Georgia College Of Emergency Physicians

EPIC

The Newsletter of the Georgia College of Emergency Physicians

Winter 2008

We welcome your comments or suggestions for future articles. Call or write at:

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www.gcep.org

Viewpoint from the President

by Maureen Olson, MD, FACEP

Maureen Olson, MD

Happy New Year! At each new year I find myself as I imagine most of you do reflecting on where I have been, where do I want to go, what has gone well and what changes I would like to make for the future. If you are reading the newspaper you would assume that weight loss and physical fitness were the top and only priority most of us have. If one takes that more metaphorically and extends that thought to losing the negative, pessimistic attitudes we've built up over the year which weigh us down and focus on improving our mental and spiritual fitness, we might actually accomplish more and adhere to our resolve longer. Strong, positive personal relationships, professional satisfaction and personal growth are essential elements in all of our lives that add richness to our everyday existence and make it possible for us to focus our attention on broader issues that may not only enhance our personal or professional situation, but contribute to the greater good of all mankind. I commend all of you for the sacrifices you make in your daily life to provide high quality care to the patients who present themselves to you for help.

As president of GCEP, I have the greatest pleasure of working with a very dynamic and energetic group of physicians who are trying to make a difference here in Georgia and nationally both for the patients and the working environment of the practicing emergency medicine physicians. There are many daunting problems that we continue to face. As we on the board continue to be vigilant about tort reform, Medicaid and

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GCEP Legislative Day

Robert Cox, MD, FACEP

The 2008 GCEP Legislative Day was a phenomenal success. Emergency medicine residents and fellows accompanied by their faculty, from the Medical College of Georgia and Emory University, joined forces with the GCEP Board and many community physician leaders to engage the General Assembly in advocacy for emergency medicine, our patients and the public. We had over 100 participants in the room for lunch and over 20 legislators came by to participate.

The morning started with an update of the current state of affairs of the capitol by our GeorgiaLink lobbyist, Trip Martin. We reviewed our list of legislative priorities and talking points (listed) and we've put the material on the web at www.GCEP.org for your review.

Although SB286, which aims to repeal the gross negligence provision of current law that pertains to emergency care, is still in committee, we are cautiously optimistic that it will not gain traction this session. Your legislative representatives will be monitor-

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Legislative: continued from page 1

Hank Siegelson, MD; Gerald Bortolazzo, MD; Ralph Griffiin, MD; GCEP Lobbyist Trip Martin

ing this closely. Matt Keadey, MD, FACEP presented his survey study results. In summary:

• SB3 has improved the medical malpractice climate for emergency physicians in Georgia, but many still feel that more time is needed to asses its impact.

• Many emergency physicians who once were considering leaving the state, retiring or changing to another specialty are now comfortable in their practice setting.

• PLI premium increases have stabilized and in some cases reductions are occurring.

• On call coverage does not currently appear to be affected and further study is needed on the lack of subspecialty care available in emergency departments across the state.

Jeff Linzer Sr., MD, FACEP reviewed with the group that although children make up 60% of the Medicaid population, their funding is low, accounting for only 29% of the state's Medicaid spending. Georgia Medicaid pays less than 80% of the Medicare reimbursement rate for over 1/3 of the most common pediatric services. Georgia certainly has room to improve regarding Medicaid reimbursement and Governor Perdue has proposed an increase in the Medicaid budget. Access to care is in jeopardy. Dr. Linzer intimated that since the incorporation of Medicaid managed care, the number of pediatric orthopedists in the Atlanta area that would accept Medicaid patients went from 8 to 1.

Emory representatives directly affected by the politics spoke about the importance of Grady to the state of Georgia. MCG representatives spoke about funding for an additional state medical school campus and we learned Mercer will be opening a new medical school campus in Savannah this year.

The visit to the capitol created excitement and intrigue with all the white-coated individuals walking around. Earl Grubbs, MD, FACEP, spent the most time there as the doctor-of-the-day in the MAG first aid station. Rumor has it; he treated someone with an acute inferior MI there with thrombolytics! (Just aspirin, but just as effective as any other available therapy prior to their angioplasty.)

During the afternoon session, we had a chance to dine with and engross the members of the General Assembly that came to fraternize. Many spoke about their perception of emergency medicine, either through policy making or personal experience. There were countless approbations for GCEP members who have made that special connection with their representative. It was clear that the General Assembly members enjoy hearing from their constituents and that our visits make a difference.

I want to thank our Chapter Executive, Tara Morrison, our GeorgiaLink powerbroker, Trip Martin, the GCEP Board, the academic and community physicians, our sponsors, and the legislators for making this day such an accomplishment. We want to see you next year!

Mike Hagues, DO, Stu Segerman, MD, and GCEP President-Elect & Legislative Chair Rob Cox, MD

Legislative Day sponsors:

Fougera – Rita Rodriquez, Sharon Smith

MMP/HBR – John Holstein, Jeff Fowler

MAG Mutual – Steve Davis

Marina Medical Billing Service – Erin Houck

Merck – Jane Hardwick

Merrill Lynch – Clint Carroll

TeamHealth – Steve McAlpine, MD, FACEP

2008 Legislative Priorities

• **Protect & Defend Civil Justice Reform** – Retain all elements of SB3 that was passed in 2005, specifically the provision regarding standard of proof for services in emergency settings.

• **Eliminate Crowding in Emergency Departments** – Educate state policy makers and DHS regarding true causes of ED crowding, consequences for patients, and effective evidence based solutions.

• Continue support for reasonable, equitable and timely **reimbursement** formulas for Georgia adult and child Medicaid patients.

• Support efforts to **develop and fund the statewide trauma network** – SB60 established the Georgia Trauma Commission to develop, administer and maintain a statewide trauma network. No funding mechanism was included in the bill.

• Participate in Governor Perdue's **Mental Health Service Delivery Commission** – Established to take a comprehensive look at Georgia's delivery of services to citizens who live with mental illnesses and substance abuse. Emergency departments are often the first contact with these citizens in crisis.

• Participate in the **Senate Joint State Stroke System Study Committee** to educate policymakers on evidence-based care standards for stroke patients.

• **Support passage of SB 86** which would require use of seat belts in trucks and result in fewer traffic fatalities and injuries statewide. Also, oppose any legislation that would repeal helmet laws.

Get involved!

GCEP is here to serve the emergency physicians and emergency patients of Georgia.

Ed Malcom Jr., MD & Senator Don Thomas, MD

• Partner with Georgia ENA to provide model language to Georgia Board of Nursing regarding emergency **nurses administering sedation drugs** in the presence of emergency physicians for procedural sedation.

• Maintain active participation and leadership on the Emergency Medical Services Medical Director's Advisory Council to the State Office of EMS and the Commissioner of Public Health.

