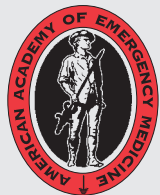


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THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



PRESIDENT'S MESSAGE

Restrictive Covenants and the California Supreme Court

Larry D. Weiss, MD JD FAAEM

On August 7, 2008, in the case of *Edwards v. Arthur Andersen LLP*, the California Supreme Court affirmed its previous interpretations of California law by declaring restrictive covenants, or "noncompetition agreements," invalid.¹ In this case, Edwards worked for Arthur Andersen as an accountant, later becoming a manager. Significantly, he never became a partner in the firm. His original contract included a noncompetition agreement. When Arthur Andersen went out of business as a result of the Enron scandal, it sold part of its firm to HSBC USA. The terms of the sale required enforcement of some aspects of the noncompetition agreement. Edwards filed suit to have the noncompetition agreement declared unlawful.

The trial court held for Andersen, stating the noncompetition agreement only applied a "narrow restraint" on Edwards' ability to practice his profession. The Court of Appeal and Supreme Court disagreed. They stated no "narrow restraint" exception to the law existed. The noncompetition agreement in this case only prevented Edwards from working for Andersen's clients for an 18 month period after termination of Edwards' employment contract with Andersen. It also prohibited Edwards from soliciting Andersen's clients for a one year period. The noncompetition agreement had no geographic restrictions, allowing Edwards to practice wherever he desired. Regardless, the court reasoned, the noncompetition agreement "restrained his ability to practice his profession."

A post-contractual restrictive covenant, or noncompetition agreement, prohibits an employee or contractor from working in a defined geographical location for a specified period of time after termination of the contract. Seven states either have an absolute or near-absolute ban on restrictive covenants in physician contracts. Tennessee has a law prohibiting restrictive covenants in emergency physician contracts. The other 42 states use a "rule of reason" to evaluate the legality of restrictive covenants. Under this rule, a court may uphold a restrictive covenant if (1) the employer or contract holder has a legitimate business interest and (2) if the restrictions are reasonable. Courts usually hold that the prevention of competition is not a legitimate business interest. Earlier editions of this

publication have a more detailed explanation of restrictive covenants.²

Under California law, the general rule states "... every contract by which anyone is restrained from engaging in a lawful profession, trade, or business of any kind is to that extent void."³ Unlike laws in some other states that specifically ban restrictive covenants in physician contracts, the California law applies to all contracts. Exceptions to this rule exist only for the sale or dissolution of businesses, including partnerships, corporations and limited liability enterprises.⁴

In conclusion, even though the *Edwards* case dealt with an accounting firm, the holding in this case and the court's analysis apply to any "profession, trade, or business."¹ Within the context of emergency medicine, contracts cannot restrain the work of an emergency physician in California after termination of a contract unless the physician served as a partner, owner or shareholder of the practice. As a matter of public policy, California law prohibited restrictive covenants since 1872. Like their model legislation dealing with medical liability, this reflects yet another instance of California serving as a fine example for other states in our country.

Disclaimer: This information does not constitute legal advice, is general in nature, and because individual circumstances differ, it should not be interpreted as legal advice. AAEM provides this information only for general informational purposes.

(Endnotes)

- 1 *Edwards v. Arthur Andersen LLP*, No. S147190 (Cal. 2008).
- 2 See, e.g.: *Common Sense* 2006; 13(5):1, 3.
- 3 Cal. Bus. & Prof. Code §16600.
- 4 Cal Bus. & Prof. Code §§16601-16602.

To sign up for **AAEM** or **AAEM/RSA membership**, go to **www.aaem.org/membership** or call 800-884-2236.

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"It's Too Late, Baby" – Not!

EDITOR'S LETTER

David Kramer, MD FAAEM

By the time you read the next issue of *Common Sense* it may be too late. That's right; emergency department schedules will be written, plans will be made. If you don't arrange for your time off to attend the upcoming 15th Annual AAEM Scientific Assembly **March 2-4, 2009**, now, you will likely miss out. There will undoubtedly be superb presentations by famed scholars that you will not hear. Networking will go on without you. Deals will be made, agreements struck and opportunities presented – all without your involvement. Smiles will predominate, and laughter will ensue. The temperature in Phoenix will be 75 degrees. What will you be doing?

But it's not too late yet. There is still time to make plans to attend. If you haven't already done so, check out the meeting brochure on our website. Then, request the time off, and register for the meeting. Remember, you have already paid for it with your dues. That's right; the Scientific Assembly (and the CME that goes along with it) remains free for all members of AAEM! The Sheraton Phoenix Downtown Hotel just opened its doors about two months ago, and I'm told it is beautiful. I hope to see all of you there. *It's not too late, baby.*



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

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

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Pre-Conference Courses

Saturday, February 28, 2009
& Sunday, March 1, 2009

8:00am–5:00pm Resuscitation for Emergency Physicians:
The AAEM Course (2 day course)

Sunday, March 1, 2009

8:00am–5:00pm Resuscitation for Emergency Physicians:
The AAEM Course (2 day course)

8:00am–5:30pm Pediatric Emergencies: Children are not
Little Adults

8:00am–12:00pm Simulation Workshop

9:00am–4:00pm Advanced Ultrasound

1:00pm–5:00pm LLSA Review 2008

1:00pm–5:00pm Simulation Workshop

1:00pm–6:00pm USAAEM Pre-conference: Emerging Trends
in Ultrasound and Trauma Care

Conference Schedule

Here's a peek at your opening speakers!

To see more and to register, visit www.aaem.org

Monday, March 2, 2009

8:00am **J. James Rohack, MD, AMA President-Elect**
Keynote Speaker
The Corporate Practice of Medicine

9:00am **Amal Mattu, MD FAAEM**
High Risk ECGs

10:00am **Corey Slovis, MD FAAEM**
Kicking the Acidosis—Sorting out Metabolic Emergencies

11:00am **Jeff Tabas, MD FAAEM**
High-Risk Problems You Can't Afford to Miss

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Please visit www.aaem.org/cemc/2009/program.php
for the current meeting and faculty schedule.

Program Schedule – Hilton Barbados

Monday, January 5

8:15 am – 12:00 pm	Educational Program
12:00 pm – 1:30 pm	Lunch
1:30 pm – 5:00 pm	Educational Program
5:00 pm – 7:00 pm	Opening Ceremony

Tuesday, January 6

8:00 am – 12:00 pm	Educational Program
12:00 pm – 1:30 pm	Lunch
1:30 pm – 5:00 pm	Educational Program

Wednesday, January 7

8:00 am – 12:00 pm	Educational Program
12:00 pm – 1:30 pm	Lunch
1:30 pm – 5:00 pm	Educational Program

Thursday, January 8

8:00 am – 11:30 am	Educational Program
11:30 am – 12:00 pm	Closing Ceremony, Awards, Research Prizes

Optional Ultrasound Course

Friday, January 9 and Saturday, January 10

8:00 am – 4:00 pm	University of the West Indies – Barbados
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CME Information

Accreditation Statement

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the American Academy of Emergency Medicine (AAEM) and the University of the West Indies. The AAEM is accredited by the ACCME to provide continuing medical education for physicians.

Designation Statement

AAEM designates this educational activity for a maximum of 27 hours of *AMA PRA Category 1 Credit(s)*[™]. Physicians should only claim credit commensurate with the extent of their participation in the activity. Up to 14 additional *AMA PRA Category 1 Credits*[™] are available by attending Ultrasound Course following CEMC[®].

Here is just a small sample of the exciting topics and world-renowned speakers:

Drugs That Can Kill a Toddler with One Pill or Swallow
 How to Read a Trauma Patient's Chest X-Ray
 Tips of the Trade: Unconventional Solutions to Conventional Problems
 Using Ultrasound to Manage Resuscitations
 When the Doctor Becomes a Patient
 Becoming a Superb Educator: Teaching Adult Learners
 Staying Sane as Faculty
 Simulation Technology for Teaching EM
 Planning for Disasters on an Institutional Level
 Burn Mass Casualty Incidents
 Terrorism: Chemical Warfare
 EMS Prototypes From Around the World
 Taking Care of the Care-Givers
 Emergency Physician Advocacy
 Collaboration in the International EM Setting
 Violence against Health-Care Workers

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Gary Gaddis	Reginald King	Harold Watson

..... and many more!

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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.

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EMTALA Community Call Plans and On-Call List Rules Finalized

Kathleen Ream, Director of Government Affairs

The Centers for Medicare & Medicaid Services (CMS) has adopted changes to EMTALA which include rules for community call plans and amends the regulations governing the on-call list. Effective October 1, 2008, the rules were part of the FY 2009 inpatient prospective payment system (IPPS) final rule.

In the 2009 IPPS proposed rule, CMS expressed its intent to revise EMTALA regulations to "clarify" that, when an unstable patient was admitted at one hospital and, subsequently, was transferred in an unstable condition via an appropriate transfer to a facility with specialized capabilities, the "receiving hospital" had an EMTALA obligation to accept the individual so long as the transfer was appropriate and the receiving hospital had the capacity to treat the individual.

CMS also finalized the regulations that would permit hospitals to meet the EMTALA requirement for maintaining an on-call physician list by participating in a formalized community call plan among hospitals, and retained all but one of the proposed call plan elements described in the proposed rule. The requirement that hospitals demonstrate evidence that they have analyzed the specialty on-call needs of the community to be served by the call plan was removed, because the proposed requirement would be "duplicative of the existing requirement that a hospital must assess the call plan annually." The final proposed call plan elements are as follows:

- Clear delineation of on-call coverage responsibilities (when each hospital is responsible for on-call coverage)
- Definition of the specific geographic area to which the call plan applies
- Signatures from the appropriate representatives of each hospital participating in the plan
- Requirements that any local and regional EMS system protocol formally includes information on "community on-call" arrangements
- A statement specifying that, even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability
- Continued compliance by participating hospitals with EMTALA regulations governing appropriate transfers
- Reassessment of the call plan on an annual basis by participating hospitals

Language stating that a hospital was required to maintain an on-call list "in a manner that best meets the needs of the hospital's patients" was removed. The regulations have been amended to state that an on-call list must be maintained "in accordance with the resources available to the hospital" and include sufficient guidance that a hospital is obligated to provide on-call services based on the resources it has available at the time, including the availability of specialists.

The final rule can be found at <http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf>

EMTALA Eye Injury Case Dismissed by Federal District Court

On August 14, 2008, the federal district court for the Eastern District of Louisiana dismissed a claim filed under EMTALA that a hospital improperly transferred an uninsured patient absent stabilizing his

eye injury (*Smithson v. Tenet Health System Hospitals Inc.*, E.D. La., No. 07-3953, 8/14/08).

The Facts

At 7:15 a.m. on August 4, 2005, Vincent J. Smithson arrived at the ED at Northshore Regional Medical Center after suffering an "open globe injury" to his eye. Smithson immediately was examined by an ED physician, Dr. Ernest Hansen, who subsequently consulted via telephone with the on-call ophthalmologist, Dr. Terrell Hemelt. Hemelt told Hansen to order a CAT scan to determine whether a foreign body was in the eye and to report the results back to Hemelt. After receiving the results at 9:45 a.m., Hemelt instructed the ED physician to ready Smithson for surgery, which Hemelt would perform when he arrived at the hospital, projected to be at noon.

At this point in the case's background narrative, some facts were in dispute. Hemelt claimed that when he arrived at the hospital, he told Smithson and his mother, as Smithson was a minor, that surgery was needed for urgent repair. Hemelt reported that when he told Smithson that his surgery fees would amount to between \$1,000 to \$2,000, Smithson, who was uninsured, asked to be transferred. Hemelt also asserted that despite informing Smithson of the risks of transfer and advising him to have the surgery at Northshore, Smithson's mother signed a form requesting a transfer. Hemelt certified on the form that the patient was stable prior to transfer.

Previous to transfer, a shield was placed on Smithson's eye, he intravenously received antibiotics, and antiemetic was administered. At about 2:30 p.m., Smithson was transferred to the Medical Center of Louisiana at New Orleans (Charity Hospital), where he arrived at that hospital's ED at 4:55 p.m. Smithson was examined at 7:30 p.m. and underwent surgery at 10:30 p.m. An infection in Smithson's eye was detected the next morning, and three days later his eye was removed.

