common SENSE

VOLUME 14, ISSUE 3
MAY/JUNE 2007

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

when minutes count

NAEMSP Joins AAEM in Expressing Concern about the ABDM under ABPS

The National Association of EMS Physicians (NAEMSP) has published its position statement in response to the American Board of Disaster Medicine (ABDM). This came alongside the concern expressed by AAEM's EMS Committee and BOD after the announcement that the ABPS had promulgated an alternative route to certification in February 2006 and planned a first certification exam in October 2006.

Extensive discussion and work by our members, those in NAEMSP and those with dual memberships, led to draft statements in each of the professional societies and approval by respective boards of directors in August and October of last year. The AAEM Position Statement (found on page 3) was published in January's *JEM*, and NAEMSP's statement in this quarter's edition of *Prehospital Emergency Care (PEC)*.

Although different in some areas of emphasis and focus to reflect each society's individual mission and limitations, the basic message is one of unity. We remain in opposition to any self-designation of a new board outside ABMS, or ad hoc efforts of ABPS to create a subspecialty outside traditional methods of preparation, without rigorous training programs preparing candidates or validated methods for certification.

We welcome other affected professional societies to evaluate their similar concerns and sign on to existing statements or draft those reflecting their own concerns.

Roger M. Stone, MD FAAEM, Chair, AAEM EMS Committee

The text of the NAEMSP statement is below:
"NAEMSP expresses concern regarding the self-designated American Board of Disaster Medicine (ABDM), a sub-board of the American Board of Physician Specialists (ABPS), a group which is not recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) as a member board. NAEMSP supports the development of new sub-specialties through the recognized ABMS/AOA processes, which involve ensuring that candidates have received appropriate preparation in approved residency or fellowship training programs in accordance with established educational standards, and evaluating candidates with comprehensive validated examinations.

Approved by the NAEMSP Board of Directors, 17 October 2006

NAEMSP Position on American Board of Disaster Medicine. Prehospital Emergency Care 2007;11:240.

INSIDE THIS ISSUE

EDITOR'S LETTER

by David Kramer, MD FAAEM

As the AAEM board of directors (BOD) meets at the SAEM Annual Meeting, I am reminded of the obligation and commitment that we have to all of you. We all have at least one boss; some of us have many. Those individuals we report to are usually easy to identify. If you are not sure who your boss is, you likely have a problem at work. We work for our boss. In addition, we all have many customers or clients. Ask yourself, "who do I work for?" At the hospital, I work for my Chair, the hospital's Office of the President, my patients, my residents, my faculty and the Director of Medical Education (I'm sure I have forgotten some and apologize to them). At home, I work for my wife and children.

Guess what. I also work for you. All of us on the AAEM BOD work for you—our organization's members. We are just like your elected government officials except we (hopefully) are not beholden to any special interests. The only lobbyists who matter to us are you. Our goals are simple. We want to uphold the tenets of AAEM and respond to our membership's needs. I hope we do our job of representing you well. If we do not, you should let us know. Every one of you has a voice and a mechanism to get that voice heard. This newsletter is your voice. You can contribute to it in two ways: articles and letters to the editor (me). If you have issues or concerns that you feel are not being addressed by your BOD, please let us know. We really do care. We have a fiduciary responsibility to the organization, and we do need to be fiscally responsible. But none of that precludes us from entertaining new ideas. Ultimately, we are here to serve you and are honored that you have placed your faith in our ability to do so. So voice your opinions, and submit your thoughts. Feel free to e-mail them to me at CSeditor@aaem.org. We look forward to sharing them with all your AAEM colleagues.

AAEM Mission Statement

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

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

Membership Information

Fellow and Full Voting Member: $365 (Must be ABEM or AOBEM certified in EM or Pediatric EM)
*Associate Member: $250 (Associate-voting status)
Emeritus Member: $250 (Must be 65 years old and a full voting member in good standing for 3 years)
International Member: $125
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.

AAEM Position Statement Opposing the Creation or Recognition of an American Board of Disaster Medicine (ABDM) under the auspices of the American Board of Physician Specialists (ABPS)

The American Academy of Emergency Medicine (AAEM), a national professional society of board-certified emergency physicians, has serious concerns about the creation of the American Board of Disaster Medicine (ABDM) by the American Board of Physician Specialists (ABPS). We note that:

A. The creation of any subspecialty board must follow a rigorous process as board certification is held out to the public as a marker of special expertise. For example, new subspecialty recognition by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) requires demonstration of a distinct body of knowledge and contributions to the scientific literature. There is extensive peer review of the application. The approval process typically takes many years to be completed. No information has been provided regarding the process used by ABPS to declare disaster medicine a recognizable subspecialty.

B. Board certification requires a distinct program of preparation. No information has been provided by ABPS regarding the educational requirements and pathway to certification status. ABPS comments imply that previously acquired knowledge and experience is widespread enough to allow for the creation of the board and the administration of certifying examinations. This approach disregards the few disaster fellowship programs and EMS fellowship programs stressing disaster medicine that already exist and bypasses the traditional method for a physician to obtain specialist status.

C. Creation of any new subspecialty board must be a transparent process and be done by experts in that particular field. No information has been provided regarding the expertise or authority of ABPS to create such a board. If, in fact, disaster medicine is a domain of multiple clinical specialties, the various concerned professional societies need to be involved in the development and ultimate creation of any board addressing this field.

D. A subspecialty board is primarily a certifying body and enforcer of established standards. We are concerned with the statement by a representative of ABPS indicating that the simple existence of a new board is "the integral step towards preparing America's Health Care system so that when disasters strike, we work together." Similarly, a subspecialty board should not be involved in "providing a knowledge base and advice to various organizations that engage in preparedness."

E. A certifying examination must be scientifically created and formally validated as a tool which predicts expertise when passed. No information is provided regarding how or by whom the first certification exam is to be written or scientifically validated.

AAEM opposes the creation of the ABDM under the ABPS. AAEM further strongly cautions against its recognition by any local, state or federal authority as a unique certifying body for expertise in disaster or preparedness fields. Until such time as a formal, standardized and recognized process is completed to create a subspecialty and an appropriate and validated certification process, we oppose the informal and ad hoc efforts of ABPS to assert expertise and authority in this area.

Statement developed by AAEM Emergency Medical Services Committee. Approved by AAEM board of directors. August 14, 2006.

Applicants for Certificate of Excellence in Emergency Department Workplace Fairness

Organization	State
Emergency Medicine Physicians	OH
Kern Medical Center	CA

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

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

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

PRESIDENT'S MESSAGE

Breaking Through Boarders

by Tom Scaletta, MD FAAEM
AAEM President

'ED Boarding Load' is defined as the number of admitted, observed or planned transfer patients divided by the number of ED rooms. The exact number of boarder hours – those after the decision to admit was made and before the patient leaves the ED – can more precisely be calculated and regularly reviewed with other benchmark data. Several abstracts from the 2007 SAEM Annual Meeting demonstrate the negative effects of excessive boarders. As well, "queuing science," a branch of operations management, can help us understand the magnitude of the boarder problem. I would like to present a simple queuing model to demonstrate the effect of boarders in a highly efficient ED.

Consider a five-bed section of a large-volume ED that will receive a steady influx of patients at the constant rate of one every 20 minutes. Assume an exemplary average turnaround time (TAT) of one hour for discharged patients and three hours for admitted patients, as well as six-minutes to turnover a room. If the admission rate is 20%, then the overall TAT is 90 minutes. Starting with an empty ED, a 24-hour 'state transition diagram' (to use a queuing theory term) demonstrates the following activity. (see figure 1)

Figure 1

Hour	Rm1	Rm2	Rm3	Rm4	Rm5	# Waiting
1	D1	D2	D3	x	X	0
2	D4	A5	D6	x	X	0
3	D7	A5	D8	D9	X	0
4	A10	A5	D11	D12	X	0
5	A10	D13	D14	A15	X	0
6	A10	D16	D17	A15	D18	0
7	D19	A20	D21	A15	X	0
8	D22	A20	D23	D24	X	0
9	A25	A20	D26	D27	X	0
10	A25	D28	D29	A30	X	0
11	A25	D31	D32	A30	D33	0
12	D34	A35	D36	A30	X	0
13	D37	A35	D38	D39	X	0
14	A40	A35	D41	D42	X	0
15	A40	D43	D44	A45	X	0
16	A40	D46	D47	A45	D48	0
17	D49	A50	D51	A45	X	0
18	D52	A50	D53	D54	X	0
19	A55	A50	D56	D57	X	0
20	A55	D58	D59	A60	X	0
21	A55	D61	D63	A60	D63	0
22	D64	A65	D66	A60	X	0
23	D67	A65	D68	D69	X	0
24	A70	A65	D71	D72	X	0

Given our assumptions, these five-beds could actually handle 26,000 patients a year … with no waiting! Surprisingly, beds are open 80% of the time allowing for immediate placement of ambulance arrivals. Now, with one change with the original assumptions – adding three hours of boarding to every admission – here is the revised diagram. (see figure 2)

Figure 2

Hour	Rm1	Rm2	Rm3	Rm4	Rm5	# Waiting
1	D1	D2	D3	x	x	0
2	D4	A5	D6	x	x	0
3	D7	A5	D8	D9	x	0
4	A10	A5	D11	D12	x	0
5	A10	A5	D13	D14	A15	0
6	A10	A5	D16	D17	A15	1
7	A10	A5	D18	D19	A15	2
8	A10	A20	D21	D22	A15	2
9	A10	A20	D23	D24	A15	3
10	A25	A20	D26	D27	A15	3
11	A25	A20	D28	D29	A30	3
12	A25	A20	D31	D32	A30	4
13	A25	A20	D33	D34	A30	5
14	A25	A35	D36	D37	A30	5
15	A25	A35	D38	D39	A30	6
16	A40	A35	D41	D42	A30	6
17	A40	A35	D43	D44	A45	6
18	A40	A35	D46	D47	A45	7
19	A40	A35	D48	D49	A45	8
20	A40	A50	D51	D52	A45	8
21	A40	A50	D53	D54	A45	9
22	A55	A50	D56	D57	A45	9
23	A55	A50	D58	D59	A60	9
24	A55	A50	D61	D62	A60	10

Not unexpectedly, the waiting room gets progressively fuller, and we know that this means patient dissatisfaction, lost revenue (walkouts) and our staff is more apt to burn out.

