common SENSE

when minutes count

VOLUME 14, ISSUE 4
JULY/AUGUST 2007

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

PRESIDENT'S MESSAGE

The Right Fight

by Tom Scaletta, MD FAAEM
AAEM President

During my AAEM talk at a prominent emergency medicine residency program, an attending physician in the audience proclaimed that not one emergency medicine professional organization has earned his membership support. After some consternation, I came to the conclusion that emergency physicians are obligated – even ethically responsible – to join a specialty society that adheres to the right principles, strongly represents their major concerns and delivers tangible benefits.

Since you are reading this in *Common Sense*, you are most likely a dues paying AAEM member and I sincerely appreciate your support. This year, I would like you to enlist your trust and commitment in an additional way.

Conditions are favorable for a precedent-setting legal action that could slam the door on the illegal corporate practice of emergency medicine. AAEM has identified a very competent legal team and has challenged TeamHealth, a national contract group, in a state where, despite strong prohibitory laws, corporate control and profiteering hinder patient care and professional rights on a large scale. AAEM's legal action intends to result in a landmark decision to help secure the interests of thousands of emergency physicians (see page 10 for information on this case).

My request is this. Please ask your professional colleagues to consider supporting AAEM's biggest legal undertaking to date by generously donating to the AAEM Foundation, a non-profit organization that will give us the financial resources we need to prevail in the right fight. Thank you.

To make a donation to the AAEM Foundation, go to www.aaem.org and click on the AAEM Foundation link -https://ssl18.pair.com/aaemorg/aaemfoundation/contribution.php.

INSIDE THIS ISSUE

EDITOR'S LETTER

Endings and Beginnings

by David Kramer, MD FAAEM

As a residency program director (PD), this is a very special time of year. I am entering my 20th year as a PD and I always have the same mixed feelings as one class goes out into the "real world" of emergency medicine while another begins residency training. Watching my graduating residents start their professional careers led to my involvement with AAEM. After all, I want the same high quality professional life for each of my residents that every member of AAEM desires. The core mission of our organization gives every graduating resident hope for fair treatment, professional longevity and career satisfaction. The job opportunities remain numerous and diverse. The role of the program director is one of education and guidance. At the point of graduation, the ball is in the individual resident's court. I am always a little sad to see another class leave the nest, but am also hopeful for all they have in their future.

On the other side is the beginning. Every new group of residents brings a level of enthusiasm, excitement and energy that is truly contagious. Our orientation lasts the entire month of July and the collegiality and teamwork that develops is wonderful to see. I always feel rejuvenated during orientation by the "newbies." Their thirst for knowledge and their desire to please is like legal steroids for a program director. It seems like every new class is better than the last. The knowledge base and requirements continue to grow; yet somehow, the residents manage to step up to the plate and knock it out of the park. I am constantly amazed at how much we mange to fit into 36 months of training. But I am far more impressed with how much the residents manage to take with them when they leave. And when they leave, I am reminded once again why we do this, what we owe them and why AAEM exists.

"Remember, every new beginning is some beginning's end." Bon Jovi

Have a great summer, and don't forget to make your plans for the AAEM Scientific Assembly in February 2008. Amelia Island, here we come!

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 quallity of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.

Membership Information
Full Voting Member (FAAEM): $365 (Must be ABEM or AOBEM certified in EM or Pediatric EM)
Affiliate Member: $365 (Must have been, but is no longer ABEM or AOBEM certified in EM) (Non-voting status)
*Associate Member: $250 (Associate-voting status)
Emeritus Member: $250 (Must be 65 years old and a full voting member in good standing for 3 years)
International Member: $125 (non-voting status)
AAEM/RSA Resident/Fellow Member: $50 (Non-voting status)
Student Member: $50 (Non-voting status)
Student free (Non-voting status)
*Associate membership is limited to graduates of an ACGME or AOA approved Emergency Medicine Program

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

American Academy
of Emergency Medicine

May 14, 2007

Lisa Madigan
Illinois Attorney General
Chicago Main Office
100 West Randolph Street
Chicago, IL 60601

Dear Attorney General Madigan:

The American Academy of Emergency Medicine (AAEM) is *the* specialty society of board certified emergency medicine physicians, a democratic organization with over 5,000 members including many who practice in Illinois. AAEM is aware of the existence of in-store medical clinic care being provided by large retail chains within the state of Illinois. Attached is a copy of a May 6, 2007, Chicago Tribune article entitled, "Doctors push law on clinics in stores – Patients are put at risk, they contend." AAEM is concerned that this practice may be in violation of one or more of the following Illinois Corporate Practice of Medicine statues:

- ILCS ch. 225 60/49, 60/50 (penalty for practicing without a license)
- ILCS ch. 225 60/22 (32) (grounds for disciplinary action -- aiding or abetting unauthorized practice of medicine)
- ILCS ch. 225 60/22 (11) (prohibition on allowing another person or organization to use their license to practice)

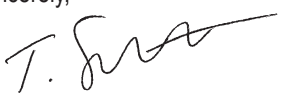
The following cases may also be relevant to this situation:

- Dr. Allison, Dentists, Inc. v. Allison (1935) 360 Ill. 638, N.E. 799 (a covenant not to compete was unenforceable because the corporation was illegally practicing dentistry)
- Winberry v. Hallihan (1935) 361 Ill. 121, 197 N.E. 552 (the state may deny corporations the right to practice professions and has the right to insist on the person obligation of the individual practitioner)
- People by Kerner v. United Medical Serv. (1936) 362 Ill. 442, 200 N.E. 157 (corporation that established a fixed fee, low cost medical clinic in Chicago in which all services were rendered by licensed physicians, whom the corporation paid, may not practice learned professions and may not do so by employing licensed physicians.)
- See People ex rel. Watson v. House of Vision (1974) 59 Ill. 2d 508, 322 N.E.2d 15, cert. denied, 422 U.S. 1008 (1975) (corporation enjoined from violating the Optometric Practice Act by allowing employees who were not licensed as optometrists to fit contact lenses)
- People ex rel. Ill. Soc'y of Orthodontists v. United States Dental Inst., Inc. (1978) 57 Ill. App. 3d 1029, 373 N.E. 2d 635 (school teaching dentistry that advised students on specific problems of patients including diagnoses, was engaged in the unlawful practice of dentistry by a corporation in violation of the Dental Practice Act and was enjoined.)

AAEM respectfully requests that your office investigate these concerns. Please let me know if I can be of personal assistance in this matter as I practice in Illinois. Thank you for your time and attention to this important matter.

Sincerely,

Sincerely,



Tom Scaletta, MD FAAEM
President, AAEM

American Academy
of Emergency Medicine

May 14, 2007

Rodney Osborn, MD
President, Illinois State Medical Society
Twenty North Michigan Avenue, Suite 700
Chicago, Illinois, 60602

Dear Dr. Osborn,

The American Academy of Emergency Medicine (AAEM) is *the* specialty society of board certified emergency medicine physicians, a democratic organization with over 5,000 members including many who practice in Illinois. AAEM has serious concerns about the in-store medical clinic trend as described in the article, "Doctors push law on clinics in stores – Patients are put at risk, they contend" that appeared in the Chicago Tribune on May 6, 2007.

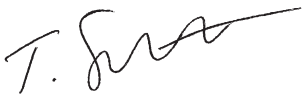
We believe that these arrangements may violate Illinois laws prohibiting the corporate practice of medicine (CPOM) and have asked the Illinois Attorney General to investigate the arrangements with regard to the following Illinois CPOM statues:

- ILCS ch. 225 60/49, 60/50 (penalty for practicing without a license)
- ILCS ch. 225 60/22 (32) (grounds for disciplinary action -- aiding or abetting unauthorized practice of medicine)
- ILCS ch. 225 60/22 (11) (prohibition on allowing another person or organization to use their license to practice)

AAEM has been involved with legal challenges regarding CPOM. We participated in a successful action against California involving Catholic Healthcare West. Subsequent challenges involved TeamHealth in California and EmCare in Minnesota. We are currently working with the Texas and Pennsylvania Medical Associations on such cases.

Please contact me to further discuss how AAEM can assist the Illinois State Medical Society, amplify your concerns, and determine whether these clinics violate Illinois CPOM laws.

Sincerely,



Tom Scaletta, MD FAAEM
President, AAEM

Illinois State Medical Society

May 23, 2007

Tom Scaletta, M.D. FAAEM
President
American Academy of Emergency Medicine
555 E. Wells Street, Suite 1100
Milwaukee, WI 53202-3823

Dear Dr. Scaletta:

I'm writing in response to your May 14th letter to ISMS regarding retail medical clinics. Thank you for the update on your contact with the Illinois Attorney General regarding the American Academy of Emergency Medicine's concerns about retail health clinics, and the potential violation of laws prohibiting the corporate practice of medicine. I have advised our General Counsel that AAEM is pursing this complaint. Please keep us informed on its status, and any feedback you receive the Attorney General's office.

For your information, I'm attaching a copy of legislation introduced on behalf of ISMS, which seeks to establish more concrete regulatory requirements applying to these new health care delivery settings. I have also included a copy of policy recently adopted by the ISMS House of Delegates.

