

EPIC



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IN THIS ISSUE:

- ◆ An Uncommon Case of Dyspnea
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From the President

Assault on a Prudent Layperson

Matt Keadey, MD, MHA, FACEP

In the early 90's, managed care organizations had taken hold of the country, as the cost of medical care escalated. To boost profits, insurers started denying emergency services when they felt the patient's condition did not warrant a visit to an emergency department. Based on a final diagnosis, insurers were denying payment for services, turning a blind eye to the nature of the presenting symptom, or the work up required to ensure an emergency medical condition did not exist. In response to this pervasive patient abuse, the American College of Emergency Physicians (ACEP) pushed a national campaign. By the start of the 20th century, patient protections were codified into law ensuring access to emergency care in over 27 states. Georgia joined this effort in 1996, as the state legislature passed a comprehensive patient protection law that included provisions for emergency services, requiring managed care companies to cover emergency care based on the principle of "prudent layperson." (Figure I, O.C.G.A. 33-20A-3 (2010)) ACEP has continued its national effort to protect patients' rights for emergency care and by 2010, 47 states had some form of patient protections for emergency care.

Although the governance of health insurance has typically been under the purview of the states, ACEP has also made a federal push for legislation. The standard was included as part of an amendment called the Patients' Bill of Rights, sponsored by Sen. Benjamin L. Cardin (D-Md.). The ACEP-supported bill was enacted in 1997 and required Medicare and Medicaid to follow a national prudent layperson standard. In 2010, the Affordable Care Act (ACA) was passed and included several important provisions. It defined emergency medical services as an essential health benefit that required coverage from all health insurance providers. The ACA also codified the prudent layperson standard as law for almost all insurance providers and made prior authorization for emergency services illegal.

Most would have thought that a patient's right to emergency care was protected, but fast forward to 2016 and the insurance companies are at it again. Insurers were making record profits, but their margins were shrinking and they were looking for the next big thing. In effort to once again increase their profits, enrich their CEO's and make Wall Street happy, their assault on prudent layperson has been reincarnated. In several states, Blue Cross/Blue Shield (BCBS) has been floating the idea of denying emergency services based on a list of diagnoses. Retrospectively, if a patient's diagnosis is contained on an arbitrary list, BCBS will review the encounter and possibly deny payment for services, if they determine an emergency did not exist. BCBS says this list was developed by a list of emergency medicine experts. However, BCBS will not share the name of the so-called experts nor have they been open to sharing the list of diagnoses citing that the information is proprietary to their business operations. This smacks of the "black box edits" most insurers have implemented many years ago to deny payment for certain services if they did not fit their billing rules.

BCBS says they are following prudent layperson because they are only reviewing the encounters and not outright denying care. We are now hearing anecdotal reports in Georgia of emergency medical conditions that BCBS denied payment. For example, a patient in a car accident was placed on a long spine board and collar. They were transported to a local ED. Thankfully, no injury existed and they were discharged with a diagnosis of cervical strain. Guess what, their insurer denied payment for care because it was not an emergency! Does this sound like a reasonable policy?

If BCBS really cared about our patients, they would invest in the provider infrastructure and improve patients access to services. For emergency medical conditions, BCBS wants patients to choose lower cost resources that supply patients with similar services, but do



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they really care? Patients go to the emergency department for ease of care and immediate answers when they are concerned that an emergency exists. Problems that we can work up in hours, often take days in their primary care doctors office. However, a zebra does not change its stripes, and incentives cost money. It is much easier path to profitability by reducing costs which include denials of care. Insurers are intimately aware of our EMTALA obligation, so our patients will always get care they need and deserve. Even if we had the list of diagnoses supplied by BCBS, we could not share it with the patient for concerns of committing an EMTALA violation. What good is a retrospective list, if we must do the work up anyway, to get to the diagnosis that the insurer will deny payment for? In addition, the last thing we want our patients doing is sitting at home fretting over whether their problem is an emergency, only to end up suffering at the hands of their own, less than expert, guess. The world we live in has created a perfect storm for emergency medicine, and our patients.

The assault on prudent layperson protections by BCBS may only be a diversion tactic to divert our interest from our other significant concern, out of network balance billing. In Georgia, we have fought off bad bills that would significantly impact patients' access to emergency care and further destabilize our fragile network of rural emergency departments. The 2018 legislative session will finally be our chance to proactively promote ideal legisla-

tion that will protect patients from balance billing due to inadequate insurance reimbursement and create a standard for all states to follow. We must see this commitment through, as we stand united, in the entire house of medicine to address this issue. Our patients deserve this!

To change the system and protect our patients' access to emergency care, we must get involved. BCBS and any other insurer who follows suit, must be held accountable for their actions. The Medical Association of Georgia wants to hear about patients who have been harmed by this new policy based on a final diagnosis. Encourage your patients to email their stories of harm or concerns to workercomp@mag.org. Patients may also contact the state insurance commissioner's office at <https://www.oci.ga.gov/ConsumerService/complaintprocess.aspx>. As emergency physicians, we must let our state legislators know that our patients' rights have been violated. The BCBS policy is an end around the state's prudent layperson protections that were enacted many years ago, to protect our patients and ensure adequate access to care in the face of an emergency, without concerns about whether their insurer will wreck economic havoc upon them. The Georgia College of Emergency Physicians needs your help in spreading the message. Resources can be found at www.GCEP.org and if you are interested, please email us to get involved.

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An Uncommon Case of Dyspnea

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Introduction

Exacerbations of congestive heart failure (CHF) are among the more common complaints seen by most emergency physicians. The familiar script of gradual onset dyspnea, orthopnea, and lower extremity edema is typically well recognized by budding physicians before graduation from medical school, as are the treatments for this condition. However, familiarity can breed complacency, and it is important to remember that other life-threatening conditions may masquerade behind common presenting symptoms. The use of point-of-care ultrasound (POCUS) can be a tremendously useful screening tool to rule out potential CHF mimics.

Case Presentation

A 70-year-old male smoker with a history of CHF and hypertension presented with three days of gradual onset dyspnea, orthopnea, and lower extremity edema. He received a rapid assessment at triage, and a typical order set for evaluation of heart failure was ordered including an EKG. The patient's vitals were only remarkable for a mild relative hypotension of 105/79 with a heart rate of 72.

The patient was placed in an acute room, and when interviewed the only significant additional items elicited were a mild intermittent substernal chest pain, family history of lung cancer and a trend of unexplained weight loss over the past few months.

Physical examination of this non-distressed patient was remarkable for surprisingly clear lung sounds given the suspicion for CHF, confirmation of the peripheral edema, JVD, and clear heart sounds with an irregularly-irregular rhythm.

The EKG performed at triage demonstrated atrial fibrillation with a rate of 108 (Figure 1). A chest X-ray of the patient demonstrated a significantly enlarged cardiac silhouette with relatively clear lung fields. The patient did have a number of new laboratory abnormalities including hyperkalemia, hyponatremia, an AKI, anemia, and mild transaminitis. The patient's pro-BNP was only mildly elevated at 235pg/ml.

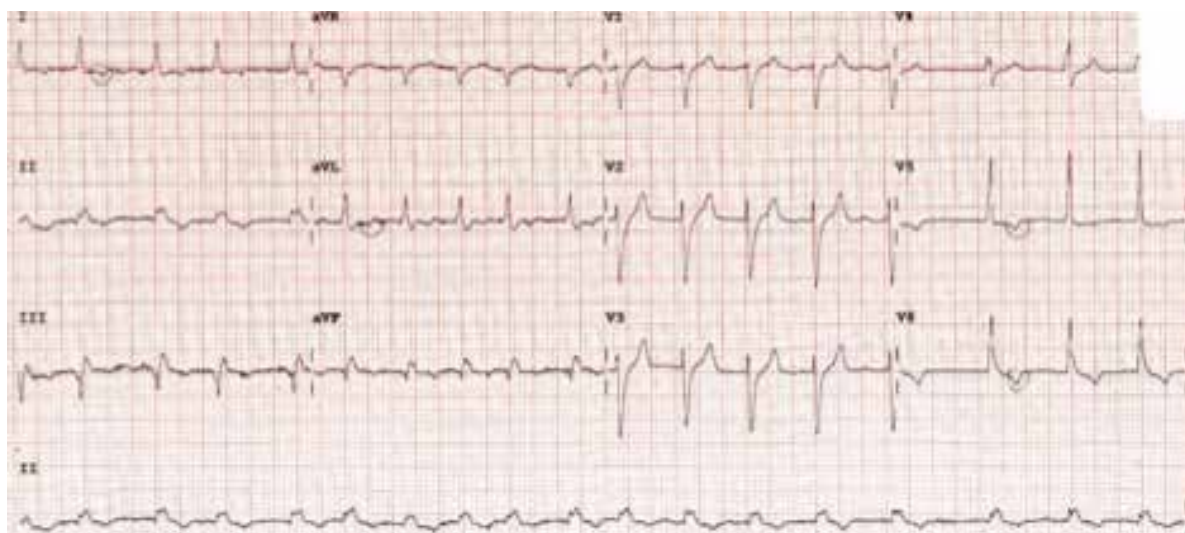


Figure 1

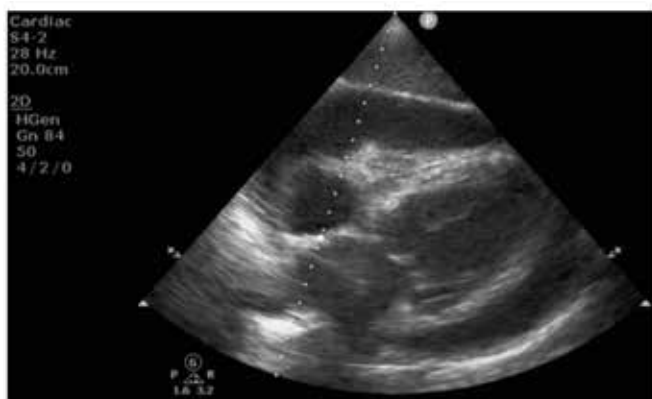


Figure 2



Figure 3

A POCUS (Figure 2 and 3) was performed on this patient which revealed a large pericardial effusion with persistent collapse of the RV while the patient was in the supine position and a dilated IVC with minimal respiratory variation. The patient was given a fluid bolus, treatment for hyperkalemia, and Cardiology was consulted. Cardiology reviewed the POCUS images and confirmed the patient to have findings consistent with incipient tamponade, and planned for urgent pericardiocentesis. Just prior to pericardiocentesis, the patient's blood pressure dropped to the 80 systolic range, prompting more fluid bolus and an expedited pericardiocentesis in the cath lab. Intra-procedural echocardiogram confirmed the diagnosis of cardiac tamponade. 900cc of serosanguinous effusion was drained from the pericardium, and the patient was subsequently diagnosed with adenocarcinoma of the lung, for which he is undergoing palliative treatment.

