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common SENSE

The Newsletter of the American Academy of Emergency Medicine — Volume 12, Issue 3— June 2005

PRESIDENT'S MESSAGE

by A. Antoine Kazzi, MD FAAEM

Star Trek 4 & The PhyAmerica Malpractice Insurance Debacle: The Humpbacked Whales and the Corporate Sharks of Emergency Medicine

In this President's Message, I would like to update you about the PhyAmerica malpractice insurance debacle which I had shared in my last President's Message. As stated at that time, the implications of this insurance travesty are critically important to our specialty, to our specialists, and to our patients. Its outcome defines the direction and outcome of any future EP group and corporate bankruptcies that could and will affect many of you!

I asked Dr. Mabley, one of the two chairs of the PhyAmerica Physicians Defense Working Group, to give you her own version of what this debacle was all about. I also invited her to share this platform to update you on the outcome of the bankruptcy proceedings.

The PhyAmerica Malpractice Insurance Debacle Update
On April 28, 2005, Judge E. Stephen Derby issued his final *Order* regarding the procedure for processing medical malpractice claims against PhyAmerica medical malpractice insurance policies. This order includes permanent protection of defendant physicians' personal assets, and a requirement that participation in the Alternate Dispute Resolution (ADR) process is mandatory if a plaintiff wishes to collect anything from the available remaining insurance policies. As one of our attorneys commented, "We couldn't have written a better *Order* ourselves."

This *Order* represents a victory for the defendant physicians. The PhyAmerica Physicians Defense Working Group and its physicians are tremendously grateful for the leadership and support of AAEM in the process of securing this essential *Order*. Our attorney, David Millstein, has given us great advice and representation.

Hand-in-hand with the Working Group Physicians, AAEM said, "This will not stand!" **And This Did NOT!**

The legal process allows for appeals, of course. Based on testimony during court, and on the fact that certain parties to this dispute may not be satisfied with Judge Derby's *Order*, this clearly may not be the last of this matter. Unanswered questions exist regarding the cause of the shortfall of medical malpractice insurance reserves. In addition, a handful of appeals have already been filed. We also anticipate additional ones. These may or may not interfere with the implementation of the ADR process and the final resolution for the defendant physicians of the cases of alleged medical malpractice. However, the solid *Order* that is now in place secures the best platform and line of defense we could want to counter any – now seriously compromised - attempts by plaintiff lawyers and hospitals to go after the individual EPs assets.

The article which follows, was written by Dr. Jill Mabley before the April 27, 2005, *Order* was issued. The background of this mess is detailed below, with some additional thoughts about what challenges the defendant physicians will face next after this bankruptcy Court *Order*.

This article is a follow-up report to Dr. Kazzi's President's Message, featured on page 1 of *Common Sense* in the March/April 2005 issue (Volume 12 / Issue 2). With the support of AAEM, the PhyAmerica Physicians Defense Working Group has actively participated in the proceedings of the United States Bankruptcy Court action (Baltimore Emergency Services, II, LLC, et. al., Debtors; United States Bankruptcy Court for the District of Maryland, Baltimore Division; Case Number 02-6-7576-SC through 02-6-7815-SD).

A confusing and frightening series of events led to the formation of the PhyAmerica Physicians Defense Working Group in February 2005. In September/October 2004, defendant physicians, who had been sued for alleged medical malpractice while working as PhyAmerica physicians prior to its bankruptcy declaration, received notification from the United States Bankruptcy Court that Sterling Healthcare had filed Omnibus Objection to Allowance of Certain Medical Malpractice Claims. This applied to both independent contractors and employees of PhyAmerica and any of the Staffing Companies or EP Groups that it had acquired prior to its bankruptcy. This document requested clarification by the Court of the process for holders of medical malpractice claims to seek recovery (money) from the medical malpractice insurance policies obtained on the defendant physicians' behalf by PhyAmerica. Sterling Healthcare, Inc., is the entity that purchased assets and obligations of the bankrupt PhyAmerica.

Of utmost importance to the defendant physicians was the exposure of the individual defendant physician's personal assets to recovery in a medical malpractice judgment, due to an acknowledged possible near-exhaustion of insurance reserve funds.

In November 2004, correspondence from Steptoe & Johnson, attorneys for American International Specialty Lines Insurance Company (AISLIC), to the defendant physicians, stated that regarding Sterling's Omnibus Objection: "Those dispute resolution procedures, and the possible near-term exhaustion of the Policy, may limit or negate the ability of AISLIC to pay claims asserted against persons or entities covered by the Policy."

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Correspondence from Western Litigation Specialists, Inc., presented defendant physicians with the following information: "This letter serves to apprise you, on behalf of AISLIC, of certain limitations in your coverage. Additionally, we are specifically reminding you of your right to retain independent counsel, at your own discretion and expense, to represent you with regard to this potential uninsured exposure."

In other words, defendant physicians were notified that they were essentially without medical malpractice insurance coverage for their ongoing cases, and that their personal assets were at risk to pay for defense costs, settlement, or judgment.

Judge Derby issued a Court Order on December 17, 2004, that established certain guidelines and protections to be used until the final ruling. Among the protections specified in this Order was protection of the personal assets of defendant physicians from collection by holders of medical malpractice claims.

Hearings regarding Sterling's Omnibus Objection took place during late March and April 2005, in Baltimore. In the few weeks before the first hearing date, defendant physician Mike Zielinski, DO FAAEM FACEP and the AAEM leadership contacted as many of the estimated 174-200 defendant physicians as possible – a task that was made daunting due to the short amount of time we had and the inaccuracies of the Court list of physicians and its out-of-date work addresses and limited contact information.

Guided by our excellent attorney David Millstein, Esq., the Working Group raised funds for legal expenses. Unfortunately, only seven defendant physicians have so far contributed to the legal expenses. These dedicated physicians make up the actual Working Group who then led, hand-in-hand with AAEM, the charge of:

1) Representing the actual physicians involved in the case – and not the corporations, lawyers, stockholders, plaintiffs, insurers and hospitals that were involved, represented and resourceful!
2) Putting a face to the physicians' names on the list that was being circulated.

The Physicians Defense Working Group then submitted an Amicus Brief to Judge Derby on behalf of ALL defendant physicians, requesting permanent protection of ALL defendant physicians' personal assets.

Attorney David Millstein, Robert McNamara, MD, Mike Zielinski, DO, and I (Dr. Mabley) were present in the court room during the first day of the hearing. On the second and third days, Mr. Millstein participated via speaker phone while Dr. Jill Mabley was present in the court room. Two broad issues were of interest to the Court: First, determining how much money was left in the medical malpractice insurance reserves (this reserve was recognized as being inadequate to fund the amount of claims, but the extent of the under funding was not well defined) and Second, determining the process for distribution of the remaining reserves to holders of medical malpractice claims. Issues of special interest to the defendant physicians included permanent protection of physicians' personal assets and payment of defense costs, past and future. Several attorneys also raised the question of why the shortfall of insurance reserves existed. The Judge pointed out that this question was not in the province of his bankruptcy court.

Many different parties were interested in the outcome of this hearing. In addition to counsel representing Sterling Healthcare, lawyers for the bankruptcy plan, multiple insurance companies, multiple hospitals, and multiple individual plaintiffs in the medical malpractice suits were in court. As the special interests of each of these groups were argued, the inevitability of prompt initiation of the appeal process became apparent.

As we waited for the Court ruling, we were optimistic about favorable treatment for defendant physicians by Judge Derby. However, we anticipate an appeal process, which could interfere further with the implementation of the Judge's *Order* and the resolution of the pending medical malpractice cases. In addition, because of the variation of timing and details of individual medical malpractice suits, and the exceptions requested by some of the parties, making sure that each defendant physician is protected will take more time, effort, and funds.

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EDITOR'S LETTER

Flame Wars

by Howard Blumstein, MD FAAEM

The history of AAEM has been marked by periodic argumentative outbursts between our leaders or members and others in the EM community that have taken opposing points of view. These discourses often deteriorate into nasty exchanges, commonly called "*Flame Wars*," that take place in quasi-public forums such as listservers (emed-l being the most frequent forum), letter and editorial sections of periodicals (usually EM-News), and just plain e-mails that are copied to wide audiences. Recent events provide a good illustration.

