

PaACEP News

PENNSYLVANIA CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
DECEMBER/JANUARY 2003-2004

Executive Privilege

A Meeting with the Secretary of Health

by Theodore Christopher, MD, FACEWP
President, PaACEP



On November 6, I traveled to Harrisburg with PaACEP President-Elect Marilyn Heine and Executive Director David Blunk to meet with newly appointed

Pennsylvania Secretary of Health, Calvin Johnson, MD, and members of his staff. We had a number of issues to bring to the table on behalf of emergency physicians throughout the state, and I was happy the Secretary agreed to meet with us face-to-face.

The Department of Health (DOH) represents the state's health and medical policing body if you will. Every state has a DOH. No one can deny that their broadcast messages for endemic infectious disease updates and alerts are both necessary and informative. In my experience, the DOH is also helpful in reviewing plans to alter or add to facility health service capabilities in expanding or renovating Emergency Departments (ED's). They are also very active in state Emergency Medical Services. Recently, they have given a watchful eye to ED patient elopements and hospital EMS diversion policies. Also, the DOH has been instrumental in organizing our state's response to bioterrorism and disaster threats, including the allocation of funds earmarked for these purposes. This has been done in conjunction with input from PaACEP as well as other key health care constituents in the state.

There is a good chance that you in the ED and/or your hospital will be visited by DOH member(s) at least once in your lifetime. Aside from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), no regulatory body evokes more anxiety and trepidation from hospital administrators than the DOH. Their visits are often unannounced and in response to a specific patient complaint or healthcare delivery deficiency that has been in some way called to their attention. Beginning January 2004, the JCAHO will follow suit. All JCAHO hospital visits, like the DOH, will be unannounced. When these organizations arrive at your institution, they want to see medical records, tour your facility and interview staff. They have essentially unlimited access. The consequences of a bad review are enormous. In essence, they can fine and shut down your ED and hospital if "rules and regulations" are not followed.

We had heard rumblings that because of hospital diversions, ED crowding and a new emphasis on patient privacy, the ED's of the State might be on the DOH's regulatory "radar screen." We decided it was a good idea to meet and share with them the reality of Pennsylvania's emergency medicine practice environment.

I had previously met Calvin Johnson on numerous occasions when he was a pediatrician working in Temple University Hospital's Pediatric Emergency Department in Philadelphia. He had come to Jefferson at least twice, once to lecture our residents, and the other time with then Philadelphia

Health Care Commissioner Estelle Richmond to speak against youth violence and advocate for violence prevention in our city. Good causes. We thought he would continue to be sensitive to health care issues in emergency departments.

In addition to the three of us and Secretary Johnson, others around the table included Anne Torregrosa (representing RoseMarie Greco from the Governor's Office of Health Care Reform), Dawn Jackson (Director, Policy and Legislative Affairs), Norris Benns, Jr. (Special Assistant to the Secretary), George Aupperlee (EMS Program Specialist), and other DOH departments. Indeed, a serious audience of health policy players.

We began by explaining how the current medical liability crisis is affecting emergency medical care in the Commonwealth. Physicians leaving the state, retiring early and not willing to assume high-risk care or perform high-risk procedures are causing patients to flood ED's in record numbers. The ED's truly represent the safety net for health care not only in the state, but also in the country, but Pennsylvania's medical

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Executive Privilege

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liability crisis is exacerbating the problem to dangerous levels. Patients are accessing the ED's for the health care they can no longer obtain from their private physicians, and the result all too often is ED crowding.

"What is your own specific premium increase experience?" We told them that the rising cost of malpractice insurance for emergency physicians is forcing many to look to hospitals to subsidize this expense. The crisis is not just with the high-risk specialties (orthopedist, neurosurgeons, general surgeons and obstetricians/gynecologists). I explained to them my own emergency physician group at Jefferson is now paying \$1 million dollars towards our premiums (up from \$250,000 just a few years ago). We argued this is money that can be better spent on additional ED

staff and equipment, and at Jefferson, more teaching and research resources for our educational programs. They seemed surprised.

"How crowded are we?" We were on a roll. We explained many ED's, especially those in the cities, are at and over capacity from the earliest hours of the day. Higher patient volumes means patients are routinely being seen upwards of 12 hours each day in ED hallways and chairs, compromising not only patient care but also patient privacy. Of course, with HIPAA regulations coming soon, this was completely understood.

