Pennsylvania is a success story when it comes to medical malpractice reforms,” – Edward G. Rendell, Governor, April 23, 2009

“A Clear and Convincing Case for Liability Reform

A success story?
We’ve all seen recent cases of dubious merit filed against emergency physicians, so-called expert witnesses playing fast and loose with the facts with minimal risk of repercussion, and trial attorneys continuing to flourish. Despite claims of victory against the malpractice crisis, we don’t hear that trial attorneys are losing business. Mediation and arbitration are often touted but infrequently utilized, and our adversarial, inefficient, costly tort system thrives. Physicians keep practicing defensive medicine. A survey from the Massachusetts Medical Society last year conservatively estimated the cost of defensive medicine at a minimum of $1.4 billion in Massachusetts alone. This directly affects access to care and exposes patients to unnecessary risk. Two-thirds of emergency physicians surveyed admitted that they altered their practice solely due to fear of lawsuits.

As we all can intuit and has been documented, cases can sometimes flip between a defense and plaintiff’s verdict based on emotion, misinterpretation of facts, and the somewhat arbitrary behavior...continued on page 6

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**Legislative Update**

**EMS Act 37**

**Douglas F. Kupas, MD, FACEP,**
Commonwealth EMS Medical Director,
Bureau of EMS,
Pennsylvania Department of Health

On August 18, 2009, Governor Rendell signed Act 37 of 2009—the much awaited rewrite of the Pennsylvania EMS Act. EMS providers in Pennsylvania respond to 1.8 million calls a year, and already lead the nation in many respects, but there is always room to improve our system. The new EMS Act declares that “[EMS] is an essential public service and frequently the health care safety net for many Commonwealth residents.”

The new Act has many system features that will improve the quality and safety of the patient care delivered by EMS personnel in the Commonwealth, and the leadership of physician medical directors will be integral to these improvements.

Some of the highlights of the new EMS Act are:

- “EMS Agencies” will be licensed to provide selected services—like ambulance service, quick response service, or special services that will be developed under the new EMS regulations. These special services may include services like critical care transport, mass gathering EMS, tactical EMS, or others. In the past, the Department of Health only licensed ambulance services.
- Physician EMS medical direction is now required at all levels (including BLS ambulances and QRS services).
- EMS quality improvement activities now specifically have peer review protection.
- To match the national EMS scope of practice model, the provider levels will be Emergency Medical Responder (formerly First Responder), EMT, Advanced EMT (a new level of provider in PA), and Paramedic. Advanced EMTs will have a scope of practice above that of an EMT, and may include skills like nebulized albuterol and other limited medications, glucose monitoring, and blindly inserted advanced airway devices.
- Registered nurses were previously permitted to provide EMS within the system in the role of Prehospital RN certification. The new Act includes similar provisions for Physician Assistants that choose to provide EMS as Prehospital Physician Extenders, and the new Act also specifically recognizes a certification for Prehospital EMS Physicians who provide direct patient care for an EMS agency.

**PaACEP News**

**Chapter’s Residents’ Day Overwhelming Success**

Over 150 residents attended PaACEP’s 2009 Residents’ Day on Wednesday, September 16, 2009. This event is a joint venture between PaACEP and a Pennsylvania emergency medicine residency program, and this year was hosted by the Hospital of the University of Pennsylvania, Department of Emergency Medicine, in Philadelphia. Residents’ Day is a great opportunity for residents, providing them with their grand rounds attendance for a week and allowing them to meet peers and faculty from other emergency medicine residency programs. PaACEP is grateful for Francis DeRoos, MD, Residency Director for the Department of EM, Hospital of the University of Pennsylvania, who coordinated the day’s events. Everyone involved was thrilled with the turn-out and the positive feedback received. The meeting provided outstanding educational value along with the opportunity to network.