As everyone should know by now, AAEM was recently involved in an incident in Minnesota in which Team Health had arranged to take over a contract to staff an ED, displacing a well established private group. The group called for help and AAEM pursued the issue aggressively, contacting the state attorney general and other state agencies and ultimately taking legal action. Facing bad publicity and legal action and apparently dissatisfied with the staffing provided by Team Health, the hospital soon rehired the old group. Victory was declared. And herein lay the trouble…

Shortly after the resolution of the crisis in Minnesota, ACEP published an announcement in its electronic newsletter that was sent to all members. The announcement described the events but seemed, in the opinion of many within the AAEM leadership, to give ACEP more credit for helping resolve the crisis than it really deserved.

A letter was written from AAEM officers to ACEP officers complaining about this and sent as an e-mail attachment. A back and forth e-mail exchange ensued.

Now, I have been in my share of flame wars. With e-mail conversations it is easy to expand the audience. Just keep hitting the "Reply to all" button and add a few people in the "cc:" section each time. Suddenly a private exchange became a public debate. And folks who can sit down and have a pleasant and reasonable face to face exchange got caught up in an increasingly hostile war of words, with neither side wanting to concede much, each side finding something offensive in the latest message from the other, and both sides wishing to get in the last word. Eventually, the exchange petered out with neither side really satisfied.

But the predictable result is bad publicity. The usual flow of negative feedback began to reach the board of directors. Emergency docs, often residents, wrote to complain about the infighting between ACEP and AAEM. "Why can't you guys work together?" they ask, and berate us for dragging our specialty through the mud.

These letter writers are correct, of course. It is a shame that young emergency docs (many of the letter writers are residents or recent graduates) are becoming so disenchanted. Why can't we just get along? The simple answer is that we can. But there are problems.

Historically, AAEM has taken aggressive positions on issues regarding fair treatment of emergency physicians and promotion of board certification. It was easy to point out how ACEP had failed to take action on these issues. And, as a fledgling organization, differentiating ourselves from ACEP was an important strategy. ACEP leadership, of course, was outraged and responded in a variety of ways. Exchanges of letters, e-mails, flame wars, debates at meetings and dueling editorials were just some of the mechanisms for highlighting the differences between the two organizations. And (in my opinion), ACEP usually came out of these encounters looking bad. So, there is a history of bad blood, which often gets dredged up in more modern exchanges.

The primary motivation these days is a battle over membership. Many emergency docs are finding that they do not have enough money to join both AAEM and ACEP. Increasingly, they are being forced to choose between the two. And both organizations want those members. Membership represents legitimacy. The more members you have, the more legitimate you appear - a sort of vote of confidence. Plus members equal dollars. The more members you have, the more money you bring in to support your organization's activities.

At the last Scientific Assembly, AAEM President Antoine Kazzi made a real effort to smooth over the waters. ACEP President Bob Suter was invited to come to the meeting, was introduced to many members, and even participated in a panel discussion. I attended a late night wine reception where Dr. Kazzi was very eager to create an atmosphere where we could all get to know each other (note to Antoine – nice room, bad wine, need more munchies next time).

Both organizations seem to have independently come up with the same basic idea: a joint task force. I was recently asked to be part of this group, and we are currently discussing the logistics of meeting. While no real agenda has been set, the suggestion has been put forward that each member should come with some ideas about task force goals.

In the wide world of emergency medicine we face many issues. I believe that the fair treatment of emergency physicians in the big, bad world of business is of paramount importance. But there are other problems like malpractice and reductions in medicare payments that are equally important. And there's no reason that the two organizations can't work together on these issues of common interest. That will be the agenda I bring to the table.

By the time this column is published, the first meeting will have occurred. But I would still like to hear your thoughts. If anyone has ideas about issues this task force should pursue, please let me know (email me at hblumste@wfubmc.edu). I am looking forward to hearing from you.

LETTER TO THE EDITOR

REGARDING THE GEOFFREY RUBEN, AEP, LETTER TO HOSPITAL CEO'S AND ADMINISTRATORS REPRINTED IN *COMMON SENSE* (VOLUME 12, ISSUE 2)

I have tried to set personal prejudices aside and look objectively at Dr. Ruben's point of view. Even if I accept Dr. Ruben's position that 7000 hours of emergency practice should be required before taking the BCEM board and that this is an acceptable route to board certification in Emergency Medicine, I still cannot understand what he thinks this BCEM certification represents. Surely, it cannot be to test competence and proficiency in something you have already been doing for 7000 hours. If one is not competent during, say, the first hour of the 7000 there is an obvious ethical dilemma in recommending or even tolerating this course of action at a time when formal, supervised training programs abound. If you fail the BCEM boards are you less competent than someone starting their first of 7000 hours? Should you be allowed to start a second 7000 hours, or even a seven thousand and first hour? If Dr. Ruben felt there was no need for board certification in Emergency Medicine, I might disagree, but at least I could understand his point of view. To propose/accept testing after 7000 hours is impossible for me to comprehend on any level.

Thomas Barry, MD FAAEM
Philadelphia, PA

Recaps and Highlights
Discussion on "The Ideal Practice Environment in Emergency Medicine."

by Jesse M. Pines, MD MBA

Bringing the stakeholders to the table was the theme of the much-anticipated discussion on "The Ideal Practice Environment In Emergency Medicine" at the AAEM Resident-planned track at the Assembly in February. The Resident Section, led by Joel Schofer, MD, assembled a star-studded cast including Robert Suter, DO, the current president of ACEP, Robert McNamara, MD, former president of AAEM, Dominic Bagnoli, MD, COO of Emergency Medicine Physicians (EMP), Lynn Massingale, MD, CEO and President of Team Health, and Carey Chisholm, MD, President of SAEM. The session was moderated by Peter Rosen, MD.

Each panel member had five minutes to give their perspective on the ideal practice environment and then the session was opened for questions from the audience. Dr. Rosen made it clear from the start that shenanigans from the audience would not be tolerated.

Dr. Suter stated that ACEP believes that it is improper for a group of any type to exploit a physician. Of the types of groups, he quoted an internal survey of ACEP that while 80 percent of ACEP members want to have the option of practicing in a democratic equity group, 14 percent of members actually do not. While ACEP positions on these issues best represent the majority, ACEP also respects the rights of those who choose to practice outside of democratic groups (i.e. in contract management groups [CMGs]) for whatever reasons they wish to do so. He emphatically stated that ACEP wishes to support doctors who have been exploited by groups and is willing to file lawsuits if that is the best way to help the doctor. Requests for assistance go through an established process, and "We do fact gathering and confirming the facts before making a decision. This takes time, and in discussion with the doctors, it may be decided that filing a lawsuit would not be useful, and might even be harmful to achieving the desired end result." Concerning the Mt. Diablo case and why ACEP did not participate, he said, "We have a process for evaluating whether to get involved in a lawsuit. We were actively evaluating whether to get involved. We just hadn't made a final decision at the time the case settled."

Next, Dr. McNamara spoke about AAEM's view on the ideal practice. An hour prior, he had given his inspiring "History and Current State of Emergency Medicine" speech that laid out the principles of fairness in the practice of emergency medicine. He summed up his views by focusing on the principle of practice ownership. "Physicians are going to serve patients best if they all have an ownership stake," he said. The only way that this can be achieved is through a democratic group structure. He later explained, "If the physicians don't want to run the entire business side of practice, we are fine with practice support, but [the physician] should control the income."

Dr. Bagnoli was next. He explained how EMP started in 1992, when he and a few other EM residency trained physicians took over a hospital very much in need of EM trained doctors. He told the story of his first shift where a well known ED patient showed up for her Demerol shot. The nurse stated, "We usually just give her the shot in her car without evaluation." "No way, she needs to be seen," he insisted. He illustrated the clinical acumen that comes with astute EM residency training. "And no, she wasn't driving," he concluded. Dr. Bagnoli went on to describe how EMP has developed in the model of AAEM principles. Each physician is an owner of the group practice after three years, ABEM or AOBEM certified, there is due process, no restrictive covenants for the partners only (which they voted on and approved), and there are open books. But once a group gets big, they are labeled as a CMG. He stated that EMP has an open and fair structure. All EMP physicians know the financial arrangements and are owners. EMP holds 33 contracts in seven states, which budgets approximately 20 percent in administrative costs. EMP even operates its own malpractice insurance. He went on to summarize, "We are in the middle of the road. We are the best of both worlds, the benefits of economies of scale of the large groups, and the principles and structure of the small independent groups, sort of the middle of the road."

