



when minutes count

common SENSE

The Newsletter of the American Academy of Emergency Medicine — Volume 12, Issue 4— Summer/Fall



PRESIDENT'S MESSAGE

by A. Antoine Kazzi, MD, FAAEM

"ENEMY MINE"

Unity in emergency medicine: What will it be? A divided house or a multiple-party system?

"It's about time the Hatfields spoke to the McCoys!"

As you all know by now, at its board meeting on May 26, 2005, the AAEM board of directors approved a major initiative to promote unity in organized emergency medicine. The board passed the following resolution to promote unity in organized emergency medicine.

Resolution and Proposal to Promote Unity in Organized EM:

"Whereas, there now exists two competing general professional societies, the AAEM and the ACEP, in the specialty of emergency medicine; and Whereas, at the federal and state level there exist certain issues where the specialty and the organizations would mutually benefit from a cooperative effort; and Whereas, there exist other issues mostly internal to the specialty of EM that are best handled by one or the other organization; therefore be it

Resolved, that the AAEM board of directors approves of the below steps and will request of the ACEP that the two organizations take the following steps towards greater unity between these societies:

1. The organizations will unify federal political efforts by contributing on a per full member basis equal funds to federal legislative action that will be pursued out of a unified Washington, D.C. office.
2. The organizations will establish one government affairs committee with membership proportionate to the number of full members.
3. The organizations will unify their political action committees with that board's representation on a proportionate basis to the number of full members and each organization will recommend this as the preferred vehicle for PAC donations by their members.

4. The organizations will institute by-laws changes to allow for the restructuring and renaming of the state chapters of ACEP and AAEM to allow for unified state ACEP/AAEM chapters that will require national membership in at least one of the organizations."

Why this and why now? Well, it has always been obvious – and often recognized - that much common ground exists between the two major EM organizations regarding federal and state legislative issues such as the malpractice crisis and ED crowding. **It has also become increasingly evident that each national organization has important activities that are best carried out by that organization alone.**

The EM community response to our public announcement – what has been referred to as the "Call for Unity" - was overwhelmingly positive and supportive. Of course, several members raised many valid concerns.

It is the belief of the AAEM board of directors that the described steps will be good for the specialty of emergency medicine while preserving the integrity of the original AAEM mission.

AAEM cannot be ignored. Critics and foes have certainly learned this the hard way over the last decade. Our AAEM membership numbers have now approached the 5,000-member milestone. Our growth rate is higher than ever – with a record-breaking 11.2 percent increase in less than one year, reported in our last board meeting. Our national, state & international activity continues, not only to increase, but to literally multiply every two to three years, both in scope and magnitude, spanning legislative, regulatory and educational activity.

We, (AAEM), have made our offer out of a position of strength and out of respect to the large numbers of hard-working ACEP members and leaders who share with us the same vision and belief in what is best for EM. So many believe that we

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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 patient.
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: \$345 (Must be ABEM or AOBEM certified in EM or Pediatric EM)
 Emeritus Member: \$225 (Must be 65 years old and a full voting member in good standing for 3 years)

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

* Associate Member: \$250 (Non-voting status)
 Resident Member: \$50 (Non-voting status)
 Student Member: \$50 (Non-voting status)

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.



EDITOR'S LETTER

by Howard Blumstein, MD FAAEM

In this column, I will make the case for AAEM members to join the AMA. Never thought I'd be doing this...

A recent proposal from the AMA Board of Directors, but not formally submitted to the House of Delegates, recommended that the AMA develop model state legislation that would prohibit the corporate practice of medicine. It would have prohibited corporations and hospitals from employing physicians.

The proposal went directly to the heart of one of AAEM's primary issues. A physician working for a corporation may come under influences that are not in her patients' best interest. The doctor may be pressured to accept substandard ED conditions, to cut corners in order to see more patients in a given period of time, or to keep her mouth shut when she sees a colleague who may be incompetent or impaired. AAEM members have reported to us that they have experienced all these problems, and more. The fear of losing one's job, of being black listed by corporate groups, or running afoul of restrictive covenants are serious threats. Bottom line: Corporations practicing medicine often put profits before patients, with the doctors being forced to implement poor medical decisions made in boardrooms by businessmen.

AAEM has helped several emergency medicine groups, under threat of losing their contracts to CMGs, by referring hospitals to their own state laws prohibiting the corporate practice of medicine. But not all states have such laws. If more states were to recognize the inherent problems with corporations employing physicians and adopt legislation suggested by the AMA, we would all enjoy unprecedented protection from predatory CMGs.

So why did the AMA take an interest in this issue? Did its leadership suddenly sit up and say "Gee, those emergency docs have a good point; we ought to do something..." Nah! What happened, I expect, is that more and more specialties have begun to experience pressure from similar CMGs, leading more and more members to call the AMA's attention to this issue. I wrote about corporate groups controlling pediatricians, oncologists, pain control specialists and pathologists in the November 2004 issue of *Common Sense*. But just open the back of a general medical journal and you will see a host of familiar CMGs offering staffing services for hospitalists,

primary care docs and other specialists. No wonder the AMA has taken notice!

Here we find powerful allies. The AMA has more power and authority than any emergency medicine society can ever hope to enjoy. And other specialty societies may be ready to come together with us under the umbrella of the AMA to fight the corporate practice of medicine in a concerted front.

But how can AAEM retain the lead in this issue? We have been addressing the problems with corporate medicine for several years. Other specialty societies are newcomers to the issue. But some are larger and enjoy the status of being members of the AMA's House of Delegates. These societies have a formal relationship within the AMA and have access to the decision making process. It is these groups that will soon begin to drive the AMA agenda on this issue, if they haven't done so already. And once the AMA throws its support against corporate medical groups, it will become much easier to bring the issue to state legislatures.

The board of directors of AAEM has long discussed becoming a House of Delegates member. Yet AAEM has neither the total membership needed to attain that status, nor the total number of AMA members that serves as alternative criteria. Calls have been issued before, asking members to join the AMA. After years of protesting "What have they ever done for me?" I did so. That didn't put us over the top in terms of the number of AMA members we need, but every member helps. And, to tell the truth, doing so has made me far more knowledgeable about medical issues in the United States.

Here's an opportunity to get the largest and most influential medical group on our side in the battle against the biggest scourge in emergency medicine today: corporate medical groups. The tide is turning against corporate medicine on a national scale. But only a strong and concerted effort by a united front representing all physicians will be able to mount the offensive necessary to bring corporate abuses to an end. We can be leaders or followers in this conflict. Only by gaining more status within the AMA will we be able to maintain a leadership role. So, please consider joining up! 🇺🇸

Rally at the US Capitol Gaining Momentum

AAEM encourages you to attend ACEP's Rally at the West Lawn of the US Capitol at 10 AM on Tuesday, September 27th. All emergency physicians, as well as residents, nurses, physician assistants, paramedics, EMTs, medical students and other concerned health care providers and citizens from across the nation are encouraged to take part in the rally.

This rally is being held to urge Congress to pass legislation needed to address the boarding of admitted

patients in hospital EDs, solve the professional liability crisis in EM and to support EM care as an essential public service. These issues are crucial for all providing EM care and our EM patients. The AAEM President, a number of board members and the AAEM governmental affairs committee leadership will be participating. If you plan to attend, please let us know at info@aaem.org.

This message was sent out as a broadcast e-mail by AAEM on 7-12-05. 🇺🇸

EMTALA Pointers

FROM THE AAEM EMTALA COMMITTEE

by Mark Reiter, MD MBA

Question:

Does EMTALA apply to private patients of a member of the hospital staff that are to be directly seen by their personal physician?

Answer:

Yes. These patients still need to be triaged similar to other emergency patients, and the hospital is obligated to provide stabilizing care under EMTALA if an emergency medical condition exists. The hospital should have protocols in place to guide this process, which may entail the emergency physician performing the medical screening exam if the patient's private physician is unable to perform it in a timely manner. If there is no emergency medical condition, the patient can then wait for care by the private physician. Some emergency physicians may choose to bill for this examination, especially if the patient encounter is lengthy or complex.

SAE 
 Sociedad Argentina de Emergencias

*First Inter-American Conference
on Emergency Medicine*
 'Consensus and Controversies in Emergency Medicine'
English language track with simultaneous Spanish translation

Sheraton Buenos Aires
 Hotel and Convention Center
 Buenos Aires, Argentina
 April 18-21, 2006
 (Preconference Workshops April 18, 2006)


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For more information
www.aaem.org (posted soon) • 800-884-2236
www.emergencias.org.ar

CME Sponsored by AAEM

Upcoming AAEM-Endorsed or AAEM Sponsored Conferences for 2005

September 24-25, 2005

- AAEM Oral Board Review Course is being held at the airport Embassy Suites in Chicago, Los Angeles, Philadelphia and Orlando.

Course sponsored and organized by the American Academy of Emergency Medicine

<http://www.aem.org>

October 6-9, 2005

- AAEM Written Board Review Course held at the Hilton Newark Airport, Newark, NJ.

Course sponsored and organized by the American Academy of Emergency Medicine.

<http://www.aem.org>

November 3-4, 2005

- Practical Emergency Airway Management Course at the University of Maryland Medical Center and State Anatomy Board, Baltimore, MD

Course sponsored by the American Academy of Emergency Medicine.

<http://www.aem.org>

November 5, 2005

- Jam Session for the Written Board Examination, Atlanta, Chicago, Dallas, East Brunswick, NJ, Los Angeles

Course sponsored by American Academy of Emergency Medicine

<http://www.aem.org>

December 1-2, 2005

- Practical Emergency Airway Management Course at the University of Maryland Medical Center and State Anatomy Board, Baltimore, MD

Course sponsored by the American Academy of Emergency Medicine.

<http://www.aem.org>

December 2, 2005

- Emergency Radiology: A Systematic Approach to Imaging in the Emergency Department Bellevue Hospital Center, NYC Department of Health, Auditorium on Ground Floor, 455 First Avenue (27th Street), NY, NY

www.med.nyu.edu/emergency/courses/

December 4-9, 2005

- Maui 2005: Current Concepts in Emergency Care Wailea Marriott, Wailea, Hawaii
- Sponsored by the Institute for Emergency Medical Education and the Washington Chapter of the American College of Emergency Medicine

<http://www.ieme.com/maui/conf1.shtml>

February 16-18, 2006

- 12th Annual Scientific Assembly
- Sponsored and organized by the American Academy of Emergency Medicine

Marriott Rivercenter, San Antonio, Texas

www.aem.org

April 19-22, 2006

- First Inter-American Conference on Emergency Medicine

Co-sponsored by the American Academy of Emergency Medicine and the Sociedad Argentina de Emergencias (SAE) and the American College of Emergency Physicians. Sheraton Buenos Aires Hotel and Convention Center
Buenos Aires, Argentina

www.aem.org (coming soon)

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.



