



Georgia College Of Emergency Physicians

EPIC

The Newsletter of the Georgia College of Emergency Physicians

Winter 2010

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Viewpoint from the President

by Robert Cox, MD, FAAEM, FACEP
president@gcep.org

As we prepare for the 2010 legislative session, we're watching the three cases dealing with aspects of SB3 that have recently been argued before the Georgia Supreme Court. See Matt Watson's *Legislative Update* for additional details. Lawmakers predict rulings during the middle or latter part of the session. While it's not clear which way the Court will rule, legislators friendly to our causes are preparing in case of an adverse decision affecting our practice. We will need your help on Legislative Day and during the session to be in touch with your State Representative and Senator to remind them (among other things) how important SB3 has been for the practice of Emergency Medicine.



Robert Cox, MD

In *Smith v. Baptiste*, the plaintiffs are challenging a part of SB3 known as the offer of judgment provision. According to that rule, a party can be ordered to pay the other side's attorney's fees if it rejects a settlement offer and doesn't get a better deal than the offer when the case is decided in court. Judge Johnson declared the offer of judgment rule unconstitutional, saying it hindered access to courts. Interestingly, this case doesn't deal with medical liability but with defamation involving a Duluth beauty salon and a former Atlanta Falcon and the radio station on which he used to appear.

Legislative Update

by Matt Watson, MD, FACEP, GCEP President-Elect
president-elect@gcep.org

Since the passage of SB3 in 2005, the medical malpractice landscape has improved for all medical providers, but specifically for emergency medicine providers. As a result of these changes, there are many more malpractice providers in the state, and malpractice insurance premiums have remained flat or even come down for many physicians. But this law has been under fire since it was passed, and presently the Georgia Supreme Court has two cases in front of it regarding Tort Reform. These two cases have been argued, and are awaiting Supreme Court decisions. They focus on different issues, but they are being closely watched by both the medical community and the trial lawyers.

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Matt Watson, MD

First is a case that challenges the "gross negligence" clause, providing protection for those providers that care for patients in the first 24 hours of emergency care. In October, both sides presented their case in *Gliemmo v. Cousineau, et al.* to the Supreme Court. Specifically challenged is the gross negligence vs. ordinary negligence standard for emergency care. "Emergency room physicians must often make rapid-fire, life-

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Why Should We Play Politics Anyway?

by Rob Higgins, MD, FACEP

Unless you have been doing way too many night shifts, you certainly should not have missed how the health care debate in Washington will profoundly affect our practice in the ED. Politicians, educated on the issues or not, will vote on the future of U.S. health care. Emergency medicine, only three percent of health care GDP, will still be affected. Wouldn't it be nice if someone from an emergency medicine practice actually took the time to speak with some of the lawmakers to give them some insight into the "good ideas and the bad ideas" on the table? Someone does – and that is just what our political advocacy program is all about.

NEMPAC has been pushing medical tort reform for years, Georgia has it now. California and Texas emergency physicians are fighting the new court rulings against balanced billing, essentially letting the insurance companies pay you what they want. Is Georgia next? Would it help you to get more pay for the uninsured trauma victims in your ED? Would it help to get some tax relief for the free EMTALA care we provide? Should we outlaw cell phone texting while driving to protect our citizens? How about banning cell phone use while driving all together? Where does the government get more money for EMS, indigent care, or to fight the next pandemic? The list is as long as you want to make it, but the decisions are not ours – at all. They are decided by our legislature.

In speaking with my legislators over the years I am urged to get involved in the seemingly "dirty politics" of lobbying and elections because politicians are often ill informed. The issues are not always black and white and the people affected are often not at the table –

have you heard of "unintended consequences" or "unfunded mandates." Legislators tell me they are surprised that doctors don't speak up more on the issues that affect them. If they don't hear from us they assume we don't care or the legislation as written meets our approval. Obviously this is not the case.

Emergency physicians are a busy lot, but a little too naïve I expect, to assume our best interests are always represented. The best way to affect change is on the local level. Meet with your state representative or senator. Ask them how you can help. Tell them if tort reform has worked for you. Go to the 2010 GCEP Legislative Day and find out how to get involved. This is the best way to help the system work for us.

The easier way, but no less important is to give money to our GEMPAC fund. Physician volunteers working with our GCEP lobbyist are pushing the issues we all care about. We donate campaign dollars to the people we want re-elected, who we know are going to fight for our issues, who we can educate on what works for EM and what doesn't. Legislators want our advice and they want to be re-elected. We can help with both.

If you haven't donated yet to the GEMPAC fund, please do so. Don't let others do all the work. Our suggested donation of \$100/member will get us only two-thirds of the way to our 2009 goal of \$100,000 dollars. We have had some success with corporate matches this year and are pushing for more academic MD donations. I would really like to see 100% involvement from the membership at any level. This would mean to me that "we get it." The legislature will continue to make our laws and will decide a big part of our future. Let's be at the table when they do.

Robert Higgins, MD, FACEP, is the managing partner at Northside Emergency Associates. He can be reached rhiggins@comcast.net.



Rob Higgins, MD

100% MEMBERSHIP

We would like to recognize our emergency medicine groups who have 100% membership:

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 Emergency Medicine Specialists of Columbus, PC
 EmergiNet, LLC and Summit Medical Services, LLC
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 Georgia Emergency Medicine Specialists, PC
 Medical College of Georgia - Faculty
 Northside Emergency Associates
 Georgia Emergency Physician Specialists, LLC

THANK YOU FOR YOUR SUPPORT!

Viewpoint: continued from page 1

The former Falcon commented during a radio broadcast about the manner in which his daughter had recently been treated at the beauty salon. According to the brief, he said the service was “whack” and discouraged listeners from visiting the salon. Apparently whack was not a positive endorsement. He and the radio station were sued for defamation and tortious interference with business relations. The defendants made an official offer of settlement of \$5,000 but the offer was not accepted, so when the defendant won the trial on summary judgment, they asked the judge to order the plaintiff to pay attorney fees per the offer of judgment statute. The former Falcon has asked the state Supreme Court to reverse the Johnson decision that the offer of judgment rule is unconstitutional.

Atlanta Oculoplastic Surgery v. Nestlehuitt is the case in which Judge Bessen declared the caps on noneconomic damages provision of SB3 unconstitutional. This case stems from elective plastic surgery that the plaintiff claimed left her disfigured. The jury awarded her \$115,000 for medical expenses, \$900,000 for pain and suffering, diminished earning capacity and loss of enjoyment of life, and \$250,000 for the loss of consortium experienced by her husband. The defense argued to Judge Bessen that SB 3 required the Nestlehutts’ damages be reduced to \$465,000—\$115,000 for medical expenses and \$350,000 for all non-economic damages. Judge Bessen responded by declaring the cap unconstitutional because it violates three basic constitutional tenets: the right to trial by jury, the separation of powers doctrine and equal protection of the laws.

The third and most germane case asks if the portion of SB3 that requires plaintiffs to prove gross negligence by emergency providers is constitutional. In *Gliemmo v. Cousineau*, it’s reported that the plaintiff’s husband called an ambulance when Mrs. Gliemmo felt a snapping in her head and pain behind her eyes. She was reportedly treated for her elevated blood pressure and anxiety and the emergency nurses said the patient admitted that she was feeling better at least three times before she left. Two days later she had a stroke that left her partially impaired. Her attorneys challenged the constitutionality of the provision on several grounds, but the trial court allowed an appeal to the high court to determine

whether or not the statute is a special law. Wade Copeland did an excellent job of arguing our cause before the Supreme Court.

