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common SENSE

The Newsletter of the American Academy of Emergency Medicine — Volume 12, Issue 1 — January /February 2005

Antitrust, ACEP and AAEM: Paralysis or Action?

The October 4, 2004 issue of *EM Today*, an ACEP newsletter, discusses an advisory opinion from the FTC and the antitrust implications of two Council resolutions proposed in 2003 regarding EM practice. Unfortunately, the ACEP spin on this matter will further solidify the paralysis caused by their leadership's mantra on the role of antitrust in professional society activities. AAEM wants you to be aware of two essential points about this matter: 1) the FTC letter only stated that these resolutions "raised antitrust issues" and did not state they violated antitrust law and, 2) the FTC letter made a specific point that professional societies can advocate for its members and the public, a point that validates AAEM's efforts!

Unfortunately, the conclusions reached by ACEP's leaders on this matter will leave us with the current state of affairs where the largest professional society has adopted the stance that it cannot intercede on behalf of the working emergency physician in their dealings with corporate EM. Additionally, the conclusions ensure no foreseeable change in the status and exposures afforded corporate groups in ACEP circles. They will continue to be accepted without challenge as a basic part of the EM fabric. Residents will continue to be exposed to ads, marketing, awards and receptions by all types of corporate staffing and management groups as a result of this latest policy

episode. Did it have to turn out this way? How can AAEM do what it is doing? Is ACEP right and AAEM reckless? Importantly, as you will see, one can take the same FTC letter and make the case that it is AAEM that is on the right track!

First, a little background is in order. The two 2003 resolutions were based on AAEM policies about notification of intent to bid on an ED contract and on the certificate of compliance for EM groups. The first critical and debatable decision was to send these directly for a FTC opinion rather than having them worked through a committee or other internal body first. Regardless, the FTC has weighed in and the ACEP response to this is contained in the *EM Today* article, excerpted below, (full article available at www.acep.org/1,34091,0.html) which quotes from the FTC opinion letter:

"The proposed rules appear capable of harming competition in the provision of (emergency physician) services, and thus raise antitrust issues," according to an opinion dated Aug. 30, 2004 and signed by Jeffrey W. Brennan, the FTC's assistant director of health care services and products.

continued on pg 4

AAEM Members Help Secure "Open Books"

You did it! A tremendous show of support by the AAEM membership has successfully secured CMS language that states physicians have "unrestricted access to claims submitted" in their name. In the Federal Register on November 14, 2004 where CMS issued its final rule on the Medicare Modernization Act (MMA) it was reported that "numerous members of that association (AAEM) commented" on the reassignment matter. As you may recall, through the efforts of AAEM, the issue of open book was brought to the attention of CMS and, more importantly, the congressional conference committee for the MMA where this wording was incorporated into the CMS integrity safeguards. The footprint of AAEM is on this important ruling from beginning to end and can be clearly seen if one reviews the comments and CMS' responses in the Federal Register (p372-833).

Equally important to note is the vigorous opposition launched by the contract groups to prevent emergency physicians from having access to this information. Opposition that proves the importance of this ruling for the working emergency physician. Here is a direct quote from the Federal Register:

"Three commenters representing groups that utilize independent contractor emergency physicians strongly oppose our implementation of the two proposed program integrity safeguard requirements: (1) joint and several liability/responsibility for Medicare overpayments; and (2) unrestricted access to the billings for services provided by independent contractors."

Regarding joint liability, these groups wanted the liability to reside solely with the physicians. They pointed out that the CMS-855-R enrollment form currently only holds the physician responsible.

Secondly, these commenters, of course, saw no need for unrestricted access to claims. CMS fortunately rejected these suggestions. CMS' response included information directly supplied by AAEM about prior upcoding activities of billing firms associated with ED contract groups. CMS, in the response, also references the reports by AAEM members of the threat of termination if one seeks access to the claims submitted on their behalf.

AAEM members should note that CMS intends to monitor the unrestricted access to claims as it is a program integrated safeguard. CMS states that independent contractors should report any denial of such access to the appropriate Medicare contractor. A physician can quickly locate their Medicare contractor on the CMS website, the direct link is www.cms.hhs.gov/medlearn/tollnums.asp. Look for provider services for Part B. Please make AAEM aware of any communications you have along these lines.

AAEM is exploring ways in which the organization can further assist its members in this area. We thank those members who supported this important effort. As noted above, their actions were critical in countering the efforts of the ED staffing industry to limit the rights of emergency physicians.

- 1 AAEM ANTITRUST
- 2 PRESIDENT'S MESSAGE
- 8 CANDIDATES STATEMENTS
- 19 JOB BANK
- 16 WASHINGTON WATCH



PRESIDENT'S MESSAGE

by A. Antoine Kazzi, MD, FAAEM

'Make no little plans. They have no magic to stir men's blood'

Daniel Burnham, 1846-1912, Chicago architect & father of the modern skyscraper

This issue of Common Sense has a number of important updates. Please read the separate articles and letters very carefully. One of them highlights a landmark "Open Books" victory that AAEM has finally achieved for all emergency physicians (EPs). Very recently released CMS regulations require any staffing companies and contract holder(s) to provide, as of January 1st 2005, EP unrestricted access to his/her individual Medicare billings. Another article updates you on the status of our planned legal challenge to EmCare in Minnesota. You also find the official letter sent by AAEM to the Florida Board of Medicine and a landmark article titled "Antitrust, ACEP and AAEM." In the latter, Dr. McNamara and I were responding, on behalf of AAEM, to recent widely publicized ACEP claims about an FTC opinion they had obtained about proposed ACEP Council resolutions that mirror AAEM policy. You will also find additional information on the upcoming Third AAEM-EuSEM Mediterranean EM Congress in Nice, France.

AAEM is currently exploring a legal challenge to the largest US emergency physician staffing company - EmCare - for its violation of the statutes restricting the corporate practice of medicine in Minnesota, and has authorized a legal initiative to reverse the Florida Board of Medicine decision regarding AAPS/BCEM. Last but not least, AAEM would have begun implementing its national strategy to deal with a very recent historical crisis: the recent PhyAmerica bankruptcy malpractice debacle that has left at least 70 emergency physicians hanging without insurance coverage in the middle of malpractice lawsuits filed against them. They are suddenly now being asked to pay out of pocket their legal costs, their lawyers and expert witnesses and any settlement or judgment that is decided on their cases. This is a terrible travesty that will have a variety of landmark national repercussions and a great impact on every EP's practice environment, career longevity and well-being.

In my last President's Message, I provided you with the first part of an overview of AAEM activities and short-term strategic plans.

The first part of the overview focused on the following 4 areas: 1) Fairness in the workplace and the empowerment of emergency physicians, 2) Patient safety through the promotion of EM as a specialty, 3) the provision of outstanding and reasonably priced educational conferences and opportunities, and 4) Membership.

In this President's Message, I will provide you with the second part of this "AAEM Overview."

AAEM OVERVIEW - PART II :

4) The AAEM Foundation & the AAEM Political Action Committee (PAC):

In order to better advocate for patients and emergency physicians, AAEM must have the financial resources to do so. Advocacy, lobbying and legal battles are very expensive. Bowing under such pressure, individual EPs traditionally agreed to unfair terms that are commonly forced upon them by contract holders and staffing companies. Individual EPs cannot do it alone. AAEM has the will and the record to prove that it will stand and fight for the rights of patients and physicians alike against any forms of corporate greed, excesses and exploitation. To better advocate on your behalf, AAEM has recently established the "AAEM Foundation" to which physicians can donate tax-deductible contributions by going to our website at www.aaem.org.

Note that this "AAEM Foundation" is a different non-profit entity than AAEM and the AAEM Political Action Committee (PAC). Donations into the "AAEM Foundation" are deposited into a different fund than the AAEM PAC fund, which you will also find on our website. The "AAEM Foundation" is there to support AAEM. It is not intended for influencing legislators or for our lobbying efforts. The AAEM PAC - a separate entity than AAEM and the "AAEM Foundation" - is charged with supporting legislative and lobbying activity at the state and national levels. Of course, both of these funds are critically important to promote and advocate for the specialty and the well-being of our patients and specialists. AAEM needs you to support BOTH funds.

If you wish AAEM to take initiatives on behalf of the EPs toiling at the bedside when they need their professional society to do so, STOP reading this message. Go to any computer internet access and login to the AAEM website. Please contribute to the AAEM Foundation AND the AAEM Political Action Committee (PAC) fund. Your help and support is vital with that regard. Lawyers,

continued on pg 7



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AAEM Mission Statement

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

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

Membership Information

Fellow and Full Voting Member: \$345 (Must be ABEM or AOBEM certified in EM or Pediatric EM)

Emeritus Member: \$225 (Must be 65 years old and a full voting member in good standing for 3 years)

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

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

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

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

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



EDITOR'S LETTER

by Howard Blumstein, MD FFAEM

Antitrust Fuss

This issue of *Common Sense* features two articles that discuss the recent Federal Trade Commission advisory solicited by ACEP and the handling of this advisory. The purpose of this editor's note is to give the background information necessary for the reader to understand what is going on and to try to place this issue in context.

The Sherman Antitrust Act of 1890 was designed to prevent a single entity, or a conspiracy of entities, from exerting unfair forces upon a free market to the detriment of consumers. Initially used to break up large monopolies such as Standard Oil, its scope has been expanded over the years. Recent examples of monopolies attacked under the act include the breakup of AT&T and, more recently, the federal government's lawsuit against Microsoft.

Antitrust concerns have been raised in organized medicine over the last several years. Every AAEM member should be aware of the Daniels suit. Named after the lead plaintiff, this lawsuit claimed that ABEM and a large number of codefendants conspired to prevent physicians from competing for practice opportunities by closing the "practice tract" that allowed experienced physicians to become available to sit for the boards. The lawsuit threatened to undermine the training and certification process that had evolved over many years. The case lingered from its filing in 1990, until it was finally dismissed by a federal judge in 2003 (abem.org/public/portal/alias__Rainbow/lang__en-US/tabID__3339/DesktopDefault.aspx#one).

In 2002, an antitrust lawsuit was filed by three physicians who had gone through the National Residency Match Program. They claimed that the program unfairly interfered with residents' and potential residents' ability to seek fair wages and working conditions. This lawsuit was dismissed after federal legislation was passed protecting the program.

Antitrust issues have recently been raised in the performance and structure of organized medical societies. The American Association of Medical Toxicologists and the American College of Medical Toxicology are two separate organizations. However, in order to join the AAMT, members also had to join the College of Medical Toxicology. Billing for dues for the AAMT was carried out by the College as well. Because of antitrust concerns raised by an attorney for the AAMT, this relationship was ended.

The genesis of the most recent controversy occurred several years ago, when AAEM began to require that advertisers and exhibitors at our meetings represent groups that are equitable and democratic. Specifically, the issues centered on fair reimbursement, equitable working conditions, democratic group structure and open access to accounting data.

In 2002, concerned about the possibility that this practice could represent violations of antitrust regulations, the board of directors sought legal advice. The resulting opinion discussed the relevant regulations and concluded that this prohibition could not be construed as an unfair restraint on business and thus did not constitute antitrust violations.

In 2003, two board resolutions were adopted. The first was a position statement that defined what constituted a democratic group. It created a certificate of compliance. Any physician group that wished to advertise in AAEM literature or recruit at our meetings would be required to complete this certificate, stating that they were in compliance with AAEM principles as defined in the resolution. The second resolution stated that AAEM members competing for hospital contracts had an ethical obligation to notify other AAEM members who already worked there. This resolution

came about because of recent events in which AAEM members may lose their contracts and possibly their jobs because of other members secretly bidding for, and taking over, hospital contracts.

Joe Wood and Antoine Kazzi, then the president and vice president of AAEM, were also members of ACEP. They submitted two resolutions for consideration by the ACEP council that were very similar to those described above. The ACEP council decided to seek legal advice regarding these two resolutions. The attorneys involved submitted the resolutions to the Federal Trade Commission for an advisory opinion regarding whether or not these resolutions violated antitrust regulations.

In the advisory opinion dated August 30, 2004, it was stated that it is unclear "... what possible procompetitive justification might exist..." in requiring notification of fellow members when submitting bids to take over a contract. The opinion goes on to conclude that the "... absence of any pro competitive rationale for the rule may suggest that it is designed to protect incumbent contract holders from competition." Two very important points must be raised about these comments. The first is that there is an obvious pro competitive rationale; more entities bidding for a contract means more competition and lower prices. Secondly, the opinion does not indicate that this is a violation; it only raises the possibility of a suggestion.

In the discussion regarding the requirement for a certificate of compliance with AAEM democratic principles, the advisory opinion noted that the ACEP meeting is the largest gathering of emergency physicians in the world. As such, requiring a certificate of compliance might represent problems. Meeting size was one of the key issues recognized in the legal opinion sought by AAEM in 2002. However, the advisory opinion went on to state "... we cannot predict what the effect of [this] proposed resolution would be, or whether it would provide a basis for antitrust liability..."

