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common SENSE

The Newsletter of the American Academy of Emergency Medicine — Volume 12, Issue 5— November/December 2005

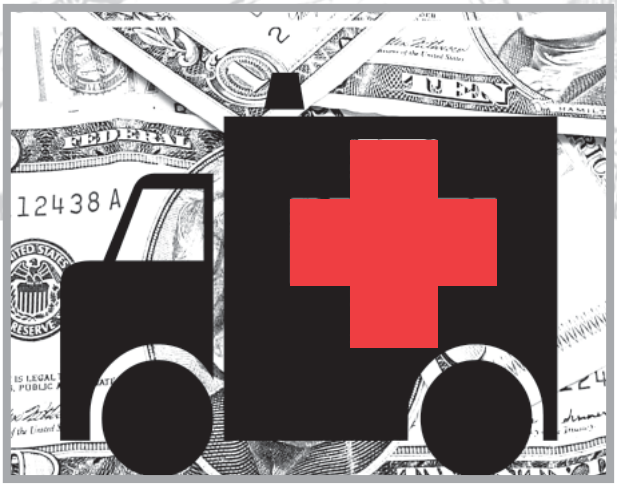
Restrictive Covenants: AAEM and its Foundation Assist Indiana Member

by Robert McNamara, MD FAAEM

In early June a member from Indiana, John Cronkhite, MD FAAEM, contacted AAEM regarding difficulties he was having related to a restrictive covenant imposed by his former multi-hospital group. Dr. Cronkhite sought our assistance, because he had read about our recent successes in acting on behalf of practicing emergency physicians. The AAEM executive committee analyzed the matter noting that a practice environment "free of restrictive covenants" is part of the AAEM mission statement, and quickly agreed to provide Dr. Cronkhite with help.

AAEM authorized Dr. Cronkhite to send our e-mail message stating AAEM would participate in a legal action similar to our recent involvement in Rhode Island to the principal owner of the group. We recently established the AAEM Foundation to financially assist emergency physicians in such actions. Given that there existed favorable case precedent in Indiana related to restrictive covenants and an EM physician from 2/21/2000 (Duneland v. Brunk, 723 N.E. 2d 963), AAEM was confident that an action seeking summary judgment in this matter would likely succeed.

Dr. Cronkhite was also advised to seek assistance from ACEP as both he and the principal owner who was engaging in this behavior were ACEP members. ACEP leadership contacted this physician and through the combined pressures of the two organizations, he was freed from his restrictive covenant. The AAEM Foundation supported Dr. Cronkhite by covering his legal costs related to the preparation for filing an action on the restrictive covenant. Dr. Cronkhite thanked AAEM stating that he was "deeply indebted" for our support and financial backing.



This, and other recent cases provide evidence that the practicing emergency physicians do not have to accept the status quo. It is also an example of the Foundation in action for the benefit of the physician at the bedside. AAEM will examine contract matters affecting our members to see if we can provide assistance. In a case like this, a collaborative effort with ACEP is possible and can benefit the physician. We appreciate your continued support both as members and for the Foundation. Donations to the AAEM Foundation can be sent directly to AAEM at 555 E. Wells Street, Suite 1100, Milwaukee, WI 53202-3823.

PRESIDENT'S MESSAGE

by A. Antoine Kazzi, MD FAAEM

THE ULTIMATE MEASURE

"The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy." Martin Luther King, Jr.

On behalf of AAEM and its state chapters, I wish to express our sorrow, support and sympathy to all the emergency physicians and communities who were affected by the destruction in the Gulf coast states. We were so proud and pleased to see how many emergency physicians came to the aid of their colleagues after Hurricanes Katrina and Rita. I had the privilege of reviewing every offer and request for assistance. I saw physicians step in to offer jobs and homes to displaced AAEM members and others donate money to local funds to support affected residents and colleagues. In addition, many members volunteered their medical services in these states.

However, the most impressive bravery that we all witnessed was that of the Louisiana, Mississippi, South Carolina, Alabama and Texas emergency physicians, residents, nurses, paramedics and medical students who chose to stay behind and those who stepped in – risking life and well-being – to take care of the affected patients and communities! The stories of heroism and bravery are many… Some staffed the Charity ED and hospital; others started field hospitals. Considering that our AAEM Louisiana state chapter is relatively the largest we have and that over 25 percent of the emergency physicians in Louisiana are AAEM members, we wish to pause and say it loud and clear to all physicians in affected states: we are so proud of you!

Martin Luther King Jr. also said, **"If life is to be complete it must include not only the dimension of length but also of breadth, by which the individual concerns himself in the welfare of others.** No man has learned to live until he can rise above the narrow confines of his individualistic concerns to the broader concerns of all humanity."

AAEM wishes to thank all of you who have helped in your own ways responding to the destruction caused by Katrina and Rita - whether you worked in the medical facilities and field hospitals immediately following the tragedies, or you have volunteered in the aftermath of the hurricanes or you provided financial support.

I wish to extend these words of genuine appreciation and gratitude to all emergency physicians and societies across the world who stepped in to help or expressed their support. Those include our brothers and sisters in ACEP, NAEMSP, SAEM, CORD, ACOEP, AACEM, the Emergency Nurses Association, the European Society of EM, and all other international organizations. The brave women and men who took a stand and helped out during these disasters did it united and worked together to do what is best for their patients and communities. Moments of unity amidst hardship are indeed most inspiring…

In Nice, during the first week of September 2005, the Presidents and Officers of many of these societies stood together and worked together to celebrate the specialty we all cherish during the Third Mediterranean Emergency Medicine Congress. ACEP President Bob Suter, SAEM President Glen Hamilton, EuSEM President David Williams, CORD President Pamela Dyne, NAEMSP President Robert O'Connor and so many others were already there when Katrina hit. It struck deep and affected the lives, homes and families of members of the AAEM Board of Directors, state chapter leaders, and conference speakers. Many of them stayed in their cities and communities while others simply interrupted their trip and returned home to help where they were needed. Sympathy and words of unity were expressed and added to the importance of the historical scientific congress that AAEM and EuSEM had organized in collaboration with more than 50 national and international societies.

These demonstrations of unity continue. While we continue to serve our AAEM vision and mission statements and to advocate for what we believe emergency medicine should be like, we have become united with others when we needed to be and were able to do so. AAEM members, directors and officers showed up in Washington DC, rallying side-by-side with the ACEP members to show support for the landmark ACEP legislative initiative called for during its Annual Scientific Assembly. Thousands of emergency physicians rallied together and sent a clear united message to our legislature: Emergency Medicine needs to be better supported by our administration! Take note of us!

continued on pg 3

AAEM Mission Statement

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

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

Membership Information

Fellow and Full Voting Member: $345 (Must be ABEM or AOBEM certified in EM or Pediatric EM)
Emeritus Member: $250 (Must be 65 years old and a full voting member in good standing for 3 years)
* Associate membership is limited to graduates of an ACGME or AOA approved Emergency Medicine program.
* Associate Member: $250 (Non-voting status)
AAEM/RSA Member: $50 (Non-voting status)
Student Member: $50 (Non-voting status)

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

President's Message- continued from pg 2

These shows of support and unity will continue; and bridges will be built when we can to make our specialty stronger! Time will show how committed we all are to this pledge. However, the process has indeed started.

I will conclude with a third statement by Dr. Martin Luther King… **"Our lives begin to end the day we become silent about things that matter."** This is one that has particular meaning to all of us who chose to join or lead the AAEM. It mirrors the spirit of the American Academy of Emergency Medicine.

AAEM will never be silent or silenced!

Yes, AAEM will continue to reach out to everyone. However, with character, transparency and integrity, AAEM will now work harder to demonstrate how it will always serve the needs and reflect the aspirations of our individual members. We will stand again and again against the Big Evils that have plagued American Medicine and US Emergency Medicine in particular: Greed and the lay corporatization of Emergency Medicine… Over the last 40 years, they struck Emergency Medicine and our healthcare system so deep that AAEM was developed by leaders who stepped forward to say, "This cannot go on! Not like this!"

And a simple review of our very visible activities indicate how committed we are to this AAEM vision and mission! The face-off is on-going and will continue! And we are becoming more effective at it!

Confrontations continue, most recently in Indiana, Rhode Island, Minnesota, California, Pennsylvania, the Delaware Valley, Maryland, Florida and Texas. A number of them are very current and continue to develop on a day-to-day basis.

As I near the end of my term, I wish to take a moment to recognize the leadership of Dr. Robert McNamara in these difficult confrontations, assisted by the talented AAEM officers and directors – and in particular Drs. Joe Wood, Tom Scaletta, Larry Weiss, Mark Reiter and Howard Blumstein. I have had the privilege of working with them and witnessing first-hand what they do, how dedicated and talented they are and how well they do it…

However, to succeed, we do need your help. Now that our increased effectiveness has become nationally obvious, emergency physicians no longer feel powerless. They have been given hope and the AAEM promise! Yes, our promise: that AAEM will do all it can to stand by them!

AAEM is now receiving many weekly calls for help from members and non-members.

Help us make sure that your future has measures that protect you from the impact and danger of Greed in Corporate Healthcare and its impact on how you practice medicine, on your patients and on your own personal and family well-being. We need your support now more than ever before. *Please get involved in the Academy.* Join our committees. Support these actions with your talent; and most importantly, please *contribute critically needed funds by donating to the AAEM Foundation!*

PRO-CON

by Howard Blumstein, MD FAAEM

Recent bills introduced in the US Senate and House of Representatives, entitled *"The National All Schedules Prescription Electronic Reporting Act of 2005"* propose to make federal money available to states for the creation of databases that track the dispensing of controlled drugs. A pharmacist or other dispenser would make an entry into a state-wide database any time more than 48 hours worth of a controlled drug is dispensed.

The database would contain identifying information about the patient and the prescriber's DEA number, as well as drug, strength and amount. The database could be searched by law enforcement agencies, including the DEA, and is exempt from HIPPA requirements.

The AAEM Board voted to support this legislation, although with some debate. Differing viewpoints on this legislation are offered as part of Common Sense's PRO & CON series. Readers are invited to review the actual legislation by going to the Library of Congress legislative information website, http://thomas.loc.gov to look it up. It is bill S 518.

IN OPPOSITION OF NASPER

by Howard Blumstein, MD FAAEM

In this opinion piece, I will describe why I think the *National All Schedules Prescription Electronic Reporting Act of 2005* will not be useful in identifying patients abusing narcotic prescriptions, and may actually harm other patients.

I try to remember that drug seekers suffer an addiction that will destroy them medically, socially and psychologically. But it is difficult. They occupy my time in the ED, which would probably be better spent on other tasks. Plus, there is the potential of the professional embarrassment of having been fooled. Basically, they make me feel used.

Having little love in my heart for drug seekers, therefore, I was initially cheered upon learning of this bill. At last we have a tool to identify drug seekers. Perhaps law enforcement officials can find people feigning illness or injury to obtain narcotics. Maybe this resource will make it easier for physicians like me to identify patients with excessive narcotic usage.

But then I began to think about the long term effects.

Drug seekers are remarkably adaptive. Perhaps a number will be identified, particularly upon the initiation of such a database. But before long, these patients will learn to keep changing the identities they use, just as they currently shift between clinics, EDs and pharmacies to avoid recognition. Thus their records become more fractured than ever.

More important, however, would be the impact on physician prescribing practices. Pain and symptom control is a topic close to my heart. I speak on this issue within our department and periodically at outside venues. Under prescribing is a chronic and pervasive problem. I plead with physicians and extenders to prescribe wisely, and anticipate the amount of medication a patient might need. All too often I encounter patients being given inadequate doses and far too few pills to cover a period during which they can be expected to have continued pain. Ten Vicodin for two weeks of pain before seeing their doctor? Please!

