common SENSE

VOLUME 15, ISSUE 4
JULY/AUGUST 2008

FAAEM
always means board certified

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

INSIDE THIS ISSUE

PRESIDENT'S MESSAGE

TORT REFORM: OUR PERMANENT ISSUE

Larry D. Weiss, MD JD FAAEM

Predictably, the subject of tort reform receded from the media spotlight when the democrats became the majority party in Congress. Although organized medicine cannot continue to place tort reform at the top of its national lobbying agenda at this time, it remains an important issue in state legislatures. Furthermore, beyond the necessity of lobbying legislatures, organized medicine has a duty to explain this issue to our patients and the general public.

Reform of our reckless tort system remains an absolute necessity for the future vitality of the medical profession. Most emergency physicians work 2-3 months per year to pay their malpractice insurance premiums and to continue feeding the litigation industry. This industry generates a tidal wave of litigation against physicians, with more than 80% of all cases having no basis in fact.[1] Furthermore, the ability of a plaintiff to recover damages has no correlation with fault.[2] The ability to recover damages only correlates with the presence of an injury. This evidence proves that we have a broken tort system. We must look to state legislatures to provide relief.

According to the Tenth Amendment to the U.S. Constitution, states have the power to legislate in the area of healthcare. We have federal healthcare laws largely because of Congress' spending powers. Because Congress now pays for more than 40% of all healthcare in our country, it has the power to make many of the rules relating to federal healthcare programs. The Federal Department of Health and Human Services issues healthcare regulations through power delegated to it by Congress. These powers exist as exceptions to the general rule that states primarily legislate in the area of healthcare.

Thus, we should turn our attention to the states in our effort to improve our tort system. For many years, legal commentators cited California's Medical Injury Compensation Reform Act of 1975 (MICRA) as a model for state medical liability reforms.[3] MICRA limits liability for non-economic damages to $250,000 in medical malpractice cases, allows defendants to inform juries of other means of recovery available to plaintiffs (collateral source rule), places limits on attorney fees, requires a 90 day notice before filing professional negligence suits, shortens the statute of limitations, provides for periodic payment of damages and allows patients and healthcare providers to agree to binding arbitration. MICRA resulted in significantly lower insurance premiums compared with similarly situated states.

Now, the 2003 reforms in Texas may serve as the ultimate model for state tort reform coalitions. Texans first passed an amendment to their state constitution allowing their proposed reforms.[4] This prevented the plaintiff bar from carrying out their

continued on page 4

You Simply Never Know

EDITOR'S LETTER

by David Kramer, MD FAAEM

When I was a resident in the early '80s, it was called "networking" and "making connections." Those of us involved in resident education understand that we are part and parcel of "systems-based practice," "interpersonal and communication skills" and "professionalism." There is a very good reason why these are three of the ACGME's Core Competencies. They are the bread and butter of becoming a successful practitioner in any specialty. As I complete my 20th year as a residency program director, I am forever thankful to my former program director and mentor, Judy Tintinalli, MD FAAEM, for teaching me these skills long before anyone had heard of core competencies. The networking I have done and the connections I have made have opened many doors and enabled me to participate in our specialty in ways I had only dreamed of as a resident.

This, of course, brings me to our rapidly approaching AAEM Scientific Assembly. Sure, the speakers will be great. Certainly the venue will be excellent. But I'd like you to think about the great networking opportunities that will present themselves in Phoenix. This will be a wonderful chance for you to expand your horizons, get involved, make connections and schmooze with leaders. In many ways, our national meetings are the golf courses of emergency medicine. For the younger members, this is the stuff that careers are made of. So put in your schedule requests early and get out to our 15th Annual Scientific Assembly on March 2-4, 2009. Your career just might take a giant step. A terrific opportunity might present itself. You simply never know.

I look forward to seeing all of you there.

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 are no longer ABEM or AOBEM certified in EM)
International Member: $125 (Non-voting status)
AAEM/RSA Member: $50 (voting in AAEM/RSA elections only)
Student Member: $50 (voting in AAEM/RSA elections only)
*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.

Recognition Given to Foundation Donors

William T. Durkin, Jr., MD FAAEM
Secretary/Treasurer

At its most recent meeting, the board of directors agreed to establish levels of recognition to those who donate to the AAEM Foundation. The Academy has long recognized those who contributed in the areas of teaching and leadership. In this way, we recognize those who provide financial support.

AAEM established its Foundation for the purposes of (1) studying and providing education relating to the access and availability of emergency medical care, and (2) defending the rights of patients to receive such care, and emergency physicians to provide such care. The latter purpose may include providing financial support for litigation to further these objectives. The Foundation will limit financial support to cases involving physician practice rights and cases involving a broad public interest. Contributions to the Foundation are tax deductible.

The information below includes a list of the different levels of contributions. The Foundation will list contributors on a calendar year basis. For those who give over a several month period, the total amount given as of the end of the year will determine their final category of giving. Members and friends may also contribute anonymously.

AAEM FOUNDATION LEVELS OF GIVING

$15,000 or more – Leadership Circle
Donors at this level receive display recognition on the AAEM website and a full page recognition in each issue of *Common Sense* for the calendar year and are entitled to use "AAEM Foundation Leadership Circle" in their own advertisements. Those at the Leadership Circle level will also be entitled to a booth at the annual AAEM Scientific Assembly and a table (eight seats) and recognition at the annual AAEM Foundation Dinner held during the Scientific Assembly.

$10,000 – President's Circle
Donors at this level receive display recognition on the AAEM website and a half page recognition in each issue of *Common Sense* for the calendar year. President's Circle members will be entitled to a table (six seats) and recognition at the annual AAEM Foundation Dinner held during the Scientific Assembly.

$5,000 – Sponsor
Donors at this level will receive recognition on the AAEM website and a quarter page recognition in each issue of *Common Sense* for the calendar year. Sponsors will receive four seats at the annual AAEM Foundation Dinner held during the Scientific Assembly.

$2,500 – Benefactor
Donors at this level will receive recognition on the AAEM website and a quarter page recognition in one issue of *Common Sense*. Benefactors will receive four seats at the annual AAEM Foundation Dinner held during the Scientific Assembly.

$1,000 – Member
Donors at this level will receive recognition on the AAEM website and in one issue of *Common Sense*. Members at this level will receive two seats at the annual AAEM Foundation Dinner held during the Scientific Assembly.

$500 – Donor
Donors at this level will receive recognition on the AAEM website and in one issue of *Common Sense*. Donors will receive one seat at the annual AAEM Foundation Dinner held during the Scientific Assembly.

$Less than $500 – Contributor
Donors at this level will receive recognition on the AAEM website and in one issue of *Common Sense*.

This is a way to recognize those who choose to support the Foundation. Anyone wishing to remain anonymous may do so. The suggested levels above are shown with the minimum contribution for each category. Levels are determined annually based upon a calendar year.

President's Message - continued from page 1

routine of challenging the constitutionality of tort reforms in state courts. The Texas reforms provided for a $750,000 cap on non-economic damages, product liability reform and changes to punitive damage and strict liability laws.[5] At least five insurance companies significantly decreased the cost of premiums in Texas within the first two years after enactment of the Texas reforms. By 2005, the volume of malpractice suits in Harris County (Houston) dropped to 50% of the 2001-2002 level.[6] This resulted in a net gain of 689 physicians, or 8.4%, in Harris County during that period of time.

In 2005, the AAEM board of directors approved the AAEM White Paper on Tort Reform.[7] This paper describes both an immediate and long term strategy to changing our tort system. The immediate strategy intends to stem the hemorrhage, while the long term strategy aims to stop the cause of bleeding. Short term reforms include caps on awards to plaintiffs, decreasing the statutes of limitations (the time during which a plaintiff must file suit), screening panels for medical malpractice suits, eliminating the collateral source rule, periodic payment of damages, limiting punitive damages and making such damages payable to the state.

However necessary, many of these short term reforms limit patient rights and are not narrowly tailored toward the causes of the liability crisis. Therefore, AAEM prefers to focus on long term changes, narrowly tailored to the causes of the liability crisis, bringing profound changes to our tort system and significant relief to society. Only the U.S. has a liability crisis because we have the world's most aberrant tort system and more than 75% of the world's attorneys.

The aberrant qualities of our tort system lead to aggressive, and even reckless, litigation, much of which is groundless, distorting our economy and draining valuable resources from more productive sectors of society. Thus, instead of reforming our tort system in ways that may limit patient rights, we should focus our efforts on the primary cause of our liability crisis: attorney behavior.

Some American practices that exist almost nowhere else in the world include contingency fees, whereby a plaintiff attorney gets a percentage of their clients' winnings, and the "American Rule," whereby each party in a civil suit pays its own attorney fees and court costs. Most countries follow the "English Rule," where the loser pays everyone's attorney fees and court costs. Banning contingency fees and adopting the "English Rule" would go a long way toward limiting groundless litigation.

Other proposed reforms would eliminate an ever-expanding list of new tort actions, including negligent infliction of emotional distress, bystander emotional distress, expanded third party liability and special circumstances (e.g., fear of cancer, fear of AIDS). The "lost chance" doctrine perhaps represents the most pernicious example of a new tort action resulting in expanded liability. Here, a plaintiff only has to prove loss of a chance of a better outcome.

AAEM also supports the right of a defendant to countersue plaintiffs and their attorneys for negligent institution of a lawsuit. Currently, in every state, a defendant must prove malice to file such a countersuit. Other reforms supported by AAEM include measures to increase expert witness accountability and the creation of administrative health courts to replace the current jury system in medical malpractice cases.

We may not achieve any of our proposed long term reforms in the near future, nor should we attempt to place them on a lobbying agenda at this time. However, lobbying should not be our only strategy. Education of the public has great value and has the potential to influence our political process in a more profound manner.

AAEM has an active tort reform committee, chaired by our Vice President, Howard Blumstein. I encourage any interested member to apply for membership on this committee by contacting our home office at info@aaem.org. Of course, no specialty society acting alone can change our tort system. I strongly encourage you to join the American Medical Association and your state and county medical societies. We have much greater strength when acting together with our medical colleagues.

Finally, I recommend membership in the American Tort Reform Association. By visiting their website at www.atra.org, you will learn about state tort reform coalitions. These coalitions link physicians with other victims of our unfair tort system including other professionals, small business people, large corporations, school districts, insurance companies and countless other sectors of our economy damaged by the litigation industry. When physicians from all specialties join forces with the many other people involved in state tort reform coalitions, successful tort reform in states will become an irresistible force. Significant tort reforms in California, Texas, Louisiana, Mississippi and a growing list of other states prove the fact that the plaintiff bar cannot prevail over common sense forever.

1 New Engl J Med 1991; 325:245-251
2 New Engl J Med 1996; 335:1963-1967
3 MICRA, codified at Cal. Civ. Code 3333.1, 3333.2; Cal. Bus. Prof. Code 6146; Cal. Code Civ. Proc. 340.5, 364, 365, 667.7, 1295.
4 Texas Proposition 12 (2003).
5 Texas H.B. 4 (2003).
6 Houston Chronicle, May 17, 2005.
7 Weiss LD, Li J. The AAEM white paper on tort reform. J Emerg Med 2006; 30:473-475.

Conference travel got you down?

Introducing...

CMEDOWNLOAD.COM ACCESS PASS

new! iPhone compatible!

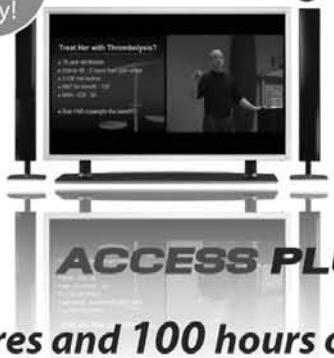
Downloadable audio & video lectures with CME are just a click away...

View FREE FULL LECTURES and ORDER NOW at www.cmedownload.com.

ACCESS PASS	$295.00* (Limited time only!)
Access from anywhere	✓
Over 500 lectures	✓
Over 120 hours of CME	✓
Downloadable video lectures	✓
Downloadable audio mp3s	✓
PDF syllabi	✓
Video iPod versions	✓

Prefer the big screen TV?

Add a *monthly* 90 minute DVD for just $100 more!



Both plans include over 500 lectures and 100 hours of CME.

What our users say:

"This is by far the best CME ever!"

"I think it is a great idea that I can now ... attend a conference in the USA in my own time at my own desk! A great innovation! Congratulations!"

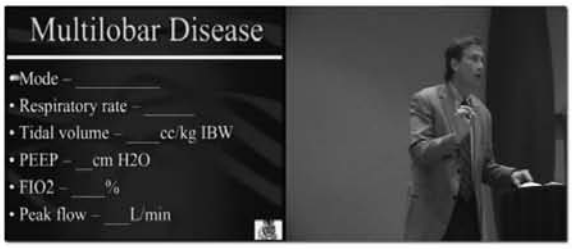
"Love the lectures with presenter on one side and the slides on the other. Feels like I am actually there."

Featured Content!

UCSF High Risk EM
Resuscitation
Cedars-Sinai Symposium
Procedure Course
EKG Workshop
Office Based Emergencies
Airway and Sedation
USC Essentials
EMRAPTV
Ultrasound
USC Trauma and Critical Care
Pediatrics
SoundBytes
International Conferences

The most online content in Emergency Medicine!

Widescreen Format!



Email info@cmedownload.com for group subscriptions.

