President's Message

Fairness and the AAEM Job Bank

Larry D. Weiss, MD JD FAAEM

In response to our members, and in reflection of our duty of fairness to our advertisers, we revised our job bank policies several times in recent years. The time has come to recognize the fact that “fairness” exists in many forms. Our Academy has long promoted the physician-owned democratic group as a model of fairness. However, this does not preclude us from designating other models of practice as “fair,” particularly the fair employment arrangement.

Two years ago, the Academy adopted its current fairness policy. According to this policy, we grant our fairness designation to emergency departments or physician groups with a predefined partnership track, due process rights, the absence of post-contractual restrictive covenants, open books and a democratic decision-making process. While using this as a model, AAEM never claimed this was the only right way to practice emergency medicine. Indeed, we currently publish advertisements from contractors and employers who cannot meet our fairness designation.

I propose that we also develop a fair employer policy, recognizing those employers who respect the practice rights of their physician employees. I work for a very fair employer, the University of Maryland. Our workplace includes no infringements of our practice rights, we have many opportunities for educational enrichment, and we even make most decisions democratically.

I spent most of my career at another university where a single individual owned the professional corporation that held the contract to manage the emergency department. I never met a fairer person in my life. He treated us generously and consistently came to our support whenever necessary. He even allowed us to make every practice decision in a democratic manner. He strongly supported our state AAEM chapter.

Even though the Academy held up the democratically owned group as a model, we never excluded other groups from our activities. We revised our job bank policies several times in an effort to remain inclusive, while screening our potential advertisers for practices that we reasonably believed operated inconsistently with state corporate practice of medicine (CPOM) laws.

Applicable laws and ethical standards require us to deal fairly and evenly with all parties relating to the profession of emergency medicine. However, applicable laws do not require us to act in a complicit manner with entities we reasonably suspect of acting in a manner contrary to law. For example, if a state CPOM law prohibits lay corporations from owning medical practices, or prohibits lay corporations from controlling physicians, then we have no obligation to further such activities.

I hope in the near future that an AAEM task force can successfully describe the characteristics of a fair employer. I hope we will always continue job bank policies allowing us to publish advertisements of all positions (1) open to AAEM diplomates, (2) in emergency departments that do not violate the legal rights of emergency physicians, and (3) in emergency departments managed by entities that do not operate in violation of state CPOM laws. We must continue to carefully offer similar opportunities to all legitimate advertisers. Certainly, we may limit advertisements open to ABEM and AOBEM eligible and certified physicians because of the target audience of our publications.

While continuing to promote the democratically owned and operated group as our model, we may also recognize other forms of fair behavior. One does not violate any law by promoting fairness, but we must be careful not to exclude those who we simply designate as unfair.

Finally, I hope by the end of my term to further modify our job bank policies by incorporating many of our members’ ideas, keeping the job bank open to all legal entities hiring ABEM/AOBEM eligible and certified physicians, while designating those positions meeting our fairness criteria. Perhaps an alternative designation of fairness could include employers who treat their employee physicians fairly while respecting their practice rights.

I look forward to any comments regarding these issues from our members. Please contact me at lweiss@aaem.org. We already incorporated ideas sent by our members to improve the job bank. I will try to personally answer every member who contributes to this effort by sending us your ideas.
Stuff Happens

EDITOR’S LETTER
David Kramer, MD FAAEM

I see it every year in our residency program: weddings, divorces, births, illnesses, deaths. Their occurrence is almost as predictable as hospital overcrowding. The issue isn’t “if something will happen,” but “when it will happen.” Both happy and sad events often have similar impact. There are coverage issues intertwined with professional issues. It’s easy to say one should “check it at the door,” but it is hard to do so. I talk about these issues every year during orientation of my new residents. I make it clear that if it doesn’t happen to them during their residency training, it will likely happen during their careers. I make it clear that the teamwork they show when others need help will be the teamwork they receive when they are in need. I’m lucky to work with a great group of residents in which virtually every one is willing to step up to the plate to help when needed. Rarely have I needed to force professional behavior upon them. Each one knows that next time s/he might be the one asking for help.

I am fortunate to also work with faculty who understand these principles. We have had our fair share of “stuff happen” to our colleagues. Each individual has helped out when needed. For those of you currently exploring the job market, I encourage you to look into the personality and professionalism of the group you are considering joining. Talk with those you did not interview with. Find out how difficult issues are handled. This can definitely impact your overall wellness and happiness with your career and life. Remember that there is a lot more to consider than just the contract you will sign. Stuff will happen. What matters is how it is dealt with.

Finally, keep in mind that AAEM’s 15th Annual Scientific Assembly is fast approaching. March will be here before you know it. Secure the dates now so you can attend what promises to be a great meeting. I hope to see you all in Phoenix.

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

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

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EM in Lesotho

Authors: Dr. David Murman and Dr. Alison Sullivan are emergency medicine residents at Boston Medical Center who both worked at Maluti Adventist Hospital in Lesotho for two months.

Editors: Christopher Doty, MD FAAEM and Andrew C. Miller, MD are both from State University of New York (SUNY) Downstate Medical Center and Kings County Hospital Center in Brooklyn, NY. Dr. Miller is a resident in the Combined EM/IM Residency at Kings County Hospital.

Background:
Lesotho is a small, largely rural country in southern Africa and is a true enclave, completely surrounded by South Africa. This mountainous country is the home to the Basotho people (a Bantu people) and was a British territory from 1886 until 1965. The current political structure is that of a parliamentary constitutional monarchy.

Geography:
Altitudes in Lesotho range from 4,500 to over 13,000 feet. High mountains cover about two thirds of the country, and snow is common in the winter months. The capital city Maseru has a population of roughly 200,000 people and is home to the flagship government hospital. The remainder of Lesotho’s two million people live in medium to very small rural towns with the majority (81%) of the country’s population living in remote rural villages.

Economy:
Eighty-six percent of Lesotho’s population is engaged in subsistence agriculture. Despite this, agricultural products make up only 14% of the $5.5 billion GDP. Thirty-five percent of the actively employed male work force is employed in South Africa, largely in the mining industry. Besides labor, Lesotho’s other major resource is water. The recent construction of two major hydropower facilities has allowed Lesotho to become almost entirely self-sufficient in electricity production and sell the power and water to the Republic of South Africa. However, in Lesotho, only 7% of households have access to electricity. Poverty is a major problem in Lesotho, with 56% of the population living on $2 per day or less, and the unemployment rate is 45%.

Healthcare In Lesotho:
Healthcare delivery in Lesotho is challenging as a result of the fact that 81% of the population lives in remote rural villages, often several hours walk over rough mountain paths from the nearest clinic. Access to healthcare in Lesotho is also limited by poverty and by lack of personnel. Basotho individuals pay directly at the point of service for their healthcare, and Lesotho has only one doctor per 20,000 people (compared to approximately 1 in 400 in the US).

The healthcare system in Lesotho is composed of health posts and health centers at a primary level, with 16 district hospitals comprising the secondary level of care. Tertiary care is made up of the referral level Queen Elizabeth II Hospital in Maseru, Mohlomi Mental Hospital, Bots’abelo Leprosy Hospital and Senakatena AIDS clinic. If a patient requires services which are not available within Lesotho, they may be referred to South Africa for further care. Health posts are run by volunteer community health workers and provide outreach type care, such as condom distribution and immunizations. Health centers are staffed by nurse clinicians, who provide outpatient primary care. The large district hospitals provide a variety of outpatient services, including both primary care and specialized clinics (such as HIV/AIDS and tuberculosis (TB) clinics), as well as inpatient services, operating theaters, labor and delivery and emergency rooms. In addition to the government run facilities, there are eight Christian Health Association (CHAL) run hospitals and 79 CHAL run health centers throughout the country. CHAL facilities are sustainable mission projects and serve approximately 40% of the population.

Contributing to Lesotho’s difficulties with retaining medical personnel, Lesotho has no formal medical education aside from nursing schools. Most Basotho who attend medical school do so in South Africa, and few return to practice in their home country. Many of the physicians practicing in Lesotho are trained in South Africa with the remainder coming from other African countries. The majority do not stay on a long term basis.

The impact of HIV/AIDS in Lesotho:
Many of Lesotho’s health problems are related to poverty, TB and the HIV/AIDS epidemic. According to Lesotho’s ministry of health and social welfare, TB accounts for 31% of institutional deaths, pneumonia 29%, diarrhoeal diseases 14%, HIV/AIDS (which clearly contribute to the above causes of death as well) 9%, pneumoconiosis associated with pulmonary TB 6%, upper respiratory infection 5%, diabetes 3%, head injury 3% and incomplete abortion 0.5%. Nutrition is also a major cause of disease in Lesotho, especially affecting children, with 13% of inpatient admissions resulting from nutritional deficiencies in children aged 0-4 and 3.5% of admissions for all age groups.

Lesotho has the third highest HIV infection rate in the world with 29.8% of the general population HIV positive. TB is very common (~550 cases/100,000 people) and is a leading cause of death according to Lesotho’s ministry of health and social welfare. In Lesotho, the majority of HIV transmission is heterosexual and mother to child. The reasons for high HIV rates in southern Africa are multi-factorial, including poverty and social instability, high levels of other STDs, sexual violence and high mobility (particularly migrant labor). Many men from all parts of Lesotho travel to South Africa to work in mines where they live in single sex housing and are away from their wives and families for months at a time, often having interactions with professional sex workers. Many of the miners are at elevated risk for developing pulmonary silicosis (25%), and combined with HIV (34%), have a 16% per year rate of acquiring TB. Additionally, labor laws in South Africa require migrant labor workers to return to their country of origin for two weeks yearly, often bringing HIV and TB with them.

The average life expectancy had declined from 50 years in 2000 to 34 years in 2005, but has improved to 40 in 2007, coinciding with increased access to free antiretroviral therapy (ART). Without the HIV/AIDS epidemic, life expectancy would be an estimated 75 years.

Emergency Medicine in Lesotho:
Lesotho is in the early stages of developing emergency medical care. Emergency medicine is not established as a specialty, and pre-hospital care consists of ambulances run by individual hospitals with no medically trained personnel aboard and no central dispatch. Many hospitals lack fuel to run ambulances. Only in cases where patients have phones and can call the hospital directly to request an ambulance are they sent. The patient is usually required to pay for the ambulance service, thus discouraging their use. As a result, there is little to no availability of medical stabilization prior to arriving in a hospital. As in many other developing countries, most patients are brought to the hospital by taxi (minibuses) or on foot. Given the rough topography of Lesotho, wheelbarrows lined with blankets and carts pulled by work-animals are sometimes used to carry patients long distances to roads. In large accidents, South African ambulances may be sent across the border to retrieve the few patients that have health insurance (often those employed by South African mines).

continued on page 9
Organizations Offer Roads to Improve Pain Management Care in Emergency Department

Al Rothstein, Public Relations, Israeli Medical Association - World Federation - United States Chapter

Emergency departments in the United States receive more than 110 million patient visits annually. In up to seventy percent of those patients, pain is the presenting complaint.

Treating pain is the challenge, and two organizations are now offering avenues that could lead to better treatment of pain in the ED, as well as other issues affecting emergency care. The organizations are the new United States Chapter of the Israeli Medical Association (IMA, www.ima-wf-usa.org) and the Pain and Emergency Medicine Institute (PEMI) at Beth Israel Medical Center in Manhattan.

“These organizations can share the latest research, and spread it around the globe,” says Knox Todd, MD MPH FAAEM, Professor of Emergency Medicine at Albert Einstein College of Medicine and Director of PEMI. “For example, research that shows a high prevalence of inadequate pain treatment in the emergency room and identifies risk factors such as extremes of age, ethnicity and cognitive function. Research also finds extensive small and large area variations in emergency department pain management practices.”

That might be because few emergency nurses or physicians are engaged in the study of emergency department pain management practices. The new organizations will encourage this kind of study.

“One result of a lack of sharing information,” says Dr. Todd, “is the outdated practice of withholding analgesics for ED patients with acute abdominal pain because of the fear of masking the diagnosis.”

“It is an example of the substantial gaps that remain between existing knowledge and daily pain management practice in the emergency department,” he says.

Dr. Todd and others want to close this gap by providing:

a) resources and information about best practices;

b) education to emergency care providers; and

c) the facilitating of research to promote improved practice.

He wants to build on the success of past research collaborations and identify themes to create opportunities for research among colleagues. This will also involve creating a network of emergency nurses and physicians committed to these goals.

Advanced Israeli Medicine

The IMA's new U.S. chapter will provide visits to and exchange programs with Israeli medical facilities for its member U.S. physicians, especially in the areas of emergency medicine and disaster recovery.

Pinchas Halpern, MD, Chair of the emergency department at Tel Aviv Medical Center and senior lecturer of emergency medicine, anesthesiology and critical care at Tel Aviv University, explains that the field of emergency medicine in Israel can not only offer advanced learning to U.S. physicians, but different philosophies of operating EDs as well.

“There seem to be fewer barriers in Israel, such as shorter waiting times in the ED and less fear of opiates,” he says.

“In Beersheba, I observed how the field of emergency medicine was being practiced, with a multidisciplinary approach,” says Roman Skylar, MD MBA FACEP, Medical Director of Aventura Hospital and Medical Center in Aventura, Florida. “In the U.S., we learn all aspects of medicine from the ED physicians, while in Beersheba, I learned it from the specialists themselves. I also observed how organized the trauma teams were and the set up of the facilities. It was quite impressive!”

“As I advance my career into becoming an ED director, observing the inner workings of EDs in other countries with fresh and different ideas will benefit my patients with fresh ideas for our facility setup.”

But American emergency physicians also have something to offer their Israeli colleagues through visits to U.S. facilities and international conferences.

“Bringing people together in the U.S. and Israel means more cooperation and learning for both,” says Dr. Todd.