Yet I frequently hear this justification: "I am afraid the DEA will come after me for prescribing too much…" It is an argument I hear from fully trained physicians as well as residents. It is pervasive. I argue that the DEA is interested in those of us who abuse the privilege of narcotic licensure, who prescribe recklessly or for personal gain. I tell colleagues that prescribing reasonable amounts of narcotic, especially with justifying documentation, should

continued on pg 9

EDITOR'S LETTER

by Howard Blumstein, MD FAAEM

Editor's Note: In its July, 2005 Issue, HealthLeader's Magazine published an article touting the advantages of outsourcing ED staffing to private companies. It included quotes from hospital administrators and Lynn Massingale, MD, chairman and CEO of Team Health. Two board members, including myself, wrote to the editor expressing concern about the one-sided nature of the article and describing the downsides of such arrangements. At the time this article went to press, we had not heard whether the letter was accepted for publication. The text of the original article can be seen at this URL: http://www.healthleaders.com/magazine/2005/jul/feature1.php?contentid=69908&categoryid=154.

We read with interest your recent article describing the benefits of contracting with private companies (known as contract management groups or CMGs) to staff hospital emergency departments, so-called "Physician Outsourcing." We feel, however, that your readership would be well served with a brief summary of the downsides of such arrangements.

There are potential legal and accreditation issues. Many states have statutory prohibitions against the corporate practice of medicine. Such laws exist because of the inherent conflict that can occur between a patient's best interests and the interests of the physician's employer. In such states, contracting with CMGs has raised legal issues. Further, your article describes how a hospital can "…say we do not want a particular physician back on our service." This would allow the hospital to avoid having to "… deal with it through the medical staff process." Such a process, however, is required by the JCAHO (see standard MS 1.20) which requires both that the medical staff be involved in corrective actions and have a mechanism for a fair hearing. Standard MS 4.50 further describes requirements for a hearing and appeal process. Arrangements such as those described in your article have the appearance of trying to circumvent these standards and may be considered violations.

Perhaps more important than these considerations, however, is the stability of the group of emergency physicians and relations between them, the hospital and the community. A physician who has ownership in a practice long term will want to make a positive contribution to the hospital and community. He is more likely to be attentive to patient and staff relations. Emergency physicians are often integrally involved with local EMS as educators or directors. Conversely, a physician working for a CMG is more likely to view a given position as temporary, both because the CMG may move him from hospital to hospital and because physicians working for CMGs must necessarily be making less money than those who are part of a private group (because the CMG must take a portion of what would have been the physician's income for operational expenses and profit).

The community also suffers when a CMG is involved. Physicians working for a CMG will consider themselves more transient than those who see a long term commitment to the area. Funds removed by CMGs for operating expenses and profit not only leave the community, but also the state.

Can a contract be easily cancelled? Yes, many have clauses that allow cancellation. But the fallout of such a decision is not mentioned. Most CMGs have restrictive covenants in their physician contracts. These clauses would make it impossible for the hospital to retain those physicians who were well liked and productive members of the medical staff. Incoming CMGs, which often depend on hiring locally available physicians, may find it difficult to achieve stable staffing, especially at more remote hospitals. This would result in constant turnover in ED staff as different physicians of varying quality move in and out. Non-interference clauses in contracts would make it impossible for physicians already present to remain behind to form a new, private group.

CMGs cannot always guarantee quality staffing. In a well publicized event earlier this year, one CMG was unable to provide adequate staffing for two newly contracted hospitals in Minnesota. After only a short period of time, with accompanying bad publicity all around, the CMG and the hospitals involved agreed to terminate the contract and the previous group returned to the emergency departments.

In summary, while CMGs may seem to offer relief from certain staffing headaches, they raise legal and regulatory issues as well as sacrifice the goodwill and permanence that a well-run private group offers. Hospital administrators may find it difficult to ensure the quality of physicians staffing their emergency department and, while contracts may offer a legal mechanism for cancellation, the practical difficulties of re-staffing their departments may make this impossible.

Howard Blumstein, MD FAAEM
Board of Directors, American Academy of Emergency Medicine

William Durkin, Jr., MD FAAEM
Secretary Treasurer, American Academy of Emergency Medicine

AAEM expresses their sympathy to the Levin family. Bill Levin, MD, passed away from lymphoma at the age of 53. Dr. Levin was a faculty member at Metropolitan Hospital (NY Med) for more than 10 years. He trained at Lincoln and was very involved as a teacher for national AAEM and ACEP, and several other organizations.

The AAEM Board is continuing to pursue this matter and contact has been made with the leadership of the Pennsylvania Medical Society and the respective county medical society. We will update you further as this progresses.

September 16, 2005

Michael Wert
Chairperson of the Board
St. Mary's Medical Center
Office of the President
1201 Langhorne-Newton Road
Langhorne, PA 19047

Re: The Corporate Practice of Medicine in the St. Mary's Emergency Department

Dear Mr. Wert,

The Delaware Valley chapter of the American Academy of Emergency Medicine (DVAAEM) and national AAEM has been made aware that St. Mary's Medical Center has awarded the exclusive contract for emergency services to Team Health, a corporate entity. AAEM is a national professional society representing approximately 5,000 specialists in Emergency Medicine while the Delaware Valley Chapter represents our members in Pennsylvania, New Jersey and Delaware. The purpose of this letter is to convey the concerns of the DVAAEM and the AAEM regarding this corporate ownership of an emergency department contract in the state of Pennsylvania. It is our belief that this represents a violation of the public protections afforded by Pennsylvania's prohibition of the corporate practice of medicine. Additionally, we are concerned that emergency physicians practicing at St. Mary's may unwittingly risk their licensure in this matter by aiding and abetting the unlawful corporate practice of medicine. We request your attention in this matter of importance to physicians and their patients.

We do not dispute the right of St. Mary's Medical Center to award an exclusive contract for emergency services, however, we believe Pennsylvania statutory and case law as well as prior opinions from the Office of the Attorney General prohibits the awarding of such a contract to a for-profit corporation. To be clear, Team Health, is a for-profit corporation as it is currently jointly owned by the venture capital firms, Madison Dearborn Partners, LLC, Cornerstone Equity Investors, LLC and Beecken Petty & Company, LLC. Confirmation of this can be quickly obtained by accessing www.teamhealth.com. On August 16, 2005, Team Health filed a registration statement with the SEC for an IPO of its common stock. In its prospectus, the company acknowledges the potential implications of state prohibitions on the corporate practice of medicine.

Pennsylvania statutory law as contained in the Medical Practice Act (63 P.S. §§ 422.1-422.5) and Osteopathic Medical Practice Act (63 P.S. §§ 217.1-271.8) indicates that medical practice is limited to licensed individuals and provides for disciplinary action against physicians who knowingly aid an unlicensed person to practice medicine. Pennsylvania case law (Neill v. Gimbel Bros. 330 PA 213, 199A.178, 1938) notes that business corporations cannot employ physicians. Pennsylvania Attorney General Opinion No. 504 states "except as to specific acts of the legislature… no corporation, whether nonprofit or otherwise, could secure, provide, or render medical services, whether prepaid or otherwise since (this) would constitute the practice of medicine by the corporation contrary to law." Finally, the PA Bureau of Occupational and Professional Affairs in a letter dated 5/3/94 to Melinda J. Roberts from John T. Henderson, Jr. Assistant Counsel reinforced the corporate practice of medicine prohibition in Pennsylvania.

You may be aware that the Board of Trustees of the American Medical Association has recently addressed this matter and provided a comprehensive review on the issue as it relates to practicing physicians. We believe the contents of their report would result in their support of our view in this matter. AAEM has recently been involved with legal challenges regarding the corporate practice of medicine and Team Health in California and a similar corporation, EmCare, Inc., in the state of Minnesota. We also participated in a successful action related to the corporate practice of emergency medicine in California involving Catholic Healthcare West. We would be happy to provide you with documents related to these matters.

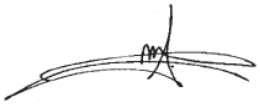
DVAAEM and AAEM are also concerned that such corporate employment arrangements may involve prohibited fee-splitting activities under current state and federal statutes. We therefore caution our members about accepting employment with corporate groups and suggest that hospitals examine such an arrangement with due diligence.

DVAAEM and AAEM believe that emergency physicians must remain free of corporate influence because of their difficult role as advocates for the under and uninsured patient. The AAEM firmly believes it is in the best interest of the patients served by St. Mary's Medical Center to have emergency physicians unencumbered by the profit concerns of a corporation.

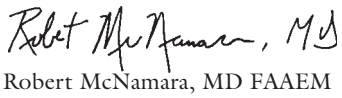
DVAAEM and AAEM are willing to assist in this matter and help you secure a physician owned group for this contract or to guide your current physicians into a physician partnership. Dr. Robert McNamara, a Past President of our organization and current Pennsylvania President of the Delaware Valley Chapter is the primary contact person for this matter. He can be reached through our offices or directly at 215-707-5030.

Thank you for your time and attention to this important matter.

Respectfully yours,



Antoine Kazzi, MD FAAEM
President
American Academy of Emergency Medicine



Robert McNamara, MD FAAEM
Pennsylvania President
Delaware Valley Chapter, American Academy of Emergency Medicine

September 16, 2005

Dennis O'Leary, MD
President, Joint Commission on the
Accreditation of Healthcare Organizations
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

Dear Dr. O'Leary,

The American Academy of Emergency Medicine (AAEM) has learned from its members that JCAHO Standard MM.4.10 is currently being enforced in a manner that may be problematic for emergency physicians and the patients we serve.

AAEM agrees with the intent of Standard MM.4.10, to decrease medication errors that occur in the practice of emergency medicine. We understand that Standard MM.4.10 mandates a pharmacist review of certain (non-urgent) medication orders before an emergency nurse can dispense that medication to a patient.

Mandatory pharmacist review before medications are given implies that the physician and nurse patient care team produce an excessive number of sequential medication errors. AAEM contends that this is not the case. Unlike typical hospital ward practice, emergency physicians are immediately available to nurses to verify the appropriateness of the ordered drug, dose and route as well as to address any unanticipated adverse reactions. When qualified emergency physicians and nurses are staffed at proper levels, the chance of medication error is very low. We have position statements posted at www.AAEM.org regarding what we believe constitute qualified emergency physicians and adequate emergency physician and nurse staffing levels.

Recruiting a pharmacist to add an extra layer of assurance would negatively impact emergency department patient flow. Especially in this era of overcrowding, such a mandate would create a bottleneck and cause waiting times and left-without-being-seen rates to increase. And, patients waiting to see a physician may harbor serious, time-sensitive medical problems such as myocardial infarction and stroke.

In order to adhere to Standard MM.4.10, hospital pharmacists would need to be up staffed and this would divert funds from other efforts to globally improve care such as acquiring information systems that automate medication checks for appropriateness, interactions with other medications and allergies. Moreover, adding mundane work to pharmacists might distract them from hospital-wide duties with more clinical impact such as mixing vasoactive drips and calculating doses of nephrotoxic medications.

In summary, AAEM respectfully challenges the Joint Commission to ask its Professional Standards Advisory Committee to change the language of Standard MM.4.10 such that a pharmacist review is not required before medications ordered by an emergency physician can be given to a patient by an emergency nurse. We invite JCAHO to use AAEM as a regular resource for input as new standards that effect emergency medicine practice are developed.

Sincerely,

Tom Scaletta, MD FAAEM
Vice-President, AAEM
on behalf of the AAEM Board of Directors

Rally at the US Capitol

AAEM members participated in a Rally at the US Capitol on September 27, 2005, during the ACEP meeting.

The road to success is always under construction.

- Unknown

The older I grow, the more I distrust the familiar doctrine that age brings wisdom.