** limited time introductory pricing.*

Upcoming AAEM–Endorsed or AAEM–Sponsored Conferences for 2008 & 2009

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

July 31-August 3, 2008
- High Altitude Medicine Course (Mt. Rainier, Washington)
  Ashford, Washington
  www.mmmedicine.com

September 18-19, 2008
- New York BEEM (The Best Evidence in Emergency Medicine)
  New York, NY
  www.beemcourse.com or NYAAEM@aaem.org

September 20-21, 2008
- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Los Angeles, Orlando, Philadelphia
  www.aaem.org

September 25-28, 2008
- AAEM Written Board Review Course
  Newark, New Jersey
  www.aaem.org

October 10-12, 2008
- The Difficult Airway Course-Emergency™
  Las Vegas, NV
  www.theairwaysite.com

October 13-15, 2008
- The Heart Course-Emergency™
  Las Vegas, NV
  http://www.theheartcourse.com/

November 10-12, 2008
- SunBEEM (The Best Evidence in Emergency Medicine)
  Mayan Riviera, Mexico
  www.beemcourse.com

November 14-16, 2008
- The Difficult Airway Course-Emergency™
  Atlanta, GA
  www.theairwaysite.com

November 19-22, 2008
- II World Congress in Emergency and Disasters
  Cancun, Mexico
  www.urgenciasmexico.org

December 7-12, 2008
- Maui 2008: Current Concepts in Emergency Care
  Maui, Hawaii
  www.ieme.com

January 5-8, 2009
- Carribean Emergency Medicine Congress (CEMC)©
  Barbados
  www.aaem.org

January 26-28, 2009
- SkiBEEM (The Best Evidence in Emergency Medicine)
  Silver Star Ski Resort, BC, Canada
  www.beemcourse.com

February 20-22, 2009
- The Difficult Airway Course-Emergency™
  Huntington Beach, CA
  http://www.theairwaysite.com

March 2-4, 2009
- 15th Annual AAEM Scientific Assembly
  Phoenix, AZ
  www.aaem.org

March 12-14, 2009
- The Difficult Airway Course-Emergency™
  Miami, FL
  http://www.theairwaysite.com

April 1-2, 2009
- AAEM Pearls of Wisdom Oral Board Review Course
  Las Vegas
  www.aaem.org

April 25-26, 2009
- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Los Angeles, Orlando, Philadelphia
  www.aaem.org

June 5-7, 2009
- The Difficult Airway Course-Emergency™
  Boston, MA
  http://www.theairwaysite.com

September 14-17, 2009
- The Fifth Mediterranean Emergency Medicine Congress (MEMC V)
  Valencia, Spain
  www.emcongress.org

September 18-20, 2009
- The Difficult Airway Course-Emergency™
  Chicago, IL
  http://www.theairwaysite.com

October 14-15, 2009
- AAEM Pearls of Wisdom Oral Board Review Course
  Las Vegas
  www.aaem.org

October 17-18, 2009
- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Los Angeles, Orlando, Philadelphia
  www.aaem.org

October 23-25, 2009
- The Difficult Airway Course-Emergency™
  Las Vegas, NV
  http://www.theairwaysite.com

November 13-15, 2009
- The Difficult Airway Course-Emergency™
  Atlanta, GA
  http://www.theairwaysite.com

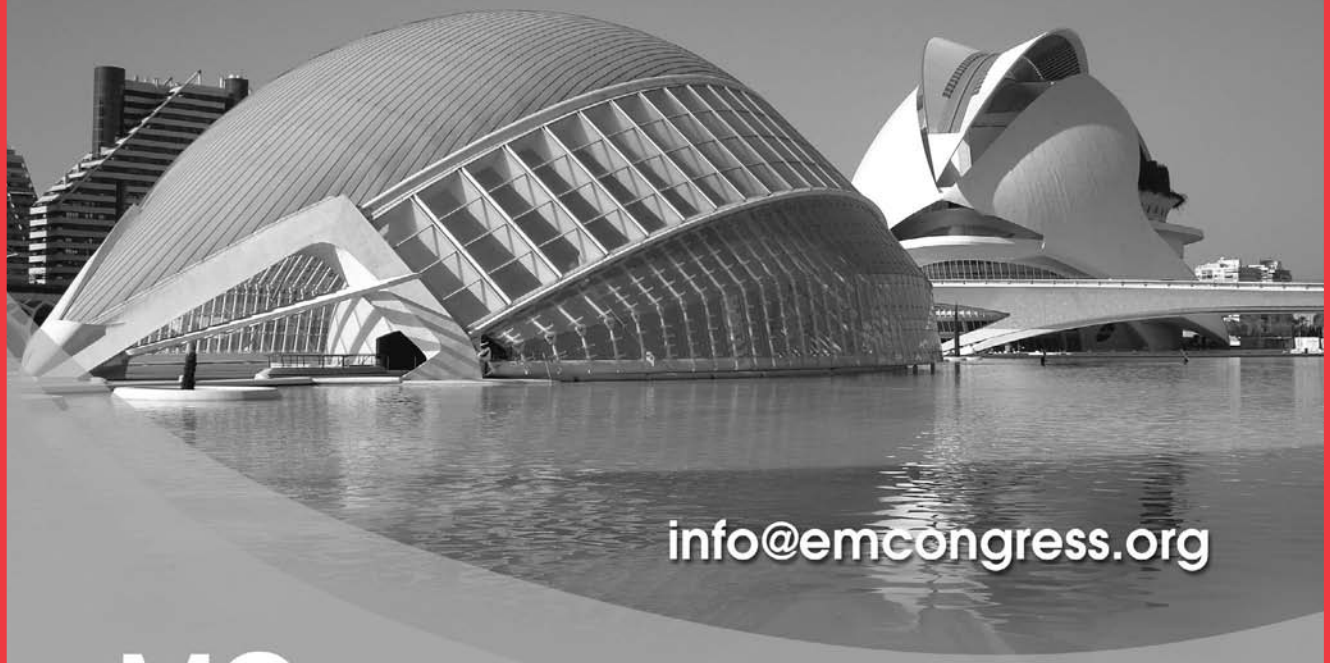
Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Kate Filipiak to learn more about the AAEM endorsement approval process: kfilipiak@aaem.org.

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

Save the Date

for the Fifth Mediterranean Emergency Medicine Congress

MEMC *Valencia*, Spain
14-17 September **2009**



info@emcongress.org

MEMC
MEDITERRANEAN
EMERGENCY MEDICINE CONGRESS

European Society for Emergency Medicine
American Academy of Emergency Medicine

Going Green

In 2007, in Sorrento, Italy, we had more than 1500 delegates from 72 nations and over 1000 abstracts presented. Do not miss it!

AAEM Endorses "Save Medicare Act 2008"

Kathleen Ream,
Director of Government Affairs

In an April 22 letter from President Larry D. Weiss, AAEM endorsed S. 2785, the *Save Medicare Act of 2008*. Introduced by Senator Debbie Stabenow (D-MI) on March 13, 2008, S. 2785 would replace cuts totaling more than 15% with positive Medicare physician payment updates from July 1, 2008, through December 31, 2009. Stabenow's bill – with 17 cosponsors – is currently under consideration by the Senate Finance Committee.

In his letter, Dr. Weiss applauded Stabenow's leadership ". . . in introducing critical legislation that would protect patients' access to care by preserving the Medicare program and warding off steep pending cuts in physician payment rates that threaten access for our senior and disabled patients." He went on to say that "AAEM supports a permanent correction to the SGR that links physician payment to the real costs of healthcare."

Grants to Help Improve Access to Primary Care
The Centers for Medicare and Medicaid Services (CMS) recently awarded grants of $50 million to 20 states to help improve access to primary medical care so that Medicaid beneficiaries could avoid improper use of hospital EDs.

Created by the Deficit Reduction Act of 2005 (DRA), these grants will help Medicaid programs fund local and rural initiatives to provide alternative healthcare settings for individuals with non-emergent medical needs.

Grantees will use the funds to:
- Establish new community health centers;
- Extend the hours of operation at existing clinics;
- Educate beneficiaries about new services; and
- Provide for electronic health information exchange between facilities for better coordination of care.

States receiving grant funds under this program are Colorado, Connecticut, Georgia, Illinois, Indiana, Louisiana, Massachusetts, Maryland, Michigan, Missouri, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah and Washington. These awards help align Medicaid efforts with Medicare's value-based purchasing strategies, also designed to avoid unnecessary ED visits through improved physician care and strategies to decrease re-admissions.

For more information on the grants, including the proposals and the amount each program will receive, go to http://www.cms.hhs.gov/GrantsAlternaNonEmergServ/

TN Medical Malpractice Bill Signed by Governor
Legislation aimed at preventing frivolous medical malpractice lawsuits in Tennessee – S.B. 2001 – was signed into law on May 15, 2008, by Governor Phil Bredesen (D). The measure, which becomes effective October 1, 2008, requires those asserting a medical negligence claim to provide a 60-day notice to providers against whom such allegations are made prior to filing a lawsuit. That notice would not apply to providers made party to the action after the filing of the complaint as a result of a defendant alleging comparative fault.

The new law also requires plaintiffs or their attorneys filing a medical malpractice claim requiring expert testimony to file a certificate of good faith within 90 days of the filing. Such certificates must state that a competent expert medical witness has been consulted and has provided a signed statement that expresses a professional belief that there is a good-faith basis to maintain the lawsuit. In addition, the measure requires the provision of "complete and unaltered copies" of the claimant's medical records within 30 days of receipt of a written request.

Both the Tennessee Medical Association (TMA) and the Tennessee Association for Justice (formerly the Tennessee Trial Lawyers Association) came out in support of the measure. "This legislation is an important step toward improving Tennessee's liability environment by addressing the significant problem of meritless lawsuits," said F. Michael Minch, Chairman of the TMA Board of Trustees. "By cutting down on the glut of lawsuits and the associated costs that clog our state's legal system, we will see a reduction in the cost of providing patient care and help Tennessee become a more attractive state to live and work for physicians in years to come." Daniel Clayton, President-elect of the Tennessee Association for Justice, stated that, "It will help eliminate, or at least significantly reduce the number of lawsuits which never should have been filed . . . although the bill is not perfect, it should accomplish its purpose."

EMTALA Round Up

Liability under EMTALA Ends at Admission
On March 24, 2008, the U.S. District Court for the Eastern District of Tennessee issued its decision determining that the potential liability under EMTALA "ends when a hospital admits in good faith a patient as an inpatient" (Anderson v. Kindred Hospital, E.D. Tenn., No. 1:05-cv-294, 3/24/08).

The Facts
Cora Cameron, now deceased, was admitted to Defendant Kindred Hospital for hemodialysis and rehabilitation. There was no dispute among the parties (i.e., Defendant and Cameron's daughters who are the Plaintiffs) that Cameron was relatively stable at admission. However, after 17 days as an inpatient, Cameron developed an emergent condition. After Kindred Hospital informed Plaintiffs that it was unable to perform dialysis on Cameron until the following day, "Plaintiffs . . . demanded that [Decedent] be taken by ambulance to Memorial Hospital for [immediate] stabilization and dialysis. An order for transportation was obtained," and Cameron was transported to the other facility. Plaintiffs filed a complaint against Kindred arguing that while EMTALA's screening and stabilization requirements apply to an "individual [who] . . . comes to a hospital," EMTALA's transfer regulation applies to all persons at the hospital, regardless of whether they have been admitted as

continued on page 10

Save The Date

Cancun
Mexico
Excitement
=
Continuing
Medical
Education

19-22 November 2008

World Congress in Emergency Medicine and Disasters

- Medicine, trauma, procedures, disaster management, prehospital care, and other updates
- Preconference sessions include EKG workshop with Richard Harrigan, 2008 LLSA with Joe Lex

✓ Jointly sponsored by AAEM
✓ More than 20 hours *AMA PRA category 1 credits*™
✓ Time to explore the Mexican Riviera
✓ Details at www.urgenciasmexico.org/cancuneng.doc

Washington Watch - continued from page 8

inpatients. Defendant moved for summary judgment on the EMTALA claim, which is the motion discussed in this case.

The Ruling

To identify EMTALA's liability boundaries, this court examined the U.S. Congress's intent for EMTALA. It also examined the regulations, promulgated by the Department of Health and Human Services (DHHS) to implement EMTALA, that state that "[i]f the hospital admits the individual as an inpatient [in good faith] for further treatment, the hospital's obligation under [the EMTALA] ends . . ."

In light of the construction of the EMTALA statute, the court determined that Plaintiff's argument failed and found that EMTALA provisions "are to be read together, creating only a single duty on the part of the hospital to stabilize patients who have emergency medical conditions before they may be transferred." The court concluded that DHHS's regulation at issue "is fully compatible with the purpose, as well as the text, of the EMTALA . . . to prevent 'patient dumping,' . . . [and that] EMTALA "was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence." Rather, the court affirmed that an EMTALA claim is not a substitute for a state law medical malpractice action. Thus, while the court granted Defendant's motion for summary judgment as to Plaintiffs' EMTALA claim, it declined to exercise jurisdiction over the remaining state-law claims.

To read the opinion, go to http://op.bna.com/hl.nsf/r?Open=mapi-7d5pmh.

Sufficient Claim for Failure to Screen Allows Case to Proceed

On April 8, 2008, the U.S. District Court for the Eastern District of California issued an order refusing to dismiss a claim for failure to screen for an emergency medical condition under EMTALA. The order was based on the court's determination in its screening of the complaint that the claim of an EMTALA violation was sufficiently alleged (Tater-Alexander v. Amerjan, E.D. Cal., No. 1:08-cv-00372, 4/8/08).

The Plaintiff's Facts as Alleged

Plaintiff Michael Tater-Alexander alleged that he visited the Defendant Clovis Community Medical Center ED seeking emergency medical services for "great pain, extreme abdominal pressure and inability to eat or drink." Plaintiff alleged that his condition involving a pancreatic cyst that required draining was made known to Defendant. Tater-Alexander also alleged that performing blood tests and the eventual administering of an IV for draining the cyst, 10 to 12 hours after Plaintiff's presentation in the ED, contributed to Plaintiff's ultimately suffering physical and emotional injury, including permanent organ failure.

Plaintiff sought damages and injunctive relief claiming that Defendant's delayed treatment violated EMTALA's screening requirement that the examination must be comparable to that offered to other patients with similar symptoms. Tater-Alexander further contended that the delay in treatment constituted an "examination so cursory that it was not designed to identify acute and severe symptoms that alert a physician to the need for immediate medical attention to prevent serious bodily injury; the hospital failed to provide screening to diagnose an emergency medical condition."

