EPIC

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Amazon Doctor

Dr. Vida Reklaitis Skandalakis, MD, FACEP

- The Emergency Medicine Action Fund
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We welcome your comments or suggestions for future articles. Call or write at:

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Get to Know Your Board of Directors

Robert J. Cox, GCEP President

EPIC: So tell us about your home town.

RC: I grew up in Newnan, GA. Other famous people from Newnan are Alan Jackson, Dale Murphy, Lewis Grizzard and Minnie Pearl!

EPIC: Impressive list if I do say so myself. Is there a Minnie Pearl High School or Museum there?

RC: No, but there is a Minnie Pearl College Scholarship for high school students with severe hearing impairment.

EPIC: What kind of work did your parents do?

RC: My dad worked his way through management in the plastic division of US Steel and now runs his own vending business. My mom opened her own beauty shop called the "Hooty Owl." The shop was downtown close to the library. I would walk there during the summer, check out and read a Hardy Boys or Nancy Drew in one of the rarely empty comfy dryer chairs and occasionally answer the phone for her when her hands were full. "Hooty Owl, may I help you?" She has since semi-retired to play tennis and golf with dad.

EPIC: What a *Hoot*. So where did you go to college?

RC: Dad was transferred to St. Louis when I was a freshman at UGA. My parents asked me if I wanted to check out the University of Missouri-Columbia. We went to visit the campus and I knew I wanted to stay. The medical school was on campus and from my dorm I could watch them launch the helicopter. I had never seen anything so cool! I finished undergrad there with a BA major in Biological Science and minors in Chemistry and Spanish.

EPIC: Chemistry and Spanish? I'm guessing you were trying to discover the secrets to hot sauce and guacamole. How did you keep yourself out of trouble during your school years?

RC: I played tennis and performed in the show chorus during high school. In college, I took Coach Busch's SCUBA training and obtained my NAUI Divemaster certification. I taught with him for several years while I was in Columbia.

EPIC: Clueless about Coach Busch. But since this was Missouri, I'm guessing he also coached the Budweiser Drinking Team. And how about medical school?

RC: I was fortunate enough to be accepted at several medical schools. My *big decision* was staying in Columbia where I knew my way around the hospital having worked in the phlebotomy and cardiology departments on the weekends, and going to Miami where there was sunshine all the time and plenty of SCUBA bubbles to blow. I'm so glad I stayed at Mizzou! One quarter of the tuition charge compared to the private schools and I would wager four times the education. I think I only have two more years of loan repayments. I pity my colleagues that chose private schools.

EPIC: So how did you choose to go into medicine?

RC: Our Honors Program in high school had a fairly rigid curriculum and we asked for one period a week to explore what other students were doing. I knew some cute coeds in the Health Occupation class so I went to spend my hour there. One day, I remember asking what they were doing, and they said getting ready to have their VICA practical nursing skills competition. I had already been working at the Newnan Hospital, starting in housekeeping, moving to the linen room and then on to orderly so I asked if I could enter and they were kind enough to allow me to participate. Long story short, I won the local competition, went to the state competition in Atlanta and won, and then represented Georgia in the national competition in Las Vegas. I was the only guy in the 51 (there was a Miss Puerto Rico) competing. I pulled off first place in the National VICA practical

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Dr. Cox is a practicing emergency physician at Henry Medical Center in Stockbridge, Georgia.

nursing skills competition! (Only downside was they didn't have any "boy" prizes, everything was pink and girly. The nurses I worked with back at the hospital got some nice thank-you gifts). What was the question again? Oh yeah, why medicine? Everywhere in healthcare I worked, the final answer to the patient's question was "I'll ask the doctor." I wanted to be able to answer the question. Doctor comes from the Latin word meaning teacher. I wanted to partner with the patient and assist them in making informed healthcare decisions. If the Congress doesn't get Obamacare repealed soon, I'm afraid my final answer to the patient will be, "I'll ask Secretary Sebelius."

EPIC: So the hot chicks led you astray. Can't tell you how many times I have heard that tale of woe. And where did you do your residency if you don't mind my asking?

RC: During my third year ER clerkships I went to Charlotte and Emory to do rotations. Charlotte had the best program on paper with all the nationally known faculty, most of them major authors of the best EM textbooks. What I experienced was that the senior residents at Grady were comfortable managing complex, sick patients and the senior residents at Carolinas would often not know the nuances of basic ED procedures like RSI. I'm glad I chose Emory.

Dr. Cox and his wife Angelia

EPIC: Yeah and the girls in Atlanta weren't bad either, were they? Out of everything else you could have done, what attracted you to EM?

RC: I fell asleep faster than the patient when I did my anesthesia rotation.

EPIC: I'm with you on that one. If you had not been a doctor, what would you have done?

RC: Teach SCUBA in the Caymans.

EPIC: SCUBA in the Caymans…actually that sounds like an excellent second career for me. Tell us about your family.

RC: : I met my lovely and wonderful wife Angelia on a blind date at the Bienville Club in Mobile. She is a former nurse who spends most of her time with volunteer work and as overseer of the renovation of the 1883 Queen Anne Victorian we live in. The third member of our family team is a little uniqueness named Matilda Anne Cox. Although her father and mother were Big Ed and Miss Tara, she belongs to us now.

EPIC: So when you aren't doing "doctor stuff," what keeps you busy?

RC: When we went to the ACEP meeting in Vegas last year, Angelia wanted to go to The Gun Store and shoot an AK-47. I tried out their Glock. I've since found out there is a whole 'nother world' out there of pistol aficionados and marksmen and have dabbled in it since.

EPIC: Rob Cox packing heat. Now that is an image I

The Cox's 1883 Queen Anne Victorian home

Rob at DC rally

had not expected. What was your worst day in the ED?

RC: During residency, working in the trauma unit one afternoon, we were notified of a GSW to the chest arriving by EMS. The trauma service was alerted by the usual fashion. The patient arrived sooner than expected and EMS said the patient lost his vitals coming into the ED. My attending controlled the airway while my friend and fellow EM resident addressed the chest wound. He had a GSW lateral to his sternum and in traumatic arrest so we performed an ED thoracotomy. As we were delivering the heart through the incised pericardium, it only took a second to see his heart was blown in half and this was a fatal wound. Simultaneously, the trauma team arrived and I told them they weren't needed. The response we received were the ABCs of ATLS: Assume, Blame, Criticize, Deny and Exaggerate. You would have thought we cut off the patient's head instead of attempting a lifesaving procedure. The Chief of Trauma wanted our heads on a platter. The worst part was that the Interim Chief of Emergency Medicine (an internist not trained in EM), instead of backing up his residents and defending EM, was agreeing with the surgeons. I remember him distinctly telling me this procedure was outdated, barbaric, should never be done without a surgeon present and no respecting ED physician would be performing it in the future.

EPIC: Never fun to be punished for doing the right thing. And your best day in the ED?

RC: A few years later, I was working overnight single coverage in a small community ED and there was a "beep-beep drop off" at the ambulance ramp. The "friends" of a young man graciously dropped him off from the back of a pick-up and left. (I'm sure they left in a hurry so they could get home to get in bed to be ready for church in the morning.) Anyway, the 19-year-old had a stab wound lateral to his sternum on the left. He was syncopal and diaphoretic as the one of the two nurses working with me wheeled him in. His pulses were palpable at the neck only and he had agonal respirations. While the nurses started the IVs, I gave him some ketamine and sux for RSI and intubated him. I did a pericardiocentesis and obtained blood and his pulse returned for a short while then faded again. The second time, there was no change with the pericardiocenteis and no blood pressure despite IV fluids so I opened his left chest. He had a tense pericardial tamponade that was easily relieved with opening the pericardium. He had a single 2 cm stab wound to the right ventricle which was easily sutured closed. His vitals returned to somewhere more compatible with living and by that time, the chief resident on call for surgery was able to come from home and with his attending, took him to the OR and closed him up. Until I moved away, I received a Christmas card every year from his mom thanking me for saving his life. I am glad I trained (sometimes without the help of some faculty) to be an emergency physician.

EPIC: That is just the kind of experience that makes it so rewarding. If you could have a superpower what would it be?

RC: X-ray vision. I'd know in a glance if that difficult reduction was back in place or not and it would certainly save me time in not having to send patients to CT!

EPIC: Well I favor x-ray vision for other reasons, but those are good. And your favorite movie?

RC: *Wizard of Oz.*

EPIC: Hmmmm…You do realize that is the ultimate chick flick, don't you? Yep, two women fighting over a pair of shoes. So is it chocolate or vanilla?

RC: Java Chip Frappuccino or I'll pass, thank you.

EPIC: I don't have a clue what that is. On a more serious note, what is the most important issue facing EM?

RC: The attack from multiple fronts that continue to spread the myth that Emergency Medicine is the problem in healthcare, not the solution. I don't have to explain to you that charges and costs are not the same and it's been shown many times that the marginal cost of another ED patient is equivalent to an office visit cost. We're cost effective as the rapid diagnostic center in the community and are experts in system and team management. The problems in the emergency department are directly attributable to the problems in healthcare in general.

EPIC: And the most important issue for the Chapter?

RC: Protecting the tort reform language specific to the ED in SB 3: " In an action involving a health care liability claim arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, no physician or health care provider shall be held liable unless it is proven by clear and convincing evidence that the physician or health care provider's actions showed gross negligence." The law is

Rob in Giza

Matilda and her princess bed

under constant attack by the trial lawyers.

EPIC: What were the highlights of your term as President?

RC: It's the highest honor to be chosen by your peers to represent the Chapter in official business and one I will not soon forget. There have been so many great opportunities to partner GCEP with other organizations to promote the interests of emergency physicians and emergency patients. The GCEP Board is an extremely busy group and my goal has always been to encourage and support the interests and activities of the members. They have expanded and continue to have a world class summer CME meeting at Hilton Head and have nurtured and matured a regional CME meeting in middle Georgia. The winter Legislative Day continues to grow for legislative advocacy and they have put together the first and annual GCEP Leadership meeting, targeting medical and group directors. They have put together a first class skills course that will debut this year in Hilton Head that may be a game changer for the procedural skill levels in rural EM as well as a source of non-dues revenue for the chapter.

EPIC: We have been lucky to have you. What is your vision for GCEP in the future?

RC: I see GCEP leading the way in exploring options to involve all practitioners of emergency medicine under its umbrella.

EPIC: Well, now that you will have more free time, where would you go for vacation if you could choose anywhere?

RC: Wow, this one is a tough one. I've been fortunate to travel to almost everywhere I want to go. One big thing I've learned in my travels is there's no place like home and I am extremely blessed to have been born in America and to have grown up in Georgia. The one trip that keeps coming to mind is our last family summer vacation growing up; we spent some time in Australia and on the way back, a few days in Hawaii. I was able to do some night dives in the lava tubes on the north shore of Hawaii. All in all, that trip rocked!

EPIC: "No place like home"…you do have this Oz thing going on, don't you? If you won the lottery and were now independently and incredibly wealthy, how would that change your life?

RC: I'd build a free standing Emergency Department closer to home. We would have state of the art equipment, service on par with the Ritz and tele-consults with the world experts in their chosen fields.

EPIC: Would have guessed you would have moved to the Caymans and built a palace at the beach, but that is just me. Any one who impressed you so much you adopted them as a role model?

RC: Dr. Chip Pettigrew has always been a mentor for me and I am always grateful for the wise advice he has given over the years.

EPIC: He is great and we share your respect for him. It has been a pleasure talking with you and thank you for your service to GCEP and the emergency physicians of Georgia.

Is Defending Patients and the Practice of Emergency Medicine in Georgia Worth at Least Five Cents per Patient Visit?

