Fowler’s

“Truths of Emergency Medicine”
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1. We have two responsibilities in emergency medicine:

(1) Is there an emergency present? Corollary, is it a life-threatening emergency, and

(2) What is the best diagnosis you can make?
2. Find out what the REAL emergency is
3. Be a fierce advocate for the needs of your patient
4. A patient with a painful condition **HAS** a painful condition until proven otherwise…

…and failure to treat pain appropriately **is mal-treatment**
5. When in doubt, take more history...
History Taking:

This seems to be a “lost black art” for so many medical providers.


Above all: RISK???
We are, after all, a specialty: Emergency Medicine
The difference between a “specialist” and a “generalist” is in the RIGOR of the application of a differential diagnosis.
6. DEVELOP a physical exam that you trust, and ALWAYS do it
Assessment skills are NOT genetically acquired
The “art” of medicine is missing from so many practitioners... ...are they not looking, or have they lost interest?
Approaching the Patient
“See what you see!”

“People look, but they don’t see”

…A. Fowler, Jr.
Alertness?
Level of distress?
Noises?
Respirations?
The pulse rate?
Skin?
Obvious things (bleeding)
That wasn't chicken.
Part of excellence is performing superior medical histories and physical exams.
Elements of our primary and secondary surveys are often jumbled or forgotten.
Primary Survey

LOC/Airway/Cspine

Respiratory Rate and Labor

Pulses, Neck and Wrist

Skin CMT/CRT

Neck appearance, NVD, Trachea

Chest appearance

Breath sounds present and equal

Brief exam of abd, pelvis, LE, UE, Back
Secondary Survey

Head
Neck
Chest/CV
Abd
Pelvis
Extr
Back
Third Survey

LOC
Airway
Breathing: R & Q
Circulation: Pulse, BP, CMT/CRT

...and any other pertinent positive or negative identified in the primary or secondary
Blood pressure =

\[(\text{Cardiac output}) \times (\text{Volume}) \times (\text{Peripheral resistance})\]
Signs of Shock

Early (compensated)
- Weak, thirsty, lightheaded
- Pale, then sweaty
- Tachycardia
- Tachypnea
- Diminished urinary output

Late (decompensated)
- Hypotension
- Altered LOC
- Cardiac arrest
- Death
Shock

Cardiogenic
- Rapid pulse
- Distended neck veins
- Cyanosis

Volume Loss
- Rapid pulse
- Flat neck veins
- Pale

Vasodilatory
- Variable pulse
- Flat neck veins
- Pale or pink
If you don’t look for cyanosis, you won’t see it.
If you don’t LOOK for JVD, you won’t see it
Ruling out “positive intrathoracic pressure” is one of the most vital points in critical care.
And, my goodness, what DO we DO with waveform capnography in the future of EM??
Only with excellence in physical assessment and commitment to patient service, can the best possible care be given.
“The Demise of the Physical Exam”
Sandeep Jauhar, MD, PhD
NEJM 354:548-551
February 9, 2006

“The Stethoscope and the Art of Listening”
Howard Marken, MD, PhD
NEJM 354:551-553
February 9, 2006
7. "It isn't what it isn't... it's what it MIGHT be that will get you in trouble... and hurt your patient"
Beware of abdominal pain AT REST, especially in the older patient... especially with co-morbid illnesses and (in hospital) elevated WBC’s
“The general rule can be laid down that the majority of severe abdominal pains which ensue in patients who have been previously fairly well, and which last as long as six hours, are caused by conditions of surgical import.”

The Early Diagnosis of the Acute Abdomen
Sir Zachary Cope
pp 5, Oxford Medical Publications, 1921
The difference between a "specialist" and a "generalist" is in the rigor of the application of a differential diagnosis.
What are our abilities to diagnose patients in the ED?

Are there limits?
What diagnostic limits do **YOU** give yourself?
8. We are not heroes...
You do not have to PROVE that your patient will do okay outside of the hospital

Ask yourself, might the patient NOT do well?