The day’s program included a variety of topics, including:

- **Planning a 21st Century Emergency Care System**, by Brendan Carr, MD, Associate Director, Division of Emergency Care Policy and Research, Department of EM, Hospital of the University of Pennsylvania.
- **Reinventing Resuscitation: Transforming Cardiac Arrest Into a Survivable Event**, by Roger Band, MD, EM 200 Clerkship Director and David Gaieski, MD, Patient Safety Officer, Director of Early Goal Directed Therapy Program, both from the Department of EM, Hospital of the University of Pennsylvania.
- **Saving Teens’ Lives: Advancing Young Driver Safety**, by Dennis Durbin, MD, MSCE, Senior Scholar Center for Epidemiology and Biostatistics, Childrens Hospital of Philadelphia.
- **Current Practices and Trends in EMS**, by Crawford Mechem, MD, FACEP, EMS Medical Director, Philadelphia Fire Department, Department of EM, Hospital of the University of Pennsylvania.
- **What ACEP/PaACEP is Doing for You**, by Hank Unger, MD, FACEP, chapter Vice President of PaACEP.

Dr. Unger stated, “I was proud to represent PaACEP before the crowd of excited young physicians and I look forward to seeing what these students will bring to the future of emergency medicine.”

**continued on page 13**
Awards and Nominations

You can submit Emergency Physician of the Year, Meritorious Award, and Outstanding Contribution to Emergency Medicine nominations via fax to (717) 558-7841 or email dblunk@pamedsoc.org.

Emergency Physician of the Year

The PaACEP board of directors is seeking nominations for the Annual PaACEP Emergency Physician of the Year award. The award recognizes emergency clinicians of unusual merit who pursue the ideal of emergency medicine. In other words, the award seeks out those practitioners who try to be the best emergency doctors they can be.

Selection criteria require 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

The deadline for nominations is March 1, 2010.

Meritorious Award Nominations

The PaACEP board of directors has established a meritorious service award to be presented at the annual membership meeting for an individual who has made a significant contribution to emergency medicine in the Commonwealth.

The following are examples of significant contribution:

• Patient care, such as new or improved patient care delivery mode of modes, quality care improvements, or cost containment.
• EMS, such as an improved organization, new or improved service, public education disaster plan.
• Teachings, such as new or improved teaching method or methods, publication(s), educational program development, evaluation mechanism(s).
• Research, clinical or basic.
• PA chapter member, who has significantly helped to promote the purpose and objectives of the chapter.
• Personal leadership, an individual whose character has been exemplified in one or more of the following examples: inspirational, innovative, diplomatic, planner, organizer, manager/administrator, arbitrator, consensus maker, decision maker.

The deadline for nominations is March 1, 2010.

Outstanding Contribution to Emergency Medicine Award

The award was created in 2005 to recognize an individual who has made a significant contribution to the practice or body of knowledge of emergency medicine, or has provided exceptional advocacy to enhance the delivery of emergency care in Pennsylvania. It is not a requirement that the recipient be either a physician or a member of PaACEP.

The deadline for nominations is March 1, 2010.
Grant and Scholarships

If you have an idea for a chapter grant project or are interested in applying for the young physician scholarship, please call 877-ER-DOC-PA, fax to (717) 558-7841, write to the chapter office at 777 East Park Drive, PO Box 8820, Harrisburg, PA 17105-8820, or email David Blunk at dblunk@pamedsoc.org.

Chapter Grant

Every year, ACEP provides grants to state chapters to help them complete innovative projects that they may otherwise be unable to do. ACEP’s board of directors approved $45,000 for its 2009-2010 Chapter Grant program. PaACEP wants to submit a project and needs your ideas!

Since 1991, Pennsylvania ACEP has been awarded seven ACEP chapter grants totaling more than $43,000. A list of the projects ACEP funded since the program began in 1983 is included on the ACEP website, www.acep.org.

The postmark deadline for submitting a letter of intent to ACEP is Friday, January 9, 2010, so plan to have your ideas in soon.

Young Physician Scholarship

The future of emergency medicine depends on the development of leaders among young emergency physicians who will advocate for our profession and our patients. As a result, the PaACEP board of directors has established a stipend for a deserving young physician who meets specified criteria to attend the annual ACEP Leadership and Advocacy Conference in Washington, DC. This year’s conference will be held May 16-19, 2010.

Candidates must be a member of ACEP and Pennsylvania ACEP, and should meet one or more of the following criteria:

• Be in the first three years of emergency medicine practice in Pennsylvania or concluding a Pennsylvania residency in emergency medicine with a commitment to stay in Pennsylvania for at least the next year.
• Should have shown evidence of leadership activity (beyond routine residency participation or chief resident responsibility) during residency.
• Has shown evidence of community or political leadership activity during residency.
• Has participated on PaACEP or ACEP committees or related activities.

