

# common SENSE

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THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



## PRESIDENT'S MESSAGE

### AAEM v. TeamHealth: The Case of a Lifetime

*by Larry D. Weiss, MD JD FAAEM*

As the first generation of board certified emergency physicians reaches its twilight years, we may reflect on our progress but cannot escape the reality of our professional problems. Some of our most intractable problems concern the prominent role of lay corporations in the practice of emergency medicine. Even though most states have statutes and case law prohibiting the lay ownership of medical practices, or the control and management of physicians by lay corporations, these corporations continue to expand throughout the country and exert a strong influence on the practice of emergency medicine.

Late last year, several of our Houston area members filed a lawsuit after the Memorial Hermann Healthcare System signed an agreement with TeamHealth. This agreement allows TeamHealth to manage emergency departments in the Memorial Hermann Healthcare System. Our members asked AAEM to join the lawsuit. We agreed to become a party in this litigation after careful consideration of the facts and a review of Texas law by our hired counsel. This represents only the second time in our history that we directly participated as a party in a lawsuit. We intend to entirely fund the costs of this litigation through voluntary donations to the AAEM Foundation.

Our members filed suit when they suddenly learned that their independent practice of medicine ended. They did not want to participate in an illegal arrangement whereby a lay corporation would manage and control their professional lives. In Texas, only physicians may own professional medical corporations. Texas courts have invalidated contracts granted to lay corporations owning or operating medical practices. These courts also held that physicians violated the Texas Medical Practice Act when they signed contracts to practice medicine with lay corporations. Suddenly presented with the option of leaving their emergency departments or signing an illegal contract, our members decided to file suit to invalidate the contract between Memorial Hermann Healthcare System and TeamHealth.

Indeed, as the first generation of ABEM certified emergency physicians approach the waning years of our careers, we bequeath a troubled specialty to our younger colleagues. We witnessed the birth and rapid development of our specialty, but we have done relatively little to resolve the intractable professional problems of emergency physicians. The abuse and exploitation of emergency physicians, the widespread violation of our practice rights, overcrowded and dangerous conditions created by hospital administrators, and the continued growth of illegal lay corporations managing more and more emergency departments continues unabated.

We have reached a point in time when we must draw a line in the sand. The top two lay corporate groups now manage more than 15% of all emergency departments and are in a state of rapid expansion. Other corporations control another 15% of all emergency

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## EDITOR'S LETTER

# Time Passes and Stuff Happens

by David Kramer, MD FAAEM

Each year at the AAEM Scientific Assembly, many of you talk about getting involved and leaving your mark on our society. Some follow through, but many do not. I was going to make an impassioned plea for all of you to strongly consider elevating your involvement to more than simply being a member. More than most other organizations, AAEM is led by its members who directly elect their board of directors. I was going to say much more about this but could not possibly say it more eloquently than our Secretary-Treasurer, Dr. William Durkin, has elsewhere in this issue of *Common Sense*. Please read his article. Then remember that the rest of us on the board feel the same way.

Our annual Scientific Assembly was a smashing success. As always, the presentations were first-rate. The information was clinically, administratively and academically relevant, timely and up to date. The

resort was excellent, and the food was too good. Our organization continues to grow, and every year our Scientific Assembly continues to impress. Old friends were reacquainted, and new ones were made. For those of you who were present, I'm sure this is all old news. For those who weren't, there is always next year (March 2-4, 2009) in Phoenix, AZ.

In AAEM, you determine what happens. You decide on the course the organization will take. You can just sit back and watch time pass and stuff happen. Or you can make stuff happen, effect change, chart the future and help mold a legacy. Don't let time pass without leaving your mark on your organization. Being a member is great. Doing more for the organization and your emergency medicine colleagues is even better. Get involved. AAEM needs you.



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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)

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\*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.



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**Elections for the AAEM Board Members  
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Assembly in Amelia Island, FL.**

**The 2008-2009 Board of Directors are listed below.**

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Megan Boysen, MD – newly elected for 2008-2009

# Chest Pain a Leading Reason for Hospital Emergency Department Visits

Chest pain that does not appear to be a heart attack when examined in hospital emergency departments, accounted for 1.6 million visits in 23 selected states in 2005, according to the latest News and Numbers from the Agency for Healthcare Research and Quality. About one-fifth of the cases – 345,000 people – were admitted to hospitals for observation or treatment.

“Non-specific” chest pain was the fourth most common cause of emergency visits. The top three: sprains and strains (2.4 million visits), bruises and other superficial injuries (2.0 million), and abdominal pain (1.7 million). In each of those categories, however, less than five percent of patients were admitted to hospitals.

## Additional highlights of the AHRQ analysis:

- Rates of emergency department visits were nearly two times higher among persons from the poorest communities compared with those from the wealthiest communities (about 481 per 1,000 persons versus 261 per 1,000 persons).
- Five additional conditions prompted at least 1 million emergency visits: back problems (1.4 million), leg and arm open wounds (1.3 million); headaches, including migraines (1.2 million); nose and throat infections, such as sinusitis and strep throat (1.1 million); and

skin infections and urinary tract infections (1.0 million each). Of these, urinary tract infections were most likely to require hospitalization – 18 percent.

- Among emergency department visits that resulted in hospitalization, pneumonia topped the list of reasons for visit. Two-thirds of the 669,500 of the people who came to emergency rooms were admitted.
- The chances of being admitted were smaller for uninsured patients (roughly 7 percent) than patients with private insurance or Medicaid (about 14 percent each) or Medicare (nearly 40 percent). Patients who were uninsured accounted for about 18 percent of hospital emergency department visits.

This AHRQ News and Numbers is based on data in Emergency Department Visits for Adults in Community Hospitals from Selected States, 2005. The report uses statistics from the Healthcare Cost and Utilization Project State Emergency Department Databases and State Inpatient Databases, which contain statistics from 23 states.

For more information or to speak with an author, contact Joyce Middleton at [Joyce.Middleton@ahrq.hhs.gov](mailto:Joyce.Middleton@ahrq.hhs.gov) or (301-427-1862).

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## Congratulations Mike Epter!

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Your Colleagues at University of Nevada School of Medicine and  
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### President's Message - continued from page 1

departments. As they expand their reach, lay corporations will convert emergency medicine from a profession to a business. By definition, professions are self regulating. Physicians, as medical professionals, should only answer to themselves or to other physicians. Do we want to remain as professionals or become "workers" in a business ultimately controlled by lay shareholders? Furthermore, lay corporate groups often violate the practice rights of emergency physicians. Their directors and officers have a fiduciary duty to shareholders, not patients. Reflecting the large presence of corporate influence in emergency medicine, a renowned Texas surgeon repeatedly referred to emergency physicians as "emergency room entrepreneurs" in op-ed articles in the medical literature. He repeatedly showed a slide at national meetings stating "Emergency Room Entrepreneurs are Hazardous to Your Health."

How many emergency physicians enjoy being subjected to such ridicule? Isn't it time to clean up our specialty? How many of us complain but do nothing to resolve our myriad problems? Instead of being upset at the Texas surgeon, we should realize that his statements have a strong basis in fact. We should thank him for drawing attention to this issue. We should be upset at ourselves for not doing more to correct our problems.

Our case against TeamHealth has the potential to become a watershed case. It has the potential of leading to the enforcement of dormant state laws around the country, passed by legislatures to protect patients from corporate control of medical care. Our case has the potential to become the single most important legal event in your career, a case that will begin to rid us of the illegal and damaging influence of lay corporations in emergency medicine.

Please take a minute to remember why you decided to join AAEM. Think about the importance of your patients, your career, your self-respect, your commitment to emergency medicine. Make a donation to the AAEM Foundation like your career depends on it, like the well-being of your patients depends on it, like your future depends on it. This will be the most important professional donation of your career. Make it the most generous professional donation of your career.

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# Upcoming AAEM–Endorsed or AAEM–Sponsored Conferences for 2008 & 2009

AAEM is featuring the following upcoming endorsed, sponsored and recommended conferences and activities for your consideration. For a complete listing of upcoming endorsed conferences and other meetings, please log onto <http://www.aaem.org/education/conferences.php>

## April 4-6, 2008

- The Difficult Airway Course-Emergency™  
Chicago, IL  
<http://www.theairwaysite.com/index.php>

## April 8-10, 2008

- Dubai International Emergency & Catastrophe Management Conference & Exhibition – IECM Dubai 2008  
<http://www.imd.ae/emergency.htm>

## April 19-20, 2008

- AAEM Pearls of Wisdom Oral Board Review Course  
Chicago, Dallas, Los Angeles, Orlando, Philadelphia  
<http://www.aaem.org>

## May 2-4, 2008

- The Difficult Airway Course-Emergency™  
Boston, MA  
<http://www.theairwaysite.com/index.php>

## May 4-7, 2008

- The Heart Course-Emergency™  
Boston, MA  
<http://www.theheartcourse.com/>

## May 21-23, 2008

- High Risk Emergency Medicine: May 2008  
San Francisco, CA  
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## June 6-8, 2008

- The Difficult Airway Course-Emergency™  
Seattle, WA  
<http://www.theairwaysite.com/index.php>

## July 16-19, 2008

- Giant Steps in Emergency Medicine 2008: The Sun, the Sea...and CME  
San Diego, CA  
[www.GiantSteps-EM.com](http://www.GiantSteps-EM.com)

## July 31-August 3, 2008

- High Altitude Medicine Course (Mt. Rainier, Washington)  
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## September 20-21, 2008

- AAEM Pearls of Wisdom Oral Board Review Course  
Chicago, Dallas, Los Angeles, Orlando, Philadelphia  
[www.aaem.org](http://www.aaem.org)

## September 25-28, 2008

- AAEM Written Board Review Course  
Newark, New Jersey  
[www.aaem.org](http://www.aaem.org)

## October 10-12, 2008

- The Difficult Airway Course-Emergency™  
Las Vegas, NV  
<http://www.theairwaysite.com/index.php>

## October 13-15, 2008

- The Heart Course-Emergency™  
Las Vegas, NV  
<http://www.theheartcourse.com/>

## November 10-12, 2008

- SunBEEM (The Best Evidence in Emergency Medicine)  
Mayan Riviera, Mexico  
[www.beemcourse.com](http://www.beemcourse.com)

## November 14-16, 2008

- The Difficult Airway Course-Emergency™  
Atlanta, GA  
<http://www.theairwaysite.com/index.php>

## January 26-28, 2009

- SkiBEEM (The Best Evidence in Emergency Medicine)  
Silver Star Ski Resort, BC, Canada  
[www.beemcourse.com](http://www.beemcourse.com)

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.

# An Invitation to Our Community Docs... Get Involved

by William T. Durkin, Jr., MD FAAEM, AAEM Secretary-Treasurer

Another successful Scientific Assembly has concluded. I'm always energized by the collegiality and enthusiasm at these events. Many I talk to at these meetings bring suggestions or ideas as to how we can improve things; others express satisfaction with the Academy and all that it is doing, while some express an interest in becoming more involved and giving something back to the organization. Then the last lecture ends, we all pack up and everyone scatters to their homes across the country.

I have a request of you. Don't leave your enthusiasm and intentions in Amelia Island! We need people with your knowledge and experience. We would love to get you involved with the Academy throughout the year.

We are primarily an organization of mature physicians who no longer rely on teachers, mentors or structured institutions to make our own decisions. We are also a membership-driven organization. Thus, the Academy is *your* organization. Our actions are based on your ideas, your motivations and your resolve.

Not sure how to get involved?

Well, to start, the Academy's committees need active participants with fresh outlooks. Scan the list, and see if one appeals to you. Meetings usually take place via email or conference call. Larger committees meet in person at the Scientific Assembly, but most of the work is done prior to such meetings.

During the year, we occasionally need people to assist with different projects. We ask for help based on a record we keep of individual membership interests. So if you haven't done so already, please inform us of your interests. If your interest isn't represented on our master list, consider forming a small interest group to discuss your idea, and then present it to the board. You may well have an area of expertise that would be useful to other members.

The state chapters are a great way to stay abreast of the local issues and have real influence on state and community issues. The Tennessee and Louisiana chapters, for example, have directly influenced their state laws in favor of emergency physicians. If your state has a chapter, join in the fun. If not, we urge you to help create one.

Do you want to support our efforts against lay corporations that illegally practice medicine? Consider a donation to the AAEM Foundation.

Unlike other specialty societies, our leadership is directly elected by our members. This reflects a unique philosophy that our organization should be directly and absolutely responsible to its membership. So when you receive the candidates' statements, please take time to read them. The candidates have spent time composing these essays and are willing to spend time leading the Academy. Reading these statements will allow you to vote for the candidates who will best represent your views and opinions.

Because the Academy's leadership comes from the grass roots level, we greatly depend on our members to work on its committees, projects and state chapters. The Academy depends on your ideas and efforts. So take your ideas, use the motivation you showed at the Scientific Assembly, and make a difference.

We are only as good as the membership itself. I know that our membership has superb talents. We need your help now to keep this organization great.

As a member of the executive committee, I am always happy to hear from individual members. Feel free to contact me if you need guidance or have an idea you would like presented to the board. To you, I am available at any time.

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for more information.



# Operations Management Committee

by Dave Eitel, MD MBA FAAEM, Chair  
On Behalf of the OMC

On Friday, February 8, 2008, the new AAEM Operations Management Committee (OMC) held its inaugural meeting at the annual Scientific Assembly in Amelia Island, Florida. The committee consists of 75 members, several of them international. Committee chair, Dr. Dave Eitel, led the in-person meeting with thirty committee members in attendance. Committee members who were unable to attend were encouraged to provide input and recommendations prior to the meeting.

"There is a phenomenal amount of talent and expertise on this committee," stated Dr. Eitel. As committee members introduced themselves during the meeting, they identified areas of interests which will help in identifying subcommittee assignments. Ideas, recommendations and minutes were captured by AAEM staff members Ms. Janet Wilson and Ms. Jody Bath.

Since this was the first meeting of the committee, time was designated to discuss the decision making process and how the committee will function. It was decided that decision making would occur by consensus. Anyone, at any time, can bring forward an issue for a formal vote. The educational suggestions, perhaps even "advice" at times, that are developed or proposed will happen with oversight from the entire OMC membership and in keeping with established AAEM board policies. Most of the work of this committee will occur "virtually," and communications will be done through an OMC listserv.

Next, the committee discussed the overall goal, defined "Operations Management" and formed a mission statement.

## Overall Goal of the Committee

The goal of the OMC is to help physicians in AAEM to better understand and deal with the operational (i.e., "service delivery"; i.e., "administrative") issues in their practices.

## Definition of "Operations Management"

The group brainstormed and accepted the following definition to get the OMC started:

"Operations management is the service delivery and administrative decisions that impact the delivery of care to patients in the emergency medicine department."

## OMC Mission Statement

The following was agreed upon as a starting point: "Improve ED national patient care/safety and maximize healthcare efficiency through improvements in operations management in collaboration with our medical colleagues, hospital administrations and national interest groups."

In addition, brainstorming occurred regarding potential topics of interest to the OMC and AAEM's membership. There was agreement that the OMC should initially focus on five problems.

## 1. Data Driven and Evidence Based Operations Management Decision Making

There was a consensus that decision making regarding the service delivery and administrative decisions that impact the delivery of care to patients should be data driven and evidence based, as we do with clinical decisions.

## 2. Understanding the Process

It became apparent through the discussion that the OMC needs to first help our AAEM colleagues understand their ED process of care. All interested EPs should be able to define what their process is, identify bottlenecks to flow and then decide how to make their processes more efficient and effective.

## Recommendations from the OMC to AAEM colleagues:

### A. How to discover your particular ED care delivery process

The best way to do this is to "get into the shoes of your patients" and walk as they would, to get through the care delivery processes of your department. You want to identify all of the steps required to get into, through and discharged from your ED. Capture all the steps on a simple pad of paper, write it down and share it with ED colleagues to see what you might have missed – because you will miss some things. We all see the world through our own set of binoculars.