The Goals

Dr. Halpern would like to see medical centers around the world:

a) make pain management part of the routine quality assurance and improvement system of the ED and the entire hospital; and

b) instill in their staffs the understanding that pain belongs to and can only be gauged by the patient. Therefore, it can only be treated adequately if we respect this understanding.

In its programs, the IMA's U.S. chapter will take on issues like the above by identifying emergency physicians and nurses with similar interests and create opportunities to enhance communications between them and their Israeli colleagues.

Dr. Halpern says, “The goal for me is to make the alleviation of pain a routine, self evident priority for all ED physicians and nurses, so we do not need to continually remind them of it. The issues in acute pain management are similar in many ways across the world, and much can be learned from each other.”

And Dr. Todd reminds us, “Brennan, Carr and Cousins have written that, ‘...a coherent international consensus is emerging: The unreasonable failure to treat pain is poor medicine, unethical practice and is an abrogation of a fundamental human right.’”

For more information about the Israeli Medical Association, visit www.ima-wf-usa.org.

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<td>AAEM Louisiana State Chapter Annual Meeting and State Business Luncheon</td>
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<td><a href="http://www.aatemla.org">www.aatemla.org</a> or contact <a href="mailto:scusimano@newsouth.net">scusimano@newsouth.net</a></td>
</tr>
<tr>
<td>November 14-16, 2008</td>
<td>The Difficult Airway Course-Emergency™</td>
<td>Atlanta, GA</td>
<td><a href="http://www.theairwaysite.com">www.theairwaysite.com</a></td>
</tr>
<tr>
<td>November 19-22, 2008</td>
<td>II World Congress in Emergency and Disasters</td>
<td>Cancun, Mexico</td>
<td><a href="http://www.urgenciasmexico.org">www.urgenciasmexico.org</a></td>
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<tr>
<td></td>
<td>Conference jointly sponsored by the Mexican Academy of Emergency Medicine and AAEM.</td>
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<tr>
<td>December 5-7, 2008</td>
<td>2008 Pediatric Emergency Medicine Conference</td>
<td>Columbus, OH</td>
<td><a href="http://www.nationwdedchildrens.org/conferences">www.nationwdedchildrens.org/conferences</a></td>
</tr>
<tr>
<td>February 7-11, 2009</td>
<td>Rocky Mountain Conference in Emergency Medicine</td>
<td>Copper Mountain, CO</td>
<td><a href="http://www.coppercme.com">www.coppercme.com</a></td>
</tr>
<tr>
<td>February 20-22, 2009</td>
<td>The Difficult Airway Course-Emergency™</td>
<td>Huntington Beach, CA</td>
<td><a href="http://www.theairwaysite.com">www.theairwaysite.com</a></td>
</tr>
<tr>
<td>March 2-4, 2009</td>
<td>15th Annual AAEM Scientific Assembly</td>
<td>Phoenix, AZ</td>
<td><a href="http://www.aaem.org">www.aaem.org</a></td>
</tr>
<tr>
<td>March 27-29, 2009</td>
<td>The Heart Course-Emergency</td>
<td>Atlanta, GA</td>
<td><a href="http://www.theheartcourse.com">www.theheartcourse.com</a></td>
</tr>
<tr>
<td>April 1-2, 2009</td>
<td>AAEM Pearls of Wisdom Oral Board Review Course</td>
<td>Las Vegas</td>
<td><a href="http://www.aaem.org">www.aaem.org</a></td>
</tr>
<tr>
<td>April 25-26, 2009</td>
<td>AAEM Pearls of Wisdom Oral Board Review Course</td>
<td>Chicago, Dallas, Los Angeles, Orlando, Philadelphia</td>
<td><a href="http://www.aaem.org">www.aaem.org</a></td>
</tr>
<tr>
<td>June 5-7, 2009</td>
<td>The Difficult Airway Course-Emergency™</td>
<td>Boston, MA</td>
<td><a href="http://www.theairwaysite.com">www.theairwaysite.com</a></td>
</tr>
<tr>
<td>June 8-10, 2009</td>
<td>The Heart Course-Emergency</td>
<td>Cambridge, MA</td>
<td><a href="http://www.theheartcourse.com">www.theheartcourse.com</a></td>
</tr>
<tr>
<td>September 18-20, 2009</td>
<td>The Difficult Airway Course-Emergency™</td>
<td>Chicago, IL</td>
<td><a href="http://www.theairwaysite.com">www.theairwaysite.com</a></td>
</tr>
<tr>
<td>October 17-18, 2009</td>
<td>AAEM Pearls of Wisdom Oral Board Review Course</td>
<td>Chicago, Dallas, Los Angeles, Orlando, Philadelphia</td>
<td><a href="http://www.aaem.org">www.aaem.org</a></td>
</tr>
<tr>
<td>October 23-25, 2009</td>
<td>The Difficult Airway Course-Emergency™</td>
<td>Las Vegas, NV</td>
<td><a href="http://www.theairwaysite.com">www.theairwaysite.com</a></td>
</tr>
<tr>
<td>October 26-28, 2009</td>
<td>The Heart Course-Emergency</td>
<td>Las Vegas, NV</td>
<td><a href="http://www.theheartcourse.com">www.theheartcourse.com</a></td>
</tr>
<tr>
<td>November 13-15, 2009</td>
<td>The Difficult Airway Course-Emergency™</td>
<td>Atlanta, GA</td>
<td><a href="http://www.theairwaysite.com">www.theairwaysite.com</a></td>
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</tbody>
</table>

Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Kate Filipiak to learn more about the AAEM endorsement approval process: kfilipiak@aaem.org.

All endorsed, supported and sponsored conferences and activities must be approved by AAEM’s ACCME Subcommittee.
EM in Lesotho - continued from page 3

The main governmental hospital, the 16 district hospitals and many of the mission hospitals have emergency rooms which are stocked with basic medical equipment such as oxygen, IV fluids, bag valve masks and IV medications such as epinephrine and atropine. These are often part of the outpatient departments of hospitals, where there are no appointments. During business hours, patients line up in the order in which they came, unless they are unable to walk or are clearly seriously ill or injured. Triage vital signs are infrequently performed, which leads to the common occurrence of very ill patients waiting several hours to be seen by a physician or nurse clinician. Most hospitals lack means to intubate and ventilate patients on an emergent basis, reserving the use of ventilators to the operating theaters. There is no standardized approach to critically ill patients. Access to pharmaceuticals varies by hospital, and there are few, if any, working pumps to run IV drips. Many antibiotics and oral antihypertensive agents are available. Oxygen is an expensive, limited commodity and is only given to those in clear respiratory distress.

Areas for future improvement:
Medical care in Lesotho is largely framed by the nation’s challenges with HIV/AIDS, TB, poverty and topography. There are many potential interventions that may be taken in order to improve health outcomes. The most important factors in improving health in Lesotho are reducing poverty and increasing access to primary/preventative care, such as access to free/low cost ART and TB treatments. Improvements to roads and transportation infrastructure would likely have the largest impact on Lesotho’s pre-hospital care. The development of a pre-hospital medical system with a centralized ambulance service and trained medical personnel may make a significant impact on health outcomes in densely populated areas of Lesotho. Potential hospital based improvements include the development and implementation of triage and improvement in nursing to patient ratios. Triage vital signs would be highly beneficial in ensuring that ill patients are promptly attended to.

Recently, a residency program in family medicine was started, which will hopefully lead to better retention of doctors in Lesotho. With these efforts and continuation of HIV/AIDS and TB prevention and treatment campaigns, Lesotho should have continued increase in average lifespan and improved health outcomes.

References

AAEM Elections
Nomination Deadline: December 2, 2008

Two At-Large positions on the AAEM Board of Directors are open as well as the Young Physicians Section (YPS) Director Position. All current, full voting and YPS members of AAEM are eligible to run. Self-nominations are allowed and encouraged. You must be a YPS member to be eligible to run for the YPS Director Position.

Elections for these positions will be held at AAEM’s 15th Annual Scientific Assembly, March 2-4, 2009, in Phoenix, AZ. 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 complete the nomination form found at http://www.aaem.org/elections/2008nominationform.pdf and send the information listed below to the AAEM office before midnight CST, on Tuesday, December 2, 2008. Any YPS member can be nominated and elected to the YPS Director Position. The nomination form and required information is the same as that for a Board position.

1. Name of nominee. Each nominee may have only three individuals as nominators/endorsers.
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.
7. A copy of the nominee’s CV.

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, a full voting or YPS member, can be nominated and elected to the Board of Directors.
Where Will You Be November 4?

Kathleen Ream
Director of Government Affairs

Be Informed!

Before going to the voting booth on November 4, make sure you know the candidates’ positions. AAEM’s Legislative Action Center contains a comprehensive resource specifically designed to meet all your 2008 election needs whether they are federal, state or local. From detailed candidate bios to voter registration services, from information about specific ballot initiatives to help in locating polling sites, all this can be found under the “Elections & Candidates” tab on the homepage of the Legislative Action Center at http://capwiz.com/aaem/home.

The features include:

• ZIP code and address-to-district matching for a list of presidential, congressional, statewide and state legislature candidates
• Candidate biographical and contact information
• Candidate position statements
• Links to candidate meet ups
• Statewide ballot initiative information
• Voter guide information including key dates and deadlines, ID needed at the polls, and links to voting machine descriptions and polling locations
• Voter registration forms

In addition, for any of your federal legislators, look up their voting record on the issues of concerns to AAEM and the emergency medicine community. Go to your representatives or senators homepage on AAEM’s Legislative Action Center, and click on the tabs “Votes” and “Bills” to see how they align with AAEM positions.

But most important, VOTE on November 4!

Low-Income Children Predominate in ED Visits

According to a recent News and Numbers summary from the Agency for Healthcare Research and Quality (AHRQ), lower-income children made almost twice as many visits to hospital EDs than higher-income children in 2005. AHRQ’s analysis, which was based on more than 12 million ED visits by children under age 18 in 23 states, compared the number of ED visits by children from low-income communities, where the average household income was $36,999, to those of children from high-income communities with an average household income of more than $61,000. The rate for those from low-income communities was 414 visits for every 1,000 children, while the rate for those from high-income communities was 223 visits for every 1,000 children.

AHRQ also found that:

• Children were treated and released in 96% of all visits. The reasons for those visits included: respiratory conditions; superficial injuries such as bruises; middle ear infections; open wounds such as cuts and scrapes on arms and legs; and muscle sprains and strains.
• For the 5% of children admitted to hospitals, the top reasons were: pneumonia; asthma; acute bronchitis; appendicitis; dehydration and other fluid and electrolyte disorders; depression and other mood disorders; and epileptic convulsions.
• Roughly 45% of the visits were covered by Medicaid, 43% were covered by private insurance, 9% were uninsured, and 3% had other types of coverage.

State News

Trial Courts Rule Cap on Noneconomic Damages Unconstitutional

A Georgia trial court has found the state’s $350,000 limit on noneconomic damages unconstitutional. Fulton County Superior Court Judge Marvin S. Arrington, Sr., said the cap violated patients’ equal protection rights and access to a jury trial. Lawyers involved expect an appeal, which would send the issue to the state Supreme Court.

A similar decision was made in Illinois, where a trial court last November struck down the state’s $500,000 cap for violating the separation of powers between the legislature and judiciary. The case was appealed to the state Supreme Court. The Litigation Center of the AMA and State Medical Societies and the Illinois State Medical Society (ISMS) filed a friend-of-the court brief in May. A ruling is expected later this year.

Physicians say the court decisions threaten to undo improvements in the medical liability environment in their respective states. Noting that, in the past three years, Georgia’s medical liability insurance rates have stabilized, companies have reported an overall drop in claims filings and defense costs, competition is on the rise, and the state has seen a 10% increase in obstetricians at a time when few were practicing; Donald Palmisano, Jr., General Counsel to the Medical Association of Georgia, stated, “What this all results in is greater access to care for patients, and that’s what we should be looking at.”

Despite similar progress in Illinois, ISMS president Shastri Swaminathan said excessive jury awards still plague the legal system and that the state’s cap is critical to help retain doctors. According to a February AMA report, states with noneconomic damage limits have an increased supply of high-risk specialists. Doctors in those areas also pay at least 17% less in insurance costs.

Trial lawyers, however, argue that the caps come at the patients’ expense and praise the courts for restoring their rights. The Georgia Trial Lawyers Association called attention to research contradicting AMA’s report. A March study conducted by the Harvard School of Public Health and George Mason University showed that most OB-GYNs’ decisions to relocate or stop practicing are unrelated to insurance premiums or tort reform.

The Georgia case poses an additional threat to liability protections for physicians involved in emergency care. Plaintiffs challenged the validity of a provision under the reform statute requiring a higher standard of proof in emergency cases – an issue central to the underlying medical claim. The court said it would take up that question in a separate ruling.

Prior state Supreme Court rulings have invalidated other medical liability reforms. In 2006, the Georgia high court declared unconstitutional the venue portion of the liability reform statute that would have allowed defendants in joint medical liability cases to transfer lawsuits to the county where the alleged negligence occurred. And in 1976 and 1997, Illinois justices struck down award limits in medical liability cases.

continued on page 12
Save The Date

Cancun Mexico

= Continuing Medical Education

19-22 November 2008
World Congress in Emergency Medicine and Disasters

• Medicine, trauma, procedures, disaster management, prehospital care, and other updates
• Preconference sessions include EKG workshop with Richard Harrigan, 2008 LLSA with Joe Lex

✓ Jointly sponsored by AAEM
✓ More than 20 hours AMA PRA category 1 credits™
✓ Time to explore the Mexican Riviera
✓ Details at www.urgenciasmexico.org/cancuneng.doc
Washington Watch - continued from page 10

Louisiana Governor Signs Bills Protecting Medical Professionals
A package of bills designed to protect medical personnel from lawsuits arising from healthcare delivered during declared emergencies was signed into law by Governor Bobby Jindal (R) on June 30, 2008. Two of the measures, SB 301 and SB 330, sponsored by Senator Joel Chaisson, II (D-Destrehan), were inspired and backed by Anna Pou, the New Orleans physician who was arrested but never indicted over patient deaths at Memorial Medical Center after Hurricane Katrina. The bills provide lawsuit protections for paid medical professionals not covered under the existing Good Samaritan Act.

