



when minutes count

common SENSE

The Newsletter of the American Academy of Emergency Medicine — Volume 13, Issue 4— July/August 2006



PRESIDENT'S MESSAGE

by Tom Scaletta, MD FAAEM

Fair Business Practices Are a Form of Environmental Conservation

A 'closed ecosystem' is an environment that has achieved a self-sustaining, natural balance. Each organism and process within the network is dependent upon and interrelated to the entire ecosystem and depends on sharing external energy sources, like sunlight. In the business equivalent, the energy is aggregate revenue, which in turn, exactly matches all salaries, benefits and other business expenses. Survival requires appropriate conservation of financial energy, cooperation of each stakeholder and a genuine concern for the well being of all participants.


Emergency physician groups can use this closed ecosystem analogy to assess, and perhaps, improve their situation. An early step in the process is to research the fair market cost of each expense. Reducing overcharges and eliminating unnecessary expenses seals "energy leaks." Another task is to improve the welfare of all parties involved in the organization by understanding and addressing individual concerns. Such exploration facilitates business agility in adapting to market forces and opportunities.

Economic siphoning of physician group ecosystems too often stems from unrealistic entitlement demands of group elders. Sometimes the original founders lay claim to permanent royalties for landing the contract, forming the group and honing the business operation. Their "exit strategy" often requires existing group members to fund a retirement bonanza.

Another example of ecological pilfering occurs in professed democratic partnerships where the founders own the group's permanent billing company charging exorbitant rates. In overtly unfair situations, a single "landlord" is paid an exorbitant amount for administrative duties and very little (if any) patient care.

Many times financial drains violate federal and state laws that prohibit fee splitting and are the chief motivator behind the corporate practice of medicine. AAEM is one organization willing to educate your CEO and medical staff about the risks inherent in unfair models and mediate an appropriate solution. With regard to preserving closed ecosystems, AAEM is becoming the emergency medicine equivalent to the EPA.

Individuals often react with anger and remorse once they appreciate that they have been exploited. Diverting "profit" outside the ecosystem often results in sub-optimal staffing levels, which creates resentment and diminished professional satisfaction. Professional burnout may occur when there is no hope for change. Encountering a physician that prefers to work elsewhere, or worse, a physician incapable of landing a better job, indirectly harms unwitting patients. On busy days, the evaluation becomes too superficial and physician extenders may be inadequately supervised.

Emergency physicians thwart unfair individuals and corporations a little bit each shift by demonstrating practice excellence and continually building relationships with the nurses, medical staff and administrators. Strong participation on interdepartmental committees keeps the hospital decision makers tuned to your concerns. Only then can you convince them that closed ecosystem models maximally motivate the emergency physicians and promote and maintain patient safety. 

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EDITOR'S LETTER

Common Sense

by David Kramer, MD FAAEM

Like many of you, I have recently read the latest (May/June 2006) issue of *Common Sense*. I was particularly intrigued with Dr. Blumstein's introduction of me as the new editor of the newsletter. Let me give you a few keys to the semantic interpretation of the written word. When someone as erudite as Howard writes, "I am sure that his leadership and ideas will overshadow my tenure in this position," he is actually challenging me to a duel. He is slapping me on the face with his glove (feel free to choose your own hackneyed phrase). All of us recognize what a great job he has done as editor. We have read his work and remain impressed with every issue. His are big shoes to fill. I feel challenged and only hope that I am up to the task. Thank you, Howard, for setting the bar so high. Only time and hindsight will tell if I can continue the high standard that has been set. Rest assured; I will not mess with success.

I start off at a distinct disadvantage. My residency's senior program coordinator told me that she finds it quite ironic that *Common Sense* will now be edited by a man with so little of it. While I know (hope?) that it was said in jest, my goal is to prove her wrong by ensuring that future editions of the newsletter contain both practical and informative columns and articles. Here is where I ask for your help. As one who has never been accused of being shy, I am very excited to have this forum in my hands. Nevertheless, it is clearly owned by you, the members of AAEM. I encourage all of you to be active participants. Read each issue, to be sure. But do more: share your ideas, insights and instructions. In other words, *contribute* to the existing body of *Common Sense*. This is your newsletter. My aim is to make it invaluable to you. In order to make contributing

your share of common sense to *Common Sense* easy, we are initiating a new feature: TalkBack to Dave. E-mail your opinions, ideas for articles and any other common sense to me at CSeditor@aaem.org.

It's funny how sometimes the seemingly insignificant can become significant. During the candidate Q&A at the last Scientific Assembly I was asked skeptically, since I am so involved with the academic world of emergency medicine, how I could possibly understand the interests of the typical AAEM member. I responded that as a program director who graduates eleven young emergency physicians each year and sends them out into the job market, "Your interests are my interests." Afterwards, a few of you told me that you really appreciated the validity of that response. Those few words really do speak volumes. All of us in AAEM (academic and non-academic) are truly aligned in our interests for a fair workplace where emergency physicians are all treated in a highly professional and ethical manner. AAEM is, and should be, many things to many emergency physicians (take a look at all the committees and task forces). The members of the organization represent many different practices, both academic and non-academic. Nevertheless, the guiding principles remain the same. When it comes to these principles, we speak with one voice.

Finally, I want to thank all of you for your vote of confidence in electing me to the AAEM Board of Directors. I am honored, humbled and privileged to be given this opportunity. I promise to make the most of it and to serve you well. One of my most important lessons has been to learn from those that I work for. For many years I have worked for my residents. Now, I also work for all of you. +



when minutes count

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AAEM Mission Statement

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

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

Membership Information

Fellow and Full Voting Member: \$345 (Must be ABEM or AOBEM certified in EM or Pediatric EM)
 Emeritus Member: \$250 (Must be 65 years old and a full voting member in good standing for 3 years)
 International Member: \$125

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

* Associate Member: \$250 (Non-voting status)
 AAEM/RSA Member: \$50 (Non-voting status)
 Student Member: \$50 (Non-voting status)

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

The AAEM Emergency Medicine Written Board Review Course

(Preparation for the Qualifying Exam and ConCert Exam)

October 5-8, 2006 • Hilton Hotel
Newark Airport • Newark, New Jersey

Please visit
www.aaem.org
for registration
information

October 5-8, 2006

Hilton Newark Airport

Newark, New Jersey

On-line Registration Available June 22, 2006
Advance Registrations Due by August 18, 2006

Registration Fees

- ☐ AAEM Members
Before August 18: \$750 – After August 18: \$850
- ☐ Non Members
Before August 18: \$875 – After August 18: \$975
- ☐ LLSA Registration Fee ☐ \$100
Before August 18: \$100 – After August 18: \$150

COURSE FEATURES

- Up to 25.25 hours of intense review of EM board materials.
- Up to 4.0 hours for the LLSA Review Course.
- Fast, intense and thorough. Great review of EM even if you aren't taking your boards.
- Reasonably Priced - Includes lunch on Friday and Saturday.
- Easy to reach in Newark.
- Experienced Faculty - Board-Certified Emergency Medicine Practitioners.

COURSE SCHEDULE

Thursday, October 5, 12:00pm - 4:00pm - LLSA Course
Thursday, October 5, 5:00pm - 7:30pm
Friday, October 6, 8:00am - 7:15pm
Saturday, October 7, 8:00am - 6:15pm
Sunday, October 8, 8:00am - 12:00pm

Upcoming AAEM-Endorsed or AAEM Sponsored Conferences for 2006–2007

August 22-26, 2006

- Marine Diving and Medicine Course
Kailua-Kona Hawaii
Organized by Mountain and Marine Medicine, LLC and the University of New Mexico
<http://www.mountainandmarinemedicine.com/Kona2006.html>


September 9-10, 2006

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

October 4-8, 2006

- 4th European Congress on Emergency Medicine
Creta Maris Convention Center
Heraklion – Crete, Greece
Sponsored by EuSEM and the University of Crete
www.ECEM2006.com

October 5-8, 2006

- AAEM Written Board Review Course
LLSA Precon course 
Thursday, October 5, 12:00 pm - 4:00 pm
Hilton Newark Airport Hotel, Newark, New Jersey
Sponsored and organized by the American Academy of Emergency Medicine
<http://www.aaem.org>

November 17-19, 2006

- Second International Emergency Medicine and Disaster Preparedness Conference
Ashok Hotel, New Delhi, India
Co-sponsored by North Shore-Long Island Jewish Health System and the American College of Emergency Physicians
Jointly Sponsored with the Society of Emergency Medicine, India and the American Academy for Emergency Medicine in India
Hosted by Fortis Hospital
www.intem2006.com

December 3-8, 2006

- Maui 2006: Current Concepts in Emergency Care
Wailea Marriott, Wailea, Hawaii
Sponsored by the Institute for Emergency Medical Education and the Washington Chapter of the American College of Emergency Physicians
www.ieme.com

March 12-14, 2007

- AAEM 13th Annual Scientific Assembly
Caesars Palace, Las Vegas, Nevada
Sponsored and organized by the American Academy of Emergency Medicine
FREE Registration for AAEM Members
<http://www.aaem.org>

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

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

We are pleased to announce that a new Young Physicians Section has been approved by the AAEM Board of Directors. All AAEM members who are within the first 7 years of practice after residency or are under the age of 40 are eligible for membership. The YPS has been formed with the goal of promoting the advancement of its members' knowledge, careers and involvement in AAEM activities. More details will be coming soon!

Please direct any questions or requests for information to one of the following individuals:

David Vega, MD; President – dvega@yorkhospital.edu

Jesse Pines, MD; Vice-President – pinesj@hotmail.com

Joel Schofer, MD; Secretary-Treasurer – jschofer@gmail.com

ACEP Pediatric Committee Updates



by Ghazala Q. Sharieff, MD FACEP FAAP FAAEM
Co-Chair, ACEP Pediatric Committee

The ACEP Pediatric Committee, under the leadership of Dr. Jill Baren and me, is committed to ensuring that important information on the acute care of children is disseminated to our emergency medicine community as rapidly as possible. This includes sharing the information with other organizations. We hope you enjoy this column and find it useful and clinically relevant.

Dr. Norman Marks, medical director of the FDA's Medwatch Program, has agreed to work closely with us on the issue of rapid information dissemination. Important pediatric information that has been released can be found on the following web pages of the FDA MedWatch website. Special thanks to Josh and Elena Broder for helping us with this wonderful contact!

http://www.fda.gov/medwatch/safety/2006_safety06.htm#Elidel

elidel/protopic contraindicated in peds < 2 yo http://www.fda.gov/medwatch/safety/2006_safety06.htm#Vapotherm

- Issues with safety of this device in premies and others http://www.fda.gov/medwatch/safety/2006_safety06.htm#teether
- Pseudomonas found in pedi teething rings http://www.fda.gov/medwatch/safety/2006_safety06.htm#Cochlear
- Updated info on meningitis in pedi pts with cochlear implants http://www.fda.gov/medwatch/safety/2006_safety06.htm#benzocaine
- Risk of methemoglobinemia and use of benzocaine sprays http://www.fda.gov/medwatch/safety/2006_safety06.htm#gentlelease
- Recall of infant formula due to metal particles in product http://www.fda.gov/medwatch/safety/2006_safety06.htm#bed
- Issue of hospital bed entrapment issues http://www.fda.gov/medwatch/safety/2006_safety06.htm#steroids
- Illegal [undeclared] steroid drugs in products sold as dietary supplements

Phenergan and Loperamide are contraindicated in children less than two years of age.

