EPIC

THE MAGAZINE OF THE GEORGIA COLLEGE OF EMERGENCY PHYSICIANS

In this issue...

Peach State Legislative Update

Governor Brian Kemp has completed the 2025 legislative session by signing a series of significant bills into law, addressing a wide range of issues.

In the healthcare realm, passing tort reform was a huge win for the state of Georgia. Keep in mind that we will need to continue to push forward on the message of how important tort reform is to healthcare as a whole. Additionally, tort reform should have a long-term positive impact on all businesses across the state.

The Passage Of Tort Reform

Procedural Changes Related to Medicine:
Georgia is one of the few states that requires a motion to dismiss to be filed at the same time a defendant's answer is due, 30 days after a complaint is served.

- Plaintiff attorneys are using the flaw in current code to create leverage unfair advantages at the initiation of litigation. The trend being seen currently is that attorneys will file complaints containing hundreds of pages or more in addition to multiple affidavits, and often against multiple defendants. Additionally, they have also had many months to prepare the complaint. The defense has 30 days to respond and concur.
- If any of the claims could be dismissed, they have to determine that and write those motions in additions to responding to every factual allegation. This creates tremendous burdens on time and on cost.
- Frequently, responses require significant hours to respond to effectively burning physicians time, taking them away from clinic, and costing tens of thousands of dollars within the first thirty days.

Specific changes to the tort laws include the following:

Anchoring:
Med-mal cases are complex and often involve medically fragile plaintiffs, there is a significant amount of sympathy built in already and the jury understands that. The medical costs are typically very high given the average resolution of claim vs. a physician is $636k. Introducing values regarding pain and suffering tends to create an unfair bias in mind of jury.

Trial Bifurcation:
Highly complex cases that require extensive testimony of experts both to causation and damages. If liability and damages are together in a case, it is far too easy for a jury to focus on those damages to the detriment of determining whether there was a failure of the standard of care.

Truth in Damages (Phantom Damages):
As it stands currently, medical bills relied upon regarding medical treatment are almost always highly inflated. If the goal of the jury is to make a plaintiff whole, the actual out of pocket costs should be considered and not inflated bills that create a windfall for plaintiff and attorney. The secondary effect is inflated bills lead to an unfair increase of non-economic damages as juries are well known to determine non-economic damages by factoring the special damages (in the absence of anchoring).

Double Recovery of Fees:
Complex litigation creates opportunities for penalties in the form of fees to arise. The consistency of filings can create opportunities strategically for unforced errors. Additionally, problems like the mirror image rule in responding to settlements and demands can unfairly create an opportunity to tax costs.

If a plaintiff is successful, then the cost award can be the sum of the contingency fee. The lawyers will also take their fee from the client's award as well.

Signed Key Healthcare Legislation - House

- HB 89 – Representative Sharon Cooper: Allows the Maternal Mortality Review Committee to review psychiatric records, creates a Regional Perinatal Center (RPC) advisory committee, and removes the requirement for maternal death inquiries to be done through an RPC.

- HB 94 – Representative Eddie Lumsden: Requires all health benefit policies (excluding those executed by the state and ERISA plans) provide coverage for standard fertility preservation services when a medically necessary treatment may cause infertility.

- HB 144 - Representative Mark Newton: Amends the state's income tax code to enhance incentives for medical and dental education.

- HB 196 – Representative Trey Kelley: Enhances reimbursement practices for pharmacies participating in the State Health Benefit Plan (SHBP). The legislation addresses concerns that independent and rural pharmacies were being underpaid due to outdated reimbursement models favoring large chain pharmacies.

- HB 197 – Representative Lee Hawkins: Strengthens the peer-to-peer review process between healthcare providers and private review agents or utilization review entities. The bill seeks to ensure that healthcare providers make a concerted effort to respond to inquiries regarding the necessity of medical treatments.

- HB 235 - Representative Rick Townsend: Mandates that public school and postsecondary institutions provide paid leave to educators donating bone marrow or organs.This policy aims to support living organ and tissue donation among the state's education workforce.

- HB 238 - Representative Eddie Lumsden: Mandates the creation of a specialized training course for law enforcement officers when responding to individuals with Alzheimer's disease or other forms of dementia.

- HB 327 - Representative Rob Leverett: Amends multiple titles of the Official Code of Georgia Annotated (O.C.G.A.) to modernize and streamline laws related to trusts, estates, probate, guardianship, and family law.

- HB 348 - Representative Bruce Williamson: Aims to modernize and expand the operational scope of captive insurance companies and limited purpose subsidiaries within Georgia.

- HB 352 – Representative Devan Seabaugh: Expands Medicaid coverage in Georgia to include continuous glucose monitors (CGMs) for individuals diagnosed with gestational diabetes.

- HB 422 – Representative Derrick McCollum: Amends the State Health Benefit Plan (SHBP) to include high-deductible health plans (HDHPs) paired with health savings accounts (HSAs).

- HB 428 – Representative Lehman Franklin: Defines and codifies an individual's right to in vitro fertilization.

- HB 473 – Representative Ron Stephens: Adds a list of drugs to the dangerous drug code section, adds certain drugs to the schedule I controlled substance code section, and safeguards access to new drugs approved by the Food and Drug Administration.

- HB 567 - Representative Katie Dempsey: Establishes a comprehensive framework for teledentistry in Georgia.

- HB 584 – Representative Jesse Petrea: Transfers oversight of drug abuse treatment and education programs, narcotic treatment programs, community living arrangements, and adult residential mental health programs from DCH to the Department of Behavioral Health and Developmental Disabilities.

- HB 645 – Representative John LaHood: Amends the state's health regulations by repealing certain provisions that required COVID-19 testing for staff members in long-term care facilities.

Signed Key Healthcare Legislation - Senate

- SB 5 – Senator Kay Kirkpatrick: Mandates that health insurers implement a program allowing for the selective reduction or elimination of prior authorization requirements. SB 5 also includes providing coverage for healthcare services related to Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS).

- SB 6 – Senator Kay Kirkpatrick: Authorizes the use of testing equipment to determine whether a controlled substance has been adulterated.

- SB 36 – Senator Ed Setzler: Strengthens protections for the free exercise of religion by imposing a "compelling interest" test for government actions that may burden religious practices.

- SB 55 – Senator Billy Hickman: Aids those with disabilities in the workforce and brings our state into compliance with federal minimum wage laws for these Georgians.

- SB 58 - Senator John Albers: Enhances the efficiency and safety of organ transportation within the state.

- SB 72 – Senator Matt Brass: Expands access to individualized investigational treatments for patients with life-threatening or severely debilitating illnesses, including rare diseases and certain cancers.

- SB 79 – Senator Russ Goodman: Combats the growing fentanyl crisis in Georgia by establishing stricter penalties for offenses related to fentanyl and its analogs.

- SB 96 – Senator Drew Echols: Aims to modernize and update provisions in the Official Code of Georgia Annotated related to the creation and maintenance of various governmental bodies, including boards, panels, authorities, centers, commissions, committees, councils, task forces, and other similar entities.

