



when minutes count

common SENSE

The Newsletter of the American Academy of Emergency Medicine — Volume 12, Issue 2— March /April 2005



PRESIDENT'S MESSAGE

by A. Antoine Kazzi, MD FAAEM

“This will not stand!”

The PhyAmerica Malpractice Insurance Debacle

This is a special issue of *Common Sense* - one that Dr. Blumstein wanted us to dedicate to the malpractice crisis. Ironically, its timing coincides with the emergence of a major corporate travesty - one that directly involves the personal assets, the lives and careers of 170-200 PhyAmerica physicians. These physicians are defendants in at least 170 malpractice lawsuits that had been filed against them and their employer, PhyAmerica, or one of the other staffing companies or groups that were acquired, at one point or another, by PhyAmerica such as Coastal, FPA, Sterling and MedPartners.

When it declared bankruptcy in 2003, PhyAmerica told these physicians not to worry about their malpractice coverage. Concerned physicians contacted PhyAmerica and were provided written reassurance that they remained adequately insured and that their defense was being handled by Western Litigation Specialists (WLS), a firm that had assumed prior to the bankruptcy the liability insurance coverage for these physicians. These physicians felt reassured and went on working with WLS-paid defense lawyers. Their cases were therefore not accounted for by the Bankruptcy court as one of the PhyAmerica liabilities. Written reassurances from PhyAmerica and WLS in hand, these physicians were not worried about their personal liabilities in these malpractice cases since they were being covered even after the PhyAmerica bankruptcy.

By the summer of 2004, the assets of bankrupt PhyAmerica were purchased by Sterling Healthcare, another national Contract Medical Group. In autumn 2004, these PhyAmerica physicians began receiving calls and letters, mainly from their defense lawyers, telling them that the WLS funds were near-exhaustion. WLS was running out of the maximum amount of money that had been allocated to pay for all expenses, settlements and judgments. The PhyAmerica physicians were being told that 1) they needed to personally begin paying for their lawyers, expert witnesses and legal expenses, and 2) their personal assets and future income were now being directly targeted by the Plaintiffs' lawyers as an alternative source of payment for any settlements or judgments against them.

Our colleagues were abandoned and uninformed defendants, left isolated in the dark to figure out on their own what to do, how to respond to pressure from defense and plaintiff lawyers asking them to make quick decisions on whether:

- 1) To individually assume the costs, expenses, settlements and judgments that were associated with the malpractice claims against them.
- 2) To settle - and to settle fast, even if the cases against them were frivolous, and if settling would have them reported to the national malpractice database - leading to blatantly unfair long-term harm to their career and to their current or future employment.

Bewildered and upset, a number of these physicians contacted AAEM. And AAEM responded!

- 1) The AAEM Board established a “PhyAmerica Physicians Defense Working Group” to be the official vehicle and voice representing the interests of the affected PhyAmerica physicians. This group was formed to give the physicians their own structure that they could use to address their needs. Membership in the Working Group was restricted to the physicians affected and to their individual legal representatives. Two of the affected PhyAmerica physicians, Michael Zielinski, DO FAAEM FACEP, and Jill Mabley, MD FAAEM, volunteered to chair this Working Group and to lead its charge - represent to the best of their abilities the interests of their colleagues. AAEM board member Dr. Kevin Rodgers assumed the role of AAEM board liaison to the Working Group.
- 2) Legal counsel and a bankruptcy lawyer were engaged by AAEM and the working group for the working group start-up - to fact find and define short-term strategy, alternatives, priorities, and objectives, the most important being providing official representation of the Working Group and AAEM members who were affected by this debacle at the March 28th Baltimore Bankruptcy Court Hearing where the judge was going to decide whether the personal assets of these physicians were or were not going to be left at the mercy of plaintiffs and their lawyers.
- 3) By the time I was submitting this article, an Amicus Brief was being filed in Court by AAEM on behalf of these physicians, and plans were in place for legal counsel, an AAEM officer and a number of PhyAmerica physicians from the working group to testify in court in Baltimore - to put a non-corporate face on the implications of the judge's decision.
- 4) AAEM staff and board members, as well as substantial AAEM Foundation funds and resources, were allocated to find, mobilize and organize this diverse group of isolated physicians spread all over the USA.
- 5) AAEM established a “PhyAmerica Malpractice Insurance Crisis Taskforce” and appointed two of the affected PhyAmerica physicians, Drs. Zielinski and Mabley, to lead this TF hand-in-hand with 2 AAEM board members (Kevin Rodgers and Howard Blumstein) and the President. The charge of the TF were:
 - a. To establish all the facts, timelines, deadlines and challenges associated with this travesty.
 - b. To execute the complex initiative of organizing the PhyAmerica Physicians Defense Working Group, collecting the myriad details of a very diverse group of physicians and cases, and developing the working groups governance.
 - c. To establish the Working Group initial strategy, its current alternatives and its short-term and long-term objectives.
 - d. To contact all physicians involved.
 - e. To disseminate the information about this travesty to the EM media and to other organizations.

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- 6) AAEM Foundation funds, which you contributed over the last 2 months. were allocated to retain legal counsel.
- 7) The AAEM Board voted to volunteer themselves to serve - Free of Charge - as expert witnesses in these malpractice cases to defend all affected EM-board certified or eligible physicians.
- 8) AAEM arranged a number of meetings and conference calls for these physicians who were able to call-in, share facts about their cases and to learn about the challenges, threats and alternatives that they were facing.
- 9) AAEM, the Working Group and Sterling Healthcare began coordinating their separate activities and are currently working together to ensure that the PhyAmerica physicians' interests are protected. At this point in time, it is apparent that the physicians' objectives are aligned with what Sterling is seeking to achieve on March 28th in Baltimore. AAEM, the Working Group and its legal counsel will be there to ensure that any decision by the judge reflect the best interest of the physicians and not the plaintiffs, their lawyers or any corporate executives. For this reason, and with those considerations in mind, we are coordinating with Sterling and held a meeting in La Jolla, with their Executive Vice-President and legal Counsel. This included the Working Group leadership, the AAEM President, Dr. McNamara, and board members (Rodgers and Blumstein). A number of affected PhyAmerica Physicians were able to participate in the meeting confer through a phone line and to ask questions that were answered by the Sterling Executive Vice President and by AAEM.
- 10) In mid-February, the ACEP leadership who attended the AAEM Scientific Assembly was informed through our open board and business meetings. The ACEP President, Dr. Suter, attended our AAEM Foundation dinner and heard from the Taskforce Chair about this debacle. The ACEP President expressed significant interest in this crisis. AAEM responded by officially inviting ACEP to work together with AAEM and to share the leadership of the malpractice insurance crisis taskforce, making it an AAEM-ACEP joint taskforce. We felt this was an outstanding opportunity to begin collaborating constructively with ACEP and that this crisis was so important and the threat to the docs was potentially so devastating that we needed to be united in our stand and activity with that regard.

- 11) A similar invitation was issued to ACOEP. AAEM would again welcome all collaboration in this very important matter and would welcome being able to collaborate with both ACEP and ACOEP on this matter preferably through a joint taskforce with representatives from the 3 organizations.

In summary, at this time, every attempt is being made to "protect the individual physicians involved in pending malpractice cases" that are inadequately covered by the under funded insurance policies. We hope the judge will decide to protect once and for all the physicians from individual liability that compromises their personal assets. This will be decided in Baltimore on March 28th. The judge may choose to continue the temporary restraining order protecting the physician defendants and develop a plan to liquidate the claims, which would then prolong this crisis. In a worse case scenario, the judge may also decide to open the way for malpractice lawyers and plaintiffs to sue all affected physicians for their personal assets.

We hope our rationale and fairness to these affected physicians will prevail. However, if this does not occur, AAEM will continue its effort to represent and support these physicians in their struggle. It will not hesitate from considering any reasonable option that would provide these affected physicians with what they deserve: justice, fairness and peace of mind.

This is nothing less than a terrible tragedy, one that is profoundly unfair to these physicians who were contracted and promised adequate malpractice insurance coverage. This crisis gravely endangers the well-being, personal assets and future of hundreds of emergency physicians. It has far-reaching implications on all our workforce, members and non-members, who work for similar groups, have worked for them, or will work with them in the future.

Our message continues to be clear: our AAEM issues are nothing less than noble, current and core to our practice. Decades of silence on corporate abuses have resulted in this potential devastation looming over the head of our colleagues and members. After serving their groups and toiling at the bedside while profiteers count numbers and profit, emergency physicians simply deserve better. On this issue, AAEM will not rest until justice prevails. This travesty will simply not stand! 



when minutes count

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AAEM Mission Statement

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

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

Membership Information

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

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

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

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

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

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

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EDITOR'S LETTER

by Howard Blumstein, MD FAAEM

"Malpractice." It is a word that strikes fear into the hearts of most physicians. The specter of losing one's personal savings. The annoyance of time lost in meetings, depositions and trial. The frustration of being accused of incompetence. The threat of being listed in databases as a bad physician. The blow to one's self-image. These are just some of the negative aspects that rush through our minds when we receive that notification of legal action against us. Been there, done that.

As Program Director for four consecutive Scientific Assemblies, I was always struck by the popularity, attendance, and close attention commanded by sessions that addressed various aspects of medical malpractice. This year's Scientific Assembly, from which I just returned, featured a record number of sessions and speakers on malpractice. Even the Keynote Address, by Dr. Bruce Hart, focused on this issue.

In keeping with that trend, this current issue of *Common Sense*, several months in the making, addresses the malpractice crisis from many different angles.

The President's Message addresses the crisis precipitated for nearly 200 physicians regarding loss of malpractice coverage after the bankruptcy of PhyAmerica. This contract management group, owned by Steve Scott (former President of Coastal), initially sought bankruptcy protection in November of 2002. It was ultimately sold to Steve Dresnick a year later. But, it turns out PhyAmerica was underinsured. Dr. Kazzi's message discusses the events that have transpired since then, focusing on AAEM's efforts to help organize these physicians into a cohesive group that can protect themselves from the failures of PhyAmerica's leadership to provide adequate insurance.

Horror stories from physicians threatened with loss of coverage serve as a wake-up call to all of us. There but for the grace of God go we all.

