

common SENSE



when minutes count

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THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



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PRESIDENT'S MESSAGE

Some of What Happened in Vegas

by Tom Scaletta, MD FAAEM
AAEM President

AAEM held its 13th Annual Scientific Assembly in Las Vegas last month, and it was a huge success. About 800 emergency physicians descended on the neon city to enjoy some of the finest lecturers in the country. There was something for everyone, including a new pre-conference course, 'Resuscitation for Emergency Physicians,' as well as cutting-edge clinical lectures, a business issues track, a review of LLSA articles, many abstract presentations and a photo competition. As always, the main program remained free for AAEM members to attend.

There were several unveilings, including the completely renovated AAEM website. We announced our latest partnerships to oversee and enhance the emergency medicine content for both Medscape and PEPID. Also, AAEM Services, in partnership with EvolveMed, shared samples of PeerCharts, a complaint-driven template system merging the best practices of safety, reimbursement and user friendliness into an affordable system.

It was refreshing to walk the aisles of an exhibit hall that screens out profiteering staffing groups. In the same vein, the AAEM Foundation, our non-profit organization dedicated to protecting the rights of physicians against corporations that violate corporate practice of medicine laws, held a hilarious yet hair-raising fundraiser with Penn & Teller.

The inaugural Meeting of Emergency Medicine Stakeholders (MESH) took place onsite, the day before the Assembly commenced. This group intends to be an inclusive gathering of mainstream emergency medicine organizations that can amplify the voice of emergency medicine when it is necessary to respond to Congress, the media or a regulatory agency. AAEM's ongoing alliance with the ENA was marked by a lecture I co-presented with their President, Donna Mason, RN MS CEN, titled, 'Who's Really In Charge,' emphasizing the importance of teamwork and interpersonal relationships.

Finally, our committees were beehives of activity and included final plans for the Fourth Mediterranean Emergency Medicine Conference (MEMC IV), which we co-organize with the European Society for Emergency Medicine (EuSEM). This September, we are going to Sorrento, Italy (details at www.EMCongress.org). I hope to see you there. Ciao!



EDITOR'S LETTER

by David Kramer, MD FAAEM

By now I am sure that you have heard and read many reports on the recent AAEM Scientific Assembly. Attendance records were broken. The educational sessions were top-notch. The Foundation event was funny, mysterious and, above all, "different." If you haven't had the opportunity to see Penn and Teller live, I highly recommend you do so. The Young Physician's Section (YPS) and the Resident and Student Association (AAEM/RSA) reception was well-attended and great fun. Basically, a great time was had by all. Needless to say, plans are already underway for next year's meeting at Amelia Island, Florida, February 7-9, 2008. I suggest you mark your calendars now and place your schedule requests as soon as possible.

But, I'm not here to talk about what you have already heard. I want to talk about what I perceived as the most interested, excited and participatory groups at the Scientific Assembly. I'm referring to the residents. There were 152 residents in Las Vegas. They asked insightful questions, actively networked with their AAEM colleagues and cheered loudly for the winners at the award ceremony. The enthusiasm with which they participated was infectious and I heard more than one member of the Board of Directors (BOD) comment on this.

I bring this up because these residents are our future leaders. It is easy to forget the enthusiasm that we all had before

we became a little long in the tooth. One of the best things about going to these meetings is what I call the "rejuvenation factor." My enthusiasm is rekindled, and I return home a better teacher, administrator and physician. So, I wanted to be sure to thank the residents who attended this year's Scientific Assembly. They make me want to do a better job for my residents back home. They also reminded me of one of the challenges for our organization. We work very hard at growing our membership. We must not forget to work equally as hard at keeping them, especially as they transition from resident to attending. I have spent time talking with both Brian Potts (AAEM/RSA President) and David Vega (YPS President) specifically about this issue. We talked extensively about ensuring that the "bang for the buck" is there for all categories of membership. I think that all of you will see strong evidence of continued efforts to retain members as they transition in their careers. Above all, we need to remind our residents that there are great opportunities for both passive and active involvement in our organization. Young physicians can have an impact and make a difference. If you are a program director and have not signed up all your residents as AAEM members, please consider doing so. You will be providing your residents with tremendous opportunities while furthering their educations. Rest assured that your BOD intends to maintain these opportunities, even as the membership continues to grow.



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AAEM Mission Statement

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

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

Membership Information

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

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

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

International Member: \$125

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

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

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

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



VIEW FROM THE PODIUM

by Kevin Rodgers, MD FAAEM

Wow! What a great meeting in Las Vegas. The best attended in the history of AAEM with 795 attendees and a tremendous lineup of speakers. First and foremost, we should all thank AAEM Executive Director, Kay Whalen, and her superb staff, Janet Wilson, Tom Derenne, Shauna Barnes, Megan Kelley and Jody Bath for their enthusiasm and tireless efforts in coordinating a nearly flawless Scientific Assembly (SCIASS). Personally, I would like to recognize the tremendous job that Kate Filipiak did as the primary manager of the meeting. Her diligence and attention to detail in no small part led to the success of the premier meeting in EM.

The list of "thank-yous" for all those who contributed is a long one, so if I leave anyone out, please forgive me. Big kudos to the Education Committee members who helped plan and coordinate the meeting; their contributions were invaluable! I'd like to thank Chris Doty and Patrick Hinfey for coordinating and judging our first ever Photo Contest and John Madden for his continued efforts with our Open Mic session, which once again showcased several excellent speakers. Thanks to Steve Hayden (Moderator and Editor in Chief of *JEM*), Howard Blumstein, David Karras, Robert McNamara and Nathan Shapiro for judging the AAEM/JEM Resident and Student Original Research Presentations. Congratulations to everyone who presented their research efforts, but especially to the winners: Amish Shah, MD – 1st Place; Nima Majlesi, DO – 2nd Place; Julia Wang, MD – 3rd Place. I'd also like to thank Richard Shih and Michael Silverman for volunteering to provide the 2005 and 2006 LLSA Reviews for the membership. And, of course, thanks to Ghazala Sharieff and Joe Lex for their support and guidance during this transition year.

I'd also like to recognize the excellent cast of speakers, most of whom are members and all of whom volunteered to serve without any honoraria. Annually, we have been very fortunate to attract the best speakers in our specialty to the SCIASS. Although we are still tabulating the evaluations, many people commented on the consistently excellent quality of presentations throughout the entire meeting. Of course, thanks to the entire faculty who arrived early to teach our Pre-conference Courses. I'd also like to thank Dr. Jon Krohmer, Deputy Chief Medical Officer, Department of Homeland Security, for taking time out from his busy schedule to share with us their plan for integrating the community EM physician into Homeland Security's response to a terrorist threat. I'd like to recognize the success of the first version of AAEM's Resuscitation for Emergency Physicians course with over 40 attendees. Feedback was overall very positive with room for focus and expansion of the curriculum for next year. Congrats to Doug Migden and Bill Brady for their efforts in developing this much needed course for AAEM members. Finally, I would like to cite AAEM's Resident and Student Association for their efforts in developing their own educational sessions. While the students learned the nuances of EM residency application and selection,

the residents examined the complex world of coding and billing and discussed a variety of group practice settings.

During the SCIASS, we also held a training session and reception for AAEM's Oral Board Review Course. The goal of the session was to attract the participation of both previous and new faculty examiners. Uniformly reviewed as the best course of its kind in the US, the course unfortunately has a consistent waiting list of more than 60 people! The only limit to course expansion has been the availability of faculty examiners. Once again, we appeal to the membership to consider volunteering one weekend a year of their time to teach Oral Boards. Not only will you help our future members pass ABEM, but you will also be raising some money to help support AAEM's many endeavors. If you are interested, please contact Tom Derenne (tderenne@aaem.org). I'd be remiss if I didn't recognize the faculty who have repeatedly volunteered their time: 5 Course Award-Michael Epter, Jon Jaffe, Michael LeWitt, Michael Matteucci, Christopher Pergrem, David A. Smith, Bruce Thompson, and Benjamin Wedro; 10 Course Award-Usamah Mossallam; 15 Course Award-Mitchell Goldman.

We would also like to congratulate A. Antoine Kazzi, MD FAAEM (Director of Emergency Medicine at the American University Hospital in Beirut, Lebanon) for the David K. Wagner Award; Mark Batts, MD FAAEM for the James Keaney Award; Peter De Blieux, MD FAAEM (Director of Resident and Faculty Development, Section of Emergency Medicine at LSU School of Medicine), Jorge Martinez, MD FAAEM (Director of Clinical Emergency Medicine Services at LSU School of Medicine/Charity Hospital), Trevor Mills, MD FAAEM (Residency Director, Section of Emergency Medicine at LSU School of Medicine/Charity Hospital) and Keith Van Meter, MD FAAEM (Chief of the Section of Emergency Medicine at the LSU School of Medicine) for the Peter Rosen Award; Richard Nunez, MD FAAEM (Charlton Memorial Hospital, Fall River, Massachusetts) for the Joe Lex Educator of the Year Award; Jim Colletti, MD FAAEM (Associate Program Director, Regions Hospital, St. Paul, MN) for the Young Educator Award; Robert C. Harwood, MD FAAEM (Program Director, Advocate Christ Medical Center, Oak Lawn, IL) for the RSA Program Director of the Year and Elizabeth Weinstein, MD (Indiana University) for the RSA Resident of the Year Award.

The Education Committee has already started planning for the 14th Annual Scientific Assembly at the Amelia Island Plantation, Florida's premier island resort, from February 7-9, 2008. Do not hesitate to share with me (kroddgers@clarian.org) any topics, speakers or innovations that you feel would contribute to the excellent quality of our Scientific Assembly. You may also submit a request for a session to the Education Committee using the form, 2008 SA Proposal Guidelines, located on the AAEM Education/Scientific Assembly webpage.

13th Annual SCIENTIFIC ASSEMBLY in Las Vegas



AAEM Board Meeting on Sunday, March 11th.



AAEM members enjoying the Welcome Reception in the exhibit hall.



AAEM members enjoy the Oral Board Reception thanking past and future examiners.



Dr. A. Antoine Kazzi is honored with the David K. Wagner Award presented by AAEM President Dr. Tom Scaletta.



AAEM/JEM Competition Winners: from left, Nima Majlesi, DO, 2nd place; Julia Wang, MD, 3rd place; Amish Shah, 1st place; with Dr. Steven Hayden, Editor in Chief of the Journal of Emergency Medicine.



Dr. Tom Scaletta, AAEM President, and board members Drs. Blumstein and Rodgers enjoy the AAEM Assembly.



Dr. Robert McNamara presents Dr. David K. Wagner with a special gift recognizing his years of service as chair of the Department of Emergency Medicine.

