EPIC

The Magazine of the Georgia College of Emergency Physicians

WINTER 2013

Georgia College of Emergency Physicians Law Day 2013

In this issue:

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Correction: In Fall 2012 issue of EPIC on page 17, Larry Mellick, MD, MS, FAAP was not listed as one of the author's of Snakebite Management in the ED: When is Fasciotomy and Dermotomy Indicated? Please excuse our error.

On the Cover:

GCEP Law Day: Tuesday, January 29th, left to right: John J. Rogers, MD, FACS, FACEP, President-Elect, Georgia College of Emergency Physicians, Board of Trustees, Emergency Medicine Foundation; W. Scott Bohlke, MD, President of the Medical Association of Georgia, Board of Directors MAG Mutual Insurance Co., Bohlker Family Practice, Brooklet, GA; Jacueline W. Fincher, MD, MACP, Board of Governors of the American College of Physicians, McDuffie Medical Associates, Thomson, GA; Matt Watson, MD, FACEP, President of the Georgia College of Emergency Physicians, partner at Northside Emergency Associates; and Matt Lyon, MD, FACEP, Secreatary/ Treasure, Georgia College of Emergency Physicians

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

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From the President

Why am I Doing This? Let me Count the Ways...

I am returning from the ACEP ED Directors Academy, racking my brain for a topic for this *EPIC*. This was one of the best conferences I have attended, and I have such a "good feeling" about the practice of emergency medicine, when it occurs to me that I need to just reinforce why I love doing this type of work. I know everyone out there practicing EM (I hope!) loves what they do, because it is too demanding of a job to do if we don't love it! There are many reasons to enjoy this specialty, and it's multifaceted. Like so many things in life, the drawbacks that we sometimes see about our own work can easily be viewed as the same attractive reasons we went there to begin with.

The first, and most important aspect of the job is to care for the patient. We are there to help those in need, when they have nowhere else to go. Or if they have some issue that is too time sensitive or complex to wait for their "regular" doctor to deal with, whether primary care or specialist. We should not forget this, because we have fought so hard to convince legislators of over the past few years that if the patient believes that their issue is emergent, then it surely must be. The prudent layperson is always right! I know that we sometimes feel that our services are taken advantage of, but until we provide that "screening examination," and are sure that the back pain exacerbation is not a dissecting AAA, then that patient is having an emergency. We need to put away the idea that we can be "inconvenienced" by a patient. There will be patients whose complaint could surely have waited until the clinic was open then next day, but something in their mind made it an emergency today… so it is!

Second is that we provide a service to our primary care and specialty colleagues. We evaluate, screen, treat and "triage" the patients to the appropriate inpatient or outpatient follow up, if necessary. We are a cost effective after-hours method for providing the care when the regular offices are closed. We determine whether the 24-year-old with chest pain has minor (pleurisy), medical (pulmonary embolus) or surgical (pneumothorax) needs, and provide appropriate treatment. Unlike some of our primary or specialty colleagues, we like the challenge of the initial differential, and the determination of what is now and what can wait: what is medical versus surgical.

Problem solving skills are an important aspect of the job, and using them on many different levels. We frequently have to puzzle out exactly why the elderly nursing home patient is sent in at 2 a.m. with no particular complaint of their own. Finding a way to stop the bleeding, or put together a skin tear, or reduce the fracture/dislocation. Getting the patient with a Dilaudid deficiency to understand that you are not a pain clinic with out setting off the "Press-Ganey" alarm. Getting the hospital administration to "fix the holes" in the call schedule. We have many different challenges we face, and find creative ways to resolve.

Another aspect of the job, which is not practiced by all in the specialty, is to protect the specialty, the patients and the providers by becoming "activists." We have to get out there and support the PAC (political action committee), and lobby the legislators. Make yourself available to your senator or congressman. Invite them to the ER to see what the issues of boarding, and psychiatric holds have on the ability to care for the population that they represent.

We also have to perpetuate the specialty. Whether by participating in a training program or an organized medicine organization such as GCEP, or being a leader within your own employment organization, we have to leave a legacy. We need to encourage the future leaders of the specialty to step up, get involved, teach, lobby, lead, heal and move forward. There are many unknowns at this time, and a lot of uncertainty as to where healthcare will be in the next 5, 10 or 20 years. But one thing is certain: it will still be here. There is no way to just "eliminate" healthcare, especially our unique entry

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

point to medical services. One way or the other, someone will be doing what we do. Maybe just a little differently than we do it now.

So, remember why you went into the job, and also reflect on the things that you have added to the job/career. Enjoy the moment, and the journey. We have one of the best jobs out there, and the day-to-day demands can make us forget why we like it. Try not to become jaded, or burned out. Love what you do!

Our last event of the year was the 2nd Leadership and Medical Directors Forum, December 4-5, at the Ritz Carlton in Reynolds Plantation near Lake Oconee, GA. We had a spectacular agenda and speakers list, as well as a delicious dinner program. Our program included updates on the psychiatric system, the narcotic monitoring program, EDIS, GEMPAC, and a national speaker, Dr. Kevin Klauer. This was one of our most successful meetings this year. Make room on your calendar for next year's event.

Finally, looking forward to 2013, there are bound to be some interesting issues to arise. GCEP needs you to be involved. Take the time, and join us at one, two or all of the events that we have for you. Helping shape and protect the environment in which ED physicians practice and care for their patients are the reasons why we exist as an organization.

ACEP Committee Interest is Now Open

Committee interest for FY 2013-14 is now open. Various ACEP publications will outline the process for members and information is also on the ACEP Web site. Members interested in serving on a committee, and who are not currently serving on a national committee, must submit a completed committee interest form and CV by May 17, 2013. The CV and any letters of support from the chapter can be attached to the online form (preferred), emailed to: mfletcher@acep.org. Chapter input is invaluable to this process. If you have personal knowledge of the level of commitment and talent exhibited by the interested member, please consider submitting a letter of support.

The online application form is available http://webapps.acep.org/Membership/committeeinterest.aspx. You will be asked for your log in and password if you are not currently logged into ACEP.org.

The committee selection process will occur in mid-June and applicants will be notified by the end of July. Members chosen to serve on committees will serve a minimum of one year, beginning with the committee's organizational meeting held during the Scientific Assembly in Seattle, October 14-17, 2013. (Funding is not provided to attend the organizational meeting.)

PLEASE NOTE: Current committee members DO NOT need to complete a committee interest form. Current committee members will soon receive the annual committee evaluation form and will have the opportunity to indicate their preferences for next year.

SAVE THE DATE!

2013 Southern Coastal Emergency Medicine Conference

June 7 - 9

Kiawah Island Golf Resort

Kiawah Island, SC

From the President-Elect

Too Smart for Politics?

John J. Rogers, MD, FACS, FACEP, President-Elect
Board of Trustees, Emergency Medicine Foundation

Those who are too smart to engage in politics are punished by being governed by those who are dumber.

Plato

427 BC – 347 BC

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Dr. Rogers is president-elect of GCEP.

On Tuesday, January 29th we met high atop the Floyd Building across the street from the Georgia State Capitol for our GCEP Legislative Day. I want to thank all of you who attended, including the residents from Emory and the Medical College of Georgia. We had several guest speakers and their messages were pertinent and well delivered.

The Governor of the Georgia Chapter of the American College of Physicians, Dr. Jacqueline Fincher, MD, MACP, spoke about the benefits Georgia would enjoy if it participated in the Medicaid Expansion Program. In brief these are:

- Provide coverage to an additional 648,000 Georgians
- Help the safety net physicians and hospitals better serve their low-income patients
- Reduce cost shifting to others in the form of higher premiums
- Help the state financially, as almost all of the cost is paid by the federal government
- Reduce the amount of uncompensated care

Senator Buddy Carter, a pharmacist, discussed the current plans for a Prescription Drug Monitoring Program in Georgia. This would be a pilot program initially funded by a federal grant. Physicians would have the opportunity to access the database, but not the obligation to do so. To gain permanent funding from the state, Senator Carter suggested that GCEP should collect stories about how such a program has been beneficial as these stories are more powerful than any logical argument one could pose to a legislator. He also suggested that we ask ACEP for similar stories from around the country.

Dr. Scott Bohlke, the current Medical Association of Georgia President, gave us an update on the advocacy and legislative issues from the MAG's perspective. For me, the main take home message was that it was crucial that physicians engage and become involved on a personal level with their legislators.

The Georgia Emergency Medicine Political Action Committee (GEMPAC) and the Georgia College of Emergency Physicians (GCEP) have adopted the following as our Legislative and Advocacy Priorities for 2013:

Protect Tort Law
- Oppose challenges to the gross negligence standard

Solutions to Boarding of Psychiatric Patients
- Work with state officials to find solutions
- Consider legislative action if no progress

Prompt Pay Legislation/Regulation
- Currently GA law only applies to 35% of carriers
- Work with ACEP on a federal solution that applies to all carriers

Fair Payment
- Work with ACEP on a federal solution
- Use of the Fair Health database for out of network reimbursement

Universal Access/Prudent Layperson Standards
- Share the Washington state experience with legislators
- Be alert and respond to similar events in Georgia

Colorado Initiative on Correct Coding
- Addresses inconsistent coding rules across carriers
- If successful, consider similar action in Georgia

Georgia Health Sciences University Emergency Medicine Residency Update

Stephen A. Shiver, MD, FACEP, Residency Program Director

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

What's in a Name? That has been a popular question in the Augusta area over the past year or so. We are in the midst of some serious name confusion. Let me explain.

The Medical College of Georgia (MCG) was founded in 1828, is one of the oldest medical schools in the South, and is the 13th oldest in the nation. The medical school flourished throughout the 19th and 20th centuries and the MCG brand was firmly established. All was well in the world.

By the dawn of the 21st century, campus activities had grown exponentially and encompassed much more than simply the medical school. Growing schools of Dentistry, Nursing, and Allied Health all called our campus home. Thus, a movement was undertaken to choose a name that better reflected global campus activities and Georgia Health Sciences University (GHSU) was born in 2010. Of course, with a name change comes a plethora of headaches. Much to our chagrin, our email went from @mcg.edu to @georgiahealth.edu. New signage started popping up all over campus. And slowly, we began to embrace "GHSU." All was well in the world once again.

The financial crisis brought unprecedented stress to both federal and state budgets. Efforts to streamline processes and maximize efficiency were in vogue and discussions were initiated to merge the newly formed GHSU with Augusta State University, a liberal arts college also in Augusta. Students and faculty at both institutions remained unconvinced of the merits of the proposal. However, the idea gained traction over time as the merger did seem reasonable, and potentially beneficial, on a number of levels. But what about the name?

Many names were floated including Arsenal University, Bartram University, University of Augusta, Georgia National University, and Georgia Regents University. Ultimately, the powers that be chose Georgia Regents University (GRU). To say that the name was not immediately embraced would be a bit of an understatement. In particular, the Augusta citizenry was in a near riotous mood. The editorial page of the venerable *Augusta Chronicle* went wild. Signs declaring "Save the A" began popping up all over town. Even our president awoke one morning with dozens of "Save the A" signs in his front yard. They were promptly removed.