The world of medical malpractice coverage is cold and insensitive. The need for such coverage represents a financial burden that may be an insurmountable hurdle for physicians trying to form an

independent group. Attempts to cut corners by purchasing inadequate insurance coverage or refusing to provide "tail" coverage to departing physicians seem unfair business practices that put the financial interests of large groups ahead of the professional interests of our colleagues and fellow Academy members. How much would such a "tail" cost? Tens of thousands of dollars (see *Medical Economics*, July 2004: <http://www.memag.com/memag/articleDetail.jsp?id=108611>)

I am a full-time faculty member in an academic emergency medicine training program. Each year, several senior residents asked me to review the contracts they have been offered. This year, not a single contract included an obligation by the employer to provide "tail" coverage upon the departure of the resident. Essentially, this means that should one of my residents decide to leave his first job for whatever reason, (even if fired) he will incur a financial penalty of tens of thousands of dollars. Cold. Very cold.

As a member of the Board of Directors, I have had the opportunity to meet or make contact with many people with unique insights into how the malpractice crisis affects emergency physicians. I have invited them to submit articles for this special issue. Larry Weiss, MD JD, a board member who is also an attorney, offers several mechanisms to reduce malpractice costs aside from the "caps" currently favored by both the White House and the AMA. David Hambright discusses the essential features that all emergency physicians must look for when reviewing their coverage. Tobey Williams is a former president of the resident section who sat on the AAEM board. I asked him to describe his efforts in putting together coverage for board certified emergency docs.

What can you and AAEM do to help crawl out from under the storm clouds generated by a legal system run amuck? The malpractice committee has begun looking for ways to fight back. Please e-mail me with suggestions. Read the articles in this issue of *Common Sense* and educate yourself about the malpractice crisis. Dr. Weiss listed several other suggestions in a discussion he presented at the Scientific Assembly: Join your state medical society, communicate with your legislators, and check out Common Good (<http://cgood.org/>), an organization committed to "Restoring Common Sense to American Law." If we can generate a critical mass of physicians working on reforming the system, I believe we will succeed. ☒



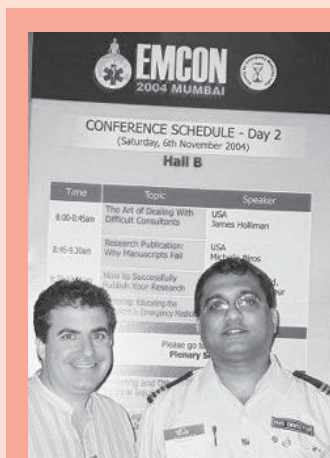
AAEM Honors Dr. Robert Simon



AAEM was pleased to attend the January 21, 2005, retirement party of Bob Simon, MD FAAEM, who held the position of Chair of Emergency Medicine at Cook County Hospital for two decades. Dr. Simon was presented with a plaque by Tom Scaletta, MD FAAEM, AAEM's Vice President and a former Cook County faculty member. The inscription reads, "to a courageous and foresighted emergency medicine leader and educator who has upheld AAEM's principles in regards to fair and satisfying practice environments." AAEM is proud to claim Dr. Simon as a dedicated member and we wish him well in the next chapter of his life.

Emergency Medicine in India

by Tom Scaletta, MD FAAEM



Dr. Tom Scaletta, VP of AAEM and Dr. Prasad Rajhans, VP of SEMI (Society for Emergency Medicine India) at the EMCON 2004 conference.

This past November, I had the pleasure of attending EMCON 2004 in Mumbai (Bombay), India. The program, endorsed by AAEM, was extremely well organized and hosted by the Leela Kempinski, an elegant and highly accommodating five-star hotel. Emergency physicians from India shared their successes and challenges in developing pre-hospital and hospital-based emergency medicine. Their dedication and efforts are vastly improving healthcare for all Indian citizens.

The journey was one of intense cultural exploration and appreciation. I walked through thousand-year-old

architectural wonders, was welcomed into mosques, and learned a great deal about Hindu, Muslim and Sikh worship. I witnessed an endless procession of sugarcane farmers slowly transporting their harvest in over laden ox carts to the factory. I became even more appreciative of human diversity and developed a stronger connection with my Indian colleagues, neighbors, and patients.

I strongly recommend that you keep your eyes on EMCON 2006, taking place in Delhi, likely in early November. Delhi is the ideal base for an initial tour through India, as it is one of the points of the Golden Triangle, which includes Agra, home of the Taj Mahal, and Jaipur, where you can take an elephant ride up to an ancient fort. You can also travel north from Delhi to the foothills of the Himalayas and the origin of the Ganges River, a beautiful and sacred area. 🇮🇳



Elephants in ornamental garb are being guided along the trail to the Amber Fort in Jaipur India's "pink city."



An ox is pulling a cartload of sugarcane along the road from Delhi to the sugar plant. India is the largest producer and consumer of sugar in the world.

The Ongoing Assault on Board Certification: AEP Responds to AAEM's Efforts

by Robert McNamara, MD FAAEM
and Joel M. Schofer, MD

The Association of Emergency Physicians (AEP) has sent the following letter to hospital administrators around the country. The letter essentially says that there is no value in certification by ABEM or AOBEM. This letter is part of a campaign to counter AAEM's recent efforts in Florida, and our previous mailings to hospital administrators espousing the quality of care value of board certification in emergency medicine. This letter highlights the need for AAEM to continue its effort as the only organization taking a strong stance against the efforts of BCEM certified physicians to gain equal footing with ABEM/AOBEM certified physicians in Florida.

For those unfamiliar with AEP, their central purpose is to represent those physicians practicing emergency medicine who are not certified by ABEM or AOBEM. The same individuals who filed suit against ABEM over the closure of the practice track (Daniel v. ABEM) founded AEP. According to AEP's website (www.aep.org) "there are many myths promoted by those who espouse that only EM-residency trained and ABEM or AOBEM certified physicians should be working in emergency departments, and AEP works to dispel these myths."

The following AEP letter contains a number of inaccuracies and

misconceptions stating:

"there is no credible evidence that ABEM or AOBEM certified physicians provide better or more efficient care."

We strongly disagree. At www.aaem.org/boardcertification/index.shtml, you will find numerous references illustrating the value of ABEM/AOBEM board certification in EM. There you will find evidence, published in the leading peer-reviewed journals of our specialty, that board certified emergency physicians improve the quality of care. Specifically, you will see that such physicians improve airway management, reduce malpractice risk, administer thrombolytics faster and improve the quality and efficiency of patient care in the emergency department.

The AEP letter is further evidence of the need for continued vigilance by AAEM in regards to board certification. As the only EM organization requiring ABEM or AOBEM for full membership, it has been an integral part of our mission. If you have not already done so, we urge you to review the documents related to the Florida matter on the front page of our web site www.aaem.org. These materials clearly illustrate why we have serious concerns about the continued efforts to devalue ABEM and AOBEM certification. 🇮🇳

This is a reprint of the letter sent to hospital administrators by the Association of Emergency Physicians, an organization of doctors working in emergency departments who are not certified by ABEM or ABOEM. It is reprinted here for informational purposes.



September, 2004

Dear Hospital CEO/Administrator,

Recently you may have received "information" from organizations representing segments of the emergency medicine community in which you were advised to have only ABEM or AOBEM certified emergency physicians in your emergency department. I am writing on behalf of the Association of Emergency Physicians (AEP), a national emergency medical organization with members throughout the U.S. and abroad. While our members have all of the various different certifications and credentials, the underlying factor distinguishing us from the other emergency medicine organizations is the devotion to fairness for all emergency medicine specialists. Because of this we want to give you another side of the story prior to your acceptance of any organization's recommendations.

You probably are aware of the two previously mentioned boards of certification. However, there is a third board which credentials physicians in emergency medicine. Board of Certification in Emergency Medicine (BCEM) is the second largest of the three boards and administered under the auspices of the American Association of Physician Specialists (AAPS/ABPS), which has been in existence for 50 years. In a number of challenges to its legitimacy by those who claim exclusive superiority for the ABMS/AOA, and their boards of certification, the AAPS and its boards of certification have been found to meet or exceed the standards set by the ABMS or AOA boards.

Foremost, there are no data demonstrating that **any** course of training and/or experience leading into the practice of emergency medicine is better than any other. And certainly, despite what some might wish to infer, there is no evidence that attainment of any of the three boards is a more or less reliable predictor than the other two of the quality of emergency medical care delivered by individuals who have achieved them.

However, while currently ABEM or AOBEM require 36 months of training to sit for their exams, BCEM requires *at least* the completion of a 36 months residency in emergency medicine or a related specialty *and* at least 7000 hours of *additional* emergency medicine experience, or post graduate training in emergency medicine plus experience, ***in addition to practice assessment*** in the form of the review of case reports of patients treated by the physician before one even can be considered to sit for the examination.

Despite the existence of emergency medicine residencies for 25 years, there is NO compelling evidence that doctors who are residency trained in emergency medicine are any better at the practice of this field than those emergency specialists with extensive emergency medicine *experience*. This is fortunate as, even though you might have been led to believe otherwise, **half or more** of the ABEM and AOBEM certified emergency doctors **have not** completed an emergency medicine residency. *Also* there is no credible evidence that ABEM or AOBEM certified physicians provide better or more efficient care.

If you wish to be assured of having an experienced physician in your emergency department hospital administrators should hire and fully credential those who are BCEM certified and/or Fellows in AEP since significant experience is necessary to achieve these two credentials and there is no substitute for experience. Remember, while residency training in emergency medicine is very valuable and highly respected by AEP, as well as others, there are alternatives for acquiring and demonstrating retention and proficiency of the essential core knowledge of the specialty besides those approved by ABEM and ABOEM.