Pascal Crosley, DO, GEMPAC Chair

On Tuesday, March 8, the GCEP Board of Directors endorsed GEMPAC's fundraising strategy of patient visit based contribution towards the PAC's legislative priorities. Emergency Physician practices across Georgia will be asked to commit at least $.05 cents per patient visit to defend and protect our patients and favorable practice environment here in Georgia. With an approximate ED state wide volume of 3.6 million visits, a contribution minimum of $.05 cents per patient visit would generate close to $200,000 towards agendas favorable to Emergency Physicians and their patients.

Your donation to the PAC will allow contributions towards election campaigns of legislators who are sympathetic to emergency medicine initiatives. GEMPAC will focus funds towards four legislative priorities:

- Tort Reform (SB3) – GEMPAC will continue to defend and strengthen the comprehensive tort reform passed in 2005 and upheld by the Supreme Court in March 2010 with a 4-3 decision. ED groups are reporting up to a 30% reduction in malpractice rates.
- Prompt, Fair Reimbursement – GEMPAC will work with the Insurance Commissioner's Office to continue to pursue insurance payers who do not comply with prompt payment law as well as support fair payment initiatives to ensure emergency physician's ability to procure usual and customary charges from commercial payers.
- Medicaid Fair Payment & Patient Access – GEMPAC will work to preserve access for 1.7 million Medicaid recipients in Georgia and support federal matching of state dollars for Medicaid and oppose Medicaid cuts for physicians.
- Psychiatric Transfers & Medical Clearance – GEMPAC will support alleviating current and predicted tensions placed on emergency departments following the Georgia's settlement with the US Justice Department and support development of community-based services and enhancement of acute inpatient resources.

Envision your current practice environment with deleterious legislation in regards to the above priorities. Your already stressed departments will swell with Psychiatric holds and patients without access, while your tort risks increase and reimbursement decreases. Your practice and your patients are at risk! Please donate to GEMPAC at least five cents per patient visit so your interests are heard and represented.

We would like to give a special thanks to Rob Higgins, MD, outgoing Chair of GEMPAC for his continued contributions towards improving the practice environment for Emergency Physicians across Georgia.

Pascal Crosley, DO
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Pascal Crosley, is the ED Medical Director at DeKalb Medical Center.

Thank you Rob for all of your outstanding work with GEMPAC!

Rob Higgins, MD, FACEP

Emergency Medicine Action Fund Announced

Nancy Calaway, ACEP Communications Manager

Nancy Calaway
ncalaway@acep.org

Nancy Calaway is the ACEP Communications Manager.

New grassroots effort aims to influence health care reform's regulatory implementation.

With changes in the health care system already underway, a new initiative is looking to positively impact the regulations that will be written and implemented under this sweeping reform. The Emergency Medicine Action Fund, launched by ACEP in February, will pool contributions from individual emergency physicians and groups, chapters, and anyone else interested in advancing emergency care to provide financial support for advocacy activities in the regulatory arena.

"This is probably the most important, defining moment for emergency medicine in our lifetime," said ACEP President Dr. Sandra Schneider. "The decisions that are made now will set the course for us for years to come and we must positively influence the regulatory agenda. This Action Fund will help us do that and create a practice environment we can thrive in."

The Emergency Medicine Action Fund will pursue a regulatory agenda that supports emergency physicians and quality emergency care. For example, evolving practice models and demonstration projects, such as accountable care organizations and bundled payments, are two areas of the Patient Protection and Affordable Care Act where the Action Fund might be able to wield some influence.

"We need to be out there with the rule writers, working to ensure that emergency medicine's perspective is valued," said Dr. Angela Gardner, ACEP Past President who first proposed a national grassroots initiative focused on federal regulatory affairs. "It is critical that we be involved in these decisions regarding the formation of the future of health care delivery. This is our opportunity to be part of it."

The following organizations have been invited to designate representatives to the initial Board of Governors – American Academy of Emergency Medicine (AAEM), Association of Academic Chairs of Emergency Medicine (AACEM), American College of Osteopathic Emergency Physicians (ACOEP), Emergency Department Practice Management Association (EDPMA), Emergency Medicine Residents' Association (EMRA), and Society for Academic Emergency Medicine (SAEM).

One of the unique features of the Emergency Medicine Action Fund is that chapters can band together to form coalitions that would be eligible to have a seat on the Board of Governors. Or chapters can organize individuals and groups in their states for collective representation. The first 10 groups of contributors at $100,000 will be granted seats on the Action Fund's Board of Governors.

"We are encouraging chapters and small to mid-sized groups to combine their resources," Dr. Schneider said. "This is intended to be an inclusive effort, and everyone's contributions are needed."

The Emergency Medicine Action Fund is modeled on a successful initiative sponsored by CAL/ACEP, CAL/AAEM, EDPMA, and rural emergency physicians in California that has raised several million dollars for state advocacy since 2004.

Wes Fields, chair of the California Emergency Medicine Advocacy Fund, said their program doubled the size of the CAL/ACEP advocacy staff, increased the number of lobbyists and consultants, and engaged in legal activities related to physician payment practices. He has been appointed by Dr. Schneider as the founding chair of the new national Action Fund.

"I view this as the best form of free speech on behalf of emergency physicians and our patients," Dr. Fields said. "It is not partisan. It is not political.

"The rule writers and the policy makers will hear emergency medicine speaking with one voice, with one set of goals, one approach," he added. "We need wide and deep support, even from those who are not members of the College."

EM ACTION FUND *Preserving the Future of our Specialty.*

CEP America, the nation's largest emergency medical partnership, will be the inaugural donor to the Emergency Medicine Action Fund, pledging $100,000.

Activities planned by the Emergency Medicine Action Fund are intended to enable participants to make contributions that would be tax-deductible business expenses (tax deductibility can be determined only by participants' tax advisors).

NEMPAC, the National Emergency Medicine Political Action Committee of the ACEP, gives contributions to candidates who have listened to the needs of emergency medicine and made a positive change. However, NEMPAC may be used only to support candidates.

The Action Fund can enhance regulatory advocacy with policy makers to ensure emergency physicians receive fair payment for their services. It can also fund numerous meetings with regulators to help guarantee that patients receive the best care, and provide funding for studies to demonstrate the value of emergency medicine.

"With the new Congressional session upon us, it is as important as ever to be active on both the legislative and regulatory fronts," Dr. Schneider said. "We will depend on all of these funds to make our case. This will be the year we ask everyone to dig a little deeper. In these challenging times, we need contributions to both the Action Fund and NEMPAC."

Find out more about the Emergency Medicine Action Fund at www.acep.org/EMActionFund.

How is the Emergency Medicine Action Fund Different from NEMPAC?

Both are valuable tools that need our continued support, but the Emergency Medicine Action Fund serves a different purpose than NEMPAC.

	NEMPAC	EM Action Fund
Gives campaign contributions to Congressional candidates	YES	
Funds meetings with regulators and policy makers		YES
Enhances emergency medicine advocacy efforts	YES	YES

Emergency Physicians Serve as Doctor of the Day

Dr. Robert Cox
Dr. Michael Hagues
Dr. Rob Higgins
Dr. Russell Mitchell
Dr. Carlo Musso
Dr. John Rogers
Dr. Matt Watson

Doctor of the Day, Dr. Mike Hauges with Govenor Deal

MAG's "Doctor of the Day" Program

J. T. "Tom" Cooper, M.D., and his partner, Evan Boddy, M.D., started the "Doctor of the Day" program in 1969 as a way of thanking the state for the scholarships that enabled them to attend medical school. Working out of the Medical Association of Georgia-sponsored Medical Aid Station at the State Capitol in Atlanta, physician volunteers provide legislators and staff with free, minor medical care for one or more days during the legislative session each year. James A. Kaufmann, M.D., is credited with establishing the Medical Aid Station. The "Doctor of the Day" is introduced in the House and the Senate at the beginning of each legislative day.

Emory Emergency Medicine Residency Update

Phillip Shayne, MD, FACEP

Phillip Shayne, MD, FACEP
pshayne@emory.edu

Dr. Phillip Shayne is Associate Professor, Residency Director and Vice Chair for Education at Emory University School of Medicine.

Emory is very proud to present the Emergency Medicine class of 2014. In line with the national trend, Emory was extremely successful in this Match, and we are delighted with the class listed below. Nine of the residents rotated with us, and 12 are women. Six are from Georgia medical schools, which is high for us; traditionally 60-70% of our residents take jobs in the state on graduation and that percentage is even higher for those with prior roots here. In addition to our regular 19 residents selected in the Match, we are also pleased to have two residents recruited from Saudi Arabia through an agreement with the Saudi Cultural Ministry. This program looks to train emergency physicians who will return to start training programs in their country.

EMORY UNIVERSITY SCHOOL OF MEDICINE

Emergency Medicine Residency Class of 2014

Ibtihal Alattas, King Abdul Aziz University, Saudi Arabia
Sultan Alwajeeh, Umm Al Qura University, Saudi Arabia
Douglas Chesson, Emory University School of Medicine
Louis Ciardulli, University of Florida College of Medicine
Megan Cloutier, Georgetown University School of Medicine
Gail Ferek, University of Florida College of Medicine
Juron Foreman, University of Pennsylvania School of Medicine
Elizabeth Iledare, Emory University School of Medicine
Kristina Lam, Mercer University School of Medicine
Alexander Moore, Morehouse School of Medicine
Jeremy Nelson, Meharry Medical College
Deepa Patel, Albert Einstein College of Medicine of Yeshiva University
Susan Podolsky, George Washington University School of Medicine and Health Sciences
Gina Porter, University of Missouri-Kansas City School of Medicine
Katie Sharpe, Georgetown University School of Medicine
Nathan Stokes, Mercer University School of Medicine
Marie Tabuteau, Philadelphia College of Osteopathic Medicine
Patrick Thomas, Georgetown University School of Medicine
Bina Vasantharam, University of California at Davis School of Medicine
Dilani Weerasuriya, Emory University School of Medicine
Jean Wheeler, Tulane University School of Medicine

Georgia Health Sciences University Residency Update

Stephen Shiver, MD, FACEP

It is with much anticipation that we await Match Day each year. Hundreds of applications, countless hours spent with ERAS (Electronic Residency Application Service), and greater than 100 interviews all culminated on March 17, 2011, with the arrival of official Match Day ceremonies. We are thrilled to welcome our incoming interns, the inaugural class with our recently ACGME approved increase in resident complement to 12 per year.

There has been significant discussion, and not a small amount of confusion, regarding the recent name change to Georgia Health Sciences University. The Medical College of Georgia was originally founded in 1828 and is the thirteenth oldest medical school in the United States. In addition to the College of Medicine, the campus is also home to four other colleges: Allied Health Sciences, Dental Medicine, Graduate Studies, and Nursing. Approximately 2,400 students are presently enrolled, supported by some 5,000 faculty and staff. The new name, Georgia Health Sciences University, encompasses all five colleges. Of note, the School of Medicine will continue to be referred to as the Medical College of Georgia.

As a practical consequence of the name change, all campus e-mail addresses will be converting from @mcg.edu to @georgiahealth.edu. The old addresses remain active, but will cease to work in coming months as the transition is completed. Please note the change in order to avoid e-mail snafus when attempting to contact colleagues on campus. We welcome any questions or comments you may have concerning our residency program. Our Program Coordinator, Courtney Buckner, may be reached at (706) 721-2613.

Georgia Health Sciences University

Stephen Shiver, MD, FACEP
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Dr. Shiver is Associate Professor of Emergency Medicine and Residency Program Director at the Medical College of Georgia. Clinical and research interests include resident education, emergency ultrasound, airway, and trauma. In addition to his emergency medicine training, he completed a general surgery residency at Wake Forest University Baptist Medical Center and is board certified by the American Board of Surgery.

