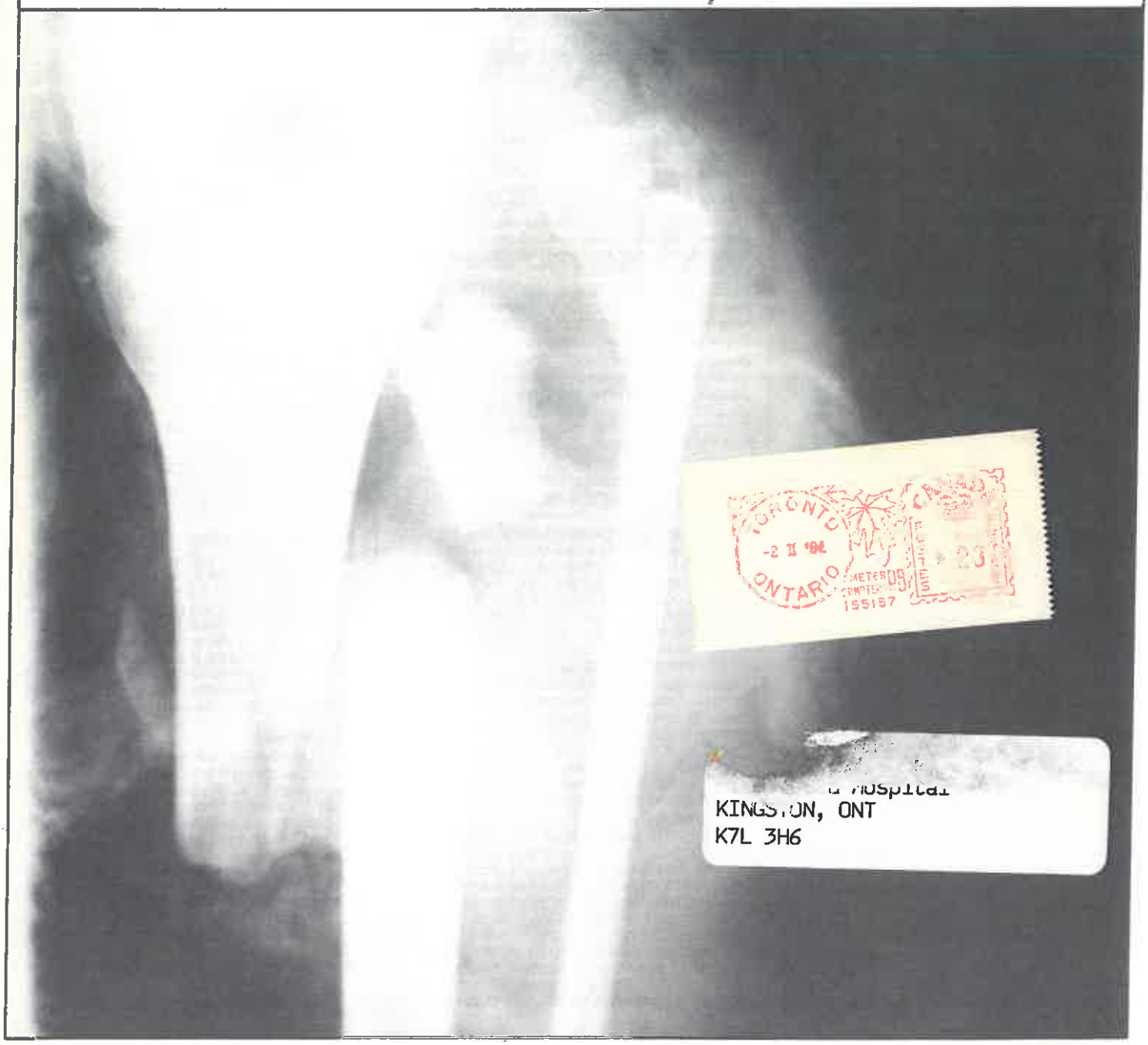
CAEP REVIEW

Audit in the Emergency Department

The Job Hunt is On

Fractures: The Continuity of Care



Information for Authors

Guidelines for submission of manuscripts for publication

The CAEP Review invites authors to contribute appropriate manuscripts for publication on topics relevant to the practice of Emergency Medicine and the organization of Emergency Medical Services. Manuscripts and other communications should be addressed to the Editor, CAEP Review, care of Department of Emergency Services, Sunnybrook Medical Centre, 2075 Bayview Avenue, Toronto, Ontario; M4N 3M5.

A covering letter should accompany submissions indicating the principal author with whom the negotiations can be undertaken regarding any revisions that are seen to be necessary prior to publication. The letter should also specify whether or not the material has been submitted to any other periodicals for consideration for publication.

Guidelines for the presentation of manuscripts

The CAEP Review adheres to the requirements for manuscripts submitted to biomedical journals as contained in the Declaration of Vancouver of January 25th, 1978.*

Manuscripts should be typed, double spaced including the title page, abstract, text, acknowledgements, references, tables and legends and illustrations. Each component of the manuscript should begin on a new page. Authors should keep copies of everything submitted.

Title Page The title page should include the title of the article which ought to be concise and informative. The title should be amenable to indexing. The title page should also contain the full name, academic degrees, and affiliations of each author. The title page should include the name of any organization sponsoring an assembly or meeting in which the article may have been originally presented. If the research has been supported by grants, such financial support should be acknowledged on the title page. Finally, the title page should also contain the address for reprint requests.

Abstracts All original contributions and review articles should be preceded by an abstract, typed, double-spaced on a second page following the title page. The abstract should be no more than 150 words, stating the purpose of the study, basic procedures involved, principal findings including statistical significance, and principal conclusion drawn. Abbreviations or symbols should be avoided wherever possible.

Below the abstract up to 10 key words or short phrases should be provided which will assist indexers in cross-indexing articles.

Text The text of original articles of a basic science or clinical nature should conform to acceptable standards for scientific articles. It should be divided into introduction, methods and materials, results, and discussion section.

Introduction The introduction section should clearly state the purpose of the article and should give only references pertinent to the rationale for undertaking the article. The review of the literature should not be included in the introductory section.

Methods and Materials The methods and materials sections should clearly and thoroughly outline the methodology and materials employed in the undertaking of the study. In particular, the selection of clinical or experimental subjects should be well defined, apparatus used should be specified, and references relating to the selection of materials and methods should be given, such that other investigators can reproduce the methods and evaluate the results. Any new or substantially modified methods should be described fully, giving reasons for their use and evaluating their limitations.

Results The results of experiment should be presented in a logical sequence in the text with tables, illustrations, graphs, etc. to clarify important results or observations.

Discussion The discussion of the findings should relate the observations to other relevant studies. It should emphasize new and important aspects of the study and conclusions. The discussion section should not comprise an exhaustive literature review.

Acknowledgement Persons who have made a substantial contribution to the study, yet who are not listed as authors may be acknowledged.

References References should be listed in the form as adopted by Index Medicus and the National Library of Medicine in United States. All authors should be listed in studies with three or fewer names. Otherwise, the first three names only should be listed. Journal name should be abbreviated again according to the style in the Index Medicus. The title of the article should be included.

Tables Each table should be typed separately on a piece of paper double-spaced. Tables should have a short heading. Explanations should appear in the footnote not in the heading. If data is from other sources, this should be indicated and permission should be obtained and acknowledged. Tables should not be submitted as photographs.

Illustrations Illustrations should be submitted as sharp, glossy, black and white photographs 5 x 7 or 8 x 10 (12.7 x 17.3 cm. or 20.3 x 25.4 cm.) Figures should be professionally drawn, lettered and photographed-free-hand or typewritten letters are unacceptable. Lettering should be consistent throughout and sufficient size that when photo reduced will still be legible. Illustration should be accompanied by a brief legend on a separate piece of paper indicating the purpose of the content of the illustrations. Abbreviations should be avoided or explained. Photographs of patients who are recognizable should be accompanied by a consent form.

Preparation of other material

The Review will consider material other than original experimental work. In particular, the Review will from time-to-time publish review articles from experts in the field who have conducted a thorough literature search. Papers submitted of this nature should comprise of extensive literature reviews on a narrow clinical topic, well-referenced, and of significant relevance to the clinical practice of Emergency Medicine.

Emergency case reports will also be accepted for publication. Such papers should comprise a brief factual presentation of an emergency case. Reports accepted for publication will be of cases of unusual problems or innovative therapies. Following the case presentation should be a brief discussion of the diagnosis and treatment and subsequently, a brief review of related literature.

The Review will also consider for publication, guests editorials from time to time. These should represent an authoritative opinion or comment on current problems faced by Canadian Emergency Physicians. They may relate to the educational, clinical research, administrative, political aspects of Emergency Medicine.

Letters to the Editor will be published regularly in the Review. Such letters should be addressed to the Editor and should comprise brief comments on topics recently discussed in the Review or elsewhere. In addition, brief communications of cases or other items of interest will be considered for publication in this section from time to time. In each case, the letter must be clearly signed by the author with a return address, and permission to publish should be indicated.

Approval to publish

All manuscripts submitted for publication will be reviewed by the Editor or other members of the Editorial Board. If any substantial changes are to be made in the manuscript, a copy will be forwarded to the author prior to publication for approval. Authors are responsible for all statements made in the text including changes suggested by the Editor. No changes will be accepted after final approval by the author has been made.