Some of the Legislative Day Sponsors

Legislators who attended GCEP Legislative Day

Representative Kathy Ashe
Representative Katie Dempsey
Representative Pat Gardner
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Representative Penny Houston
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Representative Gene Maddox
Representative Dubose Porter
Representative Tom Rice
Representative Barbara Sims
Representative John Yates
Representative Sharon Cooper
Representative Steve Tumlin
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Senator Lee Hawkins
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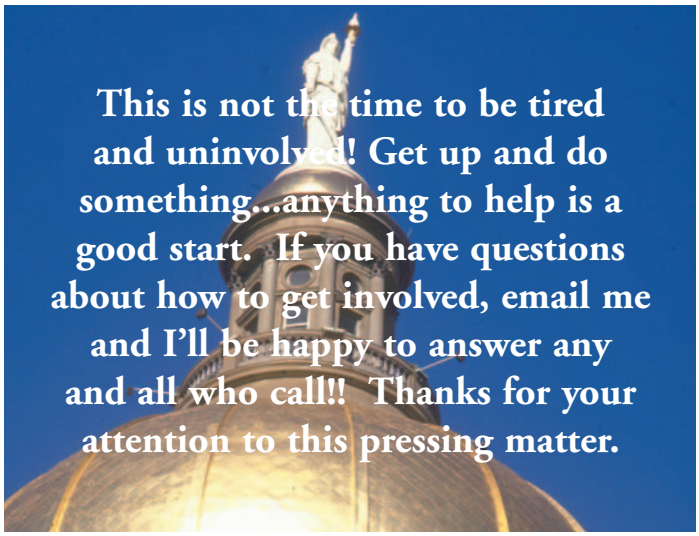
Senator Renee Unterman
Senator Michael Meyer von Bremen
Senator John Wiles
Senator Bill Jackson
Senator Judson Hill
Senator Don Thomas
Senator Dan Moody
Senator Nan Orrock
Senator Vincent Fort

From Your GEMPAC Chair

by Stu Segerman, MD, stuseg@bellsouth.net

The New Year finds Georgia emergency physicians facing a recurrent epidemic of "Tortitis," in the legislature. No, this isn't a mysterious cluster of viral infections affecting the unsuspecting public, but a "new" wave of lobbying from the legal profession to change the words of Senate Bill 3 (the landmark tort reform bill passed in 2005) from "gross negligence" to "simple negligence" in the definition of medical malpractice. I won't belabor the finer legal points of SB3, but suffice it to say that the aforementioned clause is **CRITICAL** to practitioners of emergency medicine (and all other specialties who see patients in the ED) in the state of Georgia. All the good things that have happened as a result of SB3—an increased number of medical malpractice insurance carriers in Georgia, an increase in residency graduates staying in state to practice, a stabilization and maybe a decrease in medical malpractice insurance rates in Georgia and a decrease in the number of specialists (especially surgical) refusing to take ED call—are at risk of reversal if this new wave of legal wrangling succeeds in changing our legislators' minds.



GEMPAC is the lobbying and fundraising cousin of the Georgia College of Emergency Physicians and is responsible for informing Georgia ED physicians of impending issues which affect our practice, either for the better or worse. We have been raising money to contribute to "friendly" legislators and to open the doors to neutral or unfriendly legislators so they may at least hear our side of the story in any given issue. For better or worse, that's the way politics works and we have to play along with all the other "interested parties" who do the same fundraising as us, except MORE!

GEMPAC is asking several important actions of all you reading this article:

1) Give as much money as you can or will to GEMPAC so we can do our job to help us all continue to practice emergency medicine in Georgia. Don't forget, the lawyers consider this giving to be the price of doing business and so should we!!

2) Come to GCEP Legislative Day (just had one on January 29, 2008) to learn about the issues which confront our profession.

3) Call or visit your legislators during the 2008 legislative session, to let them know that you are concerned about the possible changes to SB3 **OR** any other issues which affect your practice, ie. the lack of a cohesive trauma network in Georgia, poor if any Medicaid reimbursement causing an influx of uninsured or underinsured patients into your ED, and the paucity of specialists available to call when you have a sick patient who needs their care. You don't need to make a trip to Atlanta to contact these legislators. They all have local offices and aides who can take your information and pass it on to your representative/senator.

Viewpoint: continued from page 1

Medicare reimbursement issues, trauma network, and access to emergency care, to name a few, we are also turning our attention to providing some extra benefits to our membership. In addition, it is time for all of us to start putting our collective heads together and explore ideas for addressing the shortage of well trained emergency medicine physicians and consultants in small towns and rural Georgia. I know all of us have felt the frustration of the lack of on-call physicians. None of these are easy problems to tackle and none will have quick solutions, but many of you already have experience and suggestions that I hope you will share with us.

Check out the new GCEP website. It has a new look and should be easier to use and hopefully you will find the information posted useful. You will find a list of committees that we hope will trigger an interest for you to get involved. GCEP IS "YOU" AND CAN ONLY BE AS GOOD AND EFFECTIVE AS YOU ARE WILLING TO MAKE IT. Join us and add a new dimension to your life.

Emergency Medicine Residency at Emory

by Ben Holton, MD, Associate Residency Director

October through January is always a busy time of year in the residency calendar. October and early November are spent reviewing close to 850 applications. From this group of highly qualified applicants we must choose approximately 200 to whom we offer interviews. Late November through mid January is spent interviewing. Each year I am impressed by the quality of our applicants and am humbled by their many accomplishments. Although the whole process is tiring, I always come out of it with a new enthusiasm for the field of medicine that we practice, as the applicants remind me of all the reasons we went into it, and of the heroic things we accomplish in emergency medicine.

The high profile issue for us this fall has been Grady Memorial Hospital and its battle for the resources it needs to remain open. At this time the Grady Hospital Board has voted to pursue a change in governance to a non-profit board, and we are encouraged by this key first step. It is our hope that this step will be a springboard to increased support from the local business and philanthropic community, the counties of Fulton and Dekalb, and the State. We are also encouraged by the momentum that seems to be building for a state-wide trauma network, which would benefit Grady tremendously. We hope the outcome of this "crisis" is that Grady will have made an effective argument for its value to all citizens of the local community and the state as a whole, and that it will emerge with renewed support to serve even better.

The other big news for our Department is the appointment of Dr. Katherine Heilpern as the Ada Lee and Pete Correll Professor and Chair of Emergency Medicine. Dr. Heilpern served as interim chair after Dr. Kellermann stepped down to pursue his fellowship in health policy. We are very excited that after a national search she has been named the permanent chair.

Many of our faculty are serving in leadership roles in organized emergency medicine. Dr. Heilpern, in addition to her new role as department chair, is the president-elect of SAEM. Leon Haley and Deb Houry are on the Board of Directors for SAEM. Philip Shayne, residency director, is the treasurer of CORD (Council of Residency Directors).

Spring promises to be a busy time. We will continue to advocate for Grady as events progress. We look forward to the upcoming residency match, and we will be preparing another class of graduating residents to enter "the real world." We will also be working overtime to prepare our residents to soundly defeat the teams from MCG and the community docs at Jeopardy at the next GCEP meeting in Hilton Head.

Katherine Heilpern Named Chair of Department of Emergency Medicine at Emory

Dr. Heilpern has served as interim chair for the past year during the absence of Arthur Kellermann, MD, who has been serving as Robert Wood Johnson Health Policy Fellow for 2006-2007 in Washington, DC. Dr. Kellermann was recently named associate dean for public policy, Emory School of Medicine.

Dr. Heilpern received her undergraduate degree from the University of Virginia, and her medical degree from Emory School of Medicine. She completed her postgraduate training in internal medicine at Temple School of Medicine, and received board certification in internal medicine and emergency medicine. After residency training, she served as a medical officer for the Indian Health Service and was stationed on the Navajo reservation.

Dr. Heilpern returned to Emory in 1996. She has served as assistant dean of medical education and student affairs, and vice chair for academic affairs in the Department of Emergency Medicine. She is a recipient of the American College of Emergency Physicians National Faculty Teaching Award and the Emory Dean's Teaching Award. Dr. Heilpern serves as a member of the American College of Emergency Physicians Academic Leader Program and is a board member of the Society for Academic Emergency Medicine.

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Emergency Medicine Residency at MCG

by Larry B. Mellick, MD, MS, FAAP, FACEP, Emergency Medicine Residency Program Director

The emergency medicine residency at MCG has had a few milestones and many exciting things have happened since the last *EPIC* article was written. Highlights of events going on at MCG are provided below.