I have to give a shout out to our GEMPAC fundraisers: Drs. Higgins, Olson, Mattke and Skandalakis. Their efforts via corporate matching contests and the silent auction have raised record amounts for the GEMPAC. The more GEMPAC members and contributors we have, the stronger our voice in the political arena. I’ve attend several fundraisers to deliver the GEMPAC check and not only is the person the check is made out to grateful, but other legislators just there to support the guy at the fundraiser will make a special effort to seek me out to thank us for the contribution GEMPAC made to them! Make sure you’ve done your part by contributing. The money you have saved on PLI premiums will easily cover a donation of \$1,000 or more!

Your Secretary/Treasurer has been diligently digitizing and updating important GCEP documents and working hard on an upgraded bylaws document. If all goes according to plan, the membership should see a draft bylaws document ready for review at the Spring Meeting in Hilton Head. Thanks, Dr. Rogers!

Thank you to all the emergency physicians who have participated in our rural meeting sessions in the middle Georgia area, Savannah and Columbus. Our goals are to discuss issues common to rural emergency medicine, build fellowship, reach out to practicing emergency physicians, and expand these to other areas of the state. GCEP received a grant to develop a program on skills training/retention for rural emergency medicine and rumor has it that Dr. Lyon has been in the cadaver lab with a camera for three days. This project, once fully developed, will be a great CME program unique to Georgia and we look forward to incorporating it in the rural meeting sessions.

Let us know what’s on your mind and what your GCEP leadership can do for you. We look forward to seeing those not working the day shift at Legislative Day Feb. 9!

Rob Cox is a practicing emergency physician and can be reached at rcox@gcep.org.

“Our goals are to discuss issues common to rural emergency medicine, build fellowship, reach out to practicing emergency physicians, and expand these to other areas of the state.”

Legislative: continued from page 1

or-death decisions in a chaotic environment without the benefit of knowing the medical histories of their patients.” Emergency medicine providers, and those specialists on “ER call” to care for the patients that need further care after stabilization is provided by the ER, have a unique situation to provide mandated care for patients that they have no prior relationship with. They have little or no knowledge of their medical histories, and sometimes have no history as to why the patient has presented for care in the first place. This is a difficult diagnostic environment, and this uniquely challenging practice setting has been recognized by the legislature, and the gross negligence standard has been put in place because of this.

The challenge presented by the trial lawyers is that this is too high of a standard, and makes it impossible to prove negligence in malpractice cases. However, this legislation is not unique to Georgia – Texas, Michigan, South Carolina, Florida, Arizona and others have similar laws related to emergency care of patients.

The second challenge to the tort reform laws is in regard to the noneconomic damage cap limits for malpractice cases. It comes from a case involving a plastic

surgeon in the case of *Nestlehurst v. Atlanta Oculoplastic Surgery, PC* which is also being heard by the Georgia Supreme Court. This case was initially found in favor of the plaintiff by the jury, and awarded \$115,000 in medical expenses, and \$900,000 in pain and suffering. The plaintiff filed a motion to lift the caps and prevailed last February when a Fulton County judge ruled the state law unconstitutional. The defendant, Atlanta Oculoplastic Surgery, then appealed to the Georgia Supreme Court. If the caps are upheld, the noneconomic damages would be limited to \$350,000, making the total settlement \$465,000 rather than \$1.015 million.

The decision by the Georgia Supreme Court is pending in both of these cases. Plan to attend the Georgia College of Emergency Physicians Legislative Day on February 9, 2010. There will be an update from Carrie Lowe, JD, associate general counsel for the Medical Association of Georgia on the state of tort reform in Georgia as it will have unfolded at that time.

Dr. Watson is a partner in Northside Emergency Associates. He graduated from Jefferson Medical College and completed his Emergency Medicine Residency at Geisinger Medical Center in Danville, Pennsylvania. He can be reached at mwatson@gcep.org.



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TUESDAY, FEBRUARY 9

9:00 AM - 1:30 PM

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Medical College of Georgia Residency Update

by Stephen A. Shiver, MD, FACEP, Emergency Medicine Residency Program Director, Medical College of Georgia



Stephen Shiver, MD

Our Army interview season, which has greatly expanded, is now complete and the civilian portion is in full swing. Typically, the normal interview process runs from November through February with Match Day occurring in March. The Army match is totally different, with the interview process starting in late summer and concluding with the match in early December. We are fortunate this year to have large numbers of applicants from the Army and 600 plus applicants from the civilian side. We are ACGME approved for 10 residency positions per year and with three of these from the Army match. Its exciting to have two match days!

The ACEP Scientific Assembly in Boston was a busy time for the department. We had a large number of faculty and residents and many residency alumni attend. An emerging residency tradition is the MCG Dinner, which occurs during the week of the assembly. It is a great time when the MCG EM community comes together for fun and fellowship. An ever increasing number of alumni attend the dinner each year and it has become a highlight of the conference experience.

One of our recent educational initiatives has been a dedicated simulation suite within our office complex. Simulation cases are a regular part of our didactic curriculum. Resident resuscitation teams participate in the simulation scenarios while residents and faculty view the cases in real time via a video feed. The case is then discussed as a group. Overall, simulation has excellent educational potential and we continue to fine-tune the process. It will undoubtedly be a continued area of focus in our program going forward.

Our website has recently undergone a major overhaul. We invite you to visit www.mcge.edu/ems/residency/. We welcome any questions or comments. Our Program Coordinator, Courtney Buckner, may be reached at (706) 721-2613.

Stephen A. Shiver, MD, FACEP is associate professor of Emergency Medicine and Residency Program director at the Medical College of Georgia. Clinical and research interests include resident education, emergency ultrasound, airway, and trauma. In addition to his emergency medicine training, he completed a general surgery residency at Wake Forest University Baptist Medical Center and is board certified by the American Board of Surgery. He can be reached at sshiver@mail.mcge.edu.



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Toxicology Case Presentation

by Dr. Wafa'a Al-khamees and Dr. Brent W. Morgan, Emory University

A 69-year-old male patient presented to the hospital with the history of weakness, lower limb swelling and a non-pruritic erythematous skin rash for one week duration. Past history includes NIDDM and a positive PPD five months prior. His medications included Glipizide, INH and Rifampin. Upon further questioning he gave a history of abnormal liver function test one month after treatment had been initiated that did not necessitate termination of his antituberculous treatment.

On examination patient was conscious alert and oriented. Vital signs were 37 80bpm, 22 120/60 mmHg. Head and neck examination was notable for jaundice; lower limbs showed pitting edema with petechia skin

rash, the rest of his physical examination was unremarkable. Lab analysis showed AST 606(U) ALT 599, total bilirubin of 5, direct bilirubin of 3.5 and INR 2.2, PT 27 sec, albumin 20, ammonia level of 60 and glucose 110.

The patient was admitted with the impression of hepatic failure and INH was stopped. Hours later the patient became confused and he was started on lactulose and N-acetylcysteine treatment. He underwent extensive investigation looking for other etiologies of his liver failure all of which were unrevealing. After 15 days of hospitalization the patient recovered and was discharged home with the diagnosis of INH-Induced Hepatic Failure.