Next, Dr. Massingale addressed the audience. He quipped, "You think you're being invited TO lunch and you realize that you're being served FOR lunch." He discussed the development of Team Health over the past 25 years, from a nascent group, to a large corporation that hold hundreds of contracts. He addressed career longevity–the average tenure of more than 2000 Team Health physicians is nine years. He addressed career satisfaction. He stated that 93 percent of Team Health employees were very happy or happy with their practice situation. On average, Team Health hospitals see less than 2.0 patients per hour. He discussed the benefits of being large which included efficient administration, economies of scale and patient safety through dissemination of best practices throughout Team Health hospitals. "The newly formed Team Health residency in Florida will soon be one of the finest residencies in the country," he said. He then turned his

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TAEM UPDATE

Bioterrorism - Offense or Defense

by Jon Jaffe, MD FAAEM

In a month or so, I will participate in a half-day course on bioterrorism. The Texas A&M College of Medicine is providing this course for the second year class. The Department of Emergency Medicine has been anointed as the keeper and disseminator of this information. I suppose that this is an honor and a blessing, but I am digressing.

As I was preparing a presentation on "Global Perspective," I could not keep an image of HAZMAT suits or warheads loaded with anthrax spores in the front of my mind. Not only is there anthrax to worry about, but also smallpox, plague, botulism, tularemia, and viral hemorrhagic fevers. Even though Texas is the country's largest producer of wool and mohair, we have kept the anthrax incidence to zero. There have been no cases nationwide since the mailing of spores from Trenton, NJ, in October of 2001. So where is all of the anthrax? Most of the cases worldwide are reported from Sub-Saharan, Africa. Does that sound like anything else?

While we gear up for a tularemia disaster, HIV is capturing the heterosexual poor in the south of this country, as well as Africa and the world. Its unrelated cousin, multi drug resistant tuberculosis follows neatly. In this country we have almost eliminated maternal to fetal transmission of HIV. If we do not work hard enough on other modes of transmission, it will impact our emergency departments. Paul Farmer, MD, has shown that MDRTB and HIV can be eliminated in the poorest of circumstances, (*NEJM 1/2003*).

I am not opposed to disaster preparedness. It is what we do. It is what makes emergency medicine unique. However, the bigger "bioterror" is in our midst. We cannot just rely on an ID consult.

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

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.

The following is a list of the 2005-2006 CaL/AAEM Board

Visit www.calaaem.org for chapter information

Upcoming AAEM-Endorsed or AAEM Sponsored Conferences for 2005

June 26-30, 2005

- International Interdisciplinary Conference on Emergencies
  Sponsored by Association of Emergency Medicine of Quebec
  Montreal, Canada
  http://www.iice2005montreal.com/index.html

August 3-6, 2005

- Emergency Medicine Update: Hot Topics 2005
  Mauna Lani Hotel, Kohala Coast on the Big Island of Hawaii
  Sponsored by the UCDavis Health System
  http://www.ucdmc.ucdavis.edu/cme/Confrnce/EMHI006_8-3-05_web.pdf

September 1-5, 2005

- The Third Mediterranean Emergency Medicine Congress, Nice, France
  Sponsored by the American Academy of Emergency Medicine and the European Society for Emergency Medicine.
  www.emcongress.org

September 8-12, 2005

- Emergency Medicine Intensive Review, LLAS Review and Clinical Review Sessions
  Washington, DC
  Sponsored by Ronald Reagan Institute of Emergency Medicine at the George Washington University Medical Center.
  http://www.emedreview.info/

September 24-25, 2005

- AAEM Oral Board Review Course is being held at the airport Embassy Suites in Chicago, Los Angeles, Philadelphia and Orlando.
  Course sponsored and organized by the American Academy of Emergency Medicine.
  http://www.aaem.org

November 3-4, 2005

- Practical Emergency Airway Management Course at the University of Maryland Medical Center and State Anatomy Board
  Baltimore, MD
  Course sponsored by the American Academy of Emergency Medicine.
  http://www.aaem.org

November 5, 2005

- Jam Session for the Written Board Examination, Atlanta, Chicago, Dallas, East Brunswick, NJ, Los Angeles
  Course sponsored by American Academy of Emergency Medicine.
  http://www.aaem.org

December 1-2, 2005

- Practical Emergency Airway Management Course at the University of Maryland Medical Center and State Anatomy Board
  Baltimore, MD
  Course sponsored by the American Academy of Emergency Medicine.
  http://www.aaem.org

France is a people of the same quality as Greece and Italy. She is Athenian in beauty and Roman in grandeur. Moreover, she is generous. She gives herself. More often than other peoples, she knows the mood of devotion and sacrifice. But it is a mood that comes and goes; and this is the great danger for those who seek to run when she is content to walk, and to walk when she wishes to stay still. France has her relapses into materialism, and at certain moments the ideas which obstruct the working of her splendid mind contain nothing that recalls her greatness.... What can be done about it? The giantess plays the dwarf; great France has her fantasies of smallness.

Victor Hugo, Les Misérables, pt. 5, bk. 1 (1862)

You study, you learn, but you guard the original naiveté. It has to be within you, as desire for drink is within the drunkard or love is within the lover.

- Henri Matisse (1950)

I work in whatever medium likes me at the moment. ***- Marc Chagall***

THE VIEW FROM THE PODIUM

Third Mediterranean Emergency Medicine Conference

by Joe Lex, MD FAAEM

I think it safe to say that the upcoming Third Mediterranean Emergency Medicine Conference (MEMC3) in Nice, France, over Labor Day weekend will be the educational experience of a lifetime. Cosponsored by the European Society of Emergency Medicine (EuSEM), and the American Academy of Emergency Medicine (AAEM), this three-day conference with two days of preconferences may be the most astonishing gathering of famous names and faces of emergency medicine ever assembled in one place.

I shouldn't play favorites, but how can you go wrong attending a conference that features Peter Rosen, Judith Tintinalli, and Lewis Goldfrank, authors of three of the seminal texts in emergency medicine?

Do you subscribe to Emergency Medical Abstracts – also known as the Rick and Jerry show? MEMC3 has a morning with Rick Bukata and Jerry Hoffman, and Diane Birnbaumer and Billy Mallon on the same stage discussing the best articles of the last year or two.

Do you want the latest in Emergency Cardiac Care? Listen to the track organized by Amal Mattu that features Ian Stiell, Bill Brady, Wyatt Decker, Rich Harrigan, and Rob Rogers, along with numerous international speakers.

Is Infectious Disease your interest? Dave Talan has assembled international speakers who will give their first-hand experience with the SARS epidemic, avian influenza, diseases following the tsunami disaster, and the world-wide MRSA epidemic.

Are you a Critical Care buff who wants to know the latest on treating shock? Nate Shapiro has put together a Shock track with talks from experts Alan Jones, Richard Wolfe, and Jeff Kline.

Do you want to learn more about pain management in the emergency department? Who better than Knox Todd to moderate this track? Medical Imaging Updates? Chris Fox fills the bill here. Neurologic Emergencies? Our collaborators from FERNE have an amazing line-up of speakers and topics. Airway controversies? How about a panel with Ron Walls and Richard Levitan.

Residency training education will be covered by representatives of the Council of Residency Directors for Emergency Medicine (CORD-EM) in a preconference workshop, and a half-day track during the congress. Other preconference courses include Ultrasound, Noninvasive Ventilation, Advanced EKG Interpretation, Hospital Disaster Preparedness, Advanced Wound Care Procedures, Advanced Casting and Splinting Techniques, Pediatric Procedures, Dealing with Car Crashes On Scene, Airway Management Updates, and Basics of Research.