The real controversy lines in the manner in which ACEP handled the advisory opinion. The October 4, 2004 edition of *EM Today* (www.acep.org/1,34091,0.html), contained an article entitled "FTC: ACEP Resolutions Have Antitrust Implications." The article uses selective quotes from the advisory opinion and statements about restricting competition from ACEP officials that go beyond the scope of the resolutions in question. The article stated that Joe Wood, immediate past president of AAEM, was one of the authors of the resolutions. It also stated that similar policies had been adopted by AAEM. The clear implication is that AAEM is violating antitrust regulations. The article concludes by stating that one of the policies had been rescinded and the other had been "significantly altered."

Just to set the record straight, the policy concerning notification of fellow AAEM members when submitting the competitive bid was rescinded before the FTC issues its opinion. Although there was discussion of antitrust implications, the main reason it was rescinded was because we could not figure out a practical way to make this work smoothly. Changes in the policy requiring a certificate of compliance were merely clarifications regarding the characteristics of groups that complied with AAEM principles.

I will allow others to meditate upon the question of why ACEP felt it necessary to publicize the advisory opinion in this manner.

It seems clear to me, however, that nobody wins when professional societies are dragged into arguments about antitrust issues. I do not wish to downplay the importance of complying with these regulations. But the various organizations that have been dragged through these muddy waters, ABEM, the NRMP and AAEM, have all had good intentions. They have all sought fairness and public benefit. Efforts to interfere with these organizations' work or to sully their reputation by claiming antitrust violations have resulted in nothing but gnashing of teeth and excessive legal fees.

It is time for leadership in emergency medicine to reassess the amount of effort being put forth in antitrust issues. ■

One proposed resolution would have required emergency physician staffing groups to agree to certain specified business practices in order to participate as an exhibitor or sponsor any ACEP activities. Mr. Brennan stated in the letter that ACEP may not restrict competition by forcing its preferred model on all contractual relationships providing emergency services. He pointed out that the Supreme Court has noted that consumer choice, rather than the collective judgment of the sellers of services, should determine the range of available services.

"An agreement among ACEP members to affiliate only with entities that adopted all of the business practices listed in the proposed resolution would be highly suspect," the letter stated. "Agreements among ACEP members not to do business except on the terms contained in the resolution, or a direct ACEP prohibition of its members' accepting employment on non-conforming terms, would raise serious antitrust concerns."

The interpretation of this FTC response has worked its way through the channels and has been widely dispersed throughout the ACEP membership via national and state level publications. Resident leaders of AAEM have let us know that EMRA has accepted this as proof that they cannot restrict corporate groups from advertising or sponsoring their awards and receptions. It is evident that what is being said from all of this is along the lines of "we told you so, ACEP can do nothing in these matters". Perhaps this is the only answer ACEP wants but there is another side to the story that needs to be examined.

Importantly, as you can read for yourself above, the FTC's anti-trust concerns allude to concepts well beyond what was called for in the resolutions. Nowhere was it stated that this would require ACEP members to "affiliate only with entities that adopted all of the business practices listed." AAEM does not require this of its members, has no plans of doing so and, in fact, has had board members who worked for corporate groups! Secondly, you need to see what was left out of this article in order to interpret the seriousness of the concerns. Specifically, regarding antitrust implications, the Brennan letter focused on "whether the exclusion of non-complying entities from (advertising in) ACEP activities and publications would likely have a significant effect on the ability of those firms to recruit emergency physicians and thus to compete in the market". The question would be how this exclusion would be weighted against all of the other venues the corporate groups have for recruitment (EM News, EP monthly, e-mail, direct mailings, non-ACEP conferences, etc.).

Finally, and most importantly, there has been a glaring lack of attention to the final paragraph of the FTC letter, reproduced below, which can easily be interpreted as justifying everything that AAEM has been doing and raising questions as to why ACEP has been so paralyzed. Brennan states this: "Professional associations can, of course, respond to market conditions or behavior of market participants that it believes are detrimental to its members or the public. Antitrust law recognizes the right of groups of competitors to provide information and express their opinions. For example, nothing in the antitrust laws prohibits ACEP from providing information and fostering discussion about the costs and benefits of various means of providing contracted emergency medical services to hospitals. ACEP may also represent the interest of its members in discussions regarding, for example, Medicare billing requirements for emergency physicians. Such conduct can benefit consumer competition and welfare."

CAN respond to behavior of corporate groups that it believes are detrimental to its members or the public! Let's see now, we have a lack of due process for emergency physicians leaving them vulnerable to being fired when raising issues about the quality of care. We see restrictive covenants that affect the quality of care and the physician's professional life by removing them from a patient population and care system they are familiar with in the name of protecting the company's interest. We have the critical issue of state prohibitions on the corporate practice of medicine that can place a physicians' licensure at risk as well as violate public policy. AAEM has been involved in numerous situations such as Mount Diablo and Catholic Healthcare West where these issues have been central to the matter and where ACEP has chosen to do nothing because of antitrust concerns. AAEM continues to engage in this area as witnessed by our recent actions in Minnesota. Are we in violation of antitrust rules or fulfilling our duty to our members and the public as suggested by the last paragraph of the Brennan letter?

There are various ways to interpret this FTC opinion. ACEP has apparently chosen to take this matter as a chance to reinforce their fears about the antitrust boogey man. You need to look at this for yourself. AAEM, the smaller of the two professional societies, does not intend to alter its course and remains alone in addressing the corporate control of EM. We appreciate the support of our members and urge them to recruit colleagues to join our efforts. Hopefully, knowledgeable ACEP members will not let this interpretation of the FTC opinion go unchallenged and seek to get that society moving forward with us on this front.



Antoine Kazzi, MD FAAEM



Robert McNamara, MD FAAEM

If you would attain to what you are not yet, you must always be displeased by what you are. For where you are pleased with yourself there you have remained. Keep adding, keep walking, keep advancing.

- Aurelius Augustinus (St. Augustine), 354 A.D. – 430 A.D.



Faced with the choice between changing one's mind and proving that there is no need to do so, almost everyone gets busy on the proof.

- John Kenneth Galbraith

After you've done a thing the same way for two years, look it over carefully. After five years, look at it with suspicion. And after ten years, throw it away and start all over.

- Alfred Edward Perlman, New York Times, 1958

THE VIEW FROM THE PODIUM

Motivation and Medicine

by Joe Lex, MD FAAEM

SCIENTIFIC ASSEMBLY

AAEM's 11th Annual Scientific Assembly is put together and it's a winner. The top speakers from 2004, as determined by your evaluations, are invited back, so you'll hear plenary sessions from favorites Michelle Lin, Bruce Hart, Amal Mattu, Jeff Tabas, Ghazala Sharieff, Larry Weiss, and Peter DeBlieux.

Other favorites include Annie Sadosty, Mel Herbert, Rob Rogers, Ray Johnson, Rob Spence, Ed Panacek, Bill Brady, and Kevin Rodgers. You'll hear some voices new to AAEM, including Steve Selbst and Steve Hayden. You'll hear two Open Microphone winners from 2004, Mike Winters and Nate Shapiro.

There are several panel discussions. One is on communications and led by Scott Diering; it features physicians Peter Rosen and Jay Kaplan, and communications expert Quin Schultze from Calvin College in Michigan. Another is on medico-legal issues and features four AAEM members who are MD, JD – Joe Wood, Bob West, Bruce Hart, and Larry Weiss. The third will highlight recent CMS (Centers for Medicare & Medicaid Services) changes that affect the way we practice.

And if you're really curious to know what all the fuss is about different practice environments, you won't want to miss the panel discussion organized by the Residents' Section of AAEM. Peter Rosen, MD FAAEM, serves as moderator for a session featuring ACEP President Robert Suter, Team Health President Lynn Massingale, EMP COO Dominic Bagnoli, AAEM former President Robert McNamara, and SAEM President Carey Chisholm.

You'll get a debate on the topic "D-Dimers Are Useless," featuring Billy Mallon. You'll get the second version of SPRINT from Larry Raney.

As usual, there is no charge for AAEM members. Your Scientific Assembly is a member service and allows you to accumulate more than 18 hours of AMA PRA Category I hours.

Add to this the Open Microphone Session and the Pre- and Post-conference Courses...and you'll understand why we brag about this event. Call now for reservations at the Hilton La Jolla Torrey Pines in La Jolla (San Diego), California, February 17, 18, and 19, 2005; it's another superlative educational experience. If you haven't received your course syllabus yet, you can download one at www.aaem.org/education/scientificassembly/sa05/preprogram.pdf.

PRECONFERENCE SESSIONS

Come a day or two early and learn some new techniques in managing the difficult airway, or ultrasound-guided procedures. Pick up some new tricks about EKG interpretation or practice some little-performed pediatric procedures on lifelike models. Bring a Wi-Fi enabled laptop and get your 2004 ConCert exam out of the way with the help of

experts. Learn the Business of Emergency Medicine from experts or sharpen your Presentation and PowerPoint skills. Learn how to read a CT scan from the "man who wrote the book." If you practice in California, you can get your Bill 487 required 12 hours of End-of-Life and Pain Management credits over two days. And stick around Saturday afternoon to find out why the AAEM "Jam Session" is a favorite destination for people taking ABEM's Written Certification and Recertification Examinations.

JAM SESSION

Speaking of the Jam Session, it was another unqualified success this year. More than 120 ABEM Written Board candidates gathered the night before the exam in a hotel room in Atlanta, Chicago, Dallas, Los Angeles, and East Brunswick (NJ) to hear a summary of the Core Content delivered by AAEM members Larry Raney, Sam Mossallam, Kevin Rodgers, Nounou Taleghani, and Course Director Amal Mattu. Drs. Mattu and Rodgers will present this same Jam Session on Saturday afternoon, February 19, as a Post-Conference session designed for emergency medicine residents who have their In-Training exam on Wednesday, February 23.

IICE

At press time, I don't have any further details about AAEM's involvement with the 1st International Interdisciplinary Conference on Emergencies (IICE) in Montreal from June 25- 30, 2005, just before the world-famous Montreal Jazz Festival (www.iice2005montreal.com). AAEM has promised to provide several top-quality speakers to this gathering of more than 3000 specialists from around the world. Save the dates now and I'll give you an update in the next *Common Sense*.

MEMC3

But if you can't make it to Montreal, then you must find a way to attend MEMC3 – the 3rd Mediterranean Emergency Medicine Conference in Nice, France, September 2–5, 2005. It will be one of the most jaw-dropping conferences you could imagine (www.emcongress.org). Ghazala Sharieff and I serve as co-chairs of the Scientific Committee for the United States, with assistance from Richard Shih, Amal Mattu, Ramon Johnson, and Larry Weiss. We can already guarantee attendance and presentations by the top names in American Emergency Medicine – Peter Rosen, Judy Tintinalli, Jerry Hoffman, Rick Bukata, Diane Birnbaumer, Mel Herbert, Billy Mallon, Lewis Goldfrank...the list goes on and on. Our European counterparts are doing the same – recruiting the biggest names and the best speakers for an unforgettable experience on the French Riviera.

MEMC2 in Sitges, Spain, during 2003, allowed more than 1300 emergency medicine specialists from 66 nations to gather and to share ideas and opinions in a beautiful resort town on the shores of the Mediterranean Sea. It involved the official participation of national specialty societies for more than 40 countries with the presentation of 806 abstracts. We expect the gathering in Nice to be even bigger and more exciting.

AAEM will offer more than 20 hours of ACCME-approved American Medical Association Physician Recognition Award (AMA PRA) Category I credits.

continued on pg 6

AAEM HELPS FOSTER PHYSICIAN OWNERSHIP

by Robert McNamara, MD FAAEM

On November 17, 2004, I spoke on the “Current State of Emergency Medicine” at the SUNY Buffalo Residency Program. In attendance was AAEM member, John Radford, MD, who related that he, as a SUNY Buffalo Resident, had sat through this same talk five years ago and was motivated to take action to secure his future. John, with several colleagues, took the AAEM preachings and put them into practice successfully creating a model democratic group in Buffalo.

With the advice and support of the Buffalo academic faculty, and despite no “business” expertise, they were able to carve out a rewarding career. Some of it was out of necessity as they wanted to stay in Buffalo and democratic positions were scarce. Now, John and his group are doing their best to create opportunities for the current Buffalo residents by seeking another practice site to insert their model. This is one example of the value of AAEM but by no means the only example. It has been one of my greatest rewards to listen as numerous emergency medicine physicians tell a similar story. They either heard an AAEM talk or read our literature and then moved to seek ownership of their practice.

The experience above was four-short-days after an AAEM Board meeting where the evidence of our fulfilling the vision and mission in this regard was substantial. In the early years, all AAEM could claim was credit for raising the alarm and bringing the dangers of a steadily increasing loss of physician ownership to the attention of the EM physician community. We were shouted down and told that corporate domination was inevitable and not preventable by the actions of a professional society. Dr. Radford’s story exemplifies why it was important for AAEM to persist and to succeed.

Today, AAEM does much more than talk. We are actively engaged in the creation of physician ownership. This was the vision of AAEM that the early leadership knew we needed to fulfill. At the board meeting, we heard reports of a successful course entitled “The Business of Emergency Medicine” run by our Vice President, Tom Scaletta, MD. This is a course laying out the exact steps for emergency medicine physicians to take if they wish to become owners of their practice like Dr. Radford. At the board table was Dee Breaux, who through AAEM services offers valuable consultative help on practice start-up, contract acquisition and

maintenance with AAEM values at the core. The board, recognizing the threat of the malpractice crisis to the independent group, endorsed EMPAC, an emergency physician owned and operated risk retention group that is focused on the value of emergency medicine board certification. The government affairs representative indicated that the tremendous response from our members preserved the CMS language that physicians shall have “unrestricted success” for billings in their name.