AAEM MEMBERSHIP

Remember when you join the AMA to let them know that AAEM is your preferred professional organization.

AAEM encourages members to join the American Medical Association - Physicians Dedicated to the Health of America

For more information call AMA 1-800-AMA-3211 or visit www.ama-assn.org



When I was young, I used to admire intelligent people; as I grow older, I admire kind people.

Rabbi Abraham Joshua Heschel (1907 - 1972)

I expect to pass through life but once. If therefore, there be any kindness I can show, or any good thing I can do to any fellow being, let me do it now, and not defer or neglect it, as I shall not pass this way again.

William Penn (1644 - 1718)

For most of life, nothing wonderful happens. If you don't enjoy getting up and working and finishing your work and sitting down to a meal with family or friends, then the chances are that you're not going to be very happy. If someone bases his happiness or unhappiness on major events like a great new job, huge

amounts of money, a flawlessly happy marriage or a trip to Paris, that person isn't going to be happy much of the time. If, on the other hand, happiness depends on a good breakfast, flowers in the yard, a drink or a nap, then we are more likely to live with quite a bit of happiness.

Andy Rooney (1919 -)

THE VIEW FROM THE PODIUM

12th Scientific Assembly – San Antonio, Texas • February 16th -18th, 2006

by Joe Lex, MD FAAEM

Set aside February 16th through the 18th, 2006, for the best AAEM Scientific Assembly ever. We gather in a great city, San Antonio, Texas, for what many people consider the leading educational event in emergency medicine, the American Academy of Emergency Medicine's 12th Annual Scientific Assembly. Our hotel, the San Antonio Marriott Rivercenter, is in the heart of the city and at the center of dozens of activities, convenient to attractions on foot, in taxis, or on boats.

Although planning is only at the beginning stages as I submit this column, the Education Committee is extremely excited about what we've planned.

Keynote Speaker: We've asked Surgeon General Vice Admiral Richard Carmona to be our keynote speaker. Dr. Carmona was born and raised in New York City; he dropped out of high school and enlisted in the U.S. Army in 1967. He received his Army General Equivalency Diploma, joined the Army's Special Forces, ultimately became a combat-decorated Vietnam veteran, and started his career in medicine. Dr. Carmona has trained and worked as a paramedic, a registered nurse and a physician. He completed a surgical residency at the University of California, San Francisco, and a National Institutes of Health-sponsored fellowship in trauma, burns and critical care. He has also served as a medical director of police and fire departments and is a fully-qualified peace officer with expertise in special operations and emergency preparedness, including weapons of mass destruction. We've asked him to address us on the topic of Front-Line Preparedness.

But as you know from 2005, inviting an upper-level government official doesn't always work out. We were fortunate in having a member of Bruce Hart's caliber to step up and pinch-hit in 2005, and we've already got our "back-up" speaker for 2006. Award-winning author and physician Abraham Verghese has agreed to speak on the first day of the assembly, and will be keynote speaker should Dr. Carmona be unable to attend. Dr. Verghese's first book, *My Own Country* was a finalist in the National Book Critics Circle Awards for 1994, and was made into a movie. His second book, *The Tennis Partner*, was a *New York Times* notable book and a national bestseller. He has published extensively in the medical literature in infectious diseases and general internal medicine. His work has appeared in *The New Yorker*, *Esquire*, *Sports Illustrated*, *The New York Times*, *The Washington Post*, *The Wall Street Journal*, and *The Atlantic*. His speaking is every bit as good as his writing, and he will be a spellbinding addition to our gathering as he takes up the topic "What the Pen Teaches the Stethoscope."

Fun Activities: San Antonio is a great city, and I've got a lot of personal history there. I lived there from 1982 - 1986 while attending medical school and never tired of showing it off to visitors.

I also lived there for a few months in 1967 while in training at Ft. Sam Houston to become a medic. My father was stationed at Lackland Air Base during WWII with the Army Air Corps, and my grandfather was a member of the horse cavalry stationed at Ft. Sam during The Great War.

The Riverwalk and The Alamo are obvious choices to visit. But don't forget the wonderful San Antonio Zoo, Sea World, the Mission Tours, the Botanical Gardens, the historic King William District (known as the Kaiser Wilhelm District a long time ago, or as locals called it, "Sauerkraut Bend"), Six Flags, La Villita, the West Side barrios (where few speak English and the food is incredible, and where many restaurants have their own mariachi band), the Children's Museum, the Tower of the Americas, and so much more.

But best of all, the San Antonio Stock Show and Rodeo is in town that week and we'll be getting a block of tickets. Bring your bolo tie, your Tony Lama's, and your fist-sized belt buckle for a great show of bronco busting, bull riding, and horsemanship. We're not sure yet who the entertainers will be, but in 2005 Rodeo attendees got to see Alan Jackson, Willie Nelson, The Steve Miller Band, Asleep at the Wheel, Neil McCoy, Brad Paisley, Bill Cosby, Clay Walker, and Reba McEntyre. And if you can't make the rodeo, enjoy the ambiance of County Line Barbecue, either the original a few miles north of town or the branch on the Riverwalk.

The Assembly: Invited speakers and returning favorites include Amal Mattu, Bob McNamara, Ed Panacek, Billy Mallon, Mel Herbert, Michelle Lin, Bruce Hart, Jeff Tabas, Kevin Rodgers, and Peter DeBlieux. Newly invited this year are Judy Tintinalli, Ken Iserson, Arjun Chanmugam, Marvin Wayne, Mike Klevens, and Open Microphone speaker Jonathan Davis. The popular Point-Counterpoint returns with practitioners debating two points: Activated Charcoal is Obsolete and Paramedics Should Not Intubate in the Prehospital Setting.

Cutting edge topics to be covered in the conference include hemoglobin substitutes, recombinant factor VIIa, prevention of contrast-induced nephropathy, community-acquired MRSA, and current recommendations for post-exposure prophylaxis of needle sticks. There will be evidence-based literature reviews on cardiology, trauma, venous thromboembolic disease, pediatrics, and common HEENT emergencies.

Because of our proximity to Ft. Sam Houston, we're arranging for a military Emergency Physician to explain techniques of treating acute trauma learned from the frontlines in Iraq and Afghanistan. Kevin Rodgers, MD FAAEM, is attempting to arrange a preconference course at Ft. Sam involving acute trauma care using simulators, while

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As most of you are aware the formula for calculating Medicare payment updates to physicians is seriously flawed and has, in recent years, resulted in projected pay cuts to physicians. Organized medicine, including AAEM, then scrambles to reverse those cuts as it will create a barrier for physicians to care for Medicare patients. The Cardin-Shaw bill proposes a permanent fix to this situation and AAEM is strongly supporting this especially since these cuts may further increase the growing burden of elderly patients in the nation's emergency departments. If you wish to stay on top of this and other issues go to the AAEM web site (www.aaem.org) and sign up for our alerts on the Legislative Action Center.



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in Emergency Medicine

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June 20, 2005

The Honorable E. Clay Shaw
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Benjamin L. Cardin
U.S. House of Representatives
Washington, D.C. 20515

Dear Representatives Shaw and Cardin:

The American Academy of Emergency Medicine (AAEM), the specialty society of board certified emergency medicine physicians, wishes to express its strong support for H.R. 2356, the Preserving Patient Access to Physicians Act of 2005. We applaud your leadership in attempting to fix the manner in which Medicare payments to physicians are calculated.

The 2005 Medicare Trustees Report estimates that the current physician payment system will cut doctors reimbursements by 26% over the next six years – beginning with an across-the-board 4.3% cut on January 1, 2006. These cuts are due to the flawed Medicare payment update formula. They will threaten the ability of Medicare patients to receive needed care in the community and may lead to further crowding of our nation's emergency departments.

Payment updates are based on a sustainable growth rate (SGR) system tied to the gross domestic product (GDP). This means that when GDP declines as the economy softens, payment updates decline as well. From 1991-2003, payment rates for physicians and health professionals fell 14% behind practice cost inflation, as measured by Medicare's own conservative estimates.

H.R. 2356 repeals the SGR and replaces it with an annual Medicare payment update for physicians that reflects practice cost increases. H.R. 2356 provides doctors with a payment update of no less than 2.7%, with the annual update beginning in 2007. This bill establishes a permanent solution, so physicians can continue to give Medicare patients the care they deserve. As you may know, recent data from the CDC showed that emergency department (ED) visits have reached an all time high – 114 million in 2003 – and that the greatest increase was among those over age 65. AAEM believes it is important to keep the Medicare program strong for America's seniors and disabled so that more of them are not forced to turn to the already crowded EDs for their medical care.

AAEM and its more than 4,000 members look forward to the enactment of H.R. 2356 and offer our resources to bring this legislation to reality. Continued cuts in resources to our health care system are unsustainable. Our citizens will suffer if Medicare continues to cut payments to physicians and other health professionals.

If we can be of further assistance, please feel free to contact Kathleen Ream, AAEM's Director of Government Affairs, at 703-241-3974.

Sincerely yours,

A. Antoine Kazzi, MD FAAEM

Elections

Board Nomination Period Begins

NOMINATION DEADLINE: NOVEMBER 18, 2005

Nominations are now being accepted for all officer positions including, President, Vice-President and Secretary-Treasurer. Two At-Large positions on the AAEM board of directors are also open as well as a new Associate Member Director Position. All current, full voting members of AAEM are eligible to run. Self-nominations are allowed and encouraged.

Elections for these positions will be held at AAEM's 12th Annual Scientific Assembly, February 16-18, 2006, at the Marriott Rivercenter in San Antonio, TX. Although balloting arrangements will be made for those unable to attend the Assembly, all members will be encouraged to hold their votes until the time of the meeting.

The Scientific Assembly will feature a Candidates Forum, in which members will be able to directly question the candidates before casting their ballots. Winners will be announced during the conference and those elected will begin their terms at the conclusion of the Assembly.

