common SENSE

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

VOLUME 15, ISSUE 5
SEPTEMBER/OCTOBER 2008

FAAEM
always means
board certified

PRESIDENT'S MESSAGE

Fairness and the AAEM Job Bank

Larry D. Weiss, MD JD FAAEM

In response to our members, and in reflection of our duty of fairness to our advertisers, we revised our job bank policies several times in recent years. The time has come to recognize the fact that "fairness" exists in many forms. Our Academy has long promoted the physician-owned democratic group as a model of fairness. However, this does not preclude us from designating other models of practice as "fair," particularly the fair employment arrangement.

Two years ago, the Academy adopted its current fairness policy. According to this policy, we grant our fairness designation to emergency departments or physician groups with a predefined partnership track, due process rights, the absence of post-contractual restrictive covenants, open books and a democratic decision-making process. While using this as a model, AAEM never claimed this was the only right way to practice emergency medicine. Indeed, we currently publish advertisements from contractors and employers who cannot meet our fairness designation.

I propose that we also develop a fair employer policy, recognizing those employers who respect the practice rights of their physician employees. I work for a very fair employer, the University of Maryland. Our workplace includes no infringements of our practice rights, we have many opportunities for educational enrichment, and we even make most decisions democratically.

I spent most of my career at another university where a single individual owned the professional corporation that held the contract to manage the emergency department. I never met a fairer person in my life. He treated us generously and consistently came to our support whenever necessary. He even allowed us to make every practice decision in a democratic manner. He strongly supported our state AAEM chapter.

Even though the Academy held up the democratically owned group as a model, we never excluded other groups from our activities. We revised our job bank policies several times in an effort to remain inclusive, while screening our potential advertisers for practices that we reasonably believed operated inconsistently with state corporate practice of medicine (CPOM) laws.

Applicable laws and ethical standards require us to deal fairly and evenly with all parties relating to the profession of emergency medicine. However, applicable laws do not require us to act in a complicit manner with entities we reasonably suspect of acting in a manner contrary to law. For example, if a state CPOM law prohibits lay corporations from owning medical practices, or prohibits lay corporations from controlling physicians, then we have no obligation to further such activities.

I hope in the near future that an AAEM task force can successfully describe the characteristics of a fair employer. I hope we will always continue job bank policies allowing us to publish advertisements of all positions (1) open to AAEM diplomates, (2) in emergency departments that do not violate the legal rights of emergency physicians, and (3) in emergency departments managed by entities that do not operate in violation of state CPOM laws. We must continue to carefully offer similar opportunities to all legitimate advertisers. Certainly, we may limit advertisements open to ABEM and AOBEM eligible and certified physicians because of the target audience of our publications.

While continuing to promote the democratically owned and operated group as our model, we may also recognize other forms of fair behavior. One does not violate any law by promoting fairness, but we must be careful not to exclude those who we simply designate as unfair.

Finally, I hope by the end of my term to further modify our job bank policies by incorporating many of our members' ideas, keeping the job bank open to all legal entities hiring ABEM/AOBEM eligible and certified physicians, while designating those positions meeting our fairness criteria. Perhaps an alternative designation of fairness could include employers who treat their employee physicians fairly while respecting their practice rights.

I look forward to any comments regarding these issues from our members. Please contact me at lweiss@aaem.org. We already incorporated ideas sent by our members to improve the job bank. I will try to personally answer every member who contributes to this effort by sending us your ideas.

INSIDE THIS ISSUE

EDITOR'S Letter

Stuff Happens

EDITOR'S LETTER

David Kramer, MD FAAEM

I see it every year in our residency program: weddings, divorces, births, illnesses, deaths. Their occurrence is almost as predictable as hospital overcrowding. The issue isn't "if something will happen," but "when it will happen." Both happy and sad events often have similar impact. There are coverage issues intertwined with professional issues. It's easy to say one should "check it at the door," but it is hard to do so. I talk about these issues every year during orientation of my new residents. I make it clear that if it doesn't happen to them during their residency training, it will likely happen during their careers. I make it clear that the teamwork they show when others need help will be the teamwork they receive when they are in need. I'm lucky to work with a great group of residents in which virtually every one is willing to step up to the plate to help when needed. Rarely have I needed to force professional behavior upon them. Each one knows that next time s/he might be the one asking for help.

I am fortunate to also work with faculty who understand these principles. We have had our fair share of "stuff happen" to our colleagues. Each individual has helped out when needed. For those of you currently exploring the job market, I encourage you to look into the personality and professionalism of the group you are considering joining. Talk with those you did not interview with. Find out how difficult issues are handled. This can definitely impact your overall wellness and happiness with your career and life. Remember that there is a lot more to consider than just the contract you will sign. Stuff **will** happen. What matters is how it is dealt with.

Finally, keep in mind that AAEM's 15th Annual Scientific Assembly is fast approaching. March will be here before you know it. Secure the dates now so you can attend what promises to be a great meeting. I hope to see you all in Phoenix.

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.

EM in Lesotho

Authors: Dr. David Murman and Dr. Alison Sullivan are emergency medicine residents at Boston Medical Center who both worked at Maluti Adventist Hospital in Lesotho for two months.

Editors: Christopher Doty, MD FAAEM and Andrew C. Miller, MD are both from State University of New York (SUNY) Downstate Medical Center and Kings County Hospital Center in Brooklyn, NY. Dr. Miller is a resident in the Combined EM/IM Residency at Kings County Hospital.

Background:
Lesotho is a small, largely rural country in southern Africa and is a true enclave, completely surrounded by South Africa. This mountainous country is the home to the Basotho people (a Bantu people) and was a British territory from 1868 until 1965. The current political structure is that of a parliamentary constitutional monarchy.

Geography:
Altitudes in Lesotho range from 4,500 to over 13,000 feet. High mountains cover about two thirds of the country, and snow is common in the winter months. The capital city Maseru has a population of roughly 200,000 people and is home to the flagship government hospital. The remainder of Lesotho's two million people live in medium to very small rural towns with the majority (81%) of the country's population living in remote rural villages.

Economy:
Eighty-six percent of Lesotho's population is engaged in subsistence agriculture. Despite this, agricultural products make up only 14% of the $5.5 billion GDP.[1] Thirty-five percent of the actively employed male work force is employed in South Africa, largely in the mining industry. Besides labor, Lesotho's other major resource is water. The recent construction of two major hydropower facilities has allowed Lesotho to become almost entirely self-sufficient in electricity production and sell the power and water to the Republic of South Africa. However, in Lesotho, only 7% of households have access to electricity. Poverty is a major problem in Lesotho, with 56% of the population living on $2 per day or less, and the unemployment rate is 45%.[2]

Healthcare In Lesotho:
Healthcare delivery in Lesotho is challenging as a result of the fact that 81% of the population lives in remote rural villages, often several hours walk over rough mountain paths from the nearest clinic. Access to healthcare in Lesotho is also limited by poverty and by lack of personnel. Basotho individuals pay directly at the point of service for their healthcare, and Lesotho has only one doctor per 20,000 people (compared to approximately 1 in 400 in the US).[3]

The healthcare system in Lesotho is composed of health posts and health centers at a primary level, with 16 district hospitals comprising the secondary level of care. Tertiary care is made up of the referral level Queen Elizabeth II Hospital in Maseru, Mohlomi Mental Hospital, Bots'abelo Leprosy Hospital and Senakatena AIDS clinic.[4] If a patient requires services which are not available within Lesotho, they may be referred to South Africa for further care. Health posts are run by volunteer community health workers and provide outreach type care, such as condom distribution and immunizations. Health centers are staffed by nurse clinicians, who provide outpatient primary care. The large district hospitals provide a variety of outpatient services, including both primary care and specialized clinics (such as HIV/AIDS and tuberculosis (TB) clinics), as well as inpatient services, operating theaters, labor and delivery and emergency rooms. In addition to the government run facilities, there are eight Christian Health Association (CHAL) run hospitals and 79 CHAL run health centers throughout the country. CHAL facilities are sustainable mission projects and serve approximately 40% of the population.

Contributing to Lesotho's difficulties with retaining medical personnel, Lesotho has no formal medical education aside from nursing schools. Most Basotho who attend medical school do so in South Africa, and few return to practice in their home country. Many of the physicians practicing in Lesotho are trained in South Africa with the remainder coming from other African countries. The majority do not stay on a long term basis.

The impact of HIV/AIDS in Lesotho:
Many of Lesotho's health problems are related to poverty, TB and the HIV/AIDS epidemic. According to Lesotho's ministry of health and social welfare, TB accounts for 31% of institutional deaths, pneumonia 29%, diarrheal diseases 14%, HIV/AIDS (which clearly contribute to the above causes of death as well) 9%, pneumoconiosis associated with pulmonary TB 6%, upper respiratory infection 5%, diabetes 3%, head injury 3% and incomplete abortion 0.5%.[5] Nutrition is also a major cause of disease in Lesotho, especially affecting children, with 13% of inpatient admissions resulting from nutritional deficiencies in children aged 0-4 and 3.5% of admissions for all age groups.[6]

Lesotho has the third highest HIV infection rate in the world with 29.8% of the general population HIV positive.[7] TB is very common (~550 cases/100,000 people) and is a leading cause of death according to Lesotho's ministry of health and social welfare. In Lesotho, the majority of HIV transmission is heterosexual and mother to child.[8] The reasons for high HIV rates in southern Africa are multi-factorial, including poverty and social instability, high levels of other STDs, sexual violence and high mobility (particularly migrant labor).[9] Many men from all parts of Lesotho travel to South Africa to work in mines where they live in single sex housing and are away from their wives and families for months at a time, often having interactions with professional sex workers. Many of the miners are at elevated risk for developing pulmonary silicosis (25%), and combined with HIV (34%), have a 16% per year rate of acquiring TB. Additionally, labor laws in South Africa require migrant labor workers to return to their country of origin for two weeks yearly, often bringing HIV and TB with them.[10]

The average life expectancy had declined from 50 years in 2000 to 34 years in 2005, but has improved to 40 in 2007,[11] coinciding with increased access to free antiretroviral therapy (ART).[12] Without the HIV/AIDS epidemic, life expectancy would be an estimated 75 years.

Emergency Medicine in Lesotho:
Lesotho is in the early stages of developing emergency medical care. Emergency medicine is not established as a specialty, and pre-hospital care consists of ambulances run by individual hospitals with no medically trained personnel aboard and no central dispatch. Many hospitals lack fuel to run ambulances. Only in cases where patients have phones and can call the hospital directly to request an ambulance are they sent. The patient is usually required to pay for the ambulance service, thus discouraging their use. As a result, there is little to no availability of medical stabilization prior to arriving in a hospital. As in many other developing countries, most patients are brought to the hospital by taxi (minibuses) or on foot. Given the rough topography of Lesotho, wheelbarrows lined with blankets and carts pulled by work-animals are sometimes used to carry patients long distances to roads. In large accidents, South African ambulances may be sent across the border to retrieve the few patients that have health insurance (often those employed by South African mines).

continued on page 9

Organizations Offer Roads to Improve Pain Management Care in Emergency Department

Al Rothstein, Public Relations, Israeli Medical Association - World Federation - United States Chapter

Emergency departments in the United States receive more than 110 million patient visits annually. In up to seventy percent of those patients, pain is the presenting complaint.

Treating pain is the challenge, and two organizations are now offering avenues that could lead to better treatment of pain in the ED, as well as other issues affecting emergency care. The organizations are the new United States Chapter of the Israeli Medical Association (IMA, www.ima-wf-usa.org) and the Pain and Emergency Medicine Institute (PEMI) at Beth Israel Medical Center in Manhattan.

"These organizations can share the latest research, and spread it around the globe," says Knox Todd, MD MPH FAAEM, Professor of Emergency Medicine at Albert Einstein College of Medicine and Director of PEMI. "For example, research that shows a high prevalence of inadequate pain treatment in the emergency room and identifies risk factors such as extremes of age, ethnicity and cognitive function. Research also finds extensive small and large area variations in emergency department pain management practices."

That might be because few emergency nurses or physicians are engaged in the study of emergency department pain management practices. The new organizations will encourage this kind of study.

"One result of a lack of sharing information," says Dr. Todd, "is the outdated practice of withholding analgesics for ED patients with acute abdominal pain because of the fear of masking the diagnosis."

"It is an example of the substantial gaps that remain between existing knowledge and daily pain management practice in the emergency department," he says.

Dr. Todd and others want to close this gap by providing:

a) resources and information about best practices;
b) education to emergency care providers; and
c) the facilitating of research to promote improved practice.

He wants to build on the success of past research collaborations and identify themes to create opportunities for research among colleagues. This will also involve creating a network of emergency nurses and physicians committed to these goals.

Advanced Israeli Medicine

The IMA's new U.S. chapter will provide visits to and exchange programs with Israeli medical facilities for its member U.S. physicians, especially in the areas of emergency medicine and disaster recovery.

Pinchas Halpern, MD, Chair of the emergency department at Tel Aviv Medical Center and senior lecturer of emergency medicine, anesthesiology and critical care at Tel Aviv University, explains that the field of emergency medicine in Israel can not only offer advanced learning to U.S. physicians, but different philosophies of operating EDs as well.

"There seem to be fewer barriers in Israel, such as shorter waiting times in the ED and less fear of opiates," he says.

"In Beersheba, I observed how the field of emergency medicine was being practiced, with a multidisciplinary approach," says Roman Skylar, MD MBA FACEP, Medical Director of Aventura Hospital and Medical Center in Aventura, Florida. "In the U.S., we learn all aspects of medicine from the ED physicians, while in Beersheba, I learned it from the specialists themselves. I also observed how organized the trauma teams were and the set up of the facilities. It was quite impressive!"

"As I advance my career into becoming an ED director, observing the inner workings of EDs in other countries with fresh and different ideas will benefit my patients with fresh ideas for our facility setup."

But American emergency physicians also have something to offer their Israeli colleagues through visits to U.S. facilities and international conferences.

"Bringing people together in the U.S. and Israel means more cooperation and learning for both," says Dr. Todd.

The Goals

Dr. Halpern would like to see medical centers around the world:

a) make pain management part of the routine quality assurance and improvement system of the ED and the entire hospital; and
b) instill in their staffs the understanding that pain belongs to and can only be gauged by the patient. Therefore, it can only be treated adequately if we respect this understanding.

In its programs, the IMA's U.S. chapter will take on issues like the above by identifying emergency physicians and nurses with similar interests and create opportunities to enhance communications between them and their Israeli colleagues.

Dr. Halpern says, "The goal for me is to make the alleviation of pain a routine, self evident priority for all ED physicians and nurses, so we do not need to continually remind them of it. The issues in acute pain management are similar in many ways across the world, and much can be learned from each other."

And Dr. Todd reminds us, "Brennan, Carr and Cousins have written that, '...a coherent international consensus is emerging: The unreasonable failure to treat pain is poor medicine, unethical practice and is an abrogation of a fundamental human right'."

For more information about the Israeli Medical Association, visit www.ima-wf-usa.org.

Conference travel got you down?

Introducing...

CMEDOWNLOAD.COM ACCESS PASS

new! iPhone compatible!

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

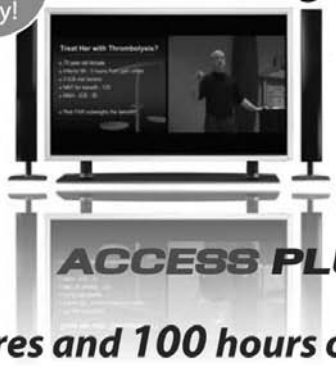
View FREE FULL LECTURES and ORDER NOW at www.cmedownload.com.

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

Limited time only!

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!"

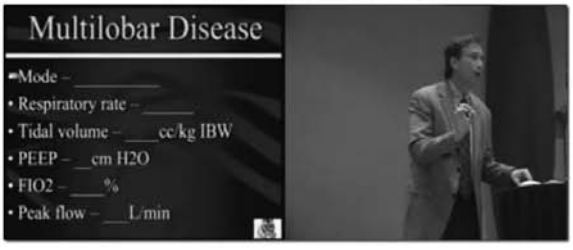
"Love the lectures with presenter on one side and the slides on the other. Feels like I am actually there."

Featured Content!

UCSF High Risk EM
Resuscitation
Cedars-Sinai Symposium
EKG Workshop
Procedure Course
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.*

Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have recently been established.

The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below that contributed from 2005-2008.

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.