- H. L. Mencken

Let us rise up and be thankful, for if we didn't learn a lot today, at least we learned a little, and if we didn't learn a little, at least we didn't get sick, and if we got sick, at least we didn't die; so, let us all be thankful.

- Buddha

THE VIEW FROM THE PODIUM

MEMC3

by Joe Lex, MD FAAEM

What an amazing gathering this was. The Third Mediterranean Emergency Medicine Congress in Nice, France, during the first week of September was one of the most astonishing assemblies of emergency medicine experts ever gathered. The spirit of mutual sharing was incredible, as politics went out the window both nationally and internationally. When two poster judges from New Orleans were unable to attend, two other familiar faces stepped forward and unhesitatingly took their places - Billy Mallon, MD FAAEM, of USC-LAC, and Bob Suter, DO FACEP, President of ACEP. The same international cooperation occurred as speakers from Palestine and Israel shared their mutual educational objectives in training emergency personnel. Speakers from Lebanon, Kosovo, Turkey, and Mexico told of their experiences with managing local, regional and national disasters. Speakers from dozens of countries shared their unique experiences of practicing emergency medicine under what we would consider less-than-ideal conditions. Others spoke with excitement about the newness of emergency medicine as a specialty in their country.

Ideas were exchanged, management methods were shared, and many thoughts were stimulated. Chris Fox, MD FAAEM, Track Chair for the Ultrasound track, told me, "Joe, I've been teaching ultrasound for a long time. I thought I had put an ultrasound probe on or in every place it was possible to do so, but these folks have opened my eyes to many new possibilities and have given me ideas that will keep me busy for two or three years." Keith Messner, MD, told me he was worried about speaking at 6 pm on a Sunday evening, that he would be talking to walls and window shades in the Business of Emergency Medicine track, but he was astonished to have a full room even at this apparent inopportune time. I think a lot of people had their eyes opened to new and exciting or different ideas of the way in which emergency medicine is practiced around the world.

The Emergency Medical Abstracts extravaganza featuring Rick Bukata, MD, Jerry Hoffman, MD FAAEM, Diane Birnbaumer, MD, and Billy Mallon, MD FAAEM, was an unqualified success. Several hundred people sat spellbound for more than three hours as these four discussed articles from the past few years. There was lively discussion as audience members unhesitatingly challenged views with which they disagreed.

For me, other highlights included introducing EM leaders from different continents to each other, watching people who had communicated only by email meet for the first time, and participating in spontaneous gatherings and discussions in the coffee shop near the lecture rooms.

In short, the Congress was a complete success. The administrative team from AAEM was invaluable and we owe a huge debt to the hard work of Janet Wilson, Kate Filipiak, Kay Whalen, and others, along with the French congress organizers. And - most amazingly - in a four-day conference with twelve simultaneous tracks I didn't hear about a single glitch in the audiovisual equipment! It took more than a year of planning and an incredible amount of individual time investment, but I can't wait to get started on the next one scheduled for 2007. I'll let you know as soon as we have a date and a venue.

12th Annual Scientific Assembly in San Antonio

Our next Scientific Assembly will run from Thursday, February 16th, through Saturday, February 18th, 2006, at the Marriott Rivercenter in San Antonio, Texas. You will be getting a program in the mail soon, but save the date now. Preconference courses include a Prehospital Medical Director Course, The Business of Emergency Medicine, 2005 LLSA (bring your laptop and take the test on-site), Trauma for the Non-Trauma Center, and Treating ED Patients with CNS Illness and Injury. There are two postconference sessions on Saturday - one for medical students on Getting into the Residency You Want, led by Ken Iserson, MD FAAEM, and one for residents on Preparing for the Inservice Exam.

The Scientific Assembly has several special features this year. We've invited Surgeon General Richard Carmona to be our Keynote Speaker but, as with all such invitations, we will not know until shortly before the conference whether he can attend. Two noted authors and speakers are also featured. Abraham Verghese, who wrote *My Own Country: A Doctor's Story* and *The Tennis Partner*, and founder of The Center for Medical Humanities & Ethics in San Antonio, will speak on the topic What the Pen Teaches the Stethoscope. Dr. Verghese is an incredible writer and speaker whom you will not want to miss. Our other special speaker is Mark Victor Hansen, co-author of the series *Chicken Soup for the Soul* and *Dare to Win*. Mr. Hansen is one of the best-known speakers in the country and has promised to tailor his message specifically for emergency physicians.

In addition, our proximity to Fort Sam Houston allows us to tap into some local expertise, and we'll hear updates in trauma and burn care from those who are doing the fieldwork. We're also trying to arrange a tour of the Fort Sam training facilities as a preconference session.

This, of course, is in addition to our "usual" list of speakers: Amal Mattu, Ed Panacek, Peter DeBlieux, Billy Mallon, Larry Weiss, Bob McNamara, Peter Rosen, and Kevin Rodgers. Other speakers scheduled to attend include Jeff Kline, Jay Kaplan, Rob Rogers, Chris Fox, Arjun Chanmugam, and Ken Iserson. Our Point-Counterpoint topics this year are sure to kick up some dust: Activated Charcoal Is Obsolete and Paramedics Should Not Intubate in the Prehospital Setting. Panels will discuss Racial Disparities in Emergency Medicine and The Ethics of Pharmaceutical Support for Medicine.

This will be my last Scientific Assembly as Chair of Education. I hand the reins over to Kevin Rodgers, MD FAAEM, and Sam Mossallam, MD FAAEM, in February. It's been a productive time for me, but five years is enough. It's time to get new blood and new ideas.

Why Can't We All Just Get Along?

I just got back from Washington D.C. I wanted to make my presence known at the ACEP-sponsored Rally at the US Capitol. I hitched a ride on a bus sponsored by Pennsylvania ACEP. No one protested my presence. Let's face it - many of the issues confronting emergency medicine cross the chasm between AAEM and ACEP. AAEM also

continued on pg 10

Upcoming AAEM-Endorsed or AAEM Sponsored Conferences for 2005

December 1-2, 2005

- Practical Emergency Airway Management Course at the University of Maryland Medical Center and State Anatomy Board
  Baltimore, MD

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

December 2, 2005

- Emergency Radiology: A Systematic Approach to Imaging in the Emergency Department
  Bellevue Hospital Center, NYC Department of Health, Auditorium on Ground Floor, 455 First Avenue (27th Street), NY, NY
  www.med.nyu.edu/emergency/courses

December 4-9, 2005

- Maui 2005: Current Concepts in Emergency Care
  Wailea Marriott, Wailea, Hawaii

  Sponsored by the Institute for Emergency Medical Education and the Washington Chapter of the American College of Emergency Physicians
  http://www.ieme.com/maui/conf1.shtml

January 10-12, 2006

- First Emergency Medicine Congress in Martinique
  Simultaneous translation into English provided.
  Kalenda Les Trois-Ilets Hotel/Resort

  Sponsored by Service d'Aide Medicale Urgente (SAMU) de Outremer
  http://www.mcocongres.com/samuoutremer

January 22-26, 2006

- Fourth Annual Western States Winter Conference on Emergency Medicine
  During the Sundance Film Festival
  The Canyons, Park City, UT
  Sponsored the Emergency Medicine Departments of: Oregon Health and Science University, University of Utah Health Sciences Center, University of California, San Diego Medical Center, University of California, Irvine
  http://www.wswcem.com

February 16-18, 2006

- 12th Annual Scientific Assembly
  Marriott Rivercenter, San Antonio, Texas

  Sponsored and organized by the American Academy of Emergency Medicine
  www.aaem.org

March 5-10, 2006

- 26th Annual Mammoth Mountain Emergency Medicine Conference
  Mammoth Lakes, CA
  http://www.mammothmountainemconf.com/
  (2006 website coming soon)

April 18-21, 2006

- First Inter-American Conference on Emergency Medicine
  Controversies and Consensus in Emergency Medicine: A Bi-Lingual Conference with Simultaneous Translation
  (Preconference workshops April 18, 2006)
  Sheraton Buenos Aires Hotel and Convention Center
  Buenos Aires, Argentina

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

April 22-23, 2006

- AAEM Pearls of Wisdom Oral Board Review Course
  Embassy Suites Airport in Chicago, Dallas, Los Angeles, Orlando, Philadelphia

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

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

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

Clinical Pathologic Case (CPC) Competition Winners from the Mediterranean Congress

1) Mohammed Fahim, MD, Saudi Arabia
2) Erwin Dhondt, MD, SFS, Major, Belgium
3) Sam Kini, MD, United States

Great job by all!

EMTALA Pointers FROM THE AAEM EMTALA COMMITTEE

Q: *Who may accept or reject transfers on the hospital's behalf?*

A: A: Under EMTALA, it is the hospital not the physician, who has the obligation to accept all appropriate transfers. The hospital can delegate this responsibility to whomever it chooses, but is liable for their decision. The person designated to accept or reject transfers may be the emergency physician, the on-call physician, an administrator, a nursing supervisor, an admitting office, or a transfer team. Since the hospital must have the capacity and resources to care for the patient, it is recommended that whomever is designated to accept transfer has an up-to-date awareness of the hospital's status at that time. In addition, we strongly recommend that the hospital designate in writing who can accept or reject transfers on its behalf, and also who CANNOT accept or reject transfers, and communicate this information to the sending hospitals.

Author:
Gerald Maloney, DO

Editor:
Mark Reiter, MD MBA

EMTALA Committee Chair:
Robert Bitterman, MD FAAEM

Join us at the 12th Annual Scientific Assembly in San Antonio and attend the Trauma Preconference Course on February 15, 2006.

Trauma Resuscitation For The Community Doc

At the end of the program, each participant will be able to:

1. Define and develop a systematic approach to the difficult airway in trauma.
2. Incorporate the gained knowledge of the physiologic changes of pregnancy into optimum treatment of the pregnant trauma victim.
3. Discuss the specific skills and knowledge required for pediatric and geriatric trauma care.
4. Recognize risk management issues in trauma resuscitation.
5. Describe and treat chest injuries that can kill within minutes if unrecognized.
6. Evaluate and treat ocular trauma and recognize its potential complications.
7. Identify, recognize, and administer care for potentially life-threatening maxillofacial injuries and potentially debilitating dental trauma.
8. Describe and recognize stable and unstable cervical spine injuries and their impact on initial trauma resuscitation.

Topics Include:

EPIDEMIOLOGY OF TRAUMA
"ABCs" – A CRASH COURSE
"FAILURE IS NOT AN OPTION" – THE DIFFICULT AIRWAY IN TRAUMA
"ONE INJURY/TWO PATIENTS" – TRAUMA IN PREGNANCY
"BIG HEAD/LITTLE BODY" – PEDIATRIC TRAUMA
"ANATOMY OF MULTISYSTEM INJURY" – TRAUMA RISK MANAGEMENT FOR THE COMMUNITY DOC
"THE GROWING POPULATION" – GERIATRIC TRAUMA
"20/20" – OCULAR INJURIES
"5 MINUTE KILLERS" – CHEST INJURIES
"A PAIN IN THE NECK" – C-SPINE INJURIES
"PUNCHED IN THE FACE" – MAXILLOFACIAL TRAUMA
TRAUMA CASE ANALYSIS – AUDIENCE/FACULTY SESSION

Pro–Con - continued from pg 3

represent no danger of adverse action by the DEA. But fear is a big motivator and it is hard to break this practice.

How long will it be before our peers, scared by the prospect of "big brother" reviewing their narcotic prescribing, feel even more fear? Will more providers prescribe pathetically inadequate amounts of narcotic? Or perhaps stop prescribing narcotics entirely?

I applaud efforts to create systems to identify (and get help for) drug seekers. Yet I question its potential effectiveness and fear that the negative impact on honest, deserving patients will far outweigh that benefit.