On August 3, 2007, Smithson (Plaintiff) sued Tenet Health System Hospitals, Inc. d/b/a Northshore Regional Medical Center, Terrell Hemelt, MD, and Louisiana State University Health Care Services Division, Medical Center of Louisiana at New Orleans. Plaintiff claimed that defendants violated EMTALA by "(1) failing to provide an appropriate medical screening for the plaintiff, (2) failing to give plaintiff stabilizing treatment, and (3) discouraging plaintiff from remaining at Northshore because he lacked insurance."

Defendant moved for summary judgment on all claims and plaintiff moved for partial summary judgment on the issues of appropriate screening and stabilizing treatment. In an interesting discussion of the technicalities of the law as applied to this case, the court denied the cross-motions for summary judgment on July 30, 2008 (*Smithson v. Tenet Health System Hospitals Inc.*, E.D. La., No. 07-3953, 7/30/08). The court found genuine issues of material fact, which must be proved at trial by presentation of evidence and which must be evaluated by the finder of fact.

The Ruling

The case was returned for a jury trial. The jury found that defendant did not violate EMTALA. The claim was dismissed.

The text of the decision on the summary judgment motions is available at: <http://op.bna.com/hl.nsf/r?Open=mapi-7hgmem>

View from the Podium

Kevin Rodgers, MD FAAEM



Get ready for Phoenix! I recently returned from a trip to Phoenix where I had the opportunity to visit the brand-spanking new Downtown Sheraton where the Scientific Assembly will take place this coming March. Built as the Sheraton's new "upscale" flagship hotel, I am confident that AAEM members attending the meeting will be quite impressed. Located in downtown Phoenix, it is close to the airport and

is surrounded by an excellent variety of restaurants and night-spots within walking distance.

I believe the 2009 Scientific Assembly will prove to be the best one yet. The Scientific Assembly Subcommittee has been hard at work since last spring developing a list of stellar speakers and engaging topics. From start to finish, you'll hear top-level presentations from the best of the best: Amal Mattu, Peter DeBlieux, Corey Slovis, Ghazala Sharieff, Jim Roberts, Stuart Swadron, Rich Bukata, Jeff Tabas, Joe Lex and many more! Several tracks are composed of quick hitting 30-minute presentations focused on answering a specific clinical question. The point-counterpoint debates return covering a number of controversial topics such as "Helicopters Save Lives." Our keynote speaker, J. James Rohack, President-Elect of the AMA, will open the Scientific Assembly on March 2nd at 8:00am discussing the Corporate Practice of Medicine. This is in addition to a myriad of important topics, such as literature updates, rational approaches to common problems and emergency imaging. Don't miss

the chance to make a presentation yourself. Join us Tuesday, for our "Open Mic" session providing any AAEM member the opportunity to present a cutting-edge topic of his/her own! All the details are available online in the Scientific Assembly preliminary program.

This year, again, we're offering a variety of stimulating pre-conference workshops. In order to shorten your time away from home, we've scheduled all of the workshops, except for the two-day Resuscitation Course, on the day before the regular assembly starts (March 1st). The re-designed Resuscitation for Emergency Physicians course, the first integrated resuscitation course designed especially for board-certified EM physicians will start on February 28. Other excellent pre-conference sessions include Advanced Ultrasound, LLSA Review 2008, Pediatric Emergencies: Children are not Little Adults and a Simulation Workshop. The Uniformed Services Chapter will also offer a pre-conference course geared toward military personnel.

The Resident and Student Association (RSA) has organized a track geared towards residents and young physicians, which will be held on Tuesday, March 3, 2009. Don't forget to watch your fellow residents compete in the AAEM/JEM Resident and Student Research Competition on Monday, March 2, 2009.

So visit the AAEM website, www.aaem.org, and register for the premier CME event in our specialty. You will not be disappointed, especially considering the cost – general registration is free to all AAEM and AAEM/RSA members!

AMA Program Provides Prescribing Data Privacy

Many physicians are interested in learning about the AMA's Physician Data Restriction Program (PDRP), which offers physicians the opportunity to restrict their prescribing information from pharmaceutical sales representatives.

According to a Gallup poll, the majority of physicians, 84%, said either they were not concerned about the release of their prescribing data or that the ability to opt-out of the release of their data to pharmaceutical sales representatives would alleviate their concerns.

In response, the AMA created the PDRP which gives physicians the option to restrict their prescribing data from sales reps. PDRP also allows doctors to register a complaint or concern about a sales representative or a pharmaceutical company's use of their prescribing data.

The Physician Data Restriction Program is available to all doctors—AMA members and nonmembers alike. The program has only been in existence since July 2006 and presently, awareness studies show only 25% to 30% of physicians know about the program. AMA needs your help to spread the word.

The AMA has the following promotional materials available for your use:

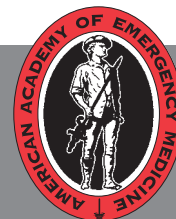
- Advertisements in a variety of sizes (PDF files)
- Short but comprehensive Q&A that can be included in newsletters or posted on websites

Please contact the AMA's Amy Jenkins (amy.jenkins@ama-assn.org) at 312-464-5919 if you would like any of these materials.

For more information on the PDRP please visit www.ama-assn.org/go/prescribingdata.

See "**Proof Positive**," the newest case on the **Remarkable Testimony** website, at...

<http://www.aaem.org/aaemtestimony/index.php>



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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>

AAEM–Sponsored Conferences

January 5-8, 2009

- Caribbean Emergency Medicine Congress
Barbados
www.aaem.org/cemc/2009

March 2-4, 2009

- 15th Annual AAEM Scientific Assembly
Phoenix, AZ
www.aaem.org

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

September 14-17, 2009

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

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

December 5-6, 2008

- Second Annual Congress of the Lebanese Critical Care Society (LCCS)
Beirut, Lebanon
www.trust-traders.com

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 25-29, 2009

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

January 26-28, 2009

- SkiBEEEM (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
<http://www.theairwaysite.com>

March 13-15, 2009

- The Difficult Airway Course-Emergency™
Miami, FL
<http://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

May 14-17, 2009

- Public Health in the ED: Surveillance, Screening and Intervention (SAEM Consensus Conference)
New Orleans, LA
www.saem.org

May 21-23, 2009

- High Risk Emergency Medicine
San Francisco, CA
www.highriskem.com

June 5-7, 2009

- The Difficult Airway Course-Emergency™
Boston, MA
<http://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 18-20, 2009

- The Difficult Airway Course-Emergency™
Chicago, IL
<http://www.theairwaysite.com>

October 23-25, 2009

- The Difficult Airway Course-Emergency™
Las Vegas, NV
<http://www.theairwaysite.com>

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- The Heart Course-Emergency
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November 13-15, 2009

- The Difficult Airway Course-Emergency™
Atlanta, GA
<http://www.theairwaysite.com>

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

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

EM in Brazil

Author: Dr. Christina Bloem is a second year fellow in international emergency medicine at George Washington University, where she is also pursuing a Masters in Public Health. She completed her emergency medicine residency at Kings County/SUNY Downstate, where she served as chief resident and was also involved in the development of their international division. Dr. Bloem is of Brazilian descent and has done medical work abroad in Peru, Brazil, Guyana, Cote d'Ivoire, India and Qatar.

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

Brazil is a country of amazing complexity and beauty. With an area of 8,547,403.5 km², it is the world's fifth largest country geographically and is the fifth most populous country, estimated at close to 170 million people today. It is neighbor to all of the countries in South America except Ecuador and Chile and has an extensive eastern sea border along the Atlantic Ocean. The country can be divided into five main regions - north, northeast, southeast, south and west central - each with its individual climatic, economic and cultural characteristics. Brazil's major cities are São Paulo, Rio de Janeiro, Brasília, Belo Horizonte, Recife, Curitiba and Porto Alegre. Modern and extensive highways cover the entire country. Racially, Brazilians have three main backgrounds: Natives, Europeans (mostly Portuguese and later immigrants from other European countries) and Africans (brought during the Trans-Atlantic Slave Trade). Due to its recently developed and expanded industrial sector, Brazil is now rated as the world's tenth largest economy at market exchange rates and the ninth largest in purchasing power. In 2003, the government identified the primary burdens of disease as infant mortality, maternal mortality, chronic disease (particularly cardiovascular disease and cancer) and injury due to road traffic accidents, violence and suicide. Brazil has a national healthcare plan called "SUS" (Sistema Único de Saúde) which provides care to the majority of the country's citizens. There are also private insurance carriers available to the more socioeconomically privileged population.

The Emergency Healthcare System

Emergency medicine (EM) is not a new field in Brazil. In 2002, the Ministry of Health outlined a document, the "Portaria 2048," which called upon the entire healthcare system to improve emergency care in order to address the increasing number of victims of road traffic accidents and violence, as well as the overcrowding of emergency departments (EDs) resulting from an overwhelmed primary care infrastructure. The document delineates standards of care for staffing, equipment, medications and services appropriate for both pre-hospital and in-hospital. It further explicitly describes the areas of knowledge that an emergency provider should master in order to adequately provide care. However, these recommendations have no enforcement mechanism and, as a result, emergency services in Brazil still lack a consistent standard of care.

Pre-hospital emergency medical services use a combination of basic ambulances staffed by technicians and advanced units with physicians on-board. No universal phone number exists for emergency calls, and the dispatch center physician determines whether the call merits an emergency transport or not. Pre-hospital physicians have variable training in emergency care, with training backgrounds ranging from internal medicine to obstetrics to surgery.

Similar to the early years of EM in the United States, emergency department physicians in Brazil come from different specialty backgrounds, many of them having taken the job as a form of supplementary income or as a result of unsuccessful private clinical practice. Since 50% of medical school graduates in Brazil do not

get residency positions, these new physicians with minimal clinical training look for work in emergency departments. In larger tertiary hospitals, the ED is divided into the main specialty areas – internal medicine, surgery, psychiatry, pediatrics – and staffed by the corresponding physicians. Still, significant delays in care can occur when patients are inappropriately triaged or when communication between the areas is inadequate. In the non-tertiary care centers, which make up the majority of hospitals in the country, emergency department physicians are largely under-trained, underpaid and overstressed by their working conditions. This has compromised patient care and created an incredible need for improvement in the emergency care system.

Emergency Medicine Training & Academics

Although the specialty is not yet officially recognized by the accrediting medical board (the Conselho Federal de Medicina, CFM), Brazil has two emergency medicine residency training programs. The first residency program was established in Porto Alegre, the capital city of Rio Grande do Sul, the southernmost state in Brazil. They have graduated more than 45 emergency trained physicians and follow the American three-year curriculum model, currently with six trainees per year. The program is well recognized in the state, and its graduates are actively sought out for employment in local emergency departments and ambulance services. The second residency program welcomed its first class of six residents in April of 2008, in Fortaleza, Ceará, and follows the curriculum model of its predecessor in Porto Alegre. The third residency program is planned to start in February 2009 in Curitiba, Paraná. Other residency programs are in planning stages in the states of São Paulo, Rio de Janeiro and Bahia.

As a way around the complex politics of changing the medical community's specialty structure, in 1992 the University of São Paulo (USP) created the "Departamento de Emergências Clínicas," which focuses on medical, non-surgical emergency training for medical students and residents. The USP emergency department attends to almost 300,000 patients annually within a large, public, tertiary care hospital complex. They have a dedicated clinical and academic core faculty, primarily trained in internal medicine, who has published emergency literature in the form of both research studies and textbooks.

Brazil also has a national emergency medicine association, ABRAEME (Associação Brasileira de Medicina de Emergência) and a few state societies, including AMERS (Associação de Medicina de Emergência do Rio Grande do Sul) and SOCEMU (Sociedade Cearense de Medicina de Urgências). The First Brazilian Emergency Medicine Congress took place in Gramado, Rio Grande do Sul in September of 2007, and the Second Brazilian Emergency Medicine Congress is scheduled for September 2009 in Fortaleza, Ceará. Porto Alegre also hosted the WINFOCUS 4th World Congress on Ultrasound in Emergency and Critical Care Medicine in March of 2008.

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Emergency Medicine as a Specialty

The leaders in emergency medicine in Brazil have worked for many years to obtain specialty status without success. Emergency medicine is considered a sub-division of internal medicine by the accrediting board of medical specialties (CFM). Resistance to paradigm shifts in the entrenched specialty structure in Brazil continues to impede emergency medicine from breaking off into its own independent field.

