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when minutes count

common SENSE

The Newsletter of the American Academy of Emergency Medicine — Volume 13, Issue 2— March/April 2006

PRESIDENT'S MESSAGE

by Tom Scaletta, MD FAAEM

Integrity without knowledge is weak and useless, and knowledge without integrity is dangerous and dreadful.
- Samuel Johnson (1709-1784)

This is my first President's Message and I would like to begin by expressing my gratitude to the founders of AAEM for their foresight in appreciating the need for organizational redesign in emergency medicine. I also wish to acknowledge the growing number of emergency physicians demonstrating the courage and commitment necessary to establish and thrive in equitable groups. Finally, I am pleased to hear that even some of the large national and regional contract groups are evolving to meet AAEM's published criteria defining workplace fairness. AAEM certainly has made the practice of emergency medicine better for many physicians and I am honored to serve as its president.

My commitment to AAEM was galvanized in the mid 1990's after I was threatened with a defamation lawsuit for exposing a local program director who financially exploited his residents by pressuring them to cover night shifts in his contracted EDs. I soon found that AAEM was the only professional organization willing to assist in my defense. Upon asking for help, then President Bob McNamara, reassuringly stated, "of course Tom, that's what AAEM is all about." Now, a decade later, AAEM remains steadfast in protecting the interests of board certified emergency physicians.

AAEM's growth remains strong and steady and there are fivefold more members than when I first joined. Most new members sign up after they learn about our bold actions to protect the rights of physicians against abusive corporations. In fact, the AAEM Foundation, a non-profit subsisting on donations, was recently established to facilitate such campaigns. Each year, AAEM becomes more powerful and far-reaching in accomplishing its mission and promoting its principles.

AAEM's values fall into three main categories. First, the community deserves access to physicians certified by ABEM, AOBEM, or the RCPS (Canada). Surprisingly, it continues into the new millennium that we must monitor state medical boards to protect our patients against wannabes. Second, AAEM is deeply concerned about the welfare of emergency physicians because fair practice environments foster high quality patient care. And third, AAEM promotes outstanding resident and graduate education. In each of these areas, AAEM is a successful advocate for its members.

AAEM Services, our management education subsidiary, links EPs to consultants that help them develop independent, fair practices. We offer a seminar called "The Business of Emergency Medicine Made Easy" in conjunction with our Scientific Assembly. Please remember that help from AAEM is only an email away at info@AAEM.org. We are always happy to link emergency physicians to all the tools and guidance they need to start-up and run successful practices.

AAEM is trying to encourage hospital CEOs to contract only with groups that emergency physicians prefer and to explain what that entails. Below is an example of a letter we have sent to encourage hospital administrators to seek an AAEM compliant group should a request for proposal (RFP) from various ED groups be initiated. Please let us know to whom you would like the next one addressed.

Dear Hospital CEO,

The American Academy of Emergency Medicine is a national professional society representing approximately 5,000 specialists in emergency medicine. Through one of our members, our executive board became aware that your hospital recently issued a RFP from various emergency medicine staffing groups. AAEM believes that emergency physicians working in a fair and supportive practice structure best serve the community, the hospital and its medical staff.

AAEM has serious concerns about the corporate ownership of an emergency department contract. In such practices, the physician is an agent of the group rather than an owner with a vested interest in top performance. Of greater concern is that these arrangements may violate state laws prohibiting the corporate practice of medicine, thereby placing the physician's licensure at risk. The American Medical Association has recently taken action to rein in the corporate practice of medicine and AAEM itself has recently been involved with legal challenges regarding the corporate practice of medicine. Recent dealings with such corporations include TeamHealth in California and EmCare in Minnesota. We also participated in a successful action related to the corporate practice of emergency medicine in California involving Catholic Healthcare West. We would be happy to provide you with documents related to these matters.

AAEM is also concerned that such corporate employment arrangements may involve prohibited fee-splitting activities under current state and federal statutes. We therefore caution our members about accepting employment with corporate groups and suggest that hospitals examine such an arrangement with due diligence. AAEM believes that emergency physicians must remain free of the profit concerns of a corporation in order to serve in the best interest of the patients.

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President's Message- continued from pg 1

The Academy has delineated structural criteria for emergency physician groups as described in the attached Certificate of Compliance document on "Fairness in the Workplace." We suggest that the attached document be used in your evaluation process of any responses to the RFP. In it, AAEM defines the boundaries within which independent groups should practice in order to be considered truly fair.

AAEM is willing to assist you in securing a fair, physician-owned group or in guiding your current physicians into a physician partnership. Thank you for your time and attention to this important matter.

During my tenure as AAEM President, I would like to see alignment of emergency physicians and nurses, hospital administrators, community leaders, healthcare agencies and professional organizations toward a unified definition of emergency care excellence. The recipe for success includes simple ingredients like qualified, adequately staffed physicians and nurses that appreciate their work environment and desire to make a long-term commitment to the hospital and community. The real challenge in achieving this goal is to develop a meaningful and extrapolatable evaluation methodology. Consequently, such a tool will motivate hospital decision makers to put key values, like those AAEM embraces, into practice. If you too are interested in working on this project, please let me know, at president@aaem.org.

AAEM Mission Statement

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

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

Membership Information

Fellow and Full Voting Member: $345 (Must be ABEM or AOBEM certified in EM or Pediatric EM)
Emeritus Member: $250 (Must be 65 years old and a full voting member in good standing for 3 years)
International Member: $125
* Associate Member: $250 (Non-voting status)
AAEM/RSA Member: $50 (Non-voting status)
Student Member: $50 (Non-voting status)

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

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

EDITOR'S LETTER

by Howard Blumstein, MD FAAEM

The "Remarkable Testimony" website is finally up and running. It has been a long time in coming. The purpose of the site is to "…make known to the emergency medicine community those physicians whose testimony in malpractice actions is remarkable for any reason." This column will describe its genesis and the response it has already generated.

The website was created at the suggestion of some members of the board of directors. Members had made clear that malpractice was one of their most important issues. They wanted AAEM to address it in a meaningful way. But how? AAEM is small as medical societies go. We don't pack the punch of the AMA or other really big organizations. So we needed to think outside the box to find a way we can make an impact. The idea was to create a website that would educate our members about some of the testimony being given in legal cases. We had long discussions regarding the content and format of the website. We agreed that we wanted to highlight both good and bad testimony. We agreed to give those physicians whose testimony was featured the opportunity to respond. We agreed that we wanted to post a complete record of the testimony given, rather than just highlights that could look as if they were taken out of context.

A call for such testimony went out by e-mail and via an article in *Common Sense*. Approximately eight examples of testimony were submitted. In screening these cases I was looking for something that jumped out at me. Something that would make my jaw drop. Something that would get the attention of our members and others who decided to peruse our web page.

Most of the submissions were from cases in which physicians were sued for failing to give tPA to patients with strokes. At the time I was viewing the submissions, I did not believe that tPA had been proven clearly effective for the treatment of strokes (I still don't). Certainly not clearly enough to be considered the standard of care. This is especially true at hospitals that do not have a great deal of experience with this therapy. I felt tremendous sympathy for those physicians who had given thought to this issue and decided that tPA was not a good idea. It is a decision we all have to make, and these docs were being punished for doing so. They were being subjected to litigation for trying to practice evidence based medicine as best they could. But while some of the testimony against them seemed unfair, it did not rise to the standard I was seeking.

Then along came the case we have posted on the website. Here was an expert claiming to have given tPA as treatment for strokes three to four times a week! How could that be? This would surely make him the world's leader in the use of tPA for strokes! In the course of his testimony he made other impossible statements. Amusingly, he called tPA "that magic bullet."

"Here," I thought, "not only do I have an example of truly remarkable testimony, but I have also have a name for the case."