 *The following awards were announced at the
13th Annual Scientific Assembly in Las Vegas.* 

David K. Wagner Award - A. Antoine Kazzi, MD FAAEM

Young Educator Award - Jim Colletti, MD FAAEM

Resident of the Year - Elizabeth Weinstein, MD

James Keaney Award - Mark Batts, MD FAAEM

Peter Rosen Award

Peter De Blieux, MD FAAEM

Jorge Martinez, MD FAAEM

Trevor Mills, MD FAAEM

Keith Van Meter, MD FAAEM

Joe Lex Educator of the Year Award - Richard Nunez, MD FAAEM

Program Director of the Year - Robert C. Harwood, MD FAAEM

Special Recognition

Departing Board Member

Tracy Boykin, MD FAAEM

Departing Board Member

Anthony B. DeMond, MD FAAEM

Departing Board Member

Richard D. Shih, MD FAAEM

Departing Board Member

Brian Potts, MD MBA

AAEM/JEM Research Competition

First Place – Amish Shah, MD

Second Place – Nima Majlesi, DO

Third Place – Julia Wang, MD

2007 AAEM Oral Board Examiners Service Awards

15 Sessions:

Mitchell Goldman, DO FAAEM

10 Sessions:

Usamah Mossallam, MD FAAEM

Kevin Rodgers, MD FAAEM

5 Sessions:

Michael Epter, DO FAAEM

Jon Jaffe, MD FAAEM

Michael LeWitt, MD FAAEM

Michael Matteucci, MD FAAEM

Christopher Pergrem, MD FAAEM

David A. Smith, MD FAAEM

Bruce Thompson, MD FAAEM

Benjamin Wedro, MD FAAEM

OIG Imposed CMPs for Alleged EMTALA aka “Anti-Dumping or COBRA” Violations

by Ann Pfeiffer, RN MS

We often hear about Civil Monetary Penalties (CMPs) levied by the Office of Inspector General (OIG) in an ominous manner. Reference to these CMPs has been used by hospitals to emphasize the importance of compliance with the Emergency Medical Treatment and Labor Act (EMTALA) Regulation and the seriousness of an EMTALA violation. But how often does the OIG impose these CMPs for EMTALA violations, and what are the related factors?

EMTALA:

42 U.S.C. § 1393dd requires: (1) hospitals that operate an emergency department to provide appropriate medical screening examinations to individuals who present to the hospital and request examination; (2) hospitals to provide stabilizing treatment or an appropriate transfer to any individual who has an emergency condition; and (3) hospitals with specialized capabilities and capacity to accept appropriate transfers of individuals with emergency medical conditions. 42 CFR 489.24 indicates, in brief, that in the case of a hospital that has an emergency department, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists for an individual who presents, regardless of ability to pay. If an emergency medical condition is determined to exist, the hospital must provide any necessary stabilizing treatment. If an individual at a hospital has an emergency medical condition that has not been stabilized, the hospital may not transfer the individual unless the transfer is an appropriate transfer and the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child. A transfer to another medical facility will be appropriate only in those cases in which the transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child. Lastly, the requirement is such that if a hospital has the capability and capacity to stabilize a patient with an emergency medical condition, the hospital must accept this patient in transfer.

Background:

Title XI of the Social Security Act (Section 1128A) authorizes the Secretary of HHS to levy CMPs and assessments against entities found to have acted improperly in dealings with HHS programs. The OIG may seek a CMP, and in some cases exclusion from the Medicare Program (Under Title XI of the Act, Sections 1128, 1156, and 1892), against any hospital that has negligently violated its EMTALA obligations. 42 U.S.C. § 1395dd(d)(1)(A) authorizes a maximum civil fine of \$25,000 for hospitals with fewer than 100 beds and a maximum fine of \$50,000 for larger hospitals.

In addition, under 42 U.S.C. § 1395dd(d)(1)(B), the OIG may also seek a CMP up to \$50,000 per incident, and in

some cases exclusion for gross and flagrant or repetitive violations, against a responsible physician, including an on-call physician, who negligently violates this statute either by signing a certification when the physician knows that the risks outweigh the benefits or misrepresenting the patient's condition or the hospital's obligation.

Most CMP cases are resolved through settlement with no decision having been made on the merits of the OIG's allegations or the respondent's defenses. The settlement agreements described in the OIG's website resulted from OIG investigations and represent a compromise by the OIG and the settling party. In each CMP case resolved through a settlement agreement, the settling party has contested the OIG's allegations and denied any liability. No CMP judgment or finding of liability has been made against the settling party.

Review:

A four and a half year period, ranging from January 2002 to July 2006, was reviewed. It is important to note that this review does not include an exhaustive examination of all investigative and legal findings, but rather an emphasis was placed on the amount of CMPs and the types of cases involved. Any reference that is made to the specific details of these cases is based upon information available to the general public on the OIG website. The information disclosed varies in each case.

During the period under review, a total of 105 cases settled, with an average of 23 cases settled per year, and a range of 20-30 cases settled per year. Broken down by year, in 2002, 24 cases settled; in 2003, 30 cases settled; in 2004 and 2005, 20 cases settled; and, in the half of the year reported of 2006, 11 cases settled.

Findings:

Historically, we have seen that EMTALA was enacted and is enforced to protect vulnerable populations. This analysis is based on the types of patients identified, but it is important to note that the settlement agreements do not always identify the category of patient or the reason the patient presented to the hospital. That being said, it is no surprise that the number one type of patient involved with CMP settlements is one who may be categorized as psychiatric/detoxification/developmentally delayed (21 cases). This is followed very closely by patients who are pregnant or post-partum (20 cases). Again, as expected, children and the elderly are noted in many cases (15 for pediatric or infant patients and 13 for senior or elderly). The other noted reasons for patients presenting includes motor vehicle accident or trauma (6 cases), cardiac concerns (4 cases), the patient required surgical intervention (6 cases), and less commonly the reason patients presented was rape, burn, hypertension (high blood pressure), shortness of breath, and that the patient was found to be incoherent. The total fines assessed were \$26,950,000, with an average of \$26,800 per case for hospitals, ranging from \$5,000 to

continued on page 7

OIG Imposed CMPs for Alleged EMTALA aka Anti-Dumping or COBRA Violations - continued from page 6

\$120,000. The average fine for physicians was \$14,000, with a range from \$10,000 to \$20,000. It is interesting to note that physicians were levied CMPs for cases that not only involved on-call issues but also medical screening examination, stabilization and transfer issues. The two cases that were settled for the highest dollar amounts both involved psychiatric patients.

CMS has ten regional offices that serve as the agency's main link to beneficiaries, health care providers, state and local governments, as well as the general public. In this sense, they are responsible for the direct oversight of the Medicare Program and any subsequent enforcement actions. Only nine regions have hospitals where these 105 CMPs were levied. Region IV had the most with 29 cases, comprising 27% or almost one third of all settlements. This region, with an office in Atlanta consists of eight Southeastern States: Alabama, Georgia, Florida, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. This is double the average number of cases per region. Region IX, consisting of California, Nevada, and Arizona, had the second most at 23 cases. Region VI, consisting of Texas and the immediately surrounding four states, comes in third place with 18 cases. Region V and Region VII, both in the Midwest, follow with 10 and 9 cases, respectively. Regions I, II, III and VIII all had relatively few, ranging from 2 to 5 cases each. Surprisingly, Region X, representing the Northwest, did not have any cases in which hospitals were levied CMPs.

EMTALA compliance is not to be determined based on outcome. It is noteworthy that nine cases indicated that there was a fatal outcome. The average fine for these cases was \$45,500, well above the average fine when the outcome was not necessarily fatal. Interestingly, in two of the cases with fatal outcomes, it was noted that the patient was considered a "frequent flyer." This was not mentioned in any of the cases where the outcome was not fatal. It is also important to note that in the State Operations Manual, Chapter Five (5480.2- EMTALA Case Referral to OIG), the OIG describes the types of cases in which they might utilize their prosecutorial discretion to include those that involve patients with trauma or acute emergency conditions, where death or serious harm results from the lack of treatment or the violation is considered egregious as prioritized by CMS.

The approximate average number of patients involved in each case was 1.8. There were 3 cases in which the number of patients involved was described as "several."

Each provision of the EMTALA regulations has a related Tag number. These designations are listed as A404: On-Call Physicians, A406: Appropriate Medical Screening Examination, A407: Stabilizing Treatment, A408: No Delay in Examination or Treatment in Order to Inquire about Payment Status, A409: Appropriate Transfer, and A411: Recipient Hospital Responsibilities. The OIG website does not provide the specific Tag number cited by CMS,

but rather a comment describing the allegation. To the best of my ability, I assigned each narrative to one or more Tags for purposes of analysis. There may be more than one Tag cited for each incident, and multiple Tags may be cited if there was more than one patient involved. That being said, the provision of an appropriate medical screening examination (Tag A406) was by far the most commonly cited, as it was included in 89 of the cases or 85% of the time. This is more than double that of any other Tag. The second most commonly cited designation was stabilizing treatment (Tag A407), cited in 45 cases, or 43% of the time. An inappropriate transfer (Tag A409) was cited in 21 cases, or 20% of the time. Failure to accept (Tag A411) was cited in 12 cases. All except two (84%) of the A411 tags had CMPs above the average.

While Tag A408 was only referenced twice, which is less than 2% of the time; there were 19 cases where the provision of care or lack thereof was based on financial issues/insurance status, which is 18% of the cases.

On call responsibilities (Tag A404) was cited in 5 cases. In three of those cases, the physicians settled payments with the OIG.

Lastly, there were 7 CMPs levied due to overcrowding or diversion issues but these CMPs averaged well below the total CMP average at \$20,600, with a median settlement of \$15,000. 5 of the 7 cases settled for \$15,000 or less. (Two of the CMPS were above \$15,000 (\$25,000 and \$50,000), three of the CMPS were \$15,000 and two of the CMPS were below \$15,000 (\$12,500 each). We can assume from these numbers that the OIG and CMS acknowledge and appreciate the state of emergency rooms today, where most experience overcrowding and often struggle with diversionary issues.

Summary:

Hospitals should review their policies and procedures on a regular basis to be certain that they are not only in compliance with the regulatory requirements but also that they are easily understood by all applicable staff. It is often beneficial for hospitals to have someone who is not familiar with the hospital's actual practices to review the policies. An outsider may more readily identify inconsistencies or vulnerabilities that might have been overlooked. Hospitals should provide focused training to all levels of staff based on their level of clinical contact and related responsibilities. It is important to utilize different training modalities to keep staff engaged and interested. EMTALA has been around for 20 years, some individuals may think they have heard all there is to hear about EMTALA and subsequently tune out updates or clarifications. Even though there is a greater awareness of EMTALA, there continues to be misconceptions. Lastly, hospitals should evaluate the effectiveness of training with follow-up tests or competencies and internal audits. Internal audits are the best way to substantiate a working knowledge of the responsibilities and obligations related to EMTALA.

Messages from the Frontline

Dr McNamara,

Thank you for your response. I really don't understand how EmCare has gotten by holding so many contracts in Texas since the corporate practice of medicine is prohibited; however, EmCare is entrenched in Texas. I recently viewed some of the documents you attached to your email on the AAEM website and am only more discouraged and upset that I am employed by EmCare. I am very interested in helping you challenge the right of EmCare to hold contracts in Texas.