### B. How to represent your particular ED flow as a diagram

Many people today use a fairly simple flow chart graphing tool called Visio, a Microsoft product, to produce a visual of what you have discovered. But you do NOT need a software tool. You can very effectively use simple post-it notes, as shown here:



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# International Emergency Medicine: The Turkish Experience

Stephan Rinnert, MD, Andrew C. Miller, MD, Murat Ersel, MD PhD  
Editor, Christopher I. Doty, MD FAAEM

## Author Introduction:

Dr. Stephan Rinnert is the Vice Chairman of Emergency Medicine at the State University of New York (SUNY) Downstate Medical Center and Kings County Hospital Center in Brooklyn, NY. Born in Germany and raised in Istanbul, Dr. Rinnert's clinical experience began as a rotating medical student in several countries including Turkey. As an attending emergency physician, he has lectured and collaborated closely with Turkish colleagues on several educational EM projects through the non-profit organization EMEDEX International.

Dr. Andrew Miller is a clinical assistant instructor in the combined Emergency Medicine & Internal Medicine Residency Program at the State University of New York (SUNY) Downstate Medical Center and Kings County Hospital Center in Brooklyn, NY. He worked alongside the Turkish Red Crescent Society in Muzaffarabad, Pakistan following the South Asian Earthquake of 2005, and has lectured in Izmir, Turkey as well.

Dr. Murat Ersel is an attending physician in the Department of Emergency Medicine at Ege University in Izmir, Turkey. He has also worked for four years with the Emergency Association of Turkey (EMAT) Disaster Committee on disaster education and preparedness.

## National History & Social Context:

Turkey is uniquely situated as a bridge between Europe and Asia, and has long been a proverbial "melting pot" of cultures, ideas, ethnicities and religions. The country is rich in archeological treasures and echoes the sounds of bygone empires. With a population approaching 70 million, the modern Turkey is a secular democracy founded by the late Mustafa Kemal Atatürk in 1923. In 2005, Turkey applied for membership in the European Union. The primary religion is Islam; however, there is a long tradition of tolerance and coexistence with other religions as well. Indeed, in addition to ornate mosques, Istanbul is home to many treasured synagogues and churches, and remains the seat of the Greek Orthodox Church.

Not surprisingly, the official language is Turkish, however numerous other languages are spoken by minority groups throughout the country including Kurdish, Dimli (or Zaza), Azeri, Kabardian, Armenian, Arabic and other lesser known languages. Ethnic minority groups are comprised of Kurds, Arabs, Lazs, Circassians, Chechens, Armenians, Greeks, Albanians, Macedonians and Bosnians. The average per capita income is 5,561 USD.

## General Overview of the Healthcare System:

The Turkish healthcare system has three major functional branches. The largest and most visible of these branches is the public hospital and clinic structure administered by the Department of Health. This accounts for the bulk of major hospitals (769 of 1205) and primary care facilities

nationally. The second major arm consists of academic university hospitals and their affiliate medical schools. This branch is governed by the Higher Education Council of Turkey. Finally, there are the many private and not-for-profit medical centers nestled primarily within major cities. Most citizens enjoy general healthcare coverage through the governmental social security system. A fraction of healthcare is also provided by the military in well equipped facilities.

## Pre-hospital Care [EMS-System]:

Turkey has a well established pre-hospital EMS system with a centralized dispatching network analogous to the 911 system employed in the United States. Since the early nineties, the EMS system has used a countrywide number "112" and physicians and nurses are stationed on ambulances. In 2005, the Ministry of Health started to staff ambulances with paramedics, and to date more than two thousand paramedics have been hired.

## Emergency Medicine:

In the early 1990s, Turkey's first emergency medicine training program was established in the southwest coastal city of Izmir, bordering the Aegean Sea. Since that time, roughly 35 emergency medicine residency training programs have been established. Over the past five years however, the EM training system in Turkey has been forced to evolve. Most university hospitals have academic emergency medicine departments with small residencies. A recent push by the Department of Health to extend residency training into their public hospitals has created a tremendous need for EM trained attendings. The fact that there are only about 300-350 emergency medicine trained attending physicians has led to several understaffed residency training programs with inadequate attending supervision. Prior to the emergence of emergency medicine as a defined specialty, most hospitals staffed their EDs with "health practitioners," i.e., physicians without any specialty training in emergency medicine or other fields. This is still the practice in most hospitals throughout the country. Accordingly, there is a wide disparity in the quality of emergency care not only regionally, but also locally within the same city. An astute public has quickly recognized such disparities and has learned to hospital shop and self triage to various facilities based on the acuity of their problems. Public EDs are often faced with ever swelling patient numbers in the face of insufficient resources. Conversely, legal and administrative burdens are far less compared to their US counterparts. Workups and documentation are more streamlined allowing faster throughput times and bed turnover. Unfortunately, many EDs are still being used as observation units and patients often remain in the ED for days or even weeks. The approach to trauma is gradually changing in the EDs where EM trained physicians practice. Those centers (commonly university hospitals) often have the most modern diagnostic

*continued on page 12*





## 2009 MEMC in Valencia

by Joseph Lex, MD FAAEM

I know that the Fall of 2009 seems to be a long time away, but you must start planning now for the Fifth Mediterranean Emergency Medicine Congress (MEMC V) co-organized by AAEM and the European Society for Emergency Medicine (EuSEM). It will be in El Palacio de Congresos de Valencia ([www.palcongres-vlc.com](http://www.palcongres-vlc.com)) in Valencia, Spain, and already promises to surpass the first four congresses.

Valencia is the third largest city in Spain and sits on the Mediterranean Sea. The city has gone under some major overhauls and is one of the premier vacationing spots of Europe. You have probably seen many of the recent upgrades along the harbor during coverage of the 2007 32nd America's Cup competition, and Valencia has also been chosen as the site for the 33rd America's Cup competition.

The city is laid out in such a way that public transportation, foot or bicycles are the logical means of getting from one place to another. In fact, there's a dedicated bicycle path directly in front of the Congress Center, and you'll be able to rent bicycles and motor scooters onsite.

Bisecting the city is what used to be the River Turia. After a disastrous flood in 1957, the river was rerouted south of the city, and the old riverbed converted to a giant public space. The park, called the "Garden of the Turia" features numerous ponds, paths, fountains, flowers, cafés, artworks, climbing walls, an athletics track, a Zen garden and more. The many bridges overhead carry traffic across the park. You can traverse much of the city on foot or bicycle without ever using a road. See [www.culturia.org](http://www.culturia.org) for more on this amazing park.

At the far end of the park is Ciudad de las Artes y las Ciencias, or the City of Arts and Sciences, a collection of several buildings including El Palau de les Arts Reina Sofia (an opera house and performing arts center with a gravity-

defying roof), L'Hemisfèric (an Imax theater, planetarium and laserium), El Museu de les Ciències Príncipe Felipe (four-story science museum) and L'Oceanogràfic (the largest aquarium in Europe).

There are more than 1500 hotel rooms within easy walking distance of the conference center, with costs ranging from the budget two-star Ibis Hotel at €59 per night to the five-star Hilton Valencia and Sorolla Palace directly across the lawn from the congress, starting at €200 per night.

Before leaving the airport, and in an effort to make the congress as "green" as possible, all attendees will receive a pass good for any of the trams, subways and buses in the city. With an accompanying set of instructions, you will be able to navigate to your hotel without having to resort to a taxi or private automobile. See [www.valenciatouristcard.com](http://www.valenciatouristcard.com) for details.

The weather, of course, will be perfect in mid-September. Mild temperatures, bright Mediterranean sunshine and low humidity are the norm. ([www.aboutvalencia.com/](http://www.aboutvalencia.com/)).

If you're a food fan, all you have to know is that Valencia was the birthplace of paella, that magnificent rice-saffron-seafood dish which tastes like nothing else on earth. The city is surrounded by orange groves, and many of the streets are lined with orange trees burdened with fruit.

There will be more than 1500 emergency physicians from around the world, representing more than 70 countries. It's a perfect chance to interact with others from around the world and to find out what's new in emergency medicine.

I'll get you more information on the program soon, but I want you to start planning now so you won't miss this experience of a lifetime – MEMC-Valencia on 14-17 September 2009.

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*EM in Turkey - continued from page 11*

and therapeutic tools available, and emergency physicians have admitting privileges.

The overall acceptance of the specialty is gradually advancing, but the specialty is facing resistance and obstacles similar to those faced by the founding fathers of emergency medicine in the US 20 years ago. For example, emergency physicians are still not included in disaster preparedness planning and relief efforts.

The Emergency Medicine Association of Turkey (EMAT) is actively involved in establishing uniform educational guidelines and parameters for the country's training programs, as well as establishing an oversight body similar to our residency review committee (RRC). In the interim, there are several projects under way to train the vast army

of health practitioners in the most basic EM topics and procedures. Additionally, programs are working with outside groups to implement the use of novel training modalities such as the employment of interactive medical simulators to help teach and improve the quality of resuscitation efforts. Moreover, the government recently increased the salaries for EM physicians; however, they still trail far behind those of other specialties.

### Future of Emergency Medicine in Turkey:

The future for EM in Turkey is bright. The present cadre of EM trained attendings is extremely active, enthusiastic and driven to bring EM to the forefront of Turkish medicine. Testament to that are the numerous changes that EMAT has introduced, and is working to introduce, to the healthcare system of Turkey.

### Emergency Medicine Documentation

- AAA risk factors: smoker  
 ischemic bowel risk factors:  
AFib  
vasculopathy  
elderly

### Bedside Risk Management:

**Risk factors are clearly and consistently placed within high-risk chief complaints to guide providers through the key clinical indicators.**

**Physician-Supervised Infusion Therapy:** given over 60 / 90 / 120 / \_\_\_\_ min

**indications:** dehydration / nausea / vomiting / pain

**fluids:** 1000 mL NS / LR      **response:** improved hydration

**additives:** 30mg 4mg morphine 4mg      **response:** improved nausea vomiting  
improved pain

For example, in your practice, how often do you *incompletely* document infusion therapy? Does your documentation support the valuable services you provide?

Email: [aaempeercharts@evolvemed.com](mailto:aaempeercharts@evolvemed.com)



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# MedPAC Recommends 1.1% Increase in Physician Payments for 2009

by Kathleen Ream, Director of Government Affairs

On January 10, the Medicare Payment Advisory Commission (MedPAC) voted to recommend that physicians in 2009 receive a 1.1% increase in payments over 2008. The recommendation, which is to appear in MedPAC's March report to Congress, is based on a staff report indicating that beneficiary access to physicians is still reasonably good. In addition, the recommendation is intended to address whether payments are adequate, as well as whether they should be updated.

Commission Chair, Glenn Hackbarth, said that the recommendation means that the commissioners are sending a message that they do not believe physician fees should be cut or frozen. Regardless of MedPAC's recommendations to Congress, however, physicians' fees are determined by the sustainable growth rate (SGR) formula that would have resulted in a 10.1% decrease for doctors in 2008, until Congress intervened at the end of 2007.

The 2009 MedPAC recommendation comes at a time when the issue of physician payments for 2008 is in flux. *The Medicare, Medicaid and SCHIP Extension Act of 2007*, signed by President Bush December 29, 2007, converted the 10.1% cut in reimbursements required by the SGR formula into a 0.5% increase. That increase expires on June 30, however. The \$3.1 billion six-month increase is being paid for in part by a fund that CMS set aside for the Physician Quality Reporting Initiative (PQRI), a program under which physicians who report quality measures are eligible for extra payments. *The Tax Relief and Health Care Act of 2006* allocated \$1.35 billion to be used for either the 2008 PQRI bonus payments or for physician fees. While CMS had decided to use the money for the PQRI, Congress overrode that decision in the bill signed at the end of December, so that most of the money is being used to fund the 0.5% increase. In the 2007 legislation, Congress did extend the PQRI to 2009, but will fund it through the Supplementary Medical Insurance (Part B) Trust Fund, without the \$1.35 billion cap on total funding that was in the 2006 law.

The 2007 law also established a \$5 billion pool of funds for future doctor updates. MedPAC's principal policy analyst, John Richardson, said that, in light of the fact that under the current SGR formula there will be cuts in physician payments through 2016, "The important takeaway at this point is to be aware of the fund's existence."

## No Material Facts: EMTALA Suit Dismissed

Based on a plaintiff's insufficient evidence, on January 29, 2008, the U.S. District Court for the Eastern District of Pennsylvania dismissed an EMTALA claim that a hospital was liable for failure to stabilize an unborn baby in imminent danger (*Torretti v. Paoli Memorial Hospital*, E.D. Pa., No. 06-3003, 1/29/08).

## The Facts

Plaintiff Honey Torretti, 34 weeks into pregnancy with a second child, phoned her obstetrician on a Friday voicing a concern about pre-term labor and decreased fetal movement, but suspected that the condition was not an emergency. Her doctor advised her to keep a routine outpatient testing appointment, which previously had been scheduled for the following Monday, at the Paoli

Memorial Hospital Testing Center (defendant). Following an examination of the routine tests that Monday, Torretti was advised to go directly to the hospital where her obstetrician practices and where further monitoring could continue in an inpatient setting.

No ambulance was called for Torretti as the doctor at the testing center did not perceive an acute emergency. Torretti was admitted to the second hospital in "pre-term labor and with 'non reassuring [fetal heart tones].'" A baby boy was delivered having low Apgar scores and in need of resuscitation and ventilation. The baby suffered permanent mental and physical damage.

Plaintiff brought suit against Paoli Memorial Hospital claiming that defendant violated EMTALA requirements to conduct an appropriate medical screening, to stabilize treatment of an unknown emergency condition and to restrict transfer until a patient is stabilized. Following discovery, defendant sought summary judgment on the EMTALA count.

## The Ruling

The standard for deciding summary judgment requires that the moving party "bears the burden of proving no genuine issue of material fact is in dispute and the court must review all of the evidence in the record and draw all reasonable inferences in favor of the nonmoving party." Thus, the federal district court iterated that to establish an EMTALA stabilization violation, "Torretti must prove she had 'an emergency medical condition, 2) the hospital actually knew of that condition, [and] 3) the patient was not stabilized before being transferred.'"

Recognizing that a reasonableness standard does not apply, the court stated that EMTALA duties will not arise when a hospital does not know of or diagnose any particular emergency medical condition. The court's obligation in this case then was to determine whether there was sufficient evidence to sustain the claim under EMTALA, by examining defendant's knowledge of plaintiff's condition "in relation to cases in which EMTALA liability has been found for failure to stabilize and in relation to cases in which no liability has been found for failure to stabilize." Numerous relevant cases were reviewed by the court and discussed in the opinion.

The district court found that plaintiff appeared at the hospital at the anticipated time of a previously scheduled appointment; Torretti did not present herself to the hospital as an emergency patient, nor did the nurse or doctor at defendant's testing center exhibit "any indication [plaintiff's] condition was an emergency." The court also determined that plaintiff's expert witness addressed only what the testing center doctor "should have known," not what the physician "actually knew at the time." Such testimony may sustain a medical malpractice suit but, wrote the court, "it is not enough to support a claim under EMTALA." Summary judgment was granted for Paoli Memorial Hospital.

To read the court's decision, go to <http://op.bna.com/hl.nsf/r?Open=psts-7bdnvs>.