Sincerely,

Geoffrey L. Ruben, MD, FAAP
President, Association of Emergency Physicians



INFORMATION SHEET:

- Other organizations might have you believe, because their members are ABEM or AOBEM certified that:
1) All of their members are residency trained in emergency medicine and, (2) this is the standard in the United States. Neither premise is true! **Only approximately one half of all ABEM and AOBEM certified emergency physicians have completed an emergency medicine residency ().**
- Of the 31,000 to 32,000 emergency medicine specialists in the United States only approximately one half are residency trained in emergency medicine ().
- A number of doctors who are claiming EM residency training is the only path to the practice of emergency medicine have completed a related residency or never completed a residency of any type. They and others still can not deny they practice emergency medicine as well or better than those who are EM residency trained.
- Most, if not all, medical organizations in this country agree that lack of board certification does not indicate that a doctor, if **experienced** in an area, is less qualified to practice a specialty than those that have certification. In fact the American Board of Medical Specialties (ABMS), the parent organization for ABEM, has a policy which states: **"In making the determination of what privileges a practitioner will be permitted to exercise, medical specialty certification or subcertification should be considered as only one of several valid and important criteria."**(). In recognition of the importance of experience, along with knowledge, in the practice of any field of medicine the ABMS has mandated that all of its boards of certification, including the ABEM, institute a process of recertification based on continuing **experience** which must be documented.
- Prior to requiring candidates for its board to complete an emergency medicine residency the ABEM accepted a certain amount of practice experience as an alternative. The ABEM correctly continues to recertify these physicians and considers them the equals of those who have completed an EM residency. Not having made the arbitrary cut off date to take the tests for the ABEM certification via the "practice track" (the AOBEM practice track is still open) does not make a doctor less qualified to practice emergency medicine. In fact, physicians who are residency trained first in another specialty in many cases are the more broadly experienced, and make exemplary emergency medicine specialists.
- While AEP encourages and supports residency training in emergency medicine, we also recognize this is not the **only manner in which a physician may get the training and knowledge necessary for high quality practice of Emergency Medicine.** Furthermore, residency programs, by and large, are paid for from federal tax dollars, in the form of Medicare Part B funds, and money contributed by the institutions at which they are centered. This increases the burden on the federal budget and hospitals, taking money from other needed areas such as emergency preparedness. From this perspective shorter, more tailored post residency training programs are a possible, desirable, and a demonstrated alternative to the full length EM residency for many physicians, hospitals, and the communities they serve.
- Of the three organizations certifying emergency physicians, the BCCEM is the second largest.

(1) "A Study of the workforce in emergency medicine: 1999", Annals of Emergency Medicine, July, 2002, Vol. 40, Number 1.

(2) From the American Board of Medical Specialties "ABMS Statement on 'Delineation of Clinical Privileges'", adopted by the ABMS Assembly, 3/18/77, Revised 9/21/95.



"When I was a young man, I wanted to change the world. I found it was difficult to change the world, so I tried to change my nation. When I found I couldn't change the nation, I began to focus on my town. I couldn't change the town and as an older man, I tried to change my family. Now, as an old man, I realize the only thing I can change is myself, and suddenly I realize that if long ago I had changed myself, I could have made an impact on my family. My family and I could have made an impact on our town. Their impact could have changed the nation and I could indeed have changed the world."

- *Unknown*

"Teach this triple truth to all: A generous heart, kind speech, and a life of service and compassion are the things which renew humanity."

- *Buddha*

"Wash what is dirty. Water what is dry. Heal what is wounded. Warm what is cold. Guide what goes off the road. Love those who are least loveable because they need it most."

- *Unknown*

THE VIEW FROM THE PODIUM

The "World Cup" of Emergency Medicine Conferences

by Joe Lex, MD FAAEM

Superlatives almost cannot do justice to what we are planning in Nice, France, over the Labor Day weekend this year. The European Society for Emergency Medicine (EuSEM) and the American Academy of Emergency Medicine (AAEM) are putting together a top-notch lineup of outstanding speakers and educators from around the world for the 3rd Mediterranean Emergency Medicine Conference (MEMC3).

This international gathering begins with Preconference Courses and an Opening Ceremony on Friday, September 2, 2005, and continues for three solid days of incredible educational experiences in a resort-like setting on the French Riviera. We have firm commitments to attend and speak from the biggest names in American emergency medicine, including Jerome Hoffman, Richard Bukata, Peter Rosen, Judith Tintinalli, Diane Birnbaumer, Billy Mallon, Lewis Goldfrank, and Ron Walls. Other AAEM favorites will also attend and speak, including Ghazala Sharieff, Amal Mattu, Larry Raney, Bob McNamara, and Nate Shapiro. I challenge you to find a more exciting emergency medicine conference anywhere in the world. And we'll even give you at least 19 hours of AMA-PRA Category 1 CME for attending.

There will be half-day or full-day educational tracks on Cardiovascular and Resuscitation Emergencies, Traumatic Emergencies, Infectious Disease, Neurologic Emergencies, Shock, Pharmacology, Toxicologic Emergencies, Pediatric Emergencies, Prehospital Medicine, Disaster Medicine, and a three-day track of "Core Content" updates.

Preconference sessions will be offered on Noninvasive Airway Management, Hospital Disaster Planning, Pediatric Procedures, Wound Management, Airway Updates, and Procedural Ultrasound.

MEMC2 was in Sitges, Spain, in September 2003. It was an unforgettable experience for anyone who attended. More than 1300 emergency practitioners from more than 60 countries around the world gathered for three days in a beach town near Barcelona. The conference's reputation now has attracted even more interest and we expect a much higher attendance in France.

In addition to several simultaneous academic tracks, more than 600 original papers will be presented in both English and French, and more than 500 posters will be displayed. If you want to brush up on your French, one complete clinical track will be conducted in that language.

We have set aside a 300-seat auditorium solely for speakers to give an update on Emergency Medicine in My Country, which was one of the most popular features at prior conferences.

The Nice Acropolis (www.nice-acropolis.com) is a superlative conference center, the biggest on the French Riviera, and we're anxious to take advantage of their facilities. Many nearby hotels are ranked three- and four-star.

And do I need to convince you about the city of Nice? It has a subtropical climate on the Mediterranean with incredible views, amazing restaurants, and outstanding museums including the Musee de Matisse (Henri Matisse lived in Nice for 40 years) and Musee National Message Biblique Marc-Chagall. Less than an hour away are the principality of Monaco (and the casinos of Monte Carlo), the Rothschild Estate, the spectacular ancient hill villages of Eze, Peillon and Peille, the Old Town of St-Paul-de-Vence, Antibes, the Picasso Museum in the Grimaldi Castle... Let's face it, if you don't go you'll kick yourself forever, so just start planning now.

Read the details of the conference as they unfold at the website – www.emcongress.org.

SOMEWHAT CLOSER TO HOME

Although not quite as exotic or distant as France, AAEM is deeply involved in the planning of an International Interdisciplinary Conference on Emergencies in Montréal, Quebec, during the last week of June. AAEM members Jerome Hoffman, Antoine Kazzi, Marvin Wayne, Robert McNamara, Amal Mattu, Ghazala Sharieff, and myself are all invited to give two or more talks at this 5-day global gathering of intensivists of every stripe. Check www.iice2005montreal.com/home.html for details and updates. Between 2000 and 3000 participants are expected at this bilingual gathering.

Montréal is another multicultural city with amazing museums, restaurants, and gardens, along with a world-class zoo. If you can't make it to Monaco, try the Casino de Montréal. Another must-see is the Montréal Biodôme.

After the Conference, stick around for the 26th Montréal Jazz Festival to hear such legends as Roberta Flack, Al Jarreau, Dave Holland, Bobby McFerrin, Madeline Peyroux, and The Five Blind Boys of Alabama with special guest Mavis Staples.

We were asked to participate in this venue because of our excellent reputation in supplying high-quality education. AAEM will offer at least ten hours of AMA-PRA Category I CME credit for American attendees.

TIME FOR A CHANGE

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

- *Alfred Edward Perlman, New York Times, 3 July 1958*

I used the quote above in my prior column for a reason. I'm entering my fifth and final year as Chair of Education for AAEM,

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TORT REFORM: We Need More Than Caps

by Larry D. Weiss, MD JD FAAEM

Some physicians, many journalists, and much of the plaintiff bar literature equate tort reform with “caps,” legislatively mandated limitations on damages that plaintiffs may recover. However, tort reform involves far more than caps. Real reform must aim at the causes of the liability crisis to provide real relief for beleaguered professionals and businesses.

Let me give you the “good news” and the “bad news” about caps. The “good news” is that caps work. Research has shown that the cap contained in California’s 1975 MICRA law resulted in far lower malpractice premiums compared with similarly situated states.

The “bad news” is that caps provide plaintiff attorneys with almost all their anti-reform propaganda. Anti-reform seminars sponsored by the plaintiff bar have almost entirely focused on how to fight caps. During the current debate regarding federal tort reforms, the plaintiff bar presented a series of tragic patients before the press and Congress, arguing that caps would unfairly prevent these patients from recovering for their injuries.

Caps are not aimed at the causes of the liability crisis. We do not have a liability crisis because American physicians repeatedly inflict millions of dollars of damages on patients. We have a medical liability crisis because of a tidal wave of groundless litigation. Over 80 percent of all suits filed against physicians in this country have no basis in fact. We have rules in our tort system that promote endless litigation. Caps only stem the hemorrhage but do not address the cause of bleeding.

However, we need caps because they work, and because we have a real crisis caused by the plaintiff bar. We should remind the media that some tragically injured plaintiffs may not totally recover for their damages because the medical liability system is financially broke. If groundless litigation did not waste untold billions of dollars every year, perhaps we would not need caps and every deserving plaintiff would fully recover for their damages.

We need long-term reforms that will change the behavior of plaintiffs and their attorneys. Instead of having incentives that promote endless litigation, we need incentives that lead to more responsible behavior. We need a general “loser-pays” rule for legal expenses in civil litigation like virtually all other countries in the world. We need to ban contingency fee contracts whereby plaintiff attorneys take a percentage of their clients’ recoveries.

Almost all other countries in the world ban contingency fee contracts and consider them unethical.

We need to give punitive damages to the government so that the benefits go to all taxpayers, instead of allowing plaintiffs and their attorneys to enjoy a windfall. We need medical review panels to screen groundless claims and to fine plaintiffs who file such claims. We need to remove barriers that unfairly prevent defendants from countersuing plaintiffs, their attorneys, and their expert witnesses. Finally, we need to eliminate new unfair court-made rules that allow plaintiffs to recover for any “lost chance” of a better outcome, negligent infliction of emotional distress, bystander emotional distress, liability to third parties, fear of disease, and “medical monitoring” which may result in a plaintiff receiving millions of dollars to “monitor” them for a disease they do not have. An especially unfair rule, referred to as “solidary liability” or “joint and several liability” allows the plaintiff to recover all damages from any one defendant. This means that if a plaintiff proves that ten different defendants caused her damages, but only the physician has any money, then the physician may pay for all the damages!

Caps provide physicians and other health care providers with short term relief. Other common reforms such as decreasing the statutes-of-limitation (the period of time during which a plaintiff may file suit), eliminating the collateral source rule (preventing juries from knowing about plaintiffs’ other means of recovery), periodic payments, and limiting punitive damages will provide similar short term relief but are not directed at the causes of the liability crisis. Also, all of these short term reforms limit plaintiff rights. We need these measures to provide us with immediate relief and we should advocate for these reforms until our government and the courts fix our broken tort system. However, in the long term, instead of limiting plaintiff rights we need changes that protect everyone’s rights by restoring fairness to our tort system.

