

Alabama EPIC

WINTER
1999

Interim Communique for Emergency Physicians in Alabama

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36103-4629 / (334) 265-0068

From The President ...

Thomas L. Arnold, M.D., FACEP

Stephen Covey, in his series of books about habits of highly effective people and families, writes about attitudes and priorities. One of the stories he uses for his books and lectures goes something like this: A young girl approaches her father's desk where is working feverishly and has papers scattered around his desk. She stands there unnoticed until she says, "Daddy, what are you doing?" Without looking up, he replies, "I'm planning and organizing my book that lists the people I need to visit and talk with and the important things I have to do." The little girl hesitates, then asks, "Am I in that book, Daddy?"

At the close of 1999, the requirements for membership in ACEP will change. Board certification and completion of a residency in Emergency Medicine will be the new requirements for membership in the college---unless one is member before the end of 1999. If you are not a member now, please join before December 31st.

Alabama ACEP has increased its membership about 20% this year, to 247 members, an all time high. Neil Christen and Leland Holman worked very hard on a membership drive and their efforts are greatly appreciated. We still have only about half the emergency physicians in the state as members. There are many benefits to membership, not the least of which are the clinical, political, social and financial rewards that an active state chapter can deliver to all the emergency physicians in the state. Place urge your colleagues to join before the deadline.

Our debt has been paid off; the chapter is now out of debt and out of the BTLs book business. Many thanks to our past presidents Sherrie Squyres and Sam Heard; president-elect Mark Mitchell, last year's treasurer; Larry Sullivan, who served three years as treasurer; John Campbell and Neil Christen; and the many others who urged this change and brought about its fruition. As a result there will be both new opportunities and challenges to the chapter. Our main source of revenue is now dues, so it is vitally important that we recruit as many members as possible before the December membership requirements change.

Alabama ACEP continues a broad range of political activities related to improving the quality of emergency medicine in Alabama. We have requested that the State Board of Nursing change its policy concerning the administration of paralytic agents in EDs and ICUs by qualified RNs. We feel the current policy is

(Continued on page 2)

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

President's Message *(Continued from page 1)*

unnecessarily restrictive in that it does not allow the RN to administer such agents *until* an airway is secured. This forces the physician to inject the drug, while he/she is performing rapid sequence intubation. In such circumstances, a team approach is consistent with better patient care. Forcing the physician to administer the drugs and perform the intubation increases the risk of a poor outcome.

The Norwood-Dingle Patient Protection Bill has gone to a conference committee, but there is much debate over its eventual fate. Conferees have been appointed, but the committee has not yet met and will probably meet after the first of the year. Rumor has it that neither Republicans nor Democrats in the Senate want a bill. Instead, they prefer to see it as a defining issue in the upcoming presidential election. Alabama ACEP will keep you informed about the progress of this most important bill—for now, if you can get to your Representative or Senator, keep the issue on their horizon, and tell them how important it is for improving the quality of patient care in Emergency Departments.

Drs. Bonnin, Johnston, Pribble and Terndrup attended the Domestic Violence Initiative Press Conference in Birmingham, and gave comments to the press. We continue to participate with many other groups in the MASA Medicaid Coalition, whose purpose is to ensure long-term funding for Medicaid in Alabama. This effort includes several children's programs, including programs to expand insurance coverage for the children of poor families.

Dr. Garvey is already lining up speakers and topics for the 17th Annual Conference, June 25-28, 2000, in Destin, FL. ACLS, ATLS, and probably APLS will be offered, in addition to an exciting and challenging educational program. Mark your calendars now so you can get the time off to attend. Don't forget to bring your family—Destin and the Sandestin Hilton have much to offer. The beach seminars start at 1:00 pm each day.

There is a lot going on with Alabama ACEP, the Holidays are upon us, and each of us will have to balance our schedules against our family responsibilities. We can each try to do something that matters. Good luck in making those things count. Merry Christmas, Happy Hanukkah, and Happy New Year. As Goethe once said, "Things which matter most must never be at the mercy of things which matter least." What do you have in your book?