IN SUPPORT OF NASPER…

by Knox Todd, MD FAAEM

I have been asked to write a "pro" paragraph or two in support of NASPER, the National All Schedules Prescription Electronic Reporting program and have agreed to do so, despite the pro/con format that brings to my mind monotonous high school debate clubs and Tucker Carlson-like shouting heads.

The cold realists among us will recognize that with prescription drug monitoring programs (PDMPs) currently operating in twenty-one states, the question is not whether to argue for or against their establishment, but to advocate for their uniform implementation, for consistent use standards, for adequate protection of patient privacy, and for research on whether PDMPs do what they are supposed to do — improve our ability to treat our patients and improve their lives.

No one would argue that health information technologies, such as electronic PDMPs or electronic medical records (EMRs), are adequately utilized in the United States. As noted recently by J. D. Kleinke, "If the state of U.S. medical technology is one of our great national treasures, then the state of U.S. health information technology is one of our great national disgraces." [1] How often do emergency physicians practice at an inferior level

continued on pg 10

The View from the Podium- continued from pg 7

wants our legislators to be aware of overcrowding, diversion, lack of on-call physicians, the rising number of underinsured and uninsured, the professional liability crisis, and the financial and social consequences of EMTALA legislation. That's an impressive list of items that merits attention by the entire community of emergency medicine and it transcends internal politics. The final agenda is universally agreed upon - better care for our patients. ACEP and AAEM have, for the most part, common goals and admirable missions.

In the past few years, AAEM committees have established links with ACEP committees. Some AAEM board members belong to ACEP, and some ACEP board members are FAAEM. Ghazala Sharieff, MD FAAEM, served as chair of ACEP's Pediatric Section; Kumar Alagappan, MD FAAEM, heads up ACEP's International Section; Peter DeBlieux, MD FAAEM, and Jeff Tabas, MD FAAEM, sit on ACEP's Education Committee. This year I spoke at Indiana, Pennsylvania, and Maryland ACEP State Scientific Assemblies, despite having resigned from ACEP several years ago (not an easy decision, as my membership number was 000024).

First Inter-American Conference on Emergency Medicine
Here is an outstanding opportunity for you to visit one of the greatest cities in the world, Buenos Aires, Argentina, for a unique educational experience. AAEM has joined with ACEP and several Latin American emergency organizations in planning this multi-track, multi-language extravaganza. ACEP considers this congress so important that they are sending two past presidents, George Molzen and Robert Suter. Antoine Kazzi, Kumar Alagappan, Aaron Hexdall, myself, and several other members will represent AAEM. Among the speakers are Lewis Goldfrank, MD FAAEM, Peter Rosen, MD FAAEM, Judith Tintinalli, MD FAAEM, and Jeffrey Kline, MD FAAEM. AAEM will provide AMA/PRA Category I CME credit for this incredible gathering. See **www.aaem.org/interamer-conference06.pdf** for more information (and notice that the cover photo of the brochure was snapped by current ACEP President Rick Blum). If you're kicking yourself for missing the conference in France, here's your chance to attend another international conference in a wonderful location…and at a reasonable price.

Medscape Collaboration
AAEM's Education Committee has been approached by Medscape to help them develop a Medscape presence for emergency physicians, and we are investigating this possibility. Medscape currently provides 14 percent of CME given in this country, and 71 percent of on-line CME. Rob Glatter, MD FAAEM, is our point person on this venture. I'll let you know results as they develop.

Pro–Con - continued from pg 9

because they lack important medical information about their patients, including information about other prescribed drugs (with the risk of unforeseen drug interactions), because they lack data from continuity physicians, including the results of prior evaluations and testing (with resultant unnecessary prescribing and wasteful testing), or because they are unaware that their patients are seeing multiple providers and obtaining multiple simultaneous prescriptions for controlled substances?

Opponents may argue that NASPER will reduce appropriate opioid prescribing in two ways. First, physicians may hesitate to prescribe controlled substances due to the "chilling" effect of regulatory oversight. Second, it could be argued that knowing a patient has received controlled substances (particularly opioids) from multiple sources will lead clinicians to make a diagnosis of "addiction" when; in fact, the patient is exhibiting "pseudoaddictive" behaviors. "Pseudoaddiction" is the term used to describe patient "drug seeking" behaviors that occur when pain is undertreated, an all too common occurrence. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated.

On both counts, the answer is not to shield ourselves from information that should legitimately inform our therapies. Practicing in the dark is hardly the high road to quality medical care. This head-in-the-sand approach overlooks the more obvious need for physician education in two areas.

First, with regard to the chilling effect of regulatory oversight, we should understand that this fear is a red herring. No emergency physician has been investigated by the Drug Enforcement Agency for prescribing that occurs as part of legitimate emergency medicine practice.

Second, we must learn much more about pseudoaddiction. We should understand that "drug seeking behavior" is a term best abandoned by our profession. For the patient in pain, seeking an analgesic of proven effectiveness is the height of rationality. In contrast to the search for controlled substances, it is likely that the most common variety of drug seeking behavior is the well documented and relentless quest by patients with self-limited viral upper respiratory infections (or parents of such patients) to obtain antibiotics. The medical profession has a long history of inappropriately prescribing such antibiotics, encouraging antibiotic resistance among common bacterial strains while risking antibiotic side-effects without a justifiable expectation of concomitant benefit. I presume that no one would argue against a PDMP targeting antibiotic use.

The concern of physicians is that patients may seek controlled substances, particularly opioids and benzodiazepines, for reasons other than those strictly related to pain relief. Such actions are best termed "aberrant drug-related behaviors" as this term suggests that there is a broad range of behaviors that are more acceptable or less acceptable in the context of pain therapy. Although addiction is the most commonly assumed explanation for such aberrant behaviors, there is an extended differential diagnosis for such behaviors that the clinician should consider, and pseudoaddiction should be at the top of our list. In fact, one likely impact of NASPER is that we will have a much clearer picture of oligoanalgesia and a better understanding of the public's unmet need for pain treatments.

The American Academy of Pain Medicine and the American Pain Foundation, a patient-advocacy group, both support NASPER because it will likely improve our ability to study prescribing patterns and learn where we are over or undertreating our patients. These groups successfully lobbied to have the HHS administer the program instead of the DEA and to have HHS study the law's effectiveness over a two-year period and report its findings back to Congress.

Relieving pain and reducing suffering are primary responsibilities of emergency medicine and much can be done to improve the care of patients in pain. We have a concurrent duty to limit the personal and societal harm that can result from prescription drug abuse. Our specialty should continue to more precisely define our own standards for excellence in pain practice and substance abuse interventions while promoting quality improvement initiatives to achieve these goals. It will take more, not less, information about our patients' controlled drug use patterns to achieve these goals, and thus we should support the NASPER surveillance system while insisting on continuing studies of its efficacy.

References:
1. Kleinke JD. Dot-Gov: Market failure and the creation of a national health information technology system. Health Affairs. 2005;24(5):1246-1262.

AAEM/RSA PRESIDENT

President's Message: Unity In Emergency Medicine

by Mark Reiter, MD MBA
AAEM/RSA President, AAEM Board of Directors

More than a decade ago, AAEM was formed to represent the emergency specialist, as there was no group willing to strongly advocate for fairness in the workplace, as well as the value of board certification and residency training. Existing groups felt that these issues were not germane to their focus or that their own antitrust policies prohibited further action. AAEM has always believed otherwise. In the last few years, AAEM has been enormously successful in changing the landscape for the emergency specialist working in the "pit," and has recently led the charge on a series of high-profile successes.

Simultaneously, as AAEM has grown to 5,000 members, we have developed into a full-service organization, offering much more than legal muscle to our members. We now have a superb reputation nationally and internationally for our educational offerings. We also have an active National and Governmental Affairs Committee and employ a lobbyist in Washington, D.C. Over the last few years, several AAEM State Chapters have formed to meet the local needs of their members.

We realize that since its inception, ACEP has been a strong voice for federal advocacy matters concerning emergency physicians. In addition, ACEP's network of state chapters produces consistent local advocacy and an excellent networking opportunity on behalf of their members.

Recently, the AAEM board approved a bold initiative to promote a united voice in organized emergency medicine. We proposed merging our federal advocacy efforts with ACEP, so that we would have a united voice as emergency physicians. Together, we can advocate more effectively for emergency physicians on core issues such as reimbursement, EMTALA, overcrowding, and professional liability. Rest assured, AAEM will continue to dedicate much of our resources and focus to fairness in the workplace. Recognizing the larger size and budget of ACEP, we proposed the leadership of this merged Governmental Affairs Committee will be proportional to the size of each group's membership, and pledged to dedicate an equal amount of funding per member as ACEP. Furthermore, recognizing the importance of our Political Action Committees, and their overlapping agendas, we proposed to merge our PACs, again on a proportional basis based on membership.

Given the importance of local politics, we proposed merging all state chapters. We envision all state AAEM and ACEP members working together on state issues, rather than dividing our local talent amongst different organizations. In recent years, ACEP has publicly declared their desire for unity in emergency medicine many times. This is a golden opportunity for ACEP to live up to those words, and do what is best for our specialty.

This is a major step for the house of emergency medicine. The greatest wish of the founders of AAEM is that there no longer be a need for AAEM to exist. Still, despite our recent successes, there is much work that we need to do.

As President of AAEM/RSA, I believe the same holds true for resident EM organizations. Perhaps in the future, residents who strongly believe in AAEM's mission and actions will be represented through a single resident organization (perhaps part of an overarching EM organization), and there will be no need for AAEM/RSA to exist. EMRA, the oldest and largest resident EM organization, requires joint membership in ACEP but has been unwilling to allow any similar arrangement with AAEM. In addition, EMRA has a seat on its board for an ACEP representative, but has no quid pro quo with AAEM. Because of these concerns and others, in 1999, AAEM formed a Resident Section to increase resident membership and leadership opportunities within AAEM and to educate residents about the core issues AAEM was founded on. In recent years, the AAEM Resident Section has enjoyed tremendous growth and now has about 2,000 members.

Last month, we announced we had become a wholly owned subsidiary of AAEM, the AAEM Resident and Student Association, allowing us to form closer relationships with other groups in emergency medicine. We are pleased that groups such as CORD and SAEM have enthusiastically responded and began including us in their upcoming activities. However, both EMRA and ACEP rejected our request.

I have had the pleasure of working with many of the talented leaders of both EMRA and ACEP on different projects over the past few years. AAEM/RSA hopes these leaders, who we have no doubt hold the interest of our specialty in the highest regard, will recognize that open, effective dialogue is the best way to become unified as a specialty. We hope that EMRA and ACEP will reconsider this action in the future, as there are many issues where we have common ground and could collaborate.

In the past month, since AAEM's announcement of our unity proposal, we have heard from many of our members. The overwhelming response has been extremely positive. We would like to continue to hear the opinions and ideas of our membership on this important proposal. Both the AAEM Board and AAEM/RSA board's email addresses are available on our website or you can email **info@aaem.org,** or use the new AAEM Discussion Forums on our website. If we have the support of our membership, AAEM and AAEM/RSA will remain committed to making this unity proposal a reality.

Finances for Residents - Part I: A New Resident

by G. Everett Stephens, MD FAAEM
University of Louisville
Department of Emergency Medicine

Medical students are in a very unusual position upon graduation- saddled with student loans often exceeding one hundred thousand dollars, a new job with very long hours and high stress, and often facing a semi-planned relocation. However, sound financial decisions in residency can build the groundwork for a successful financial life. This article is the first of two that will discuss some of the special financial concerns of residents. Part I will deal with new residents and the financial planning of a new income. Part II will address some of the concerns of a graduating resident.

