

EPIC



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From the President Fair Coverage

Matt Lyon, MD, FACEP

The summer is almost over, and it has been a hot one! GCEP has been working behind the scenes to develop educational materials for our members and patients regarding narrow insurance networks and balance billing. These efforts have required a lot of GCEP resources, particularly member time. I appreciate all the work the Executive Committee, Board of Directors and GCEP members have been doing – getting involved – to address these issues.

What is a “Narrow Network”?

A network is a group of providers (doctors) who contract with an insurance company to provide care at “in-network” rates or “contracted rates” for their members. When insurance companies contract with few or a very limited number physicians in an area, this is considered a “narrow network.” This is an attractive option for insurance companies because this saves them money as narrow networks limit access to care as well as obtaining the best rates for the insurance company. However, many patients are unaware that their policy has very limited options on selecting a doctor for a health care need. According to *Modern Healthcare* “Narrow-network plans have gained members because of their lower premiums, but experts say there is significant dissatisfaction with access, surprise bills and provider directory information.” While a patient with a non-emergent condition can call multiple doctors’ offices to see if their insurance is accepted or even ask their insurance company, this is not possible when there is an emergency. However, in many health systems, individual doctors and specialties may not have a contract with the insurance company even though the hospital does. As such, patients may receive “out of network” bills from these physicians.

What is a “Surprise Bill”?

“Surprise bill” is a term that is synonymous with a “balance bill.” This is the remainder of the charge that the patient is responsible after the insurance company pays the physician the “out of network” charge. This does not include the deductible or the co-insurance which are responsibilities of the patient. The deductible and co-insurance charges are often thought by the patient to be a surprise bill as they did not know they were responsible for these costs. However, this is not what the term “surprise bill” refers to.

Why do you care?

The surprise bill and the narrow network issues are one and the same issue. When there are there is an adequate network of physicians contracted with insurance companies, then patients are not penalized by insurance companies maintaining profits. Before the Affordable Health Care Act, narrow networks were not common and even now in Georgia narrow network health insurance is a small percentage of the market. However, with increasing costs of insurance, in the next 1-2 years, narrow network insurance is expected to be common – maybe up to 50% of the plans offered in Georgia. With large out of pocket expenses, many patients now delay care. Adding narrow networks will further shift the cost of care to the patient, particularly in emergency situations.

Did you know?

Did you know that narrow network insurance plans are particularly problematic in rural Georgia counties? A narrow network often means that patients cannot get primary care, including Obstetric care, in their county. In Georgia, we have accounts from patients who have to travel more than 90 minutes for routine Obstetric care. Further as emergency physi-



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From the President continues page 5

Suing Uncle Sam

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On May 12th ACEP sued the Federal Government. Specifically we sued the Department of Health and Human Services (HHS) because it is HHS that oversees the activities of the Center for Consumer Information and Insurance Oversight (CCIIO) of the Centers for Medicare and Medicaid Services (CMS). This historic step was not taken lightly. However the Government failed the College, failed our patients, and they failed you.

The Affordable Care Act outlined certain patient protections, including what constituted fair coverage for out of network emergency services. Fair coverage was noted to consist of the greatest of following three (GOT) amounts: the in network rate, the usual and customary charges, and the Medicare rate. The argument with CMS is about the second option, what constitutes usual and customary charges.

After many months of discussion with CCIIO, going through different CCIIO leadership every few months, and promises that our concerns would be addressed, the patient protection regulations on fair coverage were published on November 18th. This final rule ignored all of our issues, gave carte blanche to insurance companies to decide what is usual and customary charges, and did not require that insurers reveal the method they used to determine usual and customary charges. In essence, the value of your services resides in the imaginations of the insurers.

Specifically, the CCIIO of CMS:

1. Failed to provide proper guidance regarding coverage for out of network services
2. Ignored our plea to require a transparent, independent, verifiable database to determine usual and customary charges
3. Failed to provide a reasoned explanation for their decisions as required by the Administrative Procedures Act

The intent of this lawsuit is to force CMS to provide an explanation for their decision and to address our concerns in a meaningful way. It also demonstrates that the ACEP Board takes this matter seriously, and is willing to do what is necessary to protect our patients and our members.

In June at the AMA Annual meeting, Andy Slavitt the CMS Interim Director, spoke about how CMS now needed physicians to work with them. They have realized that the government cannot implement the full intent of health care reform without physicians. This coming from the same person who directed United Healthcare's failed Ingenix program that was sued by the New York Attorney General for using flawed methodology to underpay for physician services. That \$350 million dollar settlement, also led to creation of Fair Health, a database that is transparent, verifiable and independent and is now used to determine usual and customary charges for out of network services in New York.

Whether Mr. Slavitt has had a change of heart, has merely come to the practical realization that he needs physician involvement to achieve his goals, or is trying to play nice in light of our lawsuit will be left for you to decide. Regardless, we should take advantage of this opportunity to work to craft regulations that will work for us and work for our patients.

The truth is, this lawsuit is directly related to the balance billing issues we are facing in Georgia. GCEP, particularly Chip Pettigrew, Matt Keadey and a few others, have been involved in this for nearly a year. GCEP representatives have testified at several hearings, and consistently advocated on your behalf at the Capitol during the 2016 Legislative Session.

This issue is heating up again for the 2017 Legislative Session and here is where we need your help.

If you believe insurance companies should decide what your services are worth, should be able to make that determination based on their profit margin, shareholder dividend, or stock price, then I encourage you to do nothing. But if you think emergency physicians should be paid fairly, that patients deserve the full benefit of their premium dollar, that insurers need to better explain to policy holders what is covered and what is not, that they need to stop shifting costs to patients in the form of high deductibles or co-payments, that emergency physicians

cannot be forced to serve at their pleasure, then GCEP needs you.

We cannot continue this fight without funding. GCEP needs to finance this effort, for attorney fees, for consultant services, for a public relations campaign and other initiatives. So dig deep, join this fight, and contribute to GEMPAC so we can ensure our patients receive fair coverage and the full benefit of their premium dollar.

To contribute to GEMPAC go to www.gcep.org and look for the GEMPAC button.

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From the President continues:

cians, we do not take into account whether the hospital we are transferring a patient from a rural hospital is in the patient's network. This can have drastic consequences on the patients financial well-being.

What can you do?

Education is important. This is a complex issue; one that can be distorted easily. The GCEP Board of Directors and ACEP see this as an insurance issue – they should provide “Fair Coverage” to those customers who they sell insurance policy. We will be working with state representatives and senators to develop legislation which addresses “Fair Coverage.” You can support this effort. Donate your time to GCEP. Donate your money to help us educate the public and legislators. This is a critical issue in Georgia.

For a better explanation of narrow networks, balance billing and fair coverage, check out this YouTube video by ACEP's President Jay Kaplan, MD.

<https://youtu.be/m3K9-NBP71g>

GCEP is your organization. Emergency Medicine is your profession. Get involved. Stay active. Thank you for your support.