In order to nominate yourself or another full voting member for a board position, please send the following information to the AAEM office before **November 18, 2005**:

1. Name of nominee.
2. Name of nominee's medical school and year graduated.
3. Board certification status of nominee, including board and year completed.
4. Number of ED clinical hours worked each week by the nominee.
5. A candidate statement (written by the nominee, 500 word max.) listing recent AAEM contributions, accomplishments, activities, or any other information detailing why the nominee should be elected to the board.
6. Any emergency medicine related business activity in which the nominee has a financial interest.

The candidate statements from all those running for the board will be featured in an upcoming issue of *Common Sense* and will be sent to each full voting member with their membership renewal packets.

These nomination and election procedures are what set AAEM apart from other professional medical associations. We believe the democratic principles that guide them are one of AAEM's greatest strengths and are an integral part of what makes us *the* organization of specialists in emergency medicine. In AAEM, any individual, full voting member can be nominated and elected to the board of directors. 🇺🇸

The View from the Podium- continued from pg 6

I am working with the gross anatomy laboratory at my old medical school to put together a preconference cadaver-based procedure course.

All of these sessions will be fleshed out over the next several months, of course, but this will once again be the premier educational event in emergency medicine, so plan now to join us in San Antonio.

First Congreso Interamericano de Medicina de Emergencias
I had the privilege of representing AAEM, along with Aaron Hexdall, MD FAAEM, Kumar Alagappan, MD FAAEM, and ACEP President-Elect Frederick Blum, MD FACEP, at the Simposio Internacional de Medicina de Emergencias in Buenos Aires, Argentina, on May 26th and 27th. Our hosts, Sociedad Argentina

de Emergencias (SAE) President Hugo Peralta and Vice-President Silvio Aguilera, made certain that our stay was unforgettable with their remarkable hospitality, incredible food, and dazzling city.

AAEM is working with SAE on the First Congreso Interamericano de Medicina de Emergencias scheduled April 18th through the 21st at the Sheraton Buenos Aires Hotel and Convention Center. Although details are not final, it appears there will be an English language track offering AMA/PRA Category I CME credits. We'll give you more details as the time approaches, but even if you can't make the conference, consider Buenos Aires as a vacation destination. It's an amazingly beautiful city stuffed with history, art, and architectural wonders. If you liked Barcelona, you'll love Buenos Aires. 🇺🇸



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The following letter was sent to Dr. Alistair McGowan in London on behalf of AAEM.

July 11, 2005

Dr. Alistair McGowan, President
The Faculty of Accident and Emergency Medicine
35-43 Lincoln's Inn Fields
London
WC2A 3PE
United Kingdom

Dear Dr. McGowan,

On behalf of the American Academy of Emergency Medicine, I am writing to express the great sorrow and anger we felt when we heard of the injuries and loss of life in last Thursday's attacks in London. Know the people of London and all of the country will go on as gallantly as they always have confronting whatever daunting situations and uncertainties that may come tomorrow.

We especially appreciate and respect the courage and skill of the emergency and medical personnel who are always the first on the scene, frequently at great risk to themselves, to provide whatever aid and comfort is possible to the injured and their friends and families.

Again, you have our sympathy in this time of grief and anxiety and our admiration for your steadfastness during such adversity.

Sincerely,

A. Antoine Kazzi, MD
President, AAEM

AAEM Secretary/Treasurer Response to the Association of Emergency Physicians Solicitation Letter

February 26, 2005

CERTIFIED MAIL

Attorney General Bill Lockyer
Office of the Attorney General
Public Inquiry Unit
PO Box 944255
Sacramento, CA 94244-2550

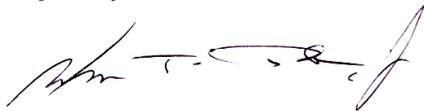
Dear Attorney General Lockyer;

I am writing you in regards to a letter sent by the Association of Emergency Physicians(AEP) to all hospital administrators within the State of California in the fall of '04 (Enclosure 1). In this letter their President, Dr. Geoffrey Ruben, solicits these administrators to hire members of his association. In enclosure 2 he goes on to list the reasons why members of his organizations should be hired to staff the emergency departments of these hospitals rather than those physicians who have been credentialed by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM). In order to be credentialed by either of these two certifying organizations one must complete an accredited residency in emergency medicine and then successfully complete a rigorous two part examination consisting of a written and an oral section.

I believe that this constitutes a direct violation of California law, specifically section 651 (h) (5) of the Business & Professions Code which was originally drafted by the California Medical Association. It also goes against the interests of the public health and well being as it advocates hiring physicians who are neither adequately trained in emergency medicine nor certified by either of the acknowledged certifying boards in the specialty. The American Academy of Emergency Medicine feels that all patients have the right to be seen by a board certified specialist in Emergency Medicine anytime they seek care in an Emergency Room.

It is our request that immediate action be taken against Dr. Ruben and AEP for violation of the state Business and Professions code. Allowing this kind of illegal solicitation misleads the recipient of this letter and places the overall public well being in jeopardy. Both I and the American Academy of Emergency Medicine are willing to assist you in this regard in any way that we can. My address and other contact information are listed above. We thank you in advance for your immediate and timely response to this matter.

Respectfully,



William Durkin, Jr., M.D., FAAEM
Secretary/Treasurer
American Academy of Emergency Medicine
Enclosures (2)



RESIDENT PRESIDENT

Transitions

by Mark Reiter, MD MBA

July is a time of change for emergency residents and students, as each takes on a higher level of responsibility. At AAEM, we are working to try to help make your transition as smooth as possible.

Senior residents have finished residency and are beginning their first job as an attending. Junior residents may be preparing for their job search. AAEM offers much information on contracts, job search, and career planning in *Rules of the Road for Emergency Residents and Graduates*, on our websites, and in our other publications. The AAEM Job Bank lists job opportunities with groups exclusively committed to fair business practices. We are in the process of creating a member network for our members to speak candidly with a fellow AAEM members about job opportunities and workplace issues in their local area. In addition, AAEM is leading the fight to create a good and fair workplace environments for our members, and is willing to lend legal support and additional assistance to our members when their rights are threatened, as we have done in several recent high-profile cases. We strongly encourage our graduating resident members to continue their membership as Associate Members; the Academy needs your support.

For our student members, we hope that you will continue on as a Resident Member. AAEM provides excellent educational benefits, such as the *Journal of Emergency Medicine*, free registration for our Scientific Assembly (including a free in-service review), our new toxicology handbook, etc. More importantly, AAEM will keep you up-to-date on important happenings in EM, and will continue to be the individual emergency physician's greatest advocate. We

offer a tremendous amount of useful information for you at www.aaemres.org as well as in *Rules of the Road for Medical Students*. Also, many members have been using our new website's Discussion Forums to get their questions answered by those who have already been there.

This is a time of transition for AAEM/RSA as well. We have made many steps in the last few months to operate more independently. We are expanding our liaison relationships with other organizations, drafting our own budget, and are operating under our own bylaws. I will continue representing fellow, resident, and student concerns to the AAEM Board, as a full voting board member.

With May's extremely successful elections behind us, the new AAEM/RSA Board is excited about our opportunities for the coming year. In the past two months, we have also significantly expanded our opportunities for involvement, with increased AAEM/RSA representation on AAEM committees and new AAEM/RSA committees. In addition, we are now launching an AAEM Representative network, and are actively recruiting a rep from each residency program. As always, we will continue to be open and transparent in all that we do, and are always looking forward to hearing from you and involving you in any of our projects, whenever possible. 🇺🇸

Mark Reiter MD MBA
President, AAEM Resident and Student Association

Internship Survival Strategies

by Elizabeth Weinstein, MD

My very first shift as an EM intern – on July 1, 2002 – was mostly a day of complex patients with dozens of comorbidities. Finally, for my last patient, I picked up what I thought was a pretty straightforward case: a 43 year old man with knee pain. The nursing note detailed a traumatic injury to an otherwise healthy male. I was relieved when I picked up the chart, because I thought I could handle knee pain. I walked into the room, introduced myself, and watched semi-horrified as my patient began to seize.

Three years, and many seizures later, I am now seasoned in the ways of alcohol withdrawal, and other events that might have previously left me incontinent. I'd like to share some of what I've learned along the way. What follows are some tips, in no particular order, for internship survival and even bliss. Take 'em for what they're worth, one person's ruminations:

Tip 1: You can never have too many trauma shears. The trauma shear is a funny thing — though ubiquitous in the ED, there are, at any given time, at least two people searching for a pair. In one observational, non peer-reviewed study, it was determined that the average life span of any given pair of shears is three-four shifts (95% CI: 1-6.2). You know how this works: someone borrows a pair, or you accidentally leave them in a patient room, or you use a pair to cut a dressing off of a skanky, smelly sore which may or may not

contain maggots and decide you really don't want to keep that pair anyway. So whenever the opportunity for free shears comes up, get some, hoard them, and use them in good health.

Tip 2: "Don't be afraid to be as stupid as you really are." Everyone enters residency with different backgrounds and different skills. Some of your peers will have never put in a central line or seen a patient seize, some of them will have spent the last 10 years working as a paramedic or a flight nurse. Internship, especially early in your internship, is a great equalizer. It is the time when everyone gets up to speed. So don't be afraid to say you've never done something, or you've never seen something, or that you have no idea what is going on with a patient. As much as you think you need to know *everything* on July 1st, the truth is that most people assume you don't know *anything*, and are pleasantly surprised when you know even a little thing.

Tip 3: Go Out After Work. The great Ben Franklin once said, "Beer is proof that God loves us and wants us to be happy." The oldest member of the Constitutional Convention (at 81), he routinely frequented the bars after a long day drafting our nation's governing document. Here is my point: if the guy who invented bifocals, the lightning rod, swim fins, and the first flexible urinary

continued on pg R2

Internship - continued from pg R1

catheter — the guy who helped draft the Declaration of Independence and U.S. Constitution — could still go out for a few drinks after work — well, you can too. So go sit yourself on a stool with your buddies and have a beer or non-alcoholic beverage and relax. Just don't go flying any kites in a lightening storm.

Tip 4: Direct deposit your checks and automatic withdrawal your bills. No matter how responsible you are, no matter how meticulous, you will at some point in residency forget to pay your phone bill (or your electric bill or your gas bill). You will come home post-call one day and find your phone service disconnected. You will find this incredibly annoying even though you have a cell phone — because, “for crying out loud, it was only \$43, and you haven't even been home to make any phone calls anyway.” Trust me, it will make you grumpy, and take time to fix — so save yourself the trouble from the outset and take yourself out of the equation. Arrange to have your regular bills automatically deducted from your checking account. Oh, and get your paycheck direct deposited.