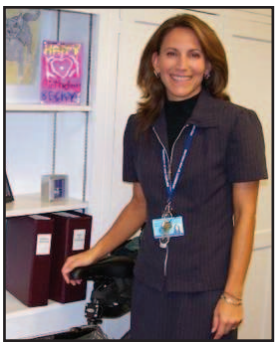
US Army Residents: Up until now the United States Army has had only three training programs for emergency medicine – Madigan Army Medical Center, Brooke Army Medical Center, and Fort Hood Army Medical Center. And now, MCG will be a fourth training venue. Beginning July 2008 we will have our first military resident. The next year we will be training four military residents.

Academics: In July 2007 the residents cashed in their excellent showing on the in-training examination. Multiple faculty members who had made brazen and careless wagers were subjected to a close shave by gleeful residents.

Ultrasound: The ultrasound program continues to mature. We recently purchased two new machines, which now adds up to a total of five US machines in the department.

Interview Season: Interviewing for new residents is always a fun and exciting time. The process is well under way and after the first week in February we will be finished and only Match Day will stand between us and another excellent recruiting year. The interest in our program seems very, very strong.

New Residency Coordinator: Our newest addition to the residency leadership team is our residency coordinator, Rebecca Lambert, MS. Becky is a welcome addition and has hit the floor running. A tremendous flurry of activity has resulted in major changes in many aspects of the residency.



Wilderness Medicine: Michael Caudell, MD has returned to MCG as our newest faculty member. Mike is working with the Center of Operational Medicine as well as is heading the Wilderness Medicine Training. He organized the first annual Wilderness Medicine Day.

Extrication Day: In October we had an exciting day in the auto junk yards. Extrication training was accomplished and two old cars were sacrificed for the event. The residents loved the opportunity to get out of the classroom and learn some new hands on skills.

Resident Newsletter: For additional information about the MCG residency training program, visit our web page and read past issues of the residents' newsletter, *The Resident Voice*. http://www.mcg.edu/ems/residency/

Residency Database: Finally, the MCG residency is seeking to develop a database of all past MCG emergency medicine residency graduates and would appreciate hearing from you if you fall into that category.

In closing, the MCG residency program is flourishing and everyone seems to be having a good time. Whoever said academic emergency medicine can't be fun?

Fellowship for Legacy Physicians

by John J. Rogers, MD

To ACEP a Legacy Physician is a member who is not certified by ABEM or AOBEM. The term has no other deeper meaning. Since they are not board certified in EM they have not been eligible for Fellowship in ACEP. However many of these physicians have contributed significantly to ACEP or their state chapters. In light of this service and commitment, it was felt that some of the Legacy Physicians (LPs) deserved the honor of Fellowship.

At the Scientific Assembly in Seattle this past October a bylaws resolution was adopted that created a path to Fellowship for Legacy Physicians who have made a significant contribution. It was never the intent of the resolution that all LPs will qualify for Fellowship, but that only those who have made a significant contribution should be so recognized. This must not be misconstrued as a reversal of the ACEP policy that physicians entering the EM workforce in the 21st century should be EM residency trained and board certified. Nor does it create new standards for membership. It is only a matter of recognizing some current members who have served ACEP or their state chapter.

A few have expressed their dismay that this will devalue the status of Fellowship. However, the three ACEP Task Forces assigned to investigate this issue decided that awarding Fellowship to this small group of LPs would not dilute the value of Fellowship held by any other member.

Since the practice track for ABEM and AOBEM closed many years ago, only EM residency trained physicians are allowed to sit for the certification exams. Beginning January 1, 2008 all new members of ACEP must be ABEM/AOBEM eligible or certified and therefore, by definition, residency trained. The population of LPs in ACEP is well defined and established. In fact over time the number of LPs in ACEP will decrease steadily and an all EMRT/EMBC organization will be realized.

The Fellowship requirements for LPs can be found in the Bylaws on the ACEP website. GCEP may be asked

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Physician Track Includes:

"You Are Feeling Very Sleepy"
Update on Procedural Sedation

"Toxic Terrors"
Interesting Cases From the GA Poison Control

"Fluid, Blood and Pressors - Sepsis"
Early Goal Directed Therapy

"What Happened?" – Syncope Update

2008 LLSA Review

Pre-Hospital Track Includes:

"No, No, No! Don't Push:"
OB Emergencies for the Pre-Hospital Provider

"Should They Stay or Should They go Now":
Refusal of Care in the Pre-Hospital Environment

"Less Lethal Force"
an Emerging Problem in Pre-Hospital Care

"A Day at the Beach"
Marine Envenomations You WILL See

Emerging Infections

EDBA Track Includes:

Technology for Data and Flow

Outstanding ED Performance

Data and Quality Measures
What is Big Brother Saying?

Show Me the Money!
(Patients and Profitability)

Emergency Medicine by the Numbers
The State of the Specialty

The Challenge of Patient Safety
The Facts

by Carl R. Menckhoff, MD, FACEP

Mark your calendars for the Georgia College of Emergency Physicians annual educational meeting. It will take place from June 13-15, 2008 at the Crowne Plaza Resort on Hilton Head Island.

This year, in addition to our traditional track focusing on important topics for Georgia Emergency Physicians, and our track focusing on pre-hospital providers, we will be partnering with the ED Benchmarking Alliance, a group founded by Emergency Department leaders seeking solutions to local service issues. We will be offering a whole new track focused on ED efficiency and administration with lecturers chosen from nationally renowned leaders in Emergency Medicine. Attendees will be invited to attend any of the lectures going on in the three tracks during their conference times. All physicians, physician assistants, nurses, EMS personnel and administrators are invited to attend what promises to be one of the best educational opportunities around.

This conference is ideally suited for both education and recreation. It begins on Friday morning with breakfast and a chance to visit the exhibits, followed by lectures until lunch. The afternoon is then free for golfing, kayaking, swimming, biking, or just having a cool drink as you soak up the sun. Or, if you prefer to sign up for the afternoon session, the EDBA track will continue through the afternoon. Friday evening there is a complementary cocktail party where you can get to know your colleagues from around Georgia and the country. Saturday begins with breakfast followed by lectures again until lunch. In the evening is the perennial favorite, the Annual Beach Party with great music, food, drink and dancing. After breakfast on Sunday, we will finish up with more lectures, as well as an Emergency Ultrasound workshop.

Also, don't forget, this year will mark the 5th annual Emergency Medicine Jeopardy competition, with teams from Emory, MCG and the courageous community docs. So far the record is Emory 2, MCG 1, Community 1. We look forward to seeing you there.

FREEDOM OF CHOICE!

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Albany, Americus, Chatsworth, Dalton, Fort Oglethorpe, Griffin, Jasper, Monroe, Thomson, and more!

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about these Georgia opportunities in
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800.424.3672, ext. 2906,
rita_offenberg@teamhealth.com

Albany, Palmyra Medical Center—200-bed facility with ED volume of 24,000. Mid-level coverage 7 days a week. High acuity and excellent back-up. The city of Albany fosters small town warmth and friendliness and is close to Columbus and 80 miles north of Tallahassee, Florida.

Americus, Sumter Regional Medical Center—Make a difference in the life of a community as you provide care in a new, modular hospital. The new home for Sumter Regional Medical Center will include approximately 65 inpatient rooms, a labor and delivery/obstetrics/nursery unit, 8 CCU rooms, 4 operating suites, and a fully functional, 24-hour ED that is supported by 10 hours a day of MLP coverage.

Griffin, Spalding Regional Hospital—38,000-volume, 21-bed Level II ED, moderate- to high-acuity cases, adjacent radiology and laboratory facilities available 24 hours, and two medical helicopter services supporting patient transfer. 38 hours of physician coverage and 12 hours of MLP coverage provided each day. The quiet, tree-lined streets and established neighborhoods make Griffin an excellent place to call home, and Atlanta is just 40 miles away.