And so this case and a description of its highlights (lowlights?) are posted on the AAEM website. The response we have received up to this point has been overwhelmingly positive. Emergency physicians from across the country have contacted us to say how excited they all are about a new and unique approach to the issue of expert testimony. One blog even picked up a discussion of the website, with positive commentary.

There are exceptions. One prominent emergency physician questioned the wisdom of our approach, stating that it will be taken by the general public as an effort to intimidate plaintiff's witnesses. I have also received two rambling e-mails, both unsigned and full of incorrect rhetoric, from an individual enraged by our website.

Are we stepping out of bounds with this website? I don't think so. AAEM's approach to its mission has always been to educate its members about key issues. We do this with *Common Sense*, presentations at the Scientific Assembly, the website and e-mail messages. The *Washington Sentinel*, the newsletter of our political representative, is another mechanism for getting out important information. And so our desire to educate the membership continues with this innovative effort. Hopefully the website will grow as news spreads and more cases are submitted.

I look forward to seeing what our membership does with this new information.

JOIN AN AAEM COMMITTEE OR TASK FORCE!

AAEM committees and task forces need your assistance to achieve their goals.
AAEM's current committees and task forces:

Academic Affairs
Critical Care
Disaster Medicine
ED Design-Through Put
ED Overcrowding
Education
EM Practice
EMS
EMTALA
Ethics
Government Affairs
Information Technology
Injury Prevention
International
Membership
Minority Affairs
Board Certification
Practice Guidelines
Customer Satisfaction
Reimbursement
Malpractice/Tort Reform

Please submit a brief letter of interest for the committee(s) and task force(s) you wish to join and a current copy of your CV to staff person, Tom Derenne, at tderenne@aaem.org.

THE VIEW FROM THE PODIUM

by Kevin Rodgers, MD FAAEM

Congrats on a Fantastic Job!
By the time you read this installment, another successful Scientific Assembly (SCIASS) in San Antonio will have passed. Despite the lack of a crystal ball, I know this to be true because of two names, Joe Lex and Ghazala Sharieff. Their superb leadership over the last five years has not only yielded the premier clinical meeting for board-certified emergency medicine physicians, but has helped develop a wide variety of educational resources as well. Every year I listen to my own residents and faculty rave about the quality of the speakers and their presentations at SCIASS. I read the reviews from those attending our board review courses (oral, written and JAM) saying they're the best in the US. I examine the CME offerings endorsed by AAEM's own ACCME committee and know I am getting a quality production. I think back on innovative ideas, such as linking with EMedHome and EMRAP, the "open-mic" sessions, the Speakers' Bureau and on-line pediatric quizzes, all of which have come to fruition. Of course, I'd be remiss if I didn't mention the three incredibly successful Mediterranean Emergency Medicine Congresses held in Stresa, Sitges and Nice. It is clear that all of these excellent educational offerings have played a significant role in the growth of our organization as well.

This is not to say that Joe and Ghazala did it alone. The Education Committee has always been one of AAEM's most productive and talented. You've heard all the names repeatedly, too many to mention individually! But as they said in *Remember the Titans,* "Attitude reflects leadership!" Ghazala and Joe have given us their very best attitude, ideas, hard work and leadership, year in and year out. They have established a "track record" that Sam and I can only hope to match in the coming years. I'm sure all AAEM members would agree that we cannot thank Joe and Ghazala (and their families) enough.
Joe and Ghazala – Thanks for Everything!

Medscape Partnership
AAEM and Medscape, LLC (**www.medscape.com**) are in the process of formalizing a collaboration to launch an emergency medicine website. Medscape, LLC, the professional editorial and educational subsidiary of WebMD Health, is an ACCME accredited CME provider, and currently offers more than 30 specialty sites. According to a report issued by the AMA/ Forrester Research Consortium in 2005, nearly 71 percent of US physicians actively use Medscape as a key source for online, up-to-date medical information.

Currently, about 17,000 emergency physicians use Medscape as a source for medical information; however, they do not have their own dedicated website. The site to be launched will provide a home to emergency physicians as well as other practitioners who seek cutting edge information in emergency medicine.

Robert Glatter, MD FAAEM, is head of the subcommittee to launch the site. Dr. Glatter will serve as Chair of the Editorial Board. Dr. Joe Lex will also serve on the Board; the remainder of the Editorial Board is currently being organized. Members of the Education Committee and others are actively being recruited to provide content and support for the project.

The site will feature a "National EM Journal Club," as well as a section entitled "AAEM's Review of the Literature." Additional plans include a section for PowerPoint type presentations, as well as a repository of MP3 EM lectures downloadable to podcast or CD for on-the-go listening for busy physicians. "Resource Centers" for relevant EM topics, CME articles on cutting edge topics and an EM discussion board will further add to the breadth of variety available on the site.

In addition to the co-branded specialty site produced in collaboration with AAEM, the *Journal of Emergency Medicine* will be featured in a "Publishers Circle" on the website, posting selected full text articles to promote the Journal to non subscribers. Conference coverage for AAEM's Scientific Assembly, as well as other sponsored meetings, will promote AAEM educational activities to practicing physicians. Overall, the co-branded EM site will serve as a showcase for AAEM materials, guidelines and messages distributed across a broad audience.

The Future
There is an incredible amount of talent within AAEM and specifically on the Education Committee itself. Sam and I can only hope to be as productive and successful as our aforementioned predecessors. To do so, we will need the ingenuity, expertise and productivity of ALL Education Committee members. I say ALL, because the committee is large (more than 55 members) and sometimes unwieldy one. The number of sub-committees has doubled in the last three years. SCIASS has grown with new educational venues being added every year. The Oral Board Review course has doubled in size. Future ideas for educational offerings include poster and photographic presentations at SCIASS, an on-line bookstore as well as on-line CME presentations such as the JAM session. To be successful we will need the active involvement of every member.

As Sam and I start a new régime, we first want to thank all of the Education Committee members who have been productive throughout the years. We cannot thank you enough; the members cannot thank you enough! Secondly, we ask you to renew your commitment to the hard work necessary to provide educational innovations and excellence for our members. For those of you reading this who are not on the Education Committee, when you see an EDCOMM member, take a moment to say "Thank You!"

Kevin Rodgers, Co-Chair, Education Committee
Sam Mossallam, Co-Chair, Education Committee

Upcoming AAEM-Endorsed or AAEM Sponsored Conferences for 2006

March 30-April 1, 2006
- Emergency Medicine – Moving Forward 2006
  Scottsdale Marriott at McDowell Mountains, Scottsdale, AZ

  Sponsored by Mayo School of Continuing Medical Education at the Mayo Clinic School of Medicine, Scottsdale, AZ
  http://www.mayo.edu/cme/emergency-medicine.html

April 7, 2006
- Clinical Management of Orthopedic Injuries Presenting to the Emergency Department
  Post-Graduate Medical School of the New York University School of Medicine, New York, NY

  Sponsored by the NYU Post-Graduate Medical School
  https://tools.med.nyu.edu/Cmecourses

April 19-21, 2006
- First Inter-American Conference on Emergency Medicine
  Controversies and Consensus in Emergency Medicine: A Bi-Lingual Conference with Simultaneous Translation
  Sheraton Buenos Aires Hotel and Convention Center
  Buenos Aires, Argentina

  Co-sponsored by the American Academy of Emergency Medicine, the Sociedad Argentina de Emergencias (SAE) and the American College of Emergency Physicians
  www.emcongress.org

April 22-23, 2006
- AAEM Pearls of Wisdom Oral Board Review Course
  Embassy Suites Airport in Chicago, Dallas, Los Angeles, Orlando, Philadelphia
  Course sponsored and organized by the American Academy of Emergency Medicine
  http://www.aaem.org

May 24-26, 2006
- High Risk Emergency Medicine
  Hotel Nikko, San Francisco, CA
  Conference sponsored by San Francisco General Hospital and the Department of Emergency Medicine at the University of California, San Francisco
  https://www.cme.ucsf.edu/cme/CourseDetail.aspx?coursenumber=MDM06Q23

May 31, 2006
- The 3rd Annual New York Symposium on International Emergency Medicine
  Schwartz Auditorium, New York University School of Medicine, New York, NY.