The candidate will submit a brief comment to the PaACEP board of directors (100 words maximum) why he or she should be selected to receive the PaACEP Young Physician Leadership Fellowship.

The application and comment submission deadline is March 1, 2010.
Spivey Call for Abstracts

The 2010 William H. Spivey, MD, FACEP, Research Presentation Competition will be held in conjunction with the PaACEP Annual Scientific Assembly, April 14-16. Presentation of abstracts is open to emergency physicians, residents, fellows, and medical students, and should address issues pertinent to emergency medicine. The presenter must be one of the authors of the abstract, although others may have contributed to the research and presentation. Original research and case series will be accepted.

To submit an abstract, complete a submission form online at www.paacep.org.

Deadline for Abstracts: Must be post-marked by February 5, 2010.

CPC Call for Submissions

Submissions are now being accepted for the 2010 State Emergency Medicine Competition to be held at the PaACEP Scientific Assembly. This event has been a great success at the meeting each year and, like the national competition, is a great way to showcase your residency program at the state level. (There is also a greater chance of winning!). The best cases are difficult, but “gettable” based on the information presented. They can and should represent unusual presentations of common or life-threatening diseases, or uncommonly encountered diagnoses.

Cases must be received by February 5, 2010, and should be sent to:

Walter Schrading, MD, FACEP
Department of Emergency Medicine, York Hospital
1001 S. George St., York, PA 17405
Phone: (717) 851-5424
Email: wschrading@wellspan.org
(If emailing, please label your subject as “2010 PaACEP CPC Submission”)

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Executive Privilege  
continued from page 1

of certain juries. In Pennsylvania, like most states, verdicts in medical liability cases are based on the burden of proof standard of “preponderance of the evidence.” This means, that in order for the jury to render a plaintiff’s verdict, they need to agree that it was more likely than not that malpractice occurred. A 51% impression that harm was done vs. a 49% impression that no harm was done is close enough. This is distinctly different from the “beyond a reasonable doubt” standard, which is typical in criminal cases. However, another standard exists. “Clear and convincing evidence” is a higher level of burden of proof and requires a plaintiff to demonstrate that their allegations are substantially more likely than not.

This year, both Utah and Arizona became the latest states that successfully passed legislation that raised the standard that plaintiffs must reach in order to prevail in medical liability cases for EMTALA-related care from preponderance of evidence to clear and convincing evidence. Similar legislation already exists in Georgia, South Carolina and Oklahoma, and is currently being pursued in Maryland, Ohio and North Carolina. By requiring a higher level of evidence to prevail, plaintiff attorneys may be reluctant to pursue marginal cases. The intended results are decreased liability premiums and increased availability of liability insurance, which in turn could enhance patient access to care. While this may seem like an emergency medicine issue, liability protection for EMTALA-related care crosses into any specialty which provided on-call services to emergency patients.

Medical liability reform has been a far cry from a success story in Pennsylvania, and caps on damages are unconstitutional under the Pennsylvania Constitution. With our high medical liability premiums and lack of Mcare abatement, it’s time we look to raise the standard of evidence in medical liability claims in Pennsylvania for all physicians to the clear and convincing standard. As a first step, the chapter introduced this concept with the Pennsylvania Medical Society Specialty Cabinet on September 15, and this was favorably received. A motion was then passed at the Pennsylvania Medical Society Board of Trustees meeting to support the adoption of the stricter standard of clear and convincing evidence as the basic standard of proof required to prevail in medical liability cases against physicians. We’ve started the engine, and now it’s time to keep working to move this initiative forward. As in states who have been successful with instituting this higher standard, we anticipate a long-term (several year) difficult project, but one worth fighting for our members. As this project evolves, we are going to need the help of each and every PaACEP member, from grassroots lobbying of legislators, to educating the public of the need of access to care across specialties, to working through the inevitable challenges that lie ahead in pursuing this goal.
It’s time. ■
PaACEP resolutions definitely stirred much debate at the ACEP Council Meeting on October 3-4 in Boston, Massachusetts. Noelle Rotondo, DO, FACEP, shared that she was proud to represent the chapter and that PaACEP’s excellent reputation is evident, based on the merits of those folks who worked so hard to advance the specialty at both the state and national level. She even heard a gentleman exclaim, “Wow, you folks from Pennsylvania do a lot of good work for the college,” referring to the PaACEP resolutions on the floor.

