

CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS

NOVEMBER 2007

“Our bodies are apt to be our autobiographies” — Frank Gelett Burgess

FROM THE PRESIDENT

LARRY LEVINE, MD, FACEP

“TAKE ME TO YOUR ER”

Last week, an extraterrestrial alien being from outer space landed, without warning, in Connecticut. Immediately, it was surrounded by a swarm of anti-terrorist agents and immobilized. It was then brought to the nearest local emergency department for a medical screening exam. This is true. I know, because I was on duty in the E.D. that day.



I examined the entity, ordered useless labs, a SMAC-5000, CBC, and full trauma panel on its fluorescent green viscous blood. I CT scanned it from crown to rump — “No acute disease”, wrote the radiologist. I called a few consultants (no one called me back) and finally I

determined that this being was not a threat to himself or others, was not in a life or limb threatening condition (I kind of fudged the EMTALA “labor issue” – I couldn’t even determine the gender) and was “medically stable” for discharge. After care instructions were given in three languages (the being was nonverbal) and I suggested that it follow up with its primary care physician in one or two days.

I shrugged my shoulders and said to myself, “another uninsured patient that really didn’t need emergency care”.

As ridiculous as this pseudo-parable is, so often is the ridiculous environment in which we practice emergency medicine. I often enjoy practicing primary care and do not shy away from prescribing refills to those disenfranchised from our system. And I like helping those with minimal behavioral

(continued on page 2)

COMMENT: SICK AND TWISTED

We used all our, er, influence in the publishing world to score this dynamite “Talk of the Town” article from the New Yorker. It’s written by surgeon/renaissance man, Atul Gawande. — ed.

The documentary filmmaker Michael Moore has more than a few insufferable traits. He is manipulative, smug, and self-righteous. He has no interest in complexity. And he mocks the weak as well as the powerful. (Recall his derision, in “Roger and Me, for an impoverished woman in Fling, Michigan, who slaughtered rabbits to make ends meet). For all that, his movie about the American health-care system, “Sicko”, is a revelation. And what makes this especially odd to say is that the move brings to light nothing that the media haven’t covered extensively for years.

Few will be surprised, surely to learn that insurance companies routinely deny people individual coverage, or jack up applicants’ rates, if they have diabetes or are obese or produced a weird blood test result in the sixth grade. It’s just that a lot of us haven’t met those people, or seen what happens to them afterward. Moore makes sure that we do.

Their travails are by turns depressing, blackly comical, and infuriating. There’s the twenty-two-year-old who was denied reimbursement for her cervical cancer treatment because someone at her insurance company thought that she was “too young” to have the disease; the seventy-nine-year-old on Medicare who works picking up trash at his local Pathmark store to pay for the medicines that he and his wife need; the thirty-something-year-old who matter-of-factly sews up a trickling five-inch gash in his leg with kitchen thread, because he doesn’t have insurance to cover an emergency-room visit.

These have become ordinary tales in America. Just this year, in my own surgical practice, I have seen a college student

(continued on page 9)

A great time will be had by all!

The CCEP Scientific Assembly and Annual Meeting

Wednesday November 14, Rocky Hill Marriott. Great speakers! (see page for details)

INSIDE:

JOBS IN CONNECTICUT NOW

2007 LEGISLATIVE WRAP-UP

FROM THE PRESIDENT

(Continued from Page 1)

health issues that could easily (and perhaps better) be handled by a good social worker. Some of my time is spent giving out simple common sense to patients who in prior times would have sought care from a family member or friend. I am more than an emergency physician, or even a primary care physician with resuscitation skills. I am a den mother to those who have lost their den.

Emergency Departments are over utilized as a result of our country's broken medical care system. Our emergency departments are the canary in the coal mine. People who are disenfranchised from our system, either because of lack of adequate insurance, behavioral, social, or criminal problems are receiving a disproportionate share of their medical care in our emergency departments. We dump every problem of our modern society on the emergency department and then complain about how our E.D.s are overcrowded and inefficient. Emergency Departments have become the first and only available option of medical care for millions of Americans.

Either by design or default, this system is not working. This canary is not flying well. There is something wrong with our coal mine. Sixteen percent of the American population has no insurance at all. Twenty-seven percent of our nation's children are underinsured, covered by Medicaid / SCHIP. And at least one-third of our E.D. visits are underinsured. Hospitals cannot afford this burden. We, as emergency physicians, work much too hard, seeing much too many patients, just to absorb this cost.