INH HEPATIC TOXICITY

INH induced hepatic dysfunction

Defined: elevated transaminases level 2-3times above their base line

Incidence: 10% of patients taking INH will develop abnormal LFT, 1% show clinical evidence of toxicity and only 0.1% developed hepatic failure if INH therapy is not discontinued, with overall mortality of 0.001%.

Risk Factors: age > 35years, alcoholics, malnutrition and pregnancy, concomitant use of other antituberculus drugs and other xenobiotics that induce cytochrome P450 notably ethanol, OCP, theophylline, rifampin plus anticonvulsants such as phenytoin, valproic acid and carbamazepine.

INH metabolism: understanding its mechanism of toxicity.

1. The first pathway of INH metabolism involves acetylation via N-acetyltransferase to acetylisoniazide followed by hydrolysis to a toxic metabolite called acetylhydrazine. Acetylhydrazine can be metabolized further to a non-toxic compound, isonicotinic acid, or it can be metabolized by cytochrome P450 to another intermediate that can contribute further in hepatotoxicity. Agents that induce cytochrome P450 put the patient at higher risk to develop toxicity.

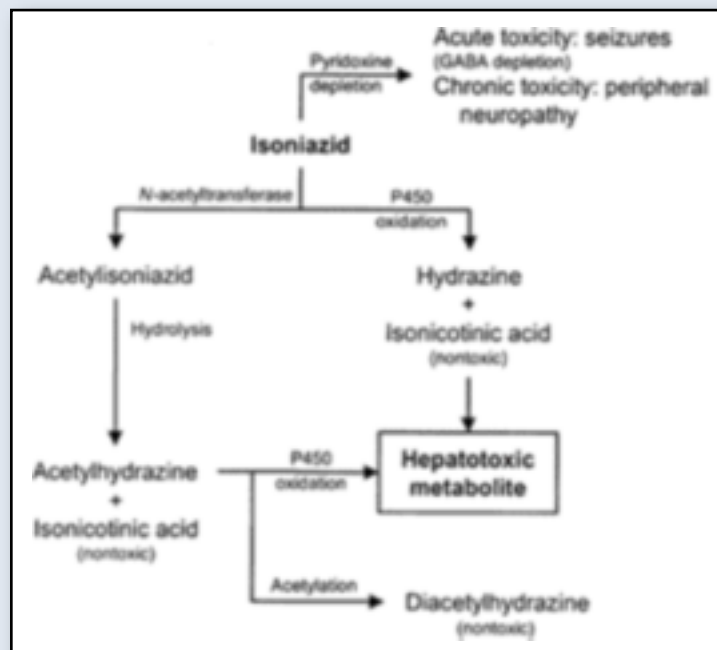
There are two forms of N-acetyltransferase responsible for acetylation, so that some patients metabolize the drug quicker than others. Studies that look at whether fast or slow metabolizers have increased risks of developing hepatotoxicity have been inconclusive.

2. The second pathway of metabolism is oxidation via cytochrome P450. INH is metabolized to a hepatotoxic hydrazine then to isonicotinic which is non-toxic.

Management of INH-induced Hepatotoxicity

First is discontinuation of INH therapy. The mainstay of treatment is symptomatic and supportive care. Pyridoxine has no role in the treatment and it does not reverse hepatic injury.

NAC can be considered because of its anti-oxidant properties. Patients on INH treatment should be monitored for early signs of hepatic injury.



Metabolism of INH

EKG Korner: A Case of Narrow Complex Tachycardia

by Ben Holton, MD, FACEP, Emory University and Stephen Shiver, MD, FACEP, EM Residency Program Director, MCG

Mr. Smith is a 55-year-old male who presents to the ED complaining of his heart racing. He woke up this morning with this sensation. He has felt a little winded with activity today, but is not short of breath at rest, and he is not having chest pain. He has not felt like he was going to pass out, but has felt a little lightheaded. His past medical history is significant for an acute MI two years ago. He currently takes an aspirin a day, and is on metformin for diabetes.

His vital signs show a temperature of 36.5, respiratory rate of 16, heart rate of 148 and a BP of 122/85. He has no JVD, his lungs are clear, his cardiac exam shows a tachycardic rhythm that sounds regular, and he has strong pulses in all four extremities.

His EKG is shown below.

The EKG shows a narrow complex tachycardia. Differential diagnosis should include sinus tachycardia, paroxysmal supraventricular tachycardia (PSVT), wandering atrial pacemaker, atrial flutter, and atrial fibrillation or an accessory pathway. A junctional tachycardia can also have a narrow complex, but it would be unusual for it to be this fast. The hallmarks of wandering atrial pacemaker and atrial fibrillation are irregularity. However, if the rate is fast enough, it can be difficult to tell if there is irregularity. Your bedside cardiac monitor

can help here. Since the monitor determines rate by measuring the R-R interval, instead of counting beats over a certain period of time like most of us do when we take a pulse, it can pick up subtle variability in rate. This variability shows up as a constantly changing heart rate on the monitor—143, 151, 149, 155, etc. Sinus tachycardia and atrial flutter, on the other hand, have a much more regular rate, and therefore the rate displayed by the monitor will be much more constant, with little variability.

Another clue that the rhythm may be atrial flutter is the rate itself. In atrial flutter, atrial impulses occur at a rate of 250-350, with the most common rate being 300. Most commonly, the ratio of atrial impulses (P waves on the EKG) to ventricular impulses is 2:1, giving a ventricular rate of 150. Anytime you see a heart rate close to 150, you should think about atrial flutter and look for flutter waves. Another common ratio for conduction is 4:1. Variable block can occur, and when it does the ven-

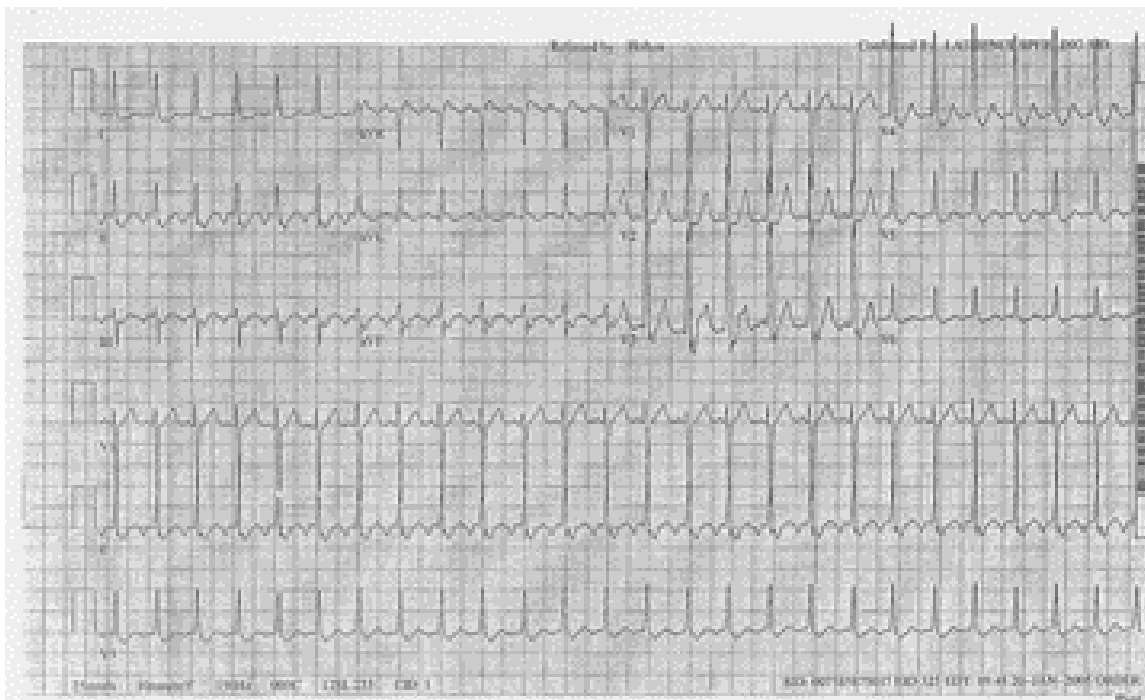
tricular rhythm will be irregular. In this EKG the rate is 150. If you look in lead V1 it looks like sinus tachycardia, but if you look in the inferior leads II, III, and AvF, you can see 2 p waves for each QRS complex. The p waves in these leads are inverted; one occurs right after the QRS complex, one occurs right before the QRS complex. If you use calipers to march out the p waves in the inferior leads, their rate is 300 per minute.