Andy Jagoda, Shelly Jacobson, Felix Ankel, Michelle Biros, Gabor Kelen, Dan Danzl, Ghazala Sharieff, Larry Weiss, Gloria Kuhn, Richard Shih, ABMS President Harvey Meislin, ex-AAEM presidents Bob McNamara and Joe Wood, Diku Mandavia, Mary Jo Wagner, Stu Swadron, Ray Johnson, Steve Davidson, Vince Markovchick… sometimes I look at the list of people who have promised to attend and speak, and I shake my head in amazement, especially since the majority are paying their own way for the joy of teaching to an international audience.

And I've only mentioned some of the American speakers. France, Turkey, Italy, Romania, Greece, Ireland, Israel, and dozens of other countries will also be represented by English-speaking presenters – the biggest names in emergency medicine from around the world.

We'll have 12 tracks running simultaneously, two of them in French. We expect to break the records set at MEMC2 in Sitges during 2003, when more than 1300 delegates from more than 70 countries attended, submitting more than 800 abstracts for Oral and Poster presentations.

Plan now – don't wait another day or your partners will beat you to it. This is the chance of a lifetime to see a spectacular line-up of speakers in a breathtaking city, Nice, France, the crown jewel of the Cote d'Azur, where Marc Chagall (**www.musee-chagall.fr/**) and Henri Matisse (**www.musee-matisse-nice.org/**) both lived because of the magnificent sunlight; both have museums dedicated to their works within walking distance of the conference.

There will be plenty for family members to do, with planned day trips to Antibes and Cannes, and an evening in Monaco and Monte Carlo. It will take you several days just to explore the incredible beauty of our host city, Nice (**www.nicetourism.com/GB/som.html**).

MEMC3 runs from Saturday, September 3 through Monday, September 5, with preconference courses on September 1 and 2. Go now to **www.emcongress.org** to register for MEMC3 and make a hotel reservation, then use your favorite travel site to arrange transportation. You cannot miss this extraordinary opportunity to visit one of the most beautiful cities in the world and hear some of the best speakers in emergency medicine.

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A final burden for defendant physicians is that they will be entered into the National Data Bank without having been able to defend themselves, if the payment to plaintiffs via the Alternate Dispute Resolution (ADR) process exceeds the threshold for Data Bank entry. The ADR process of negotiation, mediation, and arbitration is the Court-ordered process for the distribution of the remaining insurance resources. This Court-ordered process will occur instead of jury trial. We believe that an official explanation, supported by AAEM documents, can be added to any such individual EPs' files, to explain the unfair impact of the ADR process and corporate bankruptcy on the case settlement process and the affected physician. (End of Dr. Mabley's Message)

This was a costly battle. Seven brave physicians stepped in and contributed individually to support an initiative that is of key importance to all the 174-200 others who were directly affected. This small group of volunteer physicians carried the major part of the financial burden of this initiative which provided needed representation and protection for all the others. This is really not right… and I must take a moment to urge any emergency physician, member or non-member, who was affected by this debacle to consider sharing the burden of this initiative or contributing to the legal fund. Take a close look at what was done and contact Dr. Jill Mabley at jmabley@tds.net

Conclusion:
In AAEM, we have always promised you, our members, relevance and transparency. This stand we took with regard to this corporate debacle is another manifestation of our AAEM commitment to keep that promise. When I addressed you in La Jolla during our Scientific Assembly, I reaffirmed this commitment. Also, in La Jolla, I heard a wonderful statement made by our Peter Rosen Leadership Award recipient, Dr. Mark Langdorf, and would like, for reasons that will be obvious, to use his words to end this message:

"When my residents graduate, they are thrown into the big bad world of corporate medicine. They go from the protected and nurturing environment of the university, and are put at the mercy of the "sharks" of the corporate world, just like the humpbacked whales were in Star Trek 4 when they were released from the aquarium. (Those of you who know me know that I've learned everything I needed to know from Star Trek). I spent an hour the other day advising one of my senior residents regarding how to hunt for a job, and most of the hour was spent telling him what and who to avoid, who would exploit him and his training for their own profit.

It should not be this way."

Indeed, it should not be this way! And with your help, it will not be this way! Get involved in your Academy. Support our efforts and the AAEM Foundation and Political Action Committee. We simply cannot do it without you! Thank you for your confidence in AAEM and for your support!

The Third Mediterranean Emergency Medicine Congress
Nice, France
September 1-5, 2005

www.emcongress.org

Featuring:

- The active collaboration of more than 50 international EM specialty societies and organizations.
- The most impressive line-up of speakers, leaders and founders in our specialty from all over the world, coming together in one of the most charming spots in Europe.
- 12 parallel tracks at any time (English language / two tracks in French/one with simultaneous translation).
- 5 days of educational activities (19 CME credits).
- 3 days of oral and poster research presentations.

Pre-Congress Satellite Courses & Workshops

Course 1: Ultrasound Updates (9 hrs)
Course 2: Noninvasive Ventilation (9 hrs)
Course 3: Advanced Airway Course (5.5 hrs)
Course 4: Pediatric Procedures (2.5 hrs)
Course 5: Basics of Research in Emergency Medicine (5.5 hrs)
Course 6: Advanced Wound Care Management (3 hrs)
Course 7: Advanced EKG Interpretation (3 hrs)
Course 8: Hospital Disaster Preparedness (13.5 hrs)
Course 9: Advanced Casting & Splinting Techniques (2.5 hrs)
Course 10: Dealing with Car Crashes in the Field (5.5 hrs)
Course 11: Emergency Medicine Residency Directory Workshop-CORD-EM (5.5 hrs)

**Developing Country Attendees may register for one complimentary workshop to be chosen among Courses 3, 4, 5, 6, 7 & 9.*

The courses will be held on Friday, September 2nd, except Emergency Ultrasound Updates and Noninvasive Ventilation which will start on Thursday, September 1st, at 1 pm, and Hospital Disaster Preparedness which will start on Thursday, September 1st, at 8 am.

when minutes count

Co-Organizing Societies: AAEM & EuSEM

- The American Academy of Emergency Medicine (AAEM)
- The European Society for Emergency Medicine (EuSEM)

Hosting Societies: SAMU de France & SFMU

- Service d'Aide Medicale Urgente de France (SAMU de France)
- La Societe Francophone de Medecine d'Urgence (SFMU)

Organizing Societies: CORD-EM, EMDM & NAEMSP

- The Council of Emergency Medicine Residency Directors (CORD-EM)
- The European Masters for Disaster Medicine (EMDM)
- The National Association of EMS Physicians (NAEMSP)

With Special Support & Contribution from:

- The Emergency Medicine Association of Turkey (EMAT)
- La Sociedad Espanola de Medicina de Urgencias y Emergencias (SEMES)
- Foundation for Education & Research in Neurological Emergencies (FERNE)
- La Societa Italiana di Medicina d'Emergenza-Urgenza (SIMEU)
- The Emergency Nurses Association (ENA)

This Congress will feature special programs and tracks on:

- Core Clinical Topics - including special tracks on Trauma, Cardiovascular, Respiratory, Toxicological, Infectious, & Pediatric Emergencies - by the AAEM, EuSEM with contributions from our hosts (SAMU/SFMU) and international sponsoring societies
- Pre-hospital Track - by the National Association of EMS Physicians (NAEMSP), European Emergency Data Project (EED), & SAMU de France
- Disaster Medicine Track - organized by the European Master in Disaster Medicine (EMDM)
- Neurological Emergencies - organized by the Foundation for Education and Research in Neurological Emergencies (FERNE)
- Research Education
- Residency Education - organized by the Council of EM Residency Directors (CORD) & EuSEM
- International Emergency Medicine - presented by representatives of all the participating countries
- French Track - organized by SAMU de France and SFMU
- Spanish Track - organized and presented by the Spanish Society of Emergency Medicine (SEMES). Simultaneous translation will be provided.

NB: The CORD portion of the program and their speakers did not receive any form of direct sponsorship.

when minutes count

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Social Events
- Opening Reception on September 2
- Banquet Gala Dinner on September 3
- Keep the 2001 tradition going with the memorable karaoke buffet dinner and dance on the evening of the last day of the Congress on Monday, September 5. Just ask folks who attended it in Stresa/Italy or in Barcelona/Sitges! You will not want to miss it!
- Organized tours to sites around Nice, Monaco and Monte-Carlo.