When I completed residency, I came back to Texas to work, and although I did not want to work for EmCare, I didn't have many other choices since they owned the contract at the hospital where I wanted to work. Fortunately, I had a friendly and helpful medical director who was not a fan of EmCare either. Circumstances changed, he was offered the MD position at a larger hospital which EmCare had lost the contract on, and things only changed for the worst at my hospital. With his exit and the lost contract, I noticed my hourly pay dropped an average of \$37 which concerned me and I addressed

only to find an antagonized response. Then, several promises were made to increase our pay with an hourly rate (claiming that a night differential would be included, but it was not). The new rate was actually lower than my usual, but at least it was closer to what I had previously. Still, rather than keep their promise, which I have in an email to all doctors, they are now decreasing our RVU rate as stated in a contract that was received after the date to go into effect. Of course, the doctors' fees pay for EmCare, but we are not allowed to see exactly what we generate, and since EmCare owns the accounting, billing, etc., they can do whatever they want. The promises were made when EmCare thought they would retain the contract at the hospital. I have learned that they already have lost the contract from other sources, so I believe that they are trying to take as much money from this contract as they can for EmCare corporate and their shareholders; but that's just a theory that is likely true, but I can't prove it.

Again, thank you for your response. Please let me know if I can be of any help.

Texas EM physician

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- All of Our Clients are References



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**Elections for Board
Member At-Large positions
were held at the 13th
Annual Scientific Assembly
in Las Vegas.**

**The 2007-2008 Board of
Directors is listed below.**

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Kevin G. Rodgers, MD – 2008

Indrani Sheridan, MD – 2010

Andy Walker, MD – 2008

Associate Member Representative

Mark Reiter, MD MBA

AAEM/RSA President

Andrew Pickens, MD JD MBA

American Academy of Emergency Medicine Endorses D2B: An Alliance For Quality

The American Academy of Emergency Medicine (AAEM) announces the endorsement of the initiative of the American College of Cardiology (ACC) - the D2B: An Alliance for Quality. ACC's national quality improvement initiative is a Guidelines Applied in Practice program, to lower door-to-balloon ("D2B") time to 90 minutes or less for at least 75% of ST-segment elevation myocardial infarction (STEMI) patients presenting at facilities performing primary PCI. Research demonstrates that this practice reduces mortality and improves patient outcomes. This is a complex challenge requiring the coordination of paramedics, emergency nurses, emergency physicians, other hospital staff, process improvement and interdisciplinary cooperation and coordination.

AAEM joined this initiative as a "Visionary Supporter." AAEM will proudly show its support through the use of the logo and name on promotional materials, and we will be allowed to publish materials from D2B with the acknowledgement of the ACC and D2B.

To learn more about D2B: An Alliance for Quality, log on to www.d2b.acc.org

DAVID C. CONE, MD FAAEM

assumed the presidency of the National Association of EMS Physicians in January at the NAEMSP annual meeting. Dr. Cone is currently an associate professor of emergency medicine and public health at the Yale University School of Medicine. A charter member of AAEM, he was the founding chair of AAEM's EMS Committee in 1997 and has lectured on EMS topics at several AAEM Scientific Assemblies. He was part of a panel discussion at AAEM's 13th Annual Scientific Assembly in Las Vegas this March and talked on field treatment of congestive heart failure. He has been a member of the NAEMSP board since 1996 and has worked to promote strong relations between NAEMSP and AAEM.

Messages from the Frontline

Dr. McNamara

Thank you for taking the time to help me with my problem. However, I'm not sure what can be done, here is some background...

I graduated residency 5 years ago and came to work in Knoxville for TeamHealth. I was the only residency trained doctor at my hospital and in most of Knoxville. As you may already know, TeamHealth owns this entire area. TeamHealth promised me that no other FP/IM doctors would be hired at my hospital because they were going in a "new" direction.

I was an ideal employee (rather, independent contractor). Best customer service numbers at the hospital, just as fast as everyone else, well respected from the staff doctors, rapidly became asst director of my ED (ascended the corporate ladder), was responsible for the QA in my department.

One thing became evident after I assumed the QA, TeamHealth doctors (esp. the floaters) were suboptimal. Most were FP trained and overlooked a lot of serious problems. Admitted people that didn't need to be admitted and discharged some that did.

Initially, took my concerns to my superiors and these doctors were eventually not allowed to come to my hospital anymore. Oddly, they were allowed to work at other hospitals in the area. New doctors would show up and again make serious errors over and over again. Staff doctors would complain to me because I was receptive and in charge of QA. After three different doctors in three years, I started to see a pattern. TeamHealth would place a doctor at a hospital until he got kicked out and then move him to another hospital.

I eventually got labeled as having "too high of standards" and my complaints eventually got ignored. Finally, I quit. I didn't want to work with doctors who I knew were dangerous and certainly didn't want to check patients out to them. I stayed late everyday to take care of my own patients. I eventually asked TeamHealth to let me out of my contract so I could move on.

I had a 150 day "out-clause". They said no. I agreed to finish my contract. 120 days into my "out-clause," I get a phone call from my bosses (two of them) telling me not to go to work. I ask why and they won't tell me. They state that administration at the hospital has asked me not to return (the only part of my contract which gives them permission to do this). And, so, I was fired.

Now TeamHealth is interviewing other candidates for my job (young, just out of residency). I'd hate for them to go through what I went through.

Anyway, I'm not sure how you can help. I don't want my job back. I would like to keep young doctors like myself from having to go through the same thing I went through.

I feel much better now knowing people out there feel the way I do. The guys in my group made me feel like I was just a "troublemaker." They agreed with me, but are afraid to say anything because they are afraid they will get fired as well. "Protect the mother ship" is their thoughts. Besides they are FP trained and don't have the options I have.

Thanks again for letting me vent,
TN EM Physician

Thank You Oral Board Review Examiners!

Thank you to those who were volunteer examiners for the AAEM Oral Board Review Course on April 14-15, 2007. A special thank you to the examiners who were eleventh-hour replacements and the examiners in Dallas who dodged tornadoes and persevered through airport delays to arrive in time for the course, even if it meant getting in at 3 am.

Mitch Goldman, DO FAAP FAAEM
National Course Director
AAEM Oral Board Review Course

To become an Oral Board Review Course examiner, please see <http://aaem.org/education/oralboard/>



AAEM Announces the Launch of its NEW Web Design

Just like the fast pace of our emergency medicine practices, our field is ever changing with new technology, treatments and politics. As part of the commitment to keeping the most current information in the hands of people who need it, AAEM decided to find a better way to organize and present its large base of information. For the past six months, AAEM has been working to create a new web layout. This site is intended to be more user-friendly, allowing improved access to information important to the practice of emergency medicine.

There were a number of technical aspects that came into play when deciding how to improve the site, including necessary changes and updates required to keep in step with ever improving technology and resources. AAEM has implemented changes like creating a fixed-width site, so that users can see the entire webpage without scrolling back and forth, no matter their screen size. AAEM has also implemented the addition of a site map, allowing visitors to see where they are and where they would like

to go on the site. And finally, the site is now utilizing a search engine that will allow users to find information on the site that is only available in PDF form (Portable Document Format – commonly used by the Adobe program).

Outside of these technical changes, AAEM just wanted to give a fresh look to the site. There is now a members' area that allows easier membership renewal and updates, as well as easier job searches and staff contacts. AAEM has also reorganized the information contained within the site so that it is easier to find exactly what you are looking for, whether it's a position statement on improving service quality or finding out how to register for an AAEM event. Content contained on this new site will be updated as often as is needed to keep up with the rapid pace of change in emergency medicine.

Take some time to check out all AAEM's new web design has to offer at [www.aaem.org!](http://www.aaem.org)

The Conference You've Been Waiting For! Cape Cod



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MedPAC Recommends 2008 Payments, Prepares Report to Congress

by Kathleen Ream, Director of Government Affairs

On January 10, the Medicare Payment Advisory Commission (MedPAC) voted unanimously to approve a recommendation to Congress that it increase payments to doctors in 2008 under the Medicare physician fee schedule by a figure currently estimated to be 1.7%. In action the previous day, MedPAC also approved a recommendation to Congress that Medicare payments to long-term care hospitals not be increased in 2008 and that payment rates for inpatient rehabilitation facilities be raised by 1% in FY 2008.

Without congressional intervention this year, Medicare payments to doctors in 2008 will be cut by 10% under the current payment formula. While commissioners expressed considerable confusion over congressional intent regarding the \$1.35 billion "Physician Assistance and Quality Initiative Fund" created by Congress late last year for 2008, they ultimately agreed that the fund should be used to pay for the 1.7% increase but not to make the increase higher.

As for MedPAC's recommendations on ways to fix Medicare's physician payment system, it is expected that the commission's report to be filed with Congress in March will chart two alternative paths. One will probably entail setting expenditure targets encompassing all providers, not just limiting the expenditure target to physicians, which is the case under the current system. The other path would repeal the current expenditure target known as the sustainable growth rate (SGR) formula. That approach also would involve "developing and adopting new approaches for improving the value" of Medicare spending.

The commission appears divided on whether the SGR should be repealed altogether, however. If there is no agreement that the SGR should be repealed, another option would be to widen expenditure targets to include all types of providers. MedPAC Chair Glenn Hackbarth said he sees "broad agreement" on the commission for that option and for a component setting expenditure targets on a geographic basis. Other components tantamount to a transformation of the U.S. health system involve combining providers into accountable health systems that would be rated on the quality and efficiency of their care and paying them accordingly.

MedPAC is not prepared to advise Congress which of the two paths to take in overhauling Medicare's physician payment system. But commissioners cautioned that whatever path Congress takes, a substantial investment of new resources in the Centers for Medicare and Medicaid Services will be essential to establishing the new system.

MEDICAL MALPRACTICE DEBATE RESUMES

Senator John Ensign (R-NV) has reintroduced legislation he sponsored in the 109th Congress that places a \$750,000 cap on non-economic damages awarded in medical

malpractice cases. The bill – S. 243 – limits the damages collected from any one provider to \$250,000 with a total cap of \$750,000. The measure does not limit economic damages, but it does place caps on attorneys' fees. Last year, the measure faced heavy opposition from Democrats and trial lawyers, and it is likely that both will oppose it again.

Ensign said the bill is modeled after similar legislation in Texas that has helped lower medical malpractice insurance premiums for providers in that state. In its statement supporting Ensign's bill, the American Medical Association (AMA) agreed that the Texas law has kept medical malpractice premiums down and improved patients' access to care.

Meanwhile, the consumer watchdog group Public Citizen released a report on January 10th concluding that "there is no medical malpractice lawsuit crisis in America." In its news release announcing the report, Public Citizen cited as more critical problems "a lack of attention to patient safety, the high incidence of preventable medical errors and the lack of accountability for a small set of doctors who account for a majority of medical malpractice payments."

FEDERAL COURT DISMISSES SCREENING CLAIM

On December 1, 2006, the U.S. District Court for the District of Kansas granted a motion of summary judgment to a Kansas not-for-profit hospital, thereby dismissing an inadequate screening claim under Emergency Medical Treatment and Active Labor Act (EMTALA). The initial suit was brought by a woman whose husband collapsed and died after he was made to wait in a hospital emergency department (Parker v. Salina Regional Health Center Inc., D. Kan., No. 05-04066-KGS, 12/1/06).