Monroe, Walton Regional Medical Center—Excellent opportunity for an experienced medical director at this 77-bed facility with an annual ED volume of 22,000. MLP coverage, 7 days a week and a large number of internal medicine cases. The city of Monroe is 45 miles east of Atlanta and 20 miles west of Athens.

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Contact Leslie Teeple at ECC of TeamHealth
about these Georgia opportunities in
Chatsworth, **Dalton**, **Fort Oglethorpe**,
Jasper, and **Thomson**.
800.577.7707, ext. 7214,
leslie_teeple@teamhealth.com

Chatsworth, Murray Medical Center—Brand new, state-of-the-art ED! The facility's parent corporation also contracts with Murray County to provide ambulance service for the community. ED patient volume is 16,500.

Dalton, Hamilton Medical Center—41,000-volume Level II trauma center. Brand new state-of-the-art facility with 41 hours of physician coverage and 36 hours of MLP coverage a day. Twice named as a Top 100 hospital, quality care is this medical center's hallmark. In place is a hospital medicine group, a great medical staff, numerous centers of excellence, superior diagnostics, a fully accredited laboratory, an MRI center, and an advanced computer radiology system.

Fort Oglethorpe (Chattanooga area), Hutcheson Medical Center—Located in one of Georgia's fastest growing communities, this 32,000-volume ED has 36 hours of physician coverage and 24 hours of MLP coverage a day. Minutes from Chattanooga!

Jasper, Piedmont Mountainside Hospital—Recently named Hospital of the Year by the Georgia Alliance of Community Hospitals, this 35-bed, acute-care facility combines today's technology with personal care. Single coverage is provided for this 13,500-volume ED less than one hour from Atlanta.

Thomson, McDuffie Regional Medical Center—28-bed facility with an 11,500-volume ED located near Augusta in east Georgia. With thousands of miles of lakes and shoreline, Thomson offers pleasure boating, fishing, sailing, and great scenery for a family picnic.

Dr. Ralph Griffin - 2007 MAG Award Recipient

Each year, MAG awards individuals and a county medical society that deserve recognition for their outstanding contributions to the profession of medicine.

At the 2007 Medical Association of Georgia award ceremony on October 13th, GCEP's Ralph Griffin was awarded the Jack A. Raines, M.D. Humanitarian Award. This award recognizes a physician who has made an outstanding humanitarian contribution to his or her fellow man and community beyond the normal practice of medicine.

Dr. Griffin practices at the Medical Center of Central Georgia in Macon and appeared in the Macon Telegraph following the award. He has been to Russia five times in the past decade on a number of humanitarian missions, visiting orphanages, prisons, and rehab centers. Not only does he give of his time, but he also contributes financially.

The Georgia College of Emergency Physicians commends Dr. Griffin on this outstanding achievement.

New GCEP Members

Marc D Abramow, MD
Jeremy D Ackerman, MD
Jon C Allen, MD
Sean Arbuckle, DO
Sridhar Basavaraju, MD
Bradford Bellard, MD
Rachel Bengtzen
Brian L Berman, MD
Thomas N Bernard, III
Ajay Bhatt, MD
James E Black, MD
Michel Willy Blain, MD
Michael Cargile, MD, FACEP
Alexandra M Carleo
Matthew Carlisle
Connie Chan, MD
Arthur Chang, MD
John I Cheng, MD
Jeremy Chou, MD
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Jennifer Dark
Damon M Dell'Aglio, MD
Elizabeth J Demers, DO, FACEP
Patrick B. Eagleson, MD
Mark Fenig, MD
B Jason Fox, MD
Laura Frick
Billy F Gardner, II, MD, FACEP
Dwayne E Greene, MD, FACEP
Eric M Greenfield, DO
Kimberly Anne Hall-Moore, MD
Courtney M Hancock
Susanne Hardy
Sanford R Hawkins, MD
Manuel Hernandez, MD
Mark G Hogan, MD
Chad Peter Huot, MD
Paul J Jones
Wiley Jordan, III
Daniel A Kaminstein, MD
Nicholas Kimpel, DO
Harvey E Schuck, MD
Sid M Shah, MD, FACEP
Lekha A Shah, MD
Seema Sharma, MD
Heather L Simon, MD
Shruti Singal, MD
David A Slocum, MD
James L Smith, Jr, MD
Erik J Stamper, DO
Nathan Allen Stokes
Mark Eugene Sutter, MD
Dong Trieu Trang, DO
Jennifer E Tucker, MD
Eugene Buzz Walton, II, MD
Sharon Y Waters, MD
Mary Ann Wilkie, MD
John L Wood, MD
Daren Wooten, MD
Wakili S Yarima, MD
Patrick S Zelley, MD

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Dr. Heilpern recently was named president-elect of the Society for Academic Emergency Medicine, an organization whose mission is to improve patient care by advancing research and education in emergency medicine. She also was recently selected to serve on the Institute of Medicine Board on Military and Veterans' Health. Regionally, she serves on the State of Georgia Pandemic Influenza Planning Task Force and the Board of Directors of the Georgia College of Emergency Physicians.

The focus of Dr. Heilpern's research is the study of the interface between emergency medicine and infectious diseases. Since 1995, she has been a site investigator for the Centers for Disease Control and Prevention's EmergeIDNet sentinel surveillance project on emerging infectious diseases. Recent federally funded research has focused on the evaluation of emerging pathogens, such as West Nile Virus, community-acquired resistant staph infections, and the presentation and management of agents of bioterrorism and drug-resistant pathogens in the emergency care setting.

Dr. Heilpern has been an active educator with a focus on novel curriculum design and teaching methodologies for faculty and students in the health sciences. She is a co-principal investigator with the Emory School of Nursing on a federal training grant that teaches state-of-the-art didactic and procedural skills in emergency care to masters level nurse practitioner students. The grant also focuses on emergency care of underserved/vulnerable populations.

IV Infusion Codes: Unable to Bill for 2008

Hydration, Injection, and Infusion Codes Can't be Reported in the ED Setting for 2008

by Matt Keady, MD

In 2006, new language in the 2006 CPT book changed the way the hydration, injection, and infusion CPT codes (90760-90779) were being reported. The hydration codes were valued by the RUC, but a significant amount (approximately 85%) of the value is the practice expense component, which is not payable to the physician in the facility setting, including the ED. Relatively small values for physician work and professional liability were also assigned. The work values assigned were actually created by legislative intervention/direction as outlined in Section 303 of the Medicare Modernization Act, which calls for the work value to match the RVU's assigned for "a level 1 office medical visit for an established patient," or 0.17 for the past few years. Prior to the 2008 CPT language, these codes were being reported in the ED as there was no specific instruction that these codes were not to be used by physicians in the facility setting. They do contain a small work component, and CPT states in the introductory language that the "physician work related to hydration, injection, and infusion services predominantly involves affirmation of treatment plan and director supervision of staff."

Despite the language in 2006 CPT, these codes were not considered to be covered services for Medicare beneficiaries because the physician work involved with supervision is bundled into the Evaluation and Management (E/M) codes. Therefore physicians cannot report these codes to CMS. These services were initially being covered in early 2006 by other payers when reported by emergency physicians and their billing companies. Several private payers who were paying, have stopped reimbursing for these services throughout 2006 and 2007 and now consider them bundled into the E/M codes following Medicare's lead. Effective January 2008, CPT states, "These codes are not intended to be reported by the physician in the facility setting." This change impacts not only emergency physicians but all hospital based physicians for their "hydration supervision services" provided in a facility setting.

Many contentious discussions have been held with the entire CPT Editorial Panel and the appointed drug infusion work group. ACEP focused its arguments on there being no difference in the work of an emergency physician supervising hydration than for any other physician specialty providing the same service. While there are, of course, valid arguments for either these work components being all included in the E/M codes or broken out into hydration services, there does not appear to be any rational argument for the site-of-service differential situation now delineated by CPT.