Emergency Medicine Residency Class of 2014

Kimberly Rathbun, Medical College of Georgia
Erin Lurie, University of South Alabama College of Medicine
Kane Curtis, NOVA Southeastern University College of Osteopathic Medicine
Zachary Sutton, Des Moines University Osteopathic Medical Center
Joanna Adams, Virginia Commonwealth University School of Medicine
Christina Cirillo, NOVA Southeastern University College of Osteopathic Medicine
James Black, University of Texas School of Medicine at San Antonio
Taylor Haston, NOVA Southeastern University College of Osteopathic Medicine
William Arnett, University of Tennessee Health Science Center
Charlie Moore, Mercer University School of Medicine
Steven Troncone, Lake Erie College of Osteopathic Medicine
Jennifer McCain, Kansas City University of Medicine and Biosciences

Telemedicine in Trauma and Emergency Care

Colville H B Ferdinand, MD

Colville H B Ferdinand, MD
cferdinand@georgiahealth.edu

Dr. Ferdinand is associate professor of Surgery in the department of Trauma/Surgical Critical Care and General Surgery at Georgia Health Sciences University in Augusta.

Trauma is the leading cause of death for patients up to the age of 44. Overall it is the third leading cause of death. Data from the 2002 NTDB (National Trauma Data Bank) showed that in Georgia there are 65 deaths per 100,000 of population compared to a national average of 56 per 100,000. Other data showed that Georgia's trauma related mortality rate is 20% higher than the national average. If we were to improve our mortality to fall in line with the national average it is estimated that an additional 700 lives can be saved.[1]

Access to care continues to be a reason for this disparity. Of the 40,000 or so injured patients in our state less than 25% are cared for at a trauma center. The overall mortality rate from the 2003 NTDB at our designated trauma centers is 7.9%. Thus patients treated at appropriate facilities have a great chance of surviving their injuries. However we are still above the national average of 5.2%, a rate calculated from the 2002 NTDB.

This may become more of an issue given the 20.1% growth in our population from the recently concluded census. Currently there are 17 trauma centers in our state. Given our population it is estimated that we need 25 to 30 centers and have them strategically placed to better improve access.[1]

The Georgia Office of Emergency Medical Services/Trauma has grouped the 159 counties into 10 geographical EMS regions. Twenty of these counties do not have a 911 emergency call system.[2] Forty are outside of a 50 mile radius of a trauma center.[2] Region 8 has a population of about 650,000 in a 27-county area that spans 10,670 square miles in the southwestern part of the state. It has no air ambulance and one Level II Trauma Center. This dynamic, results in the label of "corridor of death" for the segment of Interstate 75 that traverses part of this region.[3]

We need to almost double our number of trauma centers at a time when there is a national shortage of trauma surgeons. In our current healthcare environment cost are increasingly becoming a factor. Most of the injured at our Level 1 Trauma Center do not have healthcare insurance. An unnecessary transfer places an extra financial burden on the system. In addition there is a socioeconomic cost to families of the injured who have to travel long distances to be with their love ones. This has to be balanced with the need to exclude injuries that exceed the capability of the non trauma designated centers and can place the patients' life at risk.

Telemedicine gives us one way to begin to tackle our states's access to care. We can consult with the rural hospitals and help them deliver better care and decrease the number of transfers that are necessary. This is not a new concept. The use of telemedicine was done by National Aeronautics and Space administration (NASA) in the 1960s. NASA ran a project to deliver healthcare to Papago Indian Reservation in Arizona between 1972 and 1975.[4] This is believed to be the first civilian program. In 1975 there were 15 such programs.[4] Since then there has been a proliferation of programs. It is estimated that the global telemedicine market would grow to 23 billion by 2015.[5]

A World Health Organization (WHO) 1997 report define telemedicine as the delivery of healthcare services, where distance is a critical factor, by healthcare professionals using information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of the healthcare providers, all in the interest of advancing the health of individuals and their communities.

Morrisey et al,[6] did an analysis of rural ambulance trip reports in the 12 counties surrounding Region 6 (Augusta area) in 1991. There were 13.1 trauma-related ambulance runs per 1,000 of population. This was about a third of all ambulance runs. 51.5% had a rural hospital as a destination. 15% were taken to a trauma center. Of the severe cases the rural hospitals transferred less than 20%. Of the cases transferred 70% were not severely injured. With

such a high percentage of not severely injured patients there is a lot of potential to impact resources.

A study in Kansas[7] looking at the use of remote teleconsultation has shown improvements in many areas of patient care. This includes early triage of the seriously ill, decrease in transfer rate, more effective utilization of ground and air transportation. A study in Scotland,[8] reviewed teleconsultation for 120 patients over a one year period between a small rural hospital and a tertiary referral center. Practitioners at both facilities believed that the use of telemedicine improved care. It obviated the need for transfer in 70 patients and save the equivalent of $105,092 in a system that has lower cost than ours.

At the 2009 American College of Surgeons Clinical Congress, Rafael Grossman[9] reported on his groups experience with telemedicine for trauma at a hospital system in Maine. There were 59 telemedicine consultations compared with an unspecified number of telephone consultations. They eliminated the need for unnecessary transfers. The level of medical errors in the teletrauma group was about one quarter of that in the telephone consultation group.

Lambrecht[10] reported on 100 teleconsults regarding trauma and reported that 68 stayed in the rural community. No significant adverse outcomes were observed among patients involved with teleconsults.

Duchesne[11] studied the impact of telemedicine on rural trauma care in Mississippi before and after the implementation of the telemedicine program. There were seven local community hospitals (LCH) and their referring trauma center (TC). Data was collected on patient demographics, Injury Severity Score (ISS) institutional volume of patients, mode of transport, length of stay in LCH, transfer time, mortality and hospital cost. Over a five year period there were 814 patients. Pre TM n = 351; post TM, n = 463. All patients were transported in the pre TM period compared to 51 in the post TM. In the post TM period there was;

1- Higher ISS 18 vs.10, $p < 0.001$,

2- Decreased length of stay at LCH 1.5 hrs vs. 47 hrs, $p < 0.001$,

3- Decreased transport time 1.7 hrs vs. 13 hrs, $p < 0.001$,

4- Decreased hospital cost $1,126,683 vs. $7,632,624, $p < 0.001$.

5- The change in the mortality did not meet statistical significance, 4.8% vs. 7.8%.

It is clear from these studies that telemedicine is safe, improve care at community hospitals while providing a significant cost savings with no increase in the mortality.

To this end a rural telemedicine program has been created to provide telemedicine for trauma and other emergency care management by trauma surgeons and other specialists on an emergent basis to health care providers within EMS Region 6 to assist with resuscitation, stabilization and transfer to definitive care. We are currently in the process of getting the participants at the Medical College of Georgia credentialed at our referring centers. It is anticipated that this program will go live within the next few weeks.

The following hospitals are taking part in this project,

1- MCG Health System, Augusta

2- Emanuel Medical Center, Swainsboro

3- Washington County Hospital, Sandersville

4- Burke County Hospital, Waynesboro

5- Jefferson County Hospital, Louisville

6- McDuffie County Hospital, Thomson

We at MCG look forward to this project. We are excited to enhance the services we provide to our referral centers and help them provide better care for the injured and those in need of emergency medical services. We also see a lot of potential for this to positively impact on the follow up process.

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Amazon Doctor

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As a child I had fantasies of running away to the jungle, canoeing up-river under the green lush canopy of the rainforest, these scenes bursting alive in the pages of the *National Geographic* mags scattered around my pink girly bedroom. I wanted to live amongst the monkeys, the panthers and the anaconda ala Mowgli. Perhaps it was Rudyard Kipling who inspired me. Or perhaps my voracious appetite for books about girl detectives on wild adventures…

So when I grew up I became, in a way, a detective. I became an emergency physician. Someone who has to unearth clues under layers of obfuscation, pull words from the mute, communicate to those who can't understand, find answers and fix problems quickly, efficiently, accurately.

How better to channel Nancy Drew? By floating up the Amazon River, holding clinics for the indigenous tribes with Amazon Promise, a non-government volunteer organization started in Peru dedicated to providing healthcare to those with the least access.

Drinking masato, a must drink fermented beverage made from yucca root presented to us by the Chief's elder wife.

Imagine precariously crouching in a long, narrow canoe, a tiny motor, the "peku-peku" named for the sound it makes, propelling the leaky boat up the creek. We do, thank God, also have a paddle. Our Indian guide Puanch is able to direct us to his father's settlement, an hour into the deepest parts of the jungle. Shak-hai, the Apu, or leader of his Achuar Indian tribe, has two wives and 20 children. He does not greet us as we arrive, making us wait as he completes important business with his young sons. He looks an unlikely chieftain, as he teaches them soccer moves in his Chuck Taylors. He has made it quite clear that his family takes priority over outsiders.

The Achuar people excel at nonverbal communication. Their roots derive from Indians who were bred to be silent predators, silent survivors. A noisy baby would have been smothered to keep the tribe safe.

In a culture that shuns contact with the modern world, Shak-hai is an anomaly. He clearly has eschewed his ancestors' violent reaction to outsiders as well as their aversion to clothing. In all other ways he does insist that his people continue to live as the Achuar have for centuries, making their own pottery, farming and hunting for their food. He has not "sold out" and taken his tribe to the city to live off the dole. He "paid" us for the healthcare that we brought by sending his second oldest son to us to work as a guide and porter, to help us lift, carry, and translate.

When Shak-hai finally brings his attention to us, we are greeted in traditional fashion by his elder wife. She brings us a bowl, brimming with "masato," the beverage favored by the Indians. To be greeted at all is a great privilege. One MUST drink what one is offered or risk insulting the tribe or worse. It is not clear to me if the stories of violence in the jungle are just legends. I will not take chances. I drink.

This yeasty fermented murky liquid has fibrous shreds floating in it. These are fragments of manioc root, or yuca, which are chewed by the women of the tribe, mouthfuls spit into a large bowl throughout the day and allowed to ferment in the jungle heat. We are told that the children chew corn and contribute to the community bowl, making the tribe's masato the sweetest and tastiest around. Only later do I witness the deplorable condition of the women's teeth and their green nasal discharge. I hope and pray to all gods, Pagan, Christian and Achuar, that the alcohol produced in this fermentation process has killed the organisms in this drink. One suspects

that the survival of this tribe means that this is so, or else Shakhai's family has a superior genetic profile.

Running a clinic in a foreign country is hard. Predicting what medicines will be required in a remote village in the jungle is challenging. Translating from English to Spanish to Achuar and back again requires mind-reading skills.

We care for patients with simple ailments, like otitis media and, of course, gastritis. We also see malnutrition in the jungle. Despite the bounty of the jungle, where more than half of all species of fauna and flora reside, there are still barriers to a nutritious diet. Rice and maize are staples here, and a diet rich in carbohydrates results in protein malnutrition and vitamin B deficiencies. Many children have the classic kwashiorkor body physique and are extremely small for their age by WHO (World Health Organization) standards.

There are also cultural barriers to nutrition. Girls and women, as hard-working as most men in this culture, will often eat last, after the most nutritious of food has been picked over by the hierarchy of males.

I fly home. Back to the luxury of flush toilets (with seats!) and clean running water. Back to the luxury of automobiles and grocery stores and shopping malls.

Back to a community that takes for granted its access to healthcare.

Would we survive as well as the Achuar without it?

Malnutrition is an issue with barriers to a nutritious diet.

Elder wife prepares masato for her guests.

Achuar teenaged boys and woman

Young mother and her seven children.

Amazon Promise team.

"A Round of Applause...."

The following companies have shown their commitment to making sure that emergency care is available to all Georgians by donating as an entire group to GEMPAC.

- Dekalb Emergency Physicians
- Emergency Care of Atlanta-St. Joseph's
- Georgia Emergency Physician Specialists-Savannah Memorial
- Northside Emergency Associates
- Paragon Emergency Physicians-Eastside Medical Center

Make sure your group is on this list next time! Find out how by contacting the GCEP Headquarters office.

