

Alabama EPIC

SUMMER/FALL
1998

Interim Communique for Emergency Physicians in Alabama

In This Issue:

- From Death Comes Life ...**
page 2
- MASA Lobbyist ...** page 2
- T'SSSSSSS The Season ...**
page 3
- Alabama Medicaid Patient 1st**
... page 4
- EMS Medical Control**
Physicians ... page 5
- Dr. Carden Johnston ...** page 5
- State Government ...** page 5
- Special Thanks ...** page 5
- Medical Association's**
Volunteers Needed ... page 6
- Interspecialty Council ...**
page 6
- ACEP Members Active at MASA**
Meeting ... page 6
- Advertisements ...** page 7
- Upcoming Events ...** page 8

EPIC is published by the

Alabama Chapter of the American
College of Emergency Physicians
P.O. Box 4629 • Montgomery, AL
36103-4629 / (334) 265-0068

From The President ...

Sherrie Squyres, M.D., FACEP

Dear Colleagues,

First, I want to thank you for the opportunity to serve as President of Alabama ACEP. We should have a busy year.

One of the main things that I would like to focus on is establishing a strong foothold for Emergency Medicine in the House of Medicine. The sad fact is that our specialty is still young and in many ways we are viewed as the stepchildren of our hospitals' medical staffs. This attitude stems from the fact that, for so many years, most emergency departments were manned by transient physicians or moonlighting residents with little or no allegiance to the hospital or community.

Although this situation still exists in some areas, we have made significant progress. More and more across Alabama, hospitals, medical staffs, and patients are insisting that their emergency departments be staffed by qualified professionals. But we have a long way to go.

In order for Emergency Physicians to have a voice in medical policy, we must work within the established framework. This means participating in activities and organizations within your own hospitals and communities in Alabama. We need to organize and work together.

I encourage you to join your County Medical Society and the Medical Association of the State of Alabama (MASA). MASA is the collective voice of physicians in our state. Although Emergency Physicians are becoming more active with MASA, we do not currently have voting representation on the MASA Board because we do not have enough Alabama ACEP members who are also MASA members.

MASA has been very receptive to the needs of emergency physicians and our patients. For instance, last year MASA worked hard before the state legislature to promote the "Patient Protection Act", which included the "Prudent Layperson" standard of Emergency. They fought a tough battle on our behalf. Alabama ACEP member physicians lobbied health committee and other legislative leaders as well. This year, MASA is focusing on upcoming elections, especially those to be held for crucial positions on the Alabama State Supreme Court.

National ACEP is having a membership drive, especially to urge those who are not Board Certified to join before 2000. Please urge your colleagues to join us, and to consider MASA membership as well. We will work hard to make their membership worth the investment.

Opinions expressed in this newsletter do not necessarily reflect the point of view of the Alabama Chapter American College of Emergency Physicians.

Check out the
Alabama ACEP Worldwide Web Site
at: www.alacep.org

FROM DEATH COMES LIFE

The the death of a patient is a sad event, and unfortunately this is an event that occurs about 120 times a day in Alabama. When a patient dies, donation must be considered. The Alabama Organ Center is the federally designated organ procurement organization for the state of Alabama. We are the link between donor hospitals and transplant recipients.

The donation process is relatively simple. Once a patient has died, or death is imminent, a call should be made to the Alabama Organ Center and the Alabama Eye Bank to determine donor suitability. If the patient does not have any donation options, this is documented in the patient's medical record and the family does not need to be approached. If the patient has donation options, the family is approached about the opportunity to accept or decline donation. It is the family's legislated right to be approached about donations. The Alabama Organ Center and/or the Alabama Eye Bank are available to help approach families about this important decision. It is important that the requestor be comfortable with donation and able to discuss this topic openly. Research has shown that donation can help families with the grieving process. If the family consents to donation, the Alabama Organ Center and the Alabama Eye Bank will coordinate the recovery of the donated organs, tissues, and eyes.

