

THE BULLETIN

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To promote the science and art of medicine, the care and well being of patients, the protection of the public health, and the interests of the medical profession.

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Thoughts for July

HAL GROTKE, M.D.



Life moves pretty fast. If you don't look around once in a while you could miss it.

National health care politics will never move as fast as Ferris Bueller's day off but there has been a rapid series of events related to the SGR of late. Don't worry, though: as of the time of this writing you haven't missed much. On June 12th President Obama dedicated his weekly address to imploring the Congress to make a permanent fix to the SGR. On the 16th the House passed a six month fix. On the 17th Congressman Thompson submitted an article to this Bulletin explaining that if the Senate bill was not passed by the 18th that CMS would start paying at the reduced rate and that when a retroactive fix went into effect those bills would have to be resubmitted. On the 18th CMS did order Palmetto and others to start paying claims received at 21.3% less than what they had been paying a month earlier. Later on the 18th the Senate passed a very clean bill giving us a 6 month retroactive reprieve. On the 21st it appeared as though the claims already paid at the lower rate would be reprocessed automatically and would not have to be resubmitted. Later on the 21st House Speaker Pelosi announced that the House would not vote on any fix to the SGR unless the bill included other jobs policy. So where we stand today (June 22nd) is that the SGR will be rescinded, probably retroactively, probably soon; but for now we are going to live with lower payments with the hope that those ultimately will prove to be partial payments. The biggest question in my mind is, "How long will it take the PPOs to match their rates to the new, albeit probably temporary, lower MediCare rate?" It is likely that this will all be ancient history by the time you read it.

So maybe things don't move so fast. That has been a whole lot of nothing. In other news not moving very fast, our local State Assembly Member's (Chesbro's) bill intended to make it easier for rural areas to recruit physicians died. This was a well meaning but misguided pilot program that would have allowed rural hospitals to employ physicians directly. The concern at CMA and HDNCMS was that this would erode the bar against corporate practice of medicine as it would make physicians answerable to administrators for medical decisions. I have my own comments on that issue. Mainly there is the issue state wide of insurance companies and IPAs denying coverage for care. Technically, I am told, that is not the same question. Patients could choose to get appropriate care; the only issue is that they would have to pay for it. That puts the onus on the patient whereas employment of physicians would put the onus on the doctor. What am I willing to give up for my patient to get appropriate care? If I were employed by the administrator I suppose I could lose my job in the

fight for the patient. Currently I only lose the time it takes to put up the fight, time for which my current (physician) employer is not paid. A fine line to be sure. In a similarly fine line I currently have a financial obligation to the hospital in the neighborhood where I practice. The demands that they have placed on me have not been particularly onerous but that could be because of my insignificance to them. Similarly, more and more of our local physicians are entering into financial agreements with the large local hospital system. Of those who I know personally, they are ethically upstanding physicians who, I suspect, would not allow their relationship with the hospital to interfere with medical decision making. We all do what we need to do to pay the bills.

On a lighter note, our Medical Society has some events coming up. The two big ones are the annual picnic on the afternoon of September 25th and our annual meeting the evening of December 2nd. It will be nice to get together with people and get everyone's thoughts on the big events of this year. §

PLEASE notify the Medical Society when there are changes in your office - new physician, new NP/PA, change in Office Manager, change in e-mail address or contact information - so we can keep the database up-to-date. THANK YOU!

Let's get real: It's not DNR, it's DNAR.

SCOTT SATTLER, M.D.



For decades our profession has used Do Not Resuscitate (DNR) as the definitive order in the management of patients for whom aggressive end-of-life medical intervention is deemed inappropriate. Let's get real. The use of this phrase is delusional. The alternative to 'Do Not Resuscitate' is to 'Resuscitate'. Resuscitate comes from the Latin *resuscitare*- to 'raise again'. It means to revive someone from unconsciousness or apparent death and make them active and vigorous once again. It means to revivify, to revitalize. Who wouldn't want their moribund patient to revive and become vigorous once again if they were dying? And who among us could refuse their own resuscitation if presented as a choice between "Do you want revived or don't you, if things go badly?" Put that way we would all say, "I know I could die during this operation.... during this chemotherapy.... during this stretch on the ventilator.... but if I do, resuscitate me! And be sure you put that order in my chart, doctor."

But the truth is that we haven't the faintest idea whether or not, in any given instance, we can resuscitate anyone. We simply can never know whether our resuscitative efforts will be successful. Yet we continue to offer the option of accomplished resuscitation or rejection of same to our most fragile patients, promulgating the illusion that restoration to active life is a given, if they but choose to let us ply our trade. "Would you like to be resuscitated, Mr. Jones, if your heart or lungs stop working after we do your pneumonectomy?" How specious.

The question we need to be asking

patients, their families and ourselves is whether or not we should attempt to perform resuscitative efforts should vital functions give way. The nursing staff's question is not, in essence, "Do you wish to institute resuscitation, doctor, if your patient is found pulseless and apneic, or is this a DNR?" Their real question is "Do you wish us to attempt resuscitation, doctor, if your patient becomes moribund, or are we to pursue comfort care instead?"