With the help of Dr. Randy Cordle, the following is a summary of the latest AHA changes in regards to children.

AMERICAN HEART ASSOCIATION CHANGES FOR CHILDREN 2006

JOURNAL: Circulation 2005; 112; 156-195

• Resuscitation Changes

- Lay rescuers no longer taught to check for a pulse;
- Only taught to give compressions and ventilations to all unconscious victims
- **Lay providers** are to initiate CPR for 5 cycles of compressions and ventilations before going for AED or activating the EMS.
- Health Care Providers (HCP) are to assume no pulse is present unless one is found in <10 seconds.
 - Cycle compressions and ventilations unless an advanced airway is in place.
- **Health Care Providers** who witness a sudden collapse may immediately acquire and use AED and activate EMS before starting CPR.

- If **nonwitnessed** sudden collapse then recommendations are the same as for the lay provider recommendations.
- NO Code if DNR order is available, dependent lividity, futile resuscitation, or signs of irreversible death.
- Consider NO Code if newborn <23 weeks gestation or <400 grams.
- When to stop resuscitative efforts:
 - First assure that the condition is not due to ingested drugs or primary hypothermia.
 - Specifically in Newborn: No signs of life after 10 minutes aggressive NALS.
 - All ages: "High degree of certainty" that patient will not respond to further resuscitation efforts.
 - 2 rounds of drugs and 20 minute standard not as predictive as previously thought.
- Parental presence supported by literature (and most parents' opinions).
 - When possible have a Pastor, Social Worker, Nurse, or Child Life Liaison stand by parent(s) to provide support and facilitate communication.

New focus on good compressions

- **"Push hard: Push Fast" with good chest recoil after compression**
 - Neonates 120 compressions/minute.
 - All others 100 compressions/minute.
- Do your best to have continuous compressions occurring without significant non-compressing periods. The rescuer delivering breaths should administer 8-10 breaths per minute. If the victim has a perfusing rhythm but is not breathing, then 12-20 breaths per minute should be given (one breath every 3-5 seconds)
- Once an advanced airway is placed, there is no need to interrupt compressions
- **Compression to Ventilation Ratios**
 - Neonates 3:1 (90:30/minute)
 - All others 30:2
 - Except 2 Health Care Provider infant & child CPR is 15:2
- **Depth of Compressions**
 - 1/3 to 1/2 chest depth
 - Confirm with Arterial-line wave form or pulse amplitude with compressions
- **How to do compressions in children and infants**
 - Keep compressions below nipple line, above xiphoid and in midline.
 - Infants: 2 fingers on sternum OK but preferable to squeeze the chest with thumbs on sternum with fingers around back.
 - Children: Use one or both hands depending on child and rescuer size and strength.
 - Assure child on hard surface whenever giving compressions.
- **AED Use in Children**
 - Infants: No real recommendation from AHA on AED use in infants due to paucity of data.
 - Children 1-8 years old: attenuated AED when immediately available; otherwise regular AED.
 - Children 8+ years: use non-attenuated (regular) AED because you need sufficient current through the heart.

Airway changes

- Cuffed ETT is now acceptable for children under 8 years of age (not newborns) in in-hospital settings.
 - May choose to leave cuff deflated
 - Keep inflation pressure <20 cm H₂O
 - If inflating cuff, tube size estimate = (age/4)+3. The standard ETT size formula for uncuffed endotracheal tubes is (age/4 +4)

continued on pg 6

ACEP Pediatric Committee Updates - continued from pg 5

Tachycardia

- Lidocaine no longer on algorithm for possible ventricular tachycardia. Use amiodarone or procainamide.

Cardioversion and Defibrillation

- Do not defibrillate or pace asystole.
- Use synchronized cardioversion for SVT and organized VT rhythms (with pulses but poor perfusion) when rapid synchronization is possible: otherwise use non-synchronized defibrillation.
- Consider adenosine with reentry tachycardias if it can be given immediately and won't delay electricity.
- Don't have oxygen blowing over chest when you attempt cardioversion.
 - **It can lead to fires.**
- Gel pads should remain >3 cm apart.
- Use small pads in <1 year old or <10 kg
- Use adult pads in >1 year old or >10 kg
 - **Cardioversion**
 - 1st shock = 0.5-1 J/kg
 - 2nd shock = 2 J/kg
 - **Defibrillation**
 - 1st shock = 2 J/kg
 - 2nd and subsequent shocks = 4 J/kg
 - No more stacked shocks!
- In general, compressions should be continued until the time of the shock and then restarted immediately afterward without a pulse check.
- With pulseless arrest, start CPR and if a shockable rhythm is identified, administer 2J/kg and resume CPR immediately.
- After 5 cycles and not before, check rhythm and pulse.
- If there is a shockable rhythm defibrillate with 4J/kg, resume CPR and administer epinephrine (repeated every 3-5 minutes).
- Give 5 cycles of CPR (about 2 minutes) and then recheck rhythm. If shockable, defibrillate again with 4J/kg, resume CPR immediately and consider amiodarone (5mg/kg) or lidocaine 1mg/kg. Magnesium (25-50mg/kg up to 2 grams) can be given for torsades.
- Continue this cycle of compressions, defibrillation and drugs.
- Recurring or refractory VT/VF should be considered potentially salvageable so resuscitation efforts should be continued if not contraindicated.

Newborns Are Not Just Small Infants!

- Events/minute, ratios, sequence and even drug dosing is different.
- Epinephrine dosing for newborns
 - Always 1/10,000 concentration
 - 0.1-0.3 cc/kg IV.
 - 1 cc/kg ET (not terribly effective)
 - Repeat every 3-5 minutes.

No High Dose Epinephrine

- High dose epinephrine definitely no longer recommended unless there is a b-blocker overdose.
- In infants and children (not newborns) the dose is always 0.1 cc/kg.
 - IV concentration is 1:10,000 (1cc=0.1mg)
 - ET concentration is 1:1,000 (1cc=1mg)
- Repeat every 3-5 minutes.

Newborns with Meconium

- It is no longer recommended to suction the oropharynx and nasopharynx at the perineum. Outcomes have not been shown to be improved with perineum suction.
- If the newborn is vigorous (Heart rate >100 beats per minute, strong respiratory effort, good muscle tone), do not try to intubate or suction, just warm and dry the baby.
- If the newborn is not vigorous, then intubate and suction immediately after birth
- **Potential Survivors Should Be Cooled!**
 - If COMA after return of spontaneous circulation (ROSC), then consider cooling to 32-34°C.
 - Don't try to warm patient just to have "normal temperature."
 - Treat fever and seizure aggressively to keep temperatures 32-34°C.
 - After arrest, consider hyperventilation only if acute/impending herniation.

End Tidal Monitors and Detectors

- Esophageal detector devices may be used
- ETCO₂ Detection and Capnography play many roles in resuscitation.
 - It is one of the ways to confirm proper endotracheal tube placement.
 - When normal waves are seen you can be confident the tube is not in the esophagus.
 - When ETCO₂ is not detected or the wave form disappears, you must use other means to prove that the ETT lies in the trachea and not in the esophagus.
 - During full arrest, if there is no lung perfusion, one may not detect ETCO₂ despite the tube being in the proper position.
 - If lung perfusion is occurring spontaneously or due to compressions, then ETCO₂ should be noted. +

AAEM Remarkable Testimony Website

A new case has recently been posted to the AAEM Remarkable Testimony website at the following link: <http://www.aaem.org/aaemtestimony/>

The AAEM Remarkable Testimony website has been created to make known to the emergency medicine community those physicians whose testimony in malpractice actions is remarkable for any reason.

Wanted: YOU!



The average emergency physician (EP) will change jobs five to six times during a career. With your help, AAEM/RSA and AAEM can help those EPs seeking new employment by building a nationwide network of AAEM physicians who are willing to discuss their local Emergency Medicine (EM) practice environment.

This new service will be free to AAEM members, available on the AAEM and AAEM/RSA websites, and available to AAEM members only. Please visit www.aaem.org or www.aaemrsa.org for more information.

Participate in **AAEM CareerNet,** a New AAEM Member Benefit to Aid Emergency Physicians Seeking New Employment



AAEM CareerNet seeks the following information:

1. Full name
2. City, state in which you wish to discuss the local EM practice environment (maximum of 2 areas)
3. Preferred method of communication (pager, email, etc.)
4. Practice Setting (e.g., Independent Group, Kaiser, CEP, etc.) (Optional)
5. Military affiliation - past or present (e.g., Army, Navy Public Health Service, etc.) (Optional)

Please direct all responses or questions to Dr. Richard McCollum at careernet@aaem.org.

Thank you for your help in developing this valuable resource for AAEM physician members!

AAEM/RSA and AAEM are seeking board certified or eligible EPs and senior EM residents to act as volunteers for the geographic regions in which they are familiar with the practice environment.

As a volunteer you will have access to update and edit your contact information and may remove yourself from the list at any time, for any reason.

Any AAEM member seeking new employment will be able to log on to a password protected portion of the website. After logging on they will see the list of AAEM member volunteers (organized by city and state) willing to discuss the local EM practice environment.

The displayed information for each volunteer will be their name and preferred method of contact (pager, email, etc.).

The AAEM member seeking new employment may then contact the volunteer in their area of interest and receive "inside" information from an EP practicing in the local community.

With this list, AAEM will be facilitating contact between the EP seeking employment and the local volunteers, but will not be censoring or monitoring the information they provide, and will not guarantee the veracity of this information. Thus, AAEM members will be using this information at their own risk.





PRESIDENT'S MESSAGE

"Why AAEM was right for me and should be right for you!"

by Brian Potts, MD MBA, AAEM/RSA President

I wanted to express my excitement about starting my term as the President of the AAEM Resident and Student Association for 2006-2007. We are planning a very active year to continue our recent increases in membership and develop new benefits for our resident and student members. As part of the Resident Board of Directors for the last four years, I have found my involvement with AAEM to be extremely rewarding and educational. I hope that my efforts in the upcoming year will hold up to the amazing achievements of our past leaders with whom I've worked: Mark Reiter, Joel Schofer, Jesse Pines and Jason May. We are indebted to them for laying the foundation for the AAEM/RSA. I plan to keep adding on the steel, bricks and mortar to their foundation to develop a stronger and more comprehensive organization that serves our members.

Many people have asked me, "How did you get involved with AAEM?" My story began when I finished my second year of medical school. Dr. Antoine Kazzi (then AAEM vice president) asked me to help him manage an EM listserv called the Cal/AAEM News Service. That summer I began monitoring multiple electronic news lines and discussion lists (AAMC, AMA/CMA, AHA News, California Healthline, OIG, CMS, and EMED-L). This task exposed me to a torrent of information, which had been completely foreign to me while I spent my previous two years studying biochemistry, anatomy, pathology and pharmacology. I began to read about the current state of emergency medicine and the health care industry, and I became more informed about issues surrounding public policy, the government's influence and current active legal cases and decisions in the courts.