Ben Holton, MD



Stephen Shiver, MD



Diagnosis: Atrial Flutter

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Hospital Spotlight: DeKalb Medical Center

by Pascal Crosley, DO, Medical Director, DeKalb Medical Emergency Department

DeKalb Medical was founded in the 1960's as a small rural hospital. Located in Atlanta Georgia, DeKalb served the local small community with minor services offered and small town southern hospitality. Over the years, the Atlanta area has experienced exceptional growth and development. This required DeKalb Medical to create and expand new service lines, physical facilities, clinical services and financial considerations. DMC did this so it can complement the growing community surrounding it and to meet the continually complex health care needs of its customers.

As with any bustling company, planning, constructing and implementing tomorrows vision for today can be challenging. DeKalb was no different. Up from the ground, DeKalb Hillandale was built. DeKalb Medical is now comprised of three campuses, North Decatur, which is known as the "Central" campus, Hillandale campus, and the Decatur campus which is the LTAC of the system.

The North Decatur campus is a 525 bed hospital with a full ICU/CCU, telemetry and 10 beds clinical decision unit. A brand new Women's Tower and outpatient surgery center was added two years ago due to the more than 6,000 deliveries at DeKalb Medical annually. The emergency department treats approximately 70,000 patients per year with 41 beds. Over the course of three years, the North Decatur ED has improved the overall ED length of stay, time to provider, left without being seen rate as well as patient satisfaction all while total admissions increased by over 10 percent. Due to these

operational improvements, the Volunteer Hospital Association (VHA) issued an award to DeKalb Medical's North Decatur ED stating that the hospital's revenue improved by \$11.5 million. Health Grades recently placed North Decatur in the top 10 percent for stroke as well.



Pascal Crosley, DO

DeKalb at Hillandale is just four years young. Being the smallest of the three campuses, Hillandale is a busy place. Located about 15 miles from central campus, we are a full service hospital offering many services to our local community. Hillandale has 100 beds, a full ICU/CCU, telemetry unit, a six-bed clinical decision unit and a busy emergency department. Hillandale has nearly 50,000 ED visits this year and it is growing. This 24-bed unit has seen more change and challenges since its birth than was expected. Most notable are the challenges that gave rise to improved patient care, improved patient satisfaction and continued census growth.

One such challenge was the closing of the OG/GYN inpatient beds, and the transferring of the OB patients to central campus. Now faced with birthing babies in the ED, as well as the rush to transfer pregnant laboring patients to the Mother-Baby unit, the ED staff had to quickly and efficiently learn OB nursing practice. ED staff education, in-services, and excellent support by the mother/baby staff has made this continuous challenge a positive learning experience as well as a seamless and



DeKalb Medical Central Campus



Hillandale Campus

transparent transition to our mothers in labor presenting for birthing.

With the expanding community came rapid emergency department census growth. Overnight, the minor RME, or rapid medical evaluation “rooms” in the ED became a physically and operationally separate area from the ED proper. This ensured that lower acuity patients were seen and discharged rapidly and efficiently, improving wait times and patient satisfaction.

The CDU or clinical decision unit, with six monitored beds, opened up within two months of its inception, fully functional to help meet the needs of the growth. “Quick registration” and “rapid triage” based on ENA standards of practice were both implemented. ED throughput has become a main topic of conversation with all services including ancillary supports, nursing units and senior leadership. Cooperation, respect and compromise on everyone’s part has improved ED throughput, thus also creating an improved atmosphere of teamwork and collegiality. With new nursing leadership in the ED, Hillandale faces new and exciting challenges and change. As a team working together with patience and cooperation, Hillandale welcomes these challenges.

Even with the increased volume and various challenges, DeKalb Medical at Hillandale made the Georgia Hospital Association (GHA) quality honor roll placing them among the top hospitals in Georgia for core measures compliance. No matter what campus one receives care from or works at, in the DeKalb Medical system you can expect nothing less than exceptional. We strive for excellence, quality, and commitment. Although the facility may have changed, the mission and vision remain the same: to improve lives through the delivery of excellent

health and wellness services, and to be recognized for its leadership in clinical and service excellence, and employee satisfaction. We are DeKalb Medical and we are **PUSHING BEYOND.**

Dr. Crosley can be reached at pascalcrosley@depmg.com.

ANNUAL MEETING

JUNE 10-13, 2010



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The RACs are coming!!!! Oops, they are already here....

by Matt Keadey, MD, FACEP, GCEP Representative to the Medicare Carrier Advisory Committee

On March 28, 2005, the Centers for Medicare and Medicaid Services (CMS) introduced a new demonstration project that would use Recovery Audit Contractors (RAC) to assist Medicare in identifying improper payments made to healthcare providers and suppliers in three states: California, Florida, and New York. The RAC Program's mission was to reduce Medicare improper payments through efficient detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments. RACs review claims on a post-payment basis. The demonstration project included two types of RACs: 1) Medicare Secondary Payer (MSP) RAC's, and 2) non-MSP claims and activity RACs. MSP RACs are responsible for identifying where Medicare should not have been the primary payer. Non-MSP claims and activity RACs (Claim RACs) are responsible for reviewing claims and medical records to identify overpayments and underpayments for Medicare claims.

The demonstration RACs have proven to be successful returning millions of dollars in overpayments to the Medicare Trust Fund. RACs are paid on a contingency basis, retaining a percentage of the amount recovered for overpayments and, as of March 1, 2006, Claim RACs receive an equivalent percentage for all underpayments identified. Approximately 96 percent of all improper payment activity identified during the demonstration project was for overpayment compared to four percent for underpayments. Claim RAC activity has resulted in \$54.1 million (FY2006) and \$247.7 million (FY2007) returned to CMS. Claims reviewed included Part A, Part B, physician, hospital, skilled nursing facility, inpatient rehabilitation, hospice, home health, clinical laboratory, and durable medical equipment, prosthetics, orthotics, and supplies claims. For FY 2007, 88 percent of all overpayments identified were from inpatient hospital and skilled nursing facility providers, a vast majority of which where the result of overpayments to inpatient hospitals. The next largest category by provider type was outpatient hospital (6%), followed by physician/supplier (3%), durable medical equipment (2%), and ambulance, lab, or other (1%). Interestingly, 99 percent of underpayments

were from inpatient and outpatient hospitals and skilled nursing facilities. Physicians accounted for the remaining one percent of underpayments.

