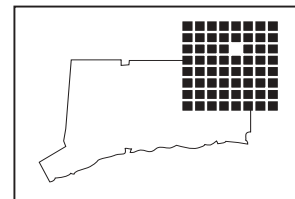




Spring



CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS

MARCH 2005

“The desire to take medicine is perhaps the greatest feature which distinguishes man from animals.”
Osler

TWO CONNECTICUT EMERGENCY PHYSICIANS IN POST-TSUNAMI SUMATRA

We delayed this issue of EPIC to interview Rob Fuller and Matt Howell, two Connecticut emergency docs who have just returned from an incredible journey to Indonesia to help the tsunami relief effort. In two sessions we sat down with Matt, Rob, and Rob's wife Natalie Coleman Fuller over slides and stories of horrific loss and inspirational teamwork. Their trip started January 8th when they flew from Newark to Stockholm to Kuala Lumpur to Jakarta and finally to Banda Aceh, which is on the northern tip of Sumatra. That's about 26 hours of flying, with another 2 day layover in Jakarta. There's plenty of cutting and pasting here, but we hope we've captured the essence of their trip.

RF: [Looking at a slide] We're flying into Banda Aceh. You can see what used to be thousands of homes, and many, many square miles of devastation. After this long trip, lots of downtime and lots of unknown, gazing down through the plane window, it suddenly occurs to me that we might be in over our heads...we aren't in Kansas anymore...

MF: The Banda Aceh airport is this small incredibly busy place. Constant stream of helicopters landing and taking off. A big army transport, looking like a miniature version of our C5, was landing right behind us. It opened up and dumped everyone's gear on the tarmac. Rob and I loaded all our bags onto an old truck and sat on top of 30 people's luggage and tents and boxes of food and rice from the



Matt Howell and Rob Fuller (on left) with their Banda Aceh ED Team from all over the world.

airport to the IMC [International Medical Corps] office in Banda Aceh. **RF:** From the truck the land was beautiful pastoral scenes of rice patties and open land...then came the mass graves. Then we drove by the trucks, all of them full to the brim with

bodies. Forty trucks in a line all full of bodies. Those are big trucks. Pretty grisly. The trucks backed up into a field between the rice patties where they had dug a huge hole, like you might build an apartment building, deep and wide. Then they dumped the bodies in and plowed them over.

EPIC: Any ceremony or anything?

RF: There was very little or none. At this point they have
(continued on page 4)

INSIDE:

JOBS IN CONNECTICUT

WORK HARDER: GET PAID MORE

RESIDENTS' CORNER

Spotlight On . . .
MIDSTATE MEDICAL CENTER

[Belated] PIX FROM OUR LAST ANNUAL MEETING



New Board members (l to r) Bryan Jordan, Michael Gutman, Mort Solomon with Sec/Treas Larry Levine.



Phil Brewer receives the Phil Stent Award from Craig Mittleman



Sue Dufel (Residency Director UConn), Tom Nowicki (Associate Director UConn), Laura Bontempo (Residency Director Yale), and Karen Jubanyik (Associate Director Yale)



Dude's head



Dan Middlebrook (PGY3 UConn), Jack Middlebrook (Intern) with Tom Nowicki



Steve Holland hands Senator Louis DeLuca his "Legislator of the Year" plaque.



CCEP Officers Dave John (President Elect), Phil Brewer (Immediate Past President), Craig Mittleman (President), Larry Levine (Secretary/Treasurer)

WORK HARDER – GET PAID MORE

SOME CONNECTICUT EDS ARE INCENTIVIZING THEIR DOCS

In most of the 31 emergency departments in Connecticut, if you outperform the other docs, you get little more than thanks from your director at occasional evaluations. Maybe it feels great to do good work, but there's no real incentive to see more patients, to sign out fewer patients at shifts end, or to perfect your documentation. That is unless you work at one of four CT EDs that incentivize their physicians. At the Norwalk, St Mary's, Day Kimball and New Britain General EDs, physicians are incentivized to perform well, and it can mean real money.