Deadlines

The CAEP Review is a quarterly publication with press dates the first day of each quarter. Copy deadlines are the 8th of the preceding month. Material to be considered for publication and review by the Editorial Board should be submitted at least sixty days prior to publication date.

Address all correspondence to:
The Editor, CAEP Review
c/o Dept. of Emergency Services,
Sunnybrook Medical Centre
2075 Bayview Avenue
Toronto, Ontario. M4N 3M5

*These requirements known as the Declaration of Vancouver were agreed upon at that city on January 25th, 1978. Members of the International Steering Committee included J. F. Murray, M.D. (Chairman); E. G. Huth, M.D.; S. Lock, M.A.M.B.; W. R. Barclay, M.D.; S. Crawford, Ph.D.; R. W. Mayo; H. R. Meiss; I. Munroe, M.D.; F. H. Porcher, M.A.; A. S. Relman, M.D.; D. A. E. Shephard, M.B.; T. Southgate, M.D. Enquiries regarding the Declaration should be sent to Dr. E. J. Huth, Annals of Internal Medicine, 4200 Pine Street, Philadelphia, PA 10904 U.S.A.

CAEP REVIEW

Vol. 2 No 1 Spring 1981

ISSN 0228-8559

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Layout, Design and Printing:
Southam Murray Printing

The CAEP Review is published quarterly by the Canadian Association of Emergency Physicans. Opinions expressed are those of the authors and do not necessarily reflect those of the Association.

Subscription is free to CAEP members, $20.00 per yr. to libraries and non-members. All correspondence including unsolicited manuscripts should be forwarded to:

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From the Editor

"Better Late than Never"

This issue of the *CAEP Review* has been late going to press and late at just about every other stage of its development. Most of the responsibility for that lies on my desk. However, I'm sure you can appreciate that starting a publication from "scratch" is not done overnight. Some changes have taken place since the last issue as you can see. I'll list a few of them.

1. Production A major change has been that we have moved to a full professional journal type of format. We have contracted a respected publishing house — Southam Murray — after requesting and receiving bids from several. The Review will be produced with a web offset press, affording flexibility to move to four or more colours when necessary, and improving the readability of the publication. The new colour process will also make the publication more attractive to advertisers, and hopefully, allow us to improve and expand the journal. The cover and contents have also been redesigned by Southam Murray's Art Department, in an attempt to make it more readable and more suitable to our readers.

2. Contents From the table of contents, you can see that the thrust of the publication has changed somewhat. Initially, the Review was essentially to be an association newsletter. It has quickly become apparent that this is not appropriate, for many reasons. First, restricting contents to news essentially precludes advertising. Without advertising revenue, subscription fees would simply be too high for CAEP to afford.

Secondly, Emergency Medicine is one of the largest medical disciplines in North America. Yet, at present, there is only one major forum for the publication of new scientific information — the *Annals of Emergency Medicine*. The *Annals* has become, in nine short years, a prestigious and respected journal. However, the practice of Emergency Medicine in Canada is quite different from that south of the border and it is growing rapidly here. Training programs are being started, accreditation standards are being established, certification exams are being set.

Parallel to these developments, is the growth of Emergency Medicine research in Canada. The concept of Emergency Medecine research used to be quite foreign to us in this country. Yet recently, activity in various Canadian centres has undergone a small boom. Much of this work is yet to be published. Hopefully, the establishment of a Canadian publication will encourage both more research and more publication of results. It is only through the orderly deviopment of an unique body of knowledge that Emergency Medicine can assume its rightful position amongst the other disciplines of academic medicine in Canada.

3. Advertising As alluded to above, the Review will now include advertisements from pharmaceutical companies, medical supply companies, placement services, and others in its pages. Advertising policy is set by the editor and the editorial board, and the Review reserves the right to refuse any advertisement. All pharmaceutical ads must first be cleared by the Pharmaceutical Advertising Advisory Board (PAAB). Clearance by the Board, signified by the PAAB/CCPP symbol on each ad indicates that the piece has been reviewed by the Board and meets its standards of taste and accuracy.

The decision to accept advertising was not an easy one for the editor. However, there was a strong feeling from the membership and from the executive that the extra revenue would allow us to produce a significantly more valuable addition to the medical literature, and to improve our communication with our members. Also, as one member put it: "Il ne faut pas être plus catholique que le Pape" — One mustn't be more catholic than the Pope.

So there will be advertising. There's not much in this issue because it takes a while to establish credibility. Hopefully, we'll have more in the future. Most of the advertisements will be either on the covers or the middle pages, and attempts will be made to ensure that articles are not interrupted. Also, only tasteful advertisements that provide meaningful information of interest to Emergency Physicians will be accepted. Hopefully, with these principles in mind, we can together with the advertisers provide Emergency Physicians with useful information to aid them in their professional activities.

4. Editorial Board We are in the process of appointing an editorial board for the publication, initially, the board will be appointed on a temporary basis. They will serve to assist the editor in soliciting articles, refereeing articles, defining editorial and advertising policy, etc. Eventually, a more permanent board will be chosen, once the Review has become established on a more secure footing. Anyone with any editorial experience who wishes to volunteer their services, I'm sure we can find something for you to do. There's a lot more work to this than may meet the eye initially.

Peter L. Lane, M.D.
Editor

Resident's Corner

The past few months have been quiet ones indeed for the Resident's Committee of CAEP, but very active ones for most residents. In fact, things have been so quiet that I sometimes wonder if CAEP *has* any resident members — we all need to become more aware of CAEP and more involved in its activities. Residents can and should become members of its committees and should contribute to shaping the future of Emergency Medicine in Canada.

So what's CAEP done for Residents lately? CAEP is currently negotiating with ACEP regarding a bulk subscription to the *Annals of Emergency Medicine* — essential reading for E.M. Residents. CAEP is also negotiating with ACEP regarding a category of ACEP membership for Canadians so that we can get some of the prerequisites of ACEP membership.

This periodical, the CAEP Review, offers E.M. Residents in Canada a chance to communicate with one another regularly, and the *Review* is eager to publish the results of any research or interesting cases that Residents may wish to report. CAEP has begun a Placement Service — the Secretary of CAEP has lists of currently available positions in Canada for Emergency Physicians.

CAEP is young, and growing fast. It needs the input of the Emergency Physicians of tomorrow, who will be most affected by its activities.

News Briefs:

1. Dr. Sheldon Glaser has been appointed as the UA/EM representative for Canadian E.M. residents. UA/EM is the University Association for Emergency Medicine, and as the name suggests is the political focus for acedemic Emergency Medicine. It sponsors regular scientific meetings which residents can attend and present papers. The next one is in San Antonio, Texas, April 12-15. Residents interested in the activities of UA/EM should contact:

Dr. Sheldon Glaser
Dept. of Emergency Medicine
Royal Victoria Hospital
687 Pine Avenue
Montreal, P.Q. H3A 1A1

2. Resident Committee contact people are:

Kingston:
Dr. M. O'Connor
Emergency Medicine
Hotel Dieu Hospital
Kingston, Ontario K7L 3H6

London:
no one appointed yet.

Montreal:
Dr. Paul Assad
Dept. of Emergency Medicine
Royal Victoria Hospital
687 Pine Avenue
Montreal, P.Q. H3A 1A1

Calgary:
Dr. P.M. Hodsman
606-1315 29th St. NW
Calgary, Alta.

Ottawa:
no residents until July '81

3. Trauma exposure for Canadian Residents has always posed a problem. Most Canadian hospitals do not have a sufficient volume of multiple injured patients to offer a reasonable experience.

The McGill programme has decided that its residents will benefit from a rotation in a New York City Hospital, likely the Bellvue. This will probably start in '81-82.

By Dr. Paul Assad,
Chairman, Resident Committee

Dr. Assad is a final year resident in the McGill Emergency Medicine training programme.

Membership

At the time of this writing, about 75% of the membership have renewed for the 1980-81 fiscal year of the Association. I would like to encourage all members to renew at their earliest convenience.

There continues to be some confusion amongst members regarding the renewal date. The fiscal year of the Association is from October 1-September 30. As such, to remain a member of the Association, it is necessary to renew in October. If anyone has any question regarding this policy, I would appreciate your dropping me a line so that I can address it personally.

As I am sure most of you have gathered, the membership data has been stored on a word processor. This allows us to better look after membership files and accounting as well as providing capability for storing CME hours in the near future. As well, we are readily able to print mailing labels for easy distribution of material. However, a decision has been made by the Executive not to allow the mailing list of our members to be released for any reason whatever. Should any outside organization wish to mail information to the membership, a decision is made regarding the pertinence of the information wished to be mailed. If the Executive feels that the mailing would be of interest to the membership (e.g. continuing medical education programs), then the mailing would be done by the Executive. If any member of the Association would like to publicize a continuing medical education program, please contact me and I would be happy to arrange distribution of any brochures.

I would like to thank all those members who have renewed for their promptness in returning their fee. I would again encourage all members who have not renewed to do so at your earliest convenience.

R.V. Gerace
Membership Chairman.

President's Notebook

I would like to take this opportunity of raising for your information a selected number of issues that are at present occupying a large portion of the time of your executive.

1. Economics

As the executive holds its meetings in different areas of Canada it is becoming increasingly apparent that the economics of Emergency Medicine are providing for many emergency physicians a great amount of concern. The working conditions and methods and levels of remuneration concern emergency physicians more than any other matter, perhaps excepting the area of recognition of Emergency Medicine as a specialty.