A robust queuing model could incorporate staffing patterns as well as seasonal, time-of-day and day-of-week influxes. It could be tailored to emulate your ED physical space, including the idiosyncrasies of certain examination spaces. Do we really need to hire a bunch of mathematicians, computer programmers and operations

Key:
'Rm1' = room #1
'D1' = the first patient was discharged
'A5' = the fifth patient was admitted
'X' = unoccupied room
□ = ED workup on patient that will be admitted
▢ = Admitted patient boarding in the ED

continued on page 9


società italiana medicina d'emergenza-urgenza
Fourth Mediterranean
Emergency Medicine Congress (MEMC IV)
15-19 September 2007
Hilton Sorrento Palace, Sorrento, Italy
Jointly organised by the
European Society for Emergency Medicine (EuSEM), the
American Academy of Emergency Medicine (AAEM), and
this year with La Societá Italiana di Medicina d'Emergenza-Urgenza (SIMEU)
Registration Opens: 1 March 2007
Early Registration Deadline: 30 June 2007
Housing Reservation Deadline: 15 July 2007
www.emcongress.org
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MedPAC Releases Report on Reforming Physician Payment Schedule

by Kathleen Ream, Director of Government Affairs

On March 1, the Medicare Payment Advisory Commission (MedPAC) released its report to Congress on the Medicare physician reimbursement formula. As expected, the report included two alternatives to the current system, known as the Sustainable Growth Rate (SGR) formula that has been used for the past 10 years to calculate physician reimbursements. The report noted that the current SGR formula would reduce Medicare physician reimbursements by 10% next year and by 40% during the next eight years.

One alternative would "drop the SGR formula approach" and "create new incentives for practitioners to provide better preventive care to head off more expensive ailments." The second alternative would "apportion physician payments on a regional basis tied to the varying costs of treating patients from one place to another" and "reward physicians who clearly improved their efficiency of care."

The report also stated that Medicare should:

- Provide physicians with more guidance on whether they overuse medical services and more accurately calculate prices to eliminate incentives for physicians to use unnecessary services;
- Encourage physicians and hospitals to organize into groups that are measurable on quality of care and efficiency;
- Establish incentives for physicians and hospitals to work together to improve the efficiency of treatment;
- Establish incentives for primary care physicians to provide more preventive and coordinated care;
- Conduct research to compare the effectiveness of different treatments for specific conditions; and
- Encourage younger physicians to establish geriatric practices.

MedPAC remained divided on whether Medicare should continue to use a target level to calculate physician reimbursements, but said in its report that any target level should apply to all health care providers in Medicare, not only physicians.

Some lawmakers expressed disappointment in the report and criticized MedPAC for not making a clear recommendation. At a House Energy and Commerce Health Subcommittee hearing, Representative Anna Eshoo (D-CA) said, "You haven't provided Congress any recommendations," adding, "There's hardly any meat on the bone. You've got to go back to the drawing boards." And Representative Diana DeGette (D-CO) said, "I think we should disband this commission and get a new one, or send this [report] back with instructions that they come up with a recommendation." Subcommittee Chair Frank Pallone (D-NJ) maintained that overhauling the SGR formula was a priority for the 110th Congress and said, "The goal is to try to do some kind of permanent fix and not continue with these annual end-of-the-year changes." He added, "We want to make an effort to do something, if possible, this year, certainly within this session of Congress."

In countering the remarks of members of the Energy and Commerce Subcommittee, House Ways and Means Health Subcommittee Chair Pete Stark (D-CA) said that members of his panel were just as likely to be divided on the issue as MedPAC members. And MedPAC Chair Glenn Hackbarth said, "The complexity of the issues makes it difficult to recommend any option with confidence."

Although MedCAP is nonpartisan, its report gives Democrats a road map for where they might find money to pay for their health care priorities, such as expanding a program that offers health insurance to poor children and finding a way to avoid the 10% payment cut to doctors scheduled for next year. With respect to MedPAC's recommendation to cut reimbursements to the private insurance component of Medicare, known as Medicare Advantage, Pallone agreed and said he wants to steer those overpayments into other health programs. Senate Finance Committee Chair Max Baucus (D-MT) said that he also would look at payments to private insurers for possible savings.

CMS Advises MedPAC of Medicare Physician Pay Reduction

In a letter to MedPAC, the Centers for Medicare & Medicaid Services (CMS) said that, unless Congress intervenes, physician payment under Medicare's pay formula will be reduced 9.9% in 2008. In 2006, Congress erased a scheduled 5% cut for physicians for 2007, but directed that the increase not be reflected in the conversion factor used to set doctor payment, making future fixes more expensive.

After a slowdown in Medicare physician spending a decade ago, CMS said that Medicare physician volume growth and service intensity is "once again experiencing significant growth." The letter continued, "Over the past several years, we have sought out the stakeholder community, particularly physicians, to review these trends to better understand the factors driving the significant rate of growth. To date, we have not been able to come to a conclusion as to the causes of this sustained increase."

CMS added that it has launched several demonstration projects to test new physician payment methodologies that link payment to quality and efficiency, but "it is too early to conclude that any specific approaches are ready for implementation as a national policy." CMS told MedPAC, "While these initiatives show promise, they are in their infancy and need further refinement and analysis before they would be appropriate for widespread adoption and use in the Medicare physician payment system."

New DAWN Report on Drug-Related ED Visits

The Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) has issued the 2005 Drug Abuse Warning Network (DAWN) report. According to this latest report,

continued on page 7

ED visits arising from non-medical use of prescription and over-the-counter drugs rose 21% between 2004 and 2005. In 2004, the number of such visits was 495,732, whereas in 2005 the number was 598,452.

Visits related to cocaine, which leads all illicit drugs, totaled 448,481. In addition, visits involving the use of methadone were up 29%, those involving the use of prescription pain relievers were up 24% and those involving anti-anxiety medications were up 19%.

Other data in the **DAWN** report show that, out of a total of 108 million ED visits to U.S. hospitals in 2005, 1.4 million were drug-related. While 31% of the drug-related ED visits involved illicit drugs, 27% involved pharmaceuticals. In commenting on the report, SAMHSA Administrator Terry Cline said that ED visits provide an opportunity to intervene with drug users and refer them to counseling or other help.

EMTALA: Court Finds Potential Liability For Hospital That Transferred Newborn

According to a federal court ruling, a baby born in a hospital operating room, who quickly developed emergency conditions and was allegedly transferred without being stabilized, is covered by EMTALA. The U.S. District Court for the District of Puerto Rico ruled in Lima-Rivera v. UHS of Puerto Rico, Inc. that the baby born to Iraida Lima-Rivera at Hospital San Pablo del Este (HSPE) "came to" the hospital within the meaning of EMTALA's provisions when he was born in the operating room. The court refused to dismiss Lima-Rivera's claims against HSPE because the allegations were sufficient to preclude summary dismissal.

In finding EMTALA potentially applied to the newborn, who ultimately died following transfer to another hospital, the court rejected HSPE's claims that the law does not apply to patients, like Lima-Rivera's baby, who are admitted as inpatients. The court cited a 1999 federal appeals court ruling that found EMTALA applies to more than just hospital emergency departments. The court, citing Lopez-Soto v. Hawayek, 175 F.3d 170 (1st Cir. 1999), said "emergency room arrival is not a prerequisite to liability under EMTALA's stabilization and transfer provisions," which "are not limited to patients who initially arrive at the emergency room."

The court also rejected the hospital's claim that a 2003 regulation issued by the Centers for Medicare & Medicaid Services (CMS) precluded imposition of EMTALA liability with respect to the period after patients are admitted to a hospital. Although CMS clarified in 42 C.F.R §489.24(d)(2)(i) that EMTALA ceases to apply when an individual is admitted as an inpatient, that regulation is an interpretive rule that lacked "the force and effect of law" and was not accorded any weight in a private lawsuit under the act. Even if the regulation were accorded any weight, the court continued, it was not in effect when the alleged EMTALA violations occurred. CMS published the rule in September 2003, but the alleged violations of EMTALA's stabilization and transfer provisions occurred four months earlier in May 2003.

Having determined that the allegations were sufficient to allow the court to have jurisdiction over Lima-Rivera's lawsuit, the court went on to consider whether the allegations were also sufficient to survive a motion to dismiss. In ruling the dismissal motion premature, the court related that the complaint alleged HSPE was a provider of hospital and emergency medical services covered by Medicare, that the newborn arrived at HSPE "seeking treatment when he was birthed in the operating room after a cesarean section," and the baby presented at the nursery with "tachypnea and evidence of hypotonia, which are medically considered critical conditions."

The plaintiffs also alleged that the hospital medical staff took no action at that time, that the baby subsequently developed upper gastrointestinal bleeding and vomited blood, that the baby was transferred to HSPE's intensive care unit, and that the baby was later transferred, despite his unstable condition, to Hospital Interamericano de Medicina Avanzada, where he died two days later. The court's decision is available at http://op.bna.com/hl.nsf/r?Open=psts-6yzqnh.