We can continue to build bigger E.D.s. Providing care to those who are less fortunate fulfills my need for *noblesse oblige*. Most emergency physicians have a strong sense of social responsibility. As a society, we have exploited this good will. But worse, I wonder, have we really served the patient's best interest?

My generation, and those before me, worked hard to create the specialty of emergency medicine. We just wanted a seat at the table in the House of Medicine. *Anyone-anything-anytime* was our rallying cry. We succeeded. We won. They took advantage of us.

The achievements of ABEM and ACEP, my leaders and mentors, are staggering. The quality of care practiced daily in American Emergency Departments is vastly improved due to the efforts of these men and women. But our society has exploited our good intentions. They have balanced the checkbook of our health care system by letting our emergency departments pay a price for issues that we choose to ignore.

Maybe it takes an emergency physician to fix this problem. Maybe only emergency medicine is in the rare position of seeing where the inadequacies in our national health care policies have led us.

We cannot fix the problems in modern emergency departments in this country until we reform our national health care system. There exists a vibrant debate on how we should do this. Join the debate. You, as an emergency physician, are both witness and expert. Your voice counts.

EMERGENCY CONTRACEPTION LAW WILL AFFECT YOUR PATIENTS (AND YOU)

At 3AM some morning you'll want to have read this memo from The Connecticut Hospital Association regarding this hot topic:

A new law went into effect on October 1, 2007, that will require all hospital emergency departments to provide female sexual assault victims with emergency contraception, except in very limited situations.

The law is Public Act 07-24, *An Act Concerning Compassionate Care for Victims of Sexual Assault*. The Act sets new statutory standards of care for the emergency treatment of sexual assault victims. It specifically requires hospitals to provide information about the availability, use and efficacy of emergency contraception to each sexual assault victim. Hospitals must also provide emergency contraception to every sexual assault victim, upon her request, after she has been provided the required information.

The only reason that a hospital may refuse to provide emergency contraception is if the patient has been determined to be pregnant based upon an FDA-approved pregnancy test. The Act dictates that a pregnancy test is the only acceptable test to determine whether emergency contraception may be withheld, and the hospital's protocol must reflect this. A protocol for care based upon an ovulation test or other method would not meet the Act's requirements.

Hospitals can meet this standard of care through internal staff, or by using an independent contractor licensed by the state as a physician, a PA, an APRN, an RN, or a nurse-midwife if the contractor is trained to conduct forensic examinations in accordance with the Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault.

Hospitals, including those that already have reference to use of emergency contraceptives in existing policies, should update their policies, procedures and protocols to demonstrate recognition of and compliance with the new Act."

SAVE THE DATE

The Connecticut College of
Emergency Physicians

Spring Symposium

April 10, 2008

CT Convention Center
Hartford

2007 LEGISLATIVE WRAP-UP

PHIL BREWER, CHAIR, GOVERNMENT RELATIONS COMMITTEE



Once again, the overall legislative session was a study in missed opportunities on all fronts including health care. The veto-proof Democratic majority failed to pass its ambitious program of healthcare reform, notable a much more inclusive insurance package for children and adolescents. CCEP worked in favor of several initiatives, in particular an anti-crowding bill, a bill to eliminate

the loophole that allows Medicaid to not pay the emergency physician for services rendered to Medicaid patients if that patient is subsequently admitted to the hospital, and a bill in support of rape victims requiring hospitals to offer post-coital contraception in the ED.

Before I get to some of the specific issues, I would like to commend Dr. Greg Shangold who stepped up to the plate and was an active advocate for CCEP this year. I was also impressed with the efforts of our lobbyists David Evans and Fred Knous who were very effective in obtaining access to key legislators and keeping track of bill progress and committee hearings. Now for the specifics:

ED CROWDING

House Bill 7293, introduced by the Public Health Committee and cosponsored by Rep. Mary Fritz would have required hospitals to develop plans to reduce ED crowding as well as creating a tool to gauge crowding throughout the state. As expected, it was opposed by the Connecticut Hospital Association and died in the appropriations committee. In view of the failure to enact overcrowding legislation, we also approached the Commissioner of Public Health to seek his support to end overcrowding. While sympathetic to our point of view, he was not willing to attempt a regulatory approach to solve the problem. He did, however, agree to convene a meeting with his staff, representatives of CHA, and CCEP representatives and our lobbyists to further discuss the issue.