  Co-Sponsored by North Shore-LIJ, NYU-Bellevue and ACEP International Section.
  http://www.iems-2006.com

September 9-10, 2006
- AAEM Pearls of Wisdom Oral Board Review Course
  Embassy Suites Airport in Chicago, Los Angeles, Orlando, Philadelphia

  Course sponsored and organized by the American Academy of Emergency Medicine
  http://www.aaem.org

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

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

Elections for the Executive Committee and Board Member At-Large positions were held at the 12th Annual Scientific Assembly in San Antonio. The 2006-2007 Board of Directors are listed below.

President
Tom Scaletta, MD - 2008

Vice President
Larry D. Weiss, MD JD - 2008

Secretary-Treasurer
Howard Blumstein, MD - 2008

Immediate Past President
Joseph P. Wood, MD JD - 2008

Past Presidents Council Representative
Robert M. McNamara, MD - 2008

Board
Tracy Boykin, MD - 2007

Anthony B. DeMond, MD - 2007

Stephen R. Hayden, MD - 2008

David Kramer, MD - 2009

James Li, MD - 2009

Kevin G. Rodgers, MD - 2008

Richard D. Shih, MD - 2007

Andy Walker, MD - 2008

Associate Board Member
Mark Reiter, MD MBA

AAEM/RSA President 2006-2007
Brian Potts, MD MBA

AAEM/RSA PRESIDENT

Emergency Medicine – What I've Learned in Residency

by Mark Reiter, MD MBA, President, AAEM/RSA

Looking back as I near the end of my residency, I have learned much about emergency medicine. I have developed a solid knowledge base through EM texts, journals and conferences. Countless shifts have sharpened my clinical skills and judgment. I have even picked up a few practical pointers from some of my patients. Here are some of the most important lessons I've learned:

Trust the judgment of the nurses you work with. I've stopped counting how many times I have been saved from disaster by an experienced nurse who recognized something I didn't.

Being a responsible aunt doesn't mean letting your 17 year old niece drive because she is a little less drunk than you are.

Be nice to your consultants. At times this can be the most challenging part of our job, but always take the high road, for your patient's sake.

When using a nail gun, don't stabilize the board you are nailing with your stomach.

Take advantage of your residency. There will never be another opportunity for you to learn as effectively.

A kaleidoscope is not that kind of a toy.

Respect the more senior members of our specialty. They can teach you many things you cannot find in a book.

When chasing a rabbit, be careful when running with an 18-inch knife, unless you like chest tubes.

Support your professional medical organizations (AAEM, ACEP, AMA, state societies, political action committees, etc.) with dues, donations and time. Without them, physicians would be working much longer and harder, paid much less and treated poorly. Yeah, pretty much like being a resident forever.

If you're driving drunk and total your car, don't then borrow someone else's car to continue driving. It does not end well.

Make sure to make time to eat and drink during a shift. Sit down when possible. We are going to be doing this job for the next few decades.

Human beings cannot fly. Period. Even if you think you are Batman.

Develop your ability to document well and see patients efficiently during residency. Do your best to understand how reimbursement in emergency medicine works. These skills will be very marketable when you are looking for your first job.

If you're a new teenage mom, don't tell me you don't want a prescription for birth control because you practice abstinence and are a virgin, especially when I delivered your baby 10 minutes ago.

Take advantage of this opportunity to find life-long mentors in your residency program.

"Just two beers, doc" can make even the most experienced alcoholic very drunk. Especially if he is just sitting on the porch "minding my own business."

Residency is a very stressful experience. Do not take it out on your friends and family. You need their support. Thank them.

If you think you are having a heart attack, taking your dog's seizure medicine won't help.

Try to find something good in every patient encounter.

The winners of the AAEM/JEM Resident & Student Research Competition (from left to right: 3rd place, Johnny Dias; moderator Peter Rosen, MD; 1st place, Gil Shlamovitz and 2nd place winner, Christopher Fischer.)

A Plain Talk Guide to AAEM's Legal Victories for Residents & Medical Students: The PhyAmerica Malpractice Insurance Debacle

by Joel Schofer, MD

The third installment in a series designed to plainly discuss the many legal victories achieved by AAEM on behalf of individual emergency physicians (EPs) nationwide.

The PhyAmerica Malpractice Insurance Debacle (2005)
Approximately 200 physicians and previous employees of PhyAmerica, one of the largest contract management groups (CMGs), were sued for malpractice for actions which occurred while they were working for PhyAmerica or one of its subsidiaries. Originally they were covered by liability insurance provided by PhyAmerica, and when PhyAmerica went bankrupt in 2003, they were assured that they were still covered by an insurance policy that was now being managed by Western Litigation Specialists (WLS).

In 2004, Sterling Healthcare, another CMG, purchased PhyAmerica and its assets. Later that year, the previously mentioned physicians began receiving notification from their attorneys that the funds provided by WLS insurance for their defense were exhausted. They were told that they would now have to start paying for their legal defense with their personal assets and that the plaintiffs' lawyers were targeting these personal assets. The physicians were under tremendous pressure to quickly decide if they would pay for their own legal defense or simply settle the cases quickly, even frivolous ones, to avoid escalating legal expenses.

A number of these frustrated, confused and abandoned physicians contacted AAEM. AAEM responded by creating a working group to organize these physicians and their legal representatives and hired a legal counsel and a bankruptcy attorney. An Amicus Brief was filed by AAEM in support of these physicians for the Baltimore Bankruptcy Court hearing that was going to decide the fate of these physicians and their assets. A significant amount of time and support was dedicated to this issue by AAEM. AAEM and its representatives met with representatives from Sterling Healthcare to ensure that the physicians' interests were known to Sterling's legal team.

On April 28, 2005, an *Order* was issued that included permanent protection of the physicians' personal assets. This issuance was a clear victory in favor of the physicians. This legal victory serves as a perfect example of how AAEM can support the individual emergency physician. One of the affected physicians stated it best when she said that the affected physicians were "tremendously grateful for the leadership and support of AAEM in the process of securing this essential *Order*."

Mathematics of Membership: New Amazing Textbook Discounts for AAEM/RSA Members

by Elizabeth Weinstein, MD

After spending close to 14 bijillion dollars on applying to medical school, paying for medical school, USMLE steps 1& 2 fees, AMCAS applications fees, flying to interviews, hotels for interviews, interview suits and interview suit dry cleaning and matching in emergency medicine, having an actual house staff salary seems like a step in the right direction. At a minimum, it marks a significant improvement over the average medical student salary of negative $30,000 annually. Nevertheless, most house staff have fairly rigid budgets to stick to, and with a median medical school indebtedness of about $120,000, every little discount helps. That's why for the last six months, AAEM/RSA, your champions of frugal living, have been working with many of the publishing houses for major emergency medicine texts to provide discounts for our members.

Now, in addition to all of the other advantages of membership (free registration at the AAEM Scientific Assembly, subscription to the *Journal of Emergency Medicine*, free Toxicology Handbook, advocacy for individual emergency physicians, etc.) your annual $50 membership dues gets you HUGE discounts on major EM texts, such as *Tintinalli's Emergency Medicine – A comprehensive study guide* (20% off), *Rosen's Emergency Medicine, 6th edition – three volume set* (10% off) and *Harwood Nuss' Clinical Practice of Emergency Medicine* (15% off).*

Even if all you bought is *Rosen's* ($299 x 10% = $29.90 savings) and *Roberts and Hedges'* (169.00 x 20% = $16.90 savings), your total discount of $46.80, pretty much pays for your AAEM membership all by itself. Add a few more titles (say *Tintinalli's:* 179.00 x 20% = $35.80) and you're making money.