*continued on page 20*



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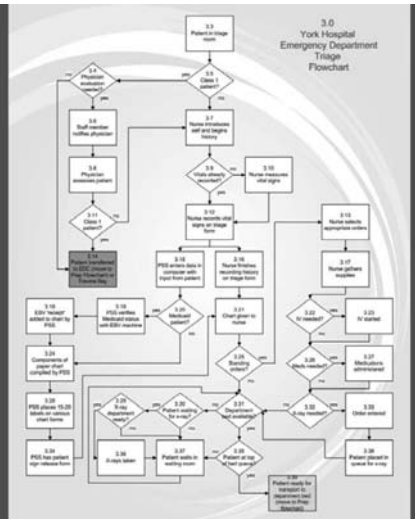
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When you acquire a software flow mapping tool you can produce a visual such as this:

Place the activity steps into a standard flow chart to document the process



This flow chart was done to capture the details of an ED's triage process. The point to be made by this graphic is that once you begin to examine your processes, you will be absolutely amazed at the complexity we have allowed to creep into how we deliver care to our patients. The goal of doing so is to begin to think about patient flow bottlenecks and potential solutions to those bottlenecks.

**Tip from an expert:**

Dr. Sheldon Jacobson reminds us that although process mapping is a great way to get started, operations flow diagrams are linear, and EDs operate under “non-linear” conditions: lots of dependencies and interdependencies. Some solutions that seem logical can make matters worse by creating additional or new bottlenecks downstream. He suggests that one way to get around this is to develop a reliable series of metrics and make each intervention small perturbations in the system. Then one waits until there has been adequate time for equilibration and evaluates the new metrics. He also reminds us that the most complex elements in the system are the personnel working in it, and most bottlenecks have structural as well as human factors.

### 3. Bottleneck (Hall 1991):

“The most important concept in any service system is that of the bottleneck. In most service systems, delays are greatly influenced by the performance of the bottleneck. To improve the performance of the entire system, one must identify the bottlenecks and improve their performance.”

#### 4. Time Traps vs. Capacity Constraints (George et al 2005)

Time traps insert delays into a process. They are sometimes erroneously labeled “bottlenecks.” The term bottleneck is imprecise, because it does not distinguish between steps that inject delays (time traps) vs. those that cannot operate at required levels (capacity constraints). Time traps are caused

by things like poor management policies, long set up times, machine or human downtime or unavailabilities or quality problems. They can change over time.

Work on the time trap that is injecting the most amount of delay into your process first. [Eitel: time traps can be fixed by “Leaning” them = using the principles of the Lean business improvement method.]

## 5. Capacity Constraints

Capacity constraints limit the capacity of the process. A capacity constraint often has less capacity than previous or subsequent steps/operations. These too can change over time: monthly, weekly and even daily [Eitel: such change is usually due to variation - variation in demand and variation within the system itself.]

Capacity constraints often have to be fixed by adding resources into the process/system. But be certain you have evaluated the impacts of variation, inter-dependency and complexity before making the assumption that more resources are needed. The assumption that more resources are needed may be incorrect.

## Two questions to the AAEM membership from the OMC:

1. Are there any bottlenecks in your ED that give you particular difficulty?

If so, please send them to the OMC. We will gather a list of important-to-the-membership bottlenecks for which the OMC may be able to develop interventions or deliver evidence based advice.

**2. Have any of you identified and/or successfully implemented a particular bottleneck solution?**

If so, please share them with the OMC. We will gather a list of potential or successfully applied bottleneck solutions to share with all AAEM members.

### How to contact the OMC:

Please submit your ED bottleneck or a particular solution to an ED bottleneck to [info@aaem.org](mailto:info@aaem.org). All feedback will be forwarded to the OMC. Feel free to contact Dave Eitel, chair of OMC, at [daveitel@comcast.net](mailto:daveitel@comcast.net) if you feel you have a specific question or concern for the Operations Management Committee.



*The following awards were announced at the  
14th Annual Scientific Assembly in  
Amelia Island, FL.*



**David K. Wagner Award** – Robert McNamara, MD FAAEM

**Peter Rosen Award** – Judith Tintinalli, MD FAAEM

**James Keaney Leadership Award** – Kevin Beier, MD FAAEM

**Young Educator Award** – Michael Epter, DO FAAEM

**Resident of the Year Award** – Daniel Nishijima, MD

**Joe Lex Educator of the Year Award** – Amal Mattu, MD FAAEM

**Program Director of the Year** – Gus Garmel, MD FAAEM

**International EM Award** – Indrani Sheridan, MD FAAEM

### Special Recognition

Departing Board Member	Stephen Hayden, MD FAAEM
Departing Board Member	Mark Reiter, MD FAAEM
Departing Board Member	Kevin Rodgers, MD FAAEM
Departing Board Member	Andrew Pickens, MD JD MBA

### AAEM/JEM Research Competition

First Place – Hannah Watts, MD

Second Place – Kristie Robson, MD

Third Place – Jonathan G. Crisp, MD

### 2007 AAEM Service Awards for Oral Board Examiners

15 sessions:	Bill Gossman, MD FAAEM Bruce Lobitz, MD FAAEM
10 sessions:	Richard D. Brantner, MD FAAEM Bryan K. Miksanek, MD FAAEM
5 sessions:	Richard Boggs, MD FAAEM Eric C. Bruno, MD FAAEM Michael Luszcak, DO FAAEM Robin A. C. Marshall, MD FAAEM Deborah R. Natale, MD FAAEM Robert C. Oelhaf, Jr., MD FAAEM John Queen, MD FAAEM William M. Shapiro, MD FAAEM Kenneth Scott Whitlow, DO FAAEM Allen S. Yee, MD FAAEM

# 14TH ANNUAL SCIENTIFIC ASSEMBLY IN AMELIA ISLAND, FL



Attendees enjoying an evening by the pool at the RSA & YPS Social.



Eric Berkowitz, PhD, Keynote Speaker, opens the Scientific Assembly on Thursday, February 7, 2008.

Amal Mattu, MD FAAEM, lectures on Emergency Cardiology

Stephen Hayden, MD FAAEM, (right), Editor-in-Chief of the *Journal of Emergency Medicine*, with the winners of the AAEM/JEM Resident and Student Research Competition, from left, Jonathan Crisp, MD, Kristie Robson, MD and Hannah Watts, MD





# 14TH ANNUAL SCIENTIFIC ASSEMBLY IN AMELIA ISLAND, FL



Tom Scaletta, MD FAAEM, AAEM President, with Judith Tintinalli, MD FAAEM, who received the Peter Rosen Award on February 7, 2008.



Attendees walking through the Photo Competition room. Seventy-four photos were on display at the Scientific Assembly.



Tom Scaletta, MD FAAEM, AAEM President, presenting Robert McNamara, MD FAAEM, with the David K. Wagner Award.



Pre-Conference courses were held February 5 and 6. The Advanced Ultrasound Course featured both didactic and interactive hands-on sessions with faculty.



Tom Scaletta, MD FAAEM, David Kramer, MD FAAEM, Robert McNamara, MD FAAEM, Mark Reiter, MD FAAEM and Gunnar Ohlen, MD PhD, at the Foundation Casino Night.

### Another EMTALA Disparate Treatment Claim Dismissed

On January 23, 2008, the U.S. District Court for the Eastern District of Missouri ruled against the claim that the medical screening received at an ED was in violation of EMTALA because it was disparate from the screening received by individuals presenting with similar symptoms (*Mead v. Salem Memorial District Hospital*, E.D. Mo., No. 4:07CV452, 1/23/08).

#### The Facts

In April 2005, Bobbie Mead (plaintiff) presented to the ED at Salem Memorial District Hospital (defendant) "with neurological signs and symptoms, including but not limited to left sided weakness." Mead came under the care and treatment of Chukwuemeka M. Ekeke, MD (defendant). Ekeke discharged Mead after examining him and diagnosing a "mild TIA, left calf strain."

Later, Mead was "transported to St. John's Hospital via air ambulance with a diagnosis of acute stroke." Plaintiff claimed that as a result of the stroke, he "suffered permanent and progressive neurological injury and damage, including but not limited to paralysis." Three years later in March 2008, Mead filed a complaint against defendants seeking damages for alleged negligent medical treatment under Missouri law and alleging a violation of EMTALA.

For the EMTALA claim, Mead argued that Ekeke 1) failed to provide an appropriate medical screening examination within the capability of the ED; 2) failed to appropriately diagnose the emergency medical condition, thus jeopardizing plaintiff's health; and 3) failed to stabilize or to provide stabilizing treatment. Defendants filed a motion to dismiss, contending that Mead's complaints are "insufficient to invoke federal jurisdiction under EMTALA."

#### The Ruling

The federal district court reviewing this case acknowledged that allegations in a complaint must be construed in plaintiff's favor when examining a motion to dismiss. And too, the court noted that a "complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of the claim that would entitle plaintiff to relief."

Proof of a lack of uniform treatment with other similarly situated patients is the cornerstone of an EMTALA claim. Yet, the court found that nowhere in Mead's complaint does he "mention that there was any disparate treatment involved." Rather, the court pointed out that plaintiff's claim is that Ekeke and the hospital "failed to properly treat and/or diagnose Plaintiff's condition, which is not a proper basis for stating a claim under EMTALA." Also as required by EMTALA, Mead neglected to allege that the "hospital determined or had any actual knowledge that he had 'an emergency medical condition,' which the hospital failed to stabilize."

Therefore, the U.S. District Court for the Eastern District of Missouri dismissed Mead's case for "failure to state a claim upon which relief can be granted . . . [and] for lack of subject matter jurisdiction."

To read this opinion, go to [http://op.bna.com/hl.nsf/id/psts-7barcr/\\$File/mead.pdf](http://op.bna.com/hl.nsf/id/psts-7barcr/$File/mead.pdf).

### EMTALA Screening of Inpatient Applies to Unborn Child

On January 24, 2008, the Wisconsin Court of Appeals, District IV, affirmed that EMTALA's medical screening requirement does not apply to inpatients, including this case of a premature infant born after his mother was admitted to a hospital and taken to the hospital birthing center where the infant was birthed (*Preston v. Meriter Hospital Inc.*, Wis. Ct. App., No. 2006AP3013, 1/24/08).

#### The Facts

Shannon Preston (plaintiff) arrived at Meriter Hospital (defendant) on November 9, 1999, where she was admitted and taken to Meriter's birthing center. More than ten hours later, Preston gave birth to a baby boy, weighing one and one-half pounds and who could not survive on his own (i.e., absent resuscitation and the administration of oxygen and fluids). The baby was provided nursing care, but the hospital did not resuscitate or treat the child, who survived for two and one-half hours.

Preston sued Meriter for medical negligence, for failing to obtain informed consent, for neglecting a patient and for violating EMTALA, 42 U.S.C. § 1395dd. A circuit court dismissed the claims. Preston appealed the dismissal and, in 2004, the District IV Court of Appeals affirmed the lower court's ruling. [See *Preston v. Meriter Hosp., Inc. (Preston I)*, 2004 WI App 61, 271 Wis. 2d 721, 678 N.W.2d 347.]

Plaintiff then appealed to the Wisconsin Supreme Court, seeking a review of the appellate court ruling, [See *Preston v. Meriter Hosp., Inc. (Preston II)*, 2005 WI 122, 284 Wis. 2d 264, 700 N.W.2d 158.] The Supreme Court reversed the dismissal "based on its determination that the phrase 'comes to the emergency department' applies to the hospital's birthing center as well as to its emergency room." However, the high court remanded the case for briefing on the issue of whether the EMTALA "screening requirement applies to inpatients or whether the newborn infant of a woman who is herself admitted to the hospital is also an inpatient by virtue of the mother's admission."

On remand, defendant moved for summary judgment on the inpatient issue, which the circuit court granted, noting that Preston's child became an inpatient, at the same time as Preston, and remained so until his subsequent death. Plaintiff then appealed the inpatient ruling.

#### The Ruling

Plaintiff argued that the state's supreme court holding that a "newborn has come to a birthing center for purposes of the screening requirement, the court implicitly held that the screening requirement continues to be in effect even after a patient's admission." The District IV appeals court, however, also saw that the higher court's question of the premature baby's inpatient status "could affect the validity of Preston's screening requirement claim."

Finding that EMTALA is silent as to whether the screening requirement applies to inpatients, the appellate judges looked to numerous federal courts of appeal that have decided upon this issue, as well as to the U.S.

*continued on page 21*



## State Chapter Updates – New York

The New York State Chapter (NY AAEM) took a pro-active stance when they became aware that an emergency department within the state of New York was choosing the next contract holder, and among those under consideration, was a corporate contract group.

The New York Education Law forbids corporations from practicing medicine [§6527(1)]. Corporations cannot hire doctors to act on their behalf and take profit from the services rendered. Splitting fees is also restricted by NY case law {United Calendar Mfg. Corp. v. Huang, 463 NYS 2d 497 (NY App. Div. 1983)}.

Given the situation, NY AAEM and AAEM sent a letter to the hospital expressing their concern about the possible violation of EP rights, as well as possible violation of New York law. The letter can be found at [http://www.aaem.org/secure/repository/files/docs/1203101382-Lenox\\_Hill\\_Support\\_Letter\\_8\\_14\\_07.pdf](http://www.aaem.org/secure/repository/files/docs/1203101382-Lenox_Hill_Support_Letter_8_14_07.pdf). In the end, the hospital selected a new ED director and has made a commitment to have all EM board certified physicians.

Are you interested in joining NY AAEM or another state chapter? Please sign up today at <https://ssl18.pair.com/aaemorg/membership/application.php>. Are you interested in setting up a State Chapter? Please see <http://www.aaem.org/statechapters/> for more information.

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Washington Watch - continued from page 20

Department of Health and Human Services regulations, 42 C.F.R. § 489.24 (2003), clarifying that “EMTALA’s stabilization requirement does not apply once a patient is admitted to a hospital.” Determining that there is “no principled basis upon which to distinguish between the screening requirement and the stabilization requirement in the context of a person’s status as an inpatient,” the Wisconsin court then decided that a hospital’s obligation under the EMTALA screening requirement “ceases to apply once an individual has been admitted to a hospital for inpatient care.” Upon admission, wrote the court, the patient’s care “is then governed by state tort and medical malpractice law which all jurisdictions agree EMTALA was not intended to preempt.”

Turning to the issue of whether Preston’s baby was an inpatient at Meriter hospital, the court of appeals cited the lower court’s statement that the care plaintiff received was “inexorably linked to the fact that she was carrying her unborn child.” The court concluded that birth was the treatment for which plaintiff presented and was the treatment affecting the premature baby. The Wisconsin appellate court ruled that the EMTALA screening requirement does not apply “when a hospital provides inpatient care to a woman that involves treating her fetus simultaneously, the unborn child is a second inpatient, admitted at the same time as the mother.”

Go to <http://www.wicourts.gov> for more details of this opinion.



# Resident & Student Association



## RESIDENT PRESIDENT'S MESSAGE

Andrew T. Pickens, IV, MD JD MBA  
President, AAEM/RSA

During my presidency, I have written a number of articles regarding a variety of topics. The common theme to all of them is that it is important as a future or present emergency medicine physician to become involved in advocacy in one form or another. This is why I initially became involved in the AAEM/RSA and why I have urged others to do so.

I recently attended AAEM's Scientific Assembly in Amelia Island. It was heartening to see how many residents and students are interested and informed regarding the preeminent issues facing the practice of emergency medicine. The importance and implications of AAEM's corporate practice of medicine litigation in Texas against TeamHealth, challenges to who can be considered board certified and the recent changes in policy of ACEP to allow non-board certified individuals to become fellows, are all issues that were discussed, among many more. There was a real passion in the debate regarding these issues. This passion is where good, strong advocacy starts.

As many of you are reading this, you most likely recently found out where you will be attending residency starting this June. I urge you to become involved outside of your residency. Our current board is comprised of four members that were serving their term as first year residents. They brought fresh ideas and enthusiasm to their positions, probably, in part, because they became involved so early in their career. In return, I believe they obtained knowledge and experience regarding the bigger picture of emergency medicine than we are often privy to when we stay within the confines of our residencies.