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2016 Legislative Update

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The 2016 annual legislative session has passed. A number of interesting bills passed through the legislature that could potentially affect emergency medicine in the state of Georgia. The Georgia College of Emergency Physicians (GCEP) has kept a close watch and maintained a presence in the capitol to ensure that we have had a voice in state affairs. GCEP continued its strong representation in the Medical Association of Georgia's (MAG) Doctor of the Day program. We staffed the clinic for two weeks in January and March. In March, we also had our legislative day on the capitol, mingling with state legislators from both the house and senate. In all, GCEP had a successful year on the steps of the capitol.

A number of bills important to emergency medicine passed through both houses of the legislature and are awaiting the Governor's signature to become Georgia Law. Senate Bill (SB) 158 was sponsored by Senator Dean Burke and supported by MAG. SB158 encompassed a number of new rules regarding insurance transparency, updated rosters and network adequacy. House Bill (HB) 979 addresses violence against emergency healthcare workers. If found guilty, an assailant could receive 5-20 years in prison for this felony. Finally, SB385 and HB1043 both addressed board certification. SB385 was amended at the last minute to include an alternative board, the American Board of Physician Specialties (ABPS). The ABPS is an alternative board that does not require a residency in emergency medicine to become board certified. In line with the Council of Residency Directors (CORD), The Emergency Medicine Resident Association (EMRA), the American College of Emergency Physicians (ACEP) and the American Board of Medical Specialties (ABMS), GCEP did not support this amended bill allowing physicians to advertise that they are board certified if credentialed through ABPS. Due to a technicality, SB385, though passed in various forms by both houses of the legislature, was not sent to the Governor's desk for signature. HB1043 was also amended late to include board certification language. The bill originally addressed vaccination status, but was amended to include a truth in advertising clause that only physicians boarded by ABMS or the American Osteopathic Association can claim to be board certified.

Two other important bills that did not pass through the legislature this session, but are important enough to be discussed are HB1095 and SB382. HB 1095 was titled The Patient Compensation Act and addressed malpractice reform. We have seen this bill before under other titles. This bill proposed to do away with our current malpractice system and set up a patient compensation panel keeping malpractice cases out of the court system. This bill has been proposed in a number of states and has been primarily supported by Jackson Healthcare and their CEO Richard Jackson. In an unlikely turn of events, the Georgia Trial Lawyer Association, GCEP and ACEP do not support this bill. Despite this bill not crossing over for the second successive year, GCEP must continue to be vigilant toward the gains we achieved in malpractice reform in 2005.

The issue of out-of-network balance billing has become a national issue as several states have recently passed laws that either limit or ban this practice. SB382, titled the Surprise Billing and Consumer Protection Act, addressed this issue. Patients are balance billed when a provider that does not participate in the patient's insurance plan provides a professional service to a patient. The balance of the bill is sent to the patient less the amount paid by the insurer, any co-pay or coinsurance amounts. This only applies to private third party payers, as balance billing is not allowed in the Medicare or Medicaid programs. GCEP anticipates that this will become a bigger problem as narrow networks are expected to triple in Georgia over the next year. Currently, Balance billing is prohibited in some form in CA, WV, NY, CT, CO, DE, FL, IL, MD, MA, NJ, TX, RI and UT. New



legislation is pending in other states including GA, WA, NC, and PA. SB382 mimicked the recently passed NY law, which banned balance billing for emergency medicine PPOs and HMOs, and set up an independent resolution process, which excluded cases of less than \$600. In addition, the NY law suggested but did not require certain payment standards for insurers.

After reviewing the landscape on this topic, the Board of Director's for GCEP feels that balance billing is a topic that will not go away and which we must address. SB382 did not cross over to the house and is dead for this legislative period, but it has been referred to Senate study committee. This will be studied over the next year and we suspect that new legislation will be brought forward in next year's session. Balance billing is an important issue because many insurance companies will not negotiate with emergency physicians for fair compensation, leaving us often out of network. In addition, unlike many ambulatory care physicians, we are required by the Emergency Medicine Treatment and Labor Act (EMTALA) to provide medical screening exams to all patients and provide subsequent stabilizing care if they have an emergency medical condition. If essence, we cannot choose who we provide care to based on their insurance status. This is a good thing since we do not want to harken back to the days of economic triage. However, I am not sure many emergency departments, which provide safety net care to many of our most vulnerable populations, will be able to tolerate a significant reduction in revenue which would result if an unfair resolution to the balance billing problem is imposed on us. This would further strain the economic situation of many rural hospitals in our state, further worsening the state's citizens' access to emergency care.

GCEP will continue to keep our eye on the capitol. If you would like to participate in the political process, please let us know. In addition, if you have any thoughts or suggestions, please do not hesitate to contact us with your ideas via the website.



To Swim or Not to Swim? A Review of Drowning Injuries in Children

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Drowning is one of the main causes of death in young children and adolescents worldwide, particularly in areas where pools and beaches are readily accessible. The population of concern is typically healthy infants and toddlers; however, adolescents are also at risk due to risk taking behaviors and potential intoxication. The American Academy of Pediatrics (AAP) has suggested abandoning any other terms for drowning (i.e. dry drowning, wet drowning), as these monikers can be confusing when classifying patients. Instead they suggest drowning be defined as “a process resulting in respiratory impairment from submersion/immersion in a liquid medium” with the added descriptor of either fatal or non-fatal. Understandably, this topic is incredibly important not only to emergency medicine physicians but also general pediatricians. This article will focus mainly on summarizing the AAP’s stance on management of drowning¹ and the new updates on BLS/PALS.² It is important to mention, however, that the main interventions to prevent morbidity and mortality associated with drowning are prevention of access to any body of water for infants/children as well as education about water safety (with special emphasis on risk taking behavior and intoxication for adolescents).^{1,3} Additionally, emergency medicine physicians should be able to distinguish between the patient who requires BLS/PALS and the patient who can be observed and then discharged safely.

Drowning injury results from asphyxia, either due to laryngospasm (resulting from inhalation of a liquid medium) or direct injury of the lung tissue producing acidosis, hypoxia and/or arrhythmia. Lung parenchyma is “directly” injured when water is inhaled, leading to disruption of surfactant from the alveoli. This disruption causes poor lung compliance, VQ mismatch, and leakage of endothelial cells. The most feared complication of lung injury associated with drowning is acute respiratory distress syndrome, which carries a grim prognosis, and further worsens hypercarbia and hypoxemia. The resulting acidosis and decreased myocardial contractility along with other physiologic changes can result in cardiac arrhythmia and possibly cardiac arrest. It has been reported that up to 2.5% of all PICU admissions are secondary to ARDS and the disease process carries up to a 60% mortality rate.⁴

When triaging a victim of drowning, it is important to discuss prognostic factors to help guide treatment. To date, there remains a paucity of clear-cut parameters to predict which victims of drowning will require more extensive resuscitation; however, some historical/physical exam findings entail a poorer prognosis than others. Prognostic factors that predict neurological outcomes include duration of submersion, time to CPR, presence of cardiac arrest, consciousness of patient at time of presentation to medical professionals, and pH upon beginning resuscitation. Submersion events lasting longer than five minutes are considered unfavorable and have been reported to be the most critical prognostic factor.⁵ Other prognostic indicators of poor outcomes include: greater than 25 minutes of CPR to achieve return of spontaneous circulation,⁵ pH of less than 7.1 upon presentation,³ and GCS score of less than 5 at presentation to medical professionals.⁶

