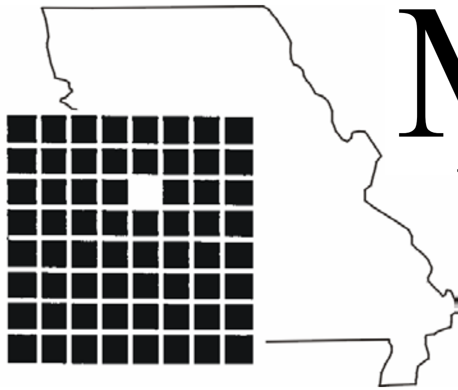

MISSOURI EPIC

EMERGENCY PHYSICIANS INTERIM COMMUNIQUE
Missouri College of Emergency Physicians

Fall 2005

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TAKING ADVOCACY TO A NEW LEVEL

By Dean Wilkerson, ACEP Executive Director

There is a "perfect storm" of challenges facing emergency medical care. The medical liability crisis, a lack of on-call specialists, crowding and boarding in the emergency department, declining reimbursement, and other problems create a very tough environment for patients to get the access and quality care they need and for emergency physicians to practice medicine as effectively as they would like. Notwithstanding these challenges, I believe we are in an exciting era for emergency medicine and have some opportunities to make great progress. But this is not going to happen by accident. It is a tough world out there and it is highly unlikely that politicians, the government, trial lawyers, managed care companies, hospitals, and even our colleagues in other medical specialties are going to just do what is right out of the goodness of their hearts to improve the conditions for emergency care. If things are going to get materially better for our patients and emergency physicians, we are going to have to take more aggressive action than we have before.

We have to increase our media advocacy to educate the public that emergency medical care is an essential community service and that emergency physicians should be highly valued and respected for what they do. We also have to step up our grassroots advocacy in every state and at the federal level. ACEP has a series of important events and activities scheduled over the next 12 months that will bring heightened awareness of the problems facing our emergency health care system and the needed solutions.

In July, we hosted a one-day summit on the crowding/boarding problem in Washington, DC. This brought together experts, stakeholders, government agencies, potential funding sources, and other organizations to learn about this serious problem and what are some of the best solutions. We issued a report and publicized the findings of this summit.

Continued on Page 2

TAKING ADVOCACY TO A NEW LEVEL *continued from page 1*

The Rally at the U.S. Capitol was a watershed event in emergency medicine. It was on Tuesday, September 27. We involved physician assistants, EMS personnel, emergency nurses, and others who have a stake in emergency care. The focus of the Rally was patient access to care and we advocated for an end to boarding, a fix to the liability crisis for emergency medical providers, and adequate funding of the safety net that is emergency care. We had more than 4,000 emergency medical professionals turn out at Capitol Hill to urge Congress to save access to emergency medical care.

A Report Card Project will be unveiled in early December issuing letter grades for each state and our nation in the areas of access to care, patient safety and quality, injury prevention/public health, and the medical liability environment. Cumulative grades will also be issued for each state. This will generate great media and public attention to what is happening in emergency care and will be a stimulus for change.

ACEP and our chapters have an opportunity to utilize the Institute of Medicine (IOM) report on “The Future of Emergency Health Care” that will be issued in April 2006. This will be a seminal report by a prestigious, independent body verifying the issues we know exist and recommending solutions.

Next spring after the Report Card and the IOM report have come out, ACEP will be calling on all of its chapters to meet with the governors of their states to ask for a governor’s task force to review the problems and develop recommendations for each state.

Key to this strategy of media advocacy and grassroots activism is that each emergency physician does their part to stand up for your profession and your patients. This will mean attending events like the Rally at the U.S. Capitol. It will mean contacting your state legislators and members of Congress. It will mean looking for individual opportunities to advocate on our issues, including letters to the editor of your newspaper, giving talks to your local civic clubs, participating on a talk radio show or public access community cable television program, and being a leader and energetic voice encouraging others around you to do the same.