Finally, in a clear rejection of the “nothing can be done” stance of the rest of organized emergency medicine, the board allocated substantial funds for the engagement of legal representation in Minnesota to address the corporate practice of medicine concerns raised by the awarding of an emergency department contract to EmCare, Inc.

You can take comfort and pride in the fact that the vision and mission are being fulfilled by AAEM. At the end of the day, the creation of groups like that started by Dr. Radford and his colleagues is the bottom line. These physicians are practicing in the model that is best for the patient, the hospital, the medical staff and the emergency physician. The physician owner is invested in the practice and highly motivated to provide the best care and service to the patient. As Dr. Radford describes it, to be in practice with one’s peers where each works for the common good of the group with no concerns about exploitation or unfairness, allows the physician to thoroughly enjoy the practice of Emergency Medicine. Such an environment encourages longevity and will allow residency graduates to have a long and successful career. Academic programs such as SUNY-Buffalo, that allow their residents to hear the AAEM message and then encourage them in pursuing ownership, deserve credit. Faculty members such as these are taking the extra step in looking out for the future of their current residents. We hope that someday all academic programs will open the door to AAEM and no longer deny their residents the chance to hear, as Dr. Radford did, an alternative vision of the future of emergency medicine practice.

With your support, AAEM will continue to spread its message and to actively engage in promoting physician ownership. Thank you for your membership. 🇺🇸

View from the Podium - continued from pg 5

This is a wonderful opportunity for you to experience the best of the Mediterranean coast on the Côte d’Azur with its proximity to Antibes, Beaulieu-sur-Mer, Cannes, Juan les Pins, Monaco, Villefranche-sur-Mer, and Monte Carlo. The weather is still marvelous in Nice during early September. You can easily see why artists like Marc Chagall, Fernand Léger, Pablo Picasso, and Henri Matisse were drawn to the area and have museums representing their work in and around the city.

Whether you are new to the MEMC, or you have already experienced the “magic” in Stresa, Italy, or Sitges, Spain, we know that you will find tremendous rewards with this experience. If you need even more convincing, visit www.nicetourism.com for more information.

SPEAKERS’ BUREAU

Just another reminder that if you want to invite one of AAEM’s world-renowned speakers to your hospital for Grand Rounds, or to your residency programs for a series of talks, we’ve made it easy for you. Download the catalogue from www.aem.org/speakersbureau.pdf and see how easy it is to get a high-quality speaker with minimal effort. If you want your own copy of the catalogue for future reference, contact Tom Derenne at tderenne@aaem.org. AAEM member Larry Raney is chairing this fledgling project, which we expect, will be quite successful.

RECOMMENDED READING

I’ve just finished a remarkable book by John Abramson, MD, called *Overdo\$ed American: The Broken Promise of American Medicine*. It’s a very well written explanation of why science - and many major medical journals - failed to give us the appropriate information about new medications. Coming to publication at about the same time as the US Market withdrawal of Vioxx, I found it a particularly timely read and strongly recommend it to all physicians and medical students.

Almost as good is Marcia Angell’s *The Truth About the Drug Companies: How They Deceive Us and What to Do About It*, also released this fall. Dr. Angell was Editor in Chief of the New England Journal of Medicine and presently serves as a Senior Lecturer in Social Medicine at the Harvard Medical School. Her title is self-explanatory.

Finally, there’s *Powerful Medicine*, by Jerry Avorn, MD. He’s chief of the Division of Pharmacoepidemiology and Pharmacoeconomics at Brigham and Women’s Hospital in Boston and presents a slightly different spin on the same topic as the two above-mentioned authors.

While I recommend all three books as fascinating reads (I read Dr. Avorn’s book during a round-trip cross-country flight), the Abramson tome is essential. Treat yourself to a fascinating look at prescription drugs and bad science. 🇺🇸

lobbying and lawsuits are very expensive and the AAEM professional dues alone cannot support adequately what we wish to do with this regard.

The majority of EPs have experienced exploitation, fee-splitting, unfair business practices, job threats and termination while simply trying to do their best for their patients. Think back about what you have personally experienced in the past or going through right now. Remember this could be you that we will need to step in to defend or to support at some point in your EM career. Help us keep this option open - to intervene legally on your behalf. Support the AAEM Foundation AND the AAEM Political Action Committee.

5) Political Presence in Washington, DC:

Our AAEM presence in Washington DC is not new. AAEM has maintained such an official representation in our national capital since 1998. However, our lobbying activity gained huge momentum 2 years ago when we first contracted Ms. Kathleen Ream and her DC firm to represent AAEM. Ms. Ream, AAEM's Government Affairs Director, was already very familiar with EM issues through her experience representing other national EM organizations. This was extremely effective in rejuvenating our national legislative activity. Working closely with our Executive Director and Committee, our lobbyist has been coordinating 1) our legislative activities and dialogues with government, legislators, medical organizations and agencies such as CMS and the OIG. Working with our Governmental Affairs Committee (GAC) and its chair Dr. McNamara, our lobbyist also produced three national services that have been most effective in getting the AAEM voice heard where and when the need is identified:

- The *Washington Sentinel* is our newly launched-monthly electronic newsletter published by AAEM and our lobbyist on behalf of the AAEM Governmental Affairs Committee. Four issues have already been widely disseminated, are available on the AAEM website, increasing our national visibility and membership awareness on this frontline.
- The *Washington Update* is a dedicated section in Common Sense. It has been rejuvenated by Ms. Ream. Bi-monthly articles provide carefully selected legislative updates of relevance to EM and to our members.
- Last but certainly not least, the *AAEM Legislative Action Center (LAC)* is an exceptionally valuable AAEM service that quickly proved itself to be a most effective system for effective communication and input between AAEM, members and leaders, and the legislature. Available through www.aaem.org, the LAC enables - within minutes - any emergency physician to identify his/her federal or state legislators or the key legislators working on specific committees, and to then send them a personalized fax, email or letter based on a template we post on the website. Users can also quickly establish any legislator's voting history and prior or current positions on certain issues.

The AAEM Legislative Action Center electronically remembers your personal data the first time you use it - making this effort very rapid and user-friendly. It literally takes 2 minutes to get counted and to express your point to your legislators. This AAEM service has been most effective in carrying our voice to Senators and Congressmen Representatives as well as to national and state agencies. The AAEM LAC has received abundant positive feedback from members and non-members who have used it in large numbers when invited to respond to our calls for action and for letter-writing. This exceptional response rate and the effectiveness of this service is actually evident in the comments to the new regulations published by CMS in November 2004. CMS clearly states that one professional organization (AAEM) and numerous EPs provided official input to CMS requesting that CMS mandates its new requirement that individual EPs have unrestricted access to their Medicare billings. AAEM, through its Legislative Action Center, was alone in sending a national call for comments to over 22,000 EPs asking them to contact CMS and to request that CMS adds unequivocal requirement for unrestricted access to the books. As you may recall, through the efforts of AAEM, the issue of open book was brought to the attention

of CMS and, more importantly, the congressional conference committee for the MMA where this wording was incorporated into the CMS integrity safeguards. The footprint of AAEM is on this important ruling from beginning to end and can be clearly seen if one reviews the comments and CMS' responses in the Federal Register (p372-833).

Finally, we have begun to give additional attention to fundraising for the national AAEM Political Action Committee (PAC). An official fundraiser is planned for Friday February 19th, 2005, at the AAEM Scientific Assembly in San Diego. We have also asked our members to donate their free registration deposit to PAC and the membership response has been most supportive with that regard.

6) "Open Books" - A Landmark Victory for AAEM and all Rank & File Emergency Physicians!

Late in November 2004, CMS published in the Federal Register its long-awaited-for new CMS regulations. These regulations are expected to begin January 1st, 2005. The new CMS regulations **mandate** that all contract holders and staffing companies must give unrestricted access of all their individual EP Medicare billings to the clinicians who provide the care at the bedside - irrespective of their employment or contractual status.

This is a true victory for AAEM and for the rank and file EPs who toil at the bedside. This was the outcome of a most difficult battle that was fought by AAEM for a decade, with Dr. McNamara at the helm. AAEM consistently requested this requirement, initially from HCFA and then later from CMS. In 1998, CMS "discovered the improper reassignment" of our professional fees to staffing companies and other entities. It then restricted or forbid such a reassignment of professional fees indicating that providers *should* have access to the information. ACEP, staffing companies and contract holders (represented by EDPMA) then began lobbying CMS and legislators to change federal CMS law and to legitimize the "reassignment" of the billings to such staffing entities.

In the meantime, staffing companies and contract holders found loopholes to continue hiding this information from the EPs toiling at the bedside and generating these professional fees. They used *sweep accounts* or made every one an employee (a status for which CMS allowed reassignment). They did that even though it meant they, the employers, now had to pay substantial additional social security taxes on every employed EP - which indicates the pressing nature of their need to keep the books closed and suggested the fee-splitting was worth such extra cost. ACEP leaders then accused AAEM of being irresponsible, blaming us for what they described to be the end of the "independent contractor status" practice option and the disappearance of its tax benefits to EPs.

Of course, AAEM then exposed to CMS the loopholes that were used by CMGs and contract holders. CMS responded last year by directing staffing entities and contract holders who were receiving these reassigned payments to disclose these billings to the EPs who were earning them even if the EPs were employed. However, staffing companies, contract holders and ACEP interpreted the CMS directive ["should" disclose] to be a recommendation and NOT a mandatory requirement ("shall disclose"). ACEP leadership went further to openly express its reservations to CMS and to the EM community in EM News stating that the disclosure of the individual billings was "burdensome" and an "unfunded mandate."

AAEM responded by writing to CMS and meeting with its top administrators in the summer of 2004 to ensure that new federal regulations include specific language mandating that contract holders and contract medical groups "open their books" to their providers. We even invited ACEP to join us on our conference call with CMS that we held to define the mechanism for implementing and clarifying the CMS directive. CMS indicated that the [shall disclose] requirement was going to be issued. AAEM (Dr. McNamara and our DC lobbyist Ms. Ream) met a second time with the CMS top administrator Mr. Mark McClellan and Dr. William D. Rodgers, CMS Medical Officer and Director, to emphasize the importance

continued on pg 10

Candidate Platform Statements

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

The elections will be held immediately following the Candidates Forum scheduled during AAEM's 11th Annual Scientific Assembly, February 17-19, 2005 at the Hilton La Jolla Torrey Pines in San Diego. Although balloting arrangements will be made available for those unable to attend the Assembly, all voting members are encouraged to hold their ballots until the time of the meeting. The forum will allow members the opportunity to question candidates directly about their vision of the association and its place in the specialty of emergency medicine. The responses offered in this session, in addition to the platform statements offered here, will provide members with the information they need to make intelligent and informed decisions.

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

Full voting members not planning to attend the Scientific Assembly should return their completed ballot to the AAEM office address listed below. Those attending the San Diego conference should remember to bring their ballots with them for voting after the special candidates form to be held on Friday, February 18 from 12:00pm to 2:00pm.

Howard Blumstein, MD FAAEM

Candidate for At-Large Board Member

Nominated by A. Antoine Kazzi, MD FAAEM
Robert McNamara, MD FAAEM

I am running for re-election to the board of directors of AAEM. I have worked for many years on behalf of the Academy and I hope to continue my work on the board.

Currently, my most important contribution is my new role as editor of Common Sense. Writing the Editor's Notes column has sharpened my awareness of the "hot" issues that affect our members. I am particularly interested in malpractice. I never knew all the ways malpractice issues can affect our membership. The next issue of Common Sense will be its first "Special Edition." It will address many of these issues. Look for this issue at the Scientific Assembly in San Diego!

Here is a brief summary of my other contributions to the academy:

- 1) First chair of the Education Committee, served as course director for the annual Scientific Assembly from 1998 thru 2001, during which I developed many innovations such as dual tracts and pre-conference courses. I have continued my involvement on the committee;
- 2) Chair, Malpractice Committee;
- 3) Helped initiate letter writing campaign to restore "Historical Caveat" in HCFA documentation standards;
- 4) Joint AAEM, ACEP, SAEM etc. medical student task force;
- 5) Author in AAEM's Rules of the Road for Medical Students.

As Medical Director at NC Baptist Medical Center, the major teaching hospital for Wake Forest University School of Medicine, I am acutely aware of the daily operational issues that affect emergency departments across the country. I am also a member of SAEM and work as part of the clinical director's task force.

What's in my future if I continue on the board? I hope to focus on malpractice and make Common Sense an ever more effective means of keeping our members up to date on those issues of importance to us all.

The American Academy of Emergency Medicine continues to grow while other organizations struggle to prevent member attrition. What a convincing testament to the recognition by newly graduating

residents (who make up many of our new members) of our pivotal role within the EM community! It's an exciting time, and I hope I will be given the opportunity to continue my contribution.

Thank you for your consideration.