The facts in this case involve plaintiff Oneita Parker, who is the surviving widow, and the defendant Salina Regional Health Center, Inc. (SRHC). On June 7, 2003, the plaintiff drove the decedent, Mr. Parker, to SRHC's ED. When plaintiff and Mr. Parker arrived at the ED, plaintiff observed the ED registration clerk with a couple and a little girl. The Parkers waited for approximately 20 minutes, during which time Mr. Parker walked, more than once, under his own power between the waiting area of the ED and outside. At the end of this 20-minute period, Mr. Parker collapsed, became unresponsive, and a Code Blue was called, triggering immediate treatment of Mr. Parker. After approximately two hours of emergency medical treatment, Mr. Parker was pronounced dead. At the time of his death, decedent weighed more than 300 pounds and had a medical history as a diabetic with congestive heart failure.

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Upcoming AAEM–Endorsed or AAEM–Sponsored Conferences for 2007

May 13-16, 2007

- 15th World Congress on Disaster and Emergency Medicine
Amsterdam, The Netherlands
Sponsored by the World Association for Disaster and Emergency Medicine
www.wcdem2007.org

May 15, 2007

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

May 16-19, 2007

- Society for Academic Emergency Medicine (SAEM) Annual Meeting 2007
Sheraton Hotel and Towers
Chicago, IL
Sponsored by the Society for Academic Emergency Medicine.
<http://www.saem.org/SAEMDNN/Default.aspx?tabid=246>

May 20-25, 2007

- Marine and Diving Medicine Course
Bonaire, Netherlands Antilles
Course organized and sponsored by Mountain and Marine Medicine, LLC and the University of New Mexico
<http://www.mountainandmarinemedicine.com/Bonaire2007.html>

May 24-26, 2007

- High Risk Emergency Medicine
Hotel Nikko, San Francisco, CA
Conference sponsored by San Francisco General Hospital and the Department of Emergency Medicine at the University of California, San Francisco
www.HighRiskEM.com

June 28-July 1, 2007

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

September 15-19, 2007

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

September 27-30, 2007

- AAEM Written Board Review Course
Marriott Newark Airport Hotel, Newark, New Jersey
Sponsored and organized by the American Academy of Emergency Medicine
<http://www.aaem.org>

October 6-7, 2007

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

December 2-7, 2007

- Maui 2007: Current Concepts in Emergency Care
Wailea Marriott, Wailea, Hawaii
Sponsored by The Institute for Emergency Medical Education (IAME) and The Washington Chapter of the American College of Emergency Physicians.
www.ieme.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.

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

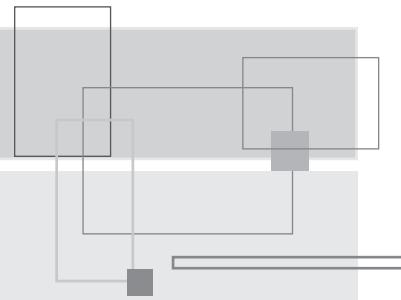
MEMC IV Poster Inside!

AAEM is co-organizing the Fourth Mediterranean Emergency Medicine Congress (MEMC IV), planned for 15-19 September 2007 in Sorrento, Italy.

All AAEM members are encouraged to attend the premier international emergency medicine Congress.

Help advertise MEMC IV by removing the poster inside this issue of *Common Sense* and posting in your office or department!

AAEM Young Physicians Section



PRESIDENT'S MESSAGE

Now is the Time to Get Involved

by David D. Vega, MD FAAEM

The following is an excerpt from an email I recently received from a fellow young physician. The last time I had seen him, he mentioned that he was working on starting a new independent group. Here is part of his reply to my inquiry about the progress he was making:

David,

*We had the practice pulled out from under our feet by the corporate practice of emergency medicine. It is all CEOs buttering each others' bread. This time it was Team -----. They have killed every independent practice in the region except one. I hope I don't sound too bitter, but it is a sad state. This gives the "Rape of Emergency Medicine"** real meaning... The private hospital is by far the best lifestyle. If it was closer to home, I would work there full time. They have excellent ER doc coverage and a real dedication to ER residency training. They don't pull in the family practice doc that will work for the least money. Something that corporate ER groups are particularly famous for. We will have to talk more in Vegas. Look forward to seeing you then.*

KF

My hope is that this message will help to remind each of us that our specialty faces many threats to the ability to safely provide the emergency care that our patients deserve. As the newest generation of emergency physicians, we must act both individually and collectively to ensure that emergency medicine is practiced by board-certified specialists who keep the interests of patients above the interests of profits. As the Young Physicians Section continues to develop, we hope to add to AAEM's proven record of supporting our specialty through continued advocacy, education and support of the individual emergency medicine specialist.

I would like to express my sincere thanks to everyone who has joined the Young Physicians Section so far and encourage you to become more involved with the section. Opportunities exist to become involved with authoring and editing articles, maintaining the website, building membership and working on special projects for the section. Take a look at the descriptions listed under the "Committees" tab on the website (www.ypsaaem.org) and let us know how you would like to get involved by sending an email to info@ypsaaem.org.

If you are a young physician reading this article and have not yet joined the Section, now is the time to do so. Sign up online at www.ypsaaem.org/membership. You must be a member of the YPS to participate in the election process, and every member has the opportunity to become involved in the development of the section.

Finally, talk to your colleagues who are not members of AAEM or the YPS and encourage them to join both the organization and the Young Physicians Section. YPS membership is open to members of AAEM who are in their first seven years of practice after residency. This is a great opportunity to get involved with a new section and influence its development and growth!

*Note: *The Rape of Emergency Medicine* is available in PDF and Palm OS formats on AAEM's homepage www.aaem.org.

The Value of Mentoring

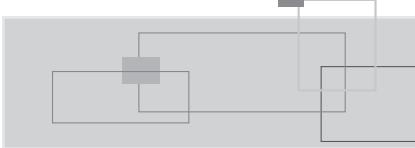
by Michael Epter, DO FAAEM
President, Nevada State Chapter
Board of Directors, Young Physicians Section
Chair: Mentoring Committee, Young Physicians Section

Simply defined, a mentor is a wise and trusted counselor or teacher. The origin of the word can be traced back to Greek mythology, and its first recorded modern usage of the term can be traced to a book entitled "Les Aventures de Telemaque," by the French writer François Fénelon [1]. In the book, the lead character is that of Mentor. This book was published in 1699 and was very popular during the 18th Century. The modern application of the term can be

traced to this publication [2]. Interestingly enough, (and if our Greek ancestors only knew) the term mentor results in over 38.9 million hits on a Google search[3].

The value of having a mentor cannot be understated. In emergency medicine, SAEM has established a Virtual Advisor Program for medical students to help gain access to information concerning emergency medicine, as well as having a unique opportunity to talk with some of the leaders of our specialty. This early contact helps us attract future leaders at an entry level in undergraduate medical education and is critical to the advancement of our field.

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AAEM Young Physicians Section

Ask the Expert

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

"Ask the Expert" is a *Common Sense* feature where subject matter experts provide answers to questions provided by YPS members. This edition features a leading authority on insurance and financial planning; Shayne Ruffing, CLU ChFC AEP is a Chartered Financial Consultant, Chartered Life Underwriter and Accredited Estate Planner with the Potter Financial Group.

Question: What is disability insurance, and how much coverage do I need?

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

Answer: Disability Insurance for Emergency Physicians: What you Need to Know in 2007
by M. Shayne Ruffing, CLU ChFC AEP

As EM practitioners, the ongoing rate of disabling injuries should be no surprise to you. In the first 20 years of a career, your disability income program is one of the most vital components of your financial plan.

The following summary is intended to be a "nuts and bolts" overview of disability terms and issues. An understanding of these terms will allow you to make an informed purchasing decision.

Simplistically, disability insurance is a product that replaces your salary in the event that you are unable to work. Consider this:

- You have just started in practice with a \$200,000 salary. Even though this is four times your residency income, you have fully allocated your new monthly income between your living expenses, loan repayments, retirement contributions and savings goals.
- Two months into your new position, you are skiing and end up severely breaking your dominant arm. The result is that you are unable to fully function for eight months.
- What happens to your lifestyle while you are without an income for eight months? How will you pay your student loan payments, your mortgage payments and your car payments?

In a well-structured financial plan, you would have built a cash reserve to give you at least three months of expenses without loss. At the end of the three months, because you are still unable to work, one or more disability insurers will begin paying you a monthly replacement salary for as long as you cannot return to the ED.

Disability insurance is the single most important type of risk management that a starting physician can have.

To determine your liability and potential need for coverage, look at your monthly income and your monthly expenses. How much of your monthly income can you afford to lose? Whatever amount of monthly income is required to continue your lifestyle should be the basis for your insurance.

For example - You have a monthly income of \$15,000. You consume \$7,000 per month, save \$3,000 per month and pay \$5,000 in taxes. In this scenario, you need a minimum of \$7,000 of disability income and perhaps as much as \$10,000 if you wanted to fully protect your standard of living.

There are some terms and techniques that you should understand before developing an appropriate income protection plan. The most pertinent are:

Definition of Disability - Own Occupation:

An own occupation (Own Occ.) period (2 yrs., 5 yrs. to age 65/67) is the length of time that you will be eligible to receive FULL benefits under your contract, as long as you cannot practice emergency medicine. Be aware that there are sub-categories of own occupation. Some variations are:

- True Own Occupation
- Own Occupation and Not Working
- Own Occupation and any Reasonable Occupation
- Transitional Own Occupation

I advise having true own occupation to at least your age 65. There are three companies that will currently do this for you.

Residual Disability:

This is as important as own occupation. Imagine you have experienced an injury that keeps you out of the ED for eight months. If your burning desire is to get back in to the ED as soon as possible, you need to understand your residual definition more than your own occupation definition. The residual clause will determine how much you receive and for how long when you go back to work as an emergency physician in your own occupation.

Guaranteed Purchase Option:

An option to purchase simply gives you the right to possibly increase your benefits in the future, if your income will justify it. It is designed to ensure that you can qualify by not having to answer medical questions. It does not guarantee that you can buy more protection. Also, understand what you have the right to buy! Is it the same quality that you have now or whatever contract the company may offer in the future? If you plan to be an academic physician for your career, you may not need this.

Cost of Living:

Every individual contract should have a cost of living (COLA) feature. This simply increases your benefit every year that you remain disabled. It protects your income from the rising cost of inflation over time.

In today's disability marketplace, there are several quality contracts for emergency physicians that can be used to

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AAEM Young Physicians Section



The Value of Mentoring - continued from page 14

In residency, most programs assign their residents an advisor - who may or may not ultimately become their mentor. One of the main weaknesses in our specialty is that during the time period following residency, perhaps the most critical period of all, there is no established mentoring program. The transition period that ensues following residency is often our most challenging time as an emergency physician. All of us recall our first night as an attending and the hyper-stimulation of emotions that we went through, "Doctor, you have a cardiac arrest in 5 minutes and a new pediatric patient with a fever in bed 5. Oh, by the way, did you see the labs on the patient in critical 4?!!" I remember my charge nurse who, if I hadn't known better, possessed a sixth sense and used nursing as a stress release from her daily job as a psychic or palm reader. I introduced myself as the new attending in the department and shook hands with her with my sweaty palm. Just as all superior emergency physicians have a gestalt for recognizing sick versus not sick, I was sized up within seconds and wondered if I could use a lifeline to phone a friend and see if there were any potential openings in medical school again or maybe at the local Home Depot. Morbidity and mortality conference would pale in comparison to hearing her voice one decibel above silent if I wasn't meeting her expectations to offer our patients top notch care that evening.