For programs that supply all of their residents with a copy of one of these major EM reference texts, this is a slam dunk – **the money saved from the discounts almost completely defrays the cost of AAEM/RSA membership for the entire residency**.

In the spirit of the overly-quoted Mastercard ™ commercial: matching in emergency medicine is priceless. Membership dues and textbooks are not. So you do the math and take advantage of our latest and greatest membership benefit.

**Please see text box for a more detailed listing of discounts.*

New AAEM/RSA Member Discounts

McGraw-Hill Products – 20% discount
Tintinalli's Emergency Medicine – A Comprehensive Study Guide
Atlas of Emergency Medicine
Current Essentials of Emergency Medicine
Emergency Medicine Examination and Board Review
and many more…

Lippincott Williams & Wilkins Products – 15% discount
Harwood-Nuss' Clinical Practice of Emergency Medicine
5 – Minute Emergency Medicine Consult
Textbook of Pediatric Emergency Medicine
and thousands of more books, software and PDA versions

Elsevier – 10% discount
Rosen's Emergency Medicine, 6th Edition – three volume set
Clinical Procedures in Emergency Medicine
Atlas of Emergency Radiology
and many more…

Galen Press – 20% off of Iserson's, *Getting into a Residency*

Kaplan Medical – discounts on their three-month Qbank Program for step 3 and booksplus Qbank

Streamlining the Residency Application Process: A New Tool for EM Applicants

by Michael Ward and Warren Wiechmann

If our experiences were anything like other fourth year medical students applying to emergency medicine (EM) residency programs, you probably started out this process by putting together a list of all of the EM programs in the country. From this point you probably eliminated the places you wouldn't live if your life depended upon it, and then added a few of them back because your advisor scared you – and now you are worried about the possibility that you might not match. After the hours of grinding away in front of a computer, chances are, you still were far from finalizing your list of programs.

In navigating the application process we found that there is currently no quick way to sort through information about EM programs. For instance, how long would it take you to find all of the Western three year programs? It would probably take a while and even then, how certain would you be that you did not miss a program? The idea for our new application tool **EM Select** was born out of our collective experiences with the current process. Using this new tool, one can instantly figure out that there are 19 three year programs in the West. And that's not all.

EM Select will allow applicants to go online, with their lists of "must haves" and "can't haves" to create their master lists of programs to which they wish to apply. From this initial list, users are able to modify the criteria for any number of variables and add or subtract programs accordingly. Perhaps more importantly, users may use this tool throughout the application process to keep notes on their interviews or chat with other users about programs.

Below, we explain the specific features of the **EM Select** program and how to use this new tool. We are excited about it and hope that you will be too.

Features of EM Select

Simulated Rank Lists – when comparing programs, you will be able to arrange them in the order in which you intend to rank them.

Email Reminders – set email reminders for interview dates, thank you notes and other important events.

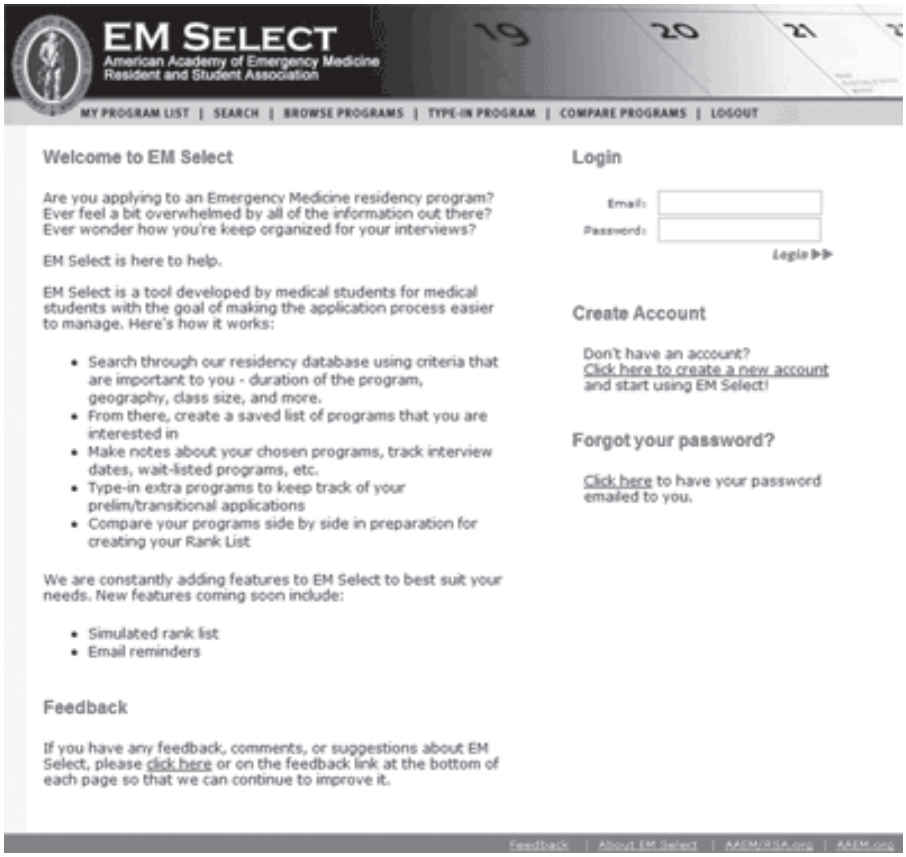
Searchable Comments – interested in seeing what other applicants thought about the programs you also interviewed for? Search shared comments that may help in deciding if a program is right for you.

EM Select was built from feedback of students that successfully made their way through the interview trail…students just like you. To ensure that EM Select is an effective tool for applicants in the years to come, we need your help. Please let us know what you would like to see in a tool like this and we'll do our best to make it happen.

To the graduating classes of 2006, we wish you the best of luck on the Match.

Warren Wiechmann
UC Irvine
Class of 2006
President, AAEM
Student Section

Michael Ward
Emory University
Class of 2006
Vice-President, AAEM
Student Section

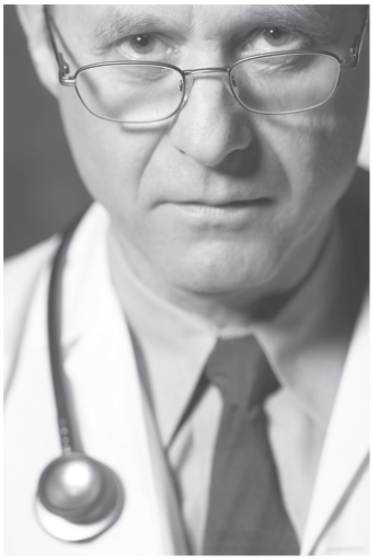


Wanted: YOU!

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

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

This new service will be free to AAEM members, available on the AAEM and AAEM/RSA websites, and available to AAEM members only.