The AAP’s *Pediatrics in Review* article states that the “most important determinants of survival are the prompt rescue from the water and immediate institution of effective basic life support.” Early initiation of effective BLS can reduce the incidence of cardiac arrest secondary to drowning. Unfortunately, only a small number of pediatric patients with cardiac arrest (~30%) receive adequate bystander CPR. Since this article has been published, a few basic life support updates have been implemented.² In the unresponsive pulseless patient, it is no longer recommended to begin resuscitation with rescue breaths; rather, a bystand-

er should begin chest compressions first (sequence of Compressions – Airway – Breaths or CAB). The new update also stresses the importance of minimizing interruptions of chest compressions to maximize cardiac and cerebral blood flow.²

After initial resuscitation, transporting the patient to a medical center with trained pediatric emergency medicine and critical care physicians is key. Patients who are unable to protect their airways or unable to maintain adequate PaO₂ or PaCO₂ may require intubation. Placement of an OG tube to decompress the stomach may also be necessary to assist with effective ventilation. Patients with cardiac arrest and resultant shock, hypothermia, or hypoxic-ischemic injury will require admission to the pediatric intensive care unit (PICU). In general, if a patient arrives and is conscious without any significant pulmonary or neurological impairment, they can often be watched for 6-12 hours (depending on the initial chest x-ray findings) prior to discharge home with arranged follow up.³

Conclusion

The ability to recognize the need for and then administer high quality BLS/CPR to drowning victims remains critical in the treatment of drowning injuries. The deliv-

ery of high quality life support reduces the acidosis, hypercarbia, and hypoxia, which along with concomitant cardiac arrest, have been shown to worsen the prognosis of drowning victims. Appropriate bystander and in-hospital management of drowning victims along with proper education and monitoring of children (including adolescents) near bodies of water can be beneficial in reducing the morbidity and mortality associated with drowning.

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Balance Billing and Protecting Our Patients

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Balance Billing is a phenomenon that has developed uniquely in the setting of emergency care. After services are rendered for patient care, the provider submits a bill for services. If the physician is contracted with the patient's insurer, the reimbursement is determined in advance and the patient is responsible for any co-payment, co-insurance and unmet deductible. If the provider is out of network, a bill is still sent to the insurer. The provider and insurer attempt to negotiate a reasonable amount for services rendered, but often cannot come to an agreement. The patient is still responsible for any co-pay, coinsurance and unmet deductible, but they may also be responsible for the balance of the bill which is the difference between the insurers reimbursement and what the provider charged for services.

Balance billing is complex issue that affects providers and patients. Due to the federal law Emergency Medical Treatment and Labor Act (EMTALA, 1986), the emergency department (ED) presents a unique situation. EMTALA requires that every provider in an ED must provide a medical screening exam (MSE) to any patient requesting an evaluation without concern for payment or insurance type. This creates the situation where providers cannot choose who they will see based on their insurance status or classification. Many states also have laws that limit transport options if an ambulance is utilized. If a patient has a special condition that requires trauma services or stroke care, the closest facility may not be in network. In addition, in emergency situations time is often a factor and transport to an in network facility may not be reasonable in a life threatening situation.

Ultimately, an unsustainable financial situation has been created for patients. Uninsured patients are profoundly affected by medical debt, but even those who are insured can be impacted (Hamel, Norton, Politz, Levitt, Claxton and Brodie, 2016). The average out of pocket expenses for many high deductible health plans is often more than an average individual can afford. Patients impacted by medical debt are also more likely to delay or withdraw from care as a result of their inability to pay for services. The lack of access to care then leads to a further downward spiral of their health.

In an effort to control costs, managed care organizations have developed "Narrow Network" health plans where Provider network management through fee negotiation limit MCO costs. In 2014, 83 percent of the "Silver" exchange plans in Georgia had narrow provider networks which surpassed all other states (Miller, 2015). As health care costs have grown, employers and consumers have increasingly selected these plans to control their health care expenditures. When a patient uses an in-network provider to obtain covered services, provider compensation and patient cost sharing are determined in advance. However, the narrow network plans often have inaccurate provider rosters. This may lead a patient a patient to use an out of network (OON) provider which in the absence of the provider's actual bill, creates a tremendous financial uncertainty for the patient. If an insurers network is not adequate, a patient's ability to access care may be limited and the likelihood of receiving a balance bill increases (Doerner, Carmago, Schnurr and Raja, 2016). If the cost of a balance bill is added, the impact of medical debt is further augmented.

In Georgia (GA), a balance-billing ban for emergency services (ES) currently does not exist. However, certain groups cannot be balance billed already. Federal and State law ban balance billing for Medicare and Medicaid recipients. Physicians who contract with managed care organizations take a discount from their typical charge master to provide services at a reduced rate and cannot balance bill their patient. The Patient Protection and Affordable Care Act (PPACA, 2010) allows balance billing in emergency situations and suggest a methodology for payment termed the greatest of three (GOT) (Federal Register, 2010). According to the GOT, OON care can reimbursed according the greatest amount of either the amount paid under Medicare, the median in network rate or the usual, customary and reasonable (UCR) rate for OON providers determined by the insurer. Under these cir-

cumstances, UCR will always be the highest amount, but the irony cannot be missed that the federal government does not consider Medicare reasonable reimbursement.

To adequately address balance billing in emergency situations, new legislation must be introduced in Georgia. Given the lack of federal guidance, a minority of states has addressed the issue (Hoadley, Ahn and Lucia, 2015). In California, the state banned balance billing in 2008. In the only study addressing the impact on providers, Pao, Riner and Chan (2014) found that insurers in California reduced payments to providers by 13% in the first year and 19% in the second year following the ban. However, the study did not look at the total lost revenue. New York has recently enacted a ban on balance billing in emergency situations. Preliminary data of their dispute resolution process shows that a small percentage of cases from EDs are presented for dispute resolution with a minority being won by EPs (Impaq International, 2014). Connecticut's (CT) law was instituted on July 1st, 2016 to address balance billing (SB 811, 2015). The law not only holds patients harmless for ED bills, but it also punishes EPs if they balance bill the patient through a felony and possibly treble damages. To determine payment in CT., the law utilizes the greatest of three methodologies, but unlike the PPACA, the method for determining UCR rates is defined. CT requires that UCR be determined by an independent, not associated with insurance company, robust, not for profit database. Currently, only one database meets these requirements, Fair Health that originated out of the NY Ingenix lawsuit.