Specifically, SB 301 states that a healthcare official cannot be held liable “as a result of an evacuation or treatment or failed evacuation or treatment” conducted according to the procedures of emergency medicine “and at the discretion of military or government authorities.” SB 330 goes a step further with a provision that grants limited immunity for medical personnel working within a disaster zone and giving medical care affected by the disaster. The bill also protects medical personnel from “simple negligence” but not from “gross negligence.” The protection in both bills is intended to apply only to individual employees, not owners of the medical facilities in question.

A separate measure, sponsored by Representative Fred Mills (D-Parks), addressed immunity related to healthcare provided outside the disaster area. That legislation, signed by Governor Jindal, went into effect on August 15, 2008.

As for Louisiana’s malpractice reform, another slate of bills altering the $500,000 cap on awards in medical malpractice suits appears dead for the session. Representative Nick Lorusso, (R-New Orleans) said representatives of the legal and medical communities will continue to work on potential compromises for next year’s regular session.

AAEM congratulates Harold A. (Hal) Thomas, MD FACEP, on assuming the presidency of the American Board of Emergency Medicine (ABEM).

Dr. Thomas served ABEM as a Director since 2001.
Save the Date
for the Fifth Mediterranean Emergency Medicine Congress
MEMC Valencia, Spain
14-17 September
2009

info@emcongress.org

MEDITERRANEAN EMERGENCY MEDICINE CONGRESS
European Society for Emergency Medicine
American Academy of Emergency Medicine

In 2007, in Sorrento, Italy, we had more than 1500 delegates from 72 nations and over 1000 abstracts presented. Do not miss it!
As an organization, AAEM recognizes Dr. Wagner’s contributions to the specialty by offering an award named in his honor to individuals who have had a meaningful impact on the field of emergency medicine and who have contributed significantly to the promotion of AAEM’s goals and objectives. Dr. Wagner himself was given the first such award in 1995.

YOUNG EDUCATOR AWARD
Nominees must be out of residency less than five years and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs.

RESIDENT OF THE YEAR AWARD
Nominees for this award must be AAEM resident members and must be enrolled in an EM residency training program. This award recognizes a resident member who has made an outstanding contribution to AAEM.

JAMES KEANEY AWARD
Nominees for this award must have 10 or more years of experience in EM clinical practice and must be AAEM members. Named after the founder of AAEM, this award recognizes an individual who has made an outstanding contribution to our organization.

PETER ROSEN AWARD
Nominees for this award must have 10 or more years of experience in an EM academic leadership position and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM in the area of academic leadership.

AAEM/RSA is pleased to announce it is currently accepting nominations for its annual EM Program Director of the Year Award. Nominees for this award must have been involved in running a program as an Assistant, Associate or Program Director for five or more years. Nominees must be AAEM members and can only be nominated by AAEM resident members. This award recognizes an EM program director who has made an outstanding contribution to AAEM. The winner of this award will be chosen by the AAEM Resident and Student Association.

Nominations will be accepted for this award until midnight CST, December 2, 2008. All nominations should be submitted in writing and should include:

1. Name of the nominee.
2. Name of the person submitting the nomination.
3. Reasons why the person submitting the nomination believes the nominee should receive the award.

The award presentation will be made to the recipient at the 15th Annual Scientific Assembly to be held in Phoenix, AZ, March 2-4, 2009.
Interested in Starting an AAEM State Chapter?

AAEM developed a toolkit just for you! AAEM’s Guide to Managing and Forming a Non-Profit State Chapter provides you with templates, documents and other important information on a CD format with an easy to follow process to start a new state chapter.

You may form a chapter with only a few interested members and a little initiative. The chapter may:

• play an instrumental role in protecting and fostering the practice of emergency medicine at both a state and national level
• provide an opportunity for emergency physicians from different parts of the state and different practice types to work cooperatively
• provide a platform to become directly involved with their state legislature

Contact info@aaem.org to receive a copy of the toolkit on CD.

Welcome to our newest 100% Residency Programs!

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• Louisiana State University – Shreveport
• St. Luke’s Hospital-Bethlehem
• The Brooklyn Hospital Center
• University of California San Francisco

To sign your program up for 100% membership, please email info@aaemrsa.org

Applicants for Certificate of Excellence in Emergency Department Workplace Fairness

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

Below you will find a listing of new applicants for Emergency Department Workplace Fairness. A complete listing of previously recognized groups can be found on our website at: http://www.aaem.org/certificateofexcellence/.

<table>
<thead>
<tr>
<th>Organization</th>
<th>State</th>
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<tbody>
<tr>
<td>Reid Hospital/Emergency Medicine of Eastern Indiana</td>
<td>IN</td>
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<tr>
<td>Southeast Emergency Consultants</td>
<td>FL</td>
</tr>
<tr>
<td>Standford/Kaiser Santa Clara, TPMG</td>
<td>CA</td>
</tr>
<tr>
<td>Valley Emergency Physicians-South Bend</td>
<td>IN</td>
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</tbody>
</table>
Pre-Conference Courses:

**February 28 - March 1, 2009**
Resuscitation For Emergency Physicians:
The AAEM Course (2 day course)

**March 1, 2009**
Advanced Ultrasound
Children Are Not Little Adults! – Pediatric Emergencies
LLSA Workshop
Simulation Workshop
Uniformed Services AAEM Course

Announcing:

Keynote Speaker:
**J. James Rohack, MD**
President-Elect of the American Medical Association

**15th Annual Scientific Assembly**

March 2-4, 2009
Sheraton Phoenix Downtown Hotel

**AAEM**

**Louisiana State Chapter**

Annual CME Event and
Annual State Business Luncheon

November 12, 2008
8:00am - 5:00pm
Sheraton Downtown Hotel
300 Canal Street
New Orleans, LA

**Invited Faculty**
Peter DeBlieux, MD FAAEM
William Freeman, MD FAAEM
Robert McNamara, MD FAAEM
Todd Thoma, MD

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www.empacmanagers.com
This year, many of our AAEM/RSA members are embarking upon their first job search as emergency physicians. While the largest influences on finding the right job may be location, quality of facilities, breadth of patients and compensation, it is also essential to evaluate the type of practice environment and the fairness of the contract that you will be signing.

Within EM, there are several types of practice settings. Understanding the structure of the myriad practice environments can be extremely confusing. Stated simply, there are three major types of physician relationships: independent groups, contract management groups (CMGs) and hospital based practices. For any of these groups, you can be hired as an employee or an independent contractor – one important difference being the IRS tax classification. In general, independent contractors are responsible for managing their own tax filings and obtaining health, life, disability, and potentially malpractice insurance, but are allowed greater tax deductions. Employees, on the other hand, may have added benefits including vacation time, educational allowances, and medical, disability and malpractice insurance, but have significant restrictions on tax deductions.

Within independent groups, there is a wide spectrum of practice structures – the most ideal being a democratic group. Democratic groups are described by: open books, a well-defined partnership track, fair profit and asset sharing and voting rights. Preferably, members will also share scheduling equity or be rewarded appropriately for less desirable shifts. Prior to joining a democratic group, the partnership track should be clearly defined. Most group members will be partners or on the “partnership track.” A partnership track will vary in length but is ideally around two years. When initially hired, you will preferably start to share profits and assets but at a lower rate than a full partner. After a certain pre-defined time period, you should have vote, profit and asset sharing which is either equal or delineated based upon individual investments (buy in) or longevity in the group. Regardless, books should be open and the compensation structure should be clearly outlined. Many groups may call themselves a “democratic” group but are missing one or many of the elements of a true democratic group. They may have an ill-defined partnership track, unequal profit sharing and voting despite equal investment, or non-physician ownership.

Contract management groups are businesses which generally hold contracts with several emergency departments in one area or across the country. As such, the individual emergency physicians typically do not have significant ownership in the group via partnership. Approximately one-third of practicing emergency physicians work for CMGs. While individual physicians may benefit from reduced administrative responsibility, they also have reduced job security, salary and vote in the group. It is important to investigate a particular group’s reputation, whether there is corporate or administrative involvement in medical decision making and to evaluate the fairness of a contract prior to signing.

You may have read about restrictive covenants in past issues of Common Sense. Restrictive covenants are “non-compete clauses” within contracts which prohibit a physician from working in a defined geographical location for a specific period of time following a voluntary or involuntary termination of their contract. Essentially, a person is indentured to the contract until they can find another job a certain, and sometimes considerable, distance away from their current employment.

Other restrictive clauses may be buried in physician contracts, for example, denying the right to due process upon termination. Due process requires informing any threatened physician just reason for termination, with the opportunity for review at a fair hearing. It is important to read a contract carefully and thoroughly – with time to discuss discrepancies with trusted colleagues, mentors or an attorney. Other components to consider are malpractice insurance, including “tail” – coverage which extends beyond your employment – as well as health, life and disability insurance.

While adding these considerations to your job search may seem overwhelming, it is important to discuss the details of your contract and employment before making a commitment. AAEM offers numerous resources that will help in this task. You can find more information on fair contracts and EM practice groups at: http://www.aaem.org/emtopics/criticalissues.php or from Rules of the Road for Emergency Medicine Residents and Graduates. Most importantly, you are now part of AAEM, an organization which fights for a fair practice environment for emergency physicians.
Congratulations on completing another challenging year of medical school! From day one, we were bombarded with facts, figures, syndromes and scales. We have worked hard to grow our fund of knowledge, but the fact of the matter is that it is impossible to remain up-to-date with research, assignments and personal medical interests. As we progress in our training, this task becomes easier as we focus on our future specialty: emergency medicine.

Resources for medical students interested in emergency medicine are bountiful, and the newly elected Medical Student Council wants to alleviate the pressure of sifting through all of the relevant journals, books and newspapers to stay updated on the latest issues surrounding emergency medicine. We will do our best to glean the facts from the most important issues facing emergency medicine and pass our findings on to you. Check your email regularly for our monthly emails highlighting journal articles, current controversies in emergency medicine as well as chapter summaries from Rules of the Road for Medical Students.

As a student member of the American Academy of Emergency Medicine, there is a myriad of resources available to supplement your education on our website. These resources will help you succeed not only as a medical student, but also as a resident and attending physician. If you have not done so already, I recommend reading Rules of the Road for Medical Students, by Drs. Antoine Kazzi and Joel Schofer. This is mailed to paid student members and is available online at www.aaemrsa.org. Articles in The Journal of Emergency Medicine and Common Sense are other excellent ways to keep abreast of the latest in emergency medicine. These publications are also available online. Another way to stay updated on the latest news is to get involved in your medical school’s Emergency Medicine Interest Group (EMIG) or start one if your school does not have one. This year the Medical Student Council will make an effort to improve communication between AAEM/RSA and the EMIGs. A goal of ours is to increase the number of EMIG Workshop Starter Kits (http://www.aaemrsa.org/resources/kits.php). If you have ideas for new workshops, email them to info@aaemrsa.org.

We will be supporting an Emergency Medicine Symposium at UCI in California. Another great day for the Student Council will be March 2nd, 2009 - we are working on obtaining a dynamic group of speakers and planning seminars for student members at the AAEM Scientific Assembly in Arizona, and we hope to see you there!

For students interested in advocacy or just looking for another way to influence their profession, you can log on to the AAEM Legislative Action Center (http://capwiz.com/aaem/home/). Our advocacy emails will direct you to other ways you can join the political realm of emergency medicine practice. Remember that students have a powerful voice; do not be intimidated if you want to get involved with politics.

Due to the continued growth of our membership, we have expanded the number of regional representatives and will likely add additional representatives to deal with interest from international emergency medicine interest groups. It is never too late to get involved with your medical school’s EMIG or at the national level with AAEM/RSA.

Finally, I would like to congratulate the new Medical Student Council: Vice President Jennifer Monroe (Chicago College of Osteopathic Medicine); Western Regional Representatives Malia Bender (University of Texas Health Science Center at San Antonio) and Rachelle Callenback (University of California, Irvine); Southern Regional Representatives Sara Kirby (University of South Carolina School of Medicine) and Ellana Stinson (Meharry Medical College); Midwest Regional Representatives Daniel Bartgen (Loyola University Chicago Stritch School of Medicine) and Melissa Hudson (Ohio State University), and the Northeast Regional Representatives Mary Chopard and Kenneth Marshall (both from Georgetown University School of Medicine). On behalf of the 2008-2009 Medical Student Council, I want to express our excitement over continuing the excellent tradition set forth by previous Councils. We look forward to working hard to improving the services and outreach of the Council, and we invite you to get involved with AAEM/RSA. Good luck with your endeavors and journey into emergency medicine!

If you have changed your e-mail address or are planning to change it, please contact the AAEM office at (800) 884-2236 or info@aaem.org to update your information.
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Medicare – Facts, Figures and the Future of America’s Largest Social Program

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Medicare is one of the most influential federally sponsored programs in existence today. It insures roughly 40 million Americans and accounts for one third of the country’s total healthcare spending. As our population continues to age and the cost of the program swells to encompass more and more of the federal budget, the influence of the Centers for Medicare and Medicaid Services (CMS), and also the Federal Government, over healthcare as a whole will likely expand.