What's happening in the states . . .

Tennessee Medical Malpractice Bill Postponed

A medical liability reform bill introduced in Tennessee this legislative session was – for the second time – postponed in the Senate Judiciary Committee, raising concerns from supporters that it could be killed for the sixth time. The legislation calls for a $250,000 cap on noneconomic damages, precertification of cases and a sliding scale for attorney fees based on a case's settlement or judgment amount.

Russ Miller, senior vice president of the Tennessee Medical Association – a major supporter of the bill – said that, while the stall is more encouraging than a disposal, the postponement worries him. "We've been debating the need for reformation of the laws concerning medical liability for five years now and the situation is not improving," Miller said. Opponents of the bill, including the Tennessee Trial Lawyers Association, dispute supporters' position that the bill is needed, in particular their claim that doctors are leaving the state due to rising malpractice insurance premiums.

Similar legislation has been introduced in Tennessee for the past five years, but it has never reached the floor. Last session it was killed by a three-to-two vote in the same committee.

Louisiana Supreme Court Voids Raising State's Medical Malpractice Cap

The Louisiana Supreme Court has vacated an appeals court ruling that the state's $500,000 cap on damages in medical malpractice lawsuits is unconstitutional and must be increased to $1.6 million or $1.7 million. In its September 2006 decision, the 3rd Circuit Court of Appeals had ruled that the $500,000 cap, established in 1975, is valued today at about $146,435 and does not adequately compensate patients who experience malpractice. In addition to vacating the decision, the Supreme Court returned two related lawsuits to the appeals court for reconsideration because of procedural issues. Sue Chopin, a spokesperson for the Louisiana Medical Mutual Insurance Company, praised the Supreme Court decision, which she said

continued on page 8

Why AAEM?

by Mark Foppe, DO FAAEM, Membership Committee Member

Why AAEM? As AAEM continues to grow, the answer to this question continues to evolve. Every member has his or her own reasons for joining AAEM, and although there are sure to be a lot of common experiences, the membership committee would like to hear from you.

A new link has been added to the AAEM website, which the membership committee encourages you to click on, and not only read the responses, but submit a quote of your own. The link can be found on the opening page when you access www.aaem.org. Clicking on the "Why AAEM" tab takes you to a screen where you can read several quotes from leaders of emergency medicine. Take a look at them, and add one of your own by clicking on the tab located in the left column which says "Submit Your Quote." This takes you to a screen that allows you and other members to share thoughts and experiences as to why AAEM is important to the future of emergency medicine.

When the leadership from the state chapters met in Las Vegas at the last Scientific Assembly, almost every chapter discussed that an obstacle they have when trying to grow membership is to answer the question – why AAEM? The membership committee developed this idea for the website last fall, and after hearing from the leadership of the state chapters, it was implemented to gain the assistance from the membership in formulating responses to this question.

I am sure my story is not unique. As a resident, I attended a talk by Bob McNamara, MD, who was invited to speak to our program. I had been "bitten by the EM bug" during my training in medical school and knew that I wanted emergency medicine as my specialty. In residency, I developed a great love for emergency medicine, but I had no idea about the issues that faced my future profession. Upon hearing the *The Rape of Emergency Medicine* lecture from Dr. McNamara, I was relieved to hear about an organization that brought these issues to light and advocated for the "pit doc." I joined AAEM as a resident member that evening.

Since that time, I have attended what I consider to be the best Scientific Assemblies our profession has to offer. You cannot find better CME opportunities in emergency medicine; the value is unsurpassed. *JEM*: nothing more needs to be said about this quality journal provided to our members.

I have witnessed AAEM come to the aid of many of our members when faced with unfair practices and the corporate practice of medicine. I have seen other organizations change the way they elect leadership to allow for representation of the individual practioner because of the stance that AAEM took.

We currently face many challenges to the specialty of emergency medicine. The IOM statement that physicians do not have to be residency-trained in emergency medicine in order to practice emergency medicine is one of them[1]. The attempt by AAPS to claim that they certify EM docs through a practice pathway and want recognition from state boards of their BCEM certification is another.

AAEM is the organization which best represents the "pit doc" and the one I can trust to take the position which protects and represents the interest of the board certified emergency medicine physician. AAEM is the organization we want to support and encourage our residents to join as our young specialty continues to grow and as we face new challenges.

1. Annals of Emergency Medicine.vol 45, Issue 5; pp 614-617. May 2007

Washington Watch - continued from page 7

would benefit health care providers. She added that the decision might delay a final decision on constitutionality of the cap for one to two years.

Utah Bill Raises Standard of Evidence in Malpractice Suits

A malpractice tort reform bill is moving through the Utah state legislature. House Bill 338, which passed the House on February 20th and then was sent to the Senate, increases the standard of evidence required to win a malpractice case against an ED health care professional from the current standard termed a "preponderance of evidence" to a "clear and convincing" standard. The bill's sponsor, Representative Bradley Last (R-St. George), said that the purpose of the measure is to help mitigate liability issues occurring in Utah. According to Last, malpractice liability is pushing doctors out of EDs nationwide, and leading to too few on-call specialists in EDs everywhere. Those opposing the bill claim that it provides doctors immunity from civil suits.

Breaking Through Boarders - continued from page 4

specialists to prove that boarders cause gridlock? Of course not. Simply ask any paramedic that has waited way too long to unload someone.

It is time to let the CEO and VP of nursing know that the inpatient team is letting down the ED and the community by not seeking creative ways to own all the admitted patients. One way to inspire inpatient directors is to transfer a proportionate share of the inpatient-staffing budget to the emergency nursing cost center for boarder care. It's time to even the playing field.

Certainly, when there are more patients in the waiting room, emergency nurses should not be assessing the skin or nutrition habits in a pneumonia admission. Emergency physicians can resist medical staff requests to relay copious admission orders to the emergency nurse. Instead, we might say, "We have twenty patients waiting and would prefer an inpatient nurse to take and carry out non-emergent orders. And, if there is anyone you could discharge tonight, that would really be appreciated." Though such confrontation is uncomfortable, if we stay focused on what is best for patients, we will demonstrate integrity.

Last year, the Institute of Medicine (IOM) published a study, "Hospital-Based Emergency Care: At the Breaking Point." We remain at the verge of collapse and need to challenge this failed system. Ultimately, success will require support from influential agencies. If eliminating boarders was incorporated into the Centers for Medicare & Medicaid Services' Pay for Performance initiative, and if the Joint Commission created a zero-tolerance standard, we would have a juicy carrot and menacing stick.

Upcoming AAEM–Endorsed or AAEM–Sponsored Conferences for 2007–2008

June 28-July 1, 2007
- Giant Steps in Emergency Medicine 2007: The Sun, the Sea….and CME
  Sea Crest Oceanfront Resort and Conference Center
  North Falmouth (Cape Cod), MA
  Conference co-sponsored by Giant Steps in Emergency Medicine and AAEM.
  www.GiantSteps-EM.com

September 15-19, 2007
- The Fourth Mediterranean Emergency Medicine Congress
  Hilton Sorrento Palace, Sorrento, Italy
  Sponsored by the European Society for Emergency Medicine (EuSEM), the American Academy of Emergency Medicine (AAEM) and the Italian Society of Emergency Medicine (SIMEU)
  www.emcongress.org

September 27-30, 2007
- AAEM Written Board Review Course
  Marriott Newark Airport Hotel, Newark, New Jersey
  Sponsored and organized by the American Academy of Emergency Medicine
  http://www.aaem.org

October 6-7, 2007
- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, Los Angeles, Orlando, Philadelphia
  Course sponsored and organized by the American Academy of Emergency Medicine
  http://www.aaem.org

November 27-30, 2007
- Sun BEEM
  Best Evidence in Emergency Medicine Course (BEEM)
  Occidental Grand Resort, Cozumel, Mexico
  Sponsored and organized by McMaster University, Continuing Health Sciences Education
  http://www.beemcourse.com/index.html

