common SENSE

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JANUARY/FEBRUARY 2008

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

FAAEM *ALWAYS* MEANS BOARD CERTIFIED

when minutes count

Thank You

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PRESIDENT'S MESSAGE

by Tom Scaletta, MD FAAEM
AAEM President

AAEM came into existence to advance the specialty of emergency medicine by protecting emergency physician rights, upholding emergency medicine board certification as a gold standard and providing excellent educational programs. What a legacy! It has been tremendously satisfying for me to represent AAEM as its president for the past two years. This has been the greatest honor of my professional career.

AAEM's maturation over the past fifteen years was like a reactive adolescent becoming a proactive adult. Simply put, we learned how to add poise to our passion. Though we are fast approaching 6,000 members, our board remains responsive and steadfast in our mission. As a result, AAEM has become the go-to organization for a wide spectrum of fairness issues.

Considerable credit for AAEM's success goes to Kay Whalen, our executive director, and her talented management team, including Janet, Jody, Kate, Megan, Shauna and Tom. We also have the advantage of Kathi Ream being our Government Affairs Director, who works hard for us on Capitol Hill.

We are extremely fortunate that Larry Weiss, MD JD, is going to be the next AAEM president. Larry has a brilliant mind and is a true gentleman of impeccable integrity. He is comfortable with adversity and challenges and has exceptional interpersonal skills. Larry has accepted this responsibility for all the right reasons, and I wish him a successful term.

Lastly, a personal thank you goes out to Karen, Jack, Peter and Mia, my wonderful family, who have been extraordinarily tolerant and supportive.

EDITOR'S LETTER

Investing in the Future

by David Kramer, MD FAAEM

As we head into the New Year, many of us take the time to reflect on the important aspects of our lives. Family, of course, comes up first in most of our minds. I have been thinking about the many conflicting responsibilities that all of us have. Clichés come to mind. Balance. See-saw. Compromise. Professional life vs. personal/family life. A fertile breeding ground for internal strife, no doubt. Is it a natural conflict? Is it unavoidable? How does one reconcile the conflicts inherent in trying to balance the two? These are difficult issues for hard-working professionals regardless of their chosen careers. It is certainly no less a problem for many of us in emergency medicine.

I am currently in my twentieth year as a residency program director. While I have taught residents many lessons, I have probably learned many more from them. Assuring that my priorities are "right" is something that I am still learning to do. At times it is a struggle. Sure, I practice many good techniques of time management. Of course, I have a "to do list." And, yes, I get a lot of satisfaction out of my career. But no one teaches me more about balance and priorities than my wife and children.

Maintaining balance in ones life is not easy. Career is typically constant. Family and significant others are (usually and hopefully) constant. Priorities, however, are often dynamic. Pressures abound. How do we know when to place one over the other? The answer certainly has to be more sophisticated than simply making sure that "the squeaky wheel gets the grease." Nevertheless, it sometimes does boil down to this hackneyed concept. As a program director, I know when my "busy season" is (we are in the middle of it right now). My wife claims that it is always my busy season. The answer to the dilemma is really quite simple. Always make time for family and the significant others in your lives. Sometimes quality wins over quantity, but when it comes to family, some time is always better than none. Always remember this: if one spouse isn't happy, neither spouse is happy. Sadly, many learn this the hard way. If your career is young, this is a lesson you should definitely learn. Many of us who are more senior grew up with the commercial phrase, "There's always room for Jell-O." I propose to you a modification: There's always time for family.

Happy New Year!
Dave Kramer

AAEM Mission Statement

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

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

Membership Information

Fellow and Full Voting Member: $365 (Must be ABEM or AOBEM certified in EM or Pediatric EM)
*Associate Member: $250 (Associate-voting status)
Emeritus Member: $250 (Must be 65 years old and a full voting member in good standing for 3 years)
Affiliate Member: $365 (Non-voting status); must have been, but is no longer ABEM or AOBEM certified in EM.
International Member: $125 (Non-voting status)
AAEM/RSA Member: $50 (Non-voting status)
Student Member: $50 (Non-voting status)
*Associate membership is limited to graduates of an ACGME or AOA approved Emergency Medicine Program.

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

Candidate Platform Statements

AAEM does not endorse any statement made by candidates and specifically rejects anticompetitive statements.

The nomination period for AAEM's upcoming elections has ended. All individuals running for an open seat on the board of directors have been identified, and the race has begun. Presented here for the benefit of all full voting and associate members of AAEM are the formal platform statements of each of the candidates.

The elections will be held immediately following the Candidates Forum scheduled during AAEM's 14th Annual Scientific Assembly, February 7-9, 2008, at Amelia Island Plantation in Amelia Island, FL. Although balloting arrangements will be made available for those unable to attend the Assembly, all voting members are encouraged to hold their ballots until the time of the meeting. The forum will allow members the opportunity to question candidates directly about their vision of the association and its place in the specialty of emergency medicine. The responses offered in this session, in addition to the platform statements offered here, will provide members with the information they need to make intelligent and informed decisions.

AAEM's democratic election process is just one of the many things that make our organization unique among medical specialty societies. Please review the information presented here carefully, and then make your arrangements to join us in Amelia Island for the Forum and final elections.

Full voting and associate members not planning to attend the Scientific Assembly should return their completed ballot to the AAEM office in the enclosed envelope. Those attending the Amelia Island conference should remember to bring their ballots with them for voting after the special Candidates Forum to be held on Friday, February 8th, from 12:00pm to 2:00pm.

Larry Weiss, MD JD FAAEM

Candidate for President

Nominated by Robert McNamara, MD FAAEM; Tom Scaletta, MD FAAEM; Joseph Wood, MD JD FAAEM

With deep gratitude, I accept the nomination to serve as president of AAEM. I have worked for many years as an advocate for my fellow physicians. Serving as your president will allow me to have the greatest possible impact as an advocate for your practice rights as emergency physicians. Unfortunately, the abuse and exploitation of emergency physicians continues to grow in both scope and intensity. This abuse often results in the violation of our practice rights. Only the Academy advocates for the rights of emergency physicians, and it has done so since its inception. Therefore, I consider service as your chief advocate as the most important responsibility of my career.

My past service includes organizing the Louisiana chapter and serving as a director and president, membership on a number of AAEM committees including the board of directors, writing AAEM's amicus brief in the Coleman v. Deno case, writing a number of policies and writing white papers on tort reform, due process rights, restrictive covenants and the corporate practice of medicine. AAEM will release the latter paper in the spring of 2008. Our series of white papers document the source of your practice rights and the basis of our advocacy on major issues.

In addition to the protection of your practice rights, we must now face new challenges to the integrity of our specialty. Some self-interested groups insist that board certification in emergency medicine should not require the completion of a residency. In reality, they base their claim on an assertion that emergency medicine has no unique knowledge base, that one may learn emergency medicine through apprenticeship, and thus, emergency medicine is not a real specialty. They make these claims aggressively, scheduling hearings before state medical boards, sponsoring bills in state legislatures and even filing suit against the New York state attorney general so that untrained emergency physicians may formally call themselves "board certified" in New York. Certainly, AAEM has always honored and revered the founders of our specialty who trained in other disciplines. However, after a very liberal practice track expired in 1988, ABEM has required the successful completion of a residency in emergency medicine to determine board eligibility. AAEM strongly supports ABEM policies. We support the integrity of emergency medicine, and we will continue to actively resist those who denigrate our specialty.

I sincerely appreciate your past support. I feel a strong duty to our members, because we have a membership that believes in fairness, academic achievement, the ethical practice of medicine, and the right of our patients to have access to quality emergency medical care. If elected, I will vigorously advocate for your rights, for the interests of our patients, and for the integrity of our profession. We will continue to reach out to other societies, but we will not compromise our mission. You can proudly place "FAAEM" in your title for the rest of your career. Others will know you have the finest credentials, you are an ethical physician, and you have the integrity to stand by your convictions.

Candidate Platform Statements

Howard Blumstein, MD FAAEM

Candidate for Vice President

Nominated by Robert McNamara, MD FAAEM; Larry Weiss, MD JD FAAEM

This is a momentous time for the Academy. We have taken bold steps to promote the twin ideals of fair treatment of our peers and the primacy of board certification. Lawsuits fighting the corporate practice of medicine, workplace fairness certification and remaining the sole organization to insist on board certification as the gold standard for qualification to practice emergency medicine; these are the leading ways AAEM has set itself apart.

For too long, we have been derided as a destructive force. The Academy has been accused of splitting asunder the house of emergency medicine and engaging in mudslinging against other organizations representing our specialty. So say our detractors.

Yet while our activities certainly draw attention to the differences between the Academy and other specialty societies, I prefer to think of our efforts as constructive, positive and beneficial. We have become the leader in promoting ideals that we all cherish. We are not really interested in bringing down contract managements groups; we are demanding a level playing field upon which private groups can compete. We want to protect the doctor-patient relationship, which is the whole reason that laws exist against the corporate practice of medicine in the first place.

I look forward to the day when more of my graduating residents feel empowered to demand contracts that protect their rights, as opposed to their current willingness to surrender those rights in favor of their geographic preferences.

My goal, therefore, is simple. As we move forward in our efforts to promote our ideals, we must take care to stress the fact that we are building a better future as opposed to destroying the present. Tom Scaletta, our outgoing president, has done a wonderful job of that (see his recent statement about fellowship and board certification). As vice president, I hope to continue along the path he has blazed for us.

Thank you for your consideration and your vote.

William T. Durkin, Jr., MD FAAEM

Candidate for Secretary-Treasurer

Nominated by Howard Blumstein, MD FAAEM; Peter Rosen, MD FAAEM; Larry Weiss, MD JD FAAEM

I would like to thank Dr. Weiss for asking me to be a part of his executive committee and Drs. Rosen and Blumstein for their nominations.

These are challenging times for the Academy and the specialty of emergency medicine. In order for the Academy to continue to thrive, we will need leaders who are dedicated, have a sense of where we have been, proven leadership abilities and clear goals in mind. I am that candidate.

As a founding member of AAEM, I am personally aware of the many abuses that were commonplace in most practice settings. Democratic physician-owned groups were the rare exception. Sadly, there are still areas of the country where one must work for a CMG if they choose to live there. The model must be changed such that the medical service organization (MSO) is hired by the physician group and works for them, not the other way around. I am proud to have supported the fight against such abuses and will continue to advocate for our members when they seek our assistance. Despite some personal hardship, I have refused to work for a CMG while on the board to avoid any conflict of interest situation.

During my time on the board of directors, I achieved the following:

- Co-founded the first state chapter; CAL/AAEM
- Served on the first CAL/AAEM board, later as treasurer
- Co-founded AAEM Services to assist members to establish their own practices
- Established the USAAEM chapter. Served as treasurer, now board liaison
- Active member of the education committee
- Corporate compliance officer
- Co-authored the first fairness doctrine
- Continuously advocated for the community hospital physician

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Candidate Platform Statements

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As Secretary/Treasurer previously, I was keenly aware of all expenditures and challenged those which I thought would not benefit the membership. I also sought out sponsorship for our educational activities. As a result, I never had to raise your dues. The only treasurer to have ever have done this. My experience in running my own business and investments over the past twenty years will be put to your advantage. After 14 years, the Academy still has no appreciable equity. One of my goals would be to build equity within the organization so that we are stronger, become more stable and less dependent upon membership dues.

While an officer in the Navy, I was a department head and later taught in the first EM residency at the Naval Hospital San Diego. I have since served as QA director, medical director of large departments. I am well aware of the issues facing most of us in private practice.

My goals for the near future are as follows:

- Work with other organizations both within as well as outside the house of organized medicine. Such a multidisciplinary approach is the best way to improve our organization. Where we share common interests with a given organization, we should work together to achieve that goal.
- We will need to pursue other sources of revenue besides taxing the membership with higher dues. Maximizing attendance, sponsorship dollars and exhibitor booths at all of our educational activities are just a couple of ways, I believe, we could begin to improve our bottom line.
- Increase equity within the organization.
- Continue to enable the resident section to recruit new members and sponsor their activities. This is very important if we are to continue our remarkable growth. I would do what was needed to strengthen their efforts and mentor new leaders.
- Continue to do whatever is necessary to uphold the value of ABEM/AOBEM certification.
- Support our international conferences and seek liaisons with our sister organizations in other countries.
- Continue to capitalize on our competitive differential advantage to maximize our growth.

Being an officer of the Academy is also about service to its members. I have taken this very seriously over the years and will continue to do so. I make an effort during all of our conferences to get out and speak with those of you in attendance, getting to know what your expectations are and where we can improve and assist. I take the privilege of being your representative very seriously and will continue to do so.

Knowledge of all aspects of the Academy, proven leadership and management skills, dedication and service to our members. These are the attributes which I bring to the office. I ask for your vote and continued support.

Mark Reiter, MD MBA FAAEM

Candidate for Secretary-Treasurer

Nominated by A. Antoine Kazzi, MD FAAEM; Tom Scaletta, MD FAAEM; Larry Weiss, MD JD FAAEM

I am pleased to accept the nomination for AAEM Secretary/Treasurer. Over my past three years on the AAEM board, I have developed an excellent working relationship with the other members. I also serve on the AAEM Services Board, helping to oversee business activities such as AAEM's new relationship with PEPID and the new AAEM PeerCharts. As AAEM Secretary/Treasurer, I will have the responsibility for ensuring that your dues dollars are used effectively to serve AAEM's mission. I am well prepared for this role, having earned an MBA with concentration in Health Care Policy, and through my prior experiences on the Board of Trustees of the Medical Society of New Jersey, the AMA Council on Legislation, and leadership roles in many other organizations. As a past president of AAEM/RSA, I already have experience working with AAEM staff on setting budgets and providing value to our members while being protective of your dues dollars.