Retail clinics have been growing in number throughout Illinois, and have become a significant concern. The clinics must be held to the same standards that apply to more traditional medical settings, to protect patient care and preserve the concept of the medical home. Thank you for sharing your views on this important issue with ISMS.

Sincerely,

William E. Kobler, M.D
Chair, Board of Trustees

Attachments
cc: Rodney C. Osborn, M.D.
Shastri Swaminathan, M.D.
Alexander R. Lerner

Twenty North Michigan Avenue, Suite 700 Chicago, Illinois 60602 Web site: www.isms.org
Telephone: 312-782-1654 Toll Free: 800-782-ISMS Fax: 312-782-2023

Technical Advisory Group Hears Testimony on EMTALA Concerns

by Kathi Ream, Government Affairs Director

The EMTALA Technical Advisory Group (TAG) held its sixth meeting in early May. During the session, five public witnesses testified on various issues surrounding EMTALA.

Amos Stoll, MD FACS, from Broward General Medical Center (FL), reported that the increasing number of patients at his hospital is stretching the capacity of the specialist physicians to provide required care. He was especially concerned about a neighboring county which has been through a crisis in neurosurgery coverage, resulting in patients transferred to Broward, often with very poor results.

David J. Ciesla, MD, Washington Hospital Center (DC), expressed concern about the increase in transfers to trauma centers of patients who do not need level-I trauma care. He reported that since 2001, there has been an 80 percent increase in transfers to trauma centers and a 20 percent decrease in the severity of injured among patients being transferred. Ciesla has found that because trauma center resources are finite, receipt of patients not needing the full range of services threatens to overwhelm the ability of trauma centers to function properly. He recommended that hospitals be encouraged to participate in state or regional trauma systems with guidelines on which patients to transfer and when to transfer.

Jeffrey Anglen, MD, Orthopaedic Trauma Association and the American Association of Orthopaedic Surgeons, described difficulties encountered – leading to unnecessary transfers, delays in care and threatened outcomes – owing again to the provision of on-call coverage by specialists. Especially in rural areas, absent on-call orthopedic surgeons' patients are transferred to trauma centers where they may spend days in the emergency department before being admitted to an inpatient bed.

Robert Waters of the Center for Telehealth & E-Health Law provided testimony regarding the legal and regulatory barriers that continue to limit the application of telemedicine. He requested that the Centers for Medicare and Medicaid Services (CMS) endorse the use of technology (e.g., phone, fax, email and transfer of digital images) to communicate with on-call physicians. CMS staff reported that changes are in the pipeline in response to the TAG's recommendation from November 2006 that the Department of Health and Human Services (HHS) strike the current language in the Interpretive Guidelines on telehealth/telemedicine and adopt a more permissive stance clarifying that the treating physician may use a variety of methods to communicate with the on-call physician. This prompted the TAG to recommend that HHS reach out to providers reminding them to take the initiative in contacting their regional offices for clarification of the Interpretive Guidelines or any other regulations regarding EMTALA, such as acceptable uses of telehealth for communication under the current Interpretive Guidelines.

The fifth public witness was Ann Pfeiffer, RN MS, Nelson Mullins Riley & Scarborough LLP (SC), who spoke about the challenges facing hospitals in complying with EMTALA relative to providing appropriate stabilization and referral of individuals with behavioral health complaints to the facility that best serves the individual's needs. She noted that complying with EMTALA and serving the patient is not easy in many states where local laws require that patients be placed within the state mental health system. Pfeiffer requested more guidance in medical screening, stabilization and transfer for these patients.

ON-CALL SUBCOMMITTEE

Chairperson John Kusske, MD, Chair of the Department of Neurological Surgeons at the University of California's Irvine Medical Center, reported on the subcommittee's work, and the TAG responded with the following recommendations for HHS consideration:

- Move the EMTALA provision dealing with maintaining a list of on-call physicians to the Medicare provider agreement.
- Change 42 C.F.R. 489.20(r)(2) to read: "Each hospital must maintain an on-call list of physicians on its medical staff who are available to examine and stabilize the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians."
- Change the Interpretive Guidelines to state the following:
  - ➢ If a hospital offers a service to the public, this service should be available for emergency care through on-call coverage.
  - ➢ To satisfy the requirement for on-call coverage, at least annually, hospital and medical staff must develop a plan for on-call coverage that includes, at a minimum, evaluation of the following factors:
    - ❑ hospital capabilities/services provided (advertised/licensed)
    - ❑ community need for ED services as determined by ED visits
    - ❑ transfers out of hospital for emergency services
    - ❑ physician resources
    - ❑ past call plan performance

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- The hospital must have a backup plan for patient care when it lacks capacity to provide services or on-call physician coverage is not available. The backup plan should consist of viable patient care options, such as the following:
  - telemedicine
  - other staff physicians
  - transfer agreements designed to ensure that the patient will receive care in a timely manner
  - regional or community coverage arrangements
- A hospital may satisfy its on-call coverage obligation by participation in an approved community/regional call coverage program (CMS to determine appropriate approval process).

The TAG requested that, for the next meeting, the On-Call Subcommittee consider recommending that specialty hospitals be required to maintain a list of on-call physicians.

ACTION SUBCOMMITTEE

Chairperson, Julie Nelson, JD, Attorney and Partner in Coppersmith, Gordon, Schermer, Owens, & Nelson, PLC (AZ), led a discussion about ways to improve public information and professional education about EMTALA. The TAG recommendations to HHS covered the following:

- More comprehensive, prominent, user-friendly CMS EMTALA Website
- Standardized regional office/state surveyor education
- Provider education
- Patient education

The Action Subcommittee also presented recommendations concerning the distinction between "capability" and "capacity" for duties of transferring and receiving hospitals. On this matter, the TAG requested the Subcommittee to revise its draft document on the duties of hospitals with specialized capabilities to accept patient transfers and present a final proposal at the next TAG meeting. The TAG also requested that the Action Subcommittee consider the EMTALA regulations guiding the responsibility of the ED staff to intervene with police officers who want to remove a patient from the ED.

FRAMEWORK SUBCOMMITTEE

Chairperson Charlotte Yeh, MD, CMS Regional Administrator, Region I (Boston, MA), presented papers that students from the Harvard University School of Public Health and the Johns Hopkins University School of Public Health helped research and write on four subject matter areas that were beyond the scope of the TAG but affect compliance with EMTALA:

- Reimbursement
- Liability
- Capacity (comprising Workforce Capacity and Inpatient Hospital Capacity)
- Disparities in Care

The TAG members will submit comments to fine-tune the papers.

This meeting may be the group's penultimate gathering before the charter's required sunset; although the TAG recommended to the HHS Secretary that the charter be extended for one year to allow the TAG to continue its work.

CMS ISSUES GUIDANCE ON HOSPITAL ER SERVICE REQUIREMENTS

At the end of April, the Centers for Medicare & Medicaid Services (CMS) issued guidance to its State Agency surveyors clarifying the responsibility of hospitals to provide emergency services if they participate in the Medicare program. The guidance makes it clear that nearly all hospitals – including specialty hospitals and others without emergency departments – must be able to evaluate persons with emergencies, provide initial treatment and refer or transfer these individuals when appropriate. The guidance does not apply to critical access hospitals that are subject to separate regulation.

The guidance came a month after CMS terminated its Medicare provider agreement with West Texas Hospital in Abilene, Texas, following the investigation of a patient death there in January after a 911 transfer (No. 54 HCDR, 3/21/07 a0b4e1n3c6). The death at West Texas Hospital, described by CMS as a physician-owned specialty surgical hospital, renewed concerns among some congressional lawmakers about physician-owned specialty hospitals, including the prevalence of hospitals using 911 to handle emergency cases.

Survey and Certification letters guide in determining whether hospitals meet all conditions of participation required to participate in the Medicare program. The recent letter reiterates Medicare's long-standing requirement that hospitals have appropriate policies and procedures in place to address individuals' emergency care needs 24 hours per day, seven days per week. The three key requirements are: the capability to appraise the emergency situation, providing initial treatment and referral when appropriate.

The letter clarifies that the Medicare Conditions of Participation (CoPs) do not permit a hospital to rely upon 911 services as a substitute for the hospital's own ability to provide these services. "Any hospital participating in Medicare, regardless of the type of hospital and apart from whether the hospital has an emergency department, must have the capability to provide basic emergency care interventions," said Leslie V. Norwalk, Esq., Acting Administrator of the Centers for Medicare & Medicaid Services.