Of all the countries in the world, only the United States has a liability crisis. We have this unique malady because we have the world’s most aberrant tort system. Caps and some other short term reforms will give us some relief, but we must focus on long term solutions that aim at the causes of the liability crisis. We must change our tort system in a way that removes perverse incentives to file endless litigation, and institute changes that promote responsible use of our tort system. +

View from the Podium - continued from pg 7

and it’s time to “look at it with suspicion.” This organization took a chance on me when I was an unknown quantity and gave me an incredible opportunity to develop some educational programs in a new and exciting way. I’m proud of our accomplishments over the last several years – the Oral Board Review Course (which prepares 200 people annually – almost 20% of those taking the boards), the Written Board Review Course, the Board Review Question Book (co-produced with Pennsylvania ACEP), the Jam Session, the Annual Scientific Assembly with its unique Open Microphone session, the Speakers’ Bureau, and the chance to work with others passionate about education, such as Scott Plantz of EMedicine, Rick Nunez of EMedHome, Mel Herbert of EMRAP, and many others.

As I explained to the Executive Committee in my letter of imminent resignation, I’m not burned out. Far from it! Rather, I think I’ve

“run the string” on things new and original. It’s time to give a new voice and new face to the organization before projects start to get hidebound and stale. AAEM is perceived as a brash young organization and deserves to have brash young ideas about education. I will oversee the Education Committee for a fifth year. When the Executive Committee chooses my replacement, I will mentor him or her until our San Antonio Scientific Assembly in 2006. At that time I will step down.

Five years is enough; I have many other projects that challenge me at both the local and international level. I will continue to serve as a member of the Education Committee, and offer my thoughts when solicited to do so. AAEM has allowed me to succeed in ways I never believed possible; I am forever grateful for the opportunity you gave me. +

11th Annual Scientific Assembly • San Diego



Dr. Levitan demonstrates a procedure to participants of the Emergency Airway Management Course



Above, Dr. Lambert and Dr. Fox direct the Ultrasound Course



▲ Participants visited the full exhibit hall where 37 companies displayed their products and services ►



More than 200 people took part in the Thursday night Welcome Reception co-sponsored by CAL/AAEM



Anissa Benson and Justin Rich from EvolveMed were on site to answer AAEM Services and template questions

11th Annual Scientific Assembly • San Diego



Resident Section Board Member Brian Potts and AAEM Vice President Tom Scaletta



Paul Sierzenski, Nathan Shapiro and John Madden enjoy the opening reception



Joseph Clinton (left) is honored with the David K. Wagner Award for his significant contributions to AAEM



(from left to right) Jesse Pines, Mark Reiter and Ziad Kazzi, members of the AAEM Resident Section

Dr. Aguilera and Dr. Peralta flew in from Argentina to attend the International Summit at the Assembly



Dr. Wood and Dr. Kazzi present Dr. Mark Langdorf (center) with the Peter Rosen Award



Kevin Rodgers and Stephen Hayden were presented with the Residency Director of the Year Award



Candidates for the Board of Directors Participated in the Candidates Forum during the Business Lunch

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September 2-5, 2005



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 - Course 3: Airway Management Update (5,5 hrs)
 - Course 4: Pediatric Procedures (2,5 hrs)
 - Course 5: Basics of Research in Emergency Medicine (5,5 hrs)
 - Course 6: Wound Care Procedures (3 hrs)
 - Course 7: EKG Interpretation (3 hrs)
 - Course 8: Hospital Disaster Preparedness (13,5 hrs)
 - Course 9: Casting & Splinting Techniques (2,5 hrs)
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Congress Social Events

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- A Banquet Gala Dinner on Saturday, September 3.
- Karaoke Buffet Dinner and Dance on the evening of the last day of the Congress on Monday, September 5.
- Organized tours to sites around Nice, Monaco and Monte-Carlo

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Go to <http://www.emcongress.org> for all information on the congress program, abstract submissions, registration, hotel accommodations, tours and social events.

Returning Control with EMPAC RRG “Its’ Not Rocket Science”

by Tobey Williams Jr., MD

AAEM has a historically short but dynamic history of returning control of our specialty back to EM physicians. The premise of understanding the business and politics behind our practices has been front and center in the mission. One of our problems has been the loss of control and decision making which we as a specialty have almost willingly, and in most cases unknowingly turned over. Over the past years we have awoken to find ourselves servants to large corporations, or even small entities where we don't have a clue as to where our profits are going. Nor are we conscious of many of the decisions made that directly affect us.

The Vision Statement of AAEM establishes that the welfare of our patients and the brightest future for emergency medicine depends upon restoring control of our practices to emergency physicians. In my years of involvement in AAEM this organization has always, in my opinion, “walked the walk and not just talked the talk.” For several years the Academy has been interested in solutions to the medical malpractice problems that our specialty has been facing. In the spirit of “for EM physicians by EM physicians,” Emergency Medicine Professional Assurance Company Risk Retention Group (EMPAC RRG) was formed and licensed on June 26, 2004. This process was a two-year endeavor that was inspired by the principles that AAEM attempts to instill in every member of the academy towards the future benefit of our specialty.


EMPAC RRG is a single specialty physician owned insurance company exclusive to emergency medicine. This means that the policyholders are the owners of the company, and there is a Board of Directors that oversees and governs the RRG. This Board of Directors is elected from the policyholders and is advised by the nation's leading experts in the fields of alternative insurance markets and Department of Insurance regulations. These insurance experts join together with practicing EM physicians to form a solid leadership structure.

Inspired by a creative business plan and driven by the dedication and passion towards the concept of returning control to our specialty, EMPAC RRG was able to obtain Lloyds of London to reinsure the program. With this strong A-rated reinsurance relationship, EMPAC RRG ably provides what our specialty demands: outlets to be innovative and creative in our efforts to significantly improve and enhance patient safety process and protocols. EMPAC offers a unique opportunity to see how emergency departments around the country can truly reduce their risk and thus minimize their long-term medical malpractice costs. EMPAC recognizes that ABEM and AOBEM certification is the cornerstone from which we will accomplish our mission.

The leadership in AAEM has maintained that solving the medical malpractice problem has become the linchpin for getting ownership back to the doctors. A common thread to being able to start a democratic group, whether from scratch or breaking away an intact group from one of the CMG's, has been obtaining malpractice insurance.

EMPAC RRG is licensed in multiple states and that list of states continues to grow as we find groups that fit the mission. Most of the standard carriers that insure our specialty will “get what the market will bear,” meaning they will charge us the highest prices that they can without losing you to another carrier. In this time of shrinking markets due to the current medical malpractice crisis these insurers have the leverage they need to drive up prices. Quality EM groups end up paying for the not so quality groups that are in the same risk pool. EMPAC RRG's mission is simple and starts with best of class emergency medicine physicians which we believe are those that are ABEM or AOBEM boarded. The company also recognizes that board certification is only the start of an underwriting process which looks at multiple factors. These factors include, but are not limited too, leadership, the quality of the consultants, and the ability to adjust and learn from prior malpractice incidents. EMPAC RRG also believes that simply having a case settled or lost should not automatically make your group high risk. These losses are extensively reviewed in a creative underwriting process. EMPAC uses experienced practicing EM physicians that are directly involved in this process of reviewing the cases that are normally punitively looked at in standard market.

In the company's numerous discussions with interested EM groups, common statements have remained indelible, and they go something like this: “they increased my rates unfairly last year” or “they handled my case improperly.” The folks at EMPAC RRG have found a solution to the “they problem,” and it starts with “we.” We are the masters of our own malpractice destiny. If you step back and look at the talent pool in emergency medicine it's impressive. Using that talent in a concerted effort with a common goal is what EMPAC RRG is all about. As the title suggests “it's not rocket science,” merely simplifying what the insurance industry has complicated for self-serving reasons.

Tobey Williams is a Past President of the AAEM Resident Section, President/Chairman EMPAC Risk Retention Group 

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RESIDENT SECTION PRESIDENT'S MESSAGE

by Joel Schofer, MD, President, AAEM/RES

The Scarlet Letters

A few days ago, it was revealed during one of our resident board conference calls that we have more resident members of AAEM than ever, well over 1000 residents! With our member recruitment efforts about to kick into overdrive due to the hard work of our Membership Committee, led by Drs. Elizabeth Weinstein and Charles Muntan, I would expect that this number will continue to grow.

I am particularly proud of the continual membership increase that our section and AAEM have enjoyed. Not simply because the numbers are so impressive, but also the quality of our members really inspires me. We clearly are not the largest organization in EM, nor are we the one you join just "to get a journal," just because you have a casual interest in being a member of an EM society, or because you were forced to join due to a dual membership requirement.

People who join AAEM do so because they believe in our mission statement. They are aware of the forces at work in EM and know that these forces may not be in their best interests. They feel that we, the leadership of AAEM, care more about their individual well-being as residents and future emergency physicians than the leadership of other organizations. At least this is what I think.

AAEM members have a certain passion about their organization and membership that I believe other organizations lack. Of course, all EM organizations have passionate leadership, but at the level of the individual member, I believe AAEM stands apart.

Let's be honest, being an AAEM member can hinder your ability to obtain a residency position or employment in certain institutions. In some places, membership in AAEM is a black mark on your

record. Show up and you will be led to a scaffold and publicly shamed for joining AAEM, forced to forever embroider the letters "AAEM" on your clothes.

But in other places, AAEM membership signifies that you are one of the enlightened ones. You are one of the EP's or EM residents who truly understands what is at stake in our specialty and that only one organization has your best interest at heart. You proudly wear "AAEM" on your clothes, embroidered in scarlet for all to see, unashamed that you belong and quite proud that you do.

When joining an organization can have a negative stigma attached to it, everyone thinks twice before they do it, whether consciously or subconsciously. The decision to join becomes that much more important, and every year, more and more EP's and residents agree to take this step and join AAEM.

Two days ago, I read the President's Message in the January 2005 edition of ACEP News. When discussing the leaders of AAEM in his message, Dr. Suter, the current ACEP president, stated "emergency physicians, especially the young physicians who are often targeted by these individuals, deserve to know the truth." Honestly, I think we already do. That is the very reason why our membership continues to grow year after year. I don't think that there is an EM society today that contains such loyal and devoted members. It is this fact, the fact that every new member is so educated and passionate about the issues which AAEM believes are important to you and me, that makes our growth so astounding.

Joel Schofer, MD is President of the AAEM Resident Section. He can be reached at jschofer@medscape.com. 