- SB 100 - Senator Randy Robertson: Allows adult adoptees in Georgia to access their original, unaltered birth certificates.

- SB 101 - Senator Randy Robertson: Mandates the inclusion of Duchenne muscular dystrophy (DMD) testing in Georgia's newborn screening system.

- SB 111 - Senator John Albers: Defines responsibilities of businesses handling personal data and to outline the rights of consumers regarding their personal information.

- SB 130 – Senator Mike Hodges: Addresses the shortage of healthcare professionals in underserved areas of Georgia by expanding medical education funding and revising the service-cancelable loan program.

- SB 140 – Senator Greg Dolezal: Amends the state's optometry regulations. The bill authorizes licensed optometrists to dispense and sell non-controlled pharmaceutical agents related to the treatment of eye diseases and conditions, provided certain conditions are met.

- SB 233 – Senator Matt Brass: Enhances Georgia's behavioral health system by restructuring the commission responsible for overseeing it.

- SB 276 – Senator Drew Echols: Addresses the state's Medicaid program by revising provisions related to the recovery of medical assistance from third-party payers. The bill aims to align state law with federal requirements and improve the efficiency of the Medicaid reimbursement process.

These legislative actions reflect Georgia's commitment to improving healthcare access and equity, particularly in reproductive health, maternal care, mental health, and substance use services. The establishment of a state-based insurance market and support for clinical trial participants further demonstrate efforts to enhance healthcare delivery and affordability for Georgians.

House Study Committees Announced

Speaker Jon Burns has officially announced the appointments to the 2025 House Study Committees.

- **Blue-Ribbon Study Committee on Insurance Rates:** The Blue-Ribbon Study Committee on Insurance Rates will conduct a thorough examination of the insurance industry's rate-setting practices, profit margins, claims processing and regulatory compliance to ensure that Georgia's businesses, citizens and consumers are not being subjected to unjustified rate hikes.

- **Rep. Matt Reeves – Chairman**
- **Rep. Eddie Lumsden – Vice Chairman**
- **Rep. Shaw Blackmon**
- **Rep. James Burchett**
- **Rep. Noel Williams, Jr.**
- **Rep. Todd Jones**
- **Rep. Emory Dunahoo**
- **Rep. Michelle Au**
- **Rep. Bruce Williamson**
- **Rep. Trey Kelley**
- **Rep. Carolyn Hugley**
- **Rep. Jaclyn Ford**
- **Rep. Karen Mathiak**
- **Rep. Chuck Efstration**
- **Rep. Joseph Gullett**

- **House Study Committee on Cancer Care Access:** This study committee will study the lack of access to quality cancer care and the need to evaluate and make recommendations for such care.

- **Rep. Lee Hawkins – Chairman**
- **Rep. Gerald Greene**
- **Rep. Karen Mathiak**
- **Rep. Deborah Silcox**
- **Rep. Jasmine Clark**

Non-Legislative Members:
Two Georgia Medical School Representatives:
Dr. Jorge Cortes (Director, Georgia Cancer Center - Augusta University Health)
Dr. Suresh Ramalingam (Director, Winship Cancer Institute)

One Primary Care Physician:
Dr. Chris Kiker (Physician - Northeast Georgia Physicians)

One Community Oncologist:
Kristin Higgins (Chief Clinical Officer at City of Hope)

One FQHC:
Jennie Wren Denmark (East Georgia Health Care)

- **House Study Committee on Evaluating Funding for Public Health:** This study committee will study how Georgia's public health system is structured and funded and evaluate what services such system currently provides to determine whether action by the state is necessary.

- **Rep. Darlene Taylor – Chair**
- **Rep. Matt Hatchett**
- **Rep. Butch Parrish**
- **Rep. Dexter Sharper**
- **Rep. Angie O'Steen**

- **House Study Committee on Improving Access to Internal Medicine in Underserved Areas:** This study committee will evaluate the most prudent and cost-effective ways to increase access to internal medicine in rural Georgia communities, with particular focus on those rural communities experiencing health transportation shortages.

- **Rep. Sandy Donatucci – Chair**
- **Rep. Angie O'Steen**
- **Rep. Leesa Hagan**
- **Rep. Carmen Rice**
- **Rep. Gary Richardson**

Non-Legislative Members:
Dr. Jean Sumner (Mercer)
Dr. John Odum (MCG - AU)
Dr. Angela Gerguis (GSU)

- **Blue-Ribbon Study Committee on Georgia's Medical Marijuana Policies:** The Blue-Ribbon Study Committee on Georgia's Medical Marijuana and Hemp Policies will study and evaluate Georgia's current laws, policies and procedures surrounding medical marijuana and other cannabis-derived drugs and hemp products to ensure that there is a level playing field that protects Georgia's families and consumers alike.

- **Rep. Mark Newton – Chairman**
- **Rep. Jordan Ridley**
- **Rep. Robert Dickey**
- **Rep. David Clark**
- **Rep. Alan Powell**
- **Rep. Spencer Frye**
- **Rep. Al Williams**
- **Rep. Michael Smith**
- **Rep. Brent Cox**

Non-Legislative Members:
Robyn Fowler
Wesley Dunn

- **House Study Committee on the Costs & Effects of Smoking:** This study committee will examine the cost of smoking, including short-term and long-term health care costs, the impact on Medicaid and Medicare, childhood health costs resulting from secondhand smoke exposure and the loss of worker productivity attributed to smoking.

- **Rep. Sharon Cooper – Chair**
- **Rep. Michelle Au – Vice Chair**
- **Rep. Lee Hawkins**
- **Rep. Ron Stephens**
- **Rep. Debbie Buckner**

- **House Study Committee on Abandoned Child Placement Following Hospital Discharge:** This study committee will provide gap analysis of community services and resources provided by the public, nonprofit and private sectors to better support minors being discharged from psychiatric hospitalization and acute hospital emergency rooms.

- **Rep. Katie Dempsey – Chair**
- **Rep. Sharon Cooper**
- **Rep. Lee Hawkins**
- **Rep. Omari Crawford**
- **Rep. Mike Cameron**

- **House Study Committee on Affordability & Accessibility of Georgia's Legitimation Process:** This study committee will study whether the legitimation process in Georgia may be improved in a way that yields it more affordable and accessible, particularly for those biological fathers with limited financial resources.

- **Rep. Carter Barrett – Chairman**
- **Rep. Teddy Reese – Vice Chairman**
- **Rep. Lynn Heffner**
- **Rep. Rob Clifton**
- **Rep. Vance Smith**

- **House Study Committee on Reinsurance for Essential Industries:** This study committee will examine the cost of the property and casualty reinsurance market and conditions necessary for public-private partnerships in Georgia's commercial property and casualty reinsurance market.

- **Rep. Darlene Taylor – Co-Chair**
- **Rep. Noel Williams, Jr. – Co-Chair**
- **Rep. Demetrius Douglas**
- **Rep. Carolyn Hugley**
- **Rep. Matthew Gambill**

To view the full press release, click HERE.

Friday Weekly Updates

Be sure to mark your calendars as we will be sending out weekly legislative updates on Friday's.