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Dr. John Rogers

Elections will be held during the annual Council Meeting in San Francisco in October.

Wrongful Death Cases Based Upon Suicide: The General Rule Has Exceptions

David A. Olson, Attorney at Law, Drew-Eckl Farnham

Ranked as high as the sixth leading cause of death in the United States (13th worldwide), and with over one million people committing suicide each year world-wide, suicide is far-reaching, complex, and sometimes perplexing for those left behind. Any number of factors might contribute to a person taking their own life, including mental health and/or other social problems. In some cases it is likely impossible to know why a particular person chose to take their own life, and in other cases a person may have left behind a note or some indication as to why they chose to end their life. As emergency physicians, you have likely dealt with suicide attempts in the hospital and know how to respond. However, in the context of a lawsuit for negligence where the defendant is blamed for the suicide death of an individual based on prior negligence, the answer on how to respond and how to dissect the concept of suicide might seem a daunting task.

Torts Must Have a Causal Link

To recover for negligence in Georgia, proof of causation is required. The Court of Appeals has held that "[n]egligence is not actionable unless it is the proximate cause of the injury, [and a] wrongdoer is not responsible for a consequence which is merely possible, according to occasional experience, but only for a consequence which is probable, according to ordinary and usual experience." *Morris v. Baxter*, 225 Ga. App. 186, 187 (483 S.E.2d 650) (1997). This rule is based in fairness, because "negligence is predicated on what should have been anticipated rather than on what happened." *Id.* The inquiry is "not whether a defendant's conduct constituted a cause in fact of an injury, but rather whether the causal connection between the conduct and the injury is too remote for the law to countenance a recovery." *Id.*

Suicide is Generally Unforeseeable

In Georgia, "[g]enerally, suicide is an unforeseeable intervening cause of death which absolves the tortfeasor of liability." *Appling v. Jones*, 115 Ga. App. 301, 303 (1) (154 S.E.2d 406) (1967). Although, "there is an exception to this general rule: Where the tortfeasor's wrongful act causes the injured party to kill himself during a rage or frenzy, or in response to an uncontrollable impulse, the wrongful act is considered to be the proximate cause of the suicide." *Id.*

In the *Appling* case, a young man killed himself about two hours after a motor vehicle accident, and the Georgia Court of Appeals held that the evidence did not establish an exception to the general rule. The court said that there was too much evidence of the young man's rational and conscious behavior after the collision, even though there was some evidence of other strange behavior by the young man. *Appling*, 115 Ga. App. 301. Thus, even a mere two hour window can mean a suicide is too remote to the original negligence to countenance an recovery by the plaintiff. In another case, the Georgia Court of Appeals also held that the exception did not apply to a man's suicide because there was no evidence that he was in a rage or frenzy or had an uncontrollable impulse. *Dry Storage Corporation et al. v. Piscopo*, 249 Ga. App. 898 (550 S.E.2d 419) (2001). In *Dry Storage*, a man was injured in a rear-end collision automobile accident. *Id.* The man killed himself after videotaping a suicide note of sorts. *Id.* In that video, he makes some connection between the accident and the suicide by stating that he can no longer live with the pain he suffers from which he attributed to the accident. *Id.* However, this was not enough for the court as it stated that "[i]n spite of that connection, from a legal point of view, proximate cause means that the suicide must have been a foreseeable result of the negligence of the tortfeasor," and citing to the *Appling* case,

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Costs Matter . . . A Lot

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Dr. Setu Mazumdar helps physicians like you make smart decisions about your money so you can take control of your financial life. He is President and Wealth Manager at Lotus Wealth Solutions, an independent fee-only wealth management firm in Atlanta, GA exclusively for physicians. Setu received his MD from Johns Hopkins School of Medicine and he is board certified in emergency medicine.

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One of the problems I see in medicine is that people are insulated from costs. We see this in emergency medicine all the time. For example why does insurance actually pay an ER bill for someone with a cough and runny nose for a few weeks? The patient pays a premium to a third party and because they've "already paid" they expect everything. Same thing on the physician side. We generally have no idea how much tests and labs cost but we order them since we don't really see the bill that the patient gets.

It's the same way with investing. There's lots of fees and expenses you don't see, but I guarantee that you're paying them. So let's uncover the different fees you're paying in your investment portfolio. This time I'll discuss the direct fees you're paying.

Fees You See

1. Trading commissions

If you trade individual stocks you'll generally pay a fee to the brokerage firm for executing the order. The good news is that commissions have come down dramatically over the past decade due to online execution. Generally trades will cost less than $20 and some deep discount firms offer trades for $7 or less. While commissions may seem cheap, remember that the commission is relative to the dollar amount of the order. So if you place an order to buy $500 of Microsoft with a $20 commission, you'll actually end up with $480 of Microsoft. This translates into a 4% commission, which is quite high. You should think of this as a 4% loss right up front. The higher the dollar amount of the order, the lower the commission as a percent of the order. The same $20 commission on a $10,000 order results in a commission percentage of just 0.20%. With frequent small dollar trades, commissions can really add up to a substantial percentage of your portfolio. Further, when you sell you have to pay another commission. This is one reason why short term trading is hazardous to your wealth.

If you're committed to buying individual stocks, you may also want to look into a DRIP (Dividend Reinvestment Plan) plan. In a DRIP you can purchase shares of a company directly from the company for a very low or no fee. When the company distributes dividends (cash from profits), those dividends are automatically reinvested in the same company's stock with no commissions. You generally don't get to decide the exact time to buy the stock or reinvest dividends. Usually the very large companies offer DRIPs. An alternative to a DRIP is to find a brokerage firm which reinvests dividends without incurring a commission.

With mutual funds you'll most likely pay a commission also. But there is a way around this in some cases. If you open accounts with a mutual fund company directly, you will generally not be charged any commissions if you buy that particular company's funds directly. Over time this setup can save you hundreds of dollars every year. It also allows you to make small purchases without worrying about paying a high percent to commissions. When you sell a mutual fund, be sure to check whether there is a redemption fee. This fee is usually incurred when you buy and sell a fund within a short time period (usually 2 months) but can be as long as one year or more. While funds do this to encourage long term investing, if you're simply selling just to reallocate your portfolio, then the redemption fee can make it difficult for you to do this. Another possible way around fund commissions is to do what is called an exchange. In this transaction you sell a specific fund from one mutual fund company and simultaneously buy another fund from the same mutual fund company. Alot of companies won't charge you the selling commission in this case.

2. Junk fees

It seems like when you buy an airline ticket there are more nonsense fees added on every year--from airport surcharges to baggage fees to drink fees now. One popu-

lar brokerage firm charges all of the following fees: annual account administration fee, broker assisted trading charge, wire transfer fee, foreign securities transaction fee, and miscellaneous check fees (if you use the account for banking purposes). One way to avoid pesky fees like these is to consolidate all your accounts with one brokerage firm. Most firms will waive most or all of these fees by doing this.

3. Other direct fees

Finally there are other direct fees you may pay. For example, if you have an IRA and convert it to a Roth IRA, there may be a fee for the conversion. Or if you have a solo 401k, you might have to hire a third party administrator to handle the accounting if the value of the account is greater than $250,000. That administrator will charge a separate annual fee to keep track of your solo 401k and report it to the IRS.

So as you can see the direct fees can add up over time. The problem is that the fees you don't see are really the ones that kill your portfolio's investment returns. That's what I'll discuss next time.

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the suicide was an unforeseeable intervening cause of death which absolved the tortfeasor of liability. *Id.*

So, even in a case where there existed video evidence of the person who took their life stating that they are doing so because of the pain that resulted from the supposed negligence of another, Georgia courts have said that a defendant cannot be held liable for the suicide as it was not a foreseeable consequence of the alleged negligence. This foreseeability, however, seemingly gives rise to another exception to the general rule when it comes to medical malpractice.

Negligence in Medical Malpractice Actions Need Only Contribute to Cause the Plaintiff's Harm

To recover for medical malpractice, "the plaintiff must establish…that the defendant's negligence either proximately caused **or contributed to cause** the plaintiff's harm." *Zwiren v. Thompson*, 276 Ga. 498, 500 (578 S.E.2d 862) (2003) (emphasis added). The defendant's negligence "need not be the sole proximate cause of the death, but only need contribute." *Bell v. Sigal*, 254 Ga. 78, 80 (326 S.E.2d 730) (1985). Thus, the gap between negligence and later suicide may seemingly be capable of being bridged in the case of medical malpractice.

There Can be a Causal Link Between Prescribed Medication and Suicide

Lately, more and more drugs seem to advertise that one side effect may be suicidal thoughts or actions. Thus, the intersection of malpractice and these medications can open the door to liability for resulting suicides.

That was what happened in the recent case of *Romona L. Floyd, Individually, as Surviving Parent of Jessica Ann Ray, deceased, and as Administratrix of the Estate of Jessica Ann Ray, deceased v. United States of America*, 2010 U.S. Dist. LEXIS 125247 (2010). In that case, the decedent, a 15-year-old female, was prescribed Prozac when it was not indicated or appropriate. *Id.* It was prescribed by a nurse practitioner on a follow-up visit from the emergency room at a clinic in Hartwell, Georgia while the decedent had been experiencing nausea, vomiting, and abdominal pain. *Id.* The nurse wrote the prescription on a prescription pad that had been pre-signed by the supervising doctor and in her notes for that visit, the nurse wrote "depression – Prozac." *Id.* After ingesting the Prozac, the decedent hanged herself, which resulted in a devastating brain injury that ultimately caused her death. *Id.*

Of course, the causal link between the ingestion of SSRIs (the Prozac) in pediatric and adolescent patients and suicidality (including the ramifications of how to define that word) was, and in medical malpractice actions must be, accompanied and supported by expert testimony. *Id.* Importantly, however, the court found the death that resulted from the suicide attempt to be caused, or contributed to, by the medical malpractice of the nurse and doctor. *Id.* The court analyzed the multitude of factors in the young female's life which may have had an impact on the suicide attempt, but the court found that all were not significant enough, or credible enough, to detract from the causal link of the Prozac being ingested by an adolescent patient and suicidal thoughts or actions. *Id.*

The court seemingly bypassed an analysis of the general rule in Georgia regarding the causation of suicide. It is likely that this was done due to the method of proving causation in medical malpractice cases, and should be taken as an example of how medical malpractice lawsuits can be a different breed of litigation, subject to varying exceptions to general rules in Georgia. Perhaps the key rests in the causal link noted between SSRIs in pediatric and adolescent patients and suicidality. If so, then there may be other scenarios where alleged medical malpractice results in a future suicide and the general rule in Georgia is applicable thereby breaking the causal chain as an unforeseeable intervening event.

Ethical Dilemmas in the Emergency Department

Richard L. Elliott, MD, PhD

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Richard L. Elliott, MD, PhD

Just as the variety and intensity of medical problems seen in Emergency Centers (EC) are greater than other healthcare settings, so are the issues in arising in medical ethics of greater variety and intensity. True, intensive care units, dialysis centers, burn centers, palliative care centers, and other specialized healthcare settings all have a high number of ethical issues associated with care, but, often, by the time patients arrive in these units, ethical issues are beginning to be recognized and addressed. Such is not necessarily the case in the EC where it may first be discovered during an effort to resuscitate a patient that a DNR order exists, that a trauma victim is a 17-year-old Jehovah's Witness, or that a patient who ingested ethylene glycol has an advance directive refusing dialysis.

Thus training in the ability to recognize and address ethical issues rapidly is especially important in emergency centers, in order that further care is not complicated by allegations of improper, unethical care. For physicians training in emergency medicine, there are several sources which discuss these training needs.[1,2] But primary care physicians and specialists in areas of medicine other than emergency medicine often train in emergency centers, provide subsequent care to EC patients, but may not receive training needed in early recognition and management of ethical issues presenting in the emergency department.