The Emergency Medicine Clerkship: A Key Component of the EM Application

by Mark Allen Lee and Jonathan Leake

The objectives in completing the fourth-year medical student rotation in emergency medicine (EM) are numerous. This rotation represents the synthesis of clinical clerkships undertaken during the third year of medical school. It is a time when students can first test their ability to formulate differentials from a vast array of clinical presentations. The EM clerkship may also be the first time a student is asked to present a brief yet formal assessment and plan. For those considering an EM Residency, it is a time to ensure that EM is the right fit for you and your personality. Is this the clinical environment that truly excites you? It is also a time for you to begin to build the foundation of experience and knowledge needed in EM. However, for those interested in a residency position, the EM clerkship provides much more than the general goals listed above.

There is arguably not a single more important component of your application than your evaluations and performance during that clerkship. This is especially true if you suspect that you might not look as well on paper. This is truly an "audition" for the program - a month long interview. It is a time in which you are evaluated for your clinical skills, general medical knowledge, the way patients receive you, and your ability to interact with the attending physicians,

residents and ancillary staff. You are evaluated on clinical presentations as well as your formal presentations during the weekly conferences. Faculty with whom you interact can become your advocates; the future authors of your letters of recommendation and your voice around the residency committee table come rank day in February. They can also represent your demise in the program.

As intimidating and stressful as this can be, it should be exactly what you desire as an applicant to the competitive field of emergency medicine. Those with confidence in their abilities have a very powerful opportunity to separate their application from all others. Impress them! Yes, the pressure is on, but everyone realizes the student is learning and new to working in the ED. Enthusiasm, honesty, reliability, and energy will carry a student far. Many residency directors will tell you that they will take their chances with a known commodity over that of an unfamiliar applicant with better numbers on an application. It is impossible for a program to know you, or for you to know them after a single day interview. The importance of completing an emergency medicine clerkship

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The Emergency Medicine Clerkship . . . continued from pg R1

at one of your top programs, and the impact that can have on a successful Match Day, cannot be underestimated. At many programs, as many as 50-60 percent of the current residents were rotators before matching to the program.

The first important decision is when to schedule your rotations. These rotations should be scheduled as early in the fourth year as possible, ideally in September and October. If you find EM is not right for you, this will give you time to switch tracks. If possible, scheduling the EM rotation in July or August will provide a huge head-start on the process. Many students complete two clerkships at programs that interest them most. Three (or more) clerkships duplicate experiences and are generally not useful. These rotations will give you time to obtain the required letters of recommendation by the required November 1 deadline. Remember that proper etiquette provides the writer with one month to write a letter of recommendation, so an October rotation may cut it short. Excellent letters of recommendation from two different EM residency programs can be a very powerful component of your application. Letters of recommendation from program directors and assistant program directors carry the most weight and should be sought after as much as possible.

There are often many other avenues to stay connected with the programs of greatest interest throughout your fourth year. These include additional shifts and the continuation of research projects initiated during the rotation. These strategies will demonstrate your continued interest in their program. This may also keep you fresh in the minds of the decision makers who have most likely reviewed close to a thousand applications along with 200 interviews over this same time period. However, a word of caution is to start the process of applying and arranging away rotations around May. Spots are limited and often are first filled by candidates of the home institution. Contact the clerkship coordinator to ensure that they are aware of your sincere interest in their program. Always be very kind to the coordinator as they are often the only one with true veto power in this whole process.

Another very important question is where to rotate. These should be institutions with EM residency programs where you have a particular interest in training. Put some careful thought into this selection to avoid committing four weeks to a program that you will not rank, or rank well down the list. Students often perform a rotation at their home program but should also do an "away" rotation at another targeted program. Institutions with residency programs often feature more of a structured teaching environment with regularly scheduled conferences. Letters of recommendation generally have a stronger influence from residency faculty than general EM physicians. Some program directors may not even read letters from non-EM or non-academic EM physicians.

Ideally, programs you choose for rotations should be diverse. This will not only give you a broader range of experience, but also give you better insight into the type of program you want to attend. The

emergency medicine program of greatest interest should be done last in order to improve your approach to EM patients and the numerous clinical skills that you perform. (Suturing, I&Ds, IVs, EJs, femoral lines, LPs, ect.) Consider rotating at a public or county program first since there is often more hands on opportunity for fourth year medical students at these locations. Certain geographic locations are also of primary importance and help establish a foothold in a region where programs are constantly in contact with one another. Whenever possible, investigate the student role at the institution, and the level of responsibility afforded to the student. These can differ significantly. Some programs allow direct involvement with numerous procedures while often managing patient care one on one with an attending physician. Others may only allow basic suturing while working with residents who often do not have the time for focused directions and comments. Talk with students who have recently completed rotations at places of interest to learn the nuances of the rotation at that institution.

While rotating you should remember that you are conducting a month long interview. Mistakes are ok but should not be frequent and certainly not repeated. Arrive 15-20 minutes early to each shift. Always be eager to help, no matter what the task. Do everything you can to expedite your patient's evaluation and work-up. If this means starting an IV or pushing them to X-ray, do it. It is well worth the reward. At the beginning of each rotation, meet with the program director to let them know you are rotating for the month, interested in EM, interested in their particular program, and will be asking for a letter of recommendation at the end of the rotation. Try to schedule shifts with them and meet again at the end of the rotation to formally ask for a letter of recommendation and review programs. Start each shift by introducing yourself to the attending and chief resident and acknowledge your interest in EM. Try to ask for verbal feedback 15-20 minutes before the end of the shift. All of this will set you apart and show interest and dedication to EM and their program.

Believe it or not, residencies are trying to sell themselves to you just as much as you are trying to sell yourself to them. Relax! A month long interview can be stressful. You must show great enthusiasm and interest. You must walk the fine line between demonstrating what you can do, while not over-stepping your ability. You must be confident in knowledge while making it apparent that you are eager to learn. You must continue to refine your approach to the EM patient and see it through. Try to work with as many of the EM Attending physicians as possible and look forward to your best interview day at that program **+**.

*M. Allen Lee MSIV
Mercer Medical School
AAEM South Regional Student Representative*

*Jonathan Leake MSIV
Emory School of Medicine*

Winners of the Resident/Student Research Competition

from left to right
3rd place Kavid Udompanyanan,
Peter Rosen, 1st place
Truman Milling, 2nd place
Christopher Lee.





"BCEM" Physicians Argue Emergency Medicine Residency Training is Unnecessary"

by Mark Reiter MD MBA

Recently, non-residency trained, non-ABEM/ABOEM-certified physicians have been appearing before boards of medicine and legislatures in various states in an attempt to equate BCEM ("Board Certification in EM") as equal to ABEM/ABOEM (American Board of EM / American Board of Osteopathic EM) certification. BCEM was created as a backdoor route for physicians ineligible to become ABEM/ABOEM-certified, because they had not completed EM residency or could not pass the ABEM written or oral boards. BCEM does not require an EM residency, rather it requires practice experience, as well as submitting case reports and passing a written test. ABEM/ABOEM-certification requires EM residency training, along with written and oral boards and continuous certification exams, and is part of the American Board of Medical Specialties (ABMS). ABMS is the umbrella body sponsored by the AMA, AHA, AAMC, etc. that all specialty-specific boards are members. BCEM is sponsored by the American Association of Physician Specialists (AAPS), which is a small organization that has similar backdoor paths for other specialties, but is predominated by BCEM members.

In the 1970s and 1980s when the specialty of EM was in its infancy, there were few EM programs and limited number of trained EM faculty. The practice track was necessary at that time. Progress in EM, as with any other specialty, demands rising standards that evolve into formal training being the only legitimate route to certification. By the time ABEM closed the practice track in 1988 (after giving several years notice), there were enough excellent training programs that a practice track no longer made sense for our evolving specialty. The ABEM practice track has been closed for 17 years and needs to stay closed; it's hard to believe this is still

an issue. It's ludicrous to believe that my colleagues in surgery, cardiology, OB/GYN, etc. would ever agree that I should be considered for board certification in their specialty by virtue of completing an EM residency and then obtaining practice experience and a completing a test in their specialty.

As an EM resident, I find it incredibly insulting that this group of physicians advocates that EM residency training is unnecessary for non-ABEM/ABOEM-certified physicians. I consider this to be a slap in the face to the approximately 4000 EM residents and fellows currently training. I'm past the midpoint of my residency, and I realize that there is still much for me to learn before I can provide my patients with the optimal care they deserve. Learning medicine is a lifelong process, and I feel that I would be doing my patients a disservice if I did not take advantage of these three years of training under the guidance of ABEM/ABOEM-certified emergency physicians. I've had the opportunity to run many medical and trauma resuscitations and made my fair share of difficult diagnoses, but I'm acutely aware of how much I still have to learn. I've performed plenty of intubations, central lines, chest tubes, orthopedic reductions, ultrasound exams, etc., but still become more proficient with each one and occasionally run into trouble.

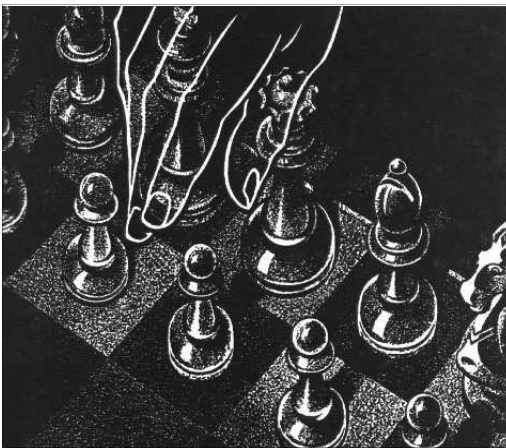
I take particular offense to those physicians with "BCEM certification" who feel that unsupervised practice experience is equivalent to an EM residency. Non-EM residency experience simply doesn't cut it; there are too many gaps in training. Most Family Practice residents have minimal critical care, surgical, trauma, and procedural experience. Surgery residents have limited

continued on pg 19

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Emergency Medicine Liability and Tort Reform

by David Smith, MD FAAEM

Much of the attention of our organization continues to be the issue of medical liability. Fortunately there is some good news to report regarding this generally unpleasant issue. The Physician Insurers Association of America has released pooled claims data from more than 40 member companies. The following table shows a comparative claim analysis from 1985 to 2003, for those specialties with average indemnity (average payout per doctor) over \$200,000. Emergency medicine also listed is fortunately not in that group but still generates significant losses as a specialty.