To support this conclusion, Plaintiff alleged that Defendant hospital delayed because Tater-Alexander "refused staff requests to wear a hospital gown because he needed and wanted to remain warm in his sweat clothes due to a physical condition that caused extreme pain when he was cold." But Plaintiff also argued that "on that occasion and on two other occasions, Defendant hospital staff had no trouble checking his vitals or recording pain intensity while Plaintiff was wearing street clothes. Plaintiff then concluded that, "the requirement of wearing a hospital gown was only the personal preference of Defendants, that failure to wear a gown did not in any way hinder or prevent an appropriate screening and that Defendants intentionally failed to diagnose his condition."

The Ruling

Reviewing the EMTALA statute and case precedent, the federal court noted that evidence that a hospital did not follow its own screening procedures can support a finding of EMTALA liability for disparate treatment. So although many inferences were possible in the procedures for screening the claim, the court must resolve all doubts in the Plaintiff's favor. The court found that "Plaintiff stated a claim of refusal on the part of Defendants to screen as distinct from a voluntary refusal on Plaintiff's part to consent to treatment." The court then concluded that Plaintiff sufficiently stated a claim – of a failure to screen for an emergency medical condition by Defendant hospital pursuant to EMTALA – as a basis for jurisdiction in the federal court.

See the court's order at http://op.bna.com/hl.nsf/r?Open=psts-7dlmr2.

No EMTALA Liability for Inadequacy in Screening Leading to Injury

The U.S. District Court for the Eastern District of California decided on April 10, 2008, to grant Defendant Memorial Medical Center (MMC) summary judgment on Plaintiff Donna Hoffman's EMTALA claims. Hoffman alleged injury caused by MMC's inadequate screening or by treatment she received, or by any departure from standard hospital screening protocols (Hoffman v. Tonnemacher, E.D. Cal., No. 1:04-cv-5714, 4/10/08).

The Facts

On May 22, 2003, Hoffman arrived at MMC's ED where she was examined by Dr. Kent Tonnemacher and diagnosed as having bronchitis with a differential diagnosis of pneumonia. Hoffman was discharged the same day with antibiotics because Tonnemacher had not been able to rule out a bacterial process. Less than 24 hours later, Hoffman returned to MMC in an ambulance and went into shock with systemic inflammatory

continued on page 12

Certificate of Excellence in Emergency Department Workplace Fairness

The American Academy of Emergency Medicine strongly supports fair working practices for emergency physicians. Consequently, it will certify excellence in the ED workplace if ED physician employees are guaranteed the following five workplace conditions:

- A reasonable due process policy.
- A reasonable policy of financial transparency that protects physicians against financial exploitation.
- A reasonable policy of financial equity that allows physicians to share in the department's profits.
- A reasonable policy of political equity that allows physicians to improve their own working conditions.
- Employment arrangements that do not impose post-contractual restrictions.

FAAEM
always means
board certified

The Academy recognizes the existence of many different emergency department business models. The following examples are provided as guidelines that comply with the principles outlined above. These guidelines are not absolute, but reflect the spirit of fairness encouraged by the Academy. Thus, any group that believes it meets conditions for fairness is encouraged to submit an application for a certificate of excellence. Applications will be reviewed by the Academy. Departments that are deemed to fall outside fairness criteria will be provided direct feedback and given ample opportunity to reapply. 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.

Principle	Examples of fair employment practices
Due process	Unilateral termination without cause and without rights defined in the medical staff bylaws is acceptable only during a provisional period of employment, not to exceed one year. Termination with cause requires a fair hearing upon request of the terminated physician.
Financial transparency	Partners are automatically provided information on total group charges, collections, management, and operational expenses, and other group income distribution on at least a quarterly basis.
Financial equity	For democratic groups, full partnership opportunities are available through a predefined process that does not exceed three years. Share distribution among partners is transparent.
Political equity	Governance procedures are published, with processes for election of leadership and partners, appointment of medical directors and administrators, and bylaws amendments.
Political equity	Practicing physicians must make all practice decisions (including those involving hiring, firing, staffing levels, and clinical processes) and have a primary fiduciary responsibility to their patients, not to a corporate entity or shareholders. No layperson (defined as a non-physician or non-practicing physician) can have a commercial interest in the practice or the right to control the professional judgment of any practicing physician. No layperson may be a corporate officer or director or occupy a position of similar control. Physician employment by hospitals or non-profit entities is permissible when in accordance with state law.
No post-contractual restrictions	Non-compete or similar clauses that affect where a physician may work upon leaving the group or upon group turnover are not conditions of employment.

Name _____

Signature _____

Title _____

Phone _____

Email _____

Hospital/Group Name _____

Address _____

City _____

State _____ Zip _____

☐ I verify that I am a current AAEM member

Washington Watch - continued from page 10

response syndrome (SIRS). Hoffman was hospitalized for several weeks while suffering severe physical damage. A year later, Hoffman filed complaints against MMC and Tonnemacher for EMTALA violations and for California law medical malpractice.

Summary judgment was granted to MMC on two of Plaintiff's inadequate screening theories and on her failure to stabilize theory, but not on the complaint stemming from Tonnemacher's alleged failure to follow the hospital's EMTALA policy. The case then proceeded to trial, resulting in a mistrial. In post trial motions, and based on the Court's concerns regarding causation testimony at trial, MMC was allowed to file a second motion for summary judgment on the issue of causation.

In this second motion, MMC contended that summary judgment was appropriate because Plaintiff could not establish that her injuries were a direct result of an EMTALA violation. Plaintiff argued that the administration of certain tests (e.g., a CBC, blood sedimentation, CT scan, prophylactic intravenous antibiotics) would have allowed Tonnemacher to rule in a bacterial infection, leading him "to administer early goal directed therapy, which would have prevented SIRS and all sequelae from manifesting."

The Ruling

Referring first to the law, the court stated, "EMTALA imposes two duties on hospital emergency rooms: a duty to screen a patient for an emergency medical condition, and, once an emergency condition is found, a duty to stabilize the patient before transferring or discharging him." A hospital provides an "appropriate medical screening" when it conducts "an examination comparable to the one offered to other patients presenting similar symptoms."

Expert testimony had "created a triable issue of fact concerning MMC's EMTALA policy . . . [requiring] a physician to rule in or rule out an emergency medical condition." Experts testified that only a blood culture, for which results are slow-developing, could rule in the bacterial infection. Plaintiff countered with experts who stated that "an accepted way to treat early sepsis in the ED is to obtain blood cultures and, although the results are not available, start performing early intervention therapy or 'prophylactic therapy' or early goal directed therapy." The court noted that "administering prophylactic antibiotics or beginning early goal directed therapy prophylactically is not part of a medical screening, rather it is . . . protective treatment that is done before a condition is ruled in or ruled out." "The failure to provide prophylactic treatment is not a failure to screen or a disparate screening," wrote the court.

Since Tonnemacher did not diagnose sepsis, the court stated that "in following MMC's EMTALA policy, there needs to be testimony about which test results would have changed Dr. Tonnemacher's diagnosis from viral bronchitis to sepsis/bacterial infection in the bloodstream such that Dr. Tonnemacher would have then treated that condition with early goal directed therapy." A complicating factor crucial to the court decision was that Hoffman had a narrow 6-hour window in which early goal directed therapy may have been instituted before Hoffman's clinical course could have become inalterable. In this case, the 6-hour window to successfully commence early goal directed therapy began about the time Hoffman came to the ED on May 22. In its ruling, the district court referred to the final expert analysis that "of the screening tools available to Tonnemacher, none would have identified/ruled in or ruled out Hoffman's bacterial infection until after the 6 hour window for administering early goal directed therapy had expired."

Thus, the court found a failure of Plaintiff to prove causation, to the extent that "Tonnemacher's failure to rule in or rule out a bacterial infection as required by MMC's EMTALA policy during the May 22 presentation did not cause Hoffman harm." Summary judgment was appropriate, and although there were no EMTALA violations, the court suggested that state malpractice law may be implicated.

See the court's decision at http://op.bna.com/hl.nsf/r?Open=psts-7dsm6x.

Welcome to our newest 100% Residency Programs!

- Baystate Medical Center
- Louisiana State University – Baton Rouge
- Louisiana State University – Shreveport
- Johns Hopkins University
- St. Luke's Hospital-Bethlehem
- University of California San Francisco
- The Brooklyn Hospital Center

To sign your program up for 100% membership, please email info@aaemrsa.org

Elections for the 2008 Uniformed Services Chapter of AAEM (USAAEM) were held in June.

NEWLY ELECTED BOARD MEMBERS INCLUDE:

President – CDR John Love, MD FAAEM
Vice President – LTC Sean Keenan, MD FAAEM
Secretary/Treasurer – CPT Michael Dickerson, MD
Resident Representative – CPT Eric Tomich, MD
Student Representative – Andrew Feldman

They will be joining continuing board members:
Immediate Past President – LCDR Joel Schofer, MD FAAEM
Air Force Representative – Nurani Kester, MD FAAEM
Retired/Reservist Representative – COL Daniel Dire, MD FAAEM
AAEM BOD Liaison – William T. Durkin, MD FAAEM

Emergency Medicine in Beirut

Joseph Lex, MD FAAEM

Okay, so I'll admit it. Pretty much everything I imagined about Beirut is wrong. It is an absolutely gorgeous, sophisticated city on the Mediterranean with a semi-tropical climate, surrounded by some of the prettiest mountains I have ever seen, covered with the famed cedars. True, there are areas which can be seen as third-world or "developing," but – excepting Arabic script – it's pretty much like any other world-class tourist city. That includes traffic jams, aggressive drivers, crazy motorcyclists and the occasional daredevil pedestrian.

I had decided to visit a few months earlier when I was invited to speak at a Critical Care meeting in Athens, followed by a site visit for the 2013 Mediterranean Emergency Medicine Congress on the Island of Kos, home of Hippocrates and location of the world's first "hospital," the Temple of Asklepios and Hygeia. I flew from Kos to Athens to Istanbul to Beirut on Wednesday and arrived - on a full flight - at 01:30. So naturally, the first thing former AAEM President Amin Antoine Nabih Kazzi did was take me on a tour of the city and then to a late-night sidewalk café. It took a little getting used to, riding around at night on streets patrolled by fully-uniformed, fully armed (AK-47) members of the military. We ate traditional Lebanese food with a few dozen other diners, many of whom were sharing the traditional after-dinner water pipe provided by the restaurant. We left at 3 am and he dropped me off at a very modern hotel near the American University, where I flopped into bed exhausted. Thursday, starting at 10 am, I gave three talks, followed by a lunch break, followed by three more talks starting at 5 pm. There were several attending physicians and department chairs present, all of whom spoke perfect English and most of whom trained in the United States. In the three years since he returned to Lebanon, Antoine has done a spectacular job establishing a full department of emergency medicine at the American University of Beirut Hospital. My residents would feel right at home there, what with the triage system, computerized physician order entry, and even electronic tracking. They'd also feel at home because he received 41 casualties (militiamen and civilians), seven of them mortally injured, in 14 hours during the first day of the recent flare-up of violence.

Some apparent remnants of the troubles a few weeks ago are many black marks on the roads where burning tires had been used as roadblocks. There are also good-sized holes in many of the buildings from Rocket Propelled Grenades (RPGs) and small arms fire. During the Civil War, the Holiday Inn seemed to be hit particularly hard, and it remains standing. There is also a beautiful monument at the site of the car bombing a few years ago that killed former Lebanese Prime Minister Rafiq Hariri and several dozen other people. The building where that atrocity occurred is still a hollowed shell (think Oklahoma City). Damage from earlier wars has not been repaired, so there is this amazing juxtaposition of Burger Kings and Givenchy stores and Hard Rock Cafes (there are two in Beirut) with empty lots, pock-marked buildings with partially collapsed roofs, and many other reminders of the troubles this area has seen in the past 40 years. My war in Viet Nam 40 years ago was completely different. I didn't receive casualties who had been huddled in a KFC, or who were picked off by snipers firing from an Office Depot.

On Friday, Antoine and I headed to Ain Wazein Hospital in the mountains outside of Beirut where he volunteers his time one shift weekly. Again, I was not sure what to expect. There were a few checkpoints as we left the city, with the car trunk examined by fully uniformed, fully armed soldiers, but then we were on a limited access four-lane highway until we turned onto a road leading up into the mountains. These narrow roads with hairpin turns have very poor signage and absolutely no guardrails. Antoine kept pointing out to me land owned by either him or his family, including some mountainside property with unbelievable views of the sea. I heard stories of battles that had occurred in these mountain villages, and we passed a memorial cemetery containing the bodies of more than 50 Druze just from this town alone who were killed in 1958. Even today, 50 years later, Druze elders stand watch at the entrance, and we had to show much respect and interest before they allowed us to explore. It helped that both Antoine and I had seen service in our respective militaries.

Finally, we arrived at a hospital on the side of a mountain, and what a revelation. This relatively small facility covers a catchment area of more than 400,000 people and is fully staffed with every specialty you can name, including neurosurgery and interventional radiology. This was their summer Emergency Medicine Symposium, and I was the only speaker. I spoke from 10:00 to 13:30, we took a break for lunch, and then I spoke again from 14:30 to 17:00. This was a new record for me - in a 36-hour period, I gave 12 hours of talks. The audience was incredibly perceptive with some penetrating questions showing they obviously followed the latest updates in medicine.