Discussion

Cardiac tamponade is an uncommon but deadly condition that may occur due to trauma or a variety of medical causes. While most physicians are aware of Beck's Triad of hypotension with a narrowed pulse pressure, JVD, and muffled heart sounds, many physicians may struggle when asked to describe typical presenting symptoms for tamponade secondary to medical conditions such as malignancy or renal failure. Further, it is important to remember that many classic symptoms of tamponade may not be present: for example, this patient initially had only mild relative hypotension, his heart sounds were not muffled, and he lacked the classically described electrical alternans on EKG. Insidious onset tamponade is a heart failure mimic, and subtle differences between the heart failure exacerbation and one such as the case described above might easily be glossed over in a busy emergency department. However, identifying cases such as these is

crucial because the diuretics typically used for the treatment of heart failure will reduce preload and provoke an acute decompensation in patients in or near tamponade. A screening POCUS to evaluate a patient's cardiac function and to rule out tamponade takes only moments, but provides tremendously useful real-time information to an ED provider.

Learning Points

- Cardiac Tamponade can be a heart failure mimic
- Cardiac Tamponade often presents without all of its classic symptoms
- A screening POCUS is a vital screening tool for patients presenting with dyspnea or chest discomfort, even if the case initially seems straightforward.

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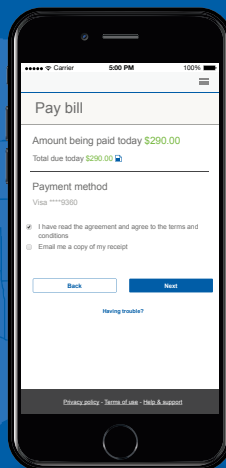
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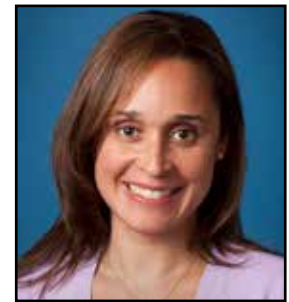
Concussions

Carmen Sulton, MD

With fall sports in full swing, concussions and minor head injuries are a common chief complaint in the Pediatric Emergency Department. Prompt recognition of head trauma is of critical importance. Head injuries account for over 600,000 Pediatric ED visits per year, and roughly 75% are due to concussion syndromes. It is of paramount importance to accurately define concussions as well perform the appropriate physical exam.

Concussion is defined as a biochemically induced brain dysfunction without any apparent radiographic injury. On the cellular level, axonal stretching often leads to potassium and sodium imbalances. The results in decreased cerebral blood flow. Concussions may be caused by a direct blow to the face or head or a force to the body with transmitted force to the head. Typically, concussions result in rapid onset of short lived neurologic impairment that spontaneously resolves. The clinical symptoms reflect a functional disturbance and not a structural injury, and as such, no abnormality is seen on radiologic imaging. Concussions may or may not involve loss of consciousness. Resolution of symptoms typically follows a sequential course, however, some symptoms may be prolonged. Some common symptoms of concussion include headache, dizziness, gait abnormalities, confusion, difficulty concentrating, vomiting, amnesia (retrograde and anterograde), light and noise sensitivity, sleep disturbances, visual changes, irritability, and disorientation; 90% of symptoms resolve in 7-10 days.

The comprehensive exam when concussion is suspected should begin with a complete neurologic exam including a Glasgow Coma Scale (GCS). This is outlined in Table 1. Cranial nerves, cerebellar function, including gait and mental status should be assessed. Typically, the GCS and physical exam are normal. Any abnormalities (concern for skull fracture, altered mental status, post-traumatic seizure, loss of consciousness greater than one minute, persistent vomiting) should raise the suspicion for traumatic brain injury (TBI) as well as the consideration for prompt neuroimaging. Additionally, high mechanism of injury should raise consideration for prompt imaging. This includes fall from a height (greater



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Table 1
Glasgow Coma Scale for Infants and Children

	CHILD	INFANT	SCORE
Eye Opening	Spontaneous	Spontaneous	4
	To Speech	To Speech	3
	To Pain	To Pain	2
	None	None	1
Best Verbal Response	Oriented and appropriate	Coos and Babbles	5
	Confused	Irritable, Cries	4
	Inappropriate Words	Cries in response to Pain	3
	Incomprehensible Sounds	Moans in response to Pain	2
	None	None	1
Best Motor Response	Obeys Commands	Moves Spontaneously and Purposefully	6
	Localizes painful stimulus	Withdraws in Response to Touch	5
	Withdraws in response to pain	Withdraws in response to Pain	4
	Flexion in response to pain	Abnormal flexion in response to pain	3
	Extension in response to pain	Abnormal extension in response to pain	2
	None	None	1

Table 2
Graduated Return to Play Guidelines

Rehabilitation Stage	Functional Exercise	Objective
1. No Activity	Complete physical and Cognitive Rest	Recovery
2. Light Aerobic Exercise	Walking, Swimming, or Stationary Cycling	Increase Heart Rate
3. Sport Specific Exercise	Sport Specific Drills, Running Drills (Football, Soccer)	Add Movement
4. Non-Contact Training Drills	Progression to more Complex Training Drills	Increase Coordination, Cognitive Load, Increase Exercise
5. Full-Contact Practice	Normal Training AFTER Medical Clearance	Assess Functional Skills Restore Confidence
6. Return to Play	Normal Game Play	

than 5' if greater than two years old and greater than 3' if less than two years old), motor vehicle crash with ejection, pedestrian-verses-auto accident without a helmet, and patients that are struck by high impact objects. With a normal neurologic exam, if concussion is suspected, CT or MRI is not routinely required.

There are several assessment tools that have been studied and used in pediatric patients with concussions, especially athletes. The most common is the Sport Concussion Assessment Tool, Version 3 (SCAT-3) and the Standard Assessment of Concussion (SAC). The SCAT-3 has gained increasing popularity. It includes several components, aimed at assessing memory, balance, coordination and orientation. Research shows sideline tools such as these aid in the rapid assessment and recognition of concussion. Concussions related to contact sports continues to be a major concern, necessitating strict return to play guidelines. The mainstay of concussion therapy mandates cognitive and physical rest within the first 24-48 hours of symptoms after injury. After this period, a gradual return to academic, social and physical activities that does not worsen symptoms appears to be best. Additionally, during the 48-hour period of rest, limited screen time (texting, television, movie theaters), appears to maximize rest and decrease exacerbation of concussion symptoms.