Obstetric and gynecologic surgery	\$254,033
Pediatrics	\$246,668
Cardiovascular and thoracic surgery	\$201,205
Neurosurgery	\$286,481
Cardiovascular diseases (non-surgical)	\$236,915
Neurology (non-surgical)	\$289,513
Radiation therapy	\$231,929
Pathology	\$228,159
Emergency medicine	\$168,567

Most prevalent patient conditions in this report for the specialty of emergency medicine are acute myocardial infarction, appendicitis and undefined chest pain. Apparent from the data is the fact that the misdiagnosis of acute myocardial infarction continues to be most troublesome for emergency physicians. These should be viewed as comparative data and not necessarily as accurate for the actual costs to practice an individual specialty.

Although negligence and poor decision making are significant contributors to the high rates of liability insurance, other significant issues also exist. Regional differences in Texas are dramatic with the Rio Grande Valley, and some counties in east Texas are significant problem areas.

Unfortunately, simply being in the wrong place at the wrong time is often the problem. It has been demonstrated that the initiation of malpractice suits correlate poorly with the occurrence of adverse events and that the severity of the patient's disability, not the occurrence of an adverse event or an adverse event due to negligence, is predictive of payment to the plaintiff⁽¹⁾. Many cases that do not have merit are settled with payments to the plaintiff because the defendant makes a poor witness or the plaintiff is severely disabled. Sometimes cases are settled because the reinsurance company has gone bankrupt and the primary insurer does not wish to incur the risk of loss beyond its resources. Thus there is significant risk even to competent practicing physicians and attention to the liability climate is important. Fortunately as a result of strong tort reform legislation in Texas, the liability crisis has been significantly impacted.

The Texas Medical Liability Trust (TMLT) is the largest writer of medical malpractice insurance in Texas. After the liability caps became effective, TMLT reduced its medical malpractice rates by 12 percent effective January 1, 2004. Rates were reduced further effective January 1, 2005. Since liability limits were imposed 15 new companies have emerged and four companies have expanded or plan to expand upon their current medical malpractice writing in the state, according to the Texas Department of Insurance. The success of tort reform in Texas demonstrates how important it is that we as physicians remain active and involved in the political process to protect both our livelihood and access to medical care.

1. Brennan, Troyen, Colin Sox, and Helen Burstin. 1996. "Relation between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation." *New England Journal of Medicine*, 335 (26): 1963-7.

AAEM and the AMA

by Joseph Wood, MD JD FAAEM

What is AAEM's relationship with the American Medical Association (AMA)? Despite a steady decline of membership, the AMA is still the largest and most powerful organization in medicine. It is not only a powerful Washington lobby, but AMA policies are still influencing reimbursement practices and physician credentialing. For instance, it was an AMA resolution, which supported the position of emergency medicine that diagnostic ultrasound is not under the exclusive domain of radiology. Almost no legislation concerning health care is passed in Congress without the AMA first weighing in. Additionally, the AMA has a significant staff which can provide assistance in litigation of importance to physicians. When AAEM filed its lawsuit against Team Health, we met with the AMA President seeking support if the litigation went the distance (this case was subsequently settled to the satisfaction of AAEM and the involved emergency physicians).

Like any large organization, the AMA has its own political structure. AAEM has been admitted to the AMA in the Specialty and Services Section. This is essentially a section made up of the various Specialty Societies. We will eventually be given a voting seat in the House of Delegates if, during our initial probationary period, we meet certain criteria. One important criteria is demonstrating that 35 percent of our members are also AMA members. You can assist by letting the AMA know you want to be counted as an AAEM member. If you are not an AMA member, you may wish to consider joining.

The AMA held its interim meeting in Atlanta, the first week in December. The House of Delegates debated and considered a

number of resolutions. However, I believe our greatest opportunity for impact starts with the Emergency Medicine Section. Not surprisingly, this section is dominated by ACEP Past-Presidents. To their credit, these physician delegates have been extraordinarily diligent in working within the AMA for the benefit of emergency physicians. Emergency physician delegates are well organized and have worked their way into various leadership positions within the AMA structure. It is likely we will see an emergency physician on the AMA Board of Trustees within the next two years.

These are important accomplishments if emergency medicine is going to have an impact on legislation and reimbursement. In short, if we want to impact AMA policy and National legislation, we'll need to work effectively with our colleagues who are already in the arena. Fortunately, I believe most of the physician delegates in the Emergency Medicine Section are open to pushing for resolutions and AMA Lobbying for legislation, which would support the traditional ban of the Corporate Practice of Medicine by non-physicians. They are also open to pushing resolutions, which promote fairness in the workplace. The Emergency Medicine Section is well organized and has initiated a caucus of hospital-based physicians. As the AAEM representative to the AMA, I will push the principles and values of our Academy by influencing the resolutions which will be initiated and supported by the Emergency Medicine Section. Please send me a note or email if you have an issue you'd like to see addressed by the AMA.

Joseph Wood is the Immediate Past President of AAEM and can be reached at jwood@aaem.org. 

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 email: andrea@emergencygroupsoffice.com

Upcoming AAEM-Endorsed or AAEM-Sponsored Conferences for 2005

April 7-8, 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.
 16 hours CME credit provided.
<http://www.aaem.org>

April 7-9, 2005

- The First Conference of the Lebanese Society of Emergency Medicine
 Beirut, Lebanon
 Sponsored by the Lebanese Society of Emergency Medicine
http://www.infomedweb.com/ourevents/emergency_medicine2005.htm

April 9-10, 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>

May 5-6, 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>

May 20, 2005

- The 2nd Annual New York Symposium on International Emergency Medicine
 Co-sponsored by The North Shore-LIJ Health System, NYU-Belleuve Emergency Services and NY ACEP
 New York, NY
www.nyacep.org

June 2-3, 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>

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>

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 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>

A few months ago, I received a submission for publication in Common Sense that advocated a single-payer system for health insurance. It was unsolicited, but the board members who forwarded it to me felt it was a good candidate for publication. The problem became how to balance it? After discussion, it was decided to have a point-counterpoint debate. E-mails were sent to the membership seeking counterpoint submissions. The counterpoint article published here came as a result of that call for submissions. Since the time of the call for submissions, I learned that the "point" article was originally published in the California-AAEM newsletter. E-mail requests to its editor asking for permission to publish it failed to get a response, but I decided to publish it anyway. I thank Cal-AAEM in advance. I would also like to thank those authors of other counterpoints that were not chosen for publication for their fine efforts. -Howard Blumstein

AAEM Point/Counterpoint: Single Payer, National Health Insurance

POINT

by Ken Weinberg, MD FAAEM

More than 43,000,000 people in the United States are without health insurance, and the numbers are projected to grow even greater. As emergency physicians across the country, we have special insight into the problems of the American health care system. We experience first hand the immediate effects of this mounting lack of insurance. We play the costly role of primary care providers for uninsured patients having no regular source of medical care. We work under dangerously overcrowded conditions, as increasing numbers of uninsured patients come to us at the primary care site of last resort. The emergency room is no substitute for ongoing comprehensive care that so many of our patients are denied. We also see, more clearly than anyone else, that emergency care for the acutely ill and injured is threatened by the growing numbers of uninsured who are forced to use emergency facilities, in the absence of any alternative.

HEALTH CARE IN AMERICA IS SICK:

There are more than 43.6 million Americans, many of them young children, who are uninsured for the full twelve months of the year. Substantially more, according to one study more than 80,000,000—one out of three of those under the age of 65—have no insurance for a portion of the year, and two-thirds were uninsured for six months or more.

Almost everyone is insecurely insured, afraid of losing their jobs and, as a consequence, losing their health benefits as well. Many are "locked" into their jobs simply to hold onto their health benefits, when they might be employed more productively and happily elsewhere.

Those who are insured are covered through a confusing mélange of HMO's, PPO's, Medicaid and Medicare, each with different rules and regulations. Physicians waste precious time and money dealing with these complex and intrusive financing mechanisms.

Insurance company bureaucrats tell patients and physicians what specialists they may see, what treatments they may undertake, and what drugs they may use. Those of us who have spent years in specialty training should not be questioned about our professional decisions by number crunchers motivated by the need to maximize insurance company profits.

Administrative costs in the private, for-profit insurance system range from 15-30 per cent to cover their marketing expenses, unnecessary administrative procedures, excessive CEO salaries, and profits. They increase our costs as well, as we are confronted with a myriad of conflicting rules and hundreds of insurance forms. In contrast, Medicare, the government-run insurance system for the elderly, offers patients their choice of doctor and hospital and has administrative costs of fewer than 3 per cent!

Finally, we have a climate where the financial constraints of the new "managed care" cause patients to feel that they can no longer trust their physician to put their interest first, and now all physicians feel the need to practice defensive medicine, causing them to over-order tests and procedures.

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COUNTERPOINT


by Ann Loudermilk, MD FAAEM FACEP

Solving the problems of health care won't be easy. But let us make sure the cure is not worse than the disease. As implied in advocating for "evidence based medicine", we should be promoting "*evidence based social policy*" as well. There is plenty of historical evidence that cast doubt on the desirability of a single payer (socialized) system. Who do you suppose will be the single payer? The very people who complain about the low payments and complicated documentation of Medicaid/Medicare are pushing for an expansion of the same system expecting it to be different. It will only be worse because there will be NO competition to encourage improvement.

We should view medicine as a necessity like food, water, clothing, etc. We all work to provide these things for our families. What happens when we "socialize" those necessities? They become complicated, mediocre, and unaccountable. I was in England many years ago on a preceptorship and saw first hand the poorer quality of socialized medicine and the energy and money spent by consumers to find better care. And can anyone deny the inefficiencies in government run systems? So one not only pays taxes to support an inefficient system but also spends their own money to get a better product. Take education. My lower middle class parents paid extra to send me to a Catholic school because they saw the value of a good education. I am not saying the intention is not noble, but we must find the best solution, not just what *seems* to be the easiest.

Do we spend too much on our Medical system in the USA? Apparently not, because many people are spending billions on health food supplements, vitamins, alternative care, etc out of their own pockets. The problem is not money available; it is how it is spent. There is plenty of money in the system, as we all know. But when you separate the payer from the provider of a service, there is no incentive for cost/quality control. The government and insurance companies have assumed the control and given us many "unfunded mandates" including wasteful paperwork and a bloated ineffectual regulatory system. To compare evidence, look at the food industry. There is no socialization of this basic need, but we provide for those of us unable to provide for themselves. As my foreign friend says, "I want to go to a country where the poor people are fat".