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

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

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

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

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

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

AAEM CareerNet seeks the following information:

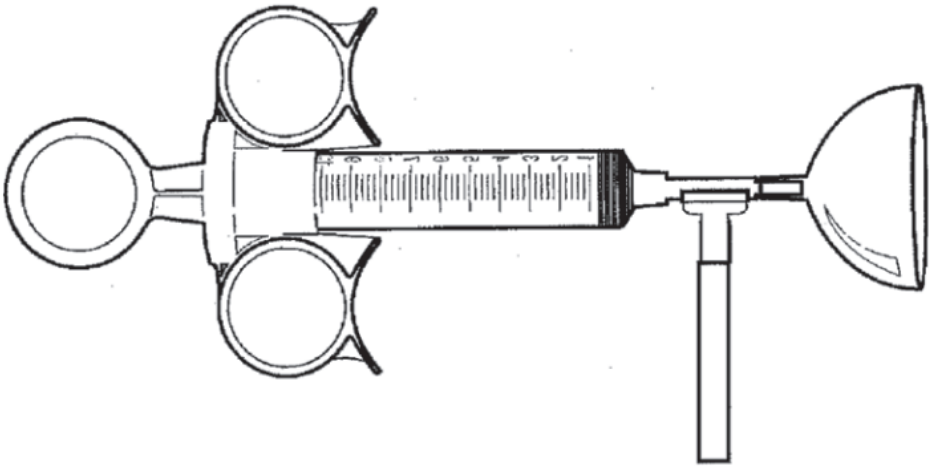
1. Full name
2. City, state in which you wish to discuss the local EM practice environment (maximum of 2 areas)
3. Preferred method of communication (pager, email, etc.)
4. Practice Setting (e.g., Independent Group, Kaiser, CEP, etc.) (Optional)
5. Military affiliation - past or present (e.g., Army,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

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

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

BRING IT ON!!!

Nose to the Grindstone
Fingers Worked to the Bone
Beating Your Head Against the Wall
Shot in the Arm
Bitten Hand That Feeds
Nose Cut Off to Spite Your Face
Head on the Chopping Block
Cat Got Your Tongue
Caught Between a Rock and a Hard Place



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California Chapter Update

California Court Upholds Balance Billing and Reasonable Reimbursement for EPs

by Steven C. Gabaeff, MD

In the matter of Prospect Medical Group v. Northridge Emergency Medical Group, a very important court decision directly addressing two major issues that impact emergency medicine, balance billing and reasonable rates of reimbursement, was filed on February 17, 2006, in the Second Appellate District, California Court of Appeal.

The decision allows balance billing of patients for all patients without prior contractual agreements with the billing emergency physician group and bans health plans from arbitrarily and unilaterally setting reimbursement rates, after the fact, with non-contracted physician groups. This published decision (giving it more import and designed to set precedent) will have immediate impact in California and, over time, be applied in other jurisdictions throughout the nation.

The California Medical Association (CMA) joined forces with the Northridge Emergency Medical Group (a southern California, two-hospital based group) by filing an amicus curiae brief (a supporting document) with the court, to convince the court that in the absence of a written contract, none can be inferred and that health plans have no authority to unilaterally set reimbursement rates or block EPs from balance billing patients when health plans refuse to pay. It specifically condemns the arbitrary use of Medicaid or Medicare rates for reimbursement, which were expressly ruled inadequate, and the use of this self serving strategy to reduce health plan expenses at the expense of emergency physicians.

The incongruity of a health plan's absolute reliance on Emergency Medical Services to provide essential services to their enrollees and reluctance to pay reasonable rates for such services, was judged by the court to be real and substantive. The court ruled that health plan reimbursement is subject to fair and equitable resolution and that either party can rely on the courts if necessary. The net effect is that health plans must pay reasonable rates of reimbursement for out of plan emergency medical services or be subject to litigation.

The CMA reported their victory with a statement reproduced in part below and the news was disseminated through CalJEM, the California AAEM Newsletter, sent to EM physicians throughout California. We are pleased to share this information with the national emergency medicine community where its legal significance can be applied from this time forward.

The court issued its opinion concluding that the Knox-Keene Act did not prohibit non-contracted physicians providing emergency

continued on pg 15

12th Annual Scientific Assembly San Antonio

The AAEM board of directors met in San Antonio.

Dr. Joe Lex (center) received an award as the departing Education Committee Chair. In his honor, the Educator of the Year Award has been renamed the Joe Lex Educator of the Year Award.

AAEM President Tom Scaletta talks with Assembly attendees at the Welcome Reception.

Vice Admiral Richard Carmona, pictured here with Dr. Kazzi, opened the assembly as keynote speaker.

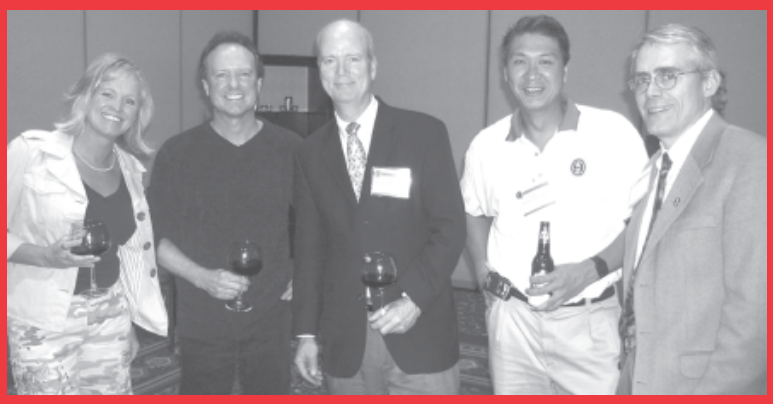
The James Keaney Leadership Award was presented to Dr. Michael Buchele and Dr. Samuel Glassner (far right).

Dr. Wood and Dr. Kazzi present Dr. Harvey Meislin with The David K. Wagner Award.

12th Annual Scientific Assembly San Antonio

AAEM/RSA members gathered at the welcome reception in the exhibit hall.

Drs. Mosallam, Glatter and Doty enjoy the AAEM Welcome Reception.



(From left to right) Cindy Young, Dr. Steve Anneken, Dr. Joe Wood, Dr. Richard Shih and Dr. Robert McNamara at the Welcome Reception.

Dr. David Lawhorn and Robin Lawhorn at the Foundation Dinner at Sunset Station.

Members of the AAEM/RSA and AAEM were recognized for their quick response when a member of the neighboring conference, the American Association of Colleges of Nursing, needed medical attention. They are pictured here with AACN President Dr. Cynthia Teel (far left).

California Chapter Update- continued from pg 11

services from "balance billing" patients for fees not paid by either the health plan or its contracting IPA. The Court also concluded that such physicians are not required to accept Medicare payment rates as payment in full. As a result, the Court concluded that the IPA in that case could not sue a group of emergency physicians for violating the unfair practice laws for balance billing their patients and could not require that these physicians charge no more than 100 percent of the Medicare rate. The Court did allow, however, the IPA to contest the reasonableness of the emergency physicians rate, just as physicians have the ability to sue plans and IPAs for the reasonable value of their services in accordance with the Bell v Blue Cross decision. This opinion fully sided with CMA's amicus curiae brief that it filed in this case supporting the emergency physicians.

Briefly stated, the Prospect Court held that Section 1379 of the Health & Safety Code did not prohibit emergency physicians from balance billing. That section provides that contracts between a plan and provider shall be in writing and shall provide that where the plan fails to pay for health care services, the enrollee shall not be liable to the provider for sums owed by the plan. The provision goes on to provide that where the contract has not been reduced to writing or fails to prohibit balance billing, no provider may collect or attempt to collect sums owed by the plan.

The Court concluded that Section 1379 refers to and includes within its scope only freely and "voluntarily negotiated contracts" between physicians and plans "based on traditional contractual principles such as a meeting of the minds." In reaching this conclusion, the court rejected the IPA's argument that "implied" contracts based on the parties' conduct or the physicians' obligation to provide EMTALA services could suffice to trigger the balance billing prohibition. The Court reasoned, among other things, that because the prohibition only applies to "sums owed by the plan," there would need to be a voluntarily negotiated agreement "as to how much the plan will pay for a particular procedure in advance of the medical procedure."

Significantly, the Court also concluded that the IPA was not entitled to a declaration imposing the Medicare rate as the reasonable rate. The Court explained that it had no authority to set rates and noted that in any event, the California Department of Managed Health Care had already opined in the record supporting the AB 1455 regulations that the Medicare rate was not appropriate, stating in the rulemaking that, "The Department recognizes that these government programs are not designed to reimburse the provider for the fair and reasonable value of the services and are therefore an inappropriate criteria."