So let's do it. Let us begin replacing the phrase DNR with the more accurate phrase DNAR across the board. This will be especially helpful when discussing end-of-life care with patients and their families, for as you have probably noticed, the use of the DNR phrase is a major conversation killer. When resuscitation is held out as the dominant option, few choose to delve into the deeper questions that beg discussion. When one can simply opt for resuscitation vs. non-resuscitation it makes it altogether too easy to defer confronting those uncomfortable, haunting questions regarding the inevitable morbidity and mortality of aging. The use of the DNAR phrase however, opens the conversational door widely, simply by bringing the reality of the "attempt" into focus. It begs the response from the patient of "What do you mean, attempt? CPR works, doesn't it? Everything I see on TV seems to say so." And this opens the door to clear up these misconceptions and to provide much needed information to the patient.

A while back, Scott Sageman, MD presented a local grand rounds dealing with the use of CPR in adult inpatients. It was

an eye-opener. In case you missed it, here are some of the highlights of his presentation:

Historical Background

CPR was developed as an emergency medical procedure to be used in the resuscitation of basically healthy victims of drowning (especially cold water drowning), electrical shock, blunt chest trauma, anesthesia complications and other potentially readily reversible conditions. It was not intended for use in persons dying from advanced heart disease, pneumonia, renal failure or other chronic systemic disease, let alone for use in all cardiac arrests. The presence of multiple organ system dysfunction reduces Code survival to no more than 1-2%. There is general agreement by medical ethicists that CPR is inappropriate when survival is not expected.

A 1960 NEJM article summarized the 1950's literature on the subject. All patients in the study had undergone either cardiac or pulmonary arrest either in the OR or in the ICU. Survival from CPR was defined as getting back a pulse. By the late 1960's studies reported that 15% of hospital patients undergoing CPR survived. 5-10% of study patients were able to leave the hospital. This included those going to long-term neurological care facilities.

By 1998 the survival rate was still 15% and the likelihood of leaving the hospital alive regardless of level of consciousness remained at 5-10%.

"Opinion" Continued on page 9

The Editorial and Publications Committee encourages our member's comments for publication. Please submit electronically prior to the 15th of the month preceding publication.

Humboldt Crabs

LUTHER COBB, M.D.



Sometimes, when the pressures of our practices, and of life in general seem to be occupying all our thoughts and our time, we might pause and reflect on the things here on the North Coast that are simply unique and delightful, and worthy of our participation and support.

One of those, for sure, are the amazing Humboldt Crabs.

I know there are many doctors in the community who are aware of what this ballclub is and what it has done, but if not, allow me a few minutes of your time. This is the sixty-sixth consecutive season that the Crabs have been in existence. They were founded in 1945, immediately after the war. It is now, believe it or not, the oldest continuously operated semi-pro baseball team in the entire United States. Originally, the players were local workers who participated in baseball as a hobby, but now the players are college students participating in the league during their summers off from school. Players for the Crabs this year come from as far away as New Mexico and Hawaii, but many are local kids as well. When they are not playing ball, they work in local business establishments, who thus help support the team. In fact, the entire organization is a volunteer effort, funded by ticket prices (which are an amazing bargain at \$7; only \$5 for the increasing numbers of us over 62); advertisements in the program (which is also a bargain at only \$2), and concessions (an even more incredible bargain, no more expensive than any local fast food

joint and trivial when compared to concessions at any major league ballpark).

And the club plays an incredibly good brand of baseball. In all their 65 previous seasons, they have never had a losing season. Ever. Just think about how improbable that is. And in most seasons, the win/loss record is not even close. Their best season was in 1985, when they went 51 and 3 for an amazing percentage of 0.944. Their worst season was way back in 1955, when it was 26 and 19, for an average of 0.578. In most major league seasons, that would be good enough to win the pennant, or at least secure a wild card spot, and that was their WORST ever. Overall, they have won 2285 and lost 685, for a winning percentage of 0.769. That's better than 3 out of 4 for three quarters of a century! I doubt there has ever been a more successful sports franchise anywhere. They make the New York Yankees look like a bunch of also-rans.

And they aren't playing a bunch of patsies either. They participate in a very competitive league, with other players representing other teams who draw from the same talent pool and have similar organizational structures. Most of their games are not laughers or runaway games. The doubleheader I attended yesterday (June 12) against the Fontanetti Athletics (who have their own distinguished history of over 50 years) was an exciting 7-4 contest in the opener, and a thrilling 5-4 victory in the nightcap, won by getting two runs in the final home inning with two outs and the

game on the line.

I have loved baseball since I was a kid growing up in Nashville and hiding my portable transistor radio under the covers to listen to the Atlanta Braves, in the glory years of Hank Aaron, Eddie Mathews, Rico Carty, and Phil Niekro play late into the night at the new Giants ballpark at Candlestick Park, knowing I would have to get up early in the morning to get to school but not being able to stand missing a crucial game. I remember smuggling a radio into the classroom to listen to the World Series, back in the good old days when they actually insisted in playing those crucial games in the daