Act. AAEM certainly acknowledges the safe harbor criteria associated with this Opinion, that fees for management expenses and overhead must be based on fair market value.

It is AAEM's opinion that, problems with fee-splitting arrangements in emergency medicine are rampant. We believe that up to half of emergency physicians are having an excess amount of their professional fee taken illegally. It is known to AAEM that there exist EM contracts where 30% or more of the net revenue is taken by the contract group for providing little more than a scheduling function.

We appreciate that the OIG has authority to impose civil monetary penalties against providers who participate in unlawful kickback schemes and that affirmative enforcement actions by the OIG are being stepped up. We congratulate the OIG on the \$5.9M settlement agreement with PharMerica, the largest civil monetary penalty for a kickback case to date. AAEM believes that there are even greater financial recovery opportunities in emergency medicine for the OIG to consider.

For instance, EmCare, one of the largest providers of emergency physician services, with 329 contracts in 39 states, is responsible for over 5 million annual patient visits and employs 4,500 physicians. The primary revenue source is emergency physician fees, and the total compensation of its non-physician CEO reported in 2005 was \$23M. This corporation, responsible for a large portion of the emergency medicine "safety net," is owned by venture capitalists. The following passage in EmCare's 2005 SEC filing relays its own valid concerns. "Regulatory authorities or other parties, including our affiliated physicians, may assert that, we are engaged in the corporate practice of medicine or that our contractual arrangements with affiliated physician groups constitute unlawful fee-splitting. In this event, we could be subject to adverse judicial or administrative interpretations, to civil or criminal penalties, our contracts could be found legally invalid and unenforceable or we could be required to restructure our contractual arrangements with our affiliated physician groups."

This summer, the Institute of Medicine released "The Future of Emergency Care in the United States Health System", emphasizing the degree of patient overcrowding we are experiencing. HHS published a related report on September 28, 2006, stating that up to half of emergency departments experienced overcrowding in 2003 and 2004, defined in part as situations where urgent patients wait more than an hour. Both studies overlooked an important cause of overcrowding – intentional understaffing of emergency physicians by emergency services contracts holders, a typical consequence of fee-splitting.

By eliminating fee-splitting from the cycle of emergency patient care, resources for care delivery can be increased at essentially no additional cost to the general public.

To repair the frayed emergency medicine safety net, profit derived from fee-splitting must be reclaimed and used to fortify emergency physician staffing levels, the primary factor in patient safety. AAEM urges the OIG to enforce existing laws prohibiting fee-splitting and hold those contract management groups accountable. We would welcome your response to our concerns and would be happy to assist you in facilitating these efforts in any way we can.

Sincerely,

Tom Scaletta, MD FAAEM  
President

c: Leslie V. Norwalk, Esq., Acting Administrator, CMS



Tom Scaletta, MD FAAEM  
President  
American Academy of Emergency Medicine  
555 E. Wells Street, Suite 1100  
Milwaukee, WI 53202-3823

NOV 14 2006

Dear Dr. Scaletta:

Thank you for your recent letter to Inspector General Levinson. He has asked me to respond on his behalf.

Your letter refers to business arrangements whereby physicians are employed by corporations that receive a percentage of the physicians' professional fees for staffing emergency rooms. You suggest that such arrangements may violate the anti-kickback statute.

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce or reward the referral of items or services for which payment may be made in whole or in part by a Federal health care program. 42 U.S.C. § 1320a-7b(b). A determination of whether a violation of the anti-kickback statute has occurred requires a case-by-case analysis of the facts and circumstances of the particular arrangement, including the intent of the parties. If you have information (in addition to the public filing referenced in your letter) regarding a specific existing business arrangement that you believe violates the anti-kickback statute, we would welcome information about the particulars of that arrangement.

This office issues formal advisory opinions concerning the application of the anti-kickback statute and other fraud and abuse sanctions to existing arrangements or arrangements that the requestors in good faith plan to undertake. The procedure for requesting an advisory opinion can be found in the Code of Federal Regulations at 42 C.F.R. Part 1008 or on the Internet at:

<http://oig.hhs.gov/fraud/advisoryopinions.html>

Any of your members who is a participant or who plans in good faith to become a participant in an arrangement of the type you describe may obtain an advisory opinion regarding it by following this procedure.

Thank you for your comments on the general question of fee-splitting arrangements in emergency medicine. Information from concerned citizens is essential to maintaining the integrity of the Federal health care programs.

Sincerely,

Lewis Morris  
Chief Counsel to the Inspector General

## Candidate Platform Statements

The nomination period for AAEM's upcoming elections has ended. All individuals running for an open seat on the board of directors have been identified and the race has begun. Presented here for the benefit of all full voting and associate members of AAEM are the formal platform statements of each of the candidates.

The elections will be held immediately following the Candidates Forum scheduled during AAEM's 13th Annual Scientific Assembly, March 12-14, 2007, at Caesars Palace in Las Vegas. Although balloting arrangements will be made available for those unable to attend the Assembly, all voting members are encouraged to hold their ballots until the time of the meeting. The forum will allow members the opportunity to question candidates directly about their vision of the association and its place in the specialty of emergency medicine. The responses offered in this session, in addition to the platform statements offered here, will provide members with the information they need to make intelligent and informed decisions.

AAEM's democratic election process is just one of the many things that make our organization unique among medical specialty societies. Please review the information presented here carefully, and then make your arrangements to join us in Las Vegas for the Forum and final elections.

Full voting and associate members not planning to attend the Scientific Assembly should return their completed ballot to the AAEM office in the enclosed envelope. Those attending the Las Vegas conference should remember to bring their ballots with them for voting after the special Candidates Forum to be held on Tuesday, March 13, from 12:00pm to 2:00pm.



### William T. Durkin, Jr., MD FFAEM

#### Candidate for At Large Board Member

*Nominated by Peter Rosen, MD FFAEM; Larry Weiss, MD JD FFAEM*

I would like to thank Dr. Rosen and Dr. Weiss for nominating me for a term on the board of directors.

As a member of the board, I will continue to advocate for the community based emergency physician and physician ownership of their practices. Ownership of our own practices is essential to become a recognized force within our hospitals and communities. The Academy needs to continue to defend our training and certification process from other groups who seek a way around this process. It is also my belief that we need to form alliances with other groups both within and without the house of medicine to better serve our membership and their patients.

I feel that I am very well qualified to serve as one of your directors. The Academy has been my passion since becoming a founding member. I have practiced in academic, community centers. My qualifications and previous accomplishments are as follows:

- Founding member of Cal/AAEM. Served on their first board and later, as Sec./Treasurer
- Co-authored the original Fairness Policy
- Co-founder of the Uniformed Services Chapter of AAEM, presently serve as their Sec./Treasurer
- Co-founder of AAEM Services
- Served as a director of AAEM for two terms
- Sec./Treasurer of AAEM – kept dues constant during my term - Only Treasurer to do so
- Member of the Education Committee
- Presently serving as Corporate Compliance Officer for AAEM
- Served in the US Navy as a physician in an operational capacity as well as in a large teaching hospital
- Director of a large community emergency department

The Academy needs to continue to stay abreast of efforts to diminish our specialty and the training required to obtain board certification within our specialty. We must continue to defend ABEM certification as the only legitimate way to become certified to practice emergency medicine. To ignore these challenges would diminish our specialty not only within the medical community but in the eyes of the lay public as well.

I would suggest that we begin to form alliances with other organizations so that we might better achieve our goals. Working with the AMA, ENA, hospital administrators as well as other groups within the medical community can only help to make a much broader impact than trying to go it on our own. There are areas where we share common interests with all of these groups. By working together with them, we can each achieve our goals and help our membership while advancing our specialty and the Academy. Co-sponsorship of certain courses might also be something we should consider in the future.

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# Candidate Platform Statements

**William T. Durkin, Jr., MD FAAEM — continued**

We need to keep focused on our competitive differential advantage and better educate our membership about reimbursement issues as well as defending them against unfair practices by the CMGs and abusive local practices. If physicians are made aware of how charges are determined, what an RVU is worth in terms of dollars, they will have a better understanding of their worth in the marketplace and be less likely to tolerate the practices of some of these groups, in my opinion. AAEM has done quite well in coming to the aid of its members against these groups. Combining education about the marketplace as well as defending against abusive practices would help quite a bit in diminishing some of these groups. The CMG or MSO (medical service organization) should work for the physician group and be contracted by the physicians rather than the physician work for the CMG.

Encouraging the community physicians to become more involved within the Academy remains a challenge. Through the expansion of state chapters we can enable more community docs to become involved and voice their opinion within the organization. Supporting the Residents' Association will allow young physicians to become involved within the organization early in their careers. Hopefully they will continue to be involved once they graduate and become part of a community group. Mentoring new leaders assures that the Academy will continue to grow and prosper.

I have always taken the responsibility of being your representative very seriously. I make it a point at all our meetings to get out and talk with the members. I listen to all that you have to say and share many of your concerns. The information, comments and suggestions you have given me are always taken back to the leadership of this organization. If elected, I will continue to make an effort to talk with as many of you as I can and address your concerns. I feel that I am very qualified to serve as your representative to the board of directors of AAEM. Thank you for your support.



## **Andrew Mayer, MD FAAEM**

**Candidate for At Large Board Member**

*Nominated by Larry Weiss, MD JD FAAEM*

AAEM has played a significant role in my professional career and has aided in my maturation as an emergency physician. When I completed my EM residency at Charity Hospital in 1990, I started working for a single hospital democratic emergency medicine group in the New Orleans area. I also started working part-time at an EmCare hospital. The lessons I learned contrasting these two work environments were both stark and brutal. I soon became a full voting partner in the first and left the EmCare hospital with a full appreciation of how corporate medicine treated

the individual physician.

This led to my involvement with AAEM. I dropped out of ACEP at this time and joined national AAEM. Many emergency physicians like me in Louisiana felt this same sense of a lack of representation by ACEP and were looking for something new. Many of us banded together and started a state AAEM chapter. I was a founding member on the first board of the Louisiana Chapter of AAEM (AAEMLa). I have remained on AAEMLa's board since the organization's founding serving as Secretary/Treasurer, Vice-President and President and am currently the Immediate Past President. We have been able to advocate for emergency physicians in our state in areas including tort reform and the corporate practice of medicine. We have a political action committee which contributes to the campaigns of politicians interested in our causes. AAEMLa has had several very successful annual chapter meetings featuring emergency medicine speakers from around the country. It has allowed a forum for practicing emergency physicians from our state to come together to discuss issues and concerns in a relaxed atmosphere. I am proud of my involvement in the birth of this chapter and its development into one of the largest and most successful state chapters in the nation.

My long term experience in a democratic emergency medicine group will be very useful to me on AAEM's board. I fully appreciate the benefits of being a partner of a democratic single hospital emergency medicine group. My group's stability of over 25 years is a testament to the value of AAEM's goals and vision. We have only board certified emergency physicians who are eager to be given the opportunity to become an equal voting partner in our democratic group. This contrasts sharply from our competing local hospital. Over the past 15 years that hospital has had their emergency department staffed by virtually every major corporate emergency medicine group. There has been a revolving door of over 200 different physicians of every conceivable background at this hospital. Our two hospitals have virtually the same group of attendings who are eager to applaud our care and shake their head at what passes for emergency medicine down the road.

I will bring to the board a totally clinical perspective of the practice of emergency medicine. I will advocate for the clinical practice of emergency medicine and if given the opportunity will fight for the individual clinician. I am honored to be nominated for the board and hope to be part of the continued development of our specialty.

### **AAEM Accomplishments**

#### **Louisiana State Chapter of AAEM**

2005-2006	Immediate Past President
2003-2004	President
2001-2002	Vice – President
1999-2000	Secretary – Treasurer



## Candidate Platform Statements



### Richard L. Paula, Jr., MD FAAEM

#### Candidate for At Large Board Member

*Nominated by James Li, MD FAAEM*

Thank you to Dr. James Li for nominating me. My association with the AAEM goes back almost 10 years. I became interested in organized emergency medicine and AAEM specifically while I was a resident at the now closed Charity Hospital in New Orleans. I got involved after a long discussion with Bob McNamara and somehow found myself as the founding president of the resident section. The resident section was formed as a fully independent arm of AAEM and gained a spot on the main board for the president, and I was quickly able to become party to the high level dialogue within the members of the board. This interaction gave me a tremendous amount of insight and helped guide our section. I authored the resident section moonlighting statement, and still hold true my belief that residents, emergency medicine residents included, should not be practicing independently prematurely.

Since finishing residency, I have been employed at Tampa General Hospital in Florida. I have continued my dedication to ensuring emergency medicine specialist care through increasing emergency medicine training in Florida. We started an Emergency Medicine residency and successfully graduated our first class in 2006 at the University of South Florida. Unfortunately, functioning as the research director of a newly formed emergency medicine residency has taken most of my time, and I have not been as active in the academy or organized EM as I would like.

My primary concern is, and has been, making sure the public gets and expects highly trained emergency medicine specialists every time a patient is treated in an emergency room anywhere in the country. I think it is important for the voting members to know that I have been employed by TeamHealth for the last six years while at Tampa General. Please take it for what you will, I am confident I can contribute to the board of directors discussions, it may prove to be true that I will be able to offer insight from my current position otherwise unavailable.

I have a few items, which I believe AAEM can help by addressing. A good start would be to add to our efforts a plan for AAEM to ask the federal government that all Veteran's Administration hospitals with emergency departments require emergency medicine training for all of its emergency medicine physicians and stop using poorly trained residents and fellows. That is one example; I will work with the board to help push emergency medicine forward in any way possible. Thank you for your consideration.



### Indrani Sheridan, MD FAAEM

#### Candidate for At Large Board Member

*Nominated by Anthony DeMond, MD FAAEM and Tom Scaletta, MD FAAEM*

To paraphrase a 12<sup>th</sup> century saying, if I can do good, it is because I am standing on the shoulder of giants. It is an honor to once again be nominated to serve on the board of directors for AAEM. I thank you all for your support.

The past decade has seen phenomenal growth in our specialty, due to the sustained efforts of those who fight for the rights of practicing emergency physicians and the patients we care for. The leaders of AAEM, both past and present, are Giants. What they have achieved on our behalf is incredible. We are challenged everyday to do more with fewer resources, budget cut-backs, frivolous litigation, restrictive contract arrangements, overcrowding and the increasing complexity surrounding every aspect of our daily practice. These pressures make it difficult to do what we came to work for: save lives, decrease suffering and do the best for our patients. Effecting change is not a battle that the individual physician or group can win alone. AAEM has taken up our cause, their vision lighting the way, their knowledge, skill and commitment providing a safer passage through treacherous waters.

The AAEM leadership is asking for our help, to sustain that momentum, to lead the way, carry the flag, to contribute fresh ideas and solutions to the evolving issues. The future climate of emergency medicine is shaped by our choices today. I have been a member of AAEM for five years, and a practicing physician working as much in the community ED setting as in academics. I am one of you. If I can bring your needs, your concerns, our collective vision directly to the ears of the leadership, perhaps we can be even more effective.

AAEM has afforded me the opportunity to serve on the Education and ACCME committees, the International Committee, to teach in the Oral Board courses, to lecture both nationally and internationally and to actively participate in the wider fraternity of emergency medicine. I have learned how to write policies, how to lobby for change, how to ask the right questions that get to the heart of what obstructs us in our daily practice, and to think about ways to fix some of the problems. The rights and privileges for which AAEM fights, allow me to hold my head high wherever I go, and to be proud to be a specialist in emergency medicine. It is time for me to contribute more deeply to the foundation and backbone of the organization. With your vote for board of directors, I can accomplish that goal. With your trust, I will be your instrument and your voice.





## Joanne Williams, MD FAAEM

**Candidate for At Large Board Member**

*Nominated by Shahram Lotfipour, MD FAAEM*

I am a founding member of the American Academy of Emergency Medicine. I have been active on the Education and International Committees. I am also soliciting participation for the Minority Affairs Task Force, of which I am Chair. That committee is, at present, still in development. I am currently the Secretary of the California Chapter of AAEM.

For the California Chapter of AAEM, I directed a course as a pre-conference session at the Scientific Assembly in San Diego, on "Pain Management and Care of the Terminally Ill." The Medical Board of California accepted that pre-conference for fulfillment of AB487 that became law through Business and Professions Code Section 2190.5. Last year, I directed a course, also sponsored by the California Chapter of AAEM, that was well attended entitled "Trauma Resuscitation for the Community Doc" as a pre-conference activity to the AAEM Scientific Assembly in San Antonio, Texas. I will be directing an encore presentation of "Trauma Resuscitation for the Community Doc" at the 2007 Scientific Assembly in Las Vegas. As a board member, my concentration will be on issues that impact the well being and future of all emergency physicians. Two of these issues are discussed as follows:

Does the emergency physician have due process? In most instances, No! Case in point, Doctor X moves his family to Anyplace, USA to take an Emergency Physician (EP) position at No Name Hospital. Two months later, Doctor X is told that his group has lost the ED contract and because of a no compete clause he has to go too – in 30 days! His "new" group partners knew the contract was ending when they hired Doctor X but chose not to inform him. The only other hospital in Anyplace, USA does not need any EPs at present. Sound familiar? This is yet an ongoing problem for EPs – lack of due process.

Back to that critical care issue! Good grief, even gynecologists and obstetricians may qualify for certification in Critical Care! EPs cannot! The EP is a REAL Critical Care Specialist. By the time the Intensive Care Physician or Cardiologist receives his or her patient, the EP has "pulled" the patient through the initial critical phase of illness. How many times has the EP physician been called to evaluate, intubate, treat or resuscitate an unstable patient in the ICU? How many times has the EP remained in the ICU treating critical patients until the critical care "specialist" arrives? Some EPs say we don't need a critical care "title," we don't need a "piece of paper," we know we are critical care specialist. Maybe, maybe not, but we deserve the right to certification and perhaps, that "piece of paper" may mean mo' money, mo' money.



## Mark Reiter, MD MBA

**Candidate for AAEM Board, Associate Member**

*Nominated by Tom Scaletta, MD FAAEM*

I am pleased to accept the nomination for re-election to the AAEM board as associate member. Over my past 18 months on the AAEM board, I have developed an excellent working relationship with the other members of the board. I have also served on the AAEM Services Board, helping to oversee business activities such as AAEM templates. I have also posted synopsis of important AAEM topics on the AAEM Discussion Forums, to keep our members well-informed. I worked with the American Medical Association to strengthen the language of a policy, that we were

able to successfully pass, that enables the AMA to assist medical societies in combating corporate practice of medicine abuses. I reviewed the S-1 filings for the TeamHealth and EMCare IPOs and created fact sheets for the AAEM board and our members. I also have worked to make the new AAEM Young Physician Section and the AAEM-AAEM/RSA Critical Care Task Force a reality.

As past President of the AAEM/RSA, I supervised our transition to a wholly-owned subsidiary of AAEM, and underwent a substantial reorganization of the AAEM/RSA. We created many new opportunities for our members and offered a variety of new benefits, including Career Network and membership discount programs.

I have also participated in AAEM committees, having served as chair of the Board Certification Taskforce. In this capacity, I have advocated against alternative board pathways for non-residency trained physicians, particularly in recent challenges in Florida, Oklahoma, Utah, and North Carolina. I also served on the EMTALA Committee, the EM Practice Committee, and participated in AAEM/RSA Committees. A member since 2001, I firmly believe in the AAEM mission and hope to have the opportunity to serve the associate members of AAEM.

I am well prepared for this role, through my prior experiences on the board of the Medical Society of New Jersey, the AMA Council on Legislation, as Vice-Chair for the North Carolina Medical Society RFS, and through roles in many

*continued on page 10*

## Candidate Platform Statements

Mark Reiter, MD MBA — continued


other organizations, as well as having earned an MBA with concentration in Health Care Policy. I'm asking for your vote, as I have the experience, skills, and enthusiasm to help AAEM continue to thrive.

American Academy of Emergency Medicine involvement (2001 to present)

- Board of directors, AAEM
- Board of directors, AAEM Services
- Board of directors, AAEM Resident and Student Association
- President, AAEM Resident and Student Association
- Vice President, AAEM Resident and Student Association
- Chair, AAEM Board Certification Taskforce
- Chair, AAEM/RSA Communications Committee
- EM Practice Committee
- EMTALA Committee and EMTALA Pointers column editor
- Liaison to AAEM-Young Physician Section
- Liaison to AMA-Resident/Fellow Section

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# EMTALA Does Not Protect Against Misdiagnosis

by Kathleen Ream, Director of Government Affairs

On October 27, 2006, the U.S. Court of Appeals for the Eleventh Circuit summarily affirmed the prior federal district trial court decision rejecting an inadequate screening claim brought by Vickie Bryant against John D. Archbold Memorial Hospital and Michael Arthur Crowley, M.D. (*Bryant v. John D. Archbold Memorial Hospital*, 11th Cir., No. 06-13168, 10/27/06).

Bryant initially sued defendants for violation of the federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395 dd. This complaint also alleged that the hospital and Crowley, the ED physician who attended to her, were liable to her under Georgia law for medical malpractice. The district trial court granted summary judgment for the defendants on the EMTALA claim and declined to exercise supplemental jurisdiction over the state law malpractice claim. Bryant appealed the grant of summary judgment on the EMTALA claim.

Although the appeals court decision is unpublished, this case appears to begin with plaintiff Bryant presenting at the John D. Archbold Memorial Hospital ED following a September 2004 motor vehicle accident. Notwithstanding the substantive attention Bryant received from ED staff, her ruptured spleen was not detected. Bryant alleged that the ED physician who treated her failed to examine her abdomen. Although the court was mindful that plaintiff and defendants disagreed as to whether the doctor “physically touched” Bryant’s abdomen during the screening, the district court determined that this particular factual dispute was not relevant and significant.

The court wrote that the “specific steps undertaken by a physician during the medical screening are not the focus of the EMTALA’s safeguards . . . EMTALA does not require hospitals to provide an examination whereby every conceivably relevant examination or test is completed.” Rather, EMTALA requires hospitals to provide a medical screening similar to the one which the hospital would provide any other patient. Thus, under EMTALA the plaintiff is obliged to furnish evidence proving how the screening received deviated from the standard screening provided at the respective hospital ED.

The trial court iterated that “EMTALA protects against inadequate screening, not misdiagnosis” such as in the failure to detect an injury. Absent the necessary facts to meet the legal requirements to file a legitimate lawsuit, the trial court found that Bryant failed to allege an actionable complaint under EMTALA. The trial court also ruled that once the claim was dismissed, it was within the court’s discretion to decline to exercise supplemental jurisdiction over the state medical malpractice law claim pursuant to 28 U.S.C. § 1367(c)(3).

The federal appeals court determined that the trial court, the U.S. District Court for the Middle District of

Georgia, “appropriately analyzed the EMTALA statute and the record evidence and properly determined that no dispute existed as to an issue of material fact.”

District Court Rules Claims Are Medical Malpractice Not EMTALA

On October 2, 2006, the U.S. District Court for the District of Puerto Rico dismissed a lawsuit claiming that a hospital violated EMTALA (*Alvarez v. Vera*, D.P.R., No. 3:04-cv-01579-HL, 10/02/06). The plaintiff was Emily Martínez Alvarez (“Martínez”) and her husband Erasmo Quiñones González. The defendants were Dr. Ariel Bermúdez Vera, Dr. Miguel Meneses, Hospital Hermanos Meléndez, JDG Medical Corporation, P.S.C., Sindicato de Aseguradores para la Suscripción Conjunta de Seguros de Responsabilidad Profesional Médico-Hospitalaria (SIMED), and the American International Insurance Company of Puerto Rico (AIICO).

## FACTS

On August 13, 2003, the plaintiff Martínez was diagnosed with a cholelithiasis condition. Co-defendant Dr. Ariel Bermúdez issued admission orders for Martínez to undergo a laparoscopic cholecystectomy which was performed by Bermúdez on August 18. During the procedure, it was found that Martínez had a dilated common bile duct and cholelithiasis. Subsequently, Martínez developed a high fever on August 20, and was kept at the hospital under observation until August 21, 2003. Prior to discharge Bermúdez entered a report that Martínez was stable and afebrile and scheduled a follow-up appointment with Martínez for the following week. On a discharge summary dated August 21, Bermúdez reported that Martínez had recovered from the surgery.

Martínez alleged that during the surgery, Bermúdez transected her common bile duct and did not realize the damage caused. She also claimed that Bermúdez did not perform any tests to determine the reason for her fever and that she had symptoms of peritonitis, severe pain and a fever when she was discharged. Martínez suffered abdominal pain from August 22 through August 25, 2003.

On August 26, Martínez went to the Hospital Hermanos Meléndez ED because she was suffering severe abdominal pain. She signed an authorization for treatment and was admitted. Dr. Miguel Meneses evaluated Martínez and ordered multiple laboratory tests and medications. Meneses did not consult with Bermúdez until after the laboratory and x-ray examinations were ordered and the results were received. Martínez subsequently was admitted to the Hospital Hermanos Meléndez by Bermúdez.

The next day, on August 27, 2003, Bermúdez performed tests to rule out his initial impression of an injury to Martínez’s common bile duct. The results of the hepatobiliary (HIDA) scan were received on August 28

*continued on page 16*

## Upcoming AAEM-Endorsed or AAEM-Sponsored Conferences for 2007

### January 22-25, 2007

- Best Evidence in Emergency Medicine Course (BEEM)  
Silver Star Mountain, British Columbia, Canada  
Sponsored and organized by McMaster  
University, Continuing Health Sciences Education.  
<http://www.beemcourse.com/index.html>

### January 27-31, 2007

- Rocky Mountain Winter Conference on  
Emergency Medicine  
Copper Mountain, Colorado  
Sponsored by Beth Israel Deaconess Medical Center,  
Boston, MA, Brigham and Women's Hospital, Boston,  
MA, Denver Health Medical Center, Denver, CO  
and others. (Please see conference website for  
complete list of sponsors.)  
[www.coppercme.com](http://www.coppercme.com)

### March 12-14, 2007

- AAEM 13<sup>th</sup> Annual Scientific Assembly  
Caesars Palace, Las Vegas, Nevada  
Sponsored by the American Academy of Emergency  
Medicine  
FREE Registration for AAEM Members  
<http://www.aaem.org>

### April 14-15, 2007

- AAEM Pearls of Wisdom Oral Board Review Course  
Chicago, Dallas, Los Angeles, Orlando, Philadelphia  
Course sponsored and organized by the American  
Academy of Emergency Medicine  
<http://www.aaem.org>  
Registration opens January 17, 2007.

### May 13-16, 2007

- 15<sup>th</sup> World Congress on Disaster and Emergency  
Medicine  
Amsterdam, The Netherlands  
Sponsored by the World Association for Disaster and  
Emergency Medicine  
[www.wcdem2007.org](http://www.wcdem2007.org)

### May 15, 2007

- A Consensus Conference on Knowledge Translation in  
Emergency Medicine  
'Establishing a Research Agenda and Guide Map for  
Evidence Uptake'  
Sponsored by Academic Emergency Medicine: The official  
journal of the Society for Academic Emergency Medicine  
Chicago, IL  
<http://www.saem.org/saemdnn/Meetings/AnnualMeeting/AEMConsensusConference2007/tabid/362/Default.aspx>

### May 24-26, 2007

- High Risk Emergency Medicine  
Hotel Nikko, San Francisco, CA  
Conference sponsored by San Francisco General Hospital  
and the Department of Emergency Medicine at the  
University of California, San Francisco  
[www.HighRiskEM.com](http://www.HighRiskEM.com)

### June 28-July 1, 2007

- Giant Steps in Emergency Medicine 2007: The Sun, the  
Sea...and CME  
Sea Crest Oceanfront Resort and Conference Center  
North Falmouth (Cape Cod), MA  
Conference co-sponsored by Giant Steps in Emergency  
Medicine and AAEM.  
[www.GiantSteps-EM.com](http://www.GiantSteps-EM.com)

### September 15-19, 2007

- The Fourth Mediterranean Emergency Medicine Congress  
Hilton Sorrento Palace, Sorrento, Italy  
Sponsored by the European Society for Emergency  
Medicine (EuSEM), the American Academy of Emergency  
Medicine (AAEM) and the Italian Society of Emergency  
Medicine (SIMEU)  
[www.emcongress.org](http://www.emcongress.org)

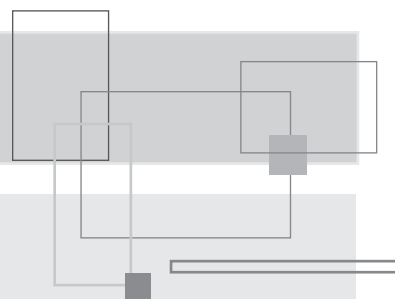
Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Tom Derenne to learn more about the AAEM endorsement approval process: [tderenne@aaem.org](mailto:tderenne@aaem.org).

All endorsed, supported and sponsored conferences and activities must be approved by AAEM's ACCME Subcommittee.

## CHANGE OF E-MAIL ADDRESS

If you have changed your e-mail address or are planning to change it, please contact the AAEM office at (800) 884-2236 or [info@aaem.org](mailto:info@aaem.org) to update your information.





# AAEM Young Physicians Section

## PRESIDENT'S MESSAGE

### Board Certification

by David D. Vega, MD FAAEM

I have to admit that the oral boards generated more than a little stress for me. The 63 days spent waiting for the results seemed more like 63 months. I would fluctuate frequently between feeling good about the exam to being sure that I failed. When the letter from East Lansing arrived, I only read the first word, "Congratulations," before I yelled a big "YES!!" and initiated my victory dance as my wife stood by, giving me that special look that only a spouse can give that says without words, "You are a strange man." Okay, maybe I was a little over-jubilant, but in that one moment, all of those years of training and studying felt officially validated.

Some time later, as the initial excitement began to wear off a bit, I began to think a little more about the whole issue of board certification. What is really so important about it? Should we be *that* concerned about a series of two examinations?

To find some answers, we can start by looking at the simple yet profound mission statement of the American Board of Emergency Medicine – "The ABEM mission is to protect the public by promoting and sustaining the integrity, quality, and standards of training in and practice of Emergency Medicine." ([http://www.abem.org/public/portal/alias\\_\\_Rainbow/lang\\_\\_en-US/tabID\\_\\_3333/DesktopDefault.aspx](http://www.abem.org/public/portal/alias__Rainbow/lang__en-US/tabID__3333/DesktopDefault.aspx)) Therein lies the crux of the importance of board certification. To ensure that the vast volume of patients cared for in emergency departments receive the best care possible, it is critical that residency training and board certification remain the standard for the practice of emergency medicine. The average emergency physician will likely have well over 50,000 patient encounters over the course of a career. These patients deserve the assurance that their physician has met the accepted standards required of a board-certified specialist.

Emergency medicine has evolved greatly since it was first officially recognized as the 23<sup>rd</sup> medical specialty in 1979 – and it continues to do so. During the infancy of our specialty, it was necessary and appropriate to have

practical experience serve as a substitute for formal training in emergency medicine. Clearly, with the many advances our specialty has made in knowledge and technology, "on the job training" is no longer appropriate. Thus, board certification must involve more than just passing the qualifying and oral examinations. We must remember that these are only two measures of the specialists' ability to adequately practice emergency medicine. Board certification actually begins for each new batch of candidates every year around July 1 with the commencement of residency training. It is only through intense, appropriately-supervised training that one can gather the basic skills necessary to practice emergency medicine today.

I know these concepts may seem like no-brainers, but there are many who still try to argue against the necessity of residency training and board certification so that they might be considered on an equal level with the fully-trained specialist. Fortunately, there were visionaries ahead of us who realized the associated risks to patient care and formed the AAEM to help protect our specialty against those acting solely in their own interests. I would encourage you to learn about the history of emergency medicine as a specialty and of AAEM as the organization that truly supports the specialty. Check out the AAEM website ([www.aaem.org](http://www.aaem.org)) and read some of the amazing history that has enabled us to practice as we do today. As the newer generation of emergency physicians, we must stay alert to the threats that face our specialty, just as our predecessors have in the past. Each of us must also serve as an advocate for the specialty on every occasion afforded us and continue to set high standards for ourselves and our residency graduates.

I hope the new year is going well for you, and I urge you to make this the year that you renew your efforts to support your specialty by getting involved with AAEM and the YPS.

**AAEM/RSA members please make sure your e-mail address is up to date. The AAEM/RSA elections will be held soon and votes are cast online. Notification of online voting and passwords are sent out by e-mail. Please contact the AAEM/RSA office at 1-800-884-2236 or by e-mail at [info@aaemrsa.org](mailto:info@aaemrsa.org) to update your information.**

## AAEM Young Physicians Section

### Getting Involved

by Michael Bohrn, MD FAAEM

"Get involved." It's something we hear a lot and in a variety of settings. In emergency medicine practice, it's something that is sometimes very difficult to do. On the heels of November's ABEM Board Exams, this phrase carries a bit more weight. Many of you remember the stresses and sacrifices associated with preparing for the ABEM Qualifying (Written) and Oral Exam. For those of you who have not yet taken the boards, you will know this soon enough! Over the last few years, I have heard colleagues from all over the country say how stressful taking the oral board examination can be. Now is the time to act and to help your fellow emergency physicians who are preparing to take this exam. Once you have successfully completed your board exams, your involvement can take a variety of formats. AAEM sponsors and runs an outstanding oral board preparation course in Philadelphia, Orlando, Chicago, Dallas and Los Angeles twice each year. Enthusiastic and energetic faculty members are always needed. Participating as a faculty member provides a number of benefits. First, it allows you to meet and interact with colleagues, both students and other faculty members, from diverse areas and clinical experiences. It also allows you a chance to hone your clinical skills and to see how other physicians, from different training programs, practice. Giving back and helping students who are preparing for one of their most stressful professional experiences is an obvious plus. Finally, participating as faculty for one of the premier oral board preparation courses is a great way to add to your professional experience and to help the Academy with its educational mission.

Of course, you can also help your colleagues without formal participation. Call a friend from your residency class and run through a few cases on the phone. Offer to help out a junior colleague in your current practice group. Call your residency and offer to give the current residents a few board preparation or clinical practice pointers. It's amazing how much this type of support can mean during your preparation for the boards.

Prior to achieving ABEM Board Certified status, there are also opportunities to create "win-win" situations. When preparing for the qualifying exam, form study groups with others you know from your local area, AAEM or other organizations, or your residency program. Offer to help out with formal or informal reviews at the residency from which you graduated or your local EM residency. These sessions are great learning experiences for current residents and also allow you to review material and even learn some new things. Alternatively, if no EM residency is nearby, offer to do educational sessions for nurses, paramedics, PAs, NPs or other provider groups. A relatively small amount of effort on your part can translate into big benefits in the respect and teamwork categories. And, you have the added benefit of enhancing your own learning. Formal teaching opportunities in written board review courses may also be available.

As you can see, there are many ways to assist your preparation for the boards. ABEM Board Certification is one of the cornerstones of AAEM membership and represents a significant milestone in your professional career. One of the keys to doing well is to continue reading and studying following completion of your residency. Finding creative ways to study and to provide benefits to others is a challenge, but it can be done. The ideas above may help guide you in this process, but the rest is up to you. *Being* involved has many potential benefits, especially during the early stages of your career. Getting involved is up to you!

*Michael Bohrn is the Associate Program Director at York Hospital and a member of the Young Physicians Section. If you have an idea for an article you would like to have published in the YPS pages of Common Sense, please email YPS president David Vega at [dvega@yorkhospital.edu](mailto:dvega@yorkhospital.edu).*

## MEMBERSHIP



Membership in the Young Physicians Section (YPS) is open to emergency medicine residency trained associate or full voting members of the AAEM who are within the first seven years of practice after residency or under the age of 40. The YPS has been formed with the goal of promoting the advancement of its members' knowledge, careers and involvement in AAEM activities. To join or for more information, go to <http://www.ypsaaem.org> or email [info@ypsaaem.org](mailto:info@ypsaaem.org).

# AAEM Young Physicians Section

## Ask the Expert

by Joel M. Schofer, MD  
Secretary-Treasurer, AAEM Young Physicians Section

“Ask The Expert” is a Common Sense feature where subject matter experts provide answers to questions provided by YPS members. This edition features a leading authority on EMTALA compliance, Stephen A. Frew, JD, Vice President-Risk Consultant, Johnson Insurance Services, LLC, of Madison, Wisconsin.

Question: What are the most important aspects of the Emergency Medicine Treatment and Labor Act (EMTALA) that a young emergency physician needs to understand?

(Submitted by Michael A. Bohrn, MD FAAEM FACEP, Associate Residency Program Director, Clinical Assistant Professor, Department of Emergency Medicine, York Hospital, York, PA)

Answer: EMTALA has numerous critical issues for compliance, but among the most important issues for new physicians to understand are these eight points:

1. EMTALA is an arbitrary government regulation -- logic or standard of care have nothing to do with it. It is like the IRS code -- the rules are the rules, and all of your logic and good intentions will not help a bit. Compliance is not optional or a matter of medical judgment or practice style.
2. EMTALA utilizes similar words to medical terms, but the definitions are entirely different. For instance, the EMTALA term “emergency medical condition” has a much broader definition than the medical term “medical emergency” or “emergent.” A patient has an emergency medical condition until all standard procedures for evaluating the patient prove they do not have one of the specifically defined conditions included in EMTALA and they are not at risk to deteriorate from or during transfer or following discharge. Forget the medical definition -- learn the legal definitions and how they are applied by the regulators.
3. EMTALA compliance is a “full contact sport.” ED physicians must be the patient advocate at all times, but that often puts the ED physician in a juggling act with conflicting demands from hospital administration, third party payers and general medical staff versus EMTALA regulations. ED physicians are often casualties in the process.
4. Good care alone does not count under EMTALA -- you have to comply and give good care, but you also have to clearly document all elements of your compliance. An omitted element, signature or blank check box can result in a citation. Illegible entries don’t count. Reliance on check box systems is helpful but is not sufficient. Federal courts have stated that the record must reflect a narrative that describes the physician’s evaluation, thought processes and plan of care -- always write or dictate a summary paragraph on even the most minor of cases. Always issue written discharge instructions that are legible and in lay language, and have a signed copy of the full form in the record -- good discharge instructions will often save you from gaps in the ED record.
5. Never forget that you are the physician with eyes on the patient. Do not let a private attending or consultant talk you out of the need for admission or evaluation over the phone. You will always live to regret it -- but your patient may not. The same doctor who told you to send the patient home will be the first to say that it is your fault BECAUSE you sent the patient home.
6. Expect professional standards of your ED nurses, but treat them with professionalism and respect -- some day they will be in the position to save you from a terrible mistake or a simple compliance oversight that could make your life miserable. Will they want to save you?
7. Not everything is EMTALA. You will often be told that something “violates EMTALA” and often it is pure fiction or intentional deception. Know the rules so you don’t get jerked around.
8. Head pain, belly pain, frequent visits to the ED, possible drug seeking conduct, intoxicated patients, suicide gestures and psych patients are ALL high risk for EMTALA violations.

There are many more concerns to EMTALA compliance, but getting these eight areas under control will go a long way toward reducing the EMTALA risk to the ED physician.

Mr. Frew’s website at [www.medlaw.com](http://www.medlaw.com) features current information on EMTALA and other medical-legal and risk management issues. His latest book on EMTALA compliance is the EMTALA Field Guide ([www.emtalafieldguide.com](http://www.emtalafieldguide.com)).

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, nor the U.S. Government.

If you have a question that you would like to have answered by an expert in a future issue of Common Sense, please send it to [jschofer@gmail.com](mailto:jschofer@gmail.com).

and revealed findings compatible with choledocholithiasis, suggesting an abdominal CT correlation and finding that Martínez could be suffering from reflux of the stomach or a biliary leak.

On the following day, August 28, Martínez was again examined by Bermúdez who reported that Martínez's problem was a bile leak and recommended that she be transferred to Hospital San Pablo for an Endoscopic Retrograde Cholangiopancreatography (ERCP) exam. Martínez claimed that this examination was unnecessary since Bermúdez had already asserted a positive diagnosis of injury to the common bile. Nonetheless, Martínez signed a Department of Emergency Room consent for transfer and on August 29 Martínez was transferred to Hospital San Pablo and submitted to an ERCP exam.

Martínez was thereafter admitted at Hospital San Pablo under the care of Bermúdez who performed the surgery to repair Martínez's bile duct injury on September 4. After the surgery, Martínez was transferred to the intensive care unit of the hospital where she stayed for four days. On September 19, 2003, Martínez was discharged with altered liver enzymes, elevated bilirubin levels and suffering from pain. Martínez claimed that she experienced constant pain and discomfort since the laparoscopic surgery was performed.

Plaintiff alleged that Hospital Hermanos Meléndez violated EMTALA in three instances: first, when they discharged Martínez on August 21, 2003, with an unstable medical emergency and without providing her further medical treatment and examination available at the hospital; second, when they failed to conduct an appropriate medical screening examination when Martínez arrived at the Hospital Hermanos Meléndez ED on August 26, 2003, and third, when they transferred Martínez on August 29, 2003, to another hospital in an unstable state and without informing her of the risks involved.

Defendants moved for summary judgment on the grounds that 1) the hospital, through its physicians and staff, screened and stabilized Martínez in accordance with EMTALA requirements and provided necessary and adequate medical treatment and 2) the claim was a medical malpractice claim brought improperly under EMTALA, therefore failing to establish a legitimate federal cause of action.

#### I. Discharge on August 21, 2003

The court noted that Martínez was admitted to the hospital following a previously scheduled elective laparoscopic cholecystectomy on August 18, where she remained for treatment of complications from this operation until August 21. The court determined that although plaintiff received medical treatment during that time, it is the quality of said treatment that was being challenged in the suit before the court. Under EMTALA protections, wrote the court, "a hospital's negligent or malfeasant care of a patient is not covered . . . EMTALA is an 'anti-dumping' statute, not a federal medical malpractice statute."

Plaintiff's first claim failed because EMTALA only applies if the hospital knew an emergency condition existed. The discharge on August 21, 2003, did not qualify as an EMTALA violation even if it were a misdiagnosis, in which case the court suggested would be better remedied under commonwealth medical malpractice law.

#### II. Emergency Room Screening on August 26, 2003

Plaintiff objected to the hospital's failure to perform abdominal x-rays or to provide immediate antibiotic treatment when Martinez presented with a fever, severe pain, elevated white blood cell count, and symptoms suggestive of peritonitis. Though the statute calls for an "appropriate medical screening examination," the court stated, "it is silent as to what qualifies as 'appropriate'." A hospital fulfills its statutory duty to screen patients in its ED if it provides for a screening examination reasonably calculated to identify critical medical systems that may be affecting symptomatic patients. "The very fact Plaintiff was admitted to the hospital and received continuous treatment is prima facie evidence that screening was effectuated," the court determined.

The district court also noted that EMTALA requires that the hospital must act "consistently with its customer screening procedure, even if said procedure would be inadequate under state malpractice law." To prove that the screening was not evenly handled, plaintiff has the burden of providing evidence to prove that Martínez received materially different screening than that provided to others in the same condition. "There is no indication that the hospital did not follow its own protocol in this case," the court found. It reinforced that an allegation that a hospital "emergency room staff are negligent is insufficient to state a claim for violation of EMTALA."

#### III. Transfer on August 29, 2003

If an emergency condition is detected during screening, then the hospital must either provide further medical treatment required to stabilize the patient or transfer the patient to another hospital in accordance with subsection (c). 42 U.S.C. 1395dd(b)(1). Martínez presented with an emergency condition and the hospital knew of this condition; therefore, leaving only the question as to whether Martínez was stable at the time of her transfer.

EMTALA defines "stabilized" as meaning "that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility." To prove a transfer violation under the statute, the plaintiff must "show not only that the patient was not stabilized and was not accepted by the receiving hospital, but also that the doctor knew or should have known that risks of transfer outweighed the benefits."

Although the hospital argued that Martínez was stable at the time of her transfer, it held that even if Martínez was not stable, she was properly transferred pursuant to the EMTALA requirements. "A hospital may transfer an unstable patient with an emergency condition if the patient or a legal representative gives informed consent

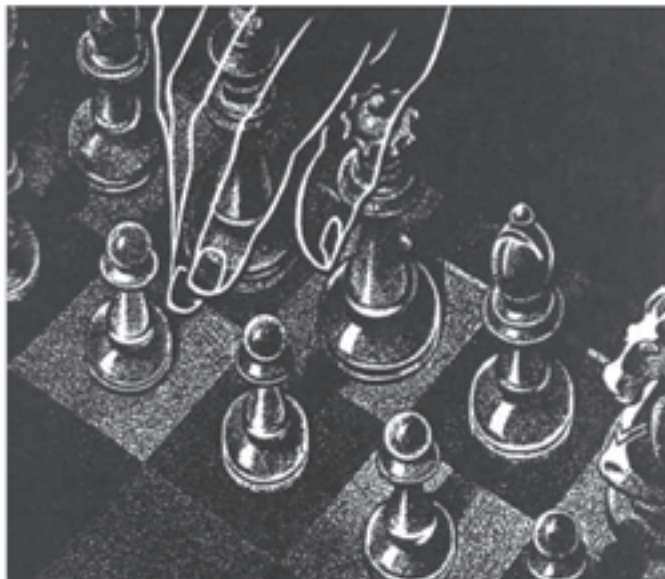
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or if a physician certifies that the anticipated benefits outweigh the risks of transfer."

The court found that Martínez was transferred to a hospital less than five minutes away in order to undergo an ERCP test, which was not available at Hospital Hermanos Melendez. The court also thought it significant to note that plaintiff was transferred under the care of the same doctor, Bermúdez, who treated her at Hospital Hermanos Melendez. "Bermúdez also assumed primary physician duties at the receiving hospital and eventually performed the surgery on Martínez at that hospital," the court wrote.

"It appears from the record that Martínez was indeed stable at the time of transfer," the court determined. "She had been admitted to the transferring hospital for 3 days prior to the transfer, and remained at the receiving hospital for 6 days after transfer but prior to her surgery. There is no indication that her condition worsened in any way during this time." The court stated

that the statutory definition of a "stabilized" condition was met and the transfer did not violate EMTALA safeguards.

An interesting court rationale also was included regarding the issue of the benefits and risks of the transfer. The court proffered that even if it accepted that Martínez's condition was not stable at the time of transfer, the evidence showed that Bermúdez believed the benefits of transfer (namely the availability of an ERCP diagnostic test) outweighed the risks. "On the transfer form," stated the court, "Bermúdez indicated as a benefit that '[p]atient can be evaluated with ERCP'. He left blank the space for indicating risks. The Court finds this sufficient to show the doctor had considered the totality of circumstances and found the benefits as indicated outweighed the risks, if any . . . Hence the conditions necessary to effectuate a proper transfer of an unstable patient were also met. Plaintiffs' final EMTALA claims is without merit."

The full text of the decision is available at <http://op.bna.com/hl.nsf/r?Open=psts-6uamgr>



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## RESIDENT PRESIDENT'S MESSAGE

### Half-way Through the Year

by Brian Potts, MD MBA - AAEM/RSA President

The winter months are always a great time of the year in each residency program. Despite the bad weather outside in many parts of the country, our emergency departments are warm, bustling engines of activity, full of sick patients needing our help. After getting settled into our new roles within the department during the summer and early fall, our interns, junior and senior residents have kicked themselves into high gear. Rotating students have a few more months under their belt to prepare for rotations in the emergency department. It is less likely that you have to worry about seeing "c/o chest pain" on a chart of a patient presenting with a chief complaint of an ingrown toenail or "lethargic" on a chart of a two-year old child who is running around their room while eating his bag of Cheetos. Things are good. Since we are half-way through the academic year, I thought I would write down a few tips and suggestions for residents at each level of training.

#### Interns

You should now feel much more comfortable seeing bread and butter emergency department patients. Try to start seeing more patients and stretch outside of your comfort zone occasionally to see how you can manage a greater number of cases at the same time. You'll begin to develop techniques that improve your efficiency. Periodically, review all your active patients and what work-ups are still pending. Use the short intervals of free time to collect lab/radiology data, check on patients and update your nurses with any changes in plan. Try to set aside some regular time at home or your favorite reading location to start systematically reading your EM textbook of choice (Rosen, Tintinalli, etc.) to increase your emergency medicine knowledge-base.

During your off-service rotations (OB, trauma, orthopedics, pediatrics), make it a point to read all relevant chapters regarding care of that respective patient population. During your ICU rotations, cover the chapters on resuscitation, cardiac and pulmonary procedures. Do as many procedures as possible while in the ICU and improve your skills in caring for the critically ill. You know that most medicine residents planning to go into endocrinology or oncology don't really care too much about central lines. If they aren't excited to do procedures on their patients, offer to do the procedures for them. Finally, be glad that you only have to be an intern for another few months.

#### Junior Residents

You are probably feeling tired and working more shifts than you'd like. In most programs, the junior residents

typically are worked the hardest and have the most shifts. Hang in there. Stick to a regular reading schedule when you have time. Don't forget about making some progress on your scholarly activity (research, etc.). You don't want to leave the entire project: collecting data, writing a manuscript and seeking a publication or presenting at a conference (if required by your program) for your final year of residency training. Spend time with your family and friends for balance. They have made it half way through your residency with you. Don't forget to thank them for their support.

#### Senior Residents

You can almost see the light at the end of the tunnel. Many should be fully entangled in their job search. "What are you going to be doing next year?" is the most common question you are asked by colleagues and staff. If you are one of the lucky ones who already have a definite answer to this question, be thankful. If not, don't worry. Create a professional resume (CV) to utilize throughout your job search. Decide on a city or region where you want to work and continue your search with a focused strategy. Make a list of every emergency department in that area to collect and record information. If you have a contact through a past graduate, faculty member or other networking, give that person a call and let them know you'd like some time to speak with them about their department and potential job opportunities. Find out which groups manage the local emergency department contracts in the area. (Editor's note: Keep in mind that some jobs are not widely advertised. Call the ED directors. You might be surprised to find an opportunity where you didn't think one existed.)

Go to [www.aaemrsa.org](http://www.aaemrsa.org) and check out the Career Network website. Career Network is an AAEM members-only resource to search an online database of physician contacts. You will be able to find practicing emergency physicians throughout the country who have offered to provide information and guidance on the job search and practice environments in their region.

If you don't have a contact at certain hospitals, get a phone number from the phone book, call, get connected to the ED and say you would like to get the name and phone number for the emergency physician who is the medical director. Give them a call and say that you are a graduating resident and would like to set up a time to meet with them. Easy enough. Go to any local emergency medicine conferences that are held to network with local doctors. Many have discovered that multiple job opportunities are available after a few hours of investigation. After

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## Setting Up Your International Elective

by Daniel Nishijima, MD and Christina Bloem, MD  
SUNY Downstate/Kings County Hospital

In 2002, Academic Emergency Medicine published an article (Dey, CC et al. Acad Emerg Med 2002; 9:679-683) that looked at the influence of international emergency medicine (IEM) opportunities on residency program selection. The authors polled all the EM interns that year and asked a variety of questions regarding international medicine. A whopping 91% of interns who responded stated an interest in IEM or international health, while 82% stated they would like to see more IEM exposure in their respective residency programs. Moreover, 62% stated that they ranked programs with IEM opportunities higher than programs that did not have IEM opportunities.

International electives are always hot topics among emergency medicine interviewees along the interview trail so these numbers are not a surprise. Although most prospective residents want the opportunity to do an international elective during their residency; as residents enter their final year of their emergency residency, the number of residents that actually do an international elective is far below 91%.

So what happens to all this excitement and hoopla over doing an international elective? Granted, as residents progress through their residency, it is not an uncommon phenomenon for idealism to erode and harden into realism. It can also be expected that marriage, children and financial barriers prevent many from fulfilling their international medicine aspirations. Many residents may not have access to the right resources. In addition, some residents might simply run out of time to set up a foreign rotation.

Here are a few suggestions on arranging an international emergency medicine elective:

### 1. Start early!

Of course this can be said for anything we decide to tackle, but it applies with added weight when setting up an international elective. Many of us have taken month long trips before, and we know how much planning it takes beforehand. Moreover, there are always unforeseen obstacles and requirements that pop up. Vaccine and visa requirements may take months to fulfill. There are also funding opportunities in the form of grants, scholarships or even departmental support that take time to apply for.

Here are some links for scholarship and funding opportunities:

<http://info.med.yale.edu/ischolar/description.html>  
[www.globalhealth.arizona.edu/Funding\\_Links.htm](http://www.globalhealth.arizona.edu/Funding_Links.htm)

### 2. Know what you want.

It is important to know what kind of experience you are looking for. You should know early on where geographically you might want to go, what language you may want to learn/improve/master and what type of setting you would want (urban vs. rural, developed vs. third world, stable vs. war torn). However, it is important to be flexible, because while there are many opportunities out there, it is never exactly as one imagines. Also, make sure you have a clear educational plan as most (if not all) residency directors will be hesitant to approve what appears to be a month long vacation.

### 3. Explore your resources.

Some residency programs make it easy. They have an established international medicine presence, either with an IM fellowship program or with international rotations in place where they send residents each year. Other programs may have very little international medicine presence. However, usually there is a contact knowledgeable in international opportunities in every program. Emergency medicine is a small world, and everyone seems to know someone if you look hard enough.

Meanwhile, the internet is an extremely valuable tool, full of hidden opportunities. "Many programs have established rotations that can be applied for and can be identified and contacted easily via the internet," recommends Dr. James Sadock, Director of the International Emergency Medicine Division at Kings County/SUNY Downstate Medical Center.

Here is a list of websites that may be used as starting points for internet searches:

- [www.inmed.us](http://www.inmed.us) (central organization that links students/residents/physicians to places to do an elective for 1-2 months, very organized, provides an "international medicine diploma" when the elective is completed)
- [www.geocities.com/medicsabroad](http://www.geocities.com/medicsabroad) (diverse site with many links to other sites)
- [www.missionfinder.org](http://www.missionfinder.org) (Christian missions around the world)
- [www.adventistdirectory.org](http://www.adventistdirectory.org) (Seventh Day Adventist mission directory, accepts non-religious also)
- [www.cabroad.org.uk/vacs/MEDEL.htm](http://www.cabroad.org.uk/vacs/MEDEL.htm) (has a nice summary about how to search for an elective as well as links to other sites)

*continued on page 22*





## Resident Journal Review

This is a new column providing journal articles pertinent to EM residents. It is not meant to be an extensive review of the articles nor is it wholly comprehensive of all the literature published. Rather it is a short list of potentially useful literature that the busy EM resident may have missed. Residents should read the articles themselves to draw their own conclusions. This edition includes articles published over a two month period, October and November 2006.

- Daniel Nishijima, MD, David Wallace, MD MPH, Christopher Doty, MD and Amal Mattu, MD.

1. Nieman CT, Manacci CF, Super DM, Mancuso C, Fallon WF. Use of the Broselow tape may result in the underresuscitation of children. *Acad Emerg Med* 2006;13:1011-1019.

The Broselow color-coded system is the most widely used tool to estimate a child's weight based on the child's length in pediatric resuscitation. Previous studies have shown that the Broselow tape is more accurate than clinical estimates of weight. The authors decided to reevaluate the concordance of the Broselow tape with the measured heights and weights of a community-based population of pediatric patients given the increased rates of obesity in children. Pediatric patients were from two cross-sectional cohorts from a suburban and an urban community. In all patients the Broselow tape correctly identified the child's color zone in 66% of the children. The best concordance was in the infant group. The tape predicted within 10% of medication dosages in 55-60% of all patients. There was a greater tendency for patients to be underdosed than overdosed. Caregivers should consider the potential inaccuracy of the Broselow tape during pediatric resuscitation.

2. Hollingsworth JM, Rogers MA, Kaufman SR, Bradford TJ, Saint S, Wei JT, Hollenbeck BR. Medical therapy to facilitate urinary stone passage: a meta-analysis. *Lancet* 2006;368:1171-79.

This was a meta-analysis that included nine studies concerning the medical facilitation of urinary-stone passage. The premise is that relaxing the ureter in the region of the stone and increasing hydrostatic pressure proximal to the stone may help to facilitate ureteral stone passage. Such relaxation can be accomplished by giving adrenergic alpha-antagonists and calcium-channel blockers, the effects of which are mediated through the active calcium-channel pumps and adrenergic alpha-1 receptors present in ureteral smooth muscle. The authors found that patients on alpha-blockers or calcium channel blockers had a 65% greater likelihood of stone passage than those not given this therapy. This finding suggests that medical therapy may be an option for facilitation of ureteral-stone passage in patients suitable for conservative management. If these findings are prospectively validated, it could reduce the need for surgery for some patients. The number needed to treat in the pooled dataset was four.

3. Luhmann J, Schootman M, Luhmann S, Kennedy R. A randomized comparison of nitrous oxide plus hematoma block versus ketamine plus midazolam for

emergency department forearm fracture reduction in children. *Pediatrics* 2006;118:e1078-e1086.

Children 5 to 17 years old with forearm fractures (n = 102) were randomized to two groups: 1) ketamine intravenous (1 mg/kg) and midazolam (0.1 mg/kg; max: 2.5 mg) or 2) 50% nitrous oxide/50% oxygen and a hematoma block 2.5 mg/kg of 1% buffered lidocaine. All patients received oral oxycodone 0.2 mg/kg at triage. Patients were videotaped at baseline, during procedure and after reduction and scored using the Procedure Behavioral Checklist score by a blinded observer. Both groups resulted in minimal changes in distress during the fracture reduction. However, the nitrous oxide/hematoma block group did have fewer adverse effects (statistically significant less ataxia, nightmares and hallucinations). Perhaps the most impressive finding in the study was that the nitrous oxide/hematoma block group had significant less recovery time (16 vs. 83 minutes).

4. Jones AE, Yiannibas V, Jhonson C, Kline JA. Emergency department hypotension predicts sudden unexpected in-hospital mortality. *Chest* 2006;130:941-946.

In this prospective cohort study, authors enrolled 4,790 nontrauma ED patients >17 years old admitted to the hospital and found that 887 patients (18%) had at least one episode of hypotension (SBP <100 mm Hg) in the ED. Patients with an episode of hypotension had a higher in-hospital mortality at all time points compared to patients without hypotension. Overall, patients in the hypotension group had a threefold increase in incidence of in-hospital mortality (8.3% vs. 2.8%). Moreover, patients in the hypotension group had a tenfold higher risk of sudden, unexpected death (2% vs. 0.2%). Using multivariate analysis, the presence of a SBP <100 was determined to be an independent predictor for in-hospital mortality.

5. Eskin B, Readie JE. Should proton pump inhibitors be used for acute peptic ulcer bleeding? *Ann Emerg Med* 2006; 48: 624-26.

This abstract presents a Cochrane Database systematic review assessing the efficacy of proton pump inhibitors when compared to placebo or histamine type 2 receptor antagonists. Six trials were included in the

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# Resident & Student Association

*Setting Up Your International Elective . . . - continued from page 20*

## **4. Dot your I's and cross your T's.**

First of all, involve your program director early so that he/she is aware of your plans and can approve your elective month. Do not forget to schedule (or request) a convenient time for your elective month. If not planned for, you may get stuck with an elective month at the beginning of the academic year leaving you with little time to set something up. Moreover, if you plan to do an elective month in Mongolia for example, do not get stuck with an elective month in the dead of winter.

You also need to find out what type of malpractice insurance your host institution will require and the necessary documents that may be needed. "In my experience, the less developed the country, the less the emphasis on things like insurance and restriction in patient care," says Dr. Sadock. Housing is another important issue to tackle early on, especially if it is not provided by the host institution. It may be difficult to find housing that is conveniently located, safe and affordable so it may require a lot of investigation beforehand. It is advisable to contact someone from the hospital or program who knows the area well and can give you tips on where to find housing.

## **5. Consider your health.**

Be sure to check the immunization requirements and malaria prophylaxis recommendations of the country to which you are traveling. Dr. Lawrence Proano, Director of University Emergency Medicine Foundation's (UEMF) International Emergency Medicine Fellowship at Brown University, recommends bringing treatment for traveler's diarrhea (e.g., Ciprofloxacin). Dr. Proano also emphasizes attention to other commonly overlooked dangers of international travel such as motor vehicle accidents which are among the leading causes of death when traveling to 3rd world countries (ref: Travelers' Health: Yellow Book Health Information for International Travel, 2005-2006). Other dangers include sunburns, STDs, alcohol or drug related crimes/injuries and jet lag/sleep disorders.

Dr. Proano highly recommends obtaining medical evacuation insurance which costs about \$3/day (e.g., MEDEX insurance; <http://www.medexassist.com/individual.cfm>). "We are used to American standards of rapid care and treatment, and in case of a mishap, it may be necessary to evacuate the traveler back to the States. This can be very expensive, up to six figures for a medically equipped jet, with MD, RN, pilot, etc. And they won't even leave their base until their fee is fully paid!" states Dr. Proano.

## **6. Cultural awareness.**

As with most travel experience, your overall experience with the country and the culture is multiplied the more you learn about it beforehand. Spend some time reviewing the history and the culture of the country you are traveling to and at least learn some of the native language. In addition, Dr. Sadock reminds us, "Remember that your way may not necessarily be the right way, even though you are a formally trained U.S. based emergency physician – not everyone practices like we do, and although that is not always a good thing, you'd be amazed how much you can learn by watching quietly and by mindfully practicing cultural sensitivity."

## **7. Have fun!**

Above all, most residents that do an international elective find that it was one of the highlights of their residency. It is an incredible opportunity to enrich your education as an emergency physician as well as enriching yourself as a person. Many residents also pair their elective time with their vacation and schedule a week or two for travel in the area. Andy Gorlin, MD, volunteered as a staff physician at Maluti Adventist Hospital in Lesotho, Africa, in 2004 for one month. He combined the rotation to line up with his vacation and spent the next two weeks traveling through game parks and coastal cities throughout South Africa.

*Resident President's Message . . . - continued from page 19*

interviews take place and you get one or more job offers, have a good lawyer review the contracts. Find and hire a lawyer who has reviewed physician employment contracts, and specifically, emergency physician contracts. In the long run, this money will be worth every penny and could save you much time, trouble and even more money in the future. Finally, make sure to enjoy your last few months of residency. We will miss our department, the staff and fellow residents more than we think.

## **CORD Academic Assembly, March 1- 3, 2007**

For residents who are considering an academic career, consider attending this CORD meeting in Orlando. This meeting provides the opportunity to meet with residents, faculty, program directors and chairs from all over the country. Some of the best speakers in emergency medicine

gather to share ideas, network, and mentor: teach and learn strategies to start and advance an academic career. There will be a resident track on March 2nd that will cover topics including, "Pursuing a Fellowship," "Tips on Applying to an Academic Position," and "Academics vs. Community Practice: Pros and Cons."

## **AAEM 13th Annual Scientific Assembly, March 12 – 14, 2007**

For all residents, remember that the AAEM Scientific Assembly is fast approaching. It will be held from March 12-14 in Las Vegas. AAEM/RSA has a wonderful resident-track planned. Come for the education, for the networking (see above), and for the fun activities planned. Stay tuned for more details and mark your calendars. See you there.



## Life as a New Attending

Mark Reiter, MD MBA

AAEM/RSA Immediate Past President and AAEM Associate Board Member

With four months under my belt as a new attending (community hospital, 60k census) here's my take on the "other side" - life after residency.

- It's really pretty good. Attending life is much better than resident life. Don't listen to that grumpy attending who tells you otherwise – he/she is a self-loathing person probably better suited for internal medicine.
- You will be surprised by how much faster you are when you are on your own.
- Seeing your very first patient as a new attending will feel pretty awkward, as does your first intubation, as well as your first time in solo coverage. But, in general, by the middle of your first shift, you'll feel comfortable and confident in your skills.
- You will get a better parking spot.
- The efficiency difference between an academic medical center and a well-run community hospital is staggering. You no longer feel like you're running a marathon with your shoelaces tied together. (*Editor's note: some of those academic centers are in community hospitals and actually have quite efficient emergency departments.*)
- You will still need to deal with occasional antagonism and general silliness from your consultants: but in general, you will have very collegial, friendly relationships.
- The first paycheck feels really, really good.
- You will find yourself mimicking many of the practice patterns of your old attendings.
- Expect much more emphasis on optimizing patient satisfaction and JCAHO mandates.
- You might even catch yourself saying, "When I was a resident..."

Resident Journal Review . . . - continued from page 21

final analysis. Proton pump inhibitor treatment did not reduce mortality but did reduce the rebleeding rate (NNT 11), need for surgical intervention (NNT 19), endoscopic interventions (NNT 9), and adverse outcomes (NNT 11). Therefore, although overall mortality was not lowered through the use of PPIs, the impacts of PPI therapy on rates of rebleeding and surgical intervention are of major clinical importance and may reduce health care costs.

Daniel Nishijima, MD, is an emergency medicine resident at SUNY Downstate/Kings County and Resident Editor for *Common Sense*.

David Wallace, MD MPH, is an emergency medicine/internal medicine resident at SUNY Downstate/Kings County.

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Amal Mattu, MD, is the Program Director for Emergency Medicine and Co-Director of EM/IM at the University of Maryland.



## Child Abuse: Bridging the Gap Between the ED and the Legal System

by Tara Torno Morley, JD, and Eric J. Morley, MD MS

Tara Morley, JD, is a former attorney for the New York City Administration for Children's Services

Eric Morley, MD MS is currently a 3<sup>rd</sup> year EM resident at SUNY Downstate/Kings County Hospital.

Child abuse, in all its forms, is unfortunately an all too common problem. The potentially abused child not only presents a clinical challenge, but also puts us into the legal system. The documentation we provide may help remove a child from a dangerous home, put a sex offender in jail and ultimately help prevent the repeated abuse of a helpless child. Despite our most sincere intentions to protect our patients, we often fall short by not understanding the legal process that our documents become a part of.

Here, we combined our experience as an EM resident in Brooklyn and a former New York City child protection lawyer, to try and address some important issues facing physicians treating abused children. We will cover a few important issues that are certainly critical to the outcome of many cases.

### *How do pictures help?*

Pictures help when there are physical signs of abuse. They should be taken with a Polaroid or digital camera. Use of these types of cameras enables the physician to determine if the picture actually depicts the injury they are viewing upon examination. If the picture does not accurately represent the visible injury, the physician should take another photograph or note the discrepancy in his or her notes. Other factors that make the injury difficult to capture on film should also be noted. For example, if a child with dark skin tone has a bruise and it is difficult to capture in a photograph, that should be recorded. This is when a physician's notes regarding the description of the bruise or injury are most important. Without such information, the photograph could actually serve as proof of lack of injury.

### *Will I have to go to court?*

The reporting/examining physician may be asked to go to court. This will occur if there is not enough evidence in the medical records, case records and other testimony to prove the abuse or neglect against the parent or other person legally responsible for the child's care.

### *How can we document our charts to help a case?*

Careful documentation in the child's medical chart is crucial in protecting the victim of abuse. It is especially important given the fact that a trial or fact finding in a particular case is likely to occur months after the physician's examination of the child. Not only can the medical record serve to refresh the recollection of

the physician, it, standing alone, can be moved into evidence and serve as a basis for a finding of abuse or neglect. Each and every element that contributes to the constellation of injuries and symptoms of abuse found during a child's examination should be documented to support the reason why the child may have been abused or neglected.

### *What happens if I report an innocent person?*

A child protective investigation will be initiated following a report to Child Services. Child Services will determine whether the case is indicated or unfounded. A case will be indicated if there is some credible evidence that the alleged abuse or maltreatment exists<sup>1</sup>. If there is no credible evidence found, the case will be unfounded<sup>1</sup>. Under New York Social Services Law §422(5) these unfounded reports are legally sealed and can only be unsealed and made available to a very limited class of persons. Disclosure of unfounded cases is limited to the state Office of Child and Family Services, local and regional fatality review team members, local Child Protective Services, a District Attorney or Assistant District Attorney, and the subject of the report<sup>1</sup>. This is the privacy protection afforded to those persons whose cases are unfounded. If a case is indicated, (credible evidence of the alleged abuse or neglect is found), there is also an extensive appeal process available. While this, and other information in this article is based, in part, on NY Social Services Law, similar laws exist in other states<sup>1</sup>.

### *What happens if there is a finding of child abuse or neglect?*

It is also important to have an awareness of the possible legal proceedings of a report of child abuse or neglect. First and foremost, the medical community should be aware of the fact that a criminal case is much more difficult to prove than a civil child prosecution case. The possible legal ramifications of proving such cases differ greatly. The purpose of a criminal case is to punish the offender and can result in incarceration of that individual. In a civil child prosecution case, the purpose is protection of the child and the child's best interests. Given a finding of abuse or neglect in a civil case the Court does not have the power to incarcerate the parent or person legally responsible. In these cases the Court can and is obligated to issue orders that are in the best interest of the child. These orders very often

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## A Mentor Makes All the Difference

by Todd A. Bialowas, MS-III

Wright State University, Boonshoft School of Medicine

Do me a favor. Give me five minutes of your time. If you are an attending or resident EM physician, try to think back to when you first got interested in emergency medicine. For some of you, it may have been during your fourth year medical school electives. Another fraction may remember some interesting EM Interest Group (EMIG) meetings during school. And still others may have caught the EM bug way before even getting into medical school, especially if you were a non-traditional student with a background in some form of health care.

But if you think about it for even a few moments, it's a good bet you will remember a special person somewhere along the line that helped you with the struggle to find your personal niche in a vast and changing medical world. That person may have been a medical school professor, a relative, a clinical clerkship preceptor or maybe a doctor you ran into once during some fateful time in a local emergency department. Perhaps it was a person completely outside of medicine. Regardless, someone helped you make the connection of who you were, what you were interested in and how that made you right for a career as an emergency physician.

Whether you knew it or not then, that person was your mentor, an essential part of the passage from college student to medical student to EM resident to attending physician. Webster's defines a mentor as "a trusted counselor or guide, a tutor or coach." But the power a mentor wields is exponentially greater than that. Mentors have the ability to not only stabilize but build and sustain a drive toward a lifelong goal for many students. They often give the students, many of whom have no concept of what type of medicine they might want to practice, a first glimpse of what their professional careers may hold in store for them. They literally hold the crystal ball that starts the quest.

Mentors are needed in just about every aspect of society, and you've probably all seen commercials recruiting them on TV. But nowhere are they needed more earnestly than for those souls lost adrift in a sea of basic science lectures and mandatory clinical clerkships in medical school. A few minutes of your time really do go a long way toward fanning the flames of the fire most medical students already possess.

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*Child Abuse: Bridging the Gap Between . . . - continued from page 24*

include mandating that the parent attend drug treatment, parenting classes, anger management, individual and/or family therapy. In addition, the Court and Department of Social Services can assist the family in gaining access to services to help with housing and public assistance. Very often the children remain in the home under the supervision of Child Services.

In cases of extreme abuse and or neglect, where the Court determines that there is an imminent risk to the child's life or health, the Court can issue an order causing the parent to temporarily lose custody of his or her child. A parent can ultimately lose their parental rights to the child, but normally, only after diligent efforts have been made to reunite the family<sup>1</sup>. In rare cases, the Court can excuse these efforts to reunite the family but only if there is a legal determination that the child was severely and/or repeatedly abused. A child is severely abused if he or she is a victim of a felony sex offense, the parent is convicted of the murder of another one of the parent's children, or he/she is harmed as a result of reckless or intentional acts of the parent committed under circumstances demonstrating a depraved indifference to human life that results in serious physical injury. Even in these extreme cases, diligent efforts to encourage and strengthen the parental relationship, including efforts to rehabilitate the respondent, can only be excused if such efforts are unlikely to be successful in the foreseeable future. In essence, the Legislature in New

York, and many other states, have fashioned the child protective laws to empower the Court and Child Services with the ability to protect children from immediate harm: and have also determined that preservation of the family is, most often, presumed to be in the child's best interest. The point is to remove the imminent dangers by temporarily removing children or excluding the offender from the home, and then make every effort to help the family heal.

### **What happens if I don't report a case?**

New York State Social Services Law § 420- Penalties for Failure to Report

1. Any person, official or institution required by this title to report a case of suspected child abuse or maltreatment who willfully fails to do so shall be guilty of a class A misdemeanor.
2. Any person, official or institution required by this title to report a case of suspected child abuse or maltreatment who knowingly and willfully fails to do so shall be civilly liable for the damages proximately caused by such failure<sup>1</sup>.

### **Reference**

<sup>1</sup> Yellowbook: New York family law statutes. Mathew Bender and Company, Inc. 2005 ed.



# Resident & Student Association

*A Mentor Makes All the Difference - continued from page 25*

I still remember the first time I was asked by an EM attending I worked with if I were interested in the specialty. I appreciated that he took the time to really talk to me about it. When he suggested I look into it because of what they saw in me, I don't think I slept that night. It was all I talked about with family and friends for days. It was a powerful experience for me; and those that know me can tell you, I'm not a very sensitive guy. At the time, I was far from being in medical school; yet it motivated me so much that I went ahead and laid out the plan I actually used for getting there.

And this urging isn't only directed at EM physicians and residents, it also pertains to the more senior medical students interested in EM as well. They also can and should be looking for ways to discover and nurture the interest that is almost boundless in the more junior medical students. Fostering that interest now will undoubtedly pay huge dividends later to the profession.

How can you help? Well, first understand that it is almost impossible for students to organize and carry out any meaningful activities without the support of interested attending physicians and motivated residents. These two groups can help suggest topics, labs, lecturers and locations that will help students develop into budding emergency physicians. They can show them the value of new procedures and modalities, and they can also give them access to equipment and logistical support when many students can't even get phone calls or emails returned by the key people who can make things happen.

Now, it would be easy to push this issue to the bottom of what is, I'm sure, a long list of things we all need to get around to. This is especially true since emergency medicine has enjoyed some outstanding growth over the last 30+ years post-inception. But by taking an active role in mentoring now, you can, in a sense, help determine the course EM will take for the next 30 years. How can you accomplish this? You can do so by seeing to it that the best and the brightest of today's medical students are shown the virtues of EM. And in doing so, you also shape what EM will become in the future by picking your own successors. It really is a win-win situation.

As the marketing folks at Nike used to say, "Just do it." Take the next step and put yourself out there. Contact your local medical school EMIG and let them know you are interested in helping them. Take the time to talk to college pre-med societies and high school groups. When someone approaches you about how they might become an EM physician one day, make the effort to have a real conversation with them about it. Simple honesty and a forthright nature when dealing directly with students is a great way to go, and it will likely be more appreciated anyway. If you can't find your local EMIG, contact me directly and I will find it for you.

"Just do it." You won't be disappointed, and those old career dreams you may have thought were long since smoldering may even be rekindled when you're looking across at someone who is sitting right now where you were "just yesterday." Remember, we are the legacy we leave behind. Do us all a favor and leave the field of emergency medicine all the richer for your presence in it.



## AAEM Wants You to Become an Oral Board Review Course Volunteer Examiner

Volunteer Oral Board Review Course examiners are wanted for the spring course, April 14-15, 2007. The course is held at airport area hotels in Chicago, Dallas, Los Angeles, Orlando and Philadelphia.

First-time examiners receive a one-time AAEM voucher for \$250.00 to be used on AAEM membership, meetings, courses or merchandise.

For more information or to apply to be an examiner, please go to [www.aaem.org/education/oral board](http://www.aaem.org/education/oral%20board).

Please email AAEM staff member, Tom Derenne, at [tderenne@aaem.org](mailto:tderenne@aaem.org)



# AAEM Membership Application

First Name <input type="checkbox"/> Miss <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms	MI	Last Name	Birthdate
Institution			Degree (MD/DO)
Preferred Mailing Address			
City	State	Zip	
Please check which address this is: <input type="checkbox"/> Work <input type="checkbox"/> Home			

Phone Number—Work	Phone Number—Home
Fax	E-mail

- 1) Have you completed or are you enrolled in an accredited residency program in Emergency Medicine? ☐ Yes ☐ No  
If yes, which program & date of completion \_\_\_\_\_
- 2) Are you a medical student with an interest in Emergency Medicine? ☐ Yes ☐ No  
If yes, program & expected date of completion: \_\_\_\_\_
- 3) Are you certified by the American Board of Emergency Medicine? ☐ Yes ☐ No.  
If yes, date: \_\_\_\_\_ Type of certification ☐ EM ☐ Pediatric EM
- 4) Are you certified by the American Osteopathic Board of Emergency Medicine? ☐ Yes ☐ No  
If yes, date: \_\_\_\_\_
- 5) Are you a member of any other EM organization? Please select all that apply.  
☐ AACEM ☐ ACEP ☐ ACOEP ☐ AMA ☐ CORD ☐ EMRA ☐ NAEMSP ☐ SAEM ☐ Other \_\_\_\_\_

Full Voting and Associate Membership dues are for the period January 1<sup>st</sup> through December 31<sup>st</sup> of the year the dues are received. Applicants who are board certified by ABEM or AOBEM in EM or Pediatric EM are only eligible for Full Voting Membership. Full Voting and Associate memberships include a subscription to *The Journal of Emergency Medicine* (JEM). Resident and Student membership dues are for the period July 1<sup>st</sup> thru June 30<sup>th</sup> of the period the dues are received. All memberships except free student membership include a subscription to *The Journal of Emergency Medicine* (JEM).