In some areas of the country the medical profession and the organizations of medicine regard emergency physicians as equal partners in the health care system and they are free to manage their economic business affairs in what ever way they feel fit. This is usually a fee for service system which allows groups of emergency physicians to have some autonomy in terms of choosing the manpower requirements of their group in a logical fashion, whilst allowing for adequate remuneration and encouragement of continuing medical education and involvement in the community and the hospital on a par with other physicians. On the other end of the spectrum, however, emergency physicians in other areas of the country are hired under very archaic circumstances at minimal levels of remuneration in a fashion that in some cases even prevents them from becoming members of the staff at their hospitals, that prevent the option of billing fee for service, that limits their continuing medical education endeavours, that does not allow them to "moonlight", that regards their skills as less than equal to other physicians, and that, all in all, presents a very repressive picture.

The executive of the Canadian Association of Emergency Physicians feels that this is a critically important area for our involvement based on the premise that where the economics of a particular sphere of medical interest are less than optimal, the development of that specialty will be less than optimal. So long as hospitals will hire the cheapest labour available to man their Emergency Departments there will be poor levels of competence and morale in those Emergency Departments.

The Executive feels that in order to exert some influence in this area, one preliminary step would involve the gathering of information regarding the various patterns of practice and economics of emergency physicians across the country and, therefore, will be producing shortly a questionnaire that will confidentially assess various factors so that we have a true picture of the situation at present. I would encourage you to participate and help us when you receive your questionnaire so that we can make sure that the information we gather is as representative as possible. Only then can we provide some leadership in attempting to provide a freer marketplace in which emergency physicians can practice.

2. Certification

Regarding the activity of the College of Family Physicians, members of the executive have had a fair amount of input into the deliberations of this college in its proposal for providing Emergency Medicine training both integrated with and added on to the standard College of Family Physicians training programme in Family Medicine. As you will have heard before in these columns, there is to be a practice eligible category which would be open to physicians who are not certified otherwise by the College of Family Physicians but will afford those physicians an opportunity to become certified by that college in Emergency Medicine. It is hoped that the College will view our proposals regarding CME credits favourably so that CAEP Category I credits will be utilized by that group. There are still a number of concerns in this area which vary directly with the amount of success we will have in our representation to the Specialty Committee of the Royal College of Physicians and Surgeons in their considerations regarding the training programmes offered by that college. One of the concerns that has been raised recently is the eligibility for College of Family Physicians' programmes for those who choose to take a rotating internship and then wish to pursue further training in Emergency Medicine but may not wish to involve themselves in the College of Family Physicians' programmes. This is an ongoing area of concern which will take further discussions.

The Royal College of Physicians and Surgeons will shortly be announcing its membership on the Specialty Committee on Emergency Medicine and suffice it to

say that those people who have so far been asked to join that committee, who are representative of a variety of specialties including Emergency Medicine, all have had an extensive background in Emergency Medicine and will, I feel, be able to put together a logical approach to a Royal College programme.

Dr. Greg Powell of Calgary is CAEP's representative on this committee and as soon as the committee has had its first meeting we should be able to give you some idea of the tenor of their approach.

3. Constitution

You will have noticed in the first CAEP Review that the constitution was printed up in full for your perusal. I do hope that any of you who feel that other or newer suggestions should be made will do so. We have had one suggestion regarding regional representation on the executive that will lead us to modify that aspect of the constitution. As you know, the constitution will be presented to the annual meeting next fall in Montreal for ratification and it would be far easier to incorporate any suggested changes now rather than on the floor of that meeting, so I would encourage you to communicate with me or Vic Wood if you have any suggestions.

4. Continuing Medical Education

Printed elsewhere in this Review you will find our new simplified proposals for continuing medical education reporting so that we can be assured of providing the membership with appropriate avenues for continuing medical education and also satisfy the requirements of our membership rules.

Again, please do not hesitate to communicate with the executive your concerns or suggestions regarding this document, because it too will be presented to the annual membership for ratification next fall.

5. Annual Meeting

Dr. Wayne Smith is in the final stages of planning for the 1981 meeting to be held in Montreal October 12-16th at the Hotel Meridien. The meeting is looking to be most successful and will, I think, be one of the best meetings on Emergency Medicine that I will have attended. The four day meeting is to be preceded by a two day ACLS course and a variety of executive and committee meetings, all of which will be open and I would encourage you to make a note in your diary to attend that meeting. It will also be important to add your voice to the deliberations that will be undertaken by the executive at that meeting so that we can speak with a representative voice in the upcoming year.

You will see in various journals over the next few months a call for abstracts for scientific papers to be presented at that meeting and I would encourage you to take advantage of this route.

6. Relationship with A.C.E.P.

The executive has undertaken ongoing negotiations with ACEP regarding a new category of membership for Canadian physicians at a reduced rate and a deal whereby the Annals of Emergency Medicine would come to you as part of the membership perks in CAEP. We will be reporting to you further on these matters as they reach fruition.

I would like, on behalf of the executive, to wish you best wishes for the New Year. I hope that it will be a year of landmark developments for emergency physicians across Canada!

Respectfully submitted,
David M. C. Walker, M.D., F.R.C.P.(C)
President,
The Canadian Association of Emergency Physicians

Editorial

'But I Thought You Said ...' or 'When is a Job Offer Not a Job Offer'

The Job Hunt is on!

For the final year resident, this time of year is often one of considerable stress . . . decisions made now will have a major determining impact on the rest of his/her professional life. Yet often the information on which those all-important decisions are made is sorely deficient.

Physicians in general, and Emergency Physicians in particular are probably one of the most regressive, backward groups in society in terms of hiring and firing practises. Rarely are vacancies predicted far enough in advance to allow for adequate advertising. Income, benefits and working conditions are almost never clarified — before or after one has been offered a job. And "job offers" and "contracts" are almost uniformly verbal. No wage earner, business executive, lawyer or engineer would put up with these deficiencies, yet physicians accept them as a matter of course.

Residents should demand from prospective employers or directors a written description of the position including: gross and net income, method of payment, benefits (both optional *and* compulsory), status of hospital and (if appropriate) university appointments, expected workload, holiday and educational leave arrangement, arrangements for office space, secretarial support, etc. For their part, potential employers or directors should require an up-to-date C.V. with three letters of reference, a letter of good standing with the relevant licensing body, and a response, in writing by a specified date either accepting or rejecting the offer.

To do less than this leaves each party unnecessarily vulnerable.

Evaluating the Job

Learning that there's a position available and getting a letter from the Director is the easy part of the Job Hunt. Now the work begins. Four months into the job is no time to find out that you misunderstood what the Director had said about benefits.

A worthwhile maxim regarding the job hunt is that you should *always* visit and have an interview with your potential new colleagues. This country may be large, but there is no way you can adequately assess the position by phone and mail from 2,000 miles away. If you're worried about the costs of such a visit, see if you can combine it with another trip (eg. an academic meeting) and see if the Director and/or your Residency Programme Director can help with travel costs. If the new Director isn't willing to help with the costs and doesn't think he needs to meet you before making an offer, think twice about the job!

Another maxim about evaluating a job is talk to as many people as you can about the position. A good Director will want you to meet others in the group so that they can get to know you. Try to talk to other physicians in the hospital, and talk to the nurses as well. Also, talk to other Emergency physicians, whose opinions you trust. Emergency Medicine is still small enough in Canada that most experienced physicians can tell you quite a bit about other groups and physicians.

The third maxim is to keep your options open. Look at several different jobs and don't be stampeded into accepting one until you've been able to evaluate them all adequately.

The final truth about evaluating a job reflects what we said initially — get it in writing! A job offer is *not* a job offer if it is not in writing. The offer should confirm what you've been told verbally in terms of income, benefits, appointments, etc. And if you are not happy with what's written, but you want the position, don't be afraid to *negotiate*! You can do this by phone first, but it is probably best to do it in writing — state exactly what you would consider, and ask them to revise their offer accordingly. You should be prepared for some bartering, so don't reveal your "bottom line" immediately. By the same token, don't inflate yourself so much that you price yourself out of the market — there *are* others looking!

With those principles in mind, then, how does one go about actually evaluating a potential job? What are the features to look for? What should be avoided?

What follows then is an attempt to itemize some of the categories you should think about when evaluating a job. It is probably best if you make up some sort of a checklist for each job you look at that incorporates the items listed below. In this way you and your family can remember the different positions when you sit down to make up your mind.

What hasn't been listed here are, for some, the most important factors — matters of lifestyle. Before you start a job hunt most of you will have an idea of what sort of communities in Canada you would consider living in. Matters such as community size, province, proximity to family and friends are all important and should obviously play a central role in making the all-important decision!

The "Maxims" of the Job Hunt

1. Always make an on-site visit
2. Talk to as many people as you can about the job
3. Don't make a decision until you've looked at all the attractive ones
4. Get it in writing!

Assessing the Position

Several features of a potential job deserve your close scrutiny. Here are a few:

1) Income:

We've all seen those alluring ads in American and Canadian Journals quoting six figure incomes south of the border. But a buck is not always a buck! A flat $60,000 paycheque with no before or after tax benefits is probably not worth as much as a $45,000 net income with a full benefit package including car leasing, paid holidays, life and disability insurance, etc.