In a separate development, CMS issued a proposed rule on April 13, 2007, that would increase transparency and public disclosure concerning emergency services. The FY 2008 acute care hospital Inpatient Prospective Payment System (IPPS) proposed rule would require a hospital to notify all patients in writing if a doctor of medicine or doctor of osteopathy is not present in the hospital 24

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Applicants for Certificate of Excellence in Emergency Department Workplace Fairness

Organization	State
Emergency Medicine Physicians	OH
Kern Medical Center	CA

Recognized as being in compliance with Certificate of Workplace Fairness Standards & Conditions

Organization	State
Baltimore Washington Medical Center	MD
Clear Lake Regional Medical Center	TX
Madison Emergency Physicians-St. Mary's Hospital	WI
Mount Sinai Hospital	IL
Newport Emergency Physicians, Inc.	RI
Southern Colorado Emergency Medical Associates	CO
St. Joseph Regional Medical Center	IN
St. Luke's Hospital	IA
UCI Medical Center	CA
Univ. of Oklahoma COM-Tulsa	OK
Watsonville Community Hospital	CA

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

Washington Watch - continued from page 7

hours a day, seven days per week. The hospital would be required to disclose how it would meet the medical needs of a patient who develops an emergency condition while no doctor is on site. CMS also invited comments on whether current requirements for emergency service capabilities in hospitals with and without emergency departments should be strengthened in certain areas, such as the types of clinical personnel that should be present at all times and their competencies, the type of emergency response equipment that should be available and whether hospital emergency departments should be required to operate 24 hours per day, seven days per week.

For more information on the emergency services guidance go to www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#

STATE UPDATE . . .

Alabama Bill Creates Statewide Trauma System

In order to ensure that patients in Alabama get to the closest hospital best suited to treat their injuries, state health officials and hospitals backed legislation that would establish a statewide trauma system. On June 7, 2007, Governor Bob Riley (R) signed the bill into law. Before this, Alabama had no system outside of the Birmingham area for routing and managing trauma patients, and an estimated 60% of the state's trauma patients initially went to hospitals without trauma care. Under the provisions of the new law, hospitals that participate and meet certain criteria will be given a classification based on the severity and types of injuries they can handle, and the system would direct patients to the nearest hospital that can adequately treat their injuries.

Trauma Bill Passes Georgia Legislature

Senate Bill 60, which sets up a trust fund for Georgia's troubled trauma care hospitals, was signed into law by Georgia Governor Sonny Perdue (R) on May 11, 2007. In addition to the trust fund, the measure creates a nine-member Georgia Trauma Care Network Commission to raise state and federal funds, grants and donations, and distribute the money to the state's trauma care hospitals. Representative Larry O'Neal (R-Warner Robins), who carried the bill on the House floor, said the state's network of trauma care hospitals needs $85 million at a minimum. While Senate Bill 60 does not put any money into the trust, other bills that would generate funds for the hospitals are under consideration and awaiting decisions in the General Assembly.

In his presentation to the House, O'Neal described the deteriorating situation with respect to Georgia's trauma system – a description backed up by the Joint Comprehensive State Trauma Services Study Committee's report in January concluding that Georgia is in a "trauma care crisis," as well as by DeKalb Medical Center's announcement last month that it is leaving Georgia's trauma network. He told the House moments before it approved Senate Bill 60 on a 158-1 vote that the measure "… might be one of the most important pieces of legislation … I have ever been involved with in my entire life." He added, "I just commend to you Senate Bill 60, which is a start. It is vital that we get this commission set up."

Society for Academic Emergency Medicine

901 N. Washington Ave. Lansing, MI 48906 (517) 485-5484 FAX (517) 485-0801

PRESS RELEASE

Contact: **Barbara A. Mulder**
Associate Executive Director
Tel: 517-485-5484 x. 207
barb@saem.org

The Lansing-based Society for Academic Emergency Medicine (SAEM) is pleased to announce that Michigan native, James R. Tarrant, MA CAE, will assume the position of Executive Director on June 4, 2007. Mr. Tarrant, who has more than 16 years of experience in medical societies, was Executive Director of the Chicago Medical Society, an organization of approximately 6000 physicians and 25 staff. He was responsible for both the day-to-day operations and for implementing long-term strategies for this 157-year-old professional membership organization. Under Mr. Tarrant's leadership, the Chicago Medical Society restructured itself to respond swiftly to the challenges of medical practice today.

Prior to this Chicago position, Mr. Tarrant was General Manager, Subsidiary Operations, for the Michigan State Medical Society. He was previously Executive Director of the Physician's Review Organization of Michigan and President of the Michigan Health Council.

Mr. Tarrant earned his Bachelor of Arts degree from Alma College and his Master's degree from Michigan State University. He was designated as a Certified Association Executive (CAE) in 1992.

Mr. Tarrant brings a fresh perspective to the Society and the SAEM office management and was considered the ideal candidate to develop a long-term relationship with the membership.

Mr. Tarrant has ample expertise in non-profit society management, fundraising, physician education and meeting planning. He has experience fostering leadership and staff collaboration; building external relationships and managing related associations and independent consultants.

On the personal side, Mr. Tarrant has close family ties in the Lansing area and spends his free time sailing his boat on Lake Michigan with wife, Marilyn. They have five sons.

The Board of Directors and the Executive Director Search Committee are very excited about Mr. Tarrant's knowledge, experience, professionalism and enthusiasm that he will bring to SAEM. The transition has the potential to transform the Society.

AAEM seeks support regarding the Corporate Practice of Medicine in Texas

In what will be a pivotal case related to the professional control of the practice of emergency medicine, emergency physicians and interested parties are asked to donate to the AAEM Foundation to support the legal efforts of AAEM in Texas. On June 27, 2007, the American Academy of Emergency Medicine (AAEM) and its Texas Chapter filed an action for Declaratory Judgment in Harris County, TX District Court seeking to invalidate the takeover of eight ED contracts by a for profit corporation. TeamHealth, an ED contract management company headquartered in Knoxville, TN, and owned by the Blackstone Group, was recently awarded the exclusive contracts for emergency services by the Memorial Hermann Health System (MHHS) in Houston, TX.

The suit, also filed on behalf of Crystal Cassidy, MD FAAEM, contends that the awarding of these contracts by the administration of the Memorial Hermann Health System was improper. The filing states that the ownership by TeamHealth creates a situation where there is lay control over physician practice in violation of the existing Texas prohibition on the corporate practice of medicine and results in an illegal fee-splitting arrangement.

AAEM Past President Robert McNamara, MD FAAEM, stated, "In addition to the legal ramifications threatening the licensure of the physicians, it is central to AAEM's involvement that the prohibition on the corporate practice of medicine exists to protect the physician-patient relationship. These laws simply state that it is not in the best interest of the patient to have a lay business influence on their physician. The danger of this influence is heightened in the emergency department where patients are vulnerable and often under or uninsured."

AAEM and its Foundation have already committed substantial time and resources surrounding this matter. On behalf of Dr. Cassidy, the AAEM Foundation had provided funding for a legal action against Emergency Consultants Incorporated (ECI) of Traverse City, MI, the prior corporate owners of five of the MHHS ED contracts. Cassidy successfully pursued a "rule 202" action in Houston and, while in the course of depositions of ECI officials, MHHS issued a RFP for its ED contracts. AAEM and the Texas Chapter sent a letter to MHHS requesting a dialogue on the corporate practice of medicine, but the offer was flatly refused.

The AAEM Foundation will be supporting the full legal costs of this action on behalf of Cassidy and the specialty of emergency medicine in Texas. We ask for the support of the emergency medicine community on this important matter. Donations to the AAEM Foundation can be made online at www.aaem.org or by mailing a check to: AAEM Foundation, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202-3823.

The AAEM Foundation is a 501(c)(3) non-profit organization established to enforce the CPOM laws and to protect the rights of physicians against corporations that violate CPOM laws.

DONATIONS TO THE FOUNDATION CAN BE MADE BY

phone at

1-800-884-2236

or online at

https://ssl18.pair.com/aaemorg/aaemfoundation/contribution.php

The AMA Annual Meeting

by Joseph Wood, MD JD FAAEM

The American Medical Association held its annual meeting in Chicago on June 23-27, 2007. Most emergency physicians probably don't belong to the AMA, and many probably question why they should belong. Currently, only about 100,000 physicians are AMA members. While this is a minority of physicians in the United States, this still makes the AMA the largest and best organized medical society. Politicians universally regard the AMA as the voice of organized medicine. Consequently, it is virtually impossible to effectively lobby in Washington if the AMA does not support the cause. If emergency medicine wishes to effectively impact issues such as reimbursement for EMTALA mandated care, emergency department crowding and liability reform, we must be able to first influence the AMA policy makers.

The annual AMA meeting is very similar to a political party convention. Each state and most specialty societies send delegates. There are caucuses of various groups with common interests. The caucuses provide greater strength and influence by virtue of greater numbers. Hundreds of resolutions are proposed by the various states and specialty societies. Like a legislative body, the AMA House of Delegates initially refers the proposed resolutions to a variety of committees for testimony and recommendations. Many proposed resolutions are filtered out or amended at the committee level. Proposed resolutions surviving the committee process are ultimately voted on by the House of Delegates.

By AMA standards, emergency medicine is a relatively small and new specialty. Nevertheless, emergency medicine is well organized and gaining stature. Recently, a practicing emergency physician, Dr. Steve Stack, was successful in gaining a seat on the AMA Board of Trustees. The AMA Section Council of Emergency Medicine is well organized, holding two three-hour meetings in which all proposed amendments are discussed, and Emergency Physician Council members are assigned to the reference committees in order to provide testimony on resolutions which may impact the practices and interest of emergency physicians.

