“Resolutions adopted by EMRA can change the field of medicine...”

Join in EMRA Council activities at Scientific Assembly in Boston

Kaedrea A. Jackson, MD, MPH, SUNY Downstate Medical Center, Brooklyn, NY, Vice Speaker of the Council

It’s my pleasure to welcome you to the 2009 ACEP Scientific Assembly in the historic city of Boston. For the past 41 years, ACEP’s Scientific Assembly has been the foremost conference devoted to emergency medicine education. With you in mind, ACEP and EMRA has an exciting selection of educational programming and social events that promises to be truly exceptional.

EMRA’s 35th Anniversary

Since 1974, EMRA has been supporting emergency medicine residents and medical students. Born from the desire of a few residents to shape the field of emergency medicine, EMRA now has more than 9,000 members. Over the years, EMRA has been involved in the development and advancement of emergency medicine.

To this day EMRA remains the largest independent resident organization in the world. From conception, we have kept true to our mission to promote excellence in patient care through the education and development of emergency medicine residency trained physicians. Come celebrate with us as we look back over the past 35 years and look forward to new and exciting endeavors.

Representative Council

At the Assembly, EMRA program representatives have many important responsibilities. As a delegate from your program, you must attend the Representative Council meeting on Tuesday, October 5th. At the meeting, program representatives may voice the concerns of their fellow residents, discuss policies and vote on resolutions.

A resolution is essentially a directive for EMRA to take a certain action or to form policy. Resolutions adopted by EMRA can change the field of medicine through passage at the American Medical Association (AMA). It’s been done

continued on page 10
the wait IS OVER.

Visit EMRA during Scientific Assembly at Booth 338 for more information.

The EMRA ABx Guide iPhone App has arrived.

Visit the App Store or download through your iTunes account on Apple.com.
Upcoming events

October 3-8, 2009  EMRA Events at ACEP Scientific Assembly  Boston, MA
October 4, 2009  EMRA Residency Fair  Boston, MA
October 5, 2009  EMRA Job Fair  Boston, MA
October 5-6, 2009  ACEP Research Forum  Boston, MA
October 14, 2009  ACEP Medical Student Professionalism & Service Award Application  Deadline
October 24-26, 2009  ABEM Oral Certification Exams  Nationwide
November 4-10, 2009  AMA Interim Meeting  Houston, TX
November 16-21, 2009  ABEM Qualifying Exams  Nationwide
February 19-20, 2010  RRC-EM Meeting  Chicago, IL
March 3, 2010  Emergency Medicine Resident Appreciation Day  Nationwide
March 3-6, 2010  CORD Academic Assembly  Orlando, FL
March 15, 2010  EMRA Spring Awards Application  Deadline
May 16-19, 2010  ACEP Leadership & Advocacy Conference  Washington, DC
June 3-6, 2010  SAEM Annual Conference  Phoenix, AZ

Advertising guidelines

Thank you very much for your interest in advertising with EM Resident. As the largest organization to represent the needs of the emergency medicine resident, we are able to reach a unique and important niche of our specialty. EMRA’s mission statement is to promote excellence in patient care through the education and development of emergency medicine residency-trained physicians. It is our belief that this provides the best patient care in an emergency department setting.

To support our mission and provide the greatest advantage to our residency-trained members searching for jobs, we welcome you to advertise in EM Resident, but require that all positions advertised in our publication be addressed only to board-certified/board-prepared, residency-trained emergency physicians.

For the sake of consistency, the use of the terms “ED,” “emergency department,” and “emergency physicians” are preferable to using “ER” or any such derivation.

Your support is very important to us, and we appreciate your compliance with these guidelines. Please respect this policy and reflect its sentiment in your advertisements. EM Resident has the right to refuse any advertisement that does not meet these guidelines.

Thank you again for advertising in EM Resident.

To place a classified or display ad in EM Resident, contact Leah Stefanini, 866.566.2492, ext. 3298, e-mail lstefanini@emra.org, or fax 972.580.2829. Information for advertisers can also be found at www.emra.org.

EM Resident is published six times per year. Ads received by November 1 will appear in the December/January issue.

EM Resident subscriptions are available only to individuals and institutions that are not considered eligible for EMRA membership as per the EMRA bylaws. For information on how to subscribe please contact Leah Stefanini, 866-566-2492 ext. 3298 or email lstefanini@emra.org.
Sitting and trying to write this final message in my series as president has definitely given me writer’s block. When I started residency, I never could have predicted how my experiences would shape my decisions as president. Now, I am equally surprised how this past year as president has influenced my life both in and out of the hospital.

The adventures on the EMRA board have given me new insight into my upcoming career. As I prepare my applications for jobs, thoughts swarm my head of what career choices I would like to make. Suddenly, it is more than academics versus community but rather the big picture. Where do I see emergency medicine in five, ten, or even twenty years? What new healthcare initiatives will shape our training and our direction? It can be intimidating to realize how much politics, organized medicine, and the choices we make on a daily basis can really affect our careers.

The experiences that I have had with this and the previous board have been nothing short of amazing. I’ve learned so much from my colleagues through each of their unique skill sets, whether legislative, technological, or even through combined training programs. The insight gained into this specialty is unparalleled by any other encounters I have had in the past. I hope that the friendships forged, and the mentorship attained lasts my entire career.

Special thanks go to the staff of EMRA. Michele, Leah, Alicia, and Griffin have made this job appear as if it requires no work at all. They are truly the driving force behind this organization. I can’t fathom for even a second how difficult the presidency must have been only five years ago without the talent of our current staff. With the combined efforts of staff and board members, we have witnessed our contribution to equity climb each year. We have successfully organized our first Regional Medical Student Symposium this past August in Baltimore. We’ve renegotiated and signed our new shared services agreement with ACEP, and expanded our deep bookstore discounts to residents. Our membership continues to climb to record numbers. We’ve improved our relations with ACOEP and other national organizations. We’ve created a new publication, the Emergency Medicine Advocacy Handbook and are in the process of finalizing an antibiotic guide application for the iPhone.

As I hand the reigns of this organization over to Edwin Lopez, I look forward to the elections at Scientific Assembly. I look forward to the renewed enthusiasm in organized medicine and the opportunities that will present themselves. I look forward to the fresh faces and energy that comes with the collaboration among our peers. Good luck to all our nominees running for a position, to our current chairs of committees and everyone in all stages of their training.
• **EMRA’s Regional Medical Student Symposium!** The first regional symposium occurred on August 8th in Baltimore, MD. Aimed at bringing all the great programming you have come to expect from the national symposium, to a more intimate regional level. We had over 120 students in attendance, ten local residencies, a didactic Ultrasound Session with five machines courtesy of GE Ultrasound, CT reading session presented by FERNE, and a residency director panel luncheon with a fantastic Q & A session. Look for this event again next year! ■

- **iPhone Antibiotic Guide Application** – Expected release in October, the EMRA Antibiotic Guide application for the iPhone. With the same format and ease of use you’ve come to expect from our hardcopy, now conveniently on your iPhone! ■

---

**Want to be an EMRA Regional Representative?**

Currently we are accepting applications for an open Regional Representative position. The purpose of the Regional Representative network is to identify and empower new leaders within our specialty, write resolutions that influence our medical practice, participate in the Representative Council, and to facilitate communication between the Program Representatives and the EMRA leadership. The following region needs a Regional Rep for 2009 – 2010 academic year:

**Region 11: MA, RI, CT, ME, NH, VT**

If interested in applying, please send your curriculum vitae and letter of intent to Kaedrea Jackson, MD, MPH at vicespeaker@emra.org by October 23rd. Check the EMRA Website and monthly Program Representative Update for any future openings.

---

**Board of Directors**

- **Joshua Moskovitz, MD, MPH**
  President
  University of Maryland
  Baltimore, MD
  president@emra.org

- **Edwin Lopez, MD**
  President-Elect
  Loma Linda University Medical Center
  Loma Linda, CA
  presidentelect@emra.org

- **Andrew Zinkel, MD**
  Immediate Past President/Treasurer
  Regions Hospital
  St. Paul, MN
  immedpastpres@emra.org

- **Eric Maur, MD**
  ACEP Representative
  Geisinger Medical Center
  Danville, PA
  aceprepo@emra.org

- **Emily Luerssen, MD**
  Academic Affairs Representative
  Madigan Army Medical Center
  Tacoma, WA
  academicaffairsrep@emra.org

- **Steven Tantama, MD**
  RRC-EM Representative
  Naval Medical Center
  San Diego, CA
  rrcemrep@emra.org

- **Lisa Bundy, MD**
  Secretary & EM Resident Editor
  University of Alabama at Birmingham
  Birmingham, AL
  emresidenteditor@emra.org

- **Julian Jakubowski, DO**
  Technology Coordinator
  Saint Barnabas Hospital
  Bronx, NY
  techcoordinator@emra.org

- **Edwin Lopez, MD**
  Speaker of the Council
  Loma Linda University Medical Center
  Loma Linda, CA
  speaker@emra.org

- **Kaedrea Jackson, MD, MPH**
  Vice Speaker of the Council
  SUNY Downstate Medical Center
  Kings County Hospital Center
  Brooklyn, NY
  vicespeaker@emra.org

- **Nathaniel Schlicher, MD, JD**
  Legislative Advisor
  St. Joseph Medical Center
  Tacoma, WA
  legislativeadvisor@emra.org

- **John Anderson**
  MSGC Chair
  University of Colorado School of Medicine
  Aurora, CO
  msgc@emra.org

---

**EMRA Staff**

- **Michele Byers, CAE**
  Executive Director
  mbyers@emra.org

- **Leah Stefanini**
  Publications/Events Coordinator
  lstefanini@emra.org

- **Alicia Hendricks**
  Website Coordinator
  ahendricks@emra.org

- **Griffin Achilles**
  Administrative Assistant
  gachilles@emra.org

---

EMRA
1125 Executive Circle
Irving, TX 75062-2522
Phone: 972.550.0920
Fax: 972.580.9690
www.emra.org

October/November 2009 5
I’m happy to announce the winners of our first EMRA Photography Contest! I would like to send a special thank you to my friend and fellow photojournalist Giuliano DePortu, MD, of the University of Puerto Rico Emergency Medicine Residency. It’s great to know there are so many others out there who share our passion for storytelling.

Thanks to all those who entered photos this year. Keep on shooting, seeing and capturing the essence of the amazing world in which we live. In our business, we don’t often see happiness. Photography is a way that we can capture a little happiness for all eternity.

It’s been a long time since I picked up a camera. Now you’ve made me miss it. I do miss the people I met, the cool things I used to do. But I realize I only traded it for other people and other cool things to do. –LB

**PHOTO CONTEST WINNERS**

**MEDICAL FEATURE**

1st PLACE WINNER

*After Work* | Paul Dhillon, MD
Royal College of Surgery, Dublin, Ireland

**NATURE WINNER**

1st PLACE WINNER

*After the Flight of the Butterfly* | Amanda Rodski, MD, MBA
Department of Emergency Medicine, Temple University Hospital, Philadelphia, PA

**NATURE RUNNER-UP**

*Cheetah with Prey*

Natalie Anne Ayres, MD, MS
Carolinas Medical Center, Charlotte, NC

**NATURE**

*Cheetah with Prey*

Natalie Anne Ayres, MD, MS
Carolinas Medical Center, Charlotte, NC
ART PHOTOGRAPHY
1st PLACE WINNER
The City from the Gate | Julio Manuel De Peña-Batista, MD
Kendall Regional Medical Center, Miami, FL

ART PHOTOGRAPHY
RUNNER-UP
Spring Reflection
Sarah Medeiros, MPH, MSIV
David Geffen School of Medicine
Los Angeles, CA

PORTRAITS 1st PLACE WINNER
Young Warrior | Jason Hamel, MSIV
Loma Linda University School of Medicine, Loma Linda, CA

EM Resident is the bi-monthly magazine of the Emergency Medicine Residents’ Association (EMRA). The opinions herein are those of the authors and not those of EMRA or any institutions, organizations, or federal agencies. EMRA encourages readers to inform themselves fully about all issues presented.

EM Resident reserves the right to review and edit material for publication or refuse material that it considers inappropriate for publication.

© Copyright 2009
Emergency Medicine Residents’ Association.

Mission Statement
EMRA promotes excellence in patient care through the education and development of emergency medicine residency-trained physicians.
PORTRAIT RUNNER-UP
Generations | Sarah Medeiros, MPH, MSIV
David Geffen School of Medicine Los Angeles, CA

OTHER RUNNER-UP
Smoke Tower
Thomas J. Corson, DO
University of Connecticut
EM Residency
Farmington, CT

PORTRAITS RUNNER-UP
Snapshot of an Epidemic
Sarah Medeiros, MPH, MSIV
David Geffen School of Medicine Los Angeles, CA

OTHER
1st PLACE WINNER
Right to Love
Sarah Medeiros, MPH, MSIV
David Geffen School of Medicine
Los Angeles, CA

OTHER
Generations | Sarah Medeiros, MPH, MSIV
David Geffen School of Medicine Los Angeles, CA
As I near the end of my three-year term on the EMRA Board of Directors, I am filled with pride and amazement in what this organization has accomplished in that time. It has grown in so many ways, and I’m sad that I will no longer have the honor and responsibility to serve its members in the future.

My responsibilities in the last year as Immediate Past President and Treasurer include acting as a sort of institutional memory for the Board as the only three year term of office, as well as working with staff and the rest of the Board to approve budget decisions and modifications in the most fiscally responsible manner. I am pleased to inform you that in spite of the massive economic downturn in the last year, EMRA’s financial position continues to improve and maintain record numbers.

At the close of the 2008-2009 fiscal year the Association had $1,200,000 in total assets and liabilities, a 26 percent increase compared to this time last year, and compared to an 8 percent increase the year before. Its year-end contribution to equity exceeded $124,000, well above and beyond the minimum required by our by-laws as well as the $10,000 contributed the year before. EMRA’s assets are largely a result of its staff’s commitment to maintaining member dues, as well as beneficial non-dues revenue streams of income. Additionally, EMRA is fortunate to have numerous, dependable supporters who contribute to its financial security through event participation and advertisement.

EMRA’s membership is up more than 11 percent from last year to a record 9,000 members, increased by more than 1,000 members spread across all membership categories. Large increases occurred in international membership, which increased by more than 100 percent and alumni membership which increased by 20 percent to more than 1,700. Member dues have only been increased once over the past 20 plus years, and even then by only 10 dollars, thanks to EMRA’s leadership and their strong commitment to maintaining affordable access to its amazing member benefits.

Our non-dues revenue has helped to increase our financial stability over the last year as well. Increased numbers of exhibitors at the Job and Residency Fairs, as well as meeting underwriter support, were major contributors to non-dues revenue.

Publication sales were also very strong. Our best seller remains the EMRA Antibiotic Guide. EMRA began selling its products on Amazon.com and close to $18,000 in sales were generated from the Amazon.com storefront. Royalties and ad revenue from EM Career Central and EM Resident magazine continued to be strong and outperform expectations.

In spite of a dramatic downturn in the stock market, EMRA’s investment portfolio has managed to slightly exceed expectations in terms of returns. The organization’s cash on hand through increased revenues has been more than enough to offset losses in the stock market, and the organization has devoted a large portion of revenue towards contribution to equity.

EMRA’s financial position is very strong and continues to improve. There are some very exciting things coming down the pipeline that will continue to improve the organization’s financial viability. The Board takes this fiduciary responsibility very seriously and is always thinking in terms of the members best interests. Thank you for the honor and privilege of being able to serve you as EMRA’s Immediate Past President and Treasurer.
Join in EMRA Council activities at Scientific Assembly

continued from cover

before. That is why it is important that program representatives be informed. The Representative Council Public Hearing, held Monday afternoon, is an informal session for all residents to hear testimony on proposed resolutions.

The Scientific Assembly Representative Council also has the important task of electing the next EMRA Board of Directors. Positions up for grabs are President-Elect, Vice-Speaker, Secretary/EM Resident Editor, Academic Affairs Representative and Technology Coordinator. Program representatives are encouraged to attend the breakfast prior to the Representative Council meeting to personally meet the candidates.

After the conclusion of the Representative Council meeting is our Town Hall meeting. This is an open forum for any resident to discuss issues they feel pertinent. Most likely, the topic of concern on many of our minds is health care reform and the emergency department.

Resident Forum
What if you are a resident attending Scientific Assembly, but you are not a program representative. What should you be doing? Keep in mind that activities open to program representatives are open to all residents. However, our resident forum does have an array of activities geared toward career planning, job search, networking and of course socializing. Our infamous Bloody Mary Breakfast kicks off the Resident Forum on Monday, October 5.

Medical Student Forum
EMRA understands that the future of emergency medicine also depends on the development and education of interested medical students. Our Medical Student Forum provides information to students that will aide them in securing a position at the residency program of their choice. Students will have access to program directors and residencies from all over the nation.

We hope that you find the programming at this year’s Scientific Assembly exceptional. While in Boston take time out to get involved and talk to us. We welcome your input and feedback. See you next year in Las Vegas!

Monday, October 5
1:00 pm – 2:00 pm Representative Council Conference Committee Orientation
Westin Waterfront, Faneuil
This is a mandatory meeting for those individuals who are serving on the Conference Committees. This includes Reference Committee, Sergeant at Arms and Tellers/Credentialors.

2:00 pm – 3:00 pm Regional Representative Meeting
Westin Waterfront, Hancock

3:00 pm – 4:30 pm EMRA Reference Committee Public Hearing
Westin Waterfront, Otis
During this meeting, the Reference Committee hears testimony from the authors of resolutions being brought forth from the Council and from anyone who would like to speak for or against the resolutions. This is your opportunity to understand more completely the reasoning and history behind the business being brought before the Rep Council. A great way to learn, understand, and participate in the Rep Council meeting the following day. REQUIRED FOR EMRA PROGRAM REPS.

6:00 pm – 8:00 pm EMRA Rep Council Reference Committee Work Meeting, Westin Waterfront, Faneuil
The work meeting is a closed session for the Reference Committee to prepare reports to be presented to the full Rep Council the following day.

Tuesday, October 6
8:00 am – 8:50 am EMRA Rep Council Welcome Breakfast & Candidate’s Forum
Westin Waterfront, Grand Ballroom C-D
This is an informal breakfast meeting for all Rep Council members where you can meet other program representatives, the EMRA Board of Directors, Rep Council officers, Regional Reps and the candidates who are running for EMRA office. REQUIRED FOR EMRA PROGRAM REPS.

9:00 am – 9:30 am EMRA Rep Council Registration
Westin Waterfront, Grand Ballroom B Foyer
All Program Reps are required to register to receive their voting credentials for the Rep Council meeting. Be prompt. Registration closes at 9:30am sharp. REQUIRED FOR EMRA PROGRAM REPS.

9:30 am – 12:00 pm EMRA Rep Council Meeting, Elections, and Town Hall Forum
Westin Waterfront, Grand Ballroom B
This is the formal business meeting where elections and resolution votes will take place. The Town Hall Forum is an open discussion forum following the business session. This mandatory meeting is your chance to shape the organization and the specialty. Don’t miss it! REQUIRED FOR EMRA PROGRAM REPS.

12:00 pm – 1:00 pm EMRA Rep Council Luncheon (Sponsored by FERNE)
Westin Waterfront, Grand Ballroom D-E
Now that July 1 has passed, interns find themselves taking on many novel responsibilities. One of these new-found joys is the need to make PowerPoint presentations for audiences on a regular basis. I thought I would go over some pearls in improving these presentations.

So let's start with the basics. Although the content of your slides is important, the layout of your presentation will speak volumes before you say a word.