To find any bill, go to **www.legis.ga.gov** and use the search box at the top left of the page. There is also an advanced search option that allows you to find bills by keyword or sponsor.

For legislative highlights and review, watch **Lawmakers**, which airs on Georgia Public Broadcasting at 7PM every night the Georgia General Assembly is in session.

LM LAWMAKERS

More information: Please reach out to our office at 770.435.5586 or reach out to us personally via our cell phones.

Travis Lindley - 404.886.5058
travis@capitolstrategy.us

Devin Krecl - 770.655.9545
devin@capitolstrategy.us

Alexus Thompson - 770.365.2740
alexus@capitolstrategy.us

A New Option for 1099 Side Income: Roth SEP IRAs

By Nolan Pendleton*

As a financial advisor who works exclusively with physicians, I'm always on the lookout for new ways to help doctors build long-term wealth. That's why I'm excited to share a new retirement savings option available since 2023: Roth SEP IRAs.

This new option could be especially beneficial for physicians who are primarily W-2 employees at a hospital or practice, but who also earn some additional 1099 income on the side. If that describes your situation, you'll want to pay close attention, as this could be a game-changer for your retirement planning strategy.

What's a Roth SEP IRA?
First, let's break down what this new account type means. SEP stands for Simplified Employee Pension, which is a type of retirement account designed for self-employed individuals or small business owners. Traditionally, SEP IRAs have only been available as traditional (pre-tax) accounts. The "Roth" designation means that contributions are made with after-tax dollars, but the growth and withdrawals in retirement are tax-free.[1]

Why This Matters for Physicians
Many of you are already maxing out your employer-sponsored retirement plans like 401(k)s, 403(b)s, or 457(b)s. But what about that extra income from moonlighting, consulting, or other 1099 work? That's where a Roth SEP IRA can come in handy. Instead of just putting that extra $10,000, $20,000, or $30,000 into a regular taxable brokerage account, you'll have the option to funnel it into a Roth SEP IRA. This means you can potentially save even more for retirement in a tax-advantaged account.

The Benefits of Going Roth
Why choose a Roth option over a traditional SEP IRA? Well, if you're already in a high tax bracket (as many physicians are) and have been max funding your pre-tax accounts, you may be looking for some strategies for tax diversification.[1]

A Roth SEP can turn into a great option if you make too much to contribute directly to a Roth IRA, have not been contributing to a backdoor Roth IRA, or run into the pro rata rules for funding a backdoor Roth. A "backdoor Roth IRA" is a strategy for high-income earners to contribute to a Roth IRA indirectly, even if their income exceeds the IRS limits for direct contributions. You'll pay taxes on the SEP Roth contributions now, but all that growth over the years will be tax-free when you withdraw it in retirement. Withdrawals of contributions to a Roth IRA can be tax-free, but withdrawals of Roth IRA earnings are tax free only if it has been 5 years since the account was first funded and you are over 59 ½.

Plus, unlike traditional IRAs or 401(k)s, Roth accounts don't have required minimum distributions (RMDs) during your lifetime. This gives you more flexibility in retirement planning and can be a powerful tool for leaving a tax-free inheritance to your heirs.

Flexibility in Timing
One of the great features of SEP IRAs, including this new Roth version, is the flexibility in contribution timing. Unlike some other retirement accounts that require contributions by December 31st, you can actually make SEP IRA contributions for a given tax year up until your tax filing deadline. If you file for an extension, that means you could potentially make contributions all the way up to October 15th of the following year.

This flexibility can be a huge advantage for physicians who might not know their exact 1099 income until after the end of the year.

Is a Roth SEP IRA Right for You?
While this option is exciting, it's important to remember that every physician's financial situation is unique. Whether a Roth SEP IRA makes sense for you depends on a variety of factors, including your current tax bracket, expected future tax rates, other retirement savings, and overall financial goals.

As always, I recommend speaking with a financial advisor who specializes in working with physicians before making any major changes to your retirement savings strategy. We can help you analyze your specific situation and determine if a Roth SEP IRA aligns with your long-term financial plans.

This option represents an exciting opportunity for many physicians to potentially boost their retirement savings in a tax-advantaged way. It's just one more tool in our toolkit to help you build the financial future you deserve after all your years of hard work and dedication to patient care.

If you're interested in learning more, we very much encourage you to ask your CPA or schedule a free 30-minute session with GenFi founding partner Ben Yin.*

---

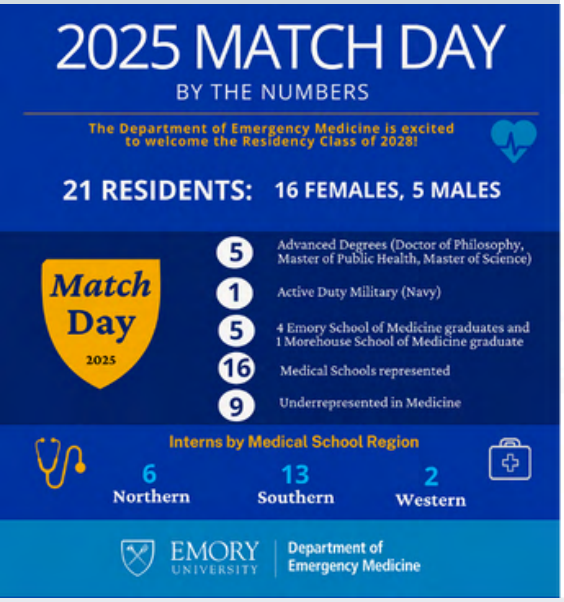
*Nolan Pendleton and Ben Yin are Financial Advisors offering investment advisory services through Eagle Strategies LLC. A registered Investment Adviser. Nolan Pendleton and Ben Yin are Registered Representatives offering securities through NYLIFE Securities LLC. Member FINRA/SIPC, a licensed Insurance Agency. Nolan Pendleton, 1143 2nd Avenue Unit A Columbus, Georgia 31901. Ben Yin, 3655 Brookside Parkway Suite 400, Alpharetta, GA 30022.

1. Neither Generational Financial Partners LLC, NYLIFE Securities LLC and its affiliates, nor its representatives, provides tax, legal, or accounting advice. Please consult your own tax, legal or accounting professionals before making any decisions.

Emory University School of Medicine
Department of Emergency Medicine

Residency and Fellowship News

The Emory EM team is excited to welcome the Class of 2028 in July. This will be the residency program's 51st class.



Congratulations to **Dr. Maurice Selby** (Mentoring and Uplifting Students in Emergency Medicine Program Leader) and the MUSE 4th year medical students:

- Lakendra Beard Morgan matched at the University of Miami Miller School of Medicine/Jackson Health System Emergency Medicine Residency Training Program
- Tori Gooden matched at Fort Worth Emergency Medicine Residency Training Program at John Peter Smith Hospital
- Hector Martinez will be joining our Emory Emergency Medicine Residency Training Program

The residency team competed in SAEM's annual Sonogames. **Drs. Shea Sparks, Duyen Vo, Luis Perez,** and their faculty captain **Dr. Jeffrey Downen** represented Emory EM. The games are a test of clinical knowledge, image interpretation, and technical skills. Eighty-eight teams competed this year and Emory made it to the final round of nine teams.