Therefore, GCEP proposes that a ban on balance billing in emergency situations is prudent for patients in GA, but certain stipulations must exist to protect providers and insurers. First and foremost, patients must be held harmless for the balance billing in emergency situations. Due to the nature of emergencies, medical care can be time critical and patient control lacking. The contentious issue revolves around the method for determining OON payment. Given fixed governmental reimbursement based on budgetary constraints and unreimbursed EMTALA mandated care, providers often utilize OON billing to maintain solvency. On the other hand, private payers are incentivized to keep payments as low as possible to maintain their profit margin. For a fair and equitable process, UCR must be rigidly defined. In some states, an Alternative Dispute Resolution process has been utilized excluding ED charges less than a specified amount. In these situations, the small balance bills may still be impactful to patients. In addition, the ADR process favors the insurers, as the process can be long and expensive. By utilizing a transparent and accurate method of determining UCR, insurers and EPs can have faith in the process while patients are no longer used as leverage in negotiations.

In GA, not much is known about the impact of balance billing, but the current state of health care could provide clues (Kaiser Family Foundation, 2014). Although GA has pockets of urbanization, most care is provided in rural settings. Access to emergency care can be limited and the financial state of rural hospitals is tenuous. GA did not implement Medicaid expansion and federal health exchanges have also been set up. This has left GA with one of the highest uninsured rates in the country leaving patients with little access to care, and potentially high medical debt. If a ban on balance billing was implemented without a means to determine UCR, I suspect the rural hospital system and providers would suffer (Bennett, Moore, and Probst, 2007). Although patients would benefit from a reduction in medical debt, access to emergency care may be impacted. As 8 rural hospitals have closed over the last 5 years, further reductions in reimbursement may lead to more hospitals closing (Ketsche, Custer, Landers, Snyder, and Towns, 2008). If a fair and transparent method of determining UCR were adopted, all parties involved would have faith and understanding in the process. In addition, administrative costs could be reduced, as the negotiation process would be eliminated.

In the 2015-16 legislative session, a bill was introduced to ban balance billing for OON care in emergency situations in Georgia. The bill was based on a New York model, but did not advance out of committee. A study committee has been formed and will meet this fall to discuss the issue and create a solution. We cannot sit on the sidelines anymore and must make out voices heard for our patients and our profession. GCEP is involved! We are actively working with our legislators to help fashion a future for our specialty and the house of medicine that is good for patients in Georgia.

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Emergency Medicine Residency Update: Augusta University at Medical College of GA

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The Emergency Medicine Residency at the Medical College of Georgia is excited to welcome the new academic year. The incoming interns continue the trend of the last several years of being even more accomplished. They come from a diverse range of schools, including Vanderbilt, Virginia Tech, and Harvard. Our residency continues to expand, with our incoming class increasing our number of residents to 39.

July is always a bittersweet time for an academic program. The departing class of seniors are one of the strongest in the history of our program. They excelled both clinically as well as academically. This class included the winners of the most recent SonoGames. Clay Carter, Jason Barter, and Daniel Reed defeated the competition out of a field of over 70 residency programs. They also had some of the highest in-service training exam scores in the country. Even more importantly that their academic accolades, every one of them is a skilled clinician that will serve their communities well.

Many of them will be working at community emergency departments across the Southeastern United States. Others will be

working much farther away, including residents that will be serving the military in locations such as Hawaii and South Korea. Some will be working in military Emergency Departments, while others will be involved with special forces work. We are proud of the service that our military graduates provide for our country.

Our department continues to expand its influence throughout the Medical College of Georgia. Several members of our faculty have undertaken the herculean task of training every resident in the hospital on the use of ultrasound. We have emerged as the local experts of bedside ultrasound and are spreading this important skill to others outside of our department. We also eagerly anticipate the upcoming Rural Emergency Medicine Conference in September 23-25. It is an honor to work with the local physicians that provide so much of the care in the state of Georgia.

This upcoming academic year holds a great deal of promise for our program. We improve every year, and the future is very exciting here at MCG.

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Balance Billing continued

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Dr. Shiver is Associate Professor of Emergency Medicine and Residency Program Director at Augusta University at 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.

WPW Syndrome

Stephen Shiver MD, FACEP

A 23-year-old male complaining of palpitations presents to triage and is brought back immediately to a resuscitation room due to high heart rate. He states that he is healthy and denies any medical problems and takes no medications. He also denies illicit drug use.

Vital Signs T 37 P 223 BP 105/70 RR 18

As you enter the room, you see a young male in no acute distress sitting on the stretcher. The PE is essentially unremarkable, except for the marked tachycardia. A 12 lead EKG is obtained.

The EKG shows a somewhat bizarre looking, very fast, wide complex rhythm. Despite the extreme tachycardia, the patient appears well overall, has no significant symptoms except palpitations, and his BP is acceptable. Thus, you have a few minutes to think about that EKG. If only my partner had picked up this one...

I'm a big fan of keeping things as simple as possible. When looking at difficult rhythms, it is often best to lump things into broad groups initially. A simple description of this scary looking EKG is "irregular wide complex tachycardia." Once you generate a broad group, think about potential rhythms. The three main items in the differential of irregular wide complex tachycardia are atrial fibrillation with underlying aberrant conduction (such as bundle branch block), polymorphic ventricular tachycardia, and pre-excited atrial fibrillation. The most common possibility would be atrial fibrillation with underlying bundle branch block. We see this rhythm quite often in older patients with cardiac disease. However, take a look at the beat to beat QRS morphologies. In atrial fibrillation with aberrant conduction, the rhythm will be irregular like it always is in atrial fibrillation, but the QRS morphologies will be the same. In this patient's EKG, the QRS morphologies are all over the place – some bigger, some smaller, some wider, some narrower. The other two options (polymorphic VT and pre-excited AF) remain possibilities, however, as they typically are very rapid rhythms with QRS complexes that vary in morphology.



Ultrasound Guided Occipital Nerve Block

Claire Abramoff, MD

Headaches are a common presentation in the emergency department. Often these patients have refractory headaches and have attempted multiple over the counter and prescription medications, to no avail, before they reach the emergency department. The greater occipital nerve block is a great technique that is easy to perform (ultrasound guided or by landmark) and can give these patients significant relief.

A greater occipital nerve block can provide quick and prolonged pain relief for patients suffering from cervicogenic headaches, occipital neuralgia, and cluster headaches. There is some evidence to support the use of this block in NSAID overuse and tension type headaches. It is thought that the greater occipital nerve can become entrapped or inflamed at the areas on the skull where the trapezius and semispinalis capitis muscles attach to the occipital bone.

The procedure is simple to perform. The patient can be positioned sitting up with the head flexed slightly forward, or laying in the prone position. The occipital artery is found by palpating along the superior nuchal line until you locate the pulsating artery, normally about 3cm lateral from external occipital protuberance (also known as the inion). The greater occipital nerve can be found medial to the occipital artery.

To do this procedure place the linear high frequency probe in a transverse orientation over the superior nuchal line lateral to the inion. Identify the pulsating occipital artery; you can utilize color flow Doppler for confirmation. Locate the greater occipital nerve medial to the artery. Inject one to three milliliters of either 1% lidocaine or a 50/50 1% lidocaine/0.25% bupivacaine mixture above the nerve, taking care to avoid injecting directly into the nerve fascicle as this can cause nerve injury. Patients will get partial or complete pain relief within minutes. Some studies have shown that patients can have prolonged improvement in their pain up to four weeks after the procedure.