It won't be easy to change this behemoth of a system but I believe we must return to the philosophy of patient centered care/control. We have to change the attitude that medical care is an entitlement. As tedious as it might be to provide/purchase ones own medical care, it will be better than having the government or ones employer do it. Let's not be so patronizing. If people are able to raise kids, buy cars, and provide for their families, they can figure out how to provide for their health. It won't all be perfect but it will beat having some bureaucracy control your medical care.

We have many historical examples on how to successfully deal with social issues without socializing a whole system. So let us use the evidence, not well intentioned emotional rhetoric, to guide our reform of a mostly successful health care system. 

OIG Guidance on Malpractice Subsidies

To AAEM members,

The HHS Office of Inspector General posted on 1/27 the final Supplemental Compliance Program Guidance for Hospitals on its website. The voluntary Supplemental Compliance Program Guidance for Hospitals outlines actions they can take to promote compliance with the rules and regulations of doing business with the Medicare, Medicaid and other Federal health care programs.

The full document is available at www.oig.hhs.gov/fraud/docs/complianceguidance012705HospSupplementalGuidance.pdf.


The section below, beginning on page 46 of this document, deals with hospital provision of malpractice subsidies and may be of interest to EM physicians.

g. Malpractice Insurance Subsidies

The OIG historically has been concerned that a hospital's subsidy of malpractice insurance premiums for potential referral sources, including hospital medical staff, may be suspect under the anti-kickback statute, because the payments may be used to influence referrals. The OIG has established a safe harbor for medical malpractice premium subsidies provided to obstetrical care practitioners in health professional shortage areas.(61) Depending on the circumstances, premium support may also be structured to fit in other safe harbors.

We are aware of the current disruption (i.e., dramatic premium increases, insurers' withdrawals from certain markets, and/or sudden termination of coverage based upon factors other than the physicians' claims history) in the medical malpractice liability insurance markets in some geographic areas.(62) Notwithstanding, hospitals should review malpractice insurance subsidy arrangements closely to ensure that there is no improper inducement to referral sources. Relevant factors include, without limitation:

- whether the subsidy is being provided on an interim basis (e.g., until an unrelated insurer is commercially available) for a reasonable fixed period in a geographic area experiencing severe access or affordability problems;
- whether the subsidy is being offered only to current active medical staff (or physicians new to the locality or in practice less than a year, i.e., physicians with no or few established patients);
- whether the criteria for receiving a subsidy is unrelated to the volume or value of referrals or other business generated by the subsidized physician or his practice;
- whether physicians receiving subsidies are paying at least as much as they currently pay for malpractice insurance (i.e., are windfalls to physicians avoided);
- whether physicians are required to perform services or relinquish rights, which have a value equal to the fair market value of the insurance assistance; and
- whether the insurance is available regardless of the location at which the physician provides services, including, but not limited to, other hospitals.

No one of these factors is determinative, and this list is illustrative, not exhaustive, of potential considerations in connection with the provision of malpractice insurance subsidies. Parties contemplating malpractice subsidy programs that do not fit into one of the safe harbors may want to consider obtaining an advisory opinion. Parties should also be mindful that these subsidy arrangements also implicate the Stark law. 

References:

61. See 42 CFR 1001.952(o).

62. See the OIG's letter on a hospital corporation's medical malpractice insurance assistance program, available on our webpage at www.oig.hhs.gov/fraud/docs/alertsandbulletins/MalpracticeProgram.pdf.

Open Books

Contacting Your Medicare Carrier

AAEM members will note that the recent issuance of the final rule for the Medicare Modernization Act included the provision for physicians to have "unrestricted access to billings submitted in their name." CMS stated that this was an important program integrity safeguard that they intended to monitor. If you have reassigned your Medicare payments to a contract group and have been denied "unrestricted access" to this information you should contact your Medicare carrier. Unrestricted should mean just that and we believe that barriers to obtaining this information such as the need to travel to corporate headquarters does not meet the definition. You can find your carrier by accessing the following link: www.cms.hhs.gov/medlearn/tollnums.asp

AAEM asks that you copy us in on any communications you have regarding this matter so that we may monitor the issue or if you prefer we can make the contact with CMS for you.

Prescription Assistance for Low Income Patients

In January this year, a conglomerate of pharmaceutical companies initiated a private discount prescription drug card available to non-Medicare low-income patients. To be eligible for the card, a single patient must earn under \$30,000 annually (\$60,000 for families). Patients using the card get discounts of around 20-40% on major drugs (Lipitor, birth control pills, diabetic meds, and the like). Participating companies include Abbott, Bristol, Glaxo, Johnson & Johnson, and Pfizer.

Patients can enroll on-line at the link <http://www.TogetherRxAccess.com>. Enrollment is simple and does not require anything more than filling in the on-line forms.



MedPAC Recommends 2006 Increase for Physicians

by Kathleen Ream, Director of Government Affairs

In a move estimated to cost \$1.5 billion over one year, on January 12, 2005, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress increase physician Medicare reimbursements by 2.7 percent in 2006.

The change would cost \$5 to \$10 billion over five years, taking into account expected Medicare physician pay reductions forecast for 2006-2012, under the sustainable growth rate formula (SGR). Cristina Boccuti, a MedPAC staff analyst, told the commissioners that any positive update would score as a large spending increase. The 2.7 percent hike, which will be in the commissioners' March report to Congress, would maintain beneficiaries' access to physicians.

Despite the recommendation, the annual physician update is controlled by the SGR, an annual target intended to control the growth in expenditures for physicians' services. Under the formula, when spending for physician services exceeds the SGR, payments must be reduced to compensate for the extra spending. Unless Congress intervenes this year, physicians will receive an approximate five percent reduction in reimbursements in 2006.

During the same session, the commissioners approved six recommendations intended to encourage more appropriate use of physician services and improve quality of care. Two of the recommendations dealt with the "Stark" law that prohibits physicians from referring Medicare/Medicaid patients for certain services to providers with which the physicians have financial relationships. However, facilities that offer nuclear medicine, including PET scans, are not included.

MedPAC staff focused on the rapidly growing volume of imaging services as part of a broader measurement initiative. Studies have shown that more imaging is not associated with improved survival in patients with heart attack, colon cancer, and hip fracture.

Of particular interest to AAEM members, the commissioners recommended that Congress direct the Secretary of Health and Human Services to use Medicare claims data to measure fee-for-service physician resource use and share the results with physicians confidentially to educate them about how they compare with aggregated peer performance. MedPAC believes that physician education through profiling will result in decreased utilization of imaging services over time.

Emergency physicians performing ultrasounds in the ED may be affected by another recommendation. The commissioners also recommended that Congress direct the Secretary to set standards for all providers who bill Medicare for performing diagnostic imaging services. While the committee did not dictate the content of such standards, the discussion focused on equipment, credentials of non-physician staff such as technicians, image quality, supervising physicians, and patient safety.

Recommendations also addressed standards for physicians who bill Medicare for interpreting diagnostic imaging studies. These standards are likely to address physician training, education, and experience. Commissioners did express support for standard setting by specialty certification boards.

Clarification was provided by MedPAC staff on teleradiology – the practice of some facilities (specifically EDs) to transmit radiologic images on off hours to a remote site (frequently overseas) for a "wet reading." They reiterated that reimbursement from Medicare for these services was applicable only to approved Medicare providers for services that are provided within the US. More information on the January meeting including transcripts of the presentations is available at www.medpac.gov.

SCREENING EFFORTS CAN REDUCE HOSPITAL COSTS

A new study examining emergency department patients with addictions find screening efforts can result in increased savings to hospitals. In the study, Dr. Larry Gentilello, professor of surgery at the University of Texas Southwestern Medical Center, concludes that, "Alcohol is by far the leading risk factor for injuries. Patients are most likely to consider changing a harmful behavior when that behavior has caused a crisis or a severe problem in their life. It appears that an injury makes patients with an alcohol problem much more responsive to counseling. If brief interventions were offered routinely to these patients nationwide, the annual net savings to hospitals and insurers could be up to \$1.82 billion."

Cost savings included avoiding the expense of repeat injuries caused by alcohol, the leading cause of injury; Gentilello estimated that hospitals save \$3.81 for every dollar spent on brief counseling of ER patients. The study results will appear in the April 2005 issue of *Annals of Surgery*.

Many U.S. hospitals do not screen patients for alcohol use because a 1947 law, the Uniform Accident and Sickness Policy Provision Law (UPPL), allows insurers to deny payment for treatment of alcohol-related injuries. The UPPL was promulgated when treatment for alcohol problems was generally not available, and regional trauma centers did not exist. It is still on the books in 36 states and the District of Columbia. Six states, however, have recently repealed this law.

OSHA BEST PRACTICES RELEASED

OSHA Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances is designed to provide hospitals with practical information to assist them in developing and implementing emergency management plans that address the protection of hospital-based emergency department personnel during the receipt of contaminated victims from mass casualty incidents occurring at locations other than the hospital. The document focuses on suggestions for appropriate training and suitable personal protective equipment for healthcare employees who may be exposed to hazardous substances when they treat victims of mass casualties. It also includes several informational appendices with practical examples of decontamination procedures and medical monitoring for first receivers who respond to a mass casualty incident.

The OSHA document can be found at www.osha.gov/dts/osta/bestpractices/firstreceivers_hospital.html.

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AAEM's GOVERNMENT RELATIONS RESOURCES

Advocacy is more than just understanding the issues. To make a difference, you have to make your voice heard. The involvement of individual emergency medicine physicians is vital to the success of AAEM's grassroots efforts. To assist you in your government relations activities, AAEM provides the following services and information:

- **AAEM E-Mail Alerts**

AAEM E-Mail Alerts provide strategic information to affect key policy issues of concern to emergency medicine. If you would like to receive future Alerts, send a note to aaemgov@aol.com or sign up directly from the homepage of AAEM's Legislative Action Center accessible at <http://capwiz.com/aaem/home>.

- **Legislative Action Center**

The Legislative Action Center located on AAEM's Web site www.aaem.org is "one-stop" shopping for federal legislative and regulatory information. It contains the important issues that AAEM is tracking for you, recent votes, current bills, and other relevant items. You can search the congressional database by name, state, committee, or leadership, and send messages to your congressional delegation directly from the site.

- Additional features include:

"Sponsor Track" which attaches information on relevant bill sponsorship on Members' bio pages; A "Vote Scorecard" listing every Member of Congress and how they voted on bills of interest to AAEM; "Megavote" provides you with a weekly e-mail on the voting patterns of your Representative and Senators; A searchable "Guide on National and Local Media" including newspapers, magazines, and TV networks and stations; users can send e-mails, faxes or printed letters to newspaper journalists, radio talk show hosts, and television commentators; and detailed "Campaign Contribution Data".