Marilyn Heine, MD, FACP, FACEP, Past President of PaACEP, stated, “The Pennsylvania chapter’s delegation to the ACEP Council is recognized for its effective advocacy for emergency physicians. As we bring issues to the Council that resonate with concerns of colleagues, network with others, and serve in leadership roles on reference committees and Council committees, we strengthen the voice of Pennsylvania’s emergency physicians in College policy.”

The ACEP Council is the broad-based national governing body of the College made up of representatives from all 53 chapters, 30 sections, and the Emergency Medicine Residents’ Association. Each year at the Annual Meeting, councilors representing each of the state chapters and sections gather to consider new national policies and changes to existing policies that are recommended to Council in the form of resolutions. The resolutions passed by Council are then sent to the ACEP board of directors for its approval and action. PaACEP President Elect Daniel Wehner, MD, MBA, FACEP, played a role in this well-tuned process through his participation in Reference Committee B, which was one of the most exciting, controversial and attended committees. He stated, “It was so awe-inspiring to sit opposite the Council, facing the best and brightest in emergency medicine, while bearing witness to enthusiastic and thought-filled debates. It was an experience that I’ll remember for a lifetime.”

One much discussed PaACEP resolution authored by Past President Theodore Christopher, MD, FACEP, requested the definition of boarding time in the nation’s emergency departments.

The Councilors discussed at length the 2-hour time frame that was in the original resolution. After debate, the adopted resolution did not include a time frame. The amended resolution stated that “ACEP adopt a policy statement which officially defines the ‘boarded patient’ as one who remains in the ED after notification of the need to admit to inpatient service and ends when the patient leaves the department.” The resolution also calls for “ACEP [to] continue its involvement with national organizations developing measurements for patient through-put.”

A second chapter resolution requested that ACEP adopt a position statement stating that the reporting of epileptic drivers to licensing authorities is unnecessary and counterproductive, and that ACEP work with legislative bodies to support enactment of both federal and state legislation which rescinds laws requiring reporting of seizures. Extensive testimony was heard from all sides, ranging from remaining silent on the matter to the need for a policy statement on the entire issue of mandatory reporting by emergency physicians. This resolution was referred to the Board, and action has been postponed until its January meeting.

Sandra Schneider, MD, FACEP, a native Pennsylvanian, was recently chosen President-Elect at the ACEP Council meeting. Dr. Schneider is currently an emergency physician at Strong Memorial Hospital in Rochester, NY. Dr. Schneider has already accomplished much throughout her career in emergency medicine, and will certainly lead ACEP with honor and distinction.

PaACEP News, October/November 2009 7
PaACEP Members Recognized at ACEP Council Meeting

At the recent ACEP meeting, the Council re-elected Dr. Rosenau to serve another three-year term. Dr. Rosenau has helped guide ACEP policy development through his service as a board of directors’ liaison to a half-dozen ACEP committees and task forces. He was recently elected to serve as Chair-elect of the Emergency Medicine Foundation (EMF). Dr. Rosenau has proven his excellent leadership skills and dedicated service over the years and the chapter is proud to have him as a representative at the national level.

Also re-elected at the Council was Robert Solomon, MD, FACEP, and newly elected board members were Jay Kaplan, MD, FACEP, and Rebecca Parker, MD, FACEP.

New Council Speaker Arlo Welge, MD, MPH, FACEP, recognized outgoing speaker Bruce MacLeod, MD, FACEP, for deftly and efficiently leading Council debate during his term, and for encouraging the participation of new councillors and alternate councillors on Council committees. The Council also adopted a PaACEP commendation resolution that recognized Dr. MacLeod for serving with distinction and dedication as Council Vice-Speaker from 2005-2007 and Council Speaker from 2007-2009, and for his tireless efforts in service to the specialty of emergency medicine, his community, and his colleagues.