ACEP MEMBERSHIP

The College begins a new era in its history on January 1, 2000 when criteria based active membership requirements go into effect. From that day on, new Active (voting) members must be either residency trained in emergency medicine or board certified in emergency medicine by an ACEP recognized certifying body. Current Active members and those who join before then will not be affected.

Starting January 1, 2000, all new Active members must meet one of the following requirements:

1. Satisfactory completion of an emergency medicine residency program accredited by the Accreditation Council on Graduate medical education (ACGME).
2. Satisfactory completion of an emergency medicine subspecialty-training program accredited by ACGME.
3. Satisfactory completion of an emergency medicine residency training program accredited by the American Osteopathic Association (AOA).
4. Satisfactory completion of an emergency medicine residency program approved by an ACEP-recognized accrediting body in a foreign country.
5. Certification by an emergency medicine certifying body recognized by ACEP.
6. Active membership in the College at any time prior to the close of business December 31, 1999.

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How to Design the Optimal Schedule for Working Shifts

Working long shifts is nothing new to emergency medicine residents. In fact all emergency physicians feel the stress of shifts at some point, no matter how long they have been practicing. The bad news is, it doesn't get any better just because you have been doing it longer. But the good news is, there is something you can do about it.

Residents are in a unique situation because they have little control over their shifts. But by taking advantage of the opportunities you do have, you will be able to make your biological clock run a little smoother. Night shifts may be inevitable, but you can still maintain peak performance while working nights and ease both the stress of a night schedule and the adjustment from day to night shifts and back again.

Alertness and Performance

The main problem, of course, is that changing shifts means changing sleeping and eating patterns that upset the body's circadian rhythms. Alertness, speed, accuracy and reaction time are related to body temperature. People do best when their temperature is high - usually in the middle of the waking period.

It's well established that performance for a wide range of tasks varies with the time of day. Most performance curves can be brought into line with 24-hour temperature curves. The higher the memory component of a task, the earlier in the day performance on such a task peaks.

"Memory is sharpest after restorative sleep. Morning people who like to go to bed and get up early have their temperature peak usually before noon. Evening types who like to get things done at night and then sleep in, have their temperature peak later, in the second half of the day," says Dennis Whitehead, MD, a former Speaker of the ACEP Council and currently medical director of emergency services and EMS Project medical director for the Dickinson County Healthcare System in Iron Mountain, Michigan.

Body temperature drops during sleep. Adjusting the body's circadian rhythms, and thereby the temperature cycle, may take as long as a week. So, inappropriate phasing, trying to stay awake or to sleep when the circadian clock says otherwise, is a problem - especially with isolated night shifts, Whitehead says.

Single Night Shift Rotations

Some emergency physicians have advocated a single night shift system, wherein each physician works a solitary night shift attached to "normal scheduling." It's difficult logistically for small groups to use this schedule exclusively, but it is a viable option for large groups.

The issue of circadian fatigue during those single night shifts can be problematic, but some adjustments to sleep schedules have been proven to be helpful, notes Whitehead. "After working an isolated night shift, go to sleep as soon as possible after work and force yourself to get up after four hours. This way you'll be sleepy at your normal bedtime and will be better able to sleep all night," he says. Sleeping longer than four hours after working will significantly retard the next night's sleep, likely causing REM deprivation if one needs to be up early for a day shift the next morning.

For those working short stretches of night shifts, so called "split sleep periods" may be an effective strategy. Sleep in two four-hour

periods adjacent to your normal sleep time. If you normally sleep from 2300 to 0700 and your night shift falls during that time, sleep for four hours immediately before and after work. Because the short rotation schedule doesn't allow for an effective shift of the sleep-wake cycle, the goal is to prevent body rhythms from shifting and still be able to stay awake and alert during the night.

Clockwise Monthly Rotations

Chronobiologists recommend clockwise shift rotation, with at least a one-month period when on long rotations to permit circadian stabilization. The body's innate circadian rhythm is a little over 25 hours, making it easier to delay bed time than to advance it.

The practice of weekly shift rotation is universally condemned in the literature because it takes at least a week for the body to adjust to the new shift, Whitehead explains. "And, while 12-hour shifts are common, an eight-hour shift makes the adjustment easier. It takes longer to reset the biological clock across a 12-hour change than it does for an eight-hour adjustment," he says.