So, my message is simple; become involved. Become involved early. Learn as much as you can. And, pardon me for being partial, but join AAEM/RSA to achieve this. Remember, *FAAEM always* means board certified. With the exception of the founders of our specialty who became practice-eligible, board certified should ALWAYS mean emergency medicine residency trained.

## Resident Journal Review: November – December 2007

*This is a continuing column summarizing journal articles pertinent to EM residents. It is not meant to provide 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 will include articles published over a two month period. These selections are from papers published in November and December 2007.*

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

**Onalan O, Crystal E, Daoulah A, Lau C, Crystal A, Lashovsky I. Meta-analysis of magnesium therapy for the acute management of rapid atrial fibrillation. The American Journal of Cardiology 2007;99:1726-32.**

This meta-analysis studied the use of magnesium sulfate for the acute management of atrial fibrillation with rapid ventricular rate. The primary outcomes analyzed were success in achieving rate control, rhythm control or both. Secondary outcomes were the time to a response and the risk of a major adverse effect. The final analysis used eight trials for rhythm control and seven trials for rate control. The total administered magnesium in trials ranged from 1.2 to 10 grams, with an initial dose of 1.2 to 5 grams given over 1 to 30 minutes.

The study design was not uniform in its comparison of magnesium sulfate therapy to placebo or standard care; however, several patterns were suggested by the Forrest plots. Magnesium was more effective than the control group for rate control (pooled OR 1.96, 95% CI 1.24 – 3.08), rhythm control (pooled OR 1.6, 95% CI 1.07 – 2.38) or either rate or rhythm control (pooled OR 4.61, 95% CI 2.67 – 7.96). Individual studies showed similar reductions in ventricular rates comparing magnesium to diltiazem or amiodarone.

This study supports further investigation into the use of magnesium sulfate for the acute management of atrial fibrillation with rapid ventricular rate. Magnesium is safe, inexpensive and widely available in emergency departments. In cases of atrial fibrillation that are difficult to control using conventional therapy, intravenous magnesium should be considered as another therapeutic option. More research is needed to explore its use as an adjunctive agent to existing pharmacotherapy, as large well-conducted trials are currently lacking.

**Gupta K, Hooton TM, Roberts PL, Stamm WE. Short-course nitrofurantoin for the treatment of acute uncomplicated cystitis in women. Arch Intern Med 2007;167:2207-12.**

*continued on page 24*



## “Resident Spotlight On” . . . Interview

by Keith Allen, MD

*Raquel M. Schears, MD MPH*  
Assistant Professor of Emergency Medicine  
College of Medicine  
Mayo Clinic

Dr. Schears graduated from the University of Wisconsin, Madison, in 1987 with degrees in the History of Medicine and Zoology. She attended medical school at Washington University School of Medicine in St. Louis and graduated in 1991. She completed her residency in emergency medicine and a Masters in Public Health at Johns Hopkins University in Baltimore, MD, in 1994. She remained at Hopkins for two more years where she was the Assistant Chief of Service. She then moved to Philadelphia where she was on the faculty of emergency medicine for five years in their then-new emergency medicine program, the Hospital of the University of Pennsylvania. In 2001, she moved to Rochester, MN, where she is now an Assistant Professor of Emergency Medicine at the Mayo Clinic. She was interviewed by Dr. Keith Allen on Wednesday, January 16, 2008. The text of the interview has been edited for length and clarity and should not be taken as a precise transcription.

Keith Allen (KA): What is it about emergency medicine that attracted you to the discipline?

Raquel Schears (RS): I think the variety of the patient presentations, the pace of the environment and some of the research aspects of the clinical practice and the patterned thinking of an emergency medicine physician where you can't focus on ten things; you have to narrow your list down and you have to be more of a thin slicer when it comes to a medical evaluation.

KA: More than one person has observed the personalities that go into different disciplines tend to be fairly stereotypical, and one of the comments that's been made of emergency medicine people is that they tend to be a little "attention deficit" in the sense that they constantly need a new stimulus. Do you think that applies to you at all?

RS: Oh yes. I think we all live for the adrenaline rush of a new case that we get to test our skills against and to take care of people. Yes, I agree. But in that same attention deficit, I do think we're able to focus and help our patients.

KA: In some people's minds, emergency medicine is a relatively young discipline still trying to find its place in this world. The EMTALA law that was passed has changed the way emergency medicine is practiced in large part. In what ways have you seen emergency medicine change as the result of EMTALA?

RS: I think hospitals are more worried about the impression or the perception that they may be dumping patients on public and county hospitals. So, I think the

transparency that's been provided with this legislation is good, because it forces private hospitals to take care of patients or at least stabilize them and take care of perinatal emergencies. So, I think it's a good thing. It's forced some transparency onto practices which were transferring patients. However, it's come without any kind of money or any kind of federal funding. So, it does create a lot of problems for those who are trying to work in overcrowded emergency departments and can't really deflect transfers and things of that nature.

KA: Do you feel that the influence of the EMTALA law will mean that emergency medicine will be practiced more as an academic discipline rather than as a component of community hospitals?

RS: No. I think that the world wants to have an emergency department they can go to. Some people may prefer an academician as their physician and maybe a broader range of hospital specialists under the same hospital umbrella. But, I don't think we'll ever divorce the EMS transfer to the ER from the American public's mind if you have a serious problem or a crisis you are transported to an emergency room. I don't think there are enough academic centers to cover the breadth of the country so for that reason, I think the community hospital emergency department will always have a place.

KA: Emergency medicine people at their very best have been characterized as folks who have a broad understanding of medicine and can answer a lot of important questions on the spot, even to the point of diagnosing unusual or rare conditions that have escaped the notice of other practitioners. In your opinion, what do you think emergency physicians do best?

RS: I think we do the paradigm best, which is that we worry about the life-threatening and limb-threatening diagnoses on a differential, and we don't necessarily bother with all the details of other less relevant past medical history in making the diagnosis of our patients. And, we have the resources associated with the emergency department that can often actually get things done a lot quicker. So, I think treatments can be started more rapidly, and the diagnosis can often actually be arrived at more rapidly than through a clinic or office setting.

KA: It does seem that people bypass the normal procedure of going to a clinic when they know that things can happen a bit more quickly through the emergency department.

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Despite its use for more than 50 years, few studies have examined a short-course of nitrofurantoin in the treatment of acute uncomplicated cystitis. This open-label study compared the efficacy of a five day course of nitrofurantoin to three days of trimethoprim-sulfamethoxazole in 338 18 to 45 year-old women. The primary outcome measure was clinical cure at 30 days; secondary outcomes were clinical and microbiologic cure at five and nine days after therapy.

The overall cure rate at 30 days was 79% for trimethoprim-sulfamethoxazole and 84% for nitrofurantoin (nonsignificant difference: -5%, 95% CI -13 to +4 %). Clinical and microbiological cure rates were also equivalent at the early follow-up visits. The treatments were tolerated similarly: at least one adverse effect was reported in 41% of patients on trimethoprim-sulfamethoxazole and 39% of patients on nitrofurantoin.

This study gives promising support for another fluoroquinolone-sparing option for the treatment of acute uncomplicated cystitis. In patients who have an allergy to sulfa drugs, in practice areas with a high prevalence of trimethoprim-sulfamethoxazole resistance or when there is a high clinical suspicion of trimethoprim-sulfamethoxazole-resistant infection, a five-day course of nitrofurantoin appears to be safe and efficacious. Additionally, although this trial was not designed to evaluate the effectiveness of a three day course of nitrofurantoin, microbiologic cure was achieved in most women (98%). Further evaluation of comparable duration therapy may result in an even more attractive alternative to conventional trimethoprim-sulfamethoxazole therapy for acute uncomplicated cystitis.

**de Jong YP, Uil SM, Grotjohan HP, Postma DS, Kerstjens HA, van den Berg JW. Oral or IV Prednisolone in the Treatment of COPD Exacerbations: A Randomized, Controlled, Double-blind Study. Chest 2007;132:1741-7.**

The optimal route of administration of systemic steroids in acute exacerbations of chronic obstructive pulmonary disease has not been rigorously studied. This prospective, randomized, double-blind, double-dummy, placebo-controlled trial investigated the equivalency of oral and intravenous corticosteroids in patients presenting with an acute exacerbation of COPD. Treatment failure was the primary outcome.

One hundred seven patients were randomized to intravenous prednisolone; 103 patients were randomized to oral prednisolone. Treatment failure was defined as death from any cause, admission to the intensive care unit, readmission to the hospital because of COPD or the necessity to intensify pharmacologic therapy. Kaplan-Meier estimates of early and late treatment failure showed no differences between the two groups.

Oral steroids are more convenient to administer and the bioavailability of prednisolone is nearly 100% under normal circumstances. This study supports the use of oral prednisone in patients with an acute exacerbation of COPD, as

long as it is feasible and the patient is not vomiting.

**Carlhom DJ, Rubenfeld GD. Barriers to implementing protocol-based sepsis resuscitation in the emergency department--results of a national survey. Critical Care Medicine 2007;35:2525-32.**

Early goal-directed therapy (EGDT) in sepsis has a validated survival benefit and is supported by evidence-based guidelines. Despite evidence and support however, implementation of protocols and practice adoption is not complete. The authors describe a nationwide survey of emergency department physicians and nurses to identify perceived barriers to implementation of EGDT.

The authors conducted structured interviews with five national experts in emergency sepsis care. The responses of these participants were used to identify perceived barriers to EGDT implementation and inform the survey instrument. If respondents were not planning on developing a written EGDT protocol, they were asked three open-ended questions about their reasoning.

The authors specifically targeted large busy urban centers; the top 25 United States Census Bureau combined statistical areas were selected for sampling. In each area, the two busiest teaching and non-teaching centers were enrolled. For each site, the clinical nurse manager and the medical director of the emergency department were contacted. Responses were obtained from 64 of 200 subjects (32%), representing 53 institutions in 24 combined statistical areas.

Fourteen institutions were not using or planning an EGDT written protocol, twenty-four hospitals were currently using an EGDT protocol, and fifteen institutions were planning a written protocol. Overall, "nursing staff required to perform EGDT" was cited as the top implementation barrier 52% of the time. The study found no differences in implementation barriers identified by physicians at academic centers compared to non-academic centers.

The studies highlight that there are many perceived barriers to the adoption of EDGT. Efforts to improve adoption of written protocols will need to address these areas of concern. Furthermore, the authors showed that while some of these concerns were shared by nurses and physicians, others were not. Efforts to improve implementation of this practice will need to account for these differences in perception.

**Anderson DR, Kahn SR, Rodger MA, et al. Computed tomographic pulmonary angiography vs. ventilation-perfusion lung scanning in patients with suspected pulmonary embolism: a randomized controlled trial. JAMA 2007;298:2743-53.**

This study was a direct comparison of ventilation-perfusion (V/Q) scanning to computed tomographic pulmonary angiography (CTPA). The investigators conducted

*continued on page 27*



## Healthcare 2008

Megan Boysen, MD  
AAEM/RSA Secretary-Treasurer

The approaching election has put healthcare in the forefront of the political debate. During the primaries, we saw a myriad of proposals including single-payer universal healthcare, government approved private insurance, the expansion of a Medicare-type system for availability to every American and tax benefits for the purchase of private health insurance. The effect of the 47 million uninsured in the United States has caught the attention of Washington, and the candidates have responded through proposed drastic changes to the current healthcare system.

Regardless of the candidate elected -- or the success of their efforts -- the practice of emergency medicine will be affected by the decisions made by national and local government. As a group, emergency physicians are unique in that we treat everyone who comes to our departments, irrespective of their ability to pay, insurance status or even citizenship. As such, we are dynamically affected by any plan which involves patient funding. The majority of proposals endorse more government involvement in healthcare, not less. While this does not necessarily mean we are on the brink of socialized medicine, it does mean that each candidate has a plan to mitigate the problem of the nation's un- and underinsured. Whether this is through tax benefits, accessible private insurance plans, the expansion of government insurance, or a single-payer system, will make itself evident in the next four, eight or forty-eight years. If government does become more involved in patient funding, increased regulation of patient care could follow.

Although the government-assisted insurance proposals could benefit our profession tremendously through providing funding for our uninsured population and alleviating overcrowding through primary care availability for all Americans, we also run the risk of increased government regulation of reimbursement, technology and clinical decision making. Compensation for studies or tests ordered in acts of "defensive medicine" could be diminished, while our medico-legal liability would remain unchanged.

Our conscientious involvement in the political process is critical. As physicians, we are intimately aware of the needs of our patients and our practice. We read the literature; we know the standard of care; and we see the results of healthcare's shortcomings in our emergency departments. As excellent patient and practice advocates, our support of legislation and candidates who represent the interests of emergency physicians, residents and the field is vital.

We have a timely opportunity this election year to shape the future via our participation, support and votes. Physician involvement in national and local healthcare decisions can be achieved in several ways. It is essential we make informed voting choices by understanding each candidate's proposal for healthcare. For quick reference, physicians can find each candidate's plan clearly outlined on his/her respective website. We can support legislation which advocates for emergency medicine through political action committees (PACs) – segregated funds devoted to representing our voice within the political system. Finally, our membership in AAEM and other medical associations helps us unify our efforts to promote quality healthcare and to protect physicians' rights.

### Spotlight On - continued from page 23

RS: That's kind of a blessing and a curse sometimes in terms of overcrowded emergency departments and also the legislation that has allowed patients to decide when they are having an "emergency." That is also a difficult concept for our future.

KA: If you were granted one wish to have one unknown issue in medicine answered, what would it be?

RS: I guess the one unknown that bothers me most is the uncertainty of predicting death. I worry with... the demand for organs far exceeding the supply that as we go into these areas we may be faulted for not being more able to predict the timing of death. There are just so many variables, and the human body is so resilient that when some people are talking about criteria to initiate evaluation for organ donation, others are using those same criteria to go to the wall and save the patient. I think there's a difficult terrain that emergency medicine has to stand and defend what may be potential donors in other people's minds. It's an uncomfortable position to be in.

KA: Do you have any advice for new emergency medicine residents with regard to the way they should embrace/envision their role in their residencies or future careers?

RS: I would encourage residents to get involved in their national structure whether that's ACEP, AAEM or SAEM. I would advise them to try and be on sections or committees to get a broader perspective of what our specialty does - there are free opportunities. As a resident in ACEP, you're allowed to pick a free section. So, there are many disciplines that don't have such a benefit. Through the lens of others who are more experienced in the field and the administration of it, I think there's a lot that a resident can gain. I put a plug in for them to be in the Humanities section of ACEP, because at least that also reminds us of our human sides and why we practice emergency medicine.

KA: Dr. Schears, thank you so much for your time. It's been a pleasure speaking with you today.

RS: You're welcome. Thank you.



## Comparing Apples to Apples Selecting a Residency Program That is Right for You

by Thomas Masters, Midwest Regional Representative, AAEM/RSA

As all fourth year medical students, program directors and residents are undoubtedly aware, by the time you read this the residency interview season will be over. For most medical students, this has been a time of miles traveled, credit cards maxed and a certain bit of understandable anxiety as we tried to make it to all of our interviews and put our best foot forward. However, as we contemplate putting our well-worn interview outfits back on mothballs, medical students faced a new (and arguably greater) challenge—selecting a program that is right for each of us.

Hopefully, for most fourth year students at this stage, getting information about each of the programs is no longer a problem. Many students will have completed away-electives at specific programs, which offer an “up close look” at a place, but with around 140 programs nationwide, it is obviously impossible to do this everywhere. The American Medical Association offers FREIDA (<http://www.amaassn.org/ama/pub/category/2997.html>), which provides the numbers on each program’s duration, residents, benefits and other factual information.

Also online, most programs have very well maintained websites that offer a bounty of information offering specifics about who they are—often including detailed curriculum and rotation schedules, ultrasound, EMS, trauma and toxicology training, sites utilized, faculty interests and information on current residents. This last resource can offer a convenient way to get in touch with residents for follow-up information and allow them to answer any questions about their residency.