If a player is being evaluated for concussion on the sidelines of a sporting event, assessment tools should be available to and executed by trained professionals. If this is not available, the athlete should be removed from play until they can be assessed by a medical professional. The incidence of concussions appears to be higher during competition than during practices. The highest proportion of documented concussions are reported in football, followed by girls' soccer. Player to player contact is the most common mechanism, followed by player to playing-surface contact. Management decisions should be made on an individualized basis. These include management of pain and nausea and properly ruling out more serious injuries. Pain control with narcotics, which cause confusion, sedation, nausea as well as rebound headache

should be avoided.

As previously stated, most symptoms resolve spontaneously over several days. After immediate pain control, the best approach is step-wise return to play. It should be emphasized to patients and families that both physical and cognitive rest is required. Activities that require concentration and attention may worsen symptoms and delay recovery. A summary of graduated return to play guidelines are shown in Table 2.

Conclusions

Concussions are a common chief complaint in the Pediatric Emergency Department. Prompt recognition of concussions is paramount. A complete physical exam as well as a complete neurologic exam is necessary to distinguish concussions from more serious traumatic head injuries. Sideline assessment tools such as the SCAT-3 aid in prompt recognition of concussions. A period of physical as well as cognitive rest will speed recovery in all patients.

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Intoxicated Drivers

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It is a situation all too common in most Emergency Departments: an intoxicated driver is brought in by EMS, often accompanied by passengers or victims from another vehicle. Of the great number of such cases, nationwide only about 13% of alcohol-positive drivers in the Emergency Department (ED) are ultimately charged with a DUI.¹ Allowing for different medical acuities of these patients, their courses tend to be relatively clear-cut – discharge to police custody once stable. However, frequently patients may arrive directly with no police knowledge of the crash, and how to handle these cases becomes more complex, both ethically and legally. These situations are encountered every shift in an ED, with some of these patients notorious to staff for presenting multiple days in a row following intoxicated crashes. The danger to themselves is obvious for all intoxicated drivers, yet one must also consider the public health risk posed by such drivers. Motor-vehicle crashes are the top cause of traumatic death in the United States, and almost one in three motor vehicle fatalities involve an intoxicated driver.² An estimated 110 million episodes of alcohol-impaired driving occur yearly in the United States, and when accounting for material losses and loss of quality-of-life and productivity, the CDC estimates over \$200 billion in annual cost to society due to alcohol-impaired crashes.³ Given the tremendous impact of these events, for those patients who arrive with no law enforcement knowledge of their intoxicated state, when is it appropriate for a physician to report that patient either to law enforcement for prosecution or the state Department of Driver Services for license evaluation? Should it be reserved only for those patients who demonstrate a repeated pattern of incidents? The law offers some answers, but leaves a great deal up to judgment.

Unlike child abuse, where all 50 states require mandatory reporting from physicians who suspect it, only six states mandate a report to law enforcement officials for alcohol-impaired crashes.⁴ However, 32 states, including Georgia, provide legal immunity for physicians who report impaired driving in good faith.⁵ A physician in doubt about reporting a patient is encouraged to discuss the matter with their hospital's legal counsel, although the time required to do so is often a luxury not afforded in a busy trauma department. Discussion with another physician about the merits of reporting a specific case may also be of use in determining a consensus, and documentation of the conversation will help establish a good faith report. However, the official position of the American College of Emergency Physicians is to “oppose[s] legislation providing permissive or mandatory reporting of the results of

patient toxicological screening, including but not limited to blood alcohol concentration levels, by physicians to law enforcement officials because such reporting fundamentally conflicts with the appropriate role of physicians in the physician-patient relationship.”⁶

The Governor’s Office of Highway Safety in Georgia officially states that “physicians are strongly encouraged to report drivers when they see concern.”⁷ As such, the takeaway is that in Georgia one has no legal obligation to report these patients but protections are in place if one chooses to do so. The legality is relatively clear, but the ethics of reporting a patient and exposing them to the possible loss of their ability to drive and criminal charges are murkier.

While the immediate benefit of reporting an impaired driver is clear—one more intoxicated driver off the street for several days to months—the long-term implications are less obvious. Physicians are not required to, and absolutely should not report every incident of illegal activity by patients. For example, while Georgia mandates the reporting of injuries suffered during the commission of crimes, it does not require it for injuries from guns, knives, and other weapons. That distinction may seem quite fine given that most weapon injuries will occur in relation to crime, but it allows a great deal of leeway for physician judgment. Emergency physicians often avoid reporting cases of gunshot wounds or stabbings, as well as many patients known to be using or selling drugs, with many physicians worrying that if a precedent is set in their community that hospital staff will notify law enforcement, many patients wounded in this manner may not seek emergency care, or spend longer traveling to reach a different facility. Taking this as a guide, it is reasonable to expect that if all intoxicated drivers are routinely reported to police, some patients may be more likely to avoid EDs for fear of legal troubles.

Many of these intoxicated drivers, as with any intoxicated patient, can be quite challenging to deal with, and the introduction of personal bias and feelings into the clinical relationship cannot be discounted. There may exist a desire to report these patients simply to have them become the police’s problem, or even a wish to see punitive action against a frustrating type of patient. These kinds of feelings are something that emergency physicians, must deal with daily, and when deciding whether to report an intoxicated driver it is crucial to step back and think for a moment about why one wants to do it. Make sure it is being done in the public’s (and ultimately the patient’s) best interest, not to relieve the physician. Again, this is where a consultation with hospital counsel or another physician can make a tremendous difference, as it allows better examination of the rationale for reporting the patient.