Afterwards, we went for coffee in an amazing restaurant carved into a hillside under a waterfall with hanging algae and vines you would have to see to believe. While Antoine chatted with the owner, I walked around admiring the view and found myself face-to-face with a small owl, which was perched under a ledge of stone about three feet away. We just stared at each other, but I think he blinked first. We then came to the Mir Amin Palace Hotel, which really was a palace until a few years ago. My room had arched doorways, 15-foot ceilings, huge windows overlooking the hills, etc. We went to dinner in the hotel restaurant, which overlooked a plaza being set up for a wedding. When I saw the camera on a 20-foot boom, I knew this would be no ordinary wedding, so we watched the opening festivities. Loud rhythmic music accompanied a group of five women and four men dancers who came down a sweeping staircase dressed in velvet, brocade and ermine-trim. These nine danced for several minutes, and then went back up the stairs

continued on page 17

REGISTRATION NOW OPEN

The American Academy of Emergency Medicine

Presents The

PEARLS OF WISDOM ORAL BOARD REVIEW COURSE

September 20-21, 2008

Chicago (full), Dallas, Los Angeles (full), Orlando and Philadelphia

To Register:

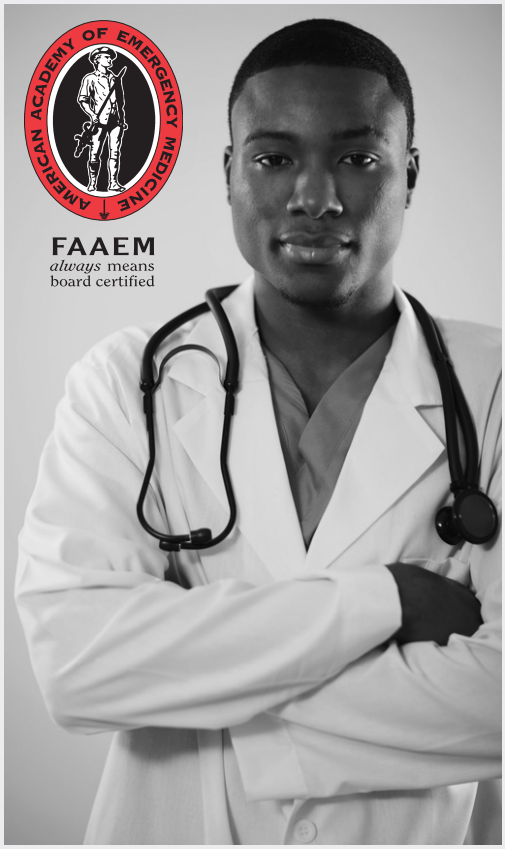
Please call: 800-884 2236 and ask for Stefanie Costello
Please note: There is no online registration.

Designed to meet the educational needs of Emergency Medicine practitioners preparing to take the ABEM or the AOBEM oral board examination.

BECOME A VOLUNTEER EXAMINER

For Future AAEM Oral Board Review Courses

For more information and online application, please go to
http://www.aaem.org/education/oralboard or
Call 800-884-2236 and ask for Tom Derenne

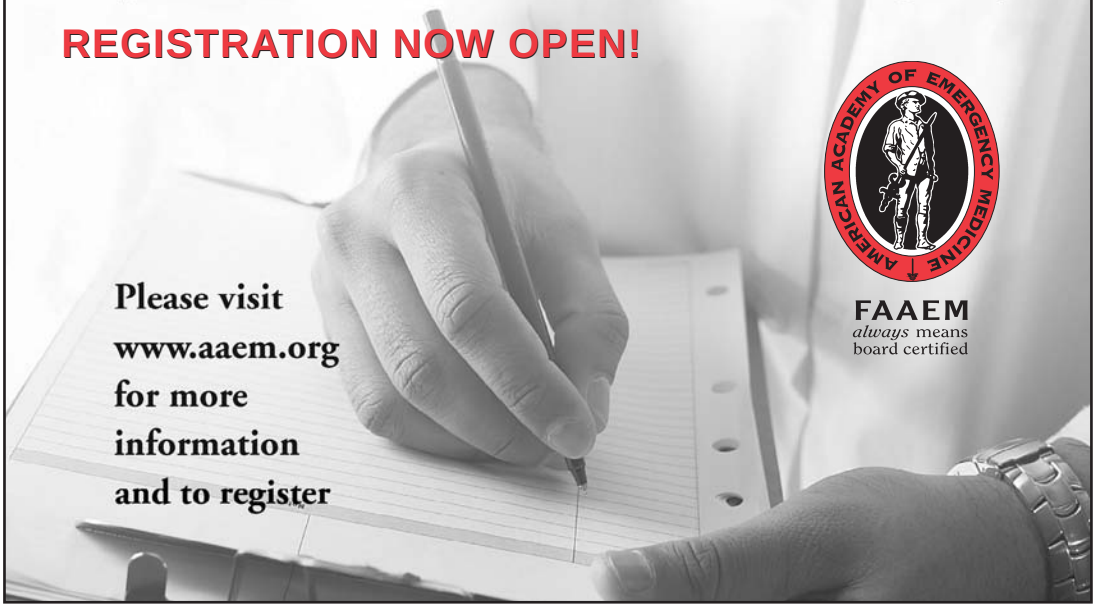


The AAEM Emergency Medicine Written Board Review Course

(Preparation for the Qualifying Exam and ConCert Exam)

September 25-28, 2008 • Newark, New Jersey

REGISTRATION NOW OPEN!



Physician Owned Insurance Company

EMPAC
RISK RETENTION GROUP

For Emergency Medicine Physicians

By Emergency Medicine Physicians

Professional Liability Insurance

EMPAC is a member-owned professional liability company. Control and interest are in the hands of Emergency Medicine physicians, and profitability is shared among insured members, not corporate shareholders.

ABEM and AOBEM Certification and Residency Training accompanied by state of the art risk management technology is the cornerstone of our mission.

- Claims Made Coverage
  Prior Acts Coverage Available
- In-Depth Underwriting
  By Active ED Physicians
- Aggressive Risk Management
  Personalized On-Site Visits
- Elite Member Insureds
  Emergency Medicine Only

A-Rated by Demotech, Inc

Contact EMPAC Managers for more information:
Lynn Pereira, Vice President Sales/Marketing
Office 888-898-9560 • Cell 407-721-4139
lpereira@empacmanagers.com
www.empacmanagers.com

Emergency Medicine in Beirut - continued from page 14

to meet the newly married couple. They accompanied them down the stairs with ululating singing and banging on ermine-trimmed tambourines. The bride and groom were dressed in traditional western formal garb - low-cut white dress with a long train and tuxedo. They stood on a glass stage lighted from below while the dancers again performed around them in the center of the circle, and then accompanied them on a walk around the swimming pool to thrones, which had been set up on the other side. The accompanying music was a curious mix of American pop and traditional Middle Eastern.

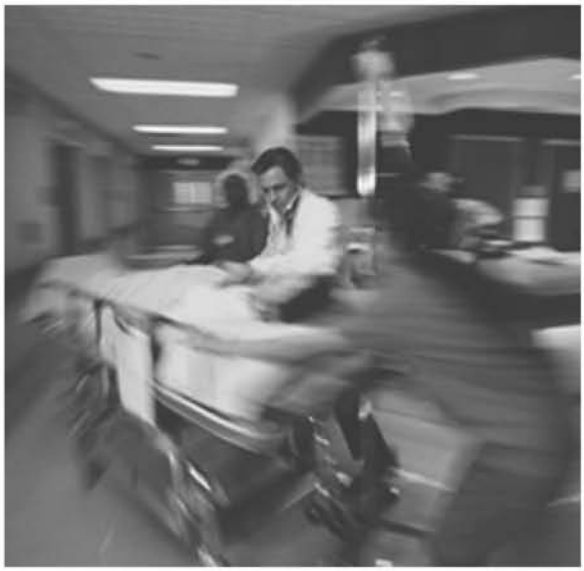
The next day we drove up the mountains avoiding potholes (which were actually mortar and RPG holes) and visited the iconic Cedars, and then a public market, before heading back to Beirut for the internal medicine graduation party at a local plush hotel. Antoine's wife is in Rumania, so I accompanied him. Prior to that, we stopped at the AUB-ER to visit a patient who is the mother of a friend of his; she had RLQ pain for three days, low grade fever, relative tachycardia, and a WBC of 17K with 94% immature white cell forms. You'll be pleased to know that, even in Lebanon, the surgeon wanted to know the results of the CT before seeing the patient. In fairness, the pain had been present long enough that she might have been a better candidate for interventional radiology, but that turned out not to be the case - she had a ruptured appendix. The medical school and residency programs at the American University of Beirut follow all ACCME guidelines and put out graduates who are accepted with open arms around the world – I spoke with a cluster of three who were all heading to the US for fellowships.

On Sunday, I checked out of the hotel, and we again headed out of Beirut, but this time to the north. We stopped briefly at the ancient harbor of Byblos, a town whose history goes back nearly 7000 years. After that, we went into a different group of mountains. Virtually every stop we made for coffee or a snack, we found someone who knew Antoine. At a small roadside convenience store, I purchased some souvenirs and ate freshly picked cherries and drank mate, while Antoine haggled with the owner, obviously a friend. We climbed to a mountain peak to visit a very contemporary Maronite Catholic church, and I noted that the clouds were below us. Finally, we stopped at Mar Sarkis Monastery, the museum and tomb of the great Lebanese author, poet, painter and seer Kahlil Gibran. The scenery in the mountains can only be described as "spectacular," with apparent shear drop-offs of several hundred meters on hairpin turns, caves carved into the sides of mountains where hermits lived (and apparently still live), and snow on the peaks, despite it being a 90°F day. Some of the scenery was just unworldly, and I'm doing some investigation about hiking in Lebanon, as I would love to go back on a four or five day trek from village to village.

After a delicious meal of fresh fish while overlooking the harbor, Antoine took me to the airport shortly after midnight. My flight from Beirut left at 3:45 am; I made all connections, and my luggage didn't get lost. I got to spend about 22 hours at home before going back to the airport for a trip to the 2nd Inter-American Congress in Emergency Medicine in Buenos Aires. More on that meeting later.

PeerCharts™

Emergency Medicine Documentation



We offer a chief complaint driven template system for emergency departments. Designed by medical directors who are committed to saving you time and money. Our templates are consistently reviewed and approved by AAEM's Reimbursement Committee and Practice Guidelines Committee.

Our Product Is..	Our Service Provides..
✓ Comprehensive	✓ Experience
✓ Affordable	✓ Expertise
✓ User-Friendly	✓ Honesty
✓ Customizable	✓ Integrity

Don't forget! A portion of all proceeds supports the AAEM Foundation!

www.peercharts.com
800.301.4901

*Register Today and Receive 1 Month FREE!

AMERICAN ACADEMY OF EMERGENCY MEDICINE

FAAEM
always means
board certified

RESIDENT PRESIDENT'S MESSAGE

Megan Boysen, MD
President, AAEM/RSA

Our presence in AAEM dates back to the formation of the resident section in 1999. Since then, we have become an independent AAEM Resident and Student Association, increased our membership three-fold (last year we had 2300 members) and accomplished feats of advocacy and education. The coming year marks the tenth year of the resident section in AAEM and is a tremendous opportunity to shape the future of emergency medicine by becoming involved in AAEM/RSA. The most obvious way to accomplish this is to become a committee member. The four AAEM/RSA committees are chaired by the at-large board members and include advocacy, communications, education and membership.

Our advocacy committee focuses on the issues facing emergency medicine such as overcrowding, insurance and government programs, the election and fair contracts. The communications committee supports our website www.aaemrsa.org and arranges email communication between the board and RSA members. The education committee's major responsibility is to plan the educational track at the Scientific Assembly in March 2009 in Phoenix, Arizona. Finally, our membership committee encourages the growth of our organization.

By choosing emergency medicine, you have declared yourself a leader. I hope you will take a step further to become a leader of leaders.

I am excited about the newly elected board which includes five returning members and five new additions. Andrew Pickens, MD JD MBA, who recently finished his residency at the University of North Carolina, will be contributing on the board as the immediate past president. Our vice president, Kalpana Narayan, MD MSc, is from Brigham and Women's Hospital in Boston, MA. Dr. Narayan was the 2007-2008 advocacy committee chair. The secretary-treasurer, Cyrus Shahpar, MD MPH MBA, is from Johns Hopkins University and served as last year's membership committee chair; he will also operate as the liaison to AAEM's Young Physicians Section (YPS). Dr. Shahpar helped increase AAEM/RSA membership by 12% last year. Mike Ybarra, MD, will join our board as an at-large board member and was the 2007-2008 president of the AAEM Medical Student Council. Dr. Ybarra will also act as the resident board liaison to the Medical Student Council. The remaining at-large board members include: Heather Jimenez, MD, Indiana University; Jennifer Kanapicki, MD, Stanford/Kaiser; Brian Ostick, MD, Christiana Care; and Alicia Pilarksi, MD, University of Nevada, Las Vegas. Greg Casey, from Philadelphia College of Osteopathic Medicine, will be the Medical Student Council president and will also be the medical student liaison to the board.

Opportunities to become involved will be emailed, but I encourage you to email me or any of the board members with your interest and questions: www.aaemrsa.org/leadership/. In addition, please mark your calendar for the Scientific Assembly, March 2-4, 2009. I look forward to the opportunity to serve you in the coming year.

Thanks to All: A Year in Review

Student President

Michael Ybarra, MD
Immediate Past President, Medical Student Council

I want to take the opportunity to thank everyone I have met and worked with over the 2007-2008 membership year and review our progress and growth as an organization. At our initial conference call nearly a year ago, we set four goals: increase communication, develop EM Select, expand the EMIG Workshop Starter Kit Series and grow our membership base. The Medical Student Council of the Academy finished the year with over a thousand members for the first time ever!

Our success in achieving these goals is due in part to the work of those that came before me – a group of very dedicated students, who are now successful residents and attending physicians. They were instrumental in bringing us to our starting point, and the medical student council in 2007-2008 worked hard to take the organization to the next level.

Ben Feinzimer, the vice president, and incoming PGY-1 in Chicago oversaw the further development of EMSelect.org, our residency program selection tool. It has become the most user-friendly and up-to-date program available, and we are proud to offer it as a free service to our paying members.

The group of regional representatives (Michael Habicht from the west, Adrian Elliott from the east, Tom Masters from the midwest and Caleb Trent from the south) created an extensive network of Emergency Medicine Interest Groups. They connected these clubs with the resources of our organization and were instrumental in expanding our membership base.

We worked as a team to increase communication, put on workshops and information sessions across the country

continued on page 20

Dreaming the Impossible Dream: Becoming Involved in Clinical Research as a Medical Student and Resident

Veronica Tucci, JD MSIV USF COM

If someone would have told me five years ago when I was a post-bac pre-medical student at City College of New York that I would be telling other medical students and residents that research is not only fun but one of the most important things we can do as physicians, I would have said he was crazy. I will be the first to admit it - I became involved with clinical research because I thought it was a box I needed to check on my AMCAS application. Little did I know, a posting for a clinical research associate in the City College pre-med office would change my life and my approach to the art and science of medicine.