I promise to keep our membership well-informed of the great work being done by the Academy. I will continue to strongly advocate for you on core issues, such as defending the value of board certification and combating corporate practice of medicine abuses. I am committed to developing new opportunities for our membership, such as the new Young Physician Section, the Critical Care Section and the Senior Physician Section. As a member since 2001, I firmly believe in the AAEM mission and hope to have the opportunity to serve you as your Secretary/Treasurer. I'm asking for your vote, as I have the experience, skills and enthusiasm to help AAEM continue to thrive.

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Candidate Platform Statements

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American Academy of Emergency Medicine involvement (2001 to present)

- Board of Directors, AAEM
- Board of Directors, AAEM Services
- Board of Directors, AAEM Resident and Student Association
- President, AAEM Resident and Student Association
- Vice President, AAEM Resident and Student Association
- Chair, AAEM Board Certification Task Force
- Chair, AAEM/RSA Communications Committee
- EM Practice Committee
- EMTALA Committee and EMTALA Pointers column Editor
- Liaison to AAEM-Young Physician Section
- Liaison to AMA-Resident/Fellow Section

Michael C. Choo, MD FAAEM

Candidate for At-Large Board Member

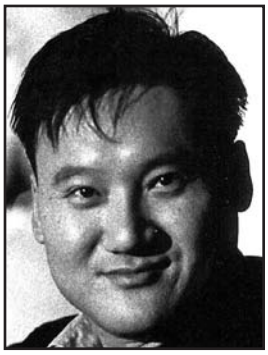
Self-Nomination

My name is Michael C. Choo, MD, and I am very interested in being considered for the AAEM At-Large Board Member position. I am a graduate of Boston University School of Medicine, Boston, MA in 1987. I completed my residency training in emergency medicine in 1990; subsequent to which I completed a fellowship in emergency department administration in 1991. I achieved my initial ABEM board certification in 1991, and my most recent recertification was in 2001. I presently work approximately 150 hours per month at Dayton Heart Hospital's Heart Emergency Center located in Dayton, Ohio, as well as Clinton Memorial Hospital's Emergency Department located in a rural community, Wilmington, Ohio. I am currently the President & CEO of our local emergency medicine physician group – Professional Emergency Specialists of Southern Ohio. I serve as an Oral Board Examiner for ABEM and attained a degree of MBA through the University of Tennessee. In addition, I serve as a Board Member to EPIC Malpractice Insurance Company which specializes in emergency medicine.

Candidate Statement

I chose to enter the field of emergency medicine in 1987 when our young medical specialty was diligently working to become recognized as a "true" specialty among the rest of the traditional medical specialties. Emergency medicine represented to me an exciting facet of medicine that specialized in "front-line" patient care where the physician was challenged to be the best diagnostician while maintaining the skill set of a critical care specialist. Through the steadfast efforts of our pioneering emergency physicians, our specialty evolved to become an essential medical service to our communities, to the medical facilities, and to our medical colleagues of all specialties. We truly focused on the highest quality emergency medicine care being delivered to our patients and our communities. This premise led to my support and enrollment with AAEM in 1993 as one of its first physician members. Despite all of our medical specialty and AAEM's past achievements, we are continuing to deal with even more difficult, complex, and highly tenuous healthcare system in our wonderful United States of America. Our specialty is entrusted to take care of any and all patients needing urgent and emergent medical services; where for a growing number of our population, we are the only healthcare provider that they have access to for care. Our specialty is dealing with declining reimbursement issues that prohibit adequate emergency medicine physician coverage in our emergency departments across the country, which only contributes further to the growing attrition of our highly seasoned EM colleagues. It is my goal and hope to use my 20 years of experience in emergency medicine, along with my business and management skills gleaned from my past 15 years of management roles, and my MBA training to assist AAEM and its members to create a system to promote local emergency medicine physician groups in continuing to provide high quality emergency medicine services to their communities.

Candidate Platform Statements



Christopher C. Lee, MD FAAEM

Candidate for At-Large Board Member

Nominated by Lewis Goldfrank, MD FAAEM

I would like to thank Dr. Lewis Goldfrank for nominating me for At Large Board Member for AAEM. Dr. Goldfrank has been one of the greatest teachers I have had the pleasure of learning from, and he has always been a role model for me. My name is Christopher C. Lee, MD FAAEM, and I am writing to be considered for At Large Board member for American Academy of Emergency Medicine.

Since 2005, I have been serving as Assistant Professor of Clinical Emergency Medicine at Stony Brook University Hospital in the Department of Emergency Medicine. I am the Course Director for "Advanced Principle of Emergency Medicine," a course offered to first year EM residents as well as 30 fourth year medical students applying to EM residency. I also serve as the Director for Center for International Emergency Medicine. In that capacity, I have been actively teaching foreign EM residents and will have two international fellows from 2008 next year. I spearheaded the International EMS Conference between Korea and USA in 2005 to 2007 with over 300 EM physician participants.

From 2000 to 2005, I worked in Flushing Hospital Medical Center in New York as Associate Director of the Emergency Department. I participated in the Joint Commission, internal peer review organization project (IPRO), continuous quality improvement (CQI), and other Center for Disease (CDC) projects on behalf of the Flushing Hospital. During my tenure at Flushing Hospital, I was heavily involved in the education of residents from other departments who were rotating through the emergency department, and introduced core curriculum of emergency medicine to these residents.

I have researched and published in over 30 peer reviewed publications in various respectable medical journals, including *The Lancet, Annals of Emergency Medicine, American Journal of Emergency Medicine, Journal of Emergency Medicine* and others. I also serve as peer reviewer for few medical journals including *European Surgical Research*. I have presented many abstracts in emergency medicine conferences. During the past three years, I also served as the Editor in Chief for the *Journal of Korean American Medical Association*. I am trying my best to escalate the level of quality of journal to be accepted into MEDLINE soon. I have no financial interest with any company or institution.

I obtained my BS in Biology from the University of California at Los Angeles. I obtained my MD from the Chicago Medical School in 1996 and did my emergency medicine residency training at NYU Medical Center/Bellevue Hospital Center. I am board certified in Emergency Medicine (ABEM).

I am confident that my 12 years of service in emergency departments both in community hospital and academic institution have well prepared for me to serve as a board member of the American Academy of Emergency Medicine. I look forward to making immediate contributions to the American Academy of Emergency Medicine.

Currently, I live in Melville, NY, married to wife Jihyun and have two children Joshua (5) and Esther (3). Thank you for your time and consideration.

John Levin, MD FAAEM

Candidate for At-Large Board Member

Self-Nomination

I have been a medical/legal expert for over 20 years. I have defended emergency physicians nationwide. I would like the opportunity to review any and all malpractice cases filed against members and assist them if possible. This is the special niche that I would like to fill if elected to the board.

Candidate Platform Statements

Andy Walker, MD FAAEM

Candidate for At-Large Board Member

Nominated by Kevin Beier, MD FAAEM

I believe passionately in the principles that AAEM was created to defend and that it fights for to this day. That is why I am a Founding Fellow of AAEM. That is why I want the opportunity to serve AAEM with another term on its board of directors. That is why I would so deeply appreciate your vote.

If this election is like every other I have witnessed in the Academy's history, there won't be a single unqualified or bad candidate for office. In a refreshing contrast to the national political process that many of us watch with disgust, you won't be seeing any attack ads in *Common Sense* or hearing any speeches at the Scientific Assembly that smear one's opponent. You won't be making a mistake, no matter who gets your vote. I hope you will vote for me though, and I hope to convince you that I will contribute significantly to AAEM, the one organization that represents only board certified specialists in emergency medicine, that fights to insure that individual emergency physicians are treated fairly, and that fights to protect our patients by keeping us as free as possible from outside, nonmedical pressures.

Although I did spend almost eight years as an academic attending at Vanderbilt, the rest of my 19 year career has been spent in community hospital, nonacademic emergency departments. In fact, for the last eight years I have been part of an independent, democratic, one hospital group in Nashville. Thus I bring the voice of a pit doc to the board and a viewpoint from outside the ivory tower. In the past two years on the board of directors, I have tried to provide wise counsel and to make good decisions, sometimes siding with the majority and sometimes taking a contrarian position. In either case, I back up my opinion with a rational argument. My highest priorities have been to keep AAEM focused on the few critical missions that led to its founding, such as protecting the sanctity of board certification and protecting individual emergency physicians from unfair exploitation; as well as to keep AAEM highly cost-effective so that its members get as much bang for the buck as possible, to keep the membership growing, because with size comes clout.

At the local level I serve as vice-president of TNAAEM, the Tennessee state chapter of AAEM. I helped lead our successful effort last year to defeat a legislative attempt to legalize restrictive covenants in physician employment contracts. When a similar bill came up in this year's legislative session, we were unable to defeat it outright, although we did come close, and we were successful in having the bill amended to exclude emergency medicine. Thus, emergency physicians in Tennessee remain free from restrictive covenants. I was one of two TNAAEM members who testified before a House subcommittee on the issue. This victory was quite an accomplishment for a handful of amateur volunteers with no outside funding. We were up against very well funded opposition, armed with professional lobbyists who had lots of political experience.

In an effort to put my money where my mouth is on expanding AAEM membership, Dr. David Lawhorn and I paid for resident memberships for the entire Vanderbilt Emergency Medicine residency program. I hope that all of you will consider doing this, either for a residency program near you or for the residency from which you graduated. At only $50 per membership the cost is quite low for most residency programs, especially when divided among several people. I believe that once exposed to AAEM, emergency medicine residents will continue to pay for membership after graduation.

Once again, you can't go wrong no matter who you vote for, but I would very much appreciate your vote for me. I have tried to serve AAEM well and I would like to continue to do so with another term on the board of directors.

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Final Meeting of Advisory Group for EMTALA

by Kathleen Ream, Director of Government Affairs

The EMTALA Technical Advisory Group (TAG) met for its final time in Washington, DC on September 17-18, 2007. Concerned that despite its efforts, the Department of Health and Human Services (HHS) has been unable to address the TAG's previous 31 recommendations in a timely manner, the TAG asked for an accounting of the status of the recommendations submitted up to this seventh meeting.

HHS reported that while no action was required for some of the recommendations, five others were implemented, and one still was in the process of implementation. The remaining 22 recommendations were under consideration. The TAG revisited its previous recommendation to "clarify a hospital's obligation under EMTALA to receive a patient who arrives by ambulance." This recommendation was one that the Centers for Medicare and Medicaid Services (CMS) adopted and implemented in Survey and Certification Letter 07-20, released April 27, 2007. The TAG suggested that HHS provide more guidance about EMTALA obligations in terms of the timeliness of triage and mitigating circumstances.

HHS staff stated that once the TAG's charter expires at the end of September, the HHS budget no longer will have adequate staff time allotted to follow up TAG activities. Staff suggested that changes to EMTALA regulations could occur through revisions to the inpatient and outpatient prospective payment systems, and statutory changes to EMTALA would require congressional action.

New Recommendations

To the remaining 22 recommendations, 23 more were added during this final TAG meeting. These include:

EMTALA Enforcement

To improve understanding about EMTALA among regional offices and state surveyors, the TAG recommended that CMS establish systems to:

- Improve consistency in regional office EMTALA interpretations and enforcement.
- Demonstrate surveyor competencies.

EMTALA and Inpatients

The Interpretive Guidelines (IGs) state that a hospital's EMTALA obligation ends when a patient is admitted to that hospital. However, the guidelines refer only to the hospital where the patient originally presented at the ED with an emergency medical condition (EMC). The regulation is silent on the obligation of a hospital with specialized capabilities to accept transfers of inpatients. To date, HHS is not enforcing any obligation on a hospital with specialized capabilities to accept the transfer of an inpatient.

Thus, the TAG recommended that HHS revise the IGs, regulations and statute as needed to clarify that:

- EMTALA does not apply when a patient develops an EMC after being admitted to a hospital.
- When a patient who is covered by EMTALA is admitted as an inpatient to the hospital and that patient's original EMC remains unstabilized, the obligation of a receiving hospital that has specialized capabilities is required to stabilize that patient's EMC under Subsection G of Title 42, U.S.C., 1395dd, is not altered.

Behavioral and Mental Health

Patients with psychiatric and/or behavioral health conditions are patients and should receive the same level of care and protections under EMTALA as those with medical conditions. The TAG recommended that HHS:

- Remove the current separate guidance on psychiatric EMCs so that the remaining rules apply equally to EMCs of either psychiatric or medical origin.
- Describe that a medical screening examination (MSE) should attempt to determine whether an individual is gravely disabled, suicidal or homicidal. The TAG supports the use of community protocols and services (e.g., police custody, nursing home settings) to determine whether an EMC exists or to ensure appropriate disposition of the patient to a safe setting.
- Explore education of ED physicians in general acute care hospitals without psychiatric services about the proper psychiatric MSE, discharge and transfer of patients with behavioral health conditions.
- Incorporate the following into the IGs:
  "The administration of chemical or physical restraints does not in itself stabilize a psychiatric EMC. It may, however, provide a temporary safe environment by minimizing risk during patient transport. Unless the hospital or physician can demonstrate that a patient is stabilized irrespective of the chemical and physical restraints, EMTALA still applies to the patient's care, any subsequent transfer and the duty of a hospital with specialized capabilities to accept that patient. For example, a patient presents to the ED actively suicidal with a plan and is determined to have an EMC. The patient is either administered a sedating medication or placed in physical restraints to prevent him/her from harming himself/herself. In this situation, the patient is still considered to have an unstabilized EMC because the patient's underlying suicidal intent persists."
- Review its position on community protocols – in consultation with state agencies and other stakeholders – in the area of mental health to address concerns regarding EMTALA transfer requirements that may conflict with state laws or local policies relating to involuntary detainment of patients needing appropriate psychiatric care.

Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers

The TAG accepted a final report on this topic by its Action Subcommittee, which included seven suggestions addressing duties of transferring hospitals and nine suggestions addressing the duties of receiving hospitals.