We have some exciting opportunities ahead. But it will take everyone doing their part. We are the “white hat” specialty. We have an important story to tell. We just need to tell it more effectively, aggressively, and as often as possible, so we can create a better future for emergency medicine.

For more information on the events listed please refer to www.acep.org

Upcoming Events:

October 20, 2005 Biotrends Midwest 2005—St. Louis, MO

October 29, 2005 Advances in Cardiac Arrest Resuscitation—Kansas City, MO

Please check our web site at www.mocep.org for more information

Rally Online to Support Emergency Medicine

Dr. Robert E. Suter, Immediate Past-President, ACEP

On September 27, thousands of ACEP Emergency Physicians rallied at the U.S. Capitol to send this message to Congress:

The most urgent fix needed for America's health care system is the over-crowding and under-funding of Emergency Rooms. Our ERs are America's front line for treating sickness and injury -- and new legislation in HR 3875, will bring critical help. Federal and state governments must recognize that ERs are an essential community service and must be funded properly, just like police and fire. Medicare and Medicaid should be fully funded, and other payers should pay their bills. Congress must reform out-of-control medical liability exposure that is driving Emergency Physicians out of business -- reducing America's emergency-response capacity.

To help pass HR 3875, The Access to Emergency Medical Services Act of 2005, there are three things you can do:

1. **Contact Congress**
2. **Tell others who share your concerns**
3. **Learn More at ACEP's www.EmergencyCareCrisis.org**

Residents Corner

Joplin residents:

PGY-4

Jason Blasenak D.O.
David Keitz D.O.
Clint Loy D.O.

PGY-3

Chad Boulware D.O.
Ryan Hall D.O.
Christy Mareshie D.O.
Alisha Wright D.O.

PGY-2

Sam Lightsey D.O.
Jennifer Mitchell D.O.

Prescription Assistance Available for Low Income Patients

The Partnership for Prescription Assistance (PPA), launched April 5, will make it easier for emergency physicians to help low-income or uninsured patients to get free or discounted medications. Patients, caregivers and physicians can access the program by calling 888-4PPA-NOW, or by going to http://www.pparx.org

The PPA will link patients to pharmaceutical company assistance programs and those run by public, private and government entities. Patients will be asked to answer a series of questions and the results will be used to determine which programs they are qualified for. Specialists will be available for both English and Spanish speakers and translation services are available in over 150 other languages. The American College of Emergency Physicians is supporter of the Partnership for Prescription Assistance.

The Aftermath of Katrina: A National Disaster Medical Team Responds

By Doug Kaufman

ST LOUIS (MD Consult) - In the aftermath of Hurricane Katrina, reliable medical aid has been crucial for victims in devastated Louisiana and Mississippi.

But with many local doctors and hospitals in the same boat as other victims, it has often fallen to outside medical teams to come in with the medicine and skills to help people reeling from Katrina's blows get back on their feet. This is where Dr Douglas Char, an emergency room physician and

Residency Program Director at Barnes-Jewish and St. Louis Children's Hospitals in St Louis, was able to lend a hand. Char, who also is an assistant professor of emergency medicine at Washington University School of Medicine in St Louis, was chief medical officer for a 35-person team of

doctors, emergency nurses, respiratory therapists, paramedics and pharmacists who spent approximately 15 days, just after Katrina hit, administering aid to the

people of Bay St. Louis, Mississippi.

Hancock Medical Center-Bay St Louis, Miss.

Photos courtesy of the Florida 1 and Missouri 1 DMAT teams.

"The level of destruction was truly amazing," Dr Char said. "Our team had been down at Hurricane Ivan last year, down in Orange Beach and Gulf Shores, Alabama. ... So we also went in with our eyes open. But the level of the destruction, and the extent of the destruction, was really

quite impressive. Having said that, once you're operational, it isn't all that different from being in a busy community ED, or a county ED. You see patients."

The easier part of their task was dealing with patients, he said.

"When a patient's in front of you, you just go into gear-that's what you always do," Dr Char said. "You triage, you prioritize patients."

"When a patient's in front of you, you just go into gear-that's what you always do. You triage, you prioritize patients."