Recognition of Bruce MacLeod, MD, FACEP

Donald M. Yealy, MD, FACEP, was honored with the Award for Outstanding Contribution in Research at the Council

Emergency Medicine Faculty Position

The Department of Emergency Medicine (EM) at Thomas Jefferson University (TJU) is seeking a board-certified or board-prepared academic emergency physician to join its well-established faculty. Current faculty now teach 35 EM residents in our long-standing 3-year training program and 4th year medical students in our required EM clerkship at Jefferson Medical College (JMC). The emergency departments at TJU Hospital (TJUH) and its Methodist Hospital Division (MHD) together see approximately 90,000 patients annually. TJUH is a Level 1 Trauma Center and a Regional Spinal Cord Center, and is home to residencies in every medical field. The MHD ED is the primary community affiliate for our EM training program. The Department of EM supports a certified Chest Pain Center, a Sexual Assault Center, the Center for Biodefense and Disaster Preparedness, two (2) internationally recognized basic science laboratories, an active clinical research program, and urban community outreach and health policy initiatives.

Academic rank, salary and benefits would be commensurate with experience. Located in Center City Philadelphia, between Independence Hall and the theater district, TJUH and Jefferson Medical College enjoy reputations as one of the best hospitals and medical colleges respectively in the East. TJUH is the major academic hospital of the Jefferson Health System (JHS). Philadelphia has much to offer culturally, educationally, and socially, plus provides easy access to New York, Washington DC, the ocean and the mountains.

TJU is an Equal Opportunity/Affirmative Action Employer and strongly encourages applications from women and minorities. Please submit a curriculum vitae and confidential letter of interest to:

Theodore A. Christopher, MD, FACEP, Professor and Chairman, Department of Emergency Medicine, Thomas Jefferson University, 239 Thompson Building, 1020 Sansom Street, Philadelphia, PA 19107-8502. Theodore.Christopher@jefferson.edu. Phone: 215-955-5105.
Guest Editorial: Ethiopian Medicine

By Charles F. Barbera, MD, MBA, FACEP, FAAEM, Chairman of the Department of Emergency Medicine at the Reading Hospital and Medical Center

This past summer, I was fortunate to be able to spend two weeks in a mission hospital in Addis Ababa, Ethiopia. Ethiopia is one of the poorest countries in the world, and has no public health system. I was asked to work in Myunsung Christian Medical Center, a Korean Presbyterian hospital, which had recently begun to open their emergency department twenty-four hours a day. It was the first hospital in this country to do so.

I was part of a team of international physicians and nurses who opened the first and only trauma center in the country, and one of the only such centers in the entire continent. As I had some experience in this type of project, I was excited at the opportunity.

On Saturday evening, I arrived at Bole International Airport in the capital city of Addis Ababa. Having been to other third world countries, I thought I was prepared for what I might see; I was not.

Poverty is pervasive. Homes were made of scrapped tin; people were soliciting everywhere. Roads were made of dirt, and there were no traffic patterns. I was driven to the hospital by the hospital general manager (equivalent to a US hospital president, but he did the job of all administrators). The hospital was located in a compound, and all employees and volunteers lived there. The physicians had apartments, which were homey, and the nurses and other staff lived in metal huts. This arrangement was coveted in Ethiopia, as the hospital provided both room and board for people who worked in the compound.

Electricity was intermittent, although the hospital’s generator could usually cover the ER, OR or the ICU. The hospital had about 100 beds, and most patients were in rooms with four other patients. The ICU was a room within the OR where the hospital’s three ventilators were housed. During my stay, the hospital downsized to two ventilators for economic reasons. Their utilization was purely on a first come - first served basis.

The ED was a room with eight beds and a trauma room. All patients were required to pay the fee to see the physician prior to services rendered, which was about five US dollars. Most would need to have family beg or sell personal items to raise this money; others chose to just go home.

After I would evaluate patients, I would order studies or medications. Unbelievably, after I used an advanced Physician Order Management-like system to enter my requests, an invoice would come up on the screen. The patient needed to pay for the tests, radiographs and medications before they were done or administered. I often bargained with patients regarding their work ups. It really made me think about the things I order. Each test was ordered separately, so I never ordered an H & H, just an H, and a chloride cost $0.70, so I never ordered one. I once ordered a portable chest x-ray. After an hour, I was told that no one had realized the portable machine that sat in the ER didn't work.