Convinced of their value, Congress passed into law Section 302 of the Tax Relief and Health Care Act of 2006 mandating expansion of Claim RAC's nationwide by January 1, 2010. To implement the nationwide Claim RAC program, CMS has developed four distinct RAC regions and assigned a Claim RAC based on a competitive process. Georgia resides in region C with 14 other states and our Claim RAC will be managed by Connolly Consulting Associates, Inc. Connolly assumed RAC responsibility February 2009 and Georgia was rolled into the program August 2009.

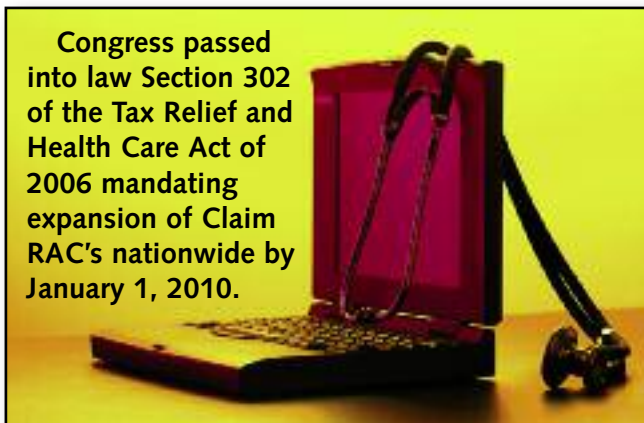
The RACs have chosen issues to review based on Office of Inspector General (OIG), Government Accounting Office (GAO) and Certified Error Rate Testing (CERT) reports. CMS has required that the

RACs post a list of claims issues that they will review on their website. All proposed new issues coming from the RAC, will be submitted and approved by CMS. Current reviews approved by CMS include wheelchair bundling, urological bundling, clinical social worker services, blood transfusions, once in a life time services, bronchoscopy procedures, IV

hydration therapy, untimed services, and pediatric codes exceeding age parameters. Claim RAC's identify overpayments and underpayments using a combination of automated and complex claims reviews. Connolly has initiated automated claims reviews with complex claims reviews set to start in early 2010.

Claims reviews are conducted in two different manners. Automated claims reviews involve analysis of claims databases using proprietary software. This does not require medical record review and involve simple objective determinations, such as improper payment for non-covered services or coding errors. Complex claims reviews do require a review of medical records by the Claim RACs. For complex claim reviews, the Claim

Congress passed into law Section 302 of the Tax Relief and Health Care Act of 2006 mandating expansion of Claim RAC's nationwide by January 1, 2010.



RAC analyzes claims data using its proprietary software to perform targeted reviews intended to identify those claims most likely to contain overpayments. Where overpayments are suspected, the Claim RAC sends to the provider a request for medical records. The provider has 45 days to respond to this request by submitting copies of the medical records. Providers are permitted to request an extension prior to the 45th day by contacting the Claim RAC. The Claim RAC must complete its review and notify the provider of its decision within 60 days of receipt of the medical records. Where an overpayment is identified, a demand letter is sent to the provider and the provider essentially has two options: (1) submit the overpayment or agree with the RAC determination permitting an offset against future payments, as applicable or (2) submit a rebuttal letter to the Claim RAC identifying the basis for dispute, to which the Claim RAC must respond within 60 days.

To be prepared, make sure your billing operations are in order. If you contract an outside billing company, ask them what they are doing to prepare for a possible RAC audit. If you do your billing internally, you may want to make sure you have done the following:

1. Make sure you have a compliance program for your practice.
2. Be proactive by conducting an audit of your billing practices to assure Medicare compliance. Sample a portion of your charts paying particular attention to the billed E & M services and medical necessity.
3. Review information available from the RACs, CMS and the OIG to identify the types of claims where improper payments have been persistent. Compare these issues to similar claims within your own practice or facility.
4. Proactively audit areas of concern and take corrective actions to prevent future improper claims.
5. Implement procedures to promptly respond to RAC requests for medical records, review results letters and demand letters.

6. Be prepared to appeal any overpayment determinations.

Dr. Keadey can be reached at mkeadey@gcep.org.

For further information the following websites may provide more information:

- www.cms.hhs.gov/RAC
- RAC Email: RAC@cms.hhs.gov
- www.connollyhealthcare.com/RAC/pages/cms_RAC_Program.aspx
- www.oig.hhs.gov/reports.html (OIG reports)
- www.cms.hhs.gov/cert (CERT reports)
- www.acep.org/practres.aspx?id=46511 (ACEP FAQ on RAC)



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Measuring the Inferior Vena Cava Diameter and Central Venous Pressure with Ultrasound

by Matt Lyon, MD, FACEP, Department of Emergency Medicine, Medical College of Georgia, mlyon@gcep.org
 Mary Ann Edens, MD, FACEP, Department of Emergency Medicine, Emory University, medens@emory.edu

Undifferentiated shock is a common presentation to the emergency department and determining the type of shock present is critical to deciding the correct treatment. Central venous pressure (CVP) describes the pressure of blood in the thoracic vena cava, near the right atrium. CVP reflects the amount of blood returning to the heart and the ability of the heart to pump blood into the arterial system. With few exceptions, the CVP is a good approximation of right atrial pressure, right ventricular end diastolic volume and circulating blood volume. Thus measurement of CVP is a useful method for determining the type of shock present and guides treatment.

The current recommendations for septic shock include continuous monitoring of CVP using a CVP catheter and pressure monitor. However placement of a catheter can take critical time and the equipment for pressure monitoring may not be readily available. By using a simple ultrasound technique, measurement of the CVP can be made non-invasively at the bedside by measuring the inferior vena cava (IVC) diameter.

A case study will help demonstrate the usefulness of this technique:

A 30 year old female with end stage renal disease due to HIV/AIDS presented to the ED in respiratory distress. Only a limited history was available due to her distress. Prior to starting bi-pap ventilation, she revealed that she had missed dialysis and had been coughing for about a week. She was tachycardic (P = 130), tachypneic, mildly hypoxic, and her blood pressure was elevated. With the history of missing dialysis, the working differential diagnosis was volume overload leading to increased CVP and pulmonary edema. Prior to ordering emergent dialysis, measurement of the IVC was made at the bedside using US. This revealed a small nearly flat IVC that collapsed completely with inspiration. This indicated a very low CVP and was inconsistent with volume overload. Treatment was started for pneumonia (including pneumocystis). She remained

in respiratory distress despite dialysis, but returned to baseline within 24 hours of treatment.

Measuring IVC diameter is simple using US. The probe is placed in the sub-xiphoid position similar to the view used in the FAST exam. After visualizing the right atrium and ventricle, the probe is rotated to pan over the IVC (Figure 1). The IVC is seen posterior to the liver as it crosses the diaphragm and joins with the right atrium (Figure 2).