Interesting parallels may be drawn between the reporting of intoxicated drivers and drivers that would be deemed unsafe either due to epilepsy or advanced age. The latter cases fall under the same legal umbrella within Georgia, permitting reporting by physicians but not mandating it. At face value, reporting a patient who presents to the ED following a seizure, or an elderly patient with poor vision and some dementia seems to be an easier choice. There is no threat of legal action from these patients, and the removal of their license may seem an appropriate action. However, this is not something that frequently falls to an Emergency Physician to do, and is not something that often should. In such situations, it is appropriate to ensure that the patient has transportation home from the ED and strongly recommend a thorough outpatient evaluation.

Ultimately, while there is some consensus that a simple state of intoxication should not be reported to police or DDS by a physician (although still legally permissible in Georgia), little concrete guidance exists for physicians considering reporting patients who display a pattern of repeat intoxication with multiple alcohol-related motor vehicle incidents. It remains up to the individual physician to decide when the risk to the public at large posed by an intoxicated driver outweighs the duty to keep that patient’s information confidential, and the criteria for that will be different for everyone. Repeat offenders may be more likely to be considered a public health risk, as with those involved in particularly egregious crashes, but there are no defined rules for when it is appropriate. Refraining from involving personal biases or feelings about the patient is important, as the decision to report them should not be taken lightly. Discussion with a fellow physician is strongly recommended in situations where one is considering a report. If one does decide to report a patient, a form is made available through the Georgia Department of Driver Services that may be filled out and submitted.⁸

However, expanded use of the DDS reporting system poses a risk of overwhelming the state’s capacity to review all such incidents. For each report to DDS by an Emergency Physician, a form will be sent to that driver that must be filled out by a different physician who is likely to be an already overwhelmed primary care physician. That physician is now presented with a rather difficult situation – to state that a patient who came to the ED intoxicated is not impaired assumes a great deal of legal risk, yet labeling each of these drivers as impaired will result in suspension of their driving license or other restrictions and may impact that patient’s livelihood and increase their risk of continued substance abuse. One possible solution to this dilemma is for DDS to create a separate unit which investigates these cases, and immunity granted to those performing the reviews such that they

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

Daniel McCollum, MD, Associate Program Director, Augusta University

As the weather turns colder, interview season has begun to heat up. We are just finishing interviews of what will be our most competitive class of military applicants to our program ever. I am very glad that I became involved in emergency medicine when I did, as I am awestruck at how impressive many of our applicants are.

Our residents continue to excel in national competitions. In the first ever ACEP Advanced Airway Shootout, a team of our residents took first place. In a further show of our resident's skills in managing the difficult airway, a team with members of other residents from our program took second place! I've already informed them that I'm disappointed that they didn't also get third place, but I feel that this is forgivable since we only entered two teams. Additionally, our own Evan Baines came in second place in a national lecturer competition with his excellent presentation on pericardial effusions.

We continue to innovate in our educational activities. We are preparing for a massive

upgrade to our Tactical Day where residents will participate in simulations related to tactical medicine. This will take place in coordination with local law enforcement, and will provide invaluable educational opportunities in an infrequently discussed branch of emergency medicine.

Our residents have also done a great deal of community service. Due to recent hurricanes, hundreds of people were displaced from their hometowns to Augusta. Many of our residents and faculty helped provide care for them at local shelters during and after the storms. Through their care, we had a great deal of success in comforting those that were displaced.

As this academic year takes off, we are truly blessed with yet another cohort of wonderful interns. It continues to be a pleasure to watch our program grow stronger every year!



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Dan graduated from the Georgia Regents University Emergency Medicine Residency Program in 2013. He is currently serving as an associate program director in the Department of Emergency Medicine at the Augusta University at Medical College of Georgia.

Ethics continued

are not legally liable for future violations by the driver. This system would help with the bureaucratic burden of the reports, but would also require substantial financial investment from the state government.

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Right Ventricular MI



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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.

Stephen Shiver MD, FACEP

A middle-aged male presents to the Emergency Department with a complaint of substernal chest pain accompanied by nausea, dyspnea, and diaphoresis. He is relatively healthy and denies any prior history of coronary artery disease. He appears quite uncomfortable but has unremarkable vital signs. An EKG was immediately obtained (Figure 1).

The patient's initial EKG reveals sinus rhythm with a rate of approximately 100, borderline first degree AV block (PR 200), and borderline intraventricular conduction delay (QRS 100). What about the ST segments? There is clear ST elevation inferiorly involving leads III and aVF. There are reciprocal changes noted in leads I, aVL, and to a lesser extent in the right sided precordial leads. Essentially, the patient has a clinical presentation consistent with acute coronary syndrome and an EKG that is consistent with inferior wall STEMI.

When you encounter an inferior STEMI, you should immediately consider right ventricular involvement. Approximately 1/4 to 1/3 of inferior STEMIs involve the right ventricle. There may be some clues on the EKG that suggest right ventricular involvement including ST elevation in lead III that exceeds that of lead II. The most definitive way to diagnose a right ventricular STEMI, however, is via a right sided EKG. Such an EKG is not hard to obtain. Essentially, it involves similar lead placement EXCEPT you place the leads across the right chest wall. A quick internet search will provide many good examples. A right sided EKG was obtained in this case (Figure 2).

To determine whether there is right ventricular involvement, simply assess leads V4 – V6. These leads are often referred to as V4R, V5R, etc., when a right sided technique is used. Any ST elevation in leads V4R, V5R, or V6R confirms the diagnosis of right ventricular STEMI. In the pictured EKG, there is clear elevation in each of these right sided leads.