Exclusive Shifts

Historically, the circadian "gold standard" for any industry requiring continuous coverage has been to work the same shift all the time. The problem for residents is that rotating shifts make this almost impossible.

With long night shift rotations, the strategy of anchor sleep may minimize circadian desynchronization. Anchor sleep is a period of at least four hours during which one sleeps every day while on a particular shift rotation. For example, if you sleep from 0800 to 1600 after working nights and from 0400 to 1200 on days off, the overlapping interval from 0800 to 1200 constitutes anchor sleep. "Sleeping until noon is preferable to sleeping all day for most people with families or other daytime commitments. By sleeping through at least half of the time normally reserved for sleep, circadian rhythms are 'anchored' to a particular schedule and minimally disrupted," Whitehead says.

The Thomas Schedule

Whitehead, along with Harold Thomas Jr., MD, and Debra Slapper, MD, have proposed a system called the Thomas Schedule that combines longer night shift rotations with isolated night shifts. In this scenario, one physician works a month or longer on nights, while another works isolated night shifts to cover for that physician's nights off. Logistically, the Thomas schedule works less well with 12-hour shifts precisely because there are more nights off for the physician on long night rotation.

The person on nights for the month should not have more than two nights off in a row, otherwise they risk readjustment to diurnal rhythms. And it's important to schedule administrative meetings early in the morning or late in the afternoon to accommodate those working nights for a month or longer.

Working shifts is one of the many challenges of an emergency medicine career. But with some careful planning, you will still be able to get a good night's sleep.

Source: ACEP Web Site. How to Design the Optimal Schedule for Working Shifts - <http://www.acep.org/public/ts990106.htm>

ALABAMA CHAPTER MEMBERSHIP HITS ALL-TIME HIGH!

Effective November 1, 1999, the Alabama Chapter membership reached an all-time high of 247! Even though several hundred more Emergency Physicians in Alabama have yet to join the College, the 247 members who have represent an approximate 20% increase just in the last 12 months. Special thanks to Neil Christen, MD, FACEP, chapter treasurer and membership committee chair, for helping plan and implement the statewide recruitment project resulting in the

Alabama Chapter's highest-ever membership. All members are asked to encourage their colleagues who are not members of ACEP to join now, especially before College membership requirements change December 31, 1999. ACEP membership is clearly an "investment" in your practice, your patients, and your future. For a membership application packet or other information, contact Dr. Christen or the Alabama Chapter ACEP office in Montgomery today!

CONGRATULATIONS TO THE FOLLOWING MEMBERS ELECTED AND RE-ELECTED AS FELLOWS!



ELECTED

William W. Beazley, DO, FACEP
Florence, Alabama

Michael A. Chandler, MD, FACEP
Vestavia Hills, Alabama

Robert J. Cox, MD, FACEP
Mobile, Alabama

John W. Crosby, MD, FACEP
Troy, Alabama

Peter W. Glaeser, MD, FACEP
Birmingham, Alabama

Yvonne C. Ortega, MD, FACEP
Brownsboro, Alabama

RE-ELECTED

Charles R. Berryman, MD, FACEP
Mobile, Alabama

Michael E. Brewer, MD, FACEP
Birmingham, Alabama

Stephen K. Burge, MD, FACEP
Hoover, Alabama

William E. Fialkowski, MD, FACEP
Birmingham, Alabama

David J. Garvey, PhD, MD, FACEP
Huntsville, Alabama

Ronald E. Graham, MD, FACEP
Scottsboro, Alabama

Ricky Phillips, MD, FACEP
Vestavia, Alabama

Samuel M. Richardson, MD, FACEP
Jacksonville, Alabama

N. Sherrie Squyres, MD, FACEP
Huntsville, Alabama

Birmingham Members Attend Press Conference

The Medical Association of the State of Alabama (MASA) co-sponsored a press conference on school violence in Birmingham in early October. The press conference was arranged to highlight the importance of domestic violence, particularly school violence, and was the 2nd such annual conference held on National Stop America's Violence Everywhere (SAVE) Day. Television and print media from Birmingham reported the event.