Of course, the standard venue that an applicant gains information is during the program’s interview day. Every interview presents an opportunity to learn something about the specific residency program that goes beyond what one can find on the internet. It gives a chance to meet the faculty and residents, ask questions and to get to know what makes this program different from any of the others at which one has interviewed. Beyond that, visiting a program can allow a person to get a “gestalt” feel for what goes into that residency.

So now that interviews are done and our rank order list is submitted to the NRMP (February 27th was the due date this year), the problem usually is not “where can I find out more about the programs,” but “how can I sort through everything that I have learned.”

For those participating in this process in the future, there are abundant resources available at most university bookstores that can be very helpful with thinking about various important criteria that go into selecting

a residency. Written for applicants to every specialty, these books sometimes risk being too general, but are usually very helpful and offer topics on optimizing the rank-order lists and deciding when or when not to rank programs. At the very least, these books are worth checking out of the library.

Another invaluable resource in emergency medicine residency selection continues to be *AAEM’s Rules of the Road for Medical Students*. Written specifically for candidates interested in emergency medicine, *Rules of the Road* offers advice on many topics including choosing between three and four years of training, university versus public versus community hospitals and sorting through other characteristics of programs. This book also offers discussions on numerous topics in emergency medicine that will continue to be relevant during residency training and beyond and is a valuable benefit of being a paid member of AAEM/RSA.

With all of these resources available, if one is still feeling “information overload” the AAEM/RSA’s EM Select (<http://emselect.org>) provides a great way to organize everything. In addition to providing program statistics and allowing AAEM members to organize their scheduled interviews and keep track of thank you notes sent and programs applied to, this website offers the option of recording the pros and cons of each of the programs. EM Select provides a way to organize both the valuable statistical and practical information about the program, as well as confidentially record impressions about the people and personalities of the residencies. As the deadline for the rank-order list approaches, EM Select is a convenient way to recall things that may have been forgotten from an interview months earlier.

Finally, if one has narrowed down his or her choices to a few programs and wants to get a closer look, most residencies offer “second look” opportunities. These low pressure shifts in the program’s emergency department provide a chance to see how residents and attendings interact, the type of patients seen and give a “snapshot” of life in that ED.

Fortunately, the national Residency Review Committee works hard to assure that residencies all meet certain criteria that will allow their graduates to function as successful attending physicians. This means that graduates of any accredited program will be well prepared. In some ways, an applicant really cannot go wrong when selecting a program and will leave his or her residency well trained. The issue is then sorting through all of the intangibles that make up the program and the applicant to arrive at the best fit.





*Resident Journal Review - continued from page 24*

a randomized controlled, investigator-blinded study of 1407 patients to determine if CTPA is a reliable safe alternative to V/Q scanning in the initial noninvasive diagnostic evaluation of patients with suspected pulmonary embolism.

Patients were recruited from outpatient clinics, emergency departments and inpatient service of five academic health centers. Patients with signs or symptoms suggestive of pulmonary embolism were risk stratified using the Wells model. Those with a score of less than 4.5 and a negative D-dimer were excluded from the study. Patients with a score of more than 4.5 or those with a lower score but with positive D-dimer were randomized to either CTPA or V/Q scanning. Single-detector scans were performed in 195 patients; multidetector scans were performed in 499 patients. All CTPA studies were interpreted by an experienced chest radiologist unaware of the patient's clinical probability of pulmonary embolism.

Patients with a negative V/Q or CTPA study had anticoagulation withheld and were followed up three months later. Baseline characteristics of patients randomized to each diagnostic arm were similar. Pulmonary embolism was diagnosed in 19% of patients studied with CTPA and 14% of patients who had V/Q scanning performed. In the three month follow-up, 2 of 561 patients in the CTPA group were subsequently determined to have a pulmonary embolism, compared to 6 of 611 in the V/Q scanning group (not statistically significant;  $p=0.29$ ).

CTPA in conjunction with clinical assessment, D-dimer testing and leg venous ultrasonography may be considered equivalent to assessment with V/Q scanning in patients with suspected pulmonary embolism. The rate of PEs at 90 days in patients with initially negative studies was not clinically or statistically significant between the two modalities.

**Yanagawa Y, Sakamoto T, Okada. Hypovolemic Shock Evaluated by Sonographic Measurement of the Inferior Vena Cava During Resuscitation in Trauma Patients. J Trauma 2007; 63:1245-1248.**

This prospective cohort study investigated the correlation between sonographic inferior vena cava (IVC) diameter

and recurrence of shock after fluid resuscitation in initially hypotensive trauma patients. The investigators enrolled all daytime trauma patients who arrived with a systolic blood pressure of less than 90 mm Hg. Of 488 trauma patients, 73 had shock; 30 patients were included in the final analysis.

On arrival in the emergency department, a SonoSite 180 was used to measure the maximum anterior-posterior diameter of the IVC, in the hepatic segment, in the expiratory phase. At the same time, the study patients were resuscitated according to ATLS guidelines. After the blood pressure normalized, the IVC was measured again. The clinical course of each patient was then dichotomized into transient resuscitation responders (i.e., patients who later developed a second episode of hypotension,  $n=17$ ) and responders (i.e., patients whose hemodynamic parameters remained stable,  $n=13$ .) Features of the two groups were compared on arrival to the emergency department and after initial fluid resuscitation. Both change in IVC diameter and change in IVC diameter multiplied by body mass index (BMI) were discriminatory between the two groups.

The authors suggest that IVC diameter could be an independent and useful measure for evaluating the degree of hypovolemia in trauma patients. One explanation is that a high catecholamine level in these patients will mask low circulating blood volume in these patients. IVC diameter, on the other hand, appears to be less influenced by circulating catecholamines and is more closely related to circulating blood volume. In this small study, IVC diameter was a more sensitive index for predicting recurrent hypotension than blood pressure alone. This parameter shows promise as a possible target to guide resuscitation; however, more studies are needed to validate its use as such.

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## Teachable Moments

by Michael Ybarra, AAEM/RSA Medical Student Council President

As medical students, we spend four years of our lives being the lowest people on the totem pole, constantly trying to improve our level of knowledge, impress our supervisors and jump over what seems like an endless array of hurdles. What sometimes gets lost in the mix of medical education is the power that we, as students, can have in affecting our patients' lives. We may not know exactly the best way to treat and manage their condition, but we have the ability to intervene in their lives in other ways that are equally important.

The interesting case that rolled through the ED door is a great way to show your attending physician that you completed the assigned reading, but it is also an important opportunity to ask questions and make a connection with a vulnerable, sick individual.

Does she smoke? Does she drink?  
Does she see a physician regularly?

While our residents and attendings have to worry about managing the entire department, medical students have the luxury of a narrow focus with a handful of patients at a time that allows us to give comprehensive care.

I had the privilege to work at the National Organization on Fetal Alcohol Syndrome and meet families and patients affected by Fetal Alcohol Spectrum Disorder (FASD). What I heard over and over again from mothers who drank alcohol or used drugs during pregnancy is that they frequently found themselves in emergency departments or

outpatient clinics hoping someone would reach out and ask them about their substance abuse.

The basis for alcohol interventions is established in the literature. A study published in the *Annals of Emergency Medicine (Annals)* in 2007, funded by the National Institute on Alcohol Abuse and Alcoholism, found that a screening (such as the CAGE test), brief intervention and referral for treatment in the emergency department was effective at reducing unhealthy drinking at three months. A similar paper published in *Lancet* in 2004 showed a reduction in unhealthy drinking at six months post-intervention. These large, multi-center studies validate what is well documented in primary care literature: office-based interventions (similar to that described in the *Annals*) show an average reduction of four drinks per week per individual. It is not perfect, but it is definitely a start.

Every year, 40,000 babies are born with fetal alcohol spectrum disorder, tens of thousands of drivers and pedestrians are killed by drunk drivers, and many more are affected by the stigma of chronic alcohol abuse. Much of this morbidity and mortality may be preventable. An emergency department visit might be the right time for a "teachable moment," and medical students are the perfect messengers. By intervening at the right time with our patients, we have the ability to make life better for thousands of people. We may not have the most knowledge on the team, but that does not mean we can't make a tremendous contribution toward improving the health of our society.

### AAEM would like to thank Eastern Carolina Emergency Physicians for their generous donation to the AAEM Foundation.

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# AAEM Young Physicians Section

## YPS PRESIDENT'S MESSAGE

*David D. Vega, MD FAAEM*

*President, Young Physicians Section*

I've said it before -- the Young Physicians Section (YPS) needs you. We are at a critical time of growth for the YPS, and we need you to get involved. The newly elected YPS board of directors will be taking their posts shortly. With new faces on the board will come the energy and ideas that will help to guide our Section in new directions. Now is the time for you to commit to helping out with the Section and make it into a valuable resource for its members.

There's no doubt about it, the early years of a career in emergency medicine are tough. Transitioning to independent practice and building a career while maintaining a balance between one's personal and professional lives is not easy. And, of course, we continually face challenges to our ability to provide even basic patient care because of overcrowding, unfair employment practices and continually increasing threats of litigation. The pressures and time constraints associated with the early years of an emergency medicine career are likely the reason that many young physicians do not get significantly involved with organizations like AAEM. But the reality is that these very issues are why each of us should be involved with AAEM, the only true specialty society in emergency medicine. Within AAEM, the Young Physicians Section has the potential to be the "go-to" resource for younger emergency physicians.

As emergency physicians, we face more challenges to providing care than any other specialists in medicine. A colleague of mine recently used the phrase "undercurrents of negativity" to describe the pressures working against us in performing our jobs in the emergency department. I like this description, because it captures the insidious nature of a lot of these challenges. Fortunately for our patients, we have been able to rise to the occasion and deliver life-saving care in the setting of these adverse conditions. However, we must recognize our limitations in being able to adapt to the challenges that are thrust upon us. As we face the potential of no longer being able to provide adequate

care to our patients because of the conditions in which we practice, we must work on local, regional and national levels to improve these conditions. This means sacrificing some of our personal time to gain a solid understanding of the underlying issues and getting involved with committees, task forces and organizations that can effect change.

So again, it comes down to the fact that you, as a younger emergency physician, must step up to the challenge and give back to the specialty that provides your livelihood. No more excuses -- now is the time. Send an email to [info@ypsaaem.org](mailto:info@ypsaaem.org) today with your comments and suggestions, or for more information on getting involved.

### A Note of Appreciation-

Since this is my last article written as president of the YPS, I wanted to take a bit of space to thank some of the individuals who have been fundamental to the development of the Young Physicians Section. David Kramer deserves special mention and thanks for helping to develop and encourage the concept of a Young Physicians Section within AAEM. Antoine Kazzi and Tom Scaletta, in their terms as presidents of AAEM, as well as the rest of the AAEM board of directors over the past two years have been tremendously supportive and have shown great vision in recognizing the importance of developing younger members of AAEM into the leaders of tomorrow. Joel Schofer, Jesse Pines and Mark Reiter were instrumental in helping to change the AAEM bylaws to allow for the formation of Sections within AAEM, and each has worked with the YPS Taskforce to help move us through the process of becoming a Section with AAEM. Along with them, Marc Haber and Mike Epter have served as the founding board of directors of the Section. AAEM's office staff has been invaluable in keeping us organized and functioning efficiently. And, of course, my thanks to all of the members of YPS who have stuck with the YPS through its infancy. Thank you everyone for your support!

## AAEM Young Physicians Section

## What's an Emergency Physician Worth?

*by Marc Haber, MD FAAEM**Vice President, Young Physicians Section*

New England Patriot cornerback Asante Samuel is eligible for free agency this year. He may even be signed by the time this is published. Asante hopes to receive a 10+ million dollar per annum salary.

This made me think, what is an emergency physician worth? Although I am happily positioned in an academic group I joined out of residency, I frequently get come-ons from ED recruiters. My Gmail inbox receives roughly two per day, and a few others are often filtered out. A recent ad told me I could work in my area for roughly 25% more than I am already making. That got me thinking, what is my true worth?

In the ED, I am a work horse. I teach. I produce. I also volunteer my time to AAEM. I don't take sick days. I enjoy working nights, though am blessed with very few, because my colleagues like them more. I will always switch my schedule to help out others on the staff. I remember Administrative Assistant's Day (for my boss as well). I do TV and radio interviews. Heck, I am even the captain of our softball team, the DNRs! I am not necessarily the best at everything I do, but I am certainly a Charlie Hustle. I work hard to do the best that I can do. I am a director's dream.

Before my ego swells further, don't forget that I was also the one to come home with grey matter on my shoes. I am stubborn. I haven't yet fully learned the work strategy of professional appeasement. I still get into battles over minute things. I occasionally fight with nurses and consultants. Furthermore, my wife is always right. I am learning wisdom, but am not yet wise.

In sum, I have the shortcomings of youth, but this is overcome by my vigor and work ethic. The majority of you are just like me, with many of the same attributes and flaws. Unique in vivo yes, but very similar on paper. So that makes me think, what are we all worth?

According to some recent salary data.... Well, sure first year graduates earn just above \$200,000 base compensation, but this is not true worth. Yes, benefits typically add 20-50K more. Yet again, this is not true worth. True worth isn't salary, despite what Asante will tell you. Depending on who you ask, one's true worth is variable. To your insurance company, true worth may equal anticipated compensation. To your family, however, true value is not as easy to calculate; it includes love, companionship and other intangibles.

Beyond salary, beyond benefits, beyond the love of our families, what is our worth to society? This is quite theoretical and difficult to measure.

What if we just disappeared? What if medical students stopped choosing emergency medicine? Who would care for our patients? Who would pick up the slack? Certainly not those approaching retirement; they have paid their dues. They realize that life is for living and is much too short to waste. Even for those with a strong sense of moral obligation, at some point one must be "selfish" and choose family over work. Mid-level providers, would they come to the rescue? Sure, to some degree PAs and NPs do and will continue to work in our EDs. As helpful as knowledgeable mid-level providers may be, they can't alone fill this theoretical void. Other physicians? From where? The busy hospitalist service? Overwhelmed office practices? Surgeons? We have enough difficulty getting them to take call due to their concerns of malpractice and low payments, let alone to work in our EDs. In reality, there is no one who can take our place. We are it.

**Our true worth? Invaluable.**

So then this begs many questions. The one most important to me is: If we are invaluable, then why have we been thus far unsuccessful in ensuring our future? With each additional day, we are allowing others to control our future. Every year we have legislators and administrators adding to our day to day grind. Antibiotics within four hours. Pain scales. Now perhaps mandated HIV testing in the ED. Some excellent ideas on paper, but of arguable value in reality. Our hospital directors and politicians may listen to our complaints, but they often don't hear them. Our colleagues see our pain on a daily basis, but have their own problems. We are being deluged, not only with patients but also by questionable policies and mandates. The increasing patient burden is a mixed blessing. In a basic economic sense, we are producing more with less; therefore, we should see a financial windfall. Yet, our quality of patient care and our own lives sometimes suffer. Each of us has seen this, and we know it will only continue, if not worsen.

This is where we, the young physicians, full of youthful vigor and enthusiasm, can make a significant difference. We can simply do our shifts and go home, hoping to withstand the flood, or we can work together, promote solutions, and push for necessary changes. We can join, participate and donate to the ED advocacy groups that promote our future. We can bring more media exposure to our concerns. We can push to get on hospital committees that affect change locally and national committees that affect change nationally. We need each other's support to promote the future of emergency medicine. I hope you start by encouraging your colleagues who are not already members, to join the YPS and make their voices heard.