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CEP America
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We proudly welcome our newest contract to our National Emergency Physician Partnership!

CHRISTUS St. Michael Health System

Texarkana, Texas; September 1, 2007

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- *Comprehensive Practice Support*
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Robert Luten, MD
"Demystifying the Pediatric Airway"

Amal Mattu, MD FAAEM
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Ghazala Sharieff, MD FAAEM
"Shock in the First Month of Life"

Richard Shih, MD FAAEM.
"LLSA Article Review"

Corey Slovis, MD FAAEM
"Electrolyte Emergencies"

Jennifer Walthall, MD
"Top EM Pediatric Articles of 2007"

Robert Wears, MD MS FAAEM
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James Wilde, MD
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Reservation Deadline:

January 7, 2008

AAEM encourages attendees to make reservations by this date. After January 7, 2008, regular room rates may apply and availability may not exist. Reservations should be made directly with Amelia Island Plantation by either phone or online. To take advantage of our preferred rates, please use the group code listed below.

All rooms are subject to a $10.00/person/night resort service fee, plus applicable tax at 7%. Tax rate subject to change without notice. Oceanview Room: $189.00/night.

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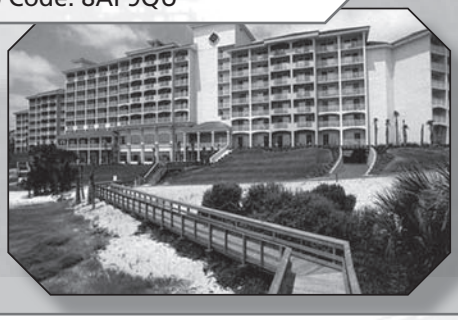

While at Amelia Island, don't forget to visit the AAEM/JEM Research Competition, Oral and Poster Presentations and AAEM's Photo Contest.

Register for the 14th Annual Scientific Assembly and Shuttle Bus Service at the following links: https://ssl18.pair.com/aaemorg/education/scientificassembly/registrationform.php
https://ssl18.pair.com/aaemorg/education/scientificassembly/transport.php

The TAG found that the term "specialized capabilities" is not clearly defined and that the current interpretation is subject to abuse, resulting in improper transfers. The TAG also recommended that HHS:

- Better define the terms "capacity" and "capability" and review regulations and IGs to ensure that the terms are used appropriately and consistently and that intent is clear throughout.

Stabilization and Follow-Up Treatment

The TAG recommended that HHS clarify that:

- An EMC does not need to be resolved to be considered stabilized for the purpose of discharge provided that, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care could be reasonably performed as an outpatient or later as an inpatient, and provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions.
- EMTALA only applies until a patient is stabilized, and a hospital has no EMTALA obligation to provide definitive treatment to the patient, although other rules (e.g., Medicare Conditions of Participation) may apply.

Deferred Care for Non-emergency Conditions

Although EMTALA only applies to patients with EMCs, the TAG members affirmed that there are ethical and policy implications when hospitals deny care to individuals with conditions not considered EMCs. Some TAG members believe that the number of patients "triaged out" of the ED is growing, generating problems for the healthcare system. Emphasizing that even though hospitals are not required under EMTALA to provide care, it is incumbent that emergency care addresses the larger context of access to care by attending to the issue of deferred care from the ED. The TAG recommended that HHS:

- Monitor and evaluate the consequences of "triaged out" and deferred care.

Referral from the ED to a Physician's Office

Noting that while the IGs state that generally a physician in the ED should not refer patients to his or her own office, such referral may be appropriate and even preferable to care in the ED. The TAG recommended that HHS:

- Revise the IGs to reflect that "There are circumstances under which a patient in the ED may be discharged or transferred to a non-hospital-owned physician's office for continuation of the MSE, for determination of whether an EMC exists, or for stabilization of an EMC."

Effect of EMTALA on Professional Liability Insurance Coverage and On-Call Coverage

EMTALA is a mandate that requires hospitals to care for patients with EMCs but provides no financial support to do so. The lack of funding and increased risk for physicians taking call combine as disincentives driving physicians away from taking ED calls. The TAG recommended that HHS support amending the EMTALA statute to include:

- Liability protection for hospitals, physicians and other licensed independent practitioners who provide services to patients covered by EMTALA.
- A funding mechanism for hospitals and physicians.

EMTALA and Private Right of Action

Eighty percent of the cases on private rights of action under EMTALA have been dismissed, suggesting that many such cases are inappropriate and may represent abuse of the legal system. More cases could have been brought to the court under some avenue other than the EMTALA private right of action. The TAG recommended that HHS:

- Seek revisions that would limit the private right of action for personal harm to only those circumstances in which there is no alternative route to claim damages through professional liability laws.

TAG chair, David Siegel, MD JD, Senior Vice President of Clinical Effectiveness and Medical Affairs for Meridian Health in Neptune, NJ, acknowledged that the TAG members "had covered a lot of ground and made significant contributions to improving EMTALA." The members were thanked for "taking time out from their very busy schedules to participate in the TAG and commended for their passion in working to benefit both patients and providers."

EMTALA Failure-to-Stabilize Petition to U.S. Supreme Court

On May 21, 2007, the United States District Court for the Southern District of Alabama affirmed the grant of summary judgment in favor of Defendant-Appellee North Mississippi Medical Center Inc. (NMMC) on all claims of the Plaintiff-Appellant Brenda L. Morgan (as personal representative of the estate of Thomas Henry Morgan, Sr., deceased). Morgan had argued that NMMC violated failure-to-stabilize provisions under EMTALA. Morgan v. North Mississippi Medical Ctr. (No. 06-16017 May 21, 2007 Docket No. 05-00499 CV-WS-B).

The Facts

While hunting, Thomas Henry Morgan, Sr., sustained injuries as a result of a 12-foot fall. Morgan presented at NMMC's ED where he was screened and diagnosed with a back injury and admitted to the hospital. While hospitalized, Morgan received an epidural injection as treatment, but also during this time, Morgan was unable to participate in physical therapy. Morgan declined to undergo an MRI examination, and after nine days, owing to concerns that he might develop bedsores or contract diseases in the hospital, Morgan was released. He died shortly after discharge. Morgan's spouse, Brenda L. Morgan, filed a claim on the deceased's behalf alleging that NMMC violated EMTALA when it "transferred her husband without stabilizing his fractured ribs or severe compression fractures in his lower vertebrae."

The Ruling

EMTALA mandates that a hospital provide necessary stabilizing treatment for an individual who comes to the hospital if the hospital determines the individual has an emergency medical condition (EMC). There was no dispute that NMMC was presented with an EMC when Morgan came to the hospital. A dispute arises as to the hospital's

continued on page 14

Washington Watch - continued from page 13

liability in regard to an individual with multiple EMCs, "even after admission as an inpatient, especially in a case where the hospital did not admit the patient for the EMC that was never stabilized," as in the Morgan case.

The appellate court noted that in 2003 the Centers for Medicare and Medicaid Services issued a final rule taking the position that a hospital's obligations "cease once the patient has been admitted to the hospital as an inpatient." Yet, other courts have observed that the stabilization requirement would not end once the patient is admitted "if a patient demonstrates in a particular case that inpatient admission was a ruse to avoid EMTALA's requirements." This latter point was cited as authority in Morgan's initial 2005 trial court decision [Morgan v. North Mississippi Medical Center, Inc., 403 F. Supp. 2d 1115, 1130 (S.D. Ala. 2005)].

In an appeal of this case the very next year, although the court denied NMMC's motion to dismiss the EMTALA claim, it did decide on summary judgment that the hospital "had not engaged in a ruse to avoid EMTALA's requirements when it admitted the patient." [Morgan v. North Mississippi Medical Center, Inc., 2006 U.S. Dist. LEXIS 74428 (S.D. Ala. 2006).] Rather, the court found that "NMMC stabilized the conditions it diagnosed even if it did not diagnose all of [Morgan's] injuries."

EMTALA is not to be used in place of a medical negligence claim under state law. Thus, the court noted that the relevant EMTALA issue "is not whether all of Mr. Morgan's serious health problems were identified as bases for admission, but whether he was admitted in good faith to stabilize those medical conditions that were diagnosed." The appeals court rejected Morgan's EMTALA claim as a matter of law, finding that Morgan "failed to substantiate her allegations" that NMMC admitted her husband "merely as a way to avoid complying with its EMTALA obligations."

This case is gaining some publicity because on October 17, 2007, Morgan appealed to the United States Supreme Court by applying to the Court for a writ of certiorari. The Court grants these petitions at its discretion and only when at least three of its nine justices believe that the case involves a sufficiently significant federal question in the public interest.

Morgan, as the petitioner, is asking for a review of the U.S. Court of Appeals' decision, arguing that the lower court's action "embraced the trial court's decision on EMTALA's reach that conflicts with decisions by other federal appeals courts . . ." and specifically questioning "whether EMTALA's obligation to stabilize emergency medical conditions ends once a patient is admitted." A decision on Morgan's petition should come down in mid-November. Should the Supreme Court deny the writ, it would be saying that it will let the lower court decision stand, particularly if the appellate court decision is found to conform to accepted precedents of previously decided cases.

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AAEM is featuring the following upcoming endorsed, sponsored and recommended conferences and activities for your consideration. For a complete listing of upcoming endorsed conferences, please log on to http://www.aaem.org/education/conferences.php

January 26-30, 2008
- Rocky Mountain Winter Conference on Emergency Medicine
  Copper Mountain, Colorado
  Sponsored by Beth Israel Deaconess Medical Center, Boston, MA, Brigham and Woman's Hospital, Boston, MA, Denver Health Medical Center, Denver, CO and others.
  www.coppercme.com

January 28-31, 2008
- Ski BEEM
  Best Evidence in Emergency Medicine Course (BEEM)
  Silver Star Mountain Resort, British Columbia, Canada
  Sponsored and organized by McMaster University, Continuing Health Sciences Education
  http://www.beemcourse.com/index.html

February 7-9, 2008
- 14th Annual AAEM Scientific Assembly
  Amelia Island Plantation, Amelia Island, FL
  Sponsored and organized by the American Academy of Emergency Medicine.
  www.aaem.org
  F R E E Registration for AAEM Members!

February 25-27, 2008
- Toxicology Course in Bogota, Columbia
  Bogota, Columbia
  Sponsored by the International Society for Emergency Care, Tufts University School of Medicine, Baystate Medical Center, and Universidad de los Andes

February 27-28, 2008
- EPEC-Emergency Medicine "Become an EM Trainer"
  Conference Iberville Suites, New Orleans, LA
  This program is sponsored by Northwestern University's Feinberg School of Medicine and The EPEC Project.
  www.epec.net

February 29-March 2, 2008
- The Difficult Airway Course-Emergency™
  Hyatt Regency, Huntington Beach, CA
  Sponsored by the Airway Management Education Center (AMEC)
  http://www.theairwaysite.com/wordpress/home/emergency-medicine/

March 10-11, 2008
- 13th Annual Scientific Assembly for Emergency Medicine in Israel, Hilton Tel Aviv, Tel Aviv, Israel
  The Israeli Association for Emergency Medicine invites health care professionals from all fields of Emergency Medicine to attend the 2008 annual scientific assembly.
  www.iaem.org.il/e

March 14-16, 2008
- The Difficult Airway Course-Emergency™
  Hyatt Regency Miami, Miami, FL
  Sponsored by the Airway Management Education Center (AMEC)
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April 2-3, 2008
- AAEM Pearls of Wisdom Oral Board Review Course
  Las Vegas
  Course sponsored and organized by the American Academy of Emergency Medicine
  http://www.aaem.org

April 4-6, 2008
- The Difficult Airway Course-Emergency™
  Hyatt Regency Chicago, Chicago, IL
  Sponsored by the Airway Management Education Center (AMEC)
  http://www.theairwaysite.com/wordpress/home/emergency-medicine/

April 19-20, 2008
- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Los Angeles, Orlando, Philadelphia
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May 2-4, 2008
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May 4-7, 2008
- The Heart Course-Emergency™
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  http://www.theheartcourse.com/

May 21-23, 2008
- High Risk Emergency Medicine
  Hotel Nikko, San Francisco, CA
  Presented by the Division of Emergency Services San Francisco General Hospital and Department of Medicine at the University of California, San Francisco
  www.HighRiskEM.com

June 6-8, 2008
- The Difficult Airway Course-Emergency™
  Westin Seattle, Seattle, WA
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  http://www.theairwaysite.com/wordpress/home/emergency-medicine/

July 16-19, 2008
- Giant Steps in Emergency Medicine 2008: The Sun, the Sea….and CME
  Hilton San Diego Resort, San Diego, CA
  Conference jointly sponsored by Giant Steps in Emergency Medicine and AAEM.
  www.GiantSteps-EM.com

September 20-21, 2008
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September 25 - 28, 2008
- AAEM Written Board Review Course
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October 10-12, 2008
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  Las Vegas, NV
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  http://www.theairwaysite.com/wordpress/home/emergency-medicine/

October 13-15, 2008
- The Heart Course-Emergency™
  Bally's Las Vegas, Las Vegas, NV
  Sponsored by the Airway Management Education Center (AMEC)
  http://www.theheartcourse.com/

November 14-16, 2008
- The Difficult Airway Course-Emergency™
  Westin Buckhead
  Atlanta, GA
  Sponsored by the Airway Management Education Center (AMEC)
  http://www.theairwaysite.com/wordpress/home/emergency-medicine/

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.