Tip 5: Read. Early in my internship, I felt overwhelmed by all of the reading I *wasn't* doing. I would go home from a shift after taking care of a patient with SVT, identify seven chapters in Tintinalli that I thought were relevant to SVT and the management of SVT and start reading. I would usually get a few pages in and promptly fall asleep. Then one day, one of my faculty said, “You know you don't need to read for hours every day. If you read for just ten minutes after every shift, you're doing great. You'll be amazed at how much you learn.” He was right. Of course, reading is a critical part of your education in residency and self-directed learning is, perhaps, one of the most important skills you will master. Everyone learns differently, and some of you may do well, sitting down and reading several chapters according to a schedule — for many of you, ten minutes of case based reading may be the cornerstone of your self-directed education. Either way, find a system that works for you and stick with it — and don't freak out about how much you haven't read — because you'll never read it all.

Tip 6: Be Nice. Yes, you will be overworked and under slept. So are most of the people who work with you, from the maintenance employees to the respiratory therapists. You do not hold the monopoly on this. You will be surprised by the number of people who work several jobs, go to school, and raise a family. Be kind to the people that you work with. Learn their names. Ask how they are doing. Say please and thank you. Being nice to the people you work with will take you far in the workplace; people will enjoy working with you and will be eager to help you when you need a hand. And, it's just the right way to behave.

Tip 7: Don't Whine. Here is a little secret: Residency isn't fair and it isn't designed to be. It is designed to train you to become a competent physician. There will be times when you feel like your schedule is the only schedule that sucks. It isn't. Every once in a while you will get hosed. Everyone does. Everybody else also works

weekends and holidays. Someone is probably taking more call than you are and working more nights than you are. There are people who are fanatical about this, who count up all the shifts that everyone is working and compare, who tally it up to the actual number of hours they are working more than the next guy. Please, do NOT be this person. No one will like you. And if I were making the schedules, I'd start giving you bad schedules on purpose. Important issues will arise during your residency and you should feel comfortable taking them to the appropriate person, but for everything else, get over it.

Tip 8: Learn your resources. A couple of years ago, one of my friends saw a goat farmer with a funny rash on his hands. After several minutes on the internet, he triumphantly announced to anyone who would listen that the patient had “Orf,” a viral disease transmitted to humans from goats and sheep that causes, well, the rash this patient exhibited. Yup, Orf. The point is medical information is all over the place — in books, websites, and our peers. We each develop our own ways of accessing this info when we need to — leaning on certain colleagues, carrying around particular handbooks, or just bookmarking some handy online databases. Just be conscious of this process during internship, and be flexible about receiving new sources.

Tip 9: Do not, under any circumstances, forget your mother's birthday During my first year of residency I forgot my mother's birthday. I remembered it every day for the week preceding her birthday, but then on her birthday I called her to ask her something and totally forgot it was her birthday, until later in the day, at which point I realized I was in big trouble. It was like my own personal John Hughes film, “57 Candles” and my mother was Molly Ringwald minus all the teenage angst. And red hair. My mother has long since forgiven me, but she still likes to bring it up every once in a while when she's asking for a favor. Residency demands a lot of your time — and your family and friends, no matter how understanding and supportive, will wish that you could carve out more time for them. Since you can't, the least you can do is make sure your loved ones know they're loved. So paste things to your wall and your calendar, email yourself, write a note on your bathroom mirror, just don't forget important days and events.

Tip 10: Be vigilant. This goes back to my knee pain patient from my first day as an intern — and yes, it would have been hard to miss his seizure. But the point is that often times patients with seemingly straightforward complaints, have more significant issues and they can be easy to miss if you aren't paying attention. Sure, the guy you see at three am for a “rash for four months” may just have dry skin, but the 47 year-old with “shortness of breath for a year”, may have been having angina and now he's having the big one. Unless you listen to your patients and pay attention to what is going on, you will never know. So just remember the basics from med school, keep your head up and your eyes open and enjoy the year. It will be a good one. 🍀

DOs in Allopathic Emergency Medicine Residencies: Opinions from Current Residents

by Quinn Holzheimer, DO

Jason Johnson, DO

Ethan Wagner, DO

As DOs (Doctor of Osteopathy), we understand the confusion associated with the difference between DO and MD post-graduate training, including the application process, the competitiveness of the applicants, and licensure issues. There were few resources available when we were applying, most of the information at the time was personal opinion often based on false assumptions and rumors. The information we presented here is compiled from several sources, and we hope it helps clarify questions a DO student may have about obtaining a position at an allopathic (MD) Emergency Medicine (EM) Residency.

#1. WHY SHOULD I CHOOSE AN ALLOPATHIC EMERGENCY MEDICINE RESIDENCY?

Often a loaded and polarizing question, this is the most personal of choices. Some students and residents feel that the MD programs have superior training and more pathology. Currently, there are no data to prove or disprove this notion. Personally, we have known several DOs who have completed their training at osteopathic EM residencies, and are extremely competent and on par with their MD colleagues. The decision for a DO to “go MD” is a difficult one. Not only does an applicant have to decide on MD vs. DO, but also location, academic vs. community, urban vs. suburban, small resident class vs. large resident class, etc. There is FAR more to a program than whether or not it is allopathic or osteopathic. We suggest that the applicant reflect on what he or she is looking for in a program. We recommend applying to both MD and DO programs. Be objective during the application and interview process. We feel that being objective is the key to comparing “apples to apples,” i.e., create an organized approach to interviewing, compare volume, hospital size, hospital support staff (scutwork), EMS exposure, etc. One may find that a certain DO program meets all the applicants’ wants and needs!

#2. ARE THERE DOS IN EMERGENCY MEDICINE?

The number of DO residents in allopathic emergency medicine residencies has steadily increased over the past several years. Not counting DOs, currently in osteopathic EM residencies, approximately 8 percent of all EM residents are DOs (314 DOs and 3663 MDs in 2003-2004). According to the Report of the Task Force on Residency Training Information, published yearly in *Annals of Emergency Medicine*, in four years, the number of residents has increased by nearly 100. Four years ago, roughly 6 percent of all EM residents were DOs. As you can see, the numbers of DO graduates training in MD EM residencies has increased over the past several years. This bodes well for DO applicants in the future. There are also several DOs in the position of Program Director (PD) or Assistant PD at several MD residencies. Similarly, DOs have served in many leadership roles in emergency medicine, for example, Robert E. Suter, DO, MHA, the current President of American College of Emergency Physicians. DO students should feel comfortable about their ability to attain leadership roles in emergency medicine as well as residency spots in Allopathic EM programs.

#3. WHAT CAN I EXPECT AT AN MD RESIDENCY COMPARED TO A DO RESIDENCY?

MD residencies are formatted in three ways: PGY 1-3, PGY 1-4, and PGY 2-4. DO programs are either PGY 2-4 or PGY 1-4. A PGY 1-3 program, or “three year” program, begins in June/July after medical school graduation and lasts three years total, including the “intern”

year, or PGY-1 year. A PGY 1-4 program, or “four year” program, begins in June/July after medical school graduation, and lasts four years total, including the “intern” year. A PGY 2-4 program begins the EM training after the intern year. Some PGY 2-4 programs will have a “linked” PGY-1 year within their institution, others will not. It is best to contact the PGY 2-4 programs individually to inquire about their intern year requirements. As a DO, you will be eligible for the ABEM certification.

#4. IS THERE A DIFFERENCE BETWEEN DOS AND MDS THAT TRAIN AT AN MD RESIDENCY?

Although there are some licensing issues (see below), once you are training at a program, there is no difference politically or academically between a DO and an MD resident.

#5. AM I COMPETITIVE FOR A MD SPOT?

Many DO students are concerned about their level of competitiveness and the existence of “discrimination” against them. We believe that a competitive applicant is a competitive applicant, MD or DO. A DO who has marginal board scores, weak Letters of Recommendation (LOR), and projected a minimal interest in EM in their application is just as “uncompetitive” as a similar MD counterpart. Similarly, a DO who has a strong application will likely find themselves a competitive applicant. The presence of discrimination is inconsequential. Although there may be a few programs that are “DO unfriendly,” there are well over 130 MD EM programs in the US, with the majority willing to examine your application objectively. Do not let a few “DO unfriendly” programs discourage your intent to apply.

#6. WHAT MAKES A COMPETITIVE APPLICANT?

Each program is different. There are many stories of very similar candidates who were offered interviews at completely different programs. No one knows what the Program Directors and staff are looking for in their candidates. However, just like medical school, those with higher grades, higher board scores, research, strong LORs, and extracurricular activities “generally” will have a stronger application than those without. Other items that “may” be looked favorably upon in an application can be: previous EMS experience, previous health care experience, involvement in EM interest groups or volunteer work. Also do not underestimate the importance of the medical student elective audition rotations. If a residency sees you “in action” and you come across as a compatible “future resident,” that can significantly boost your ranking to the program. Furthermore, attending residency journal clubs, conferences, and social activities increases candidate “face time” with residents and faculty. Remember interpersonal factors when interviewing. Residencies are often looking to see if the “applicant would fit in here at our residency.” Great interpersonal skills will often have a greater impact on your application than whether you came from an osteopathic or allopathic school. There is nothing you can do to change the fact you are a DO, but there is a lot you can do to boost your chances!

continued on pg R4

DO - continued from pg R3

#7. AS A DO, DO I NEED TO TAKE THE USMLE?

We feel that if a DO student does “well” on the mandatory COMLEX, it is not necessary to take the USMLE unless a certain program does not accept the COMLEX. If the DO student takes the USMLE and does poorly, however, it will be detrimental to the application. However, if an applicant has a poor COMLEX score, doing well on the USMLE can improve the application significantly. The DO applicant should contact each individual program to see if the program requires a USMLE score. Neither Dr. Holzheimer nor Dr. Johnson took the USMLE. A DO should perform similarly to an MD on their boards, there is no innate reason to think otherwise. DOs performing well on the USMLE are easier to compare to Allopathic students and can make the selection process for programs much easier.

#8. HOW MANY PROGRAMS SHOULD I APPLY TO, AS A DO?