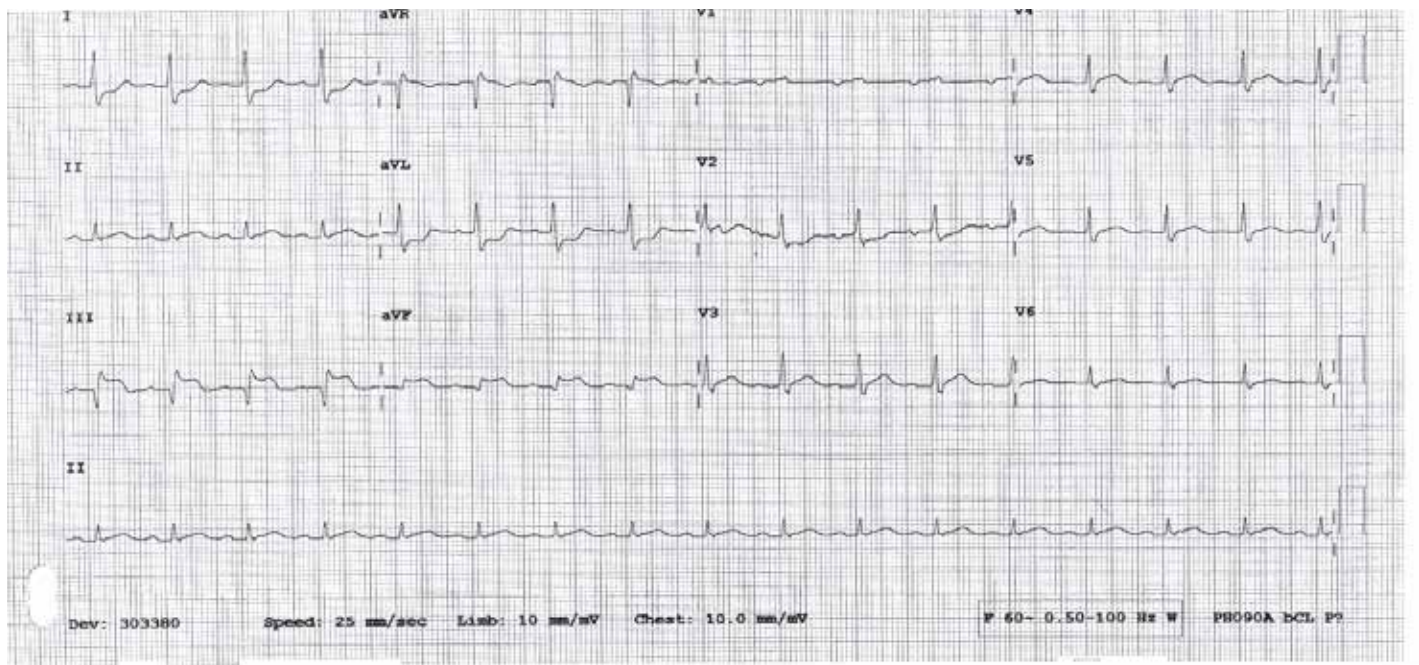


Figure 1

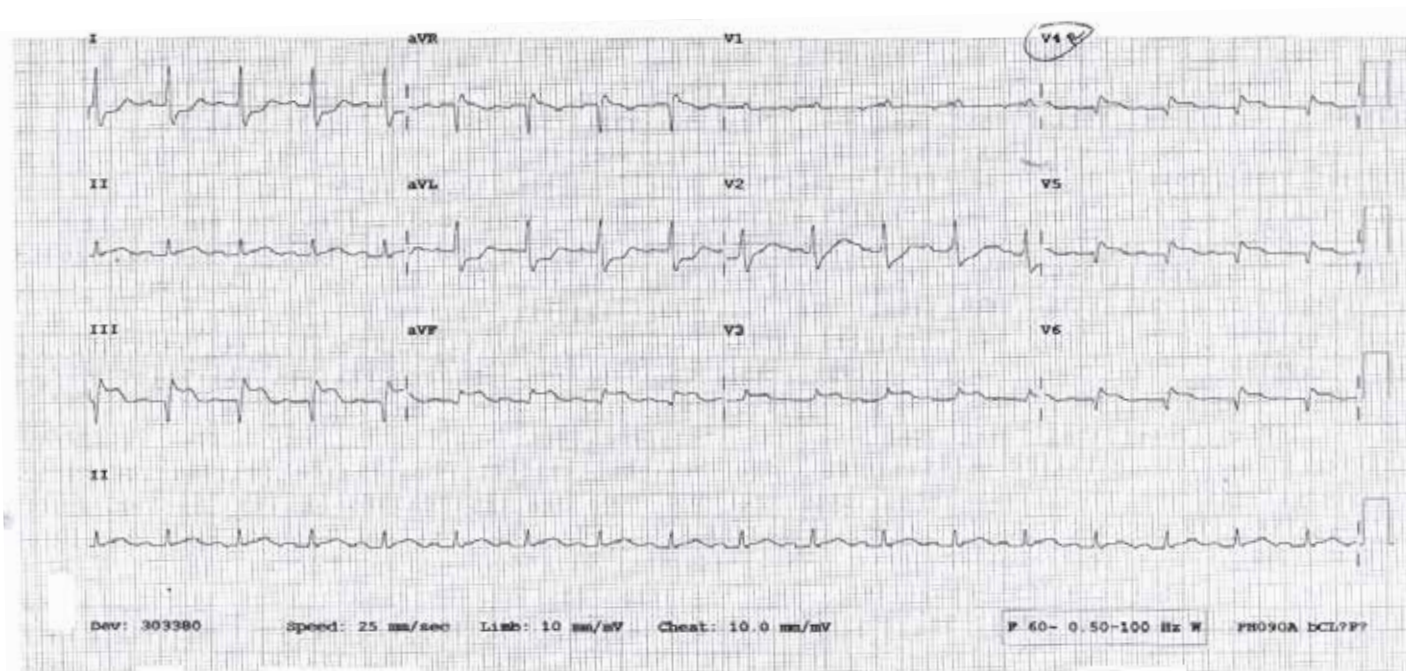


Figure 2

Why does it really matter? It turns out that right ventricular MI's act somewhat differently than other MI's. They are often referred to as being "preload dependent" or "preload sensitive". As such, agents that reduce preload, such as nitrates, are contraindicated and hypotension

should be treated with volume resuscitation. Accurate diagnosis of right ventricular MI will impress your cardiology colleagues and allow you to provide better patient care.