As a principle, pick a background color and use three additional colors of text. Make sure the colors of your fonts contrast the background. Keep in mind that 5 to 8 percent of men are colorblind to some extent, red-green being most common. So it's advisable to remove both red and green from your palette.

Keep in mind the venue in which you are giving your presentation. Due to the limitations of most projectors and ambient light in auditoriums, you are typically better off using a light background with dark text.

If you are going to be speaking in a room where the back of the audience is more than 20 feet from the screen, avoid white on a dark background. If you have a small group presentation where the computer screen is your projector, then you should use white on a dark color to help reduce glare.

Another major style point to address is the choice of font. Don't go with nonstandard fonts, otherwise you may find squares and symbols in the place of words when the host's computer doesn't have your font. I would also recommend avoiding “display fonts” (script fonts) that look pretty but can be hard to read. Instead stick with “content fonts” (e.g. Times New Roman). These fonts tend to be universally installed on computers regardless of operating system. Not only are content fonts universal, they are easier to read.

In the context of medical presentations, you should pick Serif fonts (those with “feet” like Times New Roman) over sans serif fonts (without feet like Arial). Serif fonts look more formal and the blocks of texts found in your bulleted points are easier to read.

Now that we've gone over the basics of picking a font, you need to make sure that you make sure the fonts are big enough to read. Most slides should utilize up to three fonts sizes: title, subtitle/bullet and content. Font size should range between 18 to 48 points, like title size 40, subtitle 32, and content 24.

Make sure all your slides are uniform in their usage of colors schemes, font sizes and transitions. Also your text and images should be placed within 95 percent of the PowerPoint slide to ensure proper display on most screens.

Besides looking good, you do not want to overwhelm your listeners with too many words. Limit each slide to one idea with bulleted points. There should be no more than 4 to 6 bullets per slide. Each point should be a line with no more than six words. Speak at a rate that both keep the audience engaged and allows them to process, aim for 1 to 2 slides/minute.

Make sure that you have a conclusion that summarizes the main points of your presentation, and where people can find more information about the topic. Your audience is most likely to retain information from the very beginning and the very end of your presentation so make these moments count.

Finally, don’t go crazy with multimedia or slide transitions. If you do, your audience will be distracted and won’t really focus on what you have to say. The distinction between a good presentation and a bad presentation is the whether you maintain your audience’s attention or send them into a REM state. Remember PowerPoint presentations are meant to supplement your presentation, not provide a transcript of your lecture.
DIY healthcare reform

As a “Do-It-Yourself” (DIY) kind of guy, I often see the debate over healthcare reform in terms of a robust home remodel. Many say the house of medicine is looking a little dated these days. Whether it be ten, twenty, or thirty years out of date, you do hear the sound of renovation plans coming from Capitol Hill. Yet with any good home project, there are always questions of how much work should be done, and at what cost. The plans being put forth vary from a superficial fresh coat of paint; to burning the house down and building a new one. While each of these options will have different issues depending on their final layout, there are some general trends emerging in the blueprints.

Burn the house down
This plan comes from proponents of Medicare, the VA system, and military healthcare. They see these systems as role models for public healthcare. Many want to eliminate insurance companies or substantially restrict them. The new selling line is that insurance companies steal money from healthcare that could go to treating patients. Their main target appears to be insurance companies as the source for cost savings. They purport savings from overhead, billing problems, and systemic waste. Though flashy and exciting, this plan is not likely to be cost effective, and it could harm the economy by putting people out of work.

Tear it down to the studs
Others see the major enemy not as insurance companies, but the people who decide what tests to order, medications to prescribe, and procedures to perform. These proponents speak the language of evidence based medicine, the Medical Home, and expanding hospice services. The target of this reform is physicians and other healthcare providers who spend the money, not the insurers who pay for it. Cost savings will be obtained by multiple methods still to be decided, but could include a return to gatekeepers, expanding pay for performance, and stopping payment for “unnecessary” tests or visits deemed wasteful by their administrators of the program. This program is attractive to many politicians by shifting costs away from the government to providers and patients. Most providers though would not appreciate a government mandated definition of high quality care that controls reimbursement and further intrudes into difficult medical decisions.

Patch job
Multiple quick fixes have been described including drug price control, increasing
Congratulations to the 2009-2010 EMRA-ACEP Health Policy Mini Fellowship Recipients

Alison Haddock, MD
University of Michigan
Ann Arbor, MI

Michael Dorrity, MD
Michigan State University
Sparrow Hospital
Lansing, MI


“While each of these options will have different issues depending on their final layout, there are some general trends emerging in the blueprints.”

insurance access through an exchange, decreasing physician reimbursement, and deletion of Medicare Advantage. All of these plans focus on individual problem fixes. Some are pushing for these to be put forth as a package of changes, but leave the overall structure of healthcare intact much as it is now. This plan is likely to be relatively low cost and offend smaller numbers of stakeholders. Meaningful reform though will not be obtained without putting many of these proposals into a comprehensive package.

**Touchup**

This version of reform is not really reform at all. Instead, the argument is that the US healthcare system is the jewel of the world. World leaders come here for care. The most advanced procedures are available. The healthcare industry represents 1/6th of the economy and is a driving force. Serious government reform will only damage the prestige and success of the system. Small reforms such as fixing the SGR (sustainable growth rate) or expanding Medicaid are put forth. Most agree though that many of these claims are not true for all citizens. With millions of uninsured and the systemic costs escalating, the need for reform will likely go beyond a simple touchup job. Whatever the remodel of the house of medicine looks like, the projects currently in the pipeline are still on the drawing board ready for input. As an experienced DIYer, I would remind you of a few key rules:

1. There are always hidden problems behind the drywall no matter how well you plan.
2. Any contractor (e.g. physician) you hire is not your employee; they can walk off the job anytime.
3. The bigger the project, the more ways it can go very badly.
4. Always count on a 20% cost overrun.

If you too are a DIYer in your personal or professional life, I encourage you to be involved. This home improvement project is well overdue, but no one quite agrees on what needs to be done. Your input may just be the best solution to that crooked wall or overpriced estimate. Whatever your skill set, it is time to pick up a hammer and get building!
A few days ago I caught myself while talking with the new interns about responsibly monitoring their duty hours. I had preceded my diatribe with those infamous words, “Back in my day…” Although not as bad as walking barefoot uphill both ways in the snow, I couldn’t help but laugh. As with every generation, there are a group of folks who complain that somehow today is worse, and nobody works as hard as they did.

I do remember during my internship in 2001, there were q2 call nights that lasted longer than 30 hours. I did fall asleep at red lights trying to get home. Then in 2003, stemming from the untimely death of Libby Zion, change arrived. The Accreditation Council for Graduate Medical Education (ACGME) issued the duty hours system in place today. But have things really changed? I still hear the whipper-snapper interns with similar stories, but now they’re no longer badges of courage but violations to be admonished or covered up.

In December of 2008, the Institute Of Medicine (IOM) presented their report for further recommendations on managing resident duty hours (see Table 1). The report was commissioned after a 2007 study heightened interest in medical errors due to sleep-deprived residents and interns. The report focused on alleviating fatigue, increasing supervision and improving turnovers.

The IOM urged a “rapid” implementation of the recommendations. Yet, in an age of evidence-based practice, these recommendations come without any adequate studies evaluating the impact on patient safety from the 2003 changes.

In response, the ACGME created a task force and convened an invitation-only Congress on Duty Hours this past June. Thoughtful but concerned testimony was received from a broad spectrum of organizations and residency groups. Within emergency medicine, eight of the major organizations, including EMRA, collaborated to produce our own consensus statement (publication pending as of the writing of this article).

To give a historical perspective, in 1986, emergency medicine became the first specialty to require full time faculty supervision in the hospital. In 1990, the RRC-EM required 1 day in 7 off and limited the length of an emergency department shift to 12 hours with “an equivalent time off.” And, in 1995, the duty hours for emergency medicine were reduced to a maximum of 60 clinical hours with additional education time to a maximum of 72 hours while on a rotation in the emergency department.

Although the spirit of the report was definitely lauded, the recurring theme was that a ‘one size fits all’ approach will not work.

Fortunately as one of the youngest specialties, training in emergency medicine already met most of the new recommendations. Already masters of shift work, our concern was the disruption of the circadian rhythm by alternating night and day shifts which could actually worsen fatigue.
Indirectly, a nap period with associated sleep inertia (grogginess after waking) and further “caps” on resident workload would create a further delay in consultant services. Increased patient flow-through time would increase boarding and decrease patient safety. In a similar ironic twist, there would be an increase in handovers and their associated risks. Besides losing the ability to follow patients through the entire clinical process, the recommendations shift focus from overriding consideration of the patient to overriding consideration of the length of the shift.3

With a correlation between training and competence, the least accomplished expert has at least 5,000 hours of experience. Overall with reduced exposure to patients any given shift, curriculums would need to be lengthened to ensure adequate training (particularly in the surgical services). This could reduce the number of applicants to already lengthy programs worsening the anticipated workforce shortage. Ultimately, will we be trading the unproven risk of fatigued residents for the safety of our future patients under the care of less-experienced graduates?

What I do believe is that most importantly we all need to cooperate with the ACGME now. We need to create a solution before Congress asks other organizations like OSHA or the Joint Commission to do it for us. Blood cultures anyone? ■

References

Resident Duty Hours: Enhancing Sleep, Supervision, and Safety (Table 1)

<table>
<thead>
<tr>
<th>Comparison of IOM Committee Adjustments to Current ACGME Duty Hour Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2003 ACGME Duty Hour Limits</strong></td>
</tr>
<tr>
<td>Maximum hours of work per week</td>
</tr>
<tr>
<td>Maximum shift length</td>
</tr>
<tr>
<td>Maximum in-hospital on-call frequency</td>
</tr>
<tr>
<td>Minimum time off between scheduled shifts</td>
</tr>
<tr>
<td>Maximum frequency of in-hospital night shifts</td>
</tr>
<tr>
<td>Mandatory time off duty</td>
</tr>
<tr>
<td>Moonlighting</td>
</tr>
<tr>
<td>Limit on hours for exceptions</td>
</tr>
<tr>
<td>Emergency room limits</td>
</tr>
</tbody>
</table>

Advising the Nation. Improving Health.
It’s hard to believe an entire month has already passed since I graduated from residency and began working my first shifts as an attending. Thinking back to this time last year, I was just beginning to start negotiating a contract. Once that was finalized, I began counting down the months—and eventually the days—left until graduation. After some much-needed time-off (an entire two weeks between my last shift as a resident and my first shift as an attending!), I drove in for my first 12 hours as an attending in a single-coverage emergency department.

As a resident, there are certain aspects of life that often get taken for granted, like having a fellow resident or an attending around to discuss a case or to take a second look at an X-ray or EKG. Those crutches are not there when you’re in the Land of Single Coverage. Nor is there anyone there to continue seeing patients while you are tied up doing an hour-long procedure. Instead, the patients continue to pile up and wait for you to finish. And what about those resident-work-hour rules that were so important to follow? There is no such equivalent for attending work hours.

Yet, perhaps the biggest difference I experienced has nothing to do with the people I am working with, nor with the hours that I am working. The patients and their complaints are the same as well, and at times, I still feel like a primary care physician working in an office that never closes. The biggest surprise (for lack of a better term) came in realizing just how different the resources in a small community hospital are compared to the world of academia, where I had spent my last three years.

Need a neurologist? “Sorry, we don’t have one of those here.”

Need an ultrasound or CT scan read? “Sorry, but it’s Friday afternoon and our radiologist left early today, and no, I don’t know how long it will take the outside group to read your scans. Yes, I know you’ve been waiting for two hours already, Sir, but there is unfortunately nothing else I can do and no, I don’t know how much longer it will be until I get the results of that CT scan.”

Need an MRI? “Sorry, those are only available here on Wednesdays.”

“Yes are you having chest pains? I’m sorry, but if you need a cardiac cath then I am going to have to transfer you.”

These are just a few of the things that I experienced during my first few shifts. With no one else to turn to and limited available resources, I was forced to quickly adapt to the new surroundings and to simply “make do.”

So as you continue to progress through your training, be it as a medical student or resident, be sure to take advantage of all the resources that you have at your disposal. Learn how to not only work with them, but at the same time, start thinking about how to work without them—you never know which of those crutches you might just have to do without.
The EMRA PARTY
Not Your Average Tea Party!!

Join Us at
Tuesday, October 6
9pm – 2am

THE ESTATE
One Boylston Place
(the Alley)

Voted Boston's
Best Dance Club 2009
www.theestate.com

Drink Specials All Night
$5 domestic beer
$7 wine all night

Proudly underwritten by
Emergency Medical Associates
The Sign of Excellence in Emergency Medicine®
International fieldwork reveals human strength, bravery

“I have made the journey into nothing. I have become that flame that needs no fuel.” (Hafiz, translated by Daniel Ladinsky)

Complex political emergencies, a growing category of man-made disasters, served as the focus during my International Emergency Medicine Fellowship fieldwork at Columbia University/NYPH. Examples of these include Somalia, Sudan, “Af-Pak-istan,” the Democratic Republic of Congo, and the list is growing.

Inherently protracted, these emergencies are characterized by ongoing violence and human rights abuses. An elite class manipulates existing cultural rivalries as a strategy to maximize a new economy, often a global grey economy such as oil, illegal drugs and precious stones. This causes forced migration of massive populations into conditions—magnifying an already poor health status. Infant mortality and crude mortality rates double. Rape becomes rampant. Epidemics flourish.

While waiting for political solutions, health services must be delivered to stave the innocent casualties. The bulk of my eight months in the field was in the complex political emergency of Burma.

Burma is the largest country on mainland South East Asia. It is the 41st largest country in the world, with the 24th largest population, and a 176th economic ranking measured in GDP per capita in purchasing power parity.

For 2009, Burma’s life-expectancy rate at birth is estimated at 63.39 years and an infant mortality rate of 47.6/1000 live births. Compared to other non-African states, this ranks as one of the lowest in overall health markers. “Doctors Without Borders,” in their report “Preventable Fate,” note that the Burmese government spends the smallest percentage of GDP on health care than any other country in the world.

After the British pulled out in 1886, the Burman culture (the majority ethnic group) flourished, where by 1936, it dominated its surrounding minority tribes and pushed for centralized rule.

During World War II rose Burma’s most historically influential figure, General Aung San, father of Nobel laureate and leader of the National League for Democracy [NLD], Aung San Suu Kyi. Thought of as the one person who could unify Burma, Aung San’s influence was cut short in 1948 when he was assassinated.

Followed by years of civil war, Burma has been under some form of military rule since. The current military junta under General Than Shwe has ruled since 1962. Conflict with the current junta has been particularly violent along the Thai-Burma border (TBB), with decades of oppression causing hundreds of thousands to flee their homes.
The Karenni are one group crossing the TBB into the bordering Thai state of Mae Hog Son (MHS). For 12 years, the International Rescue Committee (IRC) has been the sole health provider for tens of thousands of Karenni in MHS. Host government oversight is through the capricious local Ministries of Interior (MOI) with policies varying from state to state.

For example, refugees in MHS live in camps while those in the neighboring state of Mae Sot live within the community. Camps in MHS are guarded, and access is limited, even during medical emergencies. Flow of materials and workforce requires permission from the MOI and often a “fee.” Humanitarian agencies are not allowed to reside inside the camp and instead operate in the nearby capital city of the state. Humanitarian aid activity is a major economy for the city, and the refugees provide a source of migrant labor. Despite these highly restricted conditions, the refugees tolerate this over their homeland.

During my 5 months in MHS, I worked for IRC as a clinical consultant and advisor to medical training. Work in the field can be characterized as a slow diligence where flexibility is the key.

One day was spent fixing the generator thermostat with rice whiskey and another involved an emergent needle decompression of a rebel.

Technical knowledge was incorporated into lectures, and models of medical training in the U.S. were modified for bedside teaching in the camp clinics. We responded to diarrhea and leptospirosis outbreaks, suppressed malaria, and managed emergency obstetric care. These are the small things I remember. The bigger picture, however, haunted me – where was the impact?

Fieldwork offers more than lessons in clinical teaching, delivery and public health management. The conditions are often austere and moral challenges daunting. There were days driving into camp where we would pass refugees returning from a night of cheap labor. There was the girl raped by soldiers and a mother dying from obstructed labor. The conditions were stagnant and bleak. We cannot expect our greatest lessons to be learned under warm, genial conditions.

Despite the massive sociopolitical obstacles, they work together, form institutions, and endorse a collective efficacy that allows them to fight on their own terms. This is true bravery; in the refugees, I have met some of the bravest people in the world. 

PHOTOS COURTESY OF SOLOMAN KUAH, MD, MPH
The sidHARTe program will cover all program travel related costs incurred during the rotation. Details to follow upon sidHARTe program acceptance.

PROGRAM PURPOSE
To provide clinical training, process improvements, hands-on bedside teaching, and supervise clinical service delivery, using United States trained emergency physicians at the district level hospital in Ghana.

PROGRAM OBJECTIVES
With the support of GE Foundation and collaboration with the Ghana Health Service, we have developed a pilot project to provide technical knowledge transfer at Kintampo District Hospital and Mampong District Hospital for 3 years with United States trained Emergency Physicians service an of 6 week blocks (4-8 week blocks are also acceptable).

ELIGIBILITY
Emergency Medicine Resident Physicians must be in their third or fourth year of training at an accredited US program in Emergency Medicine by July 2008. For Emergency Medicine Attending Physicians, those who are board prepared or board certified in EM are welcome to apply.

PROCESS
Please email CV immediately with possible travel dates. You will receive an application materials on receipt of email. Physicians are asked to submit CV, a paragraph (delineating previous international experience) and two letters of recommendation—one of which must be from a program director if the applicant is an Emergency Medicine Resident Physician, addressed to Rachel Moresky, MD, MPH, FACEP. Please send all information to our Project Coordinator Beth Rubenstein, MPH, MBA via email at: sidharte@columbia.edu

APPLICATION PROCESS

Columbia University Medical Center/
NewYork-Presbyterian Hospital
International Emergency Medicine Fellowship

Reach your potential

2 year IEM Fellowship with MPH

More information at:
http://www.nypemergency.org/fellowships/int_eme.html?name1=International+Emergency+Medicine+Fellowship&type1=2Active
Meet your match... EMRA Residency Fair

If you are a medical student looking for the perfect residency program be sure to attend the EMRA Residency Fair!

EMRA Activities for Medical Students at Scientific Assembly in Boston!

**Saturday, October 3**
1:00 pm-5:00 pm  
**EMRA Medical Student Governing Council (MSGC) Meeting**  
Harvard, Marriott Copley  
What can you help accomplish as a member of this council? Come make a difference. All engaged medical students are encouraged to attend this meeting.

5:30 pm-7:30 pm  
**EMRA MSGC/EMIG Representative Mixer (by invitation)**  
VOX Populi, 755 Boylston Street  
Attend this fun and informal social opportunity to meet with other medical students, the MSGC officers, and EMIG representatives from around the country.

**Sunday, October 4**
3:00 pm – 5:00 pm  
**Hall B2, BCEC**

**EMRA Medical Student Forum**

*Which Type of Residency Program is Right for Me?*
Stephen Wolf, MD, FACEP – Denver Health Medical Center  
Grand Ballroom B, Westin Waterfront

*Common Mistakes Made When Applying to EM and How to Avoid Them*
Robert Rogers, MD, FACEP – University of Maryland  
Grand Ballroom B, Westin Waterfront

*Getting into the Residency of Your Choice*
Peter Deblieux, MD, FACEP – University Hospital, LSUHSC, New Orleans  
Grand Ballroom B, Westin Waterfront

*Interview Day Tips*
Peter Sokolove, MD, FACEP – University of California-Davis  
Grand Ballroom B, Westin Waterfront

*Medical Student Luncheon – Roundtable Discussion with Residency Programs*
Grand Ballroom D-E, Westin Waterfront

**EMRA Residency Fair, Hall B2, BCEC**
Do you know where you want to match? Attend the EMRA Residency Fair to help you scout out the more than 100 residency programs from around the country. Medical students cannot afford to miss this terrific opportunity to network with program directors, coordinators, and chief residents.
Step outside the ED to truly know your patients

“Are those eggs?”