-- Dr Douglas Char

One of the big decisions they faced was deciding who could be treated on site and who needed to be sent to a functional hospital elsewhere. For instance, patients who had suffered heart attacks, strokes or pulmonary embolisms were high priority cases and were shipped out as soon as possible.

"A heart attack patient, we could treat with thrombolytics, but, obviously, we don't have a CCU set up," he

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The Aftermath of Katrina: A National Disaster Medical Team Responds *continued from Page 4*

said.

"So part of that was finding a way to get them out to a hospital that was probably 35 or 40 miles away. If they were critical, we flew them out. We had lots of cooperation from area EMS, and from hospitals in the area. We had satellite phones, so we could contact them. We would fly patients out by helicopter," he said. "More simple cases were sent out by ground."

Dr Char's team has been together for five years, going wherever they are needed in time of disaster. The St. Louis-based unit is one of 36 Disaster Medical Assistance Teams (DMAT), part of the National Disaster Medical Systems (NDMS) located in three regions-Central, West and East. The NDMS is the medical branch of the Federal Emergency Management Agency (FEMA). Members are volunteer medical professionals who train on a yearly basis to be prepared to move in quickly to help after a disaster. They are on-call every month.

Treatment tent-yellow triage.

Photos courtesy of the Florida 1 and Missouri 1 DMAT teams.

Dr Char's team deployed August 28, the day before Katrina began pounding the Gulf Coast. By Tuesday the 30th, they got as far as Hattiesburg, Mississippi. They arrived at the Hancock Medical Center in Bay St. Louis, the only hospital in the county, on Wednesday morning, Aug. 31.

"We were the first medical asset in the area," Dr Char said. "...They're a three-story structure, and their first floor was flooded to about four feet of water. They were totally non-operational. They had been heroically maintaining their ER in what was, essentially, the surgery center waiting room, for the last two days before we arrived. Within about two hours of our arrival, we started taking new patients and they started shutting down that area, which was still flooded, dripping water, no power."

"They're a three-story structure, and their first floor was flooded to about four feet of water. They were totally non-operational. They had been heroically maintaining their ER in what was, essentially, the surgery center waiting room, for the last two days before we arrived."

-- Dr Douglas Char

After 36 hours as the only NDMS team in the area, Dr Char's team was joined by another DMAT team from Florida and strike teams from Pennsylvania, Iowa and Connecticut. Approximately a dozen teams were staged across the region as Katrina approached the Gulf Coast. After the storm passed, the DMAT teams were sent to the disaster area. The teams have tents that can be set up as temporary structures, generators and a pharmacy, all carried to the scene in trucks.

"Essentially it's a mobile field hospital that is non-surgical," Dr Char said. "We come in and we are totally self-

Continued on Page 6

The Aftermath of Katrina: A National Disaster Medical Team Responds *continued from Page 5*

sufficient for 72 hours. We bring our own water, our own fuel, our own generators. We bring cots. We set up some tents as treatment areas, one or two tents as sleeping quarters and eating quarters."

The goal is to be operational in four hours, Dr Char said. Because his team set up on a parking lot and didn't have to clear land, they were operational in two hours. In the first 12 hours they were at Hancock, Dr Char's team treated about 250 people, plus another 450 patients the next day.

"A lot of it was acute care-cuts and scrapes, heart attacks, stroke, those kind of things-which we would expect to see in a general ED," he said. "But also, people who are chronically ill who had all their medications washed away. So, diabetics who haven't had any kind of care-no medication or insulin or pills for three days. Or someone with blood pressure that is out of control.

Pharmacy tent.
Photos courtesy of the Florida 1 and Missouri 1 DMAT teams.

"Or heart patients who lost their oxygen, haven't had their medicines, have been sitting in the hot sun without water or food, for three days, and are now coming in, short of breath. COPD-ers who have lost their nebulizers and haven't had their medication. So a lot of chronic illness that was now flaring up because people were out of medications and out of care."