In addition to its lobbying activities, the AMA has developed a Litigation Support Section. This Section may assist physicians engaged in litigation involving issues impacting a large number of doctors. This may include the provisions of due process as well as policing the illegal corporate practice of medicine.

While most physicians relate to their specialty society, the AMA still plays an important role in governmental affairs. AAEM has been represented at the AMA meeting for several years. We have worked with the ACEP leadership, who are delegates to the AMA House, to protect the interest of emergency physicians. Your AMA membership strengthens our influence in this organization.

The AAEM Foundation

would like to thank the Florida Chapter of the American Academy of Emergency Medicine (FLAAEM) for their donation of $1,000. FLAAEM donated the funds to support the legal efforts of AAEM in Texas. To learn more about the Corporate Practice of Medicine and the case in Texas, please go to www.aaem.org/corporatepractice.

DAVID SORIA, MD FAAEM, FILES CLASS ACTION COMPLAINT AGAINST INPHYNET CONTRACTING SERVICES, INC. AND TEAMHEALTH, INC.

David Soria, MD FAAEM, recently filed a class action complaint against two defendants:

- InPhyNet Contracting Services, Inc., a corporation in Florida that is a wholly-owned division of TeamHealth, Inc. and
- TeamHealth, Inc., a corporation in Tennessee.

Dr. Soria worked in the ED at Wellington Regional Medical Center in Wellington, FL, and was previously employed by the defendants. According to the allegations in the suit, under the terms of employment, physicians at Wellington Regional Medical Center were offered a Physician Incentive Plan which entitled them to a percentage of profits to be paid on a quarterly basis. To see the Physician Incentive Plan, go to http://aaem.org/corporatepractice/SoriaClassActionComplaint2007.pdf#page=13.

The complaint also alleges that proper payments have not been made and that expenses incurred at certain facilities were artificially and improperly inflated making it appear as though the hospital's gross profits were reduced. Given that, the incentive compensation to Dr. Soria and others was reduced.

The exact number of class members for the case is not known at this time; however, the estimate is not less than 250 members. The class action complaint includes the following:

- Claim for Breach of Contract and Breach of Implied Covenant of Good Faith and Fair Dealing
- Claim for Violation of the Florida Deceptive and Unfair Trade Practice Act
- Claim for Breach of Fiduciary Duty and Constructive Fraud
- Claim for Unjust Enrichment
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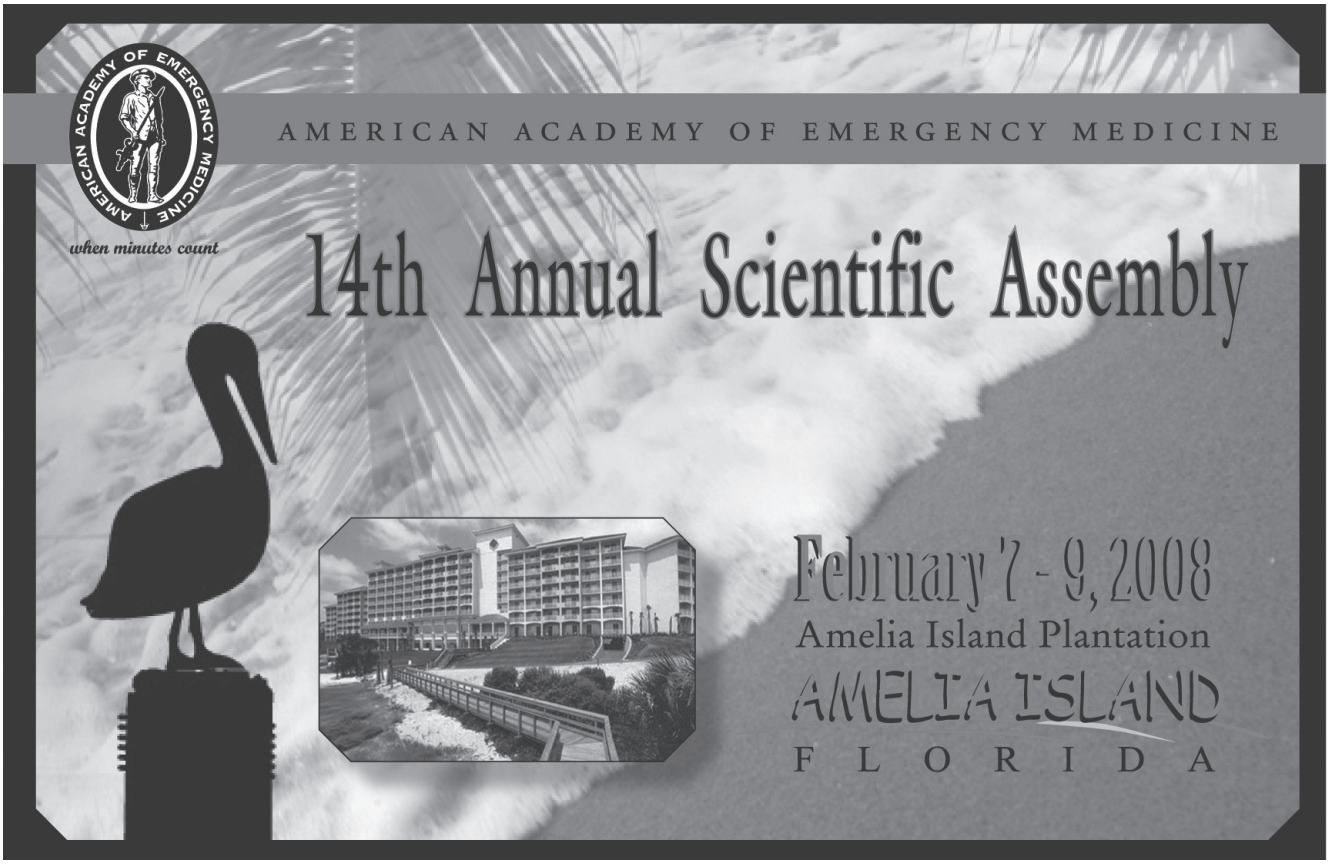
To view the legal filing, go to - http://aaem.org/corporatepractice/SoriaClassActionComplaint2007.pdf#page=1.



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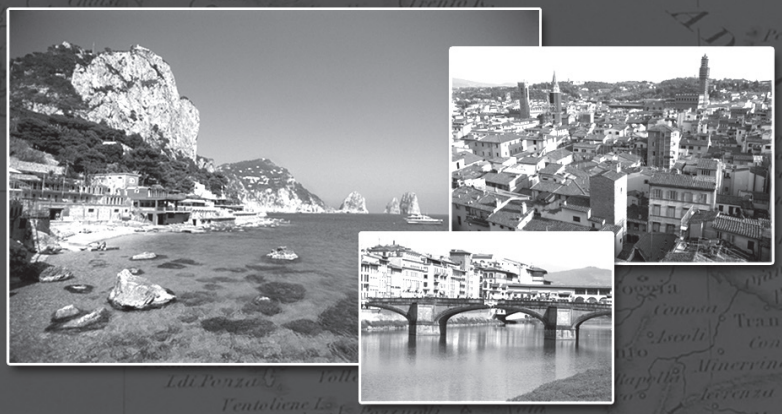

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- The Fourth Mediterranean Emergency Medicine Congress
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September 27-30, 2007
- Written Board Review Course
  Marriott Newark Airport Hotel
  Newark, NJ
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- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, Los Angeles, Orlando, Philadelphia
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- EMCON 2007
  9th International Conference on Emergency Medicine
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- Sun BEEM
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  Occidental Grand Resort, Cozumel, Mexico
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  www.beemcourse.com/index.html

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- Maui 2007: Current Concepts in Emergency Care
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YPS PRESIDENT'S MESSAGE

Solutions to Problems That Shouldn't Exist

by David D. Vega, MD FAAEM

Emergency physicians are masters of adaptation. The variety of challenges we face on a shift-by-shift basis is a driving force for many in choosing emergency medicine as a specialty. Throw us an unusual, complicated case filled with diagnostic challenges, and we'll be talking about it for days and weeks to come. Put us under the pressure of multiple ambulances bringing sick patients at the same time, and we'll do what needs to be done to take care of our patients. Those of us who are newer emergency physicians, in particular, seem to enjoy the times when we have to adapt to unusual circumstances to get the job done. We can come up with solutions for almost anything you throw at us. If we can't get it figured out, then we can certainly get the patient to someone who might be able to.

Nowhere is our adaptability better demonstrated than in our ability to care for patients in the far less than ideal conditions found in the majority of emergency departments (ED) across the country. Utilization of the ED for healthcare continually increases, as do unfunded regulations and mandates from governing bodies, which has helped to create a crisis state where waiting rooms are packed and admitted patients are held in the ED for hours or even days, severely limiting the space and resources available to care for patients. We adapt by just doing the best we can with what we are given.