I smiled to myself when a woman in the front of line posed this question to the slightly bemused server behind the counter. Her uncertainty was not uncommon in the hospital cafeteria in the early morning hours, and the eggs in question have certainly provided subject matter for many jokes.

Like most medical students, residents, faculty and staff, I had grown accustomed to lukewarm food of dubious origin. I knew what food to order at specific hospitals (and was grateful to the residents on my away rotation when they informed me of the covert late night tacos available if you knew which chef to ask). Of course hospital dining fare was not usually much of an issue on emergency medicine rotations as the only eating decisions that I had to make were what flavor of energy bar made an appropriate breakfast. Was it oatmeal raisin or perhaps yogurt peanut? Both breakfast foods in concept but...

Recently, when I was reading an issue of *Annals of Emergency Medicine*, these comical culinary musings took a more sobering tone. In the May issue of *Annals*, Robert Rodriguez led a case-control study at San Francisco General that examined the motivation for patients of specific demographics to present to the emergency department. The investigators interviewed 191 homeless enrollees as well as 63 control patients over the course of two non-continuous months, July and February.

They found that 29 percent of the homeless enrollees reported a desire for food, shelter, or safety as the primary reason for coming to the emergency department, as opposed to 10 percent of the control group. While there are a few limitations present in this interview-based study as the authors acknowledge, the results appear logically consistent with my own, albeit limited, personal experience.

The editors note that further studies will help determine if providing the lacking resources in a setting other than the hospital will decrease the strain on crowded emergency departments. However, as medical students, we have the opportunity and time to help provide these resources and serve our community as whole, regardless of the possible benefit to the emergency medical system.

I encourage you all to help out at a local soup kitchen, shelter or other resource center. The experiences in these venues help us all to develop not only as medical professionals, but also as individuals. Additionally, these experiences will help us to the community in a different way.

Most, if not all, shelters or soup kitchens have small, basic service clinics that need staffing—all of these settings need volunteers in both medical and non-medical roles. Consider both positions and listen closely to the people that you meet as you serve them bread or take their blood pressure. Their experiences and the struggles that they face living without stable shelter will enlighten and enrich you.

You may be surprised, and you will certainly be grateful for your own access to both hospital food and hospital medical care. I recently heard an emergency department chair say that emergency providers have one foot in the hospital and one foot on the streets. Take that step out and see what you find. Perhaps those scrambled eggs at the hospital cafeteria will even taste better.

John Anderson, MSIV
University of Colorado School of Medicine
Denver, CO
Medical Student Governing Council Chair
I am writing from Haxtun, Colo., where I have been for a month of rural family medicine as a third-year medical student. Haxtun is a town of roughly eight hundred people in the northeastern corner of the state.

Life is quite a bit different here, from what I’m accustomed to in Denver. There are two restaurants, a gas station, a small grocery store, and more wheat and cows than you can imagine. Despite this being a rotation in family medicine, and the town’s size, I had several very interesting experiences in emergency medicine during this month.

During my second night in Haxtun, a tornado touched down about six miles outside of town. While nothing in the town was damaged (besides the roof of my car from a fallen tree), the power went out for the rest of the night. The hospital usually has a generator, but it had recently been removed so that the hospital could upgrade to a new and improved generator. My apartment was part of the nursing home, attached to the hospital, so we were all left in the dark.

At about midnight on the night of the storm, I was paged to the “emergency room” to assist with the evaluation of a trauma patient. I grabbed my flashlight and stumbled downstairs to the hospital. When I arrived there were several nurses holding flashlights for the physician to conduct a trauma exam. He told me the patient had fallen down a flight of stairs and was complaining of a headache, chest pain and hip pain. I helped him finish his assessment, and then we stood in the dimly lit room to decide what options we had to further evaluate the patient.

Without electricity, there was no lab, no X-ray capabilities, no CT scanner, and no ultrasound. We did have a battery-powered monitor to record vitals and an EKG machine. The patient had a normal EKG, and the physical exam did not reveal any fractures or internal injuries. After completing the most thorough workup that we could, the patient was observed overnight and discharged the next day with no significant injuries.

Emergency medicine may be one of the few specialties that can be practiced in such diverse environments. From an urban Level 1 Trauma Center, to a five-bed hospital with no electricity in the middle of nowhere, to a developing country with even fewer resources than we had that evening in Haxtun. This is one of the reasons emergency medicine is so exciting. The options and opportunities to practice in this specialty are endless. Patients become acutely ill in every corner of the world and always at unpredictable times and in unforeseen circumstances. This makes emergency medicine exciting and challenging, as physicians must adapt to the circumstances as they present themselves.

My experiences in Haxtun make me excited for the future situations I will face as an emergency medicine physician—although I could have done without the fallen tree that ruined my car.

“The options and opportunities to practice in this specialty are endless.”
An overlooked, but crucial, piece of our education as medical students and residents is formal and informal feedback. Feedback is essential to developing expert performance\(^1\). Unfortunately, giving and receiving feedback is not an innate skill and takes practice and preparation.

**Preparation**

**Timing.** The ideal feedback should be delivered promptly, balance praise and constructive criticism, focus on behavior rather than personality and be done privately. These conditions are often out of the listener’s control, but knowing the ideal setting helps to set the stage for asking for feedback.

**Ask.** Be proactive about receiving feedback. Polite questioning about performance and areas to improve demonstrates enthusiasm and a desire to perform better. It also helps to discuss your goals ahead of time with your supervisor that way he/she will have specific points to discuss.

**Be ready.** Do not solicit feedback if you are not ready for it. Be in a state of mind that can actively listen and is open to suggestion.

**Active listening**

**Listen to understand.** Try to make sense of what the speaker is saying. Do not interrupt, but ask clarifying questions if necessary after the speaker has finished.

**No excuses.** Do not get defensive. You are ideally being evaluated on your actions. They speak for themselves. If you are in the unfortunate situation of getting mostly criticism, ask for specific examples and ways to improve. Take a proactive role in doing a better job next time. It is also ok to ask what you did well.

**Breathe.** Being picked apart by your attending or superior is stressful. Remember to keep your emotional cool.

**Say thank you.** Acknowledge the speaker for providing feedback. If you are upset, a simple “Thank you” is all that is required. If you are in a better mood, ask questions and make a plan to improve. If necessary, set up a time to meet again after improvements have been made.

**After**

**Process.** Try to understand the point the speaker was trying to make, because others may feel the same way. However, the beauty of feedback is that you can accept or reject it and the choice is entirely yours. Discussing the specifics with a colleague may help put things in perspective.

**Do not personalize.** Accept that you are an over-achiever, but can not do everything right. You are already a step ahead by soliciting advice to become better. Focus on changes in your future actions, rather than what you did wrong. \(\blacksquare\)

**Reference**


**Endnote**

With the current structure of medical education, it is easy for first and second year students to be immersed in lectures and books, losing sight of the ultimate goal of becoming a great clinician. Many students interested in emergency medicine have limited interaction with the emergency department staff before the third year of medical school. For that reason, the State University of New York Emergency Medicine Interest Group (EMIG) has sponsored annual events, such as training sessions in endotracheal intubation, IV access and ophthalmology as well as a lunchtime lecture series on a range of topics in emergency medicine.

The most recent program sponsored by our EMIG was a mass casualty incident (MCI) training event that brought together medical students with faculty and residents from the Department of Emergency Medicine at SUNY Upstate. With help from the SUNY Upstate EMS fellow Dr. John Lyng and several residents, this event was a great success.

The day began with a lunchtime lecture on the basics of MCI triage. Students learned about the background work and planning that occurs in order to properly manage an MCI. The students were also prepared for what was to come later that day: independently triaging patients in a mock MCI.

After the lunchtime lecture, the EMIG regrouped in the evening to simulate the scene of a bomb detonation in a classroom. Resident physicians opened the session with discussion about common injuries that a patient might sustain as a result of an MCI, such as pneumothorax, cardiac tamponade, and evisceration. Once students were equipped with the information from the lunchtime and evening lectures, they had the chance to put their knowledge into practice.

Student triage teams entered a chaotic room that simulated a disaster scene, complete with patients flopping themselves about and screaming for help. Trying not to be shocked by the life-like evisceration, or distracted by the yelling patient with blood dripping out of her ears (simulating ruptured tympanic membranes), the medical student team made their way about the room. One patient shouted for help and fainted around while another lay unconscious, with distended jugular veins and a deviated trachea.

As students moved throughout the scene, they continued to assess each patient within thirty seconds, making only brief, life saving interventions, and assigning triage tags to each patient. A major component of the exercise was to simulate the stress of a real MCI, and it is an understatement to say that the simulation was successful.

After the simulation the students gathered in a lecture room to discuss their experiences with the residents and fellow. Topics such as management of panicking patients and medical staff, management of one’s own emotions, and the proper delegation of resources were discussed.

With overwhelmingly positive responses from participating students, the exercise was a major success in several respects. First, it strengthened many students interest in emergency medicine. Second, it allowed students from all levels of medical education to begin to form relationships with the resident physicians from the emergency department. Third, it provided students with an introduction to disaster medicine.

With the growing interest in emergency medicine among SUNY Upstate medical students, and the devoted and supportive emergency department resident and attending physicians, we anticipate many more innovative and constructive academic forums from our EMIG.
Lookout for PTA in kids with sore throats

A thirteen-year-old girl complaining of sore throat for the last four to five days was brought into the emergency department by her parents. She had increased difficulty swallowing secondary to pain and was unable to open her mouth fully since this morning. On exam, she was febrile, but the other vital signs were within normal limits. She was noted to have a muffled voice, trismus, and cervical lymphadenopathy. When visualizing her oropharynx, the left tonsil was deviated inferiorly and medially past midline with displacement of the uvula to the right.

Peritonsillar abscess (PTA), formerly known as the ‘Quinsy tonsil,’ is a common deep tissue infection of the head and neck in all age groups. PTA can cause significant airway compromise in children, requiring prompt recognition and treatment. PTA develops when bacterial infection spreads through the capsule of the tonsil into the surrounding soft tissues, resulting in peritonsillar cellulitis or abscess formation. As such, many patients will have a history of antecedent strep pharyngitis, which in some cases may have worsened despite antibiotic treatment. Symptoms include progressively worsening sore throat, fever, dysphagia, or otalgia. Physical examination often reveals muffled voice, trismus, cervical lymphadenopathy, and tonsillar erythema—with swelling that is frequently unilateral and causes contralateral deviation of the uvula.

Peritonsillar abscesses typically require drainage and antibiotic therapy. Peritonsillar cellulitis typically requires only antibiotic therapy. Distinguishing between the two is difficult based solely on physical exam. Computed tomography (CT-scan) and intra-oral ultrasound are useful diagnostic modalities for characterizing location, edema, fluid collections, and proximity to vessels of the neck. Young and acutely ill children are unlikely to cooperate with either modality of imaging and require sedation. Compared to intra-oral ultrasound, CT-scans provide higher resolution imaging but have additional associated risks including radiation exposure and IV contrast. In patients with respiratory distress or signs of sepsis, it is essential to ensure airway protection, stabilize circulation, and then consider emergent imaging with otolaryngology (ENT) consultation. Children without airway compromise or signs of systemic illness typically require admission for observation and IV antibiotics. In these patients, imaging and ENT consultation may be reserved for those who fail medical therapy.

PTA is typically a poly-microbial infection, with an average of five organisms isolated per culture. Likely aerobic bacterial causes include Staphylococcus aureus, Streptococcus pyogenes, and Haemophilus influenzae. Anerobic bacteria causes include Prevotella, Porphyromonas, Fusobacterium, and peptostreptococci. Antibiotics should be chosen to provide...
coverage against aerobic, anaerobic, and beta-lactamase producing organisms. Appropriate initial antibiotics include cefoxitin, combined penicillin and beta-lactamase inhibitors, clindamycin, or carbapenems. Due to the possibility of poly-microbial infection and antibiotic resistance, fluid aspirates of abscesses, if obtained, should be sent for culture and antibiotic sensitivity.

The definitive treatment for PTA is drainage, either via needle aspiration or incision and drainage (I&D). Ninety-five percent of PTA cases in adults are treated with fine needle aspiration alone, with the remaining five percent requiring an I&D. Young children are more frequently managed operatively due to their inability to cooperate with drainage and/or when there are indications for a tonsillectomy (airway compromise, recurrent PTA).

Complications of PTA include airway obstruction, aspiration from abscess rupture into the oropharynx, erosion into the carotid artery, extension into the mediastinum, sepsis, cerebral abscess, and meningitis. Approximately ten percent of cases of PTA reoccur.

In this patient, she was made NPO, rehydrated, started on IV ampicillin/sulbactam, and admitted to the hospital for observation with ENT consultation—without requiring imaging or drainage. After 48 hours of IV antibiotics, her throat pain and swelling improved, and she was discharged to home with a 10-day course of oral amoxicillin/clavulanate.

**Pearls**
- Prompt recognition and airway management is critical in children with PTA.
- Consider PTA in patients with worsening throat pain despite treatment, trismus, or unilateral tonsillar enlargement.
- PTA is most often a poly-microbial infection with anaerobic and beta-lactamase producing organisms, thus penicillin alone provides inadequate coverage.

**References**

**Tuesday, October 6**
6:00 pm – 7:00 pm
Grand Ballroom C-E
Westin Waterfront

Come celebrate the history of EMRA at the Champagne and Cosmos 35th Anniversary Celebration!
Getting involved during residency is a daunting task. I spent most of the first two years of my residency avoiding projects and tasks because I was not “smart enough,” “needed to focus on reading/studying,” and “could not think of anything to do.” I delayed actively participating in my education with these excuses that are familiar to many residents. I now realize that being involved is a vital part of being a well-rounded physician and would like to share some of the lessons I have learned.

Lesson #1 – mentorship is essential to success.

Early in residency, I was burnt out from doing the same old thing. I was not actively involved in any projects, and it was my mentor who pushed me to take on my first real project of writing a chapter for an online publication. Even though this took a lot of time and effort, I learned a tremendous amount. This project helped to develop my interests and gave me something to focus on. In turn, the sense of accomplishment shocked me out of my complacency and gave me additional motivation.

I found that getting involved has effects beyond the immediate task. However, it is not enough to have any mentor. It is important to choose someone you are comfortable with, respect, and can emulate. They need to be willing to act as a sounding board, to provide insight, motivation, drive, and ideas that you may lack.

Lesson #2 – get organized; set goals and address what you want to accomplish.

I knew that faith, family and profession were the most important areas for me. Even though I knew that these were the
most important things, I found that I often failed to treat them as priorities. For example, I knew that regular reading was an essential element in my professional development, however my “To Do” lists were a mile long, and I found that my reading constantly took a back seat to the hundreds of other tiny tasks I needed to accomplish daily. Knowing your priorities is only the first step. We must place all of our most important tasks first, even if they are not the most urgent, then we will find there is plenty of room for all of the less significant tasks.

Lesson #3 – if something interests you or you have a question, pursue it.

Ralph Waldo Emerson wrote, “A man should learn to detect and watch that gleam of light which flashes across his mind from within, more than the luster of the firmament of bards and sages. Yet he dismisses without notice his thought because it is his. In every work of genius we recognize our own rejected thoughts; they come back to us with a certain alienated majesty.”

I first became interested in airway management, because I saw it was one of my weaknesses. Addressing a deficiency is a great way to find a niche. However, it wasn’t until I found out that a co-resident was also interested in airway management, that the idea was validated in my mind. I began working with this colleague on revising our residency’s airway curriculum. We spent our hard earned money to attend various airway courses and devoted vacation time to working on the curriculum. We compiled a basic airway manual for the junior residents, and are finishing a training curriculum for the senior residents. In addition to being able to pursue my interests, I found that—by working with a colleague—there was mutual motivation, accountability, and learning.

Lesson #4 – take risks and embrace failure.

At the end of my third year of residency, I chose to run for chief resident. I had finally learned that being involved has its benefits, and I did not want my fear of failure and my insecurity to block my personal development. I knew that I was capable of doing a good job, and I wanted the leadership experience. The decision to run was really a decision to face my fears, both of rejection and responsibility. Either way, the choice was formative and involved putting myself out there in a new, uncomfortable way that ultimately led to a great opportunity.

Lesson #5 – make lemonade.

As someone who has now become heavily involved in the residency, I have a new perspective on complaints. Every resident has complaints about their training. I now see each complaint as an opportunity to get involved. If you take this approach, there would be endless opportunities to be involved, develop your interest and grow.

“I now realize that being involved is a vital part of being a well-rounded physician and would like to share some of the lessons I learned.”
An unresponsive drug abuser

History
EMS brings you a 22-year-old white male found lying in bed unresponsive by a housemaid. Next to him was an ashtray completely full of burned oversized matches, a burned spoon and syringes on an adjacent nightstand. The patient was laying on his right side with his arm tucked under his head. He was last seen normal 24 hours prior. Electronic medical records indicate no drug allergies, current medications or significant past medical history.

Physical exam
Initial vital signs prior to intubation in the field were blood pressure 84/50, pulse 60 and irregular, respiratory rate 8, oxygen saturation 88%. His GCS was 3, and he had no gag reflex. Both pupils were dilated at 7mm. Respirations were shallow. His skin was cool, damp, and ashen in color. His right arm was grossly erythematous, tense to palpation, and pulseless.

Initial workup
CBC – WBC 24, HGB 16.3, PLT 280, 5% bands (normal is 0-8%)
Chem 10 – Na 141, K 8.6, Cl 104, CO2 17, BUN 20, Cr 3.3, Gluc 201
Blood Gas – pH 7.27, PCO2 28, PO2 292, HCO3 12.4
Urine Tox Screen – Positive for THC and opioids
INR – 2.57
Urinalysis – Myoglobin present; Trace protein and ketones
CK – 5,414 initially; 26,028 repeated one hour later.
LFTs – ALT 1789, AST 1514, GGT 158
ECG – wide QRS complexes preceded by flat p waves, depressed ST segments, T waves taller than the QRS complex, intermittent sign wave

CXR – No acute cardiopulmonary disease
Head CT without contrast – normal

Discussion
This patient became unresponsive after abusing marijuana and heroin. As a result of the pressure of his head on his arm for a prolonged period while unresponsive, he developed rhabdomyolysis. In rhabdomyolysis, muscle cells break down and release their intracellular components to the rest of the body which can cause damage to many organ systems. Etiologies include direct trauma or compression, certain drugs and toxins, especially sympathomimetics and statins. Other causes are infection, hypoxia, hyperthermia, physical exertion, high voltage electrical injuries and electrolyte abnormalities.

Rhabdomyolysis can result in hypovolemia, hyperkalemia, metabolic acidosis, acute renal failure and disseminated intravascular coagulation. Ultimately, multiple organ failure and death may result if appropriate therapies are not instituted in a timely fashion. Aside from establishing supportive care for airway, breathing, and circulation, there are specific therapies that should be considered for the complications of rhabdomyolysis.

Hypovolemia results from sequestration of fluids by damaged myocytes. This patient’s source of rhabdomyolysis was caused by focal pressure necrosis to his arm. The sequestration of fluids by the myocytes in this focal area resulted in increasing compartment pressures causing a compartment syndrome that required emergent fasciotomy.
The release of vasoactive and inflammatory substances from hypoxia and necrosis contributes to further injury and edema. Compartment syndrome necessitates emergent fasciotomy when compartment pressures are above 30 mm Hg. Also, fluid sequestration decreases intravascular volume requiring generous IV fluid replacement.