## MEMBERSHIP FEES

- ☐ Full Voting Member ..... \$365.00
- ☐ Associate Member (Associate-voting status)..... \$250.00  
\* Limited to graduates of an ACGME or AOA approved Emergency Medicine Training Program.
- ☐ Emeritus Member ..... \$250.00
- ☐ International Member ..... \$125.00
- ☐ Resident ..... ☐ 1 Year \$50 ☐ 2 Years \$80 ☐ 3 Years \$120 ☐ 4 Years \$160
- ☐ Student - includes subscription to JEM ..... ☐ 1 Year \$50 ☐ 2 Years \$80 ☐ 3 Years \$120 ☐ 4 Years \$160
- ☐ Student free - does not include subscription to JEM ..... ☐ First trial year ☐ 1 Year \$20 ☐ 2 Years \$40 ☐ 3 Years \$60
- ☐ I would like more information on the Critical Care Section
- ☐ I would like to be a member of the Uniformed Services Chapter (USAAEM) ... ☐ Full Voting—\$50.00 ☐ Assoc.—\$30.00 ☐ Res./Student Free
- ☐ I would like to be a member of the Young Physicians Section (YPS) (free at this time)
- 
- ☐ AAEM Foundation: Please consider making a voluntary contribution to the AAEM Foundation. With your donation, the AAEM Foundation will be able to fight against the corporate practice of medicine. Your donation is tax-deductible. Federal TIN: 20-2080841.....\$100.00
- ☐ Political Action Committee: Please consider making a voluntary contribution to the AAEM PAC, the political action committee of the AAEM. With your donation, AAEM PAC will be better able to support legislation and effect change on behalf of the AAEM members and with consideration to their unique concerns.....\$50.00

## PAYMENT INFORMATION

Method of Payment: ☐ check enclosed, made payable to AAEM ☐ VISA ☐ MasterCard

Card Number	Expiration Date
Cardholder's Name	Cardholder's Signature

Return this form with payment to: American Academy of Emergency Medicine, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202-3823  
All applications for membership are subject to review and approval by the AAEM Board of Directors. The American Academy of Emergency Medicine is a non-profit professional organization. Our mailing list is private. Full Voting Member (Tax deductible only up to \$348.00) / Associate Membership (Associate-voting status) (Tax deductible only up to \$230.00)

# AAEM JOB BANK

**To respond to a particular ad:** AAEM members should send their CV directly to the position's contact information contained in the ad. If there is no direct submission information, then you may submit your CV to the AAEM office noting the response code listed at the end of the position description in a cover letter. AAEM will then forward your CV to the appropriate professional.

**To register yourself in the Job Bank:** AAEM members should complete and return a Job Bank Registration Form with a current copy of their CV, which will allow them to stay current on all available positions within the bank. There is no charge for this service. Contact the AAEM office for a registration form.

**To place an ad in the Job Bank:** Equitable positions consistent with the Mission Statement of the American Academy of Emergency Medicine and absent of restrictive covenants, will be published for a one time fee of \$300, to run for a term of 12 months or until canceled. A completed copy of the Job Bank registration form, a signed copy of the Certificate of Compliance and payment must be submitted in order to place an ad in the Job Bank.

**Direct all inquiries to:** AAEM Job Bank, 555 East Wells Street, Milwaukee, WI 53202, Tel: (414) 276-7390 or (800) 884-2236, Fax: (414) 276-3349, Please contact Shauna Barnes to learn more about the AAEM Job Bank at sbarnes@aaem.org

*The following groups (identified with an\*) have submitted the AAEM Certificate of Compliance:*

## \*ALABAMA

Mobile, AL. Seeking full-time BE/BC emergency physician to join democratic 7 person group staffing community hospital with 35K visits per year. 16 bed ED, 6 bed chest pain center, 4 bed fast track. Fee-for-service, competitive salary, 401(k). Expanding patient population creating need for additional physician. MD double coverage daily, additional PA coverage weekends. Excellent backup in all specialties, stable contract since 1987. (PA 741)

## \*ALABAMA

Independent, democratic group seeking BC/BE emergency medicine physicians. 25,000 annual visits with 10 hours of MD double coverage daily. Employee status with partnership offered after six months. Equitable scheduling, competitive salary based on productivity, and benefits included. Located on the eastern shore of Mobile Bay. Fairhope is a progressive and growing Gulf Coast community. For inquiries or to submit a CV, contact Don Williams, MD FACEP at baymds@aol.com. (PA 784)

## \*CALIFORNIA

Redding. Surrounded on 3 sides by mountains and lakes, located on the Sacramento River. Democratic group staffs a 46,000+ Level II trauma, referral center as well as a community hospital within 30 miles. We offer attractive compensation and benefits, ownership potential and a balanced lifestyle opportunity. Unlimited recreational opportunities abound: water and snow skiing close by, hunt, fish, bike, boat and hike in a growing far northern California community. Contact Shasta Emergency Medical Group, Inc. PO Box 993820, Redding, CA 96099-3820. Ph 530-225-7243, Fax 530-244-4708, email: bayless@hotmail.com. (PA 750)

## \*COLORADO

Thriving and stable Southern Colorado Emergency Medicine group needs additional BP/BC emergency physicians for 50,000 patient ED. Work in a fast-paced, state-of-the-art Level II Trauma Center with a large referral base and great pathology. Join a democratic group which is physician owned and led and has over 25 years of experience. The group is committed to quality care and patient satisfaction. Benefits include equitable and flexible scheduling, relocation package, medical/dental/vision/short term disability, excellent pay and benefits. Full time, part time, locums available. Ask about our 18 month partnership track. Growing area on the front range of Colorado with healthy economy, great climate, low cost of living, and abundant recreational opportunities. A short drive for fishing, sailing, x-country and downhill skiing, climbing and more. Short two-hour interstate drive to Denver where you can enjoy "big city" amenities like professional sports teams and theater. Email inquiries with CV to rmiv@msn.com. (PA 778)

## \*ILLINOIS

Mount Sinai Hospital, primary teaching affiliate of Chicago Medical School, has full and part-time positions for EM board certified or prepared. Level I Peds and Adult Trauma Center and Fast Track with 48,000 visits. Competitive salary and benefits. Contact Leslie Zun, MD, Chairman, Department of Emergency Medicine, Mount Sinai Hospital, 15<sup>th</sup> and California, Chicago, IL 60608. Phone 773-257-6957, fax 773-257-6447 or email zun@sinai.org (PA 773)

## \*ILLINOIS

Outstanding opportunity in Rockford, IL for ABEM (or AOBEM) certified physicians to join a well-established, top quality group in an exciting practice setting. Excellent compensation and comprehensive benefit package including the exceptional benefit of distributed ownership/equity. The practice is 58K patients/annum & growing, Level II Trauma Center & Paramedic Training Center, newly constructed state of the art ED, within department, dedicated to X-ray/CT, Fast Track, Holding and Observation Beds having a high quality nursing and support staff. Please direct inquiries and CVs to Hector Aguilera, MD, FACEP c/o Mary Schwei, Infinity HealthCare, 1035 West Glen Oak Lane, Suite 101, Mequon, WI 53092-3363. Or call 1-888-442-3883 or email mschwei@infinityhealthcare.com. (PA 779)

## \*IOWA

Seeking BE/BC emergency physicians. Outstanding opportunity in SE Iowa. Excellent schools, low cost of living, WORLD CLASS DEER HUNTING, live on the Mississippi River. Only 1.4 pts/hr. Package over \$280,000. Email tobyvandenbergh@hotmail.com or call 319-524-2121. (PA 781)

## \*IOWA

Seeking BE/BC physicians for emergency department in SE Iowa. Outstanding opportunity in SE Iowa. Excellent schools, low cost of living, WORLD CLASS DEER HUNTING, live on the Mississippi River. Only 1.4 pts/hr. Package over \$210,000. Email tobyvandenbergh@hotmail.com or call 319-524-2121. (PA 782)

## \*MARYLAND

Baltimore/Towson: Recruiting full-time BC/BE Emergency physician for 60k visit, suburban ED. ED group is democratic, single hospital and stable (28 years). Competitive salary, good payer mix, beautiful campus, new, state-of-the-art ED in 2004. Contact: jmwogan@gbmc.org. (PA 759)

## \*MINNESOTA

Minnesota, Minneapolis: The Twin Cities largest democratic, physician owned emergency medicine group seeks highly motivated board trained or board-eligible physicians to join our 100 member group. Our group staffs six community hospitals with average volumes of 40K. Base salary, benefits, and productivity and performance incentives to exceed \$350K compensation. Come see what Minneapolis has to offer other than snow. Website: www.eppanet.com (PA 747)

## \*MISSOURI

Kenneth Hall Regional Hospital (KRRH) located in the St. Louis, MO Metropolitan area is currently seeking a Medical Director for its Emergency Department. KRRH is a Level II Trauma Center with a Fast Track area for urgent care and a volume of about 20,000 visits annually. Candidates should be Board Eligible/Certified in emergency medicine and preferably have previous Medical Director experience. Confidential consideration, contact Mike McManus at (618) 482-7045. Email CVs to mmcmanus@krrh.org or fax to (618) 482-7014. Website address is www.KRRH.org. (PA 775)



**\*NEW YORK**

Full or part-time. Beth Israel Medical Center's Kings Highway Division-Midwood, Flatlands and Marine Park communities in Brooklyn, NY. Team covers 40 staff hrs/day, NP team covers 15 staff hrs/day and Emergency Medicine Residents rotate in ED and ICU. Requires BC/BE in Emergency Medicine (ABEM or AOBEM). Competitive salary and benefits. Please fax CV to M. Ognibene at 718-677-5597. EOE. (PA 748)

**\*NEW YORK**

Rochester, NY. Chairman-Dept. of Emergency Medicine, Unity Health System. Opportunity to lead Unity Hospital's new, state-of-the-art Emergency Center opened in February 2006 with 30 private treatment rooms and 28 Special Care Units. Required: NYS License, Board Certified/Emergency Medicine. Prior administrative leadership preferred. Demonstrated commitment to high-quality, cost effective, evidence-based care as well as hospital-wide collaboration. For consideration, send a CV to the search committee through Paula Dolan, VP -Human Resources at pdolan@unityhealth.org. (PA 780)

**\*NORTH CAROLINA**

Wilmington area-Stable (since 1986) and democratic emergency medicine group is seeking a full-time emergency medicine board certified/board eligible physician who is committed to providing the best emergency care in the southeastern North Carolina area. Current practice sites include a 72,000 patient/year Level II Trauma center, a 30,000 patient/year community hospital, and a 12,000 patient/year community hospital, the hospitals which we are currently recruiting for. This hospital has a new emergency department, complete with adjacent helipad, and enjoys the full support of a major regional medical center. We offer a competitive salary and comprehensive benefits. Live, practice, and enjoy a great quality of life in an exceptional coastal community with beaches, golf, and historic waterfront at your doorstep. For more information please contact J. Dale Key, dkey@ecepnet.com, or at 910-202-3363. (PA 752)

**\*OKLAHOMA**

The University of Oklahoma College of Medicine-Tulsa is seeking a Director of Emergency Medicine Research. Responsibilities will include: directing a clinical research program in emergency medicine. Experience required: extensive teaching, peer-reviewed publications, IRB processes, biostatistics and grant applications. Oklahoma license and ABEM/AOBEM required. This position comes with a competitive salary and protected time. Appointment commensurate with experience. The University of Oklahoma is an EEO/AAE institution. Please send a letter of interest and CV to Mark A. Brandenburg, MD, Vice Chair, Department of Emergency Medicine, University of Oklahoma College of Medicine-Tulsa, 4502 E. 41<sup>st</sup> Street, Suite 2B09, Tulsa, OK 74135. mark-brandenburg@ouhsc.edu. (PA 770)

**\*OKLAHOMA**

Tulsa, Oklahoma -Exceptional opportunities available now for BC/BE Emergency Medicine Physicians to work in a 557-bed tertiary medical center, with a 14 bed ED (5 of those are minor care beds). •Level III Trauma Center •Over 50,000 visits annually •2 teaching services in-house •Excellent Hospitalist group •140 hrs/mo=full time •Mid-levels cover minor care Exceptional salary/benefit package being offered, including paid malpractice and equality within group structure from day one. Tulsa, pop. 400,000, is known for its cosmopolitan flair, including a performing arts center, outdoor music festivals, and an array of shopping and restaurants. Excellent public and private school system for children, along with exceptional private universities. Tulsa also has two medical schools. For further information or consideration, please contact our Tulsa recruiter, Lori at: Toll-free: 866-396-3627. Direct line: 918-518-5460 Fax: 918-518-5461, or E-mail: lbm22@aol.com (PA 772)

**\*OKLAHOMA**

The University of Oklahoma College of Medicine-Tulsa is seeks faculty member with EMS and disaster expertise to direct training and research programs in EMS/disaster medicine in Oklahoma Institute of Disaster and Emergency Medicine and new EM residency program. Fellowship training is preferred. Appointment commensurate with experience. Competitive salary and protected time. Oklahoma license and ABEM/AOBEM required. The University of Oklahoma is an EEO/AAE institution. Please send a letter of interest and CV to Mark A. Brandenburg, MD, Vice Chair, Department of Emergency Medicine, University of Oklahoma College of Medicine-Tulsa, 4502 E. 41<sup>st</sup> Street, Suite 2B09, Tulsa, OK 74135. mark-brandenburg@ouhsc.edu. (PA 774)