PRESIDENT'S CIRCLE

David W. Lawhorn, MD FAAEM

SPONSOR

Larry D. Weiss, MD JD FAAEM
Anonymous
Anonymous
Anonymous

BENEFACTOR

William T. Durkin, Jr., MD FAAEM
Samuel H. Glassner, MD FAAEM

MEMBER

Douglas John Butzier, MD MBA FAAEM
Crystal Cassidy, MD FAAEM
Mark A. Foppe, DO FAAEM
Robert E. Gruner, MD FAAEM
Robert M. McNamara, MD FAAEM
Deborah R. Natale, MD FAAEM
Paul M Peindl, MD FAAEM
Winston Daniel Ryan, MD FAAEM
Andy Walker, MD FAAEM
Theodore M. Willmore, MD FAAEM
Anonymous
Anonymous
Anonymous

DONOR

Peter G. Anderson, MD FAAEM
Michael P. Applewhite, DO FAAEM
Garo Balkian, MD FAAEM
William M. Barnett, MD FAAEM
Mark Alden Batts, MD FAAEM
John W. Becher, DO FAAEM
Kevin Beier, MD FAAEM
Michael L. Blakesley, MD FAAEM
Stephen E. Bowden, MD FAAEM
Riemke M. Brakema, MD FAAEM
Michael J. Buchele, MD FAAEM
Michael R. Burton, MD FAAEM
Terry K. Carstensen, DO FAAEM
Marcel Cesar, MD FAAEM
Woodworth B. Clum, III, MD FAAEM
Domenic F. Coletta, Jr., MD FAAEM
Robert J. Cox, MD FAAEM
Damon Dietrich, MD FAAEM
Sundeep Jayant Ekbote, MD FAAEM
Thomas W. Hale, MD FAAEM
David R. Hoyer, Jr., MD FAAEM
Robert F. Kacprowicz, MD FAAEM
A. Antoine Kazzi, MD FAAEM
Kathleen P. Kelly, MD FAAEM
Gerhard Anton Krembs, MD FAAEM
James A. Levine, MD FAAEM
Joseph R. Lex, Jr., MD FAAEM
Bruce E. Lohman, MD FAAEM
Ann Loudermilk, MD FAAEM
Michael Maxwell, MD
Andrew P. Mayer, MD FAAEM
Peter B. Mishky, MD FAAEM
James P. Moises, MD FAAEM
William D. Morris, MD FAAEM
Robert J. Nisenbaum, DO FAAEM
Pamela S. Parks, MD FAAEM
Catherine V. Perry, MD FAAEM
Vitaut N. Ragula, MD FAAEM
Nate T. Rudman, MD FAAEM
Tom Scaletta, MD FAAEM
Joel B. Stern, MD FAAEM
Richard J. Tabor, MD FAAEM
Phyllis A. Vallee, MD FAAEM
Joseph P. Wood, MD JD FAAEM

In addition to the above, there were 31 anonymous donors.

CONTRIBUTOR

Paul Ahlers, MD FAAEM
Senthil Alagarsamy, MD FAAEM
Jaime J. Aleman, MD FAAEM
Michael J. Ameres, MD FAAEM
Gregg D. Anderson, DO FAAEM
Steven Michael Anneken, MD FAAEM
Jonathan D. Apfelbaum, MD FAAEM
Carmelito Arkangel, Jr., MD FAAEM
George W. Atwell, MD FAAEM
Frederick V. Bauer, MD FAAEM
Jason R. Bell, MD FAAEM
Marny Benjamin, MD FAAEM
Michael A. Bohrn, MD FAAEM
Gary Bonfante, DO FAAEM
James G. Boslough, MD FAAEM
James K. Bouzoukis, MD FAAEM FACS
Richard D. Brantner, MD FAAEM
Peter D. Braun, MD FAAEM
J. Allen Britvan, MD FAAEM
Thomas A. Brunell, MD FAAEM
Michael Bublewicz, MD
Leo W. Burns, MD FAAEM
Harry S. Calvino, MD
Daniel B. Campbell, MD FACEP FAAEM
Carlos H. Castellon, MD FAAEM
Roger J. Chirurgi, MD FAAEM
Adam T. Cios, MD
William K. Clegg, MD FAAEM
Joseph E. Clinton, MD FAAEM
John I. Cronkhite, MD FAAEM
Patrick W. Daly, MD FAAEM
Taras J. Danyluk, DO FAAEM
Daniel F. Danzl, MD FAAEM
Robert J. Darzynkiewicz, MD FAAEM
Chad A. Davis, MD FAAEM
Richard E. Deno, MD FAAEM
Pierre G. Detiege, MD FAAEM
John Timothy DiPasquale, MD FAAEM
Shari B. Dominguez, MD FAAEM
Timothy J. Dougherty, MD FAAEM
David M. Easty, MD FAAEM
Chad R. Eller, MD FAAEM

Recognition Given to Foundation Donors

Matthew L. Emerick, MD FAAEM
Marcus J. Eubanks, MD FAAEM
Michael S. Euwema, MD FACEP FAAEM
Baruch Fertel
Michael J. Foley, MD FAAEM
William T. Freeman, MD FAAEM
Gary M. Gaddis, MD PhD FAAEM
Anthony L. Genia, Jr., MD
Kathryn Getzewich, MD
Jody P. Ghosh, MD FAAEM
Richard Russell Gill, MD FAAEM
Jeffrey J. Glinski, MD FAAEM
Simone Gold, MD FAAEM
Steven D. Goodfriend, MD FAAEM
Stephen Paul Graner, MD FAAEM
Jonathan S. Grayzel, MD FAAEM
Jonathan C. Grimes, MD FAAEM
Marc D. Haber, MD FAAEM
William B. Halacoglu, DO FAAEM
Bruce A. Hall, MD FAAEM
Jack L. Harari, MD FAAEM
Benjamin P. Harrison, MD FAAEM
Floyd Wright Hartsell, MD FAAEM
Michael L. Hasty, MD FAAEM
Peter Healy, DO
Ross A. Heller
Linda L. Herman, MD
Aaron Hexdall, MD FAAEM
Victor S. Ho, MD FAAEM
Andre L. Holder, MD
Joel S. Holger, MD FAAEM
Richard G. Houle, MD FAAEM
Keith Hughlett, MD FAAEM
Robert Benjamin Johnston, MD FAAEM
Sam P. Josvai, MD FAAEM
Shammi R. Kataria, MD FAAEM
Robert B. Kelly, MD FAAEM
Michael Kent, MD FAAEM
Eric M. Ketcham, MD FAAEM
Michael Klein, MD FAAEM
David Kramer, MD FAAEM
Steven K. Kulick, MD FAAEM
William B. Lauth, MD MMM FAAEM
Denise S. Lawe, MD FAAEM
David C. Lee, MD FAAEM
David A. Leeman, MD FAAEM
Tracy Leigh LeGros, MD PhD FAAEM
David B. Levy, DO FAAEM
Michael Kevin Levy, MD FAAEM
Winston Lightburn, MD FAAEM
William R. Little, MD FAAEM
John L. Lyman, MD FAAEM
George D. Lynch, MD FAAEM
J. Michael Lynch, MD FAAEM
Ahmed Mahmood, MD
David L. Malmud, MD FAAEM
K. Alexander Malone, MD FAAEM
Gerald E. Maloney, Jr., DO FAAEM
Keith L. Mausner, MD FAAEM
Joseph T. McCaslin, MD FAAEM
Christopher A. McCrae, MD FAAEM
Brian R. McGovern, MD FAAEM
Paul D. McMullen, MD FAAEM
Carl A. Mealie, MD FAAEM
Chris A. Meeker, MD FAAEM
Andrew C. Meltzer, MD FAAEM
Jeffrey L. Mesuk, MD FAAEM
Beverly Ann Mikuriya, MD FAAEM
Granville A. Morse, III, MD FAAEM
Hani Mowafi, MD FAAEM
Michael P. Murphy, MD FAAEM
Heather M. Murphy-Lavoie, MD FAAEM
Todd A. Nash, MD FAAEM
Michelle S. Nathan, MD FAAEM
My-Huong Nguyen, MD FAAEM
Michael D. Olgren, MS MD FAAEM
Robert Verne Oliver, MD FAAEM
Jody N. Osborne, MD FAAEM
Edward A. Panacek, MD FAAEM
Hector L. Peniston-Feliciano, MD FAAEM
Lynn Pereira
Brian R. Potts, MD
Robert H. Potts, Jr., MD FAAEM
Katherine Pryde, MD FAAEM
Mark Reiter, MD MBA FAAEM
Marc C. Restuccia, MD FAAEM
Jeffrey A. Rey, MD FAAEM
Jake Roberts, DO FAAEM
Jonathan S. Rubens, MD MHPE FAAEM
Victor A. Sasson, MD FAAEM
Jonathon P. Savage, DO FAAEM
Kenneth A. Scheppke, MD FAAEM
Stephen P. Scherr, MD FAAEM
Joel M. Schofer, MD FAAEM
Anthony M. Scialdone, MD FAAEM
Layla Seyedabadi, DO FAAEM
William M. Shapiro, MD FAAEM
Philip R. Sharp, MD FAAEM
Paul R. Sierzenski, MD RDMS FAAEM
Keith D. Stamler, MD FAAEM
Timothy D. Sturgill, MD FAAEM
Paul A. Tenorio, MD FAAEM
Josef G. Thundiyil, MD FAAEM
Jalil A. Thurber, MD FAAEM
Bryce R. Tiller, MD FAAEM
Beverly L. Timerding, MD FAAEM
Judith E. Tintinalli, MD MS FAAEM
Wenzel Tirheimer, MD FAAEM
Theodore Toerne, MD FAAEM
David M. Trantham, MD FAAEM
Mary Ann Hanes Trephan, MD FAAEM
Meredith Tucker, MD FAAEM
Matthew W. Turney, MD FAAEM
Michael J. Urban, MD FAAEM
Samuel T. Uzabel, MD FAAEM
Patricia L. Van Devander, MD MBA FAAEM
Stephen N. VanRoekel, DO FAAEM
Arlene M. Vernon, MD FAAEM
Matthew J. Vreeland, MD FAAEM
Roland S. Waguespack, III, MD FAAEM
William Bruce Watson, MD FAAEM
Scott G. Weiner, MD FAAEM
Kay Whalen
Darin G. Wiggins, MD FAAEM
Joanne Williams, MD FAAEM
Janet Wilson
Shawn P. Wilson, MD FAAEM
Wayne Wolfram, MD FAAEM
Regan Wylie, MD FAAEM
Alvaro R. Zeballos, MD FAAEM

In addition to the above, there were 947 anonymous donors.

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 onto http://www.aaem.org/education/conferences.php

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

November 12, 2008
- AAEM Louisiana State Chapter Annual Meeting and State Business Luncheon
  New Orleans, LA
  www.aaemla.org or contact scusimano@newsouth.net

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
  Conference jointly sponsored by the Mexican Academy of Emergency Medicine and AAEM.

December 5-7, 2008
- 2008 Pediatric Emergency Medicine Conference
  Columbus, OH
  www.nationwidechildrens.org/conferences

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

January 5-8, 2009
- Caribbean Emergency Medicine Congress
  Barbados
  www.aaem.org/cemc/2009

January 25-29, 2009
- 7th Annual Western States Winter Conference on Emergency Medicine
  Park City, UT
  www.wswcem.com

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

February 7-11, 2009
- Rocky Mountain Conference in Emergency Medicine
  Copper Mountain, CO
  www.coppercme.com

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

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

March 13-15, 2009
- The Difficult Airway Course-Emergency™
  Miami, FL
  www.theairwaysite.com

March 17-19, 2009
- Second International Emergency Medicine and Disaster Management Conference
  Muscat, Oman
  www.omanemergency2009.com

March 27-29, 2009
- The Heart Course-Emergency
  Atlanta, GA
  www.theheartcourse.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
  www.theairwaysite.com

June 8-10, 2009
- The Heart Course-Emergency
  Cambridge, MA
  www.theheartcourse.com

June 13-25, 2009
- Expedition Medicine 2009
  Kilimanjaro
  www.expedmed.org

August 17-21, 2009
- Expedition Medicine 2009
  Washington, D.C.
  www.expedmed.org

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

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

October 26-28, 2009
- The Heart Course-Emergency
  Las Vegas, NV
  www.theheartcourse.com

November 13-15, 2009
- The Difficult Airway Course-Emergency™
  Atlanta, GA
  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.

AAEM Elections

Nomination Deadline: December 2, 2008

Two At-Large positions on the AAEM Board of Directors are open as well as the Young Physicians Section (YPS) Director Position. All current, full voting and YPS members of AAEM are eligible to run. Self-nominations are allowed and encouraged. You must be a YPS member to be eligible to run for the YPS Director Position.

Elections for these positions will be held at AAEM's 15th Annual Scientific Assembly, March 2-4, 2009, in Phoenix, AZ. Although balloting arrangements will be made for those unable to attend the Assembly, all members will be encouraged to hold their votes until the time of the meeting.

The Scientific Assembly will feature a Candidates' Forum, in which members will be able to directly question the candidates before casting their ballots. Winners will be announced during the conference, and those elected will begin their terms at the conclusion of the Assembly.

In order to nominate yourself or another full voting member for a Board position, please complete the nomination form found at http://www.aaem.org/elections/2008nominationform.pdf and send the information listed below to the AAEM office before midnight CST, on Tuesday, December 2, 2008. Any YPS member can be nominated and elected to the YPS Director Position. The nomination form and required information is the same as that for a Board position.

1. Name of nominee. Each nominee may have only three individuals as nominators/endorsers.
2. Name of nominee's medical school and year graduated.
3. Board certification status of nominee, including Board and year completed.
4. Number of ED clinical hours worked each week by the nominee.
5. A candidate statement (written by the nominee, 500 word max.) listing recent AAEM contributions, accomplishments, activities or any other information detailing why the nominee should be elected to the Board.
6. Any emergency medicine related business activity in which the nominee has a financial interest.
7. A copy of the nominee's CV.

The candidate statements from all those running for the Board will be featured in an upcoming issue of *Common Sense* and will be sent to each full voting member with their membership renewal packets.

These nomination and election procedures are what set AAEM apart from other professional medical associations. We believe the democratic principles that guide them are one of AAEM's greatest strengths and are an integral part of what makes us the organization of specialists in emergency medicine. In AAEM, any individual, a full voting or YPS member, can be nominated and elected to the Board of Directors.

EM in Lesotho - continued from page 3

The main governmental hospital, the 16 district hospitals and many of the mission hospitals have emergency rooms which are stocked with basic medical equipment such as oxygen, IV fluids, bag valve masks and IV medications such as epinephrine and atropine. These are often part of the outpatient departments of hospitals, where there are no appointments. During business hours, patients line up in the order in which they came, unless they are unable to walk or are clearly seriously ill or injured. Triage vital signs are infrequently performed, which leads to the common occurrence of very ill patients waiting several hours to be seen by a physician or nurse clinician. Most hospitals lack means to intubate and ventilate patients on an emergent basis, reserving the use of ventilators to the operating theaters. There is no standardized approach to critically ill patients. Access to pharmaceuticals varies by hospital, and there are few, if any, working pumps to run IV drips. Many antibiotics and oral anti-hypertensive agents are available. Oxygen is an expensive, limited commodity and is only given to those in clear respiratory distress.

Areas for future improvement:

Medical care in Lesotho is largely framed by the nation's challenges with HIV/AIDS, TB, poverty and topography. There are many potential interventions that may be taken in order to improve health outcomes. The most important factors in improving health in Lesotho are reducing poverty and increasing access to primary/preventative care, such as access to free/low cost ART and TB treatments. Improvements to roads and transportation infrastructure would likely have the largest impact on Lesotho's pre-hospital care. The development of a pre-hospital medical system with a centralized ambulance service and trained medical personnel may make a significant impact on health outcomes in densely populated areas of Lesotho. Potential hospital based improvements include the development and implementation of triage and improvement in nursing to patient ratios. Triage vital signs would be highly beneficial in ensuring that ill patients are promptly attended to. Recently, a residency program in family medicine was started, which will hopefully lead to better retention of doctors in Lesotho.[13] With these efforts and continuation of HIV/AIDS and TB prevention and treatment campaigns, Lesotho should have continued increase in average lifespan and improved health outcomes.