In essence, native Augustans felt that Augusta was being left out, being forgotten, and a compromise was ultimately enacted. The "legal name" would be Georgia Regents University, but the "brand name" would be Georgia Regents University Augusta. Are you confused yet?

The fervor has now died down a bit and things are getting back to normal, or at least back to a new normal. The majority of the involved parties, even if not excited about the name, are enthusiastic about the new institution's future. Sure, some people are still having a bit of fun at our expense, coining terms such as GRUSOM for Georgia Regents School of Medicine, etc. But the signage is going up and our email is now mercifully shorter, @gru.edu.

The newly created GRU has greater than 9,000 students, approximately 1,000 faculty, and some 10,000 enterprise-wide employees. There are 9 colleges and 110 offered degrees. We even have multiple Division II sports programs and a NCAA Division I championship golf team (2010 and 2011). Change is challenging, but exciting, and times are good. Give us a call if you have questions and just embrace the new GRU! Our Program Coordinator, Janelle Davis, may be reached at (706) 721-2613.

Pediatric Emergency Medicine Fellowship at the Medical College of Georgia, Georgia Regents University, Augusta

Natalie E. Lane, MD, FAAP, PEM Fellowship Director

"When you 're finished changing, you're finished." Benjamin Franklin.

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Dr. Lane is the Pediactric Emergency Medicine Fellowship Director at the Medical College of Georgis, Georgia Regents University in Augusta, GA.

No truer words can be said for oneself, one's profession or apparently for one's own institution. Not only has the health system in our region gained a new name but also our beloved Children's Medical Center additionally has morphed into the Children's Hospital of Georgia (CHOG). Having recently worked a shift, I was surprised when one mother with children less than seven years of age lamented about the name change indicating that she can't imagine it being any other. Our visionaries feel that CHOG more appropriately identifies what we are to the state and its children.

So with the institutional changes to include not only names, but also leadership, I can't help but ask is our program still relevant and progressive? Are we keeping up with the change in pediatric emergency medicine? There is no doubt that one of the obligations of our program is to keep up with the New Accreditation System of the ACGME. Our program coordinators are being sent to seminars and maintain a close eye on publications and graduate medical education information as it is provided. Our program directors are attending conferences and webinars and bringing back information to the faculty in order to keep everyone aware of the elements critical in the development and competence of our future fellows.

It is critical that fellows in pediatric emergency medicine understand that patient satisfaction, quality and efficiency in the emergency setting are intimately linked and engagement in those issues will influence their success once they are on their own. The fellowship incorporates the fellow in a number of venues focused on these aspects. They are placed on hospital and departmental committees that focus on the improvement of patient flow and other quality issues.

Our fellowship places a great deal of focus on fellows as teachers in a variety of settings. Not only are the fellows critical to the clinical care of patients in the emergency setting, but also they serve as mentors to the students and other resident rotators within the department. This year, the fellows under the leadership of our senior fellow Dr. Anthony Saldivar, a senior medical student and pediatric and emergency medicine intern monthly mini curriculum has been developed to include didactics and simulation models on pediatric trauma, seizures, respiratory distress and toxicology. The organization and development will be under the reigns of the fellows as we go through the years.

There is no doubt that those of us who graduated from fellowship more than 10 years ago are at a disadvantage when it comes to the use of ultrasound within our clinical practice. However, not recognizing its potential value in the pediatric emergency setting would be an injustice to current and future fellows. At the Medical College of Georgia we have a great marriage between our strong Ultrasound fellowship headed by Richard Gordon (director), Matthew Lyon (section head) and Walter Kuhn (pediatric emergency medicine, international medicine and ultrasound expert) and our section on pediatric emergency medicine. In fact, our current fellow,, Matthew Steimle as well as our incoming fellow Darin Willardson will be the pioneers in our joint fellowship venture. They are planned to complete the two fellowships within a two and a half year time frame. Our program at present trains only graduates of emergency medicine programs. The PEM faculty will most likely benefit from this close association.

As director of the fellowship program, I anticipate that there will be even more challenges in the near future as healthcare evolves. We will do our best here at this program to keep up with the changes.

Research Update Emory Emergency Medicine

Phillip Shayne, MD, FACEP

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

The NRMP rank lists went in this week, wrapping up our official recruitment season. The Match Day is March 15 (fittingly or ironically my birthday) when we find out who are new residents will be. It continues to be a buyers' market for emergency medicine programs with more and more accomplished students going into emergency medicine. This year there could be more US graduates applying for emergency medicine than there are positions in the Match. Emory received greater than 1,300 applications for 19 positions, a record for us and up by more than 10% from last year. The quality of the applicants continues to improve and it is exciting to see the top students going into emergency medicine. We had 21 of our own students, between Emory and Morehouse going into EM, and I anticipate that EM will be the second most popular specialty for Emory's class of 2013 (after internal medicine). Additionally, for all their idiosyncrasies, this is a generation that really values education and life experience and many of the students are coming with extra degrees and "gap year's" where they've done amazing things. Us 'old guys' would have a hard time getting a position if we had been applying today.

The rule of thumb is to interview 10 students for every one position, so we dutifully interviewed over 200 applicants. In truth it is difficult to screen out students based on their applications and it would be great if we could meet all of them. While the vast majority of US medical students will get a position in emergency medicine, for the last few years there have been virtually no spots open for applicants to scramble into if they do not match. In fact as medical school enrollment increases and residency positions remain capped by the federal government, getting any position has become tighter and tighter. The AAMC refers to this as the "jaws of death" and predicts that soon not all medical students will be assured of a residency position.

To that end, Emory embarked on an experiment in diversifying residency funding. Emory emergency medicine has a unique arrangement through the Saudi Arabian Cultural Ministry to train some of their physicians in addition to our own. So in addition to the regular candidates, we received 35 applications from the Saudi's, interviewed a dozen and have the option of taking one or two. We currently have three Saudi physicians in the residency, raising our total number of residents to 60. So far they have been excellent, and the funding source allows us to let the resident do interesting rotations off-site. Last year we had residents on electives in Zimbabwe, Singapore, Nigeria, Turkey, and New York City. And an increased number of residents have time to devote to research and to public health work through our connections with the CDC.

EMORY UNIVERSITY SCHOOL OF MEDICINE

At home, Grady remains the heart of the residency program. The Emory residents spend two thirds of their time at Grady, the majority in the Emergency Department. The Grady ED is much different today with the addition of the state-of-the-art Marcus Trauma Center, an EPIC EMR and systemwide PACS; all installed in the last three years. While our waiting room remains crowded, we now know how many patients are waiting and the hospital has made dramatic changes in boarding and length of stay metrics. The ED rooms have been updated, and even have TVs! It has been fun to live through the Grady Renaissance and more changes are in the works. The Grady Health Foundation has a slick video that highlights some of the ordeal at http://www.gradyhealthfoundation.org/grady-tv/what-if-there-was-no-grady/.

Atlanta will host the Society for Academic

Emergency Medicine Academic Assembly in May. It has been 10 years since SAEM was last here and with participation over 2,000 it will probably be the largest Emergency Medicine conference ever in Atlanta. We look forward to being the host program and have an opportunity to highlight our work at Grady and Emory.

Coastal Emergency Medicine Conference Set for June, 2013

Matthew Bitner, MD, MEd, FACEP

For more than a decade, the Georgia, North Carolina, and South Carolina Chapters of the American College of Emergency Physicians have individually gathered Emergency Physicians, residents, nurses, nurse practitioners, physician assistants and associated professionals for cutting edge educational meetings. In 2013, they have joined together to form the Coastal Emergency Medicine Conference (CEMC), to be held June 7-9th, at the Kiawah Island Golf Resort. Even in it's inaugural year, the conference is drawing nationally recognized faculty to discuss a variety of advanced Emergency Medicine topics. From trauma, stroke and chest pain to pediatrics, toxicology and orthopedics CEMC is offering didactics to fill any of your educational needs. We've coupled these cutting edge lectures with a hand-on airway workshop as well as a highly rated LLSA review session to provide you with a comprehensive opportunity to maximize your CME time all in the setting of beautiful Kiawah Island Golf Resort and the 5 Diamond Sanctuary, a world renowned resort. Come join us to stay up to date on current best practices, see technology that is on the horizon for our specialty, and mingle with family, friends, and colleagues. Experience first hand what promises to be the premier Emergency Medicine conference on the East Coast!

STEMI With a Twist

Stephen A. Shiver, MD, FACEP

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

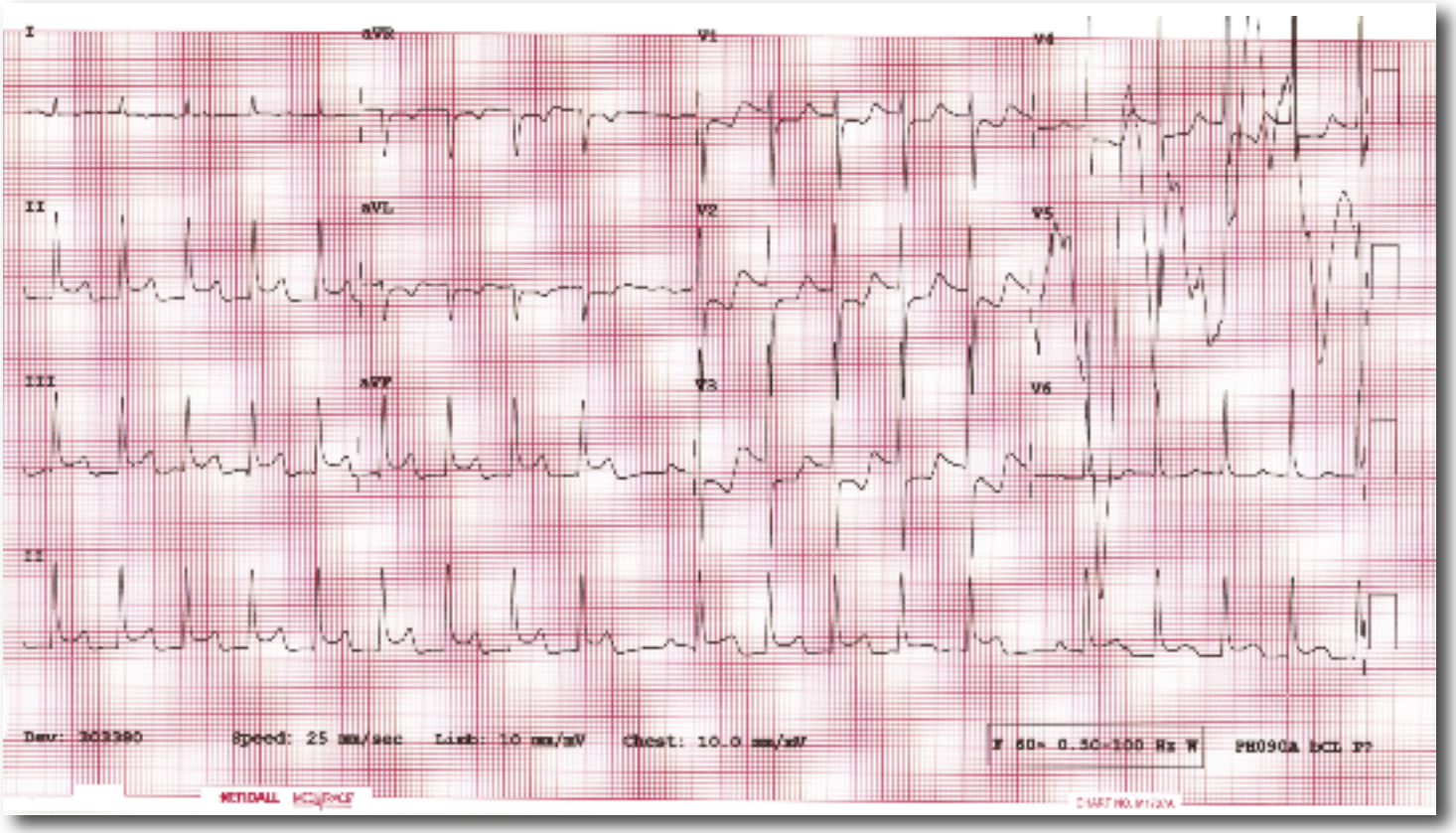
A 74-year-old male was brought to the ED by EMS for evaluation of altered mental status. During the AMS workup, the pictured 12 lead EKG was obtained. A diagnosis of inferior STEMI was made based on the ST elevation noted in leads II, III, and aVF. There are also reciprocal changes noted in leads aVL and V1-V3, a typical distribution for reciprocal changes accompanying an inferior STEMI. Also of note, the prominent R-waves, ST depression, and upright T-waves in the right sided precordial leads (V1-V3) suggest possible concomitant posterior STEMI. But what about that rhythm?