How much you make, then, is only important if its related to how its paid to you, so make sure you know. In particular, clarify if you're considered, for tax purposes a *self-employed* professional or an *employee*. If you are to be self-employed, then the $ figure you are quoted will likely be gross income. You will then be responsible for paying most of your expenses — memberships to societies and associations, CMPA, other insurance, pension plans, etc. A well planned comprehensive benefit package will likely cost you close to 15% of your gross income, and much of it is not tax deductible. However, as a self-employed professional there are a lot of deductions that can be made that otherwise couldn't — expenses of business such as business meetings, car expenses, CMPA, office expenses, etc. Also, the amount you can contribute to an RRSP is higher.

If your status is to be that of an *employee*, you should be clear on who is the employer. If its the hospital, you likely will have little or no say over what benefits you get and what is paid from before vs after tax income. However, if your "employer" is in fact the group of physicians you work with, then often you can construct quite an advantageous benefit package. As stated above, this then can be considered close to a further 15% in income.

2) How is the Group Paid:

Be sure to clarify from the outset how the group gets its money, and how it is distributed. Some examples follow:

Fee for Services (FFS): This is the method of payment of the majority of Canadian physicians and a growing number of Emergency Physicians, whereby the provincial health plan is billed for each service rendered to patients.

FFS with a basement: Any group billing fee for service should be able to guarantee a bottom figure which it is willing to pay should billings fall short.

FFS with a ceiling: Some groups, especially geographic full-time groups in universities have individual ceilings. FFS income over this ceiling may go to one or more places — you should find out where; i.e., to departmental coffers for profit-sharing among more senior members of the group; to departmental or Faculty research funds, to the Dean's office for administrative expenses, to the University etc. It behooves you also to find out how the ceilings are arrived at, and what say you have over their level now and in the future.

Global Budgets: Many groups are still on global budgets. Under these plans, the physicians are usually guaranteed a specific income, either annual or hourly. If its an annual salary figure, the hours you are expected to work should be specified. If its an hourly figure, a statement regarding the guaranteed minimum number of shifts and hours should be made.

Group Contracts: In many parts of the country this is a common form of payment. A contract is negotiated and signed between the group and the provincial health insurance plan or Health Minister. Remuneration is usually on an hourly basis to the group based on last year's census. You should inquire into who has input into these negotiations.

Hospital Contracts: There are still a few places in Canada where hospital administrators seem to feel they should employ the physicians in their Emergency Departments. Why Emergency Physicians and hence Emergency patients need this "third party" in the provision of this form of health care is unclear. Suffice it to say that a position wherein the Emergency Physician is the employee of the hospital must be evaluated very critically. It is perhaps telling that these are presently the lowest paid positions in the country with the highest turnover. "He who pays the piper, calls the tune".

3) Types of Appointments

There is a great deal of variation in the country regarding the type and level of appointments that are offered to Emergency Physicians.

"What does it matter, as long as I can work in the E.D.?" you may ask. Wrong!

Emergency Physicians should be members of the Active Staff of the hospital. Anything less is not only an insult signifying second class status. It also effectively precludes you from involvement in hospital and staff committees. If you can't speak out at the Medical Advisory Committee or elsewhere, you'll essentially have no say over what happens in the hospital or even policies in the Emergency Department.

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It's also important to determine to what hospital and, if applicable university department you are to be appointed. If the Emergency Department is an independent department, you may well assume that you'll have more say over important policies. However, be sure that the Department has enough clout with others to stand on its own. If your appointment is to the Department of Ambulatory Care, Surgery, Family Practice or something else, make sure you have input to relevant committees. Also, be sure you have access to staff meetings and other departmental functions. It should be more than "an affiliation of convenience."

Privileges are also something to be clear on. Many hospitals are now specifying, by a list of procedures, what different members of staff can and cannot do. Be careful! Such lists should be guidelines, not restrictive regulations. Nowhere is this more true than in the Emergency Department where there may only be one occasion every 3 years where you need to put in an emergency pacemaker or some other procedure. Lists constructed in Board Rooms can never hope to anticipate every possible eventuality, yet as Emergency Physicians, we must be ready for them all.

4) Clinical Material:

The day-to-day features of your clinical activity are perhaps the most important features of a job. They should be evaluated carefully.

Clinical Volume: The raw numbers are important to know. In Canada, billing fee for service, an annual volume of 25,000 patients per year should be sufficient to support a full-time group single staffed 24 hours per day (4.5 full-time Emergency Physicians). A rough rule of thumb is that an extra full-time equivalent physician will be required for every 10,000 patients over this. These numbers will be different if housestaff and teaching responsibilities are involved.

Nature of Clinical Problems: The type of patients presenting in the Emergency Department are also important. Figures detailing the number of urgent, emergent and non-urgent cases are helpful. The percentage of patients admitted is also indicative (10% is low — signifies a lot of ambulatory care; 15% is reasonable; if they say 20%, be suspicious of their data). Average billing per patient will give you an idea of both billing practises and patient types. Perhaps the most reliable index is the neighbourhood. Clinical practice in an inner city urban hospital is a lot different from practice in a small town or a residential suburb.

Procedures: What you can and can't do is probably most telling when looking at a department. Who puts on the casts, who runs the cardiac arrests, who puts in chest tubes, who sutures facial lacerations, who reduces shoulders — all of these are important questions. The answers will give you a good idea of what practising there will be like.

5) Personnel:

The final, and perhaps most important feature of a job is the people involved.

The Director: This person will likely have more to do with your satisfaction or dissatisfaction with the job than anyone. If there's a high rate of turnover in the group, look at the Director first.

The most important feature obviously is how well you get along. Personal compatibility is important — ask other members of the group how well he/she accepts suggestions, backs up his/her staff, etc.

Does the Director practise Emergency Medecine? If not, is he/she a full-time administrator, or does the Director have clinical activities elsewhere? Be sure the Director's own personal interests are aligned with those of the Department.

The Members of the Group: Have they been there long? The rate of turnover in a group tells a lot about job satisfaction. How many in the group are residency trained? How many have outside part-time practices? What sort of contribution do they make to the department? And again are you compatible?

The Nurses: Meet the lead nurse *and* other nurses. Their attitudes will tell you an invaluable amount about the Department and the group. Their level of in-service teaching and involvement in emergency nurse association activities will also say something of the morale. Again, the rate of turnover among nurses is a valuable index of departmental morale.

Taking the Plunge:

Having made your visits, completed your checklists and talked to anybody and everybody, it's now your turn. You and your family must decide when and where you want to go, based on the community, the lifestyle, the job, the income, the appointments, etc. As we said earlier, don't be afraid to barter a bit if its not quite right.

Having made up your mind, write a letter of acceptance that refers explicitly either to the written offer you got or confirms in writing the revisions that you negotiated. If it's in writing then everybody understands the agreement and you can avoid any unfortunate misunderstandings.

And if, despite all this investigation, the job isn't what you expected, don't worry. You can do it all over again next year!

Peter L. Lane, M.D.
Editor

Emergency Medicine in Kitchener-Waterloo: The First Decade

The Regional Municipality of Waterloo, formerly known as Waterloo County, is situated in the heart of South-Western Ontario. Its population of 300,000 is served by three active hospitals and one chronic care hospital. The major population centres are concentrated in Kitchener-Waterloo, which is served by The Kitchener-Waterloo Hospital (612 beds) and St. Mary's General Hospital (354 beds), and Cambridge, formerly Galt, Hespeler and Preston, which is served by Cambridge Memorial Hospital (308 beds), formerly South Waterloo Memorial Hospital. All hospitals in the Region are within approximately one-hour's drive of three university medical centres; namely, Toronto, London or Hamilton.

At the present time, all three active hospitals have twenty-four-hour-a-day coverage of their respective Emergency Departments by Emergency Associates of Kitchener-Waterloo, a group of fourteen full-time and three part-time Emergency Physicians. A few Family Physicians also participate in the coverage of Cambridge Memorial Hospital.

Emergency Department staffing by Emergency Physicians was initiated in 1971 at both Kitchener hospitals and in 1976 in Cambridge. Previously, coverage in all hospitals had been by Family Physicians. In Kitchener, a relative shortage of Family Physicians created heavily-booked offices and heavy demands on the Emergency Departments. This prompted the hospitals and the Departments of Family Practice to seek an alternative which would lessen the Family Physician's workload by removing Emergency Department coverage by them, while still providing adequate Emergency Department coverage, and attracting new Family Physicians to the community.

The first physicians to staff the Emergency Department were attracted by advertisements offering jobs as a stepping stone to establishing a practice in the community. In the first year or two, several physicians worked initially in the Emergency Department and shortly thereafter established family practices in Kitchener-Waterloo. The initial turnover was high with physicians often staying in the Emergency Department only three to six months. However, the two intended purposes were served.

Mid 1971 saw the arrival of the first two "career" Emergency Physicians and by 1973, the group was replacing departing members only by career oriented Emergency Physicians.

Initially, the two Kitchener hospitals organized the coverage. They did the hiring, provided secretarial support and space for offices and guaranteed a minimum hourly rate. As the group matured, more of their functions were taken over by the physicians until, at the present time, the only link with either hospital in an administrative sense is that Emergency Associates rents office space.