What I didn't have during those early post graduate experiences, that I look back on and laugh about with friends and colleagues, was a mentor. In addition to clinical work, the post residency transition is a challenge from both a personal and professional standpoint. Young physicians are faced with continual questions concerning job opportunities (e.g., academic versus community-based practice, group versus hospital employee, geographic practice areas), professional development and advancement, contract and financial concerns, as well as the stressors of a high-paced field. The value of having a mentor during these early years is extremely important.

For the mentor, you have the opportunity to establish an important bond with a colleague in the field and be an advocate and advisor. One of the many benefits I have personally

Ask the expert - continued from page 15

enhance or replace the benefits that you may have through your practice. A good broker will be able to advise you as to the different choices and assist you in designing the most comprehensive and cost effective program to fit your situation.

I hope that this information is valuable to you and wish you every success in your career.

Sincerely,

Shayne

Shayne Ruffing, CLU ChFC AEP is a Chartered Financial Consultant, Chartered Life Underwriter and Accredited Estate Planner with the Potter Financial Group. Shayne specializes in corporate tax leverage and executive benefits

achieved from mentoring residents and young physicians alike is watching the maturity and growth which takes place. The call from a mentee just saying "thanks" is something that brings me true happiness. I've heard it said that, "Unless we think of others and do something for them, we miss one of the greatest sources of happiness." It is remarkable just how much it can mean to the one being mentored that there is someone who has your best interests in mind, especially someone who has been down the same road.

For the mentee, you have the chance to interact with true leaders in our profession and to receive first hand exposure to the amazing camaraderie that exists within emergency medicine. It is this mutual support that defines the practice of emergency medicine and gives us the ability to care for the ultimate one that matters most – the patient. As practitioners, we all have a wealth of experiences in the clinical setting, so much so that they form the basis of successful, award-winning television shows. The sharing of these unique experiences (both good and bad) between mentor and mentee serves as an opportunity for personal and professional growth, as well as deepening the bonding experience for the parties involved. And last but not least, mentees often derive a sense of confidence and support from the knowledge that a fellow professional "has their back."

In closing, I invite both physicians who want to be mentors as well as those who want to have mentors to contact me directly by email at nvaem01@gmail.com.

What we do for ourselves on an individual basis will never permeate to the degree as what we do for our specialty and the young physicians of the future.

¹Roberts, Andy. (1999) "The origins of the term mentor.", History of Education Society Bulletin, no 64, Nov 1999, p313-329.

²Roberts, Andy. (1999) "The origins of the term mentor.", History of Education Society Bulletin, no 64, Nov 1999, p313-329.

³Google Search, "mentor"

for medical practices and can be reached at 919-302-0723 or on the web at www.potterfinancialgroup.com.

Shayne is a Financial Advisor offering Securities and Advisory Services through NFP Securities, Inc., a Broker/Dealer, Member NASD/SIPC and Federally Registered Investment Advisor. NFP Securities, Inc. is not affiliated with the Potter Financial Group.

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.

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.

Defendant sought a motion for summary judgment on plaintiff's EMTALA claim. Plaintiff listed the following points as genuine issues of material fact regarding her EMTALA claim against the defendant:

- SRHC violated EMTALA when its reception clerk sought the Parkers' insurance information prior to Mr. Parker being triaged;
- SRHC violated its own policy when it failed to provide an appropriate medical screening examination to Mr. Parker upon arrival at the ED; and that
- A 20-minute wait before receiving an appropriate medical screening examination is a violation of EMTALA and SRHC's own policy.

The court began its reasoning by reviewing the EMTALA statute which created a cause of action against hospitals that fail to appropriately screen and/or stabilize patients. As to conducting an "appropriate" medical screening examination, the court stated that hospitals specifically are obliged to create standard emergency room screening procedures based on the hospital's particular needs and circumstances. Thus, the court views the essence of EMTALA as that of a hospital's obligation measured by whether it treats every patient perceived to have the same medical condition in the same manner. EMTALA is "neither a malpractice nor a negligence statute;" so when a court must resolve failure to screen or conduct appropriate screening exam claims under EMTALA, the only question to review is "whether the hospital adhered to its own procedures, not whether the procedures were adequate if followed." Furthermore, noted the court, "mere de minimis variations from the hospital's standard procedures do not amount to a violation of hospital policy as a matter of law."

Since the plaintiff contended that SRHC violated its own policy when the reception clerk sought Mr. Parker's insurance information prior to triage, the court cited SHRC's ED policy which stated:

"Whenever any individual comes to the emergency department and requests, or someone on behalf of the individual requests an examination or treatment for a medical condition, a record will be initiated by the triage nurse. The triage nurse will determine a level of need for care as per health center policy and prior to any inquiry regarding the individual's method of payment or insurance status."

The undisputed facts show that when the Parkers first arrived at SRHC's ED, no inquiry was made as to the Parker's method of payment or insurance status. However, plaintiff argued that the hospital violated its own policy since it appeared that some inquiry was made prior to triage by virtue of Mr. Parker seating himself at the registration desk.

The court found that the Parkers approached the registration desk of their own accord, and not at the behest of the SRHC registration clerk or as a condition precedent to Mr. Parker obtaining a triage. In the court's view, these facts "amount

to a de minimis variation from hospital policy," that is so minuscule that the law does not refer to it and will not consider it. This conclusion also was supported by the federal regulations pertaining to the EMTALA statute which state:

Delay in examination or treatment.

(i) A participating hospital may not delay providing an appropriate medical screening examination . . . in order to inquire about the individual's method of payment or insurance status. . . . [However,]

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may duly discourage individuals from remaining for further evaluation.

In another one of her claims, plaintiff contended that defendants failed to provide Mr. Parker with an appropriate medical screening examination, in light of a disputed fact that upon arrival at the ED, plaintiff had advised SRHC's reception clerk that Mr. Parker was vomiting blood, experiencing difficulty breathing, had lower stomach pain and was possibly experiencing a heart attack.

The court disagreed, stating that even if it construed the disputed fact "in a light most favorable to plaintiff, the court fails to find a genuine issue . . . [T]he court's sole duty in an EMTALA case is to 'ask only whether the hospital adhered to its own procedures, not whether the procedures were adequate if followed.' To that end, plaintiff fails to reference, nor has the court found upon its own review of SRHC's ED policy, a procedure by which a reception clerk is required to report symptoms of patients arriving at the ED to a triage nurse."

Finding that to inquire further into this issue would be akin to questioning whether SRHC's procedures were adequate, the court stated that EMTALA does not permit it to do so. Moreover, it decided that "plaintiff's argument regarding the reception clerk's actions in light of Mrs. Parker's assertions to her upon Mr. Parker's arrival at the ED is more akin to a negligence claim than an EMTALA claim." Therefore, the court could not find a genuine issue on plaintiff's EMTALA claim and, as a result, granted defendant's motion for summary judgment.

For the complete decision, see <http://op.bna.com/hl.nsf/r?Open=thyd-6w8kzj>

PATIENT LEAVES HOSPITAL VOLUNTARILY THEN FILES EMTALA CLAIM

On November 30, 2006, the U.S. District Court for the Middle District of Florida affirmed a trial court's summary judgment, which dismissed a lawsuit filed by a man claiming that a medical center violated EMTALA when it forced him to leave the facility before receiving proper treatment for a drug overdose (*Johnson v. Health Central Hospital*, 11th Cir., No. 06-12426).

On November 5, 2000, Benjamin Levi Johnson (plaintiff-appellant) was diagnosed by Heath Central Hospital (defendant-appellee) emergency physicians, with an overdose of the psychiatric medication benzodiazepine and was admitted to the ICU under "suicide precautions." According to plaintiff, defendant understood the seriousness of his medical condition but failed to perform the "customary charcoal procedure to remove the pills" and stabilize him. He also asserted that when he became combative, the ICU staff became angry with his psychotic conduct and treated him disparately from other patients in similar circumstances. The following day, plaintiff was released from the Health Central facility. He says that he was still in a psychiatrically disturbed state and that Health Central should have stabilized his condition prior to release or transferred him to a mental health facility for further treatment.

In the initial complaint, Johnson claimed the following injuries resulting from his alleged premature release: (1) 60% hearing and tone recognition loss; (2) a "schizoaffective" disorder associated within non-convulsive seizures and a neuropsychiatric brain disorder; and (3) an arrest for irrational conduct, resulting in two years imprisonment. Johnson requested two damages in the amount of \$4 million for past and future physical pain, mental anguish, bodily injuries, inconvenience, medical expenses, loss of earnings and diminished earning capacity.

In response, defendant filed, and was granted, a motion for summary judgment. Health Center's motion stated that Johnson had been transported to Health Central's ED with an alleged drug overdose and cocaine intoxication, was admitted to the ICU, became fairly combative, and ultimately left against medical advice. Defendant served a request for admissions on Johnson, to which he never responded. By not responding to the request for admissions, plaintiff in effect admitted that he was evaluated by an emergency medical physician; was placed under the care of a doctor who admitted him to ICU, was monitored on a 1:1 basis, and left the Health Central facility against medical advice.

Plaintiff submitted his own affidavit questioning material issues of fact regarding whether he left the hospital by his own choice or was forced out and questioning whether he was stabilized when he was forced to leave. In his affidavit, Johnson stated that he requested to use the phone at the hospital, only to be repeatedly told that he could not use the phone. However, after continual asking, he was given a form to sign, which he signed as a condition before using the phone. Johnson said he never read the form he signed and that he did not want to leave Health Central but was forced to leave and, approximately four hours after he left, was still "hallucinating," which resulted in his assault of a police officer, leading to his arrest and imprisonment.

The district court granted Health Central's motion for summary judgment, finding that the sole question was whether defendant complied with EMTALA. The court

of appeals agreed with the trial court stating that an EMTALA violation arises when a hospital either fails to adequately screen a patient or when it discharges or transfers the patient absent stabilizing his emergency medical condition.

When viewed in the light most favorable to Johnson, the evidence, wrote the court, fails to establish that Health Central violated plaintiff's rights under the EMTALA. No evidence suggests that Johnson's medical screening was different from other patients. The court found that the only evidence that Johnson provided was "his own lay opinion that the 'customary charcoal procedure to remove the pills' should have been performed along with a psychological examination, which he was scheduled to undergo but voluntarily left the facility before receiving." Furthermore, in the issue of the stabilization requirement, the court determined that "the record fails to establish that Johnson was either 'transferred' or 'discharged' within the meaning of the EMTALA."

For a complete reading of the decision, see <http://op.bna.com/hl.nsf/r?Open=psts-6w6k8d>.

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Emergency physicians are encouraged to contact AAEM (anonymously, if desired) to report a listed group that they believe is not in compliance along with an explanation.