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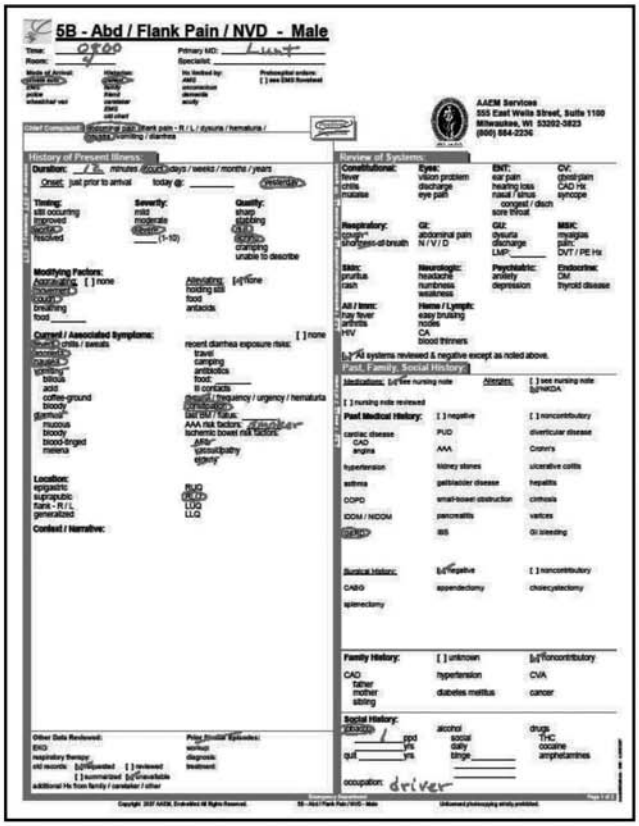
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RESIDENT PRESIDENT'S MESSAGE

Andrew T. Pickens, IV, MD JD MBA
President, AAEM/RSA

So far, it has been an outstanding year for the American Academy of Emergency Medicine Resident and Student Association. I wanted to use this month's article to bring everyone up to date on some of what has been going on and what to expect in the future. Each board member will be writing articles for this year's issues of *Common Sense* and will keep you updated on current events. In each of my columns, I will specifically discuss the activities of a couple of our committees. This month it is Membership and Education.

On October 27, the AAEM/RSA board met in Chicago for a leadership retreat. During the retreat, each position developed a short-term (one year) and long-term plan for their committee. The meeting lasted all day. Many new, good ideas were offered and developed into part of our overall plan to reach more residents and students with our educational opportunities and to move forward with the mission of the organization.

One of my primary goals as president has been to increase membership. With more members at both the student and resident levels, we are better able to educate future emergency physicians about many of the pertinent issues. As of now, the Resident and Student Association has already passed previous membership levels and is currently at the highest level it has ever been in almost every category. We expect this growth to continue as more and more individuals and programs recognize the vital role AAEM/RSA plays in helping to inform and educate future EPs. Dr. Cyrus Shahpar has taken the lead as the Chair of the Membership Committee and developed a very forward looking, intelligent plan. We expect great things.

With regard to education, the beginning of November marked the first Midwest Medical Student Symposium (MMSS) in Chicago. Dr. Michael Pulia, Chair of the Education Committee, organized this new event. Numerous medical students from the Midwest attended. Many leaders in the emergency medicine community volunteered their time to become involved and speak to these very interested future emergency medicine residents. The event was a resounding success and will serve as a template for future regional medical student symposiums. Great job Mike! Mike is also busy planning the resident track for the AAEM Scientific Assembly which will be held February 7-9, 2008, in Amelia Island, Florida.

Mike Ybarra, President of the Medical Student Council, has put together a comprehensive plan to reach all medical students interested in emergency medicine. Dr. Keith Allen is working on updating the website to help make it a much more effective tool for communication and education, Dr. Kalpana Narayan is developing the Advocacy Committee into a formidable organization, and Dr. Adrienne McFadden is the editor for the RSA section of *Common Sense*. Dr. Sarah Todd is organizing the Vice President's Council to ultimately include members from every residency program - if interested, please contact her through the RSA website.

The above are just a few of the happenings in AAEM/RSA. It is a very exciting time to be a part of this organization. Our board is extremely motivated, membership is at an all time high and our long-term plan is well defined. Our goal is to reach as many students and residents as possible with information about the issues that directly affect all current and future EPs. If you want to get involved, email me or Dr. Shahpar through the website or info@aaemrsa.org, and we will be sure to direct your inquires to the appropriate people.

CHANGE OF E-MAIL ADDRESS

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

Don't Take It Personally

Adrienne McFadden
Resident Editor, Common Sense

As a medical student, I embraced my job as a full-time learner. I approached each day with fervor, looking forward to soaking up as much knowledge as possible. As I approached the conclusion of my fourth year and medical school education, I impatiently awaited the day that a long white coat became part of my work uniform. Foolishly, I thought the lengthier coat would clue everyone into the fact that I had persevered, and at points excelled, over the past years of my educational life. I had made it!

My first day as an intern, I proudly sported my new white coat, which, by the way, resembled a trench coat on my five foot frame. Apparently, I was blissfully ignorant of the fact that the stiffness and numerous creases in my coat (an ode to the meticulous folding and packaging) revealed that I was as new to medicine as my white coat was to a non-packaged existence. Nevertheless, I was acknowledged as "doctor," which was a title that took me a few days to get used to. Yet, somehow, the message got lost in translation to my patients.

Despite my soon standardized introduction as "Dr. McFadden," I apparently was speaking a foreign language. Many of my patients translated "Dr. McFadden" into whatever member of the care staff, ancillary staff or any other person in the hospital (except for physician) they wanted to hear. I was especially flabbergasted by those few patients that I would tirelessly care for during their entire stay, maybe even inserting a central line or performing a lumbar puncture, who several hours into their stay complained that they had not seen a doctor yet. The patients that accepted the fact that I was indeed their doctor found it hard to believe that I was "old enough" to be a doctor. I was even carded… more than once.

Each shift presented the same dilemmas. I decided to ask my female attendings, who surely had experienced this at some point, what I could do to clarify the confusion. The consensus solution was to be sure to wear my white coat at all times. I even took this a step farther and made sure to put my ID badge in plain view. I have to admit, I did not notice a difference.

Intern year has come and gone, and I still occasionally get called nurse or am handed insurance cards for registration. I also still get age inquiries quite often. However, I have to admit that as I have gotten older, I look forward to the age question. I now view the mistaken identity as a back-handed compliment, not a problem; especially when I am called "nurse." After all, often times in medicine it is the nurse, not the physician, that a patient remembers most during a hospitalization because of an increased number of interactions. I would like to think that I check on my patients often enough to be the cause of my own problems. Furthermore, as a third year resident, many of my return patients remember my name before I even have a chance to do my standard introduction. I guess I am doing something right.

I hope my experiences can serve as a lesson to other female students and residents. My advice is not to take offense at the inevitable mistaken identity. The mistake is not made with malice, nor is it a reflection of the quality of care you are providing. Finally, in times of high stress, people only hear what they want to hear. It is human nature, so don't take it personally.

Applicants for Certificate of Excellence in Emergency Department Workplace Fairness

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

Organization	State
Baptist Hospital, Nashville	TN
Emergency Physicians at Sumner, PLLC	TN
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Southwestern Michigan Emergency Services, P.C.	MI
West Jefferson Emergency Physician's Group	LA

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

Advocacy Committee Report

Kalpana Narayan, MD MSc
Harvard Affiliated Emergency Medicine Residency, BWH/MGH, Boston, MA

As 2007 came to an end, there was the usual sentiment of "I should have done…" and "maybe next year I will…" As a busy resident, I always have this feeling, but thought to act upon it a little earlier by getting involved with AAEM. As the new advocacy chairperson, I decided to continue the excellent work of my predecessors in hopes to take this committee in new and exciting directions.

One of the first items on the agenda was to get the AAEM Career Network website updated. This website was designed to allow residents to view potential hospital jobsites across the country. In addition, we wanted to enable residents to get in touch with AAEM contacts in different regions to answer questions about job hunting, the local hospital systems and overall demographics. The AAEM resident/student committee felt strongly that having such a website would fill a void for soon-to-be graduating residents.

Unfortunately, the AAEM Career Network website had some small glitches. However, after some hard work by the AAEM staff and the resident/student committee this year, the site is up and running again. The user-friendly site is accessible to all AAEM members as another way to get people connected. Its new feature is the list of hospital contract types in regions of the United States. Hopefully, with the continued diligence of the AAEM staff and future committees, the database will be kept up to date as an ongoing project for the future.

Our second endeavor involves actively engaging ourselves with AAEM on issues that affect residents and students. One such issue pertained to the recent provisions made to the status of economic deferment for federal loans. This bill addressed the loss of eligibility to defer federal loan payments during residency, while also creating a hole for future medical school graduates to be ineligible for the new repayment or deferment criteria.

The AAEM/RSA advocacy committee was prepared to continue the letter writing campaign to create awareness. Fortunately, with the strong leadership of AAEM, as well as the AAMC, the bill was rewritten. It now will include those who are currently eligible for economic deferment and, surprisingly, allows an increased number of residents to qualify.

Our support and advocacy has also advanced beyond the walls of Capitol Hill. As a strong defender of the individual physician, AAEM is actively pursuing a well-publicized case against the corporate practice of medicine in Texas. AAEM/RSA strongly agrees that the corporate practice of medicine improperly exerts its control over the medical decision-making and financial reimbursement for the medical services of physicians. Not only does this infringe upon the doctor-patient relationship, it undermines the basic principle in the Hippocratic Oath - first do no harm. Therefore, the AAEM/RSA board of directors agreed to give financial support to the cause by making a donation to the AAEM Foundation.

As the year progresses, the AAEM/RSA advocacy committee hopes to take an active role in federal and state legislative issues. As an election year, it is important that physicians are aware of the issues that directly impact us and our patients. With the help of AAEM and residents who take active interest in such policy issues, I hope to encourage more young physicians to take the "should have" part of the year end sentiment and turn it into change.

For more information on the current AAEM legislative issues, please visit the AAEM website: http://www.aaem.org/advocacy/.

The AAEM Foundation would like to thank the following individuals for their contributions to help fight the Corporate Practice of Medicine.

California Chapter of AAEM (CALAAEM)
Steven Davidson, MD FAAEM
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Rick Mendelssohn, MD FAAEM
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Jon Shultz, MD
Darin Swonger
Michael Witting, MD FAAEM
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Resident Journal Review

This is a continuing column abstracting journal articles pertinent to EM residents. It is not meant to be an extensive review of the articles, nor is it wholly comprehensive of all the literature published. Rather, it is a short list of potentially useful literature that the busy EM resident may have missed. Residents should read the articles themselves to draw their own conclusions. This edition will include articles published over a two month period. These selections are from papers published in November and December 2007.

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

Sullivan FM, Swan IR, Donnan PT, et al. Early treatment with prednisolone or acyclovir in Bell's palsy. N Engl J Med 2007;357:1598-607.

This study was a double-blind, placebo-controlled, randomized trial of 551 patients with recent onset Bell's palsy. Patients were assigned to ten days of therapy in four arms: prednisolone, acyclovir, both prednisolone and acyclovir or placebo. The primary outcome of the study was improvement in facial nerve function, using the House-Brackmann score, a standardized clinical grading system for recovery of facial-nerve paralysis. This endpoint was assessed independently by a panel of three experts – an otorhinolaryngologist, a neurologist and a plastic surgeon. Among patients in the prednisolone group, 83% recovered facial function at three months, compared to 64% who did not receive prednisolone. At nine months, the recovery was 94% for prednisolone and 82% for no prednisolone. Acyclovir did not confer a therapeutic advantage at any follow-up time.

This study confirms the generally favorable outcome of patients with Bell's palsy, with 65% recovery of function at three months and 85% at nine months. In addition, the study showed that early treatment with prednisolone for ten days increased the rates of recovery to 83% and 95% respectively. There were no serious adverse events in any treatment group. This safe, effective treatment should be strongly considered by emergency department physicians when caring for patients with unilateral paralysis of the facial nerve.

Chen L, Kim Y, Santucci KA. Use of ultrasound measurement of the inferior vena cava diameter as an objective tool in the assessment of children with clinical dehydration. Acad Emerg Med 2007;14:841-5.

The inferior vena cava (IVC) diameter and collapsibility have been studied as indicators of fluid status. Aorta diameter (Ao), on the other hand, shows little variability, even in the setting of intravascular volume depletion. The ratio of these two measurements was postulated by the authors to represent an objective determination of intravascular volume status in patients that are dehydrated.

This was a prospective observational study of 36 pairs of subjects and controls, aged six months to 16 years old, designed to evaluate the change in this ratio before and after fluid resuscitation. Patients were eligible for enrollment if there was clinical evidence of dehydration requiring intravenous fluids. For each subject, an age, gender and weight matched control was enrolled. Bedside ultrasound measurements of the IVC and Ao were taken before and immediately after infusion of intravenous fluids. The ratio of IVC/Ao was smaller in children clinically assessed to be dehydrated compared to controls. After intravenous fluid administration, the ratio increased.

The accurate assessment of the degree of dehydration in children in the emergency department is challenging. The authors offer that noninvasive measurement of the Ao and IVC is an objective method of determining intravascular depletion and monitoring responsiveness to resuscitation.

Effectiveness and safety of chest pain assessment to prevent emergency admissions: ESCAPE cluster randomized trial. BMJ 2007;335:659-665.

Previous studies have shown that low risk patients with undifferentiated chest pain are less likely to be admitted to the hospital from the ED if managed in a chest pain unit. This multicenter UK study looked at whether introducing chest pain units reduces emergency admissions without increasing repeat emergency department (ED) visits and admissions over the next 30 days.

Fourteen hospitals throughout the UK were randomized to either the introduction of a chest pain unit or the continuation of routine care. Patients presenting to the ED with chest pain during the year before and the year after intervention were evaluated for the study. The main outcome measures were the proportion of chest pain ED visits resulting in admission as well as repeat ED visits and admission over the next 30 days.