# AAEM Young Physicians Section

## Ask the Expert

by Joel M. Schofer, MD FAAEM, LCDR MC USN,  
Naval Hospital Okinawa

"Ask the Expert" is a *Common Sense* feature where subject matter experts provide answers to questions provided by AAEM & YPS members. This edition features Dr. Wesley Curry, the President of California Emergency Physicians (CEP) America and Mr. John Gravette, the Director of Recruiting of CEP America.

**Question:** What type of extra ED or hospital duties and committees look good on a CV to a prospective employer?

**Answer:** This is a pretty broad question...and the answer depends on what qualities the prospective employer is looking for in a candidate. It also depends on what type of practice the employer or group has available.

First, just being a good clinician is not enough. Not all emergency physicians are equally capable in high volume and high acuity emergency department practices. It is important to know which practice is right for you and will meet your long-term expectations. Clinical knowledge, procedural ability, attention to chart documentation, risk management issues and productivity in terms of number of patients seen per hour, are key considerations for any ED group evaluating the likelihood a graduate emergency physician will succeed in their group practice. Any candidate should try to bring to the interview some quantitative or qualitative information on how he or she has performed in the past in a busy clinical practice. Also, the demonstrated ability to contribute to the team approach to patient care, and the ability to work with others, especially nurses, would be important to convey in the interview as well as in the application/references. Happy nursing and medical staff, patients and administration makes for a long-term work opportunity for the potential candidate. The more ways a candidate can articulate how he/she can contribute to the financial and operational performance of the emergency medicine practice, the greater the interest a candidate will receive.

Board certification, and/or residency training pending board certification, and published articles are pretty common now among emergency physicians applying for jobs. Unless the candidate wants to practice in a rural or difficult to recruit geographic area, think of these as the minimum credentials for the best jobs available. However, physicians who are highly productive, get few or no complaints, show up on time, don't make the nurses mad and are willing to work nights are highly desirable to most emergency medicine practices.

In the end, the "culture" of the medical practice is perhaps the most important aspect of the job to consider. This aspect of the practice could be the most difficult to assess without having someone you know who already works at the emergency medicine practice you are interested in joining. Knowing someone in the practice who can "vouch" for your abilities is very helpful. A candidate must be able to embrace the culture of the prospective practice if he or she wants to find a good career fit and fit in with the other emergency physicians who work there.

**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).**

*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.*

## 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.

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EMPAC is a member-owned professional liability company. Control and interest are in the hands of Emergency Medicine physicians, and profitability is shared among insured members, not corporate shareholders.

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# 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/Hospital			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 or Affiliate 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 student without JEM and free student membership, include a subscription to *The Journal of Emergency Medicine* (JEM).

## MEMBERSHIP FEES

- ☐ Full Voting Member ..... \$365.00
- ☐ Affiliate Member (non-voting status; must have been, but are no longer ABEM or AOBEM certified in EM) ..... \$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 (non-voting status) ..... \$125.00
- ☐ Resident/Fellow ..... ☐ 1 Year \$50.00 ☐ 2 Years \$80.00 ☐ 3 Years \$120.00 ☐ 4 Years \$160.00
- ☐ Student with JEM ..... ☐ 1 Year \$50.00 ☐ 2 Years \$80.00 ☐ 3 Years \$120.00 ☐ 4 Years \$160.00
- ☐ Student without JEM ..... ☐ 1 Year \$20.00 ☐ 2 Years \$40.00 ☐ 3 Years \$60.00 ☐ 4 Years \$80.00
- ☐ Free Student—does not include subscription to the JEM (first trial year free)
- ☐ 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) ..... ☐ Full Voting—\$25.00 ☐ Assoc.—\$25.00
- 
- ☐ AAEM Foundation: Please consider making a voluntary contribution to the AAEM Foundation. With your donation, the AAEM Foundation will be able to fight against corporations that violate CPOM Laws. 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 place an ad in the Job Bank: Positions that comply with the American Academy of Emergency Medicine's Certificate of Compliance will be published (upon approval) 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, Attn: Shauna Barnes, 555 East Wells Street, Milwaukee, WI 53202, Tel: (414) 276-7390 or (800) 884-2236, Fax: (414) 276-3349, E-mail: info@aaem.org.

## • ALABAMA

Stable, democratic group of 100% EM BC physicians seeking BC/BE applicants for full time position opening 7/2008. New/soon-to-be-grads welcome. Group emphasizes lifestyle and income. Competitive compensation based on hours/productivity. Full benefit package and partnership tract available. Hospital is for profit, privately owned, 250 beds with volume @35K. ED ultrasound and state of the art computer system/CPOE utilized. Mixed to high acuity with limited trauma. Excellent medical staff and healthcare environment. Mobile offers city living in a coastal environment, with booming industry and commerce. For further inquiries, please contact: mahoney\_ermd@hotmail.com. (PA 820) Email: mahoney\_ermd@hotmail.com

## • ARIZONA

Looking for new partners. Must be BC/BE. Come join our democratic group with a short partnership track and excellent salary. Enjoy the great outdoors and year-round activities. Prescott is located about 100 miles NW of Phoenix and at 5500 ft of elevation the weather is 15-20 degrees cooler than Phoenix. No call. Fantastic smaller community with no traffic and no smog. We are now covering 2 hospitals, Prescott and Prescott Valley. Our current combined volume is about 60k. Please email or call for more information. (PA 849) Email: robertmkec@mac.com

## • ARIZONA

Arizona-Phoenix: Our well-established, independent, democratic group is looking for new partners. We currently staff 2 state-of-the-art hospitals with full subspecialty coverage, 24-hour real-time radiology reads and hospitalist services with a third facility under construction. We offer full benefits including a very competitive salary, paid occurrence malpractice, short partnership track, health insurance, disability insurance, CME allowances, license fees and dues and much more. Successful applicants must be ABEM or ABOEM certified or eligible, excellent clinicians, team players and interested in a fantastic job. Look forward to hearing from you. (PA 860) Email: drbhow@hotmail.com Website: epspc.com

## • CALIFORNIA

CENTRAL CALIFORNIA: Stable, democratic group with recently renewed contract seeks full-time BC/BE emergency physicians to start Partnership Track. Part-time spots also available. Competitive salary. Paid malpractice. Two hospitals, 24k annual visits at each site, with 10 hours of Fast Track staffing daily at one of the sites. Affordable real estate. Two hours from beach, mountains, or Los Angeles. Four semi-professional sports teams, plus Division I NCAA college. Excellent city for raising kids, with top-ranked schools and lots of parks. Call April Smith at CCEMP (661)477-9283 or fax CV to (661)326-8022. (PA 833) Email: asmith14@earthlink.net

## • COLORADO

Durango, Colorado: Opening for Board Certified/Board Eligible ED physician in Level III, 18,000 annual volume department. New, state-of-the-art facility with excellent subspecialty coverage. Democratic, stable group with partnership track available. Durango is located in southwestern Colorado with abundant recreational opportunities. (PA 844) Email: jlmcmd@smallcircles.com

## • COLORADO

Southwest Health System, Cortez. Great opportunity in beautiful SW Colorado. Excellent recreation opportunities. Seeking a physician to provide coverage in a Level IV emergency room full time. BC/BP in emergency medicine preferred. Annual Volume: 12,000/yr. Compensation: Independent contractors; current hourly rate \$115.00/hr. Professional Liability Insurance Coverage. \$10,000 hiring bonus/moving allowance. Position qualifies for a \$10,000/year x three years student loan repayment. Option for 24/hr; 12/hr; or a mixture of 24/hr and 12/hr shifts. (PA 846) Email: dbond@swhealth.org Website: sw.health.org

## • COLORADO

ER Physicians for Ft. Carson, Colorado Springs, CO. Come to this beautiful state and enjoy all the outdoors has to offer when not enjoying the great work environment at Evans Army Community Hospital. American Hospital Service Group has a long-standing contract at this growing facility nestled in this gorgeous region. Colorado Springs has a welcoming standard of living and activities for all life styles. Board certified physicians, part-time or full-time. Any state license accepted at Federal work places, and malpractice immunity provided. Contact Megan at mjh@americanhospital.us or 301-960-4115. (PA 857) Email: mjh@americanhospital.us Website: www.americanhospital.us

## • COLORADO

Southern Colorado Emergency Medicine Associates (SCEMA), a stable, democratic group with twenty years experience at Parkview Medical Center in Pueblo, Colorado, is expanding with a free-standing ED in Pueblo West, as well as a level IV ED in Trinidad, Colorado, "The Victorian Jewel of the West." Pay is competitive with full benefits package, including 401k, family health, HSA and outstanding professional liability coverage through COPIC. No corporate overhead; great local control. Directorship available for additional stipend. Fantastic opportunity (for considerations of both practice and lifestyle) for northern NM or southern CO. Please contact Anna Olson, SCEMA.Recruiting@gmail.com. (PA 861) Email: SCEMA.Recruiting@gmail.com

## • FLORIDA

As part of an extensive faculty expansion project, we are actively recruiting for 2 full time BC/BE emergency medicine physicians at a community-based hospital in the greater Orlando-Tampa area. Recently renovated 24,000 square foot emergency department, 33 patient care bays including a 7 bed minor care area, 3 x-ray shifts, a radiology viewing area, ample work space, and a large waiting area, that services a growing volume of over 50,000 patients visits per year. Competitive salary, plus a full range of UF state benefits including sovereign immunity occurrence-type medical malpractice, health, life and disability insurance, sick leave, a generous retirement plan and a competitive compensation package. Rank - Assistant or Associate Professor. Interested? E-mail your letter of interest and CV to Kelly Gray-Eurom, MD at Kelly.grayeurom@jax.ufl.edu or fax (904-244-5666). These positions are currently open and will remain open until filled. For full consideration applications should be submitted as soon as possible. EOE/AA Employer. (PA 793) Email: Kelly.grayeurom@jax.ufl.edu

## • FLORIDA

Pensacola Emerald Coast. Fishing, sailing, hunting, colleges, symphony, water-front living. Partnership available to BC/BP Emergency Physicians in democratic group. \$220 to 350K plus malpractice paid. Level II Trauma Center with 32,000 visits/year. Contact Marguerite at marguerite.dittrick@hcahealthcare.com (PA 806) Email: marguerite.dittrick@hcahealthcare.com

• **FLORIDA**

Tallahassee - Join a well established, democratic and transparent emergency medicine group. We are a private partnership of EM specialists with stable contracts. We have been in business for almost 20 years. Our compensation is excellent and our benefits are truly unmatched. Check us out. Ron Koury, DO FAAEM FACEP, Southeast Emergency Consultants, rmkoury@comcast.net, www.southeastemergency.com (PA 868) Email: rmkoury@comcast.net Website: www.southeastemergency.com

• **GEORGIA**

Athens, Georgia: Private, democratic group of 20 physicians; all BE/BC EM. Recruiting additional physician to expand coverage. 315-bed regional referral center; all major specialties on staff; dedicated hospitalists. ED volume 60,000; admissions rate 20%. New 46-bed, state-of-the-art department currently under construction. Excellent package of clinical hours, salary and benefits. Well-established group in its 20th year at a single hospital. Large university community with abundance of sports, recreational and cultural activities; one hour from Atlanta. Contact Carolann Eisenhart, MD at 706-475-3359. (PA 823) Email: carolanneisen@charter.net

• **IDAHO**

NORTHWESTERN IDAHO - Emergency Medicine Partnership, join 4 other emergency medicine physicians, 12 hour shifts, 12 shifts per month, Heli port, 25,000 visits/year. Compensation: Equal partners, exceptional income and benefits, college town, abundant outdoor recreation, year-round golf, 19 mile paved walking path along 2 rivers, 2 other state universities within 1/2 hour drive (one Pac 10 College), commercial airport, reasonable real estate prices, highly rated public and private schools, financially sound Regional Medical Center. Contact: Eva Page, 800-833-3449, eva.page@comcast.net (PA 835) Email: eva.page@comcast.net

• **INDIANA**

South Bend: Very stable, Democratic, single hospital, 15 member group seeks an additional BC/BP emergency physician. Newer facility, 52K visits, Level II Trauma Center, double, triple and quad physician coverage. Equal pay, schedule and vote. Over 300K total package with qualified retirement plan, disability insurance, medical and CME reimbursement, etc. Very favorable Indiana malpractice environment. University town, low cost of living, good schools, 90 minutes to Chicago, 40 minutes to Lake Michigan. Contact Steven Spilger MD at 574.272.1310 or send CV to mrpolyester1@comcast.net (PA 817) Email: mrpolyester1@comcast.net

• **INDIANA**

Valley Emergency Physicians is seeking an exceptional BC/BE emergency physician to join our 14-member, democratic, physician-owned, fee-for service group. Partnership is immediate upon hire! Total first-year compensation package is at the 95th percentile (based on the most recent MGMA data). Nights, weekends and holidays are divided equally. We staff St. Joseph Regional Medical Center (South Bend and Mishawaka) where we have provided outstanding emergency care for over 30 years. A new state-of-the-art ED is under construction and will be complete in the Fall of 2009. SJRMC is affiliated with Indiana University School of Medicine - South Bend; opportunities are available for partners to teach medical students and residents in the ED. Indiana was recently selected as "America's most physician-friendly state" (favorable malpractice environment). South Bend offers strong school systems, affordable housing, all of the cultural amenities associated with a Top 20 university and easy access to Chicago (90 minutes) and Lake Michigan (35 minutes). Contact Kurt DeJong, MD at 574-276-1286 or send CV to dejongkurt@comcast.net (PA 837) Email: dejongkurt@comcast.net

• **INDIANA**

Indiana, Greater Indianapolis Area: EQUAL PAY, EQUAL SAY, FIRST DAY. Immediate financial equity with single hospital group of exclusively ABEM certified physicians. Low cost of living and competitive compensation allow a seventh partner for greater flexibility where quality of life is valued. State-of-the-art facility and outstanding support staff provide opportunity to continue 21 year tradition of exceptional service. Stable 30,000/yr census with 16 hours double coverage by MD/PA. Located in Anderson, an easy commute from northern Indianapolis suburbs. Visit our hospital and ED at www.communityanderson.com. EM BC/BE only please, reply at epchajob@gmail.com. (PA 848) Email: epchajob@gmail.com

• **IOWA**

Dubuque, Mercy Hospital, full service, 12 + beds, modern electronic ED, ED boarded providers, best partnership opportunity, democratic group with equal hospital department status since 1985. Scenic Mississippi valley area ideal size for raising family with opening Jan 2009 or sooner. Equal treatment for 1 year employee. Expanding from 6.5 to 7 doctors, age ranging from 32 to 55, 20K patients, 25% acuity, no NeuroSurg. Stable nursing and admin, with minimal waiting room time. 95% of patients seen in 30 minutes. Salary, benefits, 401 K for partner ~\$300K, malpractice included but not tail. Stock and receipts buy-in extended over years. (PA 865) Email: mksgsk1@mac.com

• **KENTUCKY**

Trover Health System is seeking outstanding Board Certified/Eligible emergency medicine physician(s) to join an exciting emergency department team. Our emergency department includes 18 ED beds, 2 trauma rooms, and 6 Fast Track beds. We offer an excellent compensation/benefit package, and offer a 12 hour shift rotation with double coverage during peak hours. Inquires can be sent to Ceil Baugh: cbaugh@trover.org, or call (800) 272-3497. CV's can be faxed to (270) 326-4523. Please visit our web site at: www.troverhealth.org (PA 805) Email: cbaugh@trover.org Website: www.troverhealth.org

• **KENTUCKY**

Outstanding Opportunity for EM BC/BE physicians interested in providing services for the military and their dependents at the Ireland Community Hospital, Emergency Room, Ft Knox Kentucky. 11 Bed ED, 1 Trauma Room. Full and part-time physicians desired. Locums available. Please direct inquiries/CVs to krystle@centralcareinc.com, or call 1-888-643-9700; Fax 1-866-248-7722. (PA 831) Email: krystle@centralcareinc.com