Congratulations to the new PGY3 resident directors:

- **Dr. Taylor Giller**: Resident Director of EMS
- **Dr. Jessica Kerstetter**: Resident Director of Recruitment
- **Dr. Luke McGrory**: Resident Director of Wellness
- **Dr. Luis Perez**: Resident Director of Ultrasound

Dr. Juhi Varshney, Medical Education Fellow, was a Clinical Pathologic Case Competition Runner Up at the Council of Residency Directors in Emergency Medicine's Academic Assembly 2025.

Distinctions

- **Dr. Tori Ehrhardt** was selected to join the ACMT Board of Directors as its Board Intern
- **Dr. Nicole Franks** is the Vice President of Clinical Outcomes Optimization for Emory Healthcare and the Interim Medical Director, Emergency Services, Emory University Hospital Midtown
- **Dr. Elizabeth Iledare** is the Medical Director for the Grady Urgent Care Center (UCC). She is also the Medical Director for Grady's Sickle Cell Acute Care Center
- **Dr. Brent Morgan** is now the Medical Director for the Georgia Poison Center
- **Dr. Katherine (Kate) Nugent** is the Medical Director for Emory Healthcare's Capacity Command Center. Kate will lead the development, operation and integration of clinical provider practice aligned with the CCC
- **Dr. Ziad Kazzi** is the 2025-2027 President for the American College of Medical Toxicology
- **Dr. Michelle Lall** is President for the Society for Academic Emergency Medicine
- **Alexis Lynch** received the Exceptional APP Award for the Emory at Grady campus
- **Dr. Alaina Steck** was recognized with the Distinguished Educator Award - Human Disease by the MD Class of 2027. The Student Curriculum Committee Foundations Faculty Awards celebrate outstanding faculty who have positively impacted medical education
- Georgia EMS Association Awards
  Dr. Arthur Yancey - Dr. John B. O'Neal, III EMS Lifetime Achievement Award
  Dr. Lekshmi Kumar - Charles B. Gillespie, MD, Distinguished Georgia E.M.S. Medical Director Award
- **Dr. Michael Zdradzinski** is Emory EM's Director for Educational Innovation and Growth. He will chair the Education Committee, and he is responsible for the departmental teaching missions including UME, GME, APP, and Faculty

Emory EM News

Emory EM's **Center for Advanced Emergency Care** will host the 2nd annual Frontiers in Advanced Emergency Care Conference on October 3, 2025 on the Georgia State campus. The conference will coincide with the 50th Anniversary Celebration weekend for the Emory EM Residency program. The medical toxicology fellowship is also celebrating their 25th anniversary.

Emory University Department of Emergency Medicine's Center for Advanced Emergency Care (CAEC) invites you to the second annual Frontiers in Advanced Emergency Care Conference. This one-day event will feature two focused tracks: Clinical Toxicology and Advanced Emergency Care. The conference offers a full day of in-depth, expert-led sessions and a keynote address providing valuable insights into the latest trends and innovations shaping the future of emergency care.

Registration will be opening soon; please fill-out the interest form for more information. If you have any questions, please email CAEC at caec@emory.edu. Stay up to date with the Center on LinkedIn and X.

Dr. Jericho Brown, Emory University Professor and acclaimed poet, came to residency conference for a special event with the Emory Surgery team on "How Language Impacts Patient Care in Acute Care and Trauma Settings."

The work of **Dr. Michael Carr** and the Prehospital and Ambulatory Virtual Emergency Services (PAVES) Program was highlighted in an Emory News Center story.

Dr. Tori Ehrhardt and **Dr. Emily Kiernan** presented a session on Medications for Opioid Use Disorder (MOUD) at the GCEP Annual Rural Medicine conference in Augusta. They were promoting the use of the Georgia Poison Center to support rural health care providers who need assistance treating patients with opioid use disorder. While at the conference, they taught an advanced airway skills lab and Dr. Kiernan gave a toxicology lecture.

Dr. Alex Isakov and Wade Miles from Emory CEPAR helped lead a training for HCID EMS in Alaska to build regional capacity for safe infectious disease transport.

Grants and Publications

Dr. Marta Rowh received an SAEM Foundation Research and Education Grant for "Identifying Sex-Based Cardiovascular Health Inequities in Medical Education using Natural Language Processing."

Dr. Daniel Wu received a $30,000 grant from the American Public Health Association in partnership with the Centers for Disease Control to support the Cardiff Model implementation in Albany, Georgia.

For the 4th year, **Jonathan Rupp, PhD**, and the **Injury Prevention Research Center at Emory** have been awarded a grant from the Georgia Governor's Office of Highway Safety to measure Georgia's rates of seat belt use and track distracted drivers.

Emory EM co-led the groundbreaking Early Minimally Invasive Removal of ICH (ENRICH) stroke trial. We now co-lead the REACH Trial & Registry. The Emergency Neurosciences Lab (ENL) spearheads the research on the Emory at Grady campus. Discover more about REACH in this Emory News Center story.

Hughes GB, Emeli I, Wheatley MA, Goyal A, Bryksin J, Moran TP, Keadey MT, Ross MA. **The Impact of a High Sensitivity Troponin HEART Pathway-Based Clinical Decision Protocol on Observation Visits.** Crit Pathw Cardiol. 2025 Mar 1;24(1):e0370. doi: 10.1097/HPC.0000000000000370. Epub 2025 Feb 21. PMID: 38968333.

Dr. Iyesatta Emeli contributed to the AI First Opinion Podcast by STAT News, in an episode titled "The Doctor is in. So is AI." They explored the intersection of artificial intelligence and emergency medicine — where innovation meets the frontlines of care.is shaping clinical decision-making, what it means for patient care, and why human insight still matters most.

The 2024 Cardiac Arrest Registry to Enhance Survival Annual Report is available for review. CARES also has a new video detailing their work: CARES: A Life-Saving Mission." Please watch and share the video widely to help raise awareness about the program and the impactful work.

Summer Daze and Chlorine Haze: Chemical Plant Fires, Swimming Pools, and Summer Cleaning

Tyler Lopachin, MD; Emily Kiernan, DO, FAACT, FACEP

Around 0500 on 29 September 2024, a warehouse storing bulk swimming pool chemicals at the Bio-Lab, Inc. facility in Convyers, Georgia was destroyed. Due to suspected storage issues (the investigation is ongoing), certain chemicals began to degrade. This ultimately ended in unwanted chemical reactions and a fire that burned for almost two hours releasing chemicals, like chlorine, into the air, and prompting evacuation and shelter-in-place orders for the surrounding areas (1).