Unfortunately, though, we are reaching the brink of our ability to adapt to the problem of overcrowding. More and more adverse events are occurring in waiting rooms where patients are spending increasing amounts of time. Patient care suffers as we are forced to see patients in the hallways. To compound matters, our experienced emergency nursing colleagues are leaving the ED for areas of the hospital with better working environments.

These problems have not suddenly appeared, but have gradually developed over the course of the past few decades. The literature includes references to overcrowding from the early 1990s (DP Andrulis et al, Emergency departments and crowding in United States teaching hospitals. Ann Emerg Med 1991 Sep;20(9):980-6). The slow, insidious nature of these problems, along with our admirable ability and willingness to continually adapt to any situation, has kept our efforts at correcting the real problems meager until recently. Fortunately, EM organizations and governing bodies are now beginning to recognize the critical importance of correcting these problems, instead of just adapting to them.

In addition, more and more evidence in the literature is demonstrating that the problems that have been previously attributed to emergency department inefficiency and other internal problems actually are more attributable to patient management at other levels in the healthcare system (S Schneider et al, Rochester, New York: a decade of emergency department overcrowding. Acad Emerg Med 2001 Nov;8(11):1022-3). The mismatch of hospital-wide demand and resources, for example, has led to increased boarding of admitted patients in the ED.* This common practice of boarding patients is increasingly being recognized as detrimental to patient care and safety, professional well-being and staff turnover, and also has been shown to have a significant financial impact through lost patient care opportunities (T Falvo et al, The Opportunity Loss of Boarding Admitted Patients in the Emergency Department. Acad Emerg Med 2007 Apr.;14(4):332-337).

Since these problems are not based solely in the emergency department, our efforts at finding solutions should include multi-disciplinary teams looking at entire hospital systems. Focusing efforts solely on the emergency department, such as expanding facility size, is insufficient (JH Han et al, The effect of emergency department expansion on emergency department overcrowding. Acad Emerg Med 2007 Apr; 14(4):338-43), while efforts involving outside departments have been shown to be successful (KJ McConnell et al, Effect of increased ICU capacity on emergency department length of stay and ambulance diversion. Ann Emerg Med 2005 May;45(5):471-8). We must always remember that we are experiencing symptoms of an ill healthcare ***system*** and that the problems are not isolated to the emergency department.

The application of information and system engineering technologies shows great promise in providing effective methods of analyzing extremely complex, hospital-wide systems of healthcare. As emergency departments continue to integrate information technology with patient care, we have the opportunity to show concrete numbers that demonstrate the detrimental effects of problems like overcrowding and boarding. These numbers can then be more easily understood by hospital administrators and our colleagues outside of emergency medicine.

I cannot think of a specialty which is faced with more fundamental challenges to basic patient care than emergency medicine. We continue to adapt to the increasing demands which are placed upon us and make the system work somehow. But we must not be complacent with just managing to survive, as we are reaching the brink of our ability to adapt. Each of us must find ways to get involved in making changes to the healthcare system.

As the Young Physicians Section continues to develop, we will continue to focus on providing members with knowledge that will allow each one of us to contribute to the solutions to these problems at the local, regional and

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Maternity, Motherhood and Medicine

Part 1 of a 2 Part Series

by C. Heather Rumsey, MD FAAEM, York Hospital Emergency Medicine Residency Program, York, Pennsylvania

I'm convinced that there should be a section on child-rearing as part of the LLSA. How many of us have time to do a literature search for the best articles on toilet training, how to handle night terrors and the best methods for removing dry erase marker stains from your hardwood?

Until the administration at ABEM realizes the dilemma that we young physicians, both male and female, face, I will help to fill in the gap with some of my experience, which includes many trials, observations and experiments in conceiving and rearing my offspring.

Let me offer a "politically incorrect" disclaimer. I happen to be involved in what some people might refer to as a traditional "nuclear" family – with me (the wife), a husband and two children. I will try to use the politically correct term "partner," but at some point I'm going to refer to my husband as my "husband" as I refuse to call him "the sperm donor," "baby daddy" or "my male counterpart" out of respect to him.

Many couples experience the dilemma of when to start having a family. Of course each situation is special, but the bottom line is (just like with many other major life decisions), THERE IS NO PERFECT TIME to conceive, carry and deliver. I'm not going to belabor the point, so you shouldn't either. However, if you think you want to have children, there are a few things you should consider.

1) Do you have a close circle of friends or couples that will support you through the next nine months and beyond?

Conceiving is the fun part, or at least it should be if all goes as planned, but the prenatal period is not all nesting, shopping and baby showers. Many couples feel very stressed with impending financial pressures, changes and expectations that they are going to have all home projects completed by the birth. A close circle of friends, with or without children, is important. It's good for both partners to have a positive outlet for issues that crop up. Maybe it's just me, but a lot of my physician friends who have chosen motherhood have more than the average number of complications. Maybe it's because we're more aware of warning signs, most of us are close to "advanced maternal age" or we're viewed by the obstetrics community as high-risk and are screened a little more vigilantly. I think it's helpful, especially if your partner has a non-medical career, to have people in "your circle" who are also non-medical and who have experienced some of these life stressors. My husband has had times where he's felt alienated, especially at some prenatal appointments where we're discussing polyhydramnios and ketones, and he's sitting with a smile of pleasant oblivion. Frustrating for him but manageable with some debriefing by me and others in our circle.

2) Do you have a good feel for what your co-workers response will be?

Although it shouldn't deter your efforts to become a parent, it's helpful to have a sense of who your "allies" at work will be. If you're a female physician reading this and planning a family, you might expect that your other female counterparts will be the most supportive, but I've not always found this to be true. I could speculate on why women are not always supportive of other women, but the bottom line is that you shouldn't assume that just because a physician has ovaries she is going to be happy for you. Sometimes your strongest allies might be those who are older (even grandparents) whose life experience gives them that extra bit of grace and understanding that younger physicians might not have. Also beware of a "wolf in sheep's clothing." Most of the time I would not advise that you tell anyone that you are pregnant (especially before eight weeks) unless you are ready to tell the whole department. We in emergency medicine tend to be gregarious, social and yes – GOSSIPERS. If you're ready to tell your staff, just let 2-3 people know, and you won't have to spend the postage on each announcement. Of course, by the time the rumor goes through, you'll be pregnant with triplets carrying the chairman's love children.

3) Be realistic with expectations for your pregnancy and your career goals while pregnant.

Listen to other nurses and physicians regarding their experiences, but don't get your mind set that you're either going to have the worst or best pregnancy. When I was pregnant with my first, I discovered that a woman I knew ran five miles a day up until her third trimester. This was WRONG on so many levels for me. First of all, the last time I ran five miles was in my early twenties, and I was definitely not pregnant. I had to put this into perspective for me and my pregnancy. Don't start a radical exercise program the minute the little line turns pink on the dipstick. You'll set yourself up for heartbreak when the physical exhaustion of the first trimester hits you at around eight weeks of pregnancy. You will gain weight – regardless of how nauseated you are! And no matter how much we may want to believe it is all "water weight," nothing ever goes exactly back where it started – unless you know a good plastic surgeon. I'm not complaining, just trying to make you aware that if a perfect body was either one of your life goals or what you started with, just be open for change. Regarding your career, most physicians can work well into their eighth month barring pregnancy complications; but make back-up plans with your scheduler for the last four weeks in case things change. I have a friend who worked her last shift the day she was induced. She's amazing regardless of this; but again, don't plan on things being this

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Ask the Expert

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

"Ask The Expert" is a *Common Sense* feature where subject matter experts provide answers to questions provided by YPS members. This edition features a leading authority on emergency cardiology, Dr. Amal Mattu from the University of Maryland.

Question: Is it safe to administer beta-blockers to a patient in whom acute myocardial infarction (AMI) versus chronic obstructive pulmonary disease (COPD) exacerbation is undifferentiated? If they are on chronic beta-blocker therapy does this mean that the acute administration will be safe and well tolerated?

Answer:

If the patient has an AMI, beta-blockers are generally recommended even if the patient has a history of COPD (assuming that there is not a concurrent COPD exacerbation). In that scenario, a beta-1 specific blocker such as esmolol would be ideal, because it is titrateable, and it can be turned off if the person develops pulmonary problems. Other beta-1 specific options would be metoprolol or atenolol, though they are not as titrateable.

With that said, however, the recent COMMIT study (the largest modern era study evaluating the use of beta-blockers in acute coronary syndrome (most patients had ST-elevation MI) did not find an overall benefit to early use of beta-blockers. Prior studies demonstrating benefits of beta-blockers were done when aspirin and other antiplatelet agents were not so routinely given. Prior to this study, it was common practice to routinely give beta-blockers to AMI patients very early in the course of treatment. I'd suggest that, based on this study, we shouldn't be in such a rush to throw beta-blockers at the patient until their hemodynamic status is stable or unless they are very tachycardic or perhaps have intractable pain.

If a patient presents with dyspnea and it is uncertain whether the patient has acute coronary syndrome vs. COPD, I'd be hesitant to give any beta-blockers until I'm certain about the diagnosis.