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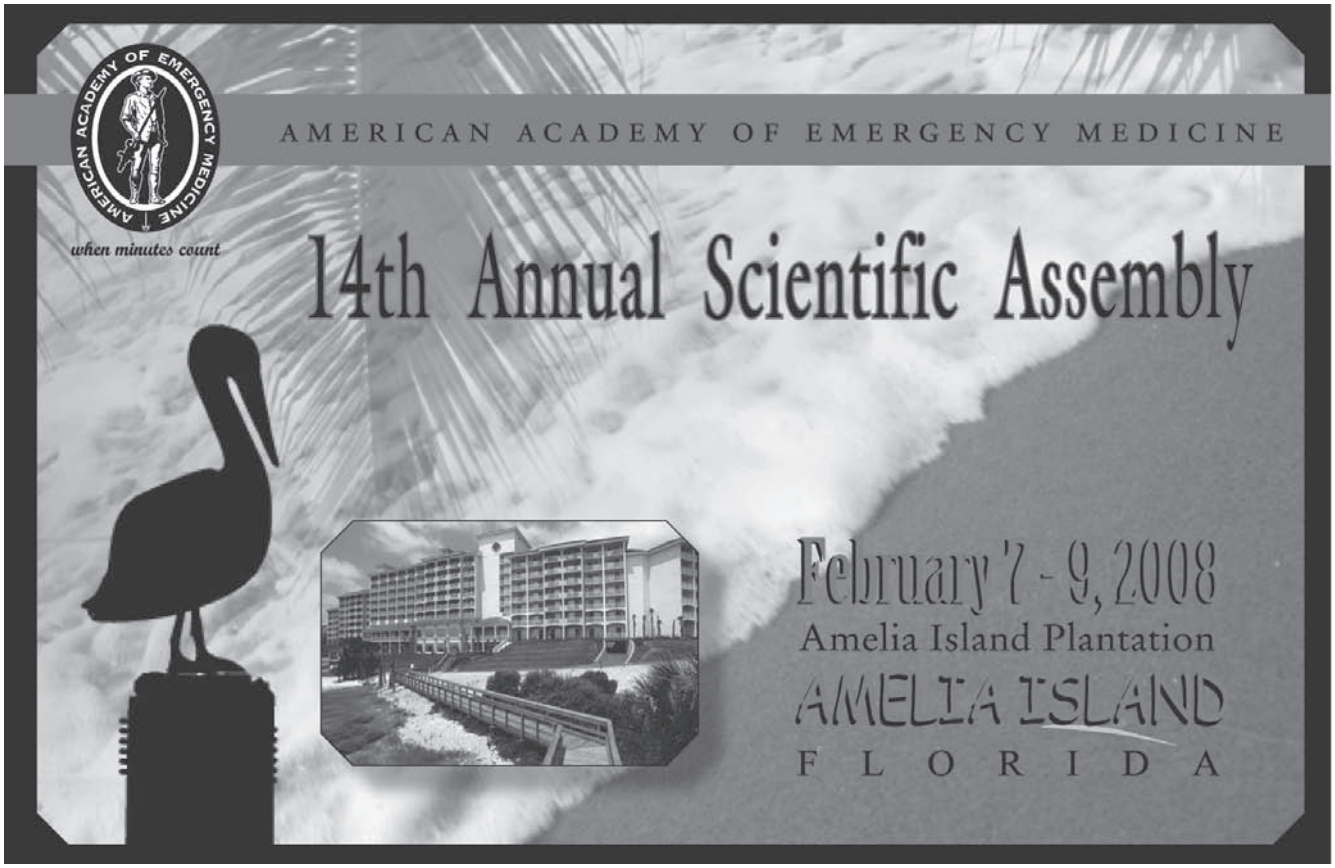

Personal Financial Management and the Young Emergency Physician: The Basics

by Jesse M. Pines, MD MBA FAAEM, Vice President, Young Physicians Section, AAEM
Attending Physician, Hospital of the University of Pennsylvania

Many physicians, especially young physicians, don't know how to manage money. I don't usually use stereotypes, but this one is true: doctors are not good financial managers. How do you learn about managing money? Personal finance is certainly not taught in medical school or residency. There's so much else to learn in emergency medicine. Now you're done with residency, and you're out in the real world with your first job. What do you do now? You're in a financial situation that is unique to physicians: you're probably in your 30s or older, you may or may not have a lot of medical school debt, and now you're making a big salary, (maybe 200k or more). Some of you may have a spouse, kids, car payments, a house payment and maybe even pet insurance. How do you keep from going broke and still have a little fun with your money?

The bad news is, if you don't know how to manage money, it's easy to make mistakes. And the more money you earn the bigger mistakes you can potentially make. The good news is that money management isn't rocket science. If you can finish medical school, you can certainly learn to manage your money. But like any field, you have to know what you're doing first. This article is intended to lay out a few easy strategies for young physicians (and maybe even some of the older ones) to ensure long-term financial health. This list of strategies is not meant to be exhaustive; it merely serves as a guide to start you on the right track. I don't claim to be the Yoda of finance. If you're really interested in learning about personal wealth management in depth, I would recommend either taking a course, going to your local bookstore and buying one of the many books on financial management or meeting with a professional financial counselor.

Step 1: Figure Out What You Have, What You Owe and What You Spend

Begin by asking yourself, "What are my assets and what are my liabilities?" Simply put, your assets are what you already have, such as cash, investments and maybe your car. Your liabilities are what you owe, like the mortgage on your house or your college and medical school debt. Once the big bucks starting rolling in, it's very easy to spend freely, especially if you're single. This is actually the best time to start budgeting and to figure out exactly what you plan to spend. It's OK to buy that new plasma TV or the diamond earrings. Just don't buy them all at once or before you have some tangible savings. Expenses can add up quickly. By writing down your assets, liabilities and a basic budget, you can figure out a starting point.

Step 2: Get Rid of Credit Card Debt

The second step is getting rid of your credit card debt. If you get nothing else out of this article, know that ridding yourself of credit card debt is the best thing you can do to improve your financial health. It's like quitting smoking. Why is credit debt so deadly? Credit cards take advantage of the worst parts of human nature. Credit cards are a racket. Convenient? Yes. And they are actually a wonderful invention if you pay your bills on time. If, however, you carry a balance on your credit card every month, they are the most expensive lender out there (except for maybe Vinny, your bookie). But instead of breaking your kneecaps if you don't pay up, credit card companies will quietly cause your savings to waste away. And who reads all that little writing on the back of the application? It basically says that after your "introductory period," they can charge you whatever they want. Credit cards want you to carry a balance because this is how they make their money. How do you get out of credit card debt? You can try to get a low interest bank loan. 'Nuff said, don't be a sucker. It's like flushing money down the drain.

Step 3: Plan to Increase Your Savings

You may ask: why should I save when it's so much more fun to spend? Gee, I'm out of residency now, shouldn't I treat myself to that BMW 7-series? That may be OK, as long as you save money every month. Saving early is the key to building wealth. The reason for this is a simple concept: time + money = more money. This wonderful economic concept is also called the time value of money. Let me give you a basic example. Let's say you start saving $1,000 per year starting at age 60 and it compounds at an annual rate of 7% per year. When you're ready to cash out at 65, it's worth $7,153.29. Wow, that's a $2,153.29 profit. Now, if we crank the clock back to age 50 and start investing the same $1,000 per year, at the end of 15 years you have $27,088.05 - - for an investment of $15,000. If you start at 40, for the same $1,000 per year investment for 25 years, you'll have $68,676.47, and if you start at 30, you'll have $148,913.46. Save early, save often and start saving now!

Step 4: Improve Your Investment Portfolio

The next step is to improve your investment portfolio, or if you don't have one, start investing in the right things. In Step 3, the assumptions were that you were making 7% a year, compounded. What if you can get a higher return by being invested in the right stocks? But in what do you invest? How you can maximize that rate of return? A

continued on page 12

AAEM Young Physicians Section

Financial Management - continued from page 11

general principle is that the more risk you take, the higher your expected return. At the same time, the more risk you take, the more money you can potentially lose. If you have a brokerage account, the mutual funds will probably give you an idea of a risk profile. Determining your individual risk depends on your own personality and your specific financial goals. The good news for physicians is that our jobs are what economists call inelastic. That means that our business doesn't fluctuate with the economy, like season tickets to your hometown NFL team. Yes, next year people will continue to get into car accidents, develop chest pain and run out of their Percocet for their chronic pain syndromes. What this means is that, barring disaster, you can pretty much plan on a stable income. But when determining your risk profile, you also need to determine what the money is going to be used for. If you need a down payment on a house in six months or need to pay your kids' tuition, you probably shouldn't be invested in a high-risk investment. In general, if you want to invest in individual stocks, you have to 1) have luck on your side and 2) be willing to watch your portfolio carefully. Picking the right stocks and beating the market is very difficult. Some trust Jim Cramer, and others may speak to an investment advisor. If you're more conservative, you might want to choose some balanced mutual funds or just keep your money invested in index funds. If you're still relatively young and don't need your invested money right away for something like a down payment on a house or kids' college, you can probably afford to take more risks and invest in riskier stocks or funds. If you're really risk-averse you can invest in bonds, but they will give you a much lower rate of return.

Step 5: Set Long-term Financial Goals

In general, you should start planning for retirement as soon as you exit the womb. In order to maintain your standard of living during retirement and not spend your kids' inheritance, you will need roughly 65% of your annual income per year. For emergency physicians, this amounts to about $100,000 per year. But what about Social Security? I can only hope that Social Security will still be around when we are able to collect. If you are born after 1960, you can start collecting social security at age 67. In 2004 dollars, your social security benefit will be $1,660 per month. This only adds up to about $20,000 per year. So where does the other $80,000 come from? The answer is retirement income. When you're planning your savings, you need to anticipate how much you will need in retirement in order to maintain your standard of living. If you need $80,000 per year in retirement savings and you're just using income from your investment account, you will need about $2 million in savings at the time you retire. Again, see Step 3, start saving now!

Step 6: Own Your House

If you can afford it, own your house. If you can't afford it, figure out a way to afford it or set a plan to buy your house. The government wants you to own your home as much as I do, but the difference is that the government will give you tax breaks. The good thing that comes from owning a house is leverage. Leverage means that you're investing other people's money (OPM) – that is, a bank's money. Let me give you an example. Let's say you have $100,000 to invest. Scenario one is that you take that $100,000 and it sits in a great mutual fund for 10 years earning a whopping 12% per year – you chose right, Indiana Jones. At the end of year 10, you have $310,585.80, or a profit of $210,585.80. Ready to retire? Now, let's take that same $100,000 and invest it in a house. When you buy a house, you can invest some of the bank's money (OPM); in fact, most loans make you put down 20%. You buy a house for $500,000. Since houses always go up in the long term (since the late 1800s, reliably), let's say it's a lean 10 years and you get 8% per year compounded on your home. At year 10, the house is worth $1,079,462.00, and for that $100,000, you just made a $979,462.00 profit minus expenses to buy and sell. That's leverage - - and you didn't pay rent and you got to deduct a lot from your taxes. So stop hemming and hawing: just do it. Despite the recent downturn, unless California sinks into the ocean as some predict, real estate will always go up.

Bottom line: if you are the head of household and primarily managing the family's money, you need to know the basics. By following these six simple steps, you will be well on your way to financial security.