They were unaware of JCAHO's recent emphasis on ED crowding, and recent JCAHO proposed standards that would require hospitals to specifically address the ED crowding issue — including sending admitted ED patients to locations other than ED hallways. Although the JCAHO has since temporarily pulled this standard, Dr. Johnson asked to see it. I promised him a copy. The general consensus is that this standard will reappear soon in some form or another. Hospitals will be required to specifically address ED crowding. I told them that JCAHO would probably not be citing ED's across the country for crowding and patient privacy issues, but that this problem is now on their "radar screen" as a patient safety issue. JCAHO understands our reality. Now, we thought, so did the DOH.

We suggested there might not be appropriate incentives for hospitals to move ED admitted patients to hospital floors. Hospitals are paid "inpatient admission" rates for patients admitted to the hospital whether or not the patients are moved from the ED to the inpatient floors. A patient "admitted to the hospital" and cared for by an inpatient medical team can stay his/her entire admission in the ED and then be discharged. In our opinions, this has to be addressed.

"We know trauma centers are closing," they remarked. We felt the need to explain. A "trauma center" is part of an emergency department. Most patients seen by trauma teams in "trauma centers" are not critically ill. Only a very small percentage of designated trauma patients end up in the operating room. An equal number of acutely ill patients are seen daily in emergency departments. The legislators and public should be equally concerned about their local emergency departments

being dangerously crowded, as they are about their trauma centers closing. Ironically, if trauma centers were to close, these patients would still arrive to be seen, evaluated and treated — to already crowded emergency departments.

"What about diversions?" We knew the DOH is now requiring hospitals to report hours of diversion. They were deeply concerned about the low threshold that some hospitals were using to go on EMS diversion, subjecting other hospitals to overwhelming ED patient volumes. Some guidelines were needed. The DOH promised to send us information about hospital diversion frequency within the state.

We did not touch upon issues concerning bioterrorism and disaster preparedness. We knew DOH has formed a state task force to address these issues. We assumed through our representatives that we would soon be hearing about initiatives in this regard. We did mention that it is currently written in DOH regulations that hospitals are supposed to activate their disaster plans whenever ED patients occupy ED hallways. Everyone agreed this is not currently being done and certainly not being reported to DOH whenever such ED capacity is reached.

The meeting ended with everyone shaking hands and promising to work together on issues involving the provision of emergency care in the Commonwealth. Ms. Torregrosa from the Governor's office commented that the meeting "had been an eye-opener" and that she "had learned a lot." I guess we had stated our positions on medical liability and ED crowding well. I commended Dr. Johnson on his new appointment and remarked how pleased PaACEP is that a physician sensitive to emergency medicine issues is now the state's Secretary of Health. Dr. Johnson concurred and pledged a willingness to work with us on these tough issues. Before he rushed off to another meeting, he asked us if we could ask our membership to support Governor Rendell's liability initiatives, especially with the legislative year coming to an end. "The Governor has a great proposal to really help the doctors." I confessed that I hadn't read Governor's proposal but would do so. *Quid pro quo.*

Such is the art and obligation of a political meeting. ■

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2003 Year of Ups and Downs

Looking Forward to Positive Change

As we go to press with this issue of “*PaACEP News*,” the state budget was just approved, and even with Mcare abatement relief, the medical malpractice crisis in Pennsylvania continues to loom.

This year has turned out to be one of ups and downs for emergency and all other physicians in the Commonwealth. Some resolves have been disheartening, such as repeal of Pennsylvania’s 30-year-old motorcycle helmet law and the continuing struggle for malpractice reform; others have brought relief, such as clarification of the use of paramedics in the ED.

As 2003 comes to a close, we take one last look back at the issues that have shaped the year and that will be the target of Chapter efforts in the year ahead.

Medical Liability Reform

When the ball dropped, bringing in 2003, Pennsylvania physicians were optimistic that “this would be the year of change” for the state’s medical liability climate. The spark was lit when President George W. Bush visited Pennsylvania in January to bring attention to the matter. Chapter President-elect Marilyn Heine, MD, was one of six Pennsylvania physicians invited to participate in a closed-door roundtable with the President in Scranton. There, he admitted the country’s medical liability system was broken and promised support for relief at the federal level.

Governor Ed Rendell immediately offered proposals to bring about much-needed relief to the Commonwealth, in the form of Mcare relief and trauma center subsidies, among others. His goal was to make the practice of medicine in Pennsylvania once again satisfying and affordable.