Congress Venue: Nice Acropolis Convention Centre

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We look forward to seeing you this September in Nice, France!

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IMMEDIATE PAST PRESIDENT'S MESSAGE

"Independence" Is At Hand

by Joel M. Schofer, MD

According to **www.dictionary.com**, something is independent when it is "not dependent on or affiliated with a larger or controlling entity." As recently as March 15, 2005, during a presentation by an ACEP board member to my residency program, it was asserted that the Emergency Medicine Residents' Association (EMRA) is an independent organization. This has never made much sense to me, as you can't join EMRA without joining the American College of Emergency Physicians (ACEP), and EMRA gets a significant amount of financial support from ACEP, and within the last two weeks it was announced by e-mail that ACEP had commenced the search for EMRA's new executive director. This does not sound like independence to me, but if some want to see this as "independence" then so be it.

As the AAEM Resident Section (AAEM/RES) has continued to grow, we have attempted to increase our influence in the world of emergency medicine (EM). We've asked all of the main organizations in EM for an official liaison so that we can stay abreast of all developments in EM and represent your interests. Unfortunately, in many cases we were simply told that we are "only a section" and not independent, and that organizations don't liaison with sections. Of course these same EM organizations choose to recognize EMRA as an "independent" organization and not as the de facto ACEP resident section that their joint membership requirement makes them. With this in mind, we are making a change to better represent your interests in EM and with other EM organizations.

The AAEM/RES board of directors has decided to make a bold move. We are going to be changing the structure of our organization. Instead of the AAEM Resident Section we are going to be known as the AAEM Resident & Student Association (AAEM/RSA). We will be a wholly owned subsidiary of AAEM and do not deny our affiliation with AAEM or pretend to be "independent." In fact, we take pride in recognizing that all of our members join us because they want to be a part of what AAEM stands for. You will not be able to join us without joining AAEM, but we will be a group of residents, fellows, and medical students who have control of our own budget, govern ourselves, and have our own website. Sound familiar?

It is unfortunate that we have to do this to be recognized as a significant voice in EM. While I feel that EMRA adequately represents the interests of EM residents and medical students on about 90 to 95 percent of the issues, it is on the other 5 to 10 percent of issues that I feel AAEM/RSA may have a difference of opinion and our voices need to be heard. We feel that this change will give us the "independence" that we need to be seen as equals with EMRA and have already been assured by a few EM organizations that it will do just that. We do not claim, however, to be truly independent because we most certainly are not. In the end, none of our member benefits will change and they are more than likely to improve. AAEM/RSA members will see one change as a result of this move, better representation in the house of EM.

Joel Schofer, MD is the Immediate Past President of the AAEM Resident & Student Association

INCOMING PRESIDENT'S MESSAGE

AAEM Resident Elections a Huge Success

by Mark Reiter, MD MBA

I am excited and honored to begin my term as President of the American Academy of Emergency Medicine Resident and Student Association. Our Association is on firm footing, with increasing membership, new benefits, improved communications, and lots of new opportunities for our members to get involved. I'd like to recognize the great work of the outgoing Board, especially Past President Dr. Joel Schofer, who has been instrumental in bringing us to where we are now.

More and more members want to get involved in AAEM/RSA! A very impressive group of twenty-four different candidates ran for eight positions on the AAEM/RSA Board, and an additional twenty-three candidates ran for six positions on the Student Board. This is incredible; nearly *fifty* different residents and students ran for elected positions, which is a testament to the good work that AAEM and AAEM/RSA have been doing. The new group is energized to follow on the successes of last year and keep improving our Association.

This year, look for AAEM/RSA to continue to take a strong stand on issues important to residents, such as the BCEM board certification controversy (learn more on our website). In addition, we will keep expanding our recently launched website at **www.aaemrsa.org**. We will also be communicating what we are doing to you through an expanded *Common Sense* Resident Section and through our website's Discussion Forums.

We will soon be releasing the AAEM Toxicology Handbook to our members, edited by past AAEM/RSA Board member Ziad Kazzi. We expect this book to quickly become a must-have resource to have on hand during your shifts.

Keep your eyes open for info about appointments to AAEM and AAEM/RSA committees. This is a great way to support AAEM, get involved, learn something, and meet new colleagues. Also, let us know if you have an idea for a project that you would like to work with AAEM/RSA on. We are also excited about recruiting an AAEM Representative at every residency program. I want to make sure we can involve as many interested residents and students as possible. Feel free to email me at **mreiter@unch.unc.edu** if you have any questions.

Mark Reiter, MD MBA is President of the AAEM Resident & Student Association

Is an MBA Right for You? An Emerging Force in the World of Medicine

by Michael Ward, AAEM Student Member

"Malpractice Crisis." "Managed Care Nightmare." "Physician Satisfaction Declining."

Unless you have been living under a rock, you have heard these headlines and others like them. Physicians are becoming less autonomous and making less money. Thinking about the challenges and frustrations that lie ahead, you should know about an exciting step that many medical students and physicians are taking to fight back – getting an MBA. This trend has become so common in today's medical schools, that the number of official dual degree programs has increased from only 6 in 1993, (Larson et al.) to 51 in 2004 – with more in progress (see figure 1). According to the American Association of Medical Colleges (AAMC), this makes the MD/MBA the third most popular program behind the 119 MD/PhD programs and the 67 MD/MPH programs. Unfortunately, there is currently no reliable data regarding the total number of MD/MBA students and professionals.

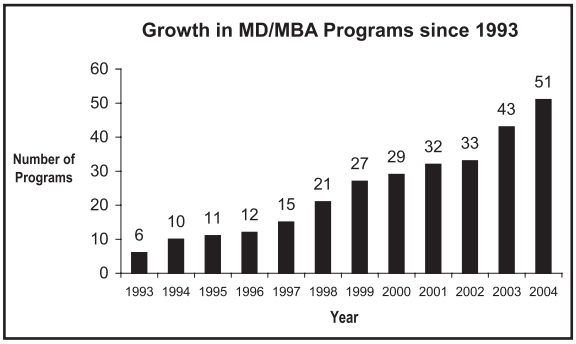

Figure 1: The Growth of Official MD/MBA Programs Since 1993

For those of you who are not familiar with what an MBA can do for you, let me explain. First and foremost, you learn a set of skills that are immediately transferable to clinical practice and your personal life. Rather than being dependent on accountants, business managers and administrators, you can have input into the decision making process because you understand the rationale and implications behind both business and medical decisions. Second, you learn a set of specific skills including negotiating, leadership, financial statement analysis, data analysis, finance, accounting, and the list goes on. Personally, you can manage your own family's finances better, know whether or not you should really invest in your friend's business plan, and even negotiate a better deal on that new car.

Simply getting an MBA is only one piece of the larger puzzle; what you do with the degree is even more important. The University of Michigan Health System (UMHS) provides an excellent example. In the year 2000, of their helicopter service, Survival Flight (SF), lost approximately $1 million and the hospital was contemplating paring back the service. However, UMHS recognized that this service was critically important to the UMHS' mission of patient care, education and research. MD/MBA Student Barry Rosenberg and faculty analyzed the value of the helicopter service to the University of Michigan. In addition to implementing changes that reduced the loss to near zero, the study revealed the incredible downstream impact of the flight patients on hospital services. While the SF patients represented 11 percent of the top 10 admitting services' patients at UMHS, they represented 22 percent of these services' revenues.

The study further revealed that patients arriving via SF represented three percent of admissions, seven percent of inpatient days, 22 percent of intensive care unit days, 11 percent of Michigan Health Service revenues, and 15 percent of inpatient Michigan Health Service revenues. These patients make up a significant portion of the University of Michigan's patient population across multiple services. While cutting back on the helicopter service would have reduced costs for this one area, it would have had a devastating impact on the rest of the healthcare system. Had this team not had the knowledge and analytical skills combined with the clinical knowledge to evaluate the SF service, the program could have been jeopardized, and the unanticipated financial affect on the hospital would have been significant.