Despite these barriers, the movement of emergency medicine in Brazil is now gaining significant speed, particularly given the headway made by the establishment of new residencies and the academic conferences of 2007 and 2008. The First Brazilian Emergency Medicine Congress produced a petition letter signed by hundreds of congress participants, sent to the CFM as a demand for specialty status. In June of 2008, leaders in emergency medicine from Porto Alegre, Fortaleza, and officials of emergency management from the State Ministries of Health joined in a meeting in the nation's capital of Brasília to emphasize the importance of adequate emergency training and the need for the specialty of emergency medicine. The Minister of Health, the Minister of Education and the Secretary of the National Medical Association of Brazil were all audience to these critical discussions.

The Future of Emergency Medicine in Brazil

Emergency medicine clearly has a growing presence in Brazil. Information exchange and development work are occurring through international collaboration, integrating Brazil ever more into the worldwide emergency medicine network. The residency programs are open to educational exchange rotations for physicians, and researchers at the University of São Paulo have expressed interest in performing joint studies with other institutions. Brazil's economic development not only brings about a "double burden" of communicable and chronic diseases, but also draws increased

international attention, putting pressure on country officials to respond appropriately to the healthcare system's new demands. The attention has reached critical mass, prompting leaders, both political and medical, to focus more on the rapidly developing field of emergency medicine, showing significant promise for achieving specialty status.

References

- Ministry of Health of Brazil. SUS from A to Z. <http://dtr2004.saude.gov.br/susdeaz/introducao/introducao.php> (accessed on July 2, 2008).
- Ministry of Health of Brazil. Portaria No2048. http://www.academiabarro-preto.com.br/portaria_2048_B.pdf (accessed on July 2, 2008).
- Bloem CMCP, Bertuzzi BD. Medicina de Emergência no Brasil e no Mundo, in: Martins HS, Damasceno MCT, Awada SB e colaboradores. Pronto-Socorro: Diagnóstico e Tratamento em Emergências. Editora Manole, Barueri-SP, 2ª edição, 2008, páginas: 3-9. (Emergency Medicine in Brazil and the World, in a Brazilian textbook entitled "Emergency Departments: Diagnostics and Treatment of Emergencies").
- Associação Brasileira de Medicina de Emergência (ABRAMEDE). www.abramede.com.br (accessed on July 3, 2008).
- Associação de Medicina de Emergência do Rio Grande do Sul (AMERS). www.amers.mapamedico.com.br (accessed on July 3, 2008).
- Ministério do Planejamento, Orçamento e Gestão. Radar Social – Principais Iniciativas do Governo Federal (Social Radar – Main Initiatives of the Federal Government). http://www.planejamento.gov.br/arquivos_down/spi/radar_social/Radar_social_completo.pdf (accessed on July 1, 2008).
- Pan American Health Organization (PAHO). Country Health Profile – Brazil, September 2002. http://www.paho.org/English/DD/AIS/cp_076.htm (accessed on July 1, 2008).
- The World Bank. Brazil Country Brief. <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/LACEXT/BRAZILEXTN/0,,contentMDK:20189430~pagePK:141137~piPK:141127~theSitePK:322341,00.html> (accessed on July 1, 2008).

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.

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:

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RESIDENT PRESIDENT'S MESSAGE

Fellowship Opportunities in Emergency Medicine

Megan Boysen, MD
President, AAEM/RSA

Over the past several months, I've spent some time speaking with my program director, faculty and mentor about fellowships in emergency medicine. Our specialty is unique in the variety of training opportunities available to us after residency. For many of us, the decision of which, if any, fellowship to choose can be confusing.

Only a few EM fellowships are recognized by the American Board of Medical Specialties (ABMS) – sports medicine, pediatric EM, toxicology, hyperbaric and undersea medicine, and hospice and palliative medicine. Many other fellowships offer additional certification or degrees, for example, a master's degree in public health, business or epidemiology. Ultrasound fellows may become registered diagnostic medical sonographers (RDMS) – however, fellowship is not required to become RDMS certified.

While certification, accreditation and/or graduate degrees are not necessary parts to many EM fellowships, accreditation ensures that a program complies with strict guidelines set forth by the overseeing medical board. Additional degrees offer added experience and expertise which are attractive to many employers and programs. For those programs which are recognized by the American Board of Medical Specialties, fellows must graduate from an accredited program in order to sit for the respective board exam. The exception to this is hospice and palliative medicine, which allows physicians to be "grandfathered" in until 2010.

Here is a list of some of the most popular fellowships in emergency medicine:

Wilderness Medicine: Wilderness medicine is a relatively new fellowship within EM, with the first program established at Stanford in 2003. Physicians are trained to meet the unique challenges and emergencies that arise in environments isolated from formal medical care. Specific foci include hyperbaric and marine medicine, altitude-related illnesses, orthopedics and wound care, tropical and travel medicine, hypothermia, animal envenomations and animal-related infections. The fellowship is typically one year.

Ultrasound: During the one-year long ultrasound fellowship, fellows complete a minimum of 800 ultrasounds. The fellowship focuses on the applicability and the teaching of ultrasound in the emergency department, while exploring future facets of ultrasound in the ED. Typically, fellows become registered diagnostic medical sonographers during or shortly after their fellowship. There are many well-established programs across the country.

Trauma and/or Critical Care: A trauma and/or critical care fellowship is available to emergency medicine residents at a limited number of programs around the nation. While board certification in critical care medicine is not available to emergency medicine specialists (currently only anesthesia, internal medicine, surgery, obstetrics and gynecology and pediatrics have accredited fellowships), the fellowship is still possible. The fellowship ranges from one to two years, depending on research involvement and whether you decide to do a medical or surgical intensive care unit track.

Toxicology: Medical toxicology is a recognized subspecialty of the American Board of Medical Specialties, focusing on the diagnosis, management and prevention of poisoning. Medical toxicologists typically manage drug overdoses, envenomations, ingestions of plant and mushroom toxins, chemical exposures and drug withdrawal. Following fellowship, medical toxicologists may practice as consultants for the intensive care unit and emergency department, faculty members or poison control center directors. They may also pursue a career in the pharmaceutical industry. The fellowship is a minimum of 24 months.

Sports Medicine: A sports medicine fellowship is recognized by the ABMS and is available to graduates of emergency medicine, pediatrics, family medicine, physical medicine and rehabilitation and internal medicine. It focuses on the non-operative medical treatment of musculoskeletal injuries, performance of pre-participation evaluations and management of acute and chronic medical conditions in athletes. Sports medicine specialists may practice in an office-based setting or in a community or academic emergency department. They are typically very active in the community, serving as team physicians, coaches or sporting event medical directors. Training is a minimum of one year.

Research: A fellowship in research is sometimes in conjunction with a Master's in clinical epidemiology or public health. Research fellowships range from one to three years. They are designed to provide training in research methodology, grant and manuscript writing and project design. This fellowship is designed for academic-bound emergency physicians.

Pediatric Emergency Medicine: Pediatric emergency specialists are in high demand in both the community and in academics. This is a two-year or three-year fellowship that focuses on caring for the acutely ill or injured child in the emergency department. After 2001, emergency physicians must have graduated from an accredited pediatric emergency medicine fellowship in order to be board-eligible.

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Simple Solutions: Medication Reconciliation

STUDENT PRESIDENT'S MESSAGE

Greg Casey

President, AAEM/RSA Medical Student Council



An elderly man sat on the edge of his stretcher, attempting to describe his abdominal pain. He did not even need to speak. Vomiting after a few minutes, I realized that this stoic individual was truly sick. As I thought through a differential, I continued to ask questions. His answers were short, but his wife helped him. When I asked about medications, he was unable to recall any of the therapies his physicians had prescribed.

His wife dug through her super-sized pocketbook but was unable to help. When we decided to admit the patient with the working diagnosis of intussusception, I talked to the patient and his wife about the importance of maintaining a list of their medications.

In the 2008 March/April edition of *Common Sense*, the immediate Past President of the AAEM/RSA Medical Student Council, Dr. Michael Ybarra, wrote about "teachable moments." There are times when we can make a difference in a patient's life by recommending simple solutions to problems that affect the care we give and our patients receive. As medical students in the emergency department, we are often limited in the number of patients we can see. However, there are advantages to this limitation. While the attending physician is managing an entire emergency department, often tending to the most critically ill, we have time to hone our skills completing detailed histories and physicals. We can learn to process information, interpret relevant data and tie it all together to make a diagnosis. Additionally, we can develop a rapport with our patients and find ourselves in a "teachable moment."

During clinical rotations, and especially my emergency medicine block, I was surprised by the number of patients that were unable to recall any of the medications they take on a regular basis. The patients who were able to remember their medications often were not sure why they were taking the drug, when they started taking it or at what dose and frequency they take the medication. While waiting for results from studies and laboratory work, we are often left with extra time that can be used to improve a patient's care by performing medication reconciliation. This often arduous task is performed by various members of the healthcare team and can be life saving.

The Institute of Healthcare Improvement has an interesting article on its website detailing the importance and challenge of medication reconciliation. [Accuracy at Every Step: The Challenge of Medication Reconciliation: www.ihi.org] Also on their website is a copy of the Joint Commission's *Journal on Quality and Patient Safety*. This report singles out patient transition points as "especially vulnerable to medication errors." Since a large percentage of hospitalized patients are admitted from the emergency department, this important transition point is a great place for students to intervene in the process to ensure accuracy. It also represents a great "teachable moment" when one can educate patients and their families about the importance of being involved in their own healthcare. When patients are admitted from the emergency department, the admitting team often copies the medication list from the patient's chart. What happens if this list is wrong? What happens if it is incomplete? Warfarin or Clonidine may not cure a case of intussusception, but they can prevent recurrent pulmonary embolus or a case of rebound hypertension while the patient is in the hospital.

During the majority of my rotations, I have had numerous opportunities to counsel patients on keeping records of their most up-to-date medications. It is the doctor's responsibility to educate the patient about the medicines being prescribed, but it is also important that patients take an active role in their care. This means learning to ask questions when something is not clear or if they are unsure what is required for treatment. At every opportunity, we can reconcile the medications a patient is taking, and mistakes can be avoided, and ultimately, lives can be saved.

Simple solutions to alleviate confusion during the course of a patient's hospital stay will go a long way to decrease medical errors. While medication reconciliation may not be as exciting as placing a chest tube or suturing a laceration, it will help prevent adverse drug reactions. Taking the extra time to thoroughly review medications with a patient may be the most successful life saving maneuver you do all shift. Good luck during your emergency medicine rotations, and remember to check your patients' medications!

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Health Insurance in America: Sizing Up the Problem

RESIDENT EDITOR'S LETTER

Michael Ybarra, MD
AAEM/RSA Resident Editor



During the height of election season, each candidate and his respective political parties had countless ads about where to take healthcare reform. Private insurers, employer based health insurance, State Children's Health Insurance Program (SCHIP), and Medicaid felt a lot like word-soup. In listening to the ideas that were put forward, I wondered – where are we now? In medicine, we gather the facts and

then make a treatment plan. In health policy, we should do the same. What follows is a second article in a series about healthcare in America – a few facts about our health insurance.

According to the Institute of Medicine, the United States is unlike any other developed country in the world in that we do not provide universal healthcare. Instead, the US has a combination of private and government insurance programs that pay for healthcare related costs.

Private health insurance is broadly defined as insurance purchased by an employer, union or individual from a private company. Government health insurance plans include Medicare, Medicaid, other state run programs, military and veterans' care and SCHIP.

The US Census Bureau reported that in 2007, 85% of Americans had some form of health insurance (253.4 million people), with 45.7 million uninsured. The Census report noted a slight decrease in the number of uninsured between 2006 and 2007, but an increase in those covered by government health insurance to 83 million – 27%.

In describing their healthcare reform plans, both presidential candidates made reference to our "employer based health system." Whether intended or not, that is indeed the cornerstone of our health insurance system, accounting for 59% of insurance policies. This fact has many practical implications – if insurance is tied to employment, the result is often that the employee is tied to their job.

There are two major laws that allow individuals to keep their insurance for a period of time if they leave or lose their job: "COBRA" of 1985, which allows an extension of benefits and "HIPAA" of 1996. There are hundreds of insurance plans that employers can choose to offer their employees. The employer then pays the vast majority of the premiums.

According to the Kaiser Foundation, on average, employees pay 16% of their individual premiums and 27% of the premium cost for their family. However, in the same Kaiser Foundation study, they note that the cost of premiums has increased by 78% since 2001 (compared to a 19% rise in wages and a 17% rise in inflation). These premiums are paid on a pre-tax basis. Many policy makers, including Senator

McCain, propose not allowing healthcare premiums for employer based insurance policies to be paid with pre-tax dollars.