References

[1]CIA, CIA World Fact Book. Accessed electronically March 18, 2008 at https://www.cia.gov/library/publications/the-world-factbook/print/lt.html

[2]CIA, CIA World Fact Book. Accessed electronically March 18, 2008 at https://www.cia.gov/library/publications/the-world-factbook/print/lt.html

[3]Partners in Health website, accessed electronically March 18, 2008 at http://www.pih.org/where/Lesotho/Lesotho-background.html

[4]Lesotho Ministry of Health and Social welfare, accessed electronically March 18, 2008 at http://www.health.gov.ls/info/fs_referal.php#services

[5]Lesotho Ministry of Health and Social welfare, accessed electronically March 18, 2008 at http://www.health.gov.ls/info/epitomology.php

[6]Lesotho Ministry of Health and Social welfare, accessed electronically March 18, 2008 at http://www.health.gov.ls/info/epitomology.php

[7]Clinton Foundation, accessed electronically March 18, 2008 at http://www.clintonfoundation.org/programs-hs-countries5.htm

[8]Ministry of Health and Social Welfare [Lesotho], Bureau of Statistics [Lesotho], and ORC Macro. 2005. Lesotho Demographic and Health Survey 2004. Calverton, Maryland: MOH, BOS, and ORC Macro.

[9]The AIDS Foundation of South Africa, accessed electronically March 18, 2008 at www.aids.org.za

[10]Williams, BG and Gouws, E, "The epidemiology of human immunodeficiency virus in South Africa." Phil. Trans. R. Soc. Lond. 356 (2001): 1077-1086.

[11]CIA, CIA World Fact Book. Accessed electronically March 18, 2008 at https://www.cia.gov/library/publications/the-world-factbook/print/lt.html

[12]UNICEF website, accessed electronically March 18, 2008 at http://www.unicef.org/infobycountry/lesotho_statistics.html

[13]Lesotho Doctors, accessed electronically June 27, 2008 at http://www.bu.edu/fammed/lesothodoctors/residents/index.html

Where Will You Be November 4?

Kathleen Ream
Director of Government Affairs

Be Informed!

Before going to the voting booth on November 4, make sure you know the candidates' positions. AAEM's Legislative Action Center contains a comprehensive resource specifically designed to meet all your 2008 election needs whether they are federal, state or local. From detailed candidate bios to voter registration services, from information about specific ballot initiatives to help in locating polling sites, all this can be found under the **"Elections & Candidates"** tab on the homepage of the Legislative Action Center at http://capwiz.com/aaem/home.

The features include:

- ZIP code and address-to-district matching for a list of presidential, congressional, statewide and state legislature candidates
- Candidate biographical and contact information
- Candidate position statements
- Links to candidate meet ups
- Statewide ballot initiative information
- Voter guide information including key dates and deadlines, ID needed at the polls, and links to voting machine descriptions and polling locations
- Voter registration forms

In addition, for any of your federal legislators, look up their voting record on the issues of concerns to AAEM and the emergency medicine community. Go to your representatives or senators homepage on AAEM's Legislative Action Center, and click on the tabs "Votes" and "Bills" to see how they align with AAEM positions.

But most important, VOTE on November 4!

Low-Income Children Predominate in ED Visits

According to a recent News and Numbers summary from the Agency for Healthcare Research and Quality (AHRQ), lower-income children made almost twice as many visits to hospital EDs than higher-income children in 2005. AHRQ's analysis, which was based on more than 12 million ED visits by children under age 18 in 23 states, compared the number of ED visits by children from low-income communities, where the average household income was $36,999, to those of children from high-income communities with an average household income of more than $61,000. The rate for those from low-income communities was 414 visits for every 1,000 children, while the rate for those from high-income communities was 223 visits for every 1,000 children.

AHRQ also found that:

- Children were treated and released in 96% of all visits. The reasons for those visits included: respiratory conditions; superficial injuries such as bruises; middle ear infections; open wounds such as cuts and scrapes on arms and legs; and muscle sprains and strains.
- For the 5% of children admitted to hospitals, the top reasons were: pneumonia; asthma; acute bronchitis; appendicitis; dehydration and other fluid and electrolyte disorders; depression and other mood disorders; and epileptic convulsions.
- Roughly 45% of the visits were covered by Medicaid, 43% were covered by private insurance, 9% were uninsured, and 3% had other types of coverage.

State News

Trial Courts Rule Cap on Noneconomic Damages Unconstitutional
A Georgia trial court has found the state's $350,000 limit on noneconomic damages unconstitutional. Fulton County Superior Court Judge Marvin S. Arrington, Sr., said the cap violated patients' equal protection rights and access to a jury trial. Lawyers involved expect an appeal, which would send the issue to the state Supreme Court.

A similar decision was made in Illinois, where a trial court last November struck down the state's $500,000 cap for violating the separation of powers between the legislature and judiciary. The case was appealed to the state Supreme Court. The Litigation Center of the AMA and State Medical Societies and the Illinois State Medical Society (ISMS) filed a friend-of-the court brief in May. A ruling is expected later this year.

Physicians say the court decisions threaten to undo improvements in the medical liability environment in their respective states. Noting that, in the past three years, Georgia's medical liability insurance rates have stabilized, companies have reported an overall drop in claims filings and defense costs, competition is on the rise, and the state has seen a 10% increase in obstetricians at a time when few were practicing; Donald Palmisano, Jr., General Counsel to the Medical Association of Georgia, stated, "What this all results in is greater access to care for patients, and that's what we should be looking at."

Despite similar progress in Illinois, ISMS president Shastri Swaminathan said excessive jury awards still plague the legal system and that the state's cap is critical to help retain doctors. According to a February AMA report, states with noneconomic damage limits have an increased supply of high-risk specialists. Doctors in those areas also pay at least 17% less in insurance costs.

Trial lawyers, however, argue that the caps come at the patients' expense and praise the courts for restoring their rights. The Georgia Trial Lawyers Association called attention to research contradicting AMA's report. A March study conducted by the Harvard School of Public Health and George Mason University showed that most OB-GYNs' decisions to relocate or stop practicing are unrelated to insurance premiums or tort reform.

The Georgia case poses an additional threat to liability protections for physicians involved in **emergency care.** Plaintiffs challenged the validity of a provision under the reform statute requiring a higher standard of proof in emergency cases – an issue central to the underlying medical claim. The court said it would take up that question in a separate ruling.

Prior state Supreme Court rulings have invalidated other medical liability reforms. In 2006, the Georgia high court declared unconstitutional the venue portion of the liability reform statute that would have allowed defendants in joint medical liability cases to transfer lawsuits to the county where the alleged negligence occurred. And in 1976 and 1997, Illinois justices struck down award limits in medical liability cases.

continued on page 12

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 10

Louisiana Governor Signs Bills Protecting Medical Professionals
A package of bills designed to protect medical personnel from lawsuits arising from healthcare delivered during declared emergencies was signed into law by Governor Bobby Jindal (R) on June 30, 2008. Two of the measures, SB 301 and SB 330, sponsored by Senator Joel Chaisson, II (D-Destrehan), were inspired and backed by Anna Pou, the New Orleans physician who was arrested but never indicted over patient deaths at Memorial Medical Center after Hurricane Katrina. The bills provide lawsuit protections for paid medical professionals not covered under the existing Good Samaritan Act.

Specifically, SB 301 states that a healthcare official cannot be held liable "as a result of an evacuation or treatment or failed evacuation or treatment" conducted according to the procedures of emergency medicine "and at the discretion of military or government authorities." SB 330 goes a step further with a provision that grants limited immunity for medical personnel working within a disaster zone and giving medical care affected by the disaster. The bill also protects medical personnel from "simple negligence" but not from "gross negligence." The protection in both bills is intended to apply only to individual employees, not owners of the medical facilities in question.

A separate measure, sponsored by Representative Fred Mills (D-Parks), addressed immunity related to healthcare provided outside the disaster area. That legislation, signed by Governor Jindal, went into effect on August 15, 2008.

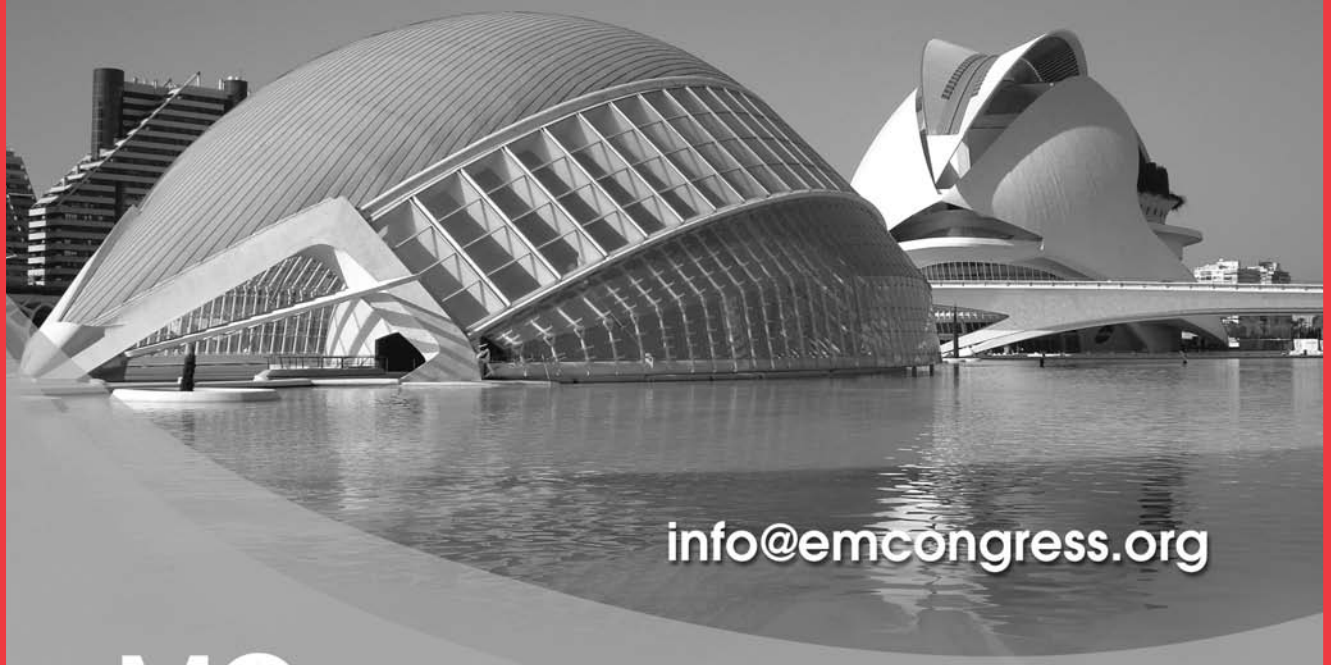
As for Louisiana's malpractice reform, another slate of bills altering the $500,000 cap on awards in medical malpractice suits appears dead for the session. Representative Nick Lorusso, (R-New Orleans) said representatives of the legal and medical communities will continue to work on potential compromises for next year's regular session.

AAEM congratulates Harold A. (Hal) Thomas, MD FACEP, on assuming the presidency of the American Board of Emergency Medicine (ABEM). Dr. Thomas served ABEM as a Director since 2001.

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!

Award Nominations Sought for AAEM Awards

DEADLINE: DECEMBER 2, 2008 - MIDNIGHT CST

AAEM is pleased to announce it is currently accepting nominations for its annual awards. Individuals can be nominated for the following awards:

DAVID K. WAGNER AWARD
As an organization, AAEM recognizes Dr. Wagner's contributions to the specialty by offering an award named in his honor to individuals who have had a meaningful impact on the field of emergency medicine and who have contributed significantly to the promotion of AAEM's goals and objectives. Dr. Wagner himself was given the first such award in 1995.

YOUNG EDUCATOR AWARD
Nominees must be out of residency less than five years and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs.

RESIDENT OF THE YEAR AWARD
Nominees for this award must be AAEM resident members and must be enrolled in an EM residency training program. This award recognizes a resident member who has made an outstanding contribution to AAEM.

JAMES KEANEY AWARD
Nominees for this award must have 10 or more years of experience in EM clinical practice and must be AAEM members. Named after the founder of AAEM, this award recognizes an individual who has made an outstanding contribution to our organization.

PETER ROSEN AWARD
Nominees for this award must have 10 or more years of experience in an EM academic leadership position and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM in the area of academic leadership.

JOE LEX EDUCATOR OF THE YEAR AWARD
This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs. Nominees must be AAEM members who have been out of their residency for more than five years.

Nominations will be accepted for all awards until midnight CST, December 2, 2008. The Executive Committee will review the nominees and select recipients for all awards except the EM Program Director of the Year Award (see below), which will be selected by the AAEM Resident and Student Association.

All nominations should be submitted in writing and should include:

1. Name of the nominee.
2. Name of the person submitting the nomination.
3. Reasons why the person submitting the nomination believes the nominee should receive the award.

Award presentations will be made to the recipients at the 15th Annual Scientific Assembly to be held in Phoenix, AZ, March 2-4, 2009.

Please submit all nominations to:
AAEM
555 East Wells Street
Suite 1100
Milwaukee, WI 53202
800-884-2236
Fax: 414-276-3349
info@aaem.org

Award Nominations Sought for AAEM/RSA Award

DEADLINE: DECEMBER 2, 2008 – MIDNIGHT CST

AAEM/RSA is pleased to announce it is currently accepting nominations for its annual EM Program Director of the Year Award.

Nominees for this award must have been involved in running a program as an Assistant, Associate or Program Director for five or more years. Nominees must be AAEM members and can only be nominated by AAEM resident members. This award recognizes an EM program director who has made an outstanding contribution to AAEM. The winner of this award will be chosen by the AAEM Resident and Student Association.

Nominations will be accepted for this award until midnight CST, December 2, 2008. All nominations should be submitted in writing and should include:

1. Name of the nominee.
2. Name of the person submitting the nomination.
3. Reasons why the person submitting the nomination believes the nominee should receive the award.

The award presentation will be made to the recipient at the 15th Annual Scientific Assembly to be held in Phoenix, AZ, March 2-4, 2009.

Please submit all nominations to:
AAEM/RSA
555 East Wells Street
Suite 1100
Milwaukee, WI 53202
800-884-2236
Fax: 414-276-3349
info@aaemrsa.org

Interested in Starting an AAEM State Chapter?

AAEM developed a toolkit just for you! AAEM's Guide to Managing and Forming a Non-Profit State Chapter provides you with templates, documents and other important information on a CD format with an easy to follow process to start a new state chapter.

You may form a chapter with only a few interested members and a little initiative. The chapter may:

- play an instrumental role in protecting and fostering the practice of emergency medicine at both a state and national level
- provide an opportunity for emergency physicians from different parts of the state and different practice types to work cooperatively
- provide a platform to become directly involved with their state legislature

Contact info@aaem.org to receive a copy of the toolkit on CD.

Adopt-A-Program & Adopt-A-Resident

Are you interested in furthering the careers of future emergency medicine residents? "Adopt" an emergency medicine residency program or an individual resident, by paying their AAEM/RSA dues. A membership in AAEM/RSA will provide residents with the opportunities to network with physicians, residents and students interested in emergency medicine. Each resident will receive the membership benefits listed at www.aaemrsa.org/membership/benefits.php.

An individual who decides to Adopt-A-Program or Adopt-A-Resident will automatically be entered into a drawing to receive two nights at the Sheraton Hotel in Phoenix, AZ, for AAEM's 15th Annual Scientific Assembly. This gift is valued at $500!

Membership for a resident costs just $50 per year, or $120 for three years. However, by signing up a residency program as a group, a 10% discount will be applied. This is a great opportunity to further the careers of emergency medicine residents across the country! Please contact info@aaemrsa.org if you are interested in our Adopt-A-Program offer.

Brian Ostick, MD

Chair, AAEM/RSA Membership Committee

Welcome to our newest 100% Residency Programs!

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

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

Applicants for Certificate of Excellence in Emergency Department Workplace Fairness

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

Below you will find a listing of new applicants for Emergency Department Workplace Fairness. A complete listing of previously recognized groups can be found on our website at: http://www.aaem.org/certificateofexcellence/.

Organization	State
Reid Hospital/Emergency Medicine of Eastern Indiana	IN
Southeast Emergency Consultants	FL
Standford/Kaiser Santa Clara, TPMG	CA
Valley Emergency Physicians-South Bend	IN

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

RESIDENT PRESIDENT'S MESSAGE

Finding a Job, the AAEM Way

Megan Boysen, MD
President, AAEM/RSA

This year, many of our AAEM/RSA members are embarking upon their first job search as emergency physicians. While the largest influences on finding the right job may be location, quality of facilities, breadth of patients and compensation, it is also essential to evaluate the type of practice environment and the fairness of the contract that you will be signing.