While this is one example, the dual degree is having a direct impact on the career paths of many physicians. No longer is the Medical Director position the only route for physician executives in addition to or after their clinical duties. MD/MBAs are taking on titles such as CEO, Entrepreneur, Consultant, Dean, Department Chair and Venture Capitalist. Even for those MD/MBAs who continue to practice medicine, their roles are evolving. They bring a unique insight to their roles that allow them to use their business skills to bring needed changes to their clinical environment; evaluating process flows, information systems, staffing and different models for healthcare delivery.

This altruistic belief was captured in a recent survey of MD/MBA students by Windsor Sherrill, PhD MHA from Clemson University. Forty MD/MBA students from six medical schools were interviewed, and results showed that one of the primary goals of these students was to make a difference in medicine. However, medical students are not alone. Maria Chandler, MD MBA at the University of California at Irvine used her business skills [to help set their MD/MBA program, and] to obtain her current position as Chief Medical Officer of a long standing not-for-profit Community Health Center known as The Children's Clinic. Regina Benjamin used her MBA to help her convert her family medical practice into a rural health clinic to serve the indigent patients in rural Louisiana.

Interested yet? There are increasingly more resources on the web for medical students interested in obtaining a business education. University of Pennsylvania MD/MBA student, Jessie Merlin, and I have created a website, **www.MD-MBA.org**, which specifically addresses the concerns and resource needs of individuals interested in the dual degree. There are numerous articles, references, and links to help evaluate whether this path is right for you. Since there are fifty-one programs in existence, chances are your campus has one or is contemplating creating one. Contact your medical school to find the program advisor and speak with them. They will be an excellent resource. Additionally, since there are numerous MD/MBAs throughout the country, find one of them through Google or any other resource available to you and speak with them. Find out why they received their MBA, what they are doing with it and ask them to be a mentor. They will be invaluable to you if you decide to pursue the degree.

While the MBA is extremely valuable, it is not right for everyone. Before you begin this process, seriously examine why you want to do this. Ask yourself a series of questions:

- Why do I want the degree?
- What do I look to gain from it?
- How does this fit in my personal goals?
- Will this make me a better physician?

The University of Michigan example demonstrates the powerful implications of understanding both the business and clinical aspects of healthcare. After all, if we continue down the path that we are currently on, the American healthcare system will bankrupt itself. Only through change led by physicians who understand the downstream clinical effects of business decisions will we be able to provide healthcare that is both superior and sustainable.

References:

"Aeromedical Service: How Does it Actually Contribute to the Mission?" Rosenberg, Barry L. BS; Butz, David A. PhD; Comstock, Matthew C. BBA; Taheri, Paul A. MD, MBA, Journal of Trauma-Injury Infection & Critical Care. 54(4):681-688, April 2003.

"MD/MBA Programs Growing, Students Explain Why Perspectives on the future generation of medical leaders" Windsor Sherrill, PhD, MHA, The Leading Edge. Fall 2004, volume 1 issue 3.

"MD/MBA Programs in the United States: Evidence of a Change in Health Care Leadership" by David B. Larson, MD, MBA; Maria Chandler, MD, MBA; and Howard P. Forman, MD, MBA, Academic Medicine, Vol. 78, No. 3, March 2003.

AAEM Update from Dr. William Rogers of CMS *(speaker at the 2005 Scientific* Assembly):

Thanks to AAEM for inviting me to speak at the 11th Annual Scientific Assembly in San Diego. The dialog was valuable to me, and I am committed to helping enforce the CMS requirement that physicians have access to information concerning billing for services they render.

I must apologize for a HUGE mistake I made in responding to a question concerning "four hours to administer antibiotics for pneumonia." I said that CMS was not going to define a time period within which antibiotics must be administered to patients with pneumonia in our hospital quality measures and I was wrong. We have defined the acceptable time period as four hours. These measures will change over time and I am well aware of the challenge that many EDs will have in meeting this target. To the extent that the target encourages hospitals to make investments which will reduce waiting times and allow for more timely treatment – the goal will be serving a useful purpose. I am concerned that some overwhelmed emergency departments will resort to creative strategies to improve their scores, which won't really improve the quality of care, an approach which should not be encouraged. If the Physicians Regulatory Issues Team at CMS can be of help to the AAEM in any way, please call or email us.

William D. Rogers, MD FACEP
Medical Officer, Office of the Administrator
Director, Physicians Regulatory Issues Team
Center for Medicare and Medicaid Services
202-236-3338

Congratulations

The American Academy of Emergency Medicine would like to congratulate Dr. Mark Reiter on his new appointment as Councilor on the AMA Council on Legislation! Through such an appointment by the Chair of the AMA Board of Trustees, he will be representing approximately 100,000 residents and fellows to the AMA Council on Legislation, helping the AMA make recommendations, and setting priorities for all federal legislative and policy matters for the AMA.

This is an incredible achievement and speaks highly of Dr. Reiter's leadership skills and potential. AAEM is extremely pleased and happy that he has been selected for such a key position. He will do an outstanding job representing the residents and fellows. Our residents, students and Academy are very fortunate to have Dr. Reiter also elected as President of the AAEM Resident & Student Association. His leadership with the AAEM Resident & Student Association and his interest in legislative issues will help all of us involved in emergency medicine.

Discussion - continued from pg 4

comments to how he has felt attacked over the years. "I am offended by our physicians being called slaves, servants, and substandard physicians." On the contrary, Team Health only hires the best of the best. "We expect the highest level of patient care in our hospitals."

Dr. Chisholm provided his perspective about an academic career. He emphasized that this career provides the "best of several worlds" including the role of clinical care provider, teacher and student for life. As a result, it perhaps affords the best protection from "burn-out" due to the variety of niches afforded. For residents who are truly interested in an academic career (that entails scholarly writing and research) he strongly encouraged completion of a fellowship following residency in order to gain expertise in a focused career area. While it is possible to access many teaching positions without fellowship training, one risks doing an "OJT" skills acquisition over the first 5 years, often at the expense of family or personal wellness. Most institutions have clinical educator tracks that do not mandate scholarly writing or research, and may be better suited for those primarily interested in bedside teaching and clinical care. Seasoned community practitioners also have an invaluable perspective to share with EM residents and students. However, because of the expanded missions of academic departments (to support research, teaching, etc., combined with disproportionate representation of underinsured patients), salaries will not parallel those found in the private setting. Graduates who may wish to return to the teaching environment should be careful to avoid locking themselves into a financial lifestyle that would preclude such a move in the future.

The session was opened to questions from the audience. One noteworthy question was from a new member of AAEM who compared AAEM's blanket "distaste for CMGs" to discrimination. Dr. Rosen answered this, by noting that abuses of physicians are not limited to contract multi-hospital groups. In fact abuse exists in academic departments as well which have some of the worst offenders. It is important to examine each group individually rather than automatically thinking every multi-hospital group is evil. Dr. McNamara explained, "…the major focus is the practice model." Individual groups (where one or a few own the contract) can practice and treat their doctors abusively. It seems like the contract groups are the worst offenders, although there are examples of abuse across the board. He then asked why AAEM only went after big CMGs. Dr. McNamara (and later Dr. Antoine Kazzi) explained that AAEM does not only go after big groups, they go after situations where there is exploitation or abuse of an emergency physician, no matter what the group size.

Another question from the audience regarded EM residency trained physicians. Dr. Bagnoli said that EMP would only hire EM residency trained physicians. Dr. Massingale differed, "we believe the future belongs to EM residency trained physicians. However, we will try to find physicians who can provide service to the community." He explained that there are not enough EM residency trained physicians out there to staff the country's EDs. Dr. Chisholm remarked, "…physicians who are not EM residency trained are not comfortable taking care of all emergency patients."

One audience member stood up and stated to the room, "[why] should we continue the bickering. What will it take for us to come together? It's tearing apart the specialty."

The 90-minute discussion was a success and remarkably tame (thanks to Dr. Rosen) given the potentially explosive nature of the topic. What was apparent was the variety of opinions that these leaders of emergency medicine have of the ideal practice situation. Having all the stakeholders at the same table was a first (as far as I know) in the recent history of the specialty. It serves as the first of hopefully many in an ongoing discussion on practice management issues in our field.

Jesse Pines, MD MBA, is the Past President of the AAEM Resident & Student Association Section.

