INBOUND

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Editor-in-Chief:

Todd Parker, M.D.

San Diego Editor-in-Chief:

Gerald Platt, M.D.

Assistant Editor:

Kylie Wainer, D.O.

From the editors:

Happy New Year, and welcome to the first 2010 issue of Inbound Magazine. We hope you enjoyed last year's issues, and have received great feedback from many of you.

First some editor news. Bad news first, uber-doc Dave Bruner has realized that there are, in fact, only 24 hours in a day, and with his extensive other academic projects he has decided to step down as Assistant Editor. With his valuable experience as an editor of Annals, he was instrumental in helping get this publication off the ground. Thanks Dave for all your work.

Now the good news...We are expanding to include San Diego, as the Navy has given us approval to make this a Navy-wide Emergency Medicine publication. As such, Gerald Platt, whose wit and wisdom was legendary at NMCP and who now is unleashing his talents on NMCSD, has signed on as the West Coast Editor-in-Chief. We are excited to have this publication expand beyond just Portsmouth, and be able to reach all Navy Residents and more Emergency Physicians. We hope to continue to expand outside of the Navy and perhaps make this a military-wide publication.

Also good news, Kylie Wainer, an EM–1 at NMCP is onboard as an Assistant Editor. She assisted with the preparation of this issue, and will be taking on an increased role in future issues. Great to have you Kylie!

Our cover photo this month is of the now-becoming-legendary mobile trauma bay deployed in Afghanistan. For those that have seen Jim Hancock's talk on the development and current utilization of this amazing vehicle, you know what an amazing story it is. For those that haven't, you should ask him (or Sean Barbabella, who provided this photo) about what it is doing. It is truly revolutionizing Operational Medicine and saving lives.

We hope you enjoy this issue, and keep the stories coming!

- *Todd and Gerald*

INBOUND is a quarterly publication to improve patient care in Navy Emergency Medicine. Stories occurred in both Navy and civilian emergency departments worldwide. For more information, or for submissions, please contact the editors at todd.parker@med.navy.mil.

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Have an interesting story, anecdote, medical humor, or cover photo? Email to todd.parker@med.navy.mil

Work, Interrupted

LCDR Todd A. Parker, M.D.

One of the key goals of this publication is to make you stop for a second and think, "Hmmm, I can see that happening to me," which perhaps will help minimize the chance that it actually happens. While much of the error reduction in Emergency Medicine is the result of increased knowledge, even more results from experience, both your's and those around you. Barry LePatner, lawyer and founder of a leading consulting firm, eloquently quoted, "Good judgment comes from experience, and experience comes from bad judgment."

But what about seasoned physicians who have handled similar cases hundreds of times who still make errors? What about the junior physician that is doing everything right, but still makes an error? Clearly experience and knowledge are important, but there are many other factors that come into play. One such factor that is nearly unavoidable is being interrupted. Interruptions happen to all physicians, yet they happen to more Emergency Medicine (EM) physicians than any other specialty. Nurses are increasingly recognizing the impact that interruptions have on their jobs, and interruptions while preparing medications are a contributor to medication errors. This is the impetus behind "In the Med Zone" cards, which serve to alert others that the nurse is in the process of preparing a medication, and should not be interrupted until she is done.

A landmark study by Chisholm, et al,[1] in the Nov 2000 Academic Emergency Medicine tackled this topic. They observed Emergency Department (ED) physicians in three separate ED settings: an urban teaching hospital, a private teaching hospital, and a rural community ED. They observed individual providers over a three hour period. They found that the average physician was interrupted (defined as a brief event requiring the provider's attention, but allowing them to return to their original task) 10.3 times per hour (every 6 minutes!). The average physician underwent a "break in task" (defined as an interruption event that resulted in changing tasks) almost 7 times per hour, or once every 8 ½ minutes! As can be expected, the number of interruptions and breaks-in-task were positively correlated with number of patients seen per hour and being simultaneously managed.

They then performed a second study, comparing ED workplace interruptions with primary care doctor office interruptions.[2] They studied the EDs in 5 community hospitals and 22 primary care offices in several Indiana cities. Twenty-two Emergency Physicians and 22 office-based Primary Care Physicians (PCPs) were observed at work. The number of interruptions, tasks, simultaneous tasks, and patients concurrently managed were recorded over 2 ½ - 3 ½ hour observation periods.