Starting on the Basics
New residents revel in the one thing they have been denied for so long: a salary. However, it is often far from a bonanza, and reasonable management is key to surviving this period. One of the cornerstones of good financial management is a budget. Simply speaking, the word 'budget' is enough to make some cringe, but only because they don't understand the purpose: to prioritize the use of money. Making a budget need not be so painful that you consistently put it off. Start by listing your fixed expenses- mortgage/rent, utilities, loan payments, car payments, insurance, savings, etc. Then add in your 'luxuries'- credit card payments, dining out, and other non-necessities. The total is what you need to earn. If what you need to earn exceeds what you bring home, now is the time to trim down expenses. Prospectively cutting corners is far easier than selling the family station wagon when you actually reach a financial dilemma.

Another worthwhile technique is keeping ALL of your receipts for an entire month. Put a shoebox beside your door, and when you come home, drop all of your receipts in it. At the end of the month, separate them into categories such as 'dining out', 'computer games' (my biggest downfall), 'gasoline', 'clothes', or any other category. Add all of the receipts up, and then look at how you actually spend your money. Often, it is an eye-opening experience that gives you a bit more resolve to stick to a budget. Try **www.kiplinger.com/personalfinance/tools** for a start in budgeting.

Saving money on a resident's salary is difficult, but developing a habit of saving is one of the most important habits to create. Some recommend hiding away 10 percent of your paycheck when deposited, so the temptation to spend it won't be as great since you don't *see it*. Even if you cannot afford to save 10 percent, try to save five percent. Or even $50 a month. Several mutual funds will allow you to set up an account by automatically debiting your bank account as little as $50 a month. This would be a good option if you don't have the self-discipline to make regular investments.

Planning for Emergencies
An emergency fund is one of the basics of financial planning and security. Your emergency fund should be at least one month's income, kept in a local savings account where it can be easily and quickly accessed. An emergency fund is just that, a fund only to be used during genuine emergencies of the family- a house fire, or one spouse becomes hospitalized or disabled. Natural disaster. Not vacations. Not credit card bills. The emergency fund is one of the cheapest ways to develop a feeling of financial security- if needed, it can provide support during hardships that cannot be foreseen. Be generous here - a few extra hundred dollars saved can make a huge difference in a bind.

Credit and Cards
According to a recent study, the average credit card debt among US graduate students is $5,800. If your credit card rate is 18%, and you pay $200 a month on that debt, it will take you over 3 years to pay it off. You will pay the credit card company almost $2000 in interest! Although credit cards can be a valuable financial tool, they must be used with extreme caution. Carrying your balance over from month to month is exactly what the credit card company wants you to do. The more interest you pay, the happier they are — and the poorer you are.

It pays to be aggressive with credit card control. I suggest having no more than 3 credit cards, and preferably only one. That card can be either a charge card or a debit card. **Charge cards** differ from credit cards in that charge cards must be paid off every month. I like charge cards better than credit cards because the realization that any spending will be due in full in just a few weeks may reduce impulse spending.

A **debit card**, in contrast, deducts directly (and immediately) from your checking or savings account. You can already guess one of the problems with a debit card - over drafting your account, and the ugly fees that may go along with it.

As long as you are aware of the disadvantages of your debit card, they have several advantages. They are deducted from your bank accounts, so you don't have to bother with writing a check each time you use it. And, if you download your transactions over the Internet into *Quicken* or *Money*, the data will tell you exactly where you spent your money, and how much. After you download your charges, all you have to do is assign them a category such as 'dining out', or 'movies', and you automatically have a way to see exactly how you are spending your money!

If you do decide that you must have a credit card, be sure to pay it off every month. Try to keep only one credit card active, and hold onto it for a long time. It may be tempting to shift from one credit card to another with all those tempting 1.9% interest rate cards advertised on TV and in the mail, but churning credit card accounts can count against you. When obtaining a mortgage or other large purchase, your credit score may be decreased for many short term credit accounts, even though you may only have one active account at a time.

One last thought on credit - those 60 or 90 days Same-As-Cash offers are tempting, but often they are set up as short term revolving loans. If you don't pay off the debt within that 60 or 90 days, you get hit with a retroactive 18% or 20%+ interest rate, all the way back to when the loan was first made! This can count against you when applying for a mortgage. Perhaps a better approach is to ask the vendor for a 5% or 10% discount if you pay cash instead of using the financing deals.

Student Loans
One of the curses of pursuing professional education are the staggering loans we accumulate while earning no salary. Some loans allow repayment to begin after residency, but lenders are increasingly requiring repayment to begin during residency. This puts a huge drain on already limited financial resources. Some

continued on pg R3

Finances- continued from pg R2

lenders allow borrowers to 'defer' or 'forebear' their loans while in residency. Deferrment means no payments are due, and no interest accrues. Forbearance means no payments are due, but the interest accrued is added to the outstanding principal. Depending on the length of your residency and the principal of your loans, this may produce a huge total you are responsible for at the end of your residency.

Depending on your financial situation, you may have no choice but to forebear. An option in this case is to make voluntary payments while in residency to help reduce the snowball effect, even if just slightly. Most lenders will allow these voluntary payments, but may require the payments go to interest instead of principal.

What about the student loan tax deduction? Fortunately, residents usually are able to qualify for the deduction. Beginning in tax year 2002, you can deduct the interest as long as you are in repayment. The deduction is limited to the first $2,500 of interest in a given tax year, and is not available to those filing *Married Filing Separately*. But here's where it hurts - the deduction is phased out for Adjusted Gross Incomes between $40,000 and $55,000 for those filing *Single*, and between $60,000 and $75,000 for those *Married Filing Jointly*[1]. So, you will quickly lose that deduction when you finish residency.

Thinking about Retirement
At such an early point in a resident's career, it is often difficult to realize the importance of saving for retirement. Overlooking retirement so early denies you of a powerful ally: compounding interest over time. Saving even a small amount as a resident can make a big difference after thirty years of compounding. For example: saving $200 a year for three years in an Individual Retirement Account (IRA) at 7% interest yields nearly $5,000 after 30 years of compounding.

An IRA (Individual Retirement Account) is an account that you may contribute a small amount to each year, and allow it to grow tax-deferred. One of the flavors of IRA is a ROTH IRA, established in 1998. Unlike a traditional IRA which is usually tax deductible (subject to limitations), the Roth IRA is NOT tax deductible. The Roth carries a huge advantage for young investors: the interest that accrues is TAX-FREE. While you may save a few hundred dollars in taxes by using a traditional IRA, that savings is quickly out paced by the tax-free growth of the Roth IRA. This means that the almost $5,000 is not taxable when you withraw it for retirement!

You have until April 15th (or when you file your taxes, whichever is earlier) to make a contribution for you and your spouse for the prior tax year. The Roth IRA is a great vehicle; be sure to use it as a resident. After residency, your higher income as an attending will make you ineligible to contribute to a Roth IRA.

Planning for the Future…
Residency is often the first 'real' job many residents have, and the financial habits developed during this time can have a huge impact on future habits. Taking the time to learn the basics of money management, and sticking to them can build habits that pay off in the future. In Part II, we will look at some of the issues facing the residency graduate as they prepare to enter private practice.

(Footnotes)
[1] IRS Publication 970

Attention Medical Students! Get Thee to an EM Conference

by Kevin Price

Walking into the large conference room of a National EM assembly can be nerve racking as a medical student. It is not uncommon to feel like an impostor who might be found out at any minute, just a newly minted third or fourth year medical student suddenly surrounded by an army of attendings. What many medical students don't realize is that the EM community encourages and enjoys the presence of students at these conferences, and at least for AAEM in particular, is excited by the growing number of medical student attendees. Last year, at my first conference, I learned this firsthand. That first morning as I made my way to the breakfast table (to try and look busy with a bagel and some coffee), Dr. Joe Lex, chair of the AAEM Education Committee, and as such the man responsible for the whole conference, offered me a smile and his hand as he welcomed me. Suddenly, with this friendly greeting from one of the finest in the field of EM, I felt all my nervousness slip away. I told him who I was and he said he was glad to see a medical student at the conference and really hoped to see more. From that brief encounter onward I had one of the most enjoyable weekends of my entire medical school career.

Though many students worry that the academic sessions will be over their heads, they are most often accessible to multiple levels of learners. The academic sessions are fascinating and invigorating. Perhaps most amazingly, these sessions are at times even very entertaining. The net result, for me, has been a growing excitement about the day when I too will be an EM physician, encountering these same cases and chief complaints, surrounded by this friendly and inviting EM community.

Another benefit of attending EM conferences as a medical student, is that it provides you with an opportunity to interact with working EP's, current residents, and academic faculty members and program directors from across the country (often over free drinks and hors'deuvers). The evening of my first EM conference and throughout the remainder of that weekend, I made many great contacts for my future in EM, including one that led to my favorite fourth year elective: Emergency Medicine Ultrasound.

Since that weekend, when I attended the 2004 AAEM Scientific Assembly, I must admit to becoming a conference junky of sorts. I have since attended four others including both regional and national conferences. Some of which even had tracks specifically designed for medical students. I am very excited that this year the Education Committee of AAEM, along with the AAEM Resident and Student Association are working hard to design a special medical student track for the February 16th-18th, 2006, Scientific Assembly in San Antonio, TX. Plans are currently underway for a talk from Dr. Kenneth Iserson, the author of Iserson's Getting Into A Residency, a panel discussion and rotating meet and greet table session with program representatives from several three year, four year, military, and osteopathic EM residency programs, and more to help students excel during their EM rotations or even their upcoming intern year. There is also a very exciting track being planned for current EM residents that will be of interest to medical students planning a future career in EM. All of this, remember, is in addition to the great educational sessions already planned for the Scientific Assembly. So start planning your trip to San Antonio now.

Please stay tuned to Common Sense and **www.aaemrsa.org** for updates and hopefully I will see you there!

A Plain Talk Guide to AAEM's Legal Victories for Residents & Medical Students: The Mount Diablo Case

By Joel Schofer, MD

AAEM continues to increase in membership, currently sustaining growth at over 10 percent a year. A major reason that AAEM is attracting new members is because of its willingness to support and defend the individual emergency physician (EP). There have been many legal triumphs over the last few years, and we often talk about these triumphs when recruiting new members. I think that a lot of the residents and medical students we talk to are unaware of the details of these victories, what the issues were in each of them, and why these issues are important to them. Honestly, even after the recruitment talks, I think that most don't quite understand all the facts and the importance of each of these situations.

Over the next year, I will provide brief summaries of each of AAEM's legal triumphs in plain talk, assuming no previous knowledge of the issues involved. I think that once you read about these cases and understand the issues at hand, you will see that AAEM is the organization offering the most support to the individual EP and will understand why membership in AAEM is so important to the future of all residents and medical students.

Mount Diablo, California (2003-2004)

This case involved Mt. Diablo hospital in Concord, California. Its emergency department (ED) was staffed by a subsidiary of Team Health, a large contract management group and one of the largest employers of EPs in the country. Team Health lost the contract to staff the ED, but three of the EPs who had worked for Team Health decided that they wanted to stay in the same ED and work for the new contractor, California Emergency Physicians. When they attempted to do this, they were personally sued by a subsidiary of Team Health for "interference" with the contract to staff the ED. This was not a malpractice case where they would have been covered by their malpractice insurance, but a civil suit where their own personal assets were at risk! They were responsible for using their own financial resources to defend the case against a subsidiary of Team Health, a multi-million dollar corporation with virtually unlimited legal resources.

The Mount Diablo emergency physicians realized that they needed help. They approached both the American College of Emergency Physicians (ACEP) and AAEM. Unfortunately, ACEP told them they could not help, that their hands were tied as they do not get involved in "private business matters." On the other hand, AAEM investigated the situation and formed a legal strategy to assist these physicians. AAEM met with the affected physicians and soon after, decided to countersue Team Health, alleging that Team Health was violating the Corporate Practice of Medicine doctrine in California.