Discussion:

The most important thing to quickly identify in this patient is the presence of an inferior, and possibly accompanying posterior, STEMI. No question, the patient would be a candidate for a quick trip to the cath lab or thrombolytic administration. The abnormal rhythm is almost an afterthought.

The majority of the rhythm strip (lead II at bottom) shows a regular, narrow complex tachycardia without obvious P-waves. It is not completely regular, however. There are three discrete areas of QRS complex grouping. The 2nd and 3rd groups of QRS complexes follow a pause and are preceded by definite P-waves. Grouped beating should always bring to mind two possibilities: Mobitz I, also known as 2nd degree AV block type I or Wenckebach, and regularly occurring premature beats, such as premature atrial contractions.

The rhythm here is actually an example of Mobitz I occurring in the setting of acute MI and tachycardia. The majority of the P-waves are buried within the T-waves, thus making interpretation difficult. The PR intervals are lengthening with each cycle until a dropped beat occurs followed by re-initiation of the same pattern.



Focus on the last grouping of QRS complexes. The initial P-wave is clearly visible. A subtle bump in the T-wave immediately following the first QRS complex in this group is in fact a P-wave. Each PR interval gets progressively longer resulting in the P-waves being buried in the T-waves.

Wenckebach is much easier to identify in a non-tachycardic rhythm, but remember that it can occur in the setting of tachycardia. The presence of grouped beating is often an important clue.

Emergency Medicine News

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I recently entered the blogosphere. Last year I began writing an online blog for Emergency Medicine News. My academic hobbies of clinical photography and video production apparently caught the eye of the editor, James Roberts, MD, who approached me about writing for the publication. The print circulation of this award winning publication is 33,000 readers and Emergency Medicine News has been ranked #1 for 18 consecutive years. The online circulation EMN's website, www.em-news.com, sees more than 25,000 unique visitors each month. Last year EMN's website had more than one million page views.

My blog is called the M2E Too! or Mellick's Multimedia EduBlog. The light hearted name was chosen to acknowledge that it is one of many excellent emergency medicine blogs. Even though it is one of many, this blog has some unique features. Besides well-researched discussions of various cutting edge clinical issues, the blog typically includes clinical photographs and a clinically instructional video. If you are interested in viewing the blogs, clinical photographs and videos, go to http://journals.lww.com/em-news/pages/default.aspx and click on the "blogs" tab.

Burns: Treat or Transfer?

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Fred Mullins, MD, FACS, is the president of Joseph M. Still Burn Centers, Inc., as well as the medical director of the nation's largest burn center – the Joseph M. Still Burn Center at Doctors Hospital in Augusta, GA. If you have any questions regarding burn care or patient transfer, you can call Dr. Mullins at 706-830-7511 or 877-863-9595, email him at fred.mullins@jmsburncenters.com, or visit the JMS website at www.jmsbc.org.

Fred Mullins, MD, FACS

With approximately 450,000 burns each year requiring medical attention, chances are you will see a burn injury in your emergency department. However, treating a burn can require the specialized care offered by a burn facility to ensure a burn patient the best possible outcome, both from an appearance and pain management point of view.

But how do you know when you should treat a patient or transfer them? How do you know what you are looking at? Is the burn first, second, third or fourth degree? What should you do to treat the burn or prepare the patient for transfer? And, what shouldn't you do?

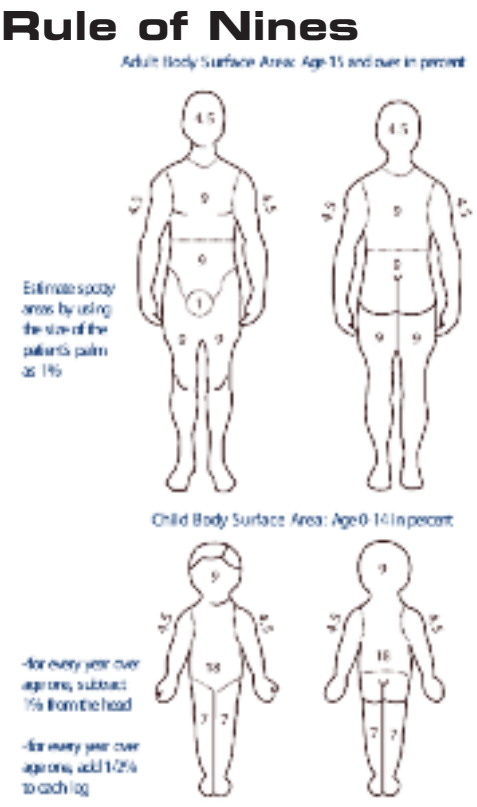
First and foremost: ignore the burned skin. Check the patient for any signs of other trauma, and respond accordingly if you find other injuries. Treating the burned skin can wait. Other severe trauma cannot.

Now, if there is no other trauma, let's focus on the burn.

Degrees of burns

There are four degrees of burn injury:

- First-degree, which involve only the first layer of skin
- Superficial and deep second-degree (partial-thickness burns), which impact the epidermis and the papillary dermis, or – in severe cases – the reticular dermis
- Third-degree (full-thickness) burns, which extend into the subcutaneous tissue
- Fourth-degree (deep full-thickness burns), involves muscle, tendon, nerves and bone.



First degree burns usually heal within a week, and are most often associated with minor sunburns. There is no blistering or sloughing of the skin, while the patient will experience minimal to moderate pain and can expect healing in less than a week.

Second degree burns are characterized by blisters forming on the skin and some sloughing, or peeling. They will blanch with slight pressure. These burns are often painful, and – with proper wound care – can heal with minimal scarring in about two weeks. Deeper second degree burns may display a pink or red wound bed, with a buildup of proteinaceous exudate or pseudoeschar. While a deeper second degree burn will blanch less and seem less painful to the patient than more superficial burns, they may require surgery to heal and pose a higher risk of infection.

Third degree burns will appear dry and leathery, and feel almost firm to the touch. Close examination will reveal clotted vessels in the burned area. However, because nerve endings are compromised in a full-thickness burn, the patient often feels little pain associated with the injury. Requiring extensive excision and skin grafting, third degree burns often result in significant scarring and are at a high risk for infections and, if a large portion of the body is affected, death.

Fourth degree burns are often associated with sustained contact with a heat source or a significant electrical injury. These burns usually expose burns and other underlying structures, leaving them with a charred appearance. Unless the injury is contained to a small area, these injuries often require amputation or other significant surgical intervention.

It is important to note that when a burn first happens, what you see initially is not always what you end up with. A burn can progress over the first 12 to 24 hours, which means they certainly need follow-up examination the next day.

Calculating TBSA

The American Burn Association recommends referring to a burn center, any patient with a partial-thickness (second degree) over more than 10 percent of their body or a third or fourth degree burn of any Total Body Surface Area (TBSA). To calculate the TBSA of a burn, you have a couple of options. First, you can usually assume that a patient's palm constitutes 1 percent of the patients' body, and then estimate the size of the burn in comparison. This is often most effective with smaller burned areas. For larger burns, it may be best to rely on the Rule of Nines:

- Each arm – 9% of the body
- Head and neck – 9%
- Each leg – 18%
- Anterior trunk – 18%
- Posterior trunk – 18%
- Perineum – 1%

(Remember, these guidelines should be adjusted for infants as their heads are often proportionally larger than an adult.)

Initial Care and Patient Transfer Preparation

If a burn patient does come to your facility, it is important that you follow your ABCs:

A – Airway
B – Breathing
C – Circulation
D – Disability

The importance of assessing the airway and breathing ability cannot be overstated. Due to the nature of their injuries, burn patients may have some sort of inhalation injury. Intubation may be necessary, but there are several factors to take into consideration:

- Is the patient's voice hoarse?
- Is the patient's Glasgow Coma Scale score below 8?
- Is the patient's chest constricted by burns? Are the burns full-thickness?
- Is there evidence of an inhalation injury, like singed facial hair or residue in the mouth?
- Does the patient show elevated levels of carboxyhemoglobin?
- If edema develops, will the patient's airway be impacted?

If you decide there is no need for intubation, the patient should be administered 100% humidified O2.

Burn patients also need large amounts of fluid. The level of Ringer's Lactate depends on the age of the victim and the mechanism of the burn injury. Adults and young adolescents should receive 30-50 cc/hr, while children under 30 Kg should receive 1 cc/Kg/hr. Injuries caused by high voltage electrical sources should receive 75-100 cc/hr. High dose vitamin C can also be administered to patients with more than 30% TBSA at 66mg/Kg/Hr.

Also, prior to transfer:

- Monitor urine output hourly via a Foley catheter
- Ensure patients are being kept warm
- Always assess pulses in the extremities.
- For chemical burns, brush off any chemical residue. Use caution when using water to rinse a chemical burn as it may cause a reaction that makes the burn worse.
- Find out about the patient's medical history and ask when and how they were burned.
- Cover the burned areas in dry dressings and try to elevate injured areas.

ABA's Guidelines for Burn Referral

The American Burn Association has established 10 criteria that warrant transferring a burn-injured patient to a specialized burn center for treatment:

- Partial-thickness burns with a ≥10% TBSA
- Burns involving the face, hands, feet, genitalia, perineum, or major joints
- Third-degree burns of any size in any age group
- Electrical burns, including lightning strikes
- Inhalation injuries
- Chemical burns
- Burn injuries in patients with pre-existing medical disorders that could complicate management, prolong recovery, or adversely affect recovery
- Any burns in a patient with concomitant trauma in which the burn poses the greatest risk of morbidity and mortality. If the trauma poses the greatest risk, the patient should be stabilized in a trauma center before being transferred to a burn center.
- Pediatric burns in settings without qualified personnel or equipment for the care of children
- Burn injuries in patients who will require special social, emotional, or long-term rehabilitative interventions.