Within EM, there are several types of practice settings. Understanding the structure of the myriad practice environments can be extremely confusing. Stated simply, there are three major types of physician relationships: independent groups, contract management groups (CMGs) and hospital based practices. For any of these groups, you can be hired as an employee or an independent contractor – one important difference being the IRS tax classification. In general, independent contractors are responsible for managing their own tax filings and obtaining health, life, disability, and potentially malpractice insurance, but are allowed greater tax deductions. Employees, on the other hand, may have added benefits including vacation time, educational allowances, and medical, disability and malpractice insurance, but have significant restrictions on tax deductions.

Within independent groups, there is a wide spectrum of practice structures – the most ideal being a democratic group. Democratic groups are described by: open books, a well-defined partnership track, fair profit and asset sharing and voting rights. Preferably, members will also share scheduling equity or be rewarded appropriately for less desirable shifts. Prior to joining a democratic group, the partnership track should be clearly defined. Most group members will be partners or on the "partnership track." A partnership track will vary in length but is ideally around two years. When initially hired, you will preferably start to share profits and assets but at a lower rate than a full partner. After a certain pre-defined time period, you should have vote, profit and asset sharing which is either equal or delineated based upon individual investments (buy in) or longevity in the group. Regardless, books should be open and the compensation structure should be clearly outlined. Many groups may call themselves a "democratic" group but are missing one or many of the elements of a true democratic group. They may have an ill-defined partnership track, unequal profit sharing and voting despite equal investment, or non-physician ownership.

Contract management groups are businesses which generally hold contracts with several emergency departments in one area or across the country. As such, the individual emergency physicians typically do not have significant ownership in the group via partnership. Approximately one-third of practicing emergency physicians work for CMGs. While individual physicians may benefit from reduced administrative responsibility, they also have reduced job security, salary and vote in the group. It is important to investigate a particular group's reputation, whether there is corporate or administrative involvement in medical decision making and to evaluate the fairness of a contract prior to signing.

You may have read about *restrictive covenants* in past issues of *Common Sense*. Restrictive covenants are "non-compete clauses" within contracts which prohibit a physician from working in a defined geographical location for a specific period of time following a voluntary or involuntary termination of their contract. Essentially, a person is indentured to the contract until they can find another job a certain, and sometimes considerable, distance away from their current employment.

Other restrictive clauses may be buried in physician contracts, for example, denying the right to due process upon termination. Due process requires informing any threatened physician just reason for termination, with the opportunity for review at a fair hearing. It is important to read a contract carefully and thoroughly – with time to discuss discrepancies with trusted colleagues, mentors or an attorney. Other components to consider are malpractice insurance, including "tail" – coverage which extends beyond your employment – as well as health, life and disability insurance.

While adding these considerations to your job search may seem overwhelming, it is important to discuss the details of your contract and employment before making a commitment. AAEM offers numerous resources that will help in this task. You can find more information on fair contracts and EM practice groups at: http://www.aaem.org/emtopics/criticalissues.php or from *Rules of the Road for Emergency Medicine Residents and Graduates*. Most importantly, you are now part of AAEM, an organization which fights for a fair practice environment for emergency physicians.

STUDENT PRESIDENT'S MESSAGE

Greg Casey
President, AAEM/RSA Medical Student Council

Congratulations on completing another challenging year of medical school! From day one, we were bombarded with facts, figures, syndromes and scales. We have worked hard to grow our fund of knowledge, but the fact of the matter is that it is impossible to remain up-to-date with research, assignments and personal medical interests. As we progress in our training, this task becomes easier as we focus on our future specialty: emergency medicine.

Resources for medical students interested in emergency medicine are bountiful, and the newly elected Medical Student Council wants to alleviate the pressure of sifting through all of the relevant journals, books and newspapers to stay updated on the latest issues surrounding emergency medicine. We will do our best to glean the facts from the most important issues facing emergency medicine and pass our findings on to you. Check your email regularly for our monthly emails highlighting journal articles, current controversies in emergency medicine as well as chapter summaries from *Rules of the Road for Medical Students.*

As a student member of the American Academy of Emergency Medicine, there is a myriad of resources available to supplement your education on our website. These resources will help you succeed not only as a medical student, but also as a resident and attending physician. If you have not done so already, I recommend reading *Rules of the Road for Medical Students,* by Drs. Antoine Kazzi and Joel Schofer. This is mailed to paid student members and is available online at www.aaemrsa.org. Articles in *The Journal of Emergency Medicine* and *Common Sense* are other excellent ways to keep abreast of the latest in emergency medicine. These publications are also available online. Another way to stay updated on the latest news is to get involved in your medical school's Emergency Medicine Interest Group (EMIG) or start one if your school does not have one. This year the Medical Student Council will make an effort to improve communication between AAEM/RSA and the EMIGs. A goal of ours is to increase the number of EMIG Workshop Starter Kits (http://www.aaemrsa.org/resources/kits.php). If you have ideas for new workshops, email them to info@aaemrsa.org.

We will be supporting an Emergency Medicine Symposium at UCI in California. Another great day for the Student Council will be March 2nd, 2009 - we are working on obtaining a dynamic group of speakers and planning seminars for student members at the AAEM Scientific Assembly in Arizona, and we hope to see you there!

For students interested in advocacy or just looking for another way to influence their profession, you can log on to the AAEM Legislative Action Center (http://capwiz.com/aaem/home/). Our advocacy emails will direct you to other ways you can join the political realm of emergency medicine practice. Remember that students have a powerful voice; do not be intimidated if you want to get involved with politics.

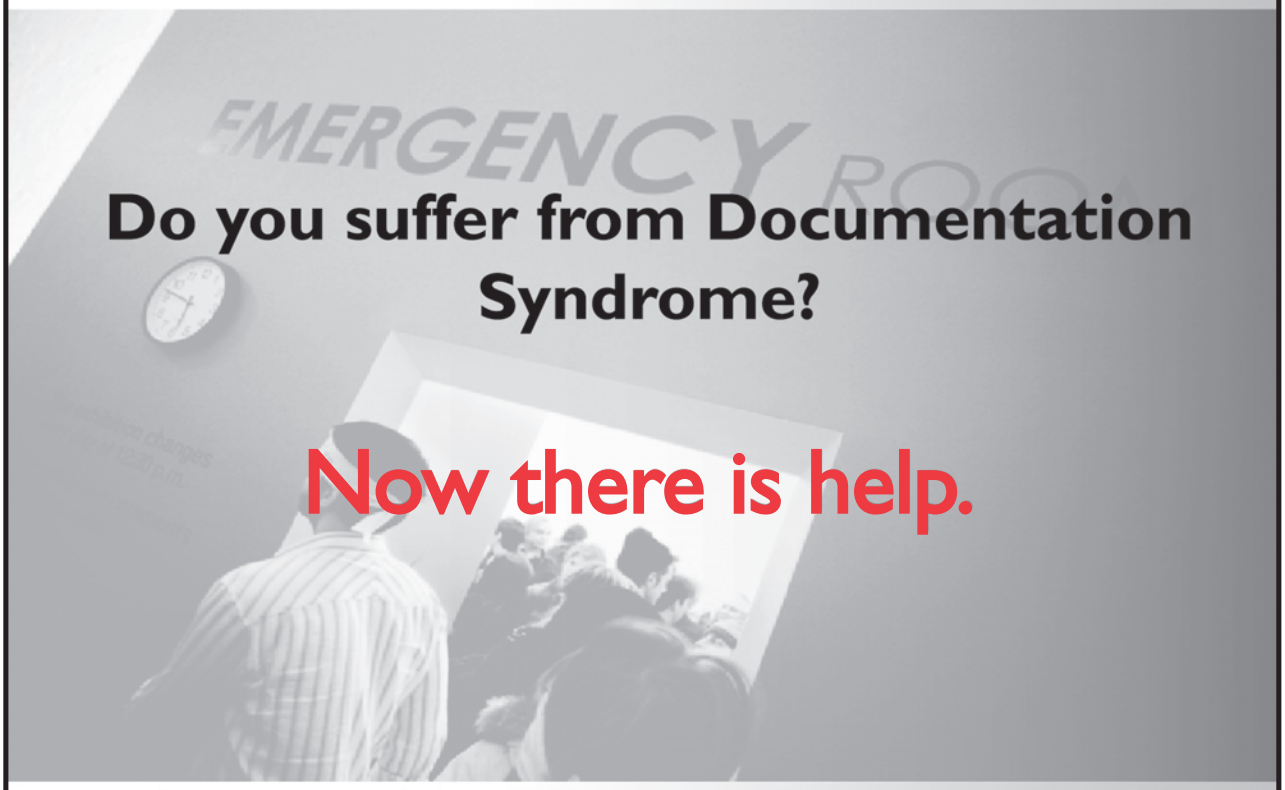
Due to the continued growth of our membership, we have expanded the number of regional representatives and will likely add additional representatives to deal with interest from international emergency medicine interest groups. It is never too late to get involved with your medical school's EMIG or at the national level with AAEM/RSA.

Finally, I would like to congratulate the new Medical Student Council: Vice President Jennifer Monroe (Chicago College of Osteopathic Medicine); Western Regional Representatives Malia Bender (University of Texas Health Science Center at San Antonio) and Rachelle Callenback (University of California, Irvine); Southern Regional Representatives Sara Kirby (University of South Carolina School of Medicine) and Ellana Stinson (Meharry Medical College); Midwest Regional Representatives Daniel Bartgen (Loyola University Chicago Stritch School of Medicine) and Melissa Hudson (Ohio State University), and the Northeast Regional Representatives Mary Chopard and Kenneth Marshall (both from Georgetown University School of Medicine). On behalf of the 2008-2009 Medical Student Council, I want to express our excitement over continuing the excellent tradition set forth by previous Councils. We look forward to working hard to improving the services and outreach of the Council, and we invite you to get involved with AAEM/RSA. Good luck with your endeavors and journey into emergency medicine!

CHANGE OF E-MAIL ADDRESS

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

www.peercharts.com



Do you suffer from Documentation Syndrome?

Now there is help.

PeerCharts™

- ✓ Comprehensive
- ✓ Affordable
- ✓ User-Friendly
- ✓ Customizable

AMERICAN ACADEMY OF EMERGENCY MEDICINE

FAAEM
always means
board certified

PeerCharts™
Emergency Medicine Documentation

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

Medicare – Facts, Figures and the Future of America's Largest Social Program

Michael Ybarra, MD
AAEM/RSA Resident Editor, Common Sense

Medicare is one of the most influential federally sponsored programs in existence today. It insures roughly 40 million Americans and accounts for one third of the country's total healthcare spending. As our population continues to age and the cost of the program swells to encompass more and more of the federal budget, the influence of the Centers for Medicare and Medicaid Services (CMS), and also the Federal Government, over healthcare as a whole will likely expand.

Medicare was established in 1965 when President Johnson signed it in to law as Title XVIII and XIX of the Social Security Act saying, "No longer will older Americans be denied the healing miracle of modern medicine." It is remembered as his most important accomplishment as President, and the cornerstone of the Great Society programs he strove for. Harry S. Truman asked Congress nearly 15 years earlier to protect seniors who have no fixed income to address the rising cost of healthcare. To recognize his contribution to the establishment of Medicare, President Johnson made President Truman the first enrollee in the burgeoning program. Over its near 40-year lifetime, Medicare has benefited 90 million people.

Currently, Medicare benefits approximately 40 million Americans, or one in seven – a number that is expected to double by 2030. It provides health insurance for individuals over 65 years of age, and now to individuals with disabilities (such as end-stage renal disease). According to the CMS, because of the aging population that continues to live longer, there are families in the U.S. who have three generations currently enrolled in Medicare – a fact that likely was not imagined by the original founders of the program.

The original amendments to the Social Security Act included two parts: Medicare Part A and B. Part A provides for inpatient hospitalization and some skilled nursing facilities (up to 100 days per year). Part B covers most services and products available to beneficiaries on an outpatient basis. It pays for doctor visits, nursing services, x-rays, lab tests, vaccinations, emergency transportation and some medications (those that require administration by a physician). Part B also pays for 'durable medical equipment' such as canes and walkers.

In the last decades, two major additions have been crafted to increase coverage and improve efficiency in the delivery of medical care to seniors. Medicare Part C was enacted in 1997 as part of President Clinton's Balanced Budget Act. The law allowed seniors to receive Medicare benefits through private insurance companies, instead of enrolling in Medicare Part A & B. Originally called "Medicare-Choice Plans," in 2003 as part of the Medicare Prescription Drug, Improvement and Modernization Act, these plans are now known as "Medicare Advantage."

Medicare Advantage allows beneficiaries to enroll in private insurance plans where the premium is paid on a monthly basis by the federal government (beneficiaries also contribute a monthly premium). In return, the private insurance plans are required to offer the same benefits that Medicare Part A & B offer, but not necessarily in the same way. For example, private insurers must cover skilled nursing facilities, but they do not have to cover them for 100 days, as Medicare Part A does.

Medicare Advantage is controversial, as some policy makers argue it is a way for the government to save on its annual expenses, while others argue that it shifts the costs to the beneficiaries themselves who are sometimes required by private insurers to pay higher co-payments and/or receive fewer benefits (or less access to care). Regardless, enrollment in these alternative programs has nearly doubled over the last three years, to nine million in 2008.

Medicare Part D went in to effect in 2006 and offers prescription drug coverage to anyone enrolled in Part A & B. To receive coverage, beneficiaries must choose between two tracks. One track is the Prescription Drug-Plan that complements A & B coverage. The other is Medicare Advantage with Prescription Drug Coverage, which is essentially equivalent to enrolling in Part C with the added benefit of prescription drugs.

The unique feature of the latest addition to Medicare is that drug benefit plans are approved by CMS but are physically administered by individual private health insurance companies (much like Medicare Part C). What this boils down to is a wealth of options, and a tremendous difference in coverage. The private companies that created drug coverage plans can choose to cover whatever drugs they wish. Some may choose to pay for both ciprofloxacin and moxifloxacin, while others will only cover levofloxacin. The only exception is that CMS does not permit coverage for benzodiazepines, cough suppressants and barbiturates.

As a whole, Medicare has solved numerous social issues. It has increased insurance coverage, contributed to an increase in life expectancy, saved millions of seniors from slipping into poverty as a result of the high cost of medical care and helped disabled Americans. In addition to all of this, Medicare has also funded graduate medical education in the form of nearly 8 billion dollars paid annually to teaching hospitals to train new physicians.

Despite these accomplishments, Medicare faces serious challenges. It currently represents 16% of all federal spending (just behind Social Security and the Department of Defense to come in at number three on the government's balance sheet). The Congressional Budget Office suggested, "Future growth in spending for Medicare and Medicaid … will be the most important determinant of long-term trends in federal spending." Medicare spending currently represents 4% of total gross domestic product in the United States. It is estimated that by 2082, it will be 19%, or the total size of the current federal government.

Most agree that something must change in order to avoid fiscal disaster – however, what that "something" is has very little consensus. The stage is set in the 2008 Presidential Election for major changes to occur regardless of who is elected. AAEM and our Government Affairs team will keep you informed of all the changes. However, your action and support is the most important part – write letters to your representatives and educate your colleagues about the challenges we face. To ensure that our own best interests are looked after as emergency physicians and that the best interests of our patients are kept paramount, it is important that we all take an active role in the debates and decision making process that lies ahead.

The facts and figures presented in this article are compiled from the online resources found at www.medicare.gov, www.cms.hhs.gov, and www.medicareadvocacy.org.

Resident Journal Review: September - October 2008

Dana Sajed, 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. This edition will include articles published over a two month period. These selections are from papers published in May and June 2008.

Burnside PR, Brown MD, Kline JA. Systematic review of emergency physician performed ultrasonography for lower-extremity deep vein thrombosis. Acad Emerg Med 2008;15:493-8.

This systematic review identified six articles which addressed the performance of emergency physician performed ultrasonography for the diagnosis or exclusion of deep venous thrombosis (DVT). Two physicians performed separate structured searches of MEDLINE and a librarian searched EMBASE, followed by a hand search of selected bibliographies for additional relevant studies. Only original research reports from emergency department (ED) patients who had signs and symptoms suggestive of DVT were included. Participants were required to have had an ultrasound performed by both emergency personnel and a subsequent study in a radiology department or vascular laboratory. Agreement between the studies was assessed.

For ED ultrasounds, the overall sensitivity from the six studies was 0.95 and the specificity was 0.96. While these numbers are promising, the authors identified substantial variability among the results through statistical testing of heterogeneity. In addition, they questioned the generalizability of the results, as the ultrasonographic skills of community practitioners may not match that of the study physicians.