Emergency Physician coverage at Cambridge Memorial Hospital began in November, 1976 after the Board of Trustees approached Emergency Associates of Kitchener-Waterloo to provide twenty-four-hour coverage.

The arrival of career-minded Emergency Physicians brought stability to the group. These physicians were not interested in Emergency Medicine as only a stepping-stone or a short term job. They sought to provide high quality care which would enable them to gain the respect of the public, the hospitals and the medical community; and at the same time, establish Emergency Medicine as a career for themselves. As the group developed and grew, it became interested in moving beyond the Emergency Department and members began serving on hospital committees and on the Section of Emergency Medicine of the Ontario Medical Association. Since 1973, a member of Emergency Associates has served on the executive body. Numerous hospital committees have been served by Emergency Physicians, including CCU, Pharmacy and Therapeutics, Audit, Patient Care and Medical Advisory Committee. As well, the group has participated in two large studies in '74 and '78 which explored patient and physician attitudes to Emergency Department care, the reasons for choosing the Emergency Department for care and the process of getting there.

Emergency Associates of Kitchener-Waterloo is administered by a three-physician executive responsible for the day-to-day management. Service is provided on a fee-for-service basis. In all three hospitals, the Emergency Physicians are responsible to the Department of Family Practice and the Emergency Department is under the direction of an Emergency Care Committee.

To help maintain high standards of care, the Emergency Physicians hold monthly teaching rounds, organize an annual workshop in Emergency Medicine, participate in at least two formal audits annually and set a continuing medical education requirement. Each physician must be competent in ACLS and complete fifty (50) hours of CME annually; of which twenty (20) hours is ACEP Category I. All members are encouraged to support the OMA Section on Emergency Medicine and C.A.E.P.

The activities of the Emergency Physician have also included pilot studies in the use of nitrous oxide — oxygen in the Emergency Department and also in the ambulance. Members of the group have been active in assisting other hospitals to establish Emergency Department coverage across the province.

The future of Emergency Medicine looks encouraging in the Waterloo Region. The ten-year history has not been uneventful, but one fact is clear: high quality care can be provided in community hospitals by Emergency Physicians. We are proud of the service we provide and we anticipate continuing to provide this service while constantly seeking innovations which will benefit the patients we serve.

by Larry Kelly, M.D.

Dr. Kelly has been an Emergency Physician in Kitchener since 1972. He is Past President of the Section on Emergency Medicine of the Ontario Medical Association and Past President of the Medical Staff of Kitchener-Waterloo Hospital.

CALL FOR ABSTRACTS

The Hotel Meridien in Montreal is the locus for the 1981 Annual CAEP Scientific Assembly

Deadline for submission of abstracts:

APRIL 30, 1981

Scientific Paper Program Chairman, Dr. David Walker, has announced that he will accept abstracts for scientific papers to be presented at the meeting. Members and others in the field are urged to submit original contributions relating to emergency medicine. Presentations at the meeting will usually be limited to ten to fifteen minutes, followed by a discussion period. A completed manuscript must be submitted no later than the day of presentation at the meeting. *CAEP Review*, the official publication of the Canadian Association of Emergency Physicians, reserves the right of first refusal on all scientific papers presented at the CAEP Annual Scientific Assembly.

Mail three copies of the abstract to:

David M. C. Walker, M.D.,
Scientific Paper Program Chairman,
CAEP '81
Division of Emergency Medicine,
Queen's University,
Kingston, Ontario K7L 3N6

Emergency Medical Training Programmes

Calgary, Alta.

Hospitals Holy Cross Hospital, Foothills Hospital, Calgary General Hospital.
University Calgary.
Programme Director Dr. G. Powell, Chief, Division of Emergency Services, Foothills Hospital, Calgary, Alta., T2N 2T9.
Type of Programme Pre-requisite 2 yrs broadly based clinical exposure, (not necessarily Family Medicine) with a minimum of one further year of Emergency Medicine.
Size 3 residents per year.
Accreditation none.
Certificate hope to be able soon to give a U of C diploma.

Ottawa, Ontario

Hospitals Ottawa General Hospital, Ottawa Civic Hospital, Children's Hospital of Eastern Ontario.
University Ottawa.
Programme Director Dr. A. F. Henry, Chief, Emergency Dept., Ottawa Civic Hospital, Ottawa, Ontario, K1Y 4E9.
Type of Programme three (3) yr post-M.D. programme, two (2) yr of which meet the requirements of the Dept. of Family Medicine Programme.
Size four residents per year.
Accreditation none per se, although it is hoped that residents will be eligible to sit the exams of the CFPC.
Certificate none.

Kingston, Ontario

Hospitals Kingston General Hospital, Hotel Dieu Hospital.
University Queen's.
Programme Director Dr. L. E. Dagnone, Emergency Dept., Hotel Dieu Hospital, Kingston, Ontario, K7L 3H6.
Type of Programme 3 yr post-M.D. or 2 yr post internship, broadly based training, research exposure in final year.
Size maximum of four (4) residents per year.
Accreditation none.
Certification none at present.

London, Ontario

Hospitals Victoria Hospital, St. Joseph's Hospital, University Hospital.
University Western Ontario.
Programme Director Dr. K. Ferguson, Director, Dept. Emergency Medicine, Victoria Hospital, 391 South St., London, Ontario, N6A 4G5.
Type of Programme two (2) yr programme after internship; broadly based training with emphasis on internal medicine.
Accreditation accepted by RCPS(C) as two yrs of internal medicine training.
Certification none.

Montreal, P.Q.

Hospitals Royal Victoria Hospital, Montreal Neurological Institute, Montreal Children's Hospital, Queen Elizabeth Hospital, St. Mary's Hospital, Jacksonville Memorial Hospital.
University McGill.
Programme Director Dr. Wayne Smith, Royal Victoria Hospital, Emergency Dept., 687 Pine Ave., W., Montreal, P.Q., H3A 1A1.
Type of Programme two yr post-internship; broad based training, elective in Jacksonville, Fla.
Size six (6) residents per year.
Accreditation LREC/ABEM (nothing Canadian as yet).
Certificate eligible to write ABEM exams in U.S.A., certifiable from McGill and Royal Victoria Hospital.

Letters to the Editor

To the Editor

First of all, let me congratulate all who pioneered CAEP — what a way we have come in 2 years!

And now the first issue of CAEP Review! An exciting moment for all physicians who have made Emergency Medicine their full time practice and are fighting for status and recognition in Canada — indeed working towards the improvement of Emergency Medical Services in Canada, has become an important endeavour for me and I welcome this wonderful means of relating with my colleagues all across the country.

It was interesting that I should receive the CAEP Review today, the day after our mock disaster was held in Mirabel Airport for which I was asked to be an evaluator. I shall not go into the details of it, but some things in Dr. Gerace's article (Taking an Active Role in Disaster Planning, CAEP Review 1:1, Sept. 1980) did bring some thoughts to light.

Indeed, I agree with him that physicians should take an active role in disaster planning, but how much we need to learn before taking such a plunge!

1. We must learn to work within a team, something most doctors are not used to, unless it is as "boss" as is the case most of the time in a hospital setting.
We must learn to take orders in many instances, (as when there is a Fire Chief in command).

2. We must learn to be humble and to listen — in disaster planning, many people know a lot more of the subject than we do and most of us still have a lot to learn. When a disaster strikes, this is no time to improvise or "play it by ear" and we must be willing to surrender our leadership to other co-ordinating agencies in order to put all our energy where it is needed, treating the patients.

3. How different the field setting is, to our nice plush, warm, well-lit, well-staffed emergency rooms! If we want to go out into the field, I feel very adamantly that we should acquaint ourselves to it well before the disaster strikes (by riding with the ambulance crews or manning sports events). We should acquaint ourselves to working in heavy clothing with cold fingers, and the psychological impact being away from our well-known and secure hospital environment. Even to the most toughened, experienced emergency physician, a burned-up teenager hanging from a tree, begging for help, is "hard to stomach".

We also need to acquaint ourselves with the equipment available in the field — most field equipment is different from its hospital counterparts, often in small ways, but time-consuming if one is not familiar with it ahead of time.

4. Dr. Gerace says that "physicians have been in the past reluctant to go out on a disaster site, feeling their expertise would be better utilized in a hospital setting". The simple resuscitative measures such as opening an airway or utilizing an I.V. infusion can be life-saving indeed, but how fast after the accident should they be performed? We all know the answer is really a few minutes. What are the chances in getting a physician out to the site that rapidly? Very small indeed in most instances.

As Dr. Gerace says, they are relatively simple, so why not teach them to those most likely to be the first responding to the scene?

When we talk of physicians going to the field of mass casualty incidents, I think we should be a little clearer as to where in the field they should be employed and to do what? And if we are going out to the field, let's make sure we are ready and can do the job! That goes for nurses too.

Again, congratulations for the most welcome addition of CAEP's contribution to the cause of EMS in Canada.

Sincerely,
Hélène Lamontagne, M.D.
St. Adèle, Québec.

To the Editor

Dear Editor:

In reply to Dr. Lamontagne's letter, I heartily agree with her comments regarding physicians outside their norma working environment. Those responsible for responding to disasters, should be thoroughly familiar with the pitfalls of working outside the hospital environmen as well as differences in the types of equipment they might employ.

Physicians are indeed reluctant to take orders. This is why a physician-co-ordinator familiar with the disaster plan and with the personnel in charge of the scene of the disaster, should take charge of all medical components in a disaster. He will then be able to co-ordinate the responsive medical personnel with those of other agencies.