What they found, as can be expected, is that Emergency Physicians were interrupted an average of 9.7 times per hour compared with 3.9 times per hour for PCPs. PCPs, however, spent an average of 11.4 minutes per hour performing simultaneous tasks compared with 6.4 minutes per hour for emergency physicians. PCPs spent significantly more time performing direct patient care, and emergency physicians spent significantly more time in analyzing data, charting, and taking reports on patients. The conclusions are obvious: Emergency Physicians experience more interruptions and manage more patients concurrently than PCPs. PCPs spend more time performing simultaneous tasks than emergency physicians, due to decreased multi-patient responsibilities. As Ozawa noted, "Critical thinking and analysis get lost in an interrupt-driven workplace." [3]

We can't hide from the fact that we work in an environment where interruption is the norm. We are constantly distracted from our tasks. But we're all great at multitasking, right? Isn't that why we went into Emergency Medi-

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cine in the first place? Well, we may not be as good as we think. As Roman Philosopher Publilius Syrus said in 100 A.D., “To do two things at once is to do neither.” Significant research has been done looking at the effects of multi-tasking, whether it be doing more than one task simultaneously, or rapidly changing from one task to another.

Author and Professional Coach Lisa Montanero sums up the challenges of multi-tasking best in her online article. [4]

“When we need to accomplish many tasks, we do 2-3 things at once, sometimes more. We do this in order to be more productive. Multi-tasking has basically become the American way. In fact, employers often include "multi-tasking" as one of the desirable traits they look for in job descriptions. But is multi-tasking really leading to increased productivity?

According to many experts, the answer is no. Multi-tasking is generally less efficient than focusing on one thing at a time. Studies show it impairs productivity. It is impossible to do 2 tasks at the same time without compromising each. Studies have shown it takes your brain 4 times longer to process than if you focused on each task separately.

David Meyer, Ph.D., a psychology professor at the University of Michigan in Ann Arbor has spent the past few decades studying multi-tasking. His research shows that not only is multi-tasking inefficient, but also can cause problems at work, at school, and even, in some cases, can be dangerous. Meyer explains, "It takes time to warm up to a new task, especially if both require the same skill level" The transition time between switching back and forth from one task to another is where multi-tasking starts to result in decreased productivity.

In addition, his studies have shown that some tasks that are frequently grouped together conflict with one another causing a decrease in productivity. Have you ever been writing an e-mail and chatting on the phone, and realize that you are saying what you are typing, or typing what you are saying? It's impossible to do both of these tasks well because each requires similar anguage skills and short-term memory. What about reading your email and talking to someone at the same time? If you're trying to actually read your email, as opposed to maybe just skimming the names in your inbox, conversation with someone becomes difficult because you're tackling two language activities at once: reading and listening.

Some people feel multi-tasking helps them stay fresh and alert, not get bored, and ward off fatigue. Some even claim they can't help it, as their brain gets easily distracted and goes from one thought and task to the next. However, most experts agree that the average person does not know how to multi-task well and, therefore, should refrain from doing it at all. Jim Loehr of the Human Performance Institute has spent a great deal of time researching multi-tasking and writes, "Human beings, sorry to say, can focus fully on only one thing at a time. When people multi-task, they are not fully engaged in anything, and partially disengaged in everything."

We know that ED physicians are interrupted at amazingly high rates, including an interruption that results in a change in your current task once every 10 minutes. We know that every time you are interrupted, and even more so when you change tasks, there is a period of

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“GOOD JUDGMENT COMES FROM EXPERIENCE, AND EXPERIENCE COMES FROM BAD JUDGMENT”

WORK, INTERRUPTED (CONT FM PG 5)

("Cognitive Errors" Continued from page 5)

refocusing on the new task. The more this happens the more time is lost in the "refocusing" period. But the very nature of our job requires that you spend as little time as possible in that refocusing period, which means that decisions are being made during that period. And this is one of the times we are most vulnerable to errors, no matter how experienced we are.