But as the year progressed, the proposed changes led to even deeper frustration, as not much movement actually occurred to make the “crisis situation” any better. In recent months, physicians’ frustration has been further fueled by the lack of passage of a state budget. All pending legislation was pushed aside as the General Assembly labored over funding issues for months.

One proposal waiting on the sidelines is an amendment to the State Constitution to remove the prohibition on caps on non-economic damages. Passed last summer by the House of Representatives, it was referred to and, as of press time, remained in the Senate Judiciary Committee.

One worthwhile venture has been the Senate Work Group to investigate the medical liability crisis in the Commonwealth.

In recent news the work group drafted a bill to provide some civil immunity for trauma centers and health care professionals at a trauma center. The Chapter responded, outlining why this immunity should also be granted to EDs (see box on page 4).

On a broader scale, in an effort to push for reform before the end of 2003, the Pennsylvania Medical Society on December 3 publicly presented a letter to the General Assembly demanding a comprehensive package to fix problems associated with the liability insurance crisis.

“We’re here today, not to point fingers or place blame,” said Daniel J. Glunk, MD, chair of the Board of Trustees of the Pennsylvania Medical Society, “but to ask the Pennsylvania Legislature and Governor Rendell to come to agreement immediately on a comprehensive package that includes both short-term relief and long-term lawsuit abuse reforms.”

In a PaACEP press release, Chapter President Ted Christopher, MD, FACEP, said: “Patients are turning to emergency departments for their care, further contributing to the already existing statewide problem of emergency department crowding. Emergency physicians are proud to serve as a health care safety net for patients, and we are committed to this role; however, unless relief comes soon, the lack of resources in emergency departments threatens to overwhelm our ability to care for our patients.”

Pennsylvania ACEP, from the start, has strongly supported the Pennsylvania Medical Society’s efforts to reform medical liability in the Commonwealth. The year ahead will be no different, as we look to the Medical Society to take the lead with general legislation and to keep the public apprised of the workings of our Legislature. The Chapter, in addition to this support, will focus its immediate efforts on the immunity issue — pushing for fair treatment of emergency physicians in light of EMTALA requirements.

Other Legislative Issues

Legislatively, public health and patient safety took a hit in July 2003 when Governor Ed Rendell signed a bill to repeal Pennsylvania’s 35-year motorcycle helmet law. The new law allows motorcyclists 21 years and older, with two years of riding experience or specified training, to go without a helmet on Pennsylvania’s roads if they choose.

In a press release issued in early September, when the new law took effect, Chapter President Ted Christopher, MD, FACEP, said:

“We are disappointed with the repeal of the law, no doubt ... Study after study has proved — and [emergency physicians] can personally testify — that helmets do indeed save lives and reduce the likelihood of debilitating injury ... Emergency physicians across the Commonwealth are committed to fighting this repeal with new legislation in the future. Until such a time when, unfortunately, statistics take this repeal back to the Legislature, emergency physicians will continue to appeal to riders to wear their helmets — for their own safety and for their loved ones ... A long, healthy life is a privilege, and this privilege now lies in each rider’s hands. Please, riders, be safe. Wear your helmets.”

The Chapter will be monitoring the statistics related to this law change, and when allowed in two years, will fight to regain a law aimed more at rider safety.

On a more positive note, Dr. Christopher and Ted Corbin, MD, of Thomas Jefferson University Hospital, met with the Pennsylvania Legislative Black Caucus of State Legislators to discuss the issue of primary seat belt enforcement. The Chapter has tried to bring primary enforcement to the legislative table for years, but members of the Caucus — though they have “no doubt” that seat belts save lives — believe some “police officers use it to continue racial

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profiling.” They were, however, impressed to see a 1999 National Black Caucus of State Legislators’ resolution supporting primary enforcement. At press time, the Chapter was researching the issue more in depth, preparing to meet again in January with the Caucus members. Leadership is optimistic on movement of this effort thus far.