The study found that there was no change in the proportion of chest pain ED visits resulting in admission (OR 0.998; 95% CI 0.94-1.059) with the introduction of a chest pain unit. Moreover, there were small increases in the proportion of repeat ED visits and admissions in 30 days. Interestingly, the introduction of a chest pain unit was associated with weak evidence of an increase in ED visits with chest pain (16% vs. 3.5%; p=0.08) looking at

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Career Opportunities in Emergency Medicine

by Caleb Trent, South Regional Representative, Medical Student Council

So you want to be an emergency medicine physician? Excellent! But what does that mean on a day-to-day basis? What if you get tired working in an emergency room? When you get older, will you burn out and have to sell used cars? Though emergency medicine (EM) is a relatively new specialty, most of our medical student colleagues, and maybe even some of us who are applying to EM residencies, have a limited vision of the field. For our own benefit and our friends' education, let us examine opportunities afforded us by a career in emergency medicine.

First, there's the whole idea of a fellowship. Though financial incentives may exist, motivation to pursue a fellowship largely comes from a genuine interest in the specific area or advantages a fellowship can provide in academic practice. While an entire article could be written to examine the advantages and disadvantages, the five emergency medicine fellowships formally recognized by the American Board of Emergency Medicine (ABEM) include hospice/palliative care (a new addition), medical toxicology, undersea and hyperbaric medicine, pediatric emergency medicine and sports medicine. I recently spoke with an EM resident at the University of Alabama in Birmingham who stated his goal was a fellowship in hyperbaric medicine. However, this was only a stepping stone to his final career plan – being the physician on a small island in the Caribbean where he would then divide his time between working in an urgent care clinic or emergency room and diving among the tropical sea life. For more information on these, see the "Subspecialty Certification" tab on ABEM's website (www.abem.org/public). If formal training (with official board sanctioned credentials) is not a requirement for your academic program or personal satisfaction, additional training is available in EMS/pre-hospital medicine, ultrasound, disaster medicine (typically associated with a Master's in Public Health - MPH), international EM (may also require a MPH) trauma/critical care, environmental health and administration just to name a few.

Academic practice is one career option for students pursuing emergency medicine. Although academic physicians comprise only ten to fifteen percent of all emergency physicians, residents coming out of either a university or community academic setting may enjoy the challenge and decide to stay on as faculty (either in their own or another institution). Academic positions may emphasize research or clinical teaching, but there are considerations about private versus academic practice. A study performed in 1999 showed what one would expect - salaries in academic practice are, on average, lower than those of emergency physicians in private practice. Additionally, academic attending physicians face time commitments devoted to teaching, research and often administrative duties. While these may be drawbacks to some, thankfully many EM residents do choose academic practices. They often cite interactions with residents (and yes, even medical students) as the most rewarding aspect of their job. They tend to be continually motivated by their opportunity to influence, train and mentor future generations of emergency physicians. Earlier this week I talked to an EM resident about his desire to potentially stay on as faculty at the university where he is currently completing residency. His eyes almost got distantly glassy as he talked with enthusiasm about all the changes he would like to make to the medical student curriculum and how he would work to make the program a regional leader within the next five years. Though the academic physician may work longer hours overall, he/she tends to have greater diversity in his/her work activities, thus increasing career longevity. Additionally, the opportunity to complete research projects and publish in an academic setting, often with institutional funding, motivates some EM doctors to stay in academics.

For those of us who are thrill seekers, extreme ADHDers, or non-traditionalists, there are many novel approaches to a career in emergency medicine. Since emergency physicians are specialists trained in resuscitation and acute illnesses, certain opportunities are uniquely suited for us. For example, take wilderness medicine. Who better than an EM trained physician to have by your side on that crazy hike-through-the-jungle, live-off-the-weird-plants, canoe-the-Amazon, get-bitten-by-the-poisonous-snake, escape-by-jeep-through-a-malaria-infested-swamp trip you've always wanted to take? Or try cruise ship medicine. Someone has an MI while dancing the night away? No problem; the emergency medicine physician on call is trained for a situation like this. Travel medicine or international medicine is something emergency physicians can pursue easily through a multitude of missionary organizations or humanitarian groups such as the International Red Cross, Doctors Without Borders (Médecine Sans Frontières) or the International Medical Corp (IMC). If leaving the country is not your cup of tea, there's plenty of work to be done here in the US. Entrepreneurial ventures abound as emergency physicians get more involved in hospital administration, occupational medicine for industry or large corporations, insurance company billing, telemedicine (phone consultation for

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data the year before and after the intervention period. The authors' conclusion is that the implementation of chest pain units does not reduce the proportion of ED patients with chest pain that are admitted.

This is a very large, laborious study that provided data from "whole system" level across a variety of hospitals. The results produced in this study conflict with prior studies showing that chest pain units were associated with decreased admissions with chest pain. These results, however, should not devalue the utility of chest pain units, as the beneficial effects of chest pain units were not measured.

Pewsner D, Juni P, Egger M, Battaglia M, Sundstrom J, Bachmann LM. Accuracy of electrocardiography in diagnosis of left ventricular hypertrophy in arterial hypertension: systematic review. BMJ 2007;335:711.

Among hypertensive patients, left ventricular hypertrophy (LVH) carries an increased risk of cardiovascular death. Accurate diagnosis of LVH is therefore an important component in the care hypertensive patients and contributes to risk stratification and subsequent management. There are many indices for evaluation of LVH on the surface electrocardiogram (ECG); however, there is debate over their individual accuracies. The authors present a systematic review of observational studies from 1966 to 2005 that evaluated the accuracy of ECG indexes for the diagnosis of LVH. Twenty-one studies were included in their analysis.

No index was found to be superior to the Sokolow-Lyon. (sum of SV1+RV5 or V6>3.5 mV). No index, including Sokolow-Lyon, was sufficiently sensitive to constitute a good screening test for left ventricular hypertrophy among hypertensive patients.

ECGs without positive indices for LVH should not be considered to constitute evidence of normal left ventricular size in hypertensive patients. More research is needed to develop reliable indices of LVH that can be determined from a surface ECG.

Stein D, York G, Boswell S, et al. Accuracy of Computed Tomography (CT) Scan in the Detection of Penetrating Diaphragm Injury. J Trauma 2007;63:538-43.

Traditionally, diaphragm injuries have been difficult to evaluate without operative intervention. Conventional CT has lacked the sensitivity to be useful for assessment of these injuries; however, the use of newer multidetector row CT (MDCT) is becoming more commonplace in trauma centers. These scanners have improved image resolution and allow for reconstructions in multiple planes. This study was a retrospective review of the admission MDCT in 803 patients with torso trauma.

In this cohort, 57 scans were interpreted as showing a diaphragm injury, 710 were interpreted as negative for a diaphragm injury and 36 were equivocal. Of the 57 MDCT positive patients, 55 were true-positive based on operative reports. A review of the medical records and operative reports of the 710 patients with negative MDCTs, 706 were true-negative. In the group interpreted as equivocal, eight additional patients were determined to have a diaphragm injury.

In this retrospective study, MDCT appeared to be a highly accurate test for identifying diaphragm injuries. Unfortunately, almost half of the cohort was lost in follow-up. Another limitation was that the lack of surgical confirmation of CT findings does not allow for precise determination of true-negatives. While this study suggests some promise for the use of MDCT in the evaluation of diaphragm injuries, there are some serious limitations. Further study with more complete follow-up and a more precise gold standard is needed before this can be considered reliable test to exclude injury.

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a fee usually associated with a university), bioterrorism response preparation and even medical forensics.

Finally, there's the "plain" emergency room physician. It's what we all truly envision when we think of a career in EM – working tirelessly in the endless cacophony that is emergency medicine – stabilizing trauma patients, reassuring a child's parents, breaking bad news to an anxious family, setting a fractured arm, treating pneumonia, admitting the elderly patient – all in the first few hours of a shift time. For many of us, this will be our decision – to become the gatekeeper of the hospital.

The career options in emergency medicine are diverse. Many EM applicants are motivated, out-of-the-box thinkers who pursue diversity and variety, not only within the practice of medicine on a daily basis, but also longitudinally in the career of medicine. It is not uncommon for a physician to begin in one of the categories which we've discussed and end up in another. That's the beauty of a career in emergency medicine – constant flexibility, guaranteed diversity and endless possibility. Can you imagine doing anything else?

"Resident Spotlight On". . . Interview

by Jonathan Garlovskky

J. Marc Liu MD

This interview took place on November 9, 2007, at 11:30AM over the phone. The interviewee, Dr. Liu MD, was made aware that the conversation he was engaged in was for the purpose of posting it on the AAEM/RSA website in the "Spotlight On" section.

J. Marc Liu, MD, Assistant Professor of Emergency Medicine, Medical College of Wisconsin, Assistant Director of Medical Services-Milwaukee County Emergency Medical Services, Medical Director, Tactical Emergency Medical Services Program-Milwaukee Fire and Police Departments.

If you would like more information on Dr. Liu, please go to aaemrsa.org.

J.G.: I know you've done an EMS fellowship; why did you choose to do that?

J.M.L.: I became interested in out-of-hospital care as a medical student during my emergency medicine rotation. I noticed that a large percentage of patients arriving at the hospital were transported there by EMS, and I had little understanding of how their system operated. I therefore began to do ride-alongs with the Chicago Fire Department and enjoyed my time with them very much. It became apparent to me that a good EMS system requires an active and collaborative medical director. I believe emergency physicians are the best equipped to service the fire and police departments due to the broad-based nature of our training. I therefore sought out an EMS fellowship that would prepare me to become a medical director for an EMS system. I knew I needed training in the principles of EMS management. This included training in the administrative aspects of EMS, such as finance/accounting, organization design and quality assurance. In addition, I was able to improve my academic skills, become a better educator and learn how to apply evidence-based medicine to the field of emergency medical services.

J.G.: What are some of the issues facing the various EMS systems?

J.M.L.: The issues facing EMS are similar to those of emergency medicine. One of them is how we are going to serve the growing population with fewer resources available. This is similar to emergency medicine where emergency departments are faced with an increasing patient volume and constant budget cuts. Currently, our society does not place EMS as a high priority. It is an ongoing effort to make the public aware that EMS is an extension of medicine in the field and that these providers are the safety net. Emergency medicine and EMS will only become more invaluable as patient volumes increase due to the declining health of our aging population. Developing creative solutions to meet the increasing demands of EMS is a priority to people in the field of EMS. It is important in the future that we as a society make the condition of our healthcare system, including the EMS system, a priority so that more resources can be made available.

J.G.: What research is currently being undertaken in EMS?

J.M.L.: To start, research in EMS has really taken off in the last 15-20 years, which is reflective of how much emergency medicine has evolved. Early on there was very little research. Once EMS was established as a discipline, there was an effort to start applying the principles of evidence-based medicine to this new field. EMS research has helped us become aware that some of the things we have always been doing may not be beneficial and that some things we are doing may actually be harmful. Currently in EMS research, there is a focus on studying resuscitation efforts in traumatic and cardiac arrests, specifically which techniques are most beneficial. There are studies evaluating endotracheal intubation and the use of alternative rescue airway devices. Studies concerning intubation are evaluating whether or not endotracheal intubation in the field is beneficial. There is also research into the uses of hypertonic saline, impedance threshold devices, how to efficiently and accurately analyze cardiac rhythms and other new equipment and protocols in CPR. There will be continued efforts in the future to employ techniques and treatments currently restricted to the hospital setting to EMS personnel in the field. Instituting these new protocols will require more research to see if they are practical and beneficial.

J.G.: You've been involved in mass casualty/disaster management. Can you tell me about some of your experiences?

J.M.L.: I had a personal interest in mass casualty/disaster medicine prior to my interest in EMS. More recently, this area of medicine has received a lot of attention due to the current state of world affairs. There are many challenges facing this field. It is hard to think about something that may never happen while already trying to deal with an overburdened medical system that is constantly facing budget cuts. One of my goals is to increase

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education and awareness of how to handle mass casualty/disaster events within the entire spectrum of healthcare providers, from doctors and nurses to technicians and other ancillary staff members. In addition, location should not keep providers from being prepared for this type of event. It should be a concern of those in rural as well as urban areas. Having a basic knowledge of disaster management is critical to healthcare professionals. People will turn to the doctors as experts when these types of situations present themselves. I specifically enjoy giving presentations regarding disaster management to the public as well as my fellow healthcare providers. I also participate in field work with a number of first responder agencies at the local and federal levels. This opportunity gives me a chance to go out in the field and provide medical support for different types of operations. For instance, serving in this capacity allowed me the chance to be deployed to recovery efforts during Hurricane Katrina. Currently, there is an effort to organize regional response systems that cross state lines that may not include federal assistance. Jurisdiction issues put up barriers to large organized medical/EMS responses that cross state lines. When a mass casualty/disaster hits in areas like this, it will be a challenge to properly distribute those in need of medical care as well as equipment and personnel. I am working with a group of people whose goal it is to coordinate interstate/regional medical/EMS response efforts in southeast Wisconsin and northern Illinois. Currently, we are trying to coordinate hospital response efforts in the event of a large regional disaster in our region.

J.G.: Do you have any advice for students/residents who are considering pursuing an EMS fellowship?

J.M.L.: My advice is get involved early. It is a good idea to spend time in the EMS environment to see if it is something you really want to pursue. Also, it has been my experience throughout my career that it is vital to have good mentors. No matter what your area of interest, find good people you admire and trust who are established in their field and can pass on advice. I am very thankful for those who have mentored me in the past and for those who continue to give me support. Currently, at the Medical College of Wisconsin, I get to work with great people who have a wealth of experience and knowledge. Don't be afraid to ask for advice and pay attention when people offer it to you. Most of your attendings are in academics because they enjoy teaching and mentoring students. It is important to stay in touch with the people who have helped you along because it's always good to have help and guidance at any stage of your career.

J.G.: Do you have any other advice or something you would like to say to members/supporters of AAEM/RSA?