Normally the IVC collapses with inspiration as blood is drawn into the right atrium (the thoracic pump) and dilates during expiration (Figure 3). As CVP increases, the normal collapsibility of the IVC decreases, and the size of the IVC approaches its maximum diameter – approximately 2.5 cm. When the CVP decreases, the



Matt Lyon, MD



Figure 1. Placement of the probe, long axis, sub-xiphoid location

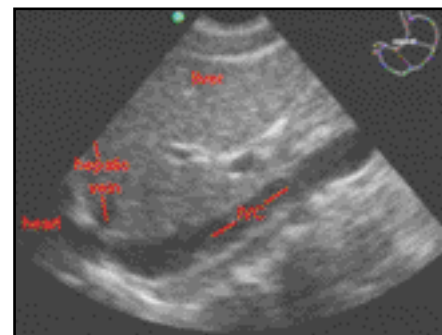


Figure 2. IVC, long axis, posterior to liver

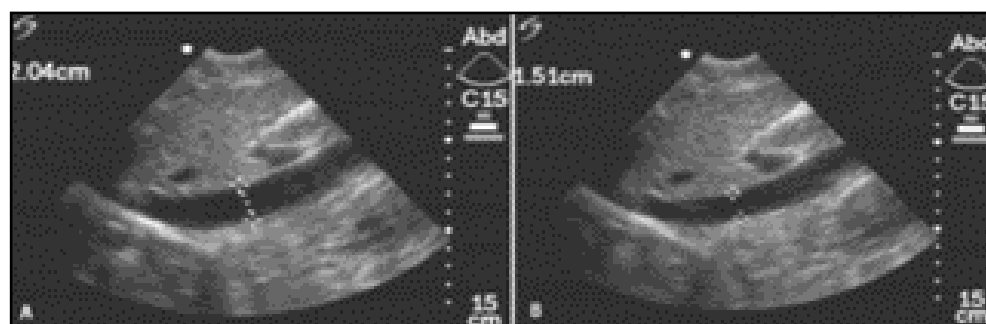


Figure 3. IVC at end expiration and maximal diameter (A) and at the end of inspiration and minimal diameter (B)

IVC Expiration	IVC Inspiration	CVP (Approximate Pressure in cm H ₂ O)
Small/ Slit Like Size	Complete Collapse	Very Low (0 – 4)
Small to Normal Size	Collapses Completely	Low (4 – 8)
Normal Size	Collapses 25 – 75%	Normal (8 – 12)
Large/ approaching 20 – 25 mm	Collapses < 25%	High (12 – 18)
Large (maximal size)	No Collapse	Very High (> 18 – 20)

Table 1 Approximate Correlation of IVC Diameter to CVP

to correct hypotension is appropriate. However when the CVP is elevated and IVC lacks collapsibility, then other means of correcting the blood pressure are appropriate (vasopressors).

This article just begins to describe how US can be used rapidly at the bedside to aid in diagnosis and treatment. Other US techniques can be added to the measurement of the IVC to further refine your differential and treatment plan. In the next few issues of the EPIC we will introduce several other quick bedside US techniques.

Matthew Lyon, MD, FACEP, is associate professor of Emergency Medicine at the Medical College of Georgia. He serves as the director of the Section of Emergency and Clinical Ultrasound as well as the director of the Emergency Department Observation Unit. Dr. Lyon has significant educational experience, lecturing both nationally and internationally, and has published over 30 peer-reviewed articles on the use of ultrasound in clinical practice. Most recently, he co-authored the useful handbook titled Emergency Ultrasound Pocket Reference. Dr. Lyon is also the primary investigator on an NIH grant involving the treatment of vaso-occlusive crisis due to sickle cell disease in an observation unit. He can be reached at mylon@gcep.org.

IVC	CVP	Other Findings	Potential Cause	Treatment
Small Complete Collapse	Low	History of Vomiting/Diarrhea	Dehydration	IV Fluids
Small Complete Collapse	Low	History of Trauma Positive FAST	Hemorrhage	Blood Transfusion IV Fluids
Small Complete Collapse	Low	Fever	Septic Shock	Vasopressors IV Fluids
Dilated Little Collapse	High	Pericardial Effusion	Tamponade	Pericardiocentesis
Dilated Little Collapse	High	Poor LV Function History of Low EF	Cardiogenic Shock	Inotropic Medications
Dilated Little Collapse	High	Dilated Right Atrium/Ventricle PE Risk Factors	Massive PE	Thrombolytics
Dilated Little Collapse	High	End Stage Renal Disease	Volume Overload	Dialysis

Table 2 Correlation of IVC and Other Findings to the Cause of Hypotension

IVC diameter decreases, and the collapsibility increases.

There are several measurements you can use to evaluate the IVC diameter, but in most instances your gestalt measurements of IVC collapsibility are more than adequate (Table 1). The ability to non-invasively determine the type of shock present is a valuable tool (Table 2). With a low CVP, the use of IV fluids

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Are Your Affairs in Order?

by Mr. David A. Olson, Attorney at Law, Epps, Pilgrim, Olson & Pruitt

All too often, physicians are burdened with the duty of informing patients or their families of terminal illnesses. That same physician is the front-line for the barrage of questions likely to follow from the patient for advice on what to do. Whether the prognosis is for one week or one year, history has drafted the time-saving cliché of ‘get your affairs in order,’ but what does that phrase really mean?

That phrase, in fact, poses many more complex and time-sensitive questions for the person that has not taken the time to confront these issues prior to hearing the news. What ‘affairs’ do I have and what ‘order’ are they supposed to be in? Take a moment and ask yourself these questions:

Do you have an up-to-date list of all assets, accounts, real estate, insurance, and retirement plans? Do you need or have a will or a trust? Is your will up-to-date? Do you have a power of attorney and a living will? Have you named guardians for minor children? How will your pets be cared for after your passing? Have you updated the primary and secondary beneficiaries on insurance and retirement plans? Have you avoided the risks of joint ownership? Your affairs are NOT in order if you answered ‘no’ or ‘I don’t know’ to any of these questions.

Waiting until after you receive a devastating prognosis to accomplish these tasks is clearly going to be more trouble than you and your family will want in that scenario. The best course of action is to take time early on to prepare for the worst. From financial affairs, funeral affairs, pets and other legal matters, you should take steps to begin the process of getting your affairs in order. Primarily, you will need to contact your lawyer to have the documents from the questions above drafted, reviewed or updated. Once that is accomplished, the following three steps are crucial to easing the burden on others during this process.

First, gather your ‘important documents,’ categorize them in a simple to understand format, and place them into one central location. Important documents will vary for everyone, but a good barometer for what constitutes importance is if it involves money, property or the government then it is probably an important document.

Second, make sure a trusted friend or family member knows where your papers are located. While entrusting family or friends to this task is acceptable, putting your

lawyer in charge of this and the next steps is a responsible and dispassionate approach to dealing with such an emotional time.

Third, you should give advance consent for your doctor and lawyer to speak with your family or caregiver as necessary. This will reduce the confusion in the event that these steps have not been taken and you are incapable of giving consent.

Establishing your desires early will ease your family’s emotional transition if you find yourself in a devastating medical condition or in the event of your passing.

These steps are merely the beginning of the planning that should occur early in your life. Everyone should contact their attorney and begin the discussion on how to ‘plan for the worst.’ In all cases, an experienced attorney will be able to navigate you through the process of estab-



David Olson

*“The best course of action is...
to prepare for the worst.”*

lishing your plan and assisting you in the decisions that must be made regarding your life, family, and property.