So what can we do about this? We can't change the fundamental workplace environment of an ED. But what we can work on is how we respond and react. First, and probably most important, is to develop routines. We have learned this throughout medical school and training, to have a routine for history, physical exam, procedures, among others. But do you also have a routine for other more mundane, but equally critical tasks? When you are giving verbal orders to a nurse during a resuscitation, do you give the order the same way every time? Do you write orders exactly the same way every time? When listening to a medical student or intern give a presentation, do you make a point to be routine in how you listen to their presentation? When you sign a chart, do you have a methodical routine for going through the chart before signing off on it? Do you perform a quick review of all labs and studies ordered to make sure you have viewed and acknowledged them? Dr. Meyer's research has shown that when multi-tasking, or when changing from one task to another, the period of refocusing is greatly shortened when going from a less familiar to more familiar task. So make as many tasks as possible "familiar." The more routine tasks you are likely to be doing while multi-tasking or refocusing, the less likely you are to make a mistake.

IN THE

THINKING ZONE!

In addition, nurses have it right…there are some times when you simply should not be interrupted, or if you are it should only be for something life and death. In most departments, a physician is fair game for everyone, from the clerks to the nurses to the patients. And as the ringleader of it all, you may feel obligated to oblige them all. Perhaps we need "In the Thinking Zone" signs. I somewhat jest, but the idea is clear…it's OK to say "hold on, I'm finishing this task." Spend that additional 30 seconds or minute doing what you need to do, then give the interrupter your full attention. When you are able to create more consistent focus yourself, you will help the entire team become more focused too. And that is ultimately in the patients' best interests.

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EASY DAY....RIGHT?

I was working in the emergency department when a 90 year-old female rolled in to the Emergency Department (ED) via ambulance from her home, where she lived with her caretaker daughter. The daughter reported that her mother had pulled out her nasogastric feeding tube…again. I got word from the nursing staff saying, "This should be a quick one! The patient just needs a nasogastric tube (NGT) put in and she can be on her way."

I thought to myself: "Easy Day." I also secretly thought, "Sweet. Here is my chance as a first year Emergency Medicine resident to shine a bit and put those surgery intern skills to use." It was bread and butter time, folks.

So I went and evaluated the patient. She was a pleasantly demented, mildly cachectic female with a handful of medical problems and an even bigger handful of medications. Alzheimer's dementia, hypertension, gastroesophageal reflux disease, chronic obstructive pulmonary disease…you've seen the movie. In addition, enteral nutrition had been required secondary to dysphagia that had not been responsive to other treatment modalities. It was uncertain if the enteral feedings were gastric or post-pyloric. The history was quite limited due to the patient's cognitive state, and while her daughter was her primary caregiver she was unable to provide many more details. But I was reassured that the vital signs were normal, she was afebrile and the remainder of her examination was benign.

I went ahead and discussed the risks, benefits, and indications for the planned procedure with the patient and her daughter. I got the green light and gathered my supplies for the slam-dunk bedside intervention. Yes, another procedure to log into New Innovations, Inc! Or at least one in the win column for job satisfaction. I even brought the medical student in, with the plan to walk him through it and let him place the plastic tube, reveling in one of the few chances a first year resident gets to impress a trainee.

We positioned the patient properly, administered some intranasal oxymetazoline and oral topical benzocaine. Besides a few evil eyes from the patient (of course directed at the medical student, not me), all went well and was uneventful.

Radiograph time. The x-ray looked...ok. The tube was only slightly past the gastroesophageal junction. Considering the patient's risk factors, my goal was to place the tube post-pyloric. No worries, I thought, and advanced the tube. Time for radiograph numero dos. And the result: post-pyloric. Success! I even got the "A-Ok" from the attending physician as he peered at the radiographs with me. I spoke with the daughter and let her know that the procedure went well and that momentarily they would be discharged. As per my normal discharge routine, I checked the online laboratory and radiology reporting system for the official radiology report. And as luck would have it, the radiographs were already dictated and in the system. I scanned through the document and to my surprise the first set of radiographs said something about a "moderate sized right pleural effusion." What? They must have the wrong patient. Granted I was mainly focused on the tube placement, but certainly I did not see anything in my periphery that looked like a pleural effusion.

Before calling radiology back to have them figure out which x-ray they had mistaken for my patient, I rechecked the film myself. Sure enough…pleural effusion. Moderate sized, at that. Unfortunately, it was game off and farewell to the discharge-to-home plan as the patient got admitted to the hospital for further evaluation and treatment.