Although occipital nerve blocks are not typically thought of as ED procedures this technique is easy to do, takes minutes and can give these frustrated patients some well needed pain control. This could be an easy addition to the practicing physician's armamentarium of pain relief tools.

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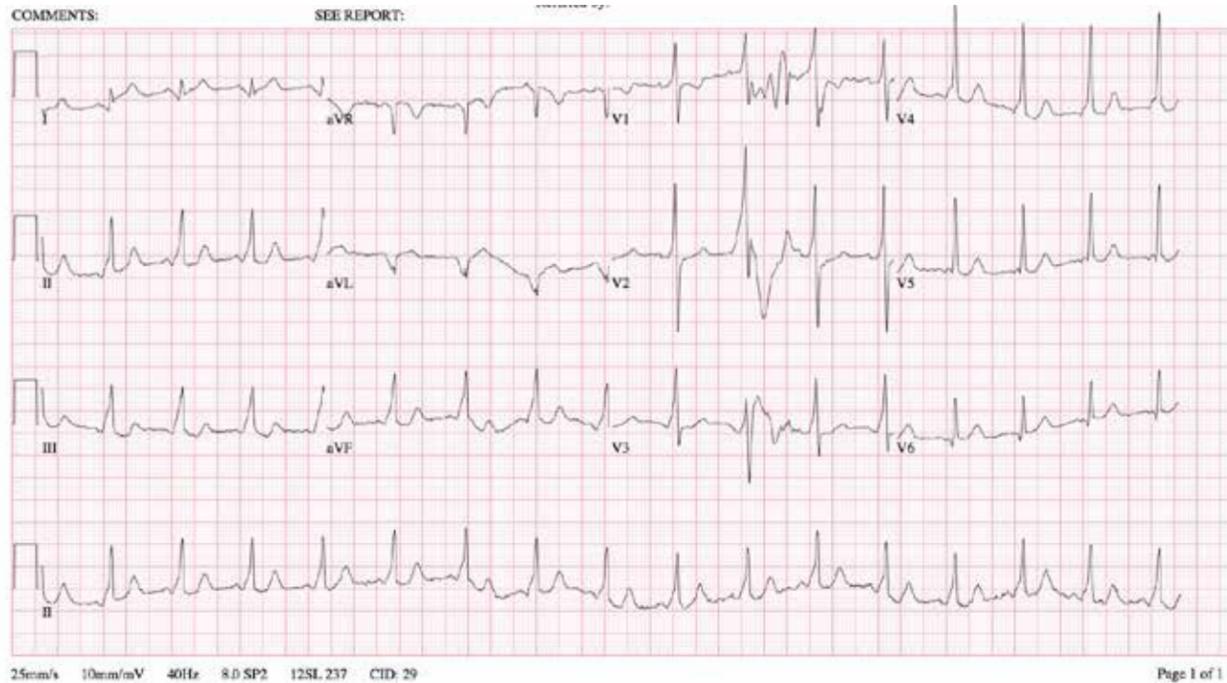
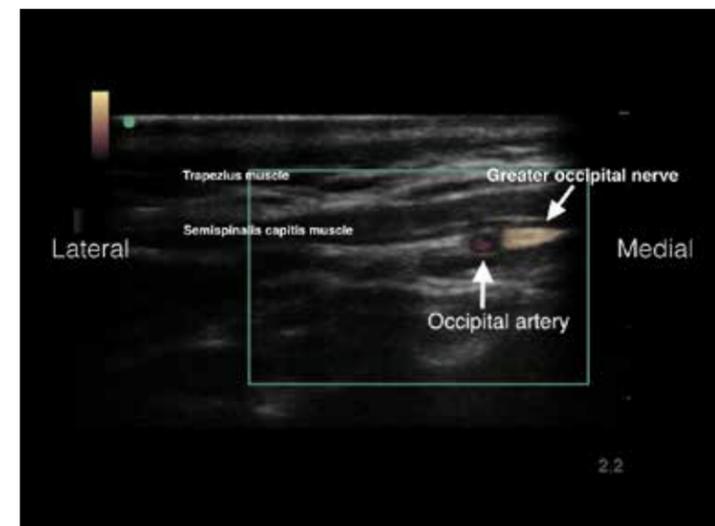
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Drugs or electricity? You could certainly treat this patient with an antiarrhythmic agent because he is stable (remember the answer is always to shock unstable tachyarrhythmias!). In this setting, however, choosing the wrong medication could have devastating consequences. When you have pre-excited AF in the differential, any agents that slow AV nodal conduction, such as calcium channel blockers, b-blockers, adenosine, etc., are absolutely contraindicated. Why? Well, if you slow conduction via the AV node when an accessory pathway exists, conduction down the accessory pathway will be favored and the rhythm can degenerate further resulting in instability and death. Currently, the most widely accepted medication in this setting is procainamide. My bias, however, would be to utilize the services of GA Power! Most national experts seem to agree. When Amal Mattu was asked what his favorite drug in the setting of possible pre-excited AF would be, he quipped

"Propofol, followed promptly by 200 J!". I wholeheartedly concur. I would use etomidate at a dose of .15-.2 mg/kg but Propofol would work just fine. The bottom line is that the drugs are complicated and electricity is not. It's safe and effective in this setting. In fact, that is what was done and a second 12 lead EKG was obtained immediately thereafter.

This EKG shows sinus rhythm with the classic findings associated with Wolff-Parkinson-White Syndrome: shortened PR interval, widened QRS, and delta waves. Thus, the diagnosis is now clear – pre-excited AF. Of course, had the rhythm been polymorphic VT, electricity would have been a fine choice and would likely have been effective.

A big thanks to one of our residency alumni, Daniel McCall, M.D., for sharing this interesting case!



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Emergency Psychiatric Care in the Age of ED Overcrowding

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Caring for the acutely decompensated psychiatric patient is a duty we willingly serve in our roles as stewards of the societal safety net that is the ED. As we diligently do for all of our patients, we provide the best care possible with the tools provided. Traditionally, our duty has been to medically screen, to assess for danger to self and/or others and finally to refer the patient to the appropriate follow up institution whether it is outpatient or inpatient. In the past, the process, though often cumbersome, could with some diligence successfully disposition and place patients in a semi-timely manner. Of late, however what were once 12-24 hour visits have ballooned into 48-96 hour stays particularly for the less affluent segment of the population. As a result of this systemic dysfunction, psychiatric patients have become ever-present fixtures in our ED's. As funding for psychiatric services continues to decrease we see a negative impact on availability of outpatient psychiatric care. This coupled with increasing scarcity of inpatient psychiatric beds amounts to a perfect storm where ingress overwhelms egress and these patients end up parked in our ED awaiting beds to open up, many for days at a time. ED's were never designed to function as holding facilities and we are being weighted down by duties for which we are ill equipped and poorly trained. This, without a doubt, contributes to potential for delivery of suboptimal care and increased risk.