X-rays were only available Monday – Friday, 9 to 5, and weekend mornings. Fortunately for me, I was not tormented by the temptation to order a CT scan, as there was none available. Most patients who visited the ED had the means to pay for the needed services. If someone required admission to the hospital, a down payment was necessary. Once, a child who had stopped breathing was intubated in the ED. The staff got him stabilized, but the ICU would not accept the child as the family had no money. A call to the general manager was required to reverse that decision. I later learned that before intubating a patient in the ER, I had to first call the ICU to make sure one of the two allotted ventilators was available.

Ethiopia, like many African countries, has no infrastructure for health care. Health care is a privilege provided only to those who can afford and have the where with all to know they need it. The average life expectancy is in the mid-forties.

Only foreigners have heart disease, as people’s poor diets and short lives don’t allow coronary disease to develop. There is no cardiac catheterization lab in the entire country. People who need this service are taken to Cairo if they can afford it. The majority of citizens on Ethiopian Airline are leaving the country for health care.

I was asked to teach the two day course of ACLS when I was at one hospital. After the first day of class, in which it was impossible for me to engage the non-English speaking audience at all, a nurse came to me and said, “Doctor Charles, the only ACLS drug we have in this country is adrenaline. We would rather learn how to read EKG’s.” As it turns out, ECG interpretation is not a competence taught in Ethiopian medical education.

I’ll end this long tale with the story about the clinic we set up at the United Nation’s refugee camp for Ethiopians expelled from Eritrea. We arrived in a van with two mobile exam rooms to a crowd of about

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Member Profile: Eric Maur, MD

Eric Maur, MD, served on the PaACEP board of directors as the resident representative for 2008-2009. He was also elected to the Emergency Medicine Residents Association board of directors. Dr. Maur certainly had a schedule that was considered overwhelmingly full, even by residency standards. Yet, he agreed to be a part of PaACEP leadership because he valued the importance of participating in an organization that represented and influenced his future as an emergency medicine physician. Dr. Maur had some parting words to say about how he balanced life between family, medicine, and responsibility.

Never again will I have to respond to the question, “are you a real doctor?” followed immediately by “…cause I don’t want to be seeing one of those interns” after I introduce myself to a patient. Done are the off-service rotations, hospital call and seemingly never-ending work hours. Coming back to residency was hard, no doubt about it, and I am looking forward to once again having more time to spend with my wife and two young children. Preschool children don’t understand why Daddy is always at work, they have a very fixed sense of logic that at times I wish I could apply to my patient interactions. For example, my three year old son has taken to saying, “I can’t listen, my ears are closed.” Oh how I wish I could use that line when I need to escape from a patient who has been rambling on about everything but the reason they are really in my emergency department.

All kidding aside, although life after residency will certainly be better, it will still be far from perfect. Our profession is by nature one of high stress. The effect of these stressors is evident in the high burn-out rates among emergency medicine physicians. We tend to focus caring for our patients above caring for ourselves. In order to be able to succeed in our profession, wellness is a necessary aspect of everyday life. So, what measures can you take to help ensure your personal wellness, which ultimately results in providing better care?

Certainly, the best things to do are simple things, such as proper sleep, diet and exercise. Make a point to take a few minutes in the middle of your shift to eat something, and be sure that you are drinking adequate amounts of fluid (and perhaps caffeine!) throughout your shift. Second, our profession is unique in that our doors never close. We need to be constantly prepared, awake, and alert, but the nature of our shifts often make sleep difficult. Be sure to maintain a proper sleep environment to help ensure an appropriate amount of sleep. Third, remember that exercise is a key component to a well-rounded life, every little bit helps!

Maintaining positive interpersonal relationships is also vital to overall wellness. The support you receive from others is essential to maintaining a balanced life. I encourage all physicians to remember that you need to care for yourself in order to provide quality patient care.

Physician wellness remains a high priority issue for ACEP as evidenced by the inclusion of a membership section dedicated to wellness. This section “provides an opportunity to learn what you can do to avoid burn-out, enjoy a balanced life, and keep the vitality necessary to be a healthy emergency physician.” More information can be found at www.acep.org.
Excellent opportunities in Pennsylvania for outstanding physicians

Lower Bucks Hospital, Bristol
This 31,000-volume ED near Philadelphia has 36 hours of physician coverage and 12 hours of MLP coverage per day.

Lewistown Hospital, Lewistown
This 30,000-volume ED near State College has 36 hours of physician coverage and 10 hours of MLP coverage per day.