First, you need to decide if you are applying to both DO and MD programs. Some DO programs are reportedly now accepting applications via ERAS, however some may require separate paper applications. In our opinion, a DO student should be *more* liberal in the number of programs he or she applies to. It is far easier to decline interviews in the middle of interview season than it is to apply late to programs if one does not have enough interviews. The later in interview season you send in your application, the lower your chances of getting interviews. Anecdotally, many residents feel that if you interview and “rank” eight programs, “statistically” you are likely to match. We have no confirmation of this concept, but this seems to hold true in our opinion. Keep in mind that if one applies to only 10 programs, the chance of getting 8 interviews is far less than if one applied to 30 or 40 programs. The authors feel it is in the applicants’ best interest to apply to as many programs as geographically and financially possible. Do not, however, apply to programs you definitely would not be interested in attending.

#9. SHOULD I COMPLETE THE AMERICAN OSTEOPATHIC ASSOCIATION INTERNSHIP?

There are currently five states that require the AOA internship in order to be licensed. These states are Florida, Michigan, Oklahoma, Pennsylvania, and West Virginia. The philosophy behind requiring the internship is that the AOA approved internship will give a broad primary care education during the PGY-1 year, leading to a well-rounded background before beginning a residency. However, the vast majority of allopathic EM programs (even 3 year programs) incorporate a “well-rounded” PGY-1 year. Many programs include general/trauma surgery, internal medicine, unit/critical care months, OB/GYN, etc. If one is pursuing a PGY 2-4 MD EM program, some residencies may accept your AOA internship as the PGY-1 year, others may not. We suggest contacting each program individually. However, if you plan on applying to PGY 1-3 or PGY 1-4 programs, and intend on completing an AOA internship, be aware that funding may be an issue for your last year of residency. HCFA will pay for a three year or four year MD residency, but not if you complete the AOA internship and intend on completing a PGY 1-3 program. Your last year (PGY-3) will not be funded by HCFA. Programs often view lack of funding with disdain. You may enroll in a PGY 1-3 EM residency in any of the five states without having to complete the internship, but may have licensing problems. However, you can have the PGY-1 year “waived” according to Resolution 42, titled “Approval of ACGME training as an AOA-approved internship.” Please refer to the AOA website for more details. If Resolution 42 is granted the PGY-1 year will be “accepted” as the AOA internship, and you will be allowed to apply for a medical license in the five states mentioned above. We suggest

you ask each program individually their views on the AOA internship. Some programs may view the AOA internship as a benefit, others may perceive it as a negative due to funding. Most Program Directors and Residency Coordinators should be able to discuss their view of the AOA internship during the application/interview process. Current DOs in the program are also a good resource for questions regarding internship requirements. We suggest contacting the AOA for the most up-to-date information regarding internship approval requirements. There are many strong opinions about the validity of the Osteopathic Internship, one should seek the opinions of their colleagues for help with this complex decision.

#10. SHOULD I DO A ROTATION AT AN MD PROGRAM?

We feel we must emphasize the importance of a strong audition rotation and good Letters of Recommendation. It is ideal if you can schedule an EM elective before your ERAS application is due. This is important not only to get LORs to submit with your application, but also to become “known” at the program you are rotating at. One should try to schedule their EM electives before March February of 4th year, as Rank Order Lists for both the applicants and the programs are due in the end of February. There are many anecdotal stories of students with “poor” applications who did an excellent job on a rotation, had a strong interview, and were matched at that program. Also, by rotating at an institution, you get a much more in-depth view of the details of the program than you would by a one day interview. If you have strong feelings towards a program (i.e. your *dream program*) we recommend completing an audition rotation!

#11. WHERE CAN I GET MORE INFORMATION ABOUT THE APPLICATION PROCESS FOR DOS?

A resource that can sometimes offer valuable information are resident or attending DOs. Be aware, though, that their information may be inaccurate, biased, or outdated. Current DO residents in MD EM programs are excellent resources, as they have been through the process and understand the difficulties in obtaining good information. We also recommend finding a “mentor” throughout medical school, especially during third and fourth year. Your mentor can be extremely helpful with reviewing your ERAS application and personal statement, and may be able to offer you useful advice regarding your options for residency. The AOA website also is helpful in regards to Resolution 42. AAEM is a good resource for students interested in EM, and there are many people in AAEM who are willing to give advice. All you need to do is ask!

We hope you found this information useful. This information does not necessarily reflect the views of AAEM. If you have any questions or comments, please contact Quinn Holzheimer, DO at qholzhei@hsc.usf.edu, Jason Johnson, DO at jjohnso@hsc.usf.edu, or Ethan Wagner, DO at ethan.wagner@wright.edu.

Quinn Holzheimer, DO, and Jason Johnson, DO, are Emergency Medicine Residents at the University of South Florida in Tampa, FL

Ethan Wagner, DO, is Chief Emergency Medicine Resident at Wright State University in Ohio 🇺🇸

President's Message- continued from pg 1

unnecessarily duplicate... and “duplicate” we often do. However, we do, because we must! What these friends-and-critics miss is that it has been unfortunately necessary to change organized emergency medicine from the outside - back to where it should have been – committed to serving the individuals and the profession – not favoring the business of EM at the expense of the interests of patients and specialists. We also need enough members and revenue to groom the leaders and develop the resources, structure and talent – human, logistic and financial – to achieve what AAEM has been established for and what we have volunteered to do for our specialty and patients. Without adequate numbers and financial resources, we simply cannot get the job done fast or adequately enough. This is a predicament therefore that we have been forced into... developing accordingly national committees, taskforces, products and activities which often duplicate what hard-working and well-meaning emergency physicians in ACEP and other EM organizations often do well.

Having said that, it has also become increasingly evident that each national organization has important activities that are best carried out by that organization alone. For that reason, the AAEM board gave significant consideration to this and felt that it was time to extend an olive branch and a hand to ACEP inviting it to join us into a proactive discussion that could benefit both organizations and their members – and certainly the whole House of Emergency Medicine. Why not unite where we need to be united, and maintain our separate structures and agendas when we also must – on the practice issues of relevance that have separated the two organizations? Why not let physicians decide what serves them best at the national level? And yet make sure that no national agenda of importance suffers from this current schism in the specialty? If AAEM, ACEP and other EM organizations – and all their members – were all obligated to equally support a united national agenda and legislative activity on the many issues that unite us – and if a Federation of EM specialty physician organizations was established under an equitable representative governance formula – this united EM vehicle in DC would speak in the name of over 45,000 emergency physicians – and not the smaller numbers that each individual organization currently has. Emergency medicine would then be seen as a bigger stakeholder in DC, in all state capitals and legislative or regulatory arenas, with nearly twice the numbers and funds to spend on those issues that are important to all of us.

And to our dedicated members who expressed concerns about the future of AAEM and fear that AAEM will lose what they want it to be – the AAEM board say it LOUD and CLEAR: **AAEM will NEVER be swallowed.**

Many of us in the AAEM leadership essentially want to consider possibly federating the House of Emergency Medicine creating a national vehicle that includes AAEM, ACEP, NAEMSP, ACOEP, SAEM, CORD and other emergency physician specialty organizations. Such a united or federated vehicle would then address what we all need and agree on. No common agenda would then suffer from the schism or separation necessary due to the issues and individual priorities that may continue to divide us and that we are each committed to provide for our individual constituency.

Such a structure would establish a larger house of EM where the individual constituencies and their interests and beliefs continue to be properly represented – not stolen through governance systems that currently empower the contract holders and their protegeses to dominate and control the agenda for all others.

What caused the split of the house of EM into many organizations is the failure to understand the importance of proper representation. Who gets to vote? How do members vote? Is it by mail or at a business meeting at a special location, date and time that are too difficult for the average individual member? Who gets to run? Who nominates? Who nominates the candidates? Who gets to be nominated? Who gets selected and/or supported to serve on committees and taskforces? How transparent are the nominees in their candidate statements? Are they asked to openly disclose their conflicts of interest and their actual beliefs on controversial practice issues?

This criticism is harsh but valid; and I challenge anyone anywhere to discuss or debate this matter that I have personally experienced in-depth during my two terms of service as an elected California ACEP board member and national councilor in ACEP and during my terms in office in AAEM and CAL/AAEM. It is only through open discussion and adequate recognition of such shortcomings, challenges and opportunities that we can build a stronger specialty and profession and a better practice for our patients and specialists.

It is, therefore; only through brave and thoughtful governance reform that we can actually consider uniting state chapters – or otherwise federating them too. I have seen ACEP leaders do this in California and should take a moment to commend the vision and brave initiative of many CAL/ACEP leaders and members who supported my beliefs that governance reform was needed half a decade ago. It took five years to get the momentum and credibility needed to make the change. However, they did make the changes needed. And I am proud of them. I certainly invite the rest of the states and national organizations to see what was done in California and to follow the model that CAL/ACEP and CAL/AAEM leaders have achieved and will continue, hopefully, to build on - despite occasional challenges and difficulties or disagreements. This is no easy process and one that will take time, humility and courage.

As I near the end of my two-year term as your AAEM President, I wish to renew the promise that so many of us have made to you – our AAEM members and friends in other EM organizations – that we, AAEM, will maintain our absolute commitment to **integrity** and **transparency** in our passionate pursuit of what is best, first for our patients, and then for the individual emergency physician specialists who are taking care of them.

I will conclude, with a comment from one of the many emergency physicians who e-mailed us about this board resolution for unity in EM...

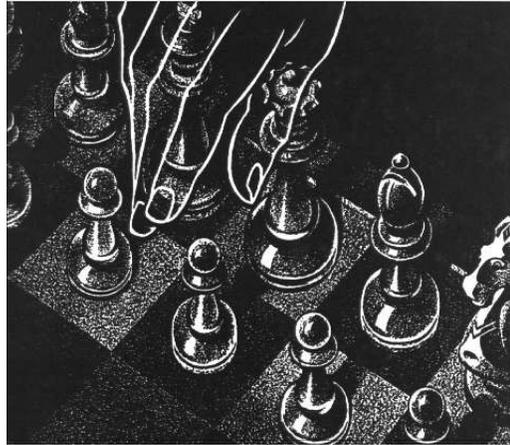
“It’s about time the Hatfields spoke to the McCoys!”