During a frank and vigorous exchange of views on August 26 the Commissioner and his staff reiterated their position against hallway boarding on inpatient units, citing their interpretation of CMS's position in our region and fire code concerns (fire codes apparently don't matter in the ED). This meeting did produce a major step forward in that the Commissioner rejected the "multifactorial" analysis of the causes of overcrowding and completely accepted the view of CCEP (as well as ACEP, the GAO, and the Institute of Medicine) that the key issue in overcrowding is prolonged boarding of admitted patients and our efforts need to concentrate on eliminating this practice. He agreed to establish an overcrowding task force whose charge will be to develop solutions to the boarding problem.

REIMBURSEMENT OF EMERGENCY PHYSICIANS FOR SERVICES PROVIDED TO MEDICAID PATIENTS

Under the current rules of the Department of Social Services, emergency physicians may bill for services to Medicaid patients who are discharged at the conclusion of their visit. Compensation for services to Medicaid patients who are subsequently admitted, however, must derive from a global payment to the hospital. The

same is not true when surgeons, radiologists, and other specialties submit their bills. This quirk lies in the tradition in Connecticut whereby all emergency physicians were hospital employees. That is no longer the case, however, with over a third of ED's now having contracts with either national or local provider groups and no longer using hospital employed physicians.

At a series of meetings arranged by our lobbyists with Sen. Harris, Rep. Merrill, DSS, DPHAS, and Appropriations staff, there was general agreement that the current regulations are unfair and unjustifiable. Unfortunately, in a Kafkaesque twist there was also a consensus that it would be more difficult to change the regulations than to pass a new law. Thus *HB 7299 An Act Concerning Reimbursement Rates To Physicians Who Provide Emergency Room Services To Medicaid Recipients* was drafted. We offered testimony at the Human Services Committee hearing on March 2 and the bill was reported out to two more committees and placed on the House Calendar but died at the end of the session. While this was unfortunate, all was not lost as Rep. Merrill agreed to insert language in the appropriations bill which would accomplish our objective. We are awaiting promulgation of the final budget act to see if she was indeed successful.

SEXUAL ASSAULT

Dr. Shangold and I have been actively involved in efforts to improve the care of victims of sexual assault, including supporting *SB 1343, AN ACT CONCERNING COMPASSIONATE CARE FOR VICTIMS OF SEXUAL ASSAULT*, which passed both houses and was signed into law by Gov. Rell. In addition, we are participants in a group including CONNSACS, Rep Merrill, and CHA, which is attempting to establish a statewide SANE program that would have the dual benefit of reducing length of stay for sexual assault victims and relieving EPs of the burden of performing sexual assault forensic exams. We have examined programs in other states, including Massachusetts, and are very optimistic that legislation establishing a statewide SANE program can be enacted in the next session.

PUBLIC SAFETY AND INJURY PREVENTION

SB 273, a bill prohibiting open containers of alcohol in passenger vehicles, was introduced but not enacted.

SB 409 would have strengthened drunk driving laws and increased the use of interlock ignition devices but died in the Judiciary Committee.

SB 703 requires that all cigarettes sold in Connecticut be fire safe, meaning when put down will automatically go out rather than continue to burn. This was passed and signed into law and will reduce the number of burn victims from domestic fires which are often caused by careless smokers.

OFFICE of the VICTIM ADVOCATE ADVISORY COMMITTEE

The OVA-AC has a designated position representing Emergency Department providers. I was appointed to this position by Rep. Chris Donovan for a term of five years ending in 2011. We are currently engaged in a search for a new State Victim Advocate. The importance of this committee to our organization is that the SVA can play an influential role in the legislative process and can, in certain areas, be an ally of Emergency Medicine. Strong support of the SANE program will be a sine qua non in our selection process.

STATE CONVENES OUTPATIENT DATA WORKING GROUP

LISA WINKLER AND TRICIA DINEEN PRIEBE

The Office of Health Care Access (OHCA) has convened a special working group aimed at creating a system to gather outpatient data in Connecticut. Extensive data is currently collected and analyzed on inpatient care, but that information only provides a piece of the equation.