What can be donated? Organ donation requires that a patient be brain dead and supported on a ventilator. It is more common to see patients that are suitable for tissue donation. Tissues can be recovered after cardiac arrest. Tissue donation includes:

- Eyes
- Bones and associated tissues
- Heart valves

One person's donation of tissue can help 100 people. Regardless of what the family chooses to donate, there is no cost to the family and the family can still have a traditional funeral with viewing.

The physician plays a vital role in the donation process. Physicians identify and refer potential donors, provide essential medical information, and support families during the loss of a loved one. The Alabama Organ Center has staff available 24 hours a day to assist you in the process. Simply call 1-800-252-3677 to talk with the Procurement Transplant Coordinator on call.

MASA Lobbyist Supports Emergency Medicine Before Congress

Medical Association of the State of Alabama (MASA) lobbyist Mark Jackson recently met in Washington with Alabama congressional leaders to support the "prudent layperson" standard of Emergency. Mr. Jackson, along with representatives of the American Medical Association (AMA), encouraged congressional leaders to support, among other provisions, managed care reform bills that contain the uniform "prudent layperson" definition of Emergency, which now applies to all recipients of Medicare and Medicaid following passage of the Balanced Budget Act of 1997. Specifically, Mr. Jackson warned congressional leaders to not set a "double standard", that is applying the "prudent layperson" standard of Emergency to Medicare and Medicaid enrollees, but a weakened or otherwise different standard to the rest of the population. The Alabama ACEP association appreciates Mr. Jackson and MASA for their continued support of Emergency Medicine.

ALABAMA ACEP

Board of Directors

OFFICERS

Sherrie Squyres, MD, FACEP
President
Huntsville

Thomas Arnold, MD, FACEP
President-Elect
Montgomery

Mark C. Mitchell, MD, FACEP
Secretary/Treasurer
Daphne

Sam B. Heard, MD, FACEP
Immediate Past President
Huntsville

BOARD MEMBERS

Christen Zuschke, MD, FACEP
Mobile

Phillip K. Bobo, MD, FACEP
Tuscaloosa

Marni J. Bonnin, MD, FACEP
Birmingham

John E. Campbell, MD, FACEP
Auburn

Neil Christen, MD, FACEP
Anniston

Robert J. Cox, MD
Mobile

David J. Garvey, PhD, MD, FACEP
Huntsville

John M. McMahon, Jr., MD, FACEP
Daphne

Rick Weber, MD
Dothan

Janet Pribble, MD
Birmingham

Michael Sternberg, MD
Mobile

COMMITTEE CHAIRS

BTLS

Neil Christen, MD, FACEP

Bylaws

Michael Sternberg, MD

Education

David J. Garvey, PhD, MD, FACEP

EMS

John M. McMahon, Jr., MD, FACEP

Legislative

Phillip K. Bobo, MD, FACEP

Membership

Neil Christen, MD, FACEP

Practice Management

Jorge Alsip, MD, FACEP

Chapter Communications

Thomas L. Arnold, Jr., MD, FACEP

Emergency Trauma Management

David J. Garvey, PhD, MD, FACEP

Public Relations

Bernard F. Kennetz, Jr., MD, FACEP

Pediatrics

Peter W. Glaeser, MD

Academic Affairs

Marni J. Bonnin, MD, FACEP

T'SSSSSSSSSSS The Season

If the current trend continues, we are in the midst of a record setting year for the number of venomous snakebites in Alabama and probably the U.S. El Niño? Since 90% of all snakebites occur April through October, there is no better time than the present for a short refresher on current recommendations for the management of venomous snakebites.

Crotalids (pit vipers) are responsible for the vast majority of the venomous bites that you will see in the ED. In Alabama, this family includes three varieties of rattlesnakes (Eastern diamondback, timber/canebrake and pigmy), the cottonmouth (water) moccasin and copperhead. Their venom is a mixture of proteolytic/eytolytic enzymes, neurotoxins, cardiotoxins, coagulants/anticoagulants, and a variety of vasoactive compounds. Signs/symptoms of envenomation may include: oozing of blood from the puncture site (hallmark), pain/burning at the site, edema (may progress rapidly), paresthesias (face, scalp, extremities), metallic or rubbery taste in mouth, ecchymosis and/or hemorrhagic blebs at site, bleeding complications (minor to severe), motor weakness/paralysis, autonomic dysfunction, tissue/muscle necrosis, hypotension/shock, kidney failure, and pulmonary edema. Severity of envenomation is graded mild, moderate or severe. Up to 25% of bites will lack signs/symptoms of envenomation (i.e. "dry bites").