AAEM would like to thank everyone who participated in the recent elections for the new YPS Board of Directors and congratulate those who were selected by the YPS membership to serve in these roles:

David Vega, MD - President
Joel Schofer, MD - Vice President
Marc Haber, MD - Secretary-Treasurer
Michael Epter, DO - At-Large Board Member
Nimish Mehta, MD - At-Large Board Member
Jesse Pines, MD MBA- At-Large Board Member

RESIDENT PRESIDENT'S MESSAGE

Cheers to All: A Year in Review

by Brian Potts, MD MBA - AAEM/RSA President

As the outgoing President of AAEM/RSA, I plan for my last President's Message to be a short review of the year and to thank those who have made everything possible. It has been a fantastic and memorable 12 months. We continued to grow our membership and develop new benefits for our student and resident members.

First, I wanted to thank each of the past presidents of the RSA for all their work and guidance during my past years serving on the board, as both a student and resident. We would not be where we are today without the achievements and dedication of Mark Reiter, Joel Schofer, Jesse Pines and Jason May. From each of them, I learned a great deal along the way in preparation for serving as the leader of AAEM/RSA for the last year. In the upcoming year, I know that the new RSA President will build upon the foundation that has been laid and do an exceptional job.

Second, I would like to thank the entire Resident Board, their committees, the Student Section leadership and AAEM staff for their help and contribution to the RSA's accomplishments this year. Let me quickly review what has been achieved:

Mark Reiter, Immediate Past President, provided fantastic guidance and advice in countless areas and strengthened our relationship with the AAEM Board.

Betsy Hall, Vice President, led the AAEM Representative Council and maintained our liaison relationship to and collaboration with AAEM's Young Physician Section (YPS).

Andrew Pickens, Secretary-Treasurer, maintained our growing budget and has left us in stronger financial standing for the year ahead.

Sarah Todd, Advocacy Chair, continued to advertise and maintain AAEM Career Network, which assists AAEM/RSA members who are investigating career opportunities in different regions of the country. She also began a new project to track and maintain a database of contract holders in different regions around the country. This project has great potential.

Maureen Gibbons, Membership Chair, developed flyers and membership materials to cultivate new membership and coordinated our connection to EM residency directors. Membership continued to grow, and we increased our number of 100% residency programs by 20% this past year.

Daniel Nishijima, *Common Sense* Editor, did incredible work coordinating and building the RSA Section within *Common Sense*, including two entirely new sections, International EM and Resident Journal Watch. All AAEM members now receive and benefit from the interesting articles that he puts together for each issue for the RSA Section.

David Trickey, Education Chair, led the Education Committee and helped to plan our successful Resident Track lectures and group panel discussion at AAEM's 2007 Scientific Assembly in Las Vegas. We also threw another great RSA party during the first night of the conference that was well attended and fun for everyone.

Jonathan Shultz, Communications Chair, improved our communication with the AAEM/RSA membership through monthly emails and made numerous updates to our website, www.aaemrsa.org, as website editor.

Megan Boysen, Student Section President, led the Student Section and coordinated our student EM interest group liaisons to connect AAEM/RSA to an increasing number of students. She helped maintain EMSelect, which was utilized by over 500 students in this last residency application cycle. She also improved communications with our student members through monthly email updates and monthly "Rules of the Road" chapter summaries to educate students about preparation for a career in EM. At AAEM's 2007 Scientific Assembly, she helped plan the Student Track with lectures and a program director panel.

Janet Wilson, AAEM/RSA Executive Director, performed her mastery for another year by running much of the day-to-day operation of the RSA. We could not do what we do each year without her!

Kay Whalen, Kate Filipiak, Jody Bath and the rest of the AAEM staff helped us throughout the year with numerous RSA projects, website development and other key administrative tasks.

Antoine Kazzi, Past President of AAEM, also deserves special thanks as my mentor and the reason I became actively involved with AAEM over six years ago.

For all residents and students, I encourage you to become more involved in AAEM/RSA. We serve our membership, and we want more members to become active in the organization. Join an AAEM/RSA committee and help guide our efforts with education,

continued on page 17

Emergency Medicine in Sweden

This is a continuing column that examines the practice of emergency medicine in various countries around the world. This issue will look at EM in Sweden. This article is written by J. Sadock, T. Arnhjort, P. Malmquist and N. Aujalay. Dr. Sadock is the director of the Division of International Emergency Medicine at SUNY Downstate/Kings County Hospital and worked in Stockholm as an attending physician. Dr. Arnhjort is a consultant in internal medicine and the Director of the Emergency Department at Södersjukhuset Hospital in Stockholm. Dr. Malmquist is a faculty member in the Department of Emergency Medicine at Södersjukhuset Hospital in Stockholm. Dr. Aujalay completed his EM training in both Sweden and New York and is currently an attending physician at Fairbanks Memorial in Alaska.

Introduction

Sweden recently established emergency medicine (EM) as a medical specialty, in conjunction with another base specialty, and ten hospitals nationwide are now trying to develop training programs for residents. Sweden currently practices the 'multidisciplinary' model of EM. As such, EM is not recognized as an independent specialty, and physicians from other disciplines provide emergency care. Alternatively, in the 'specialty' model for emergency care, emergency medicine is an independent specialty, and patients are treated by trained emergency physicians in the emergency department (ED).[1] In the European Union (EU), this system is currently practiced by the United Kingdom, Ireland, Iceland and the Netherlands.[2] We will describe the recent developments of emergency care in Sweden.

Background

Sweden is one of five Nordic countries and has a population of roughly nine million people living in an area of approximately 500,000 square kilometers. Ten percent of the population are immigrants. The leading cause of morbidity and mortality is cardiovascular disease, but the overall health status of the population is good, with an average life expectancy of 77.5 years for men and 82.1 years for women. Sweden has a large elderly population with approximately 18% of its inhabitants over the age of 65.

The Swedish healthcare system is predominantly publicly-owned with 90 public hospitals and 950 regional primary care clinics. There are very few private clinics. Emergency care is provided by larger hospitals with EDs. Urgent and Primary Care is provided by hospital-based walk-in clinics or by general practitioners in the regional clinics. Patients are often referred from these clinics to the ED for immediate care and testing.[3] Healthcare costs are covered by a national insurance program and funded by taxes on Swedish citizens who pay a very small co-payment at the time of each medical visit.

On average, there is one doctor for every 300 citizens, and close to two-thirds of the physicians are specialists. Sweden currently recognizes 62 different medical specialties. According to Sweden's National Board of Health and Welfare, a significant shortage of physicians is anticipated by 2010 if the current demand for doctors remains unchanged.[3]

Medical Education

Medical training is university-based and begins after completion of secondary school. In total, roughly 1,000 new students are admitted to the six medical schools nationwide each year. Medical students receive their degree after five and a half years of pre-clinical and clinical study. They then complete a one and a half year internship with rotations in various fields. Upon successful completion, they receive their license to practice medicine in Sweden.[3]

Once licensed, the physicians apply for a specialist training program that lasts from five to seven years, depending upon the chosen field. Upon completion, specialists will either be hospital-based or work in a regional health clinic. Specialty certification exams are not required, although some fields have introduced voluntary examinations. Accordingly, there is no compulsory recertification process.

Emergency Medical Services

A formal ambulance system has been operational in Sweden since 1983. Prior to that, emergency calls were handled by fire and police department personnel with limited training in delivering pre-hospital care.[4] Sweden, like other EU nations, has 112 as its emergency activation telephone number.

Dispatch of ambulances is controlled by a regional dispatch center, which may also coordinate fire and rescue calls. Stockholm's dispatch center is the largest in Europe and is buried 30 meters beneath the city to function as a command center in case of disaster. The average response time is approximately seven minutes to the scene. Ambulance personnel are trained in basic CPR and defibrillator use. For calls that are triaged as critical, critical care cars may be dispatched to the scene allowing a registered nurse to deliver more advanced care in the field. These nurses have additional training in anaesthesiology and advanced cardiac life support, but all vehicles are equipped with defibrillators.[5]

This system, however, may delay the time of the patient's arrival to the emergency department where more advanced care can be rendered and has come under scrutiny recently by practitioners of the "specialty" model of EM, formerly known as the Anglo-American system. To date, however, there are limited multinational studies that directly compare this model of emergency

continued on page 16

Resident Journal Review

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

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

1. Stone GW, Bertrand ME, Moses JW, et al. Routine upstream initiation versus deferred selective use of glycoprotein IIb/IIIa inhibitors in acute coronary syndromes: The ACUITY timing trial. JAMA 2007;297:591-602.

Current guidelines recommend administration of glycoprotein IIb/IIIa inhibitors either upstream (prior to angiography) or deferred for selective use in the catheterization laboratory just prior to angioplasty. This study was conducted to evaluate patients with moderate and high-risk acute coronary syndrome (ACS) and to see which strategy (upstream or deferred) resulted in better patient outcomes. This was a multi-center, prospective, randomized trial of 9,207 patients with moderate and high-risk ACS. Patients were randomized either to upstream treatment (n=4605) or deferred treatment (n=4602) with glycoprotein IIb/IIIa agents. The primary outcome measured was composite ischemic events (death, myocardial infarction or unplanned revascularization for ischemia) at 30 days. Composite ischemia at 30 days was found to be not statistically significant (7.1% in upstream group vs. 7.9% in deferred group; $p = 0.13$ for superiority) however did not meet pre-defined criteria for noninferiority ($p = 0.044$ for noninferiority). Deferred use compared with upstream use did result in reduced 30-day rates of major bleeding (4.9% vs. 6.1%; $p = 0.009$ for superiority, $p < 0.001$ for noninferiority).