This is an important opportunity for providers to be at the table as the department's policy on outpatient data gathering is formulated. All of the stake holders are part of the discussion including CHA, the Connecticut State Medical Society, federally qualified health centers and surgery centers, among others. In September, each group was given the opportunity to present their recommendations on how best to address outpatient data gathering without adding great expense to the system or overburdening providers.

In recent years, the General Assembly has looked to OHCA on policy questions, and without this part of the

picture, the agency has been hard pressed to weigh in. Although OHCA has legislative authority to gather whatever information it wants, the agency has taken a more positive approach. By bringing together the actual providers to make recommendations on how best to tackle this initiative, it is likely that all involved will be more invested in the project.

Emergency department care is of particular interest to the agency and will help to define what services are lacking within the community. As a result, CCEP requested a seat at the table and is now part of the discussion.

This is expected to be a long term project for OHCA and will likely begin with a more limited data initiative and expand to patient level information down the road. The group will meet again October 30th at the Legislative Office Building to hear OHCA's perspective and discuss next steps.

The Connecticut EPIC is published quarterly by the Connecticut College of Emergency Physicians. Opinions expressed within this newsletter do not necessarily reflect the College's nor ACEP's point of view.

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13th Annual

Management of the Difficult Airway CME Course

November 30th, 2007

Hartford Hospital

Course Director – Thomas Nowicki, MD

A course designed for the Emergency Physician who wishes to be competent in both routine and difficult airway situations.

Learn both standard and advanced techniques using high-fidelity human patient simulators and a large animal lab.

Contact:

Val Riccio (860) 545-5816

vriccio@harthosp.org

Participants are limited

Pix from Seattle:

ACEP SCIENTIFIC ASSEMBLY & COUNCIL MEETING



From the YNH residency, (l to r): Jessica Yearwood PGY-2, Kimberly Nicoll PGY-2 and Patricia McFadden PGY-3



Larry Levine (Bristol), Jennifer Dugan (Waterbury), and Greg Shangold (Windham)



Bernadette and Jeff LaFrance (Bristol), and Dave Charrish (Danbury)



YNH residents Joshua Markowitz PGY-4, Kathryn Hogan PGY-4 and Kelly Dodge PGY-4



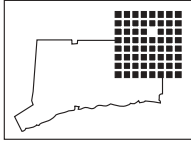
Rich Kamens (Hartford) and Jim Souzzi (PGY-3 UConn)



Old dudes Jacoby and Carius



At the Council meeting this year (l to r): must be friend of Jacoby's, Peter Jacoby, Greg Shangold, Dave John, Larry Levine, Michael Carius, Fred Tilden and Dave Wilcox



The Connecticut College of Emergency Physicians
15th Annual Scientific Assembly and Annual Meeting
Wednesday, November 14, 2007
Rocky Hill Marriott, Rocky Hill, CT

Program

| | |
|------------------|--|
| 7:30am- 8:30am | Registration/Breakfast/Exhibits |
| 8:30am- 9:30 am | Dean Wilkerson, JD, MBA, CAE ACEP: A Strategic Look at the Future of Emergency Medicine |
| 9:30am- 10:30am | Leon Haley, Jr., MD, MHA, FACEP Challenges in Safety: The Future of Health and Emergency Medicine. |
| 10:30am- 11:00am | Break/Exhibits/Poster Abstracts |
| 11:00am-12:00am | Angela Gardner, MD, FACEP Pushing the Limits: Frontiers in Wilderness Medicine. |
| 12:00pm-1:00pm | Lunch |
| 1:00pm- 1:45pm | Annual Meeting & Election Legislative Award and Phil Stent Award |
| 1:45pm- 2:00pm | Break/Exhibits/Poster Abstracts |
| 2:00pm- 3:30pm | CCEP Oral Presentations (Presenters TBD) |
| 3:30pm-3:45pm | Awards and Closing Remarks |

Accreditation: This activity has been planned and implemented in accordance with the Essential Areas and Policies for the Accreditation Council of Continuing Medical Education through joint sponsorship of ACEP and CCEP. The American College of Emergency Physicians is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The American College of Emergency Physicians designates this educational activity for a maximum of 5 *AMA PRA Category 1 Credit (s)*™. Physicians should only claim credit commensurate with the extent of their participation in the activity. (Applied to the American College of Emergency Physicians for 5 hours of ACEP Category I credit.)