In the end, many physicians enjoyed extra revenue of up to several million of dollars for two years. The impact was close to ten dollars of revenue per patient billed these services. However, based on the new 2008 CPT language, physicians and their billing entities must not continue to bill for hydration, injection, and infusion services in the ED starting in January 1st. While it may not currently have a favorable outcome for emergency medicine, there is some hope that this will be on the agenda for the upcoming CPT meeting in February.

10.1% CMS Pay Cut for Physicians Averted

Physicians were expecting a 10.1% reduction in the conversion factor used to determine payments from CMS for physician services. S. 2499(P.L. 110-173) provision will replace the 10.1% cut with a 0.5% increase. States vary widely on the impact this will have based on Medicare claims data. It is estimated for the first six months of the year in Georgia, a physician will see an average increase of $4,500 in Medicare payments. This number does not include other payers that may tie their reimbursement to the CMS conversion factor as well.

Fellowship: continued from page 7

for a letter attesting to an applicant's activity in the chapter and/or a letter of recommendation. Applicants do not need either of these letters if they have contributed to ACEP nationally and have letters of reference from two current Fellows.

Many chapters are struggling to determine what constitutes sufficient activity to merit Fellowship recognition. GCEP is formulating its policy in this regard and developing the method by which these applications will be processed. Likewise GCEP is considering how requests for letters of recommendation will be evaluated. This information from GCEP should be available soon and posted on our website. It will also be available through GCEP offices.

Make a Difference

All of our meetings are open. If you are interested in being more involved, please visit the GCEP website at **www.gcep.org**

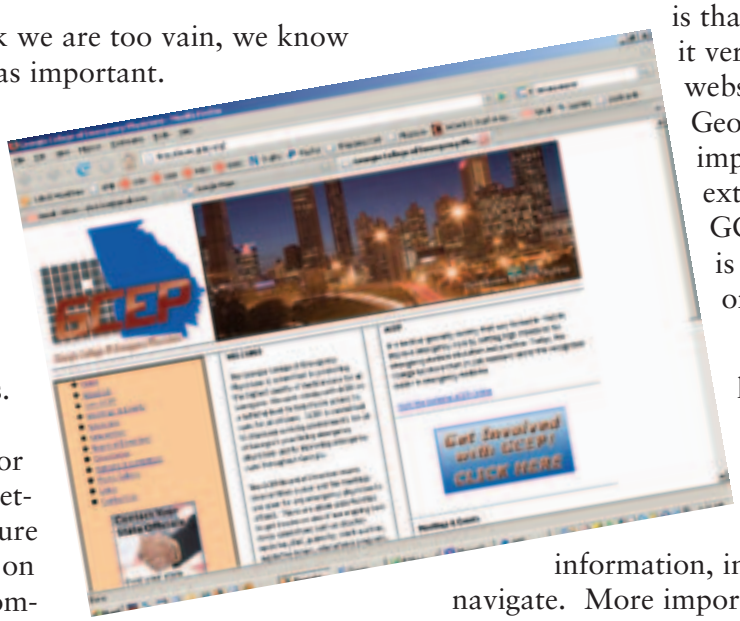
GCEP Website Gets a Face Lift

by Ethan M. Meisel, MD, FACEP

Check out the new GCEP website at www.gcep.org, we think you are going to love it. The old website, much in need of an overhaul, has been completely redesigned from the ground up. Concerned that the website was not offering the value added services that our membership has come to expect, we have recreated it entirely for you, the Georgia emergency physician.

First, let us be honest, looks count. With this in mind, the first thing you will notice when you take a stroll on gcep.org, is how much better the new site appears. From our sleek newly designed logo to our clean side navigation menu, you will love our new look.

Just so you do not think we are too vain, we know that what is inside is just as important. In other words, content matters and gcep.org is now loaded with all sorts of new content. Right away, on the homepage you will find useful information on current events, meeting information and important announcements. There is a mechanism in place to allow any group or physician to post their meeting information. Make sure you check out the section on political advocacy also, complete with links on how to write letters to your legislator and your local newspaper.



We tried to make it a valuable resource for the practicing EP, whether GCEP member or not. For example, the rise in transfers equates to increased time spent away from actual patient care. With a few clicks on gcep.org you can view our interactive map that shows you the location of nearby hospitals, view our hospital directory to find phone numbers, and even click the link to find out diversion status. Not only can you find out information about the spring meeting in Hilton Head, you can register online as well (and soon you will also be able to make your GEMPAC donation on the website).

Past issues of EPIC are archived on the website, making it possible for non-members as well as members to stay abreast of current events (and of course you will find this issue as well). Interested in putting a face with your GCEP officers and board members? Look on the website! Wondering how you can get more involved in GCEP? You can do it on the website! We have also streamlined our links page, trying to condense it down to what you want most as a practicing EP (forgot the current Children's Healthcare of Atlanta fever guidelines again…click on the link and see all the pediatric guidelines). Also keep checking back; one of the coming features in the next 1-2 months will be a link to the LLSA articles!

Unlike the old website, the new gcep.org will be a very dynamic website. One of the best features of the website is that it is internally controlled, making it very quick and easy to update. This website belongs to all the EPs of Georgia and we our constantly improving it and adding to it. To this extent, we want to hear from you. GCEP member or not, tell us if there is something you would like to see on the website!

We are very proud of our website here at GCEP. With a focus both on content, ease of use, and design, we have created a sophisticated appearing website, loaded with important and useful information, in a format that is extremely easy to navigate. More importantly, we feel we have created a website that you as a member of GCEP and a practicing physician in Georgia will be proud of!

Tort Reform: Worth Fighting For

This article was previously printed in the Medical Association of Georgia's Journal, *Volume 96, Issue 4, 2007.*

by Daniel J. Huff, Esq., Huff, Powell & Bailey, LLC

Introduction

The initial euphoria following the enactment of Georgia's tort reform legislation in February 2005 has subsided. Although two of the key provisions of Senate Bill 3's widespread medical malpractice reform – noneconomic damage caps and emergency room immunity remain intact – two other key provisions of SB3[1] have received harsh treatments by the Georgia appellate courts. While the trial court judges and appellate courts have been addressing challenges to tort reform, the Georgia Trial Lawyers Association (GTLA) is rumored to be preparing for repeal or major modification of tort reform during the 2008 legislative session. As one of the lawyers who deals with medical malpractice cases on a daily basis, I've seen how tort reform has had a dramatic positive affect on the defense of health care. In the courts and the legislature, maintaining the tort reform is just as important as enacting it in 2005.

Before reviewing the details of the tort reform statutes and case law, here's the big picture. The publicity generated in the 2004 and 2005 legislative sessions regarding tort reform is paying dividends in jury trials. Since 2004, in every case that I have tried, more prospective jurors have expressed feelings about medical liability reform during jury selection. The medical liability reform movement has entered the consciousness of the average juror. More jurors today think about the "public health" implications of individual cases. In the past, jurors would immerse themselves in the plight of one patient or their family in an effort to find in their favor. Tort reform publicity has made jurors consider the medical and business ramifications of a plaintiff's verdict. Continuing to publicize the need for medical liability reform, including attempts to repeal or revise it, is important for successful jury trials in medical malpractice actions.