With the help of sheriff's deputies, medical team members collected medications from area doctor's offices and pharmacies that had been hit by the storm. That allowed the DMAT teams to establish an extensive on-site pharmacy to supplement the supplies they brought. There were some real challenges getting people back on their medications.

"A good part of our time was spent dispensing medications to patients as we could, so they would have something to keep them going for a week or so," he said. "Patients often didn't know what the medicines were, or the bottles had washed away. So ... you're trying to guess what the best medicine might be for them, based on their condition. Often they'd say, 'I was on brand X.' You'd say, 'I don't have brand X. I have brand Y. Let me see if brand Y is close enough.' Or, 'You're on brand X at dose A. I don't have dose A, but if we take 1 1/2 of this pill, that's close to what you were on.' So it turned into a lot of therapeutic substitutions, which is a lot harder than simply saying, 'I'll refill exactly what you have.' You know, the heart patient is saying, 'I'm on a medicine for my blood pressure that starts with 'A.'

"Among the clinical (staff), I think the pharmacy staff probably had the hardest job, and worked under the most duress," Dr Char said. "We probably handed out 500 to 600 prescriptions a day, out of the back of a truck, or a tent. And all of this was looking for the bottle by hand, counting out the medications by hand, writing labels by hand. But that's what you do."

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The Aftermath of Katrina: A National Disaster Medical Team Responds *continued from Page 6*

The timeline DMAT teams expect is to initially treat the mix of acute and chronic patients. Then, after a few days, they start seeing people with gastrointestinal problems related to contaminated food and drinking water, plus injuries related to the post-disaster recovery, including broken bones, foreign objects in the eye, lacerations and more. Obviously, the disaster medical teams have to hit the ground running.

"We go with enough docs, enough nurses, that we essentially set up two 12-hour shifts," he said. "They can be very intense 12-hour shifts. ... Everybody was working like crazy the first 48 hours. After that we had help come in, an additional team came in. ... By day three or four, we had sort of fallen into a routine."

The tents were set up like a small ER, with monitors, defibrillators, oxygen and suction, plus the ability to do laceration repairs and splint minor orthopedic injuries.

"We essentially are a functioning ER," he said.

The NDMS teams slept in tents without air-conditioning, drank bottled water and ate MREs (meals ready to eat)-just like the people they were treating, Dr Char said. The heat was oppressive, and showers were't available for the first few days.

"It's pretty miserable. But not any more miserable than what the patients were dealing with."
-- Dr Douglas Char

"It's pretty miserable," Dr Char said. "But not any more miserable than what the patients were dealing with. I think in some ways, the folks who we were taking care of, knowing we were sharing the same conditions they were living in, (that) gave us a lot more credibility. ... They were grateful for our services. The most common thing (we heard) after we were done is they would thank us for being there. That we had left everything-we didn't have to do that-and were living in the same squalid living conditions they were in.

"We told them we felt like we were the lucky ones," he said. "Because we're a team, as all the teams are, that has the training and the ability and the knowledge to come into an area like that and make a difference. To make a real difference."

Whether it's ice storms, flooding, tornadoes or another hurricane, Dr Char and his team are prepared to help again.

"We're ready to go," he said. "That's why you join these teams. That's what we do."

MD consult is an on-line periodic geared to medical providers. Visit their web site at www.mdconsult.com

Results of Elections By the Council:

President-Elect: Brian F. Keaton, MD, FACEP (OH)
Speaker: Todd B. Taylor, MD, FACEP (AZ)
Vice-Speaker: Bruce A. MacLeod, MD, FACEP (PA)

New Board Members:
Kathleen M. Cowling, DO, MS, FACEP (MI)
Linda L. Lawrence MD, FACEP (CA)
David C. Seaberg, MD, CPE, FACEP (FL)
David P. Sklar, MD, FACEP (NM)

Results of Elections for Board Officers by the Board of Directors:
Board Chair: John Bibb, MD, FACEP (CA)
Vice-President: Linda L. Lawrence MD, FACEP (CA)
Secretary-Treasurer: Nicholas J. Jouriles, MD, FACEP (OH)

2005 Council Actions

Todd Taylor, MD, FACEP, Speaker

Mark DeBard, MD, FACEP, Immediate Past Speaker

On Thursday, September 29th the Board unanimously ratified all of the resolutions adopted by the Council.