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Trench Foot or Immersion Foot

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Case:

It was January in Augusta, Georgia and there had been several days straight of heavy rains and flooding. The temperatures were around 30-40° F. A 19-year-old homeless male presented to the emergency department complaining of an inability to walk properly. Earlier that evening he had been seen at another local hospital and sent out with "booties" to keep his feet dry. He had placed the booties over his shredded and soaked sneakers.

The patient's shoes and socks were removed and the following findings shown in figure 1 were noted. Edema, macerated skin, multiple ulcerations and a repulsive odor was noted without evidence of gangrene. The patient was admitted to the hospital with the diagnosis of trench foot, started on antibiotics and was educated on proper pedal hygiene. After the flooding had ceased, the patient was discharged from the hospital.

Discussion:

Trench foot was first described 200 years ago during the retreat of Napoleon's army from Russia in 1812.[1] However; it was not further analyzed until the Great War in 1914 when it caused a significant problem for the British and American troops. During that war trench foot was responsible for 75,000 British and 2,000 American casualties.[2] In 1914 soldiers would stand knee deep in near freezing water for hours at a time. The cold and moisture would seep into the boots. A painful burning sensation would be noted at first and numbness followed. However, it was the swelling that was most problematic as their feet would become too swollen to fit into their boots. Consequently, doing what seemed to make the most sense, they left their boots on and often it was for weeks at a time. Unfortunately the skin would continue to get wet, eventually forming blisters, then ulcerations, and finally gangrene. At the onset of the disease, amputations were not uncommon.[2,3]

Trench foot is characterized by a sharp painful sensation followed shortly by numbness and finally deadened sensation in the foot. Initially, authorities debated over whether this was another variant of frost bite or a separate etiology. It was soon established as its own disease and plans were made to give it an official name. However, the term "trench foot" was already widely in use.[2]

Many theories were presented as to the cause of trench foot. It was thought that venous stasis mixed with cold temperature mimicked Raynaud's syndrome and that the gangrene was due to a lack of blood flow. Others felt that it was bacterial or fungal in nature. However even when new boots were invented that kept out the mud and moisture, soldiers were still being affected. It was finally decided that the majority of trench foot was due to poor foot hygiene and exposure in the trenches. Soldiers were given a fresh pair of socks every 24 hours and ordered to change them. Additionally, they were to groom and massage their feet as well as to do "foot exercises" such as walking around or stamping their feet to prevent venous stasis.[3]

Today trench foot (non-freezing cold injury) is believed to be caused by exposure to both cold and wet environments, namely cold water with temperatures in the 0-15° C. It initially causes vasoconstriction and decreased blood flow to the foot. This is followed by episodic vasodilation which causes swelling of the extremity. The vasodilation, which occurs every 10 to 15

minutes, is considered to be an adaptive response to cold environments designed to help maintain limb function. In individuals more likely to live in cold environments, particularly those of Scandinavian descent, the vasodilation cycles can occur even more frequently. In contrast, those of African descent are more apt to suffer from cold weather injuries and have a less frequent vasodilation cycle.[1] Although cold precipitates the disease, it is not considered to be a freezing injury as is frostbite. Frost bite is considered more serious due to freezing of individual cells, coagulopathy, and the development of free radicals. Frost bite can lead to loss of digits or limbs; and this can occur weeks after the offending event.[1,4] Though military personnel were the primary patients in the 1800's and 1900's, today's trench foot population is often seen in alcoholics, hikers, and homeless individuals.[1,4,5]

Trench foot syndromes can be divided into three phases: prehyperemic, hyperemic, and post hyperemic. In the prehyperemic phase the individuals nerves are damaged by the cold, the blood vessels are constricted, and the patient has little to no feeling in his feet. This is not a painful stage. Pain occurs during the hyperemic phase, usually several hours after rewarming starts. In addition, the patient may have severe muscle spasms, edema, and eschar formation. The final or post hyperemic stage, depending on the severity of the previous two phases, may or may not be present. It is characterized by a blue extremity with increased sensitivity to cold. In the most critical cases, patients never entirely regain sensation in their feet. Because of lost neural function frequent injuries such as blisters occur frequently and especially with prolonged walking. Infections are also more common with pseudomonas specifically. These infections can progress to gangrene and amputation.[1,4]

The best treatment for trench foot is prevention. This is primarily accomplished by keeping extremities warm and dry. In cases where it is impossible to keep the feet dry it is suggested to change socks three times a day as well as dress in layers to prevent sweat buildup next to the skin.[1,2]

In summary, trench foot, although not as common, is still seen throughout the world. It occurs primarily in areas where proper foot hygiene is not observed. In the case described above, the patient was homeless, had holes in his shoes, had no extra dry clothing, and lacked shelter from the flooding. If left untreated, patients can develop limb threatening gangrene. However, if treated properly the injured feet can regain proper function as was demonstrated with our patient.

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Ultrasound Guided Regional Anesthesia: Part

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Emergency physicians routinely manage painful pathology of the extremities. The injuries that cannot be managed with local anesthesia often require procedural sedation. Procedural sedation is usually effective for treatment of these injuries, but not without risk of apnea, aspiration, and hemodynamic complications. Furthermore, procedural sedation requires several personnel for monitoring, a six-hour period of pre-procedural fasting and a period of post-procedural observation. Ultimately, procedural sedation requires significant resource utilization and emergency department length of stay.[1] Regional nerve block anesthesia is a safe alternative tool emergency physicians should consider for patients requiring treatment of painful extremity pathology.[2,3] The 2011 American Board of Emergency Medicine model of clinical practice recommends competency in regional nerve block anesthesia. Ultrasound guided nerve blocks significantly enhance block success.[4] In this two-part series we will discuss commonly used ultrasound guided nerve blocks of the I) lower extremity and II) upper extremity.

Image 1

Image 2a, 2b, and 2c

Technique

The general technique for ultrasound guided regional anesthesia is fairly uniform no matter the nerve selected to block. The patient's bed height should be adjusted to physician comfort and the ultrasound machine set up directly across from the physician performing the block. This allows the physician to easily look from the ultrasound screen to the patient with a simple nod of the head (Image 1). The clinician may choose an in-plane (long axis) or out-of-plane (short axis) approach to the nerve. The nerve on the other hand is always viewed in short axis independent of the approach technique (Image 2). I prefer the long axis approach, as it allows me to clearly see the needle tip in proximity to vascular and nerve structures. The nerves of interest are superficial relative to the skin surface, therefore the high frequency linear probe is selected for its superior near field imaging. It is also helpful to switch the machine presets to "nerve" (Image 3). The patient is prepared widely with alcohol or chlorhexadine while the scanning surface of the probe is covered in gel followed by probe cover. A full sterile probe cover/drape is not necessary for nerve blocks not utilizing indwelling catheter directed regional anesthesia. Similar to ultrasound guided peripheral venous access a simple tegaderm or latex condom style cover will suffice. Most

Image 3a and 3b

peripheral nerves have a "honeycomb" or "moon face" appearance in cross section. The surrounding epineurium and perineurium are hyperechoic, while the fasicles are hypoechoic (Image 2c). On occasion a peripheral nerve can be difficult to identify relative to neighboring tendons. Turning the gain down and slightly fanning or tilting the probe will help the nerve stand out relative to its surrounding (Image 4). A 20-22 gauge needle works well for ultrasound guided nerve blocks. It is important to make sure you have a needle long enough to reach the target nerve. I find a 2.5-inch spinal needle works very well for most any extremity nerve block. There is no evidence to suggest short bevel, atraumatic, or highly visible needles are superior to plain needles in terms of complications or nerve block success. Deciding between lidocaine and bupivicaine is obviously dependent on the duration of anesthesia required. In light of the proximity of most peripheral nerves to large vascular structures epinephrine should be mixed with the local anesthetic to prolong duration of action. As always, the provider must be mindful of the toxic doses associated with the local anesthetic they are using. In addition, accurate weight-based dosing should be calculated for nerve blocks in the pediatric population.

After optimal location for needle insertion is identified a 25-27 gauge needle is used for puncture site anesthesia with 0.5 - 1.0 cc of lidocaine. The needle used for the nerve block is then inserted at the puncture site. Under direct ultrasound visualization the needle tip is guided to a point immediately next to the target nerve. Following aspiration to assure the needle tip is not intravascular, steady pressure is applied to the plunger to deposit a test volume of anesthetic. The anesthetic should inject with little resistance and the patient should experience no more than a minor burning pain. While injecting the anesthetic the physician should see spread of the anechoic local anesthetic around the nerve. If the physician does not see spread of the anesthetic through the soft tissues he/she should stop injecting and redirect the needle to insure the local anesthetic is not being injected intravascularly. If the provider is satisfied with the spread of

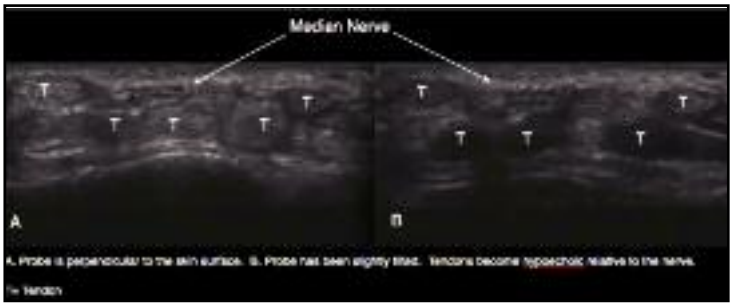

Image 4

the test doses of local anesthetic he/she may go ahead and deposit the rest of the predetermined volume of local anesthetic. It is helpful to make small adjustments of the needle tip to facilitate spread of the anesthetic circumferentially around the nerve. Of note, it is not imperative to completely incase the nerve with local anesthetic for nerve block success. For patients who require admission it may be helpful to write on the affected extremity the type of block performed, what type of local anesthetic used, and what time the block was performed. This, in conjunction with charting, should help avoid misdiagnosis of nerve injury by the admitting/consulting physician. To see the above described technique in action you can view countless ultrasound guided nerve blocks for free using online tools such as YouTube.

Fascia Iliaca block

The fascia iliaca compartment block is used to provide anesthesia to the lumbar plexus specifically, the lateral femoral cutaneous nerve and femoral nerve. The obturator nerve may also be blocked with this technique. This regional block is great for pathology to the anterior thigh, lateral thigh, knee, and fractures of the femur. Injuries to the femoral neck may not be completely anesthetized, but a good fascial iliaca block will bring the patients pain score from 8-10 to a 1-2.

To begin, the patient should be placed on a cardiac monitor to observe for dysrhythmias. Anytime large nerves are blocked there is a low risk of cardiotoxicity, particularly with large doses of bupivicaine. The ultrasound probe should be placed in a transverse axis just inferior to the inguinal ligament. The common femoral artery and common femoral vein should be easily identified at this location. Careful inspection will show the femoral nerve sitting just lateral to the femoral artery in the fascia iliaca compartment (Image 5). For a successful block the needle tip must be placed through the fascia iliaca and in the fascia iliaca compartment. Needle tip placement can be confirmed by small deposits of local anesthesia. If the needle tip is in the fascia iliaca compartment the provider will see the anesthetic spread over the iliopsoas muscle in a medial (and sometimes lateral) direction (Image 6). Once placement is confirmed the predetermined dose of anesthetic should be fully deposited. The anesthetic should spread cephalad into the pelvis. This can be

Image 5

Image 6

facilitated by direct pressure on the anterior thigh "squeezing" the anesthetic cephalad. Other sources recommend infiltrating the fascia iliaca compartment (before or after depositing the local anesthetic) with 20-30 ml of normal saline. This added volume helps "dissect" the fascia iliaca compartment up into the pelvis allowing for easier spread of the local anesthetic.