EP incentives at these EDs, and many more across the country, are based on Relative Value Units, or RVUs. The RVU is the assigned value for each of the more than 8000 CPT codes that describe physician's work. RVUs are the sum of the physician's work, practice expense, and

“each patient is seen as a revenue enhancing opportunity”, says Carius.

malpractice costs. *Work* is the expertise, effort, intensity and time applied to the service. This contributes about 55% to the RVU value. *Practice expense* makes up 42% of the RVU value, but EPs (or the hospitals that pay them) get none of it because we don't work in an “office” that incurs expenses. CMS (Medicare/Medicaid) doesn't consider taking care of 44 million uninsured patients as a practice expense. *Malpractice* is estimated for each service rendered, and is about 3% of the RVU value.

These 3 components are adjusted to the region by the “geographic practice cost index”, and the total RVU is then multiplied annually by the “Conversion Factor” to arrive at a dollar amount for the CMS payment schedule. Other payers base their fees on that.

At Norwalk, RVU-based incentivizing started in 1999. Rates were initially tied to yearly Medicare reimbursement, but because Medicare rate hikes are decreasing, they now peg RVU rates to the 3 year rolling average. The result? Bonuses range from \$22,000 to over \$100,000, says ED director Michael Carius. “Salaries are theoretically at risk, because each EP must earn more RVUs than his or her salary, but no doctor's income has actually dropped”.

The physicians benefit, and so does the ED operation. Carius says that, “...incentivizing reveals the good performers and pushes the borderline performers”. More patients are seen per doc, especially toward the end of a shift. Documentation and billing, is “much improved”. Just as with most other medical specialties and venues, “each patient is seen as a revenue enhancing opportunity”, says Carius.

St Mary's in Waterbury started RVU based incentivizing

in 2000. It is patterned after Norwalk's program but with some modifications. Each EP has an RVU target that is negotiated with the hospital. The bonus is based on RVUs over the target and caps out at 13% above base salary. Like Norwalk, the bonus is a function of work performed and how well the work is documented. Unlike Norwalk, St Mary's uses a formula that also factors in timely chart completion and customer satisfaction. Peter Jacoby, the SMH ED director, says that incentivizing has increased the number of patients seen per shift per doc. “And there's no cherry picking”, he says, “ss our program is based on RVUs not payer mix”. That means that the actual revenue generated, which has everything to do with the patient's insurance, doesn't affect a doctor's bonus. Peer pressure is a factor because the RVU pool, which better documentation creates, is decreased by those docs who don't make their target, and that's transparent to all.

At New Britain General, Jeff Finkelstein and his EP staff took FY 2003 as their RVU baseline and from there negotiated a rate over which they would get a piece of the action. Any RVUs over that creates a pool that is divided among the EPs. Like St Mary's, each EP's share is not based purely on documentation and number of patients seen. Thirty percent of the pool goes to rewarding docs for high Press Ganey scores, which is also a number that is negotiated with the hospital. 10% goes to an incentive for the ED management, as those docs do not see as many patients as the rest of the staff. 5% of the RVU pool rewards EPs who

contribute to staff education. The results after one year? The average RVU per patient increased from 2.5 to 2.73. Press Ganey scores went from the 52nd to the 75th percentile. Salaries increased by \$17,000 on average, with a high of \$23,000 and a low of \$6000. Base

salary is not at risk. “You only get RVU credit for patients you finish”, says Finklestein, “so our docs tend to finish what they start”. That makes for fewer sign-outs, better



Happily incentivised NBG doc Dennis Dolce

(continued on page 9)

TSUNAMI

(continued from page 1)

2,000 bodies a day to bury. They've already put 100,000 people in the ground. It was grunt work.

MH: On the day we arrived they were burying something like 2100 a day. When we left it was about 400 a day. Astronomical numbers.