Overall, the authors conclude that the test performance characteristics of ED ultrasounds are very good, but they call for a larger study of ED ultrasonography with a follow-up interval to assess clinically important outcomes. Until this evaluation, ED ultrasound for DVT should continue to be a "rule-in" evaluation and not a stand-along diagnostic test to "rule-out" this important cause of morbidity and mortality.

Byyny RL, Mower WR, Shum N, Gabayan GZ, Fang S, Baraff LJ. Sensitivity of noncontrast cranial computed tomography for the emergency department diagnosis of subarachnoid hemorrhage. Annals of Emergency Medicine 2008;51:697-703.

The evaluation of a patient's "worst headache of my life" usually leads to a noncontrast cranial computed tomography (CT) and a lumbar puncture. The study authors evaluated the hypothesis that noncontrast CT with current generation scanners is sufficiently sensitive for the detection of spontaneous subarachnoid hemorrhage (SAH). In addition, the investigators collected data on the presenting mental status of a group of patients with SAH, to determine the performance of CT in different clinical settings.

Their single center retrospective review identified 149 patients with the diagnosis of spontaneous SAH. Cases were gleaned from all emergency department diagnoses of SAH, cerebrospinal fluid analyses sent from the emergency department and discharge summary International Classification of Diseases, Ninth Revision (ICD-9) codes for SAH over a three and a half year period in their institution.

Of the 149 patients, 139 SAHs were identified using non-contrast cranial CT, for a sensitivity of 93%. 87 patients (58%) presented with headache and normal mental status; of these, CT identified 90% of diagnosed SAHs. Only 1 out of 61 patients with abnormal mental status and subarachnoid hemorrhage was missed on CT.

The authors conclude that current generation noncontrast CT scans are not sufficiently sensitive to rule-out the diagnosis of subarachnoid hemorrhage, and therefore, lumbar puncture must be performed when this diagnosis is being entertained. Of particular concern was the high miss rate (~10%) among patients with headache and normal mental status, as these represent the group most likely to benefit from early recognition of this intracerebral pathology.

Rodrigo GJ, Nannini LJ, Rodriguez-Roisin R. Safety of long-acting beta-agonists in stable COPD: a systematic review. Chest 2008;133:1079-87.

A meta-analysis in 2004 questioned the safety of long-acting beta-agonists (LABAs) in the setting of both asthma and chronic obstructive pulmonary disease (COPD).[1] This study suggested an increased risk of adverse events and respiratory deaths for patients using these medications. Since then, the safety and optimal strategy for use of LABAs has been debated.

The study authors performed a systematic review of MEDLINE, EMBASE, CINAHL and Cochrane Controlled Trials Register to identify trials that could address these concerns. A total of 27 randomized controlled trials were selected for analysis, representing 20,527 patients and 26,389 patient-years of follow-up. In fourteen studies comparing LABA with placebo, the overall cumulative exacerbation incidence was 7.5% in the LABA group and 10.8% in the placebo group. The number needed to treat was 30. In addition, there was no significant difference in all-cause deaths or respiratory deaths between patients assigned to LABA or placebo.

There are more than 1.4 million visits to emergency departments for COPD in the United States each year. For some patients, visits to the emergency department may represent their only contact with health professionals. As such, emergency physicians must be fluent in management of this chronic disease. Escalation of therapy, when appropriate, is one way that emergency physicians can improve the quality of life and reduce the number of exacerbations for our patients. This systematic review supports the beneficial effects and safety of LABAs in patients with stable moderate to severe COPD.

[1]Salpeter SR, Ormiston TM, Salpeter EE. Cardiovascular effects of beta-agonists in patients with asthma and COPD: a meta-analysis. Chest 2004;125:2309-21.

Janssens HJ, Janssen M, van de Lisdonk EH, van Riel PL, van Weel C. Use of oral prednisolone or naproxen for the treatment of gout arthritis: a double-blind, randomized equivalence trial. Lancet 2008;371:1854-60.

continued on page 25

Code New: How to Survive Intern Year Happy

Jennifer Kanapicki, MD
Chair, AAEM/RSA Communications Committee

After spending more than twenty years of your life in school, it has come to this; you are a doctor. Fourth year of medical school was probably one of the greatest academic years of your life with a mixture of fun, travel, celebration and apprehension. Graduation may have left you feeling like you have forgotten much of what you learned in medical school. So, you're a doctor. Now what?

Reflecting on this past year, I remember the swirling mixture of emotions about beginning residency. I had been a student all of my life. The drastic change of entering "the real world" in foreign territory was unsettling. Leaving my safe, familiar environment and heading into the unknown with new people and an anticipated paycheck seemed surreal. Such high expectations as to "save lives" felt intimidating. However, apprehension and insecurity slowly evolved to experience and confidence. Intern year has proven to be empowering and one of the most amazing years of my life thus far. I have learned not to be afraid of my pager every time it goes off. I survived shifts in the Medical Intensive Care Unit (MICU) alone. I experienced new emotions, and I found the value of a true friend who would listen after an especially horrible day. The most important learning came with the discovery of how to be comfortable in my own skin in my new role as a physician. I learned that I could handle almost anything, even if it meant just asking for help.

I can assure you that you will survive intern year and just maybe have some fun in the process. I want to inspire hope. As others have done before you, you will succeed. Here are five tips to keep you happy along the way:

1. **Don't believe the hype**:
   It is hard to ignore the stigma of intern year: grueling overnight calls, absence of family and/or friends, lack of sleep, and basically being the "scut monkey." It sounds scary and intimidating, but I live by the phrase "a good attitude is half the battle." This year I went into each rotation with an open mind. I tried not to focus on others' comments about a certain rotation. I found that the overall "hype" seemed too generalized, and I needed to seek my own truths. I often found the rumors to be false compared to my own experiences. Keeping a positive attitude boosted my team's morale as well as mine.

   Feeling like the "new kid" is hard. Every month, as the ED intern, you are starting a new rotation with other interns who may have been doing that specialty for a number of months more than you. It's tough, but by going into each rotation with a good attitude, you will be able to learn from your colleagues. In my experience, by being an active member of the team, I was treated as an equal member and not just the "ED intern." Not only did this increase what I got out of every rotation, but allowed me to thoroughly enjoy my time on off-service rotations. Remember, we are the lucky residents that get the chance to spend a month in the shoes of so many different specialties and take from them what is pertinent to our practice in the ED. Savor this opportunity, and enjoy the wide variety of medicine we get to practice!

2. **Social life - have one:**
   Residency is like nothing you've experienced before. You are suddenly spending up to eighty hours per week in a hospital; at times I felt like I should have been paying the hospital rent, instead of my landlord. A key to happiness is to try to maintain some kind of normal social life that the non-medical people of the world adhere to. This may mean going to your residency social events or creating some of your own. This not only allows you to interact with your colleagues in order to decompress, but also will afford you the opportunity to talk about something non-medical (although somehow the conversation always tends to get back to the hospital). Normal life can also mean traveling, concerts, sporting events and anything the general public takes part in. You will learn that sometimes the best option is just vegging out in front of your television after an extremely hard shift, but your mental state also sometimes requires you to venture out of your apartment into the real world. Our class decided to make the night before conference our "hang out" night; this would include a variety of activities such as bowling, dinner parties, bars, etc. Whatever your activity may be, make a conscious effort to attend, even bring your significant other if you're missing out on time with him/her too. Remember, being an ED intern is sometimes difficult since we are spread out all over the hospital: take time to hang out with your class, because they will be a vital asset to you in surviving residency.

3. **Practice good medicine:**
   I think I know how you are feeling: you've lost a great proportion of your medical knowledge in the depths of fourth year. I will tell you, your current co-interns probably feel the same. We have all been there, and although I hate to break this to you so early on, you will make mistakes. Making mistakes is part of the learning process, and a lot of the time we learn the most from our mistakes. Residents and attendings are essential tools; make sure to use them as a resource and learn from their experience.

   Another essential: Reading. Although at times reading seems to be impossible to fit into your schedule, it is vital to the practice of good medicine. My personal system was to place the patient stickers on an index card and then write the treatment plan, tips from attendings, etc., on the card. After my shift, I would spend an hour going through the cards and reading in my EM book of choice about my patients. This way you are not only pairing an illness with an actual patient, but adding in personal "tips of the trade" from your attendings. This is an excellent way to stay on top of reading and keep a reference of your patients. Another suggestion: on off-service rotations - make sure to read the relevant section of your preferred emergency medicine text. For example, when I was on orthopedics I read the musculoskeletal section of Tintinalli. Not only did this help during the rotation, but also assisted me in getting out of the rotation what was pertinent to my practice of emergency medicine.

4. **Maintain a healthy mindset and healthy living:**
   There will be times during your intern year that you will be frustrated because you're working incredibly long hours and under an extreme amount of stress. As I mentioned before, mindset is everything. If a

continued on page 25

Resident Journal Review - continued from page 23

The mainstays of treatment for gout are nonsteroidal anti-inflammatory drugs (NSAIDs) and colchicine. Both classes of medication have disadvantages (colchicine has a narrow therapeutic window and NSAIDs have cardiovascular and gastrointestinal risks). The short term use of systemic corticosteroids has been suggested as a safe alternative for management of gouty arthritis. The investigators conducted a randomized, double-blind, controlled trial to test for the equivalence of prednisolone (35mg once per day) and naproxen (500mg twice per day) in the treatment of gout. Patients were assigned to one treatment arm for five days; the primary outcome was pain in the affected joint as described by the patient. The groups had a similar reduction in pain over the study period (80% in the prednisolone group and 88% in the naproxen group). No significant side-effects were reported in the prednisolone group.

This study provides compelling evidence for a short course of prednisolone in the acute treatment of gout, as an NSAID-sparing alternative.

Mayer SA, Brun NC, Begtrup K, et al. Efficacy and safety of recombinant activated factor VII for acute intracerebral hemorrhage. The New England Journal of Medicine 2008;358:2127-37.

This phase three clinical trial examined the efficacy and safety of recombinant activated factor VII (rFVIIa), to the ends of reducing hematoma expansion and improving survival and functional outcomes for intracerebral hemorrhages. Within four hours of the onset of stroke, 841 patients were randomly assigned to one of three groups: placebo, 20ug/kg rFVIIa, or 80ug/kg rFVIIa. The investigators measured poor outcome at 90 days using a modified Rankin scale. In addition, hematoma expansion was evaluated on repeat cranial CT scans at 24 and 72 hours after the onset of stroke.

The investigators described a reduced hematoma expansion in the group of patients randomized to 80ug/kg rFVIIa, but there were no differences between the three groups in survival or functional outcome at 90 days. In addition, the authors performed and reported on a number of post hoc analyses, which were not described in the original trial design. Readers must carefully evaluate the importance of intermediate outcome measures, and even more rigorously scrutinize post hoc analyses that fall outside of initial study design. This study's intermediate outcome, reduced hematoma formation, did not translate into a meaningful clinical endpoint. This type of data-reporting puts a positive "spin" on the results. Based on the data that has been presented, it would be extremely difficult to justify the use of this expensive medication.

Interestingly, a quick review of the disclosures indicates that the study was funded by Novo Nordisk (the manufacturer of rFVIIa) and that several of the authors were either former employees of Novo Nordisk or held stock in the company at the time of the study.

Dana Sajed 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

Code New: How to Survive Intern Year Happy - continued from page 24

certain issue is bothering you, the best approach is to be active about it; instead of taking a back seat, do something! This means getting involved with your residency program and its advancement. Taking an active role will be a healthy way to manage your frustrations and benefit you, your peers and your residency program in the end. I did this by becoming an active member in applicant recruitment for my residency program. I also became a board member of AAEM/RSA, which has been such an amazing experience and fulfilled my desire to get involved on a national level. It makes me feel like I'm doing something for my specialty as well as my own well being. So if there is something about the system that interests you, get involved and make a difference.

Healthy living is also a huge aspect of intern year. I have to confess I probably did spend a month or two living on cookie dough that I swore I deserved for all my hard work. In retrospect, although immediately rewarding, it was probably not the best way to manage stress (well, maybe if it is done in moderation). I find, for most residents, being able to work out and eat healthy, helps to relieve stress. Healthy eating can be tough, and even the best hospital café doesn't always have the most nutritious options. I would try to bring fruit and my favorite water bottle to work to stay hydrated. Most residents forget to take care of the most important patient: him/herself. Always do things to make yourself happy and relieve stress, whether it is a pedicure or going to watch your favorite sporting event.

5. Remember that you are not alone:

I know that on several occasions during your intern year, you will feel alone. From my personal experience, going from medical school where I basically lived in a dorm with a roommate, to living by myself in suburbia was quite a drastic transition. I felt lonely, but gradually I met others who felt the same way I did. Throughout intern year, you will have many experiences - some good and others not so good. My best advice is to share your stories; not only does this help you vent, but it also helps you realize you are not the only person that these things happen to. The best response you can get after your toughest day of work is from a co-worker saying, "I know how you feel." Sometimes we think the stresses and strains of residency are just happening to us, but take comfort in knowing that you are not alone.

So there are my five tips for how I succeeded in being happy during my intern year. It does take work, but I am proof that it's possible. I do want to end with some advice for non-interns: the best thing you can do for new interns is to welcome them with a positive attitude, reassurance and guidance. Remember, you were once in their shoes and can be their best resource when times get tough. Interns, you will have an amazing year of learning, not only clinically, but also about yourself and the doctor you strive to become. Just remember to stop and smell the roses along the way.

EMTALA: A Lesson in the Inevitable Futility of Forced Ethics

Damon Dietrich, MD MHCM FAAEM, Secretary/Treasurer, Young Physicians Section, President, AAEM Louisiana State Chapter, Member, AAEM Operations Management Committee

The following excerpt on EMTALA is taken from a paper written by myself and Dr. Michael Crapanzano while finishing our Masters in Health Care Management. The public health paper written in April 2006 was entitled, "Emergency Department Diversion and Overcrowding: A Public Health Crisis." The scope of the paper is beyond this article, as its purpose was to investigate multiple critical issues contributing to ED diversion (EDD) and ED overcrowding (EDO). The paper offered solutions and action plans for decreasing EDD and EDO nationally. For the full paper and references, please email me at ddietr@lsuhsc.edu.

EDO and EDD are two of the most critical public health issues facing our nation's healthcare system today.[3, 4, 5]

- ED visits in 2003 rose to 114 million, up from 97 million in 1997.
- While visits increased by 17% over six years, 1128 EDs closed between 1988 and 1998, thus resulting in a dramatic increase in patient volumes and waiting times.
- US hospitals over the past ten years have closed more than 103,000 inpatient medical/surgical beds and 7800 ICU beds in an effort to control costs.
- The majority of the nation's 4000 hospitals and EDs report operating at or above critical capacity.
- In 2001, two out of every three hospitals reported diverting ambulances to other hospitals.
- EDO is reported to be most severe in areas with larger populations, higher population growth and higher than average uninsured patient volumes.

EDs represent the most critical access path to the nation's health delivery system, as the "guaranteed access point for all who need care regardless of ability to pay."[2] EDO exists when the ED has more patients than bed capacity or is over-saturated; this is a warning sign of capacity constraints under normal conditions. The March 2003 General Accounting Office Report indicated that EDO has many negative implications with regard to quality of care including prolonged patient wait times and suffering for acute problems while other patients are "boarded" in the ED, higher physician and staff stress, less confidentiality when patients are evaluated in non-traditional locations such as a hallway or on the EMS stretcher and increased transport times for ambulance patients due to diversion.[5] Contrary to public misconception, the gridlock in the ED is not in the waiting room, but rather occurs in the hallways of the ED with admitted patients waiting for beds upstairs for hours to days! The purpose of EDD was an innovative solution for EDO intended to "divert" stable patients transported by ambulance away from the hospital, thereby allowing the scarce beds remaining in the ED to be used for critical or unstable patients. EDD has been defined by The Lewin Group.[2]

- Hospitals divert when their ED can no longer accept all or specific types of patients by ambulance.
- EDD is a short-term, temporary approach used to assure that patients get the right care at the right time.
- If one ED is overcrowded and another is available, diversion assures a patient is treated in a timely manner.