Directions

Rocky Hill Marriott, 100 Capital

Boulevard, Rocky Hill, CT 860.257.6000

Traveling N. I-95N to I-91N toward Hdfd. Take Exit 23, West Street-Rocky Hill. End of ramp turn right. At light turn right.

Traveling S. I-90 Mass. Pike to I-84 West to I-91 South. Take Exit 23. At end of ramp, turn left. Second light turn right.

From Airport. Follow signs to I-91 South. Follow to Exit 23. At end of ramp, turn left. At second light, turn right.

From Providence. Take Route 6 west towards Hartford. Follow Route 6 to Route 384 and then to I-84 West.

Just before downtown, take the exit for I-91 South. Continue on 91S to exit 23. At the end of ramp, turn left. At second light, turn right.

To Register—Please Contact the CCEP Offices at 203-234-8055.

JOBS IN CONNECTICUT NOW

BRISTOL HOSPITAL

Great opportunity to join a *private group* of all ABEM certified emergency physicians staffing a 43,000 visit E.D. *Partnership opportunity*. Our Emergency Care Center includes the main E.D., the Express Care Unit, the Observation Unit and a separate behavioral health unit. We are in the process of renovation. We do not (as a rule) board admitted patients in the E.D., nor do we routinely treat patients in the hallway. The group includes six full time emergency physicians, four emergency physician assistants and several wonderful per diem MDs and PAs. We would like to expand our group to seven emergency physicians. Stable group (13 years) is dedicated to superior service quality and receives outstanding patient satisfaction surveys. Administrative opportunities are available in EMS, education, or create your own niche. Must be BC/BE in emergency medicine. Preference will be given to physicians with two years or greater post residency experience (although we will consider outstanding recent grads) and those who prefer night shifts with generous stipend. We offer an excellent compensation package. *Become an owner of our company*. To learn more about this opportunity, please contact Larry Levine MD FACEP at LPL@aol.com

DAY KIMBALL HOSPITAL

Exciting opportunity for a BE/BC emergency physician to be part of a small progressive group that is in the planning stage of a new ED. We are one of the few CT community EDs with ultrasound and have just implemented a state-of-the-art computer information system that makes our work fast, efficient and rewarding. We see 24,000 patient visits/year in a rural setting one hour from Boston and 45 min from Hartford and Providence. The housing is affordable and the schools excellent. The salary is one of the best in the region with an extraordinary hourly rate and incentive bonuses. This is a great job!. For more information, please contact Steven Wexler, MD, Director, Department of Emergency Medicine, 860 928-6545, E-mail: drwex@comcast.net.

HARTFORD HOSPITAL

Per diem opportunity for EM residency trained or EM board certified physicians in our 80,000 visit, 60 bed, ED. Our Fast-Track, run by PA/NP's, sees 23,000 visits per year. We are the main clinical site for the UConn EM Residency, a three year program with 12 great residents per year. Also, a Level I trauma center and the major toxicology program for CT with a fellowship. We have experienced PA/NP's, nurses, RT's, and ancillary help. Our call list includes most specialties. Competitive salary and benefits. Contact AJ Smally, MD FACEP at asmally@harthosp.org or 860-545-3536.

THE HOSPITAL OF CENTRAL CONNECTICUT

Due to an increase in volume, we are recruiting one outstanding emergency physician and one PA. Live within 30 minutes of Long Island Sound and take advantage of

coastal living at its finest. Give your children the opportunity to enroll in some of the nation's finest public and private education systems from kindergarten through university level. Join exclusive country clubs or get a yacht club membership. Dine at a diverse array of upscale dining options or stroll the dozens of small boutique shops that bring Madison Avenue to your hometown. Whether you're a Yankees or a Red Sox fan you are half way between both great cities, so you can catch a home game either way! What you can't find here you will find in New York City which is within easy driving distance. When you are not enjoying your time on the water or playing around in New York City you can get away to the ski resorts of Vermont or the Mountain Biking trails of the Connecticut hill country or take a scenic drive through the New England countryside. You'll find everything you need in beautiful Connecticut!