Medicare was established in 1965 when President Johnson signed it into law as Title XVII and XIX of the Social Security Act saying, “No longer will older Americans be denied the healing miracle of modern medicine.” It is remembered as his most important accomplishment as President, and the cornerstone of the Great Society programs he strove for. Harry S. Truman asked Congress nearly 15 years earlier to protect seniors who have no fixed income to address the rising cost of healthcare. To recognize his contribution to the establishment of Medicare, President Johnson made President Truman the first enrollee in the burgeoning program. Over its near 40-year lifetime, Medicare has benefited 90 million people.

Currently, Medicare benefits approximately 40 million Americans, or one in seven – a number that is expected to double by 2030. It provides health insurance for individuals over 65 years of age, and now to individuals with disabilities (such as end-stage renal disease). According to the CMS, because of the aging population that continues to live longer, there are families in the U.S. who have three generations currently enrolled in Medicare – a fact that likely was not imagined by the original founders of the program.

The original amendments to the Social Security Act included two parts: Medicare Part A and B. Part A provides for inpatient hospitalization and some skilled nursing facilities (up to 100 days per year). Part B covers most services and products available to beneficiaries on an outpatient basis. It pays for doctor visits, nursing services, x-rays, lab tests, vaccinations, emergency transportation and some medications (those that require administration by a physician). Part B also pays for ‘durable medical equipment’ such as canes and walkers.

In the last decades, two major additions have been crafted to increase coverage and improve efficiency in the delivery of medical care to seniors. Medicare Part C was enacted in 1997 as part of President Clinton’s Balanced Budget Act. The law allowed seniors to receive Medicare benefits through private insurance companies, instead of enrolling in Medicare Part A & B. Originally called “Medicare-Choice Plans,” in 2003 as part of the Medicare Prescription Drug, Improvement and Modernization Act, these plans are now known as “Medicare Advantage.”

Medicare Advantage allows beneficiaries to enroll in private insurance plans where the premium is paid on a monthly basis by the federal government (beneficiaries also contribute a monthly premium). In return, the private insurance plans are required to offer the same benefits that Medicare Part A & B offer, but not necessarily in the same way. For example, private insurers must cover skilled nursing facilities, but they do not have to cover them for 100 days, as Medicare Part A does.

Medicare Advantage is controversial, as some policy makers argue it is a way for the government to save on its annual expenses, while others argue that it shifts the costs to the beneficiaries themselves who are sometimes required by private insurers to pay higher co-payments and/or receive fewer benefits (or less access to care). Regardless, enrollment in these alternative programs has nearly doubled over the last three years, to nine million in 2008.

Medicare Part D went into effect in 2006 and offers prescription drug coverage to anyone enrolled in Part A & B. To receive coverage, beneficiaries must choose between two tracks. One track is the Prescription Drug-Plan that complements A & B coverage. The other is Medicare Advantage with Prescription Drug Coverage, which is essentially equivalent to enrolling in Part C with the added benefit of prescription drugs.

The unique feature of the latest addition to Medicare is that drug benefit plans are approved by CMS but are physically administered by individual private health insurance companies (much like Medicare Part C). What this boils down to is a wealth of options, and a tremendous difference in coverage. The private companies that created drug coverage plans can choose to cover whatever drugs they wish. Some may choose to pay for both ciprofloxacin and moxifloxacin, while others will only cover levofloxacin. The only exception is that CMS does not permit coverage for benzodiazepines, cough suppressants and barbiturates.

As a whole, Medicare has solved numerous social issues. It has increased insurance coverage, contributed to an increase in life expectancy, saved millions of seniors from slipping into poverty as a result of the high cost of medical care and helped disabled Americans. In addition to all of this, Medicare has also funded graduate medical education in the form of nearly 8 billion dollars paid annually to teaching hospitals to train new physicians.

Despite these accomplishments, Medicare faces serious challenges. It currently represents 16% of all federal spending (just behind Social Security and the Department of Defense to come in at number three on the government’s balance sheet). The Congressional Budget Office suggested, “Future growth in spending for Medicare and Medicaid will be the most important determinant of long-term trends in federal spending.” Medicare spending currently represents 4% of total gross domestic product in the United States. It is estimated that by 2082, it will be 19%, or the total size of the current federal government.

Most agree that something must change in order to avoid fiscal disaster – however, what that “something” is has very little consensus. The stage is set in the 2008 Presidential Election for major changes to occur regardless of who is elected. AAEM and our Government Affairs team will keep you informed of all the changes. However, your action and support is the most important part – write letters to your representatives and educate your colleagues about the challenges we face. To ensure that our own best interests are looked after as emergency physicians and that the best interests of our patients are kept paramount, it is important that we all take on an active role in the debates and decision making process that lies ahead.

The facts and figures presented in this article are compiled from the online resources found at www.medicare.gov, www.cms.hhs.gov, and www.medicareadvocacy.org.

This systematic review identified six articles which addressed the performance of emergency physician performed ultrasonography for the diagnosis or exclusion of deep venous thrombosis (DVT). Two physicians performed separate structured searches of MEDLINE and a librarian searched EMBASE, followed by a hand search of selected bibliographies for additional relevant studies. Only original research reports from emergency department (ED) patients who had signs and symptoms suggestive of DVT were included. Participants were required to have had an ultrasound performed by both emergency personnel and a subsequent study in a radiology department or vascular laboratory. Agreement between the studies was assessed.

For ED ultrasounds, the overall sensitivity from the six studies was 0.95 and the specificity was 0.96. While these numbers are promising, the authors identified substantial variability among the results through statistical testing of heterogeneity. In addition, they questioned the generalizability of the results, as the ultrasonographic skills of community practitioners may not match that of the study physicians.

Overall, the authors conclude that the test performance characteristics of ED ultrasounds are very good, but they call for a larger study of ED ultrasonography with a follow-up interval to assess clinically important outcomes. Until this evaluation, ED ultrasound for DVT should continue to be a “rule-in” evaluation and not a stand-alone diagnostic test to “rule-out” this important cause of morbidity and mortality.


The evaluation of a patient’s “worst headache of my life” usually leads to a noncontrast cranial computed tomography (CT) and a lumbar puncture. The study authors evaluated the hypothesis that noncontrast CT with current generation scanners is sufficiently sensitive for the detection of spontaneous subarachnoid hemorrhage (SAH). In addition, the investigators collected data on the presenting mental status of a group of patients with SAH, to determine the performance of CT in different clinical settings.

Their single center retrospective review identified 149 patients with the diagnosis of spontaneous SAH. Cases were gleaned from all emergency department diagnoses of SAH, cerebrospinal fluid analyses sent from the emergency department and discharge summary International Classification of Diseases, Ninth Revision (ICD-9) codes for SAH over a three and a half year period in their institution.

Of the 149 patients, 139 SAHs were identified using non-contrast cranial CT, for a sensitivity of 93%. 87 patients (58%) presented with headache and normal mental status; of these, CT identified 90% of diagnosed SAHs. Only 1 out of 61 patients with abnormal mental status and subarachnoid hemorrhage was missed on CT.

The authors conclude that current generation noncontrast CT scans are not sufficiently sensitive to rule-out the diagnosis of subarachnoid hemorrhage, and therefore, lumbar puncture must be performed when this diagnosis is being entertained. Of particular concern was the high miss rate (~10%) among patients with headache and normal mental status, as these represent the group most likely to benefit from early recognition of this intracerebral pathology.


A meta-analysis in 2004 questioned the safety of long-acting beta-agonists (LABAs) in the setting of both asthma and chronic obstructive pulmonary disease (COPD). 1 This study suggested an increased risk of adverse events and respiratory deaths for patients using these medications. Since then, the safety and optimal strategy for use of LABAs has been debated.

The study authors performed a systematic review of MEDLINE, EMBASE, CINAHL and Cochrane Controlled Trials Register to identify trials that could address these concerns. A total of 27 randomized controlled trials were selected for analysis, representing 20,527 patients and 26,389 patient-years of follow-up. In fourteen studies comparing LABA with placebo, the overall cumulative exacerbation incidence was 7.5% in the LABA group and 10.8% in the placebo group. The number needed to treat was 30. In addition, there was no significant difference in all-cause deaths or respiratory deaths between patients assigned to LABA or placebo.

There are more than 1.4 million visits to emergency departments for COPD in the United States each year. For some patients, visits to the emergency department may represent their only contact with health professionals. As such, emergency physicians must be fluent in management of this chronic disease. Escalation of therapy, when appropriate, is one way that emergency physicians can improve the quality of life and reduce the number of exacerbations for our patients. This systematic review supports the beneficial effects and safety of LABAs in patients with stable moderate to severe COPD.


continued on page 25
After spending more than twenty years of your life in school, it has come to this: you are a doctor. Fourth year of medical school was probably one of the greatest academic years of your life with a mixture of fun, travel, celebration and apprehension. Graduation may have left you feeling like you have forgotten much of what you learned in medical school. So, you’re a doctor. Now what?

Reflecting on this past year, I remember the swirling mixture of emotions about beginning residency. I had been a student all of my life. The drastic change of entering "the real world" in foreign territory was unsettling. Leaving my safe, familiar environment and heading into the unknown with new people and an anticipated paycheck seemed surreal. Such high expectations as to “save lives” felt intimidating. However, apprehension and insecurity slowly evolved to experience and confidence. Intern year has proven to be empowering and one of the most amazing years of my life thus far. I have learned not to be afraid of my pager every time it goes off. I survived shifts in the Medical Intensive Care Unit (MICU) alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable alone.

I can assure you that you will survive intern year and just maybe have some fun in the process. I want to inspire hope. As others have done before you, you will succeed. Here are five tips to keep you happy along the way:

1. Don’t believe the hype:
It is hard to ignore the stigma of intern year: grueling overnight calls, absence of family and/or friends, lack of sleep, and basically being the “scut monkey.” It sounds scary and intimidating, but I live by the phrase “a good attitude is half the battle.” This year I went into each rotation with an open mind. I tried not to focus on others’ comments about a certain rotation. I found that the overall “hype” seemed too generalized, and I needed to seek my own truths. I often found the rumors to be false compared to my own experiences. Keeping a positive attitude boosted my team’s morale as well as mine.

Feeling like the “new kid” is hard. Every month, as the ED intern, you are starting a new rotation with other interns who may have been doing that specialty for a number of months more than you. It’s tough, but by going into each rotation with a good attitude, you will be able to learn from your colleagues. In my experience, by being an active member of the team, I was treated as an equal member and not just the “ED intern.” Not only did this increase what I got out of every rotation, but allowed me to thoroughly enjoy my time on off-service rotations. Remember, we are the lucky residents that get the chance to spend a month in the shoes of so many different specialties and take from them what is pertinent to our practice in the ED. Savor this opportunity, and enjoy the wide variety of medicine we get to practice!

2. Social life - have one:
Residency is like nothing you’ve experienced before. You are suddenly spending up to eighty hours per week in a hospital; at times I felt like I should have been paying the hospital rent, instead of my landlord. A key to happiness is to try to maintain some kind of normal social life that the nonomedical people of the world adhere to. This may mean going to your residency social events or creating some of your own. This not only allows you to interact with your colleagues in order to decompress, but also will afford you the opportunity to talk about something non-medical (although somehow the conversation always tends to get back to the hospital). Normal life can also mean traveling, concerts, sporting events and anything the general public takes part in. You will learn that sometimes the best option is just vegging out in front of your television after an extremely hard shift, but your mental state also sometimes requires you to venture out of your apartment into the real world. Our class decided to make the night before conference our “hang out” night; this would include a variety of activities such as bowling, dinner parties, bars, etc. Whatever your activity may be, make a conscious effort to attend, even bring your significant other if you’re missing out on time with him/her too. Remember, being an ED intern is sometimes difficult since we are spread out all over the hospital: take time to hang out with your class, because they will be a vital asset to you in surviving residency.

3. Practice good medicine:
I think I know how you are feeling: you’ve lost a great proportion of your medical knowledge in the depths of fourth year. I will tell you, your current co-interns probably feel the same. We have all been there, and although I hate to break this to you so early on, you will make mistakes. Making mistakes is part of the learning process, and a lot of the time we learn the most from our mistakes. Residents and attendings are essential tools; make sure to use them as a resource and learn from their experience.

Another essential: Reading. Although at times reading seems to be impossible to fit into your schedule, it is vital to the practice of good medicine. My personal system was to place the patient stickers on an index card and then write the treatment plan, tips from attendings, etc., on the card. After my shift, I would spend an hour going through the cards and reading in my EM book of choice about my patients. This way you are not only pairing an illness with an actual patient, but adding in personal “tips of the trade” from your attendings. This is an excellent way to stay on top of reading and keep a reference of your patients. Another suggestion: on off-service rotations - make sure to read the relevant section of your preferred emergency medicine text. For example, when I was on orthopedics I read the musculoskeletal section of Tintinalli. Not only did this help during the rotation, but also it’s part of the learning process, and a lot of the time we learn the most from our mistakes. Residents and attendings are essential tools; make sure to use them as a resource and learn from their experience.

4. Maintain a healthy mindset and healthy living:
There will be times during your intern year that you will be frustrated because you’re working incredibly long hours and under an extreme amount of stress. As I mentioned before, mindset is everything. If a
The mainstays of treatment for gout are nonsteroidal anti-inflammatory drugs (NSAIDs) and colchicine. Both classes of medication have disadvantages (colchicine has a narrow therapeutic window and NSAIDs have cardiovascular and gastrointestinal risks). The short term use of systemic corticosteroids has been suggested as a safe alternative for management of gouty arthritis. The investigators conducted a randomized, double-blind, controlled trial to test for the equivalence of prednisolone (35mg once per day) and naproxen (500mg twice per day) in the treatment of gout. Patients were assigned to one treatment arm for five days; the primary outcome was pain in the affected joint as described by the patient. The groups had a similar reduction in pain over the study period (80% in the prednisolone group and 88% in the naproxen group). No significant side-effects were reported in the prednisolone group.