A review of the literature identifies six broad categories as the primary contributors to EDO and EDD as summarized in Table I.[2, 17, 18] *(table I on page 28)* Roberts' five control knobs - finance, payment, organization, behavior and regulation. The knobs are pertinent because they are fairly comprehensive, can "be adjusted by government action….and describe discrete areas of health system structure and function that matter significantly for health system performance."[6] Financing for EDs nationwide has been adversely affected by an increase in the proportion of self pay patients, increase in malpractice premiums, managed care barriers and inadequate funding at the organization level in response to the increase in ED volume and acuity. As health premiums increase and employer based healthcare coverage falls, the American uninsured population continues to rise. In 2004, 46 million Americans, or 16% of the total US population, were uninsured.[7] The ED has become the safety net for the uninsured population. Due to lack of insurance and poor access to outpatient care, these patients often wait until their medical condition worsens before seeking medical intervention. A detailed discussion of EMTALA is included in the regulation discussion and represents the focus of this article.

The regulation knob will be explored through an analysis of EMTALA. Acceptance of Medicaid and/or Medicare federal funding requires that organization to abide by EMTALA federal law 42 CFR 489.24 that states the following.[8]

"Any hospital that has an ED must provide an appropriate medical screening examination (MSE) within the capability of the hospitals ED, including ancillary services routinely available to the ED, to determine whether or not an emergency medical condition (EMC) exists." If an EMC is determined to exist, the ED must provide any necessary stabilizing treatment or an appropriate transfer to a facility that can provide the necessary resources required. Finally, a hospital "may not delay access to screening, stabilizing treatment or an appropriate transfer in order to inquire about the patient's method of payment or insurance status."

This law was refined on November 10, 2003, to allow for EDD in response to concerns over lack of understanding of EMTALA requirements. Consensus developed that the initial statutory regulations expanded EMTALA beyond the scope of its' original intent, thereby actually contributing to and exacerbating EDO.[8] Violation can result in a federal investigation of the entire hospital, a $50,000 fine to the hospital and a $10,000 fine to the physician that is determined to be noncompliant.[9] While EMTALA was intended to provide all patients the right of medical care in the ED regardless of ability to pay, a cost: benefit analysis performed by Duke University and summarized in Table II *(table II on page 28)* suggests it did just the opposite.[10]

The obvious benefit of EMTALA is to protect the patient's fundamental right to emergency medical stabilization and treatment. Before EDD, hospital-owned ambulances were forced to transport all patients to their respective hospital, regardless of capacity saturation. This was detrimental to the patients, nurses, doctors and other employees. Resources were overwhelmed, and

continued on page 28

Ask the Expert

Joel Schofer, MD FAAEM
LCDR MC USN, Naval Hospital Okinawa

"Ask the Expert" is a *Common Sense* feature where subject matter experts provide answers to questions provided by AAEM & YPS members. This edition features:

William J. Brady, MD, Professor of Emergency Medicine and Medicine, Vice Chair of Emergency Medicine Department of Emergency Medicine, University of Virginia, Charlottesville, VA

Chris A. Ghaemmaghami, MD, Associate Professor of Emergency Medicine and Medicine, Program Director, Emergency Medicine Residency, Department of Emergency Medicine, University of Virginia, Charlottesville, VA

Original question: Which chest pain patients can be safely discharged from the emergency department?

Amended question: Which chest pain patients initially suspected of acute coronary syndrome after ED evaluation can be safely discharged from the emergency department?

The appropriate evaluation and management of the chest pain patient remains a significant clinical challenge for the emergency physician. The emergency physician will use the history of the event, related medical history, physical examination, 12-lead ECG, and initial serum markers -- if obtained -- to determine the need for further inpatient evaluation.

The evaluation and subsequent management of the chest pain patient is thus deserving of significant review and consideration. Both the number of patients involved, as well as the potential diagnoses encountered in this chest pain patient group, when considered together, account for the significant clinical challenge. Contemporary numbers note the significant magnitude of the chest pain patient in the ED. Of the approximately 100 million ED visits in the United States today, 8% of these patients present with chest pain; five million of these patients are admitted for further evaluation and management of the chest pain syndrome. Ultimately, whether in the ED or the hospital, almost half of these patients are diagnosed with an acute coronary syndrome (ACS) with 1.1 million AMI and 1.2 million USA cases; further, 300,000 of these admitted patients die of cardiovascular ailments. Three million of these chest pain patients are discharged from the ED with a very low rate of missed ACS (approximately 2% for both unstable angina and AMI). Thus, the "numbers" are impressive with respect to the shear magnitude of the presentation.

Not only are the numbers impressive, but also the range of possible diagnoses, ranging from a benign musculoskeletal or gastrointestinal (GI) syndrome to a life threatening pulmonary or cardiovascular event. The differential diagnosis of chest pain includes musculoskeletal/chest wall syndrome, gastro-esophageal reflux, esophageal perforation, acute pancreatitis, other GI entities, pneumonia, pulmonary embolism with infarction, pneumothorax, aortic dissection, and acute coronary syndrome, among many other possible ailments.

In reply to this query, we will limit our response to the chest pain patient initially suspected of ACS who is evaluated in the ED. Thus the question is as follows: *Which chest pain patients initially suspected of acute coronary syndrome can be safely discharged from the emergency department after an ED-based evaluation?* First of all, it is quite easy to identify those patients clearly deserving admission to the hospital; those patients possessing the following features in the history, examination and diagnostic studies are reasonable candidates for admission to the hospital: (1) known history of coronary artery obstructive lesions with a recurrent, altered, progressive, and/or unrelenting chest pain pattern similar to past ischemic chest discomfort; (2) acute congestive heart failure with or without persistent hypotension; (3) sustained, compromising hypotension temporally unrelated to vasodilator therapy administration; (4) 12-lead electrocardiogram with obvious, clinically concerning abnormality (ST segment deviation, new bundle branch block, or dynamic ST segment/T wave changes during the episode of evaluation); and (5) markedly abnormal serum marker occurring within the appropriate clinical context. This group of chest pain patients would be likely considered "high probability" presentations for ACS based upon the various historical, examination or diagnostic results – and would require admission to the hospital for additional diagnosis and therapy. These patients are diagnosed with STEMI, NSTEMI and unstable angina (USA) and are managed with aggressive anti-anginal, anti-platelet and ant-coagulant therapies; a subgroup is treated with percutaneous coronary intervention in urgent (NSTEMI and USA) and emergent (STEMI) fashion.

At "the other end" of the ACS spectrum of clinical concern, the emergency physician is faced with the "very low probability for acute coronary syndrome" presentation. This group of patients has a markedly lower probability for ACS due to a variety of factors such as atypical host age (i.e., quite young), unusual chest discomfort description, physical examination with obvious abnormality suggesting a non-ACS source of the pain and normal or non-worrisome 12-lead ECG, to name only the most commonly evaluated features of the presentation. These individual factors, however, must not be considered in isolation – rather, these individual issues must be considered as "one small piece" of the larger diagnostic puzzle and evaluated as part of the entire picture. Exceptions to these individual factors abound in the ACS literature. For instance, the "young" 32 year-old male patient can experience ACS; the "sharp" chest pain can be a manifestation of ACS; the chest pain which is reproducible can be encountered in AMI; and the normal or

continued on page 30

EMTALA - continued from page 26

the patient invariably received inadequate care. The 2003 regulations allowed "hospital-owned ambulances … to transport patients to other hospitals, typically the closest, appropriate hospital" not on diversion.[8] This change created critical flexibility required in EMS systems, and thereby allowing more efficient use of resources for community benefit. As an extension of this regulation, many communities developed emergency services disaster/diversion plans that maximized the use of hospital beds, while discouraging closure of additional hospitals. For example, after Hurricane Katrina, www.gno.ems was created within one week after the hurricane as a diversion planning mechanism to facilitate flexibility for New Orleans EMS systems. Each hospital updated its respective bed status hourly. When patients were transported by ambulance, this information technology tool allowed the physician to divert the patient to a hospital with adequate resources. As a just-in-time mechanism, this plan improved care and resources in a debilitated, constrained environment.

Unfortunately, one of the major consequences of EMTALA has been its role in becoming a deleterious ingredient of EDO and EDD. The mandate set by the federal government came with no mechanisms for implementation and no mechanisms for funding. The largest impact was indirect, through the effects of legal controversy on market actors' concerns and expectations.[11] In effect, the alarming irony of EMTALA is staggering. The law's intent and purpose was to ensure access for an EMC; however, in reality, EMTALA actually impedes access for an EMC by overwhelming resource capacity. Thus, its effects may be better understood by considering it from the framework of law. Law is a statement of the rules of behavior with inherent moral weight. As a beneficial mechanism to societal order, law is accessible, consistent, enforced, legitimate and universal. Furthermore, "the law is not just a set of rules, but a social institution that evolves. Statutes are born of political compromise and therefore represent best efforts of a society to reconcile different interests. Hence, law maintains stability within society as it entertains innovation and reform."[12] However, EMTALA is a perfect example of **forced ethics by statutory regulation.** In contrast to ethical codes, law represents only a minimum standard for behavior. The treatment of critical patients regardless of ability of pay addresses ethics and morality. Moral codes and ethical standards provide ideals that guide behavior beyond the minimums of law.[12] In other words, healthcare providers have an ethical duty to treat the patient. We have all heard the horror stories. A critical trauma patient shows up on the EMS ramp. The emergency physician opens the door and asks the patient if he has insurance. When the patient replies no, the doctor closes the door and states, "take him to Charity boys." This egregious, irresponsible and unprofessional behavior did transpire and led to the creation of EMTALA. For these doctors are the true forefathers of the EMTALA scourge- the **MOTHER OF ALL UNFUNDED GOVERNMENT MANDATES**. With acceptance of moral and ethical obligation, the creation and evolutionary misinterpretations of the EMTALA law would never have transpired. EMTALA was concerned with upholding basic rights and duties; however, the law deprives us of moral imagination when it invades the realm of ethics. Furthermore, the law "does not seek to inspire human excellence or distinction."[12] The practice of emergency medicine should not be defined by EMTALA regulatory definitions, but rather by professional standards of excellence set by hospitals and providers. The duty to treat patients should be "found not in the hard terrain of contracts or duties of justice or obligations of fair play that might hold among strangers, where philosophers have

Table I: Causes of EDO and EDD

Category	Examples
ED beds	Lack of critical care beds
	"ED bed borders" due to Lack of adequate tertiary care in region
	Especially neurosurgery, neurology, and CT surgery
	Lack of general acute beds
	ED competes for beds with elective admissions
	Economic pressures have decreased the number of ED beds nationwide
Physician and nurse labor force	Shortage of ED trained physicians
	Shortage of nurses with ED competencies
	High burnout rate for physicians and nurses
	High RN vacancy rates hospital wide (above 11%)
	Insufficient access to primary and preventive care
Specialist coverage in ED	Global shortages in the number of specialists
	Specialist choice to not provide ED coverage
	EMTALA imposes legal ramifications upon lifestyle choices
	Higher malpractice premiums if provide ED coverage
	ED patient population has higher percentage of self pay
	Managed care barriers
	Higher liability even in presence of malpractice insurance
Patient volume	EMTALA entitles everyone to emergency care
	Continued rise in ED volume nationwide
Financial	Regional increases in self pay patient volume
	Available specialists do not agree to provide coverage for financial reasons
	Higher malpractice premiums
	Worsening payer mix
	Higher managed care barriers
	Inadequate funding for emergency care
ED operational efficiency	Test turnaround time
	Increased patient acuity
	Inadequate physical space in ED
	Language and cultural barriers
	Access to follow-up care for patients
	Increased medical record documentation requirements

Adapted from various sources (2, 17, 18)

Table II: Costs and Benefits of EMTALA

Costs	Direct financial
	As unfunded mandate, all costs are transfer costs government provided no mechanism for payment
	Modest administrative
	Compliance costs difficult to quantify
	Increase use of ED for non-emergency conditions
	Cost is equal to difference between ED visit and physician office visit
	Reduction in physician willingness to provider on-call services
	Cost is equal to consumer surplus related to any resultant reduction of services
	Reduction in insurance coverage resulting from increased awareness that hospitals cannot turn away emergency patients
Benefits	Intended to expand access to individuals who otherwise would lack access to emergency care
	In theory, should reduce avoidable deaths and disabilities
	Cost reduction if on balance more speedily-delivered emergency care is less expensive than avoidable downstream costs
Net (Through 2002)	Estimated costs of $4.4 billion
	Expected benefits of $2.1 billion

Conover and Zeitler (10)

continued on page 29

EMTALA - continued from page 28

hoped to find it, but rather in the more fertile ground of fraternity, community and their attendant obligations."[12] Proper education regarding EMTALA requirements and dispelling myths is vital to any strategy for reducing EDD and EDO. The key message to impart is that stable patients should be diverted from a hospital with critical resource capacity regardless of patient request. Once a hospital is on diversion, only unstable or critical patients should be transported to that facility, assuming the facility has the resources to care for the patient.

The author's personal experiences illustrate that many healthcare providers – doctors, nurses and paramedics – have responded to these complex issues through practice standards that ensure their own legal protection in lieu of a "true" understanding of EMTALA. One example is the common myth that if a stable patient requests a facility on diversion, EMTALA mandates that the patient must be transported to that facility regardless of diversion status. This compromises care by exhausting resources. Fear of EMTALA breach, fines and inevitable investigation create unrealistic anxiety, further perpetuating the myth. In reality, paramedics do not inform the patient of critical resource exhaustion, but rather tell the patient vaguely that he may have to wait "a little while" before being treated. A critical or sick patient cannot possibly be expected to understand the complexities of operations management or surge capacity. This is unfair to the patient, as well as the providers and hospital on diversion. EMTALA did not include a provision for patient request; rather, this provision was developed and incorporated by hospital personnel and has zero legal basis. These actions and practices are largely "understood," and thus, it is hard to quantify the "real" impact on EDO and EDD. These ill conceived misinterpretations of EMTALA could not have been anticipated at inception. However, inappropriate extensions of the law have created the undesirable evolution where an ED is required to accept all stable patients, contributing to EDO. This causes critically ill patients to be legally prevented from receiving care at the most appropriate facility. Definitive solutions to EMTALA problems are complex, expensive and resource intensive. Some direction is illustrated by the following recommendations by the American Academy of Pediatrics.[18]

- Improved efficiencies of Hospitals and EDs
- Optimization of primary care access
- Improvement of hospital and ED service capacity, particularly in critical care areas
- Link all patients to a medical home
- Integrated healthcare information technology system
- Reform of professional liability and tort
- Improved Medicaid reimbursement
- Education of consumers on appropriate usage of the ED
- Education of policy makers on the effects of EMTALA and possible solutions
- Additional research in the area of EDO

Essentially, a definitive solution is nowhere in sight, as it will require a massive educational campaign on what EMTALA is and what EMTALA is not. It will also require changes in public health policy, law and culture. I sincerely believe that emergency physicians (my brothers and sisters in the ED PIT or Hell's Kitchen as I like to call it) provide beneficent service to humanity not due to a professional oath or legal requirement, but rather our fundamental, innate, moral and ethical code of conduct. We simply need the resources required to care for our patients without government interference and roadblocks. Fair compensation for provider services and ending the practice of "boarding" are essential to moving forward. Funding various solutions requires a national commitment and recognition of emergency medicine as an essential community service. As overwhelming as this task may be, we believe local facilities can provide interim support by using a "systems" view and commitment to the problem including community leaders, EMS systems, hospitals, local policymakers, patients, providers and health plan payers. ED resources must be adequate to safeguard the public's health. We must act now.