Thanks to the following chapter members from Birmingham for attending the press conference and for showing Emergency Physician support for this public health problem: Carden Johnston, MD, Thomas Terndrup, MD, Marni Bonnin, MD, and Janet Pribble, MD.

Alabama ACEP 17th Annual Educational Conference Dates Set For June 26-28, 2000

The 17th Annual Meeting and Educational Conference has been scheduled for June 26-28, 2000, Sandestin Beach Resort Hilton, Destin, Florida. MARK YOUR CALENDAR NOW! David Garvey, PhD, MD, FACEP, member of the board of directors and education committee chair, is finalizing next year's agenda. For those of you who were unable to attend this past year's conference in June, you missed the largest attendance from both Emergency Physicians and corporate representatives in our history. Attendee comments ranged from "this lecture was excellent...I can apply the infor-

mation at work tomorrow", to "this conference was as good if not better than any national conference I've attended", and "Great conference for me and my family... I look forward to returning next year". So go ahead and make plans to attend-educational sessions, corporate representation and exhibit booths, door prizes, welcome reception, professional and career networking, the 2nd annual golf tournament, beautiful beach, and much more. For more information, contact Dr. Garvey or the Alabama Chapter ACEP office in Montgomery.

THE CORNER ON HUMOR

Music Man

A tourist in Vienna is going through a graveyard and all of a sudden he hears some music. No one is around, so he starts searching for the source.

He finally locates the origin and finds it is coming from a grave with a headstone that reads: Ludwig van Beethoven, 1770-1827.

Then he realizes that the music is the Ninth Symphony and it is being played backward! Puzzled, he leaves the graveyard and persuades a friend to return with him. By the time they arrive back at the grave, the music has changed. This time it is the Seventh Symphony, but like the previous piece, it is being played backward. Curious, the men agree to consult a music scholar.

When they return with the expert, the Fifth Symphony is playing, again backward. The expert notices that the symphonies are being played in the reverse order in which they were composed, the 9th, then the 7th, then the 5th.

By the next day the word has spread and a throng has gathered around the grave. They are all listening to the Second Symphony being played backward.

Just then the graveyard's caretaker ambles up to the group.

Someone in the group asks him if he has an explanation for the music.

"Don't you get it?" the caretaker says incredulously.

He's decomposing

1999 ACEP Council Report

By Christopher J. Rosko, MD, FACEP

Birmingham

Chapter Councilor and Past President

The 1999 ACEP Council meeting held in Las Vegas, NV was a tremendous experience for all participants. The Council is the site where the representatives of every state chapter, EMRA, and selected sections discuss and debate issues important to the practice of Emergency Medicine. It is also the place where individuals are elected to the ACEP Board of Directors. Council officers are also elected every other year. This year a new Speaker and Vice-Speaker of the Council were chosen by the Councilors present. Other issues and areas of discussion are presented to the ACEP members present each year in a Town Meeting format so the College might have input and direction on selected areas of concern.

The basic Council format is one of review, discussion, revision and debate over proposed Resolutions submitted by Committees, Sections, and the Board of Directors or individual members of the College. All resolutions are sent to a Reference Committee for review and solicitation of comments, pro and con, on the proposal. The Reference Committee attempts to synthesize the comments and information presented at the meeting and makes a recommendation to the entire Council. The Council then has the opportunity to discuss, and often debate, the issue. Finally, a vote is taken so that the proposed Resolution will have some action taken – adoption, defeat, and referral or tabled for additional review. This year, 27 Resolutions were considered: 21 were adopted, 3 were defeated, 2 were referred to the Board of Directors and 1 was referred to the Council Steering Committee. This is a fairly typical year for the Council.

Significant Resolutions included a vote amend the College Bylaws; this was a three-year project which involved many reviews and revisions. This was adopted this year. Additionally, other Resolutions that were adopted covered such issues as Ultrasound Imaging in the ED, Availability of Hospital Emergency Department on-call Specialists, Domestic Violence, False Claims Act issues, and Federation of State Medical Board issues. Referred items included the College's Principles of Ethics and Practice Sites Definition for Emergency Medicine.