Hyperkalemia results directly from intracellular release by damaged cells. This patient’s severe hyperkalemia was associated with classical electrocardiographic changes, which tend to occur in a progressive fashion. First seen are peaked T waves, shortened ST segments, and ST segment depression and are followed by a widened QRS, increased PR interval, and flattened P waves. The P wave can disappear entirely, and a sine wave may develop. This rhythm can degenerate to ventricular fibrillation or asystole.

Hyperkalemia with ECG changes should be treated with IV calcium gluconate or calcium chloride serially until the myocardium is stabilized as witnessed by a normalized ECG. Treatment with calcium is a priority because it can prevent a potential cardiac arrest. IV sodium bicarbonate and IV insulin with glucose can be given to shift potassium intracellularly. Oral or rectal sodium polystyrene sulfonate and IV furosemide should be used to increase the excretion of potassium; however, adequate fluid resuscitation should precede furosemide therapy. If severe acute hyperkalemia is refractory to the aforementioned treatments, emergent hemodialysis is indicated.

Metabolic acidosis can develop from the release of intracellular components such as phosphate and sulfate. If pH decreases below 7.1, IV sodium bicarbonate may be beneficial. Most importantly, the cause of the metabolic acidosis should be treated. Correcting a severe metabolic acidosis is important because of an increased risk of dysrhythmias at a lower pH.

Acute renal failure is secondary to myoglobin precipitation in renal tubules. Urinary alkalization by adding sodium bicarbonate to maintenance fluids prevents and treats this form of acute renal failure. After adequate IV fluid resuscitation, IV mannitol and furosemide help maintain adequate urine output.

Rhabdomyolysis is a potentially fatal but often treatable syndrome, and clinicians should keep a high level of suspicion for it. When managing these cases, it is important to consider the numerous sequelae: compartment syndrome, hypovolemia, hyperkalemia, metabolic acidosis, acute renal failure, and possible DIC leading to subsequent multiple organ failure. The patient in this case survived after a lengthy and intensive hospitalization.

**References**

Definitive treatment for PE controversial

Pulmonary embolism (PE) is a major source of morbidity and mortality among patients with all varieties of pathologic diseases involving other systems of the body. There are many important considerations when treating PE in the acute setting. Even though most patients who present with PE are stable, there is a small subset of patients who are in medical extremis. Immediate diagnosis is paramount so that drastic treatment options can be undertaken as quickly as possible.

In the stable patient, an echocardiogram, ultrasound (U/S) or CT angiogram of the chest can be obtained. However, in the critical patient, this is not always an option. Difficult questions arise when a patient has signs of right ventricular dysfunction, but still has a systemic blood pressure, described in the literature as a “submassive PE”4. Following initial stabilization of airway, breathing, and circulation, critical decisions need to be made quickly in the deteriorating patient.

The hallmark in the treatment of PE is anticoagulation. It has been convincingly shown to decrease morbidity and mortality5. The earlier therapy is begun with low molecular weight heparin (LMWH) or unfractionated heparin (UFH), the less likely the clot will propagate.

A chest x-ray and bedside U/S can assist in early administration of these drugs. A chest x-ray that shows clear lung fields and no widened mediastinum can help narrow the differential diagnoses. A bedside U/S to look at the abdominal aorta ensures that a leaking abdominal aortic aneurysm is not being missed. A bedside echocardiogram can prove that there is no pericardial effusion making aortic dissection unlikely. Furthermore, it can be used to visualize the right ventricle and evaluate its function.

Arterial blood gas results that show a significant Alveolar-Arterial (A-a) gradient can further bolster the diagnosis of PE. In the stable patient, confirmation of the clot with a CT angiogram of the chest is useful. Lastly, an ECG helps to rule out an ST elevation MI in this setting of hemodynamic compromise.

LMWH is cost effective and has better long term outcomes when compared to UFH. However, if surgical therapy is necessary, UFH can be reversed with protamine, unlike LMWH. This approach is used for unstable patients or those teetering on the edge of complete hemodynamic compromise. LMWH or UFH prevent worsening, but do not treat the clot.

Unfortunately, definitive treatment for unstable patients with a confirmed clot is controversial. Historically, patients would be taken to the OR for an open thrombectomy. This required the patient to be placed on cardiopulmonary bypass,
which was time consuming to setup. Generally, sick patients never made it to the OR prior to cardiopulmonary arrest. Some recent data, however, has shown improved results with an 89% survival rate for open thrombectomy.

Another treatment option is systemic thrombolysis using intravenous recombinant Tissue Plasminogen Activator (rTPA). Many exclusion criteria exist and radiologic evidence of PE is highly recommended prior to its use. In the emergency department, this drug has the potential to save lives; however, it can also have devastating consequences. However, it can also have devastating consequences. In one study, rTPA given to patients with emboli large enough to cause decompensation reduced mortality by 55%2. The risk/benefit ratio has to be assessed for each patient.

With the surge of interventional procedures, intra-arterial rTPA injected at the site of the clot is an emerging option. This was first used in the realm of acute blockages in the carotid peripheral arteries, but is now becoming more common for the pulmonary vessels. With this type of intervention, the survival rate can be up to 83%3.

The evidence of improved outcomes of systemic thrombolitics versus open thrombectomy is not compelling. It has been shown to have some complications independent of the underlying PE. Currently, patients receiving systemic thrombolitics who fail treatment receive a catheter embolectomy with some encouraging results2. In the crashing patient, this is the quickest way to achieve clot removal.

In summary, early recognition of PE presenting with ongoing or impending cardiovascular collapse is critical. After taking all risks and benefits into account, appropriate emergent treatment can improve survival in these patients.

References

Looking for the perfect job?

Find it at the

Monday, October 5th
5:00 pm – 7:00 pm • Hall B2, BCEC

Fellowship/Academic
Baylor College of Medicine
Boston EMS Fellowship
Brigham & Women’s Hospital
Brody School of Medicine at Eastern Carolina University
CAL/ACEP Health Policy and Advocacy Fellowship
Emergency Ultrasound Fellowship at Christiana Care
Emory University Ultrasound Fellowship
Loma Linda University Medical Center
Long Island Jewish Medical Center
Maryland Emergency Medicine Network
MedStar Health – Washington Hospital Center
Mount Sinai Hospital, Chicago
New York Hospital Queens
Oregon Health & Science University
Penn State - Milton S. Hershey Medical Center
R. Adams Cowley Shock Trauma Center
Resurrection Medical Center – Ultrasound Fellowship
SUNY Downstate/Kings County Hospital
The George Washington University
UCSF Fresno Emergency Medicine University Hospitals
University of California, San Francisco – San Francisco General Hospital
University of Kansas Hospital & Medical Center
University of Pittsburgh
University of Virginia Health System
William Beaumont Hospital

International
Global Medical Staffing
Health Force Ontario
VISTA Staffing Solutions

North Central
4M Emergency Systems, Inc.
Allen Health System/Iowa Health System
ApolloMD
Aurora Health Care
Avera McKennan Hospital BestPractices, Inc.
Canton Aultman Emergency Physicians
CEP America
EmCare, Inc.
Emergency Consultants, Inc.
Emergency Medicine Physicians (EMP)
EPMG
Genesis Healthcare System
Henry Ford Health System
Infinity Health Care
Lafayette Emergency Care
Luther Mifflint - Mayo Health System
Memorial Hospital - Belleville, IL
Ministry Health Care
Premier Health Care Services, Inc.
Qualified Emergency Specialists, Inc.
StaffCare
Team Health
Teed & Company
Trinity Health

North East
ApolloMD
Bassett Healthcare
BestPractices, Inc.
Caritas Christi Health Care
Central Vermont Medical Center
Committee of Interns and Residents/SEIU
CompHealth
Concord Emergency Medical Association
Eastern Maine Medical Center
EmCare, Inc.
Emergency Consultants, Inc.
Emergency Medical Associates (EMA)
Emergency Medicine Associates, PA, PC
Emergency Medicine Physicians (EMP)
Emergency Resource Management, Inc.
Emergency Service Associates
EPMG
Geisinger Health System
Greater Nashua Emergency Physicians
Maryland Emergency Medicine Network
MedExcel USA, Inc.
MedStar Health – Washington Hospital Center
MEP
Mercy Hospital – Portland, ME
New York Community Hospital
Phoenix Physicians, LLC
Physicians’ Practice Enhancement, LLC
Pinnacle Health System
PracticeMatch Services
Saratoga Hospital
St. Joseph Hospital – Bangor
St. Joseph’s Hospital Health Center
StaffCare
Team Health
Teed & Company
The Reading Hospital Medical Group
TIVA Healthcare, Inc.
UMass Medical School
Upstate New York Physician Recruiters
Vassar Brothers Medical Center
VISTA Staffing Solutions
EMRA Job Fair!

South Central
C & M Medical Services (LSU-Baton Rouge)
Carondelet Emergency Physicians
CEP America
Cornerstone Physicians Management Group, LLC
Cox Health
EmCare, Inc.
Emergency Consultants, Inc.
Emergency Medicine Physicians (EMP)
Emergency Physicians of St. Louis, Inc.
Emergency Service Partners
Greater Houston Emergency Physicians
Greater San Antonio Emergency Physicians
Hospital Physician Partners
Midwest Emergency Physicians, LLC
PSR
Questcare Partners
Schumacher Group
Scott & White Healthcare
Team Health

South East
ApolloMD
BestPractices, Inc.
Carolina Emergency Medicine
CEP America
Commonwealth Emergency Physicians
CompHealth
EmCare, Inc.
Emergency Consultants, Inc.
Emergency Medicine Physicians (EMP)
Emergency Physicians of Tidewater Emergency Services Network
EmergiNet
EPMG
ER Med
Florida Emergency Physicians
Hospital Physician Partners
Jackson & Coker
Mid-Atlantic Emergency Medical Associates
Peninsula Emergency Physicians, Inc.
Phoenix Physicians, LLC
Premier Health Care Services, Inc.
Schumacher Group
Sheridan Healthcare, Inc.
Southwestern Emergency Physicians
StaffCare
Suburban Emergency Physicians
Team Health
Teed & Company
TIVA Healthcare, Inc.
Trover Health System

Western
CEP America
CompHealth
EmCare, Inc.
Emergency Medicine Physicians (EMP)
Emergency Professional Services, PC
Empower Emergency Physicians
HEPA, Inc.
JJ&R Emergency Medical Group, Inc.
Kaiser Permanente
Salem Emergency Physicians Service
Schumacher Group
Sutter Emergency Medical Associates
Team Health
Valley Emergency Physicians
VISTA Staffing Solutions

Membership includes
Free stuff: Members receive free publications in print and online. Plus, receive discounts on products, publications and meetings, exclusive access to great Web content, career and financial planning guides.
- EM Resident
- EMRA Antibiotic Guide
- EM: RAP and Emergency Medicine Abstracts
- EMRA’s Career Planning Guide
- The Medical Student Survival Guide
- Pediatric EM Practice Online
- EM Practice Online

Career planning: EMRA can help you get into the emergency medicine residency of your choice, survive and thrive during your residency, and succeed after your training with resources to help you land the ideal job.

Clinical & practice tools: Learn about reimbursement issues, contracts, clinical problems and access case studies in EM with your membership. And, develop life-long skills in advocacy and health policy.

Access to www.emra.org: The EMRA Website is full of resources specifically for EM residents & students, including job listings, leadership opportunities, archives of advocacy, clinical, and financial articles.

Leadership development opportunities: Become active within organized medicine and help shape your field. Numerous committee, board and council positions are available.

Scholarships, grants, and awards: EMRA provides several scholarships, grants, and awards that are available only to EMRA members.

Friends & community: Get to know others who share your passion for emergency medicine, talk about residency life and plan for a future in this specialty. You’ll benefit from many opportunities to develop your leadership potential.

To join, call 1-866-566-2492, touch 5
www.emra.org

*Confirmed exhibitors as of 9/8/2009
EMRA gratefully acknowledges these organizations for their generous support of the many EMRA activities during Scientific Assembly.
# EMRA Activities at Scientific Assembly

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Friday, October 2</strong></td>
<td>9:00 am – 5:00 pm</td>
<td>EMRA Board of Directors Meeting</td>
<td>Berkeley, Marriott Copley</td>
</tr>
<tr>
<td></td>
<td>11:00 am – 11:50 pm</td>
<td>The Mechanics of the Job Search</td>
<td>Room 210A, BCEC</td>
</tr>
<tr>
<td><strong>Saturday, October 3</strong></td>
<td>1:00 pm – 5:00 pm</td>
<td>EMRA Medical Student Governing Council (MSGC) Meeting</td>
<td>Harvard, Marriott Copley</td>
</tr>
<tr>
<td></td>
<td>12:00 pm – 1:00 pm</td>
<td>Financial Planning for Young Physicians</td>
<td>M. Shayne Ruffing, CLU, ChFC, AEP</td>
</tr>
<tr>
<td></td>
<td>7:00 pm – 10:00 pm</td>
<td>EMRA Board of Directors Meeting</td>
<td>Suffolk, Marriott Copley</td>
</tr>
<tr>
<td><strong>Sunday, October 4</strong></td>
<td>7:00 am – 8:00 am</td>
<td>EMRA Board of Directors Meeting</td>
<td>Suffolk, Marriott Copley</td>
</tr>
<tr>
<td></td>
<td>10:00 am – 10:50 am</td>
<td>Taking Care of Business: What You Should Know about Fair Business Practices and Contracts</td>
<td>Todd Taylor, MD, FACEP and Joseph Wood, MD, JD, FACEP</td>
</tr>
<tr>
<td><strong>Monday, October 5</strong></td>
<td>8:00 am – 8:50 am</td>
<td>Welcome Reception and Bloody Mary Breakfast</td>
<td>Joshua Moskovitz, MD, MPH, EMRA President</td>
</tr>
<tr>
<td></td>
<td>9:00 am – 9:50 am</td>
<td>Regional Job Market Breakouts</td>
<td>North: Kathleen Cowling, DO, FACEP and Nick Jouriles, MD, FACEP</td>
</tr>
<tr>
<td><strong>Tuesday, October 6</strong></td>
<td>8:00 am – 8:50 am</td>
<td>Interview Day Tips</td>
<td>Peter Debilieux, MD, FACEP</td>
</tr>
<tr>
<td></td>
<td>12:00 pm – 1:00 pm</td>
<td>Medical Student Luncheon Roundtable Discussion with Residency Programs</td>
<td>Grand Ballroom D-E, Westin Waterfront</td>
</tr>
<tr>
<td></td>
<td>1:00 pm – 2:00 pm</td>
<td>EMRA Representatives to ACEP Committees Meeting</td>
<td>MIT, Marriott Copley</td>
</tr>
<tr>
<td></td>
<td>2:00 pm – 3:00 pm</td>
<td>EMRA Residency Fair Exhbitor Registration</td>
<td>Hall B2, BCEC</td>
</tr>
<tr>
<td><strong>Wednesday, October 7</strong></td>
<td>10:00 am – 12:00 pm</td>
<td>EMRA Board of Directors Meeting</td>
<td>Otis, Westin Waterfront</td>
</tr>
<tr>
<td></td>
<td>12:00 pm – 1:00 pm</td>
<td>EMRA Leaders Transition Luncheon (by invitation)</td>
<td>MJ O’Connor’s, Westin Waterfront</td>
</tr>
<tr>
<td></td>
<td>1:00 pm – 3:00 pm</td>
<td>EMRA Committee Meetings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3:00 pm – 6:00 pm</td>
<td>EMRA Board of Directors Meeting</td>
<td>Otis, Westin Waterfront</td>
</tr>
</tbody>
</table>
Your training will leave you with great knowledge and with even greater responsibility.

If you are a new resident in Emergency Medicine, welcome to the Emergency Medicine family! If you are continuing on that journey to the label that says, “residency trained,” congratulations on making it another year. All of you have more years of endless work, sleepless nights, constant studying, and stress to look forward to...but at least you can enjoy Scientific Assembly!

Of course, you knew coming in the sacrifice involved and the commitment necessary to become an emergency physician. You were aware that it would take years off your life and leave you still owing your medical school debt. And yet...you signed up anyway. In fact, you begged to be trained in our forty-year-old specialty.

And yet...you signed up anyway. In fact, you begged to be trained in our forty-year-old specialty.

You chose emergency medicine because you hear a call, and answering that call revealed that you don’t just see this as a profession. From now on, “ER Doc” won’t just be a title you’ll hold, it will be a part of who you are – a healer, a savior of life. No matter where you are, no matter what you are doing, you will be the first to hear the siren, the first to run to the victim of a mishap, the one who answers the call, “Is there a doctor on board?”

This is a good thing. I mention it not to add to the burdens that must already weigh heavily on your shoulders, but to point out that your distinct commitment and compassion for the lives of your fellow human beings is a quality that has intrinsic value far outside the trauma room or the cardiac bay.

It is because of this quality that I want to ask something of you.

Life often happens in a way that makes it easy for us to miss the larger obligations we have toward one another. The demands of work, time, and money tend to narrow our focus and cause us to turn inward. We might flip on the news or pick up the paper, or in your case, go to the Web, and feel moved by a story about an earthquake in China or the AIDS epidemic or the fifteen-year-old gunned down in front of his house. We may even feel compelled to do something about it. But inevitably, it becomes time to study for the boards, or go to work, or cook dinner, or put the kids to bed – and so we turn away from the big stuff and concentrate on simply surviving the small.

This is human and perfectly understandable, yet the survival of our country has always demanded more. It has required ordinary men and women to look beyond their own lives, to think about the larger challenges we face as a people, and then rise to meet them. This is what I’d like to ask you to do today.

In a few months or years, your residency training will come to an end. On a daily basis, you will encounter patients with every imaginable disease and ailment. There will be gunshot wounds and car wrecks and strokes. There will be rare diseases and common ones...and after awhile, you will encounter another, more pervasive affliction that affects more than just individual patients. Perhaps you will first notice it when you have to tell a patient that he needs a life-saving procedure that his insurance will not cover and his family cannot afford. Perhaps it will be when you provide a “medical screening exam,” but then cannot treat a patient until he pays. Perhaps it will be when a patient dies waiting to see you because your emergency department is so crowded.

At some point, you’ll see firsthand that there is something fundamentally broken about our health care system. You’ll realize that for millions and millions of Americans, the care you provide is becoming far too costly for them to afford. Then you’ll have to decide what, if anything, you’re going to do about it.

You’ve heard the statistics:

• 47 million Americans are uninsured.
• 5 million more became uninsured in the last 5 years.
• Family health insurance premiums are up by 65%.
• Insurance deductibles are up 50%.
Add to these the fact that the economy is in critical condition, too. Unemployment is in the double digits. From the smallest mom-and-pop stores to major corporations like GM, businesses are cutting back on insurance, workers, or both. States with bigger Medicaid bills and smaller budgets are being forced to choose whether they want their citizens to be unhealthy or uneducated. Over half of all family bankruptcies today are caused by medical bills.

This is affecting your profession, too. Whether it’s Medicaid reimbursements, the rising price of medical malpractice insurance, or having insurance companies look over your shoulder, all the hard work and sacrifice you put in during your training is becoming less rewarding than it once was.

So today I ask you to be more than just practitioners of medicine; I ask you to be advocates for medicine. I ask you to be advocates for a health care system that is fair, that is just, and that provides every single American with the best your specialty has to offer.

Just like generations before, you must dare to believe — not only as tomorrow’s physicians, but as tomorrow’s parents, workers, business owners, and yes, patients. You must choose: Will the medical miracles you perform over the next generation reach only the luckiest few? Or will history look back at this moment as the time when we finally made care available at a cost that we can afford?