The AAEM Foundation is a non-profit organization that has been established to:

- study and research matters related to the quality and integrity of the practice and management of emergency medicine in the United States,
- defend human and civil rights secured by law as they relate to the purposes of the AAEM Foundation, and
- educate persons involved in the practice of emergency medicine, the public and government officials about emergency medicine matters and rights.

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EMTALA TAG Holds First Meeting

by Kathleen Ream, Director of Government Affairs

Two clear themes emerged from the inaugural meeting of the EMTALA Technical Advisory Group (TAG) in Washington, DC, on March 30-31, 2005. It was overwhelmingly apparent that a fractured relationship exists between hospitals and their medical staffs, as evidenced by discussion on the issue of on-call specialist coverage. In addition, federal regulators were challenged with regard to the "unfunded mandate" created by the Emergency Medical Treatment and Active Labor Act (EMTALA), passed by Congress in 1986, amid growing concern over the availability of emergency health care services to the poor and uninsured. Committee members utilized the opportunity to acknowledge the role of EMTALA in a few key issues: ED overcrowding, primary care for the uninsured, and access to specialists. Attendees reminded CMS that EDs are the only element of the health care safety net whose function has been defined by federal law, which mandates that all EDs provide screening, stabilization, and/or appropriate transfer to all patients with any medical condition.

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 to review issues related to EMTALA and its implementation. The MMA also defined the composition for the EMTALA TAG – 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services or their designees.

Members appointed by the Secretary include:

- Four representatives of hospitals, including at least one public hospital representative having experience with the application of EMTALA, and at least two representatives from hospitals that have not been cited for EMTALA violations;
- Seven practicing physicians drawn from the fields of emergency medicine, cardiology or cardio-thoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;
- Two representatives of patients;
- Two staff involved in EMTALA investigations from different CMS regional offices;
- One representative from a state survey agency involved in EMTALA investigations; and
- One representative from a Quality Improvement Organization, both from areas different from that of the two CMS regional staff members.

All members are required to have technical expertise that will enable them to participate fully in the work of the EMTALA TAG. David Siegel, MD JD, an emergency and internal medicine physician from Florida Medical Quality Assurance, was appointed Chair of the group.

The majority of public testimony centered on the issue of on-call specialists with tense positions being presented from hospital and physician specialty groups. The points of contention focused on revised regulations that provide each hospital the discretion to maintain the on-call list in a manner that "best meets the needs of the hospital's patients." Hospital groups maintained that the revised regulations are reducing the willingness of physicians to take calls. One physician specialty organization said the "best meets the needs" terminology was too vague and requested that CMS adopt an affirmative rule **prohibiting** hospitals from requiring physicians to provide continuous on call coverage.

Other issues created by the revisions include a provision that permits hospitals to have internal policies prohibiting elective surgery by on-call physicians. Commentary was also provided on hospitals that invoke EMTALA by permitting physicians to "selectively take call" (of patients with whom they've established a physician-patient relationship while refusing to see other patients) and the hospital's coverage for that particular service is not adequate.

In an attempt to help resolve the multitude of issues surrounding on-call specialists, the American Hospital Association agreed to provide information from its membership with the regard to the number of hospitals who have been forced to reduce or eliminate patient services due to forced cutbacks by on call specialists. In addition to specific suggestions for language in the regulations and interpretive guidelines, discussion also included appropriateness of patient transfers, civil lawsuits arising from EMTALA, conditions of participation (Medicare), and coding modifiers to the physician fee schedule that target specific services.

Leslie Norwalk, Acting Deputy Administrator and Chief Operating Officer of CMS, clarified the role of the EMTALA TAG as an advisory group to the Secretary and CMS through its charter (see www.cms.hhs.gov/faca/emtalatag/emtalachrt.asp). She indicated that recommendations related to the enforcement of EMTALA as it pertains to the regulations or interpretive guidelines were within the reach of the group but that changes to the law that would affect the intent or requirements of the statute would require an act of Congress.

AAEM will keep you apprised of the developments from this Advisory Group as they arise.

Congress Renews Debate on Medical Malpractice AAEM Endorses Bills

On February 10, 2005, Senate Budget Committee Chairman Judd Gregg (R-NH) and Senate Health, Education, Labor, and Pensions Committee Chairman Mike Enzi (R-WY) introduced S.354, the ***HEALTH*** (***Help Efficient Accessible, Low-Cost, Timely Health Care***) ***Act of 2005***, which would impose a $250,000 cap on non-economic damages. The legislation would apply to "all health care providers, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product." S.354 is similar to legislation introduced in the last Congress, except that the new bill has a provision requiring experts called to testify in medical malpractice cases to be appropriately credentialed and experienced with standard of care in the case.

Judging from comments made upon introduction of the bill, it appears there will be few breaks in the partisan sniping that has dominated the issue in Congress in the last several years. Democrats say that Republican bills are too narrowly focused on medical litigation, fail to address patient safety problems, and fail to impose additional requirements on medical malpractice insurance carriers. While Republicans contend that the Democrats are under the thumbs of the trial lawyers.

The House companion bill – H.R.534 – was introduced on February 2, 2005, by Representative Christopher Cox (R-CA). The Small Business Committee held a hearing on the bill on February 17.

In letters dated, March 30, 2005, AAEM endorsed both the House and Senate ***HEALTH*** bills. AAEM President Antoine Kazzi stated, "Skyrocketing medical liability premiums . . . are debilitating the nation's health care delivery system forcing physicians to limit services, retire early, or move to a state with reforms where premiums are more stable. Many emergency physicians find themselves unable to obtain needed specialty consultation for victims of trauma. Without federal legislation, the crisis in our nation's emergency departments will continue to grow, and patients will find it increasingly difficult to obtain needed health care."

While the House is likely to pass medical malpractice legislation, the outlook in the Senate is less clear. Enzi told reporters at a briefing on S.354 that public opinion is beginning to turn in the direction of favoring limits on malpractice awards, which may push the Senate to act this year.

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

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

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

CALIFORNIA

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

CALIFORNIA

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

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

CALIFORNIA

Rare opportunity in Southern Central Valley. Newly formed democratic group needs BC/BE physicians to staff 20k volume ED, and second, completely new 14 bed ED to open this fall in upscale area. Excellent compensation, low cost of living, and year round recreational activities. Partnership tracks available within 24 months. (PA 669)

CALIFORNIA

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

CALIFORNIA

Lake Tahoe-seeking full-time BC/BE emergency physician. Group staffs 2 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)

FLORIDA

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

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

FLORIDA

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

FLORIDA

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

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)

GEORGIA

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

ILLINOIS

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

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

KENTUCKY

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

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

MARYLAND

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

MASSACHUSETTS

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

MASSACHUSETTS

Berkshire Medical Center, a 306-bed community teaching hospital, affiliated with the University of Massachusetts Medical School, is currently seeking a full time BC/BE Emergency Medicine Physician to join its Emergency Services Team. Competitive compensation, benefits and incentive plan is offered. Enjoy a high quality of life in an area known for its unique cultural and recreational activities, just 2 ½-3 hours from both Boston and New York City. (PA 679)

MICHIGAN

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

MINNESOTA

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

MISSISSIPPI

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

AAEM JOB BANK

MISSOURI

EM Physicians; excellent opportunity awaits you in the heart of the Ozark Mountains. Democratic EM Physician Group with immediate potential for full-time partnership. Must be residency trained or board certified in EM. Salary >$120/hr. plus benefits. Very low crime community with solid economic growth, abundance of outdoor recreation. (PA 660)

Disclosure: there is a loosely enforced non-compete clause associated with this position. It is imposed on the group by the hospital regarding a competitor hospital in town.