They were walking over corpses to get through the front door of the hospital. Just utter chaos.

EPIC: What was the hospital like when you first arrived?

RF: A week before we got there a group of emergency docs from Singapore came into Banda Aceh, and what they saw was a total nightmare. They were walking over corpses to



Banda Aceh Hospital, still wet weeks after the tsunami

get through the front door of the hospital. Just utter chaos. They used a building on higher ground, cleaned it out and opened an inpatient ward. It became "Singapore", and that's where we'd admit med/surg patients. We get there and they badly need a functioning emergency ward. That became "America". We started off with 12 beds. Then there were 15, then more. "Australia" was a field hospital ICU – 3 beds – that had x-ray and lab capabilities. "New Zealand" was ID.

EPIC: Were there any other wards?

RF: The Belgium pediatric team had arrived a few days before I did...there were a lot of kids needing admission but no ward to go to. So they washed out one of the buildings and set it up. Found cots outside in the mud, washed them out, and that was the peds ward. So the kids that we admitted went to "Belgium". "Germany" was a mobile surgical unit.

EPIC: What was the hospital like before and after the

disaster?

RF: It was your typical tropical hospital. All one level. Very open. Similar to the hospital on St Lucia where Matt and I've worked... Before the tsunami, there were

460 doctors and nurses. 160 returned. The rest fled or died. We think this is what happened: Richter 9 earthquake hits and causes lots of destruction... buildings collapse...hospital staff that didn't happen to be at work naturally go there to help... the hospital is one story tall on

pretty low-lying land. Staff gets to the hospital and then a six foot wave full of glass and metal and cement and all kinds of debris rolls over them. They didn't stand a chance. One of the hospital directors, a cardiologist, lost everything but the clothes on his back, literally. He lost his son, his home, most of his colleagues. Just one nurse of 30 that worked in the emergency ward returned. She was just delightful to work with though by our standards she wasn't that skilled. But I treated her like gold because she's the one connection to the future. She's the one person that will stay behind after we leave.



Death in Banda Aceh

EPIC: So the patients in the hospital lying in beds immediately drowned?

RF: Yes. They had 100% mortality on their inpatient units. There were no inpatients left. I have a slide somewhere of

continued on page 5

TSUNAMI

(continued from page 4)

the waterline on the walls. It's basically at neck height.

Big sheets of glass moving through the water. So people were just mutilated, completely mutilated.

EPIC: I'm trying to picture the wave...

RF: Blender or thousands of piranha is the best way to think of it. What was going on below the water level was not bath water; it's glass and suspended steel. As soon as any part of you fell below the surface, it was immediately injured. Incredibly powerful. Big sheets of glass moving through the water. So people were just mutilated, completely mutilated.

RF: Here's a picture of a one of many cars that got tumbled and wrecked. Think about the energy in a single rollover accident, then think of hundreds of them. Think about how people got mangled. Cars everywhere were just like this.

EPIC: Let's back up a little. How did you decide to do this in the first place?

MH: The tsunami hit on December 26th, and we both, independently, without saying anything to each other, started looking on-line and calling contacts. Rob has a lot of them. Rob called me on the 27th or 28th and said, "this sounds like something you'd be thinking about, well I'm thinking about it too". He says he knows this is crazy, but Natalie was on board. The next day I filled out a lot of forms online and left messages with many of global relief groups. One of them was the IMC. We didn't hear from anyone for quite a while and it was pretty discouraging. I came back from my Christmas break in Florida to Hartford on the evening of January 5th. Got a call that night saying can you be ready to go in 48 hours? That was Thursday. I said well I've got some shifts to cover...got in touch with Rob the next morning. I worked the next two days, got my shifts covered and we left Saturday.

EPIC: So Natalie, in the early part of Rob's search what did you think about this whole thing?