This opportunity is with one of the most lucrative and democratic emergency medicine practices in the state of Connecticut. Service a 72,000 volume emergency department that is set to expand by 7 beds. This will give us a total of 46 beds. The ER department utilizes the EmpowER Computer System, PACS and ED Ultrasound making this one of the most technically advanced emergency departments in the country. Benefit from comfortable 9 hour shifts, work only 7 nights in 12 weeks, have every other weekend off, and the luxury of having your schedule two years in advance. Take advantage of one of the most comprehensive benefit packages out there, which includes malpractice insurance, health, dental, disability, long term care, 403b, 457(b), 7 weeks paid time off per year, wellness program, and defined contribution pension plan. This is a great job in CT! Please contact Jeff Kinkelstein, MD, FACEP jkinkelstein@thcc.org or call 860-224-5011 x2085.

MILFORD HOSPITAL

Milford hospital, a 106-bed community hospital located on the desirable Connecticut coastline, is seeking a full-time BC/BE ABEM / AOBEM emergency physician or BC primary care physician with significant ED experience for our modern 30,000 plus visit E.D. We offer 8 and 12 hour shifts with a 1,800 clinical hour commitment, along with a very competitive salary and benefits package including medical/dental/vision, paid medical malpractice insurance, paid time off including vacation and a CME stipend.

We are also seeking a full-time BC/BE family practice physician or BC/BE emergency physician for our recently opened off-site urgent care center. We offer a very competitive salary and benefits package including medical/dental/vision, paid medical malpractice insurance, paid time off including vacation and a CME stipend.

For both positions please contact Jay Walshon, MD 203-876-4105, jay.walshon@milfordhospital.org or Jeffrey Komornik, Director HR, 203-876-4098, Milford Hospital, 300 Seaside Avenue, Milford, CT 06460. HR@milfordhospital.org, fax 203-876-4224..

(continued on page 8)

JOBS IN CONNECTICUT NOW

(Continued from Page 7)

NEW MILFORD HOSPITAL

Our 20,000 visit/yr community hospital ED is searching for a full-time, BC / BE emergency physician to join a well established EP group. We offer a competitive salary, full benefits and flexible schedule. Interested physicians should contact Dr. Koobatian at (860) 210-7418.

NORWALK HOSPITAL

We have per diem positions available for an EM residency trained, ABEM/AOBEM certified/prepared EP with EM experience to work per diem in a modern 47,000 visit ED. Norwalk Hospital is a progressive, teaching, 270-bed Level II Trauma Community Hospital located in Fairfield County on Long Island Sound, not far from New York City. We offer a unique 'virtual private practice plan,' which includes all the advantages of being a hospital employee with many of the advantages of fee-for-service. PLEASE CONTACT: Michael Carius, MD, FACEP, Chairman, Department of Emergency Medicine, Norwalk Hospital, at mcarius@acep.org or 203-852-2281.

WATERBURY HOSPITAL

Full Time and Per Diem positions available for ABEM Board Certified/Board Eligible emergency physicians to work in a Level 2 Trauma Center with 58,000 visits per year. Double and triple coverage with in-house medical and surgical house staff. Hospitalist service and pediatric and orthopedic physician assistants in-house. Prompt Care area staffed by experienced Physician Assistants 16 hours daily. Cardiac care center with 24/7 cath capability.

Radiology available 24/7. Ultrasound available in the E.D. Dedicated nursing and helpful technician staff. Attractive clinical requirement with templated schedule and overnight shifts virtually eliminated with 2 dedicated overnight physicians. Competitive salary, full benefit package offered. Generous moonlighting rate offered. Contact Chris Michos, MD @ (203) 573-6215 or CMichos@wtbyhosp.org

WEST HAVEN VA MEDICAL CENTER

VA CT is seeking a full-time physician, BE/BC in Internal Medicine or Emergency Medicine with acute care experience for an immediate opening in the Urgent Care Section at the Newington Campus. The Urgent Care Section handles acute and chronic medical problems for the veterans served by the Newington