Dr. Lamontagne implied that perhaps physicians are not necessary at a disaste scene. I must disagree with this concept. Unfortunately, at the present time in Canada, other than a few centres, paramedics trained to do medical acts do not exist. Although, I strongly support the concept of paramedic training, until it is widely available, physicians must fill the gap in providing medical care at the scene of a disaster. Even when paramedics become available, I think a physician co-ordinator will still be an essential component of the disaster response team.

I would echo her plea to personnel responding to a disaster call. They must be sure that they are aware of their responsibility and that they can do the job.

R.V. Gerace, M.D.
London, Ontario.

Guest Editorial

On Research and Review

As physicians, we need to respond to internal pressures for a greater sense of achievement in performing our professional tasks to the best of our science's ability. As physicians, we must also respond to the external pressures that are the expectations of an increasingly sophisticated patient population. Not to do so would be to run a perilous path leading to rising levels of frustration and decreasing levels of self esteem, as well as justified decreasing esteem of the profession in the eyes of its beneficiaries. We must be ever so alert and sensitive to the lowest decibels of discontent from within as well as without, lest we, our patients, and our collective community suffer from complacent mediocrity and the stagnation of the status quo.

The challenge of practising good medicine is a career long goal which we must all strive for. It is a goal which, as we progress in our years of experience, we realize demands continued disciplined effort. To that end, there are a variety of means; our patients, our journals, conferences, clinical preceptorships, sabbaticals and finally individual involvement in research and quality of care reviews.

During our undergraduate training, continued self-instruction was preached as a necessary part of our chosen profession and we were well introduced to most of the above cited means. But the ability to perform research and quality assurance studies was to be reserved for a chosen few who during under post graduate training, gained the necessary methodological tools. Though such tools are essential in order to minimize fruitless ant-like agitation performed in the name of research and review, the toils and rewards of such labour can and should be savoured by more. Such activity contributes both to physician self-instruction, as well as, to increasing levels of patient care. We need to question our practices and force them to reveal whether we are achieving what we hope to do today as well as tomorrow.

In the field of Emergency Medicine, we are all eager participants, not yet at the crossroads but on the fringe of a new frontier in research. While others are having to plant more seed in an already well-ploughed field, we are being called upon to survey and explore virgin territory. How does one study and choose the best EMS system design for the unique circumstances of a specific community? Are there more effective and efficient ways of using diagnostic and therapeutic procedures in the Emergency Department? What are the necessary and important chapters that need be studied in order to improve cost effectiveness of emergency care? How can we best store patient data for future retrieval during audit and research work? Is patient compliance to therapy dispensed in an emergency department affected by the defervescence of an initially perceived crisis? Is it affected by the nature of the singular and short lived liaison between emergency physician and patient? Need we establish admission standards for important frequent problems such as transient cerebral ischemic attacks, non-debilitating pneumonia, the first seizure in the adult, severe headache (etc.)?

How can we accurately characterize patient status and severity of illness in order to arrive at workable and meaningful collective reviews? What role should emergency medicine play in the prevention of disease?

As we all have a responsibility to the patient, I would suggest: That each of us must question the process, decisions and outcome of our work. That each of us, with proper guidance, is able to add to meaningful medical knowledge, leading to increasing standards in level of care as well as adding to our own continued education. That "on line" emergency physicians have a great likelihood of initiating research which is bent on contributing to the needs of today's patient and not research which is retired in academic archives for lack of pragmatic applicability. That CAEP, as professed in Article II of its constitution, will play an important role in research and review of emergency care in Canada. That it can best do with the input of its members.

Clinical sagacity and research acumen arrive not by chance but by design and courtship.
Wayne Smith, M.D.

NOTE: Those wishing to participate can write of their interest and inquiries by addressing themselves to the editor of the CAEP Review. Appropriate mechanisms to coordinate future work in the field will be set up by the executive.

Réflexion sur la Recherche et l'Autocritique

En tant que médecins nous devons réagir aux pressions internes pour un plus grand sentiment de réussite dans l'accomplissement de nos tâches professionnelles et ceci au meilleur de nos connaissances scientifiques. En tant que médecins nous devons aussi réagir aux pressions externes que sont les attentes d'une population de patients de plus en plus sophistiqués. Ne pas agir serait s'engager sur le sentier d'une frustration grandissante et d'un estime de soi décroissant aussi bien que d'une perte bien justifiée du respect de notre profession aux yeux des bénéficiaires. Nous devons être sensibles aux plus bas grandements de mécontentement, qu'ils soient de source interne ou externe, de peur que nous, nos patients et toute la collectivité ne sombrent dans une médiocrité complaisante et la stagnation du status quo.

Le défi de pratiquer une bonne médicine doit nous aiguillonner tout au long de nos carrières. Au fil de nos années d'experience de la profession nous réalisons tous que ce but ne s'atteint qu'à force de travail discipliné. Vers cette fin on peut recruter toute une variété de moyens tels nos patients, nos publications, les conférences, l'enseignement clinique, les congés sabbatiques et finalement les projets individuels de recherche et l'évaluation de la qualité des soins.

Lors de notre éducation sous-graduée, on nous a exhorté à voir l'auto-enseignement comme une part essentielle de notre vie professionnelle. On peut aussi dire qu'en général, tous ces moyens sout bien rodés. Mais on a toujours pensé que la capacité de mener un projet de recherche était l'apanage d'une poignée de gens choisis qui avaient déjà acquis les outils méthodologiques lors de leurs divers entraînements pré et post-gradués. S'il est vrai qu'un tel outillage est essentiel pour mener à bien tout projet de recherche ou d'évaluation de la qualité des soins, il n'en est pas moins vrai que ce genre d'activité devrait être partagé par un plus grand nombre de nos confrères. La recherche et l'auto-critique contribuent à la fois à l'auto éducation et à améliorer la qualité des soins aux patients. Nous devons remettre en question nos méthodes et les forcer à nous révéler ce que nous devons améliorer tant aujourd'hui que demain.

La médicine d'urgence est encore un champ vierge où il existe un potentiel et un besoin de recherche énormes. Alors que d'autres doivent ensemencer un terrain déjà trop bien labouré, nous aurons à arpenter et défricher des aires nouvelles:

Comment étudier choisir le meilleur système EMS pour les circonstances particulières d'une communauté? Y a-t-il des moyens plus efficaces d'utiliser les divers procédés diagnostics et therapeutiques d'une salle d'urgence? Quels sont les points essentiels à étudier pour améliorer ces coûts-bénéfices dans le domaine des soins d'urgence: Comment mieux emmagasiner les données médicales pour récupération future lors de revues de dossiers et travaux de recherche? La compliance chez les patients d'urgence est-elle affecté par la défervescence initiale d'une crise perçue ou réelle? Est elle affectée par le manque de continuité dans la relation patient-médecin d'urgence? Devons-nous établir des critères d'admission pour les problèmes majeurs fréquents tels l'ischémie cérébrale transitoire, la pneumonie non débilitante, la première convulsion chez l'adulte, les céphalées sévères? Comment caractériser et standardiser les patients et arriver à une classification précise de leur maladie permettant des études significatives? Quel est le rôle de la médicine d'urgence dans la prévention? Pour acquitter notre responsabilité au patient je suggère — que chacun de nous doit remettre en question le processus, les décisions et les résultats de notre travail — que chacun de nous, avec l'aide appropriée, peut ajouter au savoir médical valable, augmentant ainsi la qualité des soins de même que nos connaissances personnelles; — que les médecins d'urgence de première ligne seront beaucoup plus enclins à contribuer à une recherche qui est pertinente aux problèmes actuels des patients et non aux archives académiques souvent oubliées pour leur manque d'applicabilité pratique.

—Que l'ACMU, tel que promulgué dans l'article II de sa constitution jouera un rôle important dans la recherche et la critique des soins d'urgence au Canada. — Que l'ACMU l'accomplira le mieux avec l'input de tous ses membres.

La sagesse clinique et les sens critique en recherche ne s'acquièrent pas par chance mais à force de planification et persévérance.
Wayne Smith, M.D.

NB Ceux qui voudront participer peuvent contacter l'éditeur du CAEP Review. Les mécanismes appropriés pour coordonner le travail futur dans ce domaine seront mis en place par l'exécutif.

Fractures: The Continuity of Care

By R. Y. McMurtry, M.D., F.R.C.S.(C)

Introduction

A fracture is a discontinuity of bone. A simple enough definition, yet fractures encompass a fascinating and demanding variety of problems. In coping with this variety a few fundamental principles are central to the successful management of fractures. For the purposes of this communication, these principles will be considered as they apply to pre-hospital, Emergency Department and in-hospital and/or definitive management. Throughout each of these three levels of care, the same principles are in effect, yet the needs of each level require different means of application.

Management of Fractures

Patient

The patient, the limb, the fracture is a time-honoured yet sometimes neglected principle. In managing the patient, one must first consider the A,B,C's. Facial, rib or sternal fractures compromise airway while pelvic or compound (open) are sometimes associated with massive hemorrhage. For a more detailed discussion of priorities in traumatized patients, the zealous reader is referred to our previous papers.[1,2]

Limb

Consideration of the limb is the consideration of neurovascular integrity beyond or distal to the fracture. Continued perfusion is of course paramount and at each level of care, note must be made of distal pulses and capillary return. Documentation of presence or absence of the sensation of touch suffices at the scene, but a detailed neurological mapping is obligatory in the Emergency Department (given the satisfaction of other priorities and needs) and beyond.