The fascia iliaca block requires a large volume of anesthetic. I find 20-30 ml of 1.0% lidocaine with epinephrine provides 4-5 hours of good anesthesia. On the other hand, 30ml of 0.25% bupivicaine with epinephrine may extend the anesthesia out to 7-8 hours.

Image 7

Sciatic Nerve Block

The sciatic nerve block is used to provide anesthesia for the entire leg below the knee with the exception of the saphenous nerve distribution, a small cutaneous strip following the saphenous vein (Image 7). This block is excellent for the management of large abscesses, lacerations, and fractures of the leg, ankle, or foot. As long as the injury does not involve the skin of the saphenous nerve distribution the provider does not need to block the saphenous nerve.

Image 8

To begin the patient should be placed on a cardiac monitor to observe for dysrhythmias. With the leg elevated on a stack of blankets the probe is placed in the popliteal fossa (Image 1). The tibial nerve can be identified superficial to the popliteal artery. The provider then tracks the tibial nerve proximal (about 8-10cm) looking for the peroneal nerve to join the tibial nerve forming the sciatic nerve (Image 8). The block can easily be performed just superior to the bifurcation of the tibial and peroneal nerve (Image 9). The sciatic nerve is encased by popliteal fat. The further away from the nerve the provider deposits the local anesthesia (which is lipophilic) the higher the likelihood for block failure. I find that 20-30 mls of 1% lidocaine with epinephrine facilitates management of most leg pathology.

Posterior Tibial Nerve Block

The posterior tibial nerve block is used to provide anesthesia for the plantar surface of the foot (Image 10). The plantar surface of the foot is made up of extremely dense connective tissue. This connective tissue is resistant to spread of local anesthetic resulting in painful infiltration and poor local anesthesia. Therefore, the posterior tibial nerve block is excellent for lac-

erations to and foreign bodies imbedded in the plantar foot.

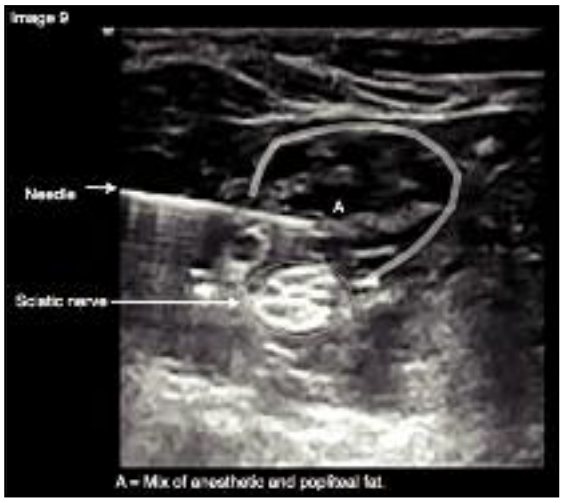

Image 9

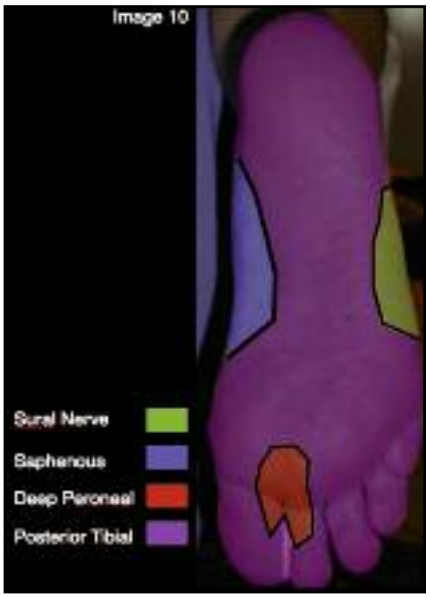

Image 10

To begin the ultrasound probe is placed just posterior to the medial malleolus. The posterior tibial artery should be easily identified. Most of the time the posterior tibial nerve lies just posterior to the artery. However, up to 40% of the time the posterior tibial nerve is actually anterior to the artery (Image 11). The provider may choose to block the nerve at this location or slide the probe proximal looking for a location to block where the nerve is not so close to the artery (usually 5-10 cm). Once the needle is positioned next to the nerve, deposit 3-5 ml of local anesthetic (Image 12). It is not imperative to completely encircle the nerve with anesthetic for good anesthesia.

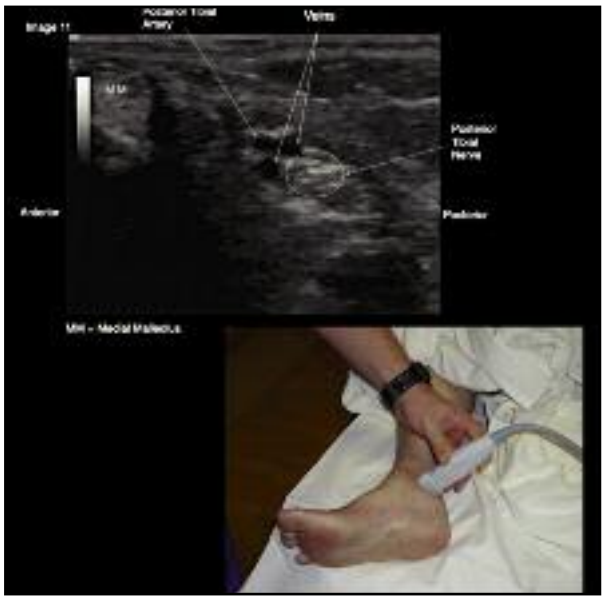

Image 11

Complications

Regional nerve blocks do come with low risk of complications and informed consent should be obtained from the patient. The most feared complication is Local Anesthetic Systemic Toxicity (LAST). Local anesthesia can induce seizure and tachydysrhytmias leading to cardiovascular collapse. The patient should be kept on a cardiac monitor for proximal nerve blocks (blocks above the knee/elbow). Aspiration before injection with concurrent needle tip visualization helps avoid intravascular injection. Should the patient experience LAST, treat seizures in the usual fashion with benzodiazapines. Tachydysrhythmias should be treated with intralipid 1ml/kg every 3-5 minutes up to 3ml/kg. Should cardiovascular collapse develop manage with standard ACLS protocol in conjunction with intralip therapy.[5]

Another feared complication is nerve injury leading to sensory or motor dysfunction. The current leading theory for nerve injury is ischemia to the fasciculi within a peripheral nerve resulting from intraneural injection of local anesthetic. Peripheral nerves are encased by a tough connective tissue layer called the epineurium. Injection of local anesthetic within the epineurium may lead to high intraneural pressure resulting in a scenario similar to a compartment syndrome. Risk of intraneural injection can be reduced by using ultrasound to visualize the tip of the needle at all times. The provider should not perform nerve blocks on patients with altered mental status. The patient should have the ability to let the provider know if they are experiencing shooting "electric" like pain with injection of anesthetic. The patient should not experience more than a minor local burning pain on injection. Intolerable pain should alert the provider to possible intraneural injection, in which case the needle should be repositioned. The provider should also discontinue infiltration and redirect the needle if they experience significant resistance with injection.

These complications are exceedingly rare. In a prospective study done by Sites and colleagues of 12,668 ultrasound guided blocks performed by anesthesiologist there was one case of LAST that occurred after placement of an indwelling bupivicaine pump catheter. The incidence of neurologic complications lasting longer than 5 days was 0.9 cases per 1000 blocks. The incidence of neurologic complications lasting longer than 6 months was 0.08 cases per

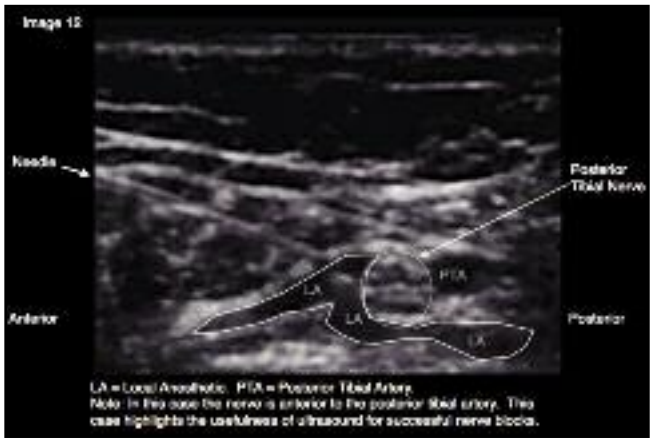

Image 12

Image 13

1000 blocks. Most of these complications consisted of minor parasthesias.[2] In a study done by Stone and colleagues looking at more than 100 ultrasound guided blocks performed by ED attendings, residents, and PAs there was no major complications. The only reported complications were 2 failed blocks.[6]

Pearls and Pitfalls

Discuss the case with consulting physician(s) before performing a nerve block on a patient who is high risk for compartment syndrome. Theoretically the anesthesia achieved could mask the development of compartment syndrome leading to delay in diagnosis.

Before performing a nerve block be sure to perform and document a good sensory and motor exam.

Be mindful of associated paralysis that comes with regional anesthesia. This is less important in patients who are non-weightbearing. However, in patients who may be discharged, the provider must consider that lower extremity blocks can significantly affect the ability to ambulate. Disposition should be a major factor in deciding between long acting and short acting anesthetic.

The needle is most visible when parallel to the scan surface. Inserting the needle 1-2 inches away from the scan surface decreases the angle of approach to the target needle and enhances needle visualization (Image 13).

Not completely evacuating the needle and syringe of air could lead to local air injection. This greatly degrades visualization of the needle tip.

Conclusion

The emergency provider often utilizes local anesthesia and procedural sedation to facilitate the management of painful extremity pathology. However, regional anesthesia is another tool available that should not be overlooked. The ultrasound guided nerve block is a safe technique when done properly. Ultrasound guided regional anesthesia can also greatly improve emergency department throughput when substituted for procedural sedation. In part two of this series, we will cover regional anesthesia of the upper extremity.

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Physician Intuition and Documentation of th Potentially Controversial Chart

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HPI: 50-year-old female presents to the ED with complaints of sudden onset of syncope after standing up from the commode post urination. She admitted to presyncopal dizziness prior to being helped to the floor by family. Patient had history of Chiari Malformation for which she had undergone a corrective neurosurgical procedure 1.5 months previously. This was complicated by a CSF leak requiring readmission X 2. She was recently discharged 2 weeks PTA and was progressing as expected in follow-up.

PE: VS 103/79 66 20 98% RA

Patient was alert and oriented and appeared well.

Exam was documented as normal including neurologic exam.

Diagnostic Testing: CT of the head revealed "isodense mass in vermis of cerebellum causing mass effect on the 4th ventricle. Minimal hydrocephalus. ECG-showed RBBB with L anterior hemiblock of unknown acuity. No old ECG was obtained.