J.M.L.: Stay involved and stay active in your organization. Medicine is constantly changing, and in general, we as physicians are not as involved as we need to be. We must stay active in helping to shape policies that will affect our patients and practices. We need to consistently educate our patients and the public on the current state of the healthcare environment. Organizations like AAEM and others are good platforms to help you get involved and work to make effective change in our system. Overall, it is the little things that will help educate your friends, family and neighbors, because everyone has a say in what will become of medicine.

Looking Forward

YPS President's Message
David D. Vega, MD FAAEM

It's hard for me to believe that my term as president of the Young Physicians Section is almost over. By the time the next issue of *Common Sense* is out, the YPS elections will have been completed, and a new president will have been elected. It was less than two years ago that YPS was formed, and although we have made a good bit of progress, we still have so much to accomplish. We need to continue our push towards the goal of making the section into a valuable resource for its membership. We must continue to build the section so it can provide meaningful assistance in achieving personal and career goals. We continue to need your input and involvement to help the section realize its full potential. We need to know what we can do to make this section into something you can really use. The first few years of practice out of residency are filled with challenges, and the Young Physicians Section exists to help members face these challenges more effectively.

No specialty is faced with more fundamental challenges to basic patient care than emergency medicine. We must be committed to making sure that our patients receive the quality of care that they deserve. This starts with personal dedication to excellence in practice through continued learning and self-improvement. Each one of us must also dedicate time to learning the issues involved with problems facing the specialty such as the corporate practice of emergency medicine and boarding of admitted patients. We must each have a thorough understanding of the underlying issues to be most effective at improving the conditions in which providers are forced to deliver less than ideal care.

The continuation of our commitment to patient care comes indirectly by being strong advocates for our specialty at the local, regional and national levels. We must continue to build society's awareness that emergency medicine is best practiced by residency-trained, board certified emergency physicians. As the newer generation of emergency physicians, we must stay alert to the threats that face our specialty, just as our predecessors have in the past. Each of us must serve as an advocate for the specialty on every occasion afforded us and continue to set high standards for ourselves and our residency graduates. As the Young Physicians Section continues to develop, we hope to add to AAEM's proven record of supporting our specialty through continued advocacy, education and support of the individual emergency medicine specialist.

I hope that the new year is going well for you, and I urge you to make this the year that you renew your efforts to support your specialty by getting involved with AAEM and YPS. Scientific Assembly is quickly approaching, and along with the meeting comes the election process for a new board of directors for YPS. We need dedicated individuals to lead the charge in the development and leadership of the section. I hope that you will consider giving back to our specialty through a leadership position within YPS. Even if a position on the board of directors is not the thing for you, leadership opportunities are available through committee service. If you want a little less of a commitment, how about helping out by submitting an article, helping with the website, building membership or working on one of the section's special projects? Your unique set of skills and experiences are needed to help YPS realize its full potential. Let us know how you would like to get involved by sending an email to info@ypsaaem.org. Don't forget to talk to your colleagues who are not members of AAEM or YPS, and encourage them to join both the organization and the Young Physicians Section.

If you finished residency within the past seven years and have not yet joined the Section, now is the time to do so. Simply check the YPS box on your AAEM membership card, or sign up online at www.ypsaaem.org/membership. You must be a member of YPS to participate in the election process, and every member has the opportunity to become involved in the development of the section.

AAEM Young Physicians Section

Marc D. Haber, MD FAAEM
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Vice President of YPS

Granted the "giving season" has just passed, but since this article is being composed in the peri-Chrismihanukkwanzakah atmosphere, I'd like to focus on the topic of giving. As a new parent, my wife and I have learned the importance of gifts. Sure, as kids we loved receiving. With utter joy, I still remember finding my Lionel train set on the last day of Hanukkah. As parents though, my wife and I have learned, or rather learned to respect, the act of gift giving. We know now to NEVER give any gift that requires batteries, has no "off" switch or cannot pass through the digestive system of the family pet. A number of my daughter's more "flamboyant" toys have met an unfortunate end in the intestines of my golden retriever. I still have no idea how Cobi could pass some of those parts, but I am guessing it has something to do with his toy poodle-sized land mines he lovingly leaves for me in the yard.

Those who are both an emergency physician and a parent with young children, have further responsibilities regarding unexpected presents. Imagine returning home after a long shift, your daughter leaping into your arms overflowing with excitement, finally having her daddy home. You are relieved to finally be with the folks who love you unconditionally. The last ten hours were spent caring for a multitude of patients for whom you bent over backwards to arrange VNA services, an actual hospital bed OUTSIDE of the ED and arranging organ donation for the unfortunate bystander of a drug deal gone wrong. Ten hours of back-breaking work without one single word of thanks. But those negatives are out the window, because now you are truly experiencing a significant benefit of our profession, the lifestyle. Then, the hot tongue of your Cobi brings you out of your brief trancelike state. Looking down, you see your pet licking some, thankfully, unrecognizable pertinacious debris on your shoes. With horror you also remember the little kiddo with neck stiffness and fever you tapped in the beginning of your shift. Within five minutes, your daughter is soaped up in the tub and you and your clothes are being autoclaved. Lesson learned, never come home in work clothes or risk bringing along some unpleasant presents. Alternative lesson, don't ever play kissy-face with your dog.

In reality, most of our patients appreciate our hard work. We are professionals; therefore, we empathize with the frustrations of our patients. Their frustrations become our frustrations. The 18 hour hallway stay of our 86 year old CHFer pains us as much as it does them. We cringe as we have to transfer a patient because our local ophthalmologist refuses to take call. Then on the way home we have to deal with the same drivers that must have caused that flood of MVCs midway through our shift. Arriving home, miraculously unharmed, that same three year old comes hurdling down the hallway towards her daddy. You feel the same elation, and this time you are changed and washed. Still though, three year olds are three year olds. A few hours later, it is nearly her bedtime. You have completed the Melissa & Doug puzzle three times, read Knufflebunny and Moon Plane five times, and thought about drinking that cold Sam Adams at least a half dozen times. Your patience tested, you remember this next gift you bring your family: the gift of leaving your work at work. Even without such a challenging job, three year olds are great at fraying that last nerve. It would be so easy to get angry with your child. But, thanks to a combination of taking the long way home and your XM car radio, you have had a chance to partially unwind prior to walking through your home's threshold. Instead of creating a scene of tears, you buckle down for one last read of Moon Plane. And sure as that adolescent diabetic is to return again in a ketotic dream, before the last page, your baby is sound asleep.

Today's over-stimulated kids would be amazed that we survived the '70s without video games more advanced than Pong. In fact, one rubber ball kept us entertained playing spud, 4-square and kick ball. Unfortunately, for the most part, these games have been replaced by Madden Football, Warcraft and other video games. Amazingly, in our current society where we flood our children's playrooms with the Doodle-bop's seizure-inducing videos and speedier versions of our childhood board games, we are shocked when they are riddled with attention deficit problems. While not a cure, perhaps there is one thing that can, at the very minimum, add to our children's development. That action is spending one-on-one time with our offspring. As scary as that sounds, not only is it the cheapest gift, it is also the most rewarding. Yet as younger physicians, we are burdened with massive loans and rising mortgages. We need to work extra hours for extra cash, just to get by. Without this supplemental income, many of us would be financially wrecked. Somehow though, we have to balance our financial needs with those of our family.

If our collective compensation were higher, perhaps moonlighting would be more elective, rather than a necessary evil. Unfortunately, due to a multitude of reasons, many have argued that our salaries are artificially low. One reason is clearly due to the unfair business practices of contract management groups (CMGs). Another way is to encourage our colleagues and current residents to at least learn about these issues, if not join AAEM in the good fight. If you are reading this as a member of AAEM, I am preaching to the choir. Perhaps, though, your colleagues may not yet be members or perhaps you haven't yet made the decision to donate to the AAEM Foundation. Please consider yourself asked!

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Ask the Expert

by Joel M. Schofer, MD
LCDR MC USN, Naval Hospital Okinawa

"Ask The Expert" is a *Common Sense* feature where subject matter experts provide answers to questions provided by YPS members. This edition features Dr. Jonathan Davis, who presented "An Evidence Based Medicine Approach to Anaphylaxis" at the AAEM 2007 Scientific Assembly.

Question: Can you give a cephalosporin to a patient who is allergic to penicillins and only had a nonspecific rash as his/her reaction? What if he/she had urticaria instead of a non-specific rash?

Answer: A great deal of confusion persists among healthcare providers regarding the use of cephalosporins in patients with a history of penicillin allergy. The best approach to this clinical conundrum first involves asking two critical questions:

1. Is a patient with a stated "penicillin allergy" actually allergic to penicillin in the first place?
2. If it is indeed a legitimate penicillin allergy, what is the potential for anaphylaxis when administering a cephalosporin?

Allergic emergencies can present with a variety of clinical manifestations, ranging from isolated skin findings (flushing, urticaria, angioedema) to respiratory failure and cardiovascular collapse. Allergic emergencies typically involve IgE antibodies (Gell and Coombs Type I, immediate hypersensitivity reactions). Much of the confusion regarding a "penicillin allergy" stems from the blurred distinction between a prior true drug allergy (Type I hypersensitivity reaction) and a non-IgE-mediated adverse drug event (vomiting, lightheadedness, diarrhea, non-specific rash). Indeed, older reports have indicated that fewer than 10% of patients claiming to have a "penicillin allergy" actually have Type I hypersensitivity to penicillin. The majority of patients with a stated "penicillin allergy" are not at risk for immediate hypersensitivity reactions to penicillins.

In the case of a legitimate penicillin allergy, what is the potential for anaphylaxis when administering a cephalosporin? The widely cited figure of "10% cross-reactivity" appears to come from seminal data examining the incidence of early 1st-generation cephalosporin reactions. However, it was later found that these early 1st-generation agents contained trace amounts of penicillin, as they were derived from the same mold.

More recent findings suggest that 1st-generation cephalosporins may pose a greater risk in penicillin-sensitive patients as compared with either 2nd- or 3rd-generation agents. However, the risk of 1st-generation agents is still minimal. A review in 2001 estimated a 4.4% cross reactivity rate based on skin testing, although the *clinical* relevance of this rate remains unclear. Interestingly, the latest evidence suggests that the immune response to cephalosporins may be more dependent on specific side-chain components, as opposed to their beta lactam ring structure.

Clearly, what we are most concerned about as practitioners is the potential for an IgE-mediated, immediate hypersensitivity reaction, and its associated morbidity and potential for fatal outcome. When combining the available data, the risk of 2nd- or 3rd-generation cephalosporins in "penicillin allergic" patients is minimal (less than 1%). When compared with an overall incidence of antimicrobial hypersensitivity in general (1 to 3%), there is no additional risk of 2nd- or 3rd-generation agents over alternative antimicrobials.

So, in a nutshell, patients with a history of a non-specific rash following penicillin administration have more than likely suffered a non-IgE-mediated response, and are not at increased risk for allergic emergencies resulting from members of the penicillin or cephalosporin families. In the case of an urticarial reaction (which may be the mildest variant on the spectrum of IgE-mediated symptoms), penicillins and *perhaps* 1st-generation cephalosporins should be avoided (although the risk of 1st-generation agents is still minimal). However, the risk of cross-reactivity to a 2nd- or 3rd-generation agent is no more likely than a reaction to any administered antimicrobial, irrespective of drug family.

Reference:

Pichichero ME. Cephalosporins can be prescribed safely for penicillin-allergic patients. J Fam Pract. 2006 Feb;55(2):106-12.

Jonathan Davis, MD FAAEM
Associate Program Director, Assistant Professor
Georgetown University Hospital & Washington Hospital Center
Washington, D.C.

If you have a question that you would like to have answered by an expert in a future issue of *Common Sense*, please send it to jschofer@gmail.com.

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, nor the U.S. Government.

YPS Article - continued from page 27

So for this year's wish list, remember to add hand sanitizer, a gift certificate to Banana Republic and a yearly subscription to XM or Sirius Satellite Radio (or a new car with this installed). Finally, perhaps the best part of the holidays, the giving. Please consider a donation to the AAEM Foundation. Help give you and your colleagues a greater voice in the business of emergency medicine and ultimately establish a better work environment.

AAEM Membership Application

First Name ☐ Miss ☐ Mr ☐ Mrs ☐ Ms | MI | Last Name | Birthdate

Institution/Hospital | Degree (MD/DO)

Preferred Mailing Address

City | State | Zip

Please check which address this is: ☐ Work ☐ Home

Phone Number—Work | Phone Number—Home

Fax | E-mail

1) Have you completed or are you enrolled in an accredited residency program in emergency medicine? ☐ Yes ☐ No
   If yes, which program & date of completion: _____

2) Are you a medical student with an interest in emergency medicine? ☐ Yes ☐ No
   If yes, program & expected date of completion: _____

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

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

5) Are you a member of any other EM organization? Please select all that apply.
   ☐ AACEM ☐ ACEP ☐ ACOEP ☐ AMA ☐ CORD ☐ EMRA ☐ NAEMSP ☐ SAEM ☐ Other_____

Full Voting and Associate Membership dues are for the period January 1st through 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 or Affiliate Membership. Full Voting and Associate memberships include a subscription to *The Journal of Emergency Medicine* (JEM). Resident and Student membership dues are for the period July 1st thru June 30th of the period the dues are received. All memberships, except student without JEM and free student membership, include a subscription to *The Journal of Emergency Medicine* (JEM).

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

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Positions that comply with the American Academy of Emergency Medicine's Certificate of Compliance will be published for a one time fee of $300, to run for a term of 12 months or until canceled. A completed copy of the Job Bank registration form, a signed copy of the Certificate of Compliance and payment must be submitted in order to place an ad in the Job Bank.