The prohibition of the corporate practice of medicine is present in certain states, including California. It prevents non-physicians from owning medical practices for profit. In other words, if you are a non-physician businessman, this law would forbid you from opening a clinic, hiring plastic surgeons, and reaping the profits of the plastic surgery practice while paying the surgeons a salary in return for their services. The same logic applies to EDs, and AAEM has long contended that Team Health and other contract management groups are businesses, owned by investors and not physicians, which "own" EDs, reap the profits of these EDs, and pays the EPs a salary as an employee. Since these investors are not all physicians, this would violate the corporate practice of medicine because non-physicians cannot own medical practices.

These lawsuits were settled out of court once AAEM counter sued. The details of the settlement are confidential, but the most important part is that the lawsuits against the individual EPs were withdrawn.

As you can see, three EPs were in trouble and were told by ACEP that their plight was a "private business matter." AAEM's answer was the 180 degree opposite. They needed help, and AAEM was there. Without the support of members like you, AAEM could not have come to the aid of the EPs in this case, and this willingness to aid individual EPs is one of AAEM's most attractive attributes.

The AAEM Resident and Student Association (AAEM/RSA) Proudly Presents the "AAEM/RSA Toxicology Handbook"

This user-friendly handbook is the culmination of more than two years of work by 40 medical toxicologists and emergency medicine practitioners from a wide range of academic programs. Our focus on the clinical aspects of common poisonings and emphasis on "tricks of the trade" make this reference a "must-have" for any emergency medicine practitioner.

The AAEM/RSA Toxicology Handbook is available as either a pocket-sized book or in a PDA format. AAEM/RSA members received either the paper or electronic version as part of their membership benefits. It is also available for purchase at www.aaem.org.

We hope that you will find this resource useful in your care of the poisoned patient.

Ziad N. Kazzi, MD & Raymond J. Roberge, MD FAAEM
Chief-Editors, AAEM/RSA Toxicology Handbook

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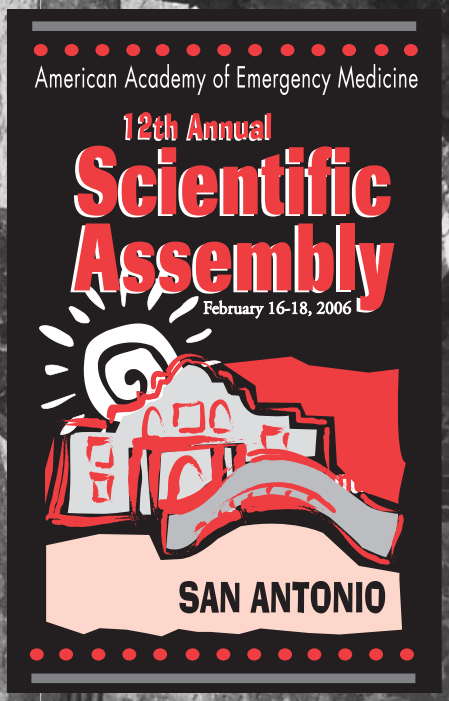

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This article was sent to me by one of our policyholder/owners in the Emergency Medicine Professional Assurance Company (EMPAC RRG). We are proud to have such a physician that emulates this kind of courage and integrity as a member. EMPAC RRG and AAEM openly support physicians in their strive to gain control and independence in the practice of emergency medicine.
Tobey Williams Jr., MD
President/Chairman
EMPAC RRG

My Quest for Independence:

I was once part of one of the largest physician practice management groups in the country. As part of that group I had excelled through the system from a physician to medical director and regional medical director. The more I learned about the practice management group and its management, the more I developed a disdain for the very physicians I had once emulated. No longer did I want to be a part of this management group. Nor did I want to leave the hospital and patients to whom I had dedicated so many years. I truly enjoyed practicing in the environment with the nurses and physicians that were part of our department.

Thus the desire to become independent grew. About four months after plan inception, the end result was an independent practice in emergency medicine owned by the physicians for the physicians.

The first phase of independence begins as you test the waters among your fellow physicians, checking their temperature for a departure from the mother manager. Know that if they are not behind your desire to become independent there are no further steps to take. Because in my situation I have provided the leadership for the previous five years at this facility, and personally hired each of the physicians involved, this was an easy task. Comments such as, "why did you wait so long" and "when can I join in" were most prevalent.

Second, of course, is to begin negotiations with the hospital. A solid relationship with the administrators is key to the successful continuation of the process. The hospital leadership in this case was 100 percent behind the course of action and wanted the takeover to occur. They did not want; however, to get dragged into a law suit. After review of the contract between the hospital and the management group, it became clear that as long as the hospital did not initiate negotiations with another entity, or try to persuade any of the employed physicians to interfere with the contract, they would be protected from legal repercussions.

The bases are now prepared for phase two. This phase consists of developing relationships with the appropriate businesses to ensure survivability, profitability and viability. The relationships established should include accounting, banking, billing and collection, payroll services, and medical liability coverage. Steering clear of attorneys will enhance your knowledge of the intricacies of your practice. Specific jobs such as filing company profiles with the state and review of contracts with specific questions should suffice. You as a physician should understand your own contract and if you do not, then you are probably not ready for such an excursion into independence at this point.

Phase three deals with the actual process of breaking away from the management group. It will be filled with a dichotomy of emotions – fear and excitement. The end result should be a win-win situation for both parties involved. Honesty, with the management group is paramount. Remember that the underlying tone of clear disdain for litigation, enhanced by the current liability crisis, is shared. This knowledge should quell some of your fears of litigation from the management group. Attempt to make a deal with the management group that your new group will pay for services from the management group such as billing and collections or management services. The management group then becomes another outsourced company for services in exchange for deferring litigation. Doctors and their management both know that no one in litigation wins and the decision to avoid a legal battle and the poor publicity that goes along with it usually prevails. The result is a term relationship where all involved are in a win win situation.

Phase four is the implementation of your puzzle. Bringing the pieces of phase two to fruition is the most exciting part of the process. Your leadership skills, developed over the entire process and prior to it even becoming a thought, are essential. Be prepared and plan for future obstructions in your path by strategizing optional plans three steps ahead.

Opening day will be remembered for the rest of your life. Remember also the very reason you decided to do this 24/7/365; never become what you rejected for the same will happen to you. Be generous, kind to your group; provide support and guidance to every single person working with you. Be a leader.

Submitted by a member of EMPAC RRG
A single specialty emergency medicine only Malpractice Insurance Company

Report Outlines Health Care Guidelines for Mass Casualty Events

A new report (**http://www.ahrq.gov/research/altstand**) from an expert panel convened by the Federal Agency for Healthcare Research and Quality outlines actions disaster preparedness planners can take to prepare for mass casualty events that may compromise the ability to deliver health care services consistent with established care standards. The panel, which included representatives from the AHA and hospitals, examined how current care standards might need to be altered to save as many lives as possible in public health emergencies involving thousands of victims. Among other actions, the report recommends developing guidance for allocating scarce health and medical care resources and a process for addressing non-medical issues related to the delivery of health care.

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FOR EMERGENCY MEDICINE PHYSICIANS

BY EMERGENCY MEDICINE PHYSICIANS

Contact EMPAC Managers for more information:

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Wanted: You!!!

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

by Chip McCullom, MD

Approximately 10 percent of all physicians change jobs annually. The average emergency physician (EP) will do so five to six times during a career. With your help, AAEM/RSA and AAEM can help those EPs seeking new employment.

AAEM and AAEM/RSA are building a nationwide network of AAEM physicians who are willing to discuss their local practice environment with EPs seeking new employment. This new service will be available on the AAEM and AAEM/RSA website. Any AAEM member seeking new employment will be able to log on to a password protected portion of the website. After logging on they will see a list of AAEM members organized by the city and state in which they have volunteered to discuss the local emergency medicine (EM) practice environment. The displayed information for each volunteer will be their name and preferred method of contact (pager, email, etc.). The AAEM member seeking new employment may then contact the volunteer in their area of interest and receive "inside" information from an EP practicing in the local community.

This service would be free to AAEM members, but AAEM can not guarantee the veracity of any information provided by these contacts and you would use this information at your own risk. AAEM will be facilitating contact between the EP seeking employment and the local volunteers, but will not be censoring or monitoring the information they provide.

AAEM and AAEM/RSA are seeking board certified or eligible EPs and senior EM residents to act as volunteers for the geographic regions in which they are familiar with the practice environment. As a volunteer you will have access to update and edit your contact information and may remove yourself from the list at any time, for any reason.

If you would like to help, please email the following information to Dr. Richard McCollum at **doctorchip@pol.net**:

1. Full name
2. City, State in which you wish to discuss the local EM practice environment (maximum of 2 areas)
3. Preferred method of communication (pager, email, etc.)
4. Employer (e.g. Independent Group, Kaiser, CEP, etc.) (optional)

Please direct all responses or questions to Dr. Richard McCollum, **doctorchip@pol.net**. Thank you for your help in developing this valuable resource for AAEM physician members!

The following letter was sent by the AAEM Secretary/Treasurer in response to the Association of Emergency Physicians solicitation letter back in February. The response from Attorney General Bill Lockyer on page 16.

Dear Attorney General Lockyer;

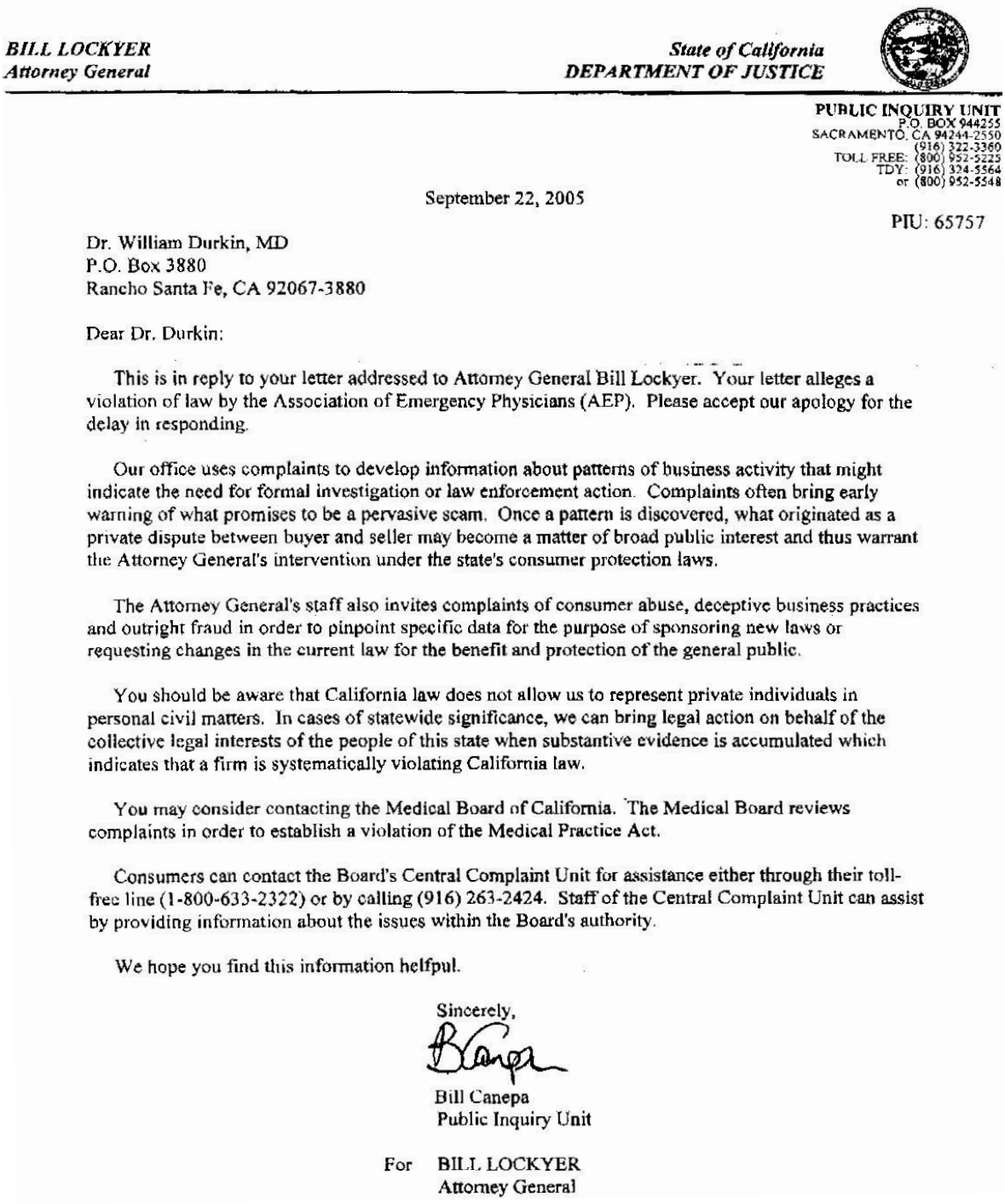
I am writing you in regards to a letter sent by the Association of Emergency Physicians(AEP) to all hospital administrators within the State of California in the fall of '04 (Enclosure 1). In this letter their President, Dr. Geoffrey Ruben, solicits these administrators to hire members of his association. In enclosure 2 he goes on to list the reasons why members of his organizations should be hired to staff the emergency departments of these hospitals rather than those physicians who have been credentialed by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM). In order to be credentialed by either of these two certifying organizations one must complete an accredited residency in emergency medicine and then successfully complete a rigorous two part examination consisting of a written and an oral section.