EDC: Patient was feeling better and was discharged with advice to follow up that day with her HMO physician and orders were written to have her lab data and CT scan report faxed to her HMO MD. Patient followed up that day, was seen by an MD (not her own) to whom she complained of sore throat and difficulty swallowing but failed to mention her visit to the ED the night before. She was discharged with a prescription for amoxicillin.

Outcome: two days later the patient was found unresponsive and was transported to the hospital by EMS and pronounced dead. Suit was filed and the ED physician settled the case for a substantial sum.

Intuition is an indispensable tool in the arsenal of the successful ED physician. It is that intangible ability to sense when a patient is going to go bad, when that infant with a fever needs a septic workup, or when that headache patient needs a lumbar puncture. As we in the ED are routinely faced with tough decisions we often must depend on our gut instincts to help us make determinations in the context of incomplete or conflicting data. Frequently our clinical findings and intuition take us in a conservative direction, which results in our performing that extra test or admitting the patient. However, at other times that intuition may take us in the opposite direction where we are inclined to take a path that may defy abnormalities in labs and diagnostic imaging studies.

In discussing the above case with the involved physician, he continues to feel that his decision-making was sound…that the history and clinical information available to him real time during the encounter pointed inexorably toward a benign etiology. In his estimation, the description of the syncopal episode was indicative of a benign cause for her symptoms. Furthermore, he brings up that the patient suffered from a chronic affliction that by definition made her dizzy, nauseated, and generally dysphoric. The syncopal episode occurred in a manner that steered him away from concern over a cardiac cause. The head CT findings were, in his mind, almost certainly chronic based on her history and the ECG, though abnormal, had a decidedly chronic look to it. In his judgment, the patient would be better managed by allowing urgent reentry into the system that had been managing her care all along, where under optimal conditions she would be seen by her PMD who knew her, had access to all her records and consultants and would know how to best care for her. Not an unreasonable conclusion when viewed from the physician's viewpoint.

However, this patient, for unknown reasons, perished in disturbingly close proximity to the time of disposition. The well-meaning physician now became the target of investigation. The plaintiff's attorney impugned his approach as overly cavalier and he opined that, on the basis of outcome, the disposition appeared to be wholly inap-

propriate. He was now free to paint the palate as he wished. To the likely delight of this attorney, the chart, though completed, was sparsely documented with a series of "normal" checkmarks. The ECG reading was not documented, the space for Head CT results read, "See report," and the WBC count was elevated at 13. No discharge vital signs were performed and no attempt was made to contact her neurosurgeon or primary care physicians to arrange follow-up.

Now…back to intuition. I am a big supporter of physician judgment. It is why medicine cannot be practiced by computer algorithm. It is all too easy for those evaluating these cases with the benefit of hindsight to find fault with the physician who has had to make urgent decisions real time. We are taught in medical school to "treat the patient and not the lab value" and the intuition-based decision made in this case was consistent with this approach. Unfortunately, where this case falls short lies in the lack of forward thinking intuition… that is the 6th sense that the disposition decision being made could be looked at as retrospectively controversial in view of the:

1) Potential lethality of the complaint (syncope) in concert with

2) the seriousness of the preexisting chronic condition (recently operated upon Chiari malformation with post operative complications) and

3) the laboratory, ECG and CT abnormalities (of unknown chronicity) noted on testing.

The combined presence of these characteristics essentially raised the bar for essential documentation and dictated that decision-making logic had to be extremely explicit and immediately evident from examining the chart. To accomplish this, notation of a call to the treating neurosurgeon to verify chronicity of the Head CT findings, acquisition of an old ECG for comparison, and documentation of phone contact with the follow up doctor all would have gone a long way toward supporting the retrospectively "controversial" disposition home.

In conclusion, the point of this article is not to dissuade the practitioner from going with the gut on tough decisions in the ED. On the contrary, that is what we do every day and we do it well. What I am suggesting is to know when to gaze into the distance on cases involving decisions that could be viewed as controversial and when to do the due diligence on creating a document that will protect you in the event of an unexpected bad outcome. Keep those intuitive feelers raised for case characteristics requiring extra complete and careful documentation of the quality care that you give.

Agency and Physician Extenders

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After testifying in a malpractice case as an expert, a colleague of mine asked me about the concept of ostensible agency. Apparently, the plaintiff's attorney was trying to assert that a supervising physician was responsible for the negligent acts of a physician's assistant. ***Agency*** is a…"fiduciary relationship created by express or implied contract or by the law, in which one party (the agent) may act on behalf of another party (the principal) and bind that other party by words or actions."[1] Ostensible agency is a legal theory of vicarious liability. ***Vicarious*** liability being…" liability that a supervisory party (such as an employer) bears for the actionable conduct of a subordinate or an associate (such as an employee) because of the relationship between the two parties."[2] To a degree, the inquiry surprised me because many physician's assistants are employees of their physicians and hence, as employers, the physicians may be held liable for the acts of their employees under the vicarious liability theory of respondeat superior where there is a clear "master/servant" relationship. However, as is often the case, the experiences of those who practice emergency medicine often fall outside of what is typical in medicine. So I began a review of the legal theories involved in agency where the law imputes responsibility upon individuals for the acts of tortfeasors who are under their "control" as it relates to physician extenders (nurse practitioners and physician assistants). The following is more of a muse rather than a treatise, and I do not intend to be necessarily comprehensive in addressing the issues below in this venue because it is beyond the scope of this discussion.[3]

But first, why must physicians be concerned about this? The last decade has seen a substantial increase in the utilization of physician extenders. The report that was published in 2000 by the Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001) advocated for the use of physician extenders. Retail Medical Clinics have that have appeared at Wal-Mart, CVS, Target, and Walgreens stores over the past decade have relied heavily upon physician extenders to make providing such services affordable (physician extenders annual salary is approximately half of that required to pay a physician for the same work).[4] Most states have licensure statutes defining physician extenders that require some kind of oversight by a physician for such individuals to practice. Many emergency department administrators have decided to hire physician extenders to help in the evaluation and management of their patients. So there is clearly a trend towards greater utilization of physician extenders over the past decade. Yet, there is insufficient information available in litigation records to accurately predict how a court may view the relationships between physician extenders and their supervising physicians. Part of the reason is that there is little case law available that defines such relationships. When a malpractice action is filed that may involve a physician extender, the plaintiff's attorney may set their sites on the physician extender's employer and the physician(s) involved in the case, rather than naming the extender as a defendant. Even with the proliferation of the Retail Medical clinics, as of 2011, there were no claims filed against their physician extenders working within that setting.[5] So any physician who is involved in a professional relationship with a physician extender has cause to understand how that relationship may be viewed under the law if one really can.

The simplest scenario for vicarious liability exists when a physician or physician group employs the physician extender directly. When such a relationship exists, and the physician extender is the tortfeasor, the physician employer may be held responsible for the wrongdoing of the physician extender-tortfeasor through the legal theory of *respondeat superior* ("let the superior make the answer").[6] This is a vicarious liability theory where employer incurs liability for the employee who is negligent while the employee is performing the tasks for which he or she was hired. It does not apply if the

tortfeasor has acted outside the scope of the practice. Nor may it apply if the employer has allowed the employee to act under the direction of someone else who has the right to supervise or direct that employee's actions, e.g. when a non-employer physician works with the physician extender with the approval of the employer. Under those circumstances, the employer may escape liability for the wrongdoing of the employee physician extender under the *Borrowed Servant Rule*, an exception to respondeat superior. The acceptance of such an exception does not necessarily mean that the non-employer supervising physician automatically will incur liability because of the acts of the tortfeasors physician extender (although it often does). Generally, respondeat superior is the most commonly used theory to attribute vicarious liability to employers, specifically, and sometimes to supervising individuals even if such persons are not employers (note that on that issue, jurisdictions differ).

Emergency medicine contract groups may employ physician extenders to provide services, and as the employer, may incur liability of the physician extender directly under the theory of respondeat superior. The same is true for a hospital that employs physician extenders. But the relationships become murky when the supervising physician is not the physician extender's employer and the plaintiff attorney wants to bring the physician (and the physician's malpractice insurer) into the suit. For example, what is the relationship between co-employees, where the physician and the physician extender are both employees of the same business corporation (e.g. a hospital)? Or what is the relationship when the supervising physician is an independent contractor and the physician extender is an employee of another business corporation. To date, this writer is unaware of any Georgia case on point, but there have been cases in other jurisdictions that have discussed such scenarios, but used the theory of respondeat superior in conflicting ways. In *Ware v Timmons* (Alabama 2006), a 17-year old died as a result of a nurse anesthetist (CRNA) removing an endotracheal tube under the supervision of the anesthesiologist.[7] Both the CRNA and the doctor were employees of the same corporation. An issue on appeal was whether the anesthesiologist could be held liable for the negligence of the CRNA under respondeat superior. The Supreme Court of Alabama asserted essentially that because each employee consents to enter into a relationship with the employer, and not each other, the co-employees cannot be in a master/servant relationship to each other. Hence, in *Ware*, respondeat superior could not hold the "supervising" doctor responsible for the acts of the CRNA tortfeasor. However, a Wisconsin case reached a different conclusion under respondeat superior. In *Petzel v. Valley Orthopedics et. al.* (Wisc. 2009), the patient sustained permanent nerve damage to her leg causing a foot drop when the defendant physician and the physician assistant operated upon her arthritic hip.[8] The physician assistant was an employee of a doctor-owned clinic whereas the orthopedic doctor was an independent contractor. However, the doctor was the physician assistant's sole supervisory physician under Wis. Adm. Code Med 8.07 (defining the scope and limitations of physician assistant practice under Wisconsin law). The doctor asserted liability could not be attributed to him for any tort of the physician's assistant under respondeat superior theory because he was not the physician assistant's employer, and hence, did not have a master/servant relationship with the physician assistant.[9] The Wisconsin appeals court asserted that it was the *right to control* that was the determinative test to be used in ascertaining a respondeat superior master/servant relationship and concluded that the physician could be held liable for the acts of the physician assistant under respondeat superior theory.[10] What may be the common law in Georgia regarding such relationships has yet to be clearly ascertained by Georgia courts. Physician assistants have to be supervised by physicians under Georgia Code 43-34-100 *et. seq.*, not unlike the Wisconsin code mentioned above and many other states. In the Wisconsin and Alabama case, the each defendant physician was physically present and supervising the physician assistant at the time of the alleged negligence. Would the issue have been decided differently if a physician assistant committed a negligent act when the supervising physician was not physically present or even concurrently aware of the patient the assistant was seeing? It seems that the answer has not yet been clarified in any jurisdiction, but such a scenario commonly occurs with physician extenders that are working in the emergency department.[11]

Finally, ostensible agency is…" agency created by operation of law and is [generally] established by a principal's actions that would reasonably lead a third person to conclude that an agency exists."[12] (This theory is sometimes called *agency by estoppel or apparent agency*.) This vicarious liability theory should be familiar to most emergency physicians. It is applied differently in different jurisdictions, but essentially it is the theory that has been used to attach liability to a hospital for the negligent act or omissions of a non-employee emergency physician. It is because of this theory of vicarious liability that in some jurisdictions there exist large signs in the emergency room notifying that the physicians are independent contractors, and indeed, some consent forms state that as well. The theory relies heavily upon the beliefs of the plaintiff. The Georgia Supreme Court addressed the ostensible agency issue with regards to emergency physicians working in a hospital in 1987 in *Richmond County Hospital Authority v. Brown et. al.* where the Court allowed the plaintiff Brown to hold the hospital liable for

the negligence of the non-employee physicians if he could…" prove the hospital represented to [the plaintiff] that its emergency room physicians were its employees…"[13] Essentially, ostensible agency applies when…" (1) the plaintiff had reasonable belief in [the] agent's authority; or (2) that such belief was generated by the holding out by acts or neglect of the ostensible principal; or (3) the plaintiff justifiably relied upon a representation of authority."[14] As applied to hospitals and emergency physicians, the ostensible agency theory application is easy to understand. Unless it is clearly represented that independent contractor emergency physicians are not hospital employees, the ostensible agency theory may attach the liability of the emergency physician to the hospital. The theory must rely upon the plaintiff's belief, which not always easy to prove because such a belief is self-serving. The theory does rely upon factual proof as well, which must be presented to the fact-finding jury, which may also no be easy to prove. It is for these reasons that we may not see ostensible agency being applied to physicians who are supervising physician extenders. Nevertheless, the facts and circumstances surrounding the interactions of the parties could potentially result in an ostensible agency theory attempt to attach liability to a supervising physician for the negligence of a physician extender.