If you ever have the opportunity to attend all or part of a Council meeting, I urge every member to sit in and listen to the discussion and debate. Although the discussion can at times seem superficial or unnecessary, the Council gives all ACEP members the opportunity to direct and initiate discussion on issues of importance to *them*. Over the past several years, I have grown to appreciate that we in Emergency Medicine share many things in common and when we gather as a national organization there is tremendous energy and enthusiasm which is contagious. The Council, like the annual Scientific Assembly, allows all ACEP members to share in the common work we all have: the care of the sick and injured. I look forward to seeing more Alabama ACEP members at the next Council meeting and Annual Scientific Assembly in Philadelphia, PA in October 2000.



**MARK YOUR
CALENDARS
NOW
FOR THE
ALABAMA ACEP
17TH ANNUAL
MEETING AND
EDUCATIONAL
CONFERENCE
June 26-28, 2000
Sandestin Resort
Hilton**

Bringing people together.



Despite the rise in technology and fear that society is slowly migrating from face to face communication, associations

continue to hold meetings that bring people together. These events often serve as the ultimate forum for a particular industry or profession, keeping the members up to speed on the latest rules and regulations of the practice.

3rd Annual Issues in Trauma Care Conference

The 3rd Annual Issues in Trauma Care Conference was held November 4-6, 1999 at the Sandestin Hilton in Destin, Florida. The conference attendees enjoyed a beautiful weekend at a superb resort. The attendees included surgeons, emergency physicians, and family practice physicians from throughout the state of Alabama.

Trauma surgeons Timothy C. Fabian, MD, FACS, Chairman of Surgery-UT-Memphis, and William G. Cioffi, MD, FACS, Chief-Division of Trauma and Burns-Rhode Island Hospital, served as the guest faculty. Dr. Timothy Fabian, discussed the evolution of management of hepatic trauma while Dr. William C. Cioffi presented current trends in the evaluation of blunt abdominal trauma. Loring W. Rue, III, MD, FACS, Professor and Chief Section of Trauma, Burns, and Surgical Critical Care – UAB Hospital, enlightened participants on the scope of the trauma problem in Alabama. Other topics of discussion included initial evaluation and management of trauma and burn patients, current trends in the management of acetabular fractures and spinal cord injuries, as well as trauma in the pediatric population. Dr. Thomas E. Terndrup, Chairman-Department of Emergency Medicine - UAB, and Dr. Kurt R. Denninghoff, Assistant Professor and Director of Research - Department of Emergency Medicine - UAB, presented interesting case presentations and discussed a unique shock monitoring tool.

Currently, plans are underway for the 4th Annual Conference to return to Destin and we hope many will make plans to attend. Details concerning the future conferences will be forthcoming. For questions regarding this conference, please contact Holly Waller, RN, BSN at (205) 934-7174 or e-mail hwaller@uabmc.edu.

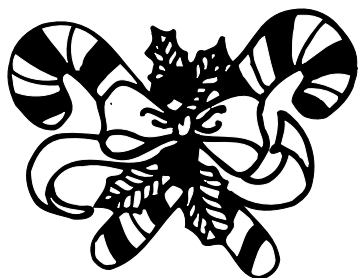
When Visiting Policymakers, Mention Your Association

The number of constituents that walk in and out of a policymaker's office can be mind-boggling. Even at the local level, our elected officials are bombarded by constituent requests and member visits to the point that it can be hard to remember every name and face. That's why it's important to let them know who you're affiliated with and why.

When you indicate to your elected leaders the associations to which you belong, they can understand the big picture needs of their constituents. Most likely, they work with your association at some level on developing policy and when you, the constituent, mention the organizations you're affiliated with, the elected official will take notice of the issues you feel strongly about. They know that, as a member, you are informed about the issues affecting your industry or profession, and are serious about making the right policy decisions that impact your cause.

Our leaders understand the power of associations and recognize the importance of working with organizations like ALABAMA ACEP. They understand that you belong to an organized group and will share your experience with peers. This understanding is reinforced when you, the voter, express your affiliation with a larger constituency.