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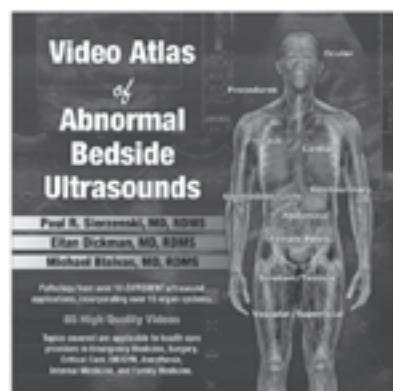
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Resident & Student Association



RESIDENT PRESIDENT'S MESSAGE

Why You Should Visit AAEM/RSA's Website: www.aaemrsa.org

by Brian Potts, MD MBA - AAEM/RSA President

Every year, due to the hard work of AAEM/RSA's board of directors and the communications committee, we have been increasing the number of resources and information available on our organization's website. I encourage you to visit the website and see for yourself. Below is an overview of what you can find on www.aaemrsa.org.

HOMEPAGE

- "Highlights" – quick links to the most utilized areas of the website including AAEM Job Bank, *Common Sense*, Washington Sentinel and all AAEM/RSA Publications
- Updated bullets for hot topics important to AAEM membership
- Career Network – an AAEM members-only resource; search an online database of physician contacts and/or find practicing emergency physicians throughout the country who have offered to provide information and guidance on the job search and practice environments in their region
- "Spotlight On" – recent interview with the movers and shakers in emergency medicine
- A Video Discussion of AAEM and ACEP 2006 – online 86 minute video with discussion from Drs. McNamara (AAEM) and Kellermann (ACEP)
- AAEM/RSA membership discounts – access negotiated discounts on multiple EM publications including a 10% discount on Elsevier's product line (features Rosen's Emergency Medicine) and a 20% discount on McGraw-Hill's product line (features Tintinalli's Emergency Medicine: A Comprehensive Study Guide)

LEADERSHIP

- Past President's Messages – read articles from the President in past issues of *Common Sense*
- 2006-2007 board of directors and committee members – see who to contact for information about AAEM/RSA
- Emergency Medicine Interest Group Representatives – find links to websites for student EM Interest Groups throughout the country
- AAEM/RSA Vision and Mission Statements
- Opportunities for involvement – read about how you can join the leadership by running for a board position, serving as a residency program representative or participating on an AAEM/RSA committee

MEMBERSHIP

- Membership applications – download a PDF application or join online
- Membership benefits – review a list of benefits you gain as an AAEM/RSA student or resident member
- 100% Residency Program Online Membership Application – help your residency program sign up all of your residents through this link to our online application

COMMUNICATION

- Discussion forums – discuss topics of interest to EM residents
- *Common Sense* – links to all past issues of AAEM's newsletter which includes articles contributed by AAEM/RSA

RESIDENT/STUDENT ISSUES

- Issues important to EM – links to educate yourself about board certification, consent, contract management groups, documentation, medical errors, moonlighting and the professional liability crisis
- Legal victories – read about key AAEM legal victories and understand why AAEM and AAEM/RSA are the organizations offering the most support to the individual emergency physician

RESIDENT/STUDENT RESOURCES

- AAEM Job Bank – link to AAEM's listing of job opportunities advertised throughout the country
- AAEM/RSA Toxicology Handbook – link to purchase our acclaimed handbook, great for students, residents and fellows
- EM Select – students can visit the searchable database of EM Residency programs, personalized program lists, keep notes from interviews, generate rank lists and compare programs – www.emselect.org
- *The Rape of Emergency Medicine* – access this publication in PDF format
- *Rules of the Road for Residents* – access this publication in PDF format
- *Rules of the Road for Students* – access online chapters
- Palm Pilot Resources for EM – review programs available for your PDA
- Personal Finance – check out "A Resident's Guide to Money Effective Strategies on Debt, Investing, and Money Management," by Mark Reiter, MD MBA, Immediate Past President of AAEM/RSA
- Links – a huge list of useful links compiled by Joel Schofer, Past AAEM/RSA President

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by Kathryn R. Challoner, MD MPH FACEP

This is a continuing column that examines the practice of emergency medicine in various countries around the world. This issue will look at EM in Ghana. This article is written by Kathryn R. Challoner, MD MPH FACEP. Dr. Challoner is currently the Co-director of the Division of International Emergency Medicine at the Department of Emergency Medicine, Keck School of Medicine, University of Southern California.

Background

Ghana is a West African nation in the Gulf of Guinea which borders Togo to the east, Burkina Faso to the south and Cote d'Ivoire to the west. In 1957, Ghana became the first British colony in Africa to achieve self-government and independence, and in 1960, Ghana became an independent republic. The republic has remained peaceful for nearly 25 years and has shown steady economic development. The population of Ghana is estimated to be 22 million with an average life expectancy of 57 years. The official language of the nation is English with a 75% literacy rate and a well-developed educational system.

As with other countries in Sub-Saharan Africa, infectious diseases pose the greatest threat to the health of Ghanaians. Diseases causing the greatest morbidity and mortality include the infectious diarrheas (including cholera), malaria, typhoid fever, measles, hepatitis, tuberculosis, yellow fever, HIV/AIDS, schistosomiasis and respiratory infections. Up to 75% of all illnesses are waterborne, although a large percentage is also caused by insect vectors. The nation has shown increasing gains in the areas of access to clean water and sanitation and the HIV/AIDS prevalence rate is estimated at 3.1%. The impact of traumatic injury is increasing, showing a steady increase in accident statistics and casualties.

Emergency Medicine in Ghana

The pre-hospital care system in Ghana is in the early stages of development. Accident victims have no access to stabilization at the site of the accident and are often transported in vehicles such as taxis and minibuses by untrained personnel. Hospitals frequently lack equipment and trained personnel to manage serious traumatic injury. Emergency medicine does not exist as a specialty in Ghana. The emergency area at Korle-Bu Teaching Hospital is staffed by medical and surgical house officers – patients presenting to the unit are cared for by the house staff of the admitting teams on call for the primary specialties (medicine or surgery). There is a separate accident center operated by the Department of Orthopedics.

Barriers to improving emergency care in Ghana go beyond technical and training issues. Economic and cultural barriers exist as well. Currently, private insurance companies cover only a very few individuals. The government funds 80% of the public health services through general taxation and donor funds. A cash and carry system is present for supplies and medicines resulting in a significant barrier to health care.

Emergency medicine is not a medical student module or elective. The specialty is still not recognized, and hospital emergency areas are not autonomous entities under focused leadership. The development of pre-hospital care services has been fueled by political agenda and leadership. Many positive meetings have been held with College leadership, the Ministry of Health, the president of the West College of Surgeons and the president of the Ghana College of Physicians and Surgeons to explore future developments.

Ghana Initiatives 2000-2006

After assessment and review, the Division of International Emergency Medicine, Department of Emergency Medicine, Keck School of Medicine, University of Southern California in collaboration with our Ghanaian colleagues designed three specific initiatives:

1) Annual Emergency Medicine Symposia: Symposia were held conjointly between the Faculties of the Department of Emergency Medicine, Keck School of Medicine University of Southern California and the College of Health Sciences Accra Ghana that focused on training in the areas of pre-hospital care and the management of traumatic injury and other selected emergencies. The first five years, a large symposium was held with the collaboration of our Ghanaian colleagues at the Korle-Bu Teaching Hospital in Accra. In 2006, a slightly different course was given that worked exclusively with the online providers from the emergency areas and accident center. To date, over 700 healthcare providers have attended one or more of these symposia.

2) Scholarship programs: To date, three faculty observational scholarships and one medical student scholarship have allowed three physicians and one medical student from the College of Health Sciences, University of Ghana to travel to the United States to observe the practice and instruction of emergency medicine at the LAC+USC Medical Center in Los Angeles for a one-month period. In 2004, a memorandum of Understanding/Instrument for the exchange of students was signed between the College of Health Sciences, University of Ghana and the Keck School of Medicine, University of Southern California.

3) Technology transfer: All medical curricular material including the emergency medicine core curriculum and teaching modules and equipment and lecture presentations on CD were left behind with the College faculty at the conclusion of every symposium. In addition, a free pharmacy was established at Korle-Bu Hospital and hundreds of thousands of dollars of medicines and medical and surgical supplies were donated.

The Future of Emergency Medicine in Ghana

Evaluations from the symposia and scholarship programs have been outstanding and have had a clear short-term impact. Realistically however, the development of an EMS system and a strong Emergency Medicine/Trauma presence is still years away. There are many barriers to overcome including existing infrastructure, economic concerns and availability of resources. While current collaboration has had immediate benefit, long term goals will require on-going efforts from both institutions.





Resident & Student Association

Resident Journal Review

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

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

1. Nigrovic LE, Kuppermann N, Macias CG, et al. Clinical prediction rule for identifying children with cerebrospinal fluid pleocytosis at very low risk of bacterial meningitis. *JAMA* 2007;297:52-60.

Most children with cerebrospinal fluid pleocytosis (CSF white blood cells ≥ 10 cells/ μ l) are admitted to the hospital and given intravenous antibiotics until bacterial meningitis can be excluded. This is a multicenter, retrospective cohort study based in 20 US pediatric emergency departments that validates the Bacterial Meningitis Score that classifies patients at very low risk of bacterial meningitis. The Bacterial Meningitis Score classifies patients at very low risk of bacterial meningitis if they lack all of the following criteria: positive CSF Gram stain, CSF absolute neutrophil count (ANC) of at least 1,000 cells/ μ l, CSF protein of at least 80 mg/dL, peripheral blood ANC of at least 10,000 cells/ μ l, and a history of seizure before or at the time of presentation. Of 3,295 patients with CSF pleocytosis, 121 (3.7%) had bacterial meningitis and 3,174 patients (96.3%) had aseptic meningitis. Of the 1,714 patients categorized as very low risk by the Bacterial Meningitis Score, there were 2 patients that had bacterial meningitis (sensitivity, 98.3%; 95% CI, 94.2-99.8%). Both patients were younger than 2 months old. Authors suggest that 2 options for well appearing children > 2 months old and a Bacterial Meningitis Score of 0 may be admission and observation without antibiotics or discharge from the ED with long-acting parenteral antibiotics with close follow up.

2. Storrow AB, Lindsell CJ, Han JH, et al. Discordant cardiac biomarkers: frequency and outcomes in emergency department patients with chest pain. *Ann Emerg Med* 2006;48:660-665.

Authors sought to evaluate the risk of acute coronary syndrome (ACS) in patients with suspected ACS and 3 groups of discordant cardiac biomarkers (CKMB+/creatinine kinase-, CKMB+/cardiac troponin-, and cardiac troponin+/CKMB-). Of 8,769 patients, 1,614 (18.4%) had acute coronary syndrome. Odds ratios with 95% confidence intervals for acute coronary syndrome (defined by coding of myocardial infarct, invasive or noninvasive diagnostic testing, revascularization, or death within 30 days) in patients with discordant markers were: CKMB+/creatinine kinase- 5.7 (4.4-7.4), CKMB +/cardiac troponin- 2.2 (1.7-2.8), and cardiac troponin +/CKMB- 4.8 (3.4-6.8). This is compared to patients without discordant cardiac markers: cardiac troponin+/CKMB+ 26.6 (18-39). This study is suggestive that discordant cardiac biomarkers should raise warning flags to emergency physicians for patients at risk for acute coronary syndrome.