We are interested in your feedback and will keep you informed as to progress related to this matter. Thank you for your support. Support the AAEM Foundation! And Your PAC! Come to your Scientific Assembly! We cannot do it without you! 🇨🇦

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office at (800) 884-2236
to update your information.**

IMPORTANT NOTICE TO CURRENT AND FORMER ABEM DIPLOMATES REGARDING EMERGENCY MEDICINE CERTIFICATION

The Emergency Medicine Continuous Certification (EMCC) program replaced the former recertification process starting January 1, 2004. All diplomates who want to maintain their certification with ABEM beyond their current certification expiration date must participate fully in the EMCC program. EMCC has four components that are briefly described below. A full description of EMCC is available on the ABEM website www.abem.org

COMPONENT ONE - PROFESSIONAL STANDING

- Participants in the EMCC process must continuously hold a current, active, valid, unrestricted, and unqualified license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada and in each jurisdiction in which they practice.
- Physicians may hold one or more additional licenses to practice medicine. Each additional license must be unencumbered.
- Participants in the EMCC program must report to ABEM all licenses they currently hold, and all licenses previously held that do not meet the ABEM "Policy on Medical Licensure" if they expired, were not renewed, were revoked or suspended on or after January 1, 2004.

COMPONENT TWO – LIFELONG LEARNING AND SELF ASSESSMENT (LLSA)

- A list of 20 readings based on the EM Model is posted on the ABEM website each year.
- 40-item LLSA tests are developed based on the annual readings.
- A new LLSA test is posted on the ABEM website in April of each year.
- Each LLSA test remains online for three years. Successful completion of 8 tests is required in a 10-year certification period.

COMPONENT THREE – ASSESSMENT OF COGNITIVE EXPERTISE

- The Continuous Certification Examination (ConCert) is a comprehensive examination based on the LLSA readings and *The Model of the Clinical Practice of Emergency Medicine* (EM Model).
- ConCert will typically occur in the tenth year of each diplomate's EMCC cycle.
- ConCert is a half-day examination, administered at computer-based testing centers around the country.

COMPONENT FOUR – ASSESSMENT OF PRACTICE PERFORMANCE (APP)

- The Board is discussing specific options that will be developed over the next several years.
- Activities will be focused on practice improvement.
- Activities will offer diplomates a choice of ways to meet requirements.
- Activities will not require that diplomates be clinically active in EM and will be available to diplomates engaged in clinical EM, teaching, research, or administration.

ABEM provides options for former diplomates to regain certification. Contact ABEM for details. 



JAM Session for Written Board Exam

Designed to give you the confidence you need to pass the Written Boards

Atlanta, GA
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Dallas, TX
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East Brunswick, NJ

Saturday November 5, 2005
6:00pm-9:15pm

For more information please see www.aem.org or call 800 884-2236



AAEM Endorses H.R.2356 – Preserving Patient Access to Physicians Act of 2005

by Kathleen Ream, Director of Government Affairs

In a letter dated June 20, 2005 (a copy of which is on page 7), AAEM applauded the leadership of Representatives E. Clay Shaw (R-FL) and Benjamin Cardin (D-MD) in attempting to fix the manner in which Medicare payments to physicians are calculated by introducing H.R.2356, **Preserving Patient Access to Physicians Act of 2005**. The Senate companion bill, S.1081, was introduced on May 19 by Senators Jon Kyl (R-AZ) and Debbie Stabenow (D-MI).

The 2005 Medicare Trustees Report estimates that the current physician payment system will cut doctors reimbursements by 26 percent over the next six years - beginning with an across-the-board 4.3 percent cut on January 1, 2006. These cuts are due to the flawed Medicare payment update formula.

Payment updates are based on a sustainable growth rate system tied to the gross domestic product (GDP). This means that when GDP declines as the economy softens, payment updates decline as well. From 1991-2003, payment rates for physicians and health professionals fell 14 percent behind practice cost inflation, as measured by Medicare's own conservative estimates.

H.R.2356 repeals the SGR and replaces it with an annual Medicare payment update for physicians that reflects practice cost increases. H.R.2356 provides doctors with a payment update of no less than 2.7 percent, with the annual update beginning in 2007. The bill establishes a permanent solution, so physicians can continue to give Medicare patients the care they deserve. Recent data from the CDC shows that ED visits have reached an all time high - 114 million in 2003 - and that the greatest increase was among those over age 65.

ED Visits Reach Record High

According to a new report from the Centers for Disease Control and Prevention (CDC), visits to U.S. EDs jumped 26 percent in the past decade, from 90.3 million in 1993, to a record high of nearly 114 million in 2003. Older Americans – many uninsured – accounted for much of the increase. Meanwhile, in that same period, the number of EDs decreased by 14 percent, the U.S. population rose 12 percent, and the age 65-and-over population rose 9.6 percent.

While the increase in visits was most pronounced among adults – especially those age 65 or older, the statistics also show a 19 percent increase in ED visits by people age 22-49, and a 15 percent increase by those age 50-64. Among people age 65-74, the ED visit rate was more than five times higher for those residing in a nursing home or other institution, compared with those not living in an institutionalized setting. In addition, at 81 visits per 100 people, Medicaid patients were four times more likely to seek ED treatment than those with private insurance who accounted for 22 visits per 100 people.

“Emergency departments are a safety net and often the place of first resort for health care for America’s poor and uninsured,” said Linda McCaig of CDC’s National Center for Health Statistics and the report’s lead author. “This annual study of the nation’s emergency departments is part of a series of surveys of health care in the United States and provides current information for the development of policies and programs designed to meet America’s health care needs.”

Other findings in the report include:

- Despite the increased number of visits, the average waiting time to see a physician – 46.5 minutes – was the same as it was in 2000. Overall, patients spent 3.2 hours in the ED, which includes time with the physician as well as other clinical services.
- Patient complaints of stomach pain, chest pain, fever, and cough accounted for nearly 20 percent of visits.
- Injury, poisoning, and the adverse effects of medical treatment accounted for more than 35 percent of ED visits. The leading causes of injuries were falls, being struck by or striking against objects or persons, and motor vehicle traffic incidents that accounted for 41 percent of injury-related visits. Ironically, some 1.7 million of the visits in 2003 were for adverse effects of medical treatment.
- More than 16 million, or 14 percent, of patients arrived at the ED by ambulance. Over a third of those patients were age 65 or older.
- More than two million patients were transferred to other facilities, while 317,000 patients either were dead on arrival or died in the ED.
- X-rays, CT scans, or other imaging tests were provided in about 43 percent of visits. Medications were provided in more than 77 percent of visits. Painkillers were the most frequent prescription, accounting for just over 14 percent of medications reported.
- About 58 percent of EDs are located in metropolitan areas, but they accounted for 82 percent of visits. Board-certified emergency medicine physicians were available at 64 percent of EDs, and almost half of all EDs had a nursing triage system.

The CDC report describes hospital, patient and visit characteristics for hospital emergency departments in the United States as well as trends in ED use between 1993 and 2003. The information is based on data from the **2003 National Hospital Ambulatory Medical Care Survey (NHAMCS) Emergency Department Summary**, which is a national probability-based sample survey of visits to emergency and outpatient departments of non Federal, short stay, and general hospitals in the United States conducted by CDC’s National Center for Health Statistics. For a copy of the full report go to www.cdc.gov/nchs.

CMS Implements Program to Recoup Emergency Health Service Costs for Undocumented Aliens

The Centers for Medicare & Medicaid Services (CMS) has finally announced the provisions of a new program to recoup costs of providing needed emergency medical care for undocumented aliens. Section 1011 of the Medicare Modernization Act set aside \$1 billion through 2008 to help hospitals and certain other emergency care providers recover a portion of their costs associated with providing emergency services under **EMTALA** to qualified individuals who are uninsured or cannot afford emergency care.

continued on pg 15



Washington Watch - continued from pg 14

Each state will receive funding based on the formula established in the law. Payments will be made directly to hospitals, certain physicians, and ambulance providers, including Indian Health Service facilities and Indian tribes and tribal organizations, as long as they did not receive payment from any other source such as the person treated or an insurance company. This program includes payments toward related hospital inpatient, outpatient, and ambulance services furnished to undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the U.S.

In a letter to House Speaker Dennis Hastert in May 2004, AAEM President Antoine Kazzi noted grave concerns regarding H.R.3722, the Undocumented Alien Emergency Medical Assistance Amendments of 2004, and urged the Speaker to oppose this legislation. Kazzi expressed AAEM's opinion that EDs are mandated to evaluate all patients regardless of their ability to pay and opposed several requirements of the proposal that would have turned emergency physicians into de facto INS agents and increased the risk that "undocumented aliens could pose a significant public health threat since the fear of deportation would inevitably prevent undocumented aliens from seeking care until it may be too late."

CMS subsequently backed off its earlier stance, acknowledging many of the same concerns expressed in Dr. Kazzi's message saying,

"In considering how providers will identify and document patient eligibility for the purposes of receiving payment under this section,

CMS believes that documentation standards should: (1) not impose requirements on providers that are inconsistent with EMTALA, (2) minimize the cost and reporting and record-keeping requirements, and (3) not compromise public health by discouraging undocumented aliens from seeking necessary treatment. We believe that asking a patient to state that he or she is an undocumented alien in an emergency room setting may deter some patients from seeking needed care. Moreover, if providers were required to request a Social Security number or other independently verifiable information from a patient, providers would need a mechanism to verify the authenticity of the information submitted."

In this final policy notice, CMS has adopted an indirect approach to determine whether a provider can seek payment for an eligible patient. CMS will not require hospital staff to ask patients directly about their citizenship or immigration status.

Providers must enroll to participate in the program and can claim payment for emergency services furnished to eligible patients beginning May 10. The six states receiving additional funding in FY 2005 based on the highest number of undocumented alien apprehensions are: Arizona, Texas, California, New Mexico, Florida, and New York.

The Federal Register notice providing final guidance regarding the implementation of Section 1011 can be found at <http://www.cms.hhs.gov/providers/section1011>.



Organization of Specialists in Emergency Medicine

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June 20, 2005

The Honorable E. Clay Shaw
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Benjamin L. Cardin
U.S. House of Representatives
Washington, D.C. 20515

Dear Representatives Shaw and Cardin:

The American Academy of Emergency Medicine (AAEM), the specialty society of board certified emergency medicine physicians, wishes to express its strong support for H.R. 2356, the Preserving Patient Access to Physicians Act of 2005. We applaud your leadership in attempting to fix the manner in which Medicare payments to physicians are calculated.