There isn’t one person reading this today who wants to turn a sick patient away because they can’t pay. Not one person wants the care they deliver denied to those whose lives depend on it.

You dedicated yourself to this profession because where there is illness, you want to cure. Where there is injury, you want to heal. Your training will leave you with great knowledge and with even greater responsibility.

We can solve this problem. Challenging as it may seem, political leaders and business owners and members of the medical profession are coming up with new and different ways to improve quality and hold down costs in our health care system. In Massachusetts, they have 97% of their citizens covered with health insurance, but that didn’t increase the availability of primary care physicians, and emergency department visits have increased by 9%. Hawaii has an innovative approach to health care funding that provides care for everyone, but taxes have increased by more than 18%.

This is why we need you. We need you to dream; we need you to speak out; we need you to act. Together, we can build a health care system in this country that finally works for every American.

We can have a system where no matter how many times you switch jobs or how large or small your employer is, you have a health care plan that stays with you forever.

We can have a system that reduces medical error and cuts costs by using 21st Century technology.

We can have a system of evidence-based health care that shares information about what works and what doesn’t, so we can actually provide patients with the care they need when they need it.

We can have the largest registry of emergency medical information that has ever existed and we can insure that emergency care is there when you need it, every time you need it.

We can do all of this — but we need your help to get it done.

Of course, no one’s forcing you to meet these challenges. Each of you has been blessed with extraordinary gifts and talents. If you want, you can finish your residency, focus on your own medical career and your own success and not give another thought to the plight of the growing millions who can’t afford the care you will provide. After all, there is no community-service requirement in the real world. No one is forcing you to care.

But I hope that you do. I hope that you care, not because you have a debt to all of those who helped you get where you are, although you do have that debt. I hope that you care, not because you have an obligation to those less fortunate, although you do have that obligation. You need to take on the challenges that your country is facing because you have an obligation to yourself. It is only when you commit something larger than yourself that you will realize your true potential.

I know that my hope is well-placed. With the field you have chosen, you’ve already shown how much you care about the lives of others; how strongly you have heard the calling to be healers in this world. Today, I ask you to remember that call always, and to remember how it could include more than the patient sitting in your waiting room or lying on a gurney in the hallway. It could also include the patients who can’t afford to get there, the ones who aren’t being provided the best care, and the general health of all Americans.

When you think about these challenges, I also ask you to remember that in this country, our history of overcoming the seemingly impossible always comes about because individuals who care really can make a difference.

A century ago, who would have dared to believe that in just one hundred years, we would add thirty years to the average lifespan and witness a 90% drop in the rate of infant death? Who would have dared to believe that with a simple vaccine, we could eliminate a disease that left millions without the ability to walk? That we could transplant a heart or resuscitate one that stopped? That we could unlock the greatest mysteries of life from the most basic building blocks of our existence?

In a time when you were lucky to live past fifty and doomed if you came down with the flu, who would have dared to believe these things?

The doctors who came before you did. They believed that in America, the most improbable of all social experiments, the place where we continue to defy the odds and write our own history, that they could be the ones to improve, extend, and save human life.

Just forty years ago, who would have dared to believe that there would be a specialty dedicated solely to the emergency patient? That there would be a body of medical knowledge devoted to acute care?

The doctors who came before you did. That small group of physicians who joined Dr. John Wiegenstein to create our specialty did.

Just twenty years ago, who would have dared to believe that emergency physicians could be more than itinerant workers? That “ER docs” could be respected members of the medical community, called upon for their expertise and clinical acumen?

The doctors who came before you did. I did. As you leave Boston, headed home to your own life, you can keep this history alive if you only find the courage to try. Good luck with this journey, congratulations on all of your achievements, and thank you for the good that you will do.
Pediatrician returns to residency to do what she loves

For many, residency can be a long, arduous rite of passage. Moving to a new city, learning a new set of skills, and trying to fit a personal life into an 80-hour work week seems almost impossible. So how could anyone possibly do it twice? Ask Dr. Martha Linker, a PGY-4 resident at the Hospital of the University of Pennsylvania. By this December, she will have completed two residencies—one in emergency medicine and another in pediatrics.

“I enjoyed pediatrics and I like to think that I’m reasonably adept at its practice,” said Linker, who trained at the Medical University of South Carolina’s pediatrics program from 2000 to 2003. “But in the end, I knew something was missing. Emergency medicine is a much better fit for my personality and academic interests.”

Coming to that realization was not easy and took some time, according to Linker. As a board-certified pediatrician, she worked as a clinical instructor in the Adolescent Medicine Division at MUSC, providing care and outreach to teen mothers and students at Burke High School and the College of Charleston.

Despite the rewards of her new position, Linker still felt there was a medical specialty out there for which she might be better suited.

“I realized that throughout my pediatric residency, I was drawn to and enjoyed taking care of the sickest patients,” said Linker, a graduate of Vanderbilt University Medical School. “I thought back to all the rotations that I had enjoyed in medical school and realized I had loved emergency medicine.”

While Linker’s decision to switch specialties came after completing residency, others have made the decision sooner. From 2006 to 2008, the National Residency Match Program received 67 waiver requests from applicants who wanted to change specialties before starting residency, according to executive director Mona Signer.

Others make the decision to switch during their residency. Reasons may include no exposure to an EM residency program at their own medical school or gaining that exposure in the 4th year when they’ve already committed to a specialty, according to Dr. Francis DeRoos.

“Working clinically during internship often makes physicians realize how much they enjoy caring for people with symptoms rather than patients who have already been labeled and worked up,” said DeRoos, residency program director at the Hospital of the University of Pennsylvania.

Naturally, Linker’s first instinct was to pursue a pediatric emergency medicine fellowship, thus combining her background in one field with her passion in another. The marriage of the two specialties seemed ideal at first, but Linker found herself stalling when it came down to filling out the applications.

“As I was getting my application ready for pediatric emergency medicine fellowships, something still didn’t seem quite right,”
Linker said. “Then, my father died suddenly and quite unexpectedly just as I was telling myself to buckle down and get these applications done.”

The death of her father caused Linker to take a step back and re-evaluate her reasons for more training. Did she want to refine her skills as a subspecialist but limit her patient population? Or did she want to expand the scope of her practice but start residency all over?

Deciding to follow her heart, Linker chose the latter and dove into applying for emergency medicine residencies. What she found was a new set of challenges awaiting her.

“Some programs were hesitant about people with prior training due to concerns that these people would already have developed a practice pattern and be more stubborn or difficult to teach,” Linker said. Other programs were skeptical about her willingness to go through another intern year, but Linker assured them she knew what she was bargaining for.

On the interview trail, Linker also encountered residency programs that welcomed the idea of training someone from another specialty. According to DeRoos, hiring doctors with a different background is “a great way to increase the intellectual diversity of the program and bring a fresh, mature perspective.”

In 2006, Linker brought that perspective to the Hospital of the University of Pennsylvania as a brand new emergency medicine resident. Almost four years later, Linker is on the cusp of completing her second residency and happy with her decision. Furthermore, her background in pediatrics helped her immensely along the way, especially with caring for adolescents.

“They are developmentally beyond the toys and paintings in a children’s hospital but also can feel out of place and intimidated by the adult emergency department environment,” Linker said. “My experience with this group definitely helps me to be more in tune to their unique situation.”

In December, Linker will join the clinical faculty of Wake Forest University, splitting her time between a dedicated pediatric emergency department and an adult emergency department.

“More time training can seem very daunting at the outset,” Linker said. “That has been a small price to pay for all that I have gained—primarily peace of mind knowing that I am on the right career path and looking forward to the future.”

The Emergency Medicine Foundation (EMF) and Emergency Medicine Residents’ Association (EMRA) are pleased to announce one of the EMF/EMRA Resident Research Grantees for the 2009-2010 year, Stacey House, MD, PhD. Dr. House is a third year resident at Washington University in St. Louis, MO. She was awarded $5,000 to develop a human recombinant FGF2 as a possible therapeutic agent to protect the myocardium during acute myocardial infarction. David Ornitz, MD, PhD will serve as her mentor.

Dr. House states that the grant writing process has allowed her to identify her research interests, develop research ideas, and seek out mentorship from a variety of physicians and researchers. In addition, the grant program’s sponsorship of grant workshops and ACEP’s Scientific Assembly will help develop her knowledge of emergency medicine research and ability to obtain future funding.

Dr. House looks forward to a career in academic emergency medicine combined with clinical care and clinically relevant basic science/translational research. She says “thank you for EMF and EMRA’s focus on helping to develop emergency medicine researchers early in their careers, so that the field of emergency medicine research can continue to expand and grow.”

If you are interested in applying for an emergency medicine research grant, please go to www.emfoundation.org or contact the Emergency Medicine Foundation by calling (800) 798-1822. Grant deadlines are Tuesday, January 12, 2010.
Plan for success!

My Friends,

You should be receiving this in early October. Your Scientific Assembly is at hand and with it the opportunity to get out of the emergency department and find out what is going on around the country. I encourage you to spend some brief time catching up on various topics of interest. If you only have ten minutes to think about your finances, here are the things that I would like for you to know:

The basics

Cash savings
Money market accounts remain an effective cash savings vehicles. Look outside of your bank to brokerage or online accounts for higher yields as well as complete mobility of services. I strongly recommend starting a monthly draft in to your savings account to build your cash reserves.

Disability income protection
The disability market is competitive with three insurance companies offering true own occupation/specialty specific contracts for emergency physicians, in most states. If you are in your final year of residency, make sure you start to evaluate disability protection prior to signing a contract. Two carriers may penalize you if you have already committed to a future practice or hospital. IMPORTANT: If you have health complications that will make insurance difficult to obtain, find out what provisions your house staff disability might have for non-medical conversions.

Life Insurance
After several years of being overly competitive, the life insurance industry has reacted to the global economic climate by gradually increasing insurance costs and reducing dividend yields. If you anticipate changes in the foreseeable future that will dictate the acquisition of life insurance, start to take a look at this now. Residents are most often best suited for term life insurance and these types of contracts have long term guaranteed premiums. Lock in the rate NOW!

Estate planning
If you own stuff, have a will. If you have children, include Guardian and Trustee provisions. It is a lot easier to make estate decisions while you are still alive….

Growth

Retirement planning
Please, please understand the advantages of investing in a Roth IRA. As residents, you are in the lowest income tax bracket that you are likely to ever be in. Use it to your advantage! If
“After several years of being overly competitive, the life insurance industry has reacted to the global economic climate by gradually increasing insurance costs and reducing dividend yields.”

you follow anything that is going on in Washington, you will understand the likelihood of higher taxes and inflation over the next stage in your career. If you can contribute more than the federal limit for Roth IRA’s, enroll in your house-staff 403(b) and get a dollar for dollar tax break as you fund your future.

**Strategy**

**Tax review**
Recent legal activity in the state of Minnesota has brought the potential for residents to be exempt from FICA back in the limelight. Keep an eye on this by occasionally googling “FICA for Medical Residents”. Why should you care? If the IRS formally recognizes residents as students, you get an automatic 7.5% pay raise by not having to contribute to the FICA system.

**IRA strategy**
Talk to your tax advisor or financial planner about the conversion opportunity in 2010. For that year only, there will be expanded opportunities to convert future taxable retirement funds in to Roth funds. You pay taxes as you convert, but that may be very advantageous if you will still be in residency or be in your transition year in 2009 or 2010.

Anything more and this article will be too lengthy. I wish you well and hope that you find value in this information.

Best Wishes and safe travels, if you are heading out to Boston.

---

**Shayne Ruffing, CLU, ChFC, AEP**

is the creator of the Confident Transition Plan™ for medical residents, the Physician Disability Income Analyzer™ and the Physician’s Financial Navigator™. Shayne specializes in executive benefit planning for physicians and medical practices. He can be reached at 800.225.7174, or via e-mail at shayne@mybpginc.com or on the web at www.IntegratedWealthCare.com.

Shayne is an Financial Advisor offering Securities and Advisory Services through NFP Securities, Inc., a Broker/Dealer, Member FINRA/ SIPC and Federally Registered Investment Advisor. The Benefit Planning Group is not an affiliate of NFP Securities, Inc.

---

Congratulations 2009 EMRA Fall Award Recipients

**AUGUSTINE D’ORTA AWARD**

Underwritten by Augustine D’Orta Foundation
Ravneet Dhillon, MD
University of Rochester

**CLINICAL EXCELLENCE AWARD**

Underwritten by Teed & Company
LCDR Lanny Littlejohn, MD
Naval Medical Center – Portsmouth

**EXCELLENCE IN TEACHING AWARD**

Underwritten by EmCare
Ryan Armstrong, MD, M.Ed.
Emory University

**LEADERSHIP EXCELLENCE AWARD**

Underwritten by Florida Emergency Physicians
Christian Coletti, MD
Christiana Care Health System

**LOCAL ACTION GRANT**

Sarah Jamison
Kings Against Violence Initiative
SUNY Downstate College of Medicine

**MENTORSHIP AWARD**

Underwritten by Kristin Harkin, MD, FACEP
Kjell Lindgren, MD, MPH
University of Texas Medical Branch/ NASA Johnson Space Center

**JOSEPH F. WAECKERLE FOUNDER’S AWARD**

Peter Sokolove, MD, FACEP
UC Davis Health System
1. “All of my pediatric patients with DKA have high WBC counts. How can I tell which patients to work up and treat for infection?”

Elevated WBC counts are common in patients with DKA and can be caused by the DKA process itself rather than by a true infection. The clinician should base the evaluation and treatment on clinical findings suggestive of infection rather than on an isolated WBC count.

2. “This child is always here for DKA. It’s clear the parents are incapable of properly caring for her.”

In addition to parental neglect, there are other important reasons for patients to present with frequent DKA. Insulin pump failure is a common reason for readmission among patients with known diabetes. Inability to access proper medication can be a treatment barrier that is difficult to overcome. Finally, some teenage patients may be skipping insulin doses in order to lose weight.

3. “The patient had a normal score on the Glasgow coma scale. I don’t understand how I missed cerebral edema.”

The Glasgow coma scale is not a sensitive marker for cerebral edema. The key to prevention is frequent reevaluation, with focus on ANY neurologic changes. A potential diagnostic strategy is shown in the ED Evaluation section of this article.

4. “I have been treating this patient for hours, and his blood glucose level will not budge.”

In this situation, it is important to consider comorbidities such as infection that may prevent appropriate lowering of glucose levels despite adequate insulin dosing. Alternatively, pharmacy errors or errors in administration may be the cause of static serum glucose levels.

5. “My pediatric patient with DKA is hyponatremic.”

DKA causes a pseudohyponatremia. Fluid shifts from the cell cause dilution of the serum sodium concentration, leading to the impression of a low serum sodium level. With correction of the serum glucose level, the serum sodium value will likely increase. Infection in chemotherapy-induced neutropenia is a significant cause of morbidity and mortality. Prompt initiation of broad-spectrum antimicrobials can significantly improve the outcome in these patients. Empiric parenteral antibiotic therapy (eg, ceftazidime, cefepime, or meropenem with or without vancomycin) should be initiated to cover S aureus, P aeruginosa, E coli, and Klebsiella organisms.

6. “My patient’s head CT scan shows narrowing of the ventricles.”

Ventricular narrowing is very common during treatment for DKA. It does not appear to correlate with disease severity and most likely reflects a pathophysiologic mechanism of DKA. Treatment for cerebral edema should be initiated on the basis of clinical change as opposed to findings on a CT scan.

7. “My patient decompensated but did not show signs or symptoms of cerebral edema.”

It is important to consider other etiologies of decompensation in DKA. Known causes of death in patients presenting with DKA include infection, electrolyte abnormalities, hypoglycemia, thrombosis, pneumonia, renal failure, and pancreatitis.

8. “I never worry about cerebral edema in my adult patients.”

It is unclear why children are uniquely susceptible to cerebral edema; nevertheless, the disease does not occur in adults. Various mechanisms have been proposed, but they are strictly theoretical at this time. The important take-home point for the emergency clinician is that DKA management in children requires more rigor and attention to detail to minimize a risk that is unique to this age group.

9. “My patient decompensated prior to therapy.”

There have been several documented incidences of cerebral edema occurring prior to initiation of therapy. These cases appear to undermine theories related to fluid administration and insulin dosing and to point instead toward a multifactorial etiology.

10. My patient has a severely elevated blood glucose level but no ketones.”

The patient likely has HHS. This disorder is distinguished by higher glucose levels than those typically found in DKA as well as the absence of ketonemia. These patients benefit from early recognition of the condition and intensive focus on rehydration and electrolyte balances.
**Subarachnoid hemorrhage**

*From the September 2009 issue of Emergency Medicine Practice. Reprinted with permission. To access your EMRA member benefit of free online access to all EM Practice and Pediatric EM Practice issues, go to www.ebmedicine.net/emra, call 1-800-249-5770, or email ebm@ebmedicine.net.*

1. **“Bacterial meningitis was at the top of my list, but I wanted to wait for the CT scan and LP results before I initiated antibiotics.”**

   Waiting for a CT scan to be completed and then interpreted, followed by an LP and an additional wait for the laboratory results, can cause significant delays of up to several hours. In a sick patient with altered mental status, focal neurologic deficits, or hypotension, time to antibiotics may be of critical importance. Parenteral antibiotics and steroids should be administered before CT scanning or the LP is complete (with blood cultures ideally obtained beforehand).

2. **“I knew the patient had AIDS and was posturing, I thought I should perform the LP as quickly as possible to evaluate for infectious meningitis”**

   Although an LP has critical value in the diagnosis of meningitis, do not overlook the fact that this patient may have a contraindication to LP (ie, evidence of increased ICP) or an alternative diagnosis (eg, brain abscess, toxoplasmosis) that would be picked up by cranial CT scan. There are established recommendations for performing a CT scan prior to an LP in patients with compromised immune systems.

3. **“I can’t believe that older man had bacterial meningitis. Although he did have a headache and was mildly confused, he did not have fever or neck stiffness.”**

   Elderly patients may not present with the typical signs and symptoms of meningitis. Although fever commonly occurs, a temperature in the reference range or hypothermia is also possible. A study of 84 afebrile elderly patients with altered mental status found that 15 of these patients (18%) had normal LP results (95% CI, 10%-26%). A final diagnosis of meningitis was made for 10 of the 15 patients (bacterial meningitis, 2 patients; aseptic meningitis, 6 patients; lymphomatous meningitis, 2 patients).

4. **“There is no way she could have bacterial meningitis. Her symptoms have persisted for 5 days. If she has had untreated bacterial meningitis for that long, she’d be dead.”**

   In a large review of adult patients with ABM, only 50% of the patients reported a symptom duration of less than 24 hours.39 Many patients will describe flu-like symptoms for several days preceding the onset of worsening headache and neck pain. Unfortunately, there is currently no reliable way to distinguish a viral syndrome from early meningitis other than doing an LP with CSF analysis. Although some lawyers and medical experts may argue that a WBC count should be obtained in these patients, no guidelines recommend use of this test in adults to determine if they will benefit from an LP.

5. **“I got the antibiotics on as quickly as possible. I left the decision to give corticosteroids to the admitting doctor.”**

   Corticosteroids are thought to work by suppressing the inflammatory response that occurs with antibiotic-induced bacterial cell lysis. Their use in immunocompetent adults with ABM is associated with a favorable survival benefit and neurologic outcome. Corticosteroids are ideally given immediately before the first dose of antibiotics in the ED.