According to the Center for Medicare and Medicaid Services (CMS), nearly 100% of large firms offer health insurance plans, compared to slightly more than half of small firms (a number that has declined as healthcare premiums have risen). Health insurance costs tend to make up a larger percentage of payrolls in small firms than in larger firms.

Also under the umbrella of "private insurance" are individuals who go out and buy their own health coverage – approximately 9% of Americans. A study done by the advocacy organization, America's Health Insurance Plans, found that on average, out-of-pocket costs are significantly higher for individuals who buy their own health insurance because they lose the cost sharing that occurs in employer plans, they have higher deductibles and higher co-payments. Individuals also do not have the same ability to pay for insurance with pre-tax dollars as do individuals who receive health benefits through their job.

The other major hand in the US health insurance industry is the federal and state governments. The federal government insures all senior citizens through Medicare, Medicare Advantage and provides prescription drugs through Medicare Part D.

Medicaid provides insurance to individuals with low income and is funded by both state and federal governments but is managed solely by the states. SCHIP provides insurance to children whose family makes too much money to qualify for Medicaid. It too is a joint venture, funded by the state and the federal government.

The government also provides insurance to military families through the Department of Defense Health System and the Veterans Health Administration. There is also the Federal Employees Health Benefits Program, which provides for the roughly two million non-military federal employees. Finally, it pays for medical care for eligible American Indians through the Indian Health Service.

When tackling a problem the size of healthcare in America, sometimes it is best to start with the facts. There are two major categories of health insurance in the United States – government and private. Each has an umbrella under which many variations exist, and each will play a major role in shaping the future of healthcare in America.

This was round two in a continuing health policy series. For more facts and figures, visit www.census.gov, and for more information on issues that affect our practice of medicine, visit www.aem.org.



Resident Journal Review: November - December 2008

David Wallace, MD MPH; Dana Sajed, MD; 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 July and August 2008.

Deitch K, Chudnofsky CR, Dominici P. The utility of supplemental oxygen during emergency department procedural sedation with propofol: a randomized, controlled trial. Ann Emerg Med. 2008 Jul;52(1):1-8

This prospective, controlled, randomized study attempted to determine whether the use of supplemental oxygen during procedural sedation with propofol would reduce the incidence of hypoxia by 20% (calculated based on previous studies). In addition, the investigators blinded the clinical staff to capnography information to assess whether oxygen administration interferes with the recognition of respiratory depression. Respiratory depression was defined as oxygen saturation $\leq 93\%$, end tidal CO₂ (ETCO₂) level ≥ 50 mm Hg, absolute ETCO₂ change from baseline ≥ 10 mm Hg, or loss of the ETCO₂ waveform.

110 adult patients were analyzed, 56 of which received supplemental oxygen and 54 of which were placed on compressed air. Ten (18%) patients in the supplemental oxygen group and 15 (28%) patients in the compressed air group experienced hypoxia. The authors calculated a difference of 10%, which was not statistically significant. Additionally, 27 of 110 (24.5%) study patients met one or more ETCO₂ criteria for respiratory depression but did not experience hypoxia; twenty of these patients received supplemental oxygen, seven received compressed air. Nine patients had ETCO₂ changes suggestive of respiratory depression prior to the onset of hypoxia (three received supplemental oxygen, six room air).

The authors' conclusions suggest that low-flow oxygen may have little impact on hypoxia during sedation with propofol. However, a trend toward reduction of hypoxia was noted. What remains to be determined is whether high-flow oxygenation or preoxygenation to 100% would decrease the incidence of hypoxia. Furthermore, their data also suggests that capnography should play a greater role in monitoring patients for respiratory depression.

Gray A, Goodacre S, Newby DE, Masson M, Sampson F, Nicholl J. Noninvasive ventilation in acute cardiogenic pulmonary edema. N Engl J Med. 2008 Jul 10;359(2):142-51

Noninvasive ventilation has become the standard of care for the management of acute pulmonary edema. Prior studies have indicated that noninvasive positive pressure ventilation reduces mortality, the rate of endotracheal intubation and intensive care unit length of stay. This multicenter study randomized 1156 emergency department patients with acute pulmonary edema to one of three treatments: standard oxygen therapy, continuous positive airway pressure (CPAP) or noninvasive intermittent positive pressure ventilation (NIPPV). Patients received standard medical therapy with nitrates, diuretics and/or opioids and received supplemental oxygenation to achieve a saturation above 92%. The trial protocol allowed further use of CPAP, NIPPV or intubation at the discretion of the treating clinician. The main outcome measured was death within seven days

of treatment. The study also looked at rates of intubation within seven days, subjective reports of dyspnea, length of hospital stay, admission to a critical care unit and 30 day mortality.

The authors reported no significant difference in the primary end point of seven day mortality between patients receiving noninvasive ventilation (CPAP or NIPPV) (9.5%) and those receiving standard oxygen therapy (9.8%). There was no significant difference in the rates of intubation, 30-day mortality, admission to the critical care unit, or myocardial infarction. Noninvasive ventilation (CPAP or NIPPV) was associated with greater reductions in dyspnea, heart rate, acidosis and hypercapnia than was standard oxygen therapy.

While the conclusions of this study seem to indicate that noninvasive ventilation did not decrease mortality or intubation compared with standard oxygen therapy, closer analysis of the results of this study show that 56 out of 363 patients started on standard oxygen treatment were switched to a form of noninvasive ventilation (43 to CPAP, 13 to NIPPV) during the study protocol. It is difficult to draw conclusions from the study results when over 15% of patients in the control group are given the experimental intervention.

Suberviola B, González-Castro A, Llorca J, Ortiz-Melón F, Miñambres E. Early complications of high-dose methylprednisolone in acute spinal cord injury patients. Injury. 2008 Jul;39(7):748-52

Recent literature in the field of spinal cord injury (SCI) suggests that the use of high-dose steroids may not be beneficial, and in fact, may be harmful due to infectious and metabolic complications. The authors of this retrospective study sought to review the outcomes of patients admitted to their hospital with SCI with regard to rates of infection and degree of neurologic improvement.

Over a ten year span, 59 patients received methylprednisolone according to the NASCIS II protocol, and 23 patients with SCI received no steroids. The rate of respiratory tract infections was significantly higher in the methylprednisolone group, as was the incidence of hyperglycemia. There was no significant difference in the rates of neurologic recovery between the two groups. Although the group of patients who did not receive methylprednisolone had a higher average injury severity score (ISS), there was no significant difference in the mortality rate between the two groups. This data adds to the growing body of evidence that the harm of giving high-dose steroids may outweigh the benefits in acute spinal cord injury.

Birnbaum A, Esses D, Bijur P, Wollowitz A, Gallagher EJ. Failure to validate the San Francisco Syncope Rule in an independent emergency department population. Annals of Emergency Medicine 2008;52:151-9

The San Francisco Syncope Rule (SFSR) is a clinical decision rule to help identify patients who are at low risk of seven day adverse

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Lyme Borreliosis, Erythema Migrans and Annular Skin Lesions

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Key Words: Lyme borreliosis, *Borrelia burgdorferi*, erythema migrans, annular skin lesions, diagnosis, therapy, Lyme carditis, myalgias, arthralgias

History:

A 68 year old female presented to an urgent care center complaining of three weeks of intermittent low grade temperature accompanied by chills, diffuse myalgias, arthralgias and rash. The patient and her husband, a retired pathologist, noted that the rash started on her right thigh, was initially quarter-sized and bright red with an even distribution that lasted for about one week and then seemed to expand and ultimately fade with the red remaining only at the border.

The review of systems was negative, and the patient denied past medical history, took no medications, and had no known drug allergies. Her family history was non-contributory. She denied tobacco and illicit drug intake and endorsed rare alcohol use. The patient had no pets, had not recently changed detergents or purchased new clothing.

Upon further questioning, the patient recounted that she and her husband returned from visiting their grandchildren in Seattle, Washington, about three weeks ago. She stated that the family had a picnic in the local park one day prior to the couple embarking on a flight back to Florida. The patient did not recall any insect bites, including tick bites. As is their usual practice when flying, the patient and her husband took three days worth of amoxicillin to "ward off" any respiratory ailments they may have come into contact with during the flight home.

Physical Examination:

The patient has normal vital signs, and physical exam with the exception of her skin which had two salmon colored patches located on the left calf (3x2 inches) and right forearm (2x2.5 inches), as well as multiple annular, dime-sized target lesions under the right axilla breast.

Initial Workup:

Routine labs were normal. Chest x-ray showed no acute process. A Lyme IgM/IgG was equivocal.

Differential Diagnosis:

The patient's dermatologic condition was determined to be erythema migrans and erythema multiforme. The extensive differential diagnoses for these conditions in adults is listed in Tables 1 and 2.

Follow Up Studies and Refined Differential:

As the patient had partially treated the spirochete infection with three days of amoxicillin, she was instructed to complete a seven day regimen of amoxicillin, and her treatment regimen was augmented with doxycycline 100mg bid for 14 days. She was also to return in two weeks for repeat ELISA testing for confirmation. The repeat ELISA test was positive and confirmed with Western blot. Patient had a baseline EKG on her return to clinic that was normal. The patient reported resolution of her symptoms with the completion of the antibiotic course.

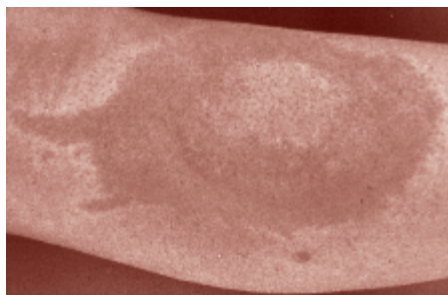
Discussion:

Lyme borreliosis (LB) or Lyme disease is caused by the spirochete, *Borrelia burgdorferi*, which is transmitted through the bite of an infected adult tick or nymph.^{1,2} *Ixodes scapularis*, also known as the deer tick, is the most common vector for Lyme disease

in North America. At present, Lyme borreliosis is the most prevalent vector-borne disease in North America, with over 20,000 cases reported annually across 46 states and the District of Columbia.² The first incidence described nearly 100 years ago by Swedish dermatologist Arvid Afzelius included key manifestations of an expanding ring-like lesion on a female patient (erythema migrans).² The initial reports of Lyme disease were documented in epidemic form in Lyme, Connecticut, in the late 1970s where 59 cases appeared in a single year, and since 1982, more than 200,000 cases have been reported to the CDC.^{3,4}

Although Florida is a low-risk area, it is essential to have a high index of suspicion for Lyme disease when evaluating patients with erythema migrans and systemic complaints. In such patients, it is crucial to elicit a thorough travel history and exposure to the elements. Indeed, our patient initially denied recent travel as she did not consider travel within three weeks to be "recent." However, she was likely infected in another low risk locale, Washington State, while at the local state park.

Lyme disease usually manifests itself as a localized infection of the skin (erythema migrans), followed by multiple spirochete reactions on the skin and body parts such as the heart, joints and nervous system.^{4,5} See Figure 1. The disease is divided into three stages.⁵ The first stage, or acute illness, occurs at the site of the tick bite and results in the development of a skin lesion as the *Borreliae* multiply and spread into the dermis layer of the skin.⁴ The usual systemic



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First Impression Biases

Heather Jiménez, MD
AAEM/RSA Board of Directors
AAEM/RSA Advocacy Committee Chair

In the emergency department, first impressions are often harsh and difficult to overcome. In seeing people at their worst, I worry I get a skewed picture of who they truly are outside their crisis. The initial snapshot in time during the history and physical exam determines what pathway, if any, is pursued for the patient. Any biases I encounter must first be recognized and then closely kept in check to ensure that a negative first impression does not lead to increased morbidity or mortality for the patient. A single encounter reinforced this for me, and luck helped prevent complications for my patient.

On a busy overnight shift, I encountered perhaps my least favorite complaint – two belly pains in a row – and no sign that anyone else was going to split them with me as we were all very busy. The first was pleasant, gracious and easily evaluated. Moving into the second room, my system encountered a shock. Before even introducing myself to the patient (who was still fully dressed with a cigarette over each ear), she stopped her conversation with her husband to relay her wishes, “what pain medication are you going to give me to take home and how much? We have no money so you are going to have to provide it from here,” – so much for my standard introduction.