If circulation is compromised, the urgency of the situation multiplies. A limb can survive up to a maximum of 6 hours without perfusion, but beyond that, major compromise of function is inevitable and amputation probable. The great majority of non-perfused limbs can be dealt with in the field since most of these cases are due to fracture mal alignment and kinking of vessels. *Simple axial traction* applied gradually, peaking at 30-60 seconds, will often yield a gratifying blush in the digits as the limb is realigned. The limb is then splinted in a reduced position and if necessary, traction is maintained manually. If a single gentle attempt fails to restore circulation, evacuation of the patient to the nearest facility capable of vascular repair is the next step. The diagnosis should be confirmed in the Emergency Department using Doppler apparatus and upon confirmation, angiography should be done unless there is no question as to the level of the lesion or time does not permit angiographic studies.

Neurological injuries are different, inasmuch as their sequelae are longterm disability rather than early loss of limb. Nonetheless, the principles of early recognition, gentle traction, reduction still apply.

Fracture

a) Classification

Discontinuities of bone (fractures) may be open (compound) or closed, axial or appendicular, overt or covert. They are also defined of course, according to anatomical location and radiological appearance. Thus, a Colles' fracture is usually a closed appendicular overt fracture involving the distal radius with a dorsal comminution, while a wedge fracture of the thoracic spine is a closed, axial, covert fracture at T3 with anterior wedging.

Establishing the above categorization of fractures is simple and self-explanatory with the exception of covert (hidden) and/or axial fractures. These may require x-ray confirmation and on occasion, tomography and/or bone scanning before the diagnosis becomes certain. This difficulty, happily, is the exception and clinical examination normally suffices.

b) Diagnosis

The most crucial diagnostic findings in an alert patient are the same for all fractures: pain, tenderness and loss of function. It is imperative that patients suspected of having sustained musculoskeletal injury be systematically assessed by *palpation* of the bones and joints and that correlation of the *point of maximum tenderness with anatomy* be carried out. Invariably, failure of diagnosis in these injuries is due to neglect of this fundamental principle. It (the principle) prevails whether dealing with a phalangeal or cervical fracture, and all health care personnel should be proficient in this basic module of musculoskeletal assessment.

Finally, if doubt exists as to the presence or absence of a fracture, in particular if it is axial, it is best to assume it exists until proven otherwise. Axial fractures in general are important more for their associated injuries (eg. associated spinal cord, head or lung injuries) than for the fractures themselves. Thus, ambulance personnel generally (and wisely) assume an injured painful back represents an unstable spine. Emergency physicians of course do the same, but should extend this caution to include a wider set of problems such as the commonly mismanaged unstable knee. Indeed, it is best to recall that the presence of negative x-rays does not rule out significant musculoskeletal pathology. The foregoing (unstable knee) is but one example, others include pure dislocations of the cervical spine which have spontaneously reduced or the Dupuytren type of ankle fracture-dislocation which may have a "normal" ankle x-ray.

Diagnosis of fractures in general is not difficult with simple observation sufficing for overt fractures, clinical examination unearthing most of the remainder. For the others, a high index of suspicion, presumption of pathology and definitive laboratory studies are the best course of action.

Specialized tests

Occasionally, specialized tests are essential to establish the presence of fractures, unfortunately however, not as often as they are ordered. In order of priority, the following sequence is suggested.

Dr. McMurtry is an orthopedic surgeon and is Acting Head of the Emergency Dept. at Sunnybrook Medical Centre, Toronto.

1. History and physical to rule out referred pain (eg. back or hip giving rise to knee pain).

2. Standard *good* quality x-rays, anteroposterior and lateral which are orthogonal (at 90°).

3. Additional views ie., obliques or specialized views such as "tunnel view" in knee.

4. Centrolateral x-ray especially in children with open epiphyseal plates.

5. Different technique eg. under penetrated and/or tangential view to show avulsion fractures.

6. Stress view *under supervision* by an Emergency physician or orthopedic resident. These include flexion-extension films of the cervical spine, stress ulnar deviation views of the wrist to show scaphoid fractures, inversion stress films of ankle, etc.

7. Anteroposterior and/or lateral tomography are often the key views in vertebral injuries and on occasion for sternoclavicular joint injury or pelvic fractures.

8, 9, 10. Examination under anesthesia with image intensifier, bone scan and computerized tomography are final steps which are in the domain of the orthopedic surgeon.

Approach to Covert Fractures

1. History and physical
2. Standard x-ray
3. Specialized views
4. Contralateral views
5. Varying techniques
6. Stress views
7. Tomography — standard
8. Examination under anesthesia and image intensifier
9. Bone scan
10. Tomography — computerized

c) Treatment

In considering treatment, a recommended management pathway from onset at injury through to definitive management will be followed. In the pre-hospital care sector, the ambulance and other emergency personnel should know and understand the classification and diagnosis of fractures plus the basic skills of history and physical. Furthermore, they must pursue the guideline of "worst case analysis" ie., assume the worst (within reason) and transport accordingly. Over and above this, however, reduction and immobilization (splinting) of fractures should be in their repertoire. By this, "anatomical" reduction is not implied, but rather the realignment of a limb with a single intelligent attempt with axial traction applied over 30-60 seconds and slowly relaxed followed by splinting.

One other caution that should be added is that pure dislocations are often resistent to reduction by this means. These are most likely to involve the hip, shoulder and elbow. This problem notwithstanding, an attempt such as outlined above will do little harm but recognition of these dislocations can prevent a fruitless attempt.

Beyond this, their role should also include cleansing open (compound) fractures with irrigation of sterile saline (1-2 litres) and proper dressing techniques. There is little risk in these therapeutic approaches and much to be gained.

Once the patient has arrived in the Emergency Department, similar principles apply — reduction and immobilization. The splinting now however, should be more durable and as non radio-opaque as possible so that meaningful x-rays can be taken. Cleansing and irrigation of open fractures *under sterile conditions* (ie., mask, cap, gown, gloves) is also carried out *once* only with a rigid rejection of any "Peeping Toms" ie., frivolous, non-sterile "let's see what we have here" perusals of the wound.

The foregoing management of course assumes that the priorities of patient, limb, fracture have been considered, that an I.V. has been started, blood has been sent for laboratory studies and cross and type done when appropriate. Something that cannot be assumed however, is that analgesia has been considered. Most patients do *not* have a contra-indication, eg., head injury, undiagnosed abdominal problem, history of addiction, yet most do NOT receive analgesia. This is the single kindest act the physician can do for the patient with a fracture.

Of equal importance are tetanus prophylaxis and the commencement of prophylactic antibiotics in open fractures.

Beyond the Emergency Department is the issue of longer term management, which again adheres to "reduction immobilization" and also return to function. Over the past decade, the major advancements in fracture care have all exploited the principle of *early function*. Two seemingly diverse schools stem from the concept, that of cast bracing which permits early weight bearing and motion of lower limb fractures and the other being ORIF which permits early motion. There is a role for each and their indications vary with the fracture and patient. Classically, however, open reduction internal fixation is indicated when more conservative methods fail to control or maintain the position of a fracture. Often, one can *obtain* but not *maintain* a reduction by closed means.

In our Trauma Unit, dealing with multiply injured patients (over 700 since June 1976), we have extended the indications for open reduction and internal fixation. Specifically, multiple injuries, multiple fractures and *open* fractures are all relative indications for open reduction and internal fixation (ORIF). There are considerable advantages conferred by immediate ORIF in terms of early motion of the limb, elimination of traction (and thus enforced recumbency), and prevention of ongoing soft tissue injury. The techniques, however, are not forgiving and their use is to be confined to those well versed in their application.

The principles involved with ORIF are simple, ie., reduction and immobilization of the *fracture* or osseous tissues, but *not* the limb. It is the fact that the *soft* tissues of the the limb can begin rehabilitation immediately, that confers the greatest advantage to ORIF.

Thus, throughout each level of care, certain principles remain inviolate in the management of fractures: the patient, the limb, and the fracture. Reduction, immobilization of the fractured limb and wound care are constant features in the pre-hospital, Emergency Department and in-hospital settings. Recent trends rightly stress the importance of immediate or early functional rehabilitation of the fractured limb.

Summary

From first aid in the field through to definitive treatment, fractures may be classified, diagnosed and treated using common principles. Errors in management occur most frequently due to neglect of simple principles rather than a lack of erudition.

References

1. McMurtry, R.Y., Nelson, Wm.R., Faclier, G., Pickard, J.J., Ontario's First Regional Trauma Unit, *Modern Medicine* 35:1, January 1980.

2. McMurtry, R.Y., Walton, D., Dickinson, D., Tile, M.: Pelvic Disruption in the Polytraumatized Patient: A Management Protocol, *Clinical Orthopedics and Related Research 151:22, September 1980.*

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CME Calendar

1. Saskatchewan Association of Emergency Physicians
February 14, 1981
"Emergency Diagnosis and Management of Common Skin Conditions encountered in the Emergency Department" and "Eye Emergencies — Diagnosis and Early Management"
Approved for 3 hours CAEP Category I
Contact:
Dr. Strother-Stewart
Director, Emergency Department
Pasqua Hospital
Regina, Saskatchewan.