The 2005 Medicare Trustees Report estimates that the current physician payment system will cut doctors reimbursements by 26% over the next six years – beginning with an across-the-board 4.3 % cut on January 1, 2006. These cuts are due to the flawed Medicare payment update formula. They will threaten the ability of Medicare patients to receive needed care in the community and may lead to further crowding of our nation's emergency departments.

Payment updates are based on a sustainable growth rate (SGR) system tied to the gross domestic product (GDP). This means that when GDP declines as the economy softens, payment updates decline as well. From 1991-2003, payment rates for physicians and health professionals fell 14% behind practice cost inflation, as measured by Medicare's own conservative estimates.

H.R. 2356 repeals the SGR and replaces it with an annual Medicare payment update for physicians that reflects practice cost increases. H.R. 2356 provides doctors with a payment update of no less than 2.7%, with the annual update beginning in 2007. This bill establishes a permanent solution, so physicians can continue to give Medicare patients the care they deserve. As you may know, recent data from the CDC showed that emergency department (ED) visits have reached an all time high – 114 million in 2003 – and that the greatest increase was among those over age 65. AAEM believes it is important to keep the Medicare program strong for America's seniors and disabled so that more of them are not forced to turn to the already crowded EDs for their medical care.

AAEM and its more than 4,000 members look forward to the enactment of H.R. 2356 and offer our resources to bring this legislation to reality. Continued cuts in resources to our health care system are unsustainable. Our citizens will suffer if Medicare continues to cut payments to physicians and other health professionals.

If we can be of further assistance, please feel free to contact Kathleen Ream, AAEM's Director of Government Affairs, at 703-241-3974.

Sincerely yours,

A. Antoine Kazzi, MD FAAEM

AAEM JOB BANK

To respond to a particular ad: AAEM members should send their 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 or visit our website @www.aaem.org.

To place an ad in the Job Bank: Equitable positions consistent with the Mission Statement of the American Academy of Emergency Medicine Physicians and absent restrictive covenants will be published for a one time fee of \$300, to run for a term of 12 months or until canceled. Revisions to a current ad will be assessed a fee of \$50.

Direct all inquiries to: AAEM Job Bank, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202-3823, Tel: (414) 276-7390 or (800) 884-2236, Fax: (414) 276-3349, E-mail: info@aaem.org.

ARIZONA

Chinle Hospital (an Indian Health Service facility) can offer a physician the opportunity to practice emergency medicine to one's fullest capabilities. We do not have the HMO/insurance constraints seen in most community hospitals. Our back up is excellent and the staff is a young and congenial group from some of the finest residency programs in the country. We are a very rural setting in the heart of the Navajo Reservation. Great skiing is available just 3 hours north. Superb slick rock for mountain biking. Outdoor activities abound. Our close-knit community is also a great place for young children. US citizenship required. A government sponsored loan repayment program is available for those who are interested. (PA 671)

The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

CALIFORNIA

Accepting BC/BE EM Physicians to join a privately held physician group which services multiple locations in Southern, Central & Northern California. Independent contractor compensation includes competitive pay, flexible scheduling, equity sharing opportunities, malpractice insurance and relocation assistance. (PA 687)

CALIFORNIA

Lake Tahoe-seeking full-time BC/BE emergency physician. Group staffs 2 EDs: Nevada (11K) and California (22K). Fee-for-service payment model. Independent contractor compensation in Nevada (no state income tax). Flexible scheduling and unparalleled recreational opportunities make for superb quality of life. Compensation and scheduling equal to partners. Partnership in one year. (PA 707)

FLORIDA

Full and part-time BC/BE Emergency Medicine physicians needed in order to expand our department at a community-based hospital in Orlando-Tampa area. Newly renovated, 24,000 square foot ED with 33 patient care bays, 7 bed minor areas, 3 x-ray suites, ample work space. Salary approximately \$120 per hour, plus excellent benefits package. Position available immediately. EOE/AA employer. (PA 646)

The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

FLORIDA

Responsible general medical care of pediatric, adolescent, adult and geriatric patients in our ED, including assessing, planning and evaluating medical care while maintaining sensitivity to their age specific, cultural and spiritual needs. Florida licensed Medical physician and Board Certified or Board Eligible in Emergency or Family Medicine required. Five years current Emergency or Family Medicine experience strongly preferred. (PA 674)

FLORIDA

Outstanding opportunity in Tampa Bay area for full-time BC/BE emergency medicine physician. 36K volume. Partnership track available. Competitive salary and benefits. Flexible scheduling. EOE/AA Employer. (PA 684)

The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

FLORIDA

The University of Florida/Jacksonville campus, Department of Emergency Medicine seeks full-time BC/BE emergency physician. The largest Level 1 Trauma Center in Northeast Florida and the region's leader in stroke treatment. Over 90K patient visits annually and modern diagnostic modalities and on call coverage for all offered specialty services. Benefits include health, life, disability insurance, vacation and sick leave, expense account, generous retirement plan and covering immunity occurrence medical liability insurance. Fax CV and letter of interest to Dr. Kelly Gray-Eurom at 904-244-5666. Deadline to apply 10/3/05. EOE/AA Employer (PA 717)

GEORGIA

Single hospital, independent group seeks board certified emergency physician. Practice within driving distance to Atlanta without big city hassles. Competitive salaries. Administrative advancement, 20,000 annual visits. Mid level Provides double coverage. New ED planned within 2 years. (PA 675)

The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

INDIANA

South Bend: Immediate partnership opportunity for outstanding BC/BE emergency physician to join our democratic, stable (30 years), fee-for-service 2 hospital group. Equal rights, weekends, holidays and compensation. University town, 90 minutes to Chicago. Email CV to info@aaem.org or fax o AAEM at (414) 276-3349. (PA 715)

INDIANA

South Bend: Very stable, Democratic, single hospital, 13 member group seeks additional BC/BE Emergency Physician. Newer facility with expansion planned. 55k visits, Level II Trauma Center, double, triple, and quad coverage. Equal pay, schedule and vote. Excellent compensation with qualified retirement plan, disability insurance, medical reimbursement, etc. University town, reasonable housing costs, good schools, 90 minutes from Chicago. (PA 720)

MASSACHUSETTS

Berkshire Medical Center, a 306-bed community teaching hospital, affiliated with the University of Massachusetts Medical School, is currently seeking a full time BC/BE Emergency Medicine Physician to Join its Emergency Services Team. Competitive compensation, benefits and incentive plan is offered. Enjoy a high quality of life in an area known for its unique cultural and recreational activities, just 2 1/2-3 hours from both Boston and New York City. (PA 679)

MASSACHUSETTS

CAPE CODE-Falmouth Hospital, stable group adding FT BC/BP EP. Community Hospital (36k annually) and satellite urgent care centers (12k annually). Fast Track. CDU. Double/triple/quad coverage indexed to seasonal volume. Quality, experienced nursing staff. Progressive leadership. Cape Cod is a great place to live and raise a family! (PA 718)

MASSACHUSETTS

The department of Emergency Medicine at Massachusetts General Hospital is seeking candidates for faculty positions at all academic levels. Special consideration will be given to those with an established track record in clinical or laboratory research and a commitment to excellence in clinical care and teaching. Academic appointment is at Harvard Medical School and is commensurate with scholarly achievements.

MGH is an equal partner in the 4-year BWH/MGH Harvard Affiliated Emergency Medicine Residency Program. The ED is a high volume, high acuity level 1 trauma and burn center for adult and pediatric patients. Annual volume is >76,000. Candidates must have at least 4 years residency plus fellowship training in Emergency Medicine. Send CV to: David F. M. Brown, MD FACEP Massachusetts General Hospital, Bulfinch 105, Department of EM, 55 Fruit Street, Boston, Massachusetts, 02114. (PA 721)

MINNESOTA

MINNESOTA, Minneapolis: The Twin Cities largest democratic, physician owned emergency medicine group seeks highly motivated board trained or board eligible physicians to join our 100 member group. Our group staffs six community hospitals with average volumes of 40K. Base salary, benefits, and productivity and performance incentives to exceed \$250K compensation. Come see what Minneapolis has to offer other than snow. (PA 688)

MISSOURI

Emergency Medicine Physician to join a staff of 5. \$140.00 per hour. Light Call. Enjoy trout fishing, water rafting, abundant golf courses in this picturesque location. Also, available in this resort community is shopping, outdoor recreation, and Universities. Located in South-Central Missouri on the edge of the Ozarks, this town straddles Interstate, 44 and 66 which provides easy access to Springfield and St. Louis. Great cohesive team environment makes for practicing meaningful medicine. Lots of administrative support. Comprehensive benefit package includes: Full family benefits, paid mal-practice insurance, life insurance, paid meals, relocation package, along with other attractive benefits. Work 1,560 hours a year, and enjoy the other facets of your life in this ideal location to raise a family. (PA 686)

The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

MISSOURI

Ozarks Medical Center is seeking a full time BC/BP EM physician. West Plains is in the heart of the Ozarks in south central Missouri and is 30 miles from a 40 thousand acre lake, excellent trout fishing and beautiful rivers. OMS is a 114 bed regional referral facility that has 18,000 annual ED visits. We have 10 hours per day of mid-level double coverage and will break ground on our new ED in Jan '05. The physician may work as an employee with a full benefits package (life, malpractice, disability, health, CME, retirement, and paid time off) or an independent contractor (malpractice paid) if desired. The hourly compensation is extremely competitive. Enjoy due process, open books, and a very supportive and progressive administration in this great town. All inquiries will remain confidential. Please e-mail your CV to info@aaem.org or fax to AAEM at 414-276-3349. (PA 670)

AAEM JOB BANK

MISSOURI

Kansas City, Missouri: Single Hospital, Democratic, Equitable scheduled group seeking BC/BE EM partner. Safe, suburban like setting. New ED under construction. 30K – 16 hours MD double coverage. No trauma/Admit Orders/Buy-In/Tail. Package includes malpractice Insurance, health/life/disability. Full retirement, contribution, bonus, vacation, and dues. (PA 689)

MISSOURI

Missouri, Springfield: Independent Democratic Group with long term contract (>19 years) looking to hire BC/BE Emergency Physician for new position created to cover increased census. \$42,000 per year in pre-tax retirement funds starting with first paycheck. Currently hourly rate is around \$139 plus health/dental/malpractice. Current yearly hours are around 1700. Equitable – every member of the group works a fixed schedule, with new members treated the same as older members. Occurrence Based Malpractice Insurance. Contact Pam Rysted at prysted@attglobal.net. (PA 714)