I met Dr. Michael Radeos, then Director of Research in emergency medicine at Lincoln Hospital, on a bleak Friday afternoon. He was sitting in a dusty office with files scattered all over the desk and old issues of Academic Emergency Medicine piled on the floor. We spoke for hours about the patient population of Lincoln Hospital, his research on asthma and how he hoped to find a way to better predict asthma exacerbations and treat patients before they experienced full-blown attacks. Dr. Radeos' enthusiasm for his project and for research in general was infectious, and needless to say, I was hooked. He believed it was his duty as a physician to improve the quality of life for his patients, and part of that duty included advancing the state of the art as we are currently reaping the benefits of those intrepid physician-scientists who came before us. He also believed that where one physician may fail, dozens working together can succeed. His legacy as a physician extends beyond the number of publications on his CV and the number of lives he has personally saved. Like any good teacher, it will live on in the countless numbers of students who he trained and who have gone on to become physicians and researchers in their own right. So why aren't physicians lining up to follow the path of this incredible emergency physician?

No one reading this article will be surprised when I say there are many obstacles to pursuing clinical research. Perhaps the greatest perceived obstacle to student and resident research is time. As students and residents, we are busy trying to master clinical skills, oral presentations and write ups. There are constant demands on our time. Sometimes it can feel as if there is nothing but hoops that we need to jump through - be it a shelf exam, an in-service exam, Step 3, faculty evaluations, etc. We are bombarded with information, our senses assaulted on a daily basis. Sometimes all we want to do is go home and collapse.

Even if we can manage to work research into our schedules, time is not the only obstacle to research. We are constantly reminded of the shrinking fiscal budgets and financial support for research. Indeed, it is often a Herculean task to find funding. Even with funding, there is no guarantee that our research will be recognized and published in a peer-reviewed journal. The picture may appear bleak, prompting the student or resident to wonder why he should even contemplate clinical research projects.

Research is more than just a line-item on a CV. It enables us to advance the art of emergency medicine,

continued on page 21

Thanks - continued from page 19

and develop our educational tools. We added two new electronic publications: the "Advocacy Quick Hits" to keep our members up-to-date on emergency medicine in the media and political realms and a "Journal Club" mailer that summarizes the most up to date research in emergency medicine in a high-yield format.

We worked with the RSA education committee to host the first-annual Midwest Medical Student Symposium at Loyola University Chicago, bringing together program directors, EM specialists and medical students. At the 2008 Scientific Assembly in Amelia Island, Florida, we invited a group of four program directors from across the country to answer questions and speak on the transition from pre-clinical to clinical years of medical school and into the first year of residency. Our four outstanding speakers (Dr. Hayden from UCSD, Dr. Rodgers from Indiana, Dr. Epter from Nevada and Dr. Caro from UF-Jacksonville) spoke on everything from "demystifying" the application process to planning the fourth year of medical school and finding the perfect mentor. The planning for the March 2-4, 2009, Scientific Assembly in Phoenix, AZ, has already begun, so if you missed this opportunity for professional development, mark your calendars now!

We also developed a section of our website called "The EMIG Workshop Starter Kits." This resource was conceived in 2006, and this year we were able to take it to the next level. We added three comprehensive presentations available to download for free. All of the information is there for the taking to use as templates for student groups looking to start their own workshops. You will find a suture guide, a history of emergency medicine, ocular emergencies, and the politics of emergency medicine.

The 2008-2009 Medical Student Council is already off and running, and they have brought new ideas to the table that will make your membership even more valuable. Thank you to all who have made this past year a success! If you are graduating from medical school, I encourage you to become a resident member, even if your program does not pay or reimburse your fees. Your membership and support of AAEM allows us to fight for our specialty across the country!

Dreaming continued from page 20

hone our skills in critical thinking and become better diagnosticians. In participating in research, we are forced to "think outside the box" and reconsider our practice of medicine and how we can improve it. For example, I recently had a patient with a history of psychiatric issues who presented to the ED with auditory hallucinations, perseveration and agitation for three days. Psychiatry and neurology were playing diagnostic hot potato with both services convinced that the patient's true problem was within the purview of the other service. The end result: even with her history of hypomania, the patient had mental status changes secondary to encephalitis. This case caused me to wonder how frequently patients with psychiatric histories are misdiagnosed or have their diagnoses delayed and whether it depends on if the diagnosis is related to neurology or any specialty. Lesson learned: take nothing for granted.

Now, after reading about the benefits to society, our profession and our patients, many students may still remain unconvinced. Becoming a better diagnostician might take a lifetime of dedicated research; we need more immediate gratification. What's in it for us? For U.S. seniors entering the 2007 Emergency Medicine Match, 100% of candidates with five or more research projects matched into EM irrespective of their other qualifications.[1] Likewise, 100% of candidates with five or more presentations, abstracts or publications matched into EM regardless of other qualifications.[2] Students entering emergency medicine are also increasingly taking into account research opportunities at residency training programs, and 22% consider research important or very important in their selection of a residency program.[3]

Similarly, residents may ask themselves the same question – what's in it for us? The ACGME requires all residents graduating from an accredited allopathic emergency medicine program participate in a "scholarly activity."[4] While this scholarly activity has been interpreted in various ways from chart review to publications and may appear to be just another hoop to jump through, it represents a grand opportunity. In addition to the benefits mentioned previously, research enables practicing physicians to hone time management skills, mentor future EM physicians, lay the groundwork for an academic career in EM, present findings in a public forum and improve public speaking abilities, publish and gain recognition for contributions to our field, make connections and build research networks.

Let's say that you are now sold and willing to participate. How do you start? The first step is to recognize what you bring to the table. Everyone has talents, and you need to know yourself. Are you creative? A good writer? Editor? Good with numbers and statistics? The right combination of people and talents on a research team can lead to prolific and high quality research.

Next, find an advisor and learn about any ongoing projects. It is particularly important to be cognizant of the advisor's availability and interest. I was extremely privileged to find mentors who are passionate about clinical research and willing to share their knowledge and experience. Not everyone has the patience or same level of dedication, and you can spend countless hours working on a project but have nothing to show at the end of the day if your advisor/mentor is unavailable to make those last minute changes to a manuscript or simply uninterested. Once you have found a research mentor and picked a project, clearly delineate the research workload, timeline and expectations for authorship. Determining a first and second (or third) author is not something that should be left until the cover letter submitting the manuscript to a journal is being drafted.

Becoming involved in research does not mean that you need to jump into a multi-center randomized control trial for your first time at bat. It can seem so overwhelming. Starting small with a case report can ease the pressure and let students and residents acclimate. It is also important to work smart, not hard. What do I mean by this? In order to do a case report, an author needs to review the literature. Why not write two articles for the price of one (i.e., a case report and a literature review)?

Thomas Edison once said that "genius is 1% inspiration and 99% perspiration." So too is getting research published. After slaving away on draft after draft, you proudly submit your manuscript to a prestigious journal only to have it rejected. Do you run away with your tail between your legs and into academic obscurity? Of course not. You try again, and submit it to another journal and then another. If you encounter significant resistance, find out why the manuscript was rejected, and revise it accordingly.

Lastly, as you progress in your career, remember to bring others along with you. If you are a resident or senior medical student, help the pre-clinical student become involved. Few things are more terrifying to a medical student than looking less than stellar in front of an attending physician, and unless you have done a ton of research and have publications as an undergraduate, your work product will not be perfect the first time around. However, it is not as daunting when it is your third case report. By revising and making suggestions to the pre-clinical student before they show it to an attending, the senior student is a mentor. This allows the pre-clinical student to comfortably enter the research arena, and the senior student is rewarded with second authorship on that paper and has fostered a research network that may bear fruit for many years to come. If the student enters another field at the same hospital (e.g., ophthalmology), you have created the perfect set-up for cross-discipline papers. Also, consider that while many students stay at their home institutions for residency, many others trek across the country to other hospitals. Now your network is not only cross-specialty but may be multi-center. So what started as a mere dream has turned into reality.

[1] http://www.nrmp.org/data/resultsanddata2007.pdf
[2] Ibid.
[3] M DeSantis, CA Marco. Emergency medicine residency selection: factors influencing candidate decisions. Acad Emerg Med. June 2005; Vol. 12, No. 6;559-561.
[4] R Summers et al. Assessment of the "Scholarly Project" Requirement for Emergency Medicine Residents: Report of the SAEM Research Directors Workshop. Acad Emerg Med. Nov 1999; Vol. 6, No. 11; 1160-1165.

Resident Journal Review: July - August 2008

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

This is a continuing column providing 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. These selections are from papers published in March and April 2008.

Valentino M, Serra C, Pavlica P, et al. Blunt abdominal trauma: diagnostic performance of contrast-enhanced US in children--initial experience. Radiology 2008;246:903-9.

This study prospectively enrolled pediatric trauma patients to evaluate the diagnostic ability of contrast enhanced ultrasound to detect solid organ injury in pediatric patients with abdominal trauma. Both conventional and contrast enhanced ultrasound exams were performed on enrolled patients. Contrast enhanced computed tomography was used as the gold standard.

Twenty-seven patients with moderate to severe injuries were included in the final analysis. Each of these patients sequentially had a conventional ultrasound exam, a contrast enhanced ultrasound exam and a contrast enhanced CT. A separate sonographer was used for contrast-enhanced and conventional studies. The sonographers and CT radiologist were blinded to the results of the other imaging studies.

Contrast-enhanced ultrasound detected 13 of 14 injuries identified on contrast enhanced CT. The sensitivity and specificity of contrast-enhanced ultrasound was 92.9% and 100% respectively.

Contrast CT is a mainstay in the evaluation of blunt abdominal trauma. While there is an established role of ultrasound in the evaluation of blunt trauma, conventional ultrasound is not a reliable method for the detection of paraenchymal injuries. Additionally, hemoperitoneum is not always present after a solid organ injury. This preliminary study suggests that contrast-enhanced ultrasound may have a role in the initial evaluation of paraenchymal injuries in pediatric patients with blunt trauma. In addition, the authors suggest that this modality may be a radiation sparing alternative for sequential evaluation of injuries identified through other means. The study does not advocate for the replacement of CT scanning in the evaluation of pediatric trauma patients; however, an expanded role of contrast-enhanced ultrasound is supported.

Fasano CJ, O'Malley G, Dominici P, Aguilera E, Latta DR. Comparison of octreotide and standard therapy versus standard therapy alone for the treatment of sulfonylurea-induced hypoglycemia. Annals of emergency medicine 2008;51:400-6.

This was a randomized, double-blind, controlled trial of octreotide therapy in a group of patients presenting to an emergency department with sulfonylurea-induced hypoglycemia. Study patients were treated with an ampule of 50% dextrose and an oral carbohydrate meal on presentation. They were then randomized to either a placebo arm or single treatment of 75ug of octreotide subcutaneously. In the group of 22 patients randomized to octreotide, serum glucose measurements were higher, and refractory episodes were less frequent. The benefit of the medication extended to the eight hour mark, which is consistent with the duration of action of octreotide.

Octreotide is not FDA approved for the treatment of sulfonylurea-induced hypoglycemia; however, it is often recommended for such use by toxicologists. This study was the first randomized, controlled trial of the somatostatin analog to this clinical end.

Menaker J, Philp A, Boswell S, Scalea TM. Computed tomography alone for cervical spine clearance in the unreliable patient--are we there yet? J Trauma 2008;64:898-903.

Newer generations of computed tomography scanners have called into question the practice getting a magnetic resonance image of the cervical spine in obtunded patients who have a negative CT scan, prior to removing a hard cervical collar. This single-center study was conducted to evaluate the sensitivity of newer generation CT scanners for the detection of significant cervical spine injuries in patients with an unreliable physical exam.

203 patients in the trauma registry had a negative CT scan of the cervical spine and had no obvious neurologic injury, but because their exam was unreliable, were kept in a stabilizing hard collar. 184 (91%) of these patients had no injuries identified on subsequent MRI, and their hard collars were removed. 18 (9%) of the patients had abnormal MRI exams, two of which required operative repair and 14 required prolonged hard collar use.

This study supports the practice of keeping the c-collar on in the emergency department, even in the setting of a negative multi-detector CT study of the cervical spine, if the patient has altered mental status or not cooperative

continued on page 23

Resident Journal Review - continued from page 22

with a physical exam. Both stable and unstable cervical spine injuries can be missed by this imaging modality, necessitating later investigation with an MRI prior to removing the collar. Of note, this study was conducted at a high volume trauma center; extrapolation to routine emergency department care may require further validation.

Moore FA, Nelson T, McKinley BA, et al. Massive transfusion in trauma patients: tissue hemoglobin oxygen saturation predicts poor outcome. J Trauma 2008;64:1010-23.

The epidemiology of trauma patients requiring massive transfusion (i.e., requiring more than 10 units of red blood cells in 24 hours) has not been well described. This multicenter cohort study from seven trauma centers enrolled 383 adult patients with hemorrhagic shock. 114 patients from the cohort required massive transfusion (MT).

Near infrared spectrometry derived tissue hemoglobin oxygen saturation (StO2) monitoring was studied as a potential early predictor of MT and risk factor for poor outcome in the MT subset.

Demographics, injury mechanisms and comorbidities did not differ between those who required MT and those who did not. In the subset of patients who required MT, 41% reached 10 transfused units within the first two hours after arrival at the trauma center. 82% reached that mark by six hours. Patients who required MT had much higher rates of multiorgan dysfunction syndrome (31 vs. 9%) and death (33 vs. 7%). Statistically significant predictors of MT in the first 30 minutes of the clinical encounter included: maximum heart rate, minimum systolic blood pressure, minimum StO2, maximum base deficit, minimum pH, maximum INR and minimum hemoglobin. In logistic regression modeling, only StO2 emerged as a significant predictor of poor outcome at both the 30 minute and 60 minute marks of the clinical encounter.