Mercy Suburban Hospital, Norristown
This 24,000-volume ED has approximately 38 hours of physician coverage per day and is located minutes from Philadelphia.

St. Joseph’s Medical Center, Reading
About 60 miles from downtown Philadelphia, this 46,000-volume ED offers 48 hours of physician coverage and 24 hours of PA coverage daily.

Wilkes-Barre General Hospital, Wilkes-Barre
This 48,000-volume ED is supported with 51 hours of physician coverage and 52 hours of MLP coverage per day. Inquire about sign-on and referral bonuses as well as other incentives.

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EMS Act 37
continued from page 2

- EMS Vehicle Operators will now be certified like other levels of EMS providers. This will allow the Department to better track EMS vehicle operators and to provide continued safety education to these providers.

The provisions of the new EMS Act become effective incrementally. On August 18, 2009, some changes to the motor vehicle code became effective, and the parts of the previous Act 45 of 1985 were continued until they are replaced by the provisions.

Some of the sections of the statute that become effective on February 1, 2010, include those related to EMS patient care reports, Medical Director of EMS Agency, Medical Command Physician and facility medical directors, Medical Command Facility, stretcher and wheelchair vans, limitations on liability, and peer review.

Remaining sections that do not become effective on February 1, 2010, will become effective when the regulations for the new EMS Act are promulgated, and this is estimated to occur in or around February 2012. These include the sections that address new provider levels like the Advanced EMT, Prehospital Physician Extenders, Prehospital EMS Physician, EMS Vehicle Operation, new EMS Agency regulations, special operations EMS, first aid and other services, and EMS Agency license sanctions.

While the passage of this legislation completed a process that took almost ten years and included input from the PaACEP EMS Committee and many of PaACEP’s leaders, the work is not done. The next step is the drafting of the regulations that correspond to this new law. The Department of Health looks forward to working with PaACEP and other stakeholder groups as the new EMS Act regulations are developed to keep Pennsylvania a leader in EMS care.

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PaACEP Members Recognized at ACEP Council Meeting
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meeting. This award is presented to a member who has made a significant contribution to research in emergency medicine. The chapter nominated Dr. Yealy for his leadership in many areas of emergency medicine research, including sepsis, emergency medical services, and clinical decision rules for both community-acquired pneumonia and heart failure. His funding portfolio tops virtually all emergency medicine investigators, and his significant findings, accomplishments and publications easily identifies Dr. Yealy as one of the leading researchers of our time.

Donald M. Yealy, MD, FACEP

Frankford Hospital has been a premier healthcare system serving Northeast Philadelphia and Bucks County for over 100 years. Our dedication to quality is seen in the way we embrace technology, advance our facilities and add services. Now we are proud to introduce a fresh new vision for health care with a new name - Aria Health. We are a three hospital system and with Level II Trauma Center.

PHYSICIANS
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As an integral member of our Emergency Department, we seek Physicians with Board Certification or eligibility in Emergency Medicine (ABEM or AOBEM). We offer an EM residency program with potential for a core curriculum position. You must be licensed to practice without restrictions in the state of Pennsylvania with current DEA. Eight, ten and twelve-hour shifts available.

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Guest Editorial: Ethiopian Medicine
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400 patients waiting for “the doctor”; that was me. We quickly
realized the space was not adequate (a similarity to health care in
the US), and moved to a barn. I was told I had 90 seconds per
patient. For many patients, it didn’t matter if I had 90 or 9,000
seconds, I wasn’t going to cure cancer, blindness, thyroid disease
and malnutrition.

I could help, however, malaria, typhus, conjunctivitis, AIDS and
other infections. I could offer some advice for chronic joint pain.
I could repair wounds, and remove foreign bodies from nares and
ears, which actually made me like a miracle worker to many people
who had dealt with these alien bodies for a long time. Having
foreign medical professionals in Africa does much more than treat
individual patients, it enables this health system to gain insight into
more developed systems. Our medical team was able to provide
physicians with training, support and motivation.

I certainly gained much more from my trip than I was able to
offer. I learned how much I take for granted, how to rely on my
physical examinations, to be prudent in my utilization of testing
and medications, and, most of all, humility. I will return, knowing
what to expect and being better able to optimize what little I can
offer. I will hopefully be able to bring the most the US has to offer,
some colleagues.