Among the chemicals stored at the Bio-Lab facility, trichloroisocyanuric acid (TCCA) and sodium dichloroisocyanurate (DCCA), were two of the suspected culprits. TCCA and DCCA are stabilized chlorine products that are used to "shock-treat" pools to keep them disinfected from bacteria and algae. They are strong oxidizers that react with water to release chlorine gas (Cl_2) and hydrogen chloride (HCl) but can also release these gases as they decompose. They are also highly reactive and can cause oxidation of organic substances, leading to combustion and fire. Proper storage of these chemicals is important for safety (2).

While Cl_2 gas released from the Bio-Lab incident makes headlines, each summer, Poison Centers (PC) answer calls from a similar exposure, swimming pools. From January 1, 2015, to December 31, 2022, PCs received 85,104 total exposures to chlorine and chloramine gas (3). Swimming pools become chlorinated by multiple mechanisms. Commonly, pools will use a solution of sodium hypochlorite (NaOCl - yes, bleach!) in water, allowing for NaOCl to dissociate into sodium and hypochlorite (OCl^-) ions. An equilibrium is created between OCl^- and hypochlorous acid (HOCl) allowing for a chlorinated, disinfected, and safe summer swimming experience. Alternatively, some pools will utilized tanks of chlorine gas (Cl_2), which will generate the HOCl when mixed with water (2). When this balance is inadvertently disrupted, or there is an equipment malfunction, chlorine gas can be released at a local swimming pool, leading to an influx of Emergency Department visits, reminiscent of a chlorine-filled World War I battlefield (4). Regardless of how people are exposed to chlorine, the resultant clinical effects are the same.

Chlorine:
Chlorine is an irritant gas with intermediate solubility, meaning that it will dissolve fairly readily into the mucous membranes in our eyes, nose, and upper airways. Unlike the highly water-soluble agents that dissolve immediately, chlorine can be tolerated for longer, leading to longer exposure times. Exposure can cause upper respiratory symptoms (e.g., eye irritation, sore throat, coughing) at low concentrations (1-30 ppm). As the concentration increases, symptoms become more pronounced and clinically serious - including lower respiratory effects (e.g. tachypnea, wheezing, cyanosis, pulmonary edema) (5-6).

Chlorine vapors are heavier than air and will stay low to the ground and collect and in poorly ventilated, low-lying, or confined areas. This can worsen symptoms and increase the capacity of the gas to reach more people, particularly children (5).

The postulated mechanisms for airway injury due to chlorine inhalation is the hydration of Cl_2 leads to formation of HCl and HOCl (just like in a pool!). Both Cl_2 and HOCl react with the lining of the upper and lower airways. Reactive oxygen species (ROS) such as superoxide (O_2^-), hydrogen peroxide (H_2O_2), and potentially hydroxyl radical can be formed both via recruited neutrophils and secondary mitochondrial dysfunction. These ROS can contribute to further airway injury, edema, inflammation, immediate airway constriction, and persistent airway reactivity (2, 6).

Management Recommendations:

Patients should be removed from exposure immediately. Given the gaseous nature of Cl_2, secondary exposure to healthcare workers is rare. Decontamination is usually unnecessary, however, gas can become trapped in clothing or hair, so take care when evaluating someone directly from the scene of an incident (5). The mainstay of treatment revolves around symptomatic and supportive care. If a patient has dyspnea or hypoxemia, humidified supplemental oxygen can be given. Nebulized or inhaled bronchodilators, like $beta_2$agonists with ipratropium bromide can be given if the patient has evidence of wheezing or bronchoconstriction. These therapies can be continued and repeated as necessary for clinical improvement. Other therapies have been evaluated, including nebulized sodium bicarbonate, but have failed to showclinically significant improvement. This therapy is typically reserved for patients who have failed oxygen and bronchodilators (common preparation for nebulization: 1 mL of sodium bicarbonate (7.5% or 8.4%) in 3 mL sterile water). Other interventions, such as corticosteroids, have been used without clear benefit (7). The risk of delayed pulmonary toxicity is low so patients can be observed for 6-8 hours after exposure. If they remain asymptomatic, they can be discharged with outpatient follow up at a primary care physician for pulmonary monitoring long term.

Bonus:

Mixing HOCl (bleach!) with acid can also cause a release of chlorine gas. While most people are not intentionally creating this gas, mixing common household cleaning products (bleach) and acetic acid (vinegar) can lead to potentially deadly effects.

Conclusion:

The Bio-Lab fire, swimming pools, and summer cleaning are reminders that inadvertent disasters can happen at any time. As Emergency Department physicians, we need to understand the basic methods of identification, decontamination, management, and disposition for these scenarios. The acute respiratory effects of chlorine exposure are best managed with removal from exposure, symptomatic, and supportive care. The Georgia Poison Center is available 24-hours a day (1-800-222-1222) to assist in the management of these acutely poisoned patients.

References:

1. https://www.csb.gov/assets/1/6/investigation_update_bio-lab_final_nov2024_(005).pdf. Accessed June 6, 2025.
2. https://i2.wp.com/www.compoundchem.com/wp-content/uploads/2015/08/Chemistry-of-Swimming-Pools.png. , Accessed June 6, 2025.
3. Atalla A, Shulman J, Rose J, Lynch M. Trends in chlorine and chloramine gas exposures reported to United States poison centers. Clinical Toxicology. 2024 Sep 1;62(9):589-95.
4. https://www.theworldwar.org/learn/about-wwi/spotlight-first-usage-poison-gas. Accessed June 6, 2025.
5. https://www.cdc.gov/niosh/ershdb/emergencyresponsecard_29750024.html. Accessed June 6, 2025.
6. Nelson L, Odujebe O. Simple Asphyxiants and Pulmonary Irritants. In: Nelson L, Howland M, Lewin N, Smith S, Goldfrank L, Hoffman R, eds. Goldfrank's Toxicologic Emergencies. 11th ed. New York: McGraw Hill; 2019:1651-1662.
7. Huynh T, Despréaux T, Loeb T, Salomon J, Mégarbane B, Descatha A. Emergency management of chlorine gas exposure – a systematic review. Clin Toxicol (Phila). 2019;57(2):77-98. https://www.ncbi.nlm.nih.gov/pubmed/30672349.

Beat the Heat
A review of heat-related illnesses
by Thuy Bui, MD

CASE - Part 1:
You are volunteering at the Superhero Sprint - CHOA's summertime 5K race. A 12-year-old male running in his first race is brought to the medical tent by his mother. He is diaphoretic and vomiting. What are you concerned about?

BACKGROUND:
All heat-related deaths and illnesses are preventable. However, despite this fact, an average of 1,220 people die from extreme heat annually per the U.S. Centers for Disease Control and Prevention (CDC).

In 2023, the United States experienced record-breaking high temperatures, leading to a significant increase in heat-related illnesses and deaths. According to the CDC's Morbidity and Mortality Weekly Report, there was a substantial rise in emergency department visits for heat-related illnesses during the warm season months of 2023. From January 1 to December 31, 2023, there were a total of 119,605 ED visits for heat related illnesses - 92% of these visits occurred during May to September.