"What have I gotten myself in to?" I thought. The real world of emergency medicine is a mess and most students and residents are completely unaware of what is happening. Most students and residents didn't seem to care about anything but their upcoming surgery clerkship exam or their next string of five ED night shifts. This needed to change. My awareness of the issues and controversies in EM and the threats to the future and well-being of EM residency graduates increased over time. Subsequently, I began to appreciate more and more what AAEM had to offer, and why AAEM continued to grow and gain more support from emergency physicians throughout the country.

As a medical student who was pursuing a joint MD/MBA degree, I had a natural inclination to investigate where the business and practice environment in emergency medicine was currently heading. My vision of the ideal practice environment was certainly not what I saw in many cases. I foresaw myself working in a democratic group at one or two hospitals as a partner with inherent rights to have a say in the management of the group. In place however, was the growing expansion and influence of large contract management groups (CMGs) which, more often than not, minimized the rights and management control of the individual emergency physician.

I talked with Dr. Kazzi and he reiterated to me the fundamental AAEM principles that emergency physicians should have control over their professional fees, an equitable ownership stake in their


practice, due process, open books and freedom from restrictive covenants. These AAEM principles will increase fairness in the workplace and directly affect our job environment.

With Dr. Kazzi's mentorship and encouragement, I ran for AAEM Student Section President. This position was the beginning of my time on the AAEM Resident Board. After serving as the Secretary-Treasurer and Vice President, I have seen AAEM stand up and actively support the individual emergency physician in multiple instances, including Mt. Diablo, Minnesota, and those affected by the PhyAmerica medical malpractice collapse. Over the past few years, AAEM has been accomplishing many great things for the EM community.

At the same time, AAEM/RSA has grown into an organization that provides more benefits for its resident and student members, and I am proud to have worked with AAEM/RSA's past leaders. Now it's my turn to guide where AAEM/RSA is headed, and I am here today writing my first President's Message for *Common Sense* telling you why AAEM was right for me and should be right for you.

So that is how I became involved. A related question is, "How can you get involved with AAEM?" I'd advise that there are many active ways to become involved with AAEM. Join an AAEM/RSA committee. We need more members to become active on our education, membership, advocacy and communications committees. This would be a great first step to get your feet wet, meet some AAEM leaders, and become more knowledgeable about AAEM and how AAEM functions to benefit you. Serve as your resident program's representative to the AAEM/RSA Representative Council. You'll hear more about what AAEM is actively doing and how you can help us spread the word. Run for an AAEM/RSA Board position. You'll have a direct voice in all activities and the future direction of AAEM/RSA. Write an article for *Common Sense*. We could always use new authors to submit articles that they feel would be useful to others.

When considering what EM organizations to support, I challenge you to ask yourself, "As emergency physicians, do we want to be treated as true professionals in emergency medicine or be treated as contract-for-hire workers?" Some emergency physicians don't mind being treated as a contract-for-hire worker. If that is what they desire, there are other EM organizations out there for them to join. Obviously, many of us want to be involved in our practice, the management of our group, and have a voice in issues that affect our reimbursement and work environment. AAEM's efforts will serve to expand the number of democratic groups that allow you to have a voice where you work. If you can't find a democratic group in the local area where you want to practice after residency, consider finding some partners and starting your own group. AAEM Services offers valuable consultative help on practice start-up, contract acquisition and maintenance with AAEM values at the core.

Seeking a career as a professional in emergency medicine, I choose AAEM because it is right for me. Consider your options for a minute, and you should realize that AAEM is also right for you. 

Why Be an AAEM/RSA Student Member?

by Megan Boysen, President, AAEM/RSA Student Section

In my first year of medical school at UC Irvine, I emailed an active researcher in the field of emergency medicine to query if he had any opportunities available for a medical student researcher. Assuming I wouldn't receive a response, I hoped that he would at least remember my name out of the dozens of medical students he hears from every year. As an afterthought, I signed my email, "Megan Boysen, MS1, AAEM member." Within a couple days, he had offered me a project. When I met with him the first time, he said to me, "I hear from a lot of students who want to be involved in emergency department research, but I knew that you were serious about emergency medicine when you told me that you were a member of AAEM."

I cannot be more encouraged by the opportunities that AAEM continues to provide for its medical student members. Throughout the past three years, I have enjoyed the many advantages of student membership, including Dr. Kazzi's and Dr. Schofer's book, *Rules of the Road for Medical Students*, participation at the Scientific Assembly, affiliation with other medical students through the Emergency Medicine Interest Group (EMIG) Network, and, for me, a sought-after research position. However, apart from the benefits I have received from this organization, I have grown to support AAEM on behalf of its foundation in representing the needs of emergency physicians.

I think it is essential for medical students to join national organizations such as AAEM. It is important to understand the issues facing physicians—issues that impact our profession positively and negatively. I am sure that we all entered medical school with some level of idealism about improving the future of health care;

however, I do not think it is idealistic to believe that the field of emergency medicine has the ability to positively impact the future of the medical profession. Through supporting legislation which supports EM, continually improving front line care through research, and combining individual struggles into a national effort, AAEM organizes our profession into a national venture towards a better state of health care.

Warren Wiechmann (Immediate Past-President, AAEM/RSA Student Section) mentioned the significant growth that we have seen in medical student membership over the past five years. Student interest in AAEM and in other national and local organizations is a testament to the quality of future emergency department physicians—physicians who will continue to fight for physicians' rights, liability reform and an improved state of health care. I am excited to be a part of this generation of physicians; I know that the future of EM will benefit from our interest and leadership.

I look forward to the year ahead in the AAEM/RSA Student Section. I am eager to work with the resident and student section and all the new student section board members: Vice President Marisa Fernandez (University of Southern California), Western Regional Representative Dina Seif (University of California, Irvine), Northeastern Representative Michael Ybarra (Georgetown University), and Midwestern Representative Todd Bialowas (Wright State University). Thank you for electing me to this position on the AAEM/RSA Student Section; I hope to help continue the excellence that is exemplified by AAEM. 🇺🇸

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Resident Journal Watch

by Daniel Nishijima, MD

Editor's Note: This is a new column providing journal articles pertinent to EM residents. It is not meant to be an extensive review of the articles nor is it wholly comprehensive of all the literature published. Rather it is a short list of potentially useful literature that the busy EM resident may have missed. Residents should read the articles themselves to draw their own conclusions. It will include articles published over a two-month period. These selections are from papers published in April and May 2006. Anyone interested in joining the Resident Journal Watch Committee or think a paper deserves inclusion, please email *Common Sense* at cseditor@aaem.org.

Comparison of Fondaparinux and Enoxaparin in Acute Coronary Syndromes. The Fifth Organization to Assess Strategies in Acute Ischemic Syndromes Investigators (OASIS-5). NEJM April 2006; 354:1464-1476

- This is a randomized trial comparing enoxaparin and fondaparinux (a selective inhibitor of factor Xa) in non-ST elevation ACS. Authors found that fondaparinux is similar to enoxaparin in reducing the risk of ischemic events at nine days, but it substantially reduces major bleeding and improves long term mortality and morbidity.

Effects of Fondaparinux on Mortality and Reinfarction in Patients With Acute ST-Segment Elevation Myocardial Infarction: The OASIS-6 Randomized Trial. The OASIS-6 Trial Group. JAMA. 2006;295:1519-1530.

- This is essentially the STEMI version of the OASIS-5. Authors found that fondaparinux reduces mortality and reinfarction without increasing bleeding and strokes.

Computed Tomographic Angiography for the Evaluation of Aneurysmal Subarachnoid Hemorrhage. Carstairs S et al. Acad Emerg Med 2006; 13: 486-492.

- This is a small pilot study looking at the utility of CT angiography for detection of cerebral aneurysms and SAH.

Oral Ondansetron for Gastroenteritis in a Pediatric Emergency Department. Freedman S et al. NEJM 2006; 354: 1698-705.

- This is a study looking at the utility of oral ondansetron in pediatric patients presenting to the ED with gastroenteritis. Authors found reduction of vomiting versus placebo though no difference in the rates of hospitalization.

Report of the Task Force on Residency Training Information (2005-2006), ABEM Task Force on Residency Training Information. Perina D et al. Ann Emerg Med. May 2006; 24: 476-91.

- Interesting overview of EM residency in the US. 🇺🇸

"Getting Involved"

by Daniel Nishijima, MD

It is an interesting entity, this "Getting Involved." They are quite possibly the most ubiquitous two words circulating throughout the various resident EM newsletters. For some, these words reverberate loudly and stir the inner souls to action. For others, it is an empty plea that fills the greater waste basket of noble (but impossibly inconvenient) ideals.

Granted, the resident's 24-hour day is unmercifully carved up by 12-hour shifts, long commutes and valiant attempts to study, leaving very little of that ever so precious free time. Who in the world has time to get involved with "Get Involved?"

Getting involved, however, incorporates a wide spectrum of time and commitment. There are so many simple ways to contribute to the greater whole of emergency medicine. Moreover, one does not need to have an affinity towards politics as often thought. While some AAEM/RSA members enjoy scouring the EM political landscape, other members may think this is as enjoyable as running barefoot through a dog park. There are many non-political issues residents can be involved in.

So remember, it doesn't need to take a lot of time, nor does it need to be political. Below are a few examples of the wide spectrum of ways that members can get involved with AAEM/RSA:

1. Running for AAEM/RSA president. Time Commitment: 365 days.
2. Running for AAEM/RSA board member. Time Commitment: 365 days (though considerably less time, fewer commitments, and less fancy pictures in suits).
3. Join a committee. Time Commitment: Varies/flexible to your schedule.
4. Go to the next AAEM conference in Las Vegas, NV. Time Commitment: 3-4 days.
5. Volunteer to mentor a medical student. Time Commitment: Varies/flexible to your schedule.
6. Write an article for *Common Sense*. Time Commitment: 1-6 hours.
7. Write letter to a legislator. Time Commitment: 30 minutes.
8. Notify us of an interesting paper to include in Resident Journal Watch. Time Commitment: 2 minutes.
9. E-mail the AAEM/RSA board an idea. Time Commitment: 1 minute.
10. Finish reading this article. Time Commitment: 30 seconds.

Emergency Medicine in Mongolia

by Allon Amitai, MD and Ganbold Lundeg, MD

Editor's Note – This is a new column that examines the practice of emergency medicine in various countries around the world. This issue will look at EM in Mongolia. This is an article written by Allon Amitai, MD and Ganbold Lundeg, MD. Allon Amitai is a graduating EM resident from SUNY Downstate/Kings County and about to begin his fellowship in International Emergency Medicine at Brown University. Dr. Amitai spent six weeks during his fourth year of residency working in China and Mongolia. Dr. Ganbold Lundeg is the chairman of Mongolia's Board of Critical Care Medicine.

Background

Mongolia is a central Asian nation of roughly 2.8 million people landlocked between China and Russia. A land of steppe, forest, desert and mountains, Mongolia has always been ill-suited for agriculture. Traditional Mongolian civilization was nomadic and pastoral, based on the herding of horses, sheep, yaks and camels. While Mongolia today is a semi-industrialized nation, half of all Mongolians still live as nomad herders, their way of life little changed over many centuries. Outside of the capital city of Ulaan Baatar, in the 21 *aimag* provinces, running water, paved roads and electrical power are rare.