6. **“I can’t believe that patient was admitted for bacterial meningitis. He did not have nuchal rigidity, and I thought I had excluded this diagnosis with negative Kernig and Brudzinski test results.”**

   The absence of nuchal rigidity or other specific signs of meningeal irritation does not exclude the possibility of ABM. Although the specificity of Kernig and Brudzinski signs is high, the sensitivity of these signs is extremely low. Similarly, the sensitivity of nuchal rigidity is only 30% for the detection of ≥ 6 WBC/mL in the CSF.

7. **“I thought for sure that patient had ABM. He had a fever and a headache and was altered. The tap was atraumatic, but his CSF showed an RBC count of 2500 cells/mL and a WBC count of 200 cells/mL. His glucose and protein levels were normal. I gave him antibiotics and steroids, but I was surprised when his CSF Gram stain came back negative.”**

   Don’t be surprised. The presentation of encephalitis can greatly overlap with that of meningitis. For patients with a Gram stain negative for organisms and a CSF analysis that is consistent with viral meningitis, think about the possibility of HSV or other viral encephalitis. Our approach in the ED is to give empiric acyclovir to these patients.

8. **“Did you just admit that patient for meningococcal meningitis? I saw his wife a few days ago and admitted her for the same thing.”**

   If only you had contacted the patient’s family and told them to come to the ED for chemoprophylaxis with ciprofloxin or rifampin after you made the initial diagnosis! Remember that household contacts, intimate nonhousehold contacts, and health care workers who have direct mucosal contact with the patient’s secretions (eg, during endotracheal intubation, respiratory suctioning) are at risk of developing meningococcal disease after exposure to a patient with meningococcal meningitis.

9. **“That older man I admitted had gram-positive rods in his CSF. I wonder what he will grow out.”**

   Don’t forget that immunocompromised patients and patients older than 50 years are susceptible to infection with L monocytogenes. In these patients, empiric antibiotic coverage should include ampicillin 50 mg/kg IV every 6 hours (maximum dose, 3 gm) as well as ceftriaxone and vancomycin.

10. **“My colleague just went to trial over a missed case of bacterial meningitis. She told me that the plaintiff’s expert witness testified that antibiotics should be given to everybody remotely suspected of having meningitis.”**

    Although antibiotics are generally considered benign, there are far-reaching consequences to their indiscriminate use in every patient who may have a serious infection. Severe morbidity—and even death—can result from allergic reactions and antibiotic-associated colitis. Haphazard antibiotic administration is also blamed for the increased prevalence of multidrug-resistant bacteria in the United States. ■
From Fluid and Electrolytes

1. All of the following are true about ADH (antidiuretic hormone) except:
   (a) It is released in response to decreases in serum osmolality.
   (b) It is released in response to decreases in intravascular volume.
   (c) It acts on the renal tubules to decrease free water excretion.
   (d) It is present in excessive amounts in the condition of SIADH (syndrome of inappropriate ADH secretion).

2. The pulmonary excretion of CO2:
   (a) Raises the serum H+ concentration
   (b) Raises the serum pH
   (c) Decreases the renal excretion of bicarbonate
   (d) Raises the serum concentration of bicarbonate

3. In human studies and experimental animal models, central pontine myelinolysis has been associated with all of the following except:
   (a) Rapid correction of symptomatic hyponatremia (less than 24 hours duration).
   (b) Correction of hyponatremia longer than 2 days duration at a rate greater than 0.6mEq/L/hour.
   (c) Correction of hyponatremia longer than 2 days duration at a rate greater than 25mEq over 48 hours.
   (d) Correction of hyponatremia longer than 24 hours duration at a rate greater than 2.5mEq/hr.

4. A healthy 17-year-old woman suffers a cardiac arrest during an infusion of magnesium sulfate for treatment of eclampsia. In addition to the initiation of CPR, the most appropriate initial treatment is:
   (a) Immediate hemodialysis
   (b) Intravenous infusion of 1 gram calcium chloride
   (c) Intravenous infusion of 140mEq of sodium bicarbonate
   (d) Intravenous infusion of 10mEq of potassium chloride

5. All of the following are true about cold water drowning except:
   (a) The arterial blood gas determination in a patient whose body temperature is 24°C does not require temperature correction.
   (b) Most victims of fresh water drowning have evidence of hemolysis as a manifestation of aspiration of large volumes of hypotonic fluid.
   (c) A 10-year-old child in asystolic cardiac arrest with a body temperature of 22°C following a 30-minute submersion requires emergent cardiopulmonary bypass.
   (d) Very few victims of salt water drowning have evidence of hemoconcentration as a manifestation of aspiration of hypertonic salt water.


ABEM names new president

Debra G. Perina, MD, of Charlottesville, Virginia, has assumed the office of President of the American Board of Emergency Medicine (ABEM). Dr. Perina has been a member of the Board of Directors since 2003 and has served ABEM in many capacities since 1994, including serving as an oral examiner, and Senior Oral Board Reviewer. She chairs the Academic Affairs Committee, the EM Model Review Task Force, the Nominating Committee, and the Residency Training Information Task Force. Dr. Perina also represents ABEM as a representative to the American Board of Medical Specialties (ABMS).

Dr. Perina received her medical degree from the West Virginia University School of Medicine in 1983, and completed her Emergency Medicine residency in 1986 at Richland Memorial Hospital / University of South Carolina School of Medicine, where she remained as faculty and subsequent Residency Director. She has been active in specialty education with many national presentations, and has authored over 50 peer reviewed manuscripts and book chapters. Dr. Perina is currently Director of Quality Improvement, Division Director, Prehospital Care, EMS Fellowship Director, and Tenured Associate Professor, Department of Emergency Medicine at the University of Virginia Health Science System, in Charlottesville, Virginia.

The American Board of Emergency Medicine establishes the credentialing requirements and examinations to evaluate physicians who seek certification in Emergency Medicine. The first examination was administered in 1980. As of December 2008, ABEM has certified 25,376 physicians.
As NYU Mini Med participants enter the NYU surgical skills laboratory, excitement fills the room. The participants have worked for weeks leading up to this day.

Through materials funded through a 2008 EMRA Local Action Grant, medical students teach them about the cardiovascular system using stethoscopes to auscultate the heart, and they learn how to read x-rays, identify fractures and stabilize the fracture by making a splint.

Now they will apply their knowledge as emergency medicine residents teach them about airway anatomy and management and they practice their clinical skills on SIM MAN. The participants also learn about cardiac anatomy through a pig heart dissection and practice their laparoscopic skills. At the end of the program, nobody wants to leave and questions abound as participants have entered the world of emergency medicine.

This past year we worked with a group of 6th graders from the Hudson Guild after school program and a group of rising 8th and 9th graders from Eagle Academy in the Bronx, N.Y. The participants had the opportunity to talk with an emergency medicine attending and learn about life as an emergency medicine physician. We hope that the positive experiences in our program may lead the participants to consider a future career in the health field.

Medical students who have participated in the NYU Mini Meds program are now entering the emergency room during their clinical rotations. And one day, we hope to see some of our young participants entering into a career in emergency medicine.
EMRA Publications

Emergency Medicine Advocacy Handbook
Ananthanarayan R. Schlicher, MD, JD
In this clear, well-thought-out handbook, Dr. Schlicher and the chapter authors outline the essential advocacy issues surrounding emergency medicine today. Not just for the politically-minded, this resource is useful for the student, resident, physician, healthcare worker, patient or concerned citizen to help understand the important issues affecting all aspects of emergency care.
Published 2009; 96 pages; Soft Cover 5.5 x 8.5
Bulk pricing available; order online at www.emra.org

Brian J. Levine, MD
A quick reference guide to antibiotic use in the emergency department. Organized alphabetically by organ system, followed by sections on “Special Topics” to make reference quick and easy for a particular disease process. Color coded.
900030 / $25.95  EMRA Member Price $15.95
Published 2008; 96 pages; Soft Cover 4 x 6

Career Planning Guide for Emergency Medicine, 2nd Edition
Gus Garmitz, MD
Get help organizing and understanding the many complex issues concerning emergency medicine careers. Topics include career possibilities, CV’s, interview tips, contract negotiations, benefits and more.
900060 / $29.95  EMRA Member Price $19.95
Published 2008; 104 pages; Soft Cover 5.5 x 8.5

Joseph R. Wind, MD, JD
Invaluable for any emergency physician entering into an employment or independent contract agreement to provide medical services on behalf of a hospital or group. What you don’t know can really hurt you!
900110 / $49.95  EMRA Member Price $29.95
Published 2007; 92 pages; Soft Cover 5.5 x 8.5

Kristin E. Harkin, MD, FACEP and Jeremy T. Cushman, MD, MS
In this clear, well-thought-out handbook, Dr. Schlicher and the chapter authors outline the essential advocacy issues surrounding emergency medicine today. Not just for the politically-minded, this resource is useful for the student, resident, physician, healthcare worker, patient or concerned citizen to help understand the important issues affecting all aspects of emergency care.
Published 2009; 96 pages; Soft Cover 5.5 x 8.5
Bulk pricing available; order online at www.emra.org

Gus Garmitz, MD
Get help organizing and understanding the many complex issues concerning emergency medicine careers. Topics include career possibilities, CV’s, interview tips, contract negotiations, benefits and more.
900060 / $29.95  EMRA Member Price $19.95
Published 2008; 104 pages; Soft Cover 5.5 x 8.5

Emergency Medicine’s Top Pediatric Clinical Problems, 2nd Edition
Gary Kitz, MD, MBA; Mark Moseley, MD, MHA
A new and improved pocket reference and quiz tool. Each chapter starts with critical actions and then logically expands with disease-specific information. The design simulates the format of an emergency medicine oral or written board exam.
900100 / $25.95  EMRA Member Price $15.95
Published 2006; 218 pages; Soft Cover 4 x 6

Emergency Medicine’s Top Pediatric Clinical Problems, 1st Edition
Dale Woolridge, MD, PhD
A new and improved pocket reference and quiz tool. Each chapter starts with critical actions and then logically expands with disease-specific information. The design simulates the format of an emergency medicine oral or written board exam.
900100 / $25.95  EMRA Member Price $15.95
Published 2006; 218 pages; Soft Cover 4 x 6

Pocket Reference Cards

Pediatric Qwic Card
Dale P. Woolridge, MD, PhD
This comprehensive quick reference card has pertinent information from proper dosages, vital stats by age, pearls, to RSI. The perfect accompaniment to the new pediatric family of publications from EMRA.
900240 / $12.00  EMRA Member Price $7.00
Published 2008; Folded; laminated 4 x 7

EMRA Sepsis Card
2009 Edition: Chris Coletti, MD and John Powell, MD; 2006 Edition: Dave Farcy, MD
Everything you need to know about improving outcomes for septic patients in the emergency department available in this newly revised pocket reference guide. This comprehensive review of sepsis treatment recommendations was developed by the EMRA Critical Care Committee.
900220 / $12.00  EMRA Member Price $7.00
Published 2009; Laminated Card 4 x 7 folded/6 x 7 flat

EMRA Airway Card
A handy pocket reference for intubation of neonates to adults. Includes helpful information on drips, tube placement and Glasgow Coma Scale. A must-have in the emergency department for patients of all ages!
900180 / $12.00  EMRA Member Price $7.00
Published 2005; Laminated Card 3 x 5.5

EMERGENCY MEDICINE RESIDENTS’ ASSOCIATION

Publications
available online at www.acem.org/bookstore
What’s important to YOU is what matters to US...

• Customized Sign-on and Tuition Bonus packages
• Paid Malpractice w/ Tail
• Free CME

You’ve been working your tail off and now deserve a healthy career that offers freedom, flexibility, financial reward… and fun!! Hospital Physician Partners appreciates this because we work in Emergency Medicine, just like you. Here are some of our job opportunities throughout the nation:

**Alabama** – SIGN-ON BONUS, Residents welcomed, FT/PT excellent Compensation - cmarvez@hppartners.com

**Florida** – 17-42K vols., FT/PT for BC/EM Physicians, close to beaches - orausch@hppartners.com

**Georgia** – 4-15K vols., FT/PT, 12 and 24 hour shifts, flexible scheduling and excellent compensation - tstrong@hppartners.com

**Mississippi** – SIGN-ON BONUS & INCREASED RATE, 15-48K vols., FT & PT southeast of Memphis - dmaloney@hppartners.com

**Missouri** – SIGN-ON BONUS, FT / PT for 13K vol. ED, Excellent Compensation - cmarvez@hppartners.com

**New Mexico** – SIGN-ON BONUS, 32K Vol., FT for BC EM Physicians, 300 days of sunshine and play - cmarvez@hppartners.com

**North Carolina** – Rewarding Directorships available from 16-50K vols. Live where others vacation - kkopodonna@hppartners.com

**Ohio** – 16-27K vols., newly constructed hospital, central to Toledo and Columbus, Osteopathic Teaching Facility - msmith@hppartners.com

**South Carolina** – 10-40K vols., Beautiful mountains, relaxing beaches - kkopodonna@hppartners.com

**Texas** – 11-40K vols., Sign-on Bonus offered & increased rate! FT & PT in San Antonio, Odessa & Port Arthur - dmaloney@hppartners.com

**Tennessee** – SIGN-ON BONUS & INCREASED RATE - dmaloney@hppartners.com

**Virginia** – 26K vol., FT & PT, Charming town with 2 major universities - rpeachee@hppartners.com

**West Virginia** – 23K vol. in rolling hills of the Appalachian Mountains - rpeachee@hppartners.com

Visit us at ACEP Booth 341 next to EMRA
Look no further with **EM Career Central**
your search is over

**EMCareerCentral.org**

The official online career resource from ACEP and EMRA,
EM Career Central offers the most targeted career listing available
for Emergency Medicine professionals. Whether you’re looking for the perfect opportunity or the perfect candidate to fill an open position in your facility, your perfect match is just a click away.

**Job Seekers**
- Search hundreds of local and national EM opportunities
- Create a customized CV with the easy Resume Builder
- Upload and store existing resumes (confidentially if preferred)
- Build your own personalized professional Career Website
- Reply online to job postings and send a cover letter with your resume
- Receive e-mail alerts of new job postings in EM and geographic locations you select

**Employers**
- Target your search to qualified EM candidates
- Access the resume database with your job posting
- Receive e-mail alerts of new CV postings
- Take advantage of flexible, competitive pricing with volume discounts
- Receive personalized customer care consultation

Visit EM Career Central today. It’s quick, convenient and confidential. And it’s available 24/7.
Successful Careers Start Here

2009 Senior EM Resident Program • Chicago, Illinois • October 28-29, 2009

EmCare invites senior level Emergency Medicine residents to the “City of the Big Shoulders” for an exciting educational opportunity. Learn about contract negotiations, hospital opportunity evaluations, financial pro forma development, successful DA/CO programs, and risk management from the biggest names in Emergency Medicine. Join us for our two-day program at the SEEP office in Downer’s Grove. We provide lodging for Wednesday night arrival through Thursday morning checkout (room and tax only), breakfast and lunch each day, and one group dinner. Participants are responsible for incidentals, transportation costs, and remaining evening meals.

When the biggest names in EM team up with the biggest company in EM, you get one of the biggest events in EM this year. Give yourself the edge you deserve and have a great time doing it.

Headlining Speakers
Dr. Dighton Packard • Dr. David Mendelson • Dr. David Myers

Topics include:
Negotiating Employment Agreements
Evaluating Contract Opportunities
The Impact of Credentials
Employment Search – Beginning to End
The Business of Malpractice
Improving Physician Documentation
Malpractice Crisis
Professional Liability Risk Management
Personal Financial Planning
Strengths and Weaknesses of Group Structures

Your career. Your lifestyle.
Find your balance at EmCare.

To register, please contact
Lisa Griegel
Lisa.Griegel@emcare.com
(800) 732-1066

* At no time will any recruiting or other enticements be allowed – this program is strictly educational.
Spectacular Finger Lakes Region

Four Seasons to live, work and enjoy

Join our team of Residency-trained Emergency Physicians!

Our state-of-the-art Emergency Department provides care to more than 40,000 patients annually. Full specialty coverage, 24/7 in-house anesthesiology, and a strong hospitalist program support the department. Emergent angioplasty services are performed on-site and a full complement of ancillary services are available around the clock. Ample physician coverage and a separate Fast Track allow for a low patient/physician ratio. These positions offer a total compensation package with full benefits and bonus potential in excess of $350,000! Loan forgiveness and residency stipends are also available.

If you are seeking a collegial opportunity offering the rewards of a balanced personal and professional lifestyle, please contact:

Eleanor Callanan, PT, MBA
Provider Recruitment & Retention
600 Ivy St, Suite 102, Elmira, NY 14905
800.295.4555 toll free;
607.737.4247
ecallanan@aomc.org
VISIT us at the EMRA Job Fair!

We are the Midwest's largest, physician-owned Emergency Medicine group headquartered in Overland Park, KS. In practice since 1978, this stable group has grown to 150+ physicians and 40+ mid-level providers. With 19 different locations spanning mid-Missouri to mid-Kansas, we're sure we can find the "right fit" for you.

Physician Employees enjoy:

• Medical Malpractice with guaranteed tail coverage
• Competitive hourly rates and night shift differentials
• Flexible scheduling with 8’s, 10’s, 12’s and 24’s
• Six-month partnership track
• Physician to patient ratios based on ACEP and AAEM guidelines
• Only Medical Scribe program in the region
• EM RESIDENT STIPEND PROGRAM

Contact
Shawn Stampfl, Director
Physician Recruitment and Retention
913-647-3240 phone / 913-406-8964 cell
sstampfl@midwestep.com www.MidwestEP.com

The Department of Emergency Medicine at the Brody School of Medicine at East Carolina University is expanding its faculty. We are seeking BC/BP emergency physicians for tenure or clinical track positions at the rank of assistant professor or above, depending on qualifications. Our current faculty possesses diverse interests and expertise leading to extensive state and national-level involvement. Through this expansion we hope to increase our depth and further develop programs in clinical toxicology and clinical research, and our cadre of clinician-educators. The emergency medicine residency is well-established and includes 12 EM and 2 EM/IM residents per year. We treat more than 90,000 patients per year in a state-of-the-art ED at Pitt County Memorial Hospital. PCMH is a rapidly growing level I trauma, cardiac and regional stroke center. Our tertiary care catchment area includes more than 1.5 million people in eastern North Carolina, many of whom arrive via our integrated mobile critical care and air medical service. Greenville, NC is a livable, family-oriented university community located ninety minutes from the Crystal Coast. Cultural and recreational opportunities are abundant. Compensation is competitive and commensurate with qualifications; excellent fringe benefits are provided. Successful applicants will possess outstanding clinical and teaching skills and qualify for appropriate privileges from ECU Physicians and PCMH. Screening will remain open until filled.

Confidential inquiry may be made to Theodore Delbridge, MD, MPH, Chair, Department of Emergency Medicine (delbridget@ecu.edu). Must apply online by using ECU OneStop on the main ECU page: www.ecu.edu.

www.ecu.edu/ecuem www.uhseast.com

Staff Care offers lucrative temporary work assignments at facilities nationwide. Try out several locations before taking a permanent job.

• We offer more opportunities and more personalized services than any other firm.
• We handle all the details for you.
• Work where you want, when you want.
• Try out several different facilities.
• Concentrate on patient care.
• Competitive hourly compensation.
• Medical malpractice insurance is provided.
• Travel and housing are provided.
• Opportunities nationwide.