NCF: Well I really felt like they couldn't not go. Both of them were trained, more than most people, to do just this kind of work. There aren't that many people, doctors or nurses or whoever, who can say that.

RF: Over the years I've actually spent many months—well more than a years worth—working in St. Lucia. There's a tropical hospital there with limited resources and you get used to rationing things like x-rays and ventilators. Matt spent some time there too and that experience was invaluable to both of us.

NCF: Rob has also spent a lot of time learning about disaster management. You don't do that just to play paintball better. You do it because eventually your skills are going to be called out and you have to respond. So I was all for it. I did have two rules: He wasn't allowed to get killed

and he wasn't allowed to fall in love.

RF: So we're drinking coffee Thursday morning and Matt calls and says, hey, Saturday morning there's a plane leaving Newark and we could be on it...So all of a sudden I had to get clearance from my boss and then the Dean of the UConn Health Center. Oh, and my passport had expired...

EPIC: Can you tell us a little bit about IMC?

RF: They're a great NGO—nongovernmental organization. They are all about human health, dignity, and education. And leaving behind a functioning infrastructure when they pull out of a place. They're in all the lousy places in the world like Central Africa during the civil wars, Bosnia when it was very dangerous. Iraq. It's as if they look at the U.S. government travel advisory about where not to go—and go there. The IMC was just spectacular at operations and logistics, very complicated stuff to orchestrate. Always a step ahead of us, knowing what we'd need, freeing us up to do what we came to do. Allowed us to be totally productive. They'd done this before, many times.

EPIC: So, what kind of people do this kind of relief work?

RF: This is Dr. Neil Joyce. He's the site clinical coordinator for the program in Banda Aceh. Really dynamic, smart, can-do sort of guy. It was about 50/50 docs and nurses. No extenders, don't know why. Two ER docs, two family medicine docs, others. There was an American orthopedist who hooked up with a Dutch field orthopedic hospital. He ended up being very busy as part of this self contained orthopedic unit out in the field. I think maybe we five became the most productive people in our group. There was a general surgeon who was dysfunctional in this environment. He left after a few days. Turns out, it can be unsettling being part of an operation like this, especially as it's setting up. You have to be very flexible, just go with it... there were definitely people on this trip that couldn't deal with it. The type A's had a problem.

EPIC: He didn't know what he was getting himself into?

RF: Yeah, he couldn't deal with the flexibility that was required in the environment. There's some wasted time...it just happens. Then other times you had to be overly productive. Kind of like the ER. There was a male OB/GYN doctor—good guy—but turns out he's a man among Muslim women who use only midwives for OB. Wouldn't consider letting a man do it. So he was useless medicine-wise and recognized that. So he went home. He was a great gofer though, and before he left he helped us organize a lot and did medical student stuff. Unpacking wounds, help with the pharmacy. There were other docs who were so far out of their environment that they couldn't do anything medically useful and chose to do nothing.

RF: This is a slide of a doc that turned out to be a real asset to the team. He's a family medicine resident. Turned out to

(continued on page 10)

JOBS IN CONNECTICUT

BRISTOL HOSPITAL

Partnership Opportunity with small private group. CEMS, LLC staffing Bristol Hospital is recruiting for an exceptional emergency physician to join its group of all ABEM / FACEP emergency physicians. Administrative opportunities and partnership track available after two years. Suburban hospital, approx 38K visits, very pleasant work environment. Dedicated medical observation unit and behavioral health observation unit. Excellent career opportunity. Call Lawrence P. Levine MD FACEP at 860.521.4250 or fax CV to 860.521.3444

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NBGH is searching for an outstanding BC/BE emergency physician to round out our staff. Compensation is outstanding. Position to start June/July 2005. Please go to our website www.nbgh-er.com for details.