To provide such training in recognizing and addressing ethical issues, we at Mercer University School of Medicine and The Medical Center of Central Georgia have, since 2005, conducted an ethics case conference for fourth year medical students, interns, and physician assistant students rotating through the Emergency Department at MCCG. The purpose of this paper is to describe the nature and frequency of cases discussed in these conferences, so that future training in EC medical ethics can focus on those issues most likely to arise in emergency settings. Based on these cases a formal curriculum could be developed, and a bibliography has been generated.

The format for the conferences is that students are told during their orientation that they are responsible for identifying a case seen in the ED which poses an issue in ethics or professionalism. The case is submitted as a single paragraph prior to our group case conference, usually held after four weeks. During the conference, led by the director of the ED and an ethicist, ethical, professional and clinical issues are clarified, and possible approaches are suggested.

For this report we have reviewed all 95 cases discussed in conferences held from 2005 through 2010 for which we had a written record. In reviewing the cases, a number of ethical and professional issues emerged, e.g., the right to refuse treatment in the ED, and, after reviewing all the cases, the author reconsidered each case and assigned it to at least one category of ethical/professional issues. In 41 cases, no one ethical/professional issue best described the

Issue	Number of cases
Utilization of ED	14
Right to refuse treatment	13
Rights of minors	13
Lack of patient truthfulness	12
Use of commitment processes	12
Drug seeking (especially opiates)	9
Futility of care	7
Confidentiality	7
Right to refuse treatment after suicide	7
Referral to child protective services	7
Surrogate decisionmaking	6
Informed consent	6
When to tell the truth to a patient	1
Assessment of competence	1
Miscellaneous ethical/professional issues	30

dilemmas, and the case was assigned more than one issue. 54 cases were assigned one issue, 33 cases had two issues assigned, and seven cases were assigned three ethical professional issues, and in one case, four issues were needed to describe the features of the case.

The table summarizes the categories of issues, and the number of cases for which that issue was thought to be either the central issue, or one of several core issues.

In arriving at these categories of ethical and professional issues we knew that the heart of many ethical dilemmas was the notion of competence, i.e., was a patient competent to refuse treatment, to consent to treatment, competent as a minor, and so forth? Rather than assign this as the central issue to most cases, thus obscuring other important concerns, we assigned competence as the central issue only once, in a case involving a mentally retarded individual with no appointed guardian who was brought to the ED for a behavioral outburst, and who then refused all interventions.

Some examples of cases presented and the ethical issues we believed best describing each case follow.

Utilization of the EC: A mother of 10 brought her 3-year-old boy to the EC after he vomited once in the morning. She had not contacted the pediatrician.

Right to refuse treatment: A 28-year-old woman, 28 weeks pregnant, was involved in a motor vehicle accident causing a laceration to the scalp and headache. She refused any imaging of her head because of fear of exposure of her baby to radiation.

Rights of minors and utilization of EC: A 16-year-old boy was brought by his mother to the EC for "counseling" because he had been non-compliant with his diabetes treatment. The necessity of having the mother present during counseling was questioned, as was the role of the EC in providing diabetes counseling under the circumstances.

Lack of patient truthfulness, drug seeking behaviors, and the role of the EC in managing chronic pain were frequently overlapping topics. For example, a 46-year-old man came to the EC complaining of vague abdominal pain, and was ridiculed by staff in the hallway because of his bizarre gyrations and writhing. When the patient believed he was not being observed, he remained calm and motionless. Although all agreed the patient was very unlikely to be experiencing much, if any, pain, the physician felt obligated to obtain a complete evaluation, stating, "I don't want him coming after my house." Thus the issue of resource utilization was also raised.

The use of commitment procedures, especially with patients who had overdosed and were refusing treatment, was common. A 31-year-old woman was found unresponsive with nearby drug paraphernalia, responded to Narcan, but denied attempted suicide. She was allowed to leave the EC after threatening legal action if detained. The issue of whether the patient should have been detained involuntarily as a danger to self was raised.

The question of ***futility of care*** was most often raised in the contexts of when CPR should be discontinued, and intubation of patients with DNR orders. For example, a 59-year-old man with stage 4 colon cancer, a hospice patient, was brought by his wife to the EC with altered mental status. Glucose was 26 and he responded to D50. His wife demanded a full evaluation to determine why he had become hypoglycemic.

We believe a compilation of ethical cases and issues might be useful in creating a bibliography and curriculum likely to address the most common ethical issues confronted in the EC by medical students, PA students, and residents in other specialties rotating through the EC. We also note several limitations to this report. First, the sample of cases is that submitted primarily by medical students at Mercer University School of Medicine. These students might not consider as ethical dilemmas situations to which they have been exposed in the curriculum and have had prior opportunities to think through (e.g., reporting HIV infection to sexual partners, informed consent and involuntary treatment in psychiatric patients). Second, since this experience is an initial one for these students, and is only four weeks long, many will not have been exposed to more advanced topics, including the ethics of research in emergency settings, responses to public health emergencies, relationships with medical industry, use of emergency contraception, and so forth.

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Spinal Epidural Abscess: A Case For Risk Factor Analysis

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A 42-year-old male with a long history of IV drug abuse presents with complaints of low back pain, malaise and diffuse myalgias for several days. He denies both trauma and history of significant back pain in the past. Exam shows an unkempt, alert individual insisting on pain medications as you walk in the room. VS: T-100.9 BP-119/70 RR-22 P-108. Skin feels warm and exhibits extensive track marks. Tenderness is noted in the low back, particularly over the midline L3-L4 region. Neurologic exam is nonfocal. No source for fever is noted.

He is medicated and discharged with a diagnosis of low back pain and "flu" and is given a prescription for pain medications.

He returns two days later with worsening pain, numbness and mild weakness in the bilateral legs. He is admitted but continues to deteriorate. Two days later an MRI is performed which shows spinal epidural abscess. He is immediately taken to surgery but the damage is done and he is discharged in a wheelchair with a need for self catheterization.

Atraumatic back pain is seen very commonly in the ED and, though at times debilitating to the sufferer, it rarely implies a threat to life or limb. Thus, in the rush of patient care it is easy to precategorize these patients in our minds as "nonsick" before entering the room and miss or dismiss subtle abnormalities in history and exam that may contradict this initial impression. Add to this the common existence of bias amongst providers and nursing against these presumed drug seeking patients and it is easy to see how a case like the above slips through the cracks.

Spinal epidural abscess is a very difficult diagnosis to make, particularly early in its course. It is a relatively uncommon finding (1 in 10,000 hospital admissions) and is not diagnosed on the first visit 75% of the time. When present, it can have devastating consequences and often results in high malpractice payouts. As rarity of condition is not an effective defense in failure to diagnose litigation, it becomes important to indicate through your charting that all potential serious diagnoses have been entertained and ruled out. In this case's first visit high risk features such as fever and history of IV drug abuse were not adequately explained in charting and, in hindsight, were indicative of something worse than garden variety back pain going on. The lack of urgency in imaging the patient on the second visit added insult to injury and unfortunately sealed the patient's fate.

The trick in these cases is to keep an open mind in these prejudice prone back pain patients, and secondly, develop a consistent routine in their evaluation. Aside from completing the customary musculoskeletal and neurologic review of symptoms and exam, develop the habit of screening all these patients for risk factors (see below) that are predictive of high risk for infectious causes of back pain. When suspicion is high, do not hesitate to order MRI of the spine emergently.

Relevant risk factors for spinal epidural abscess include:

- Fever with midline back pain
- Current IV drug abuse
- Diabetes
- Recent procedures/instrumentation, indwelling catheters(i.e. recent epidural injections for chronic pain)
- Immune compromise (HIV, chronic steroid therapy, etc.)
- Liver disease
- Renal failure
- Distant infection (i.e. cutaneous abscesses, pneumonia, etc.)

Physical exam – in any patient with the above risk factors, one should:

- Undress the patient – seems obvious but can't overemphasize this simple but often overlooked maneuver.
- Check skin for evidence of infection.
- Examine painful area for signs of tenderness, warmth or erythema.
- Observe the gait – watch for subtle abnormalities indicative of focal weakness.
- Check for saddle anesthesia and/or anal wink – full digital rectal exam not always necessary as long as the wink is present.

Diagnostic Testing

MRI is the gold standard in these cases and diagnostic delay can have significant consequences. Therefore, once a patient has been identified as a high risk for infection/abscess, awaiting return of blood tests (CBC or ESR) that have no proven ability to rule out the diagnosis of spinal epidural abscess cannot be justified. The difficulty in appropriately obtaining this test in the ED is a system problem that we must overcome to the best of our ability. Involve neurosurgical consultation early and, if necessary, transfer the patient to an institution with all hours capability for MRI (no neurosurgical coverage would be an EMTALA based justification for such a transfer.)

In conclusion, these patients are indeed difficult to diagnose. As only 8 % will present with the classic triad of back pain, fever, and neurologic deficits it is important to keep our antennae up for cases that meet criteria for MRI scanning. Addressing presence of coexisting fever and other risk factors in our charting and through diagnostic imaging is instrumental in protecting both the patient and ourselves.

ETHICS: continued from page 19

A brief bibliography is included in this paper – a more extended bibliography addressing special topics in EC medical ethics and a complete description of the cases are available from the author (Elliott_rl@mercer.edu).

We invite comments from others who have attempted to teach ethics and professionalism in emergency settings.

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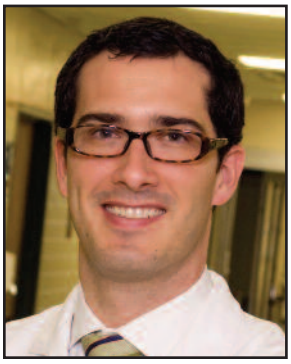
The Evaluation of DVT with Point-of-Care Ultrasound

William Manson, MD, RDMS, RDCS and Matt Lyon, MD, FACEP



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Venous thrombosis is major cause of morbidity and mortality in the United States, and a frequent root cause of presentation in many emergency departments. The sequelae of deep vein thromboses (DVT's) range from the more common chronic venous stasis, to the most serious pulmonary emboli (PE), one of the most common preventable causes of death. Approximately two-thirds of PE's are estimated to originate in the lower extremities as DVT's. Treatments with anticoagulation or Greenfield filter placement are extremely effective if utilized early enough, thus underscoring the need for rapid diagnosis. Compression ultrasonography has proven to be a highly sensitive and specific modality for the recognition of lower extremity DVT, without the need for radiation or contrast exposure. Traditional lower extremity scans review the vasculature of the entire lower extremity, require the presence of an ultrasound technologist, and are read by a radiologist, which all delay the time for potential treatment. Emergency physicians may utilize a modified two-point technique that focuses on the highest probability areas, reducing the study time to under five minutes, with a similar sensitivity and specificity, thus minimizing both the time to diagnosis and treatment.

Patients with the clinical suspicion for a DVT or PE with concomitant risk factors, the physician should begin a workup that may include but is not limited to compression ultrasonography. If the clinical suspicion and pretest probability for a pulmonary embolism are high enough that a CT with intravenous contrast will be warranted anyway, then U/S should not delay such workup or further treatment goals.

The patient should be supine with the leg in question exposed up to the inguinal ligament. There are two principle positions, one for each area of examination. The following are ideal positions; however, patient status and cooperation will ultimately determine what kind of manipulation is possible. Ideally, 30 to 40 degrees of reverse Trendelenburg will aid in the examination by increasing venous distention.