My lessons learned: Even though you

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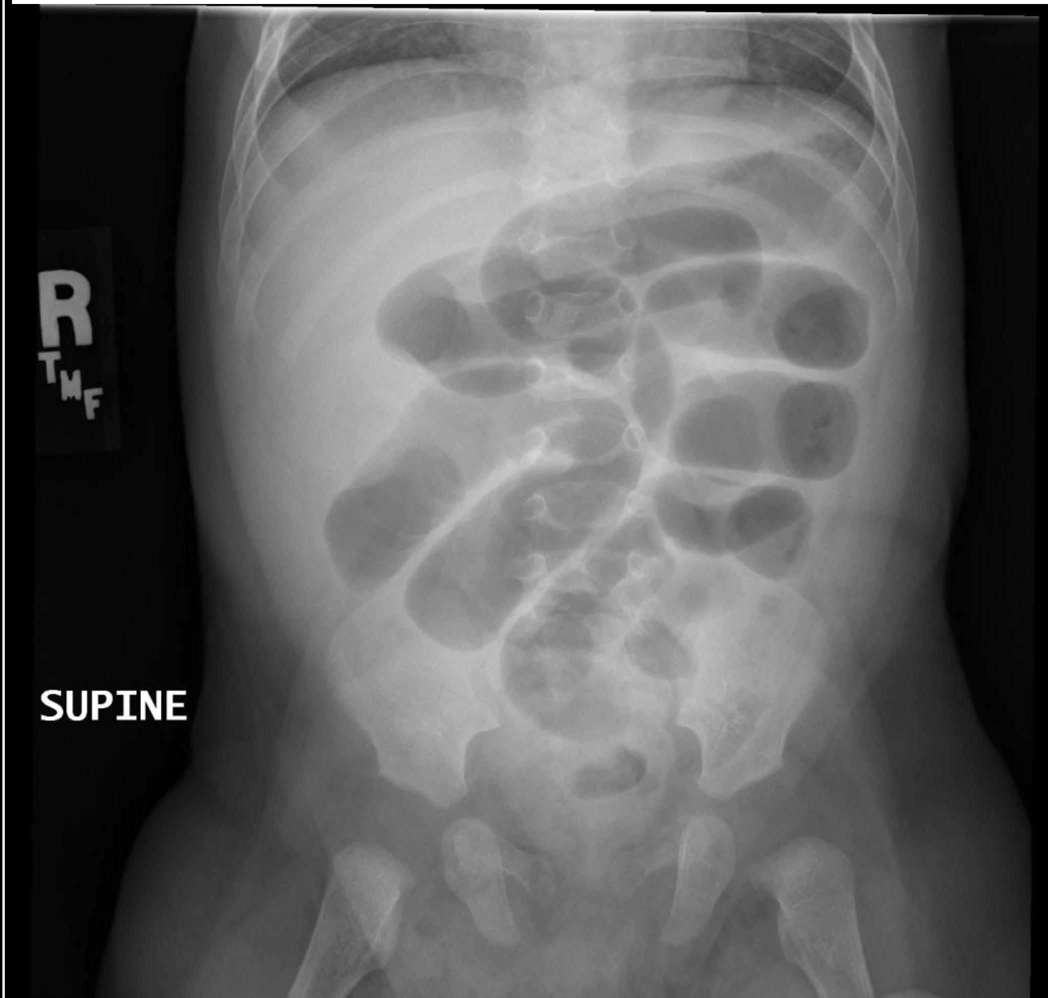
think you have a straight forward task at hand, it is imperative to maintain your systematic approaches. In this case, reading a radiograph. Whatever your mnemonic or memory tool is, I am reminded to pull it out each and every time I sit in front of an image. You may feel pressure from all corners of the ED to expedite the throughput or get that false sense of security that your evaluation is correct, particularly when other colleagues have given their approval, but remain methodical in your interpretations of data. Additionally, incorporating a verification process such as I have done with checking laboratory and radiology reports prior to discharge, may help to minimize information you may have overlooked.

What I thought would be a straightforward case and a simple procedure reminded me yet again of the true importance of using a systematic approach whenever possible in the Emergency Department As we all know, methodical and systematic approaches can help keep you focused with the high volume of confusing presentations and distractions, and avoid critical error or delay in diagnosis.