The per capita GDP in Mongolia is \$2,200 (2005 estimate), with 36.1 percent of the population living below the poverty line (2004 est.) The total infant mortality rate in Mongolia is 53.79 deaths/1,000 live births (in US 6.43 deaths/1,000 live births) and the total life expectancy of 64.52 years (in US 77.6 years). Health insurance is provided by the government, but government care is often considered of low quality. Subsequently, there is a sizeable private health market and high quality private hospitals.

Pre-hospital Care

Mongolia follows the Franco-German model of physician supplied pre-hospital care. Paramedics and EMTs do not exist in Mongolia. Most of the physicians are general practitioners, but surgical, critical care, neurology and pediatric specialists are sent on calls when appropriate. The government heavily subsidizes ambulance care: the price to a patient of an ambulance visit is approximately \$2 US dollars.

On average, it takes an hour from the time a call for emergency assistance is placed to the arrival of an ambulance in Ulaan Baatar. This is partly a problem of Ulaan Baatar traffic, but also stems from difficulty locating calls. Yurt tent suburbs with a confusing and unreliable layout surround Ulaan Baatar. When ambulances do manage to arrive, pre-hospital care is provided according to the abilities of the provider, and a decision made whether or not to evacuate the patient to a hospital. Pre-hospital care outside of Ulaan Baatar consists of Russian-made police jeep transport to triage points and local clinics.

Emergency Medicine

Emergency medicine as a specialty does not exist in Mongolia. There are however, 12 hospitals in Ulaan Baatar with public emergency rooms, and there are 74 physicians that provide 24-hour ambulance delivered care throughout Ulaan Baatar. Hospitals in Ulaan Baatar are typically specialized: there is a trauma hospital, an oncology hospital, a cardiac hospital and other hospitals dedicated to obstetrics, pediatrics, tuberculosis and indigent care. Patients presenting to public emergency rooms are cared for by physicians who have completed standardized 18-month residencies in

anesthesiology and critical care, internal medicine, pediatrics neurology, or OB-GYN, or a 36-month surgical residency.

The physician specialty encountered in the emergency room is dependent on the type of hospital to which one presents. There are four general hospitals in UB, otherwise, if patients present to a hospital with pathology not appropriate for its specialty, diagnosis and treatment are delayed and may necessitate transfer. As might be expected, this has impeded the development of EM as a specialty. Of the twelve hospitals, seven offer internal medicine services, five have surgeons on staff, three have pediatricians, and one offers an OB service. Seven of the twelve EDs provide advanced airway management through their departments of Anesthesiology/Critical Care.


Available ancillary services vary by hospital. There are three functioning CT machines in UB, seven x-ray facilities and 12 ultrasound devices, but poor maintenance has limited their applicability. To repair the CT, for example, a technician must be brought from Beijing, a 24-hour train ride away. Laboratory testing is also limited. One surgical hospital on the outskirts of UB regularly performs complex abdominal and thoracic procedures without either X-ray or laboratory tests.

Emergency Medical Education

The main medical school in Mongolia is the Health Sciences University of Mongolia, a six year program with a total of 1,700 students. Along with applied clinical training in the Trauma Hospital, critical care departments and their core clerkships, medical students receive 30 hours of dedicated emergency medical theory and mannequin training, provided by the Department of Anesthesiology and Critical Care. The content of this training is similar to that of BLS, although the BLS, PALS, ACLS and ATLS courses are not yet available or known in Mongolia.

There are no residency programs yet in existence dedicated to emergency medicine, but care of the undifferentiated patient presenting to the emergency room in extremis is generally delegated to anesthesiology and critical care physicians when available, and medical students interested in working in emergency care typically choose to do their residencies in anesthesiology and critical care. Residencies in Mongolia are still short – usually only 18 months – and there are no formal courses of post-residency continuing medical education. There exists a professional society of anesthesiology and critical care physicians, but not yet of emergency physicians.

The Future of Emergency Medicine in Mongolia

Emergency medicine in Mongolia is at a critical phase in its development. Despite the rapid strides taken by Mongolia in liberalizing its economy and adopting the latest in information technology, health care has lagged behind increasing public expectations. Private hospitals are starting to meet the demands of the affluent few, but there is an increasing public consensus that pre-hospital and emergency care must be improved. Under development now, at the Ministry of Health, are plans to open a paramedic training school and a comprehensive emergency care center. International partnerships are now being cultivated for the development of academic emergency medicine in Mongolia, with the ultimate goal of the establishment of emergency medicine as an independent specialty. 

Historical Perspectives on and Future Direction of Our EMS Committee

By Roger Stone, MD MS FAAEM
Chair, AAEM EMS Committee

Greetings to all AAEM members. In a quick synopsis of our story, Dr. Atilla Uner brought together a small group of AAEM members at the 2003 Scientific Assembly in New Orleans. There, this handful of individuals discussed the need for our growing Academy to develop a direction of travel and mission within an area very much linked to the house of emergency medicine, but as yet untapped in the face of all the other threats and opportunities we confront as a specialty.

In subsequent e-mails, individual areas of concern were discussed, and it was agreed that our inaugural position statement on EMS was in need of modernization. That task was undertaken and begun with the help of Dr. Anthony DeMond, Dr. Uner, Dr. David Cone and former President, Dr. A. Antoine Kazzi.

An equally small group met during the 2004 Assembly in Miami. Since then, our group has had multiple conference calls and met in San Diego and San Antonio. Although we still have a small membership of 19 committee members, we developed some momentum in growing the numbers, tackling our position statement and defining our work products.

Core Mission of the Committee

The provision of out-of-hospital emergency care is inexorably married to our specialty and the quality we strive for in caring for patients is enhanced by the consultancy of physicians to EMS systems. Although NAEMSP represents the physicians with a subspecialty interest in oversight of EMS systems, and many of us are fortunate to be among the early dual members of AAEM and NAEMSP, it is our belief that emergency medicine specialists with the values AAEM bring to the table not only collaborative, but also unique contributions to make in the pre-hospital phases of emergency care.

As the committee has matured, we have more clearly defined the committee's objectives and the number of people it takes to achieve those objectives. Goals include the education of our own AAEM membership on EMS issues, a voice in EMS that collaborates with the house of EM and a voice for AAEM core values within EMS. We believe a lean and effective committee to be more important than recruiting a given number.

Below are some of the work products in which we are making progress.

EMS Liaisons:

Dr. Kazzi and our group first nominated an AAEM Liaison to NAEMSP. Dr. Cone, who is currently affiliated with the NAEMSP Board, has served diligently in that position. Similarly, we are hopeful to create a liaison to the ACEP EMS Section and have extended this offer.

Updated Position Statement on EMS:

The committee and I have completed work on a final draft of an updated position statement on EMS, last released in 1998. The final draft was sent to the BOD for review and approval. The updated position statement is now on our website.

Position Statement on Due Process and Compensation:

In follow-up to discussions during past conference calls on work products advancing AAEM values, the concepts of due process and compensation for medical directors was placed on the agenda. This is a germane project for the EMS Committee which will fill a

void in this topic area and provide a position statement on this subject that is dear to AAEM. This position statement on due process and compensation will come from the AAEM point of view and then be presented to NAEMSP for their input. A literature search is the first step, which is being completed by our two newest members, a fellow and a junior faculty member.

Input on the New NHTSA National Scope of Practice Model:

The EMS Committee collated recommendations that reflect AAEM values for the writers of the Scope of Practice document. Committee members forwarded general themes and comments for recommendations about the document to me as chair. In particular, we brought up concerns about the repercussions to our specialty, as well as AAEM members who are EMS physicians, and classified the comments into concerns about funding, reimbursement, inappropriate skill sets, public health, deviation from EMS missions and medical oversight.

Educational Input to the Scientific Assembly:

Increasingly, topics or controversies in pre-hospital care, as well as the emergency medical literature, are generating pertinent material for the continuing education of our specialists. Our inaugural work product in this regard, thanks to Dr. Cone's idea, was the planning and organization for this year's pre-conference workshop on medical oversight of EMS in San Antonio. It was also NAEMSP's maiden voyage into launching the one-day version of its internationally known four-day medical director symposium, which was requested and repeated in Halifax on June 7, 2006.

Newest Need for Mobilization:

Periodically, the committee will be faced with a new hot topic that affects EMS advocacy or AAEM core values. Such is the case with a recent press release by APMS creating a new "American Board of Disaster Medicine" and a "certification exam" this fall. In this case, the sponsoring society is responsible for the BCEM alternative pathway to certification which we so strongly opposed. Hence, we see adverse effects touching on EMS and disaster medicine, as well as core values. Committee members have an opportunity to help create our contribution to a unified call for opposition by AAEM, NAEMSP and others.

Dissemination of Information:

We would like to consider developing a regular article for *Common Sense*, beginning with this description about the EMS Committee objectives and tasks. In the future, we wish to author a review article in *JEM* describing the historical perspectives in EMS and future directions.

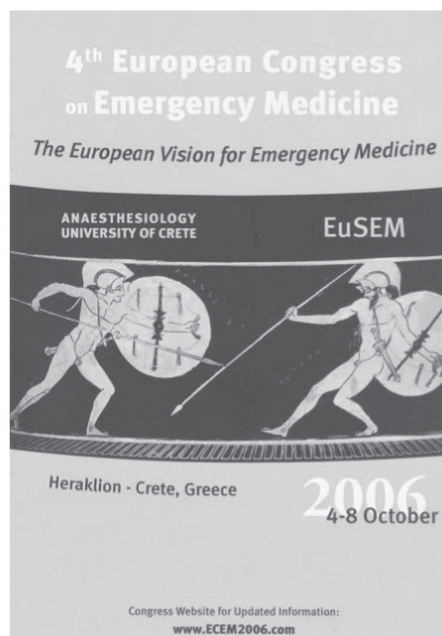
Please Join Us:

We ask members who are interested to send a CV and brief statement of intent to Tom Derenne at national AAEM (tderenne@aaem.org). Regarding recruitment, Dr. Scaletta and I welcome resident and EMS fellow representation. The EMS Committee has greeted AAEM/RSA Representatives in San Diego and San Antonio and invited residents to join the committee. Dr. Paul Hinchey of the University of North Carolina is serving as our first fellow member. +

The Fourth European Congress on Emergency Medicine

October 4-8, 2006

Crete, Greece



www.ecem2006.com

The USMC 3rd Civil Affairs Group operating in the Al Anbar Province Iraq, have begun a program to get more up to date medical references and textbooks into the hands of Iraqi civilian medical providers. Because of the war and embargos, most providers must work from books published in the early 1990s. Donation of any medical reference or textbook published within the last five years would be welcome. The 3rd Civil Affairs Group will distribute the donated books to medical providers, nurses and hospitals throughout Al Anbar province.