The 2005 Council considered 57 resolutions (two resolutions, 27 and 28, were combined): 41 were adopted, 4 were defeated, 2 were withdrawn, and 10 were referred to the Board of Directors.

There were 19 Bylaws amendments submitted to the 2005 Council. The Council adopted 14 amendments that require a 2/3 affirmative vote of the Board of Directors for adoption. The non-Bylaws resolutions adopted by the Council require a 3/4 vote of the Board to amend or overrule.

The Council adopted 2 College Manual amendments that require a majority vote of the Board for adoption.

The Council adopted 2 amendments to the Council Standing Rules. These amendments do not require adoption by the Board.

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Example is not the main thing in influencing others. It is the only thing. -- Albert Schweitzer --

2005 Council Actions *Continued from Page 8*

Standing Rules Resolutions Summary of 2005 Resolutions Requiring Board Action

Resolutions Defeated (D) or Withdrawn (W)

Resolution 9 ACEP Board of Directors' and Council Officer Compensation (W)
Resolution 12 Board Members and Council Officers Voting in Election of President-Elect (D)
Resolution 22 Associate Membership (D)
Resolution 23 Fellowship (W)
Resolution 33 Council Policy Review and Comment on ACEP Policies (D)

Resolution 44 Indemnity Fund for Ethics Cases (D)ons

Standing Rules Resolutions do not require adoption by the Board of Directors.

Resolution 30 Standing Rules Housekeeping Changes (as amended)
Resolution 31 Standing Rules Substantive Changes (as amended)

Resolutions Referred to the Board of Directors

Resolution 8 Process of Determining Compensation of ACEP Officers and Board of Directors Resolution 29 Membership Eligibility
Resolution 34 Single-Payer Health Insurance
Resolution 36 Medicare Requirement of Three-Night Hospital Stay
Resolution 39 Hospital Emergency Department Throughput Performance Measure
Resolution 40 Medical Staff Self-Governance and Independence
Resolution 46 Primary PCI without Cardiac Surgery Backup
Resolution 48 BME Oversight of Out of State Egregious Medical Testimony
Resolution 50 Regionalized Acute Care Services
Resolution 58 Disaster Medical Response

Non-Bylaws Resolutions

Requires a 3/4 vote is required to amend or overrule.

Resolution 1 Commendation for Mark L. DeBard, MD, FACEP
Resolution 2 Commendation for John A. Brennan, MD, FACEP
Resolution 3 Commendation for J. Brian Hancock, MD, FACEP
Resolution 4 In Memory of Ross S. Carol, MD, FACEP
Resolution 5 In Memory of Donald G. Gregg, MD
Resolution 6 In Memory of James E. Hayes, MD, FACEP
Resolution 24 Fellowship and Its Implications
Resolution 35 Health Courts

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2005 Council Actions *Continued from Page 9*

Resolution 37 Rural Emergency Medicine Workforce (as amended)
Resolution 38 Proper Payment Under Assignment of Benefits
Resolution 41 Non-Discrimination (by substitution)
Resolution 42 Emergency Medicine Research Funding
Resolution 43 ACEP Strategic Role in County, State and American Medical Societies
Resolution 45 Availability of Hospital Diagnostic and Therapeutic Services (by substitution)
Resolution 47 Contemporaneous Interpretation of CT Scans (by substitution)
Resolution 49 Emergency Psychiatric Transfers (by substitution)
Resolution 51 Emergency Physician Autonomy in the Performance and Interpretation of Diagnostic Imaging Studies
Resolution 52 EMS Communication Network (by substitution)
Resolution 53 Emergency Department Nurse Staffing Model (by substitution)
Resolution 54 Enhanced Communication of College Financial Information (by substitution)
Resolution 55 Recognition of Group Participation in ACEP (by substitution)
Resolution 56 In Memory of Ralston Raymond (R^2) Hannas, Jr., MD
Resolution 57 In Memory of John G. Wiegenstein, MD

College Manual Resolutions

Requires a simple majority vote for adoption.