Taking a second to regroup, I introduced myself and was interrupted with the same question again. Both frustrated and annoyed, I did not even know what the patient's concern was as the focus was on narcotics. Trying a different approach, I assured the woman we would treat her pain, but I had to get some information first. With much difficulty, I managed to gather that this patient had pain everywhere in her abdomen for a while, had a previous tubal ligation so she could not possibly be pregnant, and wanted something to eat and drink – could I get that for her. With my biases and opinion fully formed, I then attempted a fairly unsuccessful physical exam which was hindered by her inability to cooperate. Explaining that I would be back to do a pelvic exam, I left the room angry with the patient because she would not cooperate and had a seemingly single focus.

Ordering a urinalysis and UPT more because it was reflex than thought, I also included some IV pain medication in my initial plan so I could get a decent exam, or at least try again. With stable vitals and my initial impression, I wrote her off as “not sick” and a potential drug seeker. My first step when staffing though, was to look the patient up in the computer – she was not a frequenter of any system on the summary sheet, but her behavior did not sit well. I even entertained the idea that her husband put her up to this as she had not had any controlled scripts filled in the Indianapolis area and was very blunt about her wish for narcotics.

While awaiting the results, I encountered my patient roaming the hall several times asking different employees for food and drink. Becoming even more frustrated, I began digging regularly through the order pile so I could quickly get her out of the department as soon as her urine studies returned.

Then my plans were turned upside-down. The UPT was positive. Finding a staff and wheeling the ultrasound machine into the room, I had to explain to the patient, who was still hungry, thirsty and ready to leave, that she was pregnant. With a prior tubal ligation, this was a potential problem. Immediately, her husband understood my concerns, but the patient was now overjoyed and talking about a new baby. Regardless of what I said, she did not understand that there was a possibility this pregnancy would not go to term and that it could potentially kill her.

Feeling guilty that I had written this woman off, as well as concerned that she could have a potentially life-threatening ectopic pregnancy, I proceeded with the remainder of my exam. Breathing a sigh of relief, the ultrasound showed a sac in the uterus with no heartbeat or fetal pole. In my mind, I was preparing to have the patient follow up with OB in 48 hours when I saw the free fluid and what might be a clot behind her uterus. A FAST exam did not give any more information except for confirming suprapubic free fluid.

While awaiting labs, I contemplated the roller coaster I had taken this couple through, as well as the initial biases that shaped my opinion of the patient. Gone was her desire for narcotics as she planned her future with another child and her excitement of this unexpected event. Raw was her husband's emotion and his understanding that this was likely not going to end happily. And then there was my own guilt that I had brushed this patient off as not sick because of our initial interaction. Yes, I had given her pain medication and ordered the UPT and urinalysis, but in my mind I had mis-stepped in my hastily formed opinion.

After several hours of stability in the ED and still no labs, I convinced the OB resident to examine the patient. Still wandering the halls and demanding food, the patient went upstairs. The operating report available the next day indicated that the free fluid behind her uterus was blood from a ruptured ectopic and both her tubes had to be removed to prevent a repeat tubal pregnancy in the future. There was no mention of the sac or potential follow up for what had appeared to be an intrauterine early pregnancy.

Though sheer luck and habit allowed me to catch this, it still made me think. I could have sent this patient home for 48 hour follow up, and if I did, she might have died. I could have missed the pregnancy all together as I was focused on her narcotics concern instead of her presenting complaint. I could have missed seeing the side of her that was overjoyed at the potential of having another child – the side that I suspect is who she really is much of the time.

Although it is only human to form biases and opinions, this patient reinforced the need to approach every patient with an open mind and focus on how I can improve each patient's life and help them through their crisis.



A Rainy Day in Chicago, and Yet the Midwest Medical Student Symposium Succeeds!

Alicia Pilarski, DO
AAEM/RSA Board of Directors
AAEM/RSA Education Committee Chair

Despite record breaking rainfall, flight delays and road closures, the 2nd Annual Midwest Medical Student Symposium (MMSS) was a great success on September 13, in Maywood, IL! Medical students from across the country attended this AAEM/RSA sponsored conference to learn about the field of emergency medicine from program directors, faculty and residents. Our day was filled with outstanding lectures, a mentor lunch session and incredibly informative Program Director and Resident Panels. The event had booths from both AAEM and LIFESTAR – the Chicagoland area helicopter team.

The day began with Dr. Tom Scaletta, AAEM Immediate-Past President, who gave an enthusiastic and informative overview of “Emergency Medicine and the Role of AAEM.” He described the integral role AAEM has played in advocating for fair contracts and proper board certification amongst emergency physicians and EM groups. Dr. Scaletta’s lecture was an outstanding summary of many important issues facing emergency physicians and the field.

Our second lecture of the day was given by Dr. Kevin Rodgers, Program Director of Indiana University Emergency Medicine Residency and AAEM Education Committee Chair. His energy level and excitement was unmatched, even after making a two and a half hour drive in the rain from Indiana! Since most of the students in the audience would soon be applying for residency positions, Dr. Rodgers spoke about the “Top Ten: Advice for the Emergency Medicine Match.”

We were also joined by Dr. Edward Callahan, Program Director and Education Fellowship Director at the Medical College of Wisconsin, and Dr. Mark Cichon, Associate Professor at Loyola University. After driving over two hours from Milwaukee, Dr. Callahan spoke about “Amazing ER Stories/A Day in the Life of an ER Physician.” It was one of the most fun and entertaining lectures of the day! There was laughter, there were tears, and there was the occasional jaw dropping story, but everything that Dr. Callahan discussed portrayed a real-life glimpse into the life of an emergency physician. With all of that excitement, who wouldn’t want to pursue the field of emergency medicine? Dr. Cichon discussed “Opportunities in Emergency Medicine.” Not only was Dr. Cichon’s lecture informative, but it was uplifting and encouraging to everyone in the audience. He touched on the constantly changing field of emergency medicine and how those changes would impact us in the near future.

The Program Director Panel consisted of six representatives from emergency medicine residency programs from across the Midwest. The Panel included Dr. Brad Bunney, Program Director from the University of Illinois, Chicago; Dr. Steven Bowman, Program Director from Cook County Hospital; Dr. Michael Gisondi, Assistant Program Director from Northwestern University; Dr. Nicole Colucci, faculty from Resurrection Medical Center; Dr. Kevin Rodgers, Program Director from Indiana University and Dr. Edward Callahan, Program Director from the Medical College of Wisconsin. With so many residency programs represented, the students had a great overview of many types of programs. The Program Director Panel was the most highly rated part of the day.

During lunch, medical students were able to speak with program directors and residents to personally ask questions and obtain advice. Program directors, faculty and residents provided the medical students with business cards, email addresses and phone numbers for further questions and mentoring. Overall, the lunch allowed the medical students to be themselves and have a good time getting to know the amazing people who have shaped our field.

After lunch, the medical students got a slice of residency life with the Resident Panel. The panel consisted of myself, a second year resident from the University of Nevada, Las Vegas; Megan Boysen, AAEM/RSA President and second year resident from UC-Irvine; Matt Pirotte a first year resident from Northwestern University and Jessica Zuraw, a second year resident from Resurrection Medical Center. The panel answered questions about their experiences during the Match, their own residency programs and their lives as residents.

Despite the rainy day outside, the events inside proved to be worth the trip to Loyola’s campus! Of course, the day could only be considered a success because of the people involved. We are so appreciative of our amazing speakers. Their enthusiasm for emergency medicine demonstrated why they had become true mentors in our field. Our Program Director Panel was unmatched.

Our Resident Panel was honest and valuable. Loyola University Stritch School of Medicine was an outstanding venue for the event. Additionally, the following individuals were the backbone to the Midwest Medical Student Symposium: Dan Bartgen, Loyola MSIV; Janet Wilson and Jody Bath, AAEM staff and Greg Casey, Medical Student Council President.



Resident & Student Association



AAEM/RSA

Activities

Resident President's Message - continued from page 13

Medical Education, Academics/Faculty Development and Simulation: These three fellowships are typically designed for EPs interested in pursuing a career in academic emergency medicine. Typically in academics/faculty development and medical education, applicants have the opportunity to pursue some of their own areas of interest within the scope of the fellowship. Simulation focuses on medical education in the context of simulation laboratories for residents, medical students and nursing staff. Fellowships are usually one year.

International Emergency Medicine: International emergency medicine is a one to two year fellowship which introduces or improves the emergency medical care provided abroad. Fellows and fellowship-trained emergency physicians work with local healthcare providers and governments to identify needs in the community for emergency medical services, disaster relief, rural medical clinics and the trauma system. Other topics explored include tropical disease, toxicology and ultrasound. Many programs encourage or require participation in a Master's in Public Health or Epidemiology. Some fellows have the opportunity to sit for the national exam of the American Society of Tropical Medicine and Hygiene.

Injury Prevention: An injury prevention fellowship is typically a two year long fellowship focusing on injury and violence prevention research and community outreach. Many programs have an integrated MPH program and a well-funded research program through national grants.

Hyperbaric and Undersea Medicine: Hyperbaric and undersea medicine specializes in the operation of hyperbaric chambers, the use of hyperbaric oxygen therapies and the medical aspects of deep sea diving. This fellowship is one year. This subspecialty is recognized by the American Board of Medical Specialties.

Hospice and Palliative Medicine (HPM) and Geriatrics: These two fellowships are relatively recent additions to emergency medicine. After approval in 2006, ABEM administered the first hospice and palliative care examination in October 2008; after 2010, all those eligible must complete a one-year formal fellowship in HPM. The focus of the specialty is to relieve suffering, and by doing so, improve the quality of life in patients with life-threatening illnesses, coordinating end of life care and understanding the emotional and spiritual needs of families. The first geriatrics fellowship was developed at New York Presbyterian/Weill Cornell in order to address the growing aging population in the United States. It focuses on emergency care in the elderly, particularly improving access to emergency services, while minimizing the morbidity experienced from injury and illness.

Emergency Medical Services (EMS) and Disaster Medicine: Because of the relationship between the disaster medicine and EMS, these two fellowships are sometimes combined as a joint program. There are many EMS fellowships across the country, while there are a limited number of disaster medicine fellowships. EMS fellowships focus on the local, state, national and international organization of the emergency medical services system, including ground and air transportation. The disaster medicine fellowship

trains an emergency physician to prepare for, respond to and manage national and international disasters. Many programs in EMS and/or disaster medicine include a Master's in Public Health or a similar field.

Administration: An administrative fellowship is designed to train EPs for ED management and administration. Programs often combine a Master's in Business Administration or a Master's in Medical Management. Fellowships are usually one year.

Other fellowships include: Neurologic/neurovascular emergencies, cardiovascular emergencies, observation medicine, transport medicine, legal medicine, health policy, pharmacology, clinical forensic medicine, environmental health, informatics, occupational medicine, pain management and preventative health.

Things to consider when choosing a fellowship program are the amount of protected research time, the expectations for publications, salary, benefits, travel allowances, the amount of clinical shifts required, the ability to moonlight, the experience and accreditation of faculty members, the reputation of the program and the need for particular fellowship training in the local and national job environment. For more information, you can visit the "Fellows" section of www.saem.org.

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!

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Brian Ostick, MD
Chair, AAEM/RSA Membership Committee



Resident Journal Review - continued from page 18

events following a syncopal episode. The original validation cohort was 96% sensitive for unfavorable outcomes, supporting its use in disposition decisions. Since the original study was published, groups have tried to validate the rule in other patient populations. This cohort study evaluated the SFSR in 713 patients evaluated for syncope or near-syncope in a Bronx, New York hospital. Disposition was left to the treating emergency medicine attending, with predictor and outcome data independently collected for all patients. Performance characteristics were calculated.

In this cohort of patients, the sensitivity of the SFSR was 74% for detecting short-term adverse outcomes.

Clinical decision rules attempt to reduce the uncertainty of medical decision-making and inform management or disposition decisions. The results of this study suggest that the SFSR is insufficiently sensitive to identify patients at low-risk of serious short-term outcomes, and therefore cannot safely be applied for decisions about disposition in patients presenting to the emergency department with syncope.

Fitch RW, Kuhn JE. Intraarticular Lidocaine versus Intravenous Procedural Sedation with Narcotics and Benzodiazepines for Reduction of the Dislocated Shoulder: A Systematic Review. Acad Emerg Med 2008;15:703-8

Intravenous procedural sedation is standard in most emergency departments for the reduction of anterior shoulder dislocations. The authors conducted a systematic review for various outcomes following use of intraarticular lidocaine (IAL) and intravenous sedation (IVS).