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Report from Buenos Aires

by Joseph Lex, MD FAAEM

Buenos Aires, Argentina was the site of the 1st Inter-American Congress of Emergency Medicine from April 19 - 21, co-sponsored by Sociedad Argentina de Emergencias, the American Academy of Emergency Medicine and the American College of Emergency Physicians. Nearly 3,000 emergency practitioners from around the world, but mainly from South America, met at the Sheraton Hotel-Buenos Aires for an outstanding educational experience and more than 20 hours of *AMA PRA Category 1 CME™*.

More than 40 American speakers and 100 other American attendees made this a true international experience. Argentina leads the way in establishing EM as a specialty in South America, led by such pioneers as Hugo Peralta, Silvio Aguilera, Daniel Gonzalez and Liliana Caceres.

Several things made me realize the importance of this meeting. For one, ACEP was represented by three past presidents (Robert Schafermeyer, George Molzen and Robert Suter), plus current president, Frederick Blum. For another, many pioneers of the specialty as an academic body of knowledge attended - all of them AAEM members. Peter Rosen, Judith Tintinalli, Lewis Goldfrank, John Marx and Kenneth Iserson all attended and gave talks. (No AAEM dues dollars were used to support this conference, by the way. Most participants were more than happy to not only self-fund, but to pay a registration fee in order to support the meeting.)

Considering the conference was on "foreign soil," the quality of talks given was at an extremely high level. Phillip Levy's thorough, yet very useful overview on the diagnosis and treatment of congestive heart failure, Daniel McDermott's updates on the San Francisco Syncope Rules, with as yet unpublished data, Mark Langdorf's easy mnemonics to remember Sgarbossa criteria, and, of course, Billy Mallon's total dismantling of the rationale behind the most recent ATLS guidelines, were just some of the high points.

In the Thread

by David Lawhorn, MD FAAEM

When I arrived in Blount County in 1998 to work in the ED at Blount Memorial Hospital and the University of Tennessee Medical Center, I was excited about the prospect of providing my expert care as one of the few true specialists trained and boarded in the field of Emergency Medicine in all of East Tennessee.


After medical school at The UT College of Medicine in Memphis and an internship at Erlanger Medical Center in Chattanooga, I had the privilege of serving our country on active duty as a medical officer with the 42nd Field Artillery Brigade in Germany and the Persian Gulf. Later I had the very distinct privilege of helping to get the new (Four Year) Emergency Medicine Residency Training Program started at Vanderbilt. I served as Chief Resident in my fourth year.

Joe Dawson was and continues to be a great administrator at Blount Memorial. I helped take care of his wife when she became gravely ill. But I very reluctantly chose to resign my position at Blount due to what I felt were very unethical behaviors and business practices of the corporate management group, TeamHealth. And, in resigning, I accepted my obligation "not to compete." This meant that my wife and I had to put our house on the market and I had to look for a job where I could practice good emergency medicine - hundreds of miles away from Blount county. I now help run the emergency department at Sumner Regional in Gallatin, TN, where we've just had devastating losses due to tornadoes today.

English-language tracks were translated into Spanish. In the Spanish language tracks you could hear local perspectives on mountain medicine (from Argentina), cold-related injury (from Peru), COPD updates (from Chile), mental status change in children (from Uruguay), non-invasive ventilation (from Venezuela), post-resuscitation care (from Brazil), medical intelligence (from the Dominican Republic), hazardous materials (from Mexico) and treatment of shock (from Cuba), as well as speakers from Belgium and Australia.

Aaron Hexdall, MD FAAEM, served as organizer for AAEM and dedicated hundreds of hours to assure its success. From AAEM's home office, there was extremely strong support from Tom Derenne in meeting all of the ACCME requirements for attendees.

On a personal note, it was fun catching up with friends I met last year when I spoke at the SAE meeting and was made an honorary member of their society. Since I got into town a day early, I had a chance to explore the Plaza de Mayo, including the National Cathedral and crypt of Argentinean republic founder José Francisco de San Martín, leader in the War of Independence. The Arts Museum has a very complete collection of South American art through several centuries, and the MALBA (Museo de Arte Latinoamericano de Buenos Aires) had two exhibits by contemporary artists. My favorite was a small museum on Laprida Avenue dedicated solely to the works of Argentinean fantasist / surrealist Xul Solar, confidant to Jorge Luis Borges, and virtually unrecognized in his lifetime.

There are tentative plans for a 2nd Inter-American conference in 2008, possibly in Buenos Aires, but another country is not out of the question. I'll let you know as plans come together. Don't miss another opportunity like this - AAEM-quality CME in an exotic location. 

The Sumner community is also a wonderful place to be and is served well by Diane Black, Michael McDonald and Debra Maggart.

In our small democratic group of specialty trained emergency medicine doctors, four of us trained at Vanderbilt, one trained at Johns Hopkins and one trained at Harvard. Of over 140 hospitals in the state of Tennessee, only four are fully or mostly staffed by emergency medicine residency trained physicians 24 hours a day. These hospitals include Vanderbilt, St. Thomas in Nashville and Sumner Regional in Gallatin. (You may notice that none of these hospitals have their EDs managed by a corporate management group). And in our business structure we chose to adopt the high ethical standards put forth by the AMA, ACEP (The American College of Emergency Physicians) and AAEM (The American Academy of Emergency Medicine). We adopted a set of bylaws that does NOT include any restrictive covenants of non-compete. We did so because it is bad for patients and because it frankly is unethical.

The ONLY model well served by preventing good physicians from practicing medicine in a community where they have established their friends, families and patients is the model of the business person or corporate structure attempting to maintain a profit.

Just as an example, if I (or anyone) wanted to go one day to Blount County to provide medical services to Blount Memorial with a

continued on pg 16

Right Makes Might

by: Andy Walker, MD FAAEM
AAEM Board of Directors
Vice-President, TNAAEM

Although just a few months old, the Tennessee chapter of AAEM (TNAAEM) has already won a major victory for physicians in the state, defeating an attempt to legalize restrictive covenants in Tennessee. Last summer in the *Udom* case, the Tennessee Supreme Court ruled that restrictive covenants (non-compete clauses) in physician employment contracts are against the public interest and unenforceable. This was hardly a surprise since courts in other jurisdictions have reached the same conclusion, and restrictive covenants are widely considered to be a violation of medical ethics. The AMA, ACEP and most strongly AAEM, have all taken stands against non-compete clauses and consider them unethical, since by their very nature they restrict the access of patients to medical care and put the financial interests of a few physicians or hospitals above the best interests of patients.

In April, AAEM notified TNAAEM of a pending bill in the Tennessee legislature, HB3536/SB3361, which would have superseded the Supreme Court ruling and legalized restrictive covenants. If it had become law, this bill would have allowed non-compete clauses barring a physician from working in the same county or within ten miles of his current job, whichever was greater, for two years after leaving his current job! This law would have applied to physicians in all specialties, not just emergency medicine.

Usually the Tennessee Medical Association (TMA) does an excellent job of notifying doctors of pending bills that would affect them, but in this case I, and most other TMA members, was unaware of the bill's existence until AAEM warned us. This happened because the TMA chose to remain neutral on the bill, and thus did not send out any requests to doctors to lobby either for or against it. Although most physicians oppose restrictive covenants, it seems that some hospitals, large multi-physician groups and contract management groups favor them. This convinced the TMA to remain neutral on the bill and nearly led to its passage before most Tennessee physicians even learned of its existence.

In Tennessee almost all bills that fail are killed in committee or subcommittee. Most of the bills that come to a vote, pass. We didn't know about this bill until it had already cleared all committees and subcommittees and was scheduled for a vote in the House four days later! Our task seemed hopeless but TNAAEM believes that the rational response to bad odds is to try harder, so we went to work. First every member of our little chapter was notified, and then those members notified every emergency physician in Tennessee we could reach. Our legislators were buried by emails and phone calls explaining the issue and asking them to defeat the bill, and we urged the TMA to reconsider its position on the bill. We were unsuccessful in altering the stance of the TMA and, at first, it appeared that the bill couldn't be stopped either, but we did succeed in having it amended to exclude emergency physicians.

At that point, it looked like TNAAEM and ACEP's Tennessee chapter, TCEP, were fighting side by side. Many of the emergency physicians working to defeat the bill were TCEP members, including at least two members of its Board of Directors. At the time, those directors told us they were as unaware of the bill as we were before AAEM's warning, and just as opposed to it as we were. Although not as strongly worded as AAEM's policy, ACEP does after all have a policy opposing non-compete clauses as against the public interest. In fact it was TCEP's professional lobbyist who carried the amendment exempting emergency medicine to the bill's sponsors and had the bill amended as we asked. He told us at the time that he didn't fully appreciate the implications of the bill for emergency medicine until after we briefed him. TNAAEM was and is grateful for all the help, and alone I doubt we could have accomplished what we did.

TCEP's directors then met by conference call and voted to completely reverse course. TCEP notified its members and the legislature that it now opposed the amendment exempting emergency physicians from the bill, the very amendment that its lobbyist had just carried to the legislature! The chairman of TCEP's political action committee, Dr. John Proctor, also distributed a memo stating that he and TCEP's lobbyist were fully aware of the bill even before the notification from AAEM, and their decision not to oppose the bill was made after careful consideration. With the TMA neutral and TCEP in opposition to us, TNAAEM was left alone as the only organization in Tennessee fighting this destructive bill that would have legalized a violation of medical ethics. Despite the odds stacked against us, we prevailed. Our legislators listened to us and became concerned that the bill would severely restrict patients' access to care, especially in rural areas. Once on the verge of passage, the bill was voted into a "study committee" where it will remain until the legislature comes back into session next January.

In the meantime, the forces that created and pushed the bill will be working to line up more support, and they know now that they will have opposition. TeamHealth is based in Tennessee and is heavily represented on TCEP's Board of Directors. Dr. Proctor is a regional director for TeamHealth. On the other hand, TNAAEM will keep working to convince TCEP (with its larger membership) to once again change course and join us in upholding the code of ethics and doing the right thing for individual emergency physicians and our patients. We will also keep working to educate our legislators on the harmful effects of restrictive covenants on patients and the vast majority of doctors. When this battle was joined I was pessimistic, but events have shown that sometimes being right is as important as being big or powerful. Even a small group of dedicated people can achieve great things, especially when led by someone as energetic as TNAAEM's president, Dr. Kevin Beier. Sometimes the good guys win. Sometimes right makes might.

EMTALA

Pointers

FROM THE AAEM EMTALA COMMITTEE

Q:

If your hospital does not offer Obstetric or Neonatal services, and a pregnant patient in active labor presents to your ED, when can you safely conduct the patient transfer to a hospital with these services?

A:

EMTALA mandates that the receiving physician provides a "medical screening examination" to determine if an emergency medical condition (EMC) exists. An EMC is the presence of "acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in placing an individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."