Search hundreds of opportunities at:

www.StaffCare.com

(800) 685-2272

Staff Care
The Leader in Locum Tenens Staffing ©
An AMN Healthcare Company
Excellent Emergency Medicine Opportunity

Cincinnati, Ohio

Democratic, fee-for-service group
Equity partnership and profit sharing after 1 yr.
Dedicated to emergency medicine in one city—Cincinnati
6 hospitals with a wealth of disease and trauma pathology in both adult and pediatric patients
ED volumes range from 40,000 to 60,000

Monthly journal club and book review
Active in all phases of emergency care:
- EMS
- Medical Staff Committees
- Nursing and medical student education
- Mass gathering medical coverage including Cincinnati Reds games and Flying Pig Marathon
- Emergency physicians for the Cincinnati Bengals football players and popular performers at Riverbend concerts

Comprehensive Benefit Plan
- Self-directed, fully vested retirement plan
- Health, life, disability and malpractice insurance
Flexible, equitable schedule
- 8, 10 & 12 hr. shifts
- Night shift bonus program

Cincinnati is a very exciting city for both singles and families
Superb cultural and arts programs
Major League sports. Excellent schools and universities
Busy downtown with metropolitan shopping and dining

Qualified Emergency Specialists, Inc.
Providing excellence in emergency care to Cincinnati since 1984
www.qualifiedemergency.com

For further information contact any physician listed below:
Dr. Gary Gries (513) 231-1521 email: gries9@hotmail.com
Dr. Joe Rentusch (513) 624-0167 email: jrenusch@cinci.rr.com
Dr. Jarrad Lifshitz (513) 377-2297 email: jlifshitz@yahoo.com
Alpha Physician Search specializes in the placement of Emergency Physician nationwide.

New York: Diverse practice opportunities in the New York Metro area. Choose from urban academic EM, private FFS community Emergency Departments and prestigious hospital system-based settings in some of the best suburbs of New York. All positions include competitive base salaries and full employee-based benefits.

South Carolina: Enjoy one of the country’s best climates and lifestyles. Coastal “Low Country” or inland retirement communities. Full time EM opportunities at busy Emergency Departments in prime resort areas, low volume community hospitals and private FFS groups in one of the state’s best cities.

Matthew Faber
Alpha Physician Search
800.504.3411 • mfaber@alphamg.org
www.alphaps.org

Alabama, Central: A showplace for southern hospitality with beautiful weather, and high-tech jobs, central Alabama is filled with rich diversity and cultural landmarks. Hospital Physician Partners seeks Full-Time Regional Director/Lead Physician to join cohesive team. Other statewide opportunities offer diversity with ED volumes from 10,000 – 40,000. Candidates must be BC in EM with ACLS, ATLS and PALS. What’s important to you is what matters to us… physician-led, attractive compensation, paid malpractice, flexible scheduling and excellent team support. Contact Molly Smith, Physician Recruiter: (800) 877-5520 ext. 1020; email: msmith@hppartners.com or visit www.hppartners.com/emra.

Arkansas, Wynne, Helena, Forrest City and Newport: Partnership, teamwork and fantastic locations in the beautiful State of Arkansas. Seeking Full-Time experienced EM Physicians and Third Year EM Residents for locations within an hour drive of Memphis. ED volumes range from 9,000 to 15,000. What’s important to you is what matters to us… physician-led, attractive compensation, paid malpractice, flexible scheduling and excellent team support. Let us help you find the right Arkansas location to call home, Partner! Contact Deanna Maloney, Physician Recruiter: 866-maloney (866-625-6639); email: dmaloney@hppartners.com; Fax your CV to (972)562-7991 or visit www.hppartners.com/emra.

Carolina’s, Multi-Cities: Directorship and clinical staff opportunities are available from the mountains to the beaches. Hospital Physician Partners offers locations near major cities such as Raleigh, Asheville, Charlotte (NC), Myrtle Beach and Greenville (SC). Mixed volume ED’s from 7K-50k with mid-level coverage. Physicians must be BC/BP in EM. Director candidates must have administrative background. What’s important to you is what matters to us… physician-led, attractive compensation, paid malpractice, flexible scheduling and excellent team support! For details, contact Traci Spencer-Strong at Hospital Physician Partners: (800)291-4020; Fax: (919)806-0044; email: tstrong@hppartners.com or visit www.hppartners.com/emra.

Connecticut, Waterbury: Waterbury Hospital (www.waterburyhospital.org) located equidistant from New York City and Boston, seeks Physician to work 1,328 clinical hours (8 hour shifts) in the Emergency Department of a 220 bed community, acute care and teaching hospital affiliated with the Yale School of Medicine, and the Univ. of CT School of Medicine. Level II Trauma Center with Primary Care and Surgical Residency. The ED sees over 56,000 visits per year. Two dedicated overnight physicians, Fast Track staffed with PAs, pediatric and ortho PAs, Hospitalist service, ED Ultrasound, 15% admissions, computerized charting system. New England offers countless cultural and recreational opportunities and many nationally ranked schools. Must be MD or DO Board Certified/Eligible EM. Excellent compensation package including all benefits. Email: skotomski@wtbyhosp.org Phone: 203-573-6017 64 Robbins Street, Waterbury, CT 06721.

Connecticut, New London and Stamford: Lawrence & Memorial is on the coast near Mystic and sees 40,000 pts./yr. The Stamford is 45 min. from NYC near Greenwich and sees myriad opportunities. Hospital Physician Partners offers locations in the beautiful State of Arkansas. Seeking Equity Partner or Locum Tenens EM Physicians for locations within an hour drive of Memphis. ED volumes ED from 9,000 to 15,000. Other opportunities across the state. Contact Molly Smith, Physician Recruiter: (800) 877-5520 ext. 1020; email: msmith@hppartners.com or visit www.hppartners.com/emra.

Life is just too short

EmCare takes care of the business of emergency medicine, giving you the freedom to balance the medical career you’ve worked for with the lifestyle you deserve.

You save lives. We help you have one. EmCare combines the flexibility you want to provide quality medical care with the administrative support you need to focus on your goals. With opportunities at more than 400 client hospitals in 42 states, practicing medicine with EmCare can help you have the career – and the life – you’re seeking. Join the nation’s leading provider of emergency care. Join EmCare.

“A” rated Malpractice Coverage • Extensive Education Resources • Career Development Programs

For a complete listing of our career opportunities, visit WWW.EMCARE.COM or email recruiting@emcare.com

LIFE IS JUST TOO SHORT

EmCare takes care of the business of emergency medicine, giving you the freedom to balance the medical career you’ve worked for with the lifestyle you deserve.

You save lives. We help you have one. EmCare combines the flexibility you want to provide quality medical care with the administrative support you need to focus on your goals. With opportunities at more than 400 client hospitals in 42 states, practicing medicine with EmCare can help you have the career – and the life – you’re seeking. Join the nation’s leading provider of emergency care. Join EmCare.

“A” rated Malpractice Coverage • Extensive Education Resources • Career Development Programs

For a complete listing of our career opportunities, visit WWW.EMCARE.COM or email recruiting@emcare.com

Classified Advertising

October/November 2009 55
CHOOSE YOUR FUTURE . . . CHOOSE GHEP

Incentive Bonuses

Semi annual profit sharing

TOLL FREE: (888) 239–7924

GHEP
Greater Houston Emergency Physicians

• 401 K w/ corp. matching
• 1 yr track to partnership

EM Resident
MedStar Health Departments of Emergency Medicine
Washington, D.C. & Baltimore, Md.

Washington Hospital Center and Georgetown University Hospital in Washington, D.C., and Franklin Square Hospital Center and Union Memorial Hospital in Baltimore, Md., are seeking physicians board-certified or residency-trained in emergency medicine to join our Department of Emergency Medicine.

We are a cohesive group of emergency physicians who are committed to practicing state-of-the-art, “patient first” emergency care. We want to provide our patients with cutting edge medical care and be a center for innovation and excellence in emergency medicine. We wish to further our specialty through the development of world-class programs in emergency preparedness, information technology, transport medicine, event medicine, and medical education. We are seeking physicians who, in addition to practicing the highest quality care, share our vision and desire to be part of a world-class department.

Washington Hospital Center
Georgetown University Hospital
Franklin Square Hospital Center
Union Memorial Hospital

MedStar Health

Washington Hospital Center is the largest hospital in the Washington, D.C. metropolitan area. The Emergency Department has more than 82,000 annual visits and admits more than 21,000 patients a year. Georgetown University Hospital is a renowned academic institution that, along with Washington Hospital Center, is the site of a PGY 1-3 emergency medicine residency training program. The Georgetown Emergency Department treats 35,000 adult and pediatric patients annually. Franklin Square Hospital Center is a wonderful hospital located at the intersection of I-695 and I-95 in the suburbs of Baltimore. This Emergency Department has more than 108,000 annual visits, over 20% of which are pediatric, making it the busiest emergency department in Maryland. Union Memorial Hospital offers world-class cardiovascular and orthopedic surgery programs and is a regional hand surgery referral center. The Emergency Department sees over 59,000 adult and pediatric patients.

Contact William Frohna, MD, FACEP, Chairman Department of Emergency Medicine, Washington Hospital Center, at 202-877-2424 (phone), 202-877-2468 (fax), or write to him at bill.frohna@medstar.net or the Department of Emergency Medicine, Washington Hospital Center, 110 Irving Street, NW, Suite NA1177, Washington, DC. 20010.
About Gundersen Lutheran

Gundersen Lutheran is a dynamic top-rated healthcare organization based in scenic La Crosse, Wis. At Gundersen Lutheran, we serve residents of western Wisconsin, southeastern Minnesota and northeastern Iowa. Our healthcare system is anchored by one of the largest multi-specialty group practices and a teaching hospital with Level II Trauma Center. Specialty outreach, telemedicine, distance learning, digital imaging and other services link Gundersen Lutheran with regional clinics, hospital affiliates and practitioners in a 19-county service area.

La Crosse is a historic, vibrant city of more than 50,000 people nestled between bluffs and the legendary Mississippi River. La Crosse boasts a historic downtown and riverfront, a host of festivals and annual celebrations, some of the best outdoor recreation, excellent schools including three universities, affordable housing in safe neighborhoods, an endless variety of live entertainment and breathtaking beauty, making this a great place to call home.

Contact Jon Nevala, manager, medical staff recruitment, at (800) 362-9567, ext. 54224, or email jpnevala@gundluth.org
Visit online at gundluth.org

About Caritas Christi Health Care

Caritas Christi Health Care, New England’s second largest health care system, is seeking Emergency Medicine Physicians to join Caritas Emergency Medicine, a network of more than 70 Emergency Medicine physicians, in its six hospitals located in Boston, Brockton, Dorchester, Fall River, Methuen and Norwood, Massachusetts.

This dedicated group is physician-governed offering an above market compensation package including a comprehensive benefits package, with both 403b and 457 tax deferred retirement plans.

Currently, two hospitals have resident rotations, and a third hospital is to become a satellite facility of an Emergency Medicine Program in 2009. Applications are now being accepted for full, part time, and per diem staff positions.

Interested applicants should submit a CV and cover letter to:
Mark Pearlmutter, MD
Chair and Vice President, Network Emergency Services
c/o: Christine.Kady@caritaschristi.org
or call 617-562-7717

We are happy to provide additional information. Visit us on the web at www.CaritasChristi.org

Emergency Medicine: La Crosse, Wis.

BC/BP in Emergency Medicine. Join a talented and experienced team that handles approximately 30,000 visitors per year. Above market salary and benefits package to include loan forgiveness.

In order to be considered for the position you must be ABEM board certified or prepared. Please contact Jeannie McKinney or Amy Betz for more information regarding this opening.

Jeannie McKinney
jeannie_mckinney@emcare.com / 214-712-2764
Amy Betz
abetz@jpshealth.org / 817-702-8829

We support a safe, healthy and drug free work environment through background checks and controlled substance screening. EOE/AA/LEP
Getting to know the people at TeamHealth has changed my view of what I perceived a large group would be. They let me lead, and they support our team. I now know TeamHealth and its leadership to be of the highest integrity, and that is essential when I am looking for the best people to be part of my team.

Kip Wenger, DO, FACOEP, FACEP, Medical Director (far right), takes a break with colleagues during a team-building hike.

"Emergency medicine is a team sport—TeamHealth is aptly named."

Come see us in Boston, Booth 707 at the ACEP Scientific Assembly, and at TeamHealth’s physician reception, October 6, New England Aquarium.

800.818.1498 • teamhealth.com • physicianjobs@teamhealth.com
Join Us As We Grow!

QuestCare Partners
A Unique Ownership Opportunity

Join a premier emergency medicine organization owned and operated by its practicing physician members.

- Thirteen outstanding facilities in DFW and El Paso
- Cutting-edge Emergency Medicine
- Experienced Emergency Medicine Colleagues
- Exceptional compensation and benefits
- Balance between quality career and quality lifestyle

Ownership • Equality • Democracy

www.questcare.com

Visit us at the ACEP Scientific Assembly Booth #700
For more information, contact Sharon Hirst:
800.369.8397 or email shirst@questcare.net

Looking for a rewarding career opportunity in emergency medicine?
You just found it.

Pennsylvania’s Leader in Emergency Medicine

ERMI is Pennsylvania’s largest emergency medicine physician group and is part of the prestigious University of Pittsburgh Medical Center, one of the nation’s leading integrated health care systems. ERMI is a physician-led company that offers unmatched stability, and a host of other advantages:

- Multiple sites in western Pennsylvania/Pittsburgh area
- Suburban, urban, and rural settings
- Coverage averages less than two patients per hour
- Excellent compensation and benefits
- Employer-paid occurrence malpractice with tail
- Employer-funded retirement plan
- CME allowance
- Equitable scheduling
- Abundant opportunities for professional growth

For more information about joining Pennsylvania’s emergency medicine leader, contact Robert Maha, MD, at 888-647-9077, or send an e-mail to mahar@upmc.edu.
Emergency Medical Director Career Opportunity

$400,000+ Annual Salary, New Increased Stipend, Relocation Allowance plus a $20,000 Sign-On Bonus

Valley Regional Medical Center is an advanced 214-bed acute care hospital located in Brownsville, Texas that also serves South Padre Island, Harlingen and surrounding communities. The hospital has an immediate opening for an emergency medical director who is board certified in EM, and has significant ED experience and previous directorship experience. Compensation includes a $400k+ annual salary plus a $20k signing bonus, in addition to excellent benefits through EmCare – including an “A” rated malpractice insurance program with no tail obligation upon departure, CME allowance, and 401(k) and elective deferral program. The ED at Valley Regional Medical Center has 23,000 annual patient visits and provides 32 hours of physician cvg/day with 10 hours of MLP cvg/day. Brownsville is just 25 miles from the beautiful beaches of South Padre Island, a coastal resort town bordered by the Gulf of Mexico. With 5 miles of seashore shopping, fine dining, entertainment, year-round fishing, exotic tropical tours, water sports and more, you're sure to find the lifestyle you deserve in south Texas.

For further information, please contact:
Bill Masters, Physician Consultant
800-362-2731 x2493
email: bill_masters@emcare.com

ED, with an anticipated volume of 18,000. Physicians will provide 24 hours of coverage daily with 12 hours of mid-level coverage. Providers are employed by Health System Emergency Physicians, a physician-owned EM group, and will receive a competitive, guaranteed hourly rate, along with comprehensive benefits including a 401(k) and profit sharing retirement program. “Parents are drawn to the city’s exceptional schools, pleasant neighborhoods, and fine recreational facilities.” West Des Moines has also been deemed “one of the safest cities in the United States.” Contact Teri Geen at (800) 346-0747 ext. 3168, or email CVs to tgeen@psrinc.net.

Kentucky, Multi-Cities: Seeking EM Physicians committed to providing efficient, quality patient care! 9,000 – 25,000 volume EDs offer flexible 12 and 24-hr shifts at facilities in eastern KY bordering TN and WV, easily commutable from Nashville, Lexington, and Charleston. Immediate opportunity also available in a 6,000 volume ED in western KY bordering TN. All candidates must have current be BC/BP EM, current ACLS/ATLS/PALS, and be comfortable in a single physician coverage setting. What’s important to you is what matters to us… physician-led, attractive compensation, paid malpractice, flexible scheduling and excellent support. Contact Lily Santiago, Physician Recruiter: (800) 815-8377; email: lsantiago@hppartners.com; or visit www.hppartners.com/emra.

Maryland, Cumberland: With more than 12 years of service to the Maryland/Metro DC area, MEP now provides service in Cumberland, MD. Opportunities are currently available for ambitious BC/BP EM Residency-trained physicians to serve Western Maryland Health System (WMHS). J1 and H1B visas accepted. MEP offers an exceptional compensation and benefits package, with above market compensation, and malpractice with tail coverage. Leadership and ownership opportunities are available to qualified physicians. WMHS has an annual combined total volume of 64,000. Emergency services are provided at both campuses, with Memorial Hospital serving as the designated area wide Level III Trauma Center. Physicians will work at both campuses providing 24 hours of coverage. To consolidate services in one location, a new $268 million dollar state-of-the-art hospital with 275 inpatient beds, will open Fall 2009. MEP is a privately owned and physician owned and managed group. Contact AC McEwan at (301) 944-0049 or acmcewan@EmergencyDocs.com.

Maryland, Eastern Shore: Maryland Emergency Medicine Network (MEMN) is a well-established group that currently has opportunities for talented BC/BP emergency physicians seeking staff positions within Maryland. Opportunities are available in our two Eastern Shore communities that enjoy excellent public and private schools, family-centered activities, shopping, and gourmet restaurants. Choose this beautiful setting for its close proximity to the Chesapeake Bay and the Maryland/Delaware beach resorts. Enjoy boating and water sports all not far from the excitement of metropolitan life in Baltimore.
Emergency Medicine Associates, PA., P.C. (EMA), an established eleven-hospital, regional, democratic, physician-managed group seeks full and part-time BC or BP Emergency Medicine physicians to practice in Maryland, Northern Virginia and Washington, D.C.

Since 1971, EMA, the premiere provider of physician staffing & practice management in the Washington, D.C. area, has offered our physicians a quality-of-life that is unmatched!

Enjoy all the cultural amenities of the metropolitan Washington, D.C./Baltimore areas while secure in the knowledge of our 100% contract stability!

Send CV: Emergency Medicine Associates, PA., P.C., 20010 Century Blvd, Suite 200, Germantown, Maryland 20874 • Fax: 240-686-2334 Recruitment@EMAonline.com • www.emaconline.com
#1 Integrated Health System
Rewarding Emergency Medicine Opportunities

## St. John’s
Powerful Medicine
www.stjohns.com

![Image]

Enjoy working in a strong, physician-led organization known for its quality of care and patient satisfaction. Practice with qualified and experienced physicians who want you to succeed! Recently ranked the #1 Integrated Health System in the Nation, St. John’s is a model in excellence. If you are looking for stability and a wonderful community environment, your search will end here!

### EM Opportunity in Springfield, Missouri
- Flexible scheduling with 8 hour shifts
- Family friendly practice and community
- State-of-the-art Brand NEW ED
- 35 beds with 10 bed acute care center
- 89,000 patient visits per year
- Extensive specialty and sub-specialty backup

### Employed Opportunity with Compensation & Benefits Include:
- $140/hr base
- Excellent Bonus Potential
- Employee Benefits and Retirement Plans
- Occurrence Based Malpractice
- Moving Allowance

---

### Infinity HealthCare

**Emergency Medicine Opportunities**

**WISCONSIN:**
Milwaukee Area
Sheboygan
Kenosha
Appleton/Oshkosh
Beaver Dam
Green Bay
Marinette
Eau Claire
Chippewa Falls
Wisconsin Rapids
Door County

**ILLINOIS:**
Rockford
Libertyville
Evanston

Come see us at Booth #226 During ACEP

Our private practice group currently manages and staffs 21 emergency departments in Wisconsin and Illinois. Our respected, well-established emergency medicine group offers qualified, ABEM/AOBEM certified and EM residency trained physicians the opportunity to join us in a variety of practice settings.

Infinity HealthCare offers an outstanding compensation and benefit package including 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.