CCEP WELCOMES NEW MEMBERS

AKAS SHAH
CRAI-YAN, DO
JENN POST

*We also would like to welcome
the following ACEP members
who have transferred into
the Connecticut Chapter:*

J SCOTT BOMANN, DO
ROBERT GRAHAM, MD
EARL MILLER, MD
CLIFFORD SCHWARTZ, MD

SAVE THE DATE

CCEP EDUCATIONAL SYMPOSIUM / SIM LAB

THURSDAY & FRIDAY

AUGUST 18th & 19th

Foxwoods
Resort Casino

RESIDENT'S CORNER . . .

YNH STEALS JEOPARDY TITLE FROM CAUTIOUS UCONN



The teams with Jeopardy meister Peter Jacoby



The UConn Team: Larry Lampson, Michelle McDade and Shawn London



The YNH Team: Nicholas Vasquez, Samir Haydar and Simon Kotlyar



Yale residents (L - R) Richard Trepp, Alex Molina, Kenan Tarabar, Rock Ferrigno, Damian MacDonald, Kristin Lynch, and attending Basmah Safdar

Spotlight on . . .

Midstate Medical Center Emergency Services

For this edition of *Spotlight* we talked to Associate Director Tom Holmes who gave us the low-down on this busy community ED.

The Census: 47,000 patients per year, which hasn't changed much in the last few years. Midstate was built in 1998 after Meriden-Wallingford Hospital closed. The ED was designed for 28,000 patients/year, which seems, er, laughable now.

The Layout: 29 total rooms, which includes 6 "Acute Behavioral Health" beds, 4 "Minor Care" beds, and 6 observational or "Admit Hold" beds. We also have hall beds A to O (permanent letters on the wall), which are full a lot of the time.

The Staff: Eleven full time and two part time docs, with 4 full time PAs. We have 45-54 doc hours and 12 PA hours of coverage in 24. Shifts are 9 hours long and there's decent overlap. Each doc works 4 shifts/week, 2 weekends a month.



Chilly ED staffers in front of our new perennial garden: Gary Tickey, MD, Donna Files, Karen Riley, RN, Joan Roche, RN, and Jared Korab. The docs buy everyone a bottle of decent wine each February for no particular occasion and that's the point.

Our Issues: ED crowding is the big one, just like everywhere I guess. Just 128 inpatient beds says it all. We recently added a new inpatient pavilion, which helped, briefly. If you build 'em, they will come.

Recent wins:

1. We had a lot to do with MMC adopting a new "Capacity Code" protocol by which certain admitted ED patients get sent to the inpatient hallways when the house is full and the ED is in extremis.
2. We fought the good fight and recently took delivery on a new fairly high tech ultrasound machine. Now we have to figure out how to use it. But the hard part's done.
3. Two years ago we won "Team of the Year" and with it \$5000. That came to a paltry \$33.32 for each staffer, so we voted to pool the money and plant a perennial garden on a tiny plot of weeds and mud right next to the ED that had been reserved especially for cigarette butts and empty cans. Lots of digging and planting and for our labors we now have a little bit of peace and a great spot for lunch 3 seasons/year. (Actually it looks pretty good in winter too.)

What's New: We're currently piloting a "Rapid Assessment Team" in an attempt to decrease our door-to-doc time and improve overall throughput. When staffing allows we pull a nurse, a doc and a registrar to triage waiting room patients quickly. So far it's been a real success though it's not been without plenty of operational glitches. Nurses complain of chaos, which is what happens when patients wait in the ED not the Waiting Room. But patients love seeing the doc fast and love getting treated promptly. When we're "RATTING" (got to get rid of that name), we see all waiting room patients in an average of 23 minutes. And the Waiting Room is empty. Next trick is to figure a way to include ambulance patients. Not there yet.

A Philosophy? Don't think we can top those of previous "Spotlights", but our current drone is, "Hey, if we didn't have to take care of other peoples' (in)patients, we'd be fine". Oh well.

continuity of care, and perhaps better patient flow. Dennis Dolce, a staff doc at NBG says, “We usually stay late to finish dispositions because otherwise you’re handing the RVUs away to the next guy, even if it’s your work.”