This cohort study of severely injured trauma patients adds to our understanding of the rare subset requiring massive transfusion. The use of StO2 may play a future role in guiding resuscitation efforts, triaging resources and informing disposition decisions; however, further validation of this technology is needed prior to widespread adoption.

Tallman TA, Peacock WF, Emerman CL, et al. Noninvasive ventilation outcomes in 2,430 acute decompensated heart failure patients: an ADHERE Registry Analysis. Acad Emerg Med 2008;15:355-62.

Questions have been raised about the safety and efficacy of noninvasive ventilation (NIV) in the setting of acutely decompensated heart failure. Specifically, there have been concerns about the risk of myocardial infarction using this modality compared to endotracheal intubation. This is the largest study of its kind to explore these concerns.

The study investigators analyzed 37,372 admissions for heart failure at 280 hospitals. 2,430 patients required ventilatory assistance, with either NIV (n=1,760; 72%) or endotracheal intubation (n=670; 26%). A small subset required NIV followed by endotracheal intubation (n=72; 4%), but most of the noninvasive cohort were managed only with NIV (n=1,688; 96%). Patients who failed a trial of NIV had similar hospital courses compared to those who were immediately intubated. In-hospital mortality was 7.9% for patients in the NIV cohort, 13.9% in the cohort of failed NIV and 15.4% in the cohort who were initially intubated. There was no significant difference between troponin levels in patients successfully managed with NIV (7%), who failed NIV (7.4%) and who were initially intubated (13.3%).

The results of the study support the use of NIV in patients with ADHF. Their data indicate that NIV can be safely tried in this patient population and that patients who fail a trial of NIV are not placed at greater risk than those who were initially intubated.

Mitchell AM, Kline JA. Systematic bias introduced by the informed consent process in a diagnostic research study. Acad Emerg Med 2008;15:225-30.

The "healthy volunteer effect" is well described in epidemiologic research. This is a source of bias that comes from the observation that participants who volunteer for studies tend to have lower rates of morbidity than the general population. This study's investigators demonstrated a similar systematic bias through the use of the informed consent process. They hypothesized that the rate of venous thromboembolism would be lower among study participants, compared to non-participants in a minimal-risk emergency department (ED) study. The investigators demonstrated not only their primary hypothesis (6% vs. 13%), but also showed that the proportion of African Americans (40% vs. 53%), uninsured (9% vs. 24%) and Medicaid patients (16% vs. 27%) were significantly different between the two groups.

This study identified a systemic source of bias through the use of an informed consent processes in a minimal-risk emergency department investigation. This underscores the difficulty of conducting high-quality research and highlights a source of bias hereto not described in an ED-based study.

Daniel Nishijima is an emergency medicine chief resident at SUNY Downstate/Kings County Hospital.
David Wallace is the emergency medicine/internal medicine (EM/IM) chief resident at SUNY Downstate/Kings County Hospital.
Christopher Doty is the residency program director for emergency medicine and co-director of combined EM/IM at SUNY Downstate/Kings County Hospital.
Amal Mattu is the residency program director for emergency medicine and co-director of combined EM/IM at University of Maryland.

YPS PRESIDENT'S MESSAGE

Marc Haber, MD FAAEM
President, AAEM Young Physicians Section

Yesterday, I had a patient brought in by ambulance with generalized weakness and dizziness. If not a favorite chief complaint, it certainly is a common one. You know this patient, you saw her as well. She was described by the nursing staff as a "terrible historian." Instead of correcting the nurse as to the proper definition of a historian, one who records history, I nodded and tried to get a story from this woman. Nevertheless, my open and closed ended queries were for naught. She was not in a talkative, telling mood. Unfortunately, she had never been to our department before, so my computer search was unhelpful. The paramedics had jotted down the name of some medications they found in her bathroom, but were otherwise unable to provide any information. The 911 caller's identity was also a mystery. The patient was a little tachypneic and tachycardic. Auscultation revealed coarse breath sounds and a questionable holosystolic LLSB murmur. Also noted was trace edema about her ankles, occasional ecchymotic areas on her flank and upper extremities, and a non-focal, though certainly not normal neurological exam.

Obviously, the differential for someone like this is broad. And more certainly, a "gramma-gram" will be ordered (CXR, ECG, CBC, Lytes, BUN/Cr, U/A, etc…). Most certainly when we diagnosis the pneumonia, renal failure, or whatever disease she harbors today, we will initiate therapy and dispo to the appropriate unit, including the possibility of a discharge home.

Murphy's Law dictates that when something can go wrong, it will go wrong. Sure enough, she develops anaphylaxis from that aspirin or fluoroquinolone du jour. Or you cannot determine her primary care physician (PCP); therefore, you are spinning wheels trying to get her an inpatient bed. Or because you chose to ignore the next five patients brought in by triage, you got a hold of the paramedic supervisor, sent back the medics to provide you her medication vials and ultimately determined her PCP.

Fret not! Larry Page and Sergey Brin have entered the healthcare arena to help. Who are these two? These folks are Google's founders. In May, Google, Inc. unveiled their version of the electronic medical record. This new site allows users to enter, update manually or automatically and remove one's personal medical records. One can then chose with whom to share the information and even select what information each party may view. After care at the hospital, if desired, the medical center will upload your medical information into your account.

This is potentially a very powerful tool in the emergency department. Were we able to view this patient's electronic medical record perhaps we could have avoided the allergic reaction or contacted her family and PCP. Perhaps we would have been able to glean valuable information from her recent office visit at the Cleveland Clinic. As borderline ADHD physicians, we cherish high yield information; this is one such opportunity to gain high yield information with minimal effort. Cynics will argue that other modalities have greater value; an example is the medical alert bracelet or microchip. No doubt any additional information, that doesn't simply raise the volume of background noise, will benefit the overall care of the patient. That said, Google commands a lot of respect and has buckets of cash. This, along with a relative vacuum in the area of national medical records, perhaps sets Google up for success.

While it is unlikely that Google will revolutionize the way we gain access to health information, it certainly will contribute to the evolution. Perhaps city-dwelling technology worshipers will readily flock to this method, but it is doubtful that the majority of Americans will buy into this. At least not for a number of years, until the security and bugs have been vetted. Currently, I cannot imagine the majority of baby boomers feeling comfortable with the security of online records. But perhaps even less likely, are those younger workers whose hacked medical information might be considered embarrassing or even career damaging.

There are other challenges as to how emergency physicians and their patients could benefit from access to this information. This includes, though not limited to, knowing that information exists, how to gain access in an emergency and of course HIPPA and other legal concerns. Furthermore, major health systems will have to buy into this. Unless multiple hospital systems allow medical records to be uploaded, patients would have to be diligent at keeping the records current. At the time this is written, this capability is only available at The Cleveland Clinic, Beth Israel Deaconess and some well-known national pharmacies. That isn't too shabby, considering its' availibility is very recent.

Granted, this system would not have prevented the anaphylaxis in this case. At this time, an allergy bracelet would have been the best option. But in the future, I do believe that electronic medical records will be readily available and invaluable to the emergency physician. It is refreshing to see private enterprise continue this exploration. Google, Inc. has a tremendous amount of clout and capital and if used carefully and appropriately, Google Health records may be a wonderful adjunct.

Membership Application

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

Institution/Hospital Name Degree (MD/DO)

Preferred Mailing Address Please check which address this is: ☐ Work ☐ Home

City State Zip

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? _____ If completed, what year? _____
2) Are you certified by the American Board of Emergency Medicine? ☐ Yes ☐ No
   If yes, date: _____ Type of certification ☐ EM ☐ Pediatric EM
3) Are you certified by the American Osteopathic Board of Emergency Medicine? ☐ Yes ☐ No
   If yes, date: _____
4) Are you a member of any other EM organization? Please select all that apply.
   ☐ AACEM ☐ AAEM/RSA ☐ ACEP ☐ ACOEP ☐ AMA
   ☐ CORD ☐ EMRA ☐ NAEMSP ☐ SAEM ☐ Other _____
5) If you are a practicing emergency physician, please provide your primary practice location and address:

Hospital Name Address

City State Zip

Full Voting and Associate Membership dues are for the period January 1 to December 31 of the year they are received. Resident/Fellow and Student Memberships are for the period July 1 of the year they are received to June 30 of the following year (unless a multi-year membership is chosen). Full Voting, Associate, Resident/Fellow and Student with *JEM* memberships include a subscription to *The Journal of Emergency Medicine*.

MEMBERSHIP FEES

☐ Full Voting Member $365.00
☐ Associate Membership (Associate-voting status) $250.00
* *Limited to graduates (not yet board certified) of an ACGME or AOA approved Emergency Medicine Training Program.*
☐ Affiliate Membership (non-voting status) $365.00
* *Must have been, but are no longer board certified in Emergency Medicine [by ABEM or AOBEM] or in Pediatric Emergency Medicine [by ABEM or ABP].*
☐ Emeritus $250.00
☐ International $125.00
☐ Resident/Fellow Member ..... ☐ 1 Year—$50 ☐ 2 Years—$80 ☐ 3 Years—$120 ☐ 4 Years—$160
☐ Student with *JEM* Member ..... ☐ 1 Year—$50 ☐ 2 Years—$80 ☐ 3 Years—$120 ☐ 4 Years—$160
☐ Student without *JEM* Member ..... ☐ 1 Year—$20 ☐ 2 Years—$40 ☐ 3 Years—$60 ☐ 4 Years—$80
☐ Student Free Member ..... ☐ 1 Trial Year—Free
☐ I would like to be a member of the following state chapter(s) (FV=Full Voting dues/A= Associate dues. Resident/Student dues are free for all chapters but NV):
☐ CA (FV/A-$120) ☐ FL (FV-$100/A-$50) ☐ NV (FV-$75/A-$50/R-$25/S-$15) ☐ TX (FV-$50/A-$25) ☐ WI (FV-$20/A-$10)
☐ DV (FV-$50/A-$25) ☐ IA (FV-$25/A-$20) ☐ NY (FV-$80/A-$50) ☐ TN (FV-$50/A-$25)
☐ I would like to be a member of the Uniformed Services Chapter (USAAEM) ..... ☐ Full Voting—$50.00 ☐ Assoc.—$30.00
☐ I would like to be a member of the Young Physicians Section (YPS) (AAEM FV and A members only) ..... ☐ Full Voting—$25.00 ☐ Assoc.—$25.00
☐ I would like more information on the Critical Care Section

☐ AAEM Foundation: Please consider making a voluntary contribution to the AAEM Foundation. With your assistance, AAEM can fight to protect the rights of physicians and patients against corporations that violate CPOM laws. Your donation is tax deductible. Federal TIN:20-2080841 ($100 suggested) ..... $_____
☐ AAEM Political Action Committee: Please consider making a voluntary contribution to the AAEM PAC. With your donation, AAEM PAC will be better able to support legislation and effect change on behalf of AAEM members with consideration to their unique concerns. ($50 suggested) ..... $_____

PAYMENT INFORMATION

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

Card Number Expiration Date

Cardholder's Name

Cardholder's Signature

Return this form with payment to: American Academy of Emergency Medicine, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202-3823
All applications for membership are subject to review and approval by the AAEM Board of Directors.
The American Academy of Emergency Medicine is a non-profit professional organization. Our mailing list is private.
Full Voting Membership *(Tax deductible only up to $348.00)* / Associate Membership (Associate-voting status) *(Tax deductible only up to $230.00)*

AAEM JOB BANK

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

To place an ad in the Job Bank: Positions that comply with the American Academy of Emergency Medicine's Certificate of Compliance will be published (upon approval) 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, Attn: Shauna Barnes, 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

Join Pegasus Emergency Group in establishing a new and exciting ED group in Alabama! Contract to start 4/1/08. Four year track to truly democratic partnership. Open books. 33K ED census, north of Birmingham. New ED planned for summer '08. $145/hr to start, plus benefits. This is a unique and lucrative contract - a life changing opportunity! Call Jeffrey Ruzich, MD @ 518-268-5240. (PA 871)
Email: jruzich@setonhealth.org

ALABAMA

Baldwin Emergency Physicians, an independent, democratic group, is seeking full-time BC/BE emergency medicine physicians. Employee status with partnership track offered. Productivity based salary with benefits included. Two practice locations with similar volumes (28K), one in Fairhope, AL, the other in Foley, AL. Please contact Randall Knutson, MD FAAEM at rbknutson@yahoo.com or call 251-504-1174 for more information. (PA 890)
Email: rbknutson@yahoo.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 5,500 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 for more information. (PA 849)
Email: robertmkec@mac.com

ARIZONA

Phoenix: Our well-established, independent, democratic group is looking for new partners. We currently staff 2 state-of-the-art hospitals with full subspecialty coverage, 24-hour real-time radiology reads and hospitalist services with a third facility under construction. We offer full benefits including a very competitive salary, paid occurrence malpractice, short partnership track, health insurance, disability insurance, CME allowances, license fees, dues and much more. Successful applicants must be ABEM or ABOEM certified or eligible, excellent clinicians, team players and interested in a fantastic job. Look forward to hearing from you. (PA 860)
Email: drbhow@hotmail.com
Website: www.epspc.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

CALIFORNIA

Department of VANCHCS. Excellent opportunities exist for full-time or part-time emergency medicine physicians at the Sacramento VA Medical Center located in Mather, California. Outstanding working conditions allow for a satisfying career with a high quality of life along with a competitive salary and excellent benefits including malpractice insurance. Academic appointments with UC Davis School of Medicine and other institutions are available and opportunities for teaching and research abound. Candidates must be emergency medicine BC/BE and a US Citizen or PRA. EOE. For further information regarding this position contact Crystal Keeler at: crystal.keeler@va.gov. (PA 894)
Email: crystal.keeler@va.gov
Website: www.vacareers.gov

CALIFORNIA

Northern California coastal - Six Rivers Emergency Physicians, a small, democratic group staffing a single ED in Arcata with five years of contract stability is seeking BC/BE EM physician to join partnership. 17K volume with 10 bed ED and 8 hours of PA coverage daily. Immediate partnership with equal pay and scheduling. Hospitalist program, 24/7 radiology and low trauma volume. Enjoy the North Coast: mild temps, clean air, whitewater rafting, fishing, mountain biking, surfing, etc. Daily flights to San Francisco, L.A., Sacramento and Salt Lake City. Send CV in confidence to ambereve11@hotmail.com or call 626-831-0658. (PA 881)
Email: ambereve11@hotmail.com