Outpatient Clinic population. The caseload is heavily weighted towards acute care medicine of primarily an older adult male population with only minor trauma and no pediatrics, obstetrics or major trauma. Ambulances are NOT received at the facility. Patient's requiring admission are transferred to the West Haven Campus, where full inpatient services are available. Current hours for this position are 8am-4:30 pm Monday - Friday (no call or weekends). Due to the nature of the caseload, a strong medicine background with experience in acute care is required; advanced surgical/trauma skills are NOT required. The ideal candidate has completed a residency in Internal Medicine or Emergency Medicine and has experience in providing acute care. The Urgent Care Section is an alternative setting to the traditional emergency department model. VA Connecticut utilizes a computerized patient record system. Typing and basic computer skills are essential. Salary is competitive and commensurate with experience. Please call Jane Schroeder, (203) 937- 4921; Fax (203) 937 4718; E-mail jane.schroeder@va.gov

WINDHAM HOSPITAL

We are searching for fulltime and per diem BC/BE emergency physicians to join our growing, democratic team in our newly expanded state-of-the-art emergency department (digital radiology, CPOE, bedside ultrasound, complete electronic medical record) that currently sees 26,500 annual visits. The successful candidates will work with a supportive medical staff, and a first rate patient care team. Currently there is 38 hours of physician coverage daily. Full time position is for 1736 annual hours and benefits include but are not limited to malpractice and health insurance. Windham Hospital is an acute care community hospital located in Willimantic and serves 19 towns in eastern Connecticut, one-half hour from our state capitol. Enjoy a competitive compensation package, excellent schools, affordable real estate, a wide variety of recreational (hiking, biking, ocean beaches, skiing and resort towns) and cultural activities, close proximity of the University of Connecticut and Eastern Connecticut State University and easy access to Boston, Providence and New York City.

For confidential inquiries, contact: Gregory Shangold, M.D., Director, Emergency Services, Windham Hospital, 112 Mansfield Avenue, Willimantic, CT 06226 (860) 456.6745, lchasse@wcmh.org, www.windhamhospital.org

OUT OF STATE EP SEEKING WORK IN CT

I am an EM physician seeking an EM practice in Connecticut. Residency trained @ USC/LAC Medical Center. Board certified in E.M, practicing since 1984. Currently practicing in upstate NY.

Please contact 607-329-0488

COMMENT: SICK & TWISTED

(Continued from Page 1)

who couldn't afford the radiation treatment she needed for her thyroid cancer, because her insurance coverage maxed out after the surgery; a breast cancer patient who didn't have the



Atul Gawande, MD

cash for the hormone therapy she needed; and a man denied Medicare coverage for an ambulance ride, because the chest pain he thought was caused by a heart attack wasn't - it was caused by a tumor. The universal human experience of falling ill and seeking treatment - frightening and difficult enough - has been warped by our dysfunctional insurance system.

"Sicko" doesn't really offer solutions. Yes, it visits

France. But it doesn't discuss the difficulties of reforming a system that encompasses sixteen percent of the economy. It doesn't investigate the tradeoffs that universal health care will inevitably require. It's an outrage machine. Moore hopes that once people grasp the inhumanity of our system we will replace it. But will we? The movie is so effective in depicting inhumanity that it makes our failure to act seem baffling. Moore blames the familiar villains: insurance companies, pharmaceutical industry lobbyists, politicians. But plenty of countries have private insurance-not to mention politicians and lobbyists-and nonetheless have health-care systems that cover all their residents, at a lower cost, and with higher levels of satisfaction. Israel, the Netherlands, and Switzerland all provide universal coverage through multiple private insurers and, like Moore's France, spend between half and three-quarters of what we do. The finger of blame points to an obstacle different from the one the movie suggests: us.

Our health-care morass is like the problems of global warming and the national debt-the kind of vast policy failure that is far easier to get into than to get out of. Americans say that they want leaders who will take on these problems. Large majorities profess support for fundamental change. Yet when it comes to specific solutions we balk. A big reason is the cost. Even though universal health coverage can reduce the system's over-all expense-for instance, by granting every one access to preventive care and to prompt, consistent treatment for chronic illnesses-any plausible approach will shift substantial costs from the private sector to taxpayers. The cheapest proposals circulating would still require more than a hundred billion dollars a year in public funds-around a thousand dollars per American household. Taxing millionaires or cutting "waste, fraud, and abuse" won't pay for that. Then we get bogged down in the innumerable, wearying complexities: whether abortions will be covered, whether

states will be allowed to design their own systems, what's an acceptable co-payment for drugs-and on and on. Finally, Americans are deeply skeptical about government, and it doesn't take much to sow doubts about expanding its role.