The next time you meet with your elected officials, be sure to tell them you belong to associations. You don't represent just one voice but many, and in the future, your leader will have a stronger interest in working with you as well as ALABAMA ACEP.



Happy Holidays!

*from the Board & Staff of
Alabama Chapter ACEP*

CONGRATULATIONS!
W. Larry Sullivan, MD
Chapter Past Treasurer
for being elected
President-Elect of the Medical Staff
Decatur General Hospital
Decatur, Alabama

Have you ever looked for a special way to express appreciation to someone who has made a significant contribution to your life or career?

By making an honorary donation to the Emergency Medicine Foundation you can express your appreciation to someone for any reason or special occasion. You may wish to congratulate someone on his or her graduation or promotion or thank someone for their support. You may also donate a speaker's fee to EMF.

A donation made to EMF in memory of a friend or colleague will pay lasting tribute to their memory.

At the same time your donation will support research and education in emergency medicine.

Upon receipt of your donation EMF will send a card to the person or family of your choice acknowledging your gift. The amount of the gift will be kept confidential.

To make a gift to EMF send your check, type of gift, the name of the person you are recognizing and the name of the person or family to receive the acknowledgement to:

Emergency Medicine Foundation
 PO Box 619911
 Dallas, Texas 75261-9911



Emergency Medicine Foundation

Making a difference
 in emergency medicine

For additional information contact Janet McEwen at 800-798-1822, ext. 3215

Quality Advisory

This Quality Advisory, a service to members of the American Hospital Association (AHA), the American College of Emergency Physicians (ACEP) and the American Society for Healthcare Risk Management (ASHRM), provides guidance to institutions in ensuring quality health care for the patients and communities they serve.

On-Call Responsibilities for Hospitals and Physicians

A Message to AHA, ACEP, and ASHRM Members:

USA Today and the Los Angeles Times recently reported on the refusal of specialists to come to the hospital when called to care for emergency room patients. The newspapers alleged that specialized treatment sometimes isn't available because doctors won't come in when called, won't volunteer to be on call in the first place, or simply are not available.

While these cases appear to be isolated, they strike at the heart of the public's confidence in what hospitals do. They are part of a larger concern about both caring for and being accountable to our communities. That's why it's important to continue to make sure your organization is doing everything it can to provide all patients with the care they need when they need it.

Make sure you're following the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) and its regulations. Be aware that a number of jurisdictions have state-based EMTALA laws that should be followed with the same rigorous attention to detail. EMTALA is intended to ensure that all patients who come to the emergency department receive appropriate care, regardless of their insurance or ability to pay. Hospitals are required to provide patients with a medical screening examination to determine if they have an emergency medical condition and, if so, to stabilize their condition. The law prevents hospitals from transferring patients until they're stable, unless the expected benefits of transfer outweigh the risks or the patient has made a request to be transferred. Violations carry penalties of up to \$50,000 per incident and possible exclusion from Medicare and Medicaid.

After reviewing this advisory, check off the following items from your to-do list:

- Make sure your hospital's medical staff bylaws and emergency department policies regarding on-call physician responsibilities are consistent with EMTALA's requirements.
- Review EMTALA with your medical staff (including residents and interns), governing boards, senior managers, nurses and key personnel. Share copies of hospital emergency department policies and procedures with them.
- Determine when medical staff had its last training session on EMTALA. Consider whether it's time for a "refresher" course.
- Engage your community on this issue. Have your community and media relations' teams speak candidly to community leaders and local media about your policies...your procedures...your commitment to ensuring quality care.
- Encourage your medical staff, nurses, and other health care professionals to consult your hospital's risk manager for assistance and advice on EMTALA and its on-call requirements.

Jonathan T. Lord, MD

Chief Operating Officer

American Hospital Association

John C. Moorhead, MD, President

American College of Emergency Physicians

Grena Porto, President

American Society for Healthcare Risk Management

Background

In the vast majority of communities, the "on-call" system works well. It's largely invisible to the public, but is one of the cornerstones of good hospital care. Physicians respond night and day - take time from family and other activities - to be there for patients who are brought to their community hospital.