2. "Clinical Electrocardiography" March, April 1981 in St. John's, Nfld; Halifax, Toronto, Winnipeg and Vancouver.
Approved for 12 hours CAEP Category I
Contact:
Katherine A. Barber
Asst. Director
Conference and Seminar Services
Humber College
205 Humber College Blvd.
Rexdale, Ontario. M9W 5L7

3. "Emergency Program 1981"
University of Calgary/Foothills Hospital Credits*

February 4	Laboratories	6 hours
February 5, 6	Symposium	14 hours
February 7, 8	ACLS	18 hours

*Approved for Category I CAEP study credits.
Contact:
Jocelyn Lockyer
Continuing Medical Education
Faculty of Medicine
The University of Calgary
Calgary, Alberta. T2N 1N4

4. ACLS Instructors Course
April 3, 4, 5, 1981
Victoria Hospital
London, Ontario
Contact:
Dr. R. V. Gerace
Dept. of Emergency Medicine
391 South Street
Victoria Hospital
London, Ontario. N6A 4G5

Proposed Medical Education Standard

At the last meeting of the CAEP Executive, the following criteria regarding CME credits and course approval were passed. These will be recommended to the general membership at the meeting in Montreal in October. Your comments and suggestions are welcome.

A. Requirements for Membership:

Active Member:

Category I: 60 hours over a three year period.
Category II: Not reportable but recommended 90 hours per three years.

Affiliate Member:

Category I: 30 hours per three years
Category II: 45 hours per three years

Each year the renewal of membership application form will contain a section in which the number of hours of Category I CME can be reported along with course name, location and dates.

B. Definition

Category I Credits:

a) As approved by CME Committee as such
b) All A.C.E.P. Category I credits

Category II Credits:

All other CME that pertains to Emergency Medicine.

The C.M.E. Committee of C.A.E.P. will actively search for CME opportunities. Along with submitted requests for Category I credits for courses, the Committee will assign Category I credits for those courses that meet the requirements:

1. Primary orientation to Emergency Medicine practice
2. Participation, if not organized by, Emergency Physicians

NB: ACLS "provider" courses are considered Category I for those taking the course.

C. Application by Courses for Recognition:

Application, on the official form, should be received at either C.A.E.P. headquarters or the Chairman of the C.M.E. Committee at least sixty days prior to the course.

Following categorization, this information will be fed back to the course, and will also be filed with the Membership Chairman for cross reference with members' reports on CME activity, and, if enough lead time is provided, published in the Review.

Any course attended by a member which has not applied for C.A.E.P. CME credits but which, in the opinion of the member, fulfills Category I criteria, should be brought to the attention of C.A.E.P. so that retroactive approval can be assigned if appropriate.

Application for CAEP Continuing Medical Education Category I Credits

Program Title Location Dates

Sponsored by: _____
Cosponsored by: _____
Program Director: _____
Address: _____
_____
_____

Please list topics to be covered and faculty, teachers, and presentors with title and specialty or enclose brochure including this information:

Signed: _____
Dated: _____

Send Application to:
Dr. C. Neal
Emergency Department
U. of A. Hospital
Edmonton, Alta.
T6G 2B7

Audit in the Emergency Department

By W. Wilkins, M.D.

Introduction

Over the past few decades, an increasing amount of time and money has been spent on assessing the quality of Health Care. Although millions of dollars have already been expended, there seems to be little agreement on most aspects of this subject. As Donabedian states, "Ask a person to talk about high quality health care and you are likely to get a catalogue of platitudes. Ask two people and you will probably get an argument. Ask three and you will probably have chaos."[1]

Most problems stem from the basic fact that no one agrees on a definition of quality health care although all clinicians strive to achieve it.

The term quality assurance is not as nebulous and implies both measurement of the level of care provided as well as improving it if necessary. Medical audit, one type of quality assurance involves the objective and systematic evaluation of the application of current medical knowledge with the aim of improving the quality of care through an education process.[2]

This paper will outline the steps involved in developing an audit and then review an audit on headaches conducted in the Emergency Department of Victoria Hospital in London Ontario.

Dr. Wilkins is an Emergency Physician at Victoria Hospital, South Street, London, Ont. This paper was presented at the CAEP scientific assembly in Vancouver, B.C., April 1980.

Assessing Quality

The components used in assessing quality of care are as follows:

(a) Selection of Topic

The medical profession is inundated with useless data and audit results can be a prime offender. To avoid this, the topic decided upon should be a suspected problem area. The basic premise being if the audit did not display any deficiencies then it was a waste of time.

(b) Determine the Type of Data to Collect

This can be subdivided into three major aspects:

1. Structural measures — characteristics of facilities of clinicians.

2. Process measures — actions taken by the clinician.

3. Outcome measures — what happened to the patient in terms of changes in health.

Most audits use process measures since they are the easiest to apply standards to. Whether improving process results in a change in outcome its still undecided.[3]

(c) Determine the Source of Data

Charting in outpatient facilities is known to be extremely poor and one must decide if the medical record will be sufficient. Other sources such as direct observation can be used.

(d) Establish Measurement Criteria and Standards

Concise basic criteria must be developed so that definite standards of care can be applied. Most criteria should require a standard of 100%.

(e) Analyze the Data Accumulated

(f) Initiate Feedback to Correct Deficiencies

This is probably the most difficult to assess as well as to achieve in an emergency department. Various protocols and teaching sessions can be developed from the results of the audit.

Emergency Department Audit on Headaches

A retrospective audit on headaches was undertaken to assess the diagnosis and treatment of this problem with the major aim being adequate documentation of people with life-threatening disease, ie. subarachnoid hemorrhage. Over a three-month period 112 charts were reviewed of patients presenting to the Emergency Department of Victoria Hospital with headache who were examined by interns, residents, and full-time emergency staff. Criteria considered essential in the examination of a patient with headache were developed (see Figures 1,2).

Results

Documentation of duration, location, and associated symptoms occurred in about 70% of the charts. The most essential components of the history included charting of a past history of headaches and comparison of the present headache with this. Only 50% of the people were asked about past headaches, and of those asked, only 30% had the severity of their present headache compared to these past episodes.

Charting of medications and allergies to medications was extremely poor even though half of the patients were given either drugs or a prescription in the emergency department.

Basic essentials of the physical exam included vital signs, examination of pupils, fundi, neck and localizing neurological signs. These were documented in approximately 60% of the charts.

Eighty-five percent of the headaches were classified, ie. tension, migraine, sinus; and follow-up was recorded in 80% of the charts.

Other interesting data that surfaced included:

- 14 of the 112 patients were referred to Internal Medicine Services. Ten required admission and there was one death (of cerebellar hemorrhage.)
- 3 problem patients with a total of nine visits included in the audit were identified by other doctors as drug abusers. All received major narcotics when assessed in the emergency department.
- 50% of the patients received analgesia or some medication in the emergency with 20 different drugs or combinations being used. (See Appendix A)

Medications Prescribed for Headache

Demerol
Demerol & Gravol
Demerol & Stemetil
Demerol & Sparine
Morphine
Talwin
292's
Tylenol #3
Fiorinal C ½
Fiorinal C ¼
Fiorinal Plain
Codeine & Stemetil
282's
222's
Atasol #1
Stemetil & Fiorinal Plain
Stemetil
Gravol
Valium

Conclusions

Overall, the audit displayed adequate charting on the subject of headache. Major deficiencies in recording a past history of headaches as well as patient allergies were noted. The need for standardizing the pharmacologic treatment of headaches was also evident.

Whether the medical record reflects the examination carried out in the emergency department is a question that cannot be answered at this point. As well, 30 of the 112 patients were discharged with a diagnosis other than their presenting complaint of headache, ie. otitis media, contusion to head, anxiety. A detailed examination might not be applicable in all of these patients once etiology of the headaches was obvious.

The results of the study have been reviewed by the Audit and Tissue Committee of Victoria Hospital as well as at a Staff Meeting of the Department of Emergency Medicine. Emergency Department rounds have been undertaken to discuss the above problems and a protocol for management of headache in the emergency department is pending. Another audit using the same criteria will be undertaken in 18 months to assess improvement in the areas discussed above.

References

1. Donabedian, A. *Measuring and Evaluating Hospital and Medical Care.* Bull N.Y. Acad of Med 52:51 Jan. 1976
2. Bruer, R. *The Economics of Medical Audit in Press* Edinburgh, Scotland
3. Komaroff, AL. *The PSRO, Quality-Assurance Blues* N Engl J Med 298:1194 1978

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Noticeboard

A.C.L.S. Instructors Course

The Department of Emergency Medicine, Victoria Hospital, London Ontario is presenting an Instructor's Course in Advanced Cardiac Life Support to be held April 3, 4, 5, 1981 (Friday-Sunday) at Victoria Hospital, London Ontario. The course will be limited to 40 Physicians and taught in accordance with the Canadian Heart Foundation standards. Participants must have completed a BCLS rescuer course and an ACLS provider course. For further information please contact:

Dr. R.V. Gerace
Department of Emergency Medicine
391 South Street
Victoria Hospital
LONDON, Ontario N6A 4G5

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PLAN TO ATTEND CAEP SECOND ANNUAL SCIENTIFIC ASSEMBLY

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