Messes clinic treating 400 patients in one day

PaACEP had twenty members representing the chapter and we
would like to thank these delegation members for their hard work
and commitment to the specialty and the college.

Councillors
Charles Barbera, MD, FACEP
Keith Conover, MD, FACEP
Marilyn Heine, MD, FACEP
Blair Hontz, DO, Resident representative
Jack Kelly, DO, FACEP
Douglas McGee, DO, FACEP
Ericka Powell, MD, FACEP
Ralph Riviello, MD, FACEP
Noelle Rotondo, DO, FACEP
John Skiendzielewski, MD, FACEP
Amy Snover, MD, FACEP
Ron Strony, MD, FACEP
Michael Turturro, MD, FACEP
Henry Unger, MD, FACEP
Daniel Wehner, MD, FACEP

Alternates
Ted Christopher, MD, FACEP
Maria Guyette, MD,
Young Physician representative
C. James Holliman, MD, FACEP
Scott Korvek, MD, FACEP
Edward Ramoska, MD, FACEP

Important Resolutions Passed at ACEP Council Meeting
continued from page 7

Other Council actions include adopting a resolution that ACEP
prioritize addressing the workforce shortage by “lobby[ing]
appropriate governmental entities and work to remove any
barriers to increasing the number of residency program slots that
are available in emergency medicine.” In addition, the resolution
calls for ACEP to “investigate broadening access to ACGME or
AOA accredited EM residency programs to physicians who have
previously trained in another specialty.” The Council also adopted
a resolution that “ACEP form a task force to investigate strategies
to support poison centers” and another resolution that will allow
the Association of Academic Chairs in Emergency Medicine a
single seat on the Council.

Participating in the ACEP Council meeting has always been an
invigorating experience for our members. Ericka Powell, MD, FACEP,
stated, “In the shadow of possible impending doom, the
ACEP council deliberated everything from the shrinking workforce
in emergency medicine to health care reform. The college is alive
and well and so is participation and enthusiasm for shaping the
health care debate. There were also plenty of social and networking
opportunities to keep the mood light and remind us why we really
enjoy volunteering in the college—lasting, meaningful professional
friendships.”
Crozer-Keystone Health Network (CKHN) is the largest primary care and specialty physician network in Delaware County offering an array of specialty and subspecialty services. CKHN is presently expanding its Emergency Medicine Department at Delaware County Memorial Hospital (DCMH).

Located in Drexel Hill, Pennsylvania, DCMH is one of the founding hospitals of the Crozer-Keystone Health System. This 213 bed not for profit facility admits over 11,000 patients, and treats approximately 40,000 ED patients. In 2006, the hospital was named a J.D. Power and Associates Distinguished Hospital for providing outstanding inpatient and outpatient experiences.

DCMH ED is newly renovated and has 33 beds and 8 bed fast track. There are 40 hours of physician coverage in the main ED and physicians work alongside EM residents. Fast Track area is open 12 hours a day, covered by family physicians and/or a mid-level provider.

Candidates must be Board Certified/Board Eligible Emergency Medicine physicians committed to providing high quality care in a community setting. These are employed positions with competitive salary, LIABILITY INSURANCE, TAIL COVERAGE, and other excellent benefits.

Please reply with C.V. by email to dave.barlow@crozer.org.

For more information about this institution and the Crozer-Keystone Health System, please see our website at www.crozer.org.

UPMC Urgent Care - The UPMC urgent care facility located in Robinson Township, 10 miles west of Pittsburgh, PA, is seeking a physician board-certified in Family Practice, Emergency Medicine or Internal Medicine. Hours of operation are

9 am – 9 pm daily with no call and no overnight shifts. Excellent salary and benefits including paid malpractice insurance with tail coverage. Call Dr. Robert Maha at (888) 647-9077, fax (412) 432-7480 or email at mahar@upmc.edu.

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UPMC Urgent Care - The UPMC urgent care facility located in Shadyside, an urban suburb of Pittsburgh, PA, is seeking a physician board certified in Emergency Medicine, Family Practice, or Internal Medicine to join us at this new practice. Hours of operation are 9 am-9 pm daily with no call and no overnight shifts. Excellent salary and benefits including paid malpractice insurance with tail coverage. Call Dr. Joe Suyama at (412) 647-8540, fax (412) 864-3400, or email suyamaj@upmc.edu.
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