The Court concluded by reiterating that non-contracted physicians providing emergency services were entitled to reasonable compensation, and that the IPA and plans, like providers in the Bell case should be able to contest the reasonableness of the rates charged. Thus, the Court dismissed the IPA's claims for declaratory relief and unfair business practices against the emergency physicians.

There is an expectation that the plans and IPAs will make every effort to see that this opinion is overturned. In the interim, however, we can use this decision as a basis for discouraging legislators from trying to reverse this decision in other states through legislation. It would seem that the clarity of the decision will make it difficult to circumvent this ruling in the future.

In California, CalACEP, through their lobbying activities has led an effort over a two year period that has been successful in keeping proposed legislation specifically blocking balance billing from coming before the legislature. That effort indirectly allowed the Court the latitude to make this decision without legislative constraints that could have precluded the court from deciding as they did. It was ironic the victory came through the courts, not legislative efforts, but none the less, an important victory it was.

In this case, CalACEP apparently adopted a strategy used successfully by AAEM in numerous cases of financially supporting litigation in alignment with the organization's goals. Their stated contribution of $20,000, made without any public announcement, reflects CalACEP's dedication to protecting macrorevenue streams in emergency medicine which was no doubt resonant with the thrust of this case. The victory will be a benefit to all EM contractors and ultimately EM physicians.

The involvement of CalACEP in this issue and its financial contribution to the litigation came to light following a series of e-mails between the leadership of CalACEP and CalAAEM.

We, in California, and others throughout the nation, should be grateful for CalACEP's ongoing legislative efforts and we commend their use of the strategy of supporting litigation financially. We have been working here in California to identify areas of common interest to all EM physicians and here we have clearly found one. It seems clear that AAEM's strategy of supporting litigation, both financially and in published writings, to advance the rights of emergency physicians, is a strategy that has been validated once again. Moving forward we can continue to seek out such opportunities to advance our policy goals within the legal system. February 17, 2006, was a good day for emergency medicine!

The decision is available at http://fsnews.findlaw.com/cases/ca/caapp4th/slip/2006/b172737.html .

The following awards were announced at the 12th Annual Scientific Assembly in San Antonio.

David K. Wagner Award	Harvey W. Meislin, MD
Peter Rosen Award	David Kramer, MD FAAEM
James Keaney Leadership Award	Samuel H. Glassner, MD FAAEM Michael J. Buchele, MD FAAEM Stuart B. Shikora, MD FAAEM
Young Educator Award	Michelle Lin, MD FAAEM
Resident of the Year Award	Mark Reiter, MD
Joe Lex Educator of the Year Award	Michael Lambert, MD FAAEM
Program Director of the Year	Amal Mattu, MD FAAEM
International Leadership Award	Dr. Roberta Petrino Dr. Francesco Della Corte
Special Recognition	
Departing President	A. Antoine Kazzi, MD FAAEM
Departing Board Members	William T. Durkin, Jr., MD FAAEM Ghazala Sharieff, MD FAAEM
Departing Education Chair	Joseph R. Lex, Jr., MD FAAEM
Special Commendation for Meritorious Service in the Hurricane Katrina Disaster	LSU Residency Program
Resident Research Forum	First Place Gil Z. Shlamovitz, MD Second Place Christopher Fischer, MD Third Place Johnny A. Dias, MSPH
2006 AAEM Service Award plaques	**10** sessions: David Dabell, MD FAAEM Darin Wiggins, MD FAAEM **5** sessions: Michael Gould, MD FAAEM Alexandre Migala, DO FAAEM Wes Young, MD FAAEM

Texas Chapter Update

Iatroepidemics

by David Smith, MD FAAEM

There are three types of iatrogenic illness. The first is recognized complications of medical and surgical procedures that occur randomly. These are considered acceptable risks of treatment that is beneficial to the overall population of treated patients. I will call these "known complications." Although none is really ever anticipated or acceptable we must, for the present, consider that given present knowledge, an underlying rate of adverse events is unavoidable. The basis of informed consent is the disclosure of such risks and the willing participation of the patient in assuming the risk of known complications.

The second type of iatrogenic illness is that resulting from medical errors, that is, mistakes made in the course of otherwise acceptable medical practice. Since the 1999 Institute of Medicine report on medical errors, such events have been given increased attention and concern including federal funds and specific programs to limit them. Medical errors include wrong drug and dosage errors, right drug or procedure but the wrong patient, misdiagnosis and, especially in emergency medicine, delayed treatment. Surgical errors such as wrong site and wrong side surgery and procedures are also medical errors. Medical errors are the basis of legitimate medical liability claims against physicians.

A third type of iatrogenic illness and the subject of this article is the iatroepidemic. An iatroepidemic is a systematic error incorporated into acceptable medical practice. Vioxx, Thalidomide, and DES are a few names that come to mind in identifying past iatroepidemics. Such high profile cases do not necessarily represent the bulk of the problem. I choose them because they are recognizable. Obviously this problem is worth avoiding, but how? It is worth noting that informed consent does not disclose the risk of an iatroepidemic. The practitioners themselves do not know of it or and if they do, would be malicious in recommending the ill advised therapy or procedure. No method or program to reduce "medical errors" will reduce the risk of an iatroepidemic. Such programs are based on acceptable medical practice, flawed by definition, in an iatroepidemic.

Iatroepidemics have three basic requirements: financial motivation, unethical behavior and support in the medical community. First, there is always a financial motivation behind the acceptance of the unsound medical treatment or procedure. Delay for more rigorous testing of a newly introduced drug or procedure, for instance, has a cost and sometimes the delay is judged erroneously to be not worth the cost. Second, there has to be unethical behavior on the part of at least one or more of the participants. Scientific methods are valid if not nullified by human frailty. Third, the practice that constitutes the iatroepidemic has to have support in the medical community, at least at the local level. The support may be impressive. As we have seen, the drug or device may have FDA approval for the intended use. Almost always articles from well respected journals can be cited. Guidelines from professional societies and government agencies may incorporate the treatment or procedure. Frequently, silence from the unconvinced may allow an unsound medical therapy to achieve acceptance. It may not seem like drug company influence links financial motivation to unethical behavior. Nebulous political alliances may represent a relationship between unethical behavior and the acceptance of therapy within the medical community. Never is any particular individual ever manifestly evil in this process. In fact many at the root of it are amiable, hard-working people, who love their families and are respected by colleagues and have well-rounded lives. The solution to the problem is, therefore, in reforming the system not the people.

If the system fails and an iatroepidemic begins, how can we avoid participating? How do we "go against the flow" and resist the trend? May we deviate from protocol? Will not participating always have a financial disincentive? Liability may be an issue but is unlikely because as practitioners, we are judged against what the standard of care is, not what it should be. We are not the deep pockets in a Vioxx scandal nor generally expected to second guess the FDA. Do we have the time, even if we have the training and experience in research, to scour the medical literature for flaws that the FDA advisory panels, medical editors and consensus panels have overlooked? Are we articulate enough to use the fine print to argue against the bold headlines? I wouldn't have written this article if I didn't believe there was a way. Standing on the ground in the pit as we, AAEM members do, we will recognize accepted but unsound medical practice. Using our experience to the benefit of our patients will require courage, resilience and the conviction of our ideals.

EMTALA Pointers FROM THE AAEM EMTALA COMMITTEE

Q: *Does EMTALA apply if a patient is in the ED for "outpatient" laboratory testing or imaging, or hospital services such as blood pressure screening or sexual assault evidence collection?*

A: EMTALA does not apply unless the patient or any other person requests a medical evaluation. In situations where the patient is unable to voice a request, EMTALA applies if a prudent layperson would believe the person needs examination or treatment of a medical condition. If a patient presents for hospital services such as blood pressure screening or sexual assault evidence collection, EMTALA does not apply, as the patient is not seeking medical evaluation. However, if the patient also voices a medical complaint (i.e., pelvic pain or STD prophylaxis) EMTALA will then apply, obligating a medical screening examination.