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

• ALABAMA

Stable, democratic group of 100% EM residency trained, BC physicians seeking BC/BE applicants for full time position opening 7/2008. New/soon-to-be-grads welcome. Group emphasizes lifestyle and income. Competitive compensation based on hours/productivity. Full benefit package and partnership tract available. Hospital is for profit, privately owned, 250 beds with volume @35K. ED ultrasound and state of the art computer system/CPOE utilized. Mixed to high acuity with limited trauma. Excellent medical staff and healthcare environment. Mobile offers city living in a coastal environment, with booming industry and commerce. For further inquiries, please contact: mahoney_ermd@hotmail.com. (PA 820)
Email: mahoney_ermd@hotmail.com

• ARIZONA

Looking for new partners. Must be BC/BE. Come join our democratic group with a short partnership track and excellent salary. Enjoy the great outdoors and year-round activities. Prescott is located about 100 miles NW of Phoenix and at 5500 ft of elevation the weather is 15-20 degrees cooler than Phoenix. No call. Fantastic smaller community with no traffic and no smog. We are now covering 2 hospitals, Prescott and Prescott Valley. Our current combined volume is about 60k. Please email or call for more information. (PA 849)
Email: robertmkec@mac.com

• CALIFORNIA

California-Bakersfield: Pinnacle Emergency Physicians is seeking full or part time emergency physician to join a democratic group staffing a large private community hospital/referral center with 40K visit/year. All specialties covered with good back up. Employee status at $150/h with partnership track beginning after 6 months with matching 401K. Ninety miles north of LA., low cost of living, easy non-stop access to Phoenix, Denver, Salt Lake, San Francisco, Sacramento and San Diego. Abundant recreational activities locally with nearby world class white water and wind surfing, off road biking, hiking in the Sequoias, skiing 3-4 hours north and south, beaches 2 hours south and west. CV's may be faxed to 661-589-2151 or e-mailed to phogku@aol.com. For more information call 661-332-1064. (PA 788)
Email: phogku@aol.com

• CALIFORNIA

CENTRAL CALIFORNIA: Stable, democratic group with recently renewed contract seeks full-time BC/BE emergency physicians to start Partnership Track. Part-time spots also available. Competitive salary. Paid malpractice. Two hospitals, 24k annual visits at each site, with 10 hours of Fast Track staffing daily at one of the sites. Affordable real estate. Two hours from beach, mountains, or Los Angeles. Four semi-professional sports teams, plus Division I NCAA college. Excellent city for raising kids, with top-ranked schools and lots of parks. Call April Smith at CCEMP (661)477-9283 or fax CV to (661)326-8022. (PA 833)
Email: asmith14@earthlink.net

• COLORADO

Durango, Colorado: Opening for Board Certified/Board Eligible ED physician in Level III, 18,000 annual volume department. New, state-of-the-art facility with excellent subspecialty coverage. Democratic, stable group with partnership track available. Durango is located in southwestern Colorado with abundant recreational opportunities. (PA 844)
Email: jlmcmd@smallcircles.com

• COLORADO

Southwest Health System, Cortez. Great opportunity in beautiful SW Colorado. Excellent recreation opportunities. Seeking a physician to provide coverage in a Level IV emergency room full time. BC/BP in emergency medicine preferred. Annual Volume: 12,000/yr. Compensation: Independent contractors; current hourly rate $115.00/hr. Professional Liability Insurance Coverage. $10,000 hiring bonus/moving allowance. Position qualifies for a $10,000/year x three years student loan repayment. Option for 24/hr; 12/hr; or a mixture of 24/hr and 12/hr shifts. (PA 846)
Email: dbond@swhealth.org
Website: sw.health.org

• FLORIDA

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

• FLORIDA

Pensacola Emerald Coast. Fishing, sailing, hunting, colleges, symphony, water-front living. Partnership available to BC/BP Emergency Physicians in democratic group. $220 to 350K plus malpractice paid. Level II Trauma Center with 32,000 visits/year. Contact Marguerite at marguerite.dittrick@hcahealthcare.com (PA 806)
Email: marguerite.dittrick@hcahealthcare.com

• GEORGIA

Athens, Georgia: Private, democratic group of 20 physicians; all BE/BC EM. Recruiting additional physician to expand coverage. 315-bed regional referral center; all major specialties on staff; dedicated hospitalists. ED volume 60,000; admissions rate 20%. New 46-bed, state-of-the-art department currently under construction. Excellent package of clinical hours, salary and benefits. Well-established group in its 20th year at a single hospital. Large university community with abundance of sports, recreational and cultural activities; one hour from Atlanta. Contact Carolann Eisenhart, MD at 706-475-3359. (PA 823)
Email: carolanneisen@charter.net

• IDAHO

NORTHWESTERN IDAHO - Emergency Medicine Partnership, join 4 other emergency medicine physicians, 12 hour shifts, 12 shifts per month, Heli port, 25,000 visits/year. Compensation: Equal partners, exceptional income and benefits, college town, abundant outdoor recreation, year-round golf, 19 mile paved walking path along 2 rivers, 2 other state universities within 1/2 hour drive (one Pac 10 College), commercial airport, reasonable real estate prices, highly rated public and private schools, financially sound Regional Medical Center. Contact: Eva Page, 800-833-3449, eva.page@comcast.net (PA 835)
Email: eva.page@comcast.net

• ILLINOIS

Outstanding opportunity for emergency physician to join a democratic group of emergency physicians in a stable practice situation at Memorial Medical Center in Springfield. Partnership track with future profit sharing. Volume 54K with excellent ED physician coverage. State of the art 30-bed facility is entirely new in 2000, with an additional 14 beds added in 2006. A CT is also available in the ED. Excellent specialty backup. Salary is very competitive with full benefit package. Memorial is a major teaching institution of Southern Illinois School of Medicine, and emergency physicians are clinical faculty members. Springfield is the capital of Illinois with a population of over 110,000 and a very stable economy. This is an excellent opportunity for an emergency physician with superior clinical and interpersonal skills desiring a democratic, small group and a long-term practice situation. Contact David Griffen, MD, PhD, FACEP, Medical Director and Chair, 217-788-3156, fax CV in confidence to 217-788-6459, or e-mail griffen.david@mhsil.com. (PA 790)
Email: griffen.david@mhsil.com

• INDIANA

South Bend: Very stable, Democratic, single hospital, 15 member group seeks an additional BC/BP emergency physician. Newer facility. 52K visits, Level II Trauma Center, double, triple and quad physician coverage. Equal pay, schedule and vote. Over 300K total package with qualified retirement plan, disability insurance, medical and CME reimbursement, etc. Very favorable Indiana malpractice environment. University town, low cost of living, good schools, 90 minutes to Chicago, 40 minutes to Lake Michigan. Contact Steven Spilger MD at 574.272.1310 or send CV to mrpolyester1@comcast.net (PA 817)
Email: mrpolyester1@comcast.net

• INDIANA

South Bend: Immediate partnership opportunity for BC/BE Emergency Physician to join our democratic, stable (30 year), fee-for-service 2 hospital group. Equal nights, weekends and holidays and compensation. University town, 90 minutes to Chicago. Email CV to JR Reid, MD at jrreiddoc@comcast.net or call 574-850-3664. (PA 837)
Email: jrreiddoc@comcast.net

• INDIANA

Indiana, Greater Indianapolis Area: EQUAL PAY, EQUAL SAY, FIRST DAY. Immediate financial equity with single hospital group of exclusively ABEM certified physicians. Low cost of living and competitive compensation allow a seventh partner for greater flexibility where quality of life is valued. State-of-the-art facility and outstanding support staff provide opportunity to continue 21 year tradition of exceptional service. Stable 30,000/yr census with 16 hours double coverage by MD/PA. Located in Anderson, an easy commute from northern Indianapolis suburbs. Visit our hospital and ED at www.communityanderson.com. EM BC/BE only please, reply at epchajob@gmail.com. (PA 848)
Email: epchajob@gmail.com

• KENTUCKY

Trover Health System is seeking outstanding Board Certified/Eligible emergency medicine physician(s) to join an exciting emergency department team. Our emergency department includes 18 ED beds, 2 trauma rooms, and 6 Fast Track beds. We offer an excellent compensation/benefit package, and offer a 12 hour shift rotation with double coverage during peak hours. Inquires can be sent to Ceil Baugh: cbaugh@trover.org, or call (800) 272-3497. CV's can be faxed to (270) 326-4523. Please visit our web site at: www.troverhealth.org (PA 805)
Email: cbaugh@trover.org
Website: www.troverhealth.org

• KENTUCKY

Outstanding Opportunity for EM BC/BE physicians interested in providing services for the military and their dependents at the Ireland Community Hospital, Emergency Room, Ft Knox, Kentucky. 11 Bed ED, 1 Trauma Room. Full and part-time physicians desired. Locums available. Please direct inquiries/CVs to krystle@centralcareinc.com, or call 1-888-643-9700; Fax 1-866-248-7722. (PA 831)
Email: krystle@centralcareinc.com

• MAINE

Stephens Memorial Hospital in Norway, Maine, a member of MaineHealth, the premier healthcare system in Maine, has an opportunity for a BC/BP ED physician to join their state-of-the-art, Level II ED. Volume is 18,000, shared coverage with 8 ED physicians and have in-house access to advanced imaging technology, 24/7 lab, and Lifeflight capability for major trauma transports. Director potential. Excellent compensation package including paid malpractice, med. loan assistance, CME allowance, family paid Health/Dental, 403b retirement, and more. 2 1/2 hours from Boston and one hour from Portland/ocean. Enjoy arts, skiing, hiking, boating and other recreation. Four season resort community. (PA 821)
Email: fryet@wmhcc.org
Website: www.wmhcc.org

• MAINE

Northern Maine is calling you!! The Aroostook Medical Center, the regional referral center for Northern Maine, has an opening for Department Director. The annual volume at our Level II ED is 16K. Single physician coverage with 10 hours double coverage with a physician assistant and a 24/7 in-house Hospitalist team. This is an employed position with excellent starting salary and generous benefits package. All in lovely, safe, family-friendly Maine. Town features 2 colleges, and olympic skiing facility. Full-time position, with expected 5-8 hours per week of Directorship duties. (PA 838)
Email: kmoreau@tamc.org
Website: www.tamc.org

• MARYLAND

ED Physician Director - Southern Maryland Hospital Center, located outside of Washington D.C., seeks an experienced physician to lead their emergency department. Within this leadership role, you will screen, hire and manage a quality staff of ED physicians with a focus on prompt, and outstanding patient care. The majority of your shift will consist of seeing patients, as well as some administrative duties. You must possess Board Certification in Emergency Medicine and recent experience within an upper-level management position working at a 45,000+ patient visit emergency department. A competitive salary and benefits package is available. E-mail your resume to: PaulZeller@Southernmarylandhosital.com. EOE, M/F/D/V. (PA 816)
Email: PaulZeller@southernmarylandhospital.com
Website: www.smhchealth.org

• MASSACHUSETTS

Seeking compatible F/T emergency physicians to join our experienced emergency physician group. We see 40,000 patients a year. Our hospital is a busy 125-bed community hospital affiliated with a major teaching hospital. Applicants need to be board-certified or eligible. Our reimbursement is regionally competitive with a 2400 hour track to partnership. Located in Western Massachusetts, the community is vibrant and diverse and offers good educational opportunities for all ages as well as fine cultural events. Boston, New York City, New Hampshire and Vermont are all within 1-3 hours by car. (PA 834)
Email: josh_maybar@cooley-dickinson.org
Website: www.cooley-dickinson.org

• MASSACHUSETTS

Stable democratic group seeking BC/BE emergency medicine physicians for full time position opening 1/2008. Competitive benefit and reimbursement package. Partnership tract available with future profit sharing. 29,000 visits with 13 hours of MD double coverage daily. ED Fast Track now in development. Mixed to high acuity with limited trauma. Hospital is located in coastal community with outstanding schools. Located in southeastern Massachusetts, minutes from Cape Cod. One hour from Boston and Providence. (PA 841)
Email: redman5@aol.com

• MASSACHUSETTS

Charter Professional Services Corporation and North Shore Medical Center (NSMC) want you to join their dynamic team of emergency medicine physicians. Excellent democratic physician-friendly work environment. Block coverage at two prominent NSMC hospitals – Salem Hospital in Salem and Union Hospital in Lynn – within 15 minutes of each other. Flexible shifts. Excellent medical staff back-up. Competitive compensation and comprehensive benefits. Beautiful harbor town, located just 15 miles north of Boston. ID#28730C35. Contact Lin Fong at 800-678-7858 x63475; e-mail lfong@cejkasearch.com; or visit www.cejkasearch.com. (PA 851)
Email: lfong@cejkasearch.com
Website: www.cejkasearch.com

• MISSISSIPPI

Lucrative EM opportunity serving 172-bed regional hospital with 22-bed heart hospital offering excellent salary, comprehensive benefits, $40,000 sign-on bonus and full school loan repayment. Opportunity for full partnership, maximum profit sharing contribution. Warm college town offers great outdoor recreation, shopping & restaurants, exceptional housing options and schools. International airport one hour away. (PA 804)
Email: nwaters@phg.com

• MISSISSIPPI

Southeast Coastal University City with Southern Charm and Hospitality - Emergency Medicine Opportunity. Join a group of six emergency medicine physicians. Employment of $150 per hour (Potential to make over $300k). Benefits include: Paid malpractice, 32K ER visits per year, hospital is NOT a trauma center, occurrence-based malpractice – No Tail Coverage. Twelve public and private courses within a 30-mile radius, intact historic neighborhood district encompassing 115 acres, outdoor sculpture garden and Children's Literature Museum. Biking, hiking, hunting, canoeing, camping, and fishing. More outdoor activities than a carnival - Attend a play, concert or college football game, canoe down a river, or hit the links at one of the nationally ranked golf courses! (PA 809)
Email: rrector@phg.com
Website: www.phg.com