Collaborative Efforts

In recent years, collaborative efforts with other groups in the Commonwealth related to public health and issues of medical practice in Pennsylvania have moved up the priority list of the Chapter. The past year offered many opportunities for collaboration for Chapter members, including:

- Late in 2002, Edward Jasper, MD, FACEP, was named Chapter representative to a Pennsylvania Department of Health volunteer team of experts formed to assist in preparing for and managing a terrorist event. Dr. Jasper has offered reports of his meetings in “PaACEP News” throughout the year. Look for continued coverage in 2004.
- Gregory R. Frailey, DO, served on the Pennsylvania Medical Society’s newly developed Council on Patient Advocacy. The focus of the Council is to “take up the definition and potential initiatives related to patient advocacy.” Dr. Frailey says he believed his voice on behalf of Pennsylvania’s emergency physicians was heard at the Council. **Geoffrey Ruben, MD**, was recently appointed as the new emergency representative.
- In October, Bruce MacLeod, MD, FACEP, was one of two trustees elected to represent the hospital-based specialties of

radiology, anesthesiology, emergency medicine, and pathology on the Pennsylvania Medical Society Board of Trustees. The election of Dr. MacLeod and the other specialty representatives is the culmination of a two-year process by the Medical Society’s Specialty Leadership and Executive Committee to make structural and Bylaws changes to incorporate specialty society involvement in the governance of the Society. PaACEP was also represented on the Specialty Leadership Cabinet.

- Keeping sovereign immunity on the table was the goal of a November meeting of Chapter leaders and staff of the governor’s Office of Health Care Reform. Chapter President Ted Christopher, MD, FACEP, and Vice President Marilyn Heine, MD, met with the assistant to Rosemarie Greco, Secretary of Health Care Reform, to discuss the sovereign immunity issue. Drs. Christopher and Heine agreed that the meeting was a good education for the secretary’s office to realize that trauma centers are not the only facilities dealing with mandated care, but that, in fact, “regular old EDs” deal with the same issues as well.

Policy Efforts

The ACEP Council in early October adopted three PaACEP-sponsored resolutions, which direct the national organization to:

- 1) collaborate with NHTSA’s Research and Data Collection Efforts Program on relevant issues of helmet use, provide individual chapters with this scientific database from both the state and national level, actively continue to promote and endorse universal helmet laws for motorcycle riders, and actively support the development of federally legislated universal helmet laws for motorcycle riders;

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Sovereign Immunity: How Trauma Centers and EDs Compare

Chapter President Theodore Christopher, MD, FACEP, in a December letter to the Senate Work Group on medical liability reform, offered the following:

“Whether or not one is referring to a trauma center or emergency department, the following apply regarding the provision of emergency medical and trauma care:

- Providers of trauma care and emergency medical care in emergency departments are compelled by federal law (EMTALA) to evaluate every patient, not just trauma patients, regardless of their insurance status or ability to pay.
- Emergency care providers operate in a high-risk and highly complex environment. Hundreds of independent judgments must be made without benefit of knowing the patient’s prior medical history.
- Emergency care providers frequently face multiple patients, including trauma patients, with co-existing emergencies. Therefore, the need to ensure adequate coverage by emergency physicians, on-call specialist physicians, emergency nurses and other personnel is paramount.
- Emergency care providers have no control over the amount of or lack of medical care previously received by the patient. Patients may present having had no prior medical care for what might be serious medical conditions, or may have knowingly engaged in activities known to exacerbate existing medical problems.
- Although patients can be referred to other health care providers for follow-up care, emergency care providers have little or no control over the patient’s willingness or ability to obtain such care or the payer’s willingness to cover such follow-up care.
- In every community statewide, emergency care providers represent the only universal access to health care for low-income, indigent, uninsured, under-insured and even insured patients.
- Pennsylvania’s capacity for emergency care is being outstripped by patient demand for emergency care services as emergency department visits continue to rise: 4.6 million visits as of June 30, 2000, to 5.1 million visits as of June 30, 2002.
- While providers of emergency care are required to treat all patients, the government does not ensure that provision of such services are appropriately compensated. Providers of emergency care are subject to a high percentage of uncompensated or under-compensated care.
- Emergency care providers must pay for medical liability insurance and other associated costs for every single uncompensated or under-compensated patient seen by them. For a significant percentage of patients, emergency care providers actually lose money every time care is provided, regardless of whether the patient has an emergent condition or is strictly using the emergency department because the patient has no other access to health care in the state.”

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- 2) revise its current policy to reflect that the emergency physician medical director or chief of emergency medicine should be directly involved in assessing and making such recommendations; and
- 3) gather information from lending institutions on accounts receivable financing, disseminate the information to the ACEP membership, and provide a report to the 2004 Council.