I believe that this constitutes a direct violation of California law, specifically section 651 (h) (5) of the Business & Professions Code which was originally drafted by the California Medical Association. It also goes against the interests of the public health and well being as it advocates hiring physicians who are neither adequately trained in emergency medicine nor certified by either of the acknowledged certifying boards in the specialty. The American Academy of Emergency Medicine feels that all patients have the right to be seen by a board certified specialist in Emergency Medicine anytime they seek care in an Emergency Room.

It is our request that immediate action be taken against Dr. Ruben and AEP for violation of the state Business and Professions code. Allowing this kind of illegal solicitation misleads the recipient of this letter and places the overall public well being in jeopardy. Both I and the American Academy of Emergency Medicine are willing to assist you in this regard in any way that we can. My address and other contact information are listed above. We thank you in advance for your immediate and timely response to this matter.

Respectfully,

William Durkin, Jr., MD FAAEM
Secretary/Treasurer
American Academy of Emergency Medicine
Enclosures (2)



BILL LOCKYER
Attorney General

State of California
DEPARTMENT OF JUSTICE

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or (800) 952-5548

September 22, 2005

PIU: 65757

Dr. William Durkin, MD
P.O. Box 3880
Rancho Santa Fe, CA 92067-3880

Dear Dr. Durkin:

This is in reply to your letter addressed to Attorney General Bill Lockyer. Your letter alleges a violation of law by the Association of Emergency Physicians (AEP). Please accept our apology for the delay in responding.

Our office uses complaints to develop information about patterns of business activity that might indicate the need for formal investigation or law enforcement action. Complaints often bring early warning of what promises to be a pervasive scam. Once a pattern is discovered, what originated as a private dispute between buyer and seller may become a matter of broad public interest and thus warrant the Attorney General's intervention under the state's consumer protection laws.

The Attorney General's staff also invites complaints of consumer abuse, deceptive business practices and outright fraud in order to pinpoint specific data for the purpose of sponsoring new laws or requesting changes in the current law for the benefit and protection of the general public.

You should be aware that California law does not allow us to represent private individuals in personal civil matters. In cases of statewide significance, we can bring legal action on behalf of the collective legal interests of the people of this state when substantive evidence is accumulated which indicates that a firm is systematically violating California law.

You may consider contacting the Medical Board of California. The Medical Board reviews complaints in order to establish a violation of the Medical Practice Act.

Consumers can contact the Board's Central Complaint Unit for assistance either through their toll-free line (1-800-633-2322) or by calling (916) 263-2424. Staff of the Central Complaint Unit can assist by providing information about the issues within the Board's authority.

We hope you find this information helfpul.

Sincerely,

Bill Canepa
Public Inquiry Unit

For BILL LOCKYER
Attorney General

MEMBERSHIP DUES FOR THOSE IN THE GULF REGION

If you live in the Gulf Region and have been financially impacted by the hurricanes, your AAEM dues can be waived by writing a request to:

AAEM Membership
555 East Wells Street
Suite 1100
Milwaukee, WI 53202-3823

Did you miss the Third Mediterranean Emergency Medicine Congress in Nice, France?

Washington Watch

Hospital Held Liable for Alleged Negligence of Independent Contractor

by Kathleen Ream, Director of Government Affairs

On September 16, 2005, the Virginia Supreme Court declined to adopt the theory – presented by plaintiff Leasley Sanchez in the case of Sanchez v. Medicorp Health System, Va., No. 042741, 9/16/05 – that apparent or ostensible agency applies to a hospital, thereby making the hospital vicariously liable for the alleged negligence of an emergency department doctor who was an independent contractor.

The facts of this case involve plaintiff Sanchez who sought treatment for a head wound in the ED at Medicorp Health System's Mary Washington Hospital, Inc. The ED physician treating Sanchez's injuries was an employee of Fredericksburg Emergency Medical Associates, Inc. Sanchez claimed that he developed permanent weakness on his left side as a result of alleged negligent care and treatment in the ED. Sanchez filed a medical malpractice action claiming that the hospital represented the physician as its employee and agent, and that Medicorp was therefore vicariously liable for the doctor's alleged negligence under the theory of apparent or ostensible agency.

The defendant filed a demurrer [a demurrer tests the legal sufficiency of facts alleged in a plaintiff's pleading] asserting that a claim for vicarious liability based on the theory of apparent or ostensible agency is not cognizable under Virginia law. The circuit court agreed, sustaining Medicorp's demurrer. The court noted that the theory of apparent agency is not merely an extension of the doctrine of respondent superior. Instead, reasoned the court, it is different because in apparent agency there is no actual master servant relationship. Continuing, the circuit court recognized that an employer could, however, be liable for the negligence of an independent contractor if the employer had a nondelegable duty to a third party, but the court concluded that Medicorp did not have a nondelegable duty to provide competent medical treatment to ED patients.

In the appeal, Sanchez argued that the circuit court erred in sustaining the demurrer and urged the Virginia Supreme Court to hold that a hospital can be vicariously liable for the alleged negligence of a doctor working in the hospital's ED as an independent contractor. Sanchez also acknowledged that the state supreme court had never addressed the question of a hospital being vicariously liable, based on the theory of apparent or ostensible agency, for the negligence of its ED physician working as an independent contractor. "Nevertheless, Sanchez points out," wrote the court, " that the majority of jurisdictions that have addressed the issue . . . have decided, on the basis of apparent agency or agency by estoppel, to impose vicarious liability on hospitals for the negligence of emergency room physicians who were not employees of the hospitals but independent contractors."

The Virginia Supreme Court responded to this plaintiff's argument that "[i]n virtually all these cases imposing vicarious liability, the particular jurisdiction involved had already adopted the theory of apparent agency or agency by estoppel as a basis of tort liability when the jurisdiction used the theory to hold a hospital vicariously liable for negligent medical care rendered by an emergency room physician working as an independent contractor." Whereas in Virginia vicarious liability has not been imposed on an employer for the negligence of an independent contractor on the basis of apparent or ostensible agency, or agency by estoppel. Moreover, wrote the court, "[i]n Virginia, the doctrine of respondeat superior imposes tort liability on an employer for the negligent acts of its employees, i.e., its servants, but not for the negligent acts of an independent contractor."

Finding no reason to apply the theory of apparent agency or agency by estoppel to hold Medicorps vicariously liable for the alleged negligence of its independent contractor, the state Supreme Court affirmed the judgment of the circuit court.

The full text of the court's decision is available at **www.courts.state.va.us/opinions/opnscvwp/1042741.pdf**

FEDERAL COURT APPLIES STATE DAMAGES CAP TO EMTALA CLAIM

On August 18, 2005, the U.S. Court of Appeals for the Sixth Circuit found that in the case of Smith v. Botsford General Hospital (6th Cir., No. 04 1436, 8/18/05), EMTALA incorporation of state law extends to caps on damages. In this particular case, the court also ruled that Michigan's (the state in which the hospital is located) malpractice actions are applicable to EMTALA's failure-to-stabilize claim. Consequently, the court reduced the district court's noneconomic damages award to comply with the state's cap on malpractice limits.

Plaintiff Andrea Smith, personal representative of the deceased Kelly Smith, brought an action against defendant Botsford General Hospital, alleging that Botsford violated EMTALA when it failed to stabilize Kelly Smith's condition – caused by an open femur fracture – before transporting him. The trial jury found in favor of Smith and awarded $35,000.00 for economic damages and $5,000,000.00 for noneconomic damages. Botsford filed several post-trial motions seeking a new trial or a reduction in damages. The district court denied the motions, and Botsford appealed. The federal appellate court affirmed the lower court rulings, except for the challenge concerning the application of Michigan's cap on noneconomic damages.

In writing for the court, Judge Deborah L. Cook spoke first to EMTALA's civil enforcement provisions specifying that "[a]ny individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of [the Act] may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located. . ." 42 U.S.C. § 1395dd(d)(2)(A). The appellate court thus joined a majority of courts that have addressed this issue by finding that in plain language of the statute "EMTALA's incorporation of state law extends to caps on damages."

Cook then considered the next question which examined whether the plaintiff's EMTALA failure-to-stabilize claim would be regarded as a malpractice claim under state law. Undertaking the analysis for determining whether the nature of a claim is ordinary negligence or medical malpractice, Cook drew on the Michigan Supreme Court test cited in Bryant v. Oakpointe Villa Nursing Center, 684 N.W. 2d 864 (Mich. 2004).

According to Bryant, the determination of malpractice depends on the resolution of two additional questions: "(1) whether the claim pertains to an action that occurred within the course of a professional relationship; and (2) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience."

Having no dispute with the first question, the plaintiff's case was based on the second question where she objected to the classification of her claim as a malpractice action, stating that traditionally malpractice actions are premised on questions of "medical judgment." Cook wrote that Bryant acknowledged the traditional definition, but it did not limit "medical judgment" to

continued on pg 19

Washington Watch - continued from pg 18

"claims arising from a breach of the professional standard of care." Rather, Cook noted that Bryant's application of the standards reflects a broader definition to include the "need for experts."

The court determined that exercise of professional judgment indeed was necessary to meet the EMTALA stabilization requirements for transfer of an individual from a facility [42 U.S.C. § 1395dd(e)(3)(A)] for this particular case involving Kelly Smith, who weighed approximately 600 pounds and had a history of alcoholism, smoking, and drug abuse. Finding malpractice, the verdict limited the plaintiff's non-economic damages to $359,000.00 in compliance with Michigan's cap on malpractice damages.