To examine the femoral vein, the patient should be supine. External rotation and flexion of the hip will provide increased ease of access (Figure 1). To examine the popliteal vein, the patient needs to expose the popliteal fossa on the posterior-medial aspect of the knee. The patient can dangle the leg off the edge of the bed, bend the knee and externally rotate the hip (Figure 2), or if necessary the patient can be rolled onto one side.

Figure 1.
Pt position CFV

Figure 2.
Pt position Pop

Figure 3.
Probe position CFV

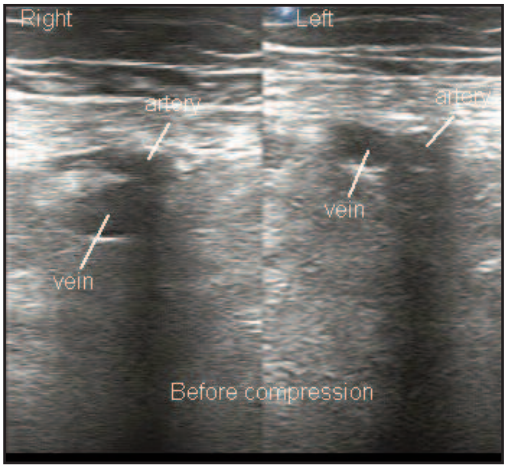


Figure 4. US fem without comp

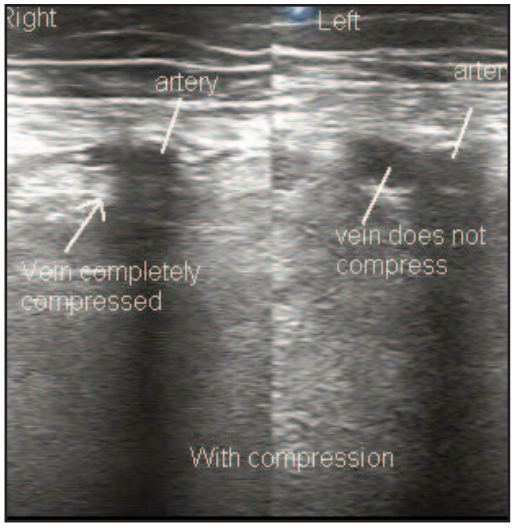


Figure 5. US fem with comp

During the bedside ultrasound examination for DVT the probe marker will point towards the patient's right. Set up the portable ultrasound machine at the bedside, with the linear transducer set at a frequency of 6.0 to 12.0 MHz. The "Two-Point" exam by emergency physicians actually covers two areas, not points: a 4 cm area including the common and superficial femoral veins, and a 4cm area including the popliteal, anterior and posterior tibial, and peroneal veins.

Femoral Vein

The study will begin with an examination of the common femoral vein just distal to the inguinal ligament. Locate the inguinal ligament, and the femoral vessels just inferior, approximately midway between the pubic symphysis and the anterior superior iliac spine. Position the transducer transversely, just distal to the inguinal ligament (Figure 3). Remember, the indicator on the probe should point towards the patient's right. The vein will be imaged in its cross-section. Identify the intersection of the greater saphenous vein with the common femoral vein. This will be your initial point of examination. The femoral artery will lie lateral to the vein.

With the transducer, apply direct pressure to attempt to compress the vein. If the vein is completely compressible, then a DVT at this site can be ruled out. If the vein is not compressible, apply more pressure until deformation of the artery is noticeable. If the vein is still not completely compressible, then a clot is likely (Figure 4 and 5).

Complete compressibility is the rule in/rule out criteria for DVT on ultrasound. Compressibility must be present in both veins, although the saphenous vein may be difficult and necessitate repositioning the angle of transducer approach. Even though the saphenous vein is technically a superficial vein, if it harbors a clot near the intersection with the common femoral vein, the clot can easily propagate.

The exam should include the section of the femoral vein 2cm proximal and 2cm distal to the intersection of the common femoral and greater saphenous veins. Distal to the saphenous vein, the common femoral vein splits into the deep and superficial femoral veins. Once the physician confirms collapse of the deep and superficial femoral veins, he or she may move on to the popliteal vein. CAREFUL: Despite its name, the superficial femoral vein is actually a DEEP vein.

Popliteal Vein

Position the patient as noted above for examination of the popliteal vessels. With the probe marker pointing towards the patient's right, manipulate the transducer until the superficial popliteal artery and vein are visible (Figure 6). The vein will be more superficial than the artery. The popliteal vessels are more easily compressible, so reducing pressure may reveal recalcitrant veins. The exam should include the distal 2cm of the popliteal vein and the most proximal aspect of the trifurcation into the anterior tibial vein, the posterior tibial vein, and the peroneal vein (Figure 7).

PEARLS

Complete compressibility is the only absolute criteria to rule out

Figure 6. Probe position Popliteal

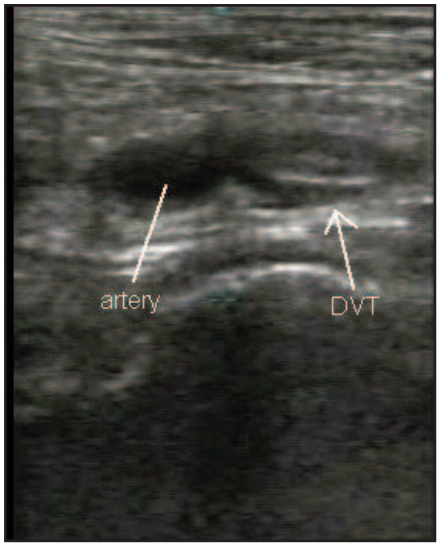


Figure 7. US pop clot

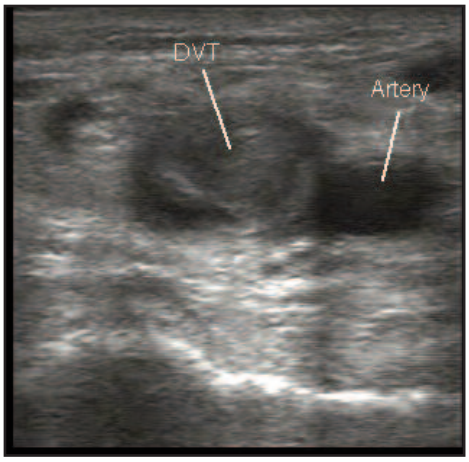


Figure 8. US DVT

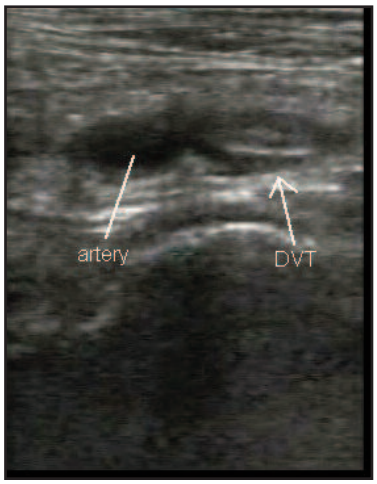


Figure 9. US lymph node

DVT. Lack of compressibility is the only absolute criteria to rule in DVT. Documentation of the most proximal aspect of the clot is important to assess progression or regression after intervention. Direct visualization of a clot (Figure 8) and Doppler flow abnormalities may suggest a DVT and if clinically appropriate may justify serial scans, but they cannot confirm a current DVT.

In obese patients, decreasing the transducer frequency to between 3.5 to 5 MHz will increase the depth of penetration, and greatly assist the examiner. However, overall image quality will be reduced.

If no vein is visible at the appropriate anatomic sight, it is possible that the transducer is already compressing the vein. Pull back slightly and re-examine the area.

Care must be taken to not over interpret vessel echogenicity as clot, for both normal blood flow and artifact may appear hyperechogenic.

Cysts are often encountered in the popliteal region, especially Baker's cysts. These can be readily distinguished by their confluency with the joint space and lack of flow on Doppler.

Lymph nodes (Figure 9) are especially common in the femoral region, but can be identified by the presence of a stalk, their superficial location and very high vascular flow on Doppler.

Approximately one third of patients will have a duplicate popliteal vein, which limits the accuracy of detecting below the knee thrombi.

Utilizing the dual-image picture or split screen option before and after compression may make comparison easier. In addition, the split screen option may be useful in hospitals that require still images for documentation.

If the site of examination is wounded, the ultrasound probe may be covered in a sterile glove with gel both inside and outside the glove.

If the examining physician is unable to obtain an adequate exam secondary to patient body habitus, patient compliance, or skill limitation, the patient will require an ultrasound study by the vascular lab. In addition, if the examining physician is unclear about the results, the vascular lab should perform the ultrasound study.

Pericarditis

Ben Holton, MD, FACEP and Stephen A. Shiver, MD, FACEP

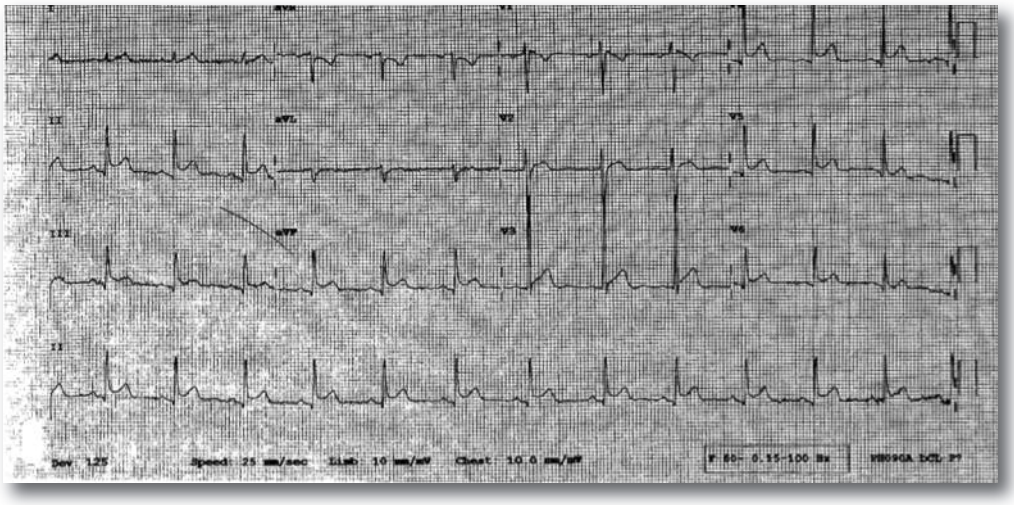
A 39 year-old male without any prior medical problems presents to the ED complaining of chest pain. The triage nurse performs a 12 lead EKG, notes ST segment elevation, and brings you the EKG pictured below.

The patient is in no acute distress with stable vitals and an O2 saturation of 98% on room air. Upon further questioning, you determine that he has been experiencing intermittent chest pain for the past several days without any associated nausea, diaphoresis, or radiation. He admits to occasional mild dyspnea. The pain is sharp, transient, and worse with inspiration.

The EKG shows a sinus, narrow complex rhythm. The most obvious abnormality is ST elevation, which is not confined to any anatomic distribution. In fact, the ST elevation can be seen in anterior, lateral, and inferior leads. There are numerous potential causes of such diffuse ST segment elevation, including a large myocardial infarction. However, the patient's history is not suggestive of ischemia. Close inspection of the tracing reveals several clues that suggest a non-ischemic etiology including a concave upward ST segment morphology and the lack of any associated reciprocal ST/T changes.

The most well known EKG abnormality in acute pericarditis is diffuse, non-anatomic ST elevation. However, there are other less well known but nonetheless important EKG changes. While the ST segments are elevated, the PR segments are depressed. Additionally, the often neglected lead aVR shows the opposite of the other leads: PR elevation and ST depression. All of these changes are present on the pictured EKG.