This study provides compelling evidence for a short course of prednisolone in the acute treatment of gout, as an NSAID-sparing alternative.


This phase three clinical trial examined the efficacy and safety of recombinant activated factor VII (rFVIIa), to the ends of reducing hematoma expansion and improving survival and functional outcomes for intracerebral hemorrhages. Within four hours of the onset of stroke, 841 patients were randomly assigned to one of three groups: placebo, 20ug/kg rFVIIa, or 80ug/kg rFVIIa. The investigators measured poor outcome at 90 days using a modified Rankin scale. In addition, hematoma expansion was evaluated on repeat cranial CT scans at 24 and 72 hours after the onset of stroke.

The investigators described a reduced hematoma expansion in the group of patients randomized to 80ug/kg rFVIIa, but there were no differences between the three groups in survival or functional outcome at 90 days. In addition, the authors performed and reported on a number of post hoc analyses, which were not described in the original trial design. Readers must carefully evaluate the importance of intermediate outcome measures, and even more rigorously scrutinize post hoc analyses that fall outside of initial study design. This study’s intermediate outcome, reduced hematoma formation, did not translate into a meaningful clinical endpoint. This type of data-reporting puts a positive “spin” on the results. Based on the data that has been presented, it would be extremely difficult to justify the use of this expensive medication.

Interestingly, a quick review of the disclosures indicates that the study was funded by Novo Nordisk (the manufacturer of rFVIIa) and that several of the authors were either former employees of Novo Nordisk or held stock in the company at the time of the study.

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5. Remember that you are not alone:
I know that on several occasions during your intern year, you will feel alone. From my personal experience, going from medical school where I basically lived in a dorm with a roommate, to living by myself in suburbia was quite a drastic transition. I felt lonely, but gradually I met others who felt the same way I did. Throughout intern year, you will have many experiences - some good and others not so good.

My best advice is to share your stories; not only does this help you vent, but it also helps you realize you are not the only person that these things happen to. The best response you can get after your toughest day of work is from a co-worker saying, “I know how you feel.” Sometimes we think the stresses and strains of residency are just happening to us, but take comfort in knowing that you are not alone.

So there are my five tips for how I succeeded in being happy during my intern year. It does take work, but I am proof that it’s possible. I do want to end with some advice for non-interns: the best thing you can do for new interns is to welcome them with a positive attitude, reassurance and guidance. Remember, you were once in their shoes and can be their best resource when times get tough. Interns, you will have an amazing year of learning, not only clinically, but also about yourself and the doctor you strive to become. Just remember to stop and smell the roses along the way.
EMTALA: A Lesson in the Inevitable Futility of Forced Ethics

Damon Dietrich, MD MHCM FAAEM, Secretary/Treasurer, Young Physicians Section, President, AAEM Louisiana State Chapter, Member, AAEM Operations Management Committee

The following excerpt on EMTALA is taken from a paper written by myself and Dr. Michael Crapanzano while finishing our Masters in Health Care Management. The public health paper written in April 2006 was entitled, “Emergency Department Diversion and Overcrowding: A Public Health Crisis.” The scope of the paper is beyond this article, as its purpose was to investigate multiple critical issues contributing to ED diversion (EDD) and ED overcrowding (EDO). The paper offered solutions and action plans for decreasing EDD and EDO nationally. For the full paper and references, please email me at ddietr@lsuhsc.edu.

EDO and EDD are two of the most critical public health issues facing our nation’s healthcare system today. ED visits in 2003 rose to 114 million, up from 97 million in 1997. While visits increased by 17% over six years, 1128 EDs closed between 1988 and 1998, thus resulting in a dramatic increase in patient volumes and waiting times. US hospitals over the past ten years have closed more than 103,000 inpatient medical/surgical beds and 7800 ICU beds in an effort to control costs. The majority of the nation’s 4000 hospitals and EDs report operating at or above critical capacity. In 2001, two out of every three hospitals reported diverting ambulances to other hospitals. EDO is reported to be most severe in areas with larger populations, higher population growth and higher than average uninsured patient volumes.

EDs represent the most critical access path to the nation’s health delivery system, as the “guaranteed access point for all who need care regardless of ability to pay.” ED visits increased by 17% over six years, 1128 EDs closed between 1988 and 1998, thus resulting in a dramatic increase in patient volumes and waiting times. US hospitals over the past ten years have closed more than 103,000 inpatient medical/surgical beds and 7800 ICU beds in an effort to control costs. The majority of the nation’s 4000 hospitals and EDs report operating at or above critical capacity. In 2001, two out of every three hospitals reported diverting ambulances to other hospitals. EDO is reported to be most severe in areas with larger populations, higher population growth and higher than average uninsured patient volumes.

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The obvious benefit of EMTALA is to protect the patient’s fundamental right to emergency medical stabilization and treatment. Before EDD, hospital-owned ambulances were forced to transport all patients to their respective hospital, regardless of capacity saturation. This was detrimental to the patients, nurses, doctors and other employees. Resources were overwhelmed, and

continued on page 28
The appropriate evaluation and management of the chest pain patient remains a significant clinical challenge for the emergency physician. The emergency physician will use the history of the event, related medical history, physical examination, 12-lead ECG, and initial serum markers -- if obtained -- to determine the need for further inpatient evaluation.

The evaluation and subsequent management of the chest pain patient is thus deserving of significant review and consideration. Both the number of patients involved, as well as the potential diagnoses encountered in this chest pain patient group, when considered together, account for the significant clinical challenge.

Contemporary numbers note the significant magnitude of the chest pain patient in the ED. Of the approximately 100 million ED visits in the United States today, 8% of these patients present with chest pain; five million of these patients are admitted for further evaluation and management of the chest pain syndrome. Ultimately, whether in the ED or the hospital, almost half of these patients are diagnosed with an acute coronary syndrome (ACS) with 1.1 million AMI and 1.2 million USA cases; further, 300,000 of these admitted patients die of cardiovascular ailments. Three million of these chest pain patients are discharged from the ED with a very low rate of missed ACS (approximately 2% for both unstable angina and AMI). Thus, the “numbers” are impressive with respect to the sheer magnitude of the presentation.

Not only are the numbers impressive, but also the range of possible diagnoses, ranging from a benign musculoskeletal or gastrointestinal (GI) syndrome to a life threatening pulmonary or cardiovascular event. The differential diagnosis of chest pain includes musculoskeletal/chest wall syndrome, gastro-esophageal reflux, esophageal perforation, acute pancreatitis, other GI entities, pneumonia, pulmonary embolism with infarction, pneumothorax, aortic dissection, and acute coronary syndrome, among many other possible ailments.

In reply to this query, we will limit our response to the chest pain patient initially suspected of acute coronary syndrome (ACS) with 1.1 million AMI and 1.2 million USA cases; further, 300,000 of these admitted patients die of cardiovascular ailments. Three million of these chest pain patients are discharged from the ED with a very low rate of missed ACS (approximately 2% for both unstable angina and AMI). Thus, the “numbers” are impressive with respect to the sheer magnitude of the presentation.

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In reply to this query, we will limit our response to the chest pain patient initially suspected of ACS who is evaluated in the ED. Thus the question is as follows: Which chest pain patients initially suspected of acute coronary syndrome after ED evaluation can be safely discharged from the emergency department?

First of all, it is quite easy to identify those patients clearly deserving admission to the hospital; those patients possessing the following features in the history, examination and diagnostic studies are reasonable candidates for admission to the hospital: (1) known history of coronary artery obstructive lesions with a recurrent, altered, progressive, and/or unrelenting chest pain pattern similar to past ischemic chest discomfort; (2) acute congestive heart failure with or without persistent hypotension; (3) sustained, compromising hypotension temporally unrelated to vasodilator therapy administration; (4) 12-lead electrocardiogram with obvious, clinically concerning abnormality (ST segment deviation, new bundle branch block, or dynamic ST segment/T wave changes during the episode of evaluation); and (5) markedly abnormal serum marker occurring within the appropriate clinical context. This group of chest pain patients would be likely considered “high probability” presentations for ACS based upon the various historical, examination or diagnostic results – and would require admission to the hospital for additional diagnosis and therapy. These patients are diagnosed with STEMI, NSTEMI and unstable angina (USA) and are managed with aggressive anti-anginal, anti-platelet and ant-coagulant therapies; a subgroup is treated with percutaneous coronary intervention in urgent (NSTEMI and USA) and emergent (STEMI) fashion.

At “the other end” of the ACS spectrum of clinical concern, the emergency physician is faced with the “very low probability for acute coronary syndrome” presentation. This group of patients has a markedly lower probability for ACS due to a variety of factors such as atypical host age (i.e., quite young), unusual chest discomfort description, physical examination with obvious abnormality suggesting a non-ACS source of the pain and normal or non-worrisome 12-lead ECG, to name only the most commonly evaluated features of the presentation. These individual factors, however, must not be considered in isolation – rather, these individual issues must be considered as “one small piece” of the larger diagnostic puzzle and evaluated as part of the entire picture. Exceptions to these individual factors abound in the ACS literature. For instance, the “young” 32 year-old male patient can experience ACS; the “sharp” chest pain can be a manifestation of ACS; the chest pain which is reproducible can be encountered in AMI; and the normal or

continued on page 30
the patient invariably received inadequate care. The 2003 regulations allowed “hospital-owned ambulances ... to transport patients to other hospitals, typically the closest, appropriate hospital” not on diversion. This change created critical flexibility required in EMS systems, and thereby allowing more efficient use of resources for community benefit. As an extension of this regulation, many communities developed emergency services disaster/diversion plans that maximized the use of hospital beds, while discouraging closure of additional hospitals. For example, after Hurricane Katrina, www.gno.ems was created within one week after the hurricane as a diversion planning mechanism to facilitate flexibility for New Orleans EMS systems. Each hospital updated its respective bed status hourly. When patients were transported by ambulance, this information technology tool allowed the physician to divert the patient to a hospital with adequate resources. As a just-in-time mechanism, this plan improved care and resources in a debilitated, constrained environment.

Unfortunately, one of the major consequences of EMTALA has been its role in becoming a deleterious ingredient of EDO and EDD. The mandate set by the federal government came with no mechanisms for implementation and no mechanisms for funding. The largest impact was indirect, through the effects of legal controversy on market actors’ concerns and expectations. In effect, the alarming irony of EMTALA is staggering. The law’s intent and purpose was to ensure access for an EMC; however, in reality, EMTALA actually impedes access for an EMC by overwhelming resource capacity. Thus, its effects may be better understood by considering it from the framework of law. Law is a statement of the rules of behavior with inherent moral weight. As a beneficial mechanism to societal order, law is accessible, consistent, enforced, legitimate and universal. Furthermore, “the law is not just a set of rules, but a social institution that evolves. Statutes are born of political compromise and therefore represent best efforts of a society to reconcile different interests. Hence, law maintains stability within society as it entertains innovation and reform.” However, EMTALA is a perfect example of forced ethics by statutory regulation. In contrast to ethical codes, law represents only a minimum standard for behavior. The treatment of critical patients regardless of ability of pay addresses ethics and morality. Moral codes and ethical standards provide ideals that guide behavior beyond the minimums of law. In other words, healthcare providers have an ethical duty to treat the patient. We have all heard the horror stories. A critical trauma patient shows up on the EMS ramp. The emergency physician opens the door and asks the patient if he has insurance. When the patient replies no, the doctor closes the door and states, “take him to Charity boys.” This egregious, irresponsible and unprofessional behavior did transpire and led to the creation of EMTALA. For these doctors are the true forefathers of the EMTALA scourge- the MOTHER O F ALL UNFUNDED GOVERNMENT MANDATES. With acceptance of moral and ethical obligation, the creation and evolutionary misinterpretations of the EMTALA law would never have transpired. EMTALA was concerned with upholding basic rights and duties; however, the law deprives us of moral imagination when it invades the realm of ethics. Furthermore, the law “does not seek to inspire human excellence or distinction.” The practice of emergency medicine should not be defined by EMTALA regulatory definitions, but rather by professional standards of excellence set by hospitals and providers. The duty to treat patients should be “found not in the hard terrain of contracts or duties of justice or obligations of fair play that might hold among strangers, where philosophers have

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hoped to find it, but rather in the more fertile ground of fraternity, community and their attendant obligations.” Proper education regarding EMTALA requirements and dispelling myths is vital to any strategy for reducing EDD and EDO. The key message to impart is that stable patients should be diverted from a hospital with critical resource capacity regardless of patient request. Once a hospital is on diversion, only unstable or critical patients should be transported to that facility, assuming the facility has the resources to care for the patient.

The author’s personal experiences illustrate that many healthcare providers – doctors, nurses and paramedics – have responded to these complex issues through practice standards that ensure their own legal protection in lieu of a “true” understanding of EMTALA. One example is the common myth that if a stable patient requests a facility on diversion, EMTALA mandates that the patient must be transported to that facility regardless of diversion status. This compromises care by exhausting resources. Fear of EMTALA breach, fines and inevitable investigation create unrealistic anxiety, further perpetuating the myth. In reality, paramedics do not inform the patient of critical resource exhaustion, but rather tell the patient vaguely that he may have to wait “a little while” before being treated. A critical or sick patient cannot possibly be expected to understand the complexities of operations management or surge capacity. This is unfair to the patient, as well as the providers and hospital on diversion. EMTALA did not include a provision for patient request; rather, this provision was developed and incorporated by hospital personnel and has zero legal basis. These actions and practices are largely “understood,” and thus, it is hard to quantify the “real” impact on EDO and EDD. These ill conceived misinterpretations of EMTALA could not have been anticipated at inception. However, inappropriate extensions of the law have created the undesirable evolution where EDs do not have the resources to care for the patients.