“It’s all about not leaving money on the table”, says Cummings

more patients felt that they weren’t being adequately recognized for their contributions to margins”, says Cummings, “And we attracted 3 physicians who like the concept of incentives”. Like other incentive programs in Connecticut, DKH uses RVUs to drive bonuses. But their formula is somewhat different. They multiply the number of patients per hour by the average charge per hour, subtract that from costs, (each doc’s salary, malpractice, billing, etc), to get the per hour difference per doc, (which can be positive or negative), and that’s the bonus. As with the other incentivized EDs, the operation and patients also benefit. “It’s uncommon to have patients awaiting disposition at change of shift”, says Cummings. “Docs feel

Day Kimball Hospital in Sharon has had an incentive program for years, but until November of 2004, it was not RVU based. Dropping reimbursement rates could not support bonuses that were not linked to better documentation and higher revenue, so they switched. “The conversion was not without turbulence”, says director Ian Cummings. “One physician left”.

But, “...physicians who documented well and who were seeing more ownership of the patient flow, and cycle times have dropped”.

Some other pearls from Cummings: ED “procedures”, per CPT terminology, include interpretation of 02 sats and rhythm strips, fluids given in the first hour, and other therapeutic and diagnostic work that we all do but often don’t document. “Also”, he says, “critical care codes are grossly underused”. Feedback to the docs is crucial, especially the rates of CPT code levels as compared to their departmental peers and available benchmarks. He notes that hospitals, “generally do a poor job billing the professional component of EM services. Use an outside billing company. Negotiate...insist on reports of your billing data...mine it on your own...”, and feed it back to the docs to give them the best shot at a good bonus. “It’s all about not leaving money on the table”, says Cummings, “You do the work; you should get paid adequately for doing it. We are a LOT cheaper than just about any other specialty”.

And the staff docs? Dennis Dolce from NBG says that, “The groups attitude around money has changed. Suddenly it matters more. And [incentivizing] eliminates the whine factor some, (though being human we still do it)...but it’s hard to bitch if you’re being paid extra for your effort. Too bad the nurses can’t get some...” Do the nurses know that the docs are being incentivized? “The RNs picked up on it”, he says, “though we call it, ‘RVU pressure from the administration’”. They know we’re being tracked and our performance measured. But we try to share the wealth”, says Dolce, “We gave a portion of the pool to staff (paid for unit secretary’s kids college tuition because she was hurting), and some extra nursing gifts etc. We also started “Tech of the Month” which is worth \$100, 12 times a year”.

Lisa Viera at St. Mary’s says that, “I’ll stay to see a few patients that I might not have seen before, and I look forward to the extra money. It’s sort of like moonlighting, just at the end of a shift.” When asked if incentivizing has altered the way she works, she says, “It’s changed my practice somewhat, but the way I practice is the way I practice. Truth is, no matter how much money is involved, you can only go so fast. “Besides”, she says, “I like to sit and talk to my patients, and I think they like it to.”

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CHAPTER OFFICE

30 Dwight Drive
Middlefield, CT 06455
(860) 349-2220 Office
(860) 349-3004 Fax

e-mail: 76032.660@compuserve.com

CCEP Website: www.ctacep.org

TSUNAMI

(continued from page 5)

be one of those well prepared. A loose flexible guy, just right for the environment. I knew that when I saw what he brought: duct tape, rope, water purifier, mosquito net. I'd jump out of a plane with this guy.

[Another slide] Here's a picture of sunrise. We always got up for the morning call-to-prayer. [Sumatra is 90% Muslim.]

This is the porch where Matt and I are sleeping. This little spigot is where we showered. Sometimes had water. There was a bucket in the garden that you could also use as a splash for a shower...