In the case of a pregnant patient in active labor, an EMC is one in which there is inadequate time for safe transfer to another hospital before delivery, or when transfer may pose a threat to the health or safety of the woman or the unborn child. If an EMC exists, to comply with EMTALA, the hospital must instead provide the best possible level of care – which may include delivery of the unborn child, and subsequent stabilization of mother and child, before transfer to the next hospital occurs.

by Richard "Chip"
McCollum, MD

In the Thread - continued from pg 14

full staff of residency trained emergency medicine physicians and retain some of the fine physicians currently on staff, under your proposition, all of the current emergency physicians working at Blount Memorial would be forced to leave. TeamHealth would be very pleased to enforce a non-compete. Why? Because in doing so, it is so threatening to the working physicians - fear of losing one's job, income and having to leave the community is so strong as to prevent any healthy competition or even raising the quality of trained physicians at one of their contracted facilities. Thus they can also engage in setting their own fees which may be significantly higher than would normally occur in a non-restrictive environment.

I will end with repeating some of the information you have been getting from other colleagues on this topic. Please listen carefully to what we are saying... and ask questions.


Dr. Kevin Beier writes:

"Tennessee is currently ranked 43rd in the US for number of emergency physicians per 100K capita. Specifically within my practice in Nashville we are severely impaired by lack of experienced and qualified emergency medicine residency-trained physicians. Many of the local quality emergency physicians are leaving the seven quality physicians in ten months and we have had no ability to hire replacements even though our efforts have been vigorous to do so. Emergency physicians frequently practice at more than one facility, and frequently contract with more than one group locally, due to the nature of emergency medicine. Restrictive covenants and non-compete clauses prevent or impair this and

further restrict patient access to medical care. By nature, non-compete clauses are always bad for patients; by design they restrict a patient's access to medical care.

Non-compete clauses have been judged unethical by the AMA (American Medical Association), and have been declared unenforceable and as against public interest by every court that has considered the matter. There is no reasonable public advantage for non-compete clauses in medicine. The advantage of non-compete clauses is for that of business, and specifically for the advantage of a small minority of physicians to gain economic leverage on a majority of physicians to enhance the minorities economic position. Even in the legal profession non-compete clauses have been deemed unethical and lawyers can be disciplined by the state bar for including such in contracts.

Members of AAEM can similarly be disciplined and expelled for placing non-compete clauses into contracts with other physicians. The Tennessee chapter of the American Academy of Emergency Medicine will oppose any bill to legalize non-compete clauses, and so will the vast majority of individual physicians in this state who become aware of the issue. I would very much like to further discuss this issue with you and any other legislative member with an interest in such either in person or by phone. Please let me know if you are able to do so, and if so when you are available. Thanks for your time and efforts. Both are much appreciated."

*Founding Member American Academy of Emergency Medicine
Former Chief Resident Vanderbilt Emergency Medicine Residency Program* 

CHANGE OF E-MAIL ADDRESS

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



by Kathleen Ream, Director of Government Affairs

Washington Watch



According to data obtained in the latest Drug Abuse Warning Network (DAWN) survey, out of the almost two million drug-related ED visits recorded in 2004, 1.3 million were associated with drug misuse or abuse. Of these 1.3 million visits, 30 percent involved illicit drugs only; 25 percent, prescription or over-the-counter medications only; 8 percent, alcohol only in patients under age 21; 15 percent involved illicit drugs and alcohol; 8 percent, illicit drugs and pharmaceuticals; and 14 percent, illicit drugs, pharmaceuticals, and alcohol. The findings are contained in a new report from the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) entitled, *Drug Abuse Warning Network, 2004: National Estimates of Drug-Related Emergency Department Visits*.

Due to changes from previous DAWN surveys – including an expanded definition of ED visits related to recent drug use, and a new sample of hospitals covering the entire United States – this latest survey is considered a new baseline for future years. As a consequence, the new data cannot be compared to data from prior years.

Based on data submitted by the 417 hospitals in its national sample, DAWN developed the following additional information:

- Cocaine was involved in 383,350 ED visits; marijuana in 215,665; heroin in 162,137; stimulants, including amphetamines and methamphetamine, in 102,843 visits. Other illicit drugs such as PCP, Ecstasy and GHB were involved with much less frequency.
- Non medical use of prescription and over-the-counter pharmaceuticals were involved in 495,732 ED visits. Over half (57%) of these non medical use visits involved more than one drug, and nearly a third (32%) involved opiates and opioid analgesics.
- The most frequently used prescription medications were benzodiazepines (144,385 visits), hydrocodone products (42,491 visits), oxycodone products (35,559 visits), and methadone (31,874 visits).
- Alcohol in combination with an illicit drug was involved in 363,641 ED visits by persons of all ages. In patients under the age of 21, alcohol alone was involved in 96,809 visits.

In commenting on the report, SAMSHA administrator Charles Curie said, "Most of the 1.3 million visits to emergency rooms involving drugs or alcohol misuse or abuse are an opportunity for the health care system to intervene and direct patients to appropriate follow-up care." The full report is available at <http://dawninfo.samhsa.gov>.

EMTALA TAG Meets for Fourth Time

Under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the Secretary of Health and Human Services was mandated to establish a Technical Advisory Group (TAG) to review issues related to EMTALA and its implementation. The fourth meeting of the EMTALA TAG occurred on May 1 and 2, 2006. The primary purpose of the meeting was to enable the TAG to consider the work that its subcommittees had completed on specific issues tackled by the main group at previous meetings, as well as discuss the written responses received from various health care organizations regarding the same issues. Some topics that the TAG addressed and actions taken at this meeting included the following:

- Clarification that CMS does not require physicians to take emergency calls as a Condition of Participation in Medicare.
- Affirmation of the TAG recommendation that hospitals with specialized capabilities not be required to maintain EDs, but that these same hospitals still be bound by the same responsibilities under EMTALA as hospitals with specialized capabilities that do have a dedicated emergency department.

- Review of the proposed revisions to the EMTALA regulations and corresponding Interpretive Guidelines submitted by the Action Subcommittee on:

- (1) Emergency physician communication with other clinicians to seek advice regarding a patient's medical history and needs that may be relevant to the medical treatment and screening of the patient.
 - (2) Definitions for "stabilization" and "emergency medical condition" as applied to psychiatric emergency patients and on transfer issues related to such patients.
 - (3) When a hospital can discourage a non-hospital-owned ambulance from coming to the ED.
 - (4) EMTALA compliance when an emergency is declared by a government authority at any level and the exceptions to compliance (e.g., massive equipment failure, bomb threat, snowstorm).
- Assessment of the proposed revisions to the Interpretive Guidelines submitted by the On-Call Subcommittee on hospital policies for:
 - (1) Physician response times.
 - (2) Availability of on-call physicians.

EMTALA Claim Dismissed: Florida Hospital not Culpable for Patient's Criminal Conduct

On summary judgment, the U.S. District Court for the Middle District of Florida threw out an EMTALA claim a man made arguing that he was coerced to leave a hospital where he had been taken for a drug overdose (*Johnson v. Health Central Hospital, M.D. Fla., No. 6:04 cv 1436 Orl 31DAB, March 20, 2006*).

The facts in this case involve the plaintiff Benjamin Levi Johnson, who overdosed on prescription medications and was taken to Health Central Hospital's ED where he underwent a medical screening examination and then was admitted to the intensive care unit. Johnson awoke and asked a nurse if he could make a phone call. He was informed that he could do so if he signed a form acknowledging that he was leaving the hospital against the advice of his physician and the hospital.

Johnson signed the form. The IVs were removed and Johnson was taken to a telephone in the hallway of the hospital where he called his boss to pick him up. Johnson left the hospital. Four hours later he assaulted a law enforcement officer, was convicted for that crime, and ended up serving 22 months in prison.

This case arose as Johnson sought to use the remedial provisions of the EMTALA to hold Health Central responsible for the consequence of his criminal conduct.

The hospital filed a motion for summary judgment. Such a motion by one of the parties to a suit contends that all necessary factual issues are settled or are so one sided that the facts need not be tried. In other words, the motion argues that no triable issue of fact exists and that the settled facts require an immediate judgment for the moving party.

The court wrote that the "undisputed facts reflect that Johnson received appropriate medical screening (under EMTALA), and was also the recipient of substantial efforts to stabilize his medical condition." The court noted that EMTALA provides a safeguard against patient dumping, not "a substitute for state law claims of medical negligence," – implying that a malpractice suit instead may have been pursued for allowing an intoxicated patient to sign out of treatment.

Nonetheless, the district court's Judge Gregory A. Presnell wrote in his ruling that Johnson's contention that "he was 'forced to

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leave the hospital by the nurse,' is patently ridiculous . . . only in America could someone make such an outlandish claim!"

Tennessee Hospital Motion for Summary Judgment Denied in EMTALA Case

On March 30, 2006, the U.S. District Court for the Western District of Tennessee found that genuine issues of material fact were set forth in a patient's lawsuit claiming that a Tennessee hospital was negligent and in violation of EMTALA when it failed to properly screen a suicidal patient and stabilize him prior to discharge from the emergency department. The court denied the hospital's motion to dismiss for summary judgment (*Card v. Amisub (SFH) Inc.*, W.D. Tenn., No. 03-2528, 3/30/06).

Plaintiff Bruce Card arrived at the emergency department of Amisub (SFH) Inc., doing business at St. Francis Hospital in Memphis, Tennessee, "requesting medical care to avert danger of harm to himself due to depression, suicidal tendencies and substance and alcohol abuse." In the ED, Card described his symptoms to the admitting nurse, who then allegedly "performed a cursory medical examination/clinical evaluation" and gave Card a list of outpatient treatment centers to phone.

According to the complaint, Card called each of the centers, and was "refused treatment by each due to his health insurance status." He told the nurse that none of the centers would accept him for treatment. The nurse allegedly responded that "they had done all they could possibly do" for him.

Card then was discharged from the hospital, and subsequently began drinking and attempted suicide by cutting his wrist. He then was admitted to another emergency medical care facility where he received stitches and was involuntarily committed for treatment.

Card filed a lawsuit alleging that SFH failed to adequately screen him upon his arrival, failed to stabilize his condition prior to discharge and violated state and common law medical malpractice laws. SFH filed a motion requesting dismissal of the lawsuit, or in the alternative, summary judgment in its favor. The district court denied the motion.

Turning to the first claim of violating EMTALA by failing to properly screen the patient, the court stated that SFH initially moved to dismiss this claim because it was unsupported by expert testimony. The plaintiff then submitted an affidavit from a licensed physician contending that Card was not properly screened and "should have been evaluated beyond the clinical assessment stage of non-professional personnel."

SFH countered that the affidavit was insufficient to establish a genuine issue of material fact regarding proper screening, emphasizing that the physician's conclusions were based entirely on a review of the admitting nurse's deposition. The federal district court judge rejected the SFH argument, noting that critical evidence, such as the clinical assessment form and all other records pertaining to Card's visit to the hospital, was missing. Card had alleged that SFH destroyed the records after he filed the lawsuit. SFH did not refute the allegation.

The court also differed with SFH's line of reasoning that dismissal is justified on the grounds that Card's failure-to-stabilize claim was merely a state law negligence action. Rather, the court clarified that an action under EMTALA "is not analogous to a state medical malpractice claim because it creates liability for refusal to treat, which state malpractice law does not."

Liability under EMTALA also requires actual knowledge of the patient's emergency condition, which the court found based on a favorable disposition to Card's claim and the expert affidavits.

Summary judgment on the failure-to-stabilize claim was inappropriate as Card had set forth a genuine issue of fact, the court held.