In today's litigious climate, it is recommended that the hospital document that the patient is not requesting a medical screening exam. This can be accomplished by having the patient sign a separate consent to treatment form that states that the patient understands his or her rights under EMTALA, is not requesting a medical screening exam to evaluate for an emergency medical condition, may change their mind at any time, and is requesting a specific hospital service distinct from a medical screening exam.

by Mark Reiter, MD MBA

Washington Watch

by Kathleen Ream, Director of Government Affairs

MedPAC Approves 2007 Recommendations
At its January 2006 meeting, the Medicare Payment Advisory Commission (MedPAC) approved final recommendations on Medicare payment updates for 2007. These recommendations will be published in its March 2006, ***Report to the Congress***.

Despite a projected negative overall Medicare margin of 2.2 percent in 2006, the Commission recommended an update to the hospital inpatient and outpatient payment rates equal to the increase in the hospital market basket (an inflation measure) minus 0.45 percentage points. For physician services, MedPAC recommended updating payments for physician services by the projected changes in input prices less the productivity expectation growth for 2007. MedPAC estimates a price inflation of 3.7 percent and productivity growth of 0.9 percent, which would make the update 2.8 percent. MedPAC will also comment in its report that it does not support the physician fee cuts scheduled through 2011, and considers the current volume control formula, known as the sustainable growth rate or SGR, to be a "flawed, inequitable mechanism."

HHS Announces Pandemic Flu Planning Efforts
In December 2005, Department of Health and Human Services (HHS) Secretary, Michael Leavitt, announced a series of efforts designed to help state and local communities, as well as decision makers outside the health care field and the general public, prepare for a possible outbreak of avian flu. The new efforts build on the Bush Administration's pandemic flu strategy and plan announced a month earlier in November.

Speaking at a pandemic planning convention for state and local health officials in Washington, D.C., Leavitt said, "This is a grand opportunity, and I believe it's a moment in time we must grasp and move forward. Today really should be viewed as the beginning of a new chapter in public health." In his comments, Department of Homeland Security (DHS) Secretary Michael Chertoff, whose department is working with HHS in emergency preparedness, said the nation's ability to handle an emergency will improve if it comes from a base of serious planning and integrated work at all levels of government. "Emergency planning does not go well when it's undertaken in the middle of a disaster," Chertoff said. "The earlier you begin to plan, the better off you are. This is not a response that the federal government can own or any state or local government can own in and of itself."

During the first four months of 2006, HHS plans to hold a pandemic summit in each state to help public health officials engage political, educational and business leaders in preparing for a possible pandemic. Calling it vital that these summits extend beyond public health and emergency preparedness, Leavitt said, "Public health people get this. If we talk to the public health community, we're talking to ourselves. We need to lift this to the broader community." He said the summits are meant to engage, inform and motivate those people who are key to helping public health officials implement a local plan, and that the summits will not be one time events.

To help local governments prepare their plan, HHS released a six page state and local pandemic influenza planning checklist.The document specifically states that the checklist is not mandatory, but designed to serve as guidance. It includes sections on community preparedness leadership and networking, surveillance, public health and clinical laboratories, health care and public health partners, infection control and clinical guidelines, vaccine distribution and use, antiviral drug distribution and use, community disease control and prevention (including managing travel related risk of disease transmission), public health communications and workforce support. In addition, Leavitt said that, in the coming days, HHS will release checklists for schools and colleges – to be followed by checklists for faith based communities, individuals and families.

Also released was a set of pandemic planning assumptions, which Leavitt said were developed after consultation and extensive study that focused primarily on the flu pandemic of 1918. He added that the assumptions build primarily from models based on the pandemic of 1918, because that year's flu strain is closer genetically to the H5N1 avian flu virus, compared to other years' strains. The assumptions include:

- Susceptibility to the pandemic influenza virus will be universal, and that efficient and sustained person to person transmission signals an imminent pandemic.
- The clinical disease rate will likely be 30 percent or higher in the overall population during the pandemic. Illness rates will be highest among school aged children and decline with age.
- Among working adults, an average of 20 percent will become ill during a community outbreak. Some persons will become infected but not develop clinically significant symptoms. Asymptomatic or minimally symptomatic individuals can transmit infection and develop immunity to subsequent infection.
- Of those who become ill with influenza, 50 percent will seek outpatient medical care.
- The number of hospitalizations and deaths will depend on the virulence of the pandemic virus.
- Rates of absenteeism (from work or school) will depend on the severity of the pandemic, and certain public health measures (e.g., closing schools, quarantining household contacts of infected individuals) are likely to increase such rates.
- The typical incubation period for influenza is approximately two days.
- People who become ill may transmit the infection for up to one day before onset of illness.
- On average, an infected person will transmit the infection to approximately two other people.
- In an affected community, a pandemic outbreak will last about six to eight weeks.
- Multiple waves (periods during which community outbreaks occur across the country) of illness could occur with each wave lasting two to three months.

Leavitt also touched on the national plan to fund state and local efforts, and said he hoped concerns that the plan funds too much or too little will be resolved soon. Some Democrats criticized the Administration's plan, contending that the $100 million allocated to state and local governments, when weighed against $130 million in cuts to CDC's budget, amounts to a $30 million cut for states to absorb. Rajeev Venkayya, Senior Director for Biodefense for the White House Homeland Security Council, rejected that contention, saying that the federal government will continue to fund state and local planning efforts, and that more details will be released soon.

Pandemic Flu Information:
More information on pandemic flu planning is available at **http://www.pandemicflu.gov/plan/convening.html**.
The checklist for state and local planning is available at **http://www.pandemicflu.gov/plan/pdf/Checklist.pdf**.

continued on pg 19

Washington Watch - continued from pg 18

Treating Children Exposed to Bioterrorism Chemicals New AHRQ Video

HHS' Agency for Healthcare Research and Quality (AHRQ) has released a 27 minute video that trains emergency responders and hospital ED staff in decontaminating children who have been exposed to hazardous chemicals during a bioterrorist attack or other disaster. ***The Decontamination of Children: Preparedness and Response for Hospital Emergency Departments*** provides a step by step demonstration of the decontamination process in real time and trains clinicians about the nuances of treating infants and children, who require special attention during decontamination procedures.

Produced for AHRQ's Bioterrorism Preparedness Research Program by Michael Shannon, MD, MPH, Chief of the Division of Emergency Medicine at Children's Hospital in Boston, the video: outlines key differences between decontaminating children and adults; provides an overview for constructing portable and permanent decontamination showers and designating hot and cold zones; and, provides steps to establishing and maintaining pediatric decontamination capacity in an ED.

A short clip of the video can be found at **www.ahrq.gov/research/deconVideo/decon512k.ram**.
A free, single copy of the video, available in DVD or VHS format, may be ordered by calling 1 800 358 9295 or by sending an e-mail to ahrqpubs@ahrq.gov.

State Appeals Court Says No EMTALA Claim If No Transfer or Discharge

On January 12, 2006, the Michigan Court of Appeals decided that a plaintiff could not pursue a claim against a hospital under ***EMTALA*** (***Emergency Medical Treatment and Labor Act***). Rather, the state court ruled that the defendant hospital was entitled to summary disposition of contract and of *EMTALA* claims brought by a plaintiff on behalf of her deceased husband (Lanman v. Kalamazoo Psychiatric Hospital, Mich. Ct. App., No. 263665, unpublished 1/12/06).