Special thanks to Dr. Jim Sinex for providing these EKG's.

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Risk and Delinquent Charting: Not Just a Billing Issue

Pete Steckl, MD, FACEP



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Dr. Steckl is the Risk Management Director for Emerginet, LLC, Atlanta, GA and member of the MAG Mutual Claims Committee and a member of the ACEP Medical Legal Committee.



Dr. X is a well-trained, astute clinician. She takes conscientious care of her patients and moves them quickly and efficiently through the system. She has one weakness. She frequently falls behind in her charting and leaves charts incomplete at the end of her shift with plans to finish them up at a later time. Though this strategy has helped her productivity, it has also resulted in a chronic backlog of charts with dates of service spanning several weeks. She always gets to them (typically after repeated reminders from medical records) but by the time she does, her memory of the encounter is often hazy and she struggles to be honest in her documentation.

On this day of encounter, she evaluates a two year old female patient who, per triage nurse documentation, presents with complaints of fever, high temperatures, headache and vomiting. Vital signs are as follows:

Temperature of 103.6 (axillary) Pulse 132 RR 28 Pulse ox 99% RA. Nursing notes indicate the patient is alert, responsive but quiet, somewhat ill appearing with a runny nose, shielding her eyes from the light.

Dr. X performs her exam, orders some Tylenol po, diagnoses the patient with Viral URI and discharges her home with instructions to take Tylenol and/or Motrin for fever and follow up with the primary medical doctor later this week for a recheck. She then moves on to evaluate her next patient.

The next day the parents return to another emergency department with their daughter who has now developed escalating temperatures to 104.7 in association with worsening headache, a stiff neck and lethargy. The patient underwent blood and spinal fluid testing that showed evidence of bacterial meningitis. The patient became sicker while in the ED and was transported by helicopter to the children's hospital where she was admitted and aggressively treated with IV

antibiotics. Unfortunately, over the length of her stay she developed septic shock requiring intubation and pressors. She suffered a long ICU stay and hospitalization with need for amputation of several fingers and toes secondary to gangrene. Her mentation and general ability to function returned to normal with therapy but she lost a substantial amount of her hearing and required bilateral hearing aids at the time of discharge.

Dr. X was notified of this outcome six weeks later when hospital risk management contacted her to notify her of the incident and outcome and the fact that her chart was incomplete. She thinks back over the myriad of toddlers that she has seen over the past six weeks and this particular patient does not come immediately to mind. She reviews the nursing notes and notes that the patient was documented as alert but crying upon discharge and vomits twice as the parents receive discharge instructions. No repeat vital signs were performed.

She believes she might have a vague recollection of the parents and that the patient appeared nontoxic to her (must have or else she wouldn't have sent her out, right?) but can't be sure. The risk management representative advises her to complete the chart to the best of her ability, but to be unfailingly honest in her depiction of what she remembers. She documents the scant information that she remembers, essentially that the patient had a supple neck, was alert and appeared nontoxic.

Fast forward one year and Dr. X is getting ready to go in for her next shift in the ED, when she hears a knock at the door. Standing there is the local sheriff with a sheaf of papers that on closer inspection indicate that she is now a defendant in a lawsuit alleging medical negligence in discharging this patient home resulting in a delay in diagnosis and treatment of her

CNS infection. She reports this to her malpractice carrier who diligently works to develop a coherent defense, but encounters much difficulty in finding an expert witness to support care. Problem being is that the rather scant documentation that Dr. X generated was easily assailable as inaccurate due to the delay in chart completion and, perhaps worse as self-serving in that it was completed with full knowledge of the serious and unfortunate outcome of the patient. The case was settled before trial for a very large amount.

The message conveyed by this disturbing story is that this was a case that was potentially easily defensible. The patient presented in a nonspecific fashion with signs and symptoms that could be consistent with a benign pediatric febrile illness. By the time she arrived at the second hospital her condition had clearly deteriorated to a point where she was easily diagnosed with much more severe CNS infection. This outcome was likely unanticipatable at the time of the first visit based on per presentation but nurse documentation is somewhat damning in a vacuum

without contradictory physician documentation. Had the chart been completed contemporaneously with clinical notes that clearly depicted her as suffering from the URI she diagnosed, that refuted some of the perhaps overzealous documentation of triage nurse, and that documented a recheck of the child post defervescence, this case could have been successfully defended in a court of law.

Completion of charts in a timely manner is commonly believed to be primarily a billing issue. Without a completed chart, the hospital and provider group are unable to submit charges to the responsible party for compensation. However, the underappreciated reality is that delinquency in charting is a real contributor to medical legal risk in the ED as depicted above. Though, we get away with bad habits such as scant, sloppy charting or delay in chart completion 95% of the time, over a career, inattentiveness to detail comes back to bite you as sheer numbers of patient encounters will tend to result in increased risk of unwanted litigation. The old adage, no chart, no defense is definitely applicable in these circumstances.