CALIFORNIA

The Permanente Medical Group seeks BC/BE EM Physicians in Sacramento, Fresno, Modesto and the San Francisco Bay Area. You'll enjoy 300+ days of sunshine/year, unbeatable outdoor activities (golf, tennis, boating, skiing and hiking), a close-knit, collegial environment that encourages/supports physicians dedicated to patient care and teaching, and the stability of an organization with more than 50 years serving our communities. With competitive salaries and a generous benefits package, TPMG, Inc. allows you to combine a medical practice of which you can be proud and a quality of life you deserve. Contact Lisa Holthaus, Lisa.Holthaus@kp.org, or call 800-777-4912. EEO/AA/M/F/D/V EMPLOYER. (PA 884)
Email: lisa.holthaus@kp.org
Website: http://physiciancareers.kp.org/ncal/

COLORADO

ER physicians for Ft. Carson, Colorado Springs, CO. Come to this beautiful state and enjoy all the outdoors has to offer when not enjoying the great work environment at Evans Army Community Hospital. American Hospital Service Group has a long-standing contract at this growing facility nestled in this gorgeous region. Colorado Springs has a welcoming standard of living and activities for all lifestyles. Board certified physicians, part-time or full-time. Any state license accepted at Federal work places, and malpractice immunity provided. Contact Megan at 301-960-4115 or by email at the address below. (PA 857)
Email: mjh@americanhospital.us
Website: www.americanhospital.us

COLORADO

Southern Colorado Emergency Medicine Associates (SCEMA), a stable, democratic group with twenty years experience at Parkview Medical Center in Pueblo, Colorado, is expanding with a free-standing ED in Pueblo West, as well a level IV ED in Trinidad, Colorado, "The Victorian Jewel of the West." Pay is competitive with full benefits package, including 401k, family health, HSA and outstanding professional liability coverage through COPIC. No corporate overhead; great local control. Directorship available for additional stipend. Fantastic opportunity (for considerations of both practice and lifestyle) for northern NM or southern CO. Please contact Anna Olson. (PA 861)
Email: SCEMA.Recruiting@gmail.com

FLORIDA

Tallahassee - Join a well established, democratic and transparent emergency medicine group. We are a private partnership of EM specialists with stable contracts. We have been in business for almost 20 years. Our compensation is excellent and our benefits are truly unmatched. Check us out. Ron Koury, DO FAAEM FACEP, Southeast Emergency Consultants. (PA 868)
Email: rmkoury@comcast.net
Website: www.southeastemergency.com

GEORGIA

Athens, Georgia: Private, democratic group of 20 physicians; all EM BC/BE. 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: ceisen@armc.org

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 or by email at the address below. (PA 835)
Email: eva.page@comcast.net

ILLINOIS

Urgent Care opportunity available for BC/BE emergency medicine physician with a well established, stable, truly democratic group in the western and southwestern suburbs of Chicago. Part-time positions also available. Competitive salary. Comprehensive benefit package. Opportunity for profit sharing available. Send cover letter/CV to Lemont Walk-In Care Facility, 15900 W. 127th St. Suite 100, Lemont, IL 60439, Attn: S. Mininni, MD Medical Director, DuPage Convenient Care, LLC. (PA 876)
Email: smmvalentine@yahoo.com

INDIANA

Valley Emergency Physicians is seeking an exceptional BC/BE emergency physician to join our 14-member, democratic, physician-owned, fee-for service group. Partnership is immediate upon hire! Total first-year compensation package is at the 95th percentile (based on the most recent MGMA data). Nights, weekends and holidays are divided equally. We staff St. Joseph Regional Medical Center (South Bend and Mishawaka) where we have provided outstanding emergency care for over 30 years. A new state-of-the-art ED is under construction and will be complete in the Fall of 2009. SJRMC is affiliated with Indiana University School of Medicine - South Bend; opportunities are available for partners to teach medical students and residents in the ED. Indiana was recently selected as "America's most physician-friendly state" (favorable malpractice environment). South Bend offers strong school systems, affordable housing, all of the cultural amenities associated with a Top 20 university and easy access to Chicago (90 minutes) and Lake Michigan (35 minutes). Contact Kurt DeJong, MD at 574-276-1286 or send CV to the email address below. (PA 837)
Email: dejongkurt@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 online. EM BC/BE only please, reply at information below. (PA 848)
Email: epchajob@gmail.com
Website: www.communityanderson.com

INDIANA

South Bend: Very stable, democratic, single hospital, 15 member group seeks additional BC/BE emergency physicians. Newer facility. 52K visits, Level II Trauma Center, double, triple and quad physician coverage. Will also be staffing a freestanding ED opening in 2009. Equal pay, schedule and vote from day one. Over 325K 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 the email address below. (PA 893)
Email: sspilger@memorialsb.org

IOWA

Dubuque, Mercy Hospital, full service, 12 + beds, modern electronic ED, ED boarded providers, best partnership opportunity, democratic group with equal hospital department status since 1985. Scenic Mississippi valley area ideal size for raising family with opening Jan 2009 or sooner. Equal treatment for 1 year employee. Expanding from 6.5 to 7 doctors, age ranging from 32 to 55, 20K patients, 25% acuity, no NeuroSurg. Stable nursing and admin, with minimal waiting room time. 95% of patients seen in 30 minutes. Salary, benefits, 401k for partner ~$300K, malpractice included but not tail. Stock and receipts buy-in extended over years. (PA 865)
Email: mksgsk1@mac.com
Website: www.DbqER.com

KANSAS

Seeking ER physicians to join Emergency Physicians of Salina, LLC. Salina Regional Health Center, located in central Kansas, opened its newly-renovated ER on April 30, 2008. With 25,000 visits annually, the ER physicians provide double coverage in 12 and 10-hour shifts. This community-owned, not-for-profit hospital serves a 13-county region with a combined population of more than 160,000. Additional benefits include: excellent specialist support, fast-track partnership, immediate family benefits package, profit sharing, 401k plan after 90 days, flexible scheduling, KMS-Qualified facility, MUA-designated area, Visa waivers and other financial incentives available through hospital. (PA 897)
Email: sstampfli@medicalcaresolutions.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, or fax 1-866-248-7722. (PA 831)
Email: krystle@centralcareinc.com

KENTUCKY

Trover Health System is seeking an outstanding EM physician to join our team. ABEM/AOBEM or eligible physician(s) may earn $170/hr, plus benefits. Practice 12/12 shifts with double coverage during peak. 18 beds + 2 trauma rooms and 6 fast track beds. 30,000 visits annually. Electronic T-System, PACS & real time Radiology reads. Madisonville is 90 minutes from Nashville, TN and relocation is not required, but you will want to once you sample the charm of western Kentucky. From bluegrass to blues, experience the outdoor adventures and good old fashioned southern hospitality. For more information please call 270-875-5538 or 800-272-3497. (PA 875)
Email: cbaugh@trover.org
Website: www.troverhealth.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

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 2,400 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 track 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. (PA 851)
Email: lfong@cejkasearch.com
Website: www.cejkasearch.com

MASSACHUSETTS

Northeast Health System (Beverly Hospital and Addison-Gilbert Hospital): Fully democratic group seeks BC/BE emergency medicine physician for full-time or part-time employment. Also seeking physician with emergency department experience for fast track expansion. 60,000 visits combined at top-ranked hospitals. Level III Trauma Center. New emergency department. Hospitalist program. Collegian environment, coastal location, close to Boston. Competitive salary. Please email CV to Saul Cohen, MD at the email address below. (PA 856)
Email: sauljenai@gmail.com

MASSACHUSETTS

Berkshire Medical Center, a 302 bed teaching hospital and Level II Trauma Center, is currently seeking a BC/BE emergency medicine physician. Annual volume for main ED and Express Care is 54,000. All subspecialties covered-including 24/7 Neurosurgical coverage. BMC is the region's leading provider of comprehensive healthcare services. With award-winning programs, nationally recognized physicians, world-class technology and a sincere commitment to the community, we are delivering the kind of advanced healthcare most commonly found in large metropolitan centers. Competitive salary and benefits package is offered, including relocation. (PA 891)
Email: blepicier@bhs1.org
Website: www.berkshirehealthsystems.org

MASSACHUSETTS

Established, multi-hospital, democratic, physician-managed group seeking a full-time/part-time board certified or board eligible emergency medicine physician. Group provides staffing for two sites, in the suburban Boston area, with a combined annual volume of approximately 75,000. Flexible schedule, comfortable work environment an excellent salary/benefits package. Please contact Linda Deverix at 508-383-1104 or the email address below. (PA 870)
Email: Linda.Deverix@mwmc.com

MICHIGAN

Bay City, Michigan: Opportunity for a BC/BE emergency physician at a growing, profitable hospital in Bay City that just opened a brand new ED in September 2007. The hospital has a friendly cooperative medical staff and coverage of all the major specialties including 24-hour catherization lab availability. Our group offers a stable contract, extremely competitive compensation, flexible, fair scheduling, pension and profit sharing plans. In addition, there is the potential for partnership after two years. If you are interested in hearing more about this opportunity, please contact Kenneth Whiteside, MD FACEP at the email address below. (PA 855)
Email: Kenneth.Whiteside@bhsnet.org
Website: baymed.org

MICHIGAN

Longstanding, democratic group seeking board certified/board eligible emergency medicine physicians. Associated with emergency medicine residency with teaching opportunities. Level 1 Trauma location and/or lower volume rural emergency departments. Competitive, equitable reimbursement and outstanding benefit package. All year recreational and "four seasons" lifestyle. Proximate to Lake Michigan and innumerable inland lakes. Excellent cultural and educational resources. Qualified emergency physicians please send CV to Attention: President of Southwestern Michigan Emergency Services, P.C. 1850 Whites Road, Suite 3, phone: 269-343-3900, fax: 269-343-5640, or email to the address below. (PA 895)
Email: swmesadmin@tds.net
Website: www.swmes.com

MISSOURI

Salem Memorial District Hospital (SMDH) is a 25-bed Critical Access Hospital that has served Salem and the Dent County surrounding area for over 35 years. Our emergency department averages 8,500 visits per year. A great schedule with twenty-four hour shifts and only seven shifts during a twenty-eight day period. A competitive salary and complete benefit package includes: malpractice insurance coverage, medical, prescription and dental insurance and reimbursement for Continuing Medical Education programs. Located in the "Heart of the Ozarks" our community has great schools, low crime and beautiful scenic areas to experience fishing, camping, canoeing and hiking. (PA 869)
Email: adminsecretary@smdh.net
Website: smdh.net

MISSOURI

UNIQUE PARTNERSHIP OPPORTUNITIES IN NEW DEMOCRATIC GROUP IN ST. LOUIS, MISSOURI: Highly desirable, outstanding full-time opportunities available with new emergency physician group located in suburban area of St. Louis. 36 bed Level II emergency department plus 7 bed fast track in a large community hospital. Good payer mix, good specialty backup. Full partnership opportunity after only 1 year. Outstanding compensation and health benefits, retention bonus and malpractice insurance. Part-time also available. Applicants MUST be EM board certified or board prepared. Send CV or inquiries to Mike Rush or Ed Ferguson at the email address below. (PA 889)
Email: mcecrush@att.net; ewferguson@gmail.com

NEVADA

ER Physicians: Multiple openings at the prestigious Mike O'Callaghan Federal Hospital, Nellis AFB, Las Vegas, NV. Full or part-time openings. Serve those who serve our country while enjoying your time off in one of the most exciting cities in the USA. American Hospital Service Group has a long-standing contract at this facility placed in a city that has something to offer everyone. Board certified physicians, part-time or full-time. Any state license accepted at Federal work places, and malpractice immunity provided. Contact Jill at 410-451-2415 or by email at the address below. (PA 858)
Email: JJT@americanhospital.us
Website: www.americanhospital.us

NEVADA

Employed opportunity with Banner Health in Fallon, NV. BC/BE emergency medicine with fully-paid malpractice with tail on departure. 24/7 Hospitalists for admissions. Competitive salary & recruitment incentives, rich benefits package & 401k retirement w/4% match after one year, CME days plus allowance and more! Fallon offers comfortable lifestyle and moderate cost of living, No State Income Tax. Close to Tahoe - snow ski in the winter, water sports in the summer! Join the BANNER HEALTH team in Fallon, NV. Send us your CV today; we'll call you for an interview tomorrow! (PA 863)
Email: doctors@bannerhealth.com
Website: www.bannerdocs.com

NEVADA

We are seeking 6 emergency physicians to join a well-established group in Las Vegas. This group covers emergency services at Sunrise, MountainView and Southern Hills Hospitals. Competitive salary (employed), full benefits, 401k, profit sharing. Call Linda Erwin, HCA Healthcare at 800-824-9275; fax: 866-283-2210; or email to the address below. (PA 880)
Email: Linda.Erwin@hcahealthcare.com
Website: www.practicewithus.com

NEW HAMPSHIRE

Physician opportunity in Nashua, NH. Tired of being recruited by all those "big brother" organizations? Want to get the FULL amount of YOUR earnings? Want input in the management of your group? Innovative group in southern NH seeks BC/BE EP to join fully democratic group with well-established pay-for-productivity plan based on personal performance. Top performers can expect one of the highest compensations in NH. Flexible/equitable scheduling from day one. One year to partnership with full benefits. Great area of New England – 1 hour to Boston, mountains and coast. Great for family life. Contact Brian Lohnes at 603-801-6226 or by email at the address below. (PA 892)
Email: lohneslink@hotmail.com

NEW JERSEY

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, MD MPH, University Hospital, 150 Bergen Street, M-219, Department of Emergency Administration, Newark, NJ 07101. Telephone 973-972-6224. Fax: 973-972-6646. (PA 845)
Email: shahidho@umdnj.edu
Website: www.njemr.com