Emblematic of the above risk is the growing disparity between quality of care provided to medical patients versus that provided to psychiatric patients while in the ED. Where the majority of medical patients are seamlessly admitted to the facility housing the ED, psychiatric patients very frequently must endure the fragmentation of care associated with transfer to a psychiatric receiving hospital. Whereas there is available immediate access to medical specialist expertise for most any medical emergency, psychiatrists are frequently inaccessible to the ED physician for immediate consultation. Similarly, while most medical patients will have necessary treatment initiated in the ED, therapeutic psychiatric medications are commonly only administered if the patient is actively severely psychotic or if his/her behavior is causing a disruption in the environment of the ED. All this together typically results in, at best, a significant delay if not a diminution in provided quality of care. Though, we have tended to accept this inequality in access to resources as out of our control, be assured that legally our duties to the patient remain the same—to evaluate them carefully, monitor them appropriately and keep them protected and safe during their ED stay. What has inexorably changed over the years has been the above noted tightening of the bottleneck of patient disposition, which extends our responsibility over a much longer period of time.

This prolongation of length of stay gives birth to new responsibilities for ED physicians and staff, many of which we are not well equipped to manage and result in added new risks. These include not only extended observation times which may lead to increased demands for security, but also expanded expectations that patients not only be housed, but have chronic medications continued and indicated new medications initiated.

With the advent of this challenging new environment where we are providing de facto inpatient psychiatric care, come risks that we are not familiar with. These pitfalls can be summarized once again as risk of failing to keep the patient safe, both behaviorally and medically.

On the behavioral side, failure to closely monitor and control the patient over an increased time period can lead to major liability risks such as suicide in the ED, escape from the ED followed by suicide, and lastly assault of ED staff or other patients. Though responsibility for managing these risks may seem to fall squarely on the hospital, it is important that the ED physician take care to explicitly place in the orders interventions ranging from

observation by security to restraint, whether it is physical or chemical. Determination of level of restraint should be guided by the patient's psychiatric history and potential for flight vs. violence. Though these are not new concerns, these patients have now become long-term guests in the ED and there is a resultant increased potential for dynamic changes in level of threat to develop over time.

On the medical side, monitoring is again key. Under current conditions, the past custom of one-time patient evaluation followed by immediate signing of 72-hour involuntary hold papers and transfer forms does not suffice in fulfilling the ethos of keeping patient safe. In this age of prolonged multi-day stays in the ED, the potential for significant changes in condition and stability increases. Thus, understandably, one might anticipate a legal expectation of adequate observation over time commensurate with that received by medical inpatients. Failure to provide regular and timely reevaluation by a medical practitioner may reflect badly on the assigned provider in the event of an untoward outcome. We thus should strongly consider a move in the direction of regular, more frequent reexaminations and documented notes in the chart.

Building on the reevaluation discussion, we should look at disposition and transfer practice as well. As in the medical patient, best practice in caring for those patients with more than a short stay in the ED demands a documented reevaluation in close proximity to the time of disposition, whether it is discharge home or to the inpatient facility. This recommendation for timely reevaluation also necessarily applies to the signing of the transfer form at the time of actual transfer. This, depending on facility, may require an adjustment in culture and attitude, as unlike past common practice, reevaluation responsibility will now necessarily fall on the ED physician on shift at the time of transfer, typically not the one who initially evaluated the patient.

Finally, I want to bring up a recent trend that seems to have occurred in concert with the development of ED overcrowding. That is a necessity for reevaluation of boarding psychiatric patients for continued evidence of need for 72-hour involuntary hold brought on by their length of stay. The question put to us is have these patients improved with or without treatment during their ED stay to

the point that they no longer meet the criteria necessary to keep them in care against their will and can thus be discharged. This is not without precedent and has been done legally over the years. It is just happening with increasing frequency as the need for beds has escalated. One should not fear to perform this when appropriate, as ethically patients should be allowed to regain their free will as soon as it is deemed safe. Nevertheless, one must realize that we step more into the realm of psychiatrist when we act to rescind a 1013 involuntary hold that was placed by another practitioner who determined a need and implemented a plan to obtain a full psychiatric evaluation and treatment that he will now not receive. The need is therefore implicit for exercising extra diligence in documenting your thought process, indications of improvement and absence of the conditions that created the need for holding the patient in the first place.

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It Takes Two

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I'm hoping this might become a recurring feature here in EPIC. The basic gist of this format is to view a particular case or issue that involves an ER-to-ER transfer through the lens of both the transferring and accepting EM physicians. This can highlight issues that are applicable to both sides of the emergency medical coin, and hopefully be able to provide better care to our patients and smooth out some of the transfer process altogether.

Transferring EM Physician Perspective

So, you're working in a rural, critical-access hospital and a patient comes in with classic ACS-type story, risk factors, and they just look like they're having the big one. ECG confirms your concern for STEMI, and now you have a decision—should you coordinate immediate transfer for primary PCI or give fibrinolytic therapy there prior to transfer?

According to the American College of Cardiology (ACC) guidelines for STEMI published in 2013 (and last updated in 2015, but not on this topic), primary PCI should be considered first-line therapy for any patients expected to receive device implementation time of <120 minutes from time of FIRST MEDICAL CONTACT. If you have the set-up to make this happen, this should be your goal. These patients need coordination of care, aspirin, nitro if indicated, consideration of opiate analgesia, and near immediate transfer to a PCI-capable facility.

There are, however, certain unavoidable delays that are recognized in the guidelines that we all encounter in the reality of practice. What if the patient has an established cardiologist that's difficult to reach immediately? What if the patient has a request to go a certain facility where it is difficult to coordinate immediate transfer? What about initial instability such as a patient that presents in cardiac arrest or a patient that requires airway protection or weather concerns for transfer if you're considering air transport? Obviously, there's more on this list; but we all know that these things happen.

The magic number published in the guidelines for consideration of fibrinolytics versus primary PCI is consistently 120 minutes from first medical contact. The DANAMI-2 study showed that there was benefit to primary PCI versus fibrinolytic therapy for times up to 110 minutes as judged by a reduction in the rate of reinfarction in the primary PCI treated group. The ACC guidelines go on to state explicitly that “even in cases where interfacility transport times are short, there may be advantages to a strategy of immediate fibrinolytic therapy versus any delay to primary PCI.” The ideal candidates, per the same guidelines, are patients with low bleeding risk that present very early after symptom onset (<2-3 hours) to a non PCI-capable hospital with expected longer delay to PCI.

In short, fibrinolytic therapy should be used, in the absence of contraindications, within the first 30 minutes of first door arrival when the 120-minute time goal cannot be met. Because fibrinolytic therapy should be administered within the first 30 minutes of first door contact in appropriate cases, practically, EM physicians practicing in hospitals that aren't PCI-capable need to have a firm grasp on what factors might play into the decision to immediately transfer a STEMI patient to a PCI capable hospital versus giving fibrinolytic therapy. More pointedly, should any concern exist about not meeting a goal for device time of <120 minutes from first medical contact, we need to be ready and comfortable to give fibrinolytics within 30 minutes of first door contact. Common, available fibrinolytic therapies include tenecteplase, alteplase, and reteplase. Take time to get familiar with dosing and administration for those that are available where you're working.