Mark Foppe DO, FAAEM FACOEP

Candidate for At-Large Board Member

Nominated by A. Antoine Kazzi, MD FAAEM
Robert McNamara, MD FAAEM

I am grateful for the nomination and the opportunity to be considered to the Board of Directors of the AAEM by the membership. I joined the Academy as a resident member, and have been active since, belonging to State Chapter FL-AAEM as well.

I firmly believed in the mission statement of the AAEM, and have annually contributed to our PAC.

I have served the Academy by sitting on the EM Practice, Governmental Affairs, and Patient Safety Committees, the Sub-committee on EMTALA, and serving as Chairperson on the AAEM's AAPS/BCEM Task Force.

Being a Fellow in the ACOEP, I am active in the college sitting on the Research Committee, serving as Director of the Research Consortium, and sit on the Board of Directors of the Foundation of Osteopathic Emergency Medicine.

A strong supporter of the my state osteopathic medical association, I serve as a political Key Contact Physician with the Florida Legislature, I was elected vice-president of District 3, and sit on the Board of Trustees for the Florida Osteopathic Medical Association.

Practicing in both the pediatric and main emergency departments at Lakeland Regional Medical Center Lakeland, Florida, I do twenty shifts a month. Practicing 180 hours a month gives me an appreciation of the issues that individual specialist in emergency medicine encounter today. If the membership elects me, I will continue the focus on the needs of the individual practicing specialist, including the integrity of our board certifications.

Stephen Hayden, MD FAAEM

Candidate for At-Large Board Member

Nominated by Peter Rosen, MD FAAEM
A. Antoine Kazzi, MD FAAEM
Robert McNamara, MD FAAEM

As an emergency medicine residency program director I care about my residents; about the quality of their education, and about promoting their specialty training. I care about my graduates; how they are treated in "the real world" and what kind of practice opportunities they will have. I care about the welfare of my patients, my friends and colleagues, and I care about the specialty of emergency medicine. That is why I have decided to run for member at large on the AAEM board of directors.

I have had the good fortune to serve organized emergency medicine in many ways over the past 10 years; most recently as the president of the Council of Residency Directors (CORD). I have become increasingly concerned about 2 related issues that AAEM has championed. One is the issue of the right standard for board certification in EM. I believe in the dictum, "It's not just the test, it's the training!" I've spent the better of part of my career creating high quality educational experiences for residents in my own program and at a national level. You will not find a more ardent supporter of residency training in EM. I am concerned by the current threats to residency training and certification in EM that the situation with the Florida Medical Board poses. I actively supported AAEM's efforts and authored a statement on behalf of CORD articulating the solidarity we have on this issue.

I have trained residents who work in a wide variety of practice environments; from small democratic groups to department chairs. I am very concerned about the exploitation of residents by corporate

continued on pg 9

Candidate Platform Statements - continued from pg 8

practices that are neither fair nor democratic, that are not run by and for EM physicians, and do not provide due process, adequate malpractice coverage, or a sense of citizenship in the group. I am deeply committed to opening the books and to prohibiting practice abuses such as fee-splitting, and the sale of EP contracts over the stock market or to venture capitalists. This cheapens the value of our profession and deprives practicing physicians of future income.

I have had the opportunity to bring CORD and AAEM closer than ever before. Under my direction CORD has reorganized its meeting structure and for the first time this February, CORD will congregate at the AAEM scientific assembly to discuss issues pertaining to residency education and training. As an associate editor for the Journal of Emergency Medicine, I have helped to publish information of value to all AAEM members and will make sure the journal continues to be a valued and responsive resource for the organization.

What I will bring to the AAEM board is a great deal of expertise in dealing with organizations both within and outside of emergency medicine. I can articulate AAEM's positions in a way that other organizations will respond to. Allow me to be a firm and dedicated champion within AAEM for these issues and for our specialty. I ask for your vote and your confidence.

Jay Poindexter, MD FAAEM

Candidate for At-Large Board Member

Nominated by William T. Durkin, Jr., MD FAAEM

I belong to AAEM because it stands for honesty and ethics in emergency medicine and I will try continue that tradition. I will work for the equitable participation by all emergency medicine physicians at their worksite. I approve of the effort to favor Ed board certification as the optimal credential for working in an emergency department. I have worked in 30+ different emergency departments in my career. This experience has led me to believe that AAEM and not ACEP is the answer to improving the lot of the ED physician. I am proud to have belonged to AAEM for the last 5 years and I look forward to many more.

Laurence Hunter Raney, MD FAAEM

Candidate for At-Large Board Member

Self-nominated

I am a recent member of this Academy, having joined in 2000. I was immediately impressed with the Academy's agenda, accomplishments, and its marvelous educational efforts. I knew I wanted to be more involved. I joined the Education Committee in 2002 and through it was able to become more active and influential in the workings and offerings in this area. But I want more. I feel the Academy has done a great deal for me, and I want to give back. As the recently appointed Chair of the Academy's Speaker's Bureau, I hope to promote our message and ideals even more broadly than we currently are. By selecting the 'Academy's Best' and making access to them easy, we are both directly and indirectly promoting our interests and ideals. As a Board member, I would see recruitment and education as my primary goals. In addition, I have always been impressed by the Academy's dedication to the working 'pit doc' and its ideals of residency training and self government. I hope to be a part of these continuing battles and the work to make our specialty all it can be.

Board members currently are expected to be available (for instance, through the Speaker's Bureau) to talk to organizations about the principles and philosophy of the Academy and its past accomplishments and future goals. I would truly enjoy representing this organization at such events, as well as promotional and educational ones.

In short, I believe I have the energy, enthusiasm and time to commit to helping this organization and would welcome the opportunity to do so.

Kevin Rodgers, MD FAAEM

Candidate for At-Large Board Member

Nominated by A. Antoine Kazzi, MD FAAEM
Joseph Wood, MD, JD FAAEM
Robert McNamara, MD FAAEM

Although I have maintained 100% attendance at BOD meetings during my tenure, just "showing up" is not enough. Effective representation and leadership requires hard work, initiative, effective communication, organization and innovative problem solving. These skills, which I have honed in my 20+ years in EM, have made me an effective and productive board member representing you, the members of AAEM.

The last 3 years have been very successful ones for AAEM. Through the leadership of the BOD, the organization has enhanced member services; significantly expanded the membership; and has successfully tackled a number of cases involving unethical business practices affecting our members (Mt. Diablo Case). Simply put, AAEM has become a "force to be reckoned with" within the house of EM. I am proud to have been a part of the dynamic growth and hope to have the opportunity to continue my leadership and service as a BOD member for the upcoming 3 years.

Although this progress comes as a result of a "team effort", I would like to review a few of my personal initiatives that have come to fruition. Recognizing that AAEM's success depends upon utilizing the talents of our membership, I assumed the task of reorganizing the Academy's committee structure and goals. Today, committee membership has grown ten fold and committee activity is at an all time high. Likewise, membership expansion must continue to be a priority for AAEM to be an effective voice for our members in the workplace. I have focused on expanding member benefits as well as mentoring the growth of our outstanding Resident Section as their BOD liaison. Concomitantly, I felt that our substantial associate membership (>500 members and the future of the academy) deserved a voice on the BOD. I introduced, lobbied for and gained passage of a by-laws amendment establishing an Associate member position on the BOD beginning in 2006. I am committed to providing the mentorship and creativity required for the continued growth of AAEM.

In conjunction with continued implementation of AAEM's mission statement, I believe we must maintain excellent communication and a degree of cooperation with each of the major organizations within EM in order to develop and protect the practice of Emergency Medicine into the future. Based on my recent involvement in a successful collaborative experience involving the 6 major EM organizations, I believe that AAEM should explore the establishment of a national "federation of EM" that could explore common problems facing our specialty as a whole.

Three years ago, I promised the members of AAEM hard work, enthusiasm, innovative ideas and leadership. I believe I have fulfilled that pledge. Confirmation lies in my nomination for re-election by our current and 2 past presidents with whom I have closely worked on the BOD. This vote of confidence signifies their belief that I will continue to be a productive member of the BOD. I maintain that same passion today for serving the members of AAEM as I did 3 years ago.

Joanne ("Dr. J") Williams, MD FAAEM

Self-nominated

AAEM CONTRIBUTIONS

I am a Founding Member of AAEM, Chair of the Minority Affairs Task Force Committee, Member of the International Emergency Medicine Committee and the Education Committee. I proudly "unofficially" represent AAEM at the International Trauma Anesthesia & Critical Care Society. I was the Opening Keynote Speaker at the TraumaCare2004 Congress jointly sponsored by the Australian Trauma Society in October of this year as well as presenter at TraumaCare2003 in Dallas, Texas; TraumaCare2002 in Stavanger, Norway and TraumaCare2000 in Mainz, Germany. I was instrumental in introducing the Academy to the Emergency Medicine Section of the National Medical Association.

CANDIDATE STATEMENT

Are We Not Critical Care Physicians?

The Critical Care Societies have no problem inviting us to join their societies. The American Board of Internal Medicine, Surgery,

continued on pg 10

Candidate Platform Statements - continued from pg 9

Anesthesiology and even Obstetrics and Gynecology have “added qualification certification” in Critical Care!

Why is it that the Emergency Physician is not listed among these “elitist”, if you will?

What does the term “critical care” mean? “Critical” is “of or relating to a crisis.” “Crisis” means, among other things, “a sudden change for better or worse during an acute illness” or “a crucial or decisive point or situation”. What about the term “care”? “Care” is “caution in avoiding harm or danger” as well as “attentiveness to detail”.

Hello!! Doesn't the Emergency Physician “fit the bill” of a “Critical Care Specialist”? Do we not “relate to a crisis”? Do we not address and treat any and all “sudden change(s) for better or worse during an acute illness”? Everyday we are challenged with “crucial or decisive points or situations”. We take “caution in avoiding harm or danger” and we DEFINITELY are “attentive to detail”!

Let's take a minute and analyze a couple of scenarios. Where are the majority of survivors of Acute Myocardial Infarctions diagnosed? In the Emergency Department! Who diagnoses and treats the initial

“critical” stage of AMI? The Emergency Physician! By the time the Cardiologist is “on the scene” the patient has, more times than not, been oxygenized, nitroglycerinized, morphinized, beta-blocked and thrombolized by the Emergency Physician. Many times these patients have been stabilized and moved to the Intensive Care Unit before the Cardiologist or Intensivist even has had a chance to get a history from the patient!

Acute Pulmonary Edema! How many patients have presented to the back door and sometimes the front door of your Emergency Department with pink foam “escaping” from their noses and/or mouth. They're “sweating bullets”, somulent to a fault or anxious beyond control. You can hear the rales before you see the patient! By the time the patient is admitted he or she has, again, been oxygenized, lasixized, nitroglycerinized, morphinized, stabilized and sometimes intubated! All this is done many times before you have even had time to call the Intensivist!

This is a serious matter. If the Emergency Physician is “qualified” to take a Critical Care Fellowship, then he or she should be “qualified” to take the examination for the “certificate of added qualification” in Critical Care! 🇺🇸

President's Message - continued from pg 7

of this unrestricted access to the books and how EPs *were* being coerced *not to ask for the information* due to a justifiable and well-documented fear of negative repercussions.

In September 2004, AAEM sent a letter to CMS reemphasizing the importance of requesting periodic automatic release of Medicare Billings to individual EPs. AAEM mounted a mass email campaign informing over 22,000 emergency physicians of the impending CMS release and asking them to provide their comments to CMS. The AAEM Legislative Action Center provided access info to CMS, talking points and a template message that we wanted CMS to hear. The response from the EPs was substantial. AAEM and the EP response to our call played a central role in the new regulations and the victory this represents. This is perhaps one of our most important accomplishments during the last decade! Done on behalf of the rank and file EPs who have previously been prohibited or restricted from “seeing the books,” this CMS decision will enable the clinicians working at the bedside to determine the widespread degree of fee-splitting that is so prevalent in EM simply to profit greedy contract holders, shareholders and corporate executives of staffing companies – in small, medium-sized and large EP groups alike.

AAEM believes that such knowledge will entice and empower emergency physicians to put an end to the widespread excessive fee-splitting which we have been denouncing for over a decade. AAEM will help with that process. This is the beginning of the end for such greedy practices in EM.

7) Enhancing the Scope and Depth of AAEM Activities and Services: Of course, passing the 5000-member landmark highlights the need to take AAEM to a new level, that the rate of our growth will continue to increase, providing us responsibility, opportunity and momentum to move the Academy into a new phase of its development.

Over the last year, the AAEM established and began developing a national structure and visible presence for its standing committees and taskforces. Over 150 AAEM members volunteered to participate in this process. Chairs were appointed and objectives were defined. The complete listing and the goals and objectives for these committees and taskforces are available on the AAEM website. References, documents and articles are also available. These committees have since then begun actively working on individual tasks and projects, developing resources and building the depth and scope needed for AAEM to become the premier EM professional society. Our members are working together to develop white papers, resources and position statements on ethics, ED overcrowding, EMTALA, ED design, information technology, patient satisfaction scores, patient safety, EMS, academic fairness, and EM ultrasonography. Most recently, AAEM's reimbursement committee released its first edition of

“Dollars and Common Sense”, its electronic newsletter which will update and educate members about reimbursement and coding issues. This e-letter is our second such product, with “the Washington Sentinel” being produced by our Government Affairs Director. Our taskforces dealt with issues of fairness policies, board certification and residency training, with bylaw changes and antitrust compliance. Representatives were sent to represent the AAEM at national meetings (e.g. IOM, SAEM, NAEMSP, AMA, CDC) and on joint taskforces, producing most recently for example (with all other EM organizations) a national curriculum for medical student education. Reports, were published, letters sent and input provided to various authorities, such as the CDC (e.g. HIV screening in the ED; public health and injury prevention). Activity also began with regard to developing AAEM practice guidelines. Our international committee began working on the international summit planned for February 2005, and worked with our membership committee to address difficult questions pertaining to fees and benefits of international members.