References:

1. Richards JR. Survey of Directors of Emergency Departments in California on Overcrowding. West J Med. 2000; 172:385 –388.
2. Lewin Group. "The Results of the AHA Survey of Emergency Department (ED) and Hospital Capacity." 2002. April 19, 2006. http://www.hospitalconnect.com/aha/press_room-info/content/EdoCrisisSlides.pdf
3. American College Emergency Physicians. "New Data Shows Upward Trend in Emergency Department Visits." June 4, 2003. April 17, 2006. www.acep.org
4. American College Emergency Physicians. "Ambulance Diversion and ED Overcrowding." June 2003. April 17, 2006. www.acep.org
5. "Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities." United States General Accounting Office Report, March, 2003.
6. Roberts MJ, Hsiao W, Berman P, Reich MR. Getting Health Reform Right. New York: Oxford University Press, 2004.
7. Hadley, Jack, and Holahan, John. "How Much Medical Care Do the Uninsured Use, and Who Pays For It?" Health Affairs, February, 2003.
8. Bitterman, Robert A. "EMTALA Update 2003: The Government's New Regulations." Sterling Healthcare Clinical Bulletin, First Quarter 2004.
9. Miller GL. Emtala.com: A resource for current information about the Federal Emergency Medical Treatment and Active Labor Act, also known as COBRA or the Patient Anti-Dumping Law. April 19, 2006. http://emtala.com/
10. Conover CJ, Zeitler EP. "Cost and Benefits of EMTALA." Center for Health Policy and Law Management. May, 2004. April 19, 2006. http://www.hpolicy.duke.edu/cyberexchange/Regulate/CHSR/HTMLs/F1-EMTALA.htm
11. Bloche, M. Gregg, and Studdert, David M. "A Quiet Revolution: Law as an Agent of Health System Change." Health Affairs, Volume 23, Number 2, April/May 2004.
12. Elias, Jaan, and Dees, Gregory J. "The Normative Foundations of Business." Harvard Business Review, June 10, 1997.
13. Internal hospital records
14. Callimachi, Rukmini. "New Orleans Uninsured Get Primitive Care." The Associated Press News Article, February, 2006.
15. Guglielmo WJ. "New Orleans' Doctors: Still MIA – Outlook – Medical Economics. March 17, 2006.
16. Wilson, Marcia J., and Nguyen, Khoa, "Bursting at the Seams: Improving Patient Flow to Help America's Emergency Departments." Urgent Matters Learning Network, George Washington University Department of Health Policy, September, 2004.
17. American College Emergency Physicians. "Emergency Department Crowding: Information Paper." April 19, 2006. April 19, 2006. http://www.acep.org/NR/rdonlyres/1FDC6583-A6F6-4022-95DF-92FCFFEE77F3/0/empcCrowdingPPR.pdf
18. Knapp JF, et al. Overcrowding Crisis in Our Nation's Emergency Departments: Is Our Safety Net Unraveling? Pediatrics vol 114, no 3. September 2004, pp. 878-888.
19. Litvak, Eugene, Ph.D. "Managing Variability in Patient Flow: Improving Quality of Care While Reducing its Cost." Presentation of the Boston University Health Policy Institute and School of Management. (see http://www.bu.edu/mvp/)

continued on page 32

AAEM Young Physicians Section

Ask the Expert - continued from page 27

nonspecifically abnormal ECG can be seen early in the course of USA or AMI. If the clinician relies solely on a single feature to "rule-out" ACS, then the diagnosis can, in fact, be missed and the patient managed inappropriately. Yet, if the less concerning features are encountered in a cluster (i.e., simultaneously in a single patient) and are analyzed in this fashion, then the likelihood of ACS is significantly lower. For example, the patient who presents with an unusual chest pain syndrome which is entirely reproducible on examination and demonstrates a normal 12-lead ECG is very unlikely to experience ACS – the combination of these factors, encountered simultaneously in a single patient, is quite powerful in "ruling out" ACS. Such patient can be safely discharged from the ED from an ACS perspective, assuming that an appropriate follow-up mechanism exists.

Once these two extreme ends of the diagnostic spectrum have been removed, the emergency physician is left with the low-to-intermediate probability presentations – this heterogeneous group truly represents the most difficult diagnostic group in the potential ACS ED population and thus the focus of this question. In addressing this rather broad patient group, the EP will use the history, ECG and serum marker analysis as the primary diagnostic tools. In this subgroup of chest pain patients, diagnostic studies (i.e., 12-lead ECG and serum troponin values) are normal or unrevealing; the risk stratification of these patients with nondiagnostic basic study results is thus challenging.

Utilizing various features of the ED evaluation, clinical decision rules have been developed to assist in this challenging process. First, the clinical history is often taught to be a major diagnostic investigation in the evaluation of the ED chest pain patient. Sanchis and colleagues[1] explored the value of the clinical history by itself in this evaluation, concluding that the clinical history itself is not a primary determinant of safe discharge. The study was comprised of 1,011 patients presenting to the ED; data regarding the patient's history reviewed included the clinical presentation (pain characteristics and number of episodes), coronary risk factors and history of ischemic heart disease and non-cardiac vascular disease. The various models noted an impressive ability to identify patients at low-risk of adverse outcomes at one year. In fact, 44% of the patients were appropriate discharge candidates with an adverse event rate of only 1.4% at one year; unfortunately, the model performed less well at 30 days with an 8% rate of adverse event, largely resulting from revascularization. The authors concluded that patient selection for discharge is not reliably determined by the clinical history itself, recommending that additional ancillary tools should be considered in this decision.

Considering the clinical history and focusing on the description of the chest sensation, Schillinger et al[2] noted that several atypical historical features are associated with a low rate of occurrence of both AMI and adverse outcome. The authors investigated the value of historical features (symptoms, medical history and risk factors) atypical for ACS in the exclusion of acute/subacute coronary events. The study population included 1,288 ED patients with chest pain; the patient histories were separated into typical or atypical for ACS using seven discomfort descriptors. Acute myocardial infarction was found in 13% of patients; a six-month adverse event rate of 19% was observed. Atypical presentations with four or more atypical descriptors was associated with low likelihood of AMI, death and revascularization; in younger patients (aged less than 40 years) with at least four atypical features, AMI was not seen, and the adverse event rate was markedly low. Conversely, typical presentations demonstrated a markedly higher rate of AMI and related poor outcome. The authors concluded that atypical features are of value in "ruling out" ACS, yet the converse is not true – that typical features are not reliable for "ruling in" AMI and related poor outcome. Thus, these two investigations suggest that the history of the event is important but cannot be used by itself to determine the need for further work-up and ultimate ED disposition.

The physical examination has largely been of limited value in this consideration.The exception to this statement includes the identification of complications of ACS, such as hypotension and pulmonary edema – yet these patients are identifiably ill and thus the disposition is reasonably straightforward. Exploring this issue, Schillinger and colleagues[3] asked the question – does the presence of pulmonary congestive in individuals with unexplained chest pain identify a subset of ED patients at increased risk of poor outcome? Such patients demonstrated higher rates of ACS diagnosis as well as increased risk for poor outcome. Thus, in this patient group, admission to the hospital for further evaluation and management of the chest pain syndrome and pulmonary congestion is usually warranted.

Other decision rules have incorporated not only the clinical history, but also the remainder of the ED data (examination, ECG and biomarker). In just such an application, the Vancouver Chest Pain Rule[4] is focused on the identification of ED chest pain patients with a low risk of acute coronary syndrome – i.e., those patients that can be safely discharged from the ED. In this study, patients greater than 25 years of age were evaluated at presentation with ultimate ACS vs. non-ACS diagnosis assigned at 30 days from the initial visit; data considered in the development of the rule included coronary artery disease risk factors, chest pain characteristics, physical examination and ECG findings and cardiac biomarker results. In the 769 patients studied, approximately 20% had ACS (10% AMI and 11.4% unstable angina); the remaining 80% of the patients were diagnosed with non-ACS conditions. The decision tool demonstrated an impressive sensitivity (98.8%) in the identification of patients who were safely discharged from the ED. In this group, the authors noted that patients who exhibited a normal initial ECG, lacked previous ischemic chest pain and were younger than 40 years demonstrated a very low risk of acute coronary syndrome. In addition, in patients over age 40 years who demonstrated a normal ECG, lacked previous ischemic chest pain, had low-risk pain characteristics, and revealed negative initial/repeat serum markers were also at low risk for ACS. This rule is certainly of value in the younger patient with a negative ED evaluation – it essentially identifies a subgroup of patients who can be safely discharged from the ED after a brief evaluation; it is of less clinical value in older patients or in those individuals with a past history of ischemic heart disease; of course, these subgroups are frequently encountered in the ED.

The use of clinical decision rules in a relatively young patient population can assist with appropriate disposition decisions. Marsan and colleagues[5] attempted to develop a clinical decision rule that young adult chest pain patients without known cardiac disease, coronary risk factors and an abnormal ECG were at extremely low risk for ACS and adverse short-term outcome. Initially, the investigators used only the data listed above; the model did not perform very well with 5.4% of patients experiencing ACS and 2.2% of patients having an adverse outcome. With the addition of serum

continued on page 31

Ask the Expert - continued from page 30

marker results into the model, a much better predictive performance was found – in young adult patients without known cardiac history, with either no classic coronary risk factors or a normal ECG and with initially normal biomarker, the risk of ACS was extremely low (0.14%); no adverse cardiovascular events at one month. Thus, in this group, the history and ECG did not perform well; the addition of the biomarker testing, however, greatly increased the rule's ability in this young population.

The Goldman criteria and the Thrombolysis in Myocardial Infarction (TIMI) risk score have been used for hospitalized patients in the determination of risk stratification. In this setting, these tools have performed reasonably well, yet neither has identified any subgroup of individuals appropriate for ED discharge. Limkakeng et al[6] combined the Goldman criteria with cardiac troponin analysis in an attempt to increase the rule set's ability to identify those low-risk patients appropriate for discharge. Unfortunately, the combination of the Goldman criteria with serum biomarkers in the ED chest pain patient did not identify a subgroup with less than 1% risk for AMI or poor outcome within 30 days. In a similar fashion, Chase et al[7] attempted to use the TIMI risk score to describe ED chest pain patients in a risk stratification sense. The investigators found that the TIMI risk score correlated very nicely with outcome; unfortunately, the scoring system did not separate patients into discrete risk groups, allowing for the identification of individuals appropriate for emergency department release, recommending that the TIMI risk score should not be used in isolation to determine disposition of ED chest pain patients.

Serum marker analysis, primarily using the troponin assay, is an important diagnostic tool in the chest pain patient suspected of ACS. Certainly, positive biomarkers with the typical rise and fall of AMI are suggestive of acute myocardial infarction; interpretation of these values within the clinical context of the patient's presentation including the 12-lead ECG allows the EP to establish the diagnosis of either NSTEMI or STEMI; in this setting, elevated serum troponin values are associated with adverse cardiovascular outcome. Little information is available regarding the use of serial troponin testing and ED disposition. Ghaemmaghami and colleagues[8] have suggested that negative serial troponin determinations, in the setting of a stable patient with a normal to near-normal ECG, is associated with an extremely low adverse event rate in adult chest pain patients who have competed the "rule out MI" ED evaluation. Such information is of extreme value in this patient population – the low to intermediate chest pain population. ED chest pain patients with undetectable circulating levels of cTnI have very low rates of ACS independent of other clinical variables. In a series of patients with undetectable circulating levels of troponin upon ED presentation and at eight hrs after presentation, there were zero deaths or AMI's and a 1.8% rate of revascularization at 30 days from time of ED visit. Measurements of highly sensitive troponin in a serial manner when combined with assessment of clinical variables (persistence of ischemic pain, hemodynamic instability, ECG changes) is a very powerful method of early diagnosis and risk assessment in the ED chest pain patient. Such information would afford the EP the ability to evaluate the patient, determine that ACS was not present and discharge the individual for timely follow-up for further risk stratification with stress imaging.

After completion of the ED evaluation, the presence of an alternative, non-coronary diagnosis is considered by some to be an appropriate discriminator in the selection of outpatient management candidates. Yet prior studies have not examined the impact of a "noncardiac" EP impression or of the utility of an obvious, alternative, noncardiac diagnosis as safe and appropriate justifications for ED discharge in the chest pain patient. Miller et al[9] asked the question "does the initial EP impression of 'noncardiac chest pain' reliably predict patients without ACS?" In this review, if the physician's initial diagnostic impression was noncardiac chest pain after the medical history, physical examination and initial 12-lead ECG, the investigators entered the patient in the study. Of 17,737 patients enrolled, 2,992 had an initial EP impression of noncardiac chest pain; in this group, 2.8% of patients experienced an adverse cardiac event. This adverse event group was characterized as follows: older, more often male, and with more frequent medical histories of diabetes mellitus, coronary artery disease, and congestive heart failure. The authors correctly concluded that, despite an initial impression of noncardiac chest pain, traditional coronary risk factors or established histories of coronary artery disease or CHF should prompt further consideration of ACS.

Beyond the initial impression, Hollander et al[10] compared the 30-day negative event rate in ED chest pain patients who were diagnosed with an alternative, noncardiac diagnosis with a group of similar individuals in whom a definitive diagnosis could not be established. The study enrolled 1,995 ED patients with potential ACS – 4% were ultimately diagnosed with AMI during hospitalization while, at thirty days, 4% required revascularization (4%) and 1% died. Thirty percent of patients were diagnosed with an obvious noncardiac diagnosis. The presence of an alternative noncardiac diagnosis was associated with a reduced risk of myocardial infarction, yet this noncardiac group experienced an elevated rate of negative outcome – meaning that chest pain patients, even without a diagnosed ACS etiology, have reasonably high rates of adverse event. This statement does not translate into the recommendation that "all chest pain patients should be admitted to the hospital;" rather, it indicates that appropriate outpatient follow-up is needed for these patient who obviously do not require inpatient management at the time of ED care.

At initial ED presentation, the chest pain patient is evaluated with the goal of ACS identification; with ACS considered unlikely, the EP then must explore the possibility of significant coronary artery disease. Little information is available regarding the prevalence and severity of coronary artery disease in this patient population. This study[11] focused on chest pain patients with non-ischemic ECGs and normal serial troponin values who remained clinically stable over the initial 12 hours of care. Of the group who might be considered candidates for early discharge, 33% of these patients had evidence of coronary artery disease at cardiac catheterization. While this high rate of CAD is troubling, it does not necessarily mandate hospital admission for all these patients; rather, it emphasizes the need for careful ED evaluation and prompt medical follow-up after discharge. And, it is important to recall that the ED-based strategy in the chest pain patient changes over the time course of the emergency department stay. Early in the process, the EP is focusing on the detection and management of ACS, particularly STEMI. As time passes in the ED, the focus shifts partially to a combined strategy of ACS detection (NSTEMI and unstable angina) and significant CAD consideration.

continued on page 32

AAEM Young Physicians Section

Ask the Expert - continued from page 31

With completion of the "rule-out MI" protocol, the EP is finally faced with the consideration – what is the likelihood of significant CAD in this patient? This paper very nicely answers this last question.

Once the ED evaluation is complete, the EP must then consider what disposition is most appropriate: admission to the hospital versus discharge with outpatient follow-up (with or without stress imagining). Lai and fellow investigators[12] explored this issue of appropriate discharge after ED evaluation in an observation unit for outpatient risk stratification via exercise stress testing. Three hundred forty-four patients were entered in the study with two patients experiencing fatal out-of-hospital cardiac events; twenty-seven subsequent chest pain visits to the emergency department occurred with nine hospital admissions and 10 readmissions to the observation unit. The authors suggested that a negative ED evaluation involving serial electrocardiograms and biomarkers can identify patients at very low risk of short-term cardiac events – thus, appropriately selected patients can be safely discharged for subsequent outpatient testing. Other studies have noted the ability of patients to follow-up in a timely fashion for stress imaging, particularly if the appointment is made at the time of ED care.[13]

Chest pain patients with recent negative inpatient evaluations for coronary artery disease not infrequently present again to the ED with continued or recurrent discomfort. The most appropriate ED evaluation strategy for these patients is often times difficult to identify. Prina and colleagues[14] investigated the outcome of hospitalized patients discharged with a diagnosis of chest pain of undetermined origin; in this study, they identified features in the presentation which would warrant further cardiac evaluation should the patient return to the ED after hospital discharge. Those "return" patients with pre-existing diabetes mellitus, established coronary artery disease, or abnormal 12-lead ECG demonstrated higher risks for adverse cardiac event; patients lacking these features experienced an excellent cardiac outcome.

Thus, there is no easy answer to the question *"Which chest pain patients initially suspected of acute coronary syndrome can be safely discharged from the emergency department after an ED-based evaluation?"* Clearly, the high and very low suspicion presentations can be managed in relatively straightforward fashion. Yet, the low to intermediate group is troublesome. Relatively younger patients with atypical descriptions of the event and unrevealing ED evaluations likely can be safely discharged with appropriate short-term follow-up. Clearly, a stable patient who remains pain free in the ED with negative serial biomarkers and normal to minimally abnormal ECG can be discharged from the ED for further evaluation on an outpatient basis. Older patients and those individuals with a past history of ischemic heart disease likely require more in-depth evaluations.

The ED evaluation can identify patients who are safely discharged with the assumption that appropriate follow-up will occur in timely fashion.It is very important, however, to understand that the ED evaluation of this subgroup of patients is only the first, or initial, step in the process. Once the EP has considered the initial presentation and completed the ED evaluation, he/she can decide if further inpatient care is necessary; if outpatient management is acceptable, then the patient, primary care physician, and/or cardiologist bear the responsibility for completion of the process initiated in the ED.