The full text of the decision is available at **www.ca6.uscourts.gov/opinions.pdf/05a0355p 06.pdf.**

ED RECORD DATA DISCOVERABLE FOR NONPARTY PATIENTS

On August 17, 2005, the Illinois Appellate Court, 1st District, affirmed the circuit court's order compelling a hospital to produce the emergency department records of treatment times and acuity designations of nonparty patients, for discovery of a wrongful death action charging hospital negligence in delaying treatment (Tomczak v. Ingalls Memorial Hospital, Ill. App. Ct., No. 01 L 8384, 8/17/05). The facts in this case involve the plaintiffs, Michael and Eleanor Tomczak, special administrators of the estate of their deceased daughter Victoria Tomczak, who filed an instant wrongful death and survival action against Ingalls Memorial Hospital. The complaint alleged that the decedent entered Ingalls' ED one evening and died early the next morning as a result of Ingalls' delay in examining Tomczak and in administering appropriate treatment.

During discovery, Tomczak served upon Ingalls several interrogatories and requests for production of documents. In response, the defendant provided a copy of its Emergency Department Daily Log which listed the sex, triage date, triage time, mode of arrival, chief complaint, treating physician, disposition, exit time, and final diagnosis for 140 patients, including the decedent. Ingalls also submitted several policy documents about the organization, plan of care, and standard of care for its ED, which revealed that the ED uses a triage process to facilitate the safe and timely treatment of each patient according to relative needs.

After receiving the documents, Tomczak served a third set of interrogatories upon the hospital, requesting that Ingalls disclose the following information for nonparty patients who were seen in the ED: (1) "Time In," i.e., the time at which the patient is placed in the ED treatment area; (2) "Treatment time," i.e., the time each patient was first examined by a physician; (3) and the triage acuity designation. The circuit court entered an order directing the plaintiffs to return the Daily Log, barring its use at trial, but modifying its discovery order so that Ingalls was only required to submit the triage time, treatment time, and triage acuity designation for all patients assessed by a triage nurse. The hospital objected to the interrogatory as overly broad, unduly burdensome, and would not reasonably lead to the discovery of relevant information. Ingalls was held in contempt of court for failing to comply with the court's discovery order. These orders form the basis for this appellate case.

Ingalls asserted that the information requested was protected from disclosure by the physician patient privilege (735 ILCS 5/8 802 [West 2002]) and by certain regulations promulgated under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. No. 104 191, 110 Stat. 1936 [1996]). The Illinois Court of Appeals disagreed and found that the nonparty patients' triage times, treatment times, and triage acuity designations are not barred from disclosure by the physician patient privilege.

"[W]e find that the nonparty patients' triage and treatment times are mere incidents of fact unnecessary to enable a physician to perform his or her professional duty", the court wrote. As such the appellate court determined that the time data would not fall within the scope of Illinois' physician patient privilege. Continuing the court affirmed that "Ingalls has failed to present any facts showing how a triage acuity designation enables a physician to serve a patient within the meaning of the physician patient privilege. A patient's acuity designation does not refer to a specific symptom, ailment, or complaint. Rather, it simply effects the time at which a patient is first treated, and there is no evidence that a physician uses the acuity rating in reaching a medical diagnosis."

Moreover, the court determined that the information requested contained neither the nonparty patients' names, nor a history of their prior or present medical conditions, treatments, or diagnoses. Accordingly, the court found that "the nonparty patients' triage times, treatment times, and triage acuity designations fall outside the category of 'protected health information' covered by regulation 164.512(e)(1)" set forth in HIPAA. In support of its decision, the appellate court noted that Supreme Court Rule 201(b)(1) allows, in effect, the circuit court "great latitude in determining the scope of pretrial discovery, as the concept of relevance for discovery purposes encompasses not only what is admissible at trial, but also that which may lead to the discovery of admissible evidence. "

The plaintiffs' theory of the case was that the defendants failed to timely diagnose and treat the decedent, and to support this theory, Tomczak sought to establish that other ED patients were examined before the decedent in contravention of the procedures established by Ingalls. The court reasoned that to make this showing, the plaintiffs clearly needed to know the information, of the of the nonparty patients, identified in the circuit court's discovery order. "Further," added the court, "the production of the information sought by the plaintiffs would not constitute an undue burden on Ingalls."

Full text of the decision is available at **www.state.il.us/court/Opinions/AppellateCourt/2005/1stDistrict/August/Html/1041746.htm**.

COURT RULES ON SCREENING ER PATIENTS

On July 27, 2005, the U.S. Court of Appeals for the First Circuit ruled that a hospital failed to provide an appropriate screening examination as required under EMTALA when it failed to follow its own protocol in screening an ED patient who allegedly complained of chest pains (Cruz Queipo v. Hospital Espanol Auxilio Mutuo De Puerto Rico, 1st Cir., No. 04 2375). Judge Kermit V. Lipez said the hospital improperly categorized Edgardo Jose Cruz Queipo, who allegedly complained of chest pains, as a "non emergency," dischargeable patient, following a screening evaluation – yet the hospital's own procedures required a stable patient with similar complaints to be placed in emergency care.

In reversing the Puerto Rico federal district court's dismissal that Cruz Queipo's claim involved allegations of malpractice rather than EMTALA violations, Lipez said the allegations of unequal treatment could involve an EMTALA violation. "EMTALA requires a hospital to even handedly administer an appropriate screening procedure to all emergency room patients." According to Lipez's ruling, the hospital records did not indicate that Cruz Queipo complained of chest pains until he returned to the hospital the next day, when he was actually diagnosed as having a heart attack. For purposes of summary judgment review, however, Lipez said he was obliged to credit Cruz Queipo's assertion that he did report such pain to hospital staff on his first visit and that

continued on pg 20

Washington Watch - continued from pg 18

they were aware of his chest pain.

Accepting Cruz Queipo's claim that he did complain of chest pains on his initial visit to the emergency room, Lipez concluded that Cruz Queipo was denied an appropriate screening under EMTALA because the hospital failed to assign Cruz Queipo to emergency care, as required under hospital protocol. Moreover, Lipez noted, "the hospital had a duty to stabilize the heart condition that culminated in a heart attack" the following day.

"Although a jury ultimately may determine that the hospital's treatment of Cruz did not violate EMTALA, the summary judgment record, viewed in the light most favorable to the plaintiffs, does not permit that conclusion as a matter of law," Lipez said, and remanded the case to the district court.

The full text of the decision can be found at **www.ca1.uscourts.gov/cgi bin/ getopn.pl?OPINION=04 2375.01A**

AAEM JOB BANK

To respond to a particular ad: AAEM members should send their CV to the AAEM office noting the response code listed at the end of the position description in a cover letter. AAEM will then forward your CV to the appropriate professional.

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

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

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

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ARIZONA

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

CALIFORNIA

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

CALIFORNIA

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

FLORIDA

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

FLORIDA

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

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

FLORIDA

The University of Florida/Jacksonville campus, Department of Emergency Medicine seeks full-time BC/BE emergency physician. The largest Level I Trauma Center in Northeast Florida and the region's leader in stroke treatment. Over 90K patient visits annually and modern diagnostic modalities and on call coverage for all offered specialty services. Benefits include health, life, disability insurance, vacation and sick leave, expense account, generous retirement plan and covering immunity occurrence medical liability insurance. Fax CV and letter of interest to Dr. Kelly Gray-Eurom at 904-244-5666. Deadline to apply 10/3/05. EOE/AA Employer (PA 717)

FLORIDA

Work with group of BC/BE Emergency Physicians in a 55K visit community hospital setting in Orlando suburbs. Enjoy employee status, benefits, retirement package and sovereign immunity. Excellent coverage with 42 hours physician coverage an d36 hours PA/NP coverage daily. Compensation $120/hr plus benefits. (PA 724)

KENTUCKY

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

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

INDIANA

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

INDIANA

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

MARYLAND

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

MASSACHUSETTS

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

MASSACHUSETTS

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

MASSACHUSETTS

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

MGH is an equal partner in the 4-year BWH/MGH Harvard Affiliated Emergency Medicine Residency Program. The ED is a high volume, high acuity level 1 trauma and burn center for adult and pediatric patients. Annual volume is >76,000. Candidates must have at least 4 years residency plus fellowship training in Emergency Medicine. Send CV to: David F. M. Brown, MD FACEP, Massachusetts General Hospital, Bulfinch 105, Department of EM, 55 Fruit Street, Boston, Massachusetts, 02114. (PA 721)

MINNESOTA

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

MISSOURI

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

MISSOURI

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

AAEM JOB BANK

MISSOURI

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

MISSOURI

Hannibal Regional Hospital is seeking a Medical Director for the Emergency Department. Qualifications include: Board certification in emergency medicine. In addition to a base salary, Incentive Bonus, Relocation monies, Tax Sheltered Annuities, and Continuing Education monies are available.

Located near the Mississippi River and just 20minutes from Mark Twain Lake that offers the appeal of a variety of recreational amenities (fishing, boating, and camping) with easy access to major metropolitan areas such as St. Louis, MO., & Springfield, IL. Contact Marcia Davis at **Marcia.davis@hrhonline.org**. (PA 722)

NEBRASKA

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

NEW HAMPSHIRE

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

NEW JERSEY

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

NEW MEXICO

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

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

NORTH CAROLINA

Democratic group in the Raleigh/Durham area seeks an emergency physician who values our specialty as much as we do. Medium-sized community hospital with excellent back-up. Our department sees 45K patients a year with a separate fast track area. We offer competitive compensation, equitable scheduling and good benefits in a fair practice environment. Our group is stable, vibrant, and seeking a strong team player who is BC/BE in EM. We are all board certified in EM, and most of us have a good sense of humor. Contact Michelle Durner at **mdurner@ams-nc.com**. (PA 712)

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

OKLAHOMA

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

OREGON

Small, stable, single-hospital, democratic, locally owned EM group seeking full-time board eligible/certified physician for 120-140 hours/month for 8 hour shifts. Salary is very competitive. We offer a generous benefit package. Clean, small-town with excellent schools. Recreational opportunities here on the east slope of the Cascades, include hunting, fishing, skiing, biking, river rafting, golf and camping. (PA 700)

OREGON

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

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

PENNSYLVANIA

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

SOUTH CAROLINA

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

TEXAS

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

VERMONT

The Emergency Department at Southwestern Vermont Medical Center has a Full-Time position for a Staff Emergency Physician. Applicants should be board certified or eligible in Emergency Medicine with Emergency Medicine training. Experience preferred. Reply to: Polly Cipperly at apply@phin.org. Website www.svhealthcare.org (PA 716)

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

VIRGINIA

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

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

VIRGINIA

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

VIRGINIA

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

WASHINGTON

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

WASHINGTON

WASHINGTON, Olympia: Full-time opportunity for residency trained BC/BP emergency physician. Established, independent, fee-for-service democratic group. Annual volume 60,000. Financial equality at one year, partnership at two years. State-of-the-art department located on the scenic Puget Sound. (PA 711)

WASHINGTON

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

WASHINGTON, D.C.

Please see ad PA731 under Maryland.

WISCONSIN

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

WISCONSIN

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

GERMANY

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

AAEM/RSA AND AAEM NEW MEMBERSHIP APPLICATION

First Name MI Last Name Degree (MD/DO)

Institution

Address

City State Zip

Please check which address this is: ☐ Work ☐ Home

Phone Number—Work Phone Number—Home

Fax E-mail

Recruited by

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

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

If not completed, expected date of completion: _____

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

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

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

If yes, date: _____

when minutes count

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

AAEM MEMBERSHIP FEES

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

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

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

AAEM/RSA MEMBERSHIP FEES

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

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

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

OPTIONAL

Are you a member of any other EM organizations? Please select all that apply.

☐ AACEM ☐ AAEM/RSA ☐ ACEP ☐ ACOEP ☐ AMA ☐ EMRA ☐ CORD ☐ SAEM ☐ NAEMSP

☐ Other _____

PAYMENT INFORMATION

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

Card Number Expiration Date

Cardholder's Name

Cardholder's Signature

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

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Milwaukee, WI 53202-3823

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