Six prospective randomized controlled trials were identified. Data on complications, pain level perceived by the patient, ease of reduction, total time for reduction and emergency department length of stay were extracted. The primary outcomes of interest were reduction success rate, pain, ease of reduction, time of reduction and complications. Compiling the data resulted in an 89.9% reduction success rate for IAL and 95.6% reduction success rate for IVS. Pain perception and ease of reduction were the same in both groups. When reported, length of stay was consistently lower in the IAL studies (78 minutes and 75 minutes compared to 186 minutes and 185 minutes), as were complication rates (0.67% compared to 13.3%).

This systematic review showed equivalent reduction success rates for IAL compared to IVS and significantly reduced length of stays and complication rates in the former. This suggests that use of IAL for the reduction of anterior shoulder dislocations will result in improved through-put times, lower complication rates and similar reduction success and pain perception. These findings argue strongly for emergency medicine practitioners to consider incorporating this technique into their management of anterior shoulder dislocations.

Vestergaard M, Pedersen MG, Ostergaard JR, Pedersen CB, Olsen J, Christensen J. Death in children with febrile seizures: a population-based cohort study. Lancet 2008;372:457-63

This large Danish cohort study identified nearly 1.7 million children to better estimate mortality after febrile seizures. The investigators linked information from national health and death registers and followed the patients for an average of 13 years. This represented 23.1 million person-years of follow-up.

232 deaths were identified in 55,215 children with a history of febrile seizures. The mortality rate ratio between children with a history of febrile seizure and those without was 80% higher during the first year after the first febrile seizure. During the second year it was 90% higher. This ratio was unchanged by restricting the group to patients with birth weight more than 2,500 grams, gestational age at birth more than 36 weeks, an Apgar score of 10 at 5 minutes and no gestational malformations. After the second year, the mortality rate was the same for patients with a history of febrile seizures and those without. For all-comers, 132 per 100,000 children died within the first two years of following a febrile seizure, compared to 67 per 100,000 for children without that history. Yet, when analyzed by type of seizure, children with simple febrile seizures had a mortality rate that was similar to the background population.

Death after febrile seizures is very rare, even in high-risk children. For simple febrile seizures, there is no increase in mortality; for complex partial seizures there is a small excess mortality in the first two years following the event. Emergency medicine practitioners can reassure parents that adverse events are uncommon following febrile seizures, and for non-complex partial seizures, there is no apparent additional mortality burden.

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Lyme Borreliosis, Erythema Migrans and Annular Skin Lesions - continued from page 19

TABLE 1. Selected Differential Diagnosis of Erythema Migrans¹⁰

Selected Differential Diagnosis of Erythema Migrans	
Diagnosis	Clinical Presentation
Erythema Migrans	Circular rash innermost portion remains dark red outer edge remains red, portion in between clears, warm, painless, fatigue, muscle and joint pain, swollen lymph nodes
Pityriasis Rosea	Herald patches singular, ovoid macule, lesion with an erythematous raised border, fine scale and central clearing
Tinea Corporis	Well-demarcated erythematous papules, plaques on the skin, borders may be raised or scaly
Sarcoidosis	Infiltrated papules and plaques, subcutaneous nodules and infiltration of old scars
Granuloma Annulare	Skin-colored to erythematous papules, smooth, raised borders, one to five cm in diameter may be isolated or coalesced into plaques
Subacute Cutaneous Lupus Erythematosus	Presents itself in annular or a papulosquamous form, arthralgias or arthritis, low grade fever, malaise or myalgias

TABLE 2. Selected Differential Diagnosis of Erythema Multiforme¹⁰

Selected Differential Diagnosis of Erythema Multiforme	
Diagnosis	Clinical Presentation
Erythema Multiforme	Central lesion surrounded by concentric rings of paleness and redness, may appear nodule, papule or macule, itching of skin, joint aches, fever
Urticaria	Pruritic, well-circumscribed erythematous lesions of the skin (wheals) with erythematous raised borders and blanched centers
Bullous Pemphigoid	Intense itching, burning sensation of the skin, redness, multiple blisters, hive like lesions
Pemphigus	Rupturing blisters on skin or mucous membranes of the skin
Acute Febrile Neutrophilic Dermatitis	Series of small red bumps on back, neck, arms and face, grow quickly in size spreading into clusters, moderate to high fever, mouth ulcers

Figure 1. Erythema Migrans Figures 1 is used with the permission of the Division of Infectious Diseases and Tropical Medicine, College of Medicine, University of South Florida, Tampa.

symptoms of the first stage include headaches, fever, myalgia, and arthralgia.⁴ In the second, or the dissemination phase, the *Borrelia* spread hematogenously and cause secondary annular skin lesions, migratory arthritis, cardiac arrhythmias and meningitis.⁴ Our patient presented during the dissemination phase and had multiple annular skin lesions. To fight off the infection, the body develops antibodies to the spirochete.⁵

Finally, the late chronic phase develops if the disease remains untreated and may occur in some cases, up to two to three years after the initial infection and demonstrate clinical signs such as destructive chronic arthritis, acrodermatitis chronica atrophicans and neuropathy.⁴

In one double-blind, placebo-controlled study with 118 infected patients, erythema migrans, due to Lyme disease presented itself with a number of secondary signs and symptoms which included fever, headaches, myalgia, arthralgia and fatigue. Myalgia or arthralgia was present in 35% of the patients with Lyme disease.¹ Our patient's presentation echoes the findings in this study.

Interestingly, the *Borrelia burgdorferi* species found in North America appears to generate an erythema migrans that is more erythema-

tous, of briefer duration and which spreads more rapidly when compared to its European counterpart *B. afzelii* or *B. garinii*. In these organisms, the erythema migrans manifest slower, less intensely inflamed and have a longer duration.³ The difference in the appearance and duration of the erythema migrans allows for early detection in the North American spirochete, *Borrelia burgdorferi*, as compared to the European species. Although rare, Lyme carditis is another complication of the disease which results in first degree AV block.⁴

Lyme disease is usually diagnosed by cultures taken from skin biopsies of erythema migrans, skin lesions in 70 to 80% of patients and from blood sample in 40 to 50% of the patients.³ Although elusive to culture from patients with Lyme arthritis, *B. burgdorferi* DNA can be detected by PCR in the joint fluid of most patients prior to antibiotic therapy.⁶ Even so, both the culture and PCR technique remain low-yield in detection in patients with acute or chronic neuroborreliosis.^{4,6} Furthermore, a two-tiered approach is used more commonly today consisting of ELISA and Western blot, using *B. burgdorferi* sonicates, which tend to have a high degree of sensitivity and specificity in detection of the disease.⁶ Indeed, our patient's diagnosis was firmly established with her second ELISA test, confirmed via Western blot.

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Lyme Borreliosis, Erythema Migrans and Annular Skin Lesions - continued from page 25

When treated in its early stages, treatment of Lyme disease has an incredible success rate which prevents further complications from developing.⁷ It is usually treated by a two to three week course of antibiotics which include oral courses of doxycycline or amoxicillin. In patients whose disease has progressed, treatment entails a four week course of oral medication or a two to four week course of IV ceftriaxone if the patient does not respond to oral therapy.^{1,6,8} Our patient reported resolution of her symptoms with completion of the antibiotic course.

In addition to antibiotics, two vaccines have been developed to combat Lyme disease, particularly in endemic regions. These vaccines use recombinant *B. burgdorferi* lipidated outer-surface protein A (rOspA) as immunogen -- LYMERix and ImuLyme.⁹ LYMERix is administered through intramuscular injections in the deltoid muscle with a single dosage of 0.5ml at a time.⁹ Three doses are given to the patient with a time lapse of one month between the first two and a year lapse between the second and third injections.^{8,9} In a randomized controlled trial of LYMERix with 10,936 subjects it was noted that the vaccine efficacy in protecting against Lyme disease with the presence of erythema migrans or objective neurologic, musculoskeletal or cardiovascular manifestations of Lyme disease after two doses was 49% and 76% after three.⁹ Subjects enrolled in the study were tested for the development of OspA antibodies at months 2, 12, 13 and 20 and from the results it was concluded that a titer greater than 1,200 ELISA units/mL correlated with protection for the disease.⁹ The Lyme disease vaccine does not protect all recipients against infection with *B. burgdorferi* and offers no protection against other tick related disease.⁹ It is best if a

person observes protective measures against ticks and seeks early diagnosis of the suspected tick borne infection.⁹

REFERENCES

- 1 Smith RP, Schoen RT, Rahn DW, Sikard VK, Nowakowski J, Parenti DL, et al. Clinical Characteristics and Treatment Outcome of Early Lyme Disease in Patients with Microbiologically Confirmed Erythema Migrans. *Ann Intern Med.* 2002;136:421-428
- 2 Bacon RM, Kugeler KJ, Griffith KS, Mead PS. Lyme Disease --- United States, 2003--2005. *CDC.* 2007; 56(23):573-576
- 3 Aguero-Rosenfield ME, Wang G, Schwartz I, Wormser GP. Diagnosis of Lyme Borreliosis. *Clinical Microbiology Reviews.* 2005; 18(3):484-509
- 4 Lelovas P, et al., Cardiac implications of Lyme disease, diagnosis and therapeutic approach. *Int J Cardiol* (2008), doi:10.1016/j.ijcard.2008.01.044
- 5 Clark K. *Borrelia* Species in Host- Seeking Ticks and Small Mammals in Northern Florida. *J of Clinical Microbiology.* 2004; 42(11):5076-5086
- 6 Engstrom SM, Shoop E, Johnson RC. Immunoblot Interpretation Criteria for Serodiagnosis of Early Lyme Disease. *Journal of Clinical Microbiology.* 2005;33(2):419-427
- 7 Klemperer MS, Hu LT, Evans J, Schmid CH, Johnson GM, Trevino RP, et al. Two Controlled Trials of Antibiotic Treatment in Patients with Persistent Symptoms and a History of Lyme disease. *N Engl J Med.* 2001; 345:85-92
- 8 Steere AC. Lyme borreliosis in 2005, 30 years after initial observations in Lyme Connecticut. *Wein klin Wochenschr.* 2006; 118/21-22:525-633
- 9 CDC. Recommendations for the Use of Lyme Disease Vaccine, 1999. *MMWR* 1999; 48(RR07);1-17
- 10 Hsu S, Le EH, Khoshevis MR. Differential Diagnosis of Annular Skin Lesions. *American Family Physician.* 2001;64:2



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AAEM Young Physicians Section

Bring On the Pain: A New Tool to Combat Drug Seeking in the ED

Michael Pulia, MD

Young Physicians Section (YPS) Board of Directors

It is 5 a.m. You grab the last chart of a long overnight shift and see a young man who presents with 10/10 lower back pain. There is no trauma, and the injury happened after he lifted a few heavy boxes. The patient reports he is allergic to morphine and tells you he cannot take "NSAIDs" because he has stomach problems. Impressed that this young man knows his allergy history and the term NSAIDs, you are quickly brought back to reality when he answers your question regarding what has worked for his pain in the past with, "What's that medication that starts with a 'd' Doc? Di....dila...dilandad....oh that's it! Dilaudid! Demerol works too. And Doc, if you could give it to me by IV that would be great, because it works faster that way. I would have taken my Vicodin which usually works, but I ran out and need a refill." Although this patient's behavior may seem particularly egregious, various permutations of this same scenario do play out daily in our emergency departments (EDs) and can unnerve even the most experienced clinicians.

As a new attending, some of my most challenging encounters have involved situations where I suspected a patient was exhibiting drug-seeking behavior. As a resident, the refusal of specific intravenous opioids or prescriptions often produced a challenging reply, "I want to see the doctor in charge." The attending would then see the patient, knowing full well that they were walking into a charged situation, and he would have to handle it. Taking on that role of final decision-maker truly brings to life the delicate balance an emergency physician (EP) must maintain between providing humane treatment of pain and falling prey to a skilled simulator.

The mantra I heard constantly throughout residency was "Do the right thing, Doctor." The problem is that in emergency medicine (EM), finding the 'right thing' to do is often easier said than done. We are constantly faced with complex, time sensitive, clinical decisions and forced to make tough decisions with limited information. From patients with altered mental status to those who simply cannot remember their medications, EPs operate in a high stakes world of incomplete data. Appropriately differentiating patients in severe pain from symptom fabricators or prescription medication diverters is not an exception to this rule.

Thankfully, we live in an era when technology can often deliver real time, critical information to the bedside, information that can assist in the decision-making process. Let me state up front, however, that I would rather fail to detect every drug seeker than withhold appropriate analgesia from one patient in real pain. Our primary role is to provide patient centered care, not act as detectives. That being said, those of us practicing in Illinois now have a new tool in our arsenal to combat those who would otherwise drain medical resources, increase the cost of healthcare, cut ahead of patients with true complaints and destroy our morale by using the ED to get high.