This study is relevant to emergency physicians because it questions whether or not it may be useful to start glycoprotein IIb/IIIa agents in the emergency department in patients with moderate and high-risk ACS. While a clear-cut management strategy did not evolve from this study, the main point to take away is that there is no definitive benefit to starting glycoprotein IIb/IIIa agents in the ED and there may be an increased risk of major bleeding by doing so.

2. Chalela JA, Kidwell CS, Nentwich LM, et al. Magnetic resonance imaging and computed tomography in emergency assessment of patients with suspected acute stroke: a prospective comparison. Lancet 2007;369:293-98.

This is a single center, prospective study comparing non-contrast CT and MRI for the emergency assessment of suspected acute stroke. A total of 356 patients were included with all patients receiving both MRI and CT with MRI being done first. Sensitivities were determined relative to final clinical diagnosis. MRI detected acute ischemic stroke in 46% of patients (sensitivity 83%; 95% CI 77-88%) while CT detected acute ischemic stroke in 10% of patients (sensitivity 16%; 95% CI 12-23%). MRI was similar to CT for the detection of intracranial hemorrhage. In patients scanned <3 hours from symptoms onset, MRI was also better at detecting acute ischemic stroke (sensitivity 73%) versus CT (sensitivity 12%). The authors concluded that MRI is the preferred imaging in the evaluation of acute stroke.

This study adds to the growing body of literature that MRI is a better diagnostic tool for the evaluation of acute stroke. While logistical difficulties limit the use of MRI as the initial diagnostic study in emergency departments, many stroke centers are using MRI to make therapeutic decisions, including the use of thrombolytic therapy.

3. Corbo J, Fu L, Silver M, et al. Comparison of laboratory values obtained by phlebotomy versus saline lock devices. Acad Emerg Med 2007;14:23-28.

The authors looked at the utility of a peripheral saline lock device (SLD) as an alternative to a second venipuncture for obtaining various blood tests. A total of 81 patients were enrolled and in 73 patients SLD could be aspirated for testing. SLD aspirates were done by placing a tourniquet proximal to the SLD and wasting 5 cc of blood before taking blood samples via vacutainer adapter. Any infusions were halted at least 2 min prior to tourniquet placement. The SLD aspirates were then compared to standard venipuncture with a 21-G butterfly needle. Samples analyzed were hematocrit, electrolytes and cardiac enzymes. Using a concordance method of the 584 paired values analyzed, 35 (6%; 95% CI 4.3-5.2%) exceeded the limits of agreement. Authors concluded that aspirating blood via a SLD provides accurate laboratory values.

The results of the study are promising, as it shows high rates of correlation between standard venipuncture and the drawing of blood through a saline lock device. This equals less patient pain and less risk for needlestick injury. The main limitation of this study is that the patients were relatively healthy. For example, none of the patients had positive troponin values.

4. Magazzini S, Vanni S, Toccafondi S, et al. Duplex ultrasound in the emergency department for the diagnostic management of clinically suspected deep vein thrombosis. Acad Emerg Med 2007;14:216-220.

continued on page 17

Emergency Medicine in Sweden - continued from page 14

care with a system that attempts to deliver the patient to the hospital after delivering less care in the field, as in the Franco-German model of emergency care.[6]

Sweden has phased out most critical care cars recently, and there are now only two remaining to cover Stockholm and the surrounding areas. Instead, it is anticipated that all ambulances will have a registered nurse present by 2007.

Emergency Department Features

Organization

ED organization varies with the type of hospital in Sweden. In general, at the major teaching hospitals, patients are triaged according to both the nature of their complaint and the acuity of their illness. A patient with a presumed "medical" complaint will be directed to the medical side of the ED, whereas a patient with a presumed "surgical" complaint would be placed in the surgical area and likewise for patients with orthopedic injuries. Patients with urgent complaints are triaged to the Urgent Care area, which is often part of the larger ED.

At Södersjukhuset (Stockholm South Hospital) in Stockholm, Sweden's largest ED, patients who are triaged as "critical" will be placed in an area for the sickest patients, regardless of the nature of their complaint. Patients who are deemed unstable may be triaged directly to the Intensive Care Units and bypass the ED altogether. The annual patient volume at Stockholm South Hospital is 88,000, with 33% percent requiring hospital admission and 3% requiring admission to an intensive care unit.

Staffing

In general, the large university EDs are staffed by interns, residents and specialists from differing fields. Depending on the work schedule for the day, a patient is as likely to see an intern as a fully-trained specialist. At Stockholm South Hospital, there is no formal system to present all cases to a specialist. If the intern or resident feels comfortable with a patient's management, they are allowed to use their best judgement and to act independently. They may call for a specialist on an on-call basis. At nights and on weekends, when patient volume is lower, there may be no specialist present in the ED at all, although a call system is in place so that someone can be reached either in-house or at home, depending on the schedule for that day.

For trauma or critical "alarm" cases, an alert system can be activated to rapidly summon a team of specialist physicians and nurses to assist the resident or intern. At Stockholm South Hospital, ED shifts for emergency residents vary from eight to eleven hours, and they may not work more than 36 hours per week.

At any given time, 15% of the residents working in the ED are rotating for three month periods as part of their training in another specialty, in addition to several rotating interns. This high turnover rate creates poorly-regulated emergency care, especially when combined with a tendency for autonomous working roles, an absence of specialists trained in emergency medicine, limited working hours and no mandatory specialist examinations.

Emergency Medicine Curriculum

The Swedish residency program is modeled after the European Curriculum for Emergency Medicine. There is currently no national consensus regarding an EM curriculum in Sweden, so each hospital is developing its own model for teaching and practicing. In general, residents will rotate through different specialties for several months at a time, in addition to working clinically in the ED.

At Stockholm South Hospital, EM residents rotate through medicine, anesthesia, general surgery, orthopaedic surgery, ophthalmology and ear, nose and throat surgery. Out of hospital rotations include working in substance abuse clinics, pediatrics and a brief EMS experience. There is also disaster training, ATLS and "AHLR," a less intensive Swedish version of ACLS.

Emergency Medicine as a Specialty

Emergency medicine had its origin in Sweden in the mid 1990s, as healthcare personnel re-evaluated the overall efficacy of emergency medical care. In Stockholm specifically, patient volumes at primary care clinics began to rise, and the overflow was absorbed by hospital emergency departments.

At Stockholm South Hospital, three factors contributed to the development of more formalized emergency medicine practice: a poor working environment for physicians with long shifts and rapid turnover, excessively long patient waiting times and a need to have fewer patient assessments by multiple specialists in the ED. Consequently, the hospital restructured its emergency department organization in 2000.

Other hospitals nationwide were facing similar problems and also began to revaluate their emergency care programs as well. During this period, the Swedish Society for Emergency Medicine (SWeSEM) was formed, and a growing interest in emergency medicine arose among the country's younger physicians.

In 2006, the Swedish Cabinet of Ministers declared emergency medicine as a medical specialty in conjunction with a base specialty in another field such as medicine or surgery. Residents will choose a base specialty and will then complete additional specialist training in emergency medicine. The total length of training may not exceed eight years, but the residents will be able to fulfill requirements in both specialties concurrently.

This development will provide Sweden with the framework to develop a national curriculum, to offer residents in emergency medicine professional security in the field and to support current efforts to develop and advance the quality of emergency medical care throughout the country.

continued on page 17

Resident Journal Review - continued from page 15

Authors evaluated the accuracy and safety of an emergency duplex ultrasound (EDUS) performed by emergency physicians in the emergency department for suspected deep venous thrombosis (DVT) compared to a formal duplex ultrasound evaluation by a radiologist. A total of 399 consecutive patients with suspected DVT were evaluated by two emergency physicians who performed an EDUS. The emergency physicians received a 30-hr ultrasound course prior to the study. Patients were classified as having a normal, abnormal or uncertain EDUS. Abnormal and uncertain studies were treated while a normal study was not. All patients had a repeat formal ultrasound by a radiologist within 24-48 hours. The EDUS findings were normal in 301 (75%) patients, abnormal in 90 (23%) patients, and uncertain in 8 (2%) patients. All abnormal ED studies were confirmed by the formal ultrasound and 3 patients with uncertain findings on the ED studies were diagnosed with distal DVT (positive predictive value 95%; negative predictive value 100%). No patients with normal findings on EDUS died or experienced venous thromboembolism at the one-month follow-up.

While the accuracy of the EDUS compared to formal US in this study is impressive and suggests that treatment decisions can be made based on EDUS by trained emergency physicians, it is questionable how applicable the results of this study are. First of all the training was extensive: a 30-hour course with lectures and supervision by a radiologist. The EDUS examination itself was also extensive, including studies of multiple proximal and distal veins with color imaging and Doppler analysis. The time constraints of a busy ED may make it difficult to consistently reproduce this extensive US study.

5. Becker T, Kharbanda A, and Bachur R. Atypical clinical features of pediatric appendicitis. Acad Emerg Med 2007;14:124-129.

In this single center, prospective, observational study, the authors evaluated the frequency of atypical clinical features among pediatric patients with appendicitis. A total of 755 pediatric patients (3-21 years old) with suspected appendicitis were enrolled and had a standardized data collection form filled out. In all, 36% of patients were diagnosed with appendicitis. Of patients with appendicitis, the most common atypical features were absence of pyrexia (83%), absence of Rovsing's sign (68%), normal or increased bowel sounds (64%), absence of rebound pain (52%), lack of migration of pain (50%), lack of guarding (47%), abrupt onset of pain (45%), lack of anorexia (40%) and absence of maximal pain in right lower quadrant (32%). In all, 44% of patients with appendicitis had 6 or more atypical features. The atypical feature that was the strongest negative predictor of appendicitis was WBC < 10,000 per cubic mm (negative LR 0.18; 95% CI 0.13-0.22).