Absolute contraindications to receiving fibrinolytic therapy for STEMI include any prior ICH, suspected aortic dissection, known malignant intracranial neoplasm, known AVM, active bleeding or bleeding diathesis (excluding menses), severe intracranial or facial trauma

within three months, intracranial or intraspinal surgery within two months, or severe uncontrolled hypertension unresponsive to emergency therapy.

Going beyond standard MONA considerations, administration of anticoagulants prior to transfer in STEMI cases that receive fibrinolytics is another area of potential improvement in many transfer cases. This is something that we need to be mindful of both as transferring and accepting EM physicians. UpToDate states a preference for unfractionated heparin (UFH) bolus and infusion, but the ACC guidelines list UFH, enoxaparin, and fondaparinux as Level 1 recommendations with only enoxaparin having an A Level of Evidence. In the setting of adjunctive therapy of fibrinolytics for STEMI, enoxaparin should be given as an IV bolus dose adjusted for age, creatinine clearance, and weight followed by a subcutaneous dose 15 minutes later. In most patients <75 years of age, this initial IV dose will be 30mg with a 1mg/kg subcutaneous dose to follow every 12 hours. In most patients >75 years of age, no IV bolus is recommended with a 0.75mg/kg subcutaneous dose every 12 hours. Regardless of age, if CrCl <30 mL/min, the dose is 1mg/kg subcutaneously every 24 hours.

The ACC guidelines also have a Class I recommendation to give clopidogrel to patients with STEMI receiving fibrinolytics with an A Level of Evidence. The recommended dose is 300mg PO for patients <75 years of age and 75mg PO for patients over 75.

This topic is obviously a conversation that should involve interventional cardiologists. No one should have a better idea about whether that time goal can be met on the accepting end than the people actually in the cath lab. As transferring EM physicians, we need to try to have some familiarity with processes at PCI-capable hospitals to be able to reach cardiologists in a timely fashion. As accepting EM physicians, we need to be able to facilitate that conversation. Knowing who's on call and having a cell number goes a long way when minutes count for treatment outcomes. Additionally, having these conversations with your cardiologists prior to an actual STEMI case may smooth and facilitate quicker pharmacological treatment.

Accepting EM Physician Perspective

So you're grinding through your shift at a tertiary care center when you accept your 5th transfer of the day, a STEMI from an outlying rural hospital. After confirming patient stability and following whatever protocols exist at your hospital for ensuring cardiology involvement, the transferring physician tells you the patient will be receiving fibrinolytics along with adjunctive MONA and anticoagulants. You confirm the anticoagulants given are within guideline recommendations. 75 minutes later, the patient arrives at your ED. What do you need to know in order to determine whether emergent PCI is indicated or whether

they need cardiology consultation and admission?

There are three main indications for PCI after receiving fibrinolytic therapy: (1) persistent ST-segment elevation, (2) persistent chest or ACS-equivalent pain, (3) presence of reperfusion arrhythmias (e.g. accelerated idioventricular rhythm.) Lack of resolution of ST-segment elevation by at least 50% in the worst lead at 60-90 minutes after should prompt strong consideration of proceeding with coronary angiography and “rescue” PCI. The REACT trial showed benefit in reduction of reinfarction with no significant survival benefit at six months in patients that failed to show ECG signs of reperfusion that were randomized to rescue PCI after fibrinolysis rather than undergoing repeat fibrinolysis or conservative care alone.

In short, you need a repeat ECG and an initial one for comparison, a good history and physical exam, and a way to get in contact with your cardiologist.

Summary and Take-Home Points

- ACC guidelines for STEMI care at hospitals that aren't PCI-capable recommend transfer to PCI-capable facility for patients expected to achieve device deployment in <120 minutes from first medical contact.
- Fibrinolytics for STEMI, if indicated, should be administered within 30 minutes of first door time.
- ASA and anticoagulants such as enoxaparin and clopidogrel are all Class I recommendations with A Level of Evidence to be administered to patients receiving fibrinolytics for STEMI prior to transfer.
- Primary indications for “rescue” PCI after receiving fibrinolytics for STEMI include: (1) persistent ST-segment elevation, (2) persistent chest or ACS-equivalent pain, (3) presence of reperfusion arrhythmias (e.g. accelerated idioventricular rhythm.)
- Discuss all STEMI treatments with available and appropriate cardiologists (prior to the actual event if possible), and know the best way to get in contact with cardiologists at your hospital or surrounding area.

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5 Simple Math Equations You Must Know



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You don't have to be a math whiz or use fancy spreadsheets to understand many parts of your personal finances. Sometimes it's just a matter of elementary school math: basic addition and subtraction.

Let's take a look at a few simple formulas you should be familiar with and some financial lessons you can learn from them:

Spending = Income - Savings

You've heard the phrase "pay yourself first" but many physicians reverse this equation to look like this:

Savings = Income - Spending

That's known as "pay yourself last"—it's one of the big reasons why so many physicians wonder why they have to continue working full time into their 60's. I've said it many times and I'll say it again: if you've practiced emergency medicine full time for the past 20+ years, and you have not built up a multi-million dollar retirement portfolio, you probably haven't saved enough.

One reason may be overspending on your home. Here's how you can apply this equation to figuring out how much you should spend on your home. Take 20% of your gross income—that should be your savings rate. Then whatever is left over after taxes is what you can spend including your mortgage. You can then calculate out the max value of the home you can buy based on terms of the mortgage.

Net Worth = Assets - Liabilities

I've met many asset-rich physicians who are actually poor. This usually means they're carrying a ton of debt. Here's an example: you buy a \$1 million home and carry \$900,000 of mortgage debt. There are physician home loans out there that you can get with very little down payment. I'm not saying those are a good deal, but I've seen physicians take the bait—especially physicians who recently graduated from residency. When you factor in other debt such as student loans, you can see that it's possible to accumulate a large amount of assets but have a negative net worth. Your goal should be to maximize net worth not assets to build wealth.

Taxable Income = Total Income - Deductions

There's a misconception that your income tax is based on your total (gross) income. If you look at the federal income tax brackets you'll see it's based on the taxable income, which is calculated after a number of deductions and exemptions. How do you maximize your deductions and minimize your taxable income? Here's a partial list of deductions that may apply to you as an emergency physician:

Partial list of federal income tax deductions	
Health savings account deduction	State and local income taxes*
Deductible part of self employment tax	Real estate and personal property taxes*
Self employed, SEP, and qualified plans	Home mortgage interest*
Medical expenses*	Gifts to charity*

*on Schedule A of federal income tax return

If you're an independent contractor, your largest deduction will likely be your retirement plan—typically a SEP IRA or individual 401k. Depending on your age, income, and type of plan, you can sock away up to \$59,000 in 2016 pretax. Assuming you are in the 33% tax bracket (married filing jointly) the contribution lowers your taxable income for tax savings of around \$20,000.

Total Return = Capital Gain + Dividends + Interest

You might disagree with me on this one, but hear me out. A popular investment strategy touted by many financial advisors and followed by many investors is to have greater exposure to dividend paying stocks. You might even think that the value of your retirement portfolio you need to build up should be based only on the dividend payouts. The idea is that you don't touch your principal and instead live off the dividends.