Children, because of multiple factors including their lower sweat rate and higher metabolic heat production, account for approximately 4% of heat-related deaths. In fact, heat stroke is the 3rd most common cause of exercise-related mortality for U.S. high school athletes. And according to the U.S. Department of Transportation, more than 970 children - over the past 25 years - have died of heat stroke because they were left or trapped in a hot vehicle.

DEFINITION:
Heat-related illness is a condition resulting from exposure to extreme heat where the body's thermoregulatory mechanism is disrupted and cannot properly cool, resulting in a rapid rise in body temperature.

During normal thermoregulation, the body loses heat through 4 mechanisms.

– Conduction (direct contact with cooler objects)
– Convection (cooler fluid/air passes over the skin)
– Radiation (transfer of heat to the environment via electromagnetic waves)
– Evaporation (transfer of heat via evaporation of sweat/saliva)

When ambient temperature is >35˚C, heat loss by radiation and convection ceases. When humidity is >75%, air is so saturated that sweat cannot evaporate. Therefore, unless some other method of cooling is introduced, some degree of heat illness will ensue. Taking into account the heat and humidity of Atlanta especially during the summer, it is imperative and potentially lifesaving to become familiar with the signs and symptoms of heat-related illness and how best to intervene when it is recognized.

CASE - Part 2:
You immediately recognize that this child is exhibiting signs of a heat related illness. He is given a salt-containing sports drink and moved to a corner of the medical tent where fans are blowing. Fifteen minutes later when you go check on him, he is no longer diaphoretic but now seems confused and more lethargic. What do you do?

HEAT CRAMPS:
Heat-related illness exists on a continuum with 3 main subcategories which are:

1. Head Cramps
2. Head Exhaustion
3. Heat Stroke

Heat cramps are usually benign. They occur as a result of salt losses causing brief but potentially severe muscle contractions. Thermoregulatory function remains intact, and the body's temperature remains normal. No work up is necessary. Treatment is rest - preferably in a cool, shady area and the encouragement of cold fluids and salty foods.

HEAT EXHAUSTION:
This usually occurs when there is mild to moderate thermoregulatory dysfunction. High ambient temperatures and/or strenuous exercise are usually the trigger causing dehydration and salt depletion. Signs and symptoms can include headache, dizziness, nausea/vomiting, diaphoresis, tachycardia, mild confusion but relatively normal mental status, weakness and potentially syncope. There can be a mild increase in body temperature but typically the temperature remains < 40˚C.

If mild, treatment is similar to the supportive care given for heat cramps. However, if symptoms are more severe, the patient may need intravenous hydration with saline containing fluids. Most symptoms should resolve after 2-3 hours of fluids and rest. No active cooling is usually needed, but patients should rest (no strenuous activity) with increased oral fluid intake for the next 24-48 hours.

If heat exhaustion is unrecognized and left untreated, it may progress to frank heat stroke which can be fatal.

HEAT STROKE:
With heat stroke, thermoregulatory mechanisms become overwhelmed and fail. Heat stroke is rapidly progressive and can be fatal. Patients present with extreme hyperthermia - body temperature >40˚C - and altered mental status. Associated systemic inflammatory response often leads to end organ damage.

There are typically 2 subtypes of heat stroke - exertional and classic. Exertional heat stroke occurs in young athletes exercising in elevated temperatures with high humidity for prolonged periods. This usually develops over a period of hours. Classic heat stroke usually occurs in patients who are more susceptible to dehydration (less efficient thermoregulation at baseline) including infants, young children, and the elderly. This typically is seen during heat waves and develops over a period of days.

A special subtype of heat stroke, however, has emerged and is becoming more prevalent. With more than 70% of heat stroke deaths occurring in children less than 2 years of age, approximately 30% of these deaths occurred when a child entered a hot location and could not escape on his own - the classic example being an infant left in a vehicle. Temperatures in motor vehicles can reach over 60˚C (140˚F) in only 40 minutes time. Sadly, an average of 37 kids die every year in vehicles because they were forgotten and left in the heat per the 2024 National Safety Council.

Patients having heat strokes will present with severe hyperthermia and altered mental status including hallucinations or psychosis progressing to seizures and potentially coma. These children often have hot, dry skin because their sweating mechanism has failed. They will be tachycardic, tachypneic and hypotensive. As end organ damage ensues, these patients will develop rhabdomyolysis, coagulopathies, pulmonary edema, and arrythmias - all of which often lead to death.

Management of heat stroke is aggressive support and active cooling. Start with your ABCs to ensure an intact airway and appropriate volume resuscitation. Simultaneously, start passive cooling - move the patient to a cool area and remove excess clothing. Early active cooling is also essential. In the pre-hospital setting, this includes external cooling methods such as immersing the patient in ice water, spraying tepid water on the skin and using fans to help with evaporative cooling, and applying ice packs to the body including areas with large blood vessels (the axilla, groin and neck).

In the hospital setting, internal cooling may be needed. This includes cooled IV fluids and internal cold-water lavages (gastric, bladder, rectal and potentially peritoneal and thoracic lavages). Evaluation in the hospital setting includes continuous core temperature and cardiorespiratory monitoring with labs to detect and treat reversible end organ damage. It is recommended to stop active cooling once the body temperature reaches 38.5˚C to prevent shivering which is counterproductive as it generates internal body heat and to help avoid hypothermia which may induce arrythmias.

Prognosis for heat stroke is directly related to duration of hyperthermia. Mortality ranges from 10-70% - greatest if treatment is delayed for more than 2 hours. Therefore, early detection and intervention is crucial in preventing heat stroke related mortality.

CASE - Part 3:
You astutely recognize that this child has progressed from heat exhaustion to heat stroke. You immediately call 911 for transport to the emergency department. While awaiting EMS arrival, you remove the child's excess clothing and immerse him in the medical tent's tub of ice. You ask the volunteer EMT to place an IV and immediately give the child a normal saline bolus. After transport arrives and upon the patient being loaded onto the ambulance, he is now more alert and taking some sips of his sports drink. The mother thanks you for taking such great care of her son. You are relieved that he is now recovering due to your early recognition and management of potentiallyfatal heat stroke. Strong work!

SUMMARY:
Heat-related illnesses are common but preventable. As healthcare experts, we are trained to recognize and treat these illnesses. However, a more important component of our job is to counsel our patients and families on strategies to prevent the development of heat-related illness.

Some recommendations include:

– Avoid being outdoor during the hottest hours of the day
– Schedule strenuous activities for cooler times of day
– Move practices indoor
– Ensure adequate water for activities < 1hr
– Consume fluids with glucose and electrolytes for activities >1 hr.
– Wear lightweight, light-colored, loose-fitting clothes
– Change clothes when they become sweat-saturated
– NEVER leave unattended children in cars for any period of time

These preventative measures, when paired with astute and early recognition of heat-related illness, can allow physicians in the ambulatory setting to avert much of the morbidity and mortality associated with extreme heat.

CME Questions:

1. Which of the following is NOT one of the body's normal thermoregulatory mechanisms to lose heat?
   a. Radiation
   b. Convection
   c. Condensation
   d. Conduction
   e. Evaporation

2. Active cooling is routinely used in the management of heat exhaustion.
   a. True
   b. False

Answers:
1. C (Condensation) - the other 4 are part of normal thermoregulation that helps the body lose heat to maintain homeostasis. Heat exhaustion and heat stroke occur when these mechanisms are disrupted or fail.