The Eastern coral snake is a member of the elapid family, and is responsible for a small but important number of envenomations along the coastal part of the state. Coral snake bites usually produce minimal local effects, but may produce serious neurotoxic/cardiotoxic effects that may have a delayed onset of up to 12 hours. An accurate history of a coral snake bite is the basis for treatment.

Field management is essentially the same for both families of snakes, and includes: keeping the patient calm/avoiding panic, applying suction early (with a Sawyer Extractor, if available), applying a loose constriction band proximal to the bite, splinting the affected extremity at heart level, and transporting the patient to the ED as soon as possible. Therapies to avoid include: sucking on the wound with the mouth, incising the wound (espec. deep/criss-cross), using cryotherapy (ice packs), applying a tight constriction band/tourniquet, and applying electric shock, (stun gun) to the wound. Do not get bit while trying to catch the snake, and do not delay transport while attempting field treatment.

Initial ED management of a patient with suspected envenomation is also the same for both pit viper and coral snake bites. Most importantly, be prepared for the worst. Address the ABC's first, and intervene as needed. Obtain appropriate history and physical (when did the bite occur, previous bite and/or antivenom therapy, current needs; espec. B-blockers). Begin IV lines (LR or NS). Monitor vital signs (cardiac, pulse ox, BP). Note and follow progression of signs/symptoms of envenomation. Obtain labs early (CBC, coags, T&S, SMA-7, CPK, UA). Provide appropriate wound care (antibiotics, dT, X-ray to r/o retained fang) and analgesia.

ED management of the pit viper versus coral snake bite differs with respect to antivenom therapy. Currently, there is a polyvalent crotalid antivenom and an Eastern coral snake antivenom, both are made by Wyeth, and both are derived from horse serum with the associated risk of hypersensitivity reactions (immediate and delayed). Administration of crotalid antivenom for a pit viper bite is based on the severity of envenomation: mild (with local reaction only, no systemic signs/symptoms, and no abnormal labs) usually requires no antivenom therapy; moderate (progressive edema, signs of systemic toxicity, labs slightly abnormal) is treated with 5-20 vials of antivenom, and severe (marked swelling of the entire extremity, serious systemic signs, altered mental status, hypotension, respiratory distress, significant bleeding, and markedly abnormal labs: coagulopathies, elevated CPK, hematuria, proteinuria) often requires 20-40 plus vials for a known coral snake bite, with or without signs/symptoms of envenomation, treatment with a minimum of 5 vials is recommended. The reason is that if treatment is delayed until neurotoxic effects are present some may be irreversible. Both types of antivenom should be administered according to the package insert. Antivenom should be given IV only (not locally or IM). Try to infuse 5-vial increments over 1-2 hours; start slowly. You will usually see results within minutes if an adequate dose is given. The end point is clinical improvement (swelling stops, systemic signs/symptoms abate, lab abnormalities correct). The major advantage of IV administration is that the infusion can be slowed or stopped if an anaphylactic reaction occurs, then restarted once the anaphylaxis is treated. When antivenom is required in the treatment of a moderate-severe envenomation, most experts do not recommend skin testing for horse serum hypersensitivity which besides being inaccurate (several false positives and false negatives) delays necessary therapy (i.e. antivenom). Instead, you can either pretreat for possible anaphylaxis with steroids, H1 and H2 blockers, or treat the anaphylaxis if and when it occurs. Expect an anaphylactic reaction to either the venom or antivenom in patients with a history of previous snakebite/antivenom therapy. Also, beware of patients on B-blockers, which may seriously complicate your treatment of anaphylaxis. Remember the treatment of significant envenomation is antivenom, and the sooner given the better.