The reality is that the only return that matters for any investment is the total return not just the dividends. Here's a hypothetical example. Suppose you have two investments A and B. Investment A pays 0% in dividends

and has a price gain of 10%. Over the same period of time, Investment B has paid 4% in dividends with a price gain of 5%. Which investment would you rather have? Obviously there are other factors to consider, but the point I'm making is that your investment decisions and your ability to withdraw money during retirement should not just be based on dividends. Money is money whether it comes from price gains or dividends. In the end it's total return that matters.

After Tax Return = Total Return - Taxes Paid

Taking the previous equation one step further, one of the goals in your investment portfolio should be to maximize after tax returns not necessarily minimize taxes. For example, which would you rather have? Investment A which has a total return of 10% and you pay 2% in taxes or Investment B which has a total return of 6% and you pay 0% in taxes. Don't let taxes dictate all of your investment decisions, and be especially careful of investment products (usually sold by commission based financial advisors) that entice you with the phrase "tax free."

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Two Loving Daughters, Two Different Wishes for Dying Mother

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It was late on a Sunday when a frail, 80 year-old woman was brought to the emergency room by ambulance. She was in respiratory distress, struggling with a nonrebreather, using accessory muscles. She was tired, had temporal wasting and appeared generally deconditioned. Her two daughters followed the ambulance, watched anxiously as we began to examine their mother, Alice, and told us she had lung cancer. Treatment had failed, and their mother had an appointment to discuss her options, mostly palliative care and hospice. As we were going through the usual routine of starting intravenous lines, drawing blood, and so forth, we talked with her about what we were doing, and mentioned that we might want to put a tube in her throat to help her breathe. Although she was in great distress, and she had not objected to anything else we were doing, Alice became even more upset when she heard about the intubation, and said very clearly that she would not like to be intubated. I (JO’s.) hesitated, as she seemed to have a clear understanding what we were talking about, and had stated her wishes quite firmly. I repeated to her that we were asking if she would consent to have a breathing tube put down her throat, and that, without it, she might not be able to breathe. She said she understood, and repeated that she did not want the breathing tube. Shortly after this, the lack of oxygen began to take its toll, and she became confused. At this point we realized we needed to explain the situation to her daughters, and to tell them of their mother’s wish. This was when our ethical dilemma began.

Both daughters seemed clearly to want the best for their mother. But one daughter insisted that, in her opinion, her mother was not unable to understand her situation, and would want to be ‘placed on the vent’ and given ‘every chance.’ When I asked what she saw that made her believe her mother did not understand when she refused the intubation, she said she wasn’t sure but it “just looked like she didn’t understand.” The other daughter indicated she thought her mother’s wish should be respected, and that was what her mother would have wanted given her medical condition and prognosis. Two daughters, two different understandings about what their mother would have wanted. And, as their mother’s breathing status was rapidly deterioration, a decision had to be made. Should I intubate or not?

Questions

One daughter disagreed with my assessment that her mother could understand what I was saying and indicated that I should disregard her wishes as she was in respiratory distress. This raises the question of how to assess competence when a patient presents *in extremis*. For us, the key points are (1) whether it was possible to do a brief examination for capacity to refuse intubation, and (2) whether the responses were consistent with previously expressed wishes. Although the examination was necessarily brief, the patient was able to give meaningful, albeit brief, logical responses, did not appear to be disoriented or hallucinating, and was quite specific in her refusal. Had she refused all procedures, e.g., insertion of IV lines, we might have questioned her understanding of her whereabouts and understanding, but the response to intubation was specific and not simply part of a pattern of refusal resulting from a confused state. Further, though she did not have an advance directive, the daughters conveyed that their mother understood her situation was terminal, and that entering hospice with palliative care meant that a cure was not possible. Thus intubation would only prolong her life, possibly with much suffering. Overall, her decision to refuse intubation was consistent with her prognosis and seemed to be the product of a lucid mind, at least at the time she made her decision.

But could refusal to intubate over the loud and insistent protests of one daughter have led

to a claim of malpractice? The usual answer is that anything is possible. But, at least in Georgia, with rare cases to the contrary, it should be quite difficult for a plaintiff to prevail in such a claim. In 2005, the Georgia General Assembly passed legislation requiring that patients filing a medical malpractice claim involving emergency care provided in a hospital emergency (or obstetrical) unit must prove by “clear and convincing evidence” that the medical provider was grossly negligent. While definitions of “gross negligence” vary from state to state, Georgia courts define “gross negligence” as being “equivalent to (the) failure to exercise even a slight degree of care” and “lack of the diligence that even careless men are accustomed to exercise.” Documentation of the patient’s mental status, lack of overt signs of confusion, and clear responses refusing intubation, even on repeated questioning, should make it very difficult to show that a physician did not exercise “even a slight degree of care.” And, when a physician obviously was attempting to preserve the wish of a dying woman, it would be difficult for a plaintiff to convince a jury of malicious intent on the part of the physician.

But what if the patient had been intubated, and awoke only to become frightened and angry at being intubated—could the second daughter have raised the issue of pain and distress on the part of mother and daughter over the mother’s prolonged suffering? Again, anything is possible, but even minimal documentation of the conversations and the basis for the intervention should serve to provide protection against a claim of gross negligence.

Resolution

I was prepared to withhold intubation for the brief time necessary until a third daughter arrived, though I was not entirely comfortable with a democratic approach, i.e., letting the third daughter’s decision break the tie. Fortunately, when all three daughters were able to come together, a joint decision was reached to make their mother comfortable, and not to intubate. She expired shortly thereafter.

But the case raised issues particular to emergency care. Many end-of-life decisions can take place over weeks, months, or years, guided by input from physicians, spiritual leaders, and family. In emergency rooms, such time is not available, especially when disputes arise between patient and family or among family members. Key information that can help in such decisions includes what the patient has previously expressed about such decisions as whether to be intubated and placed on a ventilator. The standard for surrogate decisionmaking is what the patient would have wanted had he or she been able to decide (i.e., NOT a what’s in the best interests of the patient standard!). This information about the patient’s wishes can be in the form of an advance

directive or informally as verbally expressed wishes, to family, friends, physicians, pastors, or others. But, as noted above, in the absence of a written directive, obtaining such information can be difficult in an emergency when time is short and there are conflicting views among family members.

In the absence of an advance directive or similar information on end-of-life wishes the default decision for an emergency physician is usually to provide all available care. Too often we find out, after a patient has been placed on a ventilator, that this is not what the patient wanted. As we all know, it is much harder on a family to remove a patient from a ventilator than simply to have respected a patient’s wish not have been placed on one, and patients are exposed to unnecessary and prolonged suffering as a result.

Something emergency physicians can, and should, do when seeing a patient where end-of-life care is looming is to ask whether the patient has discussed future care, and to ask about the presence of an advance directive. Hospital staff usually do this also, but, in an emergency, Patient Self Determination Act compliance is secondary to providing emergency care, so that discussions around advance directives may take place after a patient’s condition has been stabilized.

Reference

Howe EG. When family members disagree. J Clin Ethics. 2007;18(3):331-339

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