SFH's motion for summary judgment on the state and common law medical malpractice claim maintained that the plaintiff's submitted expert affidavits did not mention that SFH's actions caused Card's injuries. The court disagreed, writing that "this omission does not require the dismissal of Card's malpractice claim under the particular circumstances and procedural posture of this case." Owing to the alleged negligent loss or destruction of evidence by opposing party in a lawsuit, the court noted that plaintiff is unable to prove an essential element of his argument. In these circumstances, the federal court stated that it is proper for the trial court to create a rebuttable presumption establishing the incomplete elements of plaintiff's claim, which only could have been proved by the availability of the missing evidence.

Full text of the decision is available at <http://op.bna.com/hl.nsf/r?Open=thyd-6nsjt9>.

Court Dismisses Inappropriate EMTALA Screening Claim

On March 31, 2006, the U.S. District Court for the Eastern District of California dismissed three of Donna Hoffman's four complaints alleging that Kent Tonnemacher, an ED physician at Memorial Medical Center (MMC), in Fresno, CA, failed to provide her appropriate medical screening and stabilization, in violation of EMTALA (*Hoffman v. Tonnemacher*, E.D. Cal., No. CIV F 04-5714, 3/31/06).

The court also dismissed the plaintiff's issue of an inappropriate screening argued on disparate treatment in relation to six other patients treated by defendant Tonnemacher. At the same time, the district court rejected summary judgment to Tonnemacher and MMC on plaintiff's claim of disparate treatment based on the ED physician's failure to follow MMC's EMTALA policy, requiring a doctor to verify, or rule out, conditions that s/he suspects a patient may have.

The facts in this case begin when plaintiff arrived at MMC's ED on May 22, 2005. Tonnemacher examined and treated Hoffman, who complained of chills with hyperventilation, nasal congestion, cough, chest pain and numbness in her hands. Tonnemacher took a medical history, performed a physical examination, and ordered X-rays and a urinalysis. He diagnosed fever and bronchitis, with a differential diagnosis of possible pneumonia. He discharged her with a prescription for an antibiotic, reasoning that there may be potential concern for a bacterial illness.

Hours later, an ambulance returned plaintiff, to MMC's ED, in a septic condition. Hoffman's blood cultures were taken and examined, identifying a virulent streptococcus pneumonia bacterium. Plaintiff was admitted to MMC's ICU in critical condition. Hoffman survived the sepsis, but endured physical damage. She sued Tonnemacher and MMC for EMTALA violations and state law medical malpractice.

Expert physician witnesses for plaintiff contended that Hoffman's initial screening examination and emergency treatment were not up to applicable standards of care. The defendants countered that when Hoffman was discharged she was in stable condition, had an appropriate antibiotic prescription, and no additional medical screening or testing was indicated at that time.

The district court concurred with the defendants. Plaintiff's line of reasoning that the screening was not designed to detect an emergency medical condition and, thus was inappropriate, was aligned with the experts' testimony, which the court found were criticisms of negligence and not of EMTALA. Thus on this issue,

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the court granted MMC summary judgment, stating that “EMTALA is not a medical malpractice statute and does not establish a standard of care.”

Hoffman’s claim of inappropriate screening based on disparate treatment in relation to other patients treated by defendant, also was denied. The court found that Tonnemacher established different dispositive symptoms for other patients, so there could not be disparate treatment under EMTALA.

Plaintiff, who bore the burden of proof, could not persuade the district court of actual detection or knowledge in her stabilization claim. With the antibiotic prescription, an argument could be made that Tonnemacher did not rule out the presence of a bacterial

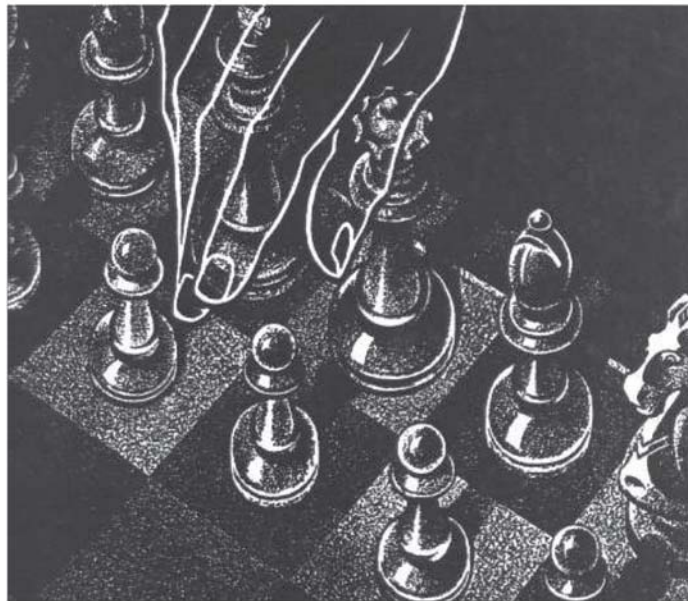
process. Yet, the uncontroverted evidence demonstrated that the ED physician diagnosed a case of bronchitis, which typically is viral, and therefore believed that Hoffman was not suffering from an emergency condition at the time of discharge. Based on the diagnosis of bronchitis, for which plaintiff offered no testimony of instability, the federal district court granted summary judgment on the stabilization claim.

The court, however, did set a hearing date for one issue. It found that the defendant “did not rule out a bacterial process, even though a bacterial process was a concern . . . it is possible for a jury to conclude that Hoffman received disparate treatment in that Dr. Tonnemacher did not follow MMC’s EMTALA policy.” 

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

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

ALABAMA

Independent, democratic group seeking BC/BE emergency medicine physicians. 24,000 annual visits with 8 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. Contact Don Williams, MD at baymds@aol.com. (PA 725)

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

ALABAMA

Mobile, AL. Seeking full-time BE/BC emergency physician to join democratic 7 person group staffing community hospital with 35K visits per year. 16 bed ED, 6 bed chest pain center, 4 bed fast track. Fee-for-service, competitive salary, 401(k). Expanding patient population creating need for additional physician. MD double coverage daily, additional PA coverage weekends. Excellent backup all specialties, stable contract since 1987. (PA 741)

ALABAMA

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

CALIFORNIA

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

CALIFORNIA

Chico: Golden opportunity at a single hospital, independent, democratic group seeking board certified emergency physician, three years experience, for level two trauma center with 39K visits/yr, high acuity, 20% admissions, double coverage 11am-2am, referral center, as well as community hospital. Close to unlimited recreation ski (water and snow) nearby, hunt, fish, hike, bike ride, all in a beautiful college town two hours from the SF Bay area. Good schools for those of us with kids. \$300,000. Must be able to move patients! Too good to be true! Maybe! Send CV to W. Voelker, Emergency Dept., Enloe Hospital, 1448 the Esplanade, Chico, CA 95926. (PA 727)

CALIFORNIA

At Kaiser Permanente, we believe in promoting a healthier lifestyle for both our patients and our physicians. And, our world-famous weather and natural attractions make Southern California an ideal place for those who love adventure and the outdoors. Opportunities throughout Southern California. Send CV to: Kaiser Permanente, Professional Recruitment, 393 East Walnut Street, Pasadena, CA 91188-8013. Phone: (800) 541-7946. Email: David.L.Lin@kp.org. We are an AAP/EEO employer. (PA 738)

CALIFORNIA

University of California, Irvine, Department of Emergency Medicine is seeking a one year Clinical Instructor for July 2006. UCI Medical Center located in Orange County is a Level I Trauma Center. This position combines emergency management/disaster medicine and public health training with that of traditional EMS. Candidates must have completed an ACGME-accredited Emergency Medicine Residency. Salary based on level of clinical work. Send email to Carl Schultz, MD, UCI Medical Center, 101 City Drive, Route 128-01, Orange, CA 92868, schultz@uci.edu. UCI is an equal opportunity employer committed to excellence through diversity. (PA 742)

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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)

FLORIDA

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

FLORIDA

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

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

FLORIDA

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

FLORIDA

Work with group of BC/BE Emergency Physicians in a 55K visit community hospital setting in Orlando suburbs. Enjoy employee status, benefits, retirement package and sovereign immunity. Excellent coverage with 42 hours physician coverage and 36 hours PA/NP coverage daily. Compensation \$120/hr plus benefits. (PA 724)

FLORIDA

Full-time BC/BE Emergency Medicine physician needed for military medical facility in Jacksonville, Florida. Level three ER with 18 patient beds, non-emergent to emergent acuity rate, and 67,000 patients/yr. Acute care clinic has 33% appointments and 67% non-emergent overflow. 160 hours per month with flexible scheduling. Competitive salary. Relocation assistance. No malpractice insurance required. Continuing Education reimbursement, 401k match, disability insurance and 26 days paid leave per year. For immediate consideration contact Nate, nparham@chesapeakectr.com. (PA 744)

GEORGIA

Emergency Medicine physician, board certified in Emergency Medicine. Military medical facility in Augusta, GA. Full-time long term contract position \$300K+. Enjoy the charm, beauty, and hospitality of the south! (PA 730)

KENTUCKY

Owensboro: 28-year, democratic, fee-for-service, 10 physicians group seeks residency trained and/or BC emergency physician for 65K visit regional hospital ED. 27,000 sq ft. 4 year old 33 bed facility with adjacent radiology dept. with 2 CT scanners. Double and triple physician coverage plus at least 12hr/day of PA coverage in fast track area. Total package in the \$150/hr range. Bonuses based on productivity. Owensboro is a great place for families, plenty of recreation, a performing arts center, symphony, nationally awarded school system, 3 colleges, and only 2 hours from Louisville or Nashville. Contact Emergency Physicians Group, PSC 270-685-0216. (PA 728)

KENTUCKY

Hospital based practice opportunity for a fast-paced EM physician to handle all aspects of the Emergency Department - Fast Track & Urgent Care. Our hospital has 34,500 visits to the ER per year. We are a growing, regional healthcare facility with 261 beds, 150 physicians & air/ground transport on site. We have an open heart program, hospitalist program & a neurosurgery program. (PA 737)

KENTUCKY

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

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INDIANA

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

INDIANA

South Bend: Very stable, Democratic, single hospital, 13 member group seeks additional BC/BE Emergency Physician. Newer facility with expansion planned. 55k visits, Level II Trauma Center, double, triple, and quad coverage. Equal pay, schedule and vote. Over 300K total package with qualified retirement plan, disability insurance, medical reimbursement, etc. University town, reasonable housing costs, good schools, 90 minutes from Chicago. (PA 720)

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MARYLAND

Community hospital located just twelve (12) miles outside Washington, D.C., is seeking ABEM/AOBEM certified physicians. These F/T positions are needed to support our increasing volumes and high acuity. Our 35 bed, level II Emergency Department sees 55k patients per year with a separate fast track area. We offer competitive compensation and benefits, flexible scheduling and a fair practice environment. This is an outstanding opportunity for someone who is patient orientated, team focused and eager to participate in department (hospital) activities, to join our new Chairman. For immediate consideration candidates should contact Elicca Evans, ED Recruiter at eliccaevans@southernmarylandhospital.com. Office 301-877-5536, Fax 301-877-7354. (PA 731)