NEW MEXICO

Santa Fe: We are an independent, democratic group seeking board certified (or board eligible) 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 the address below. (PA 829)
Email: administrator@sfep.org
Website: www.sfep.org

NEW MEXICO

Las Cruces: 35,000+ volume ED. Stable democratic 9-member group, W-2 income based on your share of production, full profit-sharing partner at 6 months, fully funded pension at 1 year; beautiful high desert university town; full-time position for board certified/prepared emergency physician available now. Contact William Einig, MD, 575-649-4220, wweinig@mac.com; or Radosveta Wells, MD, 915-833-4546, rmitova@yahoo.com. (PA 874)
Email: rmitova@yahoo.com

NEW YORK

Buffalo, NY – University @ Buffalo, Department of Emergency Medicine is seeking full-time faculty for an established, accredited EM Residency Program. Applicants should be EM board certified/eligible. Responsibilities may include clinical care, teaching/supervision of students and residents, EMS, research or administration. Compensation package includes a competitive salary, 12% retirement, health, dental, disability and 36 paid days off. Candidates should contact: G. Richard Braen, MD, Professor and Chairman, Department of Emergency Medicine, Buffalo General Hospital, 100 High Street, Buffalo, New York 14203 or email ckolek@kaleidahealth.org with CV. The University at Buffalo is an Equal Opportunity Employer/Recruiter. (PA 867)
Email: jpokerwinski@kaleidahealth.org

NEW YORK

Bassett Healthcare, a multi-specialty group in central New York State, is seeking qualified emergency medicine physicians to join our staff, serving patients in our growing multi-hospital network. Key features of this position include closed medical staff, 225+ physicians, employed position with competitive salary and 12 shifts per month. Paid malpractice, health insurance, relocation, generous vacation & CME time and retirement. PA coverage and excellent support staff. Great quality of life and excellent schools in a safe environment. Bassett is actively developing a 2-year medical school clinical campus in addition to its long-standing Medicine, Surgical and Transitional residency programs. (PA 886)
Email: debra.ferrari@bassett.org
Website: www.bassett.org

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 certified/eligible. 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. Equal Opportunity Affirmative Action Employer. (PA 824)
Email: jhoekstr@wfubmc.edu
Website: www.wfubmc.edu/em/

NORTH CAROLINA

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, or email to the address below. Equal Opportunity Affirmative Action. (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 24,000 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, or by email at the address below. (PA 827)
Email: flysgi@yahoo.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 years old and offers $165/H plus malpractice (Pre-partnership $145/H for 12 months), 401k, pretax business account, $180/H for nights. 24H hospitalist coverage for admissions in both hospitals. Top-notch 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 to the address below. (PA 850)
Email: volumizer@yahoo.com
Website: http://www.clevelandregional.org/history.cfm

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, MD, Phone: 513-231-1521 or by email to the address below. (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

Portland, Oregon metropolitan area opportunity for emergency medicine BC/BE physician. 25,000 annual visits. Good hourly pay with built-in adjustment for increased volume, full benefits plan. Small hospital with responsive administration. 64 slice scanner, 24 hour US, bedside US, EMR with tracking board, hospitalist program. Looking for physician proficient with computers and EMR's, skilled with procedures, and good people skills. Excellent nursing staff. ED techs. Good balance of peds, trauma, medical and surgical patients. Contact Elizabeth Bohnstedt at 503-873-1589 or by email to the address below. (PA 877)
Email: ebohnstedt@silvhosp.org
Website: www.silvertonhospital.org

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 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. (PA 847)
Email: Tziff@Mountnittany.org

PENNSYLVANIA

Emergency Medicine--Exciting FT opportunity for BC/BE emergency medicine physician to join a collegial group at Taylor Hospital, a 151 bed suburban not-for-profit community hospital, twenty minutes from downtown Philadelphia, PA. Ideal candidate is residency trained and committed to providing high quality care. Taylor Hospital is a member of the Crozer Keystone Health System, major provider of community healthcare. The emergency department treats all types of patients and sees over 28,000 patients annually. This is an employed position with competitive salary, LIABILITY INSURANCE WITH TAIL COVERAGE, and other excellent benefits. Please reply with CV to pam.devito@crozer.org or gregory.cuculino@crozer.org. (PA 883)
Email: pam.devito@crozer.org
Website: www.crozer.org

RHODE ISLAND

Seeking BC/BE emergency physician at 294-bed community teaching hospital affiliated with Brown University. Eleven emergency physicians care for 35,000 patients/year. Coverage/37 hours/day, plus 12 hours/PA coverage urgent care. Hospital-based residency program provides numerous opportunities, including clinical teaching appointment. Competitive salary and benefits package: paid health/dental, life/long-term disability, malpractice coverage, four weeks vacation, CME, 403B tax shelter annuity plans, paid professional memberships, board certification/paid license costs. Incentive for 50% or greater commitment to night shifts. Contact Ludi Jagminas, MD, Chief, Emergency Medicine, Memorial Hospital of Rhode Island, 111 Brewster Street, Pawtucket, RI 02860, Fax: 401-729-3112 or call 401-729-2419. EOE. (PA 872)
Email: ljagminas@mhri.org
Website: www.MHRI.org

TEXAS

Carl R. Darnall Army Medical Center at Fort Hood, Texas, is seeking a board certified emergency medicine physician. Full-time position working 8 hour shifts with a mixture of clinical and administrative duties. Serve as core faculty for the CRDAMC emergency medicine residency program. Our brand new level III trauma designated emergency department has an annual volume of 70,000 patients, low to moderate acuity. Compensation package includes competitive salary, malpractice coverage, comprehensive benefits, paid sick and vacation time, relocation allowance and annual retention bonus. For further information, please contact LTC Steve Tanksley, MD at 254-288-8302. (PA 859)
Email: Steven.J.Tanksley@amedd.army.mil

TEXAS

Covenant Medical Group, located in Lubbock, Texas, is seeking experienced BC/BE physicians to join a growing physician emergency medicine program. Our physicians enjoy all the benefits of metropolitan living, entertainment and recreation, an international airport and a major Big 12 University, Texas Tech University. Covenant Medical Group is a multi-specialty group with more than 200 physicians across western Texas and eastern New Mexico. We offer a competitive salary and an excellent benefit package that includes medical/dental insurance, life insurance, vacation/holidays, retirement plans and reimbursement for CME and other benefits. CV can be forwarded to kreeves@covhs.org. For telephone inquiries call 806-725-7875. (PA 862)
Email: kreeves@covhs.org
Website: www.covmedgroup.org

TEXAS

One of the only truly democratic partnership groups in DFW is seeking ABEM BC physicians to join our group. 70K volume in ED with 30+ beds located in the center of the Dallas-Fort Worth metroplex. Every member of the group is board certified in emergency medicine and we want to continue this excellence. Competitive hourly rates and partnership track. Contact Travis Coates, MD at 817-481-4104 or by email at the address below. (PA 882)
Email: ltcoates@charter.net

TEXAS

The Department of Emergency Medicine at the University of Texas HSC-Houston is planning to expand its residency training program to include an additional clinical site and is seeking candidates for faculty positions. Responsible for emergency departments at Memorial Hermann Hospital (level-1 trauma center and comprehensive tertiary care facility in the Texas Medical Center) and Lyndon Baines Johnson General Hospital, a community hospital. Competitive package of salary/benefits and excellent faculty development opportunities. Forward CV to: Brent R. King, MD, Chairman-Department of Emergency Medicine, University of Texas Medical School at Houston, P.O. Box 20708, Houston, Texas 77030. (PA 887)
Email: Yolanda.V.Torres@uth.tmc.edu

TEXAS

Physicians Emergency Care Associated. Established, stable group located in Dallas, Texas. Our group has staffed Methodist Health System for over 25 years. Positions available for full or part-time independent contractor. Shifts vary from a Level 2 Trauma Center, a busy, high-acuity suburban medical center and a recently opened suburban center. Individual malpractice insurance provided. Reimbursement based on productivity. Seeking ABEM BC/eligible EM physicians. For information, contact Stacey Dolotina, office manager, at 214-942-5733 or by email at the address below. (PA 888)
Email: staceydolotina@gmail.com

VERMONT

Seeking BC/BE emergency medicine physician in southern Vermont. 99-bed hospital with magnet nursing designation. Flexible scheduling with competitive pay and benefits. Advanced airway equipment available including fiber optic intubation. Within 3 hours of Boston and New York City and skiing opportunities within 40 minutes. For more information, please contact Nicole Goswami, Physician Recruiter at gosn@phin.org or by phone at 802-447-5236. (PA 878)
Email: gosn@phin.org
Website: www.greenmtnsgreatdocs.org

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 at 540-741-1167, or by email at the address below. (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 BC/BE. (PA 836)
Email: daniel.ricciardi@mjh.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 BC/BE 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

WASHINGTON

Democratic group of 13 EM board certified physicians seeking a BC/BE physician to join our single hospital group. We have enjoyed 27 years with our partner hospital, St. John Medical Center, a 193 bed, level III trauma center with an ED census of 50,000 pts/year. Consideration for full partnership after one year. In the shadow of Mt. St. Helen, our location offers a variety of outdoor opportunities. Longview is a charming and affordable city along the banks of the Columbia River. Send CV to: Holly Liberatore MD, Cascade Emergency Assoc. PO Box 2404, Longview, WA 98632 or by email to the address below. (PA 873)
Email: liberatoreh@comcast.net

WASHINGTON

Well established, democratic group 30 min. north of Seattle is looking for EM BC/BE physicians. Multi-site with over 120,000 visits annually, stable contracts, excellent compensation with generous benefits. Consideration to full partner after one year. Two of our largest sites are consolidating into a brand new, state-of-the-art 79 bed ED to be completed in 2011. Our beautiful Pacific Northwest locale is ideally situated, providing abundant recreational activities to satisfy the outdoor enthusiasts while also appealing to those who appreciate the cosmopolitan city life. To submit your CV or to request further information, please send an email to the address below. (PA 864)
Email: contact@northsoundem.com

WEST VIRGINIA

Emergency Medicine Opportunity - Join 10 other practicing emergency physicians. Excellent salary commensurate with experience. 56K ER visits per year. Level II Trauma Center with 24-hour hospitalist coverage. Comprehensive benefits, malpractice included. 8-9-10 hour shifts available. Work with medical school residents. A stunning area with excellent schools and low cost of living. "Top 100" private Liberal Arts college. Largest man-made lake in the state. State record fishing, hunting, boating and biking. Short distance to 4 major metro areas. Festivals, snow skiing, canoeing and kayaking. Historic downtown, concert halls and theater. Contact: Rob Rector at 800-492-7771 or by email to the address below. (PA 866)
Email: rrector1@phg.com
Website: www.phg.com

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

WISCONSIN

Would you enjoy living near Madison, WI? If so, please consider this outstanding emergency medicine opportunity in a scenic community, just minutes from the picturesque Wisconsin River. This democratic group divides nights, weekends and holidays equally. The ideal candidate will have strong interpersonal skills and the ability to work well with support staff and colleagues. This progressive community hospital possesses state-of-the-art technology including electronic medical records and a newly installed CT Scanner. (PA 853)
Email: akind@strelcheck.com
Website: www.strelcheck.com

WISCONSIN

Come Join Infinity HealthCare. Our private practice group currently manages and staffs 20 emergency departments in Wisconsin and Illinois. Our respected, well established emergency medicine group offers qualified, ABEM/AOEBM certified physicians the opportunity to join us in a variety of practice settings. Infinity HealthCare offers an outstanding compensation and benefit package including a retirement plan and a distributed ownership structure that provides for each physician employee to have shared equity. There are unlimited opportunities to engage in administrative/leadership roles in the hospital setting and within Infinity HealthCare. Call Mary Schwei at 888-442-3883 x 724. (PA 885)
Email: mschwei@infinityhealthcare.com
Website: www.infinityhealthcare.com

WISCONSIN

Emergency medicine physician. Gundersen Lutheran Health System, based in La Crosse seeks a BC/BE emergency medicine physician. With yearly visits in the range of 30,000 you can live a balanced lifestyle in a collegial environment with twelve experienced physicians on staff in our accredited level 2 trauma center. This position involves double coverage, residency teaching, eight hour shifts and medical control for air/ground transport and paramedics. New critical care tower to include a new TEC will be built. Contact: Jon Nevala, Medical Staff Recruitment at 800-362-9567 ext. 54224 or by email to the address below. (PA 896)
Email: jpnevala@gundluth.org
Website: http://gundluth.jobs

ANTARCTICA

Discover Antarctica! Opportunities for Lead Physician, Staff Physician, Physician Assistant/Nurse Practitioner. Raytheon is the primary contractor to the National Science foundation, providing support to three US stations in Antarctica: McMurdo Station, South Pole and Palmer Station. Medical operations are typical of family practice, emergency medicine and occupational health. Each station is a tight knit community providing dining hall services, organized recreation, laundry facilities, post office and phone & internet access. Staff are assigned during the summer (October - February) or winter season (February - November). Apply Now! (PA 879)
Email: kimberly.jones@usap.gov
Website: www.rpsc.raytheon.com.

CANADA

Our Region: The RQHR offers opportunities for medical professionals to be part of a dynamic health team providing superior patient care. Emergency physician positions provide full-time coverage for shifts in an established rotation. Physicians are contracted to work within the RQHR. The ideal candidate will hold certification in emergency medicine. A license to practice in Saskatchewan, ACLS and ATLS are required. In accordance with immigration requirements, preference will be given to Canadian citizens and permanent residents of Canada. For information please contact: Erin Roesch, Coordinator, Physician Recruitment and Retention. Phone: 306-766-2182, fax: 306-766-2842 or by email to the address below. (PA 854)
Email: erin.roesch@rqhealth.ca
Website: www.rqhealth.ca

NEW ZEALAND

Emergency physician (1.0FTE). Available from February 2009. 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 by email to the address below. (PA 843)
Email: medical.coord@nhl.co.nz
Website: http://www.northlanddhb.org.nz

FAAEM
always means
board certified

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

Pre-Sorted
Standard Mail
US Postage
PAID
Milwaukee, WI
Permit No. 1310