SB3 Provisions

Noneconomic Damages Cap

The most hotly contested provision in SB3 has always been the $350,000 cap on noneconomic damages.[2] The noneconomic damages cap is $350,000 against any number of physicians, or a single medical facility, although if more than one medical facility is named in an action for medical malpractice, the noneconomic damages cap is $700,000 from all medical facilities. Despite the obvious nature of these two provisions, the Code section goes on to provide that the aggregate amount of noneconomic damages recoverable in any such action shall not exceed $1,050,000.[3]

Of course, the noneconomic damages cap does not limit a plaintiff's award for medical expenses, wages or earning capacity, income, funeral and burial expenses, the value of domestic and other necessary services and other monetary expenses. In cases involving these economic damages like medical bills, life care plans or wrongful death actions involving patients who had significant income, the noneconomic damages cap is not dramatically impacting the value or evaluation of those cases. However, in cases that carried significant damages "uncertainty, i.e," the death of an infant or young child, or the death of a retired person, the cap has been a tool for reaching a settlement or trying a case without the exposure of an unpredictably large verdict. If a case is questionable or difficult to defend on liability, the cap allows that case to be tried, because if the case is won by the plaintiff the award would be capped. More importantly, this process facilitates a reasonable settlement in similar situations, for less than the cap amount.

The plaintiffs' attorneys are finding creative ways to adapt to this noneconomic damages cap. For example, an unborn child who dies in the third trimester of a pregnancy can become a wrongful death action brought by the child's parents.

The plaintiffs' attorneys are finding creative ways to adapt to this noneconomic damages cap. For example, an unborn child who dies in the third trimester of a pregnancy can become a wrongful death action brought by the child's parents. If the case is filed against one or more physicians, then generally the noneconomic damages cap would limit the recovery in such a case to $350,000. Traditionally, these cases do not have significant medical and burial expenses, which would be outside the cap. Normally the value of such a case, if lost, would not be above $400,000 applying the noneconomic damages cap. However, in an effort to create additional damages in this and exceed the noneconomic damages cap, plaintiffs' attorneys now routinely obtain an economist to testify with respect to the lost income for the unborn child through statistics of the average income for a high school graduate and a graduate with a four-year college degree. Naturally, these lost income figures exceed $1 million and the plaintiffs' attorneys contend that the lost income num-

bers are not subject to the noneconomic damages cap. This economic damages testimony is obviously speculative and not any way supported by any record of earnings or income. Although trial court reactions to the "creation" of economic damages like this have been mixed, we have had limited success in excluding this type of evidence on the grounds that it is speculative and not reliable. This illustrates that plaintiffs' attorneys will do whatever they can to eliminate or temper tort reform.

Plaintiffs' attorneys are also putting forth a number of constitutional challenges to the noneconomic damages cap. The entire Georgia and U.S Constitutions are being used. First, is the challenge that the noneconomic damages violate the United States and Georgia Constitutions, which require equal protection of the laws. The GTLA contends that imposing a noneconomic damages cap in medical malpractice cases and not imposing it in any other type of cases violates the equal protection of laws. Moreover, plaintiffs contend that the different damage cap amounts within the statute itself violates the Equal Protection Clause because the different cap amounts are not rationally related to the purposes intended by the noneconomic damages statute.

Ultimately, the Georgia Supreme Court will have to decide whether the noneconomic damages caps, as enacted, are constitutional and to what extent the plaintiffs may use creative legal arguments avoid their applications.

Emergency Room (ER) Liability

In an effort to provide additional legal protection to emergency care and treatment, SB3 provided special medical protection for emergency medical care. O.C.G.A. § 51-1-29.5 provides:

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.

Cases arising from the provision of emergency medical care require a higher burden of proof – clear and convincing evidence, and a higher standard of care – gross negligence. The enactment of this provision has clearly decreased the number of claims and cases arising from emergency department, however, from a practical standpoint, in cases which have been filed since the enactment of the statute, the testimony in those cases has not significantly changed. In my experience, a physician who is going to testify that an emergency room physician violated the standard of care, is not reluctant to testify that the same care constituted "gross negligence." While the clear and convincing evidence standard has not been applied to an ER case at trial, it is a difficult standard to obtain. Clear and convincing evidence is something above the normal preponderance of the evidence – but below the criminal standard of beyond a reasonable doubt. In any ER case when the defendants present expert testimony, it is going to be difficult for the plaintiffs to establish by "clear and convincing evidence" that emergency medical care was grossly negligent.

Like the noneconomic damages caps, this provision of SB3 is under attack in the courts and will be in every legislative session until it is eliminated. GTLA is currently challenging the emergency room standard on the grounds that it violates the Georgia and the United States constitutional provision that citizens receive equal protection of the law. The allegation is that there is no rational basis for holding plaintiffs in a medical malpractice case involving emergency medical services to a more difficult standard than plaintiffs in other types of medical malpractice cases. These types of challenges are currently being addressed at the trial court level, and have not yet been presented to the Georgia appellate courts. Ultimately, the Supreme Court will have to rule on the constitutionality of the emergency liability statute.

One provision of the emergency liability statute that is often ignored is that it modified some of the evidentiary laws involving emergency medical care. Traditionally, plaintiffs have been successful in excluding evidence of what brought the patient to the emergency room, on the grounds that some details of what happened to the plaintiff are not relevant to the care received. For example, if

Seeking Contributions!

Interesting case
Medical update
Medico-legal
Billing
Legislative
Other.....

If you would like to contribute to the EPIC please contact:
Tara Morrison at
tara@theassociationcompany.com

the plaintiff was involved in a motor vehicle accident while driving intoxicated, the plaintiffs have been able to exclude the circumstances of the intoxication from the trial of the case. Subsection (d) of O.C.G.A. § 51-1-29.5, provides that the trial court shall instruct the jury to consider, together with the other relevant evidence, that the circumstances constituting the emergency and the circumstances surrounding the delivery of the emergency medical care.

Expert Witness Qualifications

O.C.G.A. § 24-9-67.1 modified the general qualifications for experts to testify in civil cases and was meant to dramatically change the qualifications for expert witnesses to testify in medical malpractice actions. When it was enacted, this Code section was intended to incorporate the U.S. federal courts' expert witness standards for scientific testimony. In order to be admissible, scientific expert testimony must be reliable and based on a sound scientific methodology. In medical malpractice cases, O.C.G.A. § 24-9-67.1 also mandates that an expert be licensed to practice their profession and have "actual professional knowledge and experience" in the area of practice or specialty in which the opinion is to be given – as a result of having been regularly engaged in either the active practice of such area and specialty for at least three of the last five years and with sufficient frequency to establish an appropriate level of knowledge; or teaching within the profession three of the last five years.[4]

Despite this relatively unclear and vague standard, many in the medical community believe that this new expert qualification statute stood for the proposition that only an expert from the same specialty could testify against a specialist physician. That is not how the courts have interpreted the change in the law. The Georgia Court of Appeals has rejected this argument in five cases and the Supreme Court has denied review in each of those cases.

Although O.C.G.A. § 24-9-67.1 has effectively eliminated the pathologist testifying against the clinician, Georgia Court of Appeals has effectively returned the law regarding expert witnesses to pre-SB3 law.

Venue

O.C.G.A. § 9-10-31(c) was intended to allow trail venue in medical liability actions to be in the county where the alleged malpractice took place. This provision was largely enacted for the protection of hospitals, so that cases involving medical malpractice that happened in hospitals could be tried in the county where the hospital is located. In EHCA Cartersville, LLC v. Turner, 280 Ga. 333, 626 S.E.2d 482 (2006), the Georgia Supreme Court found that this venue provision was unconstitutional and that the plaintiff may select venue for a medical malpractice action in the county where any defendant resides. For example, all of the defendants may reside in one county, where the hospital is located and the care and treatment took place, but one physician's professional corporation may have its registered agent in another county. That case can be brought in the county here the registered agent is located, even if no defendant resides there. The plaintiff will always choose the most friendly venue. O.C.G.A. § 9-10-31.1 permits a case filed in a constitutionally-appropriate venue to be transferred to a more appropriate county for practical reasons such as availability of witnesses, the parties and evidence. Unfortunately, the provision is applied at the discretion of the trial court judge who determines whether a case can be transferred under this statute. We have had modest success in transferring cases pursuant to this statute. Practically, there are some judges who simply look for ways to move cases, while other judges are interested in hearing medical liability cases and want to keep them.