"On-call" duties come with the privilege of practicing in a hospital. They are a covenant between physician and hospital as part of their mutual responsibility to all patients who come to the hospital door. Physicians who break that covenant call into question their medical staff privileges. Every hospital should have policies to ensure appropriate "on-call" coverage of the emergency department by specialists and sub-specialists.

Hospital and Physician Requirements

Hospitals and physicians, including on-call physicians, who violate EMTALA may face stiff penalties. They could include civil fines of up to \$50,000 per violation or exclusion from participating in the Medicare and Medicaid programs. Specifically:

- Hospitals must maintain a list of physicians, including specialists and sub-specialists, who are on call to evaluate and treat patients in the emergency department.
- Hospitals are responsible for ensuring that on-call physicians respond within a reasonable period of time.
- The medical staff bylaws or policies and procedures must define the responsibility of on-call physicians to respond, examine, and treat patients with emergency medical conditions.
- Although physicians are not required to be on call at all times, hospitals must have policies and procedures that are followed when a particular specialty is not available or on-call physicians cannot respond because of situations beyond their control (for example, if the physician is performing another surgery).
- In most cases, on-call physicians must come to the hospital to examine the patient when a request is made for their services. If, however, their offices are located in a hospital-owned facility on contiguous land or on the hospital campus, the patient may be seen in the physician's office.
- If a hospital transfers a patient to another facility because an on-call physician fails or refuses to appear, it must give the on-call physician's name and address to the receiving hospital. Failure to provide this information would violate EMTALA.

If you have questions regarding the advisory, please contact Roslyne Schulman, AHA's senior associate director of policy, at (202) 626-2273, or rschulm1@aha.org; Michelle Fried, ACEP's federal affairs director, at (800) 320-0610, ext. 3014, or mfried@acep.org; or David Strickland, ASHRM's executive director, at (312) 422-3989, or dstrickland@aha.org.

Additional EMTALA information can be found on AHA's Web site at www.aha.org, ACEP's Web site at www.acep.org, and ASHRM's Web site at www.ashrm.org.

Source: ACEP Online Web Site, Dallas, TX – <http://www.acep.org/policy/PM000112.htm>

***Alabama ACEP Welcomes the following
New Members!!!***

Zenon J. Bednarski, MD
Dadeville, Alabama

C. Julian Billings
Hoover, Alabama

Mitchell David Brantley
Birmingham, Alabama

Donald D. Chapman, Jr.
Trussville, Alabama

Susan Kathleen Copley, MD
Grove Oak, Alabama

Jean Alfred Darbouze, MD
Centreville, Alabama

J. Scott Davidson, DO
Centreville, Alabama

Todd Brian Edmiston
Mobile, Alabama

Roger Dale Eiland, MD
Clanton, Alabama

Charles C. Grafeo, MD
Guntersville, Alabama

Awadhesh Gupta, MD
Mobile, Alabama

Jerry W. Hope, MD
Enterprise, Alabama

Bobby King, MD
Florence, Alabama

Jonathan Allen Jarman, MD
Atlanta, Georgia

Rhett G. Krone, MD
Winfield, Alabama

Timothy Dean Lovely, MD
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- Member Publications - "ACEP News", "EM Today", "Foresight", "24/7", "News for Emergency Medicine Residents".
- Website
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Reminder!!

The new criteria-based membership requirements for the American College of Emergency Physicians go into effect on January 1, 2000. On that date, individuals applying for active membership status for the first time must be either residency trained in emergency medicine or board certified in emergency medicine by ABEM or AOBEM. Current members and individuals that were members before that date are not effected.

For more information, call the Alabama Chapter ACEP office (334-265-0068) or the National ACEP Office/Membership Director Patty Stowe at 800-798-1822, ext. 3149.

Emerging Roles of Hospitalists

By Christopher Fernandes, MD, FACEP,

& the Continuous Quality Improvement Committee of ACEP

As anyone who works in an academic center can attest, one of the banes of our existence involves the referral of a patient to a service, especially internal medicine, with the patient then waiting for hours in the emergency department for an extensive workup, prior to exiting the department. This causes a major delay in an overcrowded department that requires all available beds for incoming patients.