Also, the Pennsylvania Medical Society House of Delegates later in the month adopted a Chapter-authored resolution:

“... that the Pennsylvania Medical Society advocate for and include, as part of its medical liability reform, the provision of sovereign immunity for physicians who provide EMTALA-mandated care in the Commonwealth of Pennsylvania.”

Adoption of this resolution has not only made advocacy of sovereign immunity a policy at the Medical Society; more importantly, it has placed the issue “on the table” for discussion in the Pennsylvania legislature.

Practice Management

The July issue of “PaACEP News” brought much-needed and –welcomed clarification from PaACEP Board Member and Commonwealth EMS Medical Director Douglas Kupas, MD, FACEP, on the employment of ED staff who are also certified as paramedics. The problem, through the years, was that the interpretation of the EMS regulations on the subject have changed, along with changing practice conditions. But interpretations differed, thus causing misunderstanding.

According to Dr. Kupas:

“While a paramedic is not authorized to function as an integral staff member in an ED, individuals who are otherwise qualified to function in a position within an ED staff, who also are trained as paramedics, can be valuable members of an ED team due to their training. It is important that the ED administration develop a job description that defines the position without linking the individual’s patient care responsibilities to the role of a paramedic as defined in the EMS regulations.”

A list of Dr. Kupas’ “dos and don’ts,” further clarifying the issue, was also found in the July issue of this publication and are also available on-line at www.paacep.org.

Membership

In March, members were asked to complete the first all-member survey developed by the Chapter in more than 14 years. The goal of the survey was to gather demographic information, as well as answers to a series of questions on training and certification, professional associations, the practice of medicine and practice environment, and compensation. Additional questions focused on what members expect of the Chapter.

The initial response to the survey was overwhelming, with a more than 41% response rate. At press time, the Chapter was re-tabulating the answers for assured accuracy; analysis and results are expected to be published in the spring.

Resident membership in PaACEP has been a high priority for many years for the obvious reason — these members are the future of our profession. In the March issue of “PaACEP News,” Seth Hawkins, MD, resident representative to the Chapter’s Board of Directors, offered his views on the importance of PaACEP, along with

comments on his experience on the board. Here is a brief excerpt of that commentary:

“Working with the board of directors of PaACEP has been an invaluable experience My two years on the board have taught me how critical PaACEP’s role is in protecting emergency physicians and promoting sensible legislation related to our field. This is in addition to PaACEP’s educational mission to enhance the clinical skills of graduated physicians As emergency physicians-in-training, we are taught how to save lives and prevent illness, one patient at a time. My time with PaACEP has taught me not only the ways solutions can be found to medical problems on a societal and legislative level, but also how critical this approach is to protect our work and our patients ... PaACEP offers the opportunity to participate in and learn about the business and legislative elements to our field, which are often neglected in residency training ... participating in these activities now allows us to protect our future tomorrow”

Pennsylvania ACEP now has two residents on its board, Robert Cannon, DO, and Rex Mathews, MD. In addition, the Chapter offers several benefits to resident members including:

- No dues at the state level
- Significantly reduced tuition to all Chapter CME programs, including free tuition to the Annual Scientific Assembly
- Involvement opportunities through Chapter committees
- Receipt of all member communications
- Chapter-stipend for one resident’s attendance to the annual ACEP Spring Leadership and Legislative Conference

More information on the all-member survey and resident membership is available through the Chapter Office, 1-888-633-5784, extension 1468.

CME in '03

The highlight of Pennsylvania ACEP’s continuing medical education programming in 2003 was April’s Scientific Assembly, marking its 30th anniversary. More than 180 emergency physicians and residents attended the three-day Assembly in Pittsburgh in April.

Included in the program were a morning of literature reviews, an afternoon devoted to new technologies and therapies, and numerous sessions dealing with health care finances within the Commonwealth and difficulties with liability insurance. Brian Keaton, MD, FACEP, a member of the ACEP Board of Directors, was the Keynote Speaker at the Chapter’s Annual Meeting, held in conjunction with the Assembly.

Other quality programming this year included:

- Oral Board Simulation Course
- Emergency Medicine Written Board Review Course
- Reimbursement and Coding Seminar
- 9th Annual National ED Information Systems Symposium
- Meet Your Non-Institutional PA Trauma Systems Foundation Trauma Requirements

In Memoriam

PaACEP was saddened to report the death of two of its members this year: Past Chapter President, Howard G. Hughes, MD, FACEP, Danville, and long-time ACEP and PaACEP member Dr. Peter Safar, of Pittsburgh.