It is simply impossible to describe in adequate detail all the activities and progress that has been made with regard to the development of our committee and taskforce structure. This is an ongoing, demanding and complex process. However it is an exceptionally important process for AAEM, one that will produce most of its impact in 5-10 years, and not only through the current national visibility which we are currently achieving.

AAEM continues to work on identifying and recruiting talent and leaders for these committees and taskforces and remains open to new ideas and suggestions. We need you.

Conclusion:

I will end my President's Message by asking you again to get personally involved in your Academy. Join our committees and taskforces! Help us recruit new members! Get one colleague every year to join AAEM. Get active in your state chapter or work with other to develop one.

Make plans to join us at our national conferences and international Mediterranean congresses. However, considering the legal battles that we have begun, I must emphasize again to you that your financial contributions are critical at this point and in the future to continue our growth, our proactive engagements and our daring initiatives. Please go now to our website and contribute donations to our PAC and to our newly established AAEM Foundation!

We need you! On behalf of AAEM and the generations of physicians who will benefit from this advocacy, thank you! 🇺🇸

Top 10 Reasons to Attend the 2005 Scientific Assembly



RESIDENT SECTION PRESIDENT'S MESSAGE

by Joel Schofer, MD, President, AAEM/RES

You need to come to the 2005 AAEM Scientific Assembly. Yes, you. It doesn't matter who you are...AAEM member, SAEM member, ACEP/EMRA member, President and member of the Hairclub for Men, or member of nothing. You need to be there, and here are the top 10 reasons to attend the Scientific Assembly in San Diego:

10. Golf. Can you say Torrey Pines? The Hilton La Jolla, the site of the Assembly, just happens to be on a world championship golf course which will be hosting the 2008 US Open. All golfers should head to the following link to find out how to get a tee time while at the conference:
<http://www.aaem.org/education/scientificassembly/sa05/golf.pdf>
9. Why not? It's FREE!
8. Peter Rosen. Come meet one of the first high profile emergency physicians to take a stand against the exploitation of EP's by contract management groups. Dr. Rosen will be speaking about the management of difficult patients for the Resident Track and moderating the 7th Annual AAEM/JEM Resident and Student Research Competition and another very exciting panel discussion to be discussed below.
7. There probably isn't a more beautiful area in the country than San Diego. The weather is perfect more than 95 percent of the days and there are miles of pristine coastline and beaches, not to mention a downtown nightlife filled with world class restaurants.
6. To encourage you to get out of the hotel and enjoy the area, there will be a resident section party Friday night at the Hard Rock Café located in the heart of La Jolla and one block away from the ocean. Come have a drink on us and get out of the hotel!
5. Have I mentioned that this whole thing is FREE?
4. Dr. Robert McNamara, a past-president of AAEM, will once again be giving his lecture on the "History and Current State of EM." This is the lecture that he gives around the country. Almost uniformly, non-AAEM members rush to join AAEM and become members after hearing his talk. It is very highly recommended.
3. If you actually made it this far and have read this much of my President's Message please e-mail me at jschofer@medscape.com and let me know. I am not kidding. I want to know if anyone has gotten this far. You might be the only one.
2. The AAEM Resident Section has organized what I believe will be the most exciting session at the Assembly. We have put together an amazing slate of speakers to participate in a panel entitled "The Ideal Practice Environment in Emergency Medicine." Representing AAEM on this panel will be Dr. McNamara, one of AAEM's most vocal advocates. The president of SAEM, Dr. Carey Chisholm, and ACEP's president, Dr. Robert Suter, will be representing their organizations. Two of the largest employers in EM will be represented by Dr. Dominic Bagnoli, Chief Operating Officer of EMP, and Dr. Lynn Massingale, President and Chief Executive Officer of Team Health. As previously mentioned, moderating the panel will be Dr. Rosen. This panel discussion will be one of the most memorable events ever at an Assembly and should not be missed.
1. The AAEM Scientific Assembly can be part of a healthy, low-carb lifestyle.

If you made it this far you must really be motivated and AAEM/RES can use motivated people. Start thinking about running for a position on our board and contact me with any questions or interest at jschofer@medscape.com. Just think. I once sold a burned out lightbulb on E-Bay for \$5.00 by touting its "melodious jingle when shaken." Next thing you know I was the president of the Resident Section. You too can reach for the skies. Run for the board. 🇨🇭

EMIG Workshops

by Chad I. Kahwaji

In the first two of years of medical school, students traditionally have very little exposure to emergency medicine. The development of an active and energetic Emergency Medicine Interest Group (EMIG) addresses this shortfall by serving two simple goals – exposure and preparation. The first goal, *exposure* to the field of emergency medicine, can be accomplished with a well-organized skills workshop or lecture series. The second goal, *preparation* for residency, can be achieved through specific workshops on fourth-year elective planning, the application process, and interviewing skills.

Contrary to popular belief, organizing a successful workshop or lecture does not necessarily rely on a large interest group or even past experience with organizing such events. It does however, require two or three motivated students, some basic planning skills, and a little guidance...this is where we come in. The AAEM Student Section Council has begun developing pre-packaged kits that will provide step-by-step instructions on how to prepare a successful workshop. These starter kits will soon be available for downloading at our newly launched website, www.aaemres.org. The remainder of the article will highlight some of the steps required to plan a Suturing skills workshop, which is one of the most popular workshops conducted by interest groups.

While it appears to be a daunting task at first, simplicity is the key to planning a Suturing Workshop. To keep it simple, the development of this event can be divided into three portions: 1) publicity and promotion, 2) required equipment, and 3) workshop content.

1. Publicity and Promotion – after a date and location have been established, promotional flyers and emails to the student body should be more than adequate to publicize the event. Providing refreshments or a meal at the event is an easy way to increase student attendance; however, it is always a good idea to have students RSVP so that you have an idea of how many students

to expect. When choosing your date, be aware of exam dates and avoid them to get a better turnout.

2. Equipment – this is usually the most time consuming portion of workshop planning. The following list of equipment should suffice: forceps, needle drivers, scissors, gloves, scalpels, disposable pads, pigs feet, and suturing supplies. The suturing equipment can be obtained from the Emergency Department or the Department of Surgery, pigs feet can be purchased at many local grocery stores, and sutures can usually be obtained from the Emergency Department or from companies such as Ethicon and US Surgical.

3. Workshop Content – content is the most important portion of the workshop, so it is critical to develop a workshop with an audience-specific level of difficulty. For first and second year medical students, two handed ties, instrument ties, simple running sutures, and simple interrupted sutures would be adequate. For third and fourth year students, one-handed ties, running subcutaneous sutures, and other techniques such as stapling and Dermabond can be incorporated into the workshop.

Funding for a Suturing workshop is often a limiting factor; however, basic workshops have been successful with a total cost of \$50-\$75. To help with the cost, most Emergency Departments are willing to offer equipment or limited funding for these events. If this is not an option, there are usually grants available from local and national Emergency Medicine societies and practice groups, as well as your medical school's Office of Student Affairs or Student Government.

This Suturing Workshop Kit preview should point you in the right direction to plan a successful event with a minimal time and monetary investment. The Student Section Council hopes that these starter kits will help your EMIG expand your workshop repertoire and become one of the more active and energetic interest groups at your medical school. +



AAEM/RES Launches New Website

by Mark Reiter MD MBA

The AAEM Residents and Students Section is proud to announce the launch of www.aaemres.org. The new website offers detailed information and resident and student specific resources unavailable anywhere else. The website will offer special sections on EM Internet Resources and EM Palm Pilot Resources, educational offerings such as the AAEM Clinical Question of the Week, tailored sections for groups such as osteopaths, online access to *Student Rules of the Road* and *Rape of Emergency Medicine*, and much more. In addition, we have created a forum for our members to better communicate with the AAEM/RES leadership and with each other, through the launch of our discussion forums and our interactive polls. Thanks to the 16 resident and student members of the AAEM/RES Communications Committee for their hard work on this project. Visit www.aaemres.org today.

Mark Reiter, MD MBA is the Vice-President of the AAEM Resident Board and AAEM/RES Communications Committee Chair. He can be reached at mreiter@unch.unc.edu. +

AMERICAN ACADEMY OF EMERGENCY MEDICINE

AAEM Residents and Students

HAVE YOU MOVED?

Please remember
to keep your
address updated.

Contact us at
info@aaem.org
or call us at
800-884-2236.



when minutes count

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August 13, 2004

Robert West, MD, JD, Editor
Common Sense
 555 East Wells Street – Suite 1100
 Milwaukee, WI 53202-3823

Dear Dr. West,

Please tell your readership how deeply and sincerely the emergency physicians of the Mt. Diablo Medical Center in Concord, CA appreciated the support and advocacy of AAEM during our recent counter suit against Team Health. By their actions and through the Academy's media our elected officers and board members helped expose the corporate conduct of Team Health in California for all to judge. AAEM's alliance with our cause lightened our burden considerably and strengthened our position immeasurably.

Coming to our aid as it did, AAEM once again distinguished itself as the true steward of Emergency Medicine. We were average emergency physicians who were sued by one of the largest law firms in America hired by one of the largest and richest contract management groups in the country. While many groups expressed a willingness to offer *amicus curiae* briefs on our behalf, it was only AAEM that put its money where its mouth is, embraced our cause and stood by our side. This action speaks volumes of what AAEM will do for its members.

As *the* ethical and member financed voice of Emergency Medicine, *Common Sense* serves all practicing emergency physicians by advocating and publicizing what is right, fair and lawful. But editorial integrity can be perilous for commercial publications which rely on advertising for revenue. Shortly after the excellent and in-depth reporting of the facts of our case by Lisa Hoffman, (AAEM Sues Team Health for Corporate Practice of Medicine, *Emergency Medicine News*, Volume XXVI, Number 3, March 2004), all paid advertising by Team Health disappeared from *EMN*. *Res ipsa loquitur*.

My colleagues and I will always be profoundly grateful for the support and assistance we received from the Academy. Because of AAEM's help I believe all large contract management groups will think twice before trying to trample emergency physicians one at a time. We have tremendous strength in our membership and each of us should take great pride and comfort in knowing the extent to which the Academy stands with us all.

Sincerely,

Samuel H. Glassner, MD, FAAEM

AAEM Invited to the CDC Acute Care Steering Committee

by Shahram Lotfipour, MD FAAEM


The Centers for Disease Control (CDC), National Center for Injury Prevention and Control (NCIPC), and Division of Disability Outcomes and Programs (DIDOP) invited representatives from multiple organizations including AAEM on March 29 and 30, 2004 for their Acute Care Treatment Research Agenda (ACTRA) Working Groups. AAEM sent two official representatives. As the Associate Editor for the California Journal of Emergency Medicine (CaJEM) for Injury Control, I was proud to serve as one of these two representatives and to provide this report on that visit.

The main impetus in organizing these working groups was that the current Injury Research agenda of the CDC did not adequately address the area of acute care clinical treatment. The working groups were focused on clinical research in the acute care arena including the emergency medical services, emergency medicine, and trauma surgery. This agenda was developed as a supplement to the existing agenda of the CDC. The working groups were composed of members from the acute care community who were charged with the mission to develop and design the future research agenda of

the CDC with regard to questions related to injury, and subsequent development and funding priorities of programs and projects.

The final goals of the meeting included:

- Finalizing the broad thematic areas
- Exploring challenges, problems, and issues relevant to each thematic area
- Define specific research topics that will address these problems and challenges
- Provide a description/justification for each research topic and to prioritize the research topics within each thematic area. The Acute Care thematic areas included Information & Data Systems, Measurement of Quality & Outcomes, Best & Needed Practices, Clinical Intervention & Prevention Services and Systemic Effect of Mass Casualties.

AAEM welcomes member participation in its Acute Care and Injury Control task force. If you are interested please contact Shahram Lotfipour at Safetynet101-medicine@yahoo.com. 



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in Emergency Medicine

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August 27, 2004

Larry McPherson, Jr., JD
Executive Director
Florida Board of Medicine
4052 Bald Cypress Way, Mail Bin #CO3
Tallahassee, FL 32399

Dear Florida Board of Medicine,

On behalf of the 5,000 members of the American Academy of Emergency Medicine (AAEM), a professional society committed to the advancement of emergency medicine, we are writing to urge the Florida Board of Medicine (FBM) to modify their 2002 decision with regard to the American Association of Physician Specialists (AAPS), in general, and to the emergency medicine certification certificates it provides, in particular.