On the horizon, pending FDA approval, is a whole new class of antivenoms which will completely revolutionize our treatment of snakebites. They are ovine-derived polyclonal Fab fragments. In clinical trials, these antivenoms have been found to have better antigen specificity, be more effective against certain venom components (particularly neurotoxins), and be non-allergenic. There is another interesting development, also in the clinical trial stage, an ELISA snakebite screening test which not only can determine if a bite/envenomation occurred, but can identify the responsible snake. Sounds like I'll be writing a snakebite update soon.

Dave Garvey, PhD, MD, FACEP, Huntsville Hospital

Alabama Medicaid PATIENT 1st Program

Phillip K. Bobo, MD, FACEP, Tuscaloosa

NOTE FROM SHERRIE SQUYRES, MD, FACEP, CHAPTER PRESIDENT

Because the Patient First Program has caused all of us a lot of concern (and frustration) for us over recent months, I asked Dr. Phillip K. Bobo to comment on the experience they have with the program in Tuscaloosa. Dr. Bobo has over twenty years of experience as an Emergency Physician, and now runs a clinic system that deals with the Patient First Program as well. The program was implemented in Tuscaloosa in October of 1997, and so maybe we can benefit from their experience. I appreciate Dr. Bobo's help and consideration.

Patient 1st is an initiative of the Alabama Medicaid Agency to assign Medicaid patients and/or allow Medicaid patients to choose a Primary Medical Provider (PMP).

The PMP is required to authorize all medical services that are rendered to the Patient 1st recipient or Medicaid will not pay for the services provided to the patient. The PMP must be available 24 hours a day. The PMP will be responsible for providing all primary care and arranging all specialty care and referrals.

The PMP is paid \$3.00/recipient/month up to \$3,000.00/month per PMP.

The Patient 1st recipients are required to receive service from the PMP or from another qualified provider to which they are referred to by the PMP. The recipient may change their PMP monthly. There is about a 45-day delay before the assignment of a new PMP will take effect.

When a Patient 1st recipient presents to their PMP, they will show their Medicaid card and the eligibility can be verified through the Medicaid Eligibility Verification System (MEVS) which will tell if they are eligible, what type of coverage they have, who the PMP is with his phone number and the number of visits used for the year.

In Tuscaloosa we have participated in the Patient 1st program since October 1, 1997. We have a substantial number of Patient 1st recipients assigned to our physicians at Emergi-Care Clinic, P.C., an urgent care and family practice center. I can only speak as to how we handle our patients.

As with most government programs, the physicians and patients are poorly educated about the program to its start-up. It became very apparent that we would have to educate ourselves and staff and educate our patients. We sent letters to all of our assigned patients explaining that we were their PMP, our location, our telephone number and our hours of operation.

When a patient presented for the first visit we would educate the patient and their families about the Patient 1st program and how it works.

The Patient 1st program does not limit Emergency Services – It uses the “Prudent Layperson” definition of an Emergency to determine if it is an emergency. The patients are advised to call us if they have a problem or if they think they have an emergency and need to go to the Emergency Department (ED). Many will call and talk with the PMP or call before going, others will just present at the ED.

When the patient presents to the ED, they should be handled as all patients are. They should first be triaged to determine if they need immediate care or if they can be handled in a non-emergent fashion.

We have an agreement with the hospitals and the ED physicians on how we want our patients handled. During the hours we are open, we want to be called after triage of all non-emergent patients and we will usually ask the patient to come to the Clinic. If they choose to be

seen by the ED Physicians and he does a medical screening exam and deems it not to be an emergency, we ask him to call and we will decide if it needs to be treated in the ED or sent to the Clinic. The patients may choose to be treated by the ED Physician, but we will not authorize the visit for payment and the patient will be responsible for the bill.

The ED Physician treats all Emergent patients. If the patient is not admitted, then the patient is referred back to the Clinic for follow-up care. If the patient needs to be admitted the physician on call for our Clinic is called and he makes arrangements for admission. We do not admit but we have an agreement with Internist, Pediatrician, Surgeon, OB-Gyn, etc. ... to admit our patients. Most PMP's admit their own patients or have the ED Physician write the admission order if appropriate.