• **MAINE**

Stephens Memorial Hospital in Norway, Maine, a member of MaineHealth, the premier healthcare system in Maine, has an opportunity for a BC/BP ED physician to join their state-of-the-art, Level II ED. Volume is 18,000, shared coverage with 8 ED physicians and have in-house access to advanced imaging technology, 24/7 lab, and Lifeflight capability for major trauma transports. Director potential. Excellent compensation package including paid malpractice, med. loan assistance, CME allowance, family paid Health/Dental, 403b retirement, and more, 2 1/2 hours from Boston and one hour from Portland/ocean. Enjoy arts, skiing, hiking, boating and other recreation. Four season resort community. (PA 821) Email: fryet@wmhcc.org Website: www.wmhcc.org

• **MAINE**

Northern Maine is calling you!! The Aroostook Medical Center, the regional referral center for Northern Maine, has an opening for Department Director. The annual volume at our Level II ED is 16K. Single physician coverage with 10 hours double coverage with a physician assistant and a 24/7 in-house hospitalist team. This is an employed position with excellent starting salary and generous benefits package. All in lovely, safe, family-friendly Maine. Town features 2 colleges, and olympic skiing facility. Full-time position, with expected 5-8 hours per week of Directorship duties. (PA 838) Email: kmoreau@tamc.org Website: www.tamc.org

• **MARYLAND**

ED Physician Director - Southern Maryland Hospital Center, located outside of Washington D.C., seeks an experienced physician to lead their emergency department. Within this leadership role, you will screen, hire and manage a quality staff of ED physicians with a focus on prompt, and outstanding patient care. The majority of your shift will consist of seeing patients, as well as some administrative duties. You must possess Board Certification in Emergency Medicine and recent experience within an upper-level management position working at a 45,000+ patient visit emergency department. A competitive salary and benefits package is available. E-mail your resume to: PaulZeller@Southernmarylandhospital.com. EOE, M/F/D/V. (PA 816) Email: PaulZeller@southernmarylandhospital.com Website: www.smhchealth.org



• MASSACHUSETTS

Seeking compatible F/T emergency physicians to join our experienced emergency physician group. We see 40,000 patients a year. Our hospital is a busy 125-bed community hospital affiliated with a major teaching hospital. Applicants need to be board-certified or eligible. Our reimbursement is regionally competitive with a 2400 hour track to partnership. Located in Western Massachusetts, the community is vibrant and diverse and offers good educational opportunities for all ages as well as fine cultural events. Boston, New York City, New Hampshire and Vermont are all within 1-3 hours by car. (PA 834)  
Email: josh\_maybar@cooley-dickinson.org  
Website: www.cooley-dickinson.org

• MASSACHUSETTS

Stable democratic group seeking BC/BE emergency medicine physicians for full time position opening 1/2008. Competitive benefit and reimbursement package. Partnership tract available with future profit sharing. 29,000 visits with 13 hours of MD double coverage daily. ED Fast Track now in development. Mixed to high acuity with limited trauma. Hospital is located in coastal community with outstanding schools. Located in southeastern Massachusetts, minutes from Cape Cod. One hour from Boston and Providence. (PA 841)  
Email: redman5@aol.com

• MASSACHUSETTS

Charter Professional Services Corporation and North Shore Medical Center (NSMC) want you to join their dynamic team of emergency medicine physicians. Excellent democratic physician-friendly work environment. Block coverage at two prominent NSMC hospitals – Salem Hospital in Salem and Union Hospital in Lynn – within 15 minutes of each other. Flexible shifts. Excellent medical staff back-up. Competitive compensation and comprehensive benefits. Beautiful harbor town, located just 15 miles north of Boston. ID#28730C35. Contact Lin Fong at 800-678-7858x63475; e-mail lfong@cejkasearch.com; or visit www.cejkasearch.com. (PA 851)  
Email: lfong@cejkasearch.com  
Website: www.cejkasearch.com

• MASSACHUSETTS

Northeast Health System (Beverly Hospital and Addison-Gilbert Hospital): Fully Democratic group seeks BC/BE emergency medicine physician for full-time or part-time employment. Also seeking physician with emergency department experience for Fast Track expansion. 60,000 visits combined at top-ranked hospitals. Level III Trauma Center. New emergency department. Hospitalist program. Collegian environment, coastal location, close to Boston. Competitive salary. Please email CV to Saul Cohen, MD at sauljenai@gmail.com. (PA 856)  
Email: sauljenai@gmail.com

• MICHIGAN

BAY CITY, MICHIGAN: Opportunity for a BC/BE emergency physician at a growing, profitable hospital in Bay City that just opened a brand new ED September 07. The hospital has a friendly cooperative medical staff and coverage of all the major specialties including 24-hour catheterization lab availability. Our group offers a stable contract, extremely competitive compensation, flexible, fair scheduling, pension and profit sharing plans. In addition, there is the potential for partnership after two years. If you are interested in hearing more about this opportunity, please contact Kenneth Whiteside MD, FACEP @ 989-894-3145. (PA 855)  
Email: Kenneth.Whiteside@bhsnet.org  
Website: baymed.org

• MISSISSIPPI

Lucrative EM opportunity serving 172-bed regional hospital with 22-bed heart hospital offering excellent salary, comprehensive benefits, \$40,000 sign-on bonus and full school loan repayment. Opportunity for full partnership, maximum profit sharing contribution. Warm college town offers great outdoor recreation, shopping & restaurants, exceptional housing options and schools. International airport one hour away. (PA 804)  
Email: nwaters@phg.com

• MISSISSIPPI

Southeast Coastal University City with Southern Charm and Hospitality - Emergency Medicine Opportunity. Join a group of six emergency medicine physicians. Employment of \$150 per hour (Potential to make over \$300k). Benefits include: Paid malpractice, 32K ER visits per year, hospital is NOT a trauma center, occurrence-based malpractice - No Tail Coverage. Twelve public and private courses within a 30-mile radius, intact historic neighborhood district encompassing 115 acres, outdoor sculpture garden and Children's Literature Museum. Biking, hiking, hunting, canoeing, camping, and fishing. More outdoor activities than a carnival - Attend a play, concert or college football game, canoe down a river, or hit the links at one of the nationally ranked golf courses! (PA 809)  
Email: rector@phg.com  
Website: www.phg.com

• MISSOURI

Salem Memorial District Hospital (SMDH) is a 25-bed Critical Access Hospital that has served Salem and the Dent County surrounding area for over 35 years. Our emergency department averages 8500 visits per year. A great schedule with twenty-four hour shifts and only seven shifts during a twenty-eight day period. A competitive salary and complete benefit package includes: Malpractice Insurance Coverage, Medical, Prescription and Dental Insurance and Reimbursement for Continuing Education Programs. Located in the "Heart of the Ozarks" our community has great schools, low crime and beautiful scenic areas to experience fishing, camping, canoeing and hiking. (PA 869)  
Email: adminsecretary@smdh.net  
Website: smdh.net

• NEVADA

ER Physicians: Multiple openings at the prestigious Mike O'Callaghan Federal Hospital, Nellis AFB, Las Vegas, NV. Full or part-time openings. Serve those who serve our country while enjoying your time off in one of the most exciting cities in the USA. American Hospital Service Group has a long-standing contract at this facility placed in a city that has something to offer everyone. Board certified physicians, part-time or full-time. Any state license accepted at Federal work places, and malpractice immunity provided. Contact Jill at 410-451-2415 or JJT@americanhospital.us. (PA 858)  
Email: JJT@americanhospital.us  
Website: www.americanhospital.us

• NEVADA

Employed opportunity with Banner Health in Fallon, NV. BC/BE Emergency Medicine with fully-paid malpractice with tail on departure. 24/7 Hospitalists for admissions. Competitive salary & recruitment incentives, rich benefits package & 401k retirement w/4% match after one year, CME days plus allowance and more! Fallon offers comfortable lifestyle and moderate cost of living, No State Income Tax. Close to Tahoe - snow ski in the winter, water sports in the summer! Join the BANNER HEALTH team in Fallon, NV. Send us your CV today, we'll call you for an interview tomorrow! (PA 863)  
Email: doctors@bannerhealth.com  
Website: www.bannerdocs.com

• NEW MEXICO

New Mexico: Santa Fe - We are an independent, democratic group seeking board certified (or Board Eligible) prepared emergency physicians for expanding opportunities. We enjoy a busy EM practice, a challenging case mix and an excellent relationship with our hospital. We offer a highly competitive productivity-based salary, benefit package and a partnership track with management opportunities. Santa Fe is a recreational paradise with many cultural activities. Contact: Karen Tiegler, Practice Manager at 505-992-0233 or by email at administrator@sfp.org (PA 829)  
Email: administrator@sfp.org  
Website: www.sfp.org

• NEW YORK

Faculty candidates interested in academic Emergency Medicine. The Division of Emergency Medicine of University Hospital UMDNJ is in an academic tertiary Level 1 trauma center with EMS medical control providing care to approximately 93,000 patients per year. We have a four year residency program currently in its third year with a mandatory four week medical student elective. Just 20 minutes from NYC. We offer a competitive salary and benefits package. Equal Opportunity Employer. Please forward your Curriculum Vitae to, Hosseinali Shahidi, M.D., MPH, University Hospital, 150 Bergen Street, M-219, Department of Emergency Administration, Newark, NJ 07101. shahidho@umdnj.edu Telephone 973-972-6224. Fax: 973-972-6646 (PA 845)  
Email: shahidho@umdnj.edu  
Website: www.njemr.com



• NEW YORK

Buffalo NY – University @ Buffalo, Department of Emergency Medicine is seeking full-time faculty for an established, accredited EM Residency Program. Applicants should be EM board certified/eligible. Responsibilities may include clinical care, teaching/supervision of students and residents, EMS, research, or administration. Compensation package includes a competitive salary, 12% retirement, health, dental, disability and 36 paid days off. Candidates should contact: G. Richard Braen, MD, Professor and Chairman, Department of Emergency Medicine, Buffalo General Hospital, 100 High Street, Buffalo, New York 14203 or email [ckolek@kaleidahealth.org](mailto:ckolek@kaleidahealth.org) with CV. The University at Buffalo is an Equal Opportunity Employer/Recruiter. (PA 867) Email: [jpokerwinski@kaleidahealth.org](mailto:jpokerwinski@kaleidahealth.org)

• NORTH CAROLINA

Durham-Established, democratic emergency medicine group is seeking a full-time BC/BE EM physician. 50,000 patients are treated annually. We offer a competitive salary and comprehensive benefits. We are located in one of the most desirable living areas on the east coast, close to beaches and mountains with an international airport. We have great weather all year round, excellent schools and 3 major universities. For more information please fax or email CV to 919-477-5474, [durhamemergency@ams-nc.com](mailto:durhamemergency@ams-nc.com). (PA 808) Email: [durhamemergency@ams-nc.com](mailto:durhamemergency@ams-nc.com)

• NORTH CAROLINA

ECEP II, P.A., a very stable (since 1984) emergency medicine group, is seeking a full-time (approx. 34 hours/week) emergency medicine physician to practice at Pender Memorial Hospital. Part of the New Hanover Health Network, Pender Memorial Hospital is located in the town of Burgaw, North Carolina, approximately 25 miles north of historic, beautiful, Wilmington. Pender County is a perfect choice for anyone who enjoys camping, fishing, boating, dining on fresh seafood, or spending a casual afternoon shopping for antiques. Whether you are looking for beautiful beaches, a relaxed family oriented lifestyle, or friendly communities, Pender County has it all for you. (PA 819) Email: [dkey@ecepnet.com](mailto:dkey@ecepnet.com) Website: [www.ecepnet.com](http://www.ecepnet.com)

• NORTH CAROLINA

Instructor/Assistant Professor appointment, Department of EM, WFUSM, subject to approval, governing boards of Wake Forest University Health Sciences. Seeking faculty with interests in cardiovascular clinical research. Have active clinical research program, industry/federally-funded investigators, staff providing patient enrollment, full departmental/university support. Salary/benefits, competitive. Start-up funding negotiable. Must be EM trained or board eligible/certified. Research fellowship/research experience preferred. Contact: James Hoekstra, MD, Chairman, Department of Emergency Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1089. Phone (336)716-4626, FAX: (336)716-5438 or email [dswaim@wfubmc.edu](mailto:dswaim@wfubmc.edu). Equal Opportunity Affirmative Action Employer. (PA 824) Email: [jhoekstr@wfubmc.edu](mailto:jhoekstr@wfubmc.edu) Website: [www.wfubmc.edu/em/](http://www.wfubmc.edu/em/)

• NORTH CAROLINA

NC: Wake Forest University Dept. of EM seeking candidates for new clinical site, Wilkes Regional Medical Center, WRMC located 45 minutes West of Winston-Salem, 32,000 annual visits with specialty backup, state-of-the-art ED. Hired as Clinical Instructor/Clinical Assistant Professor in Dept. of EM at WFUSM, compensation competitive, subject to approval of the governing boards of WFUSM. Full WFUSM benefits. Must be either residency trained in EM or board certified/board eligible. Contact: James Hoekstra, MD, Chairman, Department of Emergency Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1089. Phone: 336-716-4626, email: [jhoekstr@wfubmc.edu](mailto:jhoekstr@wfubmc.edu). Equal Opportunity Affirmative Action Employer. (PA 825) Email: [jhoekstr@wfubmc.edu](mailto:jhoekstr@wfubmc.edu) Website: [www.wfubmc.edu/em/](http://www.wfubmc.edu/em/)

• NORTH CAROLINA

Elkin, beautiful town in the foothills of North Central NC, close to Charlotte and Winston-Salem. ED with 24000 visits, with a "Quick Care" staffed by mid-levels. This is a very rare opportunity to join a new small private group. We are only looking for someone willing to make a long term commitment. Contact Steve Isaacs, MD 704-876-3981, [flysgi@yahoo.com](mailto:flysgi@yahoo.com) (PA 827) Email: [flysgi@yahoo.com](mailto:flysgi@yahoo.com)

• NORTH CAROLINA

Democratic group seeks FT BC/BE physician: Shelby Emergency Associates staffs a level III trauma center/50K and a community hospital 10 miles away seeing 25K. Our group is 16 years old and offers \$165/H plus malpractice (Pre-partnership \$145/H for 12 months), 401K, pretax business account, \$180/H for nights. 24H hospitalist coverage for admissions in both hospitals. Topnotch nurses, medical staff and supportive administration confers super comfortable work environment. \$22M 26 bed ER +12 bed FT completed 2007 at CRMC. Beautiful area of NC between Asheville and Charlotte. Broad pathology never boring during 10 & 12 hour shifts. Midlevels at both hospitals. 704-472-7777 Please email CV. (PA 850) Email: [volumizer@yahoo.com](mailto:volumizer@yahoo.com) Website: <http://www.clevelandregional.org/history.cfm>

• OHIO

Oxford, Ohio: Small, single hospital, democratic group is looking for a full or part-time emergency physician. Volume continues to increase, creating need for additional coverage. Must be Board Certified in Emergency Medicine (grandfathered ok). Continue to have excellent relationship with hospital. Located in small, safe college town, accessible to two metropolitan areas. We have many excellent academic, athletic and cultural events within 5 minutes. New billing has made a good financial picture excellent - total compensation >90th percentile. Partnership in one year. Come see us and see why we like it so much! Contact Joe Sanchez, MD at [jchez7@fuse.net](mailto:jchez7@fuse.net) (PA 792) Email: [jchez7@fuse.net](mailto:jchez7@fuse.net)