Resolution 11 Board Vacancy Replacement Procedure (as amended)
Resolution 32 Code of Ethics for Emergency Physicians

Bylaws Resolutions

Requires a 2/3 affirmative vote of the Board of Directors for adoption.

Resolution 7 Compensation of ACEP Officers and Board of Directors (as amended)
Resolution 10 Filling Board Vacancies (as amended)
Resolution 13 Election of Board Chair by the Board of Directors
Resolution 14 Indemnification for ACEP's Directors, Officers, and Employees
Resolution 15 Council Voting Privileges in a Special Election – Housekeeping Change
Resolution 16 President's Appointment of Committees – Housekeeping Change
Resolution 17 Filling Non-Recall Vacancy in Office of President-Elect (as amended)
Resolution 18 Assumption of the Office of President – Housekeeping Change
Resolution 19 Number of Officers – Housekeeping Change (as amended)
Resolution 20 Outgoing Past President to Remain a Voting Board Member Until Conclusion of Post-Council Board Meeting
Resolution 21 Council Voting Rights (as amended)
Resolution 25 Combining Life and Retired Membership Categories (as amended)
Resolution 26 Honorary Membership
Resolution 27 Active Membership Eligibility (same as Resolution 28)
Resolution 28 Active Membership Eligibility (same as Resolution 27)

For a complete breakdown of all resolutions acted on during the 2005 ACEP Council please refer to ACEP's web site at www.acep.org

The Battle of the Belt

Mary Tuel Rn. CEN
State ENA Chair Battle of the Belt
State Co-Chair Injury Prevention
Ozark Charter ENA president

Battle of the belt is going strong into its third year! During the CCC meeting we discussed the schools involved last year and the winners. They were Nerinx in St. Louis won state best average in seat belt use with a 99.5% usage; and Marion C. Early School in Morrisville won the most improved as they increased from a seat belt usage rate at the start of 23.5 % to a 65.0%.

What is new this year is that battle of the belt is moving to the fall. The month of October will be Battle of the Belt month. We hope to increase our usage numbers with a continued contact in the high schools through out the year. Sign ups for the schools are in full swing and we look forward to an even bigger competition this year. Areas in the start that did not participate last year are gearing up to take the challenge this year. With the increase in schools we will need an increase of helpers in each area.

We are also excited about the possibility of beginning a Battle of the Belt Junior this Spring. This will include the elementary school students. The idea is to have the High school students spend a week in the spring promoting Battle of the Belt to these elementary students. They will run a small seat belt check with law enforcement and provide packets for each child to take home to the parents about seat belt use and restraints for smaller children and infants. The high school students will be a great example to the younger children that seat belts are cool to wear. Our hope is that we will maximize the idea of wearing seat belts from high school down to elementary and reaching into homes were the smallest children and their parents are.

Thank you again for your continued interest and support in the challenge to keep all our kids safe on the roads.

Aging Emergency Physician Study Group

Reprinted with permission

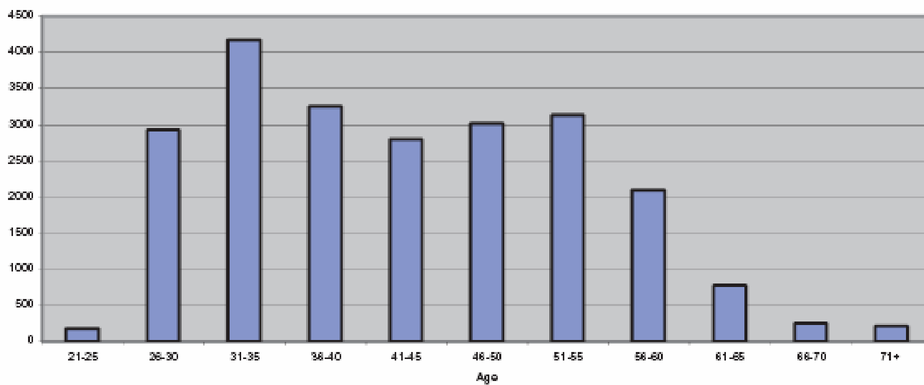
Richard Goldberg, MD, FACEP
Mitchell B. Cordover, MD

For a growing number of members of the American College of Emergency Physicians (ACEP), issues of aging and retirement are now surfacing. The specialty of emergency medicine has not just grown up, it is growing older. We are individually being faced with challenges that ACEP could well help to clarify. The Wellness Section of the College has developed a task force to promote both dialogue and research on theses issues.