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MARYLAND

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

MASSACHUSETTS

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

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MINNESOTA

Minnesota, Minneapolis: The Twin Cities largest democratic, physician owned emergency medicine group seeks highly motivated board trained or board-eligible physicians to join our 100 member group. Our group staffs six community hospitals with average volumes of 40K. Base salary, benefits, and productivity and performance incentives to exceed \$350K compensation. Come see what Minneapolis has to offer other than snow. Website: www.eppanet.com (PA 747)

MISSOURI

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

MISSOURI

Hannibal Regional Hospital is seeking a Medical Director for the Emergency Department. Qualifications include: Board certification in emergency medicine. In addition to a base salary, incentive bonus, relocation monies, tax sheltered annuities, and continuing education monies are available. Located near the Mississippi River and just 20 minutes from Mark Twain Lake that offers the appeal of a variety of recreational amenities (fishing, boating, and camping) with easy access to major metropolitan areas such as St. Louis, MO., & Springfield, IL. Contact Marcia Davis at Marcia.davis@hrhonline.org. (PA 722)

NEBRASKA

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

NEW MEXICO

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

NEW YORK

Single-hospital, happy, collegial, democratic group seeking BC/BE emergency medicine physician for expanded coverage. State-of-the-art department opening in early 2006 with US, CT, and digital radiography in ED. Full departmental status; excellent remuneration; full benefit package. Area offers excellent schools; outdoor activities; and high standard of living. (PA 729)

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NEW YORK

Full or part-time
Beth Israel Medical Center's Kings Highway Division-Midwood, Flatlands and Marine Park communities in Brooklyn, NY. Team covers 40 staff hrs/day, NP team covers 15 staff hrs/day and Emergency Medicine Residents rotate in ED and ICU. Requires BC/BE in Emergency Medicine (ABEM or AOBEM). Competitive salary and benefits. Please fax CV to M. Ognibene at 718-677-5597. EOE. (PA 748)

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NORTH CAROLINA

Democratic group in the Raleigh/Durham area seeks a BC/BE emergency physician. Medium-sized community hospital with excellent back-up and minimal trauma. Our department sees 45K patients a year with a separate fast track area. 42.5 hours of physician coverage and 30 hours of PA coverage daily. We offer competitive compensation, equitable scheduling and good benefits in a fair practice environment. Our group is stable, vibrant, and seeking a strong team player. Send responses to durhamemergency@yahoo.com. (PA 712)

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

NORTH CAROLINA

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

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

OHIO

Excellent Opportunity! Springfield Emergency Physicians; stable, democratic, FFS group seeks BC/BP physician. 1st year partnership. Compensation package over 300K. 44K volume ED. Pleasant work environment with competent nurses. Plans underway for new, state of the art Emergency Center to open 2010. Contact Rohn Kennington, Medical Director, 937-390-6102, email: twatsonfan@acclaimhim.com (PA 732)

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

OKLAHOMA

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

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

PENNSYLVANIA

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

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

PENNSYLVANIA

Faculty positions available for individual BC/BP in EM. Academic and clinical track positions available. Benefits highly competitive. Protected time for research/academic pursuits for academic track. Opportunity to work with EM residents on clinical track. Equitable scheduling. Temple University Hospital is a 600-bed tertiary care teaching hospital with a Level I Trauma Center. (PA 736)

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

RHODE ISLAND

Seeking BE/BC EM MD for full-time position in beautiful Oceanside Newport, RI. Private, single-hospital, stable, democratic group. Department is 5 years new and very computerized with 32,000 census. Position offers very competitive salary and bonuses with full benefits package. Practice the full spectrum of community emergency medicine in coastal New England. (PA 746)

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

RHODE ISLAND

Emergency Room Physician: Westerly Hospital, a pleasant seaside community located in the southwest corner of Rhode Island with 30,000 ED visits per year to our state-of-the-art Emergency Department wing, has a full-time position available for an emergency physician. Candidates must be board-certified/board-eligible in Emergency Medicine with a minimum of 2 years experience. Coastal living and a collegial atmosphere make this a great place to work. Please send CV with cover letter to M. Eddy, Medical Staff Coordinator, The Westerly Hospital, 25 Wells St., Westerly, RI, 02981. Fax 401-348-3802 or meddy@westerlyhospital.org (PA 706)

AAEM JOB BANK

SOUTH CAROLINA

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

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)

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

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. If interested, contact Tiffany Ellington: 843-777-7000 or tellington@mcleodhealth.org. (PA 753)

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

TENNESSEE

Democratic Group seeking BC/BE emergency physicians. Two hospital contracts/100,000 patients yearly. Two year full partnership. Square schedule with nights in direct proportion to number of shifts, except first 2 yrs. 2 extra overnights per schedule, \$350.00 per extra night worked. First schedule no single coverage (night or first shift). (PA 756)

VIRGINIA

Eastern Virginia – Emergency Medicine physician is being recruited for a community hospital in the Northern Neck of Virginia on the Chesapeake Bay. 1.5 hours to Richmond, 40 minutes to Williamsburg. Hourly plus 30K in benefits. 12 hour shifts. Call or email for details to SGSCHOEN@MDRSearch.com or 800-327-1585. (PA 726)

VIRGINIA

Lynchburg - Stable, Democratic Group. Level II Trauma, 75K visits, single hospital/ED. 18 member group. 8 hour shifts plus fast track. Competitive: Salary, retirement, CME, Mal-practice, medical. One or two FTE's if qualified. Flexible start date. (PA 734)

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

VIRGINIA

Newly formed democratic group in Blue Ridge Mountains of Southwest Virginia seeks BE/BC partner. Rare opportunity to join group staffing single hospital, 36K visits, no/rare trauma. Work only 3 eight hour nights every 2-3 months, 9-10 hour shifts during day, double coverage from 10am-1am, fast-track 3p-11p 7 days, high acuity, approx 25% admissions. Same group staffing this ED for over 20 years, our ED group split off to form democratic group when the multi-specialty group of which we were formerly a part sold out to hospital. 25% profit sharing bonus first year, 50% bonus second year, then full partner; (with no buy-in) after second year. Paid malpractice, health, and LTD insurance. 2 week PTO, \$5,000 CME. Great schools, wonderful family environment, good group with which to work. ED has 24/7 availability of Radiology/Hospitalists/Forensic Nurses/Psychiatric Eval by psych caseworkers. Every MD is a partner, and all but one have been here for at least 6 years. Contact Cheryl Haas, MD at 540-529-3580 or Robert Dowling, MD at 540-529-6448, or fax your CV and letter of interest to 540-387-2459. (PA 743)

WASHINGTON

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

WASHINGTON

WASHINGTON, Longview: Stable, democratic group seeking BC/BP emergency physician to join practice. Level III trauma center with census of 50,000+ and brand new ED scheduled for construction. Located on the Columbia River close to the myriad of recreational opportunities offered by the Pacific NW. Wonderful family-oriented community. Democratic scheduling and compensation. (PA 722)

WASHINGTON

Clarkston. Democratic, small, single hospital group needs full timer for 14K visits/yr ED. Non-trauma emphasis. Some state of the art amenities. Hospitalist service starting now, and new ED soon. Beautiful rural region where grassland meets Rocky Mountain foothills. Close to skiing, water sports, fishing-many types of outdoor fun. Boarding required in EM or, board eligible. Partnership track. Contact Kurt Martyn, MD kurtm@moscow.com or 509-758-4665. (PA 745)

WASHINGTON

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

WASHINGTON D.C.

Please see ad PA 731 under Maryland.

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

WISCONSIN

Full democratic group looking for a BC/BE residency trained emergency physician to join our group in central Wisconsin. We are an independent, FFS group. Outstanding compensation, full benefits and retirement package. Located in outstanding recreational area. Submit CV or to request further information contact Scott Howells, MD. (PA 735)

WISCONSIN

Located between Milwaukee and Madison, full-time opportunity with Watertown Emergency Medicine Physicians, SC, at Watertown Memorial Hospital (www.watertownmemorialhospital.com). Watertown, WI. WEP has 4 full-time ABEM certified physicians, 1 part-time EM physician, 6 midlevel providers. 17,000 annual visits, 11-hour dayshifts, 13-hour night shifts, 11-hour day PA/NP coverage on weekends and holidays. (PA 761)

WISCONSIN

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

SAUDI ARABIA

This JCI accredited hospital has an ED volume of 45,000 annually, 75% which are tertiary care. All shifts (8 hours) are triple coverage. Seeing a culture "from the inside" is a wonderful experience, and will change the way you see the world. Travel and accommodation will be provided for locums as well as permanent staff. If interested contact Hisham Alomran, MD, MPH, halomran@kfshrc.edu.sa. (PA 739)

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Do you dream of running your own business and living 2 minutes away on the beach? Established and growing urgent care practice with affluent patients (70% insurance/30% cash/0 no pay!) near beach generating \$700,000 in annual revenue with \$300,000 expenses [employees (including full time physician assistant and part time nurse practitioner), rent, utilities, supplies, and insurance]. PA/NP covers 160 hours per month, you manage and work 44 clinical hours per month (decrease PA/NP coverage, increase physician clinical time, and decrease annual expenses by \$100,000). 1860 sq. ft. furnished condo [living room, kitchen, 3 bedrooms, 2 new bathrooms with whirlpool large bathtub/steam room, and deck overlooking ocean and 5 miles of beautiful beach plus pool/whirlpool/exercise room/party room]. Package price to live and work in paradise \$2.1 million. Call 863.698.1228. (PA 755)



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1) Have you completed or are you enrolled in an accredited residency in Emergency Medicine? ☐ Yes ☐ No

If yes, program: _____ If completed, date: _____

If not completed, expected date of completion: _____

2) Are you certified by the American Board of Emergency Medicine? ☐ Yes ☐ No

If yes, date: _____ Type of certification: ☐ EM ☐ Pediatric EM

3) Are you certified by the American Osteopathic Board of Emergency Medicine? ☐ Yes ☐ No

If yes, date: _____



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Full Voting and Associate Membership dues are for the period January 1st thru 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. Resident and Student Membership dues are for the period July 1st thru June 30th of the period the dues are received. All memberships except free student membership include a subscription to *The Journal of Emergency Medicine (JEM)*.

MEMBERSHIP FEES

☐ Full Voting Member (*Tax deductible only up to \$325.00*) \$345.00

☐ Associate Membership (non-voting status) (*Tax deductible only up to \$230.00*) \$250.00

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☐ Resident ☐ 1 Year \$50 ☐ 2 Years \$80 ☐ 3 Years \$120 ☐ 4 Years \$160

☐ Student - includes subscription to JEM ☐ 1 Year \$50 ☐ 2 Years \$80 ☐ 3 Years \$120 ☐ 4 Years \$160

☐ Student free - does not include subscription to JEM ☐ First trial year ☐ 1 Year \$20 ☐ 2 Years \$40 ☐ 3 Years \$60
(Renewal after free trial year)

PAYMENT INFORMATION

Method of Payment: ☐ check enclosed, made payable to AAEM ☐ VISA ☐ MasterCard

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All applications for membership are subject to review and approval by the AAEM Board of Directors.



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