The facts in this case involve a man named Lanman who initially was taken by police to one hospital, which found him in need of inpatient psychiatric care. The police then took Lanman to the Kalamazoo Psychiatric Hospital (KPH) "where he was found in need of care but capable of giving informed consent," wrote the court. Lanman signed a voluntary admission form, was admitted for long term psychiatric care, given medicine for back pain and assigned a room. During the night, Lanman "became increasingly agitated, eventually culminating in a struggle with defendant's staff and injection of a calming drug," the court stated. The court continued that during the altercation, Lanman "stopped breathing, allegedly as a result of compression of his breathing capacity by defendant's staff during the struggle." The KPH staff performed CPR and had Lanman "transported to a general hospital emergency room, where he remained until his death a little more than two weeks later."

The decedent's spouse subsequently filed a suit against KPH, claiming a breach of contract based on the voluntary admission form and an *EMTALA* claim for failure to stabilize. The defendant appealed to the state court because the trial court had denied a motion of summary disposition (i.e., a rapid final determination by the court) of plaintiff's contract claims. The Michigan appellate court agreed with KPH's appeal, finding that the trial court had erred in denying the motion for a summary disposition. The state asserted that the plaintiff's contract claims were, in fact, tort claims because no contract for treatment existed. "The particular form in this case," wrote the appeals court in regard to the voluntary admission form, "only constitutes an offer stating the applicant's desire to be admitted to the hospital in exchange for certain promises. The contract based on this form only ***authorizes*** treatment, it does not require it."

The state court also determined that since the requirements of *EMTALA* are inapplicable in this case, summary disposition of the *EMTALA* claim is required. Inapplicability of *EMTALA* was based on the court's reasoning that the "triggering mechanism for stabilization treatment under EMTALA is transfer," and that, therefore, "*EMTALA* mandates stabilization of an individual only in the event of a 'transfer' as defined in *EMTALA*." Because KPH admitted plaintiff's decedent to the hospital for long term treatment of his psychiatric condition, and developed complications only after being treated and medicated, the majority of the state appellate court concluded that *EMTALA* was not implicated under the facts of this case.

The court majority resolved the *EMTALA* claims on the merits, finding resolution of the immunity issue unnecessary. However, a dissent also was filed with this ruling, possibly leaving open some room for other *EMTALA* claim cases. First, the dissenting opinion suggested that a "more harmonious reading of *EMTALA*'s definition of 'stabilization' does not require that a transfer actually be contemplated."

This dissenting judge reasoned that "*EMTALA* provides a benchmark [i.e., a standard to apply for treating all patients, and therefore] . . . the statute is satisfied if the hospital *could* transfer a given patient without risking deterioration of that patient's condition. If a patient could be transferred safely, the patient is 'stable' under *EMTALA*, irrespective of whether anyone in fact *intends* to transfer the patient."

Second, the dissenting judge also was unwilling to conclude that KPH "has not waived its immunity to an *EMTALA* claim." Rather, the dissent wrote, "I would not hold that an *EMTALA* claim is factually unsupportable, and I would neither confirm nor rule out a waiver of defendant's immunity." This conclusion was based on the idea that because KPH entered into an agreement with the federal government to receive federal Medicare funding, the "Social Security Act unambiguously intends to condition receipt of funds on compliance with EMTALA." The dissent recommended remand for further fact finding on a series of issues underlying the EMTALA claims.

Text of the court's majority opinion is available at **http://courtofappeals.mijud.net/documents/OPINIONS/FINAL/COA/20060112_C263665_30_263665.OPN.PDF**.

The dissenting opinion is available at **http://courtofappeals.mijud.net/documents/OPINIONS/FINAL/COA 20060112_C263665_31_263665P.OPN.PDF**.

AAEM JOB BANK

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 and absent restrictive covenants will be published for a one time fee of $300, to run for a term of 12 months or until canceled. Revisions to a current ad will be assessed a fee of $50.

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

ALABAMA

Independent, democratic group seeking BC/BE emergency medicine physicians. 24,000 annual visits with 8 hours of MD double coverage daily. Employee status with partnership offered after six months. Equitable scheduling, competitive salary based on productivity, and benefits included. Located on the eastern shore of Mobile Bay, Fairhope is a progressive and growing Gulf Coast community. Contact Don Williams, MD, at **baymds@aol.com**. (PA 725)

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

ALABAMA

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

CALIFORNIA

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

CALIFORNIA

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

CALIFORNIA

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

CALIFORNIA

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

FLORIDA

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

FLORIDA

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

FLORIDA

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

GEORGIA

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

KENTUCKY

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

KENTUCKY

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

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

INDIANA

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

MARYLAND

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

MASSACHUSETTS

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

MASSACHUSETTS

The department of Emergency Medicine at Massachusetts General Hospital is seeking candidates for faculty positions at all academic levels. Special consideration will be given to those with an established track record in clinical or laboratory research and a commitment to excellence in clinical care and teaching. Academic appointment is at Harvard Medical School and is commensurate with scholarly achievements.

MGH is an equal partner in the 4-year BWH/MGH Harvard Affiliated Emergency Medicine Residency Program. The ED is a high volume, high acuity level I trauma and burn center for adult and pediatric patients. Annual volume is >76,000. Candidates must have at least 4 years residency plus fellowship training in Emergency Medicine. Send CV to: David F. M. Brown, MD FACEP, Massachusetts General Hospital, Bulfinch 105, Department of EM, 55 Fruit Street, Boston, Massachusetts, 02114. (PA 721)

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)

MISSOURI

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

AAEM JOB BANK

MISSOURI

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

MISSOURI

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

NEBRASKA

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

NEW JERSEY

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

NEW MEXICO

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

NEW YORK

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

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

NORTH CAROLINA

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

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

OHIO

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

OHIO

Oxford, Ohio:Small, single-hospital, democratic group is looking for a full-time emergency physician. Expanding volume creating need for additional positions. Must be Board-Certified in Emergency Medicine. We have had a stable, amicable relationship with the hospital. This is a small (15,000 + students), safe college town, accessible to two metropolitan areas—many excellent cultural, academic and athletic events within 5 minutes. Practice has had excellent revenue and benefits. New billing arrangement promises even better total compensation in 2006 (>90th percentile). Partnership in one year. Come and see why we like it so much! Contact Greg Calkins, M.D. **gcalkins@woh.rr.com** (PA 740)

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

OKLAHOMA

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

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

PENNSYLVANIA

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

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

PENNSYLVANIA

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

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

RHODE ISLAND

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

SOUTH CAROLINA

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

VIRGINIA

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

VIRGINIA

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

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

VIRGINIA

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

WASHINGTON

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

WASHINGTON

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

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:

WASHINGTON

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

WASHINGTON D.C.

Please see ad PA 731 under Maryland.

WISCONSIN

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

AAEM JOB BANK

WISCONSIN

Located between Milwaukee and Madison, full-time opportunity with Watertown Emergency Medicine Physicians, SC, at Watertown Memorial Hospital (**www.watertownmemorialhospital.com**), Watertown, WI. WEP has 4 full-time ABEM certified physicians, 1 part-time EM physician, 6 midlevel providers. 17,000 annual visits, 11-hour dayshifts, 13-hour night shifts, 11-hour day PA/NP coverage on weekends and holidays. (PA 747)

GERMANY

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

SAUDI ARABIA

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

CHANGE OF E-MAIL ADDRESS

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

AAEM MEMBERSHIP APPLICATION

First Name MI Last Name Degree (MD/DO)

Institution

Address

City State Zip

Please check which address this is: ☐ Work ☐ Home

Phone Number—Work Phone Number—Home

Fax E-mail

Recruited by

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: _____

when minutes count

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

MEMBERSHIP FEES

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

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

**** 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 (Renewal after free trial year) ☐ 2 Years $40 ☐ 3 Years $60

PAYMENT INFORMATION

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

Card Number Expiration Date

Cardholder's Name

Cardholder's Signature

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.

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

when minutes count

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