Old Sawbones says… What in the Sam Hill is wrong with you Doc? Do you need to go back to medical school where Old Sawbones taught you to read xrays the same way, every time?! When you break the routine, mistakes happen and you miss things. When you order the x-ray (or any lab or study for that matter), you better darn well address *everything* on that xray or lab...that's why Old Sawbones often gets on ya for ordering all those labs!

VISUAL STIM



A 4-month old male presents with complaints of persistent vomiting per his mother. He was seen in the ED 2 days ago, had normal vitals and a generally benign exam. He was given zofran and tolerated po in the department and was discharged home. Today, his mother brings him back in because the symptoms are continuing. She is uncertain if the vomiting is bilious, but does state that he seems to be getting worse. He appears dehydrated but non-toxic, his pulse is in the 180s, his abdomen is distended, and is hemoccult negative. You obtain an Acute Abdominal Series.

What is the diagnosis?

(See Answer on page 10)

I'll Show Them!

As many of us who have worked in local emergency departments can attest, the "typical" workup in many of these ED's can be different than the workup we do at Portsmouth. Often, with an emphasis on patient flow and absolute minimization of risk, many labs and studies are ordered early in the evaluation, perhaps even from triage. I often found myself frustrated with the lack of emphasis on evidence based medicine in these workups, and the rush to order studies to definitely answer the question. This is especially true in children, which is a patient population that I will often go to extraordinary lengths to avoid performing CT scans on just to minimize their exposure to radiation.

It was one such day that I was working as a senior resident in a local emergency department, when a 15-year old male presented after having a portable basketball hoop fall on him. Apparently, after doing his best Michael Jordan impression while slam dunking the basketball, he grabbed the rim, which he then held onto briefly as he fell backwards, pulling the weight of the hoop down on him. It was apparently a slow fall, and he landed on his glutes and lower back with the rim of the hoop landing on his abdomen. He did not hit his head, and complained only of mild abdominal pain across the area where the rim had impacted his abdomen. He (and his friend with him) denied any loss of consciousness, as well as any head, neck, back, or extremity pain. His only complaint was the abdominal pain.

I performed a head to toe exam on him, clinically cleared his c-spine, and generally found him to have an unremarkable exam except for mild abdominal tenderness, not unexpected given the injury. There was no evidence of any fractures or head injury. His rectal was hemoccult negative. I performed a negative FAST exam on him, and ordered a KUB which was unremarkable.

I presented my case to the attending, with my plan to discharge the patient home with precautions. She looked at me funny, asking why I wasn't going to scan his abdomen, "because he has abdominal pain." I was fresh off my victorious discussion of the proper use of D-Dimer and CT Angiograms of the thorax in the workup and diagnosis of pulmonary embolism, and again began my discussion of the risk/benefit of exposing a 15-year old to a high dose of radiation on what would probably be a low yield scan. We went back and forth but I wasn't going to be swayed. She finally relented when I agreed to observe him in the ED for a couple hours, perform serial FAST and abdominal exams, and then scan him if he wasn't improving or if any information changed.

I went about evaluating and dispositioning my other patients, and stopped back in about every 20 or 30 minutes. I repeated the negative FAST exam a couple times, gave him some more pain medication, but I grudgingly had to admit that he was not really getting any better, in fact his abdominal pain was perhaps even getting a little worse. After 2 hours of wishing him to improve, I decided to go ahead and scan him.

Since I'm writing this story, I'm sure you can guess that the CT scan was not normal. He had a ruptured duodenum with retroperitoneal air (thus the negative KUB). We called surgery, who unfortunately did not have the ability to admit the patient due to his age, and therefore we had to transfer him to the children's hospital. He went to the operating room and ultimately did well.

What is frightening about this case is that I was initially planning on sending this patient home. He had normal vital signs, and despite his mild to moderate abdominal pain had a relatively unimpressive exam (at least initially). Because of my perception of CT scans being ordered too frequently, I was biased against or-

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dering a CT scan just because the patient had abdominal pain. I ignored the fact that despite his mild exam, the mechanism was still fairly significant. The "compromise" plan enabled the patient to stay around long enough to have their abdominal pathology declare itself. If we had given him enough pain medication, he may have gone home and minimized his symptoms until he was critically ill.