There is no “rite of passage” contrary to what you learn from your buddies

“...ah...she’ll probably do okay at home”
9. If a person is an insulin-dependent diabetic and has a potentially major problem with another major organ system, strongly consider hospital admission.
10. Once the patient is “out the door”, (or non-transported) you have lost control of the situation...
11. Always explain a tachycardia...

**Corollary:** Don't depend on the presence of a tachycardia to determine that an emergency is present.
A “physiological response”
Remember:

The Maximum Sinus Tachycardia for a patient is about 220 - age
Baby = (220 − 0) = 220

Snerd = (220 − 54) = 166

Aunt Minnie = (220 − 70) = 150
What is this rhythm?

Correct answer: “It COULD be sinus tach”
If you forget everything else that I say:

Remember that patients having near maximum sinus tachycardia at rest are dying!
Something mobilizing a massive physiological response
Your job is to determine if a rapid rhythm MAY be sinus tach.

If it is, you must take action.
What is this rhythm?

220 – 60 = 160

Correct answer: "This HAS to be an arrhythmia"
What is the ambient temperature?
What is the patient’s blood pressure?
The most common cause of tachycardia in Parkland ER is probably albuterol... ...followed by amphetamine, cocaine, sepsis, DKA...
The most common cause of bradycardia in Parkland ER is probably beta blockers... probably isn’t great physical conditioning...
The incidence of bradycardia post-hemorrhage, especially intraperitoneally, is published to be as high as 7 to over 20%.
12. If it's blue, it's broken...
If someone “FOOSH’s”, AND you find swelling OVER a bone of the involved extremity, that is a fracture
A doughy edema over the distal forearm of a kid after a fall (even with a normal x-ray) is a fracture.
And, you haven’t cleared a neck until you’ve seen T1
And, don’t assume that something potentially serious is an anatomical variant until you’ve proved it.
And, don’t chase a finding on a study until the study is done correctly ... but don’t waste time if it may be dangerous!!
“Diseases of the great vessels make humble men of proud physicians”

...Osler
Don’t be afraid to learn to read a plain skull film...

“old medicine may still be good medicine”
Just remember that a normal plain skull and spine film really means NOTHING!!!
13. Never send home (or non-transport) a sleepy baby that doesn't come to full wakefulness.

*Corollary - If the baby vomits his dose of medication, be careful unless you've seen the LP results.*
14. Give the first dose of medication before the patient is released from care...

...whether **transporting** or **NOT**!
The most closely associated factor affecting morbidity and mortality of patients seen in the ED with pneumonia is **TIME TO FIRST DOSE OF ANTIBIOTICS!**
15. A normal EKG rules out nothing
16. AMS ALWAYS means that something is wrong... 

...until you prove it otherwise...
The “computer” will come to “full on” in everybody unless there is a chemical or structural abnormality...
Corollary -
If a patient, post head trauma, is lying quietly and then STOOLS IN THE BED, the patient has a subdural hematoma until proven otherwise.
...and, perhaps most importantly...
17. You have to look HARD for a reason NOT to give a dose of Ativan to a patient in Parkland ER!!
Other postulates

• “Back pain, leg weakness, stat MRI”

• “Don’t you want to get a pregnancy test before that abdominal x-ray, doctor?”
Violence in the Emergency Department
Anticipate
Do NOT INFLAME the Situation
Evaluate
Get enough help
Sedate as needed:
Versed is good – IM, IN, IV
Other sedatives
TASER
Sux Blow-dart
ALWAYS Remember:

Once you’ve taken somebody down, you are fully responsible for them.
Finally!!
Hell for EP’s and Staff who are RUDE to EMS Crews
The Golden Rule of Survival in HOSPITAL Emergency Department Life
The Nurses
RUN the Hospital!!
When in doubt, re-read the rule!
Survival is the key...

...wining “skirmishes” means nothing
Bribery does not work, and you’ll only be fooling yourself
We'll Kick Your Ass

Kern County

Sheriff

And take your doughnuts too!
Godspeed...

...and be careful....

? or !