Amal Mattu, MD FAAEM, Program Director, Emergency Medicine Residency, Associate Professor, Department of Emergency Medicine, University of Maryland School of Medicine, Baltimore, Maryland

If you have a question that you would like to have answered by an expert in a future issue of Common Sense, *please send it to jschofer@gmail.com.*

Maternity, Motherhood and Medicine - continued from page 16

Pregnancy Goals	Career Goals	Personal Goals
Must	Must	Must
Might	Might	Might
Dreams	Dreams	Dreams

seamless. The best way to deal with this point is to make a list (see above) to keep things in perspective.

4) Lastly and not least importantly – remember your spouse/partner.

Let your partner in on the experience, including the embarrassing, the hilarious and the disappointing. Often after conception, the prenatal period becomes a period where we forget to focus on romance and relationship building. Everything's about the baby…and this can put extra strain on a relationship, trust me. It's still very important to date your partner (regardless of your marital status) during the prenatal period. Set a goal of at least one date night a month where you actually anticipate doing nothing but enjoying your partner. Sure, it would be nice to have the nursery mural finished and all of the baby clothes washed and hung in the closet, but those things are negligible if there are unresolved emotional needs and issues between you and your partner.

Conception, child birth and child-rearing change you in so many ways. It makes me chuckle sometimes that I can treat a myocardial infarction, be a chauffeur, cook, maid and an expert bottom-wiper all in one day. It's crazy most days, but I can't imagine having it any other way. There is no easy way to summarize the mixture of parenting and medicine. I do believe being a parent makes me a better physician, and the converse is true as well. Stay tuned for the next edition in this series entitled, "How to raise your children without locking them in a closet for 18 years."

AAEM Young Physicians Section

YPS President's Message - continued from page 15

national levels. As the newest generation of emergency physicians, we must act individually and collectively to facilitate changes to the current system. Each one of us must dedicate time to learning the issues involved with ED overcrowding and understanding the processes involved. We must be continual advocates for the improvement of these conditions in which providers are forced to deliver less than ideal care. We must get involved with taskforces, sections and groups that are working towards creating change.

The Young Physicians Section has opportunities for interested members to become involved with projects involving these non-clinical aspects of emergency medicine. If you are interested, please send an e-mail to info@ypsaaem.org. Also, talk to your colleagues who are not members of AAEM and encourage them to join both AAEM and the Young Physicians Section. YPS membership is open to members of AAEM who are in their first seven years of practice after residency.

*AAEM's position statement on the boarding of admitted patients is available online at http://www.aaem.org/positionstatements/

RESIDENT PRESIDENT'S MESSAGE

by Andrew Pickens, MD JD MBA

Thank You

First of all, I want to say thanks and congratulations to Brian Potts and the rest of the 2006 board. Under Brian's leadership, membership grew and the AAEM/RSA increased its national presence. I hope to continue on with the strong tradition that has been set by Brian Potts last year, Mark Reiter before him, and the rest of the past presidents.

Congratulations to All of the Newly Elected

This year we had a very competitive and talented pool of nominees. With this election comes quite a bit of responsibility for board members over the next year. We have been charged with carrying on the success of the previous board. As stated earlier, under Brian's leadership, the AAEM/RSA grew in membership, reached out to other resident organizations and increased the visibility of the AAEM/RSA. We must continue this success.

May 2007 Board Meeting

Each May brings a changing of the guard at the AAEM/RSA. This May was no different. At the 2007 SAEM meeting in Chicago, the new AAEM/RSA board convened for its first face-to-face meeting. While many faces are the same (Sarah Todd, Megan Boysen, Brian Potts and myself), we have many new faces as well. The new board is as follows:

President: Andrew Pickens, MD JD MBA, University of North Carolina-Chapel Hill

Vice President: Sarah Todd, MD MPH, Indiana University School of Medicine

Secretary-Treasurer: Megan Boysen, MD, UC Irvine Medical Center

Immediate Past President: Brian Potts, MD MBA, Alta Bates Summit Medical Center, Berkeley, CA

At-Large Board Members and Committee Chairs:

Communication: Keith Allen, MD, The Mayo Clinic

Common Sense Editor: Adrienne McFadden, MD JD, University of Maryland Medical Center

Advocacy: Kalpana Narayan, MD MSc, Harvard Affiliated Emergency Medicine Residency

Education: Michael S. Pulia, MD, University of Illinois at Chicago

Membership: Cyrus Shahpar, MD MPH MBA, Johns Hopkins University

Mike Ybarra, the president of the Medical Student Council, also serves on the RSA board. The new board members had an immediate impact at the May board meeting. With enthusiasm, the new members provided new ideas and direction for each of their committees. It was clear that board members had taken ownership of their position and were already prepared to push boundaries and expand their role in the AAEM/RSA. With this kind of excitement, dedication and drive, the outlook for the 2007-2008 year is great.

Membership

Increasing membership is the key to success for the AAEM/RSA. With an increasing number of members, we can further the mission of AAEM, and we can increase our influence as an organization. Everything we do as an organization is for the benefit of our members, and the more we have, the more we can offer. This is the theme of this administration.

New Committee Members Requested

By the time you read this article, you will have already received e-mail messages requesting your participation in any of the numerous committees offered by the AAEM/RSA. This is a great way to become involved in the organization. This year, our primary goal is to increase membership. Each committee plays a vital role in accomplishing this. If you did not receive the e-mails, or have decided late that you are still interested in a committee, you can contact the AAEM/RSA office at any time. Please feel free to share new ideas or provide insight into how things could change for the better. We are, and always have been, an open-minded organization, and a diverse group of ideas helps achieve our overall mission.

Closing Words

The practice of emergency medicine is, in many ways, at a cross-road. From the ever increasing presence of the corporate practice of emergency medicine to restrictive covenants, the world in which emergency medicine physicians practice is changing. I urge all emergency medicine residents and students to become involved in one way or another with organizations that will promote a better future for emergency medicine: a future that fits with what your vision of what the practice of emergency medicine should be. I would also urge you to consider joining the AAEM/RSA, and if you are already a member, urge others to join. Our organization, together with our parent organization, are recognized as the foremost organizations that advocate for the rights of the individual emergency medicine physician. This is something that should appeal to everyone.

Sincerely,

Andrew Pickens, MD JD MBA
AAEM/RSA President

"Finding My Voice"

by Adrienne McFadden, MD JD, University of Maryland Medical Center
Resident Editor, Common Sense

I had an epiphany a few months ago during a mid-morning bout of insomnia in the midst of a string of night shifts. I have had laryngitis for almost two years now. Two years! Let me clarify. I did not literally lose my speaking voice, but I was without a voice. The voice I am referring to is my voice as an advocate. Actually, if I am to be honest with myself, I simply had not found it.

Don't get me wrong, I talk a lot, ad nauseam (depending on whom you ask). I talk mainly about my intentions to leave a positive and lasting mark on the healthcare system, especially as it relates to access to care. I was one of the first in line to upgrade my soapbox from the standard composite cardboard box to a titanium model (I have amazing stamina when talking about things I am opinionated about)... I digress. My point is that the voice of an advocate will never be heard if it is shrouded by the chatter of infinite wishfulness.

Wishfulness does nothing for the uninsured patient who cannot afford medications and whose primary care physician is whoever happens to be working in the local emergency department. Wishfulness does not provide a working solution to the problem of boarding admitted patients in the emergency department. Wishfulness recognizes that the safety net of US healthcare is bursting at the seams but does nothing to address the problem. Finally, wishfulness will not guarantee, nor will it protect, my rights as a healthcare professional as I inch closer to the conclusion of my residency and the beginning of my career. After my epiphany, I cleared my throat, pushed aside excuses and decided it was time to act. I encourage all of you to do the same.

Advocacy is an unwritten requirement of every good emergency physician (EP). I made a lifelong commitment to advocacy somewhere between my third and fourth years of medical school, right about the time that I submitted my applications to emergency medicine residency programs. Think about it -- you did too. At any given time, EPs must be advocates for their patients, for their specialty and for the other individuals within the profession. Alas, we cannot do it alone. Lucky for us, we don't have to. We have professional organizations.

Seek membership. The easiest way to be active in advocacy is to participate. If you have already done so, challenge yourself to be an active member. This is the only way you can understand the true extent of what an organization can do for you. Join a committee. There are several available that seek your input to better serve you as a member. Finally, spread the word. There is power in numbers, and we are all in this together. So, with my new found voice, I say to you – "Raise *your* voice above the chatter, get involved and stay involved."

This is a continuing column providing a brief look at journal articles pertinent to EM residents. It is not meant to be an extensive review of the articles nor is it wholly comprehensive of all the literature published. Rather, it is a short list of potentially useful literature that the busy EM resident may have missed. Residents should read the articles themselves to draw their own conclusions. This edition will include articles published over a three month period, March through May 2007.

Resident Journal Review – May 2007

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

1. Cardiopulmonary resuscitation by bystanders with chest compression only (SOS-KANTO): an observational study. Lancet. Mar 17 2007;369(9565):920-926.