References

1. Sanchis J, Bodí V, Núñez J, et al: Limitations of clinical history for evaluation of patients with acute chest pain, non-diagnostic electrocardiogram, and normal troponin. Am J Cardiol 2008;101:613-7.
2. Schillinger M, Sodeck G, Meron G, et al: Acute chest pain--identification of patients at low risk for coronary events. The impact of symptoms, medical history and risk factors. Wien Klin Wochenschr. 2004;116:83-9.
3. Schillinger M, Domanovits H, Paulis M et al: Clinical signs of pulmonary congestion predict outcome in patients with acute chest pain. Wien Klin Wochenschr. 2002;114:917-22.
4. Christenson J, Innes G, McKnight D, et al: A clinical prediction rule for early discharge of patients with chest pain. Ann Emerg Med. 2006;47:1-10.
5. Marsan RJ Jr, Shaver KJ, Sease KL, et al: Evaluation of a clinical decision rule for young adult patients with chest pain. Acad Emerg Med. 2005;12:26-31.
6. Limkakeng A, Gibler WB, Pollack C, et al: Combination of Goldman risk and initial cardiac troponin I for emergency department chest pain patient risk stratification. Acad Emerg Med. 2001;8:696-702.
7. Chase M, Robey JL, Zogby KE, et al: Prospective validation of the Thrombolysis in Myocardial Infarction Risk Score in the emergency department chest pain population. Ann Emerg Med. 2006;48:252-9.
8. Ghaemmaghami C: Personal Communication. July 2008.
9. Miller CD, Lindsell CJ, Khandelwal S, et al: Is the initial diagnostic impression of "noncardiac chest pain" adequate to exclude cardiac disease? Ann Emerg Med. 2004 Dec;44(6):565-74. Erratum in: Ann Emerg Med. 2005;45:87.
10. Hollander JE, Robey JL, Chase MR, et al: Relationship between a clear-cut alternative noncardiac diagnosis and 30-day outcome in emergency department patients with chest pain. Acad Emerg Med. 2007;14:210-5.
11. Hillis GS, Oliner C, O'Neil BJ, et al: Coronary artery disease in patients with chest pain who have low-risk clinical characteristics and negative cardiac troponin I. Am J Emerg Med. 2001;19:118-21.
12. Lai C, Noeller TP, Schmidt K, King P, Emerman CL: Short-term risk after initial observation for chest pain. J Emerg Med. 2003;25:357-62.
13. Richards D, Meshkat N, Chu J, Eva K, Worster A: Emergency department patient compliance with follow-up for outpatient exercise stress testing: a randomized controlled trial. Can J Emerg Med Care 2007; 9:435-40.
14. Prina LD, Decker WW, Weaver AL, et al: Outcome of patients with a final diagnosis of chest pain of undetermined origin admitted under the suspicion of acute coronary syndrome: a report from the Rochester Epidemiology Project. Ann Emerg Med. 2004;43:59-67.

EMTALA - continued from page 29

20. Resar, Roger, M.D. "Capping Admissions: Luther Midelfort Mayo Health System Study." Mayo Health System, 2001.
21. Aiken, Linda, et al. "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction." Journal of the American Medical Association, 2002; 288: 1987-1993.
22. Dempsey, Christy, & Larson, Kenneth. "Improving Flow through Perioperative Services. A Practical Application of Theory." White Paper. St. John's Regional Health Center, Springfield, MO, 2002.
23. American College Emergency Physicians. "How Overcrowding Affects Your Access to Emergency Care." March, 2004. April 17, 2006. www.acep.org
24. McManus, Michael L., M.D., M.P.H. et al. "Impact of Variability in Surgical Caseload on Access to Intensive Care Services." Anesthesiology 2003; 98: 1491-1496.
25. Kingdon, J.W. "Chapter 8: The Policy Window, and Joining the Streams." Agendas, Alternatives, and Public Policies. Harper Collins College Publishers, 1995.

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 ($200 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, 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

ALABAMA

Emergency Medicine Physician Needed at Huntsville Hospital. Newly renovated 60,000 sq. ft. Emergency Department has 54 private treatment rooms, six trauma bays, patient tracking, StatScan and cardiac monitoring standard in every room. We offer a competitive salary, paid vacation, CME allowance, health/life/malpractice insurance and 401k plan. Hospital-owned, 23 physician group with Self-Governance. Huntsville Hospital, the regional referral and trauma center for North Alabama and South Central Tennessee, treats 115,000 Emergency Department patients per year, has 881 beds, 650 physicians and more than 2,000 nurses. For more information, please contact Physician Recruitment at 256-265-7073 or by email at the address below, or visit us on the web. (PA 908)
Email: physicianrecruitment@hhsys.org
Website: www.huntsvillehospital.org

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

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

COLORADO

Director - Department of Emergency Medical Services, Denver, CO. Denver Health is seeking a Director of EMS. The department oversees a busy emergency department, pre-hospital system including a paramedic school and a four-year, 56-person, EM program. DH is an integrated urban safety net system with an academic Level I Trauma Center, 500-bed hospital. Candidates must be ABEM certified, have a distinguished record in clinical care, teaching, research and leadership excellence. Must be Associate Professor or Professor of Emergency Medicine. Send CV and letter to: Patricia A. Gabow, MD, CEO, Denver Health, 777 Bannock Street MC 0278, Denver, CO 80204-4507, or by email to the address below. (PA 905)
Email: Patricia.Gabow@dhha.org

COLORADO

Durango, Colorado: Opening for Board Certified/Board Eligible ED physician in Level III, 18,000 annual volume department. New, state-of-the-art facility with excellent subspecialty coverage. Democratic, stable group with partnership track available. Durango is located in southwestern Colorado with abundant recreational opportunities. (PA 906)
Email: jlmcmd@smallcircles.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

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

INDIANA

Elkhart Emergency Physicians is a stable, physician-owned, democratic group located in North Central Indiana. Seeking BC/BE emergency physicians for full-time positions. We are a fee-for-service group, with longstanding contracts at 2 sites with annual volumes of 30K and 60K. Triple and quadruple coverage with flexible scheduling. Partnership offered after one year. Excellent benefits package including health coverage, malpractice and retirement. Profit sharing and bonus after first year. Great community with low cost of living. Contact Diane Sink at 574-523-3160 or send CV to the email address below. (PA 907)
Email: dsink@egh.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

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

MAINE

Midcoast: Miles Memorial Hospital and St. Andrew's Hospital are recruiting for one emergency physician to join a stable and collegial group. The two hospitals are located on the water in safe and vibrant coastal communities. The ED's are appropriately staffed and sized to provide an outstanding level of service to the 18,000 patients they care for each year. Competitive salary and benefit package with loan support available. Emergency Medicine board certification/eligibility preferred. E-mail CV and letter of intent to Mark Fourre MD, Chief of Emergency Medicine at the email address below. (PA 910)
Email: markf@mileshealthcare.org
Website: http://www.mainehealth.org/miles_homepage.cfm?id=509

MARYLAND

DelMar Emergency Specialists, an independent, democratic EM group seeks FT BC/BE EM physician. We staff the newly renovated ED at Union Hospital in Elkton, Maryland. We provide 36 hr physician coverage and 16 hr PA coverage daily for 18 core beds and 10 urgent care beds. This non-trauma ED sees 40k visits annually. Benefits include immediate partnership; malpractice coverage; health, dental, life, short-term and long-term disability insurances; retirement plan and CME allowance. Income is based on hourly rate and additional productivity based compensation. Please contact Laura Ellis, MD at 302-528-3926, or at the email below. (PA 899)
Email: lauraellismd@verizon.net

MASSACHUSETTS

Stable democratic group seeking BC/BE emergency medicine physicians for full-time position which opened 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 health care 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

MINNESOTA

Duluth: The Duluth Clinic is an affiliate of SMDC Health System, a nationally-recognized, 400+ physician, multi-specialty group comprised of 17 clinics and 4 hospitals. SMDC is the region's largest provider of primary, secondary and tertiary healthcare. 23-bed ED; 38,000 patient visits, 7-bed pediatric ED and 8-bed care initiation unit; admit to 333-bed hospital; adult and pediatric hospitalist support, 8 hour shifts; double coverage 19/24 hours with some triple coverage. Stretching nearly 30 miles along Lake Superior's rugged shoreline, Duluth is one of the largest and most beautiful cities in Minnesota. Visit www.visitduluth.com or www.duluthclinic.org/career. Call Sandra at 218-786-1035. (PA 900)
Email: skramer@smdc.org
Website: www.duluthclinic.org/career

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 JERSEY

Chief, Department of Emergency Medicine. UMDNJ seeks candidates for the position of Chief of the Department of Emergency Medicine. Responsibilities: oversight of emergency medicine department at UMDNJ-University Hospital, supervision of residents & students and direct patient care. Candidates must be BC in Emergency Medicine and have 3 years administrative experience in a large urban medical center. Strong clinical and teaching skills required. NJMS faculty appointment at a rank commensurate with credentials & experience. Submit letter of interest, CV and 3 professional references to: Suzanne Atkin, MD FACEP, Chief Medical Officer, UMDNJ-University Hospital, 150 Bergen St., Newark, NJ 07103. Or you may submit the information to the email address below. EOE (PA 909)
Email: atkinsh@umdnj.edu

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

NEW YORK

Single-hospital, collegial, democratic group seeking BC/BE emergency medicine physicians for expanded coverage. State-of-the-art department with US, CT and digital radiography in ED. Full departmental status; excellent remuneration; full benefit package. Employed position. Visits: 51K in 2007. Area offers excellent schools, outdoor activities, affordable housing and high standard of living. (PA 901)
Email: bjones@unityhealth.org
Website: www.unityhealth.org

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

NORTH CAROLINA

Durham - Established, democratic emergency medicine group is seeking a full-time emergency medicine BC/BE physician. 50,000 patients are treated annually. We offer a competitive salary and comprehensive benefits. We are located in one of the most desirable living areas on the East Coast, close to beaches and mountains with an international airport. We have great weather all year round, excellent schools and 3 major universities. For more information please fax CV to 919-477-5474, or email to the address below. Please feel free to visit our website. EOE (PA 902)
Email: durhamemergency@ams-nc.com
Website: www.durhamemergencyphysicians.com

NORTH CAROLINA

ER physicians for Ft. Bragg, Fayetteville, NC. Come to this beautiful state and enjoy all the outdoors has to offer when not enjoying the great work environment at Womack Army Medical Center on the Fort Bragg base. American Hospital Service Group has established itself as excelling in fulfilling Department of Defense contracts on military bases throughout the U.S. Treat those families who are serving our country! Board certified/board eligible physicians, independent contractor opportunity. Any state license accepted at Federal work places and malpractice immunity provided. Contact Emily at 800-872-8626 xt 272, or by email at the address below. (PA 903)
Email: ejavadpour@ahsg.us
Website: www.americanhospital.us

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 west 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

TEXAS

Amarillo Emergency Physicians, a fully democratic group in existence for 15 years, is seeking to add a BC/BE emergency physician. 45,000 annual volume, 54 hours/day of all physician coverage-no mid levels, minimal trauma, comprehensive specialty backup includes 24/7 in-house radiologist, CT/MRI/US and cath lab. New state-of-the-art ED in planning phase. Productivity-based compensation exceeds $215/hr. Profit sharing plan, flexible scheduling, full equal partnership at 1 year. Contact Curtis Hudson, MD at 806-433-5658 or by email at the address below. (PA 904)
Email: texasvineyards@mail.com

VERMONT

Seeking BC/BE emergency medicine physician in southern Vermont. Strong relationship with established hospitalist program. 15 hours of double coverage. Annual volume of 22,000. 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 the email address below or by phone at 802-447-5236. (PA 878)
Email: gosn@phin.org
Website: www.greenmtnsgreatdocs.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

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/AOBEM 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

WISCONSIN

EMS Medical Director, Academic Emergency Physician. Exceptional opportunity for highly motivated, EM board certified physician to join the Division of Emergency Medicine (EM) at the University of Wisconsin School of Medicine and Public Health & University of Wisconsin Hospitals and Clinics. Relevant experience required to take on role of EMS Medical Director for the City of Madison Fire Department. Clinical responsibilities in the UWHC emergency department and an administrative position as EMS Medical Director. Competitive compensation and benefits. UW EM faculty supervises EM and off-service residents, while working clinically in a busy, university-based, tertiary hospital ED. The UWHC ED is only one of two academic EDs in the state, and is a Level I Trauma, Pediatric Trauma and Burn center. Send resume and cover letter to: agh@medicine.wisc.edu, Joseph R. Cline MD FACEP, F2/211 CSC, MC 3280, 600 Highland Avenue, Madison, WI 53792-3280. EEO/AA Employer. Wisconsin caregiver and open records laws apply. Background check (PA 898)
Email: agh@medicine.wisc.edu

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.

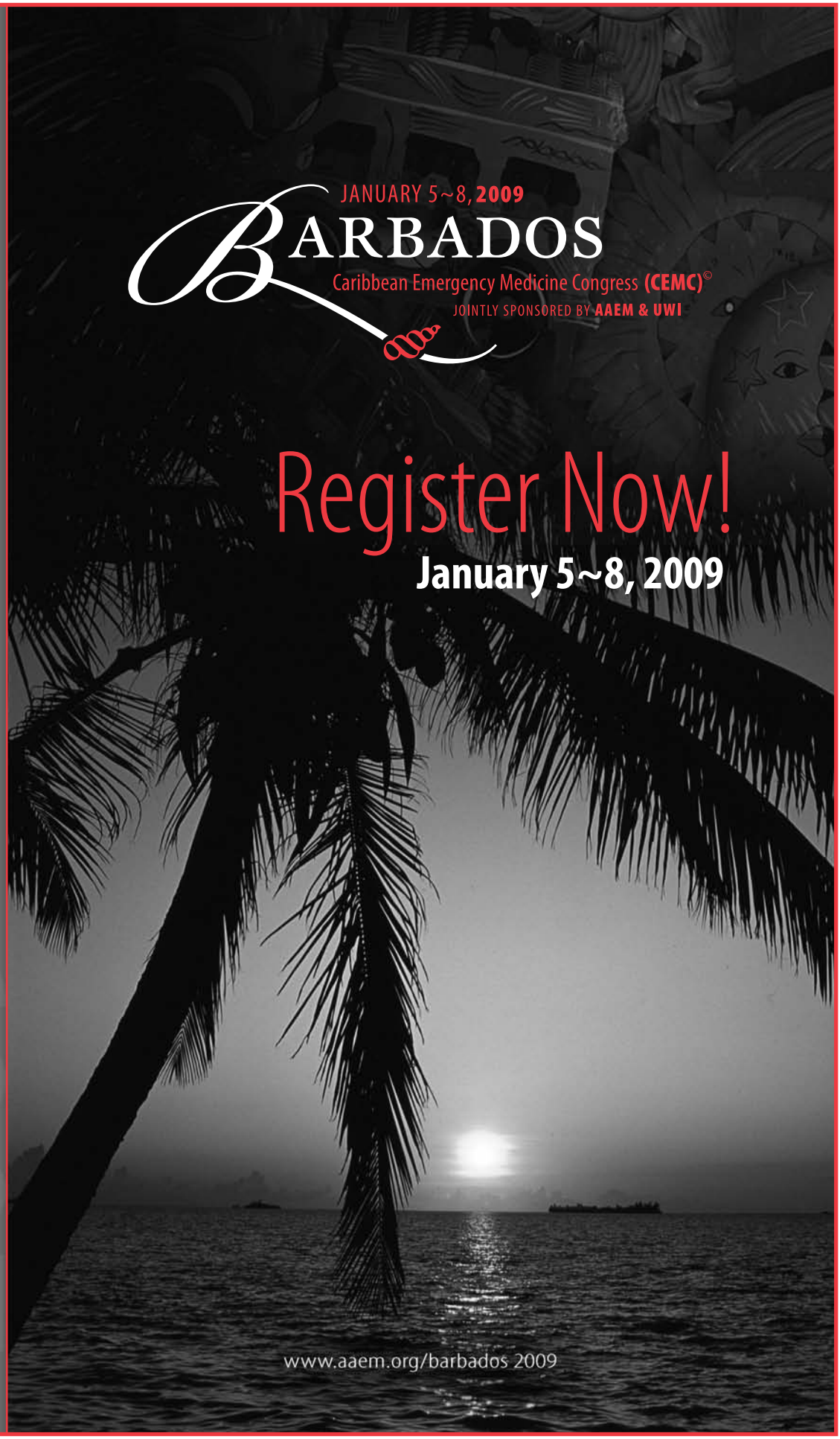
CANADA

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

Caribbean Emergency Medicine Congress (CEMC)©



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