After hours (of our Clinic) the ED Physician does a medical screening exam and determines if it is an emergent or non-emergent condition. If emergent, they do as stated above. If non-emergent, we ask that they not treat the patient and send to us the next day (we are open 7 days/week). In some cases the ED Physician may choose to treat some patients but this re-inforces the patient to return to the ED and not to the PMP.

Our staff picks up a copy of the ED medical records daily of all patients seen in the ED over the last 24 hours. These records are reviewed by the PMP. Patients are called to see how they are doing. If the patient had a non-emergent condition and was not referred by the PMP, we educate the patient about the Patient 1st program and encourage them to call or come to the Clinic for non-emergent care. If a patient continues to use the ED for non-emergency care, we will not authorize his visit and the doctor and hospital will not be paid.

I estimate that the number of ED visits by our patients have decreased 60% since October 1, 1997. You can expect your volume of Medicaid patients to decrease with the Patient 1st program if the PMP's do what they are supposed to. The purpose of the Patient 1st program is to get to the appropriate level of care in the most efficient manner and reasonable cost.

The adult portion of the Patient 1st population is the most difficult to handle. Many are dysfunctional and have numerous medical and mental problems. They are harder to educate and are the most frequent users of the ED.

After 9 months we average only 2 calls/night and they are usually before midnight or early (6 am-8 am) in the morning. The most frequent call is a child with fever. We try to make sure all of our pediatric patients have prescriptions for Tylenol and ibuprofen at home.

Dr. Squyres asked me to address the COBRA Law and Patient 1st issues. It doesn't change. It is a Federal Law and the Federal Law overrides the State Law. Patient 1st is mandated by the State. COBRA Law requires the hospital to conduct a medical screening exam on every patient whom presents to the ED to determine if a medical emergency exists. This means if the facility inquires about the payment status and requires the patient to call their PMP for authorization to treat them, then this situation is a direct violation of the COBRA Law.

Once the appropriate medical screening exam has been completed by the ED Physician and it is determined that the patient does not have an emergent condition, then they can tell the patient this is not an emergency and require payment before treatment or instruct them to go to their PMP's office, or if after hours, they can go the next day or call the PMP for further instructions.

EMS MEDICAL CONTROL PHYSICIANS

The Alabama State EMS Office of the Department of Public Health wants to remind all approved EMS Medical Control Physicians that it's the responsibility of each such physician to maintain EMS Medical Control requirements set forth by the Department. Completion of the "Alabama EMS Medical Directors Course", offered monthly across the state, is required for all physicians who work in the capacity of EMS Medical Control Physician. Certification (or recertification every four years) in Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) is also required for those physicians NOT board certified in Emergency Medicine. Physicians who maintain current board certification in Emergency Medicine are EXEMPT from certification in ACLS and ATLS. In order to avoid suspension and/or revocation of a physician's authorization as an EMS Medical Control Physician, the State EMS Office encourages all physicians issued EMS Medical Control Numbers to maintain their requirements and to report any changes or updates directly to them. For more information contact Hugh Hollon, project officer, at the Alabama State EMS Office, 334-206-5383.

DR. CARDEN JOHNSTON NAMED ALABAMA ACEP "KEY CONTACT" REPRESENTATIVE TO THE NEW FEDERAL STATE CHILD HEALTH INSURANCE PROGRAM

In an attempt to increase the number of children with health insurance, the \$48 billion State Child Health Insurance Program (SCHIP) was created as part of the Balance Budget Act of 1997. The program provides grants to states with approved plans that include outreach activities to encourage enrollment of eligible children in the new program. National ACEP has been asked by the American Academy of Pediatrics (AAP) to designate "key contact" members in each chapter or state to work with them in developing and implementing state action plans. Alabama has been recognized as developing the first approved state plan in the country. In addition, Dr. Carden Johnston of Birmingham, a pediatric emergency physician and 13-year member of the Alabama Chapter ACEP, was recently named as the Alabama ACEP "key contact" representative to the new State Child Health Insurance Program.