As always, the EKG should not be interpreted in isolation. Rather, it must be correlated with the patient's history and physical examination. Many times the diagnosis may be more difficult than in the case described. It is critical that the EKG changes of pericarditis not be confused with the EKG changes associated with STEMI since the treatment pathways are so different. Thrombolytics given in the setting of pericarditis can have disastrous consequences.



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Perils and Pitfalls of Pediatric EM: Avoiding the Trap of the Tar-Baby in Pediatric Emergency Medicine

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In pediatric emergency medicine today, we constantly find ourselves under pressure. The pressure comes from all directions – patients, their parents, the nursing staff, our medical directors, and sometimes our selves. From patients per hour, to patient satisfactions surveys, turnaround times, and 72-hour returns to the ED – these are all metrics that we are judged by, that affect our bottom dollar, and now affect how we practice in the ED.[1] Along with all these external pressures, there is one pressure that we create and force on our own selves – the pressure of dealing with results of tests that we order. Our habit of ordering tests indiscriminately is particularly troubling in our use of lab and imaging data in the generally healthy pediatric patients in the ED.

There are many reasons why we order tests for our patients, ranging from justifiable reasons, such as medical necessity, sometimes based on evidence based protocols to 'soft' reasons, such as primary physician expectation, parental demand, and our own fear of litigation. However, what do we do when a result is abnormal, especially when that finding is unexpected? Given that there is a nearly 10% error rate in laboratory data, we need to think about what an 'abnormal' result truly means.[2] Further, what kind of predicament do we get ourselves into when we order additional tests to investigate the initial abnormal result, and in the process gather larger and larger amounts of data.

This predicament has been nicely documented in the medical literature. In "Uncle Remus and the Cascade Effect in Clinical Medicine" Brer Rabbit becomes naively involved in a seemingly innocent encounter that rapidly evolves into inescapable entanglement and entrapment. Each step in this process of irreversible commitment is triggered by a straightforward prior event, explainable and understandable. The cumulative result of these simple actions, however, is an inexorably accelerating cascade that is costly and dangerous, but seemingly unavoidable. This cascade effect described by Joel Chandler Harris in the 1880's has a parallel in the medical practice of today when an innocent initial action leads to a series of prolonged and expensive investigations and interventions, frequently of no benefit to either patient or physician, and commonly a source of frustration to both.[3]

There are 'Tar-babies' at every corner in clinical medicine, and unfortunately, so many clinicians are all too eager to kick them, sometimes in the name of 'completeness,' other times assuming it is a benign act, not realizing the trap they are getting into. In the ED, we order seemingly simple tests in our determination to not 'miss' anything, no matter how unlikely it may be. Thus, we sometimes create our own triggering event that inevitably progresses into an unstoppable force. In so doing, we make the patient, ourselves, and the healthcare system helpless victims of a frustrating, runaway situation that often leads to an endless cascade of costlier interventions that are simultaneously unnecessary and unavoidable.[4]

Current recommendations question the need for extensive lab evaluation of the well appearing, febrile infant older than six months, or the necessity of a cardiac evaluation in healthy children with chest pain. These are just two of many examples where we continue to order tests regardless of their very low yield, and, thereby, add an external stressor that further decreases our control of a benign situation that is nonetheless filled with anxiety. Now what do we do with the well appearing six month old with a temperature of 40°C with a CRP of 7, with all other labs being normal, or the child with nonspecific abdominal pain with an elevated amylase but all other "belly labs" unremarkable. What we end up doing is ordering further imaging studies, more labs, and occasionally even a hospital admission,

From the Editor:

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Dr. Rogers is the Secretary-Treasurer of GCEP.

This will be my last issue as your Editor. It has been a privilege over the past two years to serve in this capaity. I have enjoyed it and learned a great deal. We have expanded our content, and increased our circulation. I trust you have found these to be improvements and value the EPIC as a source of education and information.

I want to thank Melissa Connor at Plus One Media who has been responsible for the layout, publishing, marketing and printing. Her assistance has added a degree of professionalism to this publication. And thanks to Tara Morrison, our Executive Director, for keeping us grounded in our efforts.

But I especially want to thank all of the contributors and authors. They have given us their time and shared their knowledge. Without them, none of this would have been possible.

Kindest regards,

John J. Rogers, Secretary-Treasurer, GCEP

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primarily because we do not know what do with the results we have been handed. This underscores the need to be wary of the potential impact of what we are ordering before we do it. Furthermore, by doing tests, we sometimes fool ourselves and our patients that we have moved the needle from its ground state of uncertainty into the realm of certainty; in the process we create a dangerous false sense of security.

Today, we have large amounts of technology and testing available at our fingertips with simply the click of a button. We should not call into question the technology but rather our use of it. While gathering vast amounts of data is easier than ever, it is our responsibility to prevent the triggering event, the first order of unnecessary test(s). This, then, is our challenge.

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Aggressive Catheter-Directed Treatment of Clinically Significant Pulmonary Embolus

Juan Ayerdi, MD; J. William Mix, MD; and Maurice M. Solis, MD

Drs. Ayerdi, Mix, and Solis are vascular surgeons and interventionalists with Macon Cardiovascular Institute. For more information visit their web site at maconcvi.org. For patient referrals call MCVI at (478) 743-9762.

Editor's Note: This was part of a presentation made to GCEP Middle Georgia in January 2011. GCEP Middle Georgia has been meeting quarterly for the past 3 and 1/2 years. Emergency physicians from all hospitals in the Middle Georgia area are invited to attend. Not only are these meetings educational but have help foster camaraderie among the physicians providing emergency care in this region.

In the United States, pulmonary embolism (PE) is the third most common cause of death, accounting for about 650,000 cases yearly. Statistics show that about 60% of patients who died in the hospital have had pulmonary embolism. PE is often undiagnosed and untreated. Prompt diagnosis and immediate medical intervention can greatly decrease deaths from this condition.

Pulmonary computer tomography arteriography (CTA) has become the gold standard imaging modality for the diagnosis of PE.[1] A high index of suspicion for PE should prompt a CTA even in most patients with elevated serum creatinine. CTA has very high sensitivity and specificity and has replaced both pulmonary arteriogram and V/Q nuclear medicine scanning (Fig. 1).

In general catheter-guided or surgical thromboembolectomy is considered a life-saving intervention in massive PE. However, catheter guided interventions remain controversial for submassive PE. Based on new evidence that mortality is higher in patients with submassive PE who demonstrate right heart dilation on echocardiogram or CTA the vascular surgeons at Macon Cardiovascular Institute (MCVI) Drs. Ayerdi, Mix, and Solis have instituted an aggressive treatment algorithm utilizing the latest catheter technologies.[2,3] The goal of catheter guided interventions in acute PE is to rapidly reduce RV afterload and avert impending hemodynamic collapse and death.

MCVI-PE Treatment Protocol

Patients with sub-clinical PE, usually manifested with only mild shortness of breath and or pleuritic chest pain, are treated with close observation and standard anticoagulation therapy. On the other end of the spectrum patients with massive PE, manifested by severe hypoxia and cardiogenic shock, are considered for urgent percutaneous thromboembolectomy with or without adjuvant fibrinolytic therapy depending on the presence of contraindications for lytic therapy.

Patients with submassive PE on CTA are frequently diaphoretic, moderately hypoxic and may have mild hypotension. These patients are started on a high-dose weight-based heparin protocol and admitted to the CV-ICU. Urgent echocardiograms are performed. Patients with a large clot burden and imaging evidence of right heart failure, as documented by a right ventricular diameter (RVD) to left ventricular diameter (LVD) greater than 0.9, are considered for catheter-directed therapy.

After informed consent patients are transferred to the peripheral vascular cath labs at the Luce Heart Institute for catheter–directed therapy. Single common femoral vein access is obtained with ultrasound guidance in order to avoid inadvertent arterial puncture. A removable inferior vena cava filter is place to prevent further embolization during treatment (Fig. 2). The venous access is then up-sized to a 10 or 12 Fr. Tri-port sheath (Fig 3). This sheath can accommodate two pulmonary artery catheters and has an additional port for IV heparin administration and serial laboratory monitoring.

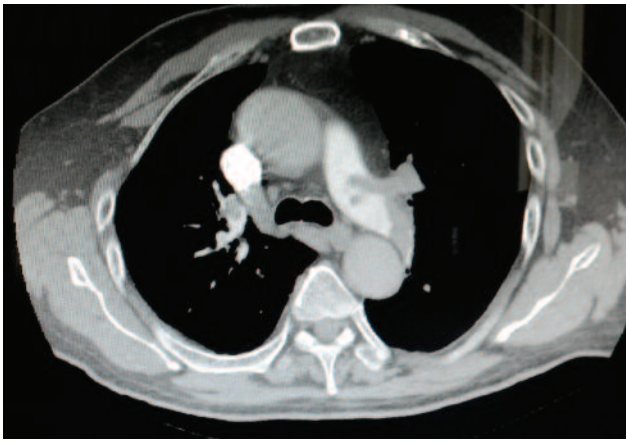

Figure 1. Pulmonary CTA demonstrating large left pulmonary artery embolus.

Figure 2. Temporary inferior vena cava filter. The hook at the tip allows subsequent removal from a jugular vein approach.

Figure 3. Triport Sheath inserted into the right common femoral vein with two catheters inserted and a middle port for infusion and blood sampling.

Figure 4. Left pulmonary arteriograms in a patient with submassive bilateral PE.

If needed, selective pulmonary angiography is obtained (Fig 4). Guidewires are fluoroscopically directed into both pulmonary arteries and then into the most affected lobe branches. Once in position the guidewires are exchanged for EKOS® EndoWave catheter systems (EKOS Corporation, Bothell, WA) which are multi-side hole infusion catheters combined with low-power ultrasound fibers for accelerated thrombolytic effect (Fig. 5 and 6). Catheter-directed thrombolysis is begun with tenecteplase (TNkase) and the patients are closely monitored in the CV-ICU. Repeat echocardiogram (and/or CTA) is performed the following morning and therapy is discontinued if right ventricular function is improved (RVD/LVD of < 0.9) which usually correlates with significant overall clinical improvement. After discontinuation on thrombolytic therapy IV anticoagulation is overlapped to oral warfarin with a goal INR of 2-2.5. The vena cava filter is removed prior to discharge unless a permanent filter is considered warranted.

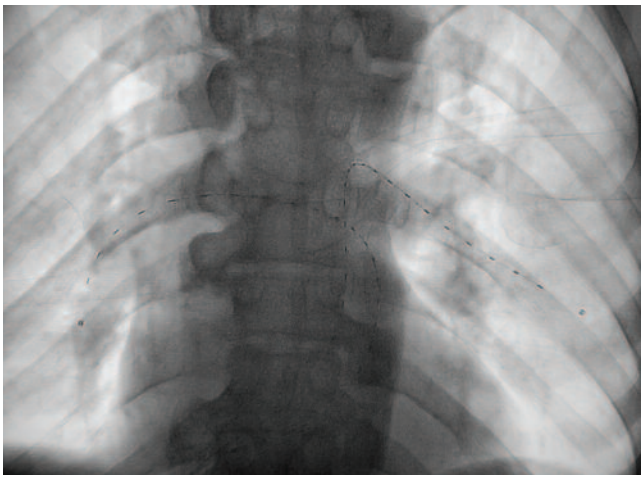

Figure 5. Bilateral EKOS® ultrasound-accelerated thrombolytic catheters placed via a single femoral vein access.

Case Illustration

A 62-year-old female, two weeks status-post sufferings multi-trauma including: C-7 compression fracture, pulmonary contusion, multiple rib fractures, and splenic/hepatic lacerations, presented with severe shortness of breath and hypotension. Her oxygen saturation was < 90% despite 100% FIO2. Echocardiogram and CTA demonstrated RVD/LVD ratio of 1.7 and a large PE clot burden. She was treated with catheter-directed, ultrasound accelerated thrombolysis using Ekos® catheters for 48 hours with resolution of her respiratory distress. Oxygen saturation was 95% on 2 L FIO2 via nasal cannula. Repeat echocardiogram demonstrated no evidence of right heart strain and CTA demonstrated significant dissolution of the PEs (Fig 7).