Dr. Hughes died in April after a long-fought battle with cancer.

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A native of New York, he earned a B.S. in Biology from Wilkes College, and an M.S. in Microbiology from Penn State. A Vietnam War veteran, he graduated from Jefferson Medical College in 1974. He spent his 29-year professional career at Geisinger Medical Center, including 10 years as an emergency physician. In addition to his service to Pennsylvania ACEP, Dr. Hughes was chairman of the Keystone Safety Belt Network, instrumental in getting Pennsylvania's seat belt law passed 16 years ago. He is survived by his wife, Bonnie, and two grown children.

An anesthesiologist by training, *Dr. Safar* revolutionized emergency care and was often called the father of modern-day CPR. Best known for his work in the 1950s and 1960s, he initiated the change from manual to mouth-to-mouth artificial ventilation worldwide. He developed CPR step A and step B, then combined the two steps into basic life support. He later extended CPR to include the

nine steps of basic, advanced, and prolonged life support, and co-initiated modern life support first aid, resuscitation, and intensive critical care medicine. Dr. Safar is fondly remembered by colleagues worldwide, not only for his innovative work in CPR, but also for his humanitarianism and genuine commitment to helping others.

2004, is sure to bring old and new challenges for PaACEP leaders and members: How will medical malpractice play out? How will the practice of emergency medicine be different from last year? Foreseeing the future has never been easy, but the Chapter is prepared to take on the old and new with the faithful commitment its members have come to rely on over the past three decades.

On a final note, a general thank you is extended to all Chapter members for making the past 30 plus years productive and successful — for attending our growing CME programs, for participating in the most recent membership survey, for doing your best to provide quality patient care in each of your hospitals, and for being great ambassadors to the public on behalf of the profession.

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Chapter Seeks Scientific Papers for Presentation at the 2004 PaACEP Scientific Assembly

February 1, 2004, is the deadline to submit scientific abstracts for the William H. Spivey, MD, FACEP, Research Competition. The contest will take place on April 21, at the Wyndham Franklin Plaza Hotel, Philadelphia, in conjunction with the annual PaACEP Scientific Assembly.

This year's contest will feature cash prizes for the best clinical and best basic science presentation is both the poster and platform competition.

Emergency physicians, residents, fellows and medical students can submit abstracts that address issues pertinent to emergency

medicine. Original research and case series will be accepted. A physician panel chaired by Ted Christopher, MD, FACEP, will review all abstracts.

Abstracts can be submitted online at www.paacep.org. ■

Awards

PaACEP Pennsylvania Emergency Physician of the Year Award

The PaACEP Board of Directors is seeking nominations for the Annual PaACEP Emergency Physician of the Year Award. Developed under the auspices of the Chapter's Board of Directors, the award will "recognize emergency clinicians of unusual merit, to encourage and acknowledge members who pursue the ideal of emergency medicine, and to promote the public image of emergency medicine." In other words, the award seeks out those practitioners working "the daily grind," trying to be the best emergency doctors they can be, and in the process portraying a "good" image of the profession to the public.

Selection criteria requires that each nominee be a current member of PaACEP, an outstanding emergency physician role model, and an effective patient advocate who:

- Upholds high professional standards,
- Maintains an active clinical practice of emergency medicine,
- Practices and promotes high quality emergency medical care,
- Promotes the public image of emergency medicine, and
- Is active in community service and education.

Any member of PaACEP may make nominations. The deadline for 2004 award nominations is February 1, 2004, with presentation of the award planned at PaACEP's Annual Scientific Assembly in April. You can fax (717-558-7841) or e-mail (dblunk@pamedsoc.org) your Emergency Physician of the Year Award nominee.

The 2003 award was presented to Debra Stoner, MD, FACEP. ■

Interested in Serving on the PaACEP Board of Directors?

You have an opportunity to serve your profession and help promote, guide, and lead it into the future. By volunteering your time to your Chapter, you can gain much more from the experience than you put into it.

If you are interested in joining the PaACEP cause through participation as a member of the board just submit your intentions in writing to the PaACEP office (fax: (717) 558-7841; e-mail: dblunk@pamedsoc.org) in care of chapter secretary Robert Cameron, by January 16, 2004. ■

PaACEP News

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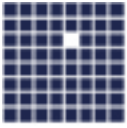
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