MISSOURI

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

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

MISSOURI

Ozarks Medical Center is seeking a full time BC/BP EM physician. West Plains is in the heart of the Ozarks in south central Missouri and is 30 miles from a 40 thousand acre lake, excellent trout fishing and beautiful rivers. OMS is a 114 bed regional referral facility that has 18, 000 annual ED visits. We have 10 hours per day of mid-level double coverage and will break ground on our new ED in Jan '05. The physician may work as an employee with a full benefits package (life, malpractice, disability, health, CME, retirement, and paid time off) or an independent contractor (malpractice paid) if desired. The hourly compensation is extremely competitive. Enjoy due process, open books, and a very supportive and progressive administration in this great town. All inquiries will remain confidential. Please e-mail your CV to **info@aaem.org** or fax to AAEM at 414-276-3349. (PA 689)

MISSOURI

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

NEBRASKA

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

NEW HAMPSHIRE

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

NEW HAMPSHIRE

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

NEW JERSEY

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

NEW JERSEY

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

NEW YORK

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

NEW YORK

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

NEW YORK

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

NEW YORK

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

OHIO

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

OREGON

Small, stable, single-hospital, democratic, locally owned EM group seeking full-time board eligible/certified physician for 120-140 hours/month for 8 hour shifts. Salary is very competitive. We offer a generous benefit package. Clean, small-town with excellent schools. Recreational opportunities here on the east slope of the Cascades, include hunting, fishing, skiing, biking, river rafting, golf and camping. (PA 710)

OREGON

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

PENNSYLVANIA

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

PENNSYLVANIA

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

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

PENNSYLVANIA

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

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

PENNSYLVANIA

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

SOUTH CAROLINA

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

AAEM JOB BANK

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

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

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

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

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

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

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

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

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

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

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

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

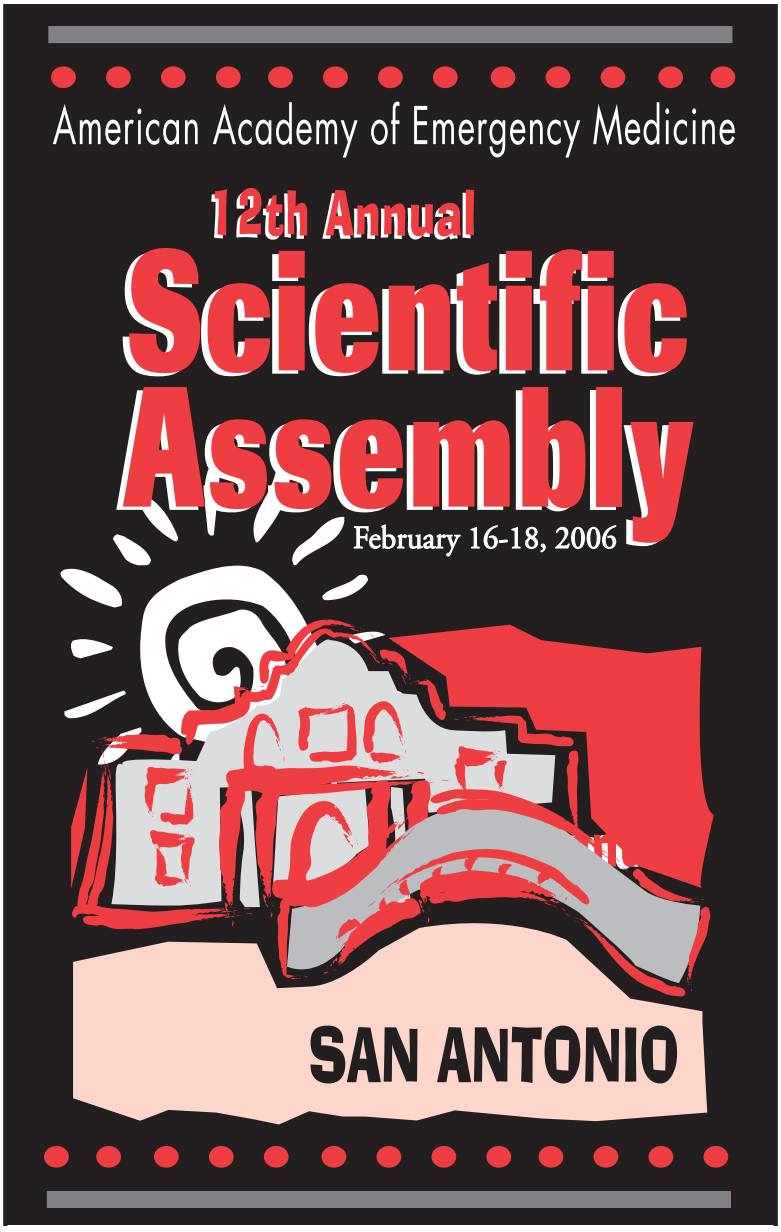
The following group has submitted the notarized AAEM Certificate of Compliance, attesting to its compliance with AAEM's Policy Statements on Fairness in the Workplace:

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

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

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

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



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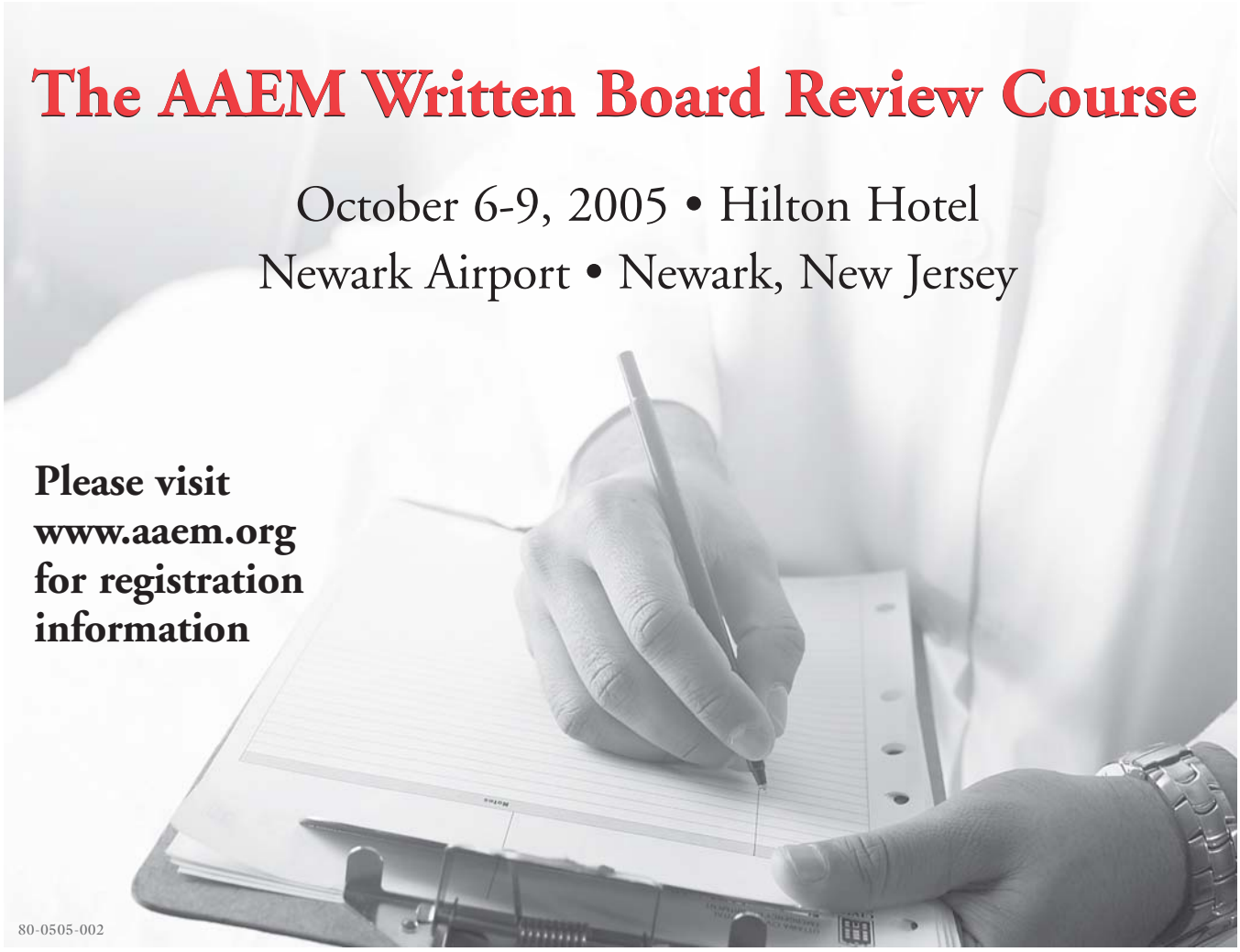

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