To be sure, there are probably easier ways for the plaintiff's attorneys to attach liability to the supervising physicians of physician extenders than to use the ostensible agency theory, some of which were discussed above. Ultimately, it is all about attaching more malpractice insurers to a case from which damages may be obtained. Other legal theories exist to attach liability to physicians working with physician extenders. For example, this discussion did not touch upon other concepts such as negligent supervision, hiring, and retention of physician extenders. Nor did we discuss the evolution of "standards of care" that may be unique to physician extenders. Perhaps, they can be left for another time.

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1. Blacks Law Dictionary, 7th Ed.

2. Id.

3. For a detailed discussion of numerous issues involved with the utilization of physician extenders, see generally McLean, T.R., Crossing the Quality Chasm: Autonomous Physician Extenders Will Necessitate a Shift to Enterprise Liability Coverage for Health Care Delivery, 12 Health Matrix 239(2002); See also McClean, T.R., The Schitzophrenia of Physician Extender Utilization, 20 Ann. Health L. 205 (2011); For an interesting discussion of two recent cases involving the relationship between physicians and physician extenders see Burkle, C.M., The Advance of the Retail Health Clinic Market: The Liability Risk Physicians May Potentially Face When Supervising or Collaborating With Other Professionals, Mayo Clinic Proc. Nov. 2011; 86(11) 1086-1091.

4. See Mclean, T.R., The Schizophrenia of Physician Extender Utilization, 20 Ann. Health L. 205, 208(2011).

5. See Burkle, C.M., The Advance of the Retail Health Clinic Market: The Liability Risk Physicians May Potentially Face When Supervising or Collaborating With Other Professional, Mayo Clinic Proc., November 2011; 86(11): 1086-1091 at 1090.

6. Black's Law Dictionary, 7th Ed.

7. Ware v. Timmons, 954 S0. 2d 545, 556 (2006), 2006 LEXIS 94

8. Pezel v. Valley Orthopedics et. al., 2009 WI App 106; 320 Wis. 2d 621; 770 N.W.2d 787; 2009 Wisc. App. LEXIS 451.

9. Id. at 632 et.seq.

10. Id. at 636.

11. For a more in-depth discussion contrasting Ware and Petzel, see Burkle, FN 3, above.

12. Black's Law Dictionary, 7th Ed.

13. Richmond County Hospital Authority v. Brown et. al., 257 Ga. 507,510; 361 S.E.2d 164; 1987 LEXIS 945.

14. See above McLean, T.R., Crossing the Quality Chasm, FN 3, at 268.

Available

Challenging, Difficult or Hateful Patients in the ED

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An inebriated patient, BAL 320, presented to the ED after a motor vehicle accident in which she lost control of her vehicle and struck an elderly pedestrian. The victim was also brought into the hospital and found to have sustained an intracranial hemorrhage that required surgical intervention. The driver was belligerent and uncooperative with all the members of the staff, which, in combination with her apparent lack of remorse towards victim made caring for her challenging. Several staff, including physicians were observed treating her harshly.

The Emergency Department probably sees more "difficult" patients than anywhere else in the hospital. Patients who are intoxicated with alcohol or drugs, patients seeking opiates, patients brought in by law enforcement – we know who these patients are and generally do an excellent job of setting aside our personal feelings in order to render care. But we all have limits to our capacity for empathy, and the case above illustrates an especially challenging situation – a patient whose irresponsible driving injured another person, now also our patient, so that we are confronted not only with a belligerent patient, but also with the consequences of her actions. To make it worse, the hostile patient shows no concern whatsoever for the injuries she has caused to another. This behavior challenges empathy, and not surprisingly, even a seasoned staff used to caring for difficult patients lost composure.

What do we know about the dynamics of difficult patients? What ethical issues arise? And what can we suggest to ED staff when they are confronted with such patients?

Who are "difficult" patients? In general, these are patients who evoke negative emotions from physicians that make it difficult to remain dispassionate in rendering care. But it would be more accurate to speak of difficult situations rather than difficult patients, as it is often a combination of patient characteristics (drug seeking, hygiene, language, behaviors), environmental circumstances (e.g., crowded ED, time of day), and physician factors (e.g., fatigue, past experiences with the patient or similar patients) that create a difficult encounter.[1,2,3] What might be a difficult patient in one setting, for example an outpatient primary care practice, might include a patient with unexplained physical symptoms ("crocks") as such symptoms are especially frustrating for patient and physician. Even the term "crock" reflects the sense that such encounters involve difficulty beyond the ordinary. In the ED, additional factors contribute to making certain clinical encounters difficult, including the lack of an on-going therapeutic relationship, high stress levels in patient and significant others, and the overall stress level with which emergency physicians must cope.[4,5]

However, even though it is the overall encounter which creates difficulty, there are certain patient characteristics that many ED physicians would agree contribute to making clinical encounters difficult. These include patients who are aggressive, intoxicated or addicted, patients who seem to be manipulating the ED for drugs or admission, and patients having more severe personality disorders. Such patients frequently evoke feelings of anger, guilt, hatred, and hopelessness in physicians. The problem in our case is that treatment could have been compromised due to such feelings generated in hospital staff by the patient's behaviors, and this is never acceptable, as our duty is to provide care regardless of the patient's blameworthiness.

The challenges such patients and encounters present to the physician are easy to recognize, but meeting the challenges is not so easy. In our case, there are legal requirements in the ED via EMTALA to assess and stabilize the driver, so that as much as we might not want to participate in her care, we have no choice. The duty to care for the driver in emergencies is also recognized in the AMA's Principles of Medical Ethics: "VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care."[6] Thus the option available in other settings of discharging a difficult patient from a practice is not available, and we sometimes have

to see the same hostile, abusive, intoxicated, noncompliant patients over and over again.

Additional duties to our patient flow from the ethical duties of beneficence and non-maleficence. As physicians, we have an ethical duty to provide care (beneficence) and to avoid causing harm (non-maleficence) regardless of how we feel about a patient. These duties are also codified in the AMA's Principles of Medical Ethics:

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

Thus emergency physicians are in a uniquely difficult position of having little choice about whom they serve, are frequently faced with patients who challenge our professionalism and ethical duties, and must meet these challenges in a stressful environment. We recognize the difficulties in managing a difficult encounter and offer the following suggestions with humility.

Suggestions for Coping with Difficult Encounters

1. Anticipate challenging encounters and plan accordingly. Is this a patient we have seen before who challenged us? Can we review what interventions have worked, and what haven't? Sometimes discussing such a patient with another staff member, even before meeting the patient, can lead to developing a clinical approach that defuses tension enough that we can act dispassionately in providing care.

2. Recognize that the difficult behaviors we are confronted with are the result of the patient's underlying pathology, e.g., personality disorder, addiction, pain, or other medical condition. The difficult behaviors can feel personal to us when we are treated abusively or feel we are being manipulated, but rarely are we even perceived by the patient as a distinct person. Understanding that the behaviors are part of the problem is another way of helping us to maintain emotional distance so that we can provide care in a professional manner.

3. Try to find some part of the patient with which we can establish empathy. Difficult patients are difficult in part because it is so hard to establish a relationship where we feel empathic. We sometimes find it helpful to know that patients do not choose to be hateful, but their personal resources are such that it is the best way they know how to get what they think they need (addictive medications, emergency medical care, admission). It is easy in our case to be empathic to the innocent victim, the pedestrian, but much more difficult even to want to be empathic to the driver who seems to deserve blame, not empathy. Under such circumstances, it might be helpful to consider that, as badly as the driver has behaved and is behaving, it is the best she can manage given her personality, pain, and intoxication. It may also be helpful to consider that, with our help, and if we avoid actions that make things worse, it is likely she will do better in the near future as she sobers up and the nature of her situation sinks in. These considerations should not rationalize accepting abuse, but might help us to respond more rationally.

4. Avoid making things worse. With our patient it was tempting to remind the patient of the harm she had caused the victim, but taking an accusatory position would not have improved her care, and almost certainly would have increased her hostility. This would have made it even harder to provide care in a professional manner. Thus another task for the ED physician might be to recognize a deteriorating relationship developing between the patient and help staff avoid escalating the situation with ill-advised comments.

5. Examine environmental issues contributing to a difficult encounter. For example, some hostile or abusive patients are more easily managed when seen by more than one staff member at a time, or transferred to a quieter area of the ED.

6. Physician, know thyself. Are there specific patients who bring out the worst in ourselves? It is not uncommon for certain patients to remind us of people with whom we have had problems. It can be extraordinarily hard for us to distinguish the patient from others we have known in the past, but making the distinction is critical if we are to avoid overgeneralizing and making mistakes in assessing the patient's unique circumstances.

7. Patient care conferences focusing on difficult patients can help staff to recognize potentially problematic encounters and to devise strategies for coping with them. Such conferences can also be useful in allowing staff to express their frustrations, and to understand that some patients bring out feelings that make us uncomfortable, and to understand that while we have little control over how we feel, we do have a responsibility for how we respond to those feelings.

We offer these suggestions in the hope that other physicians will consider their utility and share with us strategies they have found useful in managing difficult encounters.

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5 Bold Financial Moves to Make 2013 Your Best Year Yet

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We're already a few months into this year. How are those new year resolutions you made a few months back coming along? Don't fear. I've got some financial moves to reinvigorate the rest of the year for you. Why not make this the year you take big action with your finances?

I'm not talking about just any type of action. I'm talking about MASSIVE action. The type of action that made you endure four years of medical school and another 3-4 years of residency. The type of action that pushes you to see several crashing ER patients at the same time when you're alone on a night shift with sphincter tone maxed out.

What I'm about to tell you is unorthodox and unconventional and your first thought might be, "this doesn't apply to me" or "there's no way I can do that!" But I can assure you from personal experience that acting on even one of these strategies can have a powerful impact on your financial life.