As physicians, you are looked to frequently by your patients who are searching for the answers to these very questions. You should lead by example by speaking with an attorney early to assist you in getting your own affairs in order. While you must always be cautious to never practice law by giving advice on legal matters, you will then be able to offer a helping hand by giving your patients a few guidelines to accompany an otherwise passé phrase of ‘get your affairs in order.’ And, as always, you will be able to offer them the best, modern advice of ‘you really should talk to an attorney.’

Mr. Olson is a partner in the Law Offices of Epps, Pilgrim, Olson & Pruitt. His law firm offers a full range of legal services to its clients in the Metro Atlanta area and North Georgia where he practices many types of law including criminal defense, general civil litigation, business and employment law, and more. He is a graduate of the Georgia Institute of Technology and the University of Miami School of Law. Mr. Olson can be reached at david@epp-legal.com or (678) 455-4610.

EMS News: NIH Halts CPR Trial and the Value of Impedance Threshold Device in CPR

by Matt Bitner, MD, mbitner@gcep.org and Michael Hagues, MD, FACEP, hagues@sfhga.com

The NIH recently halted a clinical trial examining two techniques of out of hospital CPR. Studies have given conflicting results about whether paramedical should perform CPR for 30 – 90 seconds before checking if defibrillation was needed or if CPR for at least three minutes was better. After 11,500 patients had been studied the trial was halted. There were no differences in outcomes and it was felt further recruitment into the trial would not change the results. Dr. Ian Stiell of the Ottawa Hospital Research Institute in Canada concluded that both techniques appeared to be equally beneficial.

A second trial involved the use of an inspiratory impedance threshold device (ITD). An ITD is a small plastic

device that can be attached to a face mask or endotracheal tube. It is designed to improve circulation by enhancing changes in intrathoracic pressure during CPR. Animal and initial human studies suggested that use of an ITD increased coronary blood flow and blood pressure. However in the NIH trial, survival and neurologic outcomes were the same regardless if an ITD or a sham device was used.



Matt D. Bitner, MD

EKG Korner: continued

The pathophysiology of atrial flutter is a reentrant mechanism. Treatment has two goals: 1. Rate control, and 2. Conversion back to a sinus rhythm. Rate control can be achieved with agents that slow conduction through the AV node. Calcium channel blockers, such as diltiazem, and beta blockers are considered first line agents. Digoxin can be used as a second line agent, or in patients with CHF. Adenosine will not be effective from a therapeutic standpoint due to its short half-life. It can be an effective diagnostic tool to slow the rate long enough to make the flutter waves more clearly seen. After rate control is achieved, conversion can be attempted with Class IA antiarrhythmics such as procainamide, or with Class III agents such as amiodarone or ibutilide. Sometimes just rate control will lead to conversion. In the unstable patient, synchronized cardioversion at 25-50 joules is the preferred treatment.

Beware the patient with an accessory pathway! In a patient who has an accessory pathway who is in atrial fibrillation or atrial flutter, all of the agents that slow conduction through the AV node, including adenosine, calcium channel blockers, beta blockers, and digoxin, should be avoided. If given they can selectively inhibit the AV node and allow the atrial impulses to be conducted down the accessory pathway instead. The accessory pathway does not have the built-in rate limiting effects of the AV node, and can lead to 1:1 conduction of atrial impulses, leading to ventricular rates of 250-300, which can be disastrous.

In summary, always think of atrial flutter when the heart rate is near 150, control the rate with calcium channel blockers or beta blockers, convert with procainamide or amiodarone or ibutilide, and always consider whether the patient might have an accessory pathway before giving AV nodal blocking agents.

Ben Holton, MD is a graduate of Vanderbilt University and Emory University Medical School, conducted residency at Carolinas Medical Center in Charlotte, NC, and is on faculty at Emory in the Dept. of Emergency Medicine since 1993. Currently serve as a Society Mentor to medical students under Emory Medical School's new comprehensive redesign of its undergraduate medical education curriculum. He can be reached at bholton@emory.edu.

Stephen A. Shiver, MD, FACEP is associate professor of Emergency Medicine and Residency Program director at the Medical College of Georgia. Clinical and research interests include resident education, emergency ultrasound, airway, and trauma. In addition to his emergency medicine training, he completed a general surgery residency at Wake Forest University Baptist Medical Center and is board certified by the American Board of Surgery. He can be reached at sshiver@mail.mcg.edu.

The EPIC welcomes Letters to the Editor and original articles. For original articles include a brief biography and a photo in JPEG format. Forward all images in JPEG format as well. Send them to Dr. Rogers, Editor at jrogers@gcep.org or editor@gcep.org

Asset Allocation Drives Returns

by Setu Mazumdar, MD, President and Wealth Manager, Lotus Wealth Solutions



Setu Mazumdar, MD

As you start your busy ED shift EMS rolls in your first patient: a 40-year-old male involved in a high speed MVA complaining of chest pain and abdominal pain. His vital signs reveal a heart rate of 160, a BP of 80/40, a RR of 30 and a pulse ox of 85% on 100% oxygen. You also notice a 2 cm laceration on his foot. What do you do first: intubate him or suture his toe laceration?

You might think this is a ridiculous question and I should be shot for even asking it. We all know to address the airway first, but when it comes to managing investment portfolios most individual investors and financial advisors do not concentrate on the most important piece.

Asset Allocation Defined

Before looking at the academic evidence it's important to understand some basic terminology. An asset class is simply an investment with unique risk characteristics. Examples of broad asset classes include stocks, bonds, real estate, and commodities. These asset classes can be further subdivided. For example, stocks can be categorized as large company or small company stocks, U.S. or international stocks, growth or value stocks. Asset allocation is simply the mix of different asset classes that makes up your investment portfolio.

The Evidence

What does financial science conclude as the most important determinant of investment returns? A landmark study of 91 pension funds in 1986 looked at the contribution of asset allocation, stock picking, and market timing (jumping in and out of the market) on the variation in portfolio returns. The study concluded that "total return to a plan is dominated by investment policy decisions," referring to asset allocation as the key in explaining variations in portfolio returns. In fact in that study asset allocation explained about 94 percent of variations in portfolio returns. Subsequent studies not only confirmed these findings but they also showed similar results in other time periods and internationally as well. Perhaps the most interesting finding in follow up studies is that stock picking and market timing actually detract from investment performance – from 1 to 2 percent annually. If the broad market returns 10 percent over time, you're losing between 10 to 20 percent of your returns by trying to pick the winning stocks or predicting market trends. So, if you are trying to pick the winning stocks, or your advisor is trying to pick the winning stocks (or thinks he knows a money manager or mutual

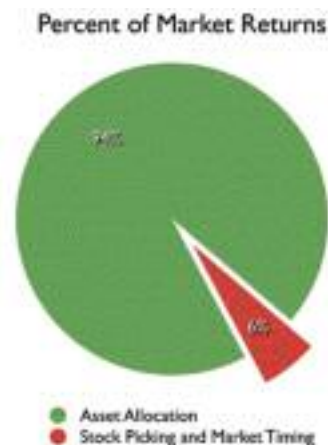
fund manager who can pick the winning stocks or time the market), guess what? You are choosing the toe laceration over the airway! If you don't do this with patients, don't do it with your investments.

Risk and Return

Since asset allocation drives returns and an asset class reflects underlying risk, it's actually risk that fundamentally drives returns. When you hear of someone getting really high returns, always ask how much risk they took to get those returns. While you can achieve high returns, you must take more risk to do so. Riskier asset classes include small company stocks, international stocks, and commodities among others.