The graph shows the age distribution for ACEP's current membership. It shows a bimodal curve with a large number of members in their mid-30s and another large group in their early to middle 50s. In fact, 41% of members are older than 46 years, and 28% are past 50. If membership stayed just as it is, in 5 years time nearly 1 in 5 ACEP members would be over 60 years old.

Continued on Page 12

Aging Emergency Physician Study Group *Continued from Page 11*



The implications of this trend go far beyond the manpower needs of the nation's emergency departments (EDs). Wellness issues abound. Resistance to circadian stress, for example, begins to decline at age 40 and is clearly reduced by age 50. Emergency medicine is a physically taxing specialty, shift changes not withstanding. Will we as a College need to suggest policies to take this into account?

The ability to function well after a long runs of shifts varies by individual and patient load, but whether age affects this is an open question. Shift duration is a well-known stressor and may be less well-tolerated by the aging physician. Can aging but experienced

physicians handle high patient volumes, with their input overloads, better or less well than their younger colleagues? These practices may need to reflect our changing demographics.

Many emergency physicians work as independent contractors with no retirement benefits other than ones we make for ourselves. Those who work as employees for hospitals or groups may not have a Aging Emergency Physician Study Group clear idea of their benefit package or a real plan for such realities as health insurance. Many will need comprehensive financial planning to be prepared for retirement. And even with financial security, retirement itself is a well-recognized stressor. For physicians, who are reputedly career-oriented and certainly hard-working, the transition to leisure can be a difficult one. What career alternatives exist to bridge the gap between work and retirement? Are there ways we can prolong our career in a way that recognizes the inevitable changes of age?

In a February 15, 2005, article in the *Annals of Internal Medicine*, (Volume 142, Issue 4) Choudhry, et al, wrote a controversial meta-analysis suggesting that private practice physicians with "more experience" (read older) may be at risk of delivering lower-quality care. There was a predictable outcry, pointing out that his measures of quality primarily focused on adherence to guidelines and well established protocols. While articles using hard outcome data were few, his work brings up an important point. Is there a dimension of patient safety in discussions about older physicians?

It is not unreasonable to suggest that levels of professional competence vary through one's career, peaking with experience and then declining at some point. Is this clinically significant? How do we measure it? Is it consistently age-related? These are issues that bear research and discussion.

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Success is not the key to happiness. Happiness is the key to success. If you love what you are doing, you will be successful. -- Herman Cain --

Aging Emergency Physician Study Group *Continued from Page 12*

To capsulize the task force's questions:

1. Are there ways to enhance and prolong the careers of emergency physicians in the latter stages of their practice?
2. Are there predictable areas of concern that are more significant to older emergency physicians, such as circadian stress, shift duration, recovery time, and the physical demands of the specialty?
3. What can be done to facilitate the transition of emergency physicians from active practice to retirement? Are there practice, financial, and policy changes that could smooth the transition and allow EDs to continue to benefit from their most experienced physicians?
4. What can younger physicians, practice groups, hospital, and employers do, looking into the future, to use the concerns of the older emergency physician to enhance careers in the specialty?
5. Are there issues of patient safety to take into account in the physician's own planning of an emergency medicine career?

Toward these ends, the task force has established four initial goals, as follows:

1. Identify issues of concern to emergency physicians in the latter stages of their careers.
2. Identify pertinent literature and develop an annotated bibliography for commentary and distribution.
3. Identify pertinent institutional resources, also to be annotated and distributed.
4. Encourage, conduct, and distribute pertinent surveys/studies on subjects related to this area.