This was a prospective, multicenter, observational study of resuscitation techniques for bystander cardiopulmonary resuscitation. 4,068 adult patients with out-of-hospital cardiac arrest were included for analysis. Comparisons were made in the 30-day neurological outcome, between no bystander resuscitation, chest compressions without ventilation and conventional CPR. The researchers found that cardiac-only resuscitation is equivalent or superior to conventional bystander CPR in adult patients with witnessed out-of-hospital cardiac arrest, from a neurological standpoint. Cardiac-only resuscitation resulted in a higher proportion of patients with favorable neurological outcomes than conventional CPR in patients with apnea (6·2% vs. 3·1%;p=0·0195), with shockable rhythm (19·4% vs. 11·2%, p=0·041), and with resuscitation that started within four min. of arrest (10·1% vs. 5·1%, p=0·0221). However, there was no evidence for any benefit from the addition of mouth-to-mouth ventilation in any subgroup. The authors posit several reasons for the equivalent and better outcomes in the cardiac-only resuscitation group, but suggest that interruption of chest compressions was the main reason why conventional CPR did not result in better neurological outcomes.

Emergency medicine physicians should be informed about pre-hospital protocols for resuscitation. Studies such as SOS-KANTO will stimulate further research about the best methods for out-of-hospital resuscitation in cardiac arrest.

2. Lipiner-Friedman D, Sprung CL, Laterre PF, et al. Adrenal function in sepsis: the retrospective Corticus cohort study. Critical Care Medicine. Apr 2007;35(4):1012-1018.

This was a twenty center retrospective cohort study of patients who had undergone an ACTH stimulation test within the 24 hours following the onset of sepsis. 562 patients were included in the analysis, representing the largest cohort study to date for the investigation of adrenal function in patients with severe sepsis and septic shock. The study confirmed that nonsurvivors had higher baseline cortisol levels and a blunted response to corticotropin. The study confirmed that in severe sepsis and septic shock, adrenal insufficiency can be defined by a change in cortisol level of less than 9ug/mL or a baseline less than 15ug/mL. Additionally, the study found that treatment with etomidate was associated with an increased risk of dying, especially among patients who did not receive steroids.

Early recognition and treatment of sepsis is associated with improved outcome. The CORTICUS cohort findings draw attention to the importance of adrenal evaluation in severe sepsis and septic shock.

3. Moscati RM, Mayrose J, Reardon RF, et al. A multicenter comparison of tap water versus sterile saline for wound irrigation. Acad Emerg Med. May 2007;14(5):404-409.

This is the first multicenter, randomized, prospective comparison of infection rates for irrigation with tap water compared to sterile saline before closure of wounds in the emergency department. 715 patients from three hospitals were enrolled in the study. In the sterile saline group, 11 subjects developed wound infections, for a rate of 3.3%. In the tap water (TW) group, 12 subjects developed wound infections, for a rate of 4%. The researchers performed a crude cost comparison between the two irrigation groups. The total additional cost of wound irrigation with saline amounts to $72,880,000 compared with $7,280,000 for irrigation with TW. The adjusted annual savings nationally of irrigating wounds with TW rather than saline would be $65,600,000.

This study supports a safer more economical alternative to sterile saline for the irrigation of wounds in the emergency department.

4. Rubinshtein R, Halon DA, Gaspar T, et al. Usefulness of 64-slice cardiac computed tomographic angiography for diagnosing acute coronary syndromes and predicting clinical outcome in emergency department patients with chest pain of uncertain origin. Circulation. Apr 3 2007;115(13):1762-1768.

These researchers designed a three-month prospective study of the utility of 64-slice cardiac computed tomographic angiography in patients presenting to an emergency department with chest pain of uncertain origin. 58 patients were enrolled. The patients had no new ECG changes or elevated biomarkers of cardiac injury.

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Emergency Medicine – Taking the Plunge

By Michael Ybarra, President AAEM/RSA Medical Student Section Council

Congratulations! If you are reading this publication, you have made two important life decisions. First, you are considering a career in emergency medicine. Second, and perhaps more important, your interest in AAEM means that you are both serious and committed to active involvement in the field.

Many of you may already be aware of what AAEM has to offer to students – a free copy of *Rules of the Road for Medical Students* by Drs. Kazzi and Schofer (online for student free members and paperback version for student paid members), free registration at the Scientific Assembly, access to EM Select and discount offers with some of the country's largest publishers (for all paid members) and a subscription to the *Journal of Emergency Medicine* (for all $50 paid members). However, in addition, your membership to AAEM multiplies your voice by 5,000, letting the issues you care about be heard on the national level. Over the past year alone, AAEM has seen tremendous legal and legislative victories on issues that really matter to our future, such as liability reform, fair business practices and reimbursement.

As practicing physicians out in the "real world," the conditions we will face will be influenced by everything from our local communities to state and national politics. These forces are shaping medicine right now; and unfortunately, as students, our work does not end with shelf exams and patient write-ups. We often have the luxury of going through our four years with blinders that protect us from the goings on of the outside world. By the time we get to residency (let alone in to actual practice); the healthcare industry will look drastically different even from when we started four years prior. So now that you have taken the plunge, I encourage everyone to be aware, be active and be an advocate for our future field!

Be aware – subscribe to CAL/AAEM, AAEM Political Action Committee or other listservs that provide concise information on important EM issues. Read the headlines from your local paper's health section, and learn both sides of major issues. Visit the AAEM legislative action center and join the American Medical Association. Find out how your congressman stands on important legislation.

Be active – you do not have to be president of your EMIG to make a difference. Instead, find an issue that matters to you and write a summary, give a talk at your EMIG meeting, or prepare a flyer. Come to the 14th Annual AAEM Scientific Assembly in Florida on February 7-9, 2008. Talk to your attending physicians about how they stay involved. Get into the emergency department outside of your required rotations – send an email or drop by during your EM professor's office hours.

Be an advocate – go to capwiz (http://capwiz.com/aaem/home/) and write a letter, leave a phone message or forward an interesting article to your local, state and national representatives. Tell your family and friends about the problems that we will face in the coming years.

As the Medical Student Council President, and with the help of the incoming board, I will take this same approach when planning the coming year. Keep your eyes and ears open for monthly emails with information that helps us all stay aware, new and exciting lectures for the EMIG starter kits, opportunities to get involved in and ultimately present your research, and our student track at the 14th Annual Scientific Assembly in Amelia Island, Florida!

Thank you for your support in the recent election. I would also like to congratulate the incoming Medical Student Council: Vice President, Ben Feinzimer (Chicago College of Osteopathic Medicine); Western Regional Representative, Michael Habicht (University of California, Irvine); Northeast Regional Representative, Adrian Elliot (Howard University); Southern Regional Representative, Caleb J. Trent (University of Tennessee) and Midwest Regional Representative, Thomas Masters (Wright State University Boonshoft School of Medicine), who was appointed by the board to represent the region during the Council's May meeting. I would also like to thank the previous board for their work, especially immediate past president, Megan Boysen! On behalf of the 2007-2008 Medical Student Council, I want to express our profound excitement for the work that lies ahead, strengthening the services already offered by AAEM and finding new and exciting ways to reach out to medical students across the country.

Resident Journal - continued from page 21

23 of the patients in this cohort had positive findings by multidetector computed tomography (MDCT); acute coronary syndrome was subsequently diagnosed in 20 of these 23 patients. In a 15-month follow-up, no deaths or myocardial infarctions were observed in the 35 patients who were discharged from the emergency department after evaluation and MDCT findings. The study found that MDCT had a high positive and negative predictive value for identifying patients with acute coronary syndrome among patients with chest pain of uncertain origin.

This small study encourages further research in the role of MDCT as a diagnostic tool in the emergency department evaluation of chest pain of uncertain origin.

5. Smits M, Dippel DW, Steyerberg EW, et al. Predicting intracranial traumatic findings on computed tomography in patients with minor head injury: the CHIP prediction rule. Annals of Internal Medicine. Mar 20 2007;146(6):397-405.

Four hospitals in the Netherlands conducted a prospective, observational study of patients with minor head injury. The CT in Head Injury Patients (CHIP) Study included 3,181 patients with a GCS of 13 to 14, or 15 with one risk factor. Outcomes for this study were any intracranial traumatic CT finding or neurosurgical intervention. Both the New Orleans Criteria (NOC) and the Canadian CT Head Rule (CCHR) have been externally validated; both rules identify all patients requiring neurosurgical intervention and most with traumatic findings in CT. Generalizability of these rules, however, is limited by the patient subsets that were used (e.g., inclusion of only patients with a history of loss of consciousness). The authors present a detailed prediction rule and a simplified prediction rule. The CHIP prediction rule is more widely applicable to patients in the emergency department presenting with minor head trauma.

If clinical suspicion is high, the decision to perform a head CT is simple. Emergency medicine physicians are challenged when information is sparse and the likelihood of serious injury is uncertain. Some of the existing algorithms for performing a CT of the head after minor head trauma rely on information that may not be available in an undifferentiated emergency department population. The CHIP prediction rule offers another way to guide medical decision making for patients with minor head trauma.