Massive Action #1: Chop off 10% of your shifts

I took my first ABEM board exam in 2001 and passed my ABEM Concert recertification exam at the end of last year. Boy, have things in the ER changed in the past decade--much of it for the worse. Patient satisfaction scores seemed like a fad. Now they're used to determine what we're paid. Electronic medical records were rare. Soon they'll be required.

With all these changes and job stress, no wonder almost 60% of EPs experience at least one symptom of burnout and why depression and suicide rates are higher among physicians.

I think you'll agree that working just one or twp less shifts per month can have a positive impact on your lifestyle, your mood, and your family.

That doesn't necessarily mean that you'll make less income.

Why? Because you'll probably last longer. Let's say you work full time and make $300,000 in annual income. By working 10% less shifts, you'll make $270,000, but you might be able to work 13 years by working less shifts versus only 10 years by working more shifts. Your lifetime income actually increases by almost $500,000, and you do it with less stress.

Massive Action #2: Demand a 20% raise

No matter which ER group I worked for, there was always a shortage of doctors, holes in the schedule, and an ever increasing number of patients to be seen.

If you're an independent contractor or hospital employee--and especially if you're well liked by the nursing staff, patients, and consultants--what's stopping you from demanding more money?

Let's face it: money is the 10,000 pound elephant in the room. Doctors are scared to ask for more of it because you think they'll fire you. Our attitude is "put up and shut up" with all the nonsense that's thrown at us. Unfortunately that doesn't benefit you.

If you don't ask for more money, contract management groups, hospital admin, and everyone else will trample all over you. They're watching their bottom line not yours. Step up to the plate and tell them, "I provide incredible value to you, the hospital, the community, and to patients, day and night, weekends and holidays. I generate revenue for you. It's because of ME that you have a job."

Do this: If you're making $125 per hour, demand $150 per hour. If you're making $150 per hour, insist on $180 per hour. That won't dent your boss's bottom line, but it'll sure do wonders to yours.

Massive Action #3: Sock away 30% of your gross income

Suppose you (and your spouse if married) make a combined gross income of $350,000 this year. The government takes 30% of it, so you're left with about $250,000 in income after taxes. That's about $20,000 per month to do whatever you want.

If that's not enough money to "live" on, then you've probably got a spending problem. Make your next car a Nissan instead of an Infiniti. Voila! You just freed up over $10,000 and you'll still make it to your next ER shift on time.

Quite frankly if you can't contribute $50,000 to your retirement portfolio every year, then be prepared to work for a long, long time. The government sure isn't going to be sympathetic to you since you already make "too much money" and you aren't paying your "fair share" in taxes.

Do this: Max out your SEP IRA or 401(k), contribute to a traditional IRA, and then invest in a taxable account. Total contributions should equal at least $100,000. That still leaves you with $150,000 to spend or over $12,000 per month. C'mon if that ain't enough, don't bother reading the rest of this article.

Massive action #4: Pay off 50% of your mortgage-- all at once

When most people talk about their mortgages, they talk about refinancing from their current 4% rate down to 3% and save a few hundred or few thousand bucks a year. Or they talk about paying a bit extra every month to pay it off two or three years earlier.

There's a compelling reason right now to keep your mortgage since interest rates are so low in the hopes of earning higher returns with outside investments, but the psychological impact of paying it off completely is worth alot more than the uncertain investment return you'd get by keeping it.

Do this: if your mortgage balance is 25% or less of your gross income, whatever cash you have after basic living expenses and taxes, apply half of that to your mortgage. Do the same next year and kiss it goodbye. Think about how you'd feel the day after when you walk into your next ER shift--it'll be the first time you've smiled in a long time.

Massive Action #5: Dump 100% of your junk investments

Remember when you bought some Facebook stock on its IPO only to see your investment tank in a matter of weeks? What about that real estate venture that turned out not to be such a sure thing? Or all those investments your financial advisor persuaded you would beat the market but didn't?

Time to clean house. Here's a simple question to ask yourself and get this done the easy way: "Do I understand every investment I own?" Every investment you answered "no" to should be axed, and if a financial advisor sold it to you, think about tossing him too.

There you go. Five big steps--or rather leaps--to sprint ahead this new year. It takes some guts to do it, but in the end you'll be glad you did.

Emergency Medical Care – A Divided Court of Appeals Offers Guidance on the ER Statue

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The reader may recall this author's past article about a jury verdict warning that some medical care rendered in the emergency department may not be subject to the higher standard of proof applicable to emergency department physicians for medical malpractice claims pursuant to Georgia's 2005 tort reform law. However, despite some interpretation of the 2005 statute by juries, Georgia's appellate courts have not provided much guidance on how to apply the 2005 statute, which provided that a plaintiff must prove that a health care provider committed gross negligence otherwise the health care providers cannot be held liable for rendering emergency care in the emergency department. From the defense perspective, the purpose of the statute was to make it harder for plaintiffs to win cases against emergency room personnel. Two recent cases considered by the Georgia Court of Appeals revealed divergent opinions among the appellate judges related to that purpose. Divergent opinions about the law is not new as in 2010, the law survived a constitutional challenge at the state Supreme Court by a vote of 4-3.

One recent Court of Appeals decision was pro-plaintiff. The Court said that defendants did not establish that the higher standard for emergency room physicians applied in the case. According to the Court, the case revolved around a claim that the emergency department did not meet some obligation to timely transfer a patient to another hospital which could provide the care the plaintiff needed. In the other recent case, the court ruled for the defense, but it was a split decision and the Court struggled in its analysis of what evidence might meet the gross negligence standard. Interestingly, because both decisions were split, each will only have limited precedential value.

The defense-win case, *Johnson v. Omondi*, No. A12A1347, involved a wrongful death suit over care provided in an emergency room in Albany, Georgia. In that case, plaintiff's decedent, a teenage boy, went to the emergency department eight days post knee surgery complaining of chest pain. The emergency physician saw the teenager and discharged him after running tests and treating the pain with medication. Two weeks after the emergency department visit, an ambulance transported the teenager back to the hospital, but he died at the hospital from a bilateral pulmonary embolism. Plaintiff's, the boy's parents, claimed negligence by the doctor in not properly ruling out a pulmonary embolism during the initial emergency department visit. The judge in that case granted summary judgment for the doctor citing the gross negligence standard, but plaintiff's appealed. Ultimately, the decision was a 5-2 split to affirm that the doctor was entitled to summary judgment.

The majority opinion cited a 2008 Court of Appeals ruling, *Pottinger v. Smith* which stood for the proposition that in order to satisfy the gross negligence standard codified at O.C.G.A. § 51-1-29.5, a plaintiff suing over emergency care must prove by clear and convincing evidence that the health care provider "failed to exercise even slight care."

In the Johnson case, the facts were not really disputed, but plaintiffs claimed that their expert's opinions created a dispute over whether the emergency physician exercised even a "slight degree of care." The appellate judge noted that plaintiff's expert did not use the "magic words" from the Pottinger case, but even if the expert used that language, a trial judge still must analyze admissibility of that expert's testimony and opinion. "Indeed, if an expert affidavit is all that is needed to preclude summary judgment, then OCGA § 51-1-29.5 would be

rendered meaningless," wrote the appellate judge.

The majority opinion noted that it was undisputed that the physician spent time with the teenager and his mother in the emergency department, ordered a chest X-ray, ordered an EKG, interpreted the results of each himself, and evaluated multiple diagnoses, including a possible pulmonary embolism. In doing so, the majority opinion stated the physician clearly provided at least a slight degree of care.

The dissent thought the majority opinion simply tried to reach a particular result by ignoring conflicts in evidence and not properly applying a de novo review of evidence in the record. According to the dissent, the opinion of plaintiffs' expert was based on facts that should create a dispute for a jury, including a contention by the expert that the physician misinterpreted test results and should have performed a CT scan.

As is clear from previous jury verdicts, the dissent said the gross negligence statute does not prohibit a judge to allow an emergency room case to be decided by a jury. The dissenting opinion declared that the majority opinion incorrectly suggested that health care providers have some sort of immunity for emergency care so long as "some care" was provided.

The defense won the appeal, but only three of all seven judges fully concurred with the majority opinion. Two judges concurred in judgment only, which means the opinion is not binding precedent for subsequent cases.

The same panel of judges allowed a different emergency room case (Dailey v. Abdul-Samed, No. A12A1109) to go to a jury. Unlike the Johnson case, the central issue on appeal was that the gross negligence standard did not apply because the emergency department visit did not constitute an emergency.

In this case, the plaintiff went to an emergency room in December 2005 claiming he accidentally shot paint thinner into one of his fingers while cleaning a paint sprayer. Plaintiff arrived at the emergency department shortly after midnight, and was transferred to another hospital that morning by ambulance, approximately nine hours later. At the second hospital, a surgeon amputated part of plaintiff's finger.

Plaintiff sued the emergency physician and a physician's assistant who saw him at the first hospital. Plaintiff claimed defendants should be liable for not transferring plaintiff more quickly. The disputed issue related to the hospital's attempts to find an available hand surgeon at another hospital who could accept plaintiff for surgery.

The trial court judge granted summary judgment for the defendants under the gross negligence standard, but the court of appeals reversed the decision to send the case to a jury. The same appellate judge who wrote the dissent in the Johnson case wrote the court's majority opinion for this case. The majority said defendants did not meet the burden to show that the gross negligence standard should be applied in this case.

The majority wrote that "[w]hile Defendants provided some care to [plaintiff] upon his arrival to the…emergency department, it was their alleged lack of emergent care—namely, their delay in transferring him to a hand surgeon—that led to this suit." Thus, the appellate court said the core allegations of plaintiff's lawsuit were that defendants did not provide emergency care, meaning the higher standard should not apply. This does not mean that defendants were automatically liable for plaintiff's claims, but the appellate decision merely means that there was a factual dispute over defendants' conduct while plaintiff was in the emergency room.

Just as in the Johnson case, the court's opinion in Dailey has limited precedential value because the judges were split in the decision. Lawyers for the defendants indicated there will likely be further appeal to the Supreme Court of Georgia. Perhaps gloating in victory, the plaintiff's lawyers originally said the appellate opinion reinforced the idea that defendants must prove and establish that the higher gross negligence standard applies in a case. However, of significant note, the judge who authored the majority opinion later revised the court's opinion to remove earlier language that implied that emergency room personnel defendants bear some burden to prove that the higher gross negligence standard applies to their cases.

These two cases seem to suggest that there is no universal answer for which emergency department cases will get to a jury. Further, it at least appears somewhat clear that defendants do not bear some burden to prove that the gross negligence standard applies to each "emergency room" case, but not having that burden is not conclusive that the higher standard applies for every case that arises from some sort of interaction within the emergency department. While these two recent decisions might offer some guidance in that 1) expert opinions will not automatically result in a triable jury issue, and 2) the facts of each case will be scrutinized to determine if the gross negligence standard applies, the decisions are not binding precedent for future cases. Further, the clarity of the supposed guidance is "muddy" at best. The real conclusion to be drawn is that there is a vast gap between the opinions of the appellate judges as it relates to the 2005 law. Clarification by the Supreme Court of Georgia should be expected, but considering the 2010 split decision of the Supreme Court justices, there still may not be consensus.

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