Some direction is illustrated by the following recommendations by the American Academy of Pediatrics.19

• Improved efficiencies of Hospitals and EDs
• Optimization of primary care access
• Improvement of hospital and ED service capacity, particularly in critical care areas
• Link all patients to a medical home
• Integrated healthcare information technology system
• Reform of professional liability and tort
• Improved Medicaid reimbursement
• Education of consumers on appropriate usage of the ED
• Education of policy makers on the effects of EMTALA and possible solutions
• Additional research in the area of EDO

Essentially, a definitive solution is nowhere in sight, as it will require a massive educational campaign on what EMTALA is and what EMTALA is not. It will also require changes in public health policy, law and culture. I sincerely believe that emergency physicians (my brothers and sisters in the ED PIT or Hell’s Kitchen as I like to call it) provide beneficent service to humanity not due to a professional oath or legal requirement, but rather our fundamental, innate, moral and ethical code of conduct. We simply need the resources required to care for our patients without government interference and roadblocks. Fair compensation for provider services and ending the practice of “boarding” are essential to moving forward. Funding various solutions requires a national commitment and recognition of emergency medicine as an essential community service. As overwhelming as this task may be, we believe local facilities can provide interim support by using a “systems” view and commitment to the problem including community leaders, EMS systems, hospitals, local policymakers, patients, providers and health plan payers. ED resources must be adequate to safeguard the public’s health. We must act now.

References:
13. Internal hospital records
19. Litvak, Eugene, Ph.D. “Managing Variability in Patient Flow: Improving Quality of Care While Reducing its Cost.” Presentation of the Boston University Health Policy Institute and School of Management. (see http://www.bu.edu/mvp/)

continued on page 32
nonspecifically abnormal ECG can be seen early in the course of USA or AMI. If the clinician relies solely on a single feature to “rule-out” ACS, then the diagnosis can, in fact, be missed and the patient managed inappropriately. Yet, if the less concerning features are encountered in a cluster (i.e., simultaneously in a single patient) and are analyzed in this fashion, then the likelihood of ACS is significantly lower. For example, the patient who presents with an unusual chest pain syndrome which is entirely reproducible on examination and demonstrates a normal 12-lead ECG is very unlikely to experience ACS – the combination of these factors, encountered simultaneously in a single patient, is quite powerful in “ruling out” ACS. Such patient can be safely discharged from the ED from an ACS perspective, assuming that an appropriate follow-up mechanism exists.

Once these two extreme ends of the diagnostic spectrum have been removed, the emergency physician is left with the low-to-intermediate probability presentations – this heterogeneous group truly represents the most difficult diagnostic group in the potential ACS ED population and thus the focus of this question. In addressing this rather broad patient group, the EP will use the history, ECG and serum marker analysis as the primary diagnostic tools. In this subgroup of chest pain patients, diagnostic studies (i.e., 12-lead ECG and serum troponin values) are normal or unrevealing; the risk stratification of these patients with nondiagnostic basic study results is thus challenging.

Utilizing various features of the ED evaluation, clinical decision rules have been developed to assist in this challenging process. First, the clinical history is often taught to be a major diagnostic investigation in the evaluation of the ED chest pain patient. Sanchis and colleagues explored the value of the clinical history by itself in this evaluation, concluding that the clinical history itself is not a primary determinant of safe discharge. The study was comprised of 1,011 patients presenting to the ED; data regarding the patient’s history reviewed included the clinical presentation (pain characteristics and number of episodes), coronary risk factors and history of ischemic heart disease and non-cardiac vascular disease. The various models noted an impressive ability to identify patients at low-risk of adverse outcomes at one year. In fact, 44% of the patients were appropriate discharge candidates with an adverse event rate of only 1.4% at one year; unfortunately, the model performed less well at 30 days with an 8% rate of adverse event, largely resulting from revascularization. The authors concluded that patient selection for discharge is not reliably determined by the clinical history itself, recommending that additional ancillary tools should be considered in this decision.

Considering the clinical history and focusing on the description of the chest sensation, Schillinger et al. noted that several atypical historical features are associated with a low rate of occurrence of both AMI and adverse outcome. The authors investigated the value of historical features (symptoms, medical history and risk factors) atypical for ACS in the exclusion of acute/subacute coronary events. The study population included 1,288 ED patients with chest pain; the patient histories were separated into typical or atypical for ACS using seven discomfort descriptors. Acute myocardial infarction was found in 13% of patients; a six-month adverse event rate of 19% was observed. Atypical presentations with four or more atypical descriptors was associated with low likelihood of AMI, death and revascularization; in younger patients (aged less than 40 years) with at least four atypical features, AMI was not seen, and the adverse event rate was markedly low. Conversely, typical presentations demonstrated a markedly higher rate of AMI and related poor outcome. The authors concluded that atypical features are of value in “ruling out” ACS, yet the converse is not true – that typical features are not reliable for “ruling in” AMI and related poor outcome. Thus, these two investigations suggest that the history of the event is important but cannot be used by itself to determine the need for further work-up and ultimate ED disposition.

The physical examination has largely been of limited value in this consideration. The exception to this statement includes the identification of complications of ACS, such as hypotension and pulmonary edema – yet these patients are identifiably ill and thus the disposition is reasonably straightforward. Exploring this issue, Schillinger and colleagues asked the question – does the presence of pulmonary congestive in individuals with unexplained chest pain identify a subset of ED patients at increased risk of poor outcome? Such patients demonstrated higher rates of ACS diagnosis as well as increased risk for poor outcome. Thus, in this patient group, admission to the hospital for further evaluation and management of the chest pain syndrome and pulmonary congestion is usually warranted.

Other decision rules have incorporated not only the clinical history, but also the remainder of the ED data (examination, ECG and biomarker). In just such an application, the Vancouver Chest Pain Rule is focused on the identification of ED chest pain patients with a low risk of acute coronary syndrome – i.e., those patients that can be safely discharged from the ED. In this study, patients greater than 25 years of age were evaluated at presentation with ultimate ACS vs. non-ACS diagnosis assigned at 30 days from the initial visit; data considered in the development of the rule included coronary artery disease risk factors, chest pain characteristics, physical examination and ECG findings and cardiac biomarker results. In the 769 patients studied, approximately 20% had ACS (10% AMI and 11.4% unstable angina); the remaining 80% of the patients were diagnosed with non-ACS conditions. The decision tool demonstrated an impressive sensitivity (98.8%) in the identification of patients who were safely discharged from the ED. In this group, the authors noted that patients who exhibited a normal initial ECG, lacked previous ischemic chest pain and were younger than 40 years demonstrated a very low risk of acute coronary syndrome. In addition, in patients over age 40 years who demonstrated a normal ECG, lacked previous ischemic chest pain, had low-risk pain characteristics, and revealed negative initial/repeat serum markers were also at low risk for ACS. This rule is certainly of value in the younger patient with a negative ED evaluation – it essentially identifies a subgroup of patients who can be safely discharged from the ED after a brief evaluation; it is of less clinical value in older patients or in those individuals with a past history of ischemic heart disease; of course, these subgroups are frequently encountered in the ED.

The use of clinical decision rules in a relatively young patient population can assist with appropriate disposition decisions. Marsan and colleagues attempted to develop a clinical decision rule that young adult chest pain patients without known cardiac disease, coronary risk factors and an abnormal ECG were at extremely low risk for ACS and adverse short-term outcome. Initially, the investigators used only the data listed above; the model did not perform very well with 5.4% of patients experiencing ACS and 2.2% of patients having an adverse outcome. With the addition of serum

continued on page 31
marker results into the model, a much better predictive performance was found – in young adult patients without known cardiac history, with either no classic coronary risk factors or a normal ECG and with initially normal biomarker, the risk of ACS was extremely low (0.14%); no adverse cardiovascular events at one month. Thus, in this group, the history and ECG did not perform well; the addition of the biomarker testing, however, greatly increased the rule’s ability in this young population.

The Goldman criteria and the Thrombolysis in Myocardial Infarction (TIMI) risk score have been used for hospitalized patients in the determination of risk stratification. In this setting, these tools have performed reasonably well, yet neither has identified any subgroup of individuals appropriate for ED discharge. Limkakeng et al combined the Goldman criteria with cardiac troponin analysis in an attempt to increase the rule set’s ability to identify those low-risk patients appropriate for discharge. Unfortunately, the combination of the Goldman criteria with serum biomarkers in the ED chest pain patient did not identify a subgroup with less than 1% risk for AMI or poor outcome within 30 days. In a similar fashion, Chase et al attempted to use the TIMI risk score to describe ED chest pain patients in a risk stratification sense. The investigators found that the TIMI risk score correlated very nicely with outcome; unfortunately, the scoring system did not separate patients into discrete risk groups, allowing for the identification of individuals appropriate for emergency department release, recommending that the TIMI risk score should not be used in isolation to determine disposition of ED chest pain patients.

Serum marker analysis, primarily using the troponin assay, is an important diagnostic tool in the chest pain patient suspected of ACS. Certainly, positive biomarkers with the typical rise and fall of AMI are suggestive of acute myocardial infarction; interpretation of these values within the clinical context of the patient’s presentation including the 12-lead ECG allows the EP to establish the diagnosis of either NSTEMI or STEMI; in this setting, elevated serum troponin values are associated with adverse cardiovascular outcome. Little information is available regarding the use of serial troponin testing and ED disposition. Gaemmepagh and colleagues have suggested that negative serial troponin determinations, in the setting of a stable patient with a normal to near-normal ECG, is associated with an extremely low adverse event rate in adult chest pain patients who have competed the “rule out MI” ED evaluation. Such information is of extreme value in this patient population – the low to intermediate chest pain patient population. Chest pain patients with undetectable circulating levels of cTnI have very low rates of ACS independent of other clinical variables. In a series of patients with undetectable circulating levels of troponin upon ED presentation and at eight hrs after presentation, there were zero deaths or AMI’s and a 1.8% rate of revascularization at 30 days from time of ED visit. Measurements of highly sensitive troponin in a serial manner when combined with assessment of clinical variables (persistence of ischemic pain, hemodynamic instability, ECG changes) is a very powerful method of early diagnosis and risk assessment in the ED chest pain patient. Such information would afford the EP the ability to evaluate the patient, determine that ACS was not present and discharge the individual for timely follow-up for further risk stratification with stress imaging.

After completion of the ED evaluation, the presence of an alternative, non-coronary diagnosis is considered by some to be an appropriate discriminator in the selection of outpatient management candidates. Yet prior studies have not examined the impact of a “noncardiac” EP impression or of the utility of an obvious, alternative, noncardiac diagnosis as safe and appropriate justifications for ED discharge in the chest pain patient. Miller et al asked the question “does the initial EP impression of “noncardiac chest pain” reliably predict patients without ACS?” In this review, if the physician’s initial diagnostic impression was noncardiac chest pain after the medical history, physical examination and initial 12-lead ECG, the investigators entered the patient in the study. Of 17,737 patients enrolled, 2,992 had an initial EP impression of noncardiac chest pain; in this group, 2.8% of patients experienced an adverse cardiac event. This adverse event group was characterized as follows: older, more often male, and with more frequent medical histories of diabetes mellitus, coronary artery disease, and congestive heart failure. The authors correctly concluded that, despite an initial impression of noncardiac chest pain, traditional coronary risk factors or established histories of coronary artery disease or CHF should prompt further consideration of ACS.

Beyond the initial impression, Hollander et al compared the 30-day negative event rate in ED chest pain patients who were diagnosed with an alternative, noncardiac diagnosis with a group of similar individuals in whom a definitive diagnosis could not be established. The study enrolled 1,995 ED patients with potential ACS – 4% were ultimately diagnosed with AMI during hospitalization while, at thirty days, 4% required revascularization (4%) and 1% died. Thirty percent of patients were diagnosed with an obvious noncardiac diagnosis. The presence of an alternative noncardiac diagnosis was associated with a reduced risk of myocardial infarction, yet this noncardiac group experienced an elevated rate of negative outcome – meaning that chest pain patients, even without a diagnosed ACS etiology, have reasonably high rates of adverse event. This statement does not translate into the recommendation that “all chest pain patients should be admitted to the hospital,” rather, it indicates that appropriate outpatient follow-up is needed for these patients who obviously do not require inpatient management at the time of ED care.

At initial ED presentation, the chest pain patient is evaluated with the goal of ACS identification; with ACS considered unlikely, the EP then must explore the possibility of significant coronary artery disease. Little information is available regarding the prevalence and severity of coronary artery disease in this patient population. This study focused on chest pain patients with non-ischemic ECGs and normal serial troponin values who remained clinically stable over the initial 12 hours of care. Of the group who might be considered candidates for early discharge, 33% of these patients had evidence of coronary artery disease at cardiac catheterization. While this high rate of CAD is troubling, it does not necessarily mandate hospital admission for all these patients; rather, it emphasizes the need for careful ED evaluation and prompt medical follow-up after discharge. And, it is important to recall that the ED-based strategy in the chest pain patient changes over the time course of the emergency department stay. Early in the process, the EP is focusing on the detection and management of ACS, particularly STEMI. As time passes in the ED, the focus shifts partially to a combined strategy of ACS detection (NSTEMI and unstable angina) and significant CAD consideration.

continued on page 32
Once the ED evaluation is complete, the EP must then consider what disposition is most appropriate: admission to the hospital versus discharge with outpatient follow-up (with or without stress imagining). Lai and fellow investigators explored this issue of appropriate discharge after ED evaluation in an observation unit. The authors suggested that a negative ED evaluation involving serial electrocardiograms and biomarkers can identify patients at very low risk of short-term cardiac events – thus, appropriately selected patients can be safely discharged for subsequent outpatient testing. Other studies have noted the ability of patients to follow-up in a timely fashion. Three hundred forty-four patients were entered in the study with two hundred nine patients discharged with outpatient follow-up (with or without stress imagining). Lai and fellow investigators explored this issue of appropriate discharge after ED evaluation in an observation unit. The authors suggested that a negative ED evaluation involving serial electrocardiograms and biomarkers can identify patients at very low risk of short-term cardiac events – thus, appropriately selected patients can be safely discharged for subsequent outpatient testing. Other studies have noted the ability of patients to follow-up in a timely fashion for stress imaging, particularly if the appointment is made at the time of ED care.