STATE GOVERNMENT

On November 3, 1998, Alabama Citizens will begin making decisions on how they want this state to be governed. Will we continue to move to the conservative side of the street or will we slide back into the governments of yesteryear? On that date the election for the 140 member state legislature, the Lt. Governor, the Governor, **three Supreme Court Justices**, and all remaining Constitutional Offices will be held. On that date we will decide who will lead us into the next century.

There are so many good reasons to get involved in the 1998 elections. The legislature we elect will reign over the movement of managed care into the state. The justices we elect will ultimately decide the fate of Alabama's out of control tort system and the governor we elect will lead us into the new millennium.

It is up to us to see that conservative, pro-medicine candidates are elected to office. No one will do it for us. November is a short time away. We must get involved today!

You no doubt are aware of the reputation the Alabama Supreme Court has obtained. National publications have called Alabama "Tort Hell," a "Plaintiff's Paradise," and "Trial Lawyer Heaven." Based on some of the recent decisions rendered by the Court, you probably agree that it is a reputation which is unfortunate, but deserved.

Medicine and business have a very real chance in 1998 to return the Court to its proper balance—fair, neutral and reasonable. It is highly unlikely that there will be such a rare opportunity (3 of 9 members up for election) again anytime soon. The Supreme Court seats up for election are as follows:

Supreme Court Justice Place No. 3

Glenn Murdock (R)
Douglas Johnstone (D)

Supreme Court Justice Place No. 2

Gorman Houston (R)
Janie Baker Clark (D)

Supreme Court Justice Place No. 1

Jean Brown (R)
Roger Miles Monroe (D)

All of these races will be extremely competitive. The plaintiff trial lawyers have taken some hits in the last few skirmishes, but they will make a stand in 1998. If you think the 1996 race between Harold See and Kenneth Ingram was expensive, you haven't seen anything yet.

For more information regarding the elections call MASA's Governmental Affairs Office at 1-800-239-1333.

SPECIAL THANKS!!!

to

Dr. W. Larry Sullivan

Past Secretary/Treasurer, Huntsville, AL

for your leadership on the chapter's fundraising project that raised \$5,000, for your outstanding efforts as the chapter's longest serving secretary/treasurer and for your overall contributions and dedication to the Alabama ACEP association.

ALABAMA, Decatur: Full-time opportunity available in a 14,000 annual volume ED. ED is fully-equipped with excellent support staff. Independent Contractor status, NO RESTRICTIVE COVENANTS, fully accredited CME, and paid malpractice insurance. Contact Kathy Hurley with Stering at 1-800-728-2129 or fax CV to 1-205-995-8580. khurley@fpamm.com

Florida, Panhandle: Seeking Emergency Medicine physicians that are Board Certified in a Primary Care Specialty or BE/BC in EM to complete the practice at a 17,000 annual volume ED. Independent Contractor status, competitive remuneration and flexible scheduling. Contact Michelle Campos with Sterling Healthcare Group at 1-800-701-5903 or fax CV to 1-888-372-5032.

Volunteers Needed for Public Safety Medical Advisory Board

(Reprinted with permission from "The Leadership Letter", July 1998, of the Medical Association of the State of Alabama)

The Alabama Department of Public Safety, (DPS), Driver's License Division, are looking for a few good physicians to serve on the Medical Advisory Board to the Department of Public Safety. Time away from the practice is minimal. Once a year, normally in December, the Medical Advisory Board meets in Montgomery to assist Alabama's highway enforcement officials in making decisions involving the revocation or suspension of an individual's license based on medical determinations, for example someone who suffers from seizures or visual deficiencies or any other medical ailment that may impair their operating an automobile. Individual's names are kept confidential, so the physicians' role is that of medical expert solely to determine the existence or nonexistence of particular medical conditions. Also, the DPS occasionally will forward information via mail to solicit medical expertise. A minimum of eighteen (18) physicians may serve on the Medical Advisory Board. Currently, there are eight Alabama physicians serving. The term of service is four years. With the expansion of the Board to 18 members, however, new terms are staggered and fall in the following format: 6 members to serve 2 year terms, 6 members to serve 3 years terms and 6 members to serve 4 year terms. Members are paid a per diem to cover expenses for their service. Colonel L.N. Hagan, Director of DPS, will make appointments from a list of nominees submitted by MASA.