2. B (False) - active cooling (ice water immersion, cold water lavages) is a routine part of heat stroke management since it is potentially lifesaving. However, because there are risks involved, it is not routinely used for less severe heat exhaustion.

"What's Going on Down There?"
Managing Urology Emergencies in the Peds ED

Presented By:
ED Physician Community Outreach Group
Speaker:
Dr. Shuvro De
August 6, 2025
12:30pm - 1:30pm

~ Please join us via Webex using the link below~

https://choa123.webex.com/choa123/j.php?MTID=m1fd9b2b0ea3897276b0db85e5ea17d2e

Questions for the Q & A can be submitted in advance to: rhoneia.starks@choa.org

Children's Healthcare of Atlanta is accredited by the Medical Association of Georgia to provide continuing medical education for physicians.

Children's designates this live activity for a maximum of 1 AMA PRA Category 1 CreditTM . Physicians should claim only the credit commensurate with the extent of their participation in the activity.

2025 Summer MCG Update

Spring has brought many transitions here at Wellstar MCG. With the departure of our longstanding Chair Dr. Richard Schwartz, Vice Chair of Clinical Operations Dr. Steve Shiver has taken the helm as Interim Chair. Dr. Nick Musisca is handing Residency leadership over to Dr. JR Barrett. Dr. Barrett has been APD/AoPD for 6 years at MCG and is well versed in the duties and needs of our residency program. He is well loved by the current resident body and has the department's full support in the role. Dr. Barrett went to college for his undergraduate years at Johns Hopkins University, returned to Augusta for medical school at MCG and completed his residency in Emergency Medicine at the University of Pennsylvania. He is an Augusta native dedicated to the UME and GME success for our trainees. He will be supported by the continued efforts of Dr. Lizz Olson as APD and the steadfast expertise and dedication of Ms. Bridgette Beard who has been a bedrock presence in the residency over the tenure of three and soon to be four Program Directors.

We'd like to thank our outgoing Chief Residents Drs. Barber, Caviston, Fuller and Miccio for their service over the past year. They have been leaders amongst a very strong class of 2025, and we have no doubt they will be an asset to their future teams. We welcome the incoming chiefs Drs. Crawley, Dill, Mihalcin, and Weston. They have enormous shoes to fill, but we are confident they are up to the task.

We are thrilled for our graduating seniors and proudly share their post-graduation positions for next year:

Dr. Cooper Barber	Field Surgeon - Fort Stewart, Savannah, GA
Dr. John Beach	Emergency Medicine Physician - Fort Eisenhower
Dr. Benjamin Caviston	Flight Surgeon - Soto Cano Air Force Base, Honduras
Dr. Dung Dinh	Flight Surgeon - Egypt – MFO Sharm-El-Sheik
Dr. Nicole Fuller	PEM Fellowship - Wellstar Medical College of Georgia
Dr. Benjamin Gold	Sports Medicine Fellowship - Duke University
Dr. Kevin Hendrickson	Emergency Medicine Physician - Fort Drum, NY
Dr. Samuel Lyon	Emergency Medicine Physician - Fort Cavazos, TX
Dr. Brendan Miccio	EMS Fellowship - Wellstar Medical College of Georgia
Dr. Steven Nguyen	Flight Surgeon - Hunter Army Airfield, Savannah, GA
Dr. Chijoke Ohamadike	Piedmont Hospital – Augusta, GA
Dr. Christopher Rowley	Piedmont Hospital – Augusta, GA
Dr. Emily Serbinowski	Emergency Medicine Physician - Landstuhl, Germany
Dr. Aaron Walker	Medicine Physician - Camp Humphreys, Korea

We had a great showing at Coastal Emergency Medicine this June with the following presentations:
Dr. Nicole Fuller – New Chief Seminar Speaker – Interdisciplinary Collaboration
Dr. Ryan Hodgeman – New Chief Seminar Speaker – The PD Told Me To Do It
Dr. Dan McCollum – Literature Review
Dr. Joshua Mihalcin - Pecha Kucha Session: History of Military Medicine
Dr. Nick Musisca – New Chief Seminar Speaker – Who is a Chief Resident?

We look forward to welcoming the incoming class of 2028!
We look forward to welcoming new residents to our program. We have the incoming class of 2028 as well as incoming PGY2 Dr. Bryan Turner from Piedmont Macon, GA and PGY3 Dr. Bilal Tasneem from Garden City, MI.

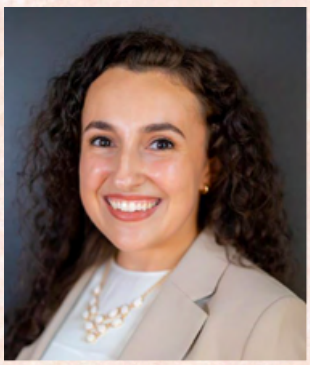
Nicholas J Musisca, MD FACEP
Residency Program Director
Associate Professor
Department of Emergency Medicine
Wellstar/Medical College of Georgia
Augusta University

Wellstar Kennestone Emergency Medicine Update

Welcoming new faces…

June marks an important time of transition for all residencies. Please join me welcoming the class of 2028. This promises to be another terrific group, many of whom are well known to us from their AI rotations last year. We are very proud of the group we have marched, and cannot wait for them to get started.

We are also welcoming two rising EM3s to fill out next year's group of graduates. Dr. Ariele Clay and Dr. Sumeja Aljic are both Gorgia natives who completed their first two years of training at the Piedmont Macon Emergency Medicine Residency Program. They were strong. Candidates for chief resident should their program have continued, and we are fortunate to have recruited them to join us at Kennestone.



...and celebrating the familiar

Our 2025 graduation is June 27 where we will recognize our outstanding EM3 class. Their contributions to the program and their service to our patients will not be forgotten. We will miss them all but are excited about the next steps in their careers.

Ultrasound Division Update

As we close out another academic year, we're proud to share that all our third-year residents will be graduating with their ultrasound requirements fully completed. We're confident they will carry their skills forward as outstanding additions to the emergency medicine workforce.

This quarter has also marked exciting progress in our ultrasound infrastructure. We've upgraded to new Mindray ultrasound systems and are preparing to launch Exo Works software, which will streamline our workflow and expand our educational capabilities.

Finally, we extend our heartfelt thanks to Kyle Embertson, MD, our ultrasound director, who has led the division for the past five years and will be relocating to Kentucky to be closer to family. We're grateful for his leadership and are excited to begin a new chapter with a transition in leadership and continued momentum in innovation and education.

Taking residency to the pre-hospital setting

Our program continues to innovate not only in the ED but in the pre-hospital environment where are EMS director Dr. Infanzon is improving community care on a daily basis. His leadership has provided multiple opportunities for our trainees to be involved in growing in building pre-hospital healthcare systems including Marietta Fire where Dr. Brian Goldstone serves as an assistant medical Director. Additionally, Dr. Paige Yeager provided event coverage at a local festival with Cobb fire. We are also involved with our residents in planning for coverage for the major-league baseball All-Star game this July and are participating in research with an industry partner for a novel, hemostatic agent that has been deployed in the field. These are truly unique opportunities that can only be found at Kennestone.