Healthcare confronts us with a difficult test. We have never corrected failure in something so deeply embedded in people's lives and in the economy without the pressure of an outright crisis. The welfare reforms of 1996 made changes that profoundly affected peoples' lives, but only those poor, which was why voters supported the experiment. We adopted rules to protect clean water, clean air, and endangered animal species, but the costs seemed small and were largely hidden from taxpayers.

In the past few months, John Edwards and Barack Obama have put forward coherent proposals to achieve universal or near-universal coverage. For the first time in a decade and a half, the prospects for reform seem genuinely promising. But the fight is about to begin. For example, Rudy Giuliani recently outlined a tax-credit-based health plan that would come nowhere near covering everyone; for one thing, he would let insurers continue to exclude people with preexisting conditions. Its main purpose, it seems, is to let him attack other proposals as involving a big government takeover of medical care.

If, in 2009, we actually swear in a President committed to universal health care, the fight will turn ugly. The plan most likely to gather broad support will look something like the Edwards/Obama approach, which would subsidize health insurance for everyone who does not receive coverage through work or through existing programs. It would provide a choice of private insurance options, as in the Netherlands, and would probably add a Medicare-like government option as well. And it would require Americans to obtain coverage for, at a minimum, their children.

People on the right will attack the plan as a tax-and-spend nightmare, because it will have to include some mixture of increases in business and personal income taxes. And they'll say that it dictates your medical choices and gives government too much control. People on the left-Moore included-will attack the plan as a boondoggle for insurance companies, because it isn't single-payer, and will say that it gives government too little control. Others will attack it for what it does or doesn't do about malpractice litigation, birth control, acupuncture, and so forth. The debate will become angry and murky and mind-numbingly complicated, and the temptation will be to put off reform yet again.

That's exactly when you'll need to remind yourself of what's really at stake. So if, in the throes of the debate, you find yourself experiencing blurred vision, headache, and vertigo, here's a prescription: go uninsured, and see what's it like to try to get care. Or watch the movie. Either way you'll be outraged again.

Thanks to Midstate EP Rich Remnick, whose brother David happens to be Editor-in-Chief at the New Yorker.

THE NEW ENGLAND EMERGENCY ULTRASOUND COURSE

This course brings together top experts in Emergency Ultrasound from around New England and New York for a comprehensive emergency ultrasound course at Foxwoods Resort and Casino on Thursday and Friday January 24th and 25th 2008.

While this course will be an excellent introduction for physicians with no experience in ultrasound, the level of the instructors and material will allow physicians with more experience to reinforce and enhance their understanding and application of bedside emergency ultrasound. We anticipate participation from all the major emergency ultrasound vendors (GE, Philips, Seimens, Sonosite, Ultrasonix, and Zonare), which will allow experience with a machine your ED already owns or give you a chance to compare/ experiment with machines you may be considering purchasing. While this course is geared towards emergency physicians, the subject matter may be of interest to other physicians or ancillary medical personnel with an interest in bedside ultrasound, particularly critical care physicians and anesthesiologists.

This course has been formed by a consortium of emergency ultrasound directors from New England and

New York and this year is sponsored by the Connecticut College of Emergency Physicians (CCEP) and the Yale Section of Emergency Medicine. The course is directed by Dr. Chris Moore, a national leader and experienced teacher in emergency ultrasound. The course will provide 16 hours of AMA Category I CME through the American College of Emergency Physicians and will be sufficient to satisfy the introductory training requirements for ACEP recommended physician credentialing. A handout with lecture material as well as the "Pocket Manual of Emergency and Critical Ultrasound" will be provided to participants.

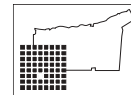
In order to ensure adequate instructor/model/machine to student ratio enrollment in this course will be limited. Register today!

A brochure will be mailed to all CCEP members. Persons interested in registering should contact Kathy Bozzi, Yale Section of EM at 203-785-3843 or

Kathy.bozzi@yale.edu. Other questions can be directed to chris.moore@yale.edu. There is a also special rate on hotel rooms at Foxwoods under the New England Emergency Ultrasound Course, space is limited, call 1-800-FOXWOODS to reserve.

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