For detailed information please contact:
Mary Schwej or Johanna Bartlett,
Email: jhc-careerops@infinityhealthcare.com
Toll free: 888-442-3883 Fax: 414-290-6781
111 E. Wisconsin Ave, Suite 2100 Milwaukee, WI 53202

www.infinityhealthcare.com

---

### Classified Advertising

and Washington, DC. Employee status with excellent compensation package including shift differential and incentive plan. Malpractice insurance provided. Please forward CV and letter of interest to Susan Kamen at skamen@memn.org or via fax 410-328-8028. Phone 410-328-1859 for additional information.

**Maryland, Hagerstown:** MEP, a privately owned Emergency Medicine physicians group, expanded their services to Hagerstown, MD. Within an hour from Washington DC and Baltimore, greater Hagerstown is the fastest growing metro area in Maryland with affordable housing and numerous outdoor activities. Experience the small-town living, hospitality, and friendliness of this area. BC/BE Emergency Medicine Residency-trained physicians are invited to serve Washington County Hospital (WCH). WCH has a 35-bed ED with an annual volume of 66K, an 8-bed Fast Track, and is a Level III Trauma Center. A new hospital and ED will open in 2010. Physicists’ coverage is 56 hours. MEP offers an exceptional compensation and benefits package, with above market compensation, and malpractice with tail coverage. Leadership and ownership opportunities are available to qualified physicians. Contact AC: McEwan at (301) 944-0049 or email CV to acmcewan@emergencydocs.com.

**Michigan, Battle Creek:** BC Emergency Medicine physician sought for democratic group in 50,000 volume ED. Excellent package offers shareholder status at one year with no buy-in! Benefits include pension, family medical plan, CME, incentive income, malpractice, more. Stable group with outstanding physician retention record. Contact Kim Avalos Rooney, Premier Health Care Services, (800) 726-3627, ext. 3674, krooney@phcsday.com, fax (937) 312-3675.

**Michigan, Grand Blanc:** FT/PT, EM, BC/EP physicians for two 20,000 volume satellite ED’s and/or FT/PT, EM, BC/EP physicians for 64,000 volume main ED. Genesys Regional Medical Center is a beautiful 400 bed state-of-the-art hospital built in 1997 with a 26-position EM Residency and most speciality residencies. Our EM physician corporation offers employee status with full benefits, including CME allowance, dues coverage, first year Profit Sharing, malpractice coverage, and very competitive hourly compensation. Applicants please call or send CV to: Michael J. Jule, DO, FACEP, Director Emergency Services, One Genesys Parkway, Grand Blanc, Michigan 48439-1477, or email to mjule@genesys.org, or call(810) 606-5951.

**Mississippi, Oxford, Columbus:** Great college towns, state-of-the-art emergency departments, terrific lifestyle! Located 85 miles southeast of Memphis, Oxford is home to the University of Mississippi and Columbus is home to Mississippi State University. Seeking full time physicians; ED volumes range 30,000 – 45,000. **Sign-on bonus with**
OUTSTANDING EM OPPORTUNITIES IN NY

- Earn up to $165/hour (depending on the site)
- Programs for Residents: availability varies—ask for details
- Career development/advancement opportunities
- 11 different sites to choose from with volumes ranging from 12K to 40K
- Many sites are commutable from the New York City metro area

MedExcel USA, Inc. offers unparalleled opportunities for EM residents looking to practice in the Northeast. From low volume rural EDs to state of the art urban trauma centers MedExcel USA, Inc. provides physicians with a wide variety of potential practice settings. An extremely competitive compensation package includes a base salary, modified RVU and profit sharing.

MedExcel USA, Inc. is a quality-driven physician owned emergency medicine management group. We offer many innovative programs, including a “no-Wait ED” and a “Pain Sensitive ED” as well as unparalleled career opportunities and professional development.

We offer a nurturing, physician friendly environment in which to develop your future. Career development opportunities are available for those interested in an administrative career track. Stop by Booth 243 for more details.

South Jersey Health System
Emergency Physician Services, P.A.

New Jersey

Southern NJ democratic group incorporated for 10 years looking for BC/BP EM physician interested in stability and lifestyle.

Join a group of physicians dedicated to providing top-notch EM services at our Regional Medical Center in Vineland, Elmer Hospital in Elmer, and a SED in Bridgeton. This family-oriented community is close to city and shore with the option of suburban, urban or shore living.

Salary competitive with an excellent benefit package. Full partner/shareholder eligibility after one year with board certification. PT opportunities are also available.

Contact
Scott Wagner, M.D. or William DiCindio, D.O.
Emergency Medicine
South Jersey Health System
856-641-7733
e-mail wagners@sjhs.com
or dicindio@sjhs.com

Building Long-Term Partnerships in Emergency Medicine

Visit us at ACEP Scientific Assembly
Booth 500 • Boston • October 5-8, 2009

OPPORTUNITIES AS BIG AS TEXAS!

ESP is a democratic physician-owned group with over 23 hospital partners across Central and East Texas. With compensation models to maximize income, fair scheduling, paid malpractice, mentoring/leadership programs and Partnership opportunity, we truly have our physicians’ best interests at heart!

For further information on joining this dynamic team contact us at 888-800-8237.

www.eddocs.com
Teaching Hospital Affiliated with Columbia University; Paid Malpractice, Health Insurance, Relocation, Generous Vacation & CME Time; Retirement; PA Coverage and Excellent Support Staff. State of the Art Facilities; Great Quality of Life. Excellent Schools in a Safe Environment. Bassett has maintained a formal affiliation with Columbia University College of Physicians and Surgeons since 1947, and has actively participated in joint teaching and research initiatives throughout this relationship. Bassett joined the New York-Presbyterian Healthcare System in 2003. In 2009, Bassett formalized a relationship with Columbia to bring a medical campus of the College of Physicians and Surgeons to Cooperstown, NY. Cooperstown is a beautiful, historic village located on Otsego Lake, with year round cultural and recreational opportunities. It is a family-oriented community with excellent schools. It is home to the National Baseball Hall of Fame, the Fenimore Art Museum and the internationally acclaimed Glimmerglass Opera. For more information please contact: Colleen Donnelly, Bassett Healthcare, One Atwell Road, Cooperstown, NY 13326 or at (607) 547-6982; or Email colleen.donnelly@bassett.org or visit our web-site at www.bassett.org.

North Carolina, Charlotte: Emergency Medicine Opportunity in Charlotte, NC metro area. Mid-Atlantic Emergency Medical Associates (MEMA), an independent, self managed, physician owned practice of 60 physicians based in Charlotte, NC has outstanding opportunities for BC/BP EM physicians. We staff 5 hospitals throughout the greater Charlotte region. Opportunity for equal ownership in a stable local group founded on fairness and equality. Community practice with no academic affiliations. Flexible rotating schedule provides maximum time for family and leisure. Compensation package includes salary, incentive based profit sharing, health, life, disability, medical liability insurance, CME, excellent 401K/ profit-sharing retirement plan. The greater Charlotte area offers an excellent quality of life, unlimited recreational opportunities, good schools, lovely neighborhoods, very family friendly. Send CV, Cover Letter to Mary Lu Leatherman, Physician Recruiter, 704-377-2424, mleatherman@memanet.net, or visit our website, www.mema.net.

North Carolina, Charlotte, Greensboro/Winston-Salem, Greenville and central coast areas: A variety of partnership opportunities for Summer 2010 in our EDs seeing 40,000-100,000+ pts/yr. EMP is an exclusively physician owned/managed group with open books, equal voting, equal profit sharing, equity ownership, funded pension, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

North Carolina, Kinston: Located in the center of eastern North Carolina, Kinston is less than 60 miles to the east are some of the most beautiful beaches of the Carolina coast and 35 miles from Greenville. 200-bed full-service community hospital treats 39,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD, (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

North Carolina, Morehead City: Located in a sound-side seaport, Morehead City is a thriving, growing community. New 21,000 sq ft ED sees 37,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

North Carolina, New Bern: Respected 313-bed regional medical center located at the intersection of the Trent and Neuse Rivers just off the central coast. 65,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

Ohio, Barberton: Barberton Citizens Hospital is a full-service community hospital in southern suburban Akron with 38,000 ED visits/yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

Ohio, Cambridge: Southeastern Ohio Regional Medical Center is a 177-bed, full-service facility and Level III Trauma Center treating 34,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

Ohio, Cincinnati: Opportunity for BC/BP EM physician with democratic group. 66,000 volume ED is located in a desirable suburb and has 58 hours of daily physician coverage plus additional PA coverage. Excellent package includes incentive income, malpractice, employer-funded pension, family medical plan, CME, more. Contact Kim Avals Rooney, Premier Health Care Services, (800) 726-3627, ext. 3674, krooney@phcsday.com, fax (937) 312-3675.

Ohio, Dayton area: EM physician opportunity with Democratic group at 27,000 volume ED in Greenville - a family-oriented town commutable from Dayton. Excellent package includes malpractice, family medical plan, employer-funded pension, expense account, incentive income plus shareholder opportunity at one year with no buy-in. Contact Michele Wilkerson, Premier Health Care Services, 800-726-3627, ext 3672; mwilkerson@phcsday.com, fax (937) 312-3673.
TeamHealth has been very supportive of my interests, including my passion for ultrasound and teaching, which has enabled me to teach others in the techniques of emergency ultrasound at the INDO-US Emergency Medicine Summit and to work with residents. The physician leaders within TeamHealth have been excellent mentors. TeamHealth, research, teaching, and camaraderie have made my career more gratifying.

Charlotte Derr, MD, FACEP, Associate Program Director and Emergency Ultrasound Director (right), with resident Jennifer Fredericks, MD, PhD.

“I’ve been able to carve out my own niche in giving back to the specialty.”

Come see us in Boston, Booth 707 at the ACEP Scientific Assembly, and at TeamHealth’s physician reception, October 6, New England Aquarium.

TeamHealth has been very supportive of my interests, including my passion for ultrasound and teaching, which has enabled me to teach others in the techniques of emergency ultrasound at the INDO-US Emergency Medicine Summit and to work with residents. The physician leaders within TeamHealth have been excellent mentors. TeamHealth, research, teaching, and camaraderie have made my career more gratifying.

800.818.1498 • teamhealth.com • physicianjobs@teamhealth.com

In the business of saving lives, how about we start by improving yours.

We’re passionate about emergency medicine. And we believe satisfied medical professionals provide better care. Join our team at one of five excellent Maryland facilities and enjoy the lifestyle you deserve, including:

- A healthy work-life balance
- Above-market compensation
- Ownership opportunities
- Comprehensive health benefits
- Malpractice insurance
- 401(k) with company contributions
- FT, PT, and PT with benefits positions available

Visit us at the EMRA job fair!

Emergency medicine physicians, please contact Amy-Catherine McEwan at 301.944.0049 or e-mail CV to ACMcEwan@emergencydocs.com.

JOIN MEP

EmergencyDocs.com
YOUR PARTNER IN EMERGENCY CARE
Join EMA’s experienced team of emergency physicians:
- 100% physician owned and managed
- Democratic structure
- Full, equal and early partnership within 4 years
- Excellent compensation package, including comprehensive health coverage, disability insurance, 401(k), malpractice

Please visit EMA in Booth #535.

Transforming EDs into Centers of Excellence for 30 Years

Emergency Physicians of Tidewater (EPT) is a progressive, democratic group serving 7 hospitals in the Virginia Beach/Norfolk area. The practice includes level 1 and 2 trauma centers, as well as diverse community settings. EPT provides faculty for and directly supervises an EM residency program. Great niche opportunities in U/S, EMS, administration, tactical medicine, forensics, and hyperbarics. Well-staffed facilities. Competitive financial package leading to full partnership and profit sharing. Great, affordable coastal area with moderate year-round temperatures and beaches minutes away. Only EM BC/BP candidates accepted. Send CV to Emergency Physicians of Tidewater, 4092 Foxwood Dr., Ste. 101, Virginia Beach, VA 23462 • Phone (757) 467-4200 • Fax (757) 467-4173 • E-mail chercasp7@aol.com
JOIN US IN ORLANDO

The Best Career Option
For Emergency Medicine Physicians!

- $150/hr RVU Based Pay
- Sign-on Bonus
- Relocation Assistance
- Partnership Opportunity
- Leadership Opportunities
- 138 hours/month Full-time + Benefits
- Comprehensive Benefits Package
- Eight Florida Hospitals - 350,000 ED visits
- EM Residency

VISIT OUR BOOTH AT THE EMRA
JOB FAIR AND AT THE ACEP
SCIENTIFIC ASSEMBLY 2009
(BOOTH 766)

FEP is celebrating its 40th anniversary as a stable organization serving Florida Hospital in the largest ED system in the country. Orlando is a rapidly expanding multi-cultural city, with many attractions, dozens of acclaimed golf courses, famous beaches, and excellent school systems! Florida currently has no state income tax, which means that most providers moving into Florida do get an automatic raise if they leave a taxable state. FEP offers relocation assistance including realtor services and banking/mortgage options. Please visit our website at www.floridaep.com.

Contact:
Brian A. Nobie, MD, FACEP
or David Sarkarati, DO, FACEP
At (800) 268-1318
Email CV’s to Susan Yarcheck at: syarcheck@psrinc.net or by fax to (407) 875-0244

FEP Mission Statement

Dedicated to Excellence in Emergency Medical Care While Providing a Human Touch to Those in Need...Since 1969
Exciting Academic EM Opportunity, Get in on the Ground Floor!

The Baylor College of Medicine, a top medical school, is in the process of developing an Emergency Medicine Program & Residency in the world’s largest medical center.

We are recruiting stellar Emergency Medicine BC/BP Clinician Educators and Clinician Researchers at all academic ranks who will be an integral part of building the future of Emergency Medicine at BCM. We offer a highly competitive academic salary and benefits.

The program will be based out of Ben Taub General Hospital, a busy county trauma center in the heart of Houston that sees more than 90,000 emergency visits per year. BCM is affiliated with the Texas Children’s Hospital and eight world class hospitals and clinics in the renowned Texas Medical Center. These affiliations along with the medical school’s preeminence in research will help to create one of the strongest emergency medicine programs in the country.

Interested parties, please email your CV to Dr. Shklezen Hoxhaj, hoxhaj@bcm.tmc.edu, 713-873-2626. BCM is an AA/EOE.

Physician owned and operated, EPMG offers a variety of career paths including academic, clinical, and administrative. At EPMG you’ll enjoy flexible scheduling, allowing you to choose a work and lifestyle balance that suits your personal situation. We value your time. At EPMG we employ our clinicians, which provides all the benefits of employment including: competitive compensation, full paid family medical benefits, Rx, dental, vision, life, LTD, 401(k), paid malpractice with tail, performance based bonuses, and much more.

EPMG employs board certified physicians who have completed our rigorous interview screening process. We only hire clinicians with superior references and affiliations. Our sites range in volumes from 8,700 to 88,000, and our facilities have a local, core group of clinicians. Work for the best! If you are interested in a career with EPMG, please contact Tynia Arnold at 800-466-3764, x335 or tarnold@epmgpc.com. Visit us on the web at www.epmgpc.com.

EPMG cares about you, your family, and your career.
outdoor activities, a low cost of living and the amenities of Pittsburgh are easily accessible. We offer an outstanding compensation/benefit package including: paid malpractice insurance with tail, employer-funded retirement plan, paid health insurance, CME allowance, and more. Board certification/prepared in EM. Call Dr. Robert Maha at 888-647-9077/Fax 412-432-7480 or e-mail mahar@upmc.edu. EOE.

Pennsylvania, York: Memorial Hospital in York is host to a respected osteopathic EM residency program and sees 41,000 annual ED visits. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD, (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

Texas, Longview and Marshall: EM Physician – Beautiful East TX Location. BC/BP Residency-trained Emergency Physicians are invited to join an established, growing practice. Physicians will provide service to Good Shepherd Medical Center, Longview and Marshall, Texas (GSMC). Potential candidates will be working with Longview Emergency Medicine Associates (LEMA), a locally owned and operated Emergency Medicine physician group. Physicians receive productivity compensation, and paid professional liability insurance. In addition to this, a two year partnership track is also available. GSMC, Longview is a Level II regional trauma referral center, with an annual volume over 80,000. GSMC, Marshall is a Level II trauma center, seeing 26,000 patients annually. Physicians cover 54 hours while mid-levels cover 31 hours. Just 121 miles east of Dallas, Longview features captivating lakes, lush countryside, and excellent schools. Experience great shopping, fine dining, or the fine arts of the symphony orchestra in your leisure time. Contact Teri Geen at (800) 346-0747 ext. 3168 or email tgeen@psrinc.net.

Virginia, North Central: Emergency Medicine residency trained physician to join a private group that staffs a 175 bed community hospital in a desirable suburb in north central Virginia. Competitive hourly rate plus benefits, insurances, and opportunity for additional hours. For details contact Scott Berger at scott@mdrsrch.com or 800-327-1585 x203.

Virginia, Richmond: Beckley & Ronceverte: Excellent opportunities await you in southern West Virginia! Join our progressive, physician-governed group and earn lucrative productivity-based compensation at 22,000 volume EDs enhanced with mid-level coverage. Enjoy working with a strong nursing team and supportive medical staff towards achieving patient satisfaction and efficiency goals. Physicians must be BC/BP EM. What’s important to you is what matters to us…attractive compensation, paid malpractice, flexible scheduling and regional leadership. For details, contact Lily Santiago at Hospital Physician Partners: (800)815-8377; email: lsisantiago@HPPartners.com or visit www.hppartners.com/emap.

West Virginia, Charleston: BC/BP Emergency Medicine physician opportunity within academic environment. Three-hospital system has 100,000 annual ED visits and includes Level I facility. Numerous allopathic & osteopathic residencies including EM. Democratic group provides family medical, employer-funded pension, CME, malpractice, plus shareholder status at one-year with no buy-in! Contact Rachel Klocakow, Premier Health Care Services, (800) 406-8118, klocakow@phcsday.com, fax (954) 986-8820.

West Virginia, Wheeling: Ohio Valley Medical Center is a 250-bed community teaching hospital with a brand new ED under construction. AOA approved Osteopathic EM and EM/UI residency program. Enjoy teaching opportunities, full-specialty back up, active EMS, and two campuses seeing 26,000 and 22,000 pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD, (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.
Premier’s grass is greener.

“Premier has provided me with many career opportunities to grow professionally. I can tailor my work responsibilities to challenge myself while still enjoying time with my family.”

Nathaniel Sherman III, MD
Premier Physician since 1991
Chair, Diversity Task Force
Premier Board Member, 2004 to present

Visit us in Booth 547 at ACEP Scientific Assembly

You have a voice in your future.

- Competitive first-year compensation packages up to $300,000 or more!
- Democratic Group with true equity ownership, voting rights, and no buy-in
- Shareholder Status within one year
- Additional incentive income opportunity
- Excellent paid benefits including: pension, family medical plan, CME, malpractice
- Solid malpractice and acclaimed risk management programs
- Leadership development & growth opportunities

Premier Health Care Services, Inc.

Physician Owned and Managed Since 1987
Dayton, Ohio • (800) 726-3627

www.premierhcs.net
When you find the right fit

Corporate suits can rub you the wrong way. They're often more concerned about the bottom line than watching your back. Emergency Medicine Physicians is owned by emergency medicine residency trained physicians who are dedicated to delivering the best in emergency medicine – and living life to its fullest. If your perfect fit includes a schedule you make your first year, the right location and a democratic organization with equal equity, try us on for size. Stop by booth #1101 at the Boston Scientific Assembly or check us out at emp.com.

EMP
Emergency Medicine Physicians

EMP.com  800-828-0898  twitter.com/empdocs
Opportunities across the USA.