Chest pain patients with recent negative inpatient evaluations for coronary artery disease not infrequently present again to the ED with continued or recurrent discomfort. The most appropriate ED evaluation strategy for these patients is often times difficult to identify. Prina and colleagues investigated the outcome of hospitalized patients discharged with a diagnosis of chest pain of undetermined origin; in this study, they identified features in the presentation which warrant further cardiac evaluation should the patient return to the ED after hospital discharge. Those “return” patients with pre-existing diabetes mellitus, established coronary artery disease, or abnormal 12-lead ECG demonstrated higher risks for adverse cardiac event; patients lacking these features experienced an excellent cardiac outcome. Thus, there is no easy answer to the question “Which chest pain patients initially suspected of acute coronary syndrome can be safely discharged from the emergency department after an ED-based evaluation?” Clearly, the high and very low suspicion presentations can be managed in relatively straightforward fashion. Yet, the low to intermediate group is troublesome. Relatively younger patients with atypical descriptions of the event and unrevealing ED evaluations likely can be safely discharged with appropriate short-term follow-up. Clearly, a stable patient who remains pain free in the ED with negative serial biomarkers and normal to minimally abnormal ECG can be discharged from the ED for further evaluation on an outpatient basis. Older patients and those individuals with a past history of ischemic heart disease likely require more in-depth evaluations.

The ED evaluation can identify patients who are safely discharged with the assumption that appropriate follow-up will occur in timely fashion. It is very important, however, to understand that the ED evaluation of this subgroup of patients is only the first, or initial, step in the process. Once the EP has considered the initial presentation and completed the ED evaluation, he/she can decide if further inpatient care is necessary; if outpatient management is acceptable, then the patient, primary care physician, and/or cardiologist bear the responsibility for completion of the process initiated in the ED.

**References**


**EMTALA - continued from page 29**

## Membership Application

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1. Have you completed or are you enrolled in an accredited residency program in Emergency Medicine?  
   - Yes  
   - No  
   **If yes, which program?**  
   **If completed, what year?**

2. Are you certified by the American Board of Emergency Medicine?  
   - Yes  
   - No  
   **If yes, date:**  
   **Type of certification:** EM  
   **Pediatric EM**

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4. Are you a member of any other EM organization? Please select all that apply.  
   - AACEM  
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   - ACOEP  
   - AMA  
   - CORD  
   - EMRA  
   - NAEMSP  
   - SAEM  
   - Other

5. If you are a practicing emergency physician, please provide your primary practice location and address:

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Email: ambereve11@hotmail.com

**COLORADO**

The Permanente Medical Group seeks BC/BE EM Physicians in Sacramento, Fresno, Modesto and the San Francisco Bay Area. You’ll enjoy 300+ days of sunshine/year, unbeatable outdoor activities (golf, tennis, boating, skiing and hiking), a close-knit, collegial environment that encourages/supports physicians dedicated to patient care and teaching, and the stability of an organization with more than 50 years serving our communities. With competitive salaries and a generous benefits package, TPMG, Inc. is expanding with a free-standing ED in Pueblo, Colorado, as well as a level IV ED in Trinidad, Colorado, “The Victorian Jewel of the West.” Pay is competitive with full benefits package, including 401k, family health, HSA and outstanding professional liability coverage through COPIC. No corporate overhead; great local control. Directorship available for additional stipend. Locations (for considerations of both practice and lifestyle) for northern NM or southern CO. Please contact Anna Olson. (PA 861)

Email: SCEMARecruiting@gmail.com

**COLORADO**

Director - Department of Emergency Medical Services, Denver, CO. Denver Health is seeking a Director of EMS. The department oversees a busy emergency department, pre-hospital system including a paramedic school and a four-year, 56-person, EM program. DH is an integrated urban safety net system with an academic Level I Trauma Center, 500-bed hospital. Candidates must be ABEM certified, have a distinguished record in clinical care, teaching, research and leadership excellence. Must be Associate Professor or Professor of Emergency Medicine. Send CV and letter to Patricia, Gabow, MD, CEO, Denver Health, 777 Bannock Street MC 0278, Denver, CO 80204-4507, or by email to the address below. (PA 905)

Email: Patricia.Gabow@dhha.org

**COLORADO**

Durango, Colorado: Opening for Board Certified/Board Eligible ED physician in Level I, 18,000 annual volume department. New, state-of-the-art facility with excellent subspecialty coverage. Democratic, stable group with partnership track available. Durango is located in southwestern Colorado with abundant recreational opportunities. (PA 906)

Email: jmccmrcs@smallcircles.com

**FLORIDA**

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

Email: rnkoury@comcast.net
Website: www.southeasterneergency.com

**IDAHO**

Northwestern Idaho - Emergency Medicine Partnership, join 4 other emergency medicine physicians, 12 hour shifts, 12 shifts per month, Hell port, 25,000 visitors/year. Compensation: Equal partners, exceptional income and benefits, college town, abundant outdoor recreation, year-round golf, 19 mile paved walking path along 2 rivers, 2 other state universities within 1/2 hour drive (one Pac 10 College), commercial airport, reasonable real estate prices, highly rated public and private schools, financially sound Regional Medical Center. Contact: Eva Page, 800-833-3449 or by email at the address below. (PA 835)

Email: eva.page@comcast.net
ILLINOIS

Urgent Care opportunity available for BC/BE emergency medicine physicians with a well established, stable, truly democratic group in the western and southwestern suburbs of Chicago. Part-time positions also available. Competitive salary. Comprehensive benefit package. Opportunity for profit sharing available. Send cover letter/CV to Lemont Walk-in Care Facility, 15900 W. 127th St. Suite 100, Lemont, IL 60439, Attn: S. Mininni, MD Medical Director, DuPage Convenient Care, LLC. (PA 876)

Email: smmvalen1@yandex.com

INDIANA

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

Email: dejongkurt@comcast.net

INDIANA

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

Email: ephajob@gmail.com Website: www.communityanderson.com

INDIANA

South Bend: Very stable, democratic, single hospital, 15 member group seeks additional BCBE emergency physicians. Newer facility. 52 visits combined at top-ranked hospitals. Level III Trauma Center, is currently seeking a BC/BE emergency medicine physician for full-time position which opened 1/2008. Competitive benefit and reimbursement package. Partnership track available with future profit sharing. 29,000 visits with 13 hours of MD double coverage daily. ED fast track now in development. Mixed to high acuity with limited trauma. Hospital is located in coastal community with outstanding schools. Located in southeastern Massachusetts, minutes from Cape Cod. One hour from Boston and Providence. (PA 841)

Email: redman5@aol.com

Massachusetts

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

Email: fliong@ckjasearch.com

Website: www.ckjasearch.com

Massachusetts

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

Email: sauljenai@gmail.com

Massachusetts

Berkshire Medical Center, a 302 bed teaching hospital and Level II Trauma Center, is currently seeking a BC/BE emergency medicine physician. Annual volume for main ED and Express Care is 54,000. All subspecialties covered including 24/7 Neurosurgical coverage. BMC is the region’s leading provider of comprehensive healthcare services. With award-winning programs, nationally recognized physicians, world-class technology and a sincere commitment to the community, we are delivering the kind of advanced health care most commonly found in large metropolitan centers. Competitive salary and benefits package is offered, including relocation. (PA 891)

Email: blpicer@bhs1.org

Website: www berkshirehealthsystems.org

Massachusetts

Established, multi hospital, democratic, physician-managed group seeking a full-time/part-time board certified or board eligible emergency medicine physicians. Group provides staffing for two sites, in the suburban Boston area, with a combined annual volume of approximately 75,000. Flexible schedule, comfortable work environment an excellent salary/benefits package. Please contact Linda Deverix at 508-383-1104 or the email address below. (PA 870)

Email: Linda.Deverix@mwmc.com

IOWA

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

Email: mkogak1@mac.com Website: www.DBerER.com

KANSAS

Seeking ER physicians to join Emergency Physicians of Salina, LLC. Salina Regional Health Center, located in central Kansas, opened its newly-renovated ER on April 30, 2008. With 25,000 visits annually, the ER physicians provide double coverage in 12 and 10-hour shifts. This community-owned, not-for-profit hospital serves a 13-county region with a combined population of more than 160,000. Additional benefits include: excellent specialist support, fast-track partnership, immediate family benefits package, profit sharing, 401K plan after 90 days, flexible scheduling, MUA-qualified facility, Visa waivers and other financial incentives available through hospital. (PA 897)

Email: ssatmfl@medicalcare resolves.com

KENTUCKY

Trover Health System is seeking an outstanding EM physician to join our team. ABEM/AOBEM or eligible physician(s) may earn $170/hr. plus benefits. Practice 12/12 shifts with double coverage during peak. 16 beds + 2 trauma rooms and 6 fast track beds. 30,000 visits annually. Electronic T-System, PACS & real time Radiology reads. Madisonville is 90 minutes from Nashville, TN, and relocation is not required, but you will want to once you sample the charm of western Kentucky. From bluegrass to blues, experience the outdoor adventures and go old fashioned southern hospitality. For more information please call 270-473-5536 or 800-272-3497. (PA 875)

Email: dbauge@trover.com Website: www.troverhealth.org

MAINE

Northern Maine is calling you! The Aroostook Medical Center, the regional referral center for northern Maine, has an opening for Department Director. The annual volume at our Level II ED is 16k. Single physician coverage with 10 hours double coverage with a physician assistant and a 24/7 in-house Hospitalist team. This is an employed position with excellent starting salary and generous benefits package. All in lovely, safe, family-friendly Maine. Town features 2 colleges and Olympic skiing facility. Full-time position, with expected 5-6 hours per week of Directorship duties. (PA 838)

Email: kmaroue@tmc.org Website: www.tmc.org

MAINE

Midcoast: Miles Memorial Hospital and St. Andrew’s Hospital are recruiting for one emergency physician to join a stable and collegial group. The two hospitals are located on the water in safe and vibrant coastal communities. The ED’s are departmentally staffed and sized to provide an outstanding level of service to the 18,000 patients they care for each year. Competitive salary and benefits package with loan support available. Emergency Medicine board certification/ eligibility preferred. E-mail CV and letter of intent to Mark Foure, MD, Emergency Medicine at the email address below. (PA 810)

Email: markt@milleshealthcare.com Website: http://www.mainehealth.org/miles_homepage. cfm?id=509

MARYLAND

Demar Emergency Specialists, an independent, democratic EM group seeks FT BC/BE EM physician. We staff the newly renovated ED at Union Hospital in Elkton, Maryland. We provide 36 hour physician coverage and 16 hr PA coverage daily for 18 core beds and 10 urgent care beds. This non-trauma ED sees 40k visits annually. Benefits include immediate partnership; malpractice coverage; health, dental, life, short-term and long-term disability insurances; relocation plan and CME allowances. Income is based on hourly rate and additional productivity based compensation. Please contact Laura Ellis, MD at 302-528-3926, or at the email below. (PA 899)

Email: lauraeliss@verizon.net

Email: dsink@egh.org
MICHIGAN
Bay City, Michigan: Opportunity for a BC/BE emergency physician at a growing, profitable hospital in Bay City through the brand new ED in September 2007. The hospital has a friendly cooperative medical staff and coverage of all the major specialties including 24-hour catherization lab availability. Our group offers a stable contract, extremely competitive compensation, flexible, fair scheduling, pension and profit sharing plans. In addition, there is the potential for partnership after two years. If you are interested in hearing more about this opportunity, please contact Kenneth Whiteside, MD FACEP, at the email address below. (PA 855)
Email: Kenneth.Whiteside@bhhsnet.org
Website: baymed.org

MICHIGAN
Longstanding, democratic group seeking board certified/board eligible emergency medicine physicians. Associated with emergency medicine residency with teaching opportunities. Level 1 trauma location and/or lower volume rural emergency departments. Competitive, equitable reimbursement and outstanding benefit package. All year recreational and “four seasons” lifestyle. Proximate to Lake Michigan and innumerable inland lakes. Excellent cultural and educational resources. Qualified emergency physicians please send CV to Attention: President of Southwestern Michigan Emergency Services, P.C. 1850 Whites Road, Suite 3, phone: 269-543-3800, fax: 269-543-6840, or email to the address below. (PA 895)
Email: swmesadmin@tds.net Website: www.swmes.com

MINNESOTA
Duluth: The Duluth Clinic is an affiliate of SMDC Health System, a nationally-recognized, 400+ physician, multi-specialty group comprised of 17 clinics and 4 hospitals. SMDC is the region’s largest provider of primary, secondary and tertiary healthcare. 23-bed ED; 38,000 patient visits, 7-bed pediatric ED and 8-bed care initation unit; admit to 333-bed hospital; adult and pediatric hospitalist support, 8-hour shifts; double coverage 19/24 hours with some triple coverage. Stretching nearly 30 miles along Lake Superior’s rugged shoreline, Duluth is one of the largest and most beautiful cities in Minnesota. Visit www.visitduluth.com or www.duluthclinic.org/career. Call Sandra at 218-786-1035. (PA 900)
Email: skramer@smdc.org Website: www.duluthclinic.org/career

MISSOURI
Southern Missouri District Hospital (SMDH) is a 25-bed Critical Access Hospital that has served Salem and the Dent County surrounding area for over 35 years. Our emergency department averages 8,500 visits per year. A great schedule with twenty-four hour shifts and only seven shifts during a twenty-eight day period. A competitive salary and complete benefit package includes: malpractice insurance coverage, medical, prescription and dental insurance and reimbursement for Continuing Medical Education programs. Located in the “Heart of the Ozarks” our community has great schools, low crime and beautiful scenic areas to experience fishing, camping, canoeing and hiking. (PA 869)
Email: adminsecretary@smdh.net Website: smdh.net