ACEP Groups 100% Club

Athens-Clarke Emergency Specialists – Athens

Emory University School of Medicine (Faculty) – Atlanta

Medical College of Georgia (Faculty) – Augusta

Northside Emergency Associates – Atlanta

Joint and Several Liability

The Georgia tort reform change that likely will withstand any constitutional challenge are the modifications to Georgia's joint and several liability law, which involves multiple defendant cases. Prior to the enactment of SB3, in cases where the plaintiff was not contributorily negligent, the jury simply determined whether a defendant, in a multiple-defendant case, was negligent. If a defendant was found to be negligent, even as little as 1 percent negligent, then all the defendants found liable shared equally in the amount of the verdict. The plaintiff could also recover the entire verdict from any defendant. This longstanding joint and several law provided a direct hardship on defendants with minimal exposure and defendants with deep pockets. SB3 changed the joint and several law in civil actions so that the jury may assign a percentage of fault to each party, including the plaintiff, as well as nonparties designated by the defendants as has having responsibility, whether named by the plaintiff or not. The amount of recovery by the plaintiff as to each defendant

will be limited by their percentage, as assigned by the jury.

Interestingly, the one case that has gone to trial where the new joint and several law has been applied resulted in one defendant being assigned 48 percent and the other defendant being assigned 52 percent of the total liability. Under the old law the defendants would have shared the verdict 50/50. Although the GTLA is not happy with the change in the law for joint and several liability when it comes to many other substantive areas of tort law, it is generally not viewed as unfavorably in medical malpractice cases.

Offer of Judgment

The Georgia Offer of Judgment Act codified at O.C.G.A. § 9-11-68 was modified in 2006 to reflect many perceived problems in the statute. Although this is not a "loser pays" statute it does have some teeth when one party is being unreasonable about a civil case. The statute provides that either party may make an offer of settlement or judgment to the other side which, if not accepted, and the offering party achieves a substantially comparable result at the trial of the case, will allow the prevailing party to petition the trial court for recovery of attorneys' fees and costs. Necessary to the recovery of attorneys fees and costs is that the offer of judgment was made in good faith. This statute also allows parties to request that the court allow the jury to consider whether a claim or defense in a civil case is frivolous and award attorneys' fees and costs as damages.

The practical effect of the Offer of Judgment statute has been to put pressure on unreasonable parties and parties presenting frivolous claims with the threat of attorneys' fees and costs.

Conclusion

The landscape in medical liability cases is changing for the better. Although we will be fighting numerous challenges to the tort reform legislation enacted in 2005 over the next several years, the benefit from the legislation itself, as well as the publicity the tort reform legislation debate generated, will be providing positive results in trial courts throughout the state. We need to do what we can to maintain tort reform and oppose all challenges to eliminate it. Vigilance in the medical community in supporting tort reform legislation on a statewide and individual patient basis is critical. Do not underestimate the value of your contribution to the public dialogue regarding issues facing physicians in medical liability claims.

Daniel Huff has been defending civil lawsuits for 16 years and is one of the talented attorneys MAG Mutual Insurance Company utilizes to defend its physician policyholders. He has devoted the majority of his career to defending physicians, hospitals and other health professionals in medical liability cases. In 2003, Mr. Huff and his partners formed the law firm of Huff, Powell & Bailey, LLC, which focuses on defending medical professional liability cases. Mr. Huff has represented every medical specialty and has tried more than 30 medical liability cases. In the last year alone, he has successfully defended seven cases that went to trial. Mr. Huff speaks to attorneys and physicians about medical liability litigation and regularly file's appellate briefs on behalf of the Medical Association of Georgia and the Georgia Defense Lawyers Association.

References

1. Senate Bill 3 or SB3 was the bill that set forth all of the tort reform legislation enacted in 2005. This paper discussed the key provisions of SB3 that apply to medical malpractice cases. Not covered in this paper is the medical authorization to seek medical records, statements of remorse or apology being inadmissible and Composite State Board reporting changes.

2. O.C.G.A. § 51-13-1.

3. O.C.G.A. § 51-13-1(e). This damages cap could only be implicated in a case with two or more medical facilities and at least one medical provider.

4. O.C.G.A. § 24-9-67.1(c).

MAG Mutual Announces 10% Insurance Savings for Georgia Physicians

MAG Mutual Insurance Company announced that for policies effective November 1, 2007, its Georgia insured physicians and surgeons will save an average of 10% when purchasing their medical professional liability insurance. With the passage of Georgia's tort reform law in February 2005, MAG Mutual promised to pass on the savings as the benefits of the law appeared. Since that time, the number of claims against physicians and the amount paid per claim have declined. The tort reform law is working as intended by the Georgia legislature. The 10% savings is the combination of a rate reduction, the recently announced policyholder dividend and the company's new 0% financing plan for installment payment of premiums. Savings for individual policyholders will range from a minimum of 5% to as much as 15%, depending on the physician's medical specialty and other factors.

MAG Mutual Insurance Company is a physician-owned and led mutual insurance company, based in Atlanta, Georgia. It is the 8th largest medical professional liability company in the U.S. and just celebrated its 25th anniversary of serving Georgia's physicians.

Toxicology Case Files of the GA Poison Center

by Carl Skinner, MD and Brent Morgan, MD

A 65-year-old male, constipated for the past week, ingested Epsom salt 100% granule from Perfect Choice diluted in 1 pint of water to relieve his symptoms. He began feeling weak and later that day went to the emergency room. He has a past medical history significant for hypertension, diabetes, and enlarged prostate.

It was found that the patient had had his prostate biopsied about two months previously. He stated that his main problem has been not being able to have a bowel movement. He presented to the emergency department hypotensive, weak, and very sleepy.

His initial serum magnesium level was 5.7 mEq/L.

A Foley was placed in the patient and he was noted to have over 800cc urine retention. His BUN 32, Cr 2.6. His repeat Mg returned at11.4 mEq/l. The patient was not initially dialyzed due to possible obstructive uropathy and treated with lasix and fluids overnight to see if he would improve. His next Mg level returned at 9.4. He was then dialyzed with a post magnesium of 6.4. The patient somehow lost his vascular access and was not dialyzed again. He was later intubated for possible ARDS and began to develop pancreatitis. His Mg level reached normal after 5 days and his BUN, Cr, amylase, and lipase normalized. He eventually recovered and was discharged home.

THE QUESTIONS:

1. What does Epsom salt contain?
2. What clinical effects are expected from different levels of hypermagnesemia?
3. What is the role of Mg in the body?
4. What ekg findings are expected?
5. What is the treatment for hypermagnesemia and how might it work?
6. What other drugs can cause hypermagnesemia?
7. What other kinds of cathartics are there and how do they work?
8. What are some complications of these cathartics?