NEBRASKA

Vibrant hospital setting with a new ED-14 treatment rooms with trauma and cardiac rooms and ultrasound and x-ray. Five member group seeks a replacement for a BC/BE Emergency Physician. Average 13,000 visits/year and have 12-hour per day mid-level coverage. Very competitive salary with comprehensive benefits package including malpractice; 401k with 4% match; up to \$5,000 for CME; health, dental, life and disability insurance; moving expenses paid; possible student loan repayment. Hidden paradise with a lifestyle that provided abundant outdoor recreation, highly rated schools, safe environment and regional airport. Website: www.gprmc.com (PA 708)

NEW HAMPSHIRE

Democratically governed New Hampshire EM group serving 30,000 patient population seeks BL/BE physician. Competitive salary and benefits, close to ocean, mountains and metropolitan area. New department opened in August 2004. (PA 683)

NEW JERSEY

Large acute, community hospital in central New Jersey seeks a full-time Board-Certified or Emergency Medicine Physician to care for patients of all ages at a Walk-In/Urgent Care center. Night/Weekend hours. The ideal candidate for this position will be an experienced physician with good leadership skills who is interested in expanding a new program. Full-time position with paid malpractice and excellent benefit package. (PA 676)

NEW JERSEY

EMERGENCY ROOM: Community hospital located in Hudson County, New Jersey has immediate FULL TIME opportunities for an EMERGENCY ROOM DIRECTOR & FULL/PART TIME & PER DIEM PHYSICIAN OPENINGS. Candidates must be Board Certified or Eligible in Emergency. EOE (PA 709)

NEW MEXICO

Santa Fe – We are an independent, democratic group seeking residency trained board certified or board eligible prepared emergency physicians for expanding opportunities. We enjoy a busy EM practice, a challenging case mix and an excellent relationship with our hospital. We offer a highly competitive productivity based salary, benefit package and a two year partnership track with management opportunities. Santa Fe is a recreational paradise with many cultural activities. Contact Cathy Roche at crocke@comcast.net. (PA 719)

NEW YORK

Bassett Healthcare, a regional, trauma II, referral, teaching and research center affiliated with Columbia University, located in Cooperstown, NY, seeks emergency medicine physicians. Opportunities to work in a progressive environment and to participate in teaching, research, paramedic training, and tele-medicine activities are available. BC/BE EM trained. Competitive Salary. (PA 665)

The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

NORTH CAROLINA

Democratic group in the Raleigh/Durham area seeks an emergency physician who values our specialty as much as we do. Medium-sized community hospital with excellent back-up. Our department sees 45K patients a year with a separate fast track area. We offer competitive compensation, equitable scheduling and good benefits in a fair practice environment. Our group is stable, vibrant, and seeking a strong team player who is BC/BE in EM. We are all board certified in EM, and most of us have a good sense of humor. Contact Michelle Durner at mdurner@ams-nc.com. (PA 712)

The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

OKLAHOMA

Immediate openings for BE/BC Emergency Medicine physicians. Level II E.D. 3000 visits per month. Salary/benefits competitive. Ample Emergency Room training/experience a must. General acute care 336 bed hospital located in university town – minutes from Tulsa. Enjoy life with access to one of the largest man-made lake in the world. (PA 713)

OREGON

Small, stable, single-hospital, democratic, locally owned EM group seeking full-time board eligible/certified physician for 120-140 hours/month for 8 hour shifts. Salary is very competitive. We offer a generous benefit package. Clean, small-town with excellent schools. Recreational opportunities here on the east slope of the Cascades, include hunting, fishing, skiing, biking, river rafting, golf and camping. (PA 700)

OREGON

FT BE/BC physician for 120-140 hours/month for 8 hour shifts. Salary/benefits very competitive. Oregon 45,000 rural population community is located at the base of the beautiful Cascade Mountains, with all-season recreation and excellent family atmosphere. Website: www.mwmc.org. (PA 710)

PENNSYLVANIA

Seeking additional BC/BE Emergency Medicine physicians at Hamot Medical Center, 358-bed hospital & Level II Trauma Center. ED volumes over 50,000. Newly built ED with 35 private rooms/ 3 dedicated trauma rooms. Enjoy Erie, a beautiful waterfront city. (PA 672)

The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

PENNSYLVANIA

Established and prospering single hospital physician group in the South Hills of Pittsburg seeking BP/BC emergency physician. Equal equity partnership potential after one year in this democratic group. Our volume (46,000/annually) is growing and we seek strong players focused on quality care and patient satisfaction. Excellent compensation, comprehensive benefits and a strongly funded pension are part of this excellent career opportunity. (PA 658)

The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

PENNSYLVANIA

Faculty position available. BC/BP in EM required. Protected time for research/academic pursuits on academic track. Level 1 Trauma Center with 90,000 visits annually. Equal opportunity/affirmative action employer. Applications from women and minorities strongly encouraged. (PA 690)

SOUTH CAROLINA

One of the nations largest democratic, physician owned groups is recruiting EM BC/BE physicians. Carolina Care staffs the three major medical centers in the Columbia area (level I and III trauma). Involvement includes affiliation with The University of South Carolina Emergency Medicine Residency Program, Pediatric ED, Hyperbarics, Toxicology, CDU, and Ultrasound. (PA 701)

TEXAS

NORTHEAST HOUSTON TEXAS single hospital group seeks BCEM physician for full-time position. Comprehensive value of position is avg. of \$180/hr +, and is based on fee-for-service. (PA 673)

TEXAS

San Angelo: FT position of BC/BE EM physician to join independent democratic group. 45K ED with fast track. 10 hr shifts. Regional trauma/referral center, helicopter service, excellent medical and administrative support. Newly remodeled 28 bed ED. Great family oriented city and schools. 4yr University, Hunting, Fishing, RVU Compensation at \$165/hr +. (PA 678)

The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

VERMONT

The Emergency Department at Southwestern Vermont Medical Center has a Full-Time position for a Staff Emergency Physician. Applicants should be board certified or eligible in Emergency Medicine with Emergency Medicine training. Experience preferred. Reply to: Polly Cipperly at apply@phn.org. Website www.svhealthcare.org (PA 716)

VIRGINIA

Single hospital fair and democratic group in coastal location. 18 year tenure at community hospital. No major trauma fee for service arrangement with short partnership tract, great pay and benefits, and extra stipend for night shift schedule. 31,000 annual ED visits. Live in Williamsburg, on the water, or in suburban or rural areas. (PA 681)

The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

VIRGINIA

Emergency Physicians of Tidewater serves seven hospitals in the Norfolk area, including level 1 and 2 trauma centers. The group provides faculty and supervision of an Emergency Medicine residency. Competitive financial package, great coastal climate. (PA 702)

WASHINGTON

PEAM Group opportunity at the new Legacy Salmon Creek Hospital in Vancouver, WA for a BC/BE Peds/EM Physician. Beginning August 15th with partnership eligibility after 1-year. Provide PED coverage and help in the development of a pediatric emergency care system. Relocation assistance! (PA 705)

WASHINGTON

WASHINGTON, Olympia: Full-time opportunity for residency trained BC/BP emergency physician. Established, independent, fee-for-service democratic group. Annual volume 60,000. Financial equality at one year, partnership at two years. State-of-the-art department located on the scenic Puget Sound. (PA 711)

WISCONSIN

Exceptional opportunity to join a brand new emergency department. This state of the art facility is recognized as one of the nation's "Top 100 Hospitals". Reside in a family friendly community which offers many cultural and recreational amenities including a \$15 million performing arts center, boating and water sports, and major sporting events. The new physician will receive a highly competitive hourly wage as well as a full fringe benefit package. (PA 636)

AAEM JOB BANK

WISCONSIN

URGENT CARE!! Consider this exceptional opportunity to assume an Urgent Care faculty position with a premier educational institution in metropolitan Wisconsin. A high quality of life, a wonderful fringe benefit package and a great location in urban/suburban practice setting further enhance this opportunity. (PA 650)

WISCONSIN

Outstanding Emergency Medicine opportunity in a scenic community, just minutes from the picturesque Wisconsin River and an hour from Madison. This democratic group divides nights, weekends and holidays equally. The ideal candidate will have superior interpersonal skills and the ability to work well with support staff and colleagues. This progressive community hospital possesses state of the art technology including electronic medical records and a new CT Scanner. (PA 680)

WISCONSIN

Fort Atkinson: Superb opportunity! Excellent small town living environment close to Milwaukee, Madison, and Chicago. Democratic group enjoys pleasant community practice, comfortable workload, competitive salary/benefits package. Shifts are equitably distributed with flexible scheduling options. Group will occupy new ED by year's end. Seeking BC/BE physician to become full partner. (PA 706)

GERMANY

Small Army community hospital seeks 6 month hire (extension possible) of ER physician in Level III ED (no trauma). Located in Würzburg, Germany and ideal for European travel. Approximately 14 shifts/month in ED with approximately 15,000 visits/year from soldiers, their family members and retirees. (PA 704)

GUAM

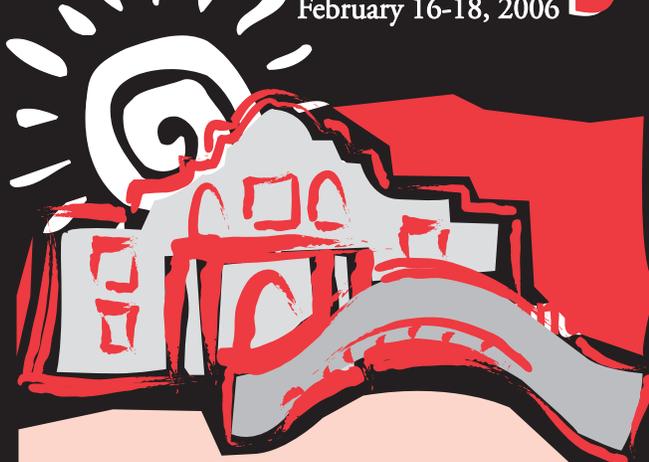
PT EM physicians (flexible scheduling) for Guam Memorial Hospital (GMH) located in the Western Pacific on the island of Guam (US Territory). Guam has world class golfing, diving, hiking, and there are regular direct flights to most of the Pacific Rim, Hawaii, Japan and Australia. The applicant must have an adventurous spirit and be accepting of a warm climate and slow paced lifestyle (and EMD). (PA 651)

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