**\*PENNSYLVANIA**

The Department of Emergency Medicine at Drexel University College of Medicine is conducting interviews for Program Director of Emergency Medicine. Candidate must be residency trained and board certified in Emergency Medicine. Subspecialty board certification and research experience are highly desired. The Drexel University College of Medicine carries on the fine tradition started with the first three year residency in Emergency Medicine at the Medical College of Pennsylvania (MCP) in 1971. (PA 769)

**\*PENNSYLVANIA**

Outstanding ED Physician Needed in State College, PA; home of Penn State University. Featuring:Independent democratic group, Fee / service, Stable, amicable relationship with administration, Volume: 44,000+, 42.5 physician hours/day, 20-22 PA hours/day, In-house dictation/transcription, Excellent nursing/ techs/ IV team, Superb admitting/ consulting staff, CT/ultrasound 24/7, University community: great schools/ sports/culture/without crime. E-mail Tziff@Mountnity.org or call Sally Arnold at 814-234-6110 ext. 7850. Or mail: Theodore L. Ziff, MD FACEP, 1800 East Park Ave., State College, PA 16803. 814-234-6110. (PA 776)

**\*RHODE ISLAND**

Emergency Room Physician: Westerly Hospital, a pleasant seaside community located in the southwest corner of Rhode Island with 30,000 ED visits per year to our state-of-the-art Emergency Department wing, has a full-time position available for an emergency physician. Candidates must be board-certified/board-eligible in Emergency Medicine with a minimum of 2 years experience. Coastal living and a collegial atmosphere make this a great place to work. Please send CV with cover letter to M. Eddy, Medical Staff Coordinator, The Westerly Hospital, 25 Wells St., Westerly, RI, 02981. Fax 401-348-3802 or meddy@westerlyhospital.org (PA 706)

**\*RHODE ISLAND**

Seeking BE/BC EM MD for full-time position in beautiful Oceanside Newport, RI. Private, single-hospital, stable, democratic group. Department is 5 years new and very computerized with 32,000 census. Position offers very competitive salary and bonuses with full benefits package. Practice the full spectrum of community emergency medicine in coastal New England. (PA 783)

**\*SOUTH CAROLINA**

Opportunity for a BC/BE emergency medicine physician to join a highly successful ED. Level I trauma center has a volume over 100,000 visits annually. ED includes hospital wide digital PACS, ED tracking, bedside registration and EMR. The 72 bed center includes Pediatrics, Women's, Behavioral Health, Chest Pain Center, Trauma Major/ Minor Care. (PA 751)

**\*SOUTH CAROLINA**

McLeod Regional Medical Center is seeking EM Physicians for full time employment. Competitive salary and benefits. Hospital Employee. 80+ hours of daily coverage in 8, 10, and 12 hour shifts, with additional NP hours. McLeod has 371 beds and is a Level II Trauma center. Contact Tiffany Ellington: 843-777-7000 or tellington@mcleodhealth.org. (PA 753)

**\*TENNESSEE**

Democratic Group seeking BC/BE emergency physicians. Two hospital contracts/100,000 patients yearly. Two year full partnership. Square schedule with nights in direct proportion to number of shifts, except first 2 yrs. 2 extra overnights per schedule, \$350.00 per extra night worked. First schedule no single coverage (night or first shift). Please contact Russ Galloway for details 615-895-1637, GAL1958@comcast.net. (PA 756)

**\*VIRGINIA**

Newly formed democratic group in Blue Ridge Mountains of Southwest Virginia seeks BE/BC partner. Rare opportunity to join group staffing single hospital, 36K visits, no/rare trauma. Work only 3 eight hour nights every 2-3 months, 9-10 hour shifts during day, double coverage from 10am-1am, fast-track 3p-11p 7 days, high acuity, approx 25% admissions. Same group staffing this ED for over 20 years, our ED group split off to form democratic group when the multi-specialty group of which we were formerly a part sold out to hospital. 25% profit sharing bonus first year, 50% bonus second year, then full partner, (with no buy-in) after second year. Paid malpractice, health, and LTD insurance. 2 week PTO, \$5,000 CME. Great schools, wonderful family environment, good group with which to work. ED has 24/7 availability of Radiology/Hospitalists/Forensic Nurses/Psychiatric Eval by psych caseworkers. Every MD is a partner, and all but one have been here for at least 6 years. Contact Cheryl Haas, MD at 540-529-3580 or Robert Dowling, MD at 540-529-6448, or fax your CV and letter of interest to 540-387-2459. (PA 743)

**\*VIRGINIA**

We are a democratic group located near Charlottesville, Virginia, in the Central Shenandoah Valley. The Shenandoah National Park is visible from our ambulance entrance! Charlottesville is home to the University of Virginia and is a growing thriving city. Outdoor activities abound. The group has a contract with a single hospital and we care for 58,000 patients yearly. The acuity is high and we see a full range of emergencies, including trauma. A fast track is staffed by two excellent nurse practitioners. Our group is fully democratic; partnership is expected at one year. Reimbursement is tied to productivity and there is complete equity between partners. ABEM certification or eligibility is required. Contact: asher.brand@gmail.com or phone: 540-241-0938. (PA 787)

**\*WYOMING**

Located in northeast Wyoming between the Big Horn Mountains and Black Hills, Campbell County Memorial Hospital is the healthcare leader in northeast Wyoming. The medical campus consists of a 90 bed JCAHO accredited community and area trauma hospital and a 150 bed long term care facility. Campbell County Memorial Hospital is seeking a board eligible/board certified emergency medicine physician. Hospital employed position; 23,000 patient visits; physician double coverage; eight hour shifts; democratic group of physicians; excellent compensation package; several annual bonus opportunities; sign-on bonus; student loan repayment; relocation; full employee benefit package including health and dental insurance, retirement, premium executive disability, and CME allowances. For more information, contact Tami Beckham at Campbell County Memorial Hospital at (307) 688-1554 or email tami.beckham@ccmh.net. (PA 785)

**\*AUSTRALIA**

**SPECIALIST EMERGENCY MEDICINE PHYSICIANS NEEDED**-We have positions available immediately for Emergency Medicine Physicians in Australia's National Capital of Canberra offering a role with professional variety and a great lifestyle. For more information, please submit CVs, or direct questions to Sue Freeman at sue@myheadhunter.com or visit our website at www.healthprofessioninternational.com. (PA 777)

**\*GUAM**

Seeking Full Time BE/BC Emergency Room Physicians at Guam Memorial Hospital Authority. Guam is located 1,596 miles from the Philippines. It offers a beautiful climate, and abundance of recreational activities. Compensation is compatible with AAEM fair employment guidelines and includes vacation, sick leave and holiday pay. (PA 786)

**ALABAMA**

Alabama Gulf Coast: ABEM/AOBEM physician. Democratic Group. Partnership track. Full Employee benefits with Pension (up to \$44k). FFS arrangement. \$110/hr. Package value >\$275k. Community Hospital. New 18 bed ED. 26k volume. White sand beaches. Outdoor activities. Excellent schools. For information: John Meade, MD @ 850-380-4766 or e-mail: jmeade@statdoc.com. (PA 757)

**CALIFORNIA**

Medical Director. Beautiful Bay Area. Medical-Legal Company based in Berkeley provides case evaluation and expert witness testimony services to law firms and insurance companies nationwide. Must be Board-Certified or eligible in Emergency Medicine. Must be personable, outgoing, and poised. Must have medical-legal and administrative experience. Flexible hours. Competitive compensation and benefits. Email cover letter, CV, letters of recommendation and salary requirements to medicalexpert@amfs.com. For additional information, please see our website: www.medicalexpert.com. (PA 768)

**CALIFORNIA**

Emergency Medicine Partnership

New position for BC/BP Emergency Medicine physician to join democratic, compatible group. Well-equipped hospital ER's. Low trauma volume. Medical community provides good specialty support. Envious private practice climate with very low managed care. Competitive income, malpractice insurance, partnership and profit sharing. No urban commuting or crowding problems. Located on the coast of Northern California. Excellent schools, university and college. Spectacular scenery and stimulating cultural environment. Send CV in confidence: Sharon Mac Kenzie. macken@sonic.net (800) 735-4431 Fax: (707) 824-0146. (PA 771)

**FLORIDA**

Full-time BC/BE Emergency Medicine physician needed for military medical facility in Jacksonville, Florida. Level three ER with 18 patient beds, non-emergent to emergent acuity rate, and 67,000 patients/yr. Acute care clinic has 33% appointments and 67% non-emergent overflow. 160 hours per month with flexible scheduling. Competitive salary. Relocation assistance. No malpractice insurance required. Continuing Education reimbursement, 401k match, disability insurance and 26 days paid leave per year. For immediate consideration contact Nate, nparham@chesapeakectr.com. (PA 744)

**KENTUCKY**

St. Claire Regional a mission based hospital seeking BE/BC Emergency Medicine Physician. Eleven county service area with 30K + ED visits annually. Investment underway for new Health Education/Research facility. This university town is found near Cave Run Lake. Competitive salary/benefit package. Submit CV's to: ambaker@st-claire.org (PA 754)

**NEW YORK**

Emergency room staff physician BC/BE in Emergency Medicine. Excellent salary & benefit package. Please call for more information (914-944-8313). Please submit CV to apply@executivehealthsearch.com. (PA 763)

**TEXAS**

Texas A&M University System, Health Science Center. Full time emergency medicine faculty positions available in Corpus Christi, Texas. Outstanding opportunity for academic career oriented individuals. Protected academic time for research and interaction with residents and medical students. Excellent clinical environment in high acuity emergency department of regional tertiary facility. Academic appointment commensurate with experience. Superb remuneration and benefits package. Candidates must be board certified/board prepared in emergency medicine. Responsibilities included teaching and clinical supervision of rotating residents. An application for an EM residency has been submitted to the ACGME. Corpus Christi is a coastal paradise where recreational opportunities abound. For further information please contact Bel Flores at 2626 Hospital Blvd. 3W, Corpus Christi, Texas, 78405 or call 361-902-6570. (PA 762)

**WASHINGTON**

Clarkston. Democratic, small, single hospital group needs full timer for 14K visits/yr ED. Non-trauma emphasis. Some state of the art amenities. Hospitalist service starting now, and new ED soon. Beautiful rural region where grassland meets Rocky Mountain foothills. Close to skiing, water sports, fishing-many types of outdoor fun. Boarding required in EM or Board Eligible. Partnership track. Contact Kurt Martyn, MD kurtm@moscow.com or 509-758-4665. (PA 745)

## WASHINGTON

Emergency Medicine Physician

Board Certified/Residency trained in emergency medicine. Madigan Army Medical Center, Ft. Lewis, Washington. Part-time/Full-time positions available. Any state license accepted. Medical Malpractice included. Please reply to Betsy Weixel at blw@americanhospital.us. (PA 749)

## WASHINGTON

Full-time BC/EM physician to work as an independent contractor with the PhyAmerica Government Services, Inc. at Naval Hospital Bremerton, WA. No WA state license required. Work 40 hours per week. Contact Ruby Mangum 1-800-476-4157 ext. 4645 rmangum@phyamerica.com. (PA 766)

## WASHINGTON

Washington, Kitsap Peninsula: We staff two brand-new EDs seeing a total of 60,000 pts/annually and seek a full-time BC EM Physician to expand coverage. Established, progressive, democratic group with excellent compensation and benefit package. Mountain and Ocean recreation opportunities abound. One-hour ferry ride to Seattle. See Website: www.harrisonmedical.org Email CV to: Gail Donovan at gdonavan@harrisonmedical.org. (PA 765)


## WISCONSIN

Green Bay, WI - Full time opportunity for 1-2 board certified EM physicians. We offer a democratic, independent, FFS Group. 28,000/year visits with 14-16 hours/day of MP, PA or MD double coverage. Level III ED. Certified Heart Center and Stroke Center. Excellent pay & full benefits. (PA 758)

## Urgent Care Practice For Sale

## FLORIDA



Do you dream of running your own business and living 2 minutes away on the beach? Established and growing urgent care practice with affluent patients (70% insurance/30% cash/0 no pay!) near beach generating \$700,000 in annual revenue with \$300,000 expenses [employees (including full-time physician assistant and part-time nurse practitioner), rent, utilities, supplies, and insurance]. PA/NP covers 160 hours per month, you manage and work 44 clinical hours per month (decrease PA/NP coverage, increase physician clinical time, and decrease annual expenses by \$100,000)]. 1860 sq. ft. furnished condo (living room, kitchen, 3 bedrooms, 2 new bathrooms with whirlpool large bathtub/steam room, and deck overlooking ocean and 5 miles of beautiful beach plus pool/whirlpool/exercise room/party room). Package price to live and work in paradise - \$2.1 million.



AMERICAN ACADEMY OF EMERGENCY MEDICINE

# 14th Annual Scientific Assembly

**February 7 - 9, 2008**  
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