MEDICAL ASSOCIATION'S INTERSPECIALTY COUNCIL

(Adapted with permission from "The Leadership Letter", July 1998, of the Medical Association of the State of Alabama)

Fourteen representatives from specialty groups, including Alabama ACEP board member Dr. Phillip Bobo, met with Medical Association of the State of Alabama (MASA) president Dr. Joel Pittard to organize an Inter-Specialty Council within the Medical Association. The goal of the Inter-Specialty Council will be to explore opportunities where MASA can partner with the specialties to make all of the physician organizations stronger. The attendees agreed that collaboration was needed among all physician organizations to ensure the voice of medicine was heard with continuity and consistency. The group decided that each specialty would appoint two representatives, not including staff, to participate in quarterly meetings. Two meeting dates were established, one to coincide with the MASA Leadership Conference in March and the other to be held in June at annual session. The remaining meeting dates will be called by the chair of the committee. For more information about the MASA Inter-Specialty Council, contact Mr. Richard Carson, director, at MASA 334-263-6441.

ALABAMA ACEP WELCOMES THE FOLLOWING MEMBERS ELECTED DURING THE ANNUAL MEETING TO THE BOARD OF DIRECTORS

Rick Weber, MD, Dothan
Janet Pribble, MD, Birmingham
Christen Zuschke, MD, FACEP, Mobile

CONGRATULATIONS!

Seeking a BC/BP EM Physician to join an all-ABEM certified group in a 39k-volume ED. Work in a new state-of-the-art ED now in the final stages of construction; 30 beds plus specialized treatment areas including an eight-bed observation unit and a fast track. Progressive 400-bed community hospital with 13 external clinics. Family-oriented, low cost-of-living community with an abundance of outdoor activities; a short drive from beautiful Gulf beaches.

Stable eight-physician group, excellent remuneration, democratic scheduling, independent contractor status.

**Contact James C. Jones, DO, FACEP,
334/793-8931; fax: 334/677-6699, Dothan, Alabama.**

ALABAMA ACEP MEMBERS ACTIVE AT MASA MEETING

Several Alabama ACEP members were active at the Medical Association of the State of Alabama's (MASA) annual session, held June 25-28 in Point Clear. Dr. Brad Frisbie of Birmingham, who helped develop the MASA world wide web site, was one of the invited speakers for the educational sessions and gave a presentation on computer systems. In addition, Dr. Frisbie was also elected chairman of the Young Physicians Section for 1998-99. Dr. Jorge Alsip, a Mobile emergency physician, was elected to Alabama's AMA delegation as an alternate delegate, in addition to presiding over a portion of the annual meeting in his role as MASA Vice Speaker. Dr. Adam Robertson of Birmingham and Dr. Phillip Bobo, an Alabama ACEP board member from Tuscaloosa, were both re-elected to their position as counsellors.

ALABAMA ACEP CONGRATULATES THE FOLLOWING BOARD MEMBERS ELECTED DURING THE ANNUAL MEETING TO SERVE AS OFFICERS

Thomas Arnold, MD, FACEP,
President-Elect, Montgomery

Mark Mitchell, MD, FACEP,
Secretary/Treasurer, Daphne

Congratulations!

\$\$\$ FOR IDEAS

Submit Chapter Grant Proposals Now

If you have an idea for a chapter grant project, please contact the Alabama chapter TODAY about applying for a chapter grant.

The Board of Directors of ACEP approved \$45,000 for this year's Chapter Grant Program, of which up to \$13,500 is earmarked for chapter development grants.

ACEP President-Elect John C. Moorhead, MD, FACEP, said, "I strongly encourage your chapter to submit applications for the chapter grant program. The Board considers the number of submissions as an indicator of support for the program."

The Chapter Grant packets were mailed on July 15 to chapter presidents and executive directors to allow more time for them to work with members to develop ideas and submit them as letters of intent.