As is often the case in a physician's "how I practice medicine" learning curve, the pendulum may swing too far one way or the other. We put a great emphasis on evidence based medicine, and weighing the risks and benefits of any test, study, or procedure before ordering it. Radiologic studies are no exception, and knowing how to avoid unnecessary radiologic exposure is an important part of refining your clinical skills. But just as important as knowing when not to order a study is knowing when to order that study, and this was one of those times. And if you are not going to order the study, you should absolutely be sure you have a solid alternative plan that takes into account the risk you are assuming by not scanning. I failed to do both; I did not want to scan him, but I also didn't plan on serial observations. Hopefully, he would have gone home, the pain would have progressively worsened, and he would have returned to give me another chance to get the diagnosis right. Or, he could have gone home and done what most 15-year olds do and go to their room and shut their door, where he would have stayed getting progressively sicker, and this story would have a much unhappier ending.

Old Sawbones says... Not much else to say here...I worry that all these fancy newfangled clinical guidelines and decision rules are just excuses for doctors to stop thinking. You're paid the big bucks for thinking son, not just moving the meat! And in this case you forgot that this kid had a basketball rim equivalent of a handlebar injury, which we all know can do some damage. We should think about radiation, but also think about what you might be missing.

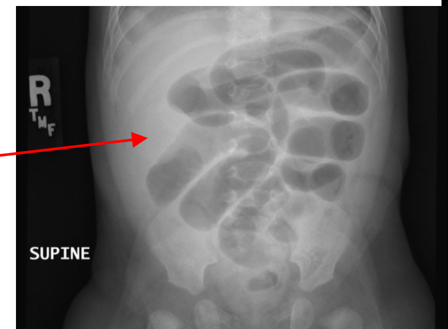
VISUAL STIM (Continued from page 8)

Answer: Intussusception

- Epidemiology:
  - Second most common cause of bowel obstruction in the 2 month—5 year old age group
  - 95% - no identified leading edge (If do, Meckels, Lymph nodes, HSP, Lymphoma most common)
  –Ileocecal valve most common site, colonic second most common

- Classic Triad:
  - Vomiting (usually *non*-bilious!)
  - Colicky abdominal pain
  - Blood in stool (while 65% are hemoccult positive, currant jelly stool is *late* finding)
  - Consider diagnosis in any child with abdominal pain, or in infants if you have a weak, vomiting infant with poor feeding

- Findings:
  - Mass in lower, mid, or upper right quadrant
  - May have electrolyte abnormalities from persistent vomiting
  – Xrays may demonstrate "target" or "doughnut" sign to right of spine, may show obstruction
  - Ultrasound may further suggest diagnosis



- ED Management:
  - Fluid/electrolyte replacement with pain control
  - Air/contrast enema (verify peds surgery availability in event of perforation)
  –Contraindications: Perforation, completion obstruction, signs of ischemia
  - Admit for observation after successful procedure (up to 15% recurrence rate in first 24 hours)

Be the Calm in the Storm…Not the Clown in the Circus

Who doesn't love Friday nights in the Emergency Department? Emergency Physicians are often the life of the party for a reason…they have seen just about everything.

On one of these humanity testing Friday nights the pace had been brisk but not oppressive. At the time I was an early senior EM resident. Those of you that have been doing this line of work for a while will recognize that there is always this awareness that anything can come in at any time. This low-grade tension helps our kind not be surprised by anything. Ok, nearly anything. This was one of those nearly anything moments.

The image is so vivid I remember where I was standing and which way I turned to see what I saw. While proceeding towards one of the GYN rooms on the outskirts of the Emergency Department, I hear a sudden boisterous commotion. There was clattering, there was yelling, there was laughing, there were gasps, there were incomprehensible words intermixed with quite comprehensible four letter words and impressive euphemisms. When I turned, my eyes widened. An enormous grin split my face. The entire Emergency Department staff was frozen and mouths agape with eyes affixed to the developing scene.

Down the opposite passageway, led by the Charge Nurse, was a gaggle of police carrying a man in his early 20's towards the Psychiatric room. The police and security personnel had the young man suspended in the air by his right arm and his leg. His left leg dragged on the ground while his left arm was handcuffed to his right behind his back. While all of the people carrying him were clothed, he was outfitted in nothing but one sock, a pair of well-used "tighty whities" and a football helmet that had been through a few wars. Out of the face of the helmet came a stream of belligerence that reminded me of the father's incoherent diatribes on "A Christmas Story". I have never seen someone combine "nearly incomprehensible" and foul mouthed comedic flair so fluidly.