In 2007, the Illinois Senate enacted legislation that expanded state monitoring of habit forming prescription drugs. Acting under this directive, the Department of Human Services established the online Illinois Prescription Monitoring Program (PMP). In less than one

minute, any registered pharmacist or EP can log on to the secure website and access a patient's recent Class II-V prescription history. According to Stan Tylman, IL-PMP Manager, the online program went live on January 1, 2008, and is funded by a combination of State funds and Federal grant money. As of September 2008, nearly 400 EM clinicians (NPs, PAs and EPs) have enrolled in the new program.

With 10 to 15% of patients entering the ED already meeting criteria for chemical dependency, the good news is that Illinois is not alone.¹ In 2005, Kentucky went live with the nation's first self-serve, real time, web-based prescription monitoring program (KASPER).² According to the DEA, as of July 2008, 38 states have enacted legislation setting up PMPs; 29 of those programs are currently operating, and nine are still in the start-up phase. In addition, 11 states are in the process of proposing, preparing or considering similar legislation.³ Mr. Tylman reports that Illinois is among those states with the most advanced systems, along with NY, CA, KY, OH and AL. He was also proud to mention this program is one of the most cost effective nationwide with annual operating costs of around \$250,000; other states are spending up to \$1 million annually. You can view a list of all the states with current or developing PMPs on the DEA's website.³ http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm#1

The explosion of activity in the area of PMPs can be traced back to 2002 when Congress appropriated Federal funds to the Department of Justice and established the Harold Rogers' Prescription Drug Monitoring Program.⁴ This program provides start-up grant money to states without current systems, but also helps fund states looking to expand on existing programs. Each year there is an open application process; the annual list of recipients can be viewed online.⁴ <http://www.ojp.usdoj.gov/BJA/grant/prescripdrugs.html>. If your state is still in the planning phase, I encourage you to contact your state legislators, and make them aware of the available Federal funding and how valuable this information is to EPs. Most public servants would jump at the chance to attach their names to a program that improves public safety and reduces criminal activity.

Individual state programs are likely just the beginning of what the future holds for prescription monitoring. The Integrated Justice Information Systems (IJIS) Institute is leading a project funded by the Bureau of Justice Assistance (BJA) to develop a system for the interstate exchange of prescription drug monitoring program data. IJIS created a pilot project between California and Nevada to share PMP information. In May 2007, a test of the pilot project demonstrated successful sharing of information between the neighboring states.³

Currently, IJIS is developing a shared hub server that can be used to facilitate and broker data exchanges centrally between states. By establishing a centralized system, each state with a PMP can communicate more economically than by using 49 individual state-to-state exchange pipelines. The Ohio Board of Pharmacy has

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AAEM Young Physicians Section

Ask the Expert

Joel Schofer, MD FAAEM

LCDR MC USN, Christiana Care Health System

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

Megan Boysen, MD, President, AAEM Resident and Student Association
Department of Emergency Medicine, University of California, Irvine

Question: What advice would you give to a 4th year medical student who wants to do EM?

Answer: Emergency medicine (EM) is an outstanding field; it is exciting, challenging, stimulating and interesting. The more experience I had with EM as a medical student, the more certain I became that it was an excellent fit for me.

Advice #1: Gain as much exposure to EM as you can during medical school. Do your EM rotations early in your fourth year, talk to your attendings and residents, shadow, go to local and national EM meetings, read the review books and listen to lectures online. Not only will this help you in making your decision, it will help you prepare for your interviews.

The additional exposure you gain in other specialties will also help you be prepared for the upcoming year.

Advice #2: Don't skimp on your ICU rotation, electives and sub-internships. By the time you're a fourth year, you may be a little exhausted from the 20+ years of schooling you have just completed. While it's important you take a break and refresh for the upcoming year, don't skimp on your rotations. This is a tremendous opportunity to learn dermatology, ophthalmology, neurology and critical care from the experts in each field. This experience will be invaluable to you as a resident in the emergency department.

Advice #3: Get a whole new experience on your away rotations. If your medical school was affiliated with a private community hospital, do an externship at a large county ED and vice versa. Each residency program has its own pace and patient demographic. When applying to programs, it is good to have an idea about which type of environment you thrive in. It's also good for interviewers to know that you can survive in the "county" or the "community" setting.

Advice #4: Offer to write a case report. If you come across an interesting case, offer to write it up. Chances are, you haven't stumbled upon a large, prospective, randomized, double-blind control trial on which to be lead-investigator. Case reports are a great way to become involved in the peer-review process and to develop your skills as an author and researcher. It will give you an opportunity to be mentored by an EM faculty member who can help you with your manuscript, offer advice and potentially write a letter of recommendation for your residency application.

Advice #5: Go to the pre-interview social event. When you go on your interviews, most programs will have a happy hour the night before or after your interview. Make room for these events in your schedule when you are planning your flights and accommodations. Socializing with the residents is often the best way to know if you will fit with a program. They will be your colleagues for the next three to four years -- having fun with them will make your long hours in residency tolerable.

Advice #6: Find an exotic rotation. There are plenty of reasons to travel across the country or hemisphere: wilderness medicine, toxicology, ultrasound or your sub-internship. Find an excuse to go to Hawaii, New York, Utah, California or even Australia. If arranged far enough in advance, most medical schools will count your away credit towards your graduation requirements.

Advice #7: Start IVs, in kids. Rarely will you have the opportunity to have two to three patients at a time. Use the extra time you have to start IVs, place NG tubes, learn your way around the ultrasound machine, look in kids' ears, check out the rash in bed 25, read EKGs or learn how to use a slit lamp. The more experience you gain, the more comfortable you will feel when you start your residency next year.

And finally, **advice #8:** Go with your gut. If you don't think a program is a good fit for you, you're probably right. Almost every EM program in the nation will train you to become an excellent emergency physician. Choose the program where your needs will be supported so that you will be able to thrive.

Be assured that you are choosing a great field. Enjoy your interviews, rotations and experiences as a fourth year medical student. Good luck! I look forward to seeing you on the interview trail.

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

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

AAEM Young Physicians Section

Bring On the Pain - continued from page 27

agreed to serve as the host agency and work under the guidance of the IJIS PDMP Committee to acquire and operate the hub for the duration of the prototype.³ In the near future, EPs may have online access to prescription histories for patients from any state.

Since becoming an attending on July 1st of this year, I have experienced at least five encounters where prompt access to the prescription database had a significant impact on my care management. The most striking example is the patient mentioned above. Turns out he had filled 46 prescriptions for narcotic medications in 2008, most recently just two days before his visit to our ED. When confronted with this information, he quietly collected his belongings and quickly left the ED. It was a successful and painless conclusion to the encounter. I came away with a new sense of empowerment from a situation that usually produces cynicism and frustration. Undoubtedly, the patient was off to the next ED, hoping to find another provider too busy to look him up or who is still unaware of the IL-PMP. However, I believe he will think twice before coming back to our ED seeking drugs.

The EM applications of PMPs extend beyond simply detecting drug seeking behavior. The databases can provide useful information about recently filled prescriptions for an unconscious or uncooperative overdose patient, insight into the home opioid regimen of a patient with unusually high requirements of IV analgesics and confirm exact medications that a patient has received from other practitioners or his own pain specialist. Some state programs will even proactively notify physicians when patients are seeing multiple prescribers for the same class of drugs.² Each of these applications will assist EPs in managing the care of complex patients. In addition to benefits inside the ED, these programs have been extremely successful in terms of law enforcement. The DEA has seen measurable reductions in "doctor shopping" and prescription drug diversion in states with PMPs.³

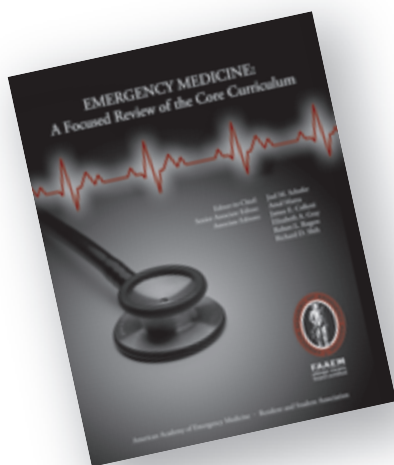
There are, of course, pitfalls associated with any new information. EPs must be ever vigilant against mischaracterizing the patient with past drug-seeking behavior who is now presenting with a truly painful medical condition. In addition, there is the potential for significant privacy violations with ongoing access to this type of information. The appropriate use of these databases is governed by state privacy laws and federally mandated by HIPAA. Professional, civil and criminal disciplinary action could result from improper usage.⁵

The management of pain in the ED is a multifaceted topic that requires careful consideration of psychosocial, legal, medical and ethical concerns. For a more in-depth discussion, I recommend Dr. Millard's article, "Grounding Frequent Flyers, Not Abandoning Them: Drug Seekers In The ED," which successfully addresses the various facets of this clinical challenge.² Access to an online PMP is not a panacea, but in the right circumstance, it can provide the missing piece of data that helps you make a difficult decision. It is important not to oversimplify this complex issue, and the purpose of this article is simply to highlight an evolving resource for clinicians who struggle daily in murky waters, striving to make informed decisions and "do the right thing."

References:

1. Rockett IR, Putnam SL, Jia H, Smith GS. Assessing substance abuse treatment need: A statewide hospital emergency department study. *Ann Emerg Med.* 2003;41:802-813.
2. Millard WB. Grounding Frequent Flyers, Not Abandoning Them: Drug Seekers In The ED. *Ann Emerg Med.* 2007;49:481-485.
3. DEA Office of Diversion Control. Q&A's - Prescription Drug Monitoring Programs http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm#1 (accessed 4 September 2008).
4. Bureau of Justice Assistance. Harold Rogers Prescription Drug Monitoring Program. <http://www.ojp.usdoj.gov/BJA/grant/prescripdrugs.html> (accessed 4 September 2008).
5. Illinois Department of Human Services. Illinois Prescription Monitoring. <https://www.ilpmp.org/index.php> (accessed 4 September 2008).

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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

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 the email address below 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 at 800-777-4912 or email the address below. EEO/AA/M/F/D/V EMPLOYER. (PA 884)
Email: lisa.holthaus@kp.org
Website: http://physiciancareers.kp.org/ncal/

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 the email address below. (PA 894)
Email: crystal.keeler@va.gov
Website: www.vacareers.gov

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 as 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 at the email address below. (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@dha.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. Pristine hospital with 55,000 visits annually. We are a private partnership of EM specialists with stable contracts. We have been in business for almost 20 years. Our compensation is excellent and our benefits are truly unmatched. Check us out. Ron Koury, DO FAAEM FACEP, Southeast Emergency Consultants. (PA 868)
Email: rmkoury@comcast.net
Website: www.southeastemergency.com

GEORGIA

Georgia, Athens: Private, democratic group of 19 physicians, all BE/BC (ABEM/AOBEM) in EM, is recruiting additional physicians, to expand coverage. 315-bed regional referral center with all major specialties on staff as well as dedicated hospitalists. ED volume 62,000 with 20% admissions rate. New 46-bed, state-of-the-art ED just completed in 2008. Superb medical community with a new branch of the state medical school starting classes in 2010. Excellent package of clinical hours, salary and benefits. All physicians are group employees; partnership in 2 years with no buy-in. Community is home to a large university with an abundance of sports, recreational and cultural activities; only an hour drive from Atlanta. Contact Carolann Eisenhart, MD at 706-475-3359 or by email at the address below. (PA 923)

Email: ceisen@armc.org

IDAHO

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

Email: eva.page@comcast.net

ILLINOIS

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

Email: smnvalentine@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: mksksk1@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

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 Foure 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

MARYLAND

Between Baltimore/DC/Annapolis: Private, profitable, single-hospital, democratic group seeking additional outstanding community BC/BE partner. Only group in region with AAEM's Workplace Fairness Certificate. 94K+ visits, new 17-bed addition (including a third ED radiology suite). Amazingly efficient (40% discharged patients have LOS under 2 hours). Strong specialty support/tertiary transfer systems. Group very politically active (chair is hospital VP/CMO). Propofol; Zonair-Z1 ultrasound; don't write admitting orders; in-house peds/intensivists; flexible hospitalists for challenging admissions. Minimum double coverage plus 92 hours/day PA support. Nights just 7 hours. Waterfront/urban/small town communities all close. Outstanding fringe benefits/salary and transparent profit sharing. Email CV to the address below. (PA 925)