Submit your ideas now to Leland Holman, Alabama ACEP, 334-265-0068, fax 334-265-1233, or alacep@alacep.org.

ALABAMA

**Team Health's Emergency Medicine Division
has full-time emergency medicine opportunities
in Birmingham, Cullman, Montgomery and Enterprise, Alabama.
These facilities have volumes ranging from of 24,000 to 35,000.**

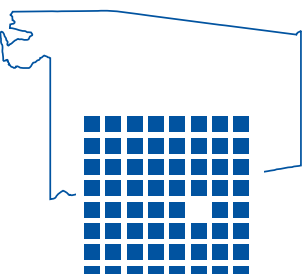
**Team Health is seeking physicians that are
BC/BE in EM, IM or FP with extensive ED experience.
Known as "The Heart of Dixie," Alabama offers a wide
variety of historical and cultural attractions as well
as recreational activities. Team Health offers competitive
compensation, paid malpractice insurance
and flexible scheduling with no on-call.**

For more information, call Amy Curmi at (800) 539-0173.

No J-1 opportunities available.

UPCOMING EVENTS

- Sept. 22 Birmingham Emergency Physicians Association – Monthly Meeting, 6:30 pm,**
Birmingham. Call Dr. Marri Bonnin for more info. 205-591-6515
- Oct. 20 State Emergency Medical Control Committee – Quarterly Meeting, 10:00 am,**
The RSA Tower, Montgomery
Call the Alabama State EMS Office for more info. 334-206-5383
- Oct. 27 Birmingham Emergency Physicians Association – Monthly Meeting, 6:30 pm,**
Birmingham. Call Dr. Marri Bonnin for more info. 205-591-6515
- Nov. 6-7 Advanced Trauma Life Support (ATLS) Provider/Refresher Course –**
Birmingham Regional EMS System Office, 8:00 am
Call Birmingham Regional EMS System Office for more info. 205-934-2595
- Nov. 10 Birmingham Emergency Physicians Association – Monthly Meeting, 6:30 pm,**
Birmingham. Call Dr. Marri Bonnin for more info. 205-591-6515
- Nov. 18 Alabama ACEP**
Board of Directors Meeting, 10:00 am, Alabama ACEP Office, Montgomery
Call Alabama ACEP for more info. 334-265-0068
- 1999**
- Jan. 26 State Emergency Medical Control Committee**
Quarterly Meeting, 10:00 am, The RSA Tower, Montgomery
Call the Alabama State EMS Office for more info. 334-206-5383
- Jan. 31-**
- Feb. 2 Medical Association of the State of Alabama (MASA)**
Annual Washington Conference, Washington, DC
Call MASA governmental affairs office for more info. 334-261-2000
- Feb. 6-7 Advanced Trauma Life Support (ATLS) Provider/Refresher Course**
Birmingham Regional EMS System Office, 8:00 am
Call Birmingham Regional EMS System Office for more info. 205-934-2595
- Feb. 17 Alabama ACEP**
Board of Directors Meeting, 10:00 am, Alabama ACEP Office, Montgomery
Call Alabama ACEP for more info. 334-265-0068
- Mar. 5-6 Medical Association of the State of Alabama (MASA)**
Annual Leadership Conference, The Wynnfrej Hotel, Birmingham
Call MASA education department for more info. 334-263-6441
- Apr. 20 State Emergency Medical Control Committee**
Quarterly Meeting, 10:00 am, The RSA Tower, Montgomery
Call the Alabama State EMS Office for more info. 334-206-5383
- Jun. 10-13 Medical Association of the State of Alabama (MASA)**
Annual Session, Bay Pointe Resort, Panama City, Florida
Call MASA for more info. 334-263-6441
- Jun. 14-16Alabama ACEP**
Annual Meeting & Educational Conference, Sandestin Hilton Resort, Destin, FL
Call Alabama ACEP for more info. 334-265-0068



ALABAMA CHAPTER
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS
P.O. Box 4629
MONTGOMERY, AL 36103-4629