One new concept that could potentially impact on this impasse involves the use of hospitalists. These physicians specialize in inpatient medicine, and manage the care of hospitalized patients for primary care physicians. A number of papers have looked at the impact of hospitalists on efficiency of care. Diamond et al have addressed this issue in a teaching hospital setting,¹ demonstrating reduced median length of stay and median cost-of-care compared to the usual care by internal medicine and family medicine private practice physicians and housestaff. Readmission rates were also decreased.

This paper has significant implications for emergency medicine. As the authors emphasize, hospitalists are present throughout the day, and

hence able to evaluate patients and make decisions at any time. Thus, there is less difficulty in dealing with physician unavailability due to rounds or academic teaching. Finally, these physicians would theoretically be more committed to a hospital mission statement that emphasizes prompt, efficient patient care.

Does this mean that hospitalists would nullify the usefulness of teaching hospitals in educating postgraduate and undergraduate physicians? Not necessarily. It should be possible to integrate hospitalists into the academic mission of teaching hospitals. The emphasis, however, should be on patient care first, with teaching as a secondary (but still important) outcome. Thus, hospitalists could, in one scenario, make the decision regarding admission in the emergency department, and then having the patient evaluated further on the ward by housestaff. Another scenario could have the hospitalist function during disadvantaged hours, eg, during housestaff rounds, weekends, evenings, nights—any time that housestaff are most reluctant to see patients.

Most of the literature has emphasized the inpatient benefits of

hospitalists. We can only hope for a paper in the not too distant future regarding potential benefits of hospitalists to the emergency department.

Reference:

1. Diamond H, Goldberg E, Janosky J: The effect of fulltime faculty hospitalists on the efficiency of care at a community teaching hospital. *Ann Intern Med* 1998; 129:197-203.

Definitions

By Christopher Fernandes, MD, FACEP

“Theory of Bad Apples”: Best described by Berwick in 1989, as “quality by inspection” where quality is achieved by discovering bad apples and removing them from the lot. This is in contrast to CQI, which focuses on systems problems rather than staff inadequacies or sloth.

Hospitalists: physicians specializing in inpatient medicine, and managing the care of hospitalized patients for primary care physicians.

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UPCOMING EVENTS • 1999-2000

Dec. 9 State EMS Advisory Board

1:00 p.m., The Wynfrey Hotel, Birmingham. For more information contact the State EMS office at 334-206-5383.

Dec. 28 Association of Birmingham Emergency Physicians

Monthly meeting, 6:30 p.m., Birmingham
For more information contact Dr. Marni Bonnin, 205-591-6515

Jan. 18 State Emergency Medical Control Committee

Quarterly meeting, the RSA Tower, Montgomery. For more information contact the State EMS office at 334-206-5383.

Jan. 25 Association of Birmingham Emergency Physicians

Monthly meeting, 6:30 p.m., Birmingham
For more information contact Dr. Marni Bonnin, 205-591-6515

Feb. 29 Association of Birmingham Emergency Physicians

Monthly meeting, 6:30 p.m., Birmingham
For more information contact Dr. Marni Bonnin, 205-591-6515

Feb. 27-29 MASA Annual Governmental Affairs Conference

The Willard Hotel, Washington, DC. For more information contact MASA Governmental Affairs, 334-261-2000.

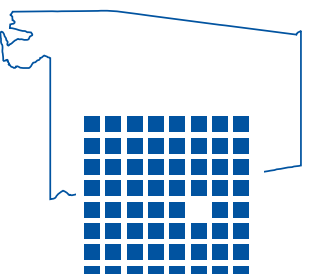
Mar. 28 Association of Birmingham Emergency Physicians

Monthly meeting, 6:30 p.m., Birmingham
For more information contact Dr. Marni Bonnin, 205-591-6515

June 25-28 17th Annual Alabama ACEP Educational Conference

Sandestin Resort Hilton, Destin, FL. For more information contact Dr. David Garvey at Alabama ACEP, 334-265-0068.

If you know of courses, meetings or other events that you'd like listed in this calendar, please notify Alabama ACEP at telephone 334-265-0068 or fax 334-265-1233.



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