The Florida Board of Medicine (FBM) 2002 decision to allow physicians holding AAPS certificates to advertise themselves as board certified was based on flawed testimony that omitted critical information about the AAPS requirements in the field of Emergency Medicine. Crucial evidence and information well known to the witnesses who spoke to support the AAPS petition were excluded. In addition, principal stakeholders were not invited to provide testimony. These omissions occurred even though they were very well known to most if not all of the witnesses and representatives who spoke on behalf of the AAPS petition, including at least one serving on the board of the FBM.

This was done in clear violation of Florida statute 64B8-11.001 which states: "No physician shall disseminate or cause the dissemination of any advertisement or advertising which is any way false, deceptive or misleading. Any advertisement or advertising shall be deemed by the Board to be false, deceptive, or misleading if it:

- a) Contains a misrepresentation of facts; or
- b) Makes only a partial disclosure of facts;"

Public testimony to Healthcare agencies and testimony to the FBM are a form of advertising and should therefore, in our opinion, be subject to the rules of this Florida statute.

AAPS administers a Board Certification in Emergency Medicine (BCEM). The current FBM rules give physicians holding BCEM certificates equal status to physicians certified by the American Board of Emergency Medicine (ABEM), or the American Osteopathic Board of Emergency Medicine (AOBEM), which are sponsored respectively by the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA).

AAEM strongly believes that the practice of emergency medicine is best conducted by a specialist in emergency medicine, which we define as a physician who has achieved, through personal dedication and sacrifice, certification by either ABEM or AOBEM. Since 1988, ABEM and AOBEM have required a minimum three years of residency training in emergency medicine as well as passing rigorous written and oral examinations to become respectively ABEM-or AOBEM-certified. In fact, this plan was announced in 1978. This year, ABEM has mandated Emergency Medicine Continuous Certification, where diplomates must pass annual written examinations in addition to the more comprehensive 10-year re-examination in order to maintain ABEM certification.

Since 1980, this specialty-specific residency training in emergency medicine has been and remains recognized and accepted as the gold standard in our field by the House of Medicine, the AMA and the AOA. Both the AAEM and the American College of Emergency Physicians (ACEP) require emergency medicine-specific residency training in order to become a Fellow and full voting member within each organization.

Residency programs offer the richest learning environment most emergency physicians (EPs) will ever experience, providing immediate access to the latest academic knowledge from experts dedicated to guiding and counseling young emergency physicians. The Emergency Medicine Residency Review Committee (RRC) and the AOA impose, monitor and enforce very strict requirements on emergency medicine residency programs, ensuring that residents are exposed to high patient volume and acuity, substantial pediatric and critical care experience, gain proficiency with a multitude of emergency procedures, and are exposed to topics such as professionalism, research, teaching, administration, and emergency medical services. *The RRC accreditation monitors this process to ensure that credentialed faculty who are ABEM-or AOBEM-certified emergency physicians supervise the emergency medical care provided by residents while they are training in emergency medicine.*

BCEM does not require emergency medicine specialty-specific substantial residency training in the principal pathway used by the physicians who are taking its test and securing its certificates. One can become BCEM certified after completing (1) an anesthesia or primary care residency and (2) five years (7000 hours) of clinical practice or a one-year unaccredited emergency training program at the University of Tennessee followed by one year of clinical practice (or two years of this program). *Prior to the year 2000, BCEM did not require the completion of ANY residency training for physicians holding its emergency medicine certificates.*

In addition, the minutes of the public hearings, of the AAPS ad hoc committee and of the Florida Board of Medicine do not reveal any testimony indicating that the AAPS-BCEM emergency medicine practice track is the source of an estimated 69-76% of all AAPS certificates. In other words, this BCEM practice track has been and remains the sole source of about three-quarters of the AAPS activity for the last 8 years, while the 13 other AAPS boards are currently graduating an estimated average of 2 graduates per year in the whole USA. This would translate into an estimated average of less than 1 Florida applicant every 25 years in each of the 13 non-Emergency AAPS Boards. One should then reflect again over the issue of comparability of the AAPS Boards with ABMS and whether the appropriate attention and process were given to this issue, to the motivations or conflicts of interest of representatives who did not reveal this information and to the omission of many primary stakeholders' testimony, all of which were obvious or well-known to the AAPS representatives.

The FBM minutes we have been able to review indicate that no witness or AAPS representative revealed to the FBM that a number of the witnesses were leaders or members of national organizations which had fought and lost a very expensive antitrust national lawsuit against the American Board of Emergency Medicine (ABEM) and the Council of Emergency Medicine Residency Directors (CORD) that lasted a minimum of 5 years. The outcome of the lawsuit should have been considered in the FBM deliberations and consideration.

AAEM believes the aforementioned omissions in testimony and the substantial differences between BCEM/AAPS and ABMS were **inappropriate and grave** breaches in the process that led to the Florida Board of Medicine decision about the comparability of AAPS boards to the ones certified by ABMS and the AOA.

Omissions and inappropriate process continued when the FBM took a second look at this matter in 2003 due to an FMA-supported challenge to the 2002 FBM decision and when the FBM reaffirmed in 2004 the 2002 decision to approve AAPS' petition. AAEM believes this process was equally flawed through the inappropriate omission of the facts and stakeholders which were not evident at that time to the FMA or to the FBM. The evidence and vital information was however well known to AAPS, to its representatives and to say the least very readily available to the members of the AAPS ad hoc committee and to representatives who played the key role coordinating or supporting this AAPS effort.

At least one FBM board member himself holding an AAPS-BCEM certificate gave testimony and served as witness and jury. In fact, he had been serving as a *Governor* for the American Academy of Emergency Physicians (AAEP) – by far the largest academy among the AAPS academies – these Academies being an integral part of the AAPS governance structure.

Florida statute 64B8-11.001 states “*Special recognition must require completion of an allopathic medical residency program approved by the ACGME or the Royal College of Physicians & Surgeons of Canada that includes substantial and identifiable training within the allopathic specialty training being recognized.*” AAEM certainly agrees with this rule. AAEM believes that it is highly inappropriate that the witnesses and representatives who were involved in three years of hearings and the ensuing FBM committee work gave no attention to the AAPS lack of compliance with this rule when it comes to BCCEM and three-quarters of the AAPS graduates.

We are gravely concerned that physicians with no standardized, supervised, substantial training in emergency medicine could claim proficiency in performing pediatric intubations, emergency vaginal deliveries, administration of thrombolytics, multiple-victim trauma resuscitations, orthopedic reductions, and hundreds of other skills needed to simultaneously manage multiple patients with diverse problems in a busy emergency department.

Allowing BCCEM physicians to claim certification in emergency medicine that is equal or comparable in status and value to ABEM or AOBEM after acquiring variable unsupervised exposure critically undermines the value of Emergency Medicine residency training in protecting unsuspecting emergency patients from the unnecessary risk of inadequately trained physicians, who practice EM unsupervised and learn through trial and error. If you can learn unsupervised on the job, why have residencies in any medical or surgical specialty?

AAEM recognizes the Florida Board of Medicine's duty and commitment to protect the patients of Florida and to ensure that they are treated only by physicians who are legitimately credentialed and performing within their scope of practice. AAEM urges the FBM 1) to reevaluate its previous decision regarding AAPS and its board certification in emergency medicine (BCCEM) and 2) to support ABEM/ ABOEM certification and their requirement for ACGME-or AOA-accredited emergency medicine residency training as the standard in emergency medicine. Please feel free to contact me with any questions.

Sincerely,



A. Antoine Kazzi, MD, FAAEM
President, the American Academy of Emergency Medicine

TEXAS CHAPTER UPDATE

TAEM The Texas Hospital Association and Strange Neighbors

By Jon Jaffe, MD FAAEM

TAEM represented itself and AAEM at the Texas Hospital Association meeting October 27 and 28, 2004, in Austin Texas. Dr. David Smith and I worked the floor with emergency medicine residents Derrick and Norma Cooney, Jonathan Skelton, and Mark Gamber. The meeting itself is one of the largest gatherings of hospital administrators and their suitors that one can find. It gave us the opportunity to exclaim AAEM and its mission, and provided the residents an unencumbered opportunity to meet with hospital administrators.

Once a year we don business attire and discuss the importance of board certification to CEOs and managers of hospitals from 25 to 900 beds. Many of the administrators, including CEOs, did not appreciate the meaning of board certification in emergency medicine, nor realize that there were residents in emergency medicine so eager to talk with them. So far this just seems like a rehash of last year, but wait there's more. Our neighboring booth to the left, as we faced the visitors, was none other than EmCare. They were aware of our positions. Two days of somewhat painful cordiality began.

Some of the most interesting banter, besides their recognition of Dr Smith's online interest group rants, was the discussion of board certified physicians at small rural hospitals. "You are not going to get them to go to a twenty-five bed hospital." Emcare smirked. The door was open.

We countered "Would you rather pay someone who is both interested and board certified a fair dollar, or pay a contract group the same amount to bring in another unqualified, rehabbing, burned out anesthesiologist, flying in from wherever?" While there was no immediate comment from the EmCare side, many of the rural administrators affirmed our points with interest. Will this cause an

immediate change in the awarding of contracts? I do not think so, but it is a start.

We had humble booth in comparison to many, with brochures and AAEM pins to give away to the interested.



David Smith, MD FAAEM (past TAEM President)

This year we raffled off an iPod, which attracted many visitors to the site. One was the CEO of a hospital located just north of Austin, where board certified emergency physicians do not staff the ED. Drs Gamber and Skelton engaged him for a considerable amount of time that they would not have had under ordinary circumstances.

Each year this meeting becomes more productive. While it may not seem as glamorous as an hour with an elected official, it got the word out to many who knew nothing about quality emergency medicine or AAEM. We eagerly anticipate next year.

Jon Jaffe, MD FAAEM, is President of the AAEM Texas state chapter. +

No Prop 67...And the End of Life Course

by Shahram Lotfipour, MD FAAEM

I am certain I was not the that was disappointed when Proposition 67 did not pass. With increasing numbers of uninsured in California and the persistent underinsured, it would have been a shot in the arm for the California Emergency Care, Prehospital Care and On-Call services. It seemed to me it came down to most people just feeling that another tax is not something they want to vote for no matter how small...although they did not hesitate to vote for the billions in bonds for stem cell and the children's hospitals. We were outgunned and out-funded, and perhaps we could have done more to promote it locally and regionally. Furthermore, the issue we were making to the voters could not have been timelier given the closure of so many trauma centers in California over the past year. I guess what makes it worse is how the trauma system closure could affect not only our trauma infrastructure, but it also burdens non-trauma emergency care centers at times of saturation. The opposition to Proposition 67 illustrates that no one is going to fix this system for us and we will have to use our creativity to preserve emergency care in California every way we can.

I would like to invite all of our California members to join us at the End of Life/Pain Management Preconference course at the Assembly. This will be a two day Preconference course on February 15 and 16 at the AAEM Assembly in San Diego. The End of life course will help satisfy the AB 487 state requirements. The Pain Management and End of Life credits are required for California licensure by 2006. Some of the topics covered in this course include "Pathophysiology of Pain," "Pain Assessment in the Pediatric & Adult Populations," "Pain Medication Overdose in the Elderly," "The Dilemma of Drug Seekers," and "Risk Management Issues in End of Life and Pain Management." The End of Life course will be offered the two days immediately preceding the Assembly. Dr. Joanne Williams has spent

considerable volunteer time organizing this course for you. I hope this serves as a valuable resource to our members. If you are interested in this course please register at www.aaem.org.

The Cal/AAEM board of directors recently voted to make Cal/AAEM membership free for all California medical students and residents. We welcome your participation and we will provide the California Journal of Emergency Medicine and full benefits to you at no cost. To become Cal/AAEM members please contact AAEM or talk to your program director.

I also look forward to meeting all of you at the Assembly in San Diego. We will be holding elections for upcoming open positions in our board of directors in the next few months. Please consider nominating yourself or a close associate of yours. Nominations can be directed to myself or to AAEM at info@aaem.org. I welcome your participation and input as a board member. Please make your commitment to Cal/AAEM today.

I want to encourage every AAEM member in California to not only join Cal/AAEM, but to contribute to the Political Action Committee in AAEM (AAEM-PAC). I challenge every member to join me and the other Cal/AAEM board members in supporting and contributing though your Cal/AAEM society to the many challenges our state faces in Emergency Care each and every day. I welcome your comments and suggestions.

Happy New Year and God Bless.

Shahram Lotfipour, MD FAAEM is the president of the Cal-AAEM State Chapter. He can be reached at safetynet101-calaaem@yahoo.com.



109th Congress Expected to Tackle Several Health-Related Issues

by Kathleen Ream, Director of Government Affairs

Summarizing the outcome of the 2004 elections, the United States Senate remains in Republican control with 55 Republicans, 44 Democrats, and one Independent, who will caucus with the Democrats. There are nine new Senators in the 109th Congress – two Democrats and seven Republicans. As expected, the House of Representatives stays in Republican control with a slightly larger margin. The composition of the House is 231 Republicans, 201 Democrats, and one Independent with two runoff elections on December 4 for the 3rd and 7th districts of Louisiana.