• NEW MEXICO

New Mexico: Santa Fe – We are an independent, democratic group seeking 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 partnership track with management opportunities. Santa Fe is a recreational paradise with many cultural activities. Contact: Karen Tiegler, Practice Manager at 505-992-0233 or by email at administrator@sfep.org (PA 829)
Email: administrator@sfep.org
Website: www.sfep.org

• NEW YORK

Faculty candidates interested in academic Emergency Medicine. The Division of Emergency Medicine of University Hospital UMDNJ is in an academic tertiary Level 1 trauma center with EMS medical control providing care to approximately 93,000 patients per year. We have a four year residency program currently in its third year with a mandatory four week medical student elective. Just 20 minutes from NYC. We offer a competitive salary and benefits package. Equal Opportunity Employer. Please forward your Curriculum Vitae to, Hosseinali Shahidi, M.D., MPH, University Hospital, 150 Bergen Street, M-219, Department of Emergency Administration, Newark, NJ 07101. shahidho@umdnj.edu Telephone 973-972-6224. Fax: 973-972-6646 (PA 845)
Email: shahidho@umdnj.edu
Website: www.njemr.com

• NORTH CAROLINA

Durham - Established, democratic emergency medicine group is seeking a full-time BC/BE EM physician. 50,000 patients are treated annually. We offer a competitive salary and comprehensive benefits. We are located in one of the most desirable living areas on the east coast, close to beaches and mountains with an international airport. We have great weather all year round, excellent schools and 3 major universities. For more information please fax or email CV to 919-477-5474, durhamemergency@ams-nc.com. (PA 808)
Email: durhamemergency@ams-nc.com

• NORTH CAROLINA

ECEP II, P.A., a very stable (since 1984) emergency medicine group, is seeking a full-time (approx. 34 hours/week) emergency medicine physician to practice at Pender Memorial Hospital. Part of the New Hanover Health Network, Pender Memorial Hospital is located in the town of Burgaw, North Carolina, approximately 25 miles north of historic, beautiful, Wilmington. Pender County is a perfect choice for anyone who enjoys camping, fishing, boating, dining on fresh seafood, or spending a casual afternoon shopping for antiques. Whether you are looking for beautiful beaches, a relaxed family oriented lifestyle, or friendly communities, Pender County has it all for you. (PA 819)
Email: dkey@ecepnet.com
Website: ecepnet.com

• NORTH CAROLINA

Instructor/Assistant Professor appointment, Department of EM, WFUSM, subject to approval, governing boards of Wake Forest University Health Sciences. Seeking faculty with interests in cardiovascular clinical research. Have active clinical research program, industry/federally-funded investigators, staff providing patient enrollment, full departmental/university support. Salary/benefits, competitive. Start-up funding negotiable. Must be EM trained or board eligible/certified. Research fellowship/research experience preferred. Contact: James Hoekstra, MD, Chairman, Department of Emergency Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1089. Phone (336)716-4626, FAX: (336)716-5438 or email dswaim@wfubmc.edu. Equal Opportunity Affirmative Action Employer. (PA 824)
Email: jhoekstr@wfubmc.edu
Website: www.wfubmc.edu/em/

• NORTH CAROLINA

NC: Wake Forest University Dept. of EM seeking candidates for new clinical site, Wilkes Regional Medical Center, WRMC located 45 minutes West of Winston-Salem, 32,000 annual visits with specialty backup, state-of-the-art ED. Hired as Clinical Instructor/Clinical Assistant Professor in Dept. of EM at WFUSM, compensation competitive, subject to approval of the governing boards of WFUHS. Full WFUSM benefits. Must be either residency trained in EM or board certified/board eligible. Contact: James Hoekstra, MD, Chairman, Department of Emergency Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1089. Phone: 336-716-4626, email: jhoekstr@wfubmc.edu. Equal Opportunity Affirmative Action Employer. (PA 825)
Email: jhoekstr@wfubmc.edu
Website: www.wfubmc.edu/em/

•NORTH CAROLINA

Elkin, beautiful town in the foothills of North Central NC, close to Charlotte and Winston-Salem. ED with 24000 visits, with a "Quick Care" staffed by mid-levels. This is a very rare opportunity to join a new small private group. We are only looking for someone willing to make a long term commitment. Contact Steve Isaacs, MD 704-876-3981, flysgi@yahoo.com (PA 827)
Email: flysgi@yahoo.com

• NORTH CAROLINA

Asheville, North Carolina. Rare opportunity to join stable, democratic group at Mission Hospital, located in beautiful North Carolina Mountains. We are seeking a board certified emergency physician for an immediate full time opening on partnership track. Mission Hospital is the Regional Medical Center for Western North Carolina, Level 2 Trauma Center with full complement of specialty back up and outstanding medical community. Annual volume of 95,000 visits. Asheville is a vibrant city in which arts, entertainment and outdoor activity abound. Further inquiries please contact Jason Hunt at jasonhuntmd@mac.com. (PA 840)
Email: jasonhuntmd@mac.com

• NORTH CAROLINA

Democratic group seeks FT BC/BE physician: Shelby Emergency Associates staffs a level III trauma center/50K and a community hospital 10 miles away seeing 25K. Our group is 16 y.o. and offers $160/H plus malpractice, 401K, pretax business account, $180/H for nights. 24H hospitalist coverage for admissions in both hospitals. Topnotch nurses, medical staff and supportive administration confers super comfortable work environment. $22M 26 bed ER +12 bed FT completed 2007 at CRMC. Beautiful area of NC between Asheville and Charlotte. Broad pathology never boring during 10 & 12 hour shifts. Midlevels at both hospitals. 704-472-7777 Please email CV. (PA 850)
Email: volumizer@yahoo.com
Website: http://www.clevelandregional.org/history.cfm

• OHIO

Oxford, Ohio: Small, single hospital, democratic group is looking for a full or part-time emergency physician. Volume continues to increase, creating need for additional coverage. Must be Board Certified in Emergency Medicine (grandfathered ok). Continue to have excellent relationship with hospital. Located in small, safe college town, accessible to two metropolitan areas. We have many excellent academic, athletic and cultural events within 5 minutes. New billing has made a good financial picture excellent - total compensation >90th percentile. Partnership in one year. Come see us and see why we like it so much! Contact Joe Sanchez, MD at jchez7@fuse.net (PA 792)
Email: jchez7@fuse.net

• OHIO

Qualified Emergency Specialists, Inc., physician-owned, fee-for service, democratic group dedicated to emergency medicine in one city, Cincinnati, OH. Visits range from 40,000-60,000 at six hospitals. Our own Journal Club, active in EMS education, marathon and stadium medicine. Full vesting, Medical and Malpractice insurance. Flexible, equitable scheduling. Cincinnati offers superb cultural and artistic programs. Excellent schools and colleges. Cincinnati Reds and Bengals. Please Contact: Gary Gries, M.D., Phone: 513-231-1521 or email:gries9hotmail.com (PA 828)
Email: LLindseys@msn.com
Website: www.qualifiedemergency.com

• OHIO

Springfield, Ohio: Because we will assume responsibility for two additional ED facilities in January, we are looking for full and part-time EM board certified physicians. We are a democratic, fee-for-service group that has an excellent working relationship with the hospital. We are located between Dayton and Columbus and offer an attractive compensation package. Please contact Annette Nathan, MD at skidocim@aol.com or call the Administrative Assistant at 937-328-9301. (PA 839)
Email: skidocim@aol.com

• OREGON

Sunny Southern Oregon - Klamath Falls: Unique Oregon Opportunity in Top 100 places to live location. Full-time position for BC/BE ER Physician in brand new department. BC/BE colleagues and excellent specialty backup. Equitable, flexible scheduling of 9 hour shifts. 36 hours coverage per day on a annual volume of approximately 25,000. Compensation in excess of $160/hr with full benefits and retirement. 300 days of sunshine per year. Visit our website: www.skylakes.org. Contact Mike Poe at 541-274-6258 or MPoe@skylakes.org (PA 811)
Email: MPoe@skylakes.org
Website: www.skylakes.org

• PENNSYLVANIA

The DEM at Penn State Hershey Medical Center is seeking board-certified or prepared, academic minded emergency physicians to join our faculty. Located in beautiful Hershey, PA, the state-of-the-art ED cares for >50,000 with 56 hours of attending coverage daily, with additional MLP support. Research, service and educational missions provide opportunities for integrated faculty development. Outstanding schools, low crime rate and a small town atmosphere allow a pleasant lifestyle next to a world class academic medical center. Confidential inquires to Thomas Terndrup, MD (Chair), DEM (H043), PO Box 850, Hershey, PA 17033, Phone 717-531-8955 or email tterndrup@hmc.psu.edu. EOE. (PA 812)
Email: cdeflitch@hmc.psu.edu
Website: www.hmc.psu.edu

• PENNSYLVANIA

Outstanding ED Physician Needed in State College, PA; home of Penn State University. Featuring: Independent democratic group, Fee / service, Stable, amicable relationship with administration, Volume: 44,000+, 42.5 physician hours/day, 20-22 PA hours/day, In-house dictation/transcription, Excellent nursing/ techs/ IV team, superb admitting / consulting staff, CT/ultrasound 24/7, University community: great schools, sports and culture, without crime. E-mail Tziff@Mountnittany.org or call Sally Arnold at 814-234-6110 ext. 7850. Or mail: Theodore L. Ziff, MD FACEP, 1800 East Park Ave., State College, PA 16803. 814-234-6110. (PA 847)
Email: Tziff@Mountnittany.org

• SOUTH CAROLINA

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

• TENNESSEE

NASHVILLE-stable democratic group with two hospital contracts, held over 25 years, 100k visits/yr. Outstanding remuneration with 2 year full-partnership track, square and flexible schedule. The Nashville area is an outstanding growing & dynamic community that offers the benefits of a big city and the esthetics of a small town. It is a great place to raise a family without state income tax. This is an outstanding opportunity both professionally and financially. Please contact Russ Galloway, gal1958@comcast.net, 615-895-1637 or Kevin Beier,khbeier@hotmail.com 615-661-0825. (PA 813)
Email: Gal1958@comcast.net

• TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• TEXAS

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

• UTAH

Democratic, happy stable group, gets along with administration seeking residency trained/BC EP for our Level 2, 56,000+ facility in Provo, UT, just 20 minutes from Snowbird. FT averages 23 hours per week with 8 week vacation per year. Call Ken Armstrong (801) 362-4119 or email CV. (PA 818)
Email: ken.uvep@hotmail.com

• VIRGINIA

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

• VIRGINIA

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

• VIRGINIA

Unparalleled career opportunity in Virginia with Fredericksburg Emergency Medical Alliance, Inc. TRULY democratic, progressive and stable group 50 miles south of Washington, DC. State-of-the-art computerized ED with 95K volume. Highly competitive FFS compensation, great schedule, and stable malpractice coverage. Contact Linda Dempsey 540-741-1167, linda.dempsey@medicorp.org (PA 832)
Email: linda.dempsey@medicorp.org

• VIRGINIA

Charlottesville VA: Live and work in this beautiful college town minutes from the Blue Ridge Mountains. We are an established, single hospital, democratic group looking for a FT or PT physician. 33k census, 8-hr shifts, 40 hr/day Physician coverage with Minor Care Area open 3 days a week. We offer medical coverage, CME stipend, fully funded retirement, and partnership track for FT physician. Must be EM BE/BC. (PA 836)
Email: daniel.ricciardi@mjh.org

• WASHINGTON

Full-time opportunity for BC/BE emergency physician. Established, independent, fee-for-service democratic group. Annual volume 65,000. Financial equality at one year, partnership at two years. State-of-the-art department located in the scenic Puget Sound area. Mountain and water recreation readily available. Send CV to Paul Fleming, MD, Medical Director, 413 Lilly Rd. NE, Olympia, WA 98506 or paul.fleming@providence.org. (PA 815)
Email: paul.fleming@providence.org

• WASHINGTON

We are seeking an outstanding ED physician and Director to join our superb group of physicians and PA's. ED volume of approximately 30,000/yr seeing complex and critical adult medical cases, and small volume of trauma, peds, GYN. Double coverage during most of the day. Large multi-specialty downtown clinic/hospital provides 24/7 specialty back-up in all areas. Teach residents rotating through the ED. Successful candidate to be EM BE/BC with 2 years experience. VMMC will start construction in 2008 for a new hospital wing with a new state-of-the-art ED. (PA 852)
Email: christi.lenz@vmmc.org
Website: www.vmmc.org

• WISCONSIN

Watertown Emergency Physicians, S.C., in Watertown, WI, is looking for a board certified emergency medicine physician (ABEM or AOBEM) to work one weekend shift a month plus two to three regular shifts a month for an average of six shifts a month. Last year we had over 17,000 annual visits. We have 11-hour day shifts from 7am-6pm and 13-hour night shifts from 6pm–7am. We also have 11-hour/day PA/ NP coverage on weekends and holidays. Watertown is located equidistant between Milwaukee and Madison, WI, 45 minutes away. (PA 822)
Email: rlynch@wahs.com
Website: www.wahs.com

• WYOMING

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

• LEBANON

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

• NEW ZEALAND

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

• NEW ZEALAND

Emergency Physician (1.0FTE). Come live and work in Whangarei, New Zealand! White sandy beaches, green hills, blue sea and subtropical climate with some of the best fishing/diving in the world. Whangarei has a population of 70k, just 2 hours north of Auckland. We need an energetic, quality Emergency Physician to join our team. We have a modern ED, and a progressive practice with good patient mix. Vacancy No: MD07-009. Close Date: Open. Interested? Contact: Shelley Mackey, Northland District Health Board, PO Box 742, Whangarei, New Zealand phone: +64 9 4304101 or email:medical.coord@nhl.co.nz (PA 843)
Email: medical.coord@nhl.co.nz
Website: http://www.northlanddhb.org.nz

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