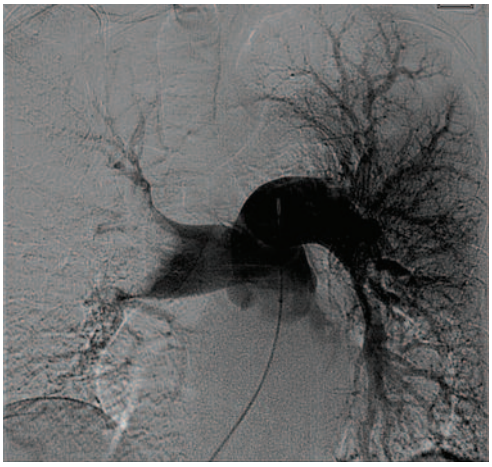

Figure 6. a) Pre-treatment pulmonary arteriogram demonstrating saddle embolus in the right main pulmonary artery.

Figure 6. b) Post-treatment pulmonary arteriogram demonstrating near complete resolution of the thrombus.

The Future

MCVI and the Medical Center of Central Georgia have been selected as one of 25 centers in the US to participate in a multicenter, open-label, single arm clinical trial using ultrasound accelerated thrombolysis with the Ekos® catheters in patients with sub-massive PE. In the near future MCVI will have available Angio Vac® an innovative large suction cannula used in combination with extracorporeal bypass for the extraction of massive pulmonary artery and venous thrombi.

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Significantly Reducing ER Fatalities by Closing Them

Herschel Knapp, PhD, hknapp@ucla.edu

Several meta analytic studies have found that Emergency Room (ER) deaths rank in the top five most annoying happenstances in hospital settings, constituting the ultimately unnecessary consumption of IV tubing, atropine, emesis basins, and clean linen (Gower & Kloopy, 2004). Such deaths have also been attributed to the leading cause of E.R. related defibrillator surprises (Avera, 1995).

In light of rising healthcare costs coupled with a shortage of qualified ER personnel, the futility of dealing with such irritating patients needed to be seriously addressed in a cost-effective manner that best served the ER staff.

Methods

Three local hospitals (Sisters of Perpetual Trauma, Anytown Community Hospital, Rekcuf Healthcare Systems) were recruited to partake in this two-year study. Per HIPPO protocol, all patient identifying information was gathered and maintained in a deidentified manner in order to facilitate the confidentiality of all study participants except for Rose Kay Gordon, 852 Bedford Street #D, Chicago, IL 60609, who was a real bitch (hey Rosey…don't even THINK of suing us…we know all about your thing with the barbershop quartet, your involvement in that little "incident" with Shure-Bet Capitol Ventures, and that totally disgusting rash on your you-know-what).

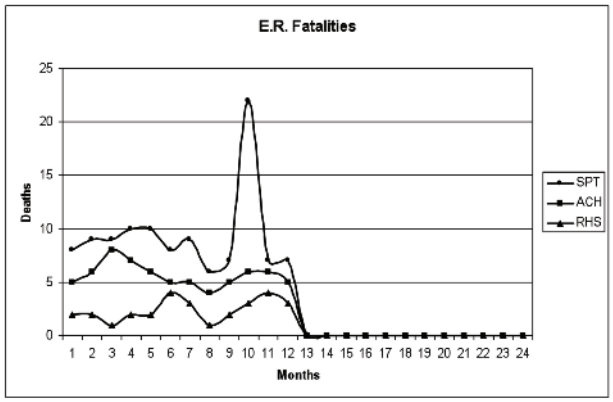
Chart audits were conducted to calculate total ER deaths at each facility. These numbers were validated by concurrent counts of body bags at each site, producing a significantly interesting aggregated correlation (r=.71, p= .4077). Year 1 (months 1-12) constituted the experimental year, wherein patients were tended to in the traditional manner with mean wait times allocated as such: Triage 1 =7 hours, Triage 2 = 23.75 hours, Triage 3 = 9.5 hours; these durations were quadrupled on holidays, weekends, and Wednesdays. Year 2 (months 13-24) constituted the control year, wherein the three ERs were concurrently closed.

Results

During the baseline year, ER fatalities were virtually out of control, with an aggregate mean of 5.08 deaths per month (SD = 3.93) across the three facilities ranging from 1 death in months 3 and 8 at Rekcuf Healthcare Systems to 22 deaths in month 10 at Sisters of Perpetual Trauma. The anomalous spike of 22 deaths in that month unexpectedly exceeded the quota of 8 deaths by 14. Critical chart audits matched 13 of these individuals to the 13 bewildered people who attended the Vera Hruba Ralston movie marathon; the 14th victim was identified as the projectionist. Death certificates of these 14 losers reveal the cause of death to be acute cinematic induced boredom. Autopsy findings reveal that all 14 expired during reel one of the first film. These patients were pronounced dead in the theatre lobby, and then again in the waiting room of the hospital when they failed to approach the triage nurse when their number was called.

Virtually regardless of variability of fatality rates observed during the baseline year across the three sites, at the onset of the intervention (month 13), ER fatalities dropped fairly steadily by 100% ($p < .0001$), suggesting the effectiveness of such closures as a reliable method for radically reducing ER fatalities. The intervention and corresponding statistics was successfully sustainable throughout the remaining 11 months of the intervention year wherein a consistent monthly fatality mean of 0.00 (SD = 0.00) was observed (see Figure 1, Table 1, then Figure 1 again).

Figure 1 – A Pretty Picture Depicting ER



Fatalities Before and After Closure

Hospital	Year 1 (ERs Open)		Year 2 (ERs Close)		%	p
	Mean	SD	Mean	SD		
Sisters of Perp. Trauma	9.33	4.19	0.00	0.00	-100%	< .0001
Anytown Comm. Hosp.	5.66	1.07	0.00	0.00	-100%	< .0001
Rekcuf Healthcare Syst.	2.41	0.99	0.00	0.00	-100%	< .0001
Total	5.80	3.93	0.00	0.00	-300%	< .0003

Table 1 – ER Fatalities Before and After Closure

Conclusions

The findings of this pilot study clearly provided support for our hypothesis that closing ERs leads to a substantial reduction in fatalities in those facilities, and vice versa. In light of emerging healthcare reform, this model should be considered a valuable intervention in terms of managing healthcare cost savings, convenience to healthcare professionals, and easing the undue hardship on insurance companies.

The observed results of this innovative pilot study will provide the basis for expanding this model to test the reproducibility of these results in the closures of other sites notorious for inordinately high fatality rates such as urgent cares, ICUs, CCUs, surgical centers, and Vera Hruba Ralston film festivals.

References

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GCEP Legislative Day 2011

Matthew Watson, MD

Matt Watson, MD, FACEP
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A partner in Northside Emergency Associates, Dr. Watson graduated from Jefferson Medical College, and completed his Emergency Medicine Residency at Geisinger Medical Center in Danville, PA.

The Georgia College of Emergency Physicians had another exciting and educational Legislative Day 2011. Getting the membership at large involved in the activities of our legislators is key in developing relationships that we can count on when the time comes to truly negotiate and advocate for the interests of our patients. There was a great deal of involvement from not only our membership, but also the representatives and senators as well.

Our day started with time to visit with our wonderful sponsors, who continue to see the value and importance not only in helping us provide these opportunities to the members, but they also get to experience the activities as well. Our vendors were involved in discussions with the members about how the specific legislative issues impact the doctors, the patients, and of course, their specific interaction point with the health care community.

I would like to take the time to personally thank the continued support from MAG, MMP, MedData, ApolloMD, TEAMHealth, as well as support from GlaxoSmithKline and IrriMax.

Members were then briefed on the current issues that were "on the hill" that day, and for the session. We had an update from our GeorgiaLink liaison, Trip Martin, who filled us in on the issues regarding trauma care funding, pharmacy tracking, balance billing, as well as a review of the potential for tort reform challengers to rear their heads (which didn't happen!). Other tope legislative issues included the prompt pay bill, and changes in the child safety restraint ages for motor vehicles.

Our visit across the street to the gold dome was well coordinated, and efficient this year. Most everyone got to meet their representative, and introduce themselves, and make their availability known to the senators and representatives. We need to realize that the opportunity for information exchange between us and our elected officials is a two way street. Often times we have as much to offer them in the way of opinions, or even just factual information about "how things are done" in health care, so that they can be making informed decisions when they decide to vote on a particular bill. But we also can be advocates for our patients and our selves, by making the legislators aware of how we would like them to act on the bills that are being voted upon.

This led to the luncheon, where over 20 legislators joined us, and took the time to update us on the issues that they feel are important to them, and to our specialty. We heard from the various elected legislators, who in their "real lives" are pharmacists, nurses, lawyers, and businessmen. All were very supportive of the unique situations that we practice in, and nearly all of them have been either a patient or a family member of a patient at one time or another. By making our specialty real, it helps them to hear us and put a feeling or emotion with the issues we raise.

As always, we would encourage all of you to contact your elected congressperson, and invite them to your ER, or go and visit them in their district office. Ask them what you can do to help them, and let them know that you are out there providing care for their voting constituents. And feel free to contact GCEP if you need more information about advocacy, or if you want to get more involved with the chapter.

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GCEP Medical Directors and Leadership Conference

Robert M. Risch, MD, MBA, FACEP

On March 8, 2011 the Georgia College of Emergency Physicians sponsored the inaugural Georgia's Medical Directors and Leadership at the Ritz Carlton, Reynolds Plantation in Oconee Georgia. The purpose of this meeting was to engage the emergency medicine leadership in the state in the following:

- To create a forum for the ED leadership in Georgia
- To provide leadership education for ED leaders
- To discuss legislative priorities in Georgia

The meeting was structured in two parts, First Dr. Pascal Crosley led a discussion on leadership issues. This was followed by a discussion of psychiatric care difficulties and reimbursement issues led by Rob Cox, GCEP President, and Chip Pettigrew. They discussed the Georgia Regional Hospital problems and issues with balance billing and fair payment.

The second half of the meeting our guest speakers Mr. Greg Hawkins, an assistant to the Insurance Commissioner, and Dr. Frank Shelp the Commissioner of Behavioral Service. Those in attendance were able to directly speak with these gentlemen to discuss our issues. The discussion was lively and of obvious significant impact on how we care for our patients in Georgia.

We will be hosting a Medical Directors and Leadership Happy Hour on Thursday night, June 9th, 2011 just prior to the GCEP Summer meeting in Hilton Head. For more information please go to the GCEP web site at GCEP.org. Planning for the next meeting is under way, but planned for December 2011. If you are in emergency medicine leadership and would like to attend please contact Tara Morrison, tara@theassociationcompany.com.

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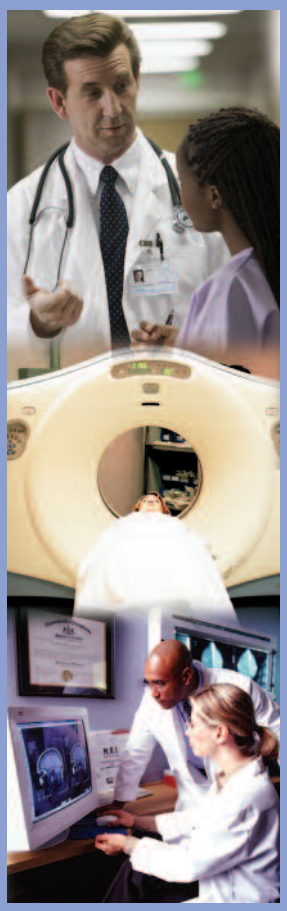

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