Email: joel.e.klein@gmail.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

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

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: blepazier@bhs1.org
Website: www.berkshirehealthsystems.org

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 catheterization 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

MISSOURI

Excellent employment opportunity for BC/BE physicians! New state-of-the-art, 18-bed emergency department just opened in August 2008. Hannibal Regional Medical Group, a division of Hannibal Regional Hospital, is a growing multi-specialty group. HRMG encompasses a physician-friendly environment which focuses on patient-centered care. Nice community, low cost of living, only 2 hours north of St. Louis. Excellent benefits and compensation. Contact Alicia Rollins for more details at 573-231-9610 or by email at the address below. (PA 917)
Email: alicia.rollins@HRHonline.org
Website: www.HRHonline.org

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.njem.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; or Radosveta Wells, MD, 915-833-4546. Contact may also be made by email to the addresses below. (PA 874)
Email: wweinig@mac.com or 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 your CV to the email address below. The University at Buffalo is an Equal Opportunity Employer/Recruiter. (PA 867)
Email: kcolek@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

NEW YORK

Urgent Care Center in outstanding suburb of Rochester, NY, is recruiting a Medical Director. Salary range is \$200,000 to \$240,000 per year depending on experience. Annual bonus based on productivity. Pension, health insurance, 4 weeks of vacation and 1 week of CME is included. Please email CV to the address below. (PA 912)
Email: cpattison@rochester.rr.com

NORTH CAROLINA

Democratic group seeks FT BC/BE physician: Shelby Emergency Associates staffs a level III trauma center/50K and a community hospital 10 miles away seeing 25K. Our group is 16 years old and offers \$165/H plus malpractice (Pre-partnership \$145/H for 12 months), 401k, pretax business account, \$180/H for nights. 24H hospitalist coverage for admissions in both hospitals. Top-notch nurses, medical staff and supportive administration confers super comfortable work environment. \$22M 26 bed ER +12 bed FT completed 2007 at CRMC. Beautiful area of NC between Asheville and Charlotte. Broad pathology never boring during 10 & 12 hour shifts. Midlevels at both hospitals. 704-472-7777 Please email CV to the address below. (PA 850)
Email: volmizer@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

NORTH CAROLINA

WFUSM, Department of Emergency Medicine is seeking candidates to staff an affiliated site, Wilkes Regional Medical Center, 45 minutes west of Winston-Salem. Annual visits: 32,000. State-of-the-art ED. Hired as Clinical Instructor/Clinical Assistant Professors in the Department of Emergency Medicine of WFUSM, subject to approval of the governing boards, WFU Health Sciences. Full benefits. Compensation extremely competitive. Board certified/eligible physicians. Contact: James Hoekstra, MD, Chairman, Department of Emergency Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1089. Phone: 336-716-4626, Fax: 336-716-5438 or email to the address below. Equal Opportunity Affirmative Action Employer. (PA 913)
Email: jhoekstr@wfubmc.edu
Website: www.wfubmc.edu/em/

NORTH CAROLINA

WFUSM, Department of EM is seeking Medical Director to staff an affiliated site, Wilkes Regional Medical Center, 45 minutes west of Winston-Salem. Annual visits: 32,000. State-of-the-art ED. Hired as Clinical Instructor/Clinical Assistant Professors in the Department of Emergency Medicine of WFUSM, subject to approval of the governing boards, WFU Health Sciences. Full benefits. Compensation extremely competitive. Board certified/eligible physicians. Contact: James Hoekstra, MD, Chairman, Department of Emergency Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1089. Phone: 336-716-4626, Fax: 336-716-5438 or email to the address below. Equal Opportunity Affirmative Action Employer. (PA 914)
Email: jhoekstr@wfubmc.edu
Website: www.wfubmc.edu/em/

NORTH CAROLINA

Raleigh - Exciting New Emergency Medicine Opportunities around the Triangle! ApolloMD is now hiring BC/BE physicians to work in Smithfield, NC (50K annual volume) Johnston Memorial Hospital; Sanford, NC (30K annual volume) Central Carolina Hospital and Dunn, NC (36K annual volume) Betsy Johnson Regional Medical Center. Live in Raleigh/Durham/Cary and enjoy being 2 hours from the beach and 2 hours from the beautiful NC mountains! Productivity-based compensation averaging \$300k. A-rated malpractice & tail included, equal member partnership day-one. No Non-compete. (PA 915)
Email: hchappell@apollomd.com
Website: www.apollomd.com

NORTH CAROLINA

WFUSM/EM seeking candidates to provide clinical care/resident education at three new affiliated clinical sites in the Moses Cone Health System in Greensboro. Residents in IM, FM, pediatrics and EM. Full specialty backup, electronic medical record, ultrasound, CT, CDU. Hired as Clinical Affiliate Faculty/Department of EM/WFUSM, subject to approval of the governing boards of Wake Forest University Health Sciences. Benefits: health insurance, malpractice, retirement, CME and tuition remission. Compensation competitive. Board certified/eligible in EM. Contact: James Hoekstra, MD, Chairman, Department of EM, Medical Center Boulevard, Winston-Salem, NC 27157-1089. Phone: 336-716-4626, Fax: 336-716-5438/email to the address below. Equal Opportunity Affirmative Action Employer. (PA 921)
Email: jhoekstr@wfubmc.edu
Website: www.wfubmc.edu/em/

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 at the email 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. Call Sally Arnold at 814-234-6110 ext. 7850. Or mail: Theodore L. Ziff, MD FACEP, 1800 East Park Ave., State College, PA 16803. Or email to the address below. (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 email CV to either of the addresses below. (PA 883)
Email: pam.devito@crozer.org or gregory.cuculino@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

RHODE ISLAND

Seeking BC/BE EM MD for full-time position in beautiful oceanside Newport, RI. Group is private, single-hospital, stable and democratic. Group certified with AAEM Certificate of Excellence for Workplace Fairness. Hospital is financially sound with supportive administration and medical staff. Department is very computerized. 31,000+ census. 33-34 hours/day MD coverage plus 12 hours PA daily coverage. ED ultrasound program. Position offers very competitive salary and bonuses with full benefits package. If you want to practice the full spectrum of community emergency medicine in coastal New England, this is your position! (PA 918)
Email: ghebel@lifespan.org

SOUTH CAROLINA

Rock Hill - Medical Director Opportunity! A premier physician-owned, physician-run group dedicated to providing the best clinical and operational service seeks high-quality ABEM certified physician to manage a 52K volume ED in Rock Hill, SC. Piedmont Medical Center is located approximately 25 miles from Charlotte, NC. Productivity-based compensation averaging \$300k plus monthly stipend, A-rated malpractice & tail included. No non-compete. Email CV to Heather Chappell, at the address below or call 919-461-7130. Inquiries will remain confidential. (PA 916)
Email: hchappell@apollomd.com
Website: www.apollomd.com

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 or by email at the address below. (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. For telephone inquiries call 806-725-7875. CV can be forwarded to the email address below. (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: tcoates@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

TEXAS

Weight Know More medical weight loss clinics are expanding into Dallas! Part-time emergency room physicians with the following licenses are needed -Texas state medical, state-controlled dangerous substance and DEA. Two days a week, flexible schedule, attractive hourly wage. Please send resumes to the email address below. (PA 922) Email: wkmpartners@gmail.com Website: Weightknowmore.com

TEXAS

Veterans Administration North Texas Health Care System, Dallas, TX. VA North Texas Health Care System (VANTHCS) is actively seeking applicants for a position as full-time staff of Emergency Medicine Service. We are recruiting for a Physician who is board eligible/certified in Emergency Medicine, Internal Medicine or Family Medicine with Emergency Medicine experience that is energetic, with strong customer service, and should have recent emergency department or critical care experience whose mission is to provide a continuum of quality care to our veterans. Candidate must be physically capable of shift work, including nights. Clinical responsibilities include direct patient care and mid-level provider supervision. Current ACLS certification is required. Qualifications must include U.S. citizenship and an active medical license to practice in any state, territory or commonwealth of the U.S. or in the District of Columbia. Candidates should forward their Curriculum Vitae to: Al Richard Physician Recruiter (05), 4500 S. Lancaster Road, Dallas, TX 75216 or email it to the address below. (PA 924) Email: alcintiad.richard@va.gov

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.greenmtsgreatdocs.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

VIRGINIA

Stable, democratic EM group is seeking potential partner with competitive salary and 1 year partnership track. 18K volume with 4 on/6 off schedule; located in the beautiful upper Shenandoah Valley of VA. We are part of a regional system with excellent coverage for sub-specialties. Please call either Jack Potter, MD (540) 536-8485 or Jeff Berry, MD (540) 535-8183 cell. (PA 911) Email: jpotter@valleyhealthlink.com

VIRGINIA

The Johnston Memorial Hospital Emergency Department located in Abingdon, VA, currently has two BC/BE Emergency Medicine Trained Physician Opportunities. The growth is due to increasing volumes in the ER, averaging 37K annually. 9-10 hour shifts per day. This is a hospital-employed position with full benefits which include: generous sign on bonus, relocation assistance, educational loan assistance, hourly pay rate, productivity bonus, paid Malpractice, full benefits and CME Reimbursement. (PA 920) Email: tmclaughlin@jmha.org Website: www.jmh.org

WASHINGTON

We are seeking an outstanding ED physician and director to join our superb group of physicians and PAs. 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 Liberator 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/AOEBM certified physicians the opportunity to join us in a variety of practice settings. Infinity HealthCare offers an outstanding compensation and benefit package including a retirement plan and a distributed ownership structure that provides for each physician employee to have shared equity. There are unlimited opportunities to engage in administrative/leadership roles in the hospital setting and within Infinity HealthCare. Call Mary Schwei at 888-442-3883 x 724. (PA 885) Email: mschwei@infinityhealthcare.com Website: www.infinityhealthcare.com

WISCONSIN

Emergency medicine physician. Gundersen Lutheran Health System, based in La Crosse seeks a BC/BE emergency medicine physician. With yearly visits in the range of 30,000 you can live a balanced lifestyle in a collegial environment with twelve experienced physicians on staff in our accredited level 2 trauma center. This position involves double coverage, residency teaching, eight hour shifts and medical control for air/ground transport and paramedics. New critical

care tower to include a new TEC will be built. Contact: Jon Nevala, Medical Staff Recruitment at 800-362-9567 ext. 54224 or by email to the address below. (PA 896)
Email: jnevala@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

WISCONSIN

Seeking Emergency Medicine board certified/prepared Emergency Physician for the Division of Emergency Medicine at the University of Wisconsin School of Medicine and Public Health in Madison, Wisconsin. Seeking faculty positions at all academic levels. Experience in academic medical center and/or EM residency program preferred. EM faculty provide clinical services in the Emergency Department (ED) of the University of Wisconsin Hospital & Clinics, a busy, university-based, tertiary care, referral hospital. Our ED is only one of two academic EDs in Wisconsin, and is a Level I Trauma and Burn Center for adult and pediatric patients. EM faculty supervise EM and off-service residents and medical students. Join a faculty of over 20 emergency physicians and pediatric emergency physicians. Send CV/cover letter to: Joseph R. Cline MD FACEP, F2/211 Clinical Science Center MC 3280, 600 Highland Avenue, Madison, WI 53792-3280 or by email to the address below. EEO/AA Employer, Wisconsin caregiver/open records laws apply. Background check. (PA 919)
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)
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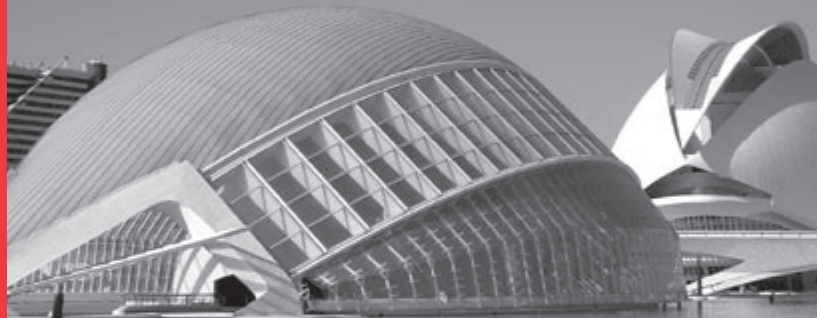
CANADA

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

Save the Date

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14-17 September 2009
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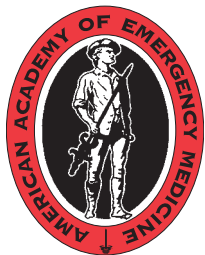


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