Residents saving lives in the field

Finally, I want to close with some examples of the incredible care our residents are providing. In addition to the tens of thousands of lives they impact every year, a few remarkable instances of truly cutting-edge management demonstrate their commitment to going above and beyond. Recently, Dr. Tatiana Peduri and Dr. Daniel Cha responded to a serious motorcycle collision with the Cobb Fire Medical Operations team. They assisted in administering prehospital blood products, airway management, and transition of care in the trauma bay. Our residents were involved in the care of this patient from just after the moment of injury through resuscitation in the trauma bay, cannulation on ECMO, and their care in the trauma ICU. Just recently, the patient was successfully discharged from the hospital, neurologically intact, and now begins the next stage of recovery and rehabilitation. What began as a traumatic arrest ended with ROSC and a chance at survival thanks in no small part to the efforts of our resident physicians.

And defeating poisons!

Toxicology Case of the Month: The Seeds of Seizure.

compliments of Dr. Jamil Williams

Case: A 69-year-old female with a past medical history of type 1 diabetes mellitus presented to the emergency department after being found unresponsive at home after a seizure. On arrival, the patient was mildly hypertensive and required intubation for airway protection.

Additional Details: The patient's husband, when questioned with an interpreter, reported that the patient had for the first time ingested approximately 10 Ginkgo biloba seeds earlier that day, which were steamed as per traditional preparation methods.

Discussion:

- Ginkgo biloba, derived from the Ginkgo tree (Ginkgo biloba), is primarily used as a herbal supplement for improving cognitive function, treating symptoms of anxiety and depression, and as an antioxidant. However this is consumed in the form of an extract/capsule of the tea leaves. It is generally non-toxic although there are many drug interactions to be aware of.
- The ingestion of raw Ginkgo biloba seeds, however, is unusual and is associated with toxic effects. The seeds, when improperly prepared or consumed in excess, contain ginkgotoxin (4'-O-methylpyridoxine), which is a neurotoxin that can cause seizures, particularly in individuals who consume large quantities.
- Mechanism: Ginkgo toxin acts as an antagonist at the pyridoxal phosphate binding site, interfering with pyridoxine (vitamin B6) metabolism, which is critical for the synthesis of neurotransmitters in the central nervous system. This leads to seizures by disrupting normal neuronal firing.

Patient Course:

- Toxicology consulted. Patient was given 2g of vitamin B6 for seizure prophylaxis and AMS and was admitted to the ICU
- She was given an additional 2g of vitamin B6 on day 2 of her hospital stay for continued altered mental status after extubating.
- During her ICU stay, she was placed on continuous EEG and had no repeat seizure-like activity
- She was extubated within 36 hours and was able to make a full recovery. She was discharged 5 days after admission.

The Kennestone team continues to do amazing things every day, and I am honored to be a part of the difference they make.

Ted Stettner, PD
Emergency Medicine Program Director
Kennestone Regional Medical Center
Associate Professor, Augusta University

Northeast Georgia Health System Update

GME Emergency Medicine Mass Casualty Incident

On Thursday, March 6th, the Center for Simulation and Innovation hosted our third Mass Casualty Incident (MCI) simulation, marking our largest exercise to date with the participation of all three residency groups. This year's simulation featured a simulated semi-truck explosion in the old emergency department, accompanied by organophosphate exposure that required decontamination efforts.

Thanks to the collaboration with our Emergency Preparedness Team, the hospital's decontamination tent was set up to practice decontaminating critically ill patients requiring immediate medical attention. In addition to the training at the main center, a separate group of residents was dispatched to the Hall County Fire Training Facility, where a second scene was staged. This scenario involved a multi-vehicle accident, where patients required prolonged extrication and on-site treatment before being transported back to the simulation lab for advanced care and further disposition.

Within the simulation center, two hospital environments were recreated: Gainesville Hospital with nine treatment rooms and Habersham Hospital with five treatment bays. To enhance the realism, resources and supplies were intentionally limited to help learners experience the logistical challenges of coordinating through an emergency operations center.

The event was designed to provide emergency medicine residents, frontline nurses, and chaplains with realistic training scenarios. We were once again fortunate to collaborate with local fire departments, EMS, and the Gainesville Police Department to enrich the experience.

Key training objectives included rapid triage and prioritization of patients based on injury severity, effective communication and teamwork across interdisciplinary teams, the implementation of treatment protocols, and coordination with external agencies to ensure efficient resource utilization and optimal patient care. This simulation served as a vital opportunity for physician residents to sharpen their readiness and response skills.

By simulating realistic emergency scenarios and fostering interdisciplinary collaboration, the exercise played a crucial role in strengthening our collective ability to manage MCIs effectively, minimizing their impact on patients and communities. Ongoing training and preparedness remain essential to ensuring the highest standard of care during unforeseen emergencies.

GEDS

GEORGIA EMERGENCY DEPARTMENT SERVICES

GME Emergency Medicine Sim Wars

SimWars is a competition where teams of healthcare professionals compete in simulated patient scenarios. The goal of the competition is to evaluate participants' teamwork, communication, and clinical management abilities in high-pressure, real-world-like situations. Emergency medicine residents participated in their first SimWars competition on February 6th, with all three classes of residents taking part. The competition included a variety of challenging scenarios: a critical GI bleed that required central venous catheter (CVC) placement and advanced cardiac life support (ACLS), a pediatric trauma scenario that involved intubation, resuscitation, and chest tube placement, and the final round, which focused on ACLS for a pregnant mother in need of a perimortem c-section and neonatal resuscitation (NRP) for the newborn. Eight countries, represented by resident teams, competed in three rounds of SimWars to determine the final winner. Each round presented different, high-stakes medical scenarios to test the residents' clinical skills, teamwork, and ability to manage complex emergencies.

1st Place: Germany: Ziad Faramand, Erin Jackson, Andy Shah
2nd Place: France: Brett Sell, Nikhil Patel, Brian Legvold, DJ Patton
3rd Place: USA: Seth Illu, Ukoha Kalu, Michael Tucker

Observation Medicine

Due to our robust volumes and efficiency we were asked to present at the 2025 Gulf States Hospital Medicine Conference. Laura Reed, MSN, FNP-C, EOU Lead APP presented the financial argument for a protocol-driven observation unit and the requirements for efficient staffing of the unit.

--

Jason Konzelmann, MD, FACEP
Observation Units Medical Director
Director of Administrative Division, Northeast Georgia EM Residency
Clinical Asst Professor, Dept of Emergency Medicine, MCG-Augusta
Georgia Emergency Department Services (GEDS)

ARE YOU INTERESTED IN JOINING A WOMEN IN EM COMMITTEE?

If you are interested, please click HERE and fill out the form

(takes less than 30 seconds)