The Optimal Asset Allocation

Determining the appropriate amount of risk depends on your unique risk preferences, particularly your ability, willingness, and need to take risk. As physicians most of us are able to take more risk due to our relatively stable and higher incomes. Willingness is purely psychological and answers the question, "Can I sleep at night with my current portfolio?" If you can't, tone down your risk. Your need to take risk depends on your financial goals and likelihood of meeting them. If your goals are modest or you have a high savings rate or low expenses, you may not need to take much risk in your portfolio.



Source: Brinson, "Determinants of Portfolio Performance"

Conclusion

Asset allocation, which reflects investment risk, primarily determines investment returns. In this context it does not matter whether you own Google stock, Microsoft stock, or Coca-Cola stock. It's simply the underlying asset class that provides the airway for your portfolio.

Setu Mazumdar, MD is president and wealth manager at Lotus Wealth Solutions, an independent fee-only wealth management firm in Atlanta, GA. Lotus Wealth Solutions provides investment portfolio management and comprehensive financial planning for physicians. Setu received his MD from Johns Hopkins School of Medicine and he is board certified in emergency medicine. He can be reached at setu@lotuswealthsolutions.com or 404-816-9555, www.lotuswealthsolutions.com.

Strength Through Teamwork

by Jack Rodgers RN, BSN, NREMT-P

While sitting in the EMS station during a recent shift, my partner and I happened across a movie entitled, "Something the Lord Made." The film is set in Nashville in the 1930's. A research doctor by the name of Albert Blalock takes in a young man to work as a laboratory assistant, without knowing of the young man's desire to be a doctor himself. The movie goes on to chronicle the duo's pioneering work in vascular surgery, developing a procedure aimed at saving the lives of children diagnosed with Tetralogy of Fallot.

One important detail I failed to mention about the doctor and his assistant – the research doctor is a well respected white man from a very affluent family. The lab

assistant, Vivien Thomas, is an African-American carpenter who comes from a long line of slaves. They are two very different people in terms of background but have one common goal – the well-being of their patients.



Jack Rodgers, RN

Those of us who choose to work in emergency medicine fit that same description. We hail from different walks of life and all have different reasons for selecting the paths that we've chosen. But if we are to succeed in meeting the needs of our patients, we must put any differences aside and practice with a united focus. We, together, must strive for nothing less than safe practice while ensuring safe care to those reaching out for our help. That's why it's vital that the relationship between ED physicians and emergency nurses all across the Peachstate be a strong one.

"The way the doctor and the nurse worked together made me feel better."

Emergency departments across the country are facing unique challenges. We are the safety net of the American health care system so our departments are crowded beyond capacity. Our beds are constantly clogged with admitted patients who are unable to get inpatient beds. We are also being asked to "broaden our horizons" and focus more attention on the way we care for the psychiatric patient. Our physicians are being taxed and our nurses are getting frustrated. That's why it's imperative that we work on solutions to these problems together.

The Emergency Nurses Association has established a goal related to advocacy and collaboration – be the key thought leader representing emergency nursing in practice and healthcare policy. We are especially proud here in Georgia that so many of our chapters are making an effort to reach that goal by working hand-in-hand with our ED doctors to put policies and protocols into place that make it easier for us all to target our biggest concerns. Our organization would like to see Georgia recognized as a national leader when it comes to collaborating among our peers – all disciplines that work in and through the emergency department – in order to address our problems.



Dr. Alfred Blalock and Vivien Thomas during ground-breaking "blue baby" cardiac surgery in 1945. Permission from Johns Hopkins Medicine archives.



Dr. Mark Cousineau (left) confers with Courtney Yeagan, RN (right) about a patient assigned to their care. (St. Francis Hospital in Columbus)

continued on page 19

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Get to Know Your Board of Directors:

Matt Bitner, MD, Director at Large

by John J. Rogers, MD, FACEP, jrogers@gcep.org

It was his grandfather, a country doctor who eventually became a radiologist and founded a school of radiology, who first influenced Matt into a career in medicine. I remember pouring over medical books in his study when I was a child. After graduating from Hampden Sydney College in Virginia as a member of Phi Beta Kappa, Matt attended the University of Miami School of Medicine. He graduated in 2004, again having distinguished himself academically as a member of the Alpha Omega Alpha Honor Society.

His academic, clinical and teaching abilities were recognized with several awards during his residency at Emory University where he continued his training as a Fellow in Pre-Hospital and Disaster Medicine. During this Fellowship he was awarded the SAEM Medtronic/Physio-Control EMS Research Fellowship. He has served as a Medical Director and consultant to several Emergency Medical Services, including Grady EMS. Because of this expertise he lectures widely including visits to Bogota, Columbia, Kigali, Rwanda, Tbilisi in the Republic of Georgia and most recently Maputo, Mozambique.



Matt D. Bitner, MD

Dr. Bitner also serves as a medical director at marathon and cycling events including the Tour de Georgia, Tour of Missouri, and the Tour of California. These activities afforded him an opportunity to meet Lance Armstrong whom he describes as a very nice guy.

It was in geometry class in middle school that he met his wife, Alison. They live in Decatur, Georgia with their young daughter Kinsley and Bella their beloved dog, the fourth member of their family.

Matt is an emergency physician practicing clinically at Emory University Hospital and Grady Memorial Hospital. He is an assistant professor in the Department of Emergency Medicine at the Emory University School of Medicine. In June of 2010 he will complete his first term as an elected Director at Large of the Georgia College of Emergency Physicians. He serves on several committees for ACEP and SAEM and is the heart and soul behind the EMS/Pre-Hospital Track during the GCEP Annual Meeting every June.

Strength Through Teamwork: continued

I hear comments from colleagues around Georgia about the trust they've been able to build with physicians in their facilities. In recent days, I have heard good comments from doctors about the attitudes and abilities of ED nurses. As we continue to work together to meet the needs of our customers, it's my strong belief that we will find solutions to the problems that we face which, in turn, will lead to lower "left without treatment" numbers and higher patient satisfaction scores. Case in point – a comment card left by a patient recently treated in my facility noted that, "the way the doctor and the nurse worked together made me feel better."

We work in the emergency department for a reason. Whether it be the adrenaline rush, the constant movement, or even the novelty that goes along with the complaints that some of our patients present with, we have chosen to put ourselves on the frontlines of the healthcare battle. It's time that we focus our attention on becoming one force, doctors and nurses, united in the

fight to meet the needs of those who walk into our already crowded waiting rooms. And the only way that those patient needs can be effectively met is by addressing their care with a team approach.

In the movie mentioned earlier, Dr. Blalock told a group gathered to recognize his achievements this: "I believe so many people could not have accomplished so much without a strong, unified effort." That applied to his surgery team in the 1940's. And it certainly applies to the emergency department teams assembled in hospitals around Georgia today.

Editor's Note: Dr. Blalock was born in Culloden, Georgia. He attended the Georgia Military Academy in Milledgeville and the University of Georgia before embarking on his medical studies.

Mr Rodgers is a graduate of Columbus State University and currently works as a staff nurse in the emergency department at St. Francis Hospital in Columbus. He is the President-Elect of the Georgia State Council of the Emergency Nurses Association and is a frequent lecturer for state and regional nursing educational conferences.

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