"Sue me...you'd be laughing too!"

[Pause to let the screaming satirical naked battering ram visual sink in.]

Call me cynical, but I immediately went out on a limb and suspected substance abuse here. Once I un-cemented my feet from the floor I bolted to the designated psych room. No one was going to take this case from me.

I arrived, childish grin in place, to the patient being placed face down. The screeching profanity continued to stream. This 10x10 room very soon had 12-13 people in it. Some were gawking, some were laughing, some were yelling profanity back at the patient, and some were trying to reason with him. The only group missing was the group that was going to evaluate and treat the patient. That is mostly my job but I was busy being a part of the laughing group. One sock, handcuffs, baggy "tighty whities", a football helmet, and entertaining language...sue me. You'd be laughing too.

When the nurse responsible for the patient broke away from the gawking group she turned her wide-eyed stare toward me pleadingly. I grinned and shrugged my shoulders. That wasn't what she was looking for. After a good ole' senior nurse glare I flinched and remembered I was the Doctor. I stepped to the patient's head, (which was face down at the foot of the bed) and began my evaluation. Getting nowhere fast I looked up and asked for some intramuscular chemical restraint. Looking about the room and outside the door, I realized the

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crowd watching our circus sideshow meant there was no one watching the other 25 patients that had come to us in their hour of need that night. Using my Texas born vernacular, I looked around and said “Y’all git”. Nothing. I tried it again without the big smile, and just as folks started to move out the staff attending on that side walked in.

I wasn’t certain whether I was in trouble or saved, but I stepped aside, certain his years of experience had equipped him to resolve the situation. To my surprise he formed a completely new group of rubbernecking bystanders. His strategy to quiet the continuing concert of profanities and incomprehensible sounds was to walk directly up to the patient, lean down to the patient’s ear, and as loudly as he could used the “tool of last resort” in a military hospital: pulling rank. For a brief moment there was silence, after which the young sailor replied “Yes Sir” and emphatically stated how much he respected his “*%@&ing rank.” Despite his apparent sincerity, the pause in the noise lasted only seconds. The attending threw up his hands, chuckled, said “I tried” and walked out.

We continued to negotiate with the patient to no end, and I finally used intramuscular persuasion. With less stimulation and more chemical restraint the patient became quite reasonable – the snoring a fair exchange for his previous tirade. In the melee I forgot to ask the police what happened to this guy. We had a name, a command, and a patient that was currently not able to communicate effectively. That was it. As I started the “let him sleep it off with frequent re-evaluations” protocol I tried to remember what was wrong with the other patients I was supposedly caring for.

I went about reopening the emergency department for business, having been effectively shut down for at least 30 minutes. I walked into the next patient’s room retaining my sophomoric smile. I got a cold stare. He did not seem to be nearly as entertained as I was. This episode repeated itself as I spent the rest of the night playing catching up, feeling one step behind on every patient.

Sophomoric means “the wisdom of the fool.” I thought it fit. The pain of the rest of that night confirmed I did not handle this appropriately. Many lessons were reinforced for me that day.

We are not there to be entertained. Grinding an Emergency Room to a halt so we can all be a part of a spectacle is unacceptable. In this era of 6 hour waits, 12 hour stays, and boarding ICU patients, moments like this affect the care of the truly sick. Fortunately, he improved as his blood alcohol level dropped. He got tanked up with nausea control and released to his less than thrilled command.

For those of you expecting a brain bleed story, my apologies. He was just a mean drunk. He didn’t have a brain bleed, but that headache three rooms down might have, and if she did I had just delayed her care 30 minutes. No different than rubbernecking on the road, rubbernecking in the department has no place when it impacts the flow of operations. By becoming the leader of this spectacle rather the leader of the solution I contributed to the problem and potentially endangered other patients’ lives.

We need to be the calm in the storm, the one who restores order in our otherwise daily chaos. Around every dramatic presentation lie patients there because they need you. They all deserve a timely evaluation, appropriate treatment, and a physician that isn’t a clown.