- **Washington Sentinel**

The *Washington Sentinel* – AAEM's monthly newsletter on legislative and regulatory issues of concern to emergency medicine. You can receive the *Washington Sentinel* as a downloadable PDF document by sending an e-mail note to aaemgov@aol.com.

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As a result of this, health care costs in the US consume close to 15% of our GDP, as compared to 7-10% in countries in most of the rest of the world, the majority of which have national, universal health care. Moreover, we rank among the lowest of the industrialized countries in measures such as infant mortality, infant birth weight, and longevity and patient satisfaction.

I am an advocate for single-payer national health insurance, universal health care that would cover everyone. This is the only way to address the systemic problems of health care in the United States. Health care should be a right not dependent on financial status or the vagaries of employment, particularly in an economy that creates fewer and fewer long-term jobs with decent benefits.

Everyone should have access to a regular source of care so they will only show up in emergency rooms when there is a true emergency. As physicians in the richest, most powerful nation in the world, we are troubled by the fact that vast segments of our population cannot afford the health care they need and are unable to pay for their prescription drugs. What is our response to seeing so many patients who have put off treatment until they are forced to head to the nearest emergency room? And how do we feel when we find that medical bills are the cause of half of all bankruptcy cases in this country?

In a time when tort reform has become the rallying cry in the battle over onerous malpractice fees, we should adopt a plan that will put physicians and patients back on the same side, where the high costs of settlements would be slashed because the costs of long-term care responsible for so much of those high settlements would be included in the budget for coverage that all of us would have?

The savings from switching to a single payer, Expanded and Improved Medicare for All system would pay for healthcare and prescription drug coverage for everyone. As AAEM has taken the lead in espousing democratic principles within our specialty, so should we take the lead in espousing proper healthcare coverage for all in our society. 🇺🇸

BCEM - continued from pg 13

medical, pediatric, and OB/GYN experience. Internal Medicine residents have minimal surgical, trauma, pediatric, orthopedic, and OB/GYN experience, and so on. These residents have limited exposure to the breadth of patients seen in the ED, managing patient flow, and performing many ED procedures such as LPs, vaginal deliveries, procedural sedation, etc.

Many non-residency trained BCEM physicians are likely outstanding doctors, and some may be better than many of their residency trained ABEM/ABOEM-certified colleagues. However, at the end of the day, we should be doing what is in the best interest of our patients. It takes supervised experience to become a good emergency physician. It is not fair to patients when unsupervised physicians "learn on the job." I'd imagine many BCEM physicians performed their first (or second or third) chest tube, vaginal delivery, difficult airway, etc. without supervision. This has the potential for disastrous outcomes. How do you fix mistakes when you don't know what you did wrong?

AAEM and AAEM/RES are taking a strong stand on this issue. As the only EM specialty society requiring ABEM/ABOEM-certification for full membership, this issue related to one of the core parts of our mission statement. In addition, we are reaching out to other organizations such as ACEP, EMRA, CORD, SAEM, AACEM, for their help. We are prepared to represent our membership in each state where this issue arises. As we take this battle to individual states where BCEM physicians bring this issue forward, we will need our local members to assist us in representing our case. Please keep informed through AAEM's communications to you, and we hope you will offer to participate if and when we come to your state.

Mark Reiter MD MBA

EM-2, University of North Carolina

Vice President, AAEM Resident Section

EMPAC

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"

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EMPAC RRG is dedicated to a stable and affordable solution to the professional liability problems facing the practicing emergency medicine physician. EMPAC RRG is committed to the highest quality of patient safety in our emergency departments. We at EMPAC RRG recognize that ABEM and AOBEM certification and residency training accompanied by state of the art risk management technology is the cornerstone to the mission.

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- Entity and Physician Extenders Share a Single Limit
of Liability with the Insured Physician Involved in a
Claim or Suit
- Coverage Provided for Service on Professional
Association Committees

Contact EMPAC Managers for more information:

Contact EMPAC Managers by phone toll free at 888.898.9560
or online at www.EMPACmanagers.com
Emergency Medicine Professional Assurance Company
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To respond to a particular ad: AAEM members should send their CV to the AAEM office noting the response code listed at the end of the position description in a cover letter. AAEM will then forward your CV to the appropriate professional.

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

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

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

ARIZONA

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

CALIFORNIA

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

CALIFORNIA

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

CALIFORNIA

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

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

CALIFORNIA

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

FLORIDA

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

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

FLORIDA

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

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

FLORIDA

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

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 a long-term practice situation. (PA 621)

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

INDIANA

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

KANSAS

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)

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 1/2-3 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 E.D. with its own emergency medicine residency program, involvement in resident lectures, teaching skills labs, and attending conferences and journal clubs is available without having to live or work in the city. Partnership and profit sharing based on number of hours worked and achievable within 18 months. (PA 652)

MINNESOTA

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)

AAEM JOB BANK

MISSISSIPPI

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

MISSOURI

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

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

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. Comprehensive benefit package includes: Full family benefits, paid mal-practice 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)

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MISSOURI

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

NEW HAMPSHIRE

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

NEW HAMPSHIRE

Democratically governed New Hampshire EM group serving 30,000 patient population seeks 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 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. Competitive Salary. (PA 665)

NEW YORK

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

NEW YORK

Director, Pediatric Emergency Medicine

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

OHIO

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

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

PENNSYLVANIA

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

PENNSYLVANIA

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

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

PENNSYLVANIA

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

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PENNSYLVANIA

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

SOUTH CAROLINA

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

TEXAS

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

TEXAS

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

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)

AAEM JOB BANK

WASHINGTON

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

See www.HarrisonHospital.org (PA 659)

WEST VIRGINIA

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

WEST VIRGINIA

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

WISCONSIN

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

WISCONSIN

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

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

Wausau: Premier ED group recruiting BC/BE Emergency physician to replace our retiring founder. Single hospital, FFS. Democratic group with equal distribution of shifts. Outstanding community, outdoor activities and schools. Partnership after one year, comprehensive benefit package with compensation approaching \$300K for 1500hrs/year. (PA 685)

GUAM

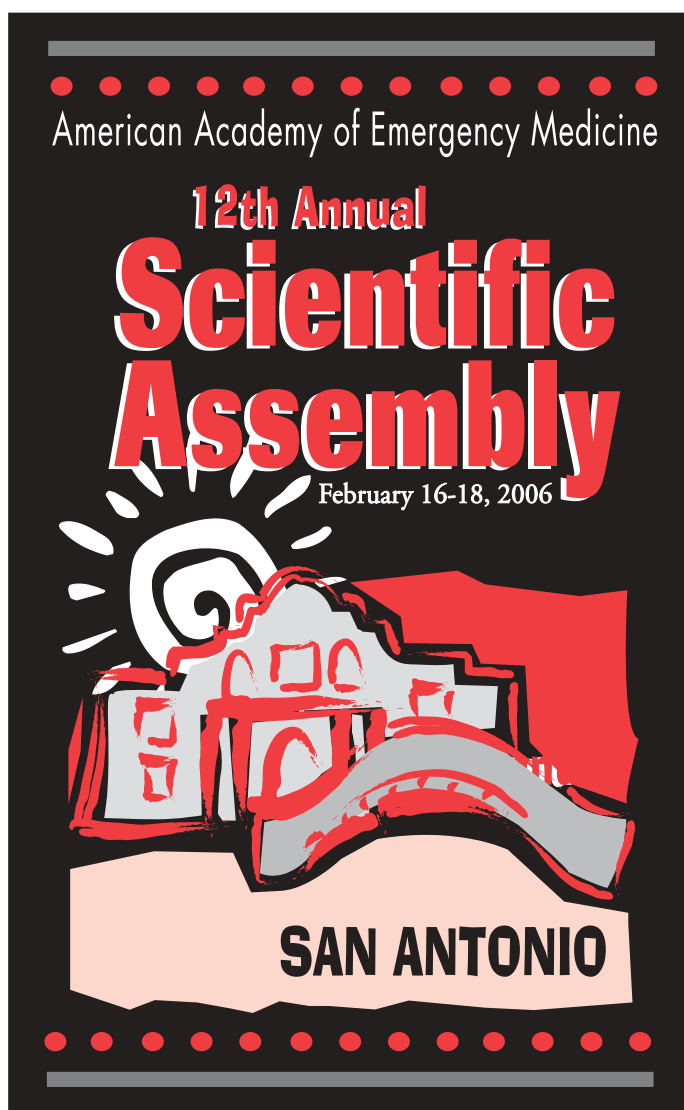
PT EM physicians (flexible scheduling) for Guam Memorial Hospital (GMH) located in the Western Pacific on the island of Guam (US Territory). Guam has world class golfing, diving, hiking, and there are regular direct flights to most of the Pacific Rim, Hawaii, Japan and Australia. The applicant must have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

NEW ZEALAND

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

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.



American Academy of Emergency Medicine

12th Annual Scientific Assembly

February 16-18, 2006

SAN ANTONIO

The poster features a stylized illustration of a city skyline with a large, prominent building, likely the convention venue, set against a dark background with a red and white color scheme. The text is bold and clear, with the event name in large, red, outlined letters.

AAEM MEMBERSHIP APPLICATION

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- 1) Have you completed or are you enrolled in an accredited residency in Emergency Medicine? ☐ Yes ☐ No
If yes, program: _____ If completed, date: _____
If not completed, expected date of completion: _____

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

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



Full Voting and Associate Membership dues are for the period January 1st thru December 31st of the year the dues are received. Applicants who are board certified by ABEM or AOBEM in EM or Pediatric EM are only eligible for Full Voting Membership. Resident and Student Membership dues are for the period July 1st thru June 30th of the period the dues are received. All memberships except free student membership include a subscription to *The Journal of Emergency Medicine (JEM)*.

MEMBERSHIP FEES

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

☐ Associate Membership (non-voting status) (*Tax deductible only up to \$205.00*) \$225.00

** Limited to graduates of an ACGME or AOA approved Emergency Medicine Training Program.*

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

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

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

PAYMENT INFORMATION

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

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Return this form with payment to: American Academy of Emergency Medicine, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202
All applications for membership are subject to review and approval by the AAEM Board of Directors.



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.

To donate to the AAEM Foundation, please complete the form below and return it to:
AAEM, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202-3823

or make an online donation at:

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