THE ANSWERS:

1. Magnesium sulfate
2. >3 Nausea, vomiting, weakness, cutaneous flushing
   >5 ECG changes: prolonged PR, QRS, QT intervals
   >7-10 Hypotension, loss of deep tendon reflexes, sedation
   >10 Muscle paralysis, respiratory arrest, hypotension, arrhythmias
   >14 Death from respiratory arrest or asystole
3. 4th most abundant cation in the body
   - < 1% in extracellular fluid
   - Nl serum Mg is 0.7-1.0mM, 1/3 is protein bound
   - 95% of intracellular Mg is bound to other molecules especially ATP
   - Intracellular free Mg concentration is 0.5mM (1000x that of Ca) or 5mM bound Mg
   - Maintained through active sodium-magnesium antiporter
   - Mechanism of entrance into cells is unknown, probable regulated channels
   - Essential cofactor in enzymatic reactions
   - Stabilizes macromolecules including DNA, RNA, and ribosomes
   - Direct role in mitochondrial oxidative metabolism
   - Extracellular Mg crucial for nl neuromuscular excitability and nerve conduction
4. PR, QRS, QT interval prolonged
5. Hypotension – fluids, dopamine
   - Forced diuresis using intravenous furosemide and normal saline – may enhance elimination
   - Ca may antagonize the effects of Mg
6. Antacids, Cathartics, Lithium
7. Magnesium citrate and sulfate salts – osmotic gradient establishing an osmotic gradient and draws water into gut.
   - Results in increased gut motility. Mg also releases cholecystokinin, a gi hormone, stimulates gi motor activity.
   - Bisacodyl and phenolphthalein – stimulant cathartics.
   - Induction of nitric oxide synthase and thus increased nitric oxid production.
   - Sorbitol – probable osmotic action, but little known.
   - Mineral Oil
8. Overall risks include dehydration, absorption of Mg or other salts, hypokalemia and metabolix alkalosis from dehydration and activation of renen-angiotensin-aldost sytetm.
   - Rectal prolapse in the elderly
   - Hypertonic phosphate enema or phosphosoda – Hypocalcemia, hyperphosphatemia, hypokalemia
   - Mg containing – neuromuscular toxicity, coma
   - Sorbitol – hypernatremia, dehydration, gas formation with abdominal distention
   - Mineral oil – aspiration risks

Pediatric Perspective: Information You Can Use

Intramuscular Epinephrine is Superior to Subcutaneous Administration

A patient presents to the ED with urticaria, angioedema and wheezing after eating some peanuts. You plan as part of your initial treatment to give the child some epinephrine to help reverse the actions caused by histamine and other inflammatory and vasoactive substances. But don't order the epi to be given subcutaneously! Recent studies have shown that intramuscular (IM) administration is much more effective.

It's important to note that the use of subcutaneous (subQ) epinephrine is based on anecdotal experience. Two studies in both children and adults have shown that IM epinephrine, especially when administered in the thigh (vastus lateralis), is more rapidly absorbed and has a higher peak concentration than when given subQ. (Neither of these studies was drug company sponsored). In children the peak concentration was reached in 8 (±2) minutes IM compared with 34 (±14) minutes subQ. The peak plasma concentration was almost 20% higher IM vs. subQ. This is of importance since epinephrine is considered the most important first line therapy in anaphylaxis and delayed absorption could decrease its effectiveness. It should be noted that the dose of IM epi is the same as the SQ was: 0.01mg/kg IM up to a max dose of 0.5mg per dose or 0.5ml of 1:1000.

Because of its risk of cardiac arrhythmias, intravenous epinephrine should be reserved for those patients who are in cardiac arrest, profoundly hypotensive or who have failed to respond to multiple IM doses.

So remember, next time you need to give epinephrine for an allergic reaction, give it IM instead of subQ.

References:

Simons FE, Roberts JR, Gu X, Simons KJ. Epinephrine absorption in children with a history of anaphylaxis. J Allergy Clin Immunol. Jan 1998;101(1 Pt 1):33-7.

Simons FE, Gu X, Simons KJ. Epinephrine absorption in adults: intramuscular versus subcutaneous injection. J Allergy Clin Immunol. Nov 2001;108(5):871-3.

Joint Task Force on Practice Parameters, American Academy of Allergy, Asthma and Immunology; American College of Allergy,Asthma and Immunology and Joint Council of Allergy, Asthma and Immunology. The diagnosis and management of anaphylaxis: an updated practice parameter. J Allergy Clin Immunol. Mar 2005;115(3 Suppl 2):S483-523.

Ceftriaxone Use Should be Limited

The Food and Drug Administration has recently added a black box warning to ceftriaxone (Rocephin®) concerning intravenous (IV) administration in neonates and recent IV calcium administration. While the warning does not directly affect older children it does give pause to reflect on ED antibiotic use. For example, ceftriaxone is not indicated for the routine use in treating otitis media nor should it (or any other antibiotic) be given to an otherwise healthy febrile child just because they have a fever. For children who can tolerate oral fluids, oral antibiotics are usually the best course of therapy for most documented bacterial infections. Overuse of antibiotics is leading to increasing drug resistance.

For more information see:

- http://www.fda.gov/medwatch/safety/2007/safety07.htm#Rocephin
- http://www.cdc.gov/ncidod/diseases/submenus/sub_ear_Infection.htm
- http://www.cdc.gov/drugresistance/community/files/ads/otitis_media.htm
- http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5641a2.htm

Silent Auction Donations Needed

Once again GEMPAC will host a silent auction at the annual June meeting in Hilton Head. Last year was a great success and we anticipate an even bigger success this year. Some of the items already secured for auction include an original oil painting by one of Georgia's professional artists, Carol Griffin. There is a beach house on Hilton Head Island that is sure to draw a lot of interest as well. WE NEED YOUR HELP. Please contact Tara Morrison at taramorrison@bellsouth.net with your donation. Be creative. A round of golf, two hours at a shooting range, antiques, art, jewelry, homemade items, hot air balloon ride, tickets to a sporting event, lake house, beach house, rare coins, collectables (just to name a few possibilities) will make the auction more interesting. Contact Tara and she will forward the information to the silent auction committee. Naturally, you will want to mark your calendar to attend the summer conference and bid on your favorite items. See you there.

When Words Matter: Diagnostic Terminology

The diagnosis you write in the medical record can affect your reimbursement. It is important to be as specific as possible to help third-party payors understand exactly what your patient was treated for. Based in the International Classification of Diseases, 9th ed., Clinical Modification (ICD-9-CM), here are a few examples of common diagnosis coding problems:

You write this as your diagnosis	It codes to this	More specific diagnosis could include
Diarrhea	Diarrhea (non infectious) 787.91	Infectious diarrhea 009.2 Presumed infectious diarrhea 009.3 Rotavirus enteritis 008.61
Acute gastroenteritis (AGE)	Other and unspecified non-infectious gastroenteritis and colitis 558.9	Infectious AGE 009.0 Presumed infectious AGE 009.2 Gastroenteritis due to food poisoning 005.9 Allergic enteritis 558.3
Vomiting	Vomiting alone 787.03	Nausea and vomiting 787.01 Persistent vomiting (non-obstetrical related) 536.2 Vomiting in newborn (feeding problem of the newborn) 779.3

Upcoming Events

SE Regional SAEM Conference
March 14-15, 2008
Louisville, KY
Society for Academic Emergency Medicine
www.saem.org/saemdnn/Meetings/SAEMRegionalMeetings/SoutheasternRegionalMeeting/tabid/242/Default.aspx

12th International Conference on Emergency Medicine 2008
April 3-6, 2008
San Francisco, CA
International Federation for Emergency Medicine
http://meetings.acep.org/2008icem

Emergency Medicine & Acute Care/A Critical Appraisal - Series 27
May 25-28, 2008
Hilton Head, SC
CAL/ACEP, Center for Medical Education, EM Abstracts
http://ccme.org/index.html?gclid=CICbiYORl5ECFRgzkgodjSzfHQ

SAEM Annual Meeting
May 29-June1, 2008
Washington, DC
Society for Academic Emergency Medicine
www.saem.org/SAEMDNN/Default.aspx?tabid=639

GCEP Spring Meeting
June 13-15, 2008
Hilton Head, SC
Georgia College of Emergency Physicians
www.gcep.org

ACEP Scientific Assembly
October 27-30, 2008
Chicago, IL
American College of Emergency Physicians
http://meetings.acep.org/scientificassembly

Difficult Airway Course-Emergency
November 14-16 2008
Atlanta, GA
Airway Management Education Center
www.theairwaysite.com

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