These questions are essential to the future of emergency medicine, and they are ones we will each have to face. The section encourages anyone interested in participating in this important effort to contact Richard M. Goldberg, MD, FACEP, at *janard@adelphia.net*.

OUTSTANDING OPPORTUNITY in GEORGIA!!

Due to expansion and retiring partners, this 26 year old, stable, democratic, physician owned group has openings for additional ER trained, ABEM boarded physicians.

Compensation is in excess of 300K annually, fully funded pension after two years of employment, generous expense account CME allowance and beautiful weather year round!

This is truly a unique opportunity of a lifetime. All interested candidates, please fax your CV to 229-317-2214 or visit our website at www.swepalbany.com

Inanimate objects are classified scientifically into three major categories - those that don't work, those that break down and those that get lost. -- Russell Baker --

President's Message

- Mark your calendar. CCC August 8-11 2006 Tan-Tar-A. I was privileged to attend the Nineteenth Combined Clinical Conference on Emergency Care. The Conference was held at the beautiful Tan-Tar-A Resort in Osage Beach, Mo. The Conference was sponsored by the Missouri College of Emergency Physicians (MoCEP), the Missouri Nurses Association, the Aeromedical Transport Association, and the Missouri Emergency Medical Service Association.
- Approximately sixty physicians attended, and although the physician attendance was an all time record, this number represents a woefully small percent of our MoCEP membership.
- "Weapons of Mass Destruction", an excellent presentation by Dr. Robin McFee, included global, national, and regional implications.
- We were privileged to have Dr. Robert Suter present "The Direction of Emergency Medicine". Dr. Suter addressed protecting our practice and why it is important to contribute financially as well as politically. Dr. Suter also presented "Advances in pain management" and how it affects our practice. Dr. Suter is a talented emergency medicine physician, an excellent educator and has demonstrated exemplary leadership skills as our ACEP President during the past year. Thanks Bob, it was a pleasure.
- A newcomer to the CCC; Dr. Charles (Chuck) Sheppard presented "Myths in Emergency Medicine" and once again reminded me that medicine is dynamic and much of what I learned in school has no scientific basis.
- Dr. Christopher Carpenter presented "Geriatric Emergencies". This was a research based presentation and I hope Dr. Carpenter will be a regular at the CCC. I look forward to an annual update.
- "Headaches in Children" presented by Dr. Kimberly Quayle was timely and very informative. Dr. Quayle presented mechanisms for guiding a child headache workup. I certainly benefited from this presentation.
- "Trauma Ultrasound" by Dr. O. John Ma was a refreshing review. Dr. Ma's mastery of ultrasonography is truly amazing. This was a "hands on" presentation included in the CCC tuition.
- Dr. Dennis Whitehead presented "Surviving Shift Work". We can protect our physical and mental health by properly rotating our ever changing shifts. Dr. Whitehead also brought his expertise and insight to us on "Rural Emergency Medicine" and existing barriers that keep residency trained emergency medicine physicians from practicing in a rural setting.
- Many thanks to Drs. Christine Sullivan, Stefanie Ellison, Christopher Carpenter, Doug Char, and Chandra Aubin for the great job they did on the 2005 LLSA presentation; including the CD that contains Article listings, Power Point Presentation, Handouts, and Sample Test. The LLSA review was included in the tuition and will be an annual part of the CCC.
- There were many more quality presentations at the CCC. This represents only the ones I attended.
- Finally, I want to Thank Drs. Doug Char, Ted McMurry and Christine Sullivan for a job well done. Without their involvement on the conference planning committee, none of this would have happened.

Most importantly, I learned a thing or two. I saw and visited with old friends. We had an excellent MoCEP general membership and board meeting. A good time was had by all. Join us at the 2006 CCC.

Barry D. Spoon, D.O.

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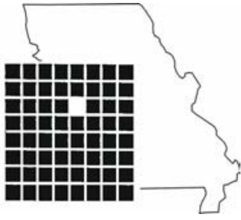

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