3. Pawar KS, Bhoite RR, Pillay CP, et al. Continuous pralidoxime infusion versus repeated bolus injection to treat organophosphorus pesticide poisoning: a randomized controlled trial. *Lancet* 2006;368:2136-2141.

In this randomized controlled trial based in India, 200 patients with moderately severe poisoning by anticholinesterase pesticide were randomized to a control group (1g pralidoxime over 1 hr every 4 hrs for 48 hrs) and a study group (constant infusion of 1g pralidoxime/hr for 48 hrs). All patients were given a 2g loading dose of pralidoxime over 30 minutes. Primary outcome measures were median atropine dose needed within 24 hrs, proportion of patients who needed intubation, and number of days on ventilatory support. Patient in the high dose study group required less atropine during the first 24 hrs than controls (6 mg vs. 30 mg; $p < 0.0001$), they required intubation less frequently (88% vs. 64%; $p=0.0001$), and they required ventilatory support for less days (10 days vs. 5 days; $p < 0.0001$). This is the first known randomized trial that includes high dose pralidoxime and is suggestive that high dose pralidoxime is superior to lower intermittent bolus dosing. Whether or not this will change dosing regimens (WHO recommends 8 mg/kg/hr maintenance dosing) remains to be seen; however, this is a relatively well done study on a topic that is difficult to do randomized controlled studies.

4. Allemann Y, Hutter D, Lipp E, et al. Patent foramen ovale and high-altitude pulmonary edema. *JAMA* 2006;296:2954-2958.

It has been previously theorized that in persons with patent foramen ovale (PFO) are more susceptible to high-altitude pulmonary edema (HAPE) because high-altitude hypoxic pulmonary hypertension initiates right-to-left shunting which in turn aggravates hypoxemia. Authors did Doppler echocardiography at low (550 m) and high-altitude (4559 m) on 2 sets of climbers: 16 documented HAPE-susceptible climbers and 19 documented HAPE-resistant climbers. They found that the frequency of PFO is 4 times greater in climbers susceptible high-altitude pulmonary edema (HAPE) than in climbers resistant to HAPE both at low altitudes (56% vs. 11%, $p=0.04$; OR 10.9) and high altitudes (69% vs. 16%, $p=0.001$; OR 11.7). While this study does not establish causality between PFO and HAPE, it does suggest that right-to-left shunting across a PFO may play a role in the pathogenesis of HAPE and may help predict who may be susceptible to HAPE.

continued on page 23



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Resident President's Message - continued from page 20

Go to www.aaemrsa.org and add our website to your list of favorites for quick reference. Search the website, read the articles and learn about AAEM/RSA's mission and the many benefits of joining and supporting our organization. If you have any suggestions for information

or online resources that we should add, please email me at bpotts@uci.edu. We are always looking to further develop AAEM/RSA's website to make it more useful for our membership.

Resident Journal Review - continued from page 22

5. Tang H and Ng JH. Googling for a diagnosis – use of Google as a diagnostic aid: internet based study. BMJ 2006;333:1143-1145.

Ever wonder how good Google is as a diagnostic aid? Authors looked at 26 diagnostic cases presented in the case records of the New England Journal of Medicine and took 3-5 search terms from each case record and entered them in Google without knowing the final diagnosis. Authors then used the Google search results to select the most likely diagnosis and compared it to the actual diagnosis. Authors found Google searches to have the correct diagnosis in 16 (58%) of the cases.

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

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

Christopher Doty is the Associate Residency Director of Emergency Medicine and Program Director of EM/IM at SUNY Downstate/Kings County.

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



Emergency Medicine in Chile

by Judith Tintinalli, MD MS

This is a continuing column that examines the practice of emergency medicine in various countries around the world. This issue will look at EM in Chile. This article is written by Judith Tintinalli, MD MS. Dr. Tintinalli is a Professor and founding Chairman of the Department of Emergency Medicine at the University of North Carolina at Chapel Hill. Dr. Tintinalli has been a pioneer in the development and organization of emergency medicine in Chile and various other countries around the world.

Background

Things Chilean: Patagonia, Magellan Strait, Torres del Paine, Pisco, Pucon, the Elqui Valley, the Atacama Desert, Tierra del Fuego.

Chile is a long strip of land bordered on the north by Bolivia and Peru, on the east by the Andes and Argentina, and on the south and west by the Antarctic and Pacific Oceans, respectively. It has some of the most stunning geography in the world. The capital is Santiago which has a population of approximately 15 million.

Chile was discovered in 1536 by Almagro and was a Spanish colony until its independence in 1818. Chile retains much of its Spanish influence in culture, music and literature. In 1950, Chile was devastated by an enormous tsunami with simultaneous earthquakes, floods and Andean volcano eruptions. The town of Valparaiso was saved from destruction by the work of hundreds of citizens who worked day and night to dig, by hand, artificial channels to divert the destructive lava flows and floods around the town.

The socialist president Salvador Allende governed from 1970-73 until overthrown in a military coup by Pinochet in 1973. Today, it is a democratic republic with its first woman president, Michelle Bachelet, elected in 2006. Santiago demonstrates a unique mix of socialism and capitalism. Looking down from my hotel room in downtown Santiago, I saw dozens of buses leapfrogging around each other racing to bus stops! It turns out that the driver's salary is determined by the number of riders captured (sort of like RVUs/shift), so there is intense competition for each bus to get to the bus stop first.

Healthcare

Healthcare is provided by a network of health ministry hospitals and clinics, university teaching hospitals and private hospitals and clinics. In Santiago, I visited a major health ministry hospital with over 1,000 inpatient beds. It is staffed by a group of heroic individuals. Heroic is an understatement. Funds are scarce, and everything is in short supply - nurses, bandages, even light bulbs. Much of the medical care is provided by medical students.

Hallways are filled with patients, and waits for ED care are long. Physician salaries are low. Inpatient stays are long, and the environment was reminiscent of US city hospitals in the 1960s.

In contrast, the Catholic University Hospital is modern, functional and extremely efficient. All specialties are available. The emergency department has its own electronic medical record system and computerized radiology system. CT, MRI and ultrasound are available 24 hours a day. Continuous Quality Improvement (CQI) and ED length of stay are everyday tools used to monitor and improve patient care. The Catholic University has recently opened an ultramodern satellite hospital in a Santiago suburb, with an adult and pediatric ED and staffed with emergency physicians and pediatric emergency medicine specialists.

Medical Education

Medical training follows the European system. Medical school entry is by competitive examination. Medical students have a great deal of responsibility in the public hospital rotations. However, residency positions are available for only the top 10-15% of medical school graduates. Medical school graduates who cannot get into a residency, and who stay in Chile, are assigned to staff rural or city clinics or emergency departments! There is little, if any, Continuing Medical Education (CME) for those physicians and no telemedicine system. For individuals selected for residency programs, facilities and training are on a par with, and perhaps even superior to, that in the US and western Europe. Residencies are sponsored by either the government or by hospitals. Thus, the numbers of residency positions are limited by funding.

At the Catholic University, medical student training is extremely contemporary. There is a well-equipped simulation lab, including examination rooms with two-way mirrors for teacher observation. Emergency medicine faculty have been leaders in the development of this program.

EMS

The EMS system is a bipartite system consisting of a free, state-run EMS system and a subscription-based private EMS system. The state system has been structured exactly like SAMU (Services D'Aide Medical Urgente) of France. As a matter of fact, the current EMS head is a native of France. SAMU headquarters is on the top floor of the city hospital. SAMU can activate ground units and helicopters and uses a sophisticated set of SAMU-derived algorithms. EMTs are well-trained in ALS, PALS and ATLS.

Private systems are hospital-associated. Patients call specific phone numbers and are always taken to the associated, private hospital. Trauma, however, is

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EMSelect: An Invaluable Resource

by Marisa Fernandez, MSIV; University of Southern California, Keck School of Medicine
Vice-President, AAEM Student Section

Background

As a third year medical student planning to apply to emergency medicine (EM) residency programs, I remember feeling lost and a little overwhelmed. It was time to pick my sub-internship rotations, and I didn't know how to choose among the options between them. I was plagued with questions about the educational and clinical experience I would have at each program. How could I find out about a program's reputation? Although I searched through numerous sources on the web, I found that one of the very best sites was right here with AAEM. EMSelect.org is a comprehensive resource for those that need to learn about and prepare for applications to EM programs.

As the brainchild of last year's AAEM/RSA's Medical Council, EMSelect.org is a website designed specifically for medical students applying to EM residencies. The intention of the creators was to provide not only a source of vital statistics on each residency, but also a forum where AAEM members could share their interview experiences and thoughts on the program in general.

For 3rd years

A major draw to this site is that it is very applicable/adaptable to your needs from the beginning of third year all the way until match day. As a third year, I wanted to learn about each program and develop a plan as to where I would apply. It's helpful to determine this early – you will most likely want to rotate at your favorite programs, and many of the more competitive residencies require that you apply for your away rotation with them well in advance. For each of the programs in the US, the most important information is given (e.g., length of program, number of residents taken, MD or DO, fellowships, hospital volume statistics, etc.). I was able to query the database by state and then flag those programs I liked in order to consolidate them into a personalized list.

For 4th years

As a fourth year, EMSelect.org has been an amazing interview resource. My most difficult task during this period of time was keeping organized, which with the speed at which interview season travels, is easier said than done. It began with customizing my list of residencies by using the 'Add programs' function to include my preliminary and transitional internship programs. I even used the schedule function to keep track of my flights and the resident hosted pre-interview social events. After each interview, I was able to review my personalized list and make notes about each place that I visited, writing comments, and my pros and cons. I also used the program to track whether or not I had written thank you notes.

Nearing the end of interview season, I used the site to compare my programs side by side while generating my rank list. My customized page allowed me to see all of my different program comments in one list: which was invaluable in judging the programs. As I went through each of my interview experiences, I used the pull down menu provided to rank each program.

What to look forward to

The AAEM/RSA board is hard at work to make this website even better – we plan to allow users to make their pro/con and comment lists public to be shared with other EMSelect members. Information about interview day, what to expect about off-service rotations, fellowship opportunities and thoughts on the program can be shared within the AAEM community, making you that much better informed. With membership climbing to over 450 users, EMSelect.org promises to be the tool of the future for all EM residency applicants.

Using EMSelect.org

EMSelect.org is an outstanding way to organize yourself during the interview process from beginning to end. AAEM/RSA members simply need to register on EMSelect.org. Non-members can enjoy a free two-week trial period – to continue the account, simply sign up for membership at www.aaemrsa.org.

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Emergency Medicine in Chile - continued from page 24

generally referred to SAMU and the city hospitals. It is not anticipated that the public-private systems would someday merge. The private ambulance services are important economically, are well-established and provide outstanding service.