• OHIO

Qualified Emergency Specialists, Inc., physician-owned, fee-for service, democratic group dedicated to emergency medicine in one city, Cincinnati, OH. Visits range from 40,000-60,000 at six hospitals. Our own Journal Club, active in EMS education, marathon and stadium medicine. Full vesting, Medical and Malpractice insurance. Flexible, equitable scheduling. Cincinnati offers superb cultural and artistic programs. Excellent schools and colleges. Cincinnati Reds and Bengals. Please Contact: Gary Gries, M.D., Phone: 513-231-1521 or email: [gries9hotmail.com](mailto:gries9hotmail.com) (PA 828) Email: [LLindseys@msn.com](mailto:LLindseys@msn.com) Website: [www.qualifiedemergency.com](http://www.qualifiedemergency.com)

• OHIO

Springfield, Ohio: Because we will assume responsibility for two additional ED facilities in January, we are looking for full and part-time EM board certified physicians. We are a democratic, fee-for-service group that has an excellent working relationship with the hospital. We are located between Dayton and Columbus and offer an attractive compensation package. Please contact Annette Nathan, MD at [skidocim@aol.com](mailto:skidocim@aol.com) or call the Administrative Assistant at 937-328-9301. (PA 839) Email: [skidocim@aol.com](mailto:skidocim@aol.com)

• OREGON

Sunny Southern Oregon - Klamath Falls: Unique Oregon Opportunity in Top 100 places to live location. Full-time position for BC/BE ER Physician in brand new department. BC/BE colleagues and excellent specialty backup. Equitable, flexible scheduling of 9 hour shifts. 36 hours coverage per day on a annual volume of approximately 25,000. Compensation in excess of \$160/hr with full benefits and retirement. 300 days of sunshine per year. Visit our website: [www.skylakes.org](http://www.skylakes.org). Contact Mike Poe at 541-274-6258 or [MPoe@skylakes.org](mailto:MPoe@skylakes.org) (PA 811) Email: [MPoe@skylakes.org](mailto:MPoe@skylakes.org) Website: [www.skylakes.org](http://www.skylakes.org)

• PENNSYLVANIA

The DEM at Penn State Hershey Medical Center is seeking board-certified or prepared, academic minded emergency physicians to join our faculty. Located in beautiful Hershey, PA, the state-of-the-art ED cares for >50,000 with 56 hours of attending coverage daily, with additional MLP support. Research, service and educational missions provide opportunities for integrated faculty development. Outstanding schools, low crime rate and a small town atmosphere allow a pleasant lifestyle next to a world class academic medical center. Confidential inquiries to Thomas Terndrup, MD (Chair), DEM (H043), PO Box 850, Hershey, PA 17033, Phone 717-531-8955 or email [tterndrup@hmc.psu.edu](mailto:tterndrup@hmc.psu.edu). EOE. (PA 812) Email: [cdeflitch@hmc.psu.edu](mailto:cdeflitch@hmc.psu.edu) Website: [www.hmc.psu.edu](http://www.hmc.psu.edu)

• **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 and culture, without crime. E-mail Tziff@Mounntnity.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 847) Email: Tziff@Mounntnity.org

• **TENNESSEE**

NASHVILLE-stable democratic group with two hospital contracts, held over 25 years, 100k visits/yr. Outstanding remuneration with 2 year full-partnership track, square and flexible schedule. The Nashville area is an outstanding growing & dynamic community that offers the benefits of a big city and the esthetics of a small town. It is a great place to raise a family without state income tax. This is an outstanding opportunity both professionally and financially. Please contact Russ Galloway, gal1958@comcast.net, 615-895-1637 or Kevin Beier, khbeier@hotmail.com 615-661-0825. (PA 813) Email: Gal1958@comcast..net

• **TEXAS**

Texas, Central: FT opportunity in 45,000 volume ED. Competitive RVU pay, paid malpractice/tail coverage, and partnership track with a stable, democratic, doctor-owned group. Within an hour of Austin and Lake Travis, this area also offers rock climbing, natural caverns, parks and lakes. Contact Lisa Morgan, Emergency Service Partners, 888/800-8237 or lisa@eddocs.com. (PA 794) Email: lisa@eddocs.com

• **TEXAS**

Texas, Kerrville: Live and work where others vacation! Seeking EM physicians for 24,000 volume ED located in the beautiful Texas Hill Country. RVU based compensation, plus benefit package that includes health insurance, pension, paid malpractice and partnership opportunity. For details, contact Lisa Morgan, Emergency Service Partners, 888/800-8237 or lisa@eddocs.com. (PA 795) Email: lisa@eddocs.com

• **TEXAS**

Texas, Bryan/College Station: 56K volume Level 3 Trauma Center. Democratic group with partnership track, wholly physician owned and operated. Bryan/College Station is home to Texas A&M. Appreciate the arts, outdoor recreation, and easy commute to professional sporting events, fine dining, shopping and the coast. Contact Gretchen Moen at gretchen@eddocs.com or 800-888-8237. (PA 796) Email: gretchen@eddocs.com

• **TEXAS**

Texas, Palestine: 26K annual volume in beautiful east Texas needs full time emergency trained doctors. BC/BP in emergency medicine preferred. Partnership track and paid malpractice/tail coverage. Contact Gretchen Moen at gretchen@eddocs.com or 800-888-8237. (PA 797) Email: gretchen@eddocs.com

• **TEXAS**

Texas, Palestine Medical Director: Great administrative opportunity in East Texas/ Tyler area! Sign on bonus, monthly stipend, partnership, generous employer contribution to 401(k), health, dental and life insurance, and paid malpractice/tail. Close to Tyler and within 2 hours of DFW and Houston. For more information, contact Gretchen Moen at gretchen@eddocs.com or 800-888-8237. (PA 798) Email: gretchen@eddocs.com

• **TEXAS**

Texas, Houston: Large downtown hospital needs full time emergency or urgent care specialized doctors. 32K volume with state of the art technology. Competitive hourly plus RVU, paid malpractice/tail and partnership track! Houston is a large city offering culture, affordable housing and a great standard of living. Contact Gretchen Moen at gretchen@eddocs.com or 800-888-8237. (PA 799) Email: gretchen@eddocs.com

• **TEXAS**

Texas, Seguin: Seeking BC/BP EM physician. Annual patient volume of 25,000. Paid malpractice and tail coverage, licensure/ CME reimbursement, equitable scheduling and partnership! This growing community is located on the banks of the Guadalupe River. Gorgeous homes and picturesque views. Contact Gretchen Moen at gretchen@eddocs.com or 800-888-8237. (PA 802) Email: gretchen@eddocs.com

• **TEXAS**

Carl R. Darnall Army Medical Center at Fort Hood, Texas, is seeking a board certified emergency medicine physician. Full time position working 8 hour shifts with a mixture of clinical and administrative duties. Serve as core faculty for the CRDAMC Emergency Medicine Residency Program. Our brand new level III Trauma designated Emergency Department has an annual volume of 70,000 patients, low to moderate acuity. Compensation package includes competitive salary, malpractice coverage, comprehensive benefits, paid sick and vacation time, relocation allowance and annual retention bonus. For further information, please contact LTC Steve Tanksley, MD. (PA 859) Email: Steven.J.Tanksley@amedd.army.mil

• **TEXAS**

Covenant Medical Group, located in Lubbock, Texas, is seeking experienced BE/BC physicians to join a growing physician emergency medicine program. Our physicians enjoy all the benefits of metropolitan living, entertainment and recreation, an international airport and a major Big 12 University. Texas Tech University. Covenant Medical Group is a multi-specialty group with more than 200 physicians across West Texas and Eastern New Mexico. We offer a competitive salary and an excellent benefit package that includes medical/dental insurance, life insurance, vacation/holidays, retirement plans and reimbursement for CME and other benefits. CV can be forwarded to kreeves@covhs.org. For telephone inquiries call 806/725-7875. (PA 862) Email: kreeves@covhs.org Website: www.covmedgroup.org

• **UTAH**

Democratic, happy stable group, gets along with administration seeking BC EP for our Level 2, 56,000+ facility in Provo, UT, just 20 minutes from Snowbird. FT averages 23 hours per week with 8 week vacation per year. Call Ken Armstrong (801) 362-4119 or email CV. (PA 818) Email: ken.uvep@hotmail.com

• **VIRGINIA**

Unparalleled career opportunity in Virginia with Fredericksburg Emergency Medical Alliance, Inc. TRULY democratic, progressive and stable group 50 miles south of Washington, DC. State-of-the-art computerized ED with 95K volume. Highly competitive FFS compensation, great schedule, and stable malpractice coverage. Contact Linda Dempsey 540-741-1167, linda.dempsey@medicorp.org (PA 832) Email: linda.dempsey@medicorp.org

• **VIRGINIA**

Charlottesville VA: Live and work in this beautiful college town minutes from the Blue Ridge Mountains. We are an established, single hospital, democratic group looking for a FT or PT physician. 33k census, 8-hr shifts, 40 hr/day Physician coverage with Minor Care Area open 3 days a week. We offer medical coverage, CME stipend, fully funded retirement, and partnership track for FT physician. Must be EM BE/BC. (PA 836) Email: daniel.ricciardi@mjh.org

• **WASHINGTON**

We are seeking an outstanding ED physician and Director to join our superb group of physicians and PA's. ED volume of approximately 30,000/yr seeing complex and critical adult medical cases, and small volume of trauma, peds, GYN. Double coverage during most of the day. Large multi-specialty downtown clinic/hospital provides 24/7 specialty back-up in all areas. Teach residents rotating through the ED. Successful candidate to be EM BE/BC with 2 years experience. VMHC will start construction in 2008 for a new hospital wing with a new state-of-the-art ED. (PA 852) Email: christi.lenz@vmhc.org Website: www.vmmc.org

• **WASHINGTON**

Well established, democratic group 30 min. north of Seattle is looking for EM BC/ BP physicians. Multi-site with over 120,000 visits annually, stable contracts, excellent compensation with generous benefits. Consideration to full partner after one year. Two of our largest sites are consolidating into a brand new, state-of-the-art 79 bed ED to be completed in 2011. Our beautiful Pacific Northwest locale is ideally situated, providing abundant recreational activities to satisfy the outdoor enthusiasts while also appealing to those who appreciate the cosmopolitan city life. To submit your CV or to request further information, please send an email to contact@northsoundem.com (PA 864)

• **WEST VIRGINIA**

Emergency Medicine Opportunity - Join 10 other practicing emergency physicians. Excellent salary commensurate with experience. 56K ER visits per year. Level II Trauma Center with 24-hour hospitalist coverage. Comprehensive benefits, malpractice included. 8-9-10 hour shifts available. Work with Medical School residents. A stunning area with excellent schools and low cost of living. "Top 100" private Liberal Arts college. Largest man-made lake in the state. State record fishing, hunting, boating and biking. Short distance to 4 major metro areas. Festivals, snow skiing, canoeing and kayaking. Historic downtown, concert halls and theater. Contact: Rob Rector at (800) 492-7771 or e-mail rrector1@phg.com (PA 866) Email: rrector1@phg.com Website: www.phg.com

• **WISCONSIN**

Watertown Emergency Physicians, S.C., in Watertown, WI, is looking for a board certified emergency medicine physician (ABEM or AOBEM) to work one weekend shift a month plus two to three regular shifts a month for an average of six shifts a month. Last year we had over 17,000 annual visits. We have 11-hour day shifts from 7am-6pm and 13-hour night shifts from 6pm-7am. We also have 11-hour/day PA/NP coverage on weekends and holidays. Watertown is located equidistant between Milwaukee and Madison, WI, 45 minutes away. (PA 822) Email: rlynch@wahs.com Website: www.wahs.com

• **WISCONSIN**

Would you enjoy living near Madison, WI? If so, please consider this outstanding Emergency Medicine opportunity in a scenic community, just minutes from the picturesque Wisconsin River. This democratic group divides nights, weekends and holidays equally. The ideal candidate will have strong interpersonal skills and the ability to work well with support staff and colleagues. This progressive community hospital possesses state of the art technology including electronic medical records and a newly installed CT Scanner. (PA 853) Email: akind@strelcheck.com Website: www.strelcheck.com

• **WYOMING**

90 minutes from Denver, CO, and 30 minutes from the mountains. Immediate and outstanding opportunity for one full-time, ABEM certified (eligible), ER physician to be employed at Level II Trauma Center, in Cheyenne, Wyoming. Guaranteed first year income, plus incentive. Relocation & Sign-on Bonus. Eligible to be Licensed in Wyoming. (PA 803) Email: selina.irby@crmcwy.org

• **CANADA**

Our Region: The RQHR offers opportunities for medical professionals to be part of a dynamic health team providing superior patient care. Emergency physician positions provide full-time coverage for shifts in an established rotation. Physicians are contracted to work within the RQHR. The ideal candidate will hold certification in emergency medicine. A license to practice in Saskatchewan, ACLS and ATLS are required. In accordance with immigration requirements, preference will be given to Canadian citizens and permanent residents of Canada. For information please contact: Erin Roesch, Coordinator, Physician Recruitment and Retention. Phone: (306) 766-2182. Fax: (306) 766-2842. Email: erin.roesch@rqhealth.ca (PA 854) Email: erin.roesch@rqhealth.ca Website: www.rqhealth.ca

• **LEBANON**

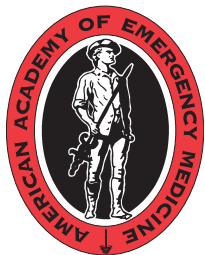
The Faculty of Medicine and Medical Center of the American University of Beirut, Beirut, Lebanon, is establishing a high quality Academic Department of Emergency Medicine. We are actively seeking experienced emergency medicine physicians for this development. Candidates must be board-certified or -eligible in emergency medicine by the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine and must have at least three years successful experience in emergency medicine. Excellent opportunities exist for faculty development, research and teaching. The compensation is competitive and the position offers excellent benefits. The deadline for submitting applications is July 15th, 2007. The American University of Beirut is an affirmative action, equal opportunity employer. To apply please send a cover letter, CV and names of three references to the contact information below: Amin Antoine N. Kazzi, MD, FAAEM Chief of Service & Medical Director, Emergency Department AUB Faculty of Medicine and Medical Center American University of Beirut P.O.Box 11-0236 / Medical Dean's Office Riad El-Solh / Beirut 1107 2020, Lebanon (PA 814) Email: ak63@aub.edu.lb

• **NEW ZEALAND**

CONSULTANT - EMERGENCY SERVICES Taranaki District Health Board, New Plymouth, New Zealand - Vacancy No. 4492 We are seeking a person with emergency/trauma care experience for a permanent/long term position, who must be eligible for registration with the Medical Council of New Zealand. For a copy of the job description and application form, please visit our website or contact Charles Hunt, Medical Recruitment & Development Manager on 06-753 6139 Ext 8464 or email: charles.hunt@tdhb.org.nz. For more information on the role itself, please email Dr Sampsa Kiuru, Consultant, e-mail sampsa.kiuru@tdhb.org.nz or Dr Kelly Pettit, Consultant, e-mail: kelly.pettit@tdhb.org.nz (PA 810) Email: charles.hunt@tdhb.org.nz Website: http://www.tdhb.org.nz

• **NEW ZEALAND**

Emergency Physician (1.0FTE). Come live and work in Whangarei, New Zealand! White sandy beaches, green hills, blue sea and subtropical climate with some of the best fishing/diving in the world. Whangarei has a population of 70k, just 2 hours north of Auckland. We need an energetic, quality Emergency Physician to join our team. We have a modern ED, and a progressive practice with good patient mix. Vacancy No: MD07-009. Close Date: Open. Interested? Contact: Shelley Mackey, Northland District Health Board, PO Box 742, Whangarei, New Zealand phone: +64 9 4304101 or email: medical.coord@nhl.co.nz (PA 843) Email: medical.coord@nhl.co.nz Website: http://www.northlanddhdhb.org.nz



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**FAAEM**

***Always* means board certified.**

To join now, contact the American Academy  
of Emergency Medicine at 800/884-2236.  
For additional information see [www.aaem.org](http://www.aaem.org)  
or contact [info@aaem.org](mailto:info@aaem.org).