Old Sawbones says... Wow! Old sawbones wishes he could have seen this one, then again he’s seen this many times and in many forms over the last hundred or so years! You nailed it “Tex”, stay focused on your job. You’re the one everyone is going to be looking to set the example...decide what example you’re going to set! And Momma was right, always wear clean underwear...you never know when you’ll end up in the emergency room!

"ALMOST" LOST TO FOLLOW-UP

I was the senior resident working the floor one afternoon when an ambulance arrived from a local base. We had not received a call from the EMS crew, but that was not unusual for minor issues. In rolls a young active duty soldier who had injured his knee during training. He was awake, alert, and while he seemed uncomfortable was not in major distress.

His leg was elevated in the stretcher with the most unusual form of leg immobilizer I had ever seen. I think my elementary school age niece builds better looking contraptions for her Barbie dolls! It seemed to be doing the trick, however, as he was unable to move his leg. The EMT's gave the report that he was in the midst of a physically demanding training exercise when he felt something in his knee give out, and the on-scene medical personnel wanted him seen here. We began to remove the contraption from his knee, and were unsure whether to give it back to the EMT's or send it in to the Museum of Modern Art. We decided they might want to reuse it so we gave it back to them and they departed.

Luckily there was a note from the on-scene provider, a Physician's Assistant, stating that he thought the patient had a patellar tendon rupture. The patient described a popping sensation when he planted and twisted his leg, and thought that he felt his kneecap dislocate laterally but then pop back in. Regardless, he was unable to walk on it afterwards.

The exam was difficult due to his pain, and he could not actively flex or extend his knee due to both the pain and swelling. X-rays did not show any fractures, but the sunrise view did not appear normal with the patella appearing slightly misaligned. We suspected a dislocated patella with a probable partial patellar tendon rupture.

So I discussed my plan with the Emergency Department attending to put him in a knee immobilizer, provide him crutches and make him non-weightbearing, with R.I.C.E. treatment, and put in a referral to follow up expeditiously with orthopedics. She agreed with the plan. I instructed him to call the following day to schedule his appointment, and that if he could not be seen that week for any reason he should return to the emergency department and we would consult orthopedics directly. Easy button…pressed: "That was easy!"

So I was in conference several days later, and the EM1 doing his orthopedics month said "Hey, remember that guy you saw with the patellar dislocation. . . " The remainder of the discussion focused on the fact that he was ALMOST lost to follow up, and should have had his patellar tendon rupture repaired within 72 hours. In other words, orthopedics should have been called that day. Current orthopedic literature suggest that repair of the patellar tendon within 72 hours leads to better outcome, and that is the treatment of choice in our orthopedic department. Fortunately, the patient was able to be seen within 48 hours or so, and went to the OR the next day. The total joint orthopedic staff said "they got to him in time but he was almost a lost to follow-up".

While the patient ultimately had a successful repair, I learned an important lesson that day. In addition to gaining some additional knowledge about the management of patellar tendon ruptures, I realized that we may not have the most up-to-date practice recommendations of our consultant's specialties. If there is any chance that intervention is required, putting in a generic referral may not be adequate, as the consultant may not see the patient in the proper time frame. If you are referring someone who is likely to require a procedure, it is best to consult directly with the person who will be doing the procedure to make sure you are discharging them under optimal conditions and

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with the most optimal follow up. One of the downsides to practicing in the fishbowl of emergency medicine is that we may be criticized by consultants for not knowing every subtle detail of every single specialty out there, and therefore at times may be loathe to consult. We must also remember, however, that we don't know everything, and ultimately we want to do what is right for the patient. This patient wasn't lost to follow up, but if he had waited even a couple days to call the outcome could have been very different.

Old Sawbones says...

This reminds me of what a professor once said to me when I showed up about 10 seconds before class started…"You're almost late!" My reply "So I'm on time!" This patient was "almost" lost to follow up, but he wasn't actually lost, and that's important. But don't let your ego get in the way of good care...unless you're certain how to manage somethin', look it up! And don't forget that when a consultant will need to be involved, help them be successful and make sure you know what you're doing. If you're in doubt, swallow yer pride and give 'em a call!

FAST (LAUGH) TRACK

The lighter side of medicine

Specialty Selection Flowchart: Did you choose the right one?