It is well known that pediatric patients often have an atypical presentation of appendicitis. This study reaffirms this by providing a relatively large prospective cohort of pediatric patients outlining the frequency of atypical clinical features in appendicitis. One does have to question whether 18-21 year olds should be considered pediatric patients.

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Resident President's Message - continued from page 13

membership, advocacy and communications. Serve as your residency program's representative to the AAEM/RSA Representative Council. Run for an AAEM/RSA Board position.

If you are a graduating student, I hope that you continue your membership as a resident member. If you are a graduating resident like me, we hope that you will maintain your ties as a member of AAEM. The newly developed Young Physician Section (YPS) of AAEM will be a great organization for recent graduates to stay connected.

Support AAEM, since AAEM will stand to support you throughout your career.

EM in Sweden - continued from page 16

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Spotlight On Dr. David K. Wagner

by Daniel Nishijima, MD

David K. Wagner has been one of the biggest contributors to emergency medicine since its very beginning. Dr. Wagner played a leading role in the establishment of the American Board of Emergency Medicine (ABEM) and has been one of the biggest supporters of AAEM over the years. I had the great pleasure to sit down and interview Dr. Wagner at the 2007 AAEM Scientific Assembly in Las Vegas. It was an amazing experience to speak to this very warm and humble physician who has been working in the emergency department for 41 years. During the hour we spoke, it was a pleasure to see numerous previous residents and colleagues stop by and exhibit obvious respect and affection for Dr. Wagner.

Q. How did you enjoy this year's Scientific Assembly?

I loved it. I try to go the SA every year and the change over the years is dramatic. The quality of presentations this year is very impressive. You can tell that the physicians that came out here are not just here to play the slots; they have a lot of energy and are excited to learn from some really great speakers.

Q. What are you doing currently?

Although I have recently stepped down as chair of the Department of Emergency Medicine, I am still very active as a professor at Drexel University College of Medicine. I still do 1-2 shifts per week in the emergency department. I also work with Drexel medical students 1-2 days per week in the Problem Based Learning track, facilitating clinical scenarios. I also teach Medical Ethics courses with the medical school. I truly enjoy working with residents and medical students, as they are very knowledgeable, and not just in medicine.

Q. You have been in emergency medicine from its inception. What have been the biggest changes over the years?

I think one of the most important changes that I've seen is the level of respect that our field has gained over the years. In the very beginning, there was very little respect for emergency medicine among the different fields, and there was very little belief that emergency medicine would amount to much or even last. However, over time, emergency medicine has become a cornerstone of healthcare.

This due respect has occurred because of credible residencies that have gotten better and better over the years as emergency medicine is getting more and more competitive. We continue to attract better and better medical students. The residents have gotten better each year.

The second big area of change is that emergency medicine has emerged as a critical organ in healthcare and a legitimate area of specialization. I think our colleagues from different health fields have finally developed a mutual respect for emergency medicine.

Q. What are some of the problems facing emergency medicine today?

There are many problems facing healthcare in the United States as a whole, such as the growing number of uninsured, the overcrowding of the emergency department and the limited access to healthcare for many. The US spends the most per capita in healthcare, yet it has some of the least favorable outcomes of all the developed countries around the world. The problems facing healthcare in this country involve all fields, and emergency medicine is big enough to be at the table of decision makers in directing the healthcare field in this country. We must remember that emergency medicine is a specialty that grew out of the demands of our patients rather than out of the demands of physicians. We must continue to put the patients' best interests at the forefront.

Q. Why are you involved with AAEM?

While ACEP focuses on practice management and SAEM focuses on academic emergency medicine, AAEM, I think, focuses on the best of those two areas. For example, AAEM has a more structured and stringent approach to practice management. There is definitely room for all three organizations, and all three are prospering. I definitely think that the goals and principles of AAEM appeal to residents. AAEM realizes that residents are the future of emergency medicine, and I think residents see and understand this.

Q. As someone who has had a long and prosperous career, what type of advice would you give to residents starting their careers?

First of all, there isn't a single path for everyone. You need to look within and see what you want and how to get there. If someone told me what I'd be doing with my career as an intern, I'd say they were crazy. There have been so many zigs and zags in my career that have been unexpected. I'd recommend keeping an open mind, follow your vision and don't be afraid to take some zigs and zags. A lot of it is serendipity and luck. But if you construct your goals around being a quality physician first and foremost, and enjoy what you do, you will be fine.

AAEM/RSA in Las Vegas: A Recap of the 13th Annual AAEM Scientific Assembly

by Daniel Nishijima, MD, AAEM/RSA Common Sense Resident Editor

Over 200 residents and students from around the country descended on Las Vegas for the 13th Annual AAEM Scientific Assembly. They were rewarded with presentations from some of the biggest names in emergency medicine, a wide selection of top-notch courses and a stimulating slew of original research by residents and students. All of this in the palatial settings of Caesars Palace, blue skies and unusually warm March weather (mid-80s!) for Las Vegas. Here's a quick recap of all the events and awards:

Awards

Every year AAEM recognizes individuals who have made significant contributions to AAEM and emergency medicine over the past year. This year the following individuals were awarded:

David K. Wagner Award
awarded to individuals who have had a meaningful impact on the field of emergency medicine and who have contributed significantly to the promotion of AAEM's goals and objectives.

A. Antoine Kazzi, MD FAAEM
Antoine Kazzi is the Director of Emergency Medicine at the American University Hospital in Beirut, Lebanon.

Young Educator Award
recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs and has been out of residency less than five years.

Jim Colletti, MD FAAEM
Jim Colletti is the Associate Program Director in Emergency Medicine at the Emergency Medicine Residency Program at Regions Hospital in St. Paul, MN.

Resident of the Year Award
recognizes a resident member who has made an outstanding contribution to AAEM.

Elizabeth Weinstein, MD
Elizabeth Weinstein is a fifth year combined - EM-Pediatrics resident at Indiana University School of Medicine.

James Keaney Award
recognizes an individual who has made an outstanding contribution to our organization.

Mark Batts, MD FAAEM
Mark Batts in an emergency physician at Edward Hospital in Naperville, IL.

Peter Rosen Award
recognizes individuals who have made an outstanding contribution to AAEM in the area of academic leadership.

Peter De Blieux, MD FAAEM
Peter De Blieux is the Director of Resident and Faculty Development, Section of Emergency Medicine at LSU School of Medicine.

Jorge Martinez, MD FAAEM
Jorge Martinez is the Director of Clinical Emergency Medicine Services at LSU School of Medicine/Charity Hospital.

Trevor Mills, MD FAAEM
Trevor Mills is the Residency Director, Section of Emergency Medicine at LSU School of Medicine/Charity Hospital.

Keith Van Meter, MD FAAEM
Keith Van Meter is the Chief of the Section of Emergency Medicine at the LSU School of Medicine.

Joe Lex Educator of the Year Award
recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs.

Richard Nunez, MD FAAEM
Richard Nunez is at Charlton Memorial Hospital in Fall River, Massachusetts.

Program Director of the Year
recognizes an EM program director who has made an outstanding contribution to AAEM. The winner of this award will be chosen by the AAEM Resident and Student Association.

Robert C. Harwood, MD FAAEM
Robert Harwood is the emergency medicine program director at Advocate Christ Medical Center in Oak Lawn, IL

AAEM/JEM Original Research Competition
Amish Shah, MD - 1st Place
Nima Majlesi, DO - 2nd Place
Julia Wang, MD - 3rd Place

continued on page 20

Las Vegas/Scientific Assembly - continued from page 19

Monday
Monday brought a full day of activities and talks. The conference opened with a bang with Jon Krohmer, MD, Deputy Chief Medical Officer, US Department of Homeland Security, as the keynote speaker. He was followed by a strong lineup of emergency medicine's biggest hitters including Amal Mattu with his annual cardiology literature updates, Brent Asplin who spoke about the IOM report and Corey Slovis who tackled emergencies in the alcoholic patient. The afternoon session included presentations by William Brady, Ghazala Sharieff, Maureen McCollough and Tom Scaletta, among others.

Meanwhile, Stephen Hayden, Editor-in-Chief of the *Journal of Emergency Medicine* moderated the AAEM/JEM Resident and Student Original Research Competition. First place was awarded to Amish Shah, MD, from Lincoln Medical Center, who described a novel method for measuring central venous pressure. Second place went to Nima Majlesi, DO, from Morristown Memorial Hospital, who studied the lack of efficacy of steroids in acute migraine headaches. Third place went to Julia Wang, MD, from Kern Medical Center, who studied the significance of laboratory testing for the medical clearance of psychiatric patients in the ED.

The current AAEM/RSA board, presided over by President Brian Potts, held its last in-person meeting of the year. Among the topics discussed were expanding the AAEM Career Network website to include regional contract holders, action items from the latest CORD meeting, planning for the transition to the new board and planning for the SAEM conference in May.

Meanwhile, Megan Boysen, President of the RSA Medical Student Section, and her student colleagues put together another successful Student Track for the 50-plus students who attended the Scientific Assembly this year. The Student Track was highlighted by a great presentation "Succeeding in Medical School, the Match and Residency," by Gus Garmel, MD, from the Stanford/Kaiser Emergency Medicine Residency Program. This was followed by a Program Director Panel featuring directors from around the country.

The RSA events capped off, as the RSA and the Young Physicians Section (YPS) jointly hosted the RSA/YPS party held at the beautiful Empress Court within Caesars Palace. PEPID, LLC, graciously helped sponsor the party with drinks and appetizers.