Create Your Year Around Financial Planning Calendar

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As we enter the holiday season in the next few months, you may start neglecting your personal finances and might think there isn't much to do. Oh how wrong you are! Just like preparing for the ABEM Concert exam, taking your LLSA tests (aren't those fun?), and getting your CME, keeping your financial house in order is an ongoing requirement—if you want to build wealth that is! So I've put together a sample year round financial planning calendar you can use to make sure your finances are always up-to-date. Month by month I've listed the main action steps you need to take within various parts of your financial life. You can customize this for your own situation—or if you've hired a good financial planner, that person should be guiding you throughout the year:

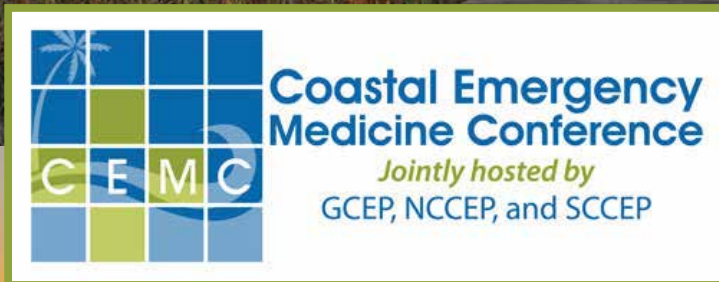
	January	February	March
Investments	1/15 deadline for last year individual 401k employee contribution (if incorporated) Review portfolio for tax losses Review risk tolerance and adjust investment allocations	Review portfolio for tax losses	3/15 deadline for last year individual 401k and SEP IRA contribution (if incorporated) Rebalance portfolio Review portfolio for tax losses
Taxes	1/15 - Pay Q4 estimated taxes Organize all tax documents (1099s, W2s, K1s, receipts) and send to CPA	Meet with CPA for personal and corporate tax return	3/15 File corporate tax return (if formed LLC or corporation)
Cash Flow	Review income, expenses, and net cash flow for the month Review liquidity and emergency fund and make sure it is adequate	Review income, expenses, and net cash flow for the month Review liquidity and emergency fund and make sure it is adequate	Review income, expenses, and net cash flow for the month Review liquidity and emergency fund and make sure it is adequate Determine YTD savings rate (contributions, employer matches) - adjust to make sure you max out by year end
Insurance	Contact insurance company; update homeowners and auto insurance (amounts of coverage, premiums)		
Other	Update household balance sheet (Net worth, assets, liabilities) Update retirement projections Check credit score Re-evaluate long term financial goals (retirement, education, charity...)		

	April	May	June
Investments	4/15 deadline for last year individual 401k and SEP IRA contributions (if sole proprietor), IRA/Roth IRA contributions, HSA contributions Review portfolio for tax losses	Review portfolio for tax losses	Rebalance portfolio Review portfolio for tax losses
Taxes	File previous year personal income tax return or extension - pay any taxes due 4/15 - Pay Q1 estimated taxes		6/15 - Pay Q2 estimated taxes Review YTD income and adjust tax withholding and estimated taxes
Cash Flow	Review income, expenses, and net cash flow for the month Review liquidity and emergency fund and make sure it is adequate	Review income, expenses, and net cash flow for the month Review liquidity and emergency fund and make sure it is adequate	Review income, expenses, and net cash flow for the month Review liquidity and emergency fund and make sure it is adequate Determine YTD savings rate (contributions, employer matches) - adjust to make sure you max out by year end
Insurance			Review disability insurance needs and update monthly benefit
Other			

	July	August	September
Investments	Review portfolio for tax losses	Review portfolio for tax losses	Rebalance portfolio Review portfolio for tax losses 9/15 deadline for last year individual 401k and SEP IRA contributions (if incorporated and filed extension)
Taxes	7/31 deadline to file Form 5500 (for individual 401k) Review possible current year tax deductions		9/15 - Pay Q3 estimated taxes Review YTD income and adjust tax withholding and estimated taxes
Cash Flow	Review income, expenses, and net cash flow for the month Review liquidity and emergency fund and make sure it is adequate	Review income, expenses, and net cash flow for the month Review liquidity and emergency fund and make sure it is adequate	Review income, expenses, and net cash flow for the month Review liquidity and emergency fund and make sure it is adequate Determine year to date savings rate (contributions, employer matches) - adjust to make sure you max out by year end
Insurance			Review life insurance policies and needs (terms, amounts, premiums) - adjust if needed
Other	Update 529 plan contributions, allocations, and college savings projections		Review employee group benefits for next year (group life, group disability, group health, FSA)

	October	November	December
Investments	Review portfolio for tax losses 10/15 deadline for last year individual 401k and SEP IRA contributions (if sole proprietor and and filed extension)	Review portfolio for tax losses	Rebalance portfolio Review portfolio for tax losses Year end dividend and capital gains distributions - determine whether to reinvest or take as cash
Taxes			Review YTD income and adjust tax withholding and estimated taxes 12/31 deadline for charitable contributions, medical expenses, business expense deductions
Cash Flow	Review income, expenses, and net cash flow for the month Review liquidity and emergency fund and make sure it is adequate	Review income, expenses, and net cash flow for the month Review liquidity and emergency fund and make sure it is adequate Determine year to date savings rate (contributions, employer matches) - adjust to make sure you max out by year end	Review income, expenses, and net cash flow for the month and YTD Review liquidity and emergency fund and make sure it is adequate
Insurance			Review long term care insurance policies and needs
Other	Make employee group benefits elections for next year 10/1 start date to submit FAFSA application for next academic year		Take Required Minimum Distributions (RMD) for current year 12/31 deadline for current year 529 plan contributions (some states 4/15 deadline) Organize all important financial planning documents (insurance policies, tax returns, wills, investment statements) Review estate plan with attorney (every 3-5 years)

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