6. Sun BC, Mangione CM, Merchant G, et al. External validation of the San Francisco Syncope Rule. Annals of Emergency Medicine. Apr 2007;49(4):420-427, 427 e421-424.

592 patients with either syncope of near-syncope were enrolled at a single academic emergency department for evaluation of the performance of the SFSR. Patients were contacted 14-days later for a structured interview; the primary outcome was the capacity of the SFSR to predict seven-day serious clinical events. Outcome events were established in a high proportion of patients (97%). There were 56 (12%) patients who had a serious seven-day clinical event; 16 (3%) received this diagnosis after the initial ED evaluation. Sensitivity and specificity of the SFSR for the primary outcome were 89% and 42%. In this external validation cohort, the SFSR had a lower sensitivity and specificity than in previous reports.

Syncope is a common complaint in the emergency department. Application of the SFSR in this cohort demonstrated poor sensitivity for finding patients with a seven-day serious event. Prior studies have focused on the incidence of outcomes at one-year intervals, but this is less useful for making decisions about disposition of a patient in the emergency department. This study suggests that further validation studies are needed before universal adoption of the SFSR as a part of emergency department decision-making.

7. Zehtabchi S. Evidence-based emergency medicine/critically appraised topic. The role of antibiotic prophylaxis for prevention of infection in patients with simple hand lacerations. Annals of Emergency Medicine. May 2007;49(5):682-689, 689 e681.

Three randomized trials were evaluated after a search of MEDLINE, EMBASE, the Cochrane Library and other databases. Relative risks of infection after antibiotic use were 1.05, 0.73 and 1.07 for the three included studies. There was no clinically or statistically significant benefit to antibiotic use among the 778 total subjects. In these trials, the differences in infection rates between antibiotic and control groups failed to reach statistical significance. This was found regardless of route or choice of antibiotic. This review focused on patients with uncomplicated wounds.

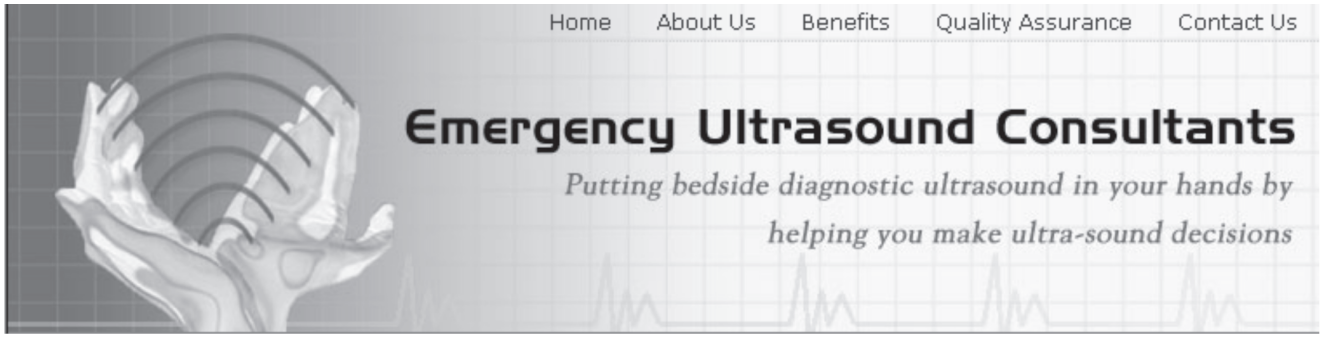
The use of prophylactic antibiotics for uncomplicated hand lacerations has been rigorously studied few times in the past 30 years. This review compiles the existing data on the topic and provides an evidence anchor for clinicians considering antibiotics for uncomplicated hand lacerations.

Daniel Nishijima is a resident in emergency medicine residency at SUNY Downstate/Kings County.

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

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

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



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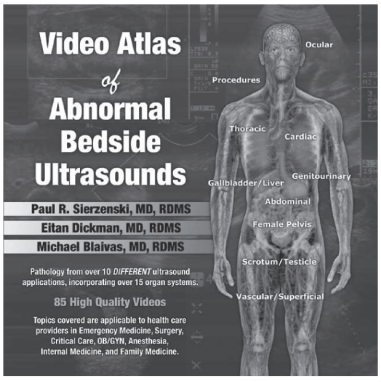

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Institution/Hospital Degree (MD/DO)

Preferred Mailing Address

City State Zip

Please check which address this is: ☐ Work ☐ Home

Phone Number—Work Phone Number—Home

Fax E-mail

1) Have you completed or are you enrolled in an accredited residency program in emergency medicine? ☐ Yes ☐ No
   If yes, which program & date of completion: _____

2) Are you a medical student with an interest in emergency medicine? ☐ Yes ☐ No
   If yes, program & expected date of completion: _____

3) Are you certified by the American Board of Emergency Medicine? ☐ Yes ☐ No
   If yes, date: _____ Type of certification ☐ EM ☐ Pediatric EM

4) Are you certified by the American Osteopathic Board of Emergency Medicine? ☐ Yes ☐ No
   If yes, date: _____

5) Are you a member of any other EM organization? Please select all that apply.
   ☐ AACEM ☐ ACEP ☐ ACOEP ☐ AMA ☐ CORD ☐ EMRA ☐ NAEMSP ☐ SAEM ☐ Other_____

Full Voting and Associate Membership dues are for the period January 1st through December 31st of the year the dues are received. Applicants who are board certified by ABEM or AOBEM in EM or Pediatric EM are only eligible for Full Voting Membership. Full Voting and Associate memberships include a subscription to *The Journal of Emergency Medicine* (JEM). Resident and Student membership dues are for the period July 1st thru June 30th of the period the dues are received. All memberships, except student without JEM and free student membership, include a subscription to *The Journal of Emergency Medicine* (JEM).

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☐ Full Voting Member $365.00

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☐ I would like to be a member of the Young Physicians Section (YPS) (free at this time) (not available to Resident & Student Members)

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☐ Political Action Committee: Please consider making a voluntary contribution to the AAEM PAC, the political action committee of the AAEM. With your donation, AAEM PAC will be better able to support legislation and effect change on behalf of the AAEM members and with consideration to their unique concerns..... $50.00

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

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

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

The following group (entries listed with an *) have submitted the AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

• ALABAMA

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

• ALABAMA

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

• CALIFORNIA

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

• CALIFORNIA

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

• COLORADO

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

• FLORIDA

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

• FLORIDA

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

• FLORIDA

St. Petersburg - Surrounded by the waters of Tampa Bay and the Gulf of Mexico, a stable democratic group seeks a full-time board certified/board prepared emergency physician to work in a Level II Trauma Center with 45,000 visits annually. Competitive RVU compensation and comprehensive benefits package including a partnership track. Excellent relationship with staff members, hospital attendings and hospital administration who are committed to quality care. Submit your CV and/or inquiries to Connie Gratzer at Congratepsp@aol.com or call 1-727-553-7300. (PA 807)
Email: Congratepsp@aol.com

• ILLINOIS

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

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

• ILLINOIS

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

• INDIANA

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

• IOWA

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

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

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

• MAINE

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

• MARYLAND

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

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Email: rrector@phg.com
Website: www.phg.com

• MISSOURI

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

• NORTH CAROLINA

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

• NORTH CAROLINA

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

• NORTH CAROLINA

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

• OHIO

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

• OKLAHOMA

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

• OKLAHOMA

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

• OREGON

Unique Oregon Opportunity in Top 100 places to live location. Full-time position for BC/BE ER Physician in brand new department. BC/BE colleagues and excellent specialty backup. Equitable, flexible scheduling of 9 hour shifts. 36 hours coverage per day on an annual volume of approximately 25,000. Compensation in excess of $160/hr with full benefits and retirement. Call: 541-883-6629 (PA 811)
Email: FAlmendarez@skylakes.org
Website: www.skylakes.org

• PENNSYLVANIA

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

• PENNSYLVANIA

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

• SOUTH CAROLINA

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

• SOUTH CAROLINA

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

• SOUTH CAROLINA

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

• TENNESSEE

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

•TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• UTAH

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

• VIRGINIA

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

• VIRGINIA

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

• WASHINGTON

Full-time opportunity for BC/BE emergency physician. Established, independent, fee-for-service democratic group. Annual volume 65,000. Financial equality at one year, partnership at two years. State-of-the-art department located in the scenic Puget Sound area. Mountain and water recreation readily available. Send CV to Paul Fleming, MD, Medical Director, 413 Lilly Rd. NE, Olympia, WA 98506 or paul.fleming@providence.org. (PA 815)
Email: paul.fleming@providence.org

• WYOMING

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

• WYOMING

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

• AUSTRALIA

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

• GUAM (USA)

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

• LEBANON

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

• NEW ZEALAND

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

CALIFORNIA

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

CALIFORNIA

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

common SENSE
555 East Wells Street / Suite 1100
Milwaukee, WI 53202-3823

when minutes count

The AAEM Emergency Medicine Written Board Review Course

(Preparation for the Qualifying Exam and ConCert Exam)

September 27-30, 2007 • Newark, New Jersey

Marriott Newark Airport Hotel

when minutes count

Please visit www.aaem.org for more information