Tuesday
The next day brought more great presentations from the likes of Michelle Lin, Mel Herbert, William Mallon, Joe Lex and Peter DeBlieux discussing topics from pitfalls in orthopedic radiography to managing the septic patient. Despite the many distractions Las Vegas provides, it was amazing to see packed audiences for all of these great presentations.

The afternoon session brought the AAEM/RSA Resident Track. Eric Maniago led off with a vital "Coding/Charting/Billing" presentation. It was a topic that residents requested during the planning stages of the Resident Track and was well-received. Dr. McNamara flexed his oratory muscles and gave his usual dynamic presentation on "The Future of Emergency Medicine." This presentation by Dr. McNamara should be a requirement for all emergency residents to see at least once. The final hour of the AAEM/RSA track was a group practice panel moderated by Dr. Potts. The panel included emergency physicians from academic programs, Indian health services, the military and various group practices.

Wednesday
The conference wound down the final day with a panel discussion looking at managing the violent patient in addition to more great presentations by J. Christian Fox, Jay Kaplan, Dale Birenbaum, Michael Luszczak, Michael Winters and Chandra Aubin. In a parallel track, Richard Shih and Michael Silverman reviewed LLSA articles.

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 or info@aaem.org to update your information.

Student Track at the Scientific Assembly

by Megan Boysen, MSIV
President, Student Section 2006-2007
Future PGY-1, Emergency Medicine, UC Irvine Medical Center; Orange, CA

Over the past five years, the medical student section of AAEM/RSA has continued to gain strength as an active voice within the Academy. This was clearly evident during the 13th Annual Scientific Assembly in Las Vegas. Over 50 students were in attendance, participating in both the JEM Resident/Student Research Competition and the Medical Student Track on Monday, March 12.

Dr. Gus Garmel of Stanford/Kaiser Emergency Medicine Residency Program was the Student Track's distinguished speaker. In a truly outstanding presentation, Dr. Garmel discussed, "Succeeding in Medical School, the Match and Residency." Directly following Dr. Garmel's talk was the Program Director Panel, featuring Kevin Rodgers, Indiana University/Methodist Hospital; Stuart Swadron, Los Angeles County and University of Southern California; Deana Young and Michael Epter, University of Nevada, Las Vegas; LTC Benjamin Harrison, Madigan Army Medical Center; Jonathan Davis, Georgetown/Washington Hospital Center and Gus Garmel. Many students also attended the AAEM/RSA and Young Physicians Section social event, the opening reception, the Resident Track and the main conference speakers.

If it was your first time attending an emergency medicine conference, you may have realized what a tremendous opportunity it was to further your professional growth. Not only was it a head-first introduction to the field, it was also a chance to socialize with faculty and program directors outside the setting of a rotation or interview. You may have answered some of the following questions: Is emergency medicine the right field for me? Are these the type of people I see myself socializing with throughout my career? What's going on in EM research? Do these topics interest me? How can I become more involved in EM leadership? How can I start to make contacts with faculty members and mentors? How can I strengthen my EM residency application?

Hopefully, you came away from the conference with a new-found fervor for the field of emergency medicine. If you were unable to attend, opportunities await you in AAEM in 2008 or through ACEP, SAEM, regional meetings or the Southern California Student Workshop Symposium, to name a few.

This year's success at the Scientific Assembly stemmed not only from the dedication of AAEM's staff and leadership, but also from the active involvement of resident and student members. The enthusiastic participation of young AAEM members at this year's conference is a testament to the quality of emergency physicians who will lead AAEM into the future.

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

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

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

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

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

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

* CALIFORNIA

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

* COLORADO

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

* FLORIDA

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

* FLORIDA

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

Rochester, NY. Chairman-Dept. of Emergency Medicine, Unity Health System. Opportunity to lead Unity Hospital's new, state-of-the-art Emergency Center opened in February 2006 with 30 private treatment rooms and 28 Special Care Units. Required: NYS License, Board Certified/Emergency Medicine. Prior administrative leadership preferred. Demonstrated commitment to high-quality, cost effective, evidence-based care as well as hospital-wide collaboration. For consideration, send a CV to the search committee through Paula Dolan, VP–Human Resources at pdolan@unityhealth.org. (PA 780)
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Email: mark-brandenburg@ouhsc.edu

* OKLAHOMA

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

* PENNSYLVANIA

The Department of Emergency Medicine at Drexel University College of Medicine is conducting interviews for Program Director of Emergency Medicine. Candidate must be residency trained and board certified in Emergency Medicine. Subspecialty board certification and research experience are highly desired. The Drexel University College of Medicine carries on the fine tradition started with the first three year residency in Emergency Medicine at the Medical College of Pennsylvania (MCP) in 1971. Send CVs to Richard J. Hamilton, MD, Chairman Dept of EM, DUCOM 245 N. 15th St., Mailstop 1011, Philadelphia, PA 19102 or fax: 215-762-1302. (PA 769)
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* PENNSYLVANIA

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

* RHODE ISLAND

Emergency Room Physician: Westerly Hospital, a pleasant seaside community located in the southwest corner of Rhode Island with 30,000 ED visits per year to our state-of-the-art Emergency Department wing, has a full-time position available for an emergency physician. Candidates must be board-certified/board-eligible in Emergency Medicine with a minimum of 2 years experience. Coastal living and a collegial atmosphere make this a great place to work. Please send CV with cover letter to M. Eddy, Medical Staff Coordinator, The Westerly Hospital, 25 Wells St., Westerly, RI, 02981. Fax 401-348-3802 or meddy@westerlyhospital.org (PA 760)
Email: meddy@westerlyhospital.org

* SOUTH CAROLINA

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

* SOUTH CAROLINA

McLeod Regional Medical Center is seeking EM Physicians for full time employment. Competitive salary and benefits. Hospital Employee. 80+ hours of daily coverage in 8, 10, and 12 hour shifts, with additional NP hours. McLeod has 371 beds and is a Level II Trauma center. Contact Tiffany Ellington: 843-777-7000 or tellington@mcleodhealth.org. (PA753)
Email: tellington@mcleodhealth.org

* SOUTH CAROLINA

Growing/stable South Carolina Emergency Medicine group needs additional BP/BC emergency physicians for 80,000 patient ED. Join a democratic group which is physician owned and led. The group is committed to quality care and patient satisfaction utilizing Press Gainey measures. Our group has no financial or staffing differential for partnership. Growing area within the midlands of South Carolina with healthy economy, great climate, low cost of living and abundant recreational opportunities. Send CVs to Carolina Care, PA, 215 Redbay Rd., Elgin, SC 29045, 803-622-3081, or email gconde@carolinacare.com. (PA789)
Email: gconde@carolinacare.com

*• TENNESSEE

Democratic Group seeking BC/BE emergency physicians. Two hospital contracts/100,000 patients yearly. Two year full partnership. Square schedule with nights in direct proportion to number of shifts, except first 2 yrs. 2 extra overnights per schedule, $350.00 per extra night worked. First schedule no single coverage (night or first shift). Please contact Russ Galloway for details 615-895-1637, GAL1958@comcast.net. (PA756)
Email: GAL1958@comcast.net

* TEXAS

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

* TEXAS

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

* TEXAS

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

* TEXAS

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

* TEXAS

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

* TEXAS

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

* TEXAS

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

* TEXAS

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

* TEXAS

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

* VIRGINIA

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

* VIRGINIA

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

* WYOMING

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

* WYOMING

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

* AUSTRALIA

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

* GUAM (USA)

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

* LEBANON

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

* NEW ZEALAND

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

ALABAMA

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

CALIFORNIA

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

CALIFORNIA

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

FLORIDA

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

KENTUCKY

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

NEW YORK

Emergency room staff physician BC/BE in Emergency Medicine. Excellent salary & benefit package. Please call for more information (914-944-8313). Please submit CV to apply@executivehealthsearch.com. (PA 763)
Email: apply@executivehealthsearch.com

TEXAS

Texas A&M University System, Health Science Center. Full time emergency medicine faculty positions available in Corpus Christi, Texas. Outstanding opportunity for academic career oriented individuals. Protected academic time for research and interaction with residents and medical students. Excellent clinical environment in high acuity emergency department of regional tertiary facility. Academic appointment commensurate with experience. Superb remuneration and benefits package. Candidates must be board certified/board prepared in emergency medicine. Responsibilities included teaching and clinical supervision of rotating residents. An application for an EM residency has been submitted to the ACGME. Corpus Christi is a coastal paradise where recreational opportunities abound. For further information please contact Bel Flores at 2626 Hospital Blvd. 3W, Corpus Christi, Texas, 78405 or call 361-902-6570. (PA 762)
Email: Belinda.flores@christushealth.org

WASHINGTON

Washington, Kitsap Peninsula: We staff two brand-new EDs seeing a total of 60,000 pts/annually and seek a full-time BC EM Physician to expand coverage. Established, progressive, democratic group with excellent compensation and benefit package. Mountain and Ocean recreation opportunities abound. One-hour ferry ride to Seattle. See Website: www.harrisonmedical.org Email CV to: Gail Donavan at gdonavan@harrisonmedical.org. (PA 765)
Email: gdonavan@harrisonmedical.org
Website: www.harrisonmedical.org

WASHINGTON

Full-time BC/EM physician to work as an independent contractor with the PhyAmerica Government Services, Inc. at Naval Hospital Bremerton, WA. No WA state license required. Work 40 hours per week. Contact Ruby Mangum 1-800-476-4157 ext. 4645 rmangum@phyamerica.com. (PA 766)
Email: rmangum@phyamerica.com

WISCONSIN

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

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

when minutes count