Some of the health issues likely to arise in the 109th Congress include:

MEDICAL MALPRACTICE

President Bush and the House of Representatives will continue to champion medical malpractice reform in the 109th Congress as a cornerstone of broader reforms needed in the U.S. health care system. Key elements of the President's reform plan include many of the non-economic provisions sought by medical organizations such as:

- Punitive damages can total no more than twice the economic damages, or \$250,000, whichever is greater.
- No state preemption of state damage caps, but federal caps would be imposed on states not having their own caps.
- Limit contingency fees paid to attorneys (no more than 40% of the first \$50,000 in damages, 33% of the next \$50,000, 25% of the next \$500,000, and 15% of any amount exceeding \$600,000).
- Unlimited compensation for "economic losses," i.e., lost income and medical expenses, including long-term care and a \$250,000 pain and suffering cap.

PATIENT SAFETY

Almost five years after the Institute of Medicine issued a report finding that roughly 98,000 people die annually due to preventable medical errors, House and Senate negotiators have been unable to bridge the gap between their competing patient safety bills this year (S. 720; H.R. 663). Nonetheless, the bills enjoyed overwhelming, bipartisan support, making the likelihood of enactment in the 109th Congress highly probable. Both bills are designed to improve patient safety by establishing a voluntary medical errors reporting system, as well as federal evidentiary privilege and confidentiality protections to encourage providers to report errors. Under the legislation proposed in both chambers, the Secretary of HHS would certify private and public organizations as "patient safety organizations" (PSOs) to analyze reported errors in order to help prevent similar mistakes in the future.

HEALTH INFORMATION TECHNOLOGY (HIT)

The Bush White House and the Department of Health and Human Services (HHS) have made HIT one of their top policy priorities. Last summer, President Bush unveiled a plan designed to help overcome the barriers to fully integrating IT into the U.S. health care system. The major provisions include:

- Ensuring that most Americans have electronic health records within 10 years.
- Completing and adopting standards that will allow medical information to be stored and shared electronically while ensuring privacy and security.
- Doubling funding to \$100 million for HIT demonstration projects.
- Making changes in public health care financing programs to foster movement toward HIT solutions.
- Introducing information tools into clinical practice, electronically connecting clinicians to other clinicians, using information tools to personalize care delivery, and advancing surveillance and reporting for population health improvement.

In Congress, strong bipartisan support exists for promoting HIT as a way to improve patient safety and the quality of health care delivery and treatment. HIT legislation thus could become one of the major points of consensus in the 109th Congress.

MEDICARE

The Bush Administration and Congress once again will face a range of Medicare issues in the 109th Congress. Due to the depth and breadth of the changes enacted in the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA), Congress likely will consider a bill making technical corrections to the relatively new law. In addition, they will need to act on other aspects of Medicare due for review in 2005 and 2006. The physician reimbursement update and the moratorium on outpatient rehabilitation therapy caps expire in 2005, and the hospital inflation update expires in 2006. The 109th Congress also could consider further structural changes to the program. If Congress does move forward with major Medicare legislation to tackle all of these issues, the legislation likely would be folded into a larger budget reconciliation bill along with other items, such as tax code changes and amendments to other entitlement programs (e.g., *Medicaid and Temporary Assistance for Needy Families*).

Despite their continued minority status, Democrats likely will use any Medicare bill as an opportunity to press for changes in the MMA. In particular, Democrats might seek to lift the ban preventing the HHS Secretary from negotiating Medicare prescription drug prices with pharmaceutical companies. Democrats also could push to plug the so-called "donut hole" in the Medicare prescription drug benefit, i.e., the 100% of annual out-of-pocket drug expenses for which beneficiaries are responsible after they have spent \$2,250, but before their expenses have reached \$3,600. However, such a change would be costly and face serious resistance from fiscal conservatives.

PRESCRIPTION DRUG IMPORTATION

In the presidential and congressional races, the issue of access to lower cost prescription drugs played a prominent role in the debate. Despite passage of the *Pharmaceutical Market Access Act of 2003* (H.R. 2427) and public support for access to lower priced prescription drugs, the Senate has yet to pass legislation allowing for the importation of drugs from abroad. In spite of its significant congressional support, the Bush Administration has been cool to the idea of importation. The Administration has cited patient safety and terrorism concerns as primary reasons for its opposition to the passage of importation legislation. President Bush has appointed the Surgeon General to lead a federal task force to determine what is needed to ensure the safe importation of drugs. In the second presidential debate, Bush said he would permit drug imports if the medications could be shown to be safe. He is supposed to receive a report on the issue from the government's drug importation task force by December 8. The pharmaceutical industry is resolutely opposed to drug imports.

COVERAGE OF THE UNINSURED AND MEDICAID REFORM

The number of uninsured Americans increased by almost four million people since 2001. Moreover, since 2000, employer-sponsored health insurance premiums increased by nearly 60% for family coverage, with family premiums increasing 11.2% between 2003 and 2004. Against this backdrop, President Bush and the Republican Congress will continue to propose a series of measures designed to provide coverage for more Americans and alleviate the rising cost of health insurance, while limiting the role of the federal government in the health care system.

continued on pg 17



Washington Watch - continued from pg 16

The Administration also has laid out plans to give individuals more control of their health care spending by way of proposed tax breaks. The President is expected to follow through on putting in place changes in Medicare that will increase the role of private insurers in the government run health program for older and disabled people.

While state revenues and fiscal health improved in FY 2004, states were given a boost by \$20 billion in temporary federal aid, half of which was designated specifically for Medicaid. Nonetheless, state budget shortfalls could top \$40 billion in FY 2005, placing continued stress on Medicaid – the nation's largest public health insurance program and the second largest program in most state budgets. President Bush likely will include a Medicaid reform plan in his FY 2006 proposed budget. His Administration will look for ways to reduce Medicaid expenditures, which also would help to narrow the federal budget deficit. Independent analyses estimate that the president's proposals would provide health care insurance to 6-8 million people who don't have it now. The White House says the number is closer to 11 million.

Telehealth

Although telemedicine (also referred to by many as telehealth) may not yet be a household word, President Bush has cited telemedicine as one way to improve patient care and reduce costs. It is not clear how telemedicine will fare in the second Bush Administration. The Health Resources and Services Administration's Office for the Advancement of Telehealth, the granting organization responsible for telemedicine, has seen its budget cut over the past four years. On the other hand, President Bush has said that he will expand broadband access to homes and businesses – a basic need for more sophisticated telehealth applications. The Administration also supported the release of several government reports stating that regulatory and market policies hinder the adoption of telemedicine. This technology would have the greatest impact in rural areas where access to primary care is a critical need.

Voters Divide on Medical Malpractice Issues

Doctors and trial lawyers spent millions of dollars in an unprecedented, four-state election battle over limiting damage awards and attorney fees in malpractice cases. The voters' verdict: a virtual stalemate reflecting deeply divided public opinion.

In Wyoming and Oregon, voters narrowly defeated doctor-backed proposals to implement caps on awards – results were almost 50-50 in each state while Nevada voters reaffirmed a 2002 cap on non-economic awards, but eliminated the exceptions where higher judgments are possible. Nevada and Florida voters supported limits on attorneys' fees, but Floridians also approved two lawyer-backed proposals intended to benefit malpractice victims.

STATE-BY-STATE RESULTS STATE-BY-STATE RESULTS

In **Florida**, voters overwhelmingly approved constitutional amendments that cap damages in medical negligence cases, grant the public access to information on adverse medical incidents, and prohibit physicians who have committed medical malpractice three or more times from being licensed to practice in Florida. The future of the latter two referendums is unclear at this time, however. Since the election, injunctions have temporarily suspended further implementation.

The malpractice initiative votes are the latest in a long-running political battle between physicians and trial attorneys involving medical malpractice in Florida. Under the first initiative, known as Amendment 3, claimants who enter into a contingency fee agreement with attorneys would be entitled to at least 70% of the first \$250,000 in all damages received and 90% of damages in excess of \$250,000. The ballot initiative was sponsored by Citizens for a Fair Share, a political action committee supported by the Florida Medical Association.

During the campaign, physicians had argued that the amendment

would limit "frivolous" lawsuits and "outrageous" trial attorney fees in medical liability cases. They also said the measure would guarantee that patients received a fair share of an award as well as ensure access to medical care by keeping physicians in business in the state. "It is clear the voters in Florida overwhelmingly agreed with their trusted physicians and not the attorneys; it was time to do more to help solve our medical liability crisis," Sandra Mortham, executive vice president of the Florida Medical Association, said in a written statement. "What's more, our citizens recognized that if something did not change, we would continue witnessing more and more of our quality doctors limit their specialty practices and others leave our state altogether."

The trial bar disagreed, maintaining that the physician initiative instead would restrict injured patients' access to the courts, increase the cost of medical care, and force taxpayers to bear the financial burden of care of insolvent malpractice victims. "The health care industry and big insurance companies are pushing Amendment 3 so that they don't have to pay," Floridians for Patient Protection, a PAC sponsored by the Academy of Florida Trial Lawyers, said on its Web site. "The FMA leadership has fooled many good and conscientious doctors into believing that Amendment 3 will help victims and their families. Amendment 3 will make it nearly impossible to punish irresponsible and incompetent doctors. This will be an invitation to the worst doctors in the nation to come to Florida where they will be able to escape punishment for their deadly mistakes."

Nevada voters passed Question 3, which changes state law to limit judgments against physicians, with the aim of stabilizing doctors' medical malpractice insurance costs even though the so-called "Keep our Doctors in Nevada" question failed to pass the 2003 Nevada Legislature. It limits the fees that attorneys who represent injured patients could collect in any malpractice judgment or settlement. A lawyer would receive 40% of the first \$50,000 recovered; 33% of the next \$50,000; 25% of the next \$500,000; and 15% of the amount that exceeds \$600,000.

The Nevada Legislature limited to \$350,000 the award that an injured patient could receive for pain and suffering in 2002, but allowed a higher judgment if there is gross negligence or exceptional circumstances. Question 3 keeps the limit at \$350,000 but eliminates the exceptions where higher judgments are possible.

The American Medical Association issued a statement applauding Nevada voters' decision to enact Question 3. "Today's victory for patients and physicians will help strengthen Nevada's medical liability reforms by deleting exceptions to its \$350,000 limit on non-economic damages, placing limits on attorney contingency fees, and more," the statement said.

A proposed amendment to **Oregon's** constitution that would have limited damage awards in medical liability cases was defeated by voters in a close decision but a rural health group favoring a cap said the issues raised in Measure 35 will likely be revisited by the Legislature. The measure would have limited non-economic damages for patient injuries caused by health care providers' negligence or recklessness to \$500,000.

The amendment had support from doctors, hospitals, and other providers, as well as from non-health-related business groups. Advocates claimed that costly jury awards had driven up the cost of medical malpractice insurance and were forcing some physicians out of business. Opponents stressed that the measure would not necessarily have lowered insurance rates, nor improved patient care. Moreover, they said there was no evidence that non-economic damage awards were increasing. The Oregon Trial Lawyers Associations and several labor unions were among those leading the opposition.

continued on pg 21

THE EUROPEAN SOCIETY FOR EMERGENCY MEDICINE
AND
THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



THE THIRD MEDITERRANEAN EMERGENCY MEDICINE CONGRESS

NICE ACROPOLIS
NICE, FRANCE
SEPTEMBER 2-5, 2005

To respond to a particular ad: AAEM members should send their CV to the AAEM office noting the response code listed at the end of the position description in a cover letter. AAEM will then forward your CV to the appropriate professional.

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

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

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

ARIZONA

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

ARKANSAS

Residency Director: Board Certified emergency physician for our Department of Emergency Medicine at University of Arkansas for Medical Sciences. Applicant should have a demonstrated interest in resident education and program administration. UAMS has a well-established (1983) program in Emergency Medicine with 24 residents in a 1,2,3 format. There is a superb 10-person faculty group—all board certified or prepared. Excellent benefits package and protected time. Little Rock is a very pleasant urban/suburban environment—rarely cold in winter, scenic with abundant outdoor activities and a delightful riverfront: the amenities of a large city without the problems. Applicants please submit cover letter and CV to AAEM Executive Office. University of Arkansas is an Equal Opportunity Employer. (PA 645)

CALIFORNIA

Far Northern: Surrounded by mountains and lakes, located on the Sacramento River. Democratic group staffs 40,000 volume, Level II trauma, referral center, as well as a community hospital. We offer attractive compensation, ownership potential and balanced lifestyle opportunity for emergency physicians. BC/BP preferred. (PA 631)

CALIFORNIA

Part-time/full-time position available in hospital group. Board certified, ACLS, ATLS, and PALS. Three years experience required. 30,000 ED visits/yr. with 20% admission rate and high acuity. Excellent back-up, medical staff. Double coverage from noon to midnight. Evening PAs. Close to beautiful Monterey Bay; 90 minutes from San Francisco. (PA 640)

CALIFORNIA

The University of California, Davis, School of Medicine is recruiting full-time faculty in the Division of Emergency Medicine. A residency training program in EM started 12 years ago and currently has 30 residents. Our ED is a Level I trauma center, poison center, and paramedic base station and training center. EM residents anticipating graduation as well as board certified MD are eligible to apply. For consideration, send CV and letter outlining interests and experience to AAEM executive office. (PA 647)

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

CALIFORNIA

Rare opportunity in Southern Central Valley. Newly formed democratic group needs BC/BE physicians to staff 20k volume ED, and second, completely new 14 bed ED to open this fall in upscale area. Excellent compensation, low cost of living, and year round recreational activities. Partnership tracks available within 18 months. (PA 669)