*You never hear about the earthquake that killed thousands.
But that was only thousands. Now it's hundreds of thousands.*

RF: This is another shot from our house. It's a neighborhood that's pretty high above sea level and was not affected by the water of the tsunami. That mound of concrete is the house immediately behind our house. It was pan caked by the earthquake, the fourth strongest earthquake in the last 100 years. Did lots of damage before the water came in. You never hear about the earthquake that killed thousands. But that was only thousands. Now it's hundreds of thousands. This flattened house had the smell of dead bodies in it.

EPIC: What supplies did you bring with you?

RF: We were really well prepared. Matt and I felt like we could be dropped in the jungle and survive for 5 days at least. We had sleeping bags, water purifiers, maps, tents, mosquito nets, enough food to last five days, easy.

EPIC: Did you get paid?

RF: Something like \$20 a day. That's thousands of rupiah, don't know how much. Lots of bills.



"many, many square miles of devastation..."

EPIC: What kind of clinical equipment did you have?

RF: The Australian portable field machine on campus did about 15 or 25 X-Rays a day. It would get hot and have to cool off for 45 minutes after each use. We were always afraid that it was going to burn out. If the machine breaks, that's it. So we had to be careful about who to take pictures of.

EPIC: Was it mainly bones that you were interested in?

RF: Not really. Bones, we'd make them straight and not take pictures, before or after reduction. No need. I would

take an x-ray of a patient who had near drowning pneumonitis who wasn't getting better, thinking that maybe he had an empyema that I might need to put a tube into.

Mostly I took chest x-rays of people who were getting sicker and sicker and sicker. Most of them eventually died. Couldn't do much for them, except try to make them comfortable.

EPIC: Vents?

RF: No vents.

EPIC: What kind of patients did you see? What could you do for them?

RF: Lots of drowning pneumonitis. Not much to do for that. Those who hadn't already died from it just came in and died quickly or slowly over a few days. Tetanus too. I have a slide of a patient with diffuse muscle rigidity...something you don't see a whole lot of in Connecticut.

MH: By our last week we were getting to be more like a regular emergency department. The population began coming back. This town was over 300,000 people initially.

They came back on their mopeds and then came the traffic accidents, routine trauma cases. Head injuries. I had some interesting OB cases. Had a breech delivery...3 A.M. patient comes in contracting, about to deliver. The baby's butt right there. "Oh oh, not good", I said to myself. I can do a *regular* delivery but not...anyway. Right as the butt presented I got some help from someone who wasn't OB but he'd done a bunch of deliveries. Luckily he knew more than I did. Baby did fine.

EPIC: So how did a day go?

RF: We'd have morning coordinator's meeting to review the infrastructure. The Australians would say something like, "We've got water to two of the buildings, toilets actually working. Electricity in four of the

(continued on page 11)

TSUNAMI

(continued from page 10)

buildings. We did five operations and we have X patients with Y issues.” The American team would say things like, “No electricity, no water, saw 120 patients and I’m holding 32 patients that need beds. We need some help.”

EPIC: Jeez, just like Connecticut.

RF: Yea! Like I said, we came prepared. Then we’d see patients all day long. Lots of tetanus, aspiration pneumonia, wound infections. Not much to do for them. Sometimes the lights went out, but we had headlamps, like miners.

EPIC: So what will you remember the most?

MH: One of my best memories is the camaraderie...it was like a mini UN. We developed real relationships,

especially with Australia. Amazingly helpful. We had no running water and no electricity, and their army engineers came over and strung wire and put up the lights. If you needed something you didn’t sit there trying to figure out who’s responsible, like we do every day at work here. You just asked anyone and they’d help. We were all pulling together. Also, I was struck by people’s resilience. In Lamno [a village where Matt was for about a week] people just got on with their lives. “Got to plant new fields”, they said, “rebuild our homes, pull ourselves up by our bootstraps. Let’s do it”. No one looked to handouts from anyone...very impressive and inspiring.

The International Medical Corps website is:
<http://www.imcworldwide.org>

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