Emergency Medicine

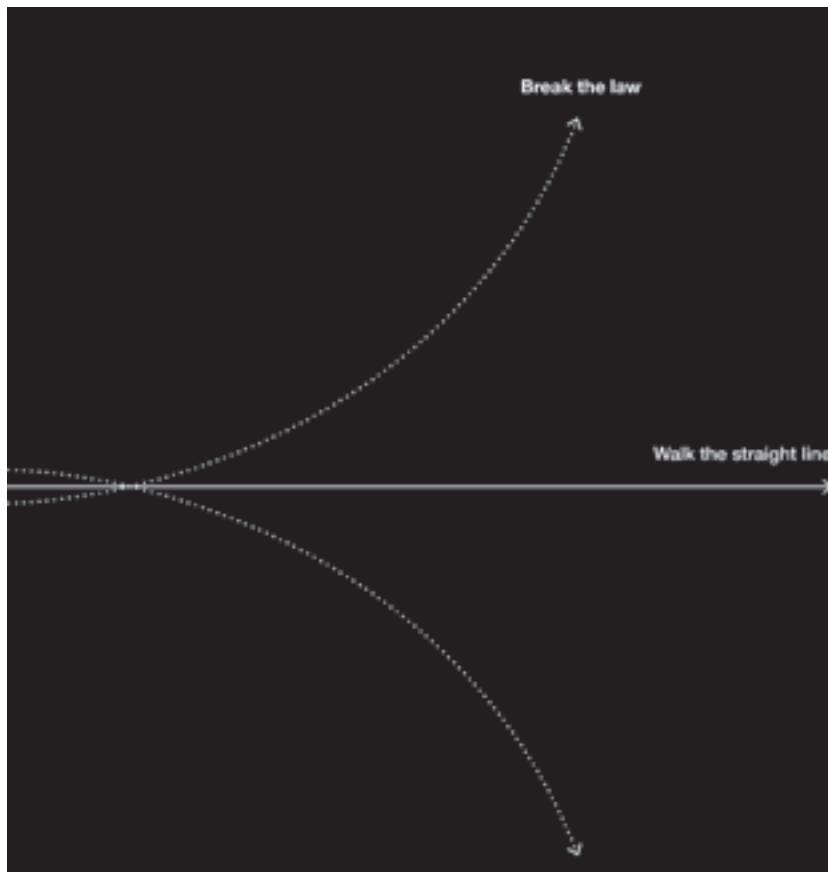
The University of Chile has had an emergency medicine residency for several years and has attracted residents from Ecuador, Bolivia, Columbia, and Peru, besides Chile. Very recently, a program has been developed at the Catholic University, and the two programs were combined into one this year with a single program director. The curriculum is quite similar to that of emergency medicine residencies in the US, Canada and Australasia. The emergency medicine residents are bright, motivated and cosmopolitan. They would function very well in any US emergency department.

There are three major obstacles to the growth of emergency medicine in Chile: 1) resistance to change the traditional methods of EM care, 2) resistance to establishing an academic identity for emergency

medicine and 3) lack of government recognition of EM and the resultant lack of jobs for graduated emergency medicine residents. Clinics and emergency departments outside of Santiago are staffed with non-residency trained physicians. However, if the Bachelet government recognizes the need for emergency medicine (and there are hopeful signs), things can change quickly. The Chilean Ministry of Health is acutely interested in the collection and aggregation of emergency department and clinic data as markers for acute illness and injury, disease prevention and surveillance. If this can be realized, Chile will move rapidly into the 21st Century of healthcare and will bring emergency medicine along with it.

Summary

I'd put Chile on my list of 'must-see' countries. From north to south, it is spectacular! Chile is the economic leader of South America. While the current healthcare system is radically stratified based on economics, improvements in healthcare are major goals of the Bachelet administration. The Catholic University and University of Chile in Santiago have all the necessary ingredients for the growth of a vigorous specialty of emergency medicine.



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

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

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

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

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

*ALABAMA

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

*CALIFORNIA

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

*CALIFORNIA

Bakersfield, Ca. Seeking full or part time BE/BC Emergency Physicians to join newly formed democratic group staffing a large private community hospital/referral center with 40k visits per year. All specialties covered with good backup. Employee status @ \$150/h with partnership track beginning after 6 months. Ninety miles north of LA, low cost of living, easy non stop access to Phoenix, Houston, Salt Lake and San Francisco. Abundant recreational activities locally with nearby world class white water and wind surfing, off road biking, hiking in the Sequoias. Skiing 3-4 hours north and south. Beaches 2 hours south or west. Junior and Senior Residents welcome to apply for back-up double covered shifts. Submit CVs to Pinnacle Emergency Physicians at phogku@aol.com, 661-332-1064 or fax 661-589-2151. (PA 788)

*COLORADO

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

*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)

*ILLINOIS

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

*ILLINOIS

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

*ILLINOIS

Outstanding opportunity for Emergency Physician to join a democratic group of Emergency Physicians in a stable practice situation at Memorial Medical Center in Springfield. Partnership track with future profit sharing. Volume 54K with excellent ED physician coverage. State of the art 30-bed facility is entirely new in 2000, with an additional 14 beds added in 2006. A CT is also available in the ED. Excellent specialty backup. Salary is very competitive with full benefit package. Memorial is a major teaching institution of Southern Illinois School of Medicine, and Emergency Physicians are clinical faculty members. Springfield is the capital of Illinois with a population of over 110,000 and a very stable economy. This is an excellent opportunity for an Emergency Physician with superior clinical and interpersonal skills desiring a democratic, small group and a long-term practice situation. Contact David Griffen, MD, PhD, FACEP, Medical Director and Chair, 217-788-3156, fax CV in confidence to 217-788-6459, or e-mail griffen.david@mhsil.com. (PA 790)

*IOWA

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

*IOWA

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

*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)

*MARYLAND

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

*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. Email: nwaters@phg.com. (PA 804)

*MISSOURI

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

*NEW YORK

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

*NORTH CAROLINA

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

*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 excellence 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 Greg Calkins, MD at gcalkins@wohrr.com. (PA 792)

*OKLAHOMA

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

*OKLAHOMA

Tulsa, Oklahoma-Exceptional opportunities available now for BC/BE Emergency Medicine Physicians to work in a 557-bed tertiary medical center, with a 14 bed ED (5 of those are minor care beds). • Level III Trauma Center • Over 50,000 visits annually • 2 teaching services in-house • Excellent Hospitalist group • 140 hrs/mo=full time • Mid-levels cover minor care

Exceptional salary/benefit package being offered, including paid malpractice and equality within group structure from day one. Tulsa, pop. 400,000, is known for its cosmopolitan flair, including a performing arts center, outdoor music festivals, and an array of shopping and restaurants. Excellent public and private school system for children, along with exceptional private universities. Tulsa also has two medical schools. For further information or consideration, please contact our Tulsa recruiter, Lori at: Toll-free: 866-396-3627. Direct line: 918-518-5460 Fax: 918-518-5461, or E-mail: lrb22@aol.com (PA 772)

*OKLAHOMA

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

*PENNSYLVANIA

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

*PENNSYLVANIA

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

*RHODE ISLAND

Emergency Room Physician: Westerly Hospital, a pleasant seaside community located in the southwest corner of Rhode Island with 30,000 ED visits per year to our state-of-the-art Emergency Department wing, has a full-time position available for an emergency physician. Candidates must be board-certified/board-eligible in Emergency Medicine with a minimum of 2 years experience. Coastal living and a collegial atmosphere make this a great place to work. Please send CV with cover letter to M. Eddy, Medical Staff Coordinator, The Westerly Hospital, 25 Wells St., Westerly, RI, 02981. Fax 401-348-3802 or meddy@westerlyhospital.org (PA 760)

*SOUTH CAROLINA

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

*SOUTH CAROLINA

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

*SOUTH CAROLINA

Growing/stable South Carolina Emergency Medicine group needs additional BP/BC emergency physicians for 80,000 patient ED. Join a democratic group which is physician owned and led. The group is committed to quality care and patient satisfaction utilizing Press Gainey measures. Our group has no financial or staffing differential for partnership. Growing area within the midlands of South Carolina with healthy economy, great climate, low cost of living and abundant recreational opportunities. Send CVs to Carolina Care, PA, 215 Redbay Rd., Elgin, SC 29045, 803-622-3081, or email gconde@carolinacare.com. (PA 789)

*TENNESSEE

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

*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)

*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)

*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)

*TEXAS

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

*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)

*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)

*TEXAS

Texas, Houston Medical Director: Great administrative opportunity in vibrant downtown Houston! Sign on bonus, monthly stipend, partnership buy-in, and great benefits including 401(k) with generous employer contribution, health, dental and life insurance, paid malpractice/tail coverage and productivity based compensation. Contact Gretchen Moen at gretchen@eddocs.com or 800-888-8237. (PA 800)

*TEXAS

Texas, San Antonio Area: Medical Director needed for 25,000 volume ED only 20 minutes from San Antonio. Great administrative opportunity right on the Guadalupe River. Sign on bonus, monthly stipend, partnership buy-in and great benefits including 401(k) with generous employer contribution, health, dental and life insurance, paid malpractice/tail coverage and productivity based compensation. Have the best of both worlds: peaceful riverside living with a quick commute to urban areas! Contact Gretchen Moen at gretchen@eddocs.com or 888-800-8237. (PA 801)

*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)

*VIRGINIA

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

*VIRGINIA

Seeking BC/BE candidate who wants to be a long-term participant in the continued growth of emergency medicine in our community. We are located in the southeastern corner of Virginia with a great climate and rapidly growing economy. We are a single-hospital, fully democratic group providing care at our hospital since it opened in 1976. We are fifteen physicians and eight PAs providing 54 hours of physician coverage and 50 hours of PA coverage daily. 63,000 ED visits this year with relatively high complexity patients with minimal to no major trauma. Recently renovated 28-bed ED with a 9-bed fast track and separate 24-hour cardiac catheterization and angioplasty. Real-time transcription and computerized medical records. Excellent remuneration, benefits and full partnership. Email inquiries with CV to neivabeach@yahoo.com. (PA 791)

*WYOMING

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

***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. Contact: selina.irby@crmcwy.org. (PA 803)

***AUSTRALIA**

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

***GUAM**

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

ALABAMA

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

CALIFORNIA

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

CALIFORNIA**Emergency Medicine Partnership**

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

KENTUCKY

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

NEW YORK

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

TEXAS

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

WASHINGTON**Emergency Medicine Physician**

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

WASHINGTON

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

WASHINGTON

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

WISCONSIN

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

Urgent Care Practice For Sale**FLORIDA**

Do you dream of running your own business and living 2 minutes away on the beach? Established and growing urgent care practice with affluent patients (70% insurance/30% cash/no pay!) near beach generating \$700,000 in annual revenue with \$300,000 expenses [employees (including full-time physician assistant and part-time nurse practitioner), rent, utilities, supplies, and insurance]. PA/NP covers 160 hours per month, you manage and work 44 clinical hours per month (decrease PA/NP coverage, increase physician clinical time, and decrease annual expenses by \$100,000)]. 1860 sq. ft. furnished condo [living room, kitchen, 3 bedrooms, 2 new bathrooms with whirlpool large bathtub/steam room, and deck overlooking ocean and 5 miles of beautiful beach plus pool/whirlpool/exercise room/party room]. Package price to live and work in paradise - \$2.1 million. Call 863.698.1228. (PA 755)



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