FLORIDA

Full and part-time BC/BE Emergency Medicine physicians needed in order to expand our department at a community-based hospital in Orlando-Tampa area. Newly renovated, 24,000 square foot ED with 33 patient care bays, 7 bed minor areas, 3 x-ray suites, ample work space. Salary approximately \$120 per hour, plus excellent benefits package. Anticipated start date: 2-15-04 (sooner for part time positions). EOE/AA employer. (PA 646)

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

FLORIDA

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

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

FLORIDA

Naples, Florida-Seasonal MD/DO: Dynamic Independent EM Group is seeking Board Certified EM physician to provide triple coverage December through April. No nights. 40 hours/wk. World class community. (PA 654)

GEORGIA

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

ILLINOIS

Springfield. Outstanding opportunity for Board Certified Emergency Physician at tertiary care trauma center. Democratic group, partnership track, stable practice situation, 45,000 visits, excellent coverage. ED new in 2000 with own CT. Salary \$155 per hour with benefits including health insurance. Exceptional opportunity for an Emergency Physician with superior clinical and interpersonal skills desiring a democratic small group and a long-term practice situation. (PA621)

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

INDIANA

South Bend: Outstanding opportunity for BC/BE Emergency Physician to join our independent, democratic, fee-for-service group. Immediate partnership available, highly competitive compensation, stable group, seeking 12th partner. ED volume 36,000 annual. University of Notre Dame nearby. 90 minutes to downtown Chicago. (PA 653)

KENTUCKY

Owensboro: 27-year, democratic, fee-for-service, 10-physician group seeks residency trained and/or BC emergency physician for 63K visit regional hospital ED. 27,000 sq ft 3 year old 33 bed facility with adjacent radiology dept. with 2 CT scanners. Double and triple physician coverage plus at least 12 hr/day of PA coverage in fast track area. Total package in the \$150/hr range. Bonuses based on productivity. Owensboro is a great place for families, plenty of recreation, a performing arts center, symphony, nationally awarded school system, 3 colleges, and only 2 hours from Louisville or Nashville. (PA 656)

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

MARYLAND

Outstanding opportunity for EM BC/BE Emergency Physician. Stable (>72 years), progressive, single hospital, democratic group. Partnership track. Innovative, beautiful, brand new (5/27/04) state-of-the-art facility serves 52K visit ED. Very high quality hospital in bucolic, suburban location. Competitive salary and benefits. (PA 662)

MASSACHUSETTS

Democratic group seeking BC/BP EP for full time position. We staff two community hospitals with annual volumes of 42,000 and 16,000. Excellent physician coverage and medical staff backup at both facilities. Partnership track with equitable scheduling and compensation. Competitive salary and benefits. Beautiful coastal community located 30 minutes North of Boston. Outstanding opportunity for physician desiring democratic practice environment. (PA 643)

MICHIGAN

FREMONT: One of the largest democratic groups in the nation is looking for a BC/BE emergency physician to help staff a growing rural western Michigan E.D. with 18-19,000 visits/year. Have every recreational, hunting and fishing opportunity just outside your back door while you enjoy excellent schools, excellent hospital backup and a great place to raise a family. Gerber Hospital supported student loan repayment plan negotiable for long term commitment practice to this area. Because this physician group also staffs a large Grand Rapids academic E.D. with its own emergency medicine residency program, involvement in resident lectures, teaching skills labs, and attending conferences and journal clubs is available without having to live or work in the city. Partnership and profit sharing based on number of hours worked and achievable within 18 months. (PA 652)

MINNESOTA

Minneapolis: The Twin Cities largest democratic, physician owned emergency medicine group seeks highly motivated board certified or board-eligible EM physicians to join our 100-member group. Our group staffs six community hospitals with average volumes of 40K. Base salary, benefits, and productivity and performance incentives to exceed \$250K compensation. Come see what Minneapolis has to offer other than snow. Website: www.eppanet.com (PA 601)

MISSISSIPPI

A full-time permanent Emergency Medicine opportunity is currently available at Keesler Air Force Base in Biloxi, MS. 33,000 annual patient visits, Level I, 12 ED physicians, double-coverage, 10 to 12 hour shifts, 160 hrs./mo. Competitive compensation package. Active MS license preferred. (PA 655)

MISSOURI

EM Physicians; excellent opportunity awaits you in the heart of the Ozark Mountains. Democratic EM Physician Group with immediate potential for full-time partnership. Must be residency trained or board certified in EM. Salary >\$120/hr. plus benefits. Very low crime community with solid economic growth, abundance of outdoor recreation. (PA 660) Disclosure: there is a loosely enforced non-compete clause associated with this position. It is imposed on the group by the hospital regarding a competitor hospital in town.

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

AAEM JOB BANK

MISSOURI

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

NEW HAMPSHIRE

Seeking BC/BE physicians to join democratically governed group in Southern NH serving 29,000 patients annually. Competitive salary and benefits. Great location. (PA 634)

NEW HAMPSHIRE

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

NEW JERSEY

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

NEW YORK

Academic Emergency Physician — Exciting position for an experienced, board certified/eligible emergency physician to join the faculty of the Department of Emergency Medicine, a full academic department of the Mount Sinai School of Medicine in New York City. The Mount Sinai School of Medicine is a leader in medical education and research. The hospital is a 900-bed tertiary center with an annual ED census of over 70,000. The EM residency is fully accredited. Academic rank commensurate with qualifications. We are an equal opportunity employer fostering diversity in the workplace. Please submit confidential letter and C.V. to the AAEM executive office. (PA 637)

NEW YORK

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

NEW YORK

Clinical Director, Department of Emergency Medicine: Our Lady Mercy Medical Center, Bronx, NY, is seeking an experienced, energetic Director to lead our Emergency Services Department. With full adult and pediatric services, the department averages 55,000 visits annually in a community setting. This high-profile position is responsible to the Executive Vice President for Medical Affairs, and as Program Director, to the Associate Dean of New York Medical College; also functions as Chair of the Emergency Management Committee. Must be board certified in Emergency Medicine with a minimum of 10 years experience in Emergency Medicine, and 3 years in a leadership role with proven clinical and administrative skills. (PA 668)

NEW YORK

Director, Pediatric Emergency Medicine Mount Sinai School of Medicine seeks a Director for its Division of Pediatric Emergency Medicine. The ideal candidate will have excellent academic leadership skills, a history of scholarly academic accomplishments, and the vision to advance the emergency care of children and the education of our trainees. EEO (PA 677)

OHIO

Opportunity with St. Anne Mercy Hospital. The community hospital opened in 2002 and now provides healthcare services in Toledo, Ohio. St. Anne's provides treatment to patients in the ED, which includes a triage area, treatment/observation rooms, and dedicated pediatric and obstetrical room. (PA 639)

Seeking a BE/BC Emergency Medicine trained physician to join a busy private Emergency Medicine practice in northwest Ohio. The main hospital affiliation, St. Charles Mercy Hospital, is a 386-bed community hospital with 41,000 emergency room visits in 2003. We offer an extremely competitive salary and benefits. Emergency Medicine training a must. (PA 657)

PENNSYLVANIA

Emergency Physician: Northeastern Hospital, part of Temple University Health System, currently has a full time BC/BP emergency physician opportunity available. This growing emergency department of 35,000 annual visits seeks an excellent physician committed to high quality care and superior patient satisfaction. Competitive salary, benefits and malpractice insurance provided. (PA 641)

PENNSYLVANIA

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

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

PENNSYLVANIA

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

SOUTH CAROLINA

SC, Coastal. Immediate opening for BP/BC physician. Conway Medical Center is 15 miles from Myrtle Beach area. 36K visits, level 3 trauma center. Democratic group, immediate partnership, no restrictive covenants. Great local schools, very competitive compensation. Partners enjoy the beach intercostals waterway, water sports and many other outdoor activities. (PA 667)

TEXAS

In need of Emergency Physician for rural 12-bed ED. Democratic group compensating at \$85/hr., transitioning to FFS. 12k volume, minimal trauma, 12-hour shifts, growing, adding second hospital in 18 months. Close to Austin, TX. (PA 632)

TEXAS

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

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

UTAH

Provo: Democratic group seeking BC/BP EP for a full time position. We staff two hospitals with annual volumes of 50,000 and 12,000. Democratic partnership track with equitable scheduling and compensation. 20 minutes from skiing with beautiful mountain canyons in your backyard. (PA 644)

WASHINGTON

Kitsap Peninsula: Our Bremerton ED has undergone a remodel and expansion. Seeking a full-time, BC EM Physician to help us expand coverage. Established, democratic group, with excellent compensation and benefit package. Country and oceanfront lifestyle with diverse outdoor recreation opportunities. One hour ferry from downtown Seattle. See www.HarrisonHospital.org (PA 659)

WASHINGTON

Olympia: Full-time opportunity for BC/BP emergency physician. Established, independent, fee-for-service democratic group. Annual volume 55,000. Financial equality at one year; partnership at two years. State-of-the-art department located on the scenic Puget Sound. (PA 661)

WEST VIRGINIA

DC-Baltimore metro area/Gateway to Shenandoah Valley. Democratic, fee-for-service group seeking BC/BE EP. 32K ED in rapidly growing area with low cost of living and easy access to both metro and wilderness areas. Rapid partnership progression, excellent compensation, equitable shift distribution, and supportive hospital staff. (PA 620)

WEST VIRGINIA

WV University School of Medicine has outstanding open rank opportunities available in a high volume community hospital for BE/BC EM physicians. Duties include direct patient care, teaching/supervising medical students, and EM/family medicine residents. 24-hour radiology readings, rapid lab/x-ray turnaround, bedside registration, template-based charting, generous mid-level and nursing coverage. Area offers culturally diverse, large-city amenities, a safe family setting, excellent school systems and recreational opportunities. Salary and rank commensurate with experience. Competitive employment package including occurrence based malpractice. Submit letter of interest, electronic CV, and three references. (PA 682)

WISCONSIN

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

WISCONSIN

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

GUAM

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

NEW ZEALAND

Have a go at a recharge. Level 2 regional ED on South Island. This is a similar/dissimilar adventure. Income/but costs less. Expect time for recreation, shifts are 8 hours, 4 on/4 off. Requirements: great patient care, experience, control of personal baggage. David.davis@sdhb.govt.nz to arrange phone time. (PA 642)

Washington Watch - continued from pg 17

The history of tort reform in Oregon goes back to 1987, when the legislature passed a bill establishing a \$500,000 cap on non-economic damages. In 1999, the Oregon Supreme Court ruled that cap unconstitutional, saying the Legislature did not have the authority to limit a jury's award (*Lakin v. Senco, Ore., No. S44110, 7/15/99*). Since the Lakin ruling, jury awards for non-economic damages have increased substantially and medical liability insurance premiums have more than doubled, according to the Oregon Medical Association. The association said that this increased insurance cost has led to a shortage of certain specialists such as obstetricians and neurosurgeons in several rural areas of the state.

Wyoming voters narrowly defeated – by 7995 votes – a proposed constitutional amendment that would have allowed the state Legislature to enact laws limiting the amount of damages for non-economic losses in medical malpractice cases. Meanwhile, voters narrowly approved a related measure that would let the state legislature enact laws requiring alternative dispute resolution or medical panel review before a person files a lawsuit against a health care provider (Constitutional Amendment C). However, the measure was within the 1% of the mandatory recount variance and will now face a recount.

Wyoming's constitution does not allow caps to be imposed on non-economic awards in medical malpractice cases. Many health care providers and insurance companies point to that prohibition on caps as a leading cause for recent sharp increases in medical malpractice insurance premiums for providers. Previous attempts to remove the ban on caps legislatively have failed. Governor Dave Freudenthal (D) said in a recent news conference he was surprised voters had killed the measure. "Now the public has told us what they want, and the issue is really off the table." According to Freudenthal, the debate has been between whether the state should try to limit the amount of money insurance companies pay out in medical malpractice awards or whether it must shift insurance risk to the public sector. "The question now is how do we help underwrite the cost of insurance to make it affordable to the practitioner" and therefore keep the doctors in Wyoming, he said. "If we're not going to limit the payouts, we have to look at other strategies to make malpractice insurance affordable."

It is unclear what, if any effect, the state referendums will have on health care legislation in the 109th Congress. Even with Republicans gaining as many as four additional Senate seats, battles are still expected in that chamber over medical malpractice legislation. Doctors vowed to keep pressing their cause, hoping President Bush's re-election and Republican gains in Congress might weaken Democratic opposition to federal legislation capping malpractice awards.

CHANGE OF E-MAIL ADDRESS

If you have changed your e-mail address or are planning to change it, please contact the AAEM office at (800) 884-2236 to update your information.

AAEM Committees and Taskforces Want YOU!

Many new and existing AAEM committees and taskforces need your assistance to achieve their goals. The following committees and taskforces are currently recruiting additional members.

ED Design/Through Put Subcommittee

ED Overcrowding Taskforce

EMTALA Taskforce

EMS Committee

Ethics Committee

Membership Committee

Please send the committee/taskforce(s) you wish to join, a brief statement of intent and your current CV to AAEM staff member, Tom at tderenne@aaem.org.

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