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

NEVADA
Employed opportunity with Banner Health in Fallon, NV. BC/BE emergency medicine with fully-paid malpractice with tail on departure. 24/7 Hospitalists for admissions. Competitive salary & recruitment incentives, rich benefits package & 401k retirement w/4% match after one year, CME days plus allowance and more! Fallon offers comfortable lifestyle and moderate cost of living. No State Income Tax. Close to Tahoe - snow ski in the winter, water sports in the summer! Join the BANNER HEALTH team in Fallon, NV. Send us your CV today; we’ll call you for an interview tomorrow! (PA 663)
Email: doctors@bannerhealth.com Website: www.bannerdocs.com

NEW HAMPSHIRE
Physician opportunity in Nashua, NH. Tired of being recruited by all those “big brother” organizations? Want to get the FULL amount of YOUR earnings? Want input in the management of your group? Innovative group in southern NH seeks BC/BE EP to join fully democratic group with well-established pay-for-productivity plan based on personal performance. Top performers can expect one of the highest compensations in NH. Flexible/equitable scheduling from day one. One year to partnership with full benefits. Great area of New England – 1 hour to Boston, mountains and coast. Great for family life. Contact Brian Lohnes at 603-801-6226 or by email at the address below. (PA 892)
Email: lohnleslink@hotmail.com

NEW JERSEY
Faculty candidates interested in academic emergency medicine. The Division of Emergency Medicine of University Hospital UMDNJ is an academic tertiary Level 1 trauma center with EMS medical control providing care to approximately 93,000 patients per year. We have a four-year residency program currently in its third year with a mandatory four week medical student elective. Just 20 minutes from NYC. We offer a competitive salary and benefits package. Equal Opportunity Employer. Please forward your Curriculum Vitae to, Hosseinial Shadidi, MD MPH, University Hospital, 150 Bergen Street, M-219, Department of Emergency Administration, Newark, NJ 07101. Telephone: 973-972-6224, Fax: 973-972-8646. (PA 845)
Email: shahidi@umdnj.edu Website: www.njmem.com

NEW JERSEY
Chief, Department of Emergency Medicine, UMDNJ seeks candidates for the position of Chief of the Department of Emergency Medicine. Responsibilities: oversight of emergency medicine department at UMDNJ-University Hospital, supervision of residents & students and direct patient care. Candidates must be BC in Emergency Medicine and have 3 years administrative experience in a large urban medical center. Strong clinical and teaching skills required. NJMS faculty appointment at a rank commensurate with credentials & experience. Submit letter of interest, CV and 3 professional references to: Suzanne Atkin, MD FACEP, Chief Medical Officer, UMDNJ-University Hospital, 150 Bergen St., Newark, NJ 07103. Or you may submit the information to the email address below. EOE (PA 909)
Email: atkinh@umdnj.edu

NEW MEXICO
Las Cruces: 35,000+ volume ED. Stable democratic 9-member group, W-2 income based on your share of production, full profit-sharing partner at 6 months, fully funded pension at 1 year; beautiful high desert university town; full-time position for board certified/prepared emergency physician available now. Contact William Einig, MD, 575-649-4220, weinig@mac.com; or Radovesta Wells, MD, 915-833-4546, rmittova@yahoo.com. (PA 674)
Email: rmittova@yahoo.com

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

NEW YORK
Bassett Healthcare, a multi-specialty group in central New York State, is seeking qualified emergency medicine physicians to join our staff, serving patients in our growing multi-hospital network. Key features of this position include closed medical staff, 225+ physicians, employed position with competitive salary and 12 shifts per month. Paid malpractice, health insurance, relocation, generous vacation & CME time and retirement. PA coverage and excellent support staff. Great quality of life and excellent schools in a safe environment. Bassett is actively developing a 2-year medical school clinical campus in addition to its long-standing Medicine, Surgical and Transitional residency programs. (PA 686)
Email: debra.ferrari@bassett.org Website: www.bassett.org

NEW YORK
Email: bjoness@unityhealth.org Website: www.unityhealth.org

EVADA
ER Physicians: Multiple openings at the prestigious Mike O’Callaghan Federal Hospital, Nellis AFB, Las Vegas, NV. Full or part-time openings. Serve those who serve our country while enjoying your time off in one of the most exciting cities in the USA. American Hospital Service Group has a long-standing contract at this facility placed in a city that has something to offer everyone. Board certified physicians, part-time or full-time. Any state license accepted at Federal work places, and malpractice immunity provided. Contact Jill at 410-451-2415 or by email at the address below. (PA 858)
Email: JIT@americanhospital.org Website: www.americanhospital.us
NORTH CAROLINA
Democratic group seeks FT BC/BE physician: Shelby Emergency Associates seeks a level III trauma center/50K and a community hospital 10 miles away seeing 25K. Our group is 16 years old and offers $165H plus malpractice (Pre-partnership $145H for 12 months). 401k, pretext business account, $180/H for nights. 24H hospitalist coverage for admissions in both hospitals. Top-notch nurses, medical staff and supportive administration centers super comfort work environment. $220-26 bed ER +12 bed FT completed 2007 at CRMIC. Beautiful area of NC between Asheville and Charlotte. Broad pathology never boring during 10.5 & 12 hour shifts. Midlevels at both hospitals. 704-472-7777 Please email CV to the address below. (PA 850)
Email: ebohnstedt@silvhosp.org
Website: http://www.clevelandregional.org/history.cfm

NORTH CAROLINA
Durham - Established, democratic emergency medicine group is seeking a full-time emergency medicine BC/BE physician. 50,000 patients are treated annually. We offer a competitive salary and comprehensive benefits. We are located in one of the most desirable living areas on the East Coast, close to beaches and mountains with an international airport. We have great weather all year round, excellent schools and 3 major universities. For more information please fax CV to 919-477-5474, or email to the address below. Please feel free to visit our website. EOE (PA 902)
Email: durhamemergency@ams-nc.com
Website: www.durhamemergencyphysicians.com

NORTH CAROLINA
ER physicians for FL Bragg, Fayetteville, NC. Come to this beautiful area and enjoy the outdoors has to offer when not enjoying the great work environment at Womack Army Medical Center on the Fort Bragg base. American Hospital Service Group has established itself as excelling in fulfilling Department of Defense contracts on military bases throughout the U.S. Treat those families who are serving our country! Board certified/board eligible physicians, independent contractor opportunity. Any state license accepted at Federal work places and malpractice insurance provided. Contact Emily at 800-872-8626 xt 272, or by email at the address below. (PA 839)
Email: ejvadpour@ahag.us
Website: www.americanhospital.us

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

OREGON
Portland, Oregon metropolitan area opportunity for emergency medicine BC/BE physician. 25,000 annual visits. Good hourly pay with built-in adjustment for increased volume, full benefits plan. Small hospital with responsive administration, 64 slice scanner, 24 hour US, bedside US, EMR with tracking board, hospitalist program. Looking for physician proficient with computers and EMR’s, skilled with procedures, and good people skills. Excellent nursing staff. ED techs. Good balance of pediatrics, trauma, medical and surgical patients. Contact Elizabeth Bohnstedt at 503-873-1589 or by email to the address below. (PA 877)
Email: ebohnstedt@silvhosp.org
Website: www.silverhosp.org

PENNSYLVANIA
Outstanding ED Physician Needed in State College, PA. home of Penn State University. Featuring: independent democratic group, fee/service, stable, amicable relationship with administration. Volume: 40,000 +, 42.5 physician/hours/day, 20-22 PA/hours/day, In-house dictation/transcription, excellent nursing/techs/IV team, superb admitting/consulting staff. OTR/ultrasound 24/7. University community: great schools, sports and culture, without crime. Email or call Sally Arnold at 814-234-6110 ext. 7750. Or mail: Theodore L. Ziff, MD FACEP, 1800 East Park Ave., State College, PA 16803. (PA 847)
Email: Tziff@Mountnittany.org

PENNSYLVANIA
Emergency Medicine--Exciting FT opportunity for BC/BE emergency medicine physician to join a collegial group at Taylor Hospital, a 151 bed suburban not-for-profit community hospital, twenty minutes from downtown Philadelphia, PA. Ideal candidate is residency trained and committed to providing high quality care. Taylor Hospital is a member of the Crozer Keystone Health System, major provider of community healthcare. The emergency department treats all types of patients and sees over 28,000 patients annually. This is an employed position with competitive salary, LIABILITY INSURANCE WITH TAIL COVERAGE, and other excellent benefits. Please reply with CV to pam.devito@crozer.org or gregory.cuculino@crozer.org. (PA 883) Email: pam.devito@crozer.org
Website: www.crozer.org

RHODE ISLAND
Seeking BC/BE emergency physician at 294-bed community teaching hospital affiliated with Brown University. Eleven emergency physicians care for 35,000 patients/year. Coverage 37 hours/day, plus 12 hours/PA coverage under urgent care. Hospital-based residency program provides numerous opportunities, including clinical teaching appointment. Competitive salary and benefits package: paid health/dental, life-long term disability, malpractice coverage, four weeks vacation, CME, $43B tax shelter annuities, paid professional memberships, board certified/certified, fully funded benefits. Incentive for 50% or greater commitment to night shifts. Contact Ludi Jagnamins, MD, Chief, Emergency Medicine, Memorial Hospital of Rhode Island, 111 Brewster Street, Pawtucket, RI 02860, Fax: 401-729-5112 or call 401-729-2419. EOE. (PA 872)
Email: ljjagnamins@mhri.org
Website: www.mhri.org

TEXAS
Carl R. Damal Army Medical Center at Fort Hood, Texas, is seeking a board certified emergency medicine physician. Full-time position working 8 hour shifts with a mixture of clinical and administrative duties. Serve as core faculty for the CRDAMC emergency medicine residency program. Our brand new level III trauma designated emergency department has an annual volume of 70,000 patients, low to moderate acuity. Compensation package includes competitive salary, malpractice coverage, comprehensive benefits, paid sick and vacation time, relocation allowance and annual retention bonus. For further information, please contact LTC Steve Tanksley, MD at 512-254-8302. (PA 839)
Email: Steven.J.Tanksley@amedd.army.mil

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

TEXAS
One of the only truly democratic partnership groups in DFW is seeking ABEM BC physicians to join our group. 70K volume in ED with 30+ beds located in the center of the Dallas/Worth metroplex. Every member of the group is board certified in emergency medicine and we want to continue this excellence. Competitive hourly rates and partnership track. Contact Travis Coates, MD at 817-481-4104 or by email at the address below. (PA 882)
Email: travisc@charter.net

TEXAS
The Department of Emergency Medicine at the University of Texas HSC-Houston is planning to expand its residency training program to include an additional clinical site and is seeking candidates for faculty positions. Responsible for emergency departments at Memorial Hermann Hospital (level-1 trauma center and comprehensive tertiary care facility in the Texas Medical Center) and Lyndon Baines Johnson General Hospital, a community hospital. Competitive package of salary/benefits and excellent faculty development opportunities. Forward CV to: Brent R. King, MD, Chairman-Department of Emergency Medicine, University of Texas Medical School at Houston, P.O. Box 20708, Houston, Texas 77030. (PA 887)
Email: Yolanda.V.Torres@uth.tmc.edu

TEXAS
Physicians Emergency Care Associated, established, stable group located in Dallas, Texas. Our group has staffed Methodist Health System for over 25 years. Positions available for full or part-time independent contractor. Shifts vary from a Level 2 Trauma Center, a busy, high-acuity suburban medical center and a recently opened suburban center. Individual malpractice insurance provided. Reimbursement based on productivity. Seeking ABEM BC/BE eligible EM physicians. For information, contact Stacey Dolotina, office manager, at 214-942-5733 or by email at the address below. (PA 888)
Email: staceydolotina@gmail.com

TEXAS
Amarillo Emergency Physicians, a fully democratic group in existence for 15 years, is seeking to add a BC/BE emergency physician. 45,000 annual volume, 54 hours/day of all physician coverage-no mid levels, minimal trauma, comprehensive specialty backup includes 24/7 in-house radiologist, CT/MR/US and cath lab. New state-of-the-art ED in planning phase. Productivity-based compensation exceeds $215/hour. Profit sharing plan. flexible scheduling, full equal partnership at 1 year. Contact Curtis Hudson, MD at 806-433-5658 or by email at the address below. (PA 904)
Email: texasmeyears@gmail.com

VERMONT
Seeking BC/BE emergency medicine physician in southern Vermont. Strong relationship with established hospitalist program. 15 hours of double coverage. Annual volume of 22,000. Flexible scheduling with competitive pay and benefits. Advanced airway equipment available including fiber optic intubation. Within 3 hours of Boston and New York City and skiing opportunities within 40 minutes. For more information, please contact Nicole Goswami, Physician Recruiter at the email address below or by phone at 802-447-5236. (PA 878)
Email: gosn@pnh.org
Website: www.greenmtnsgreatdocs.org

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

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

WASHINGTON
Democratic group of 13 EM board certified physicians seeking a BC/BE physician to join our single hospital group. We have enjoyed 27 years with our partner hospital, St. John Medical Center, a 193 bed, level III trauma center with an ED census of 50,000 pts/year. Consideration for full partnership after one year. In the shadow of Mt. St. Helen, our location offers a variety of outdoor opportunities. Longview is a charming and affordable city along the banks of the Columbia River. Send CV to: Holly Liberator MD, Cascade Emergency Assoc. PO Box 2404, Longview, WA 98632 or by email to the address below. (PA 873)
Email: liberatore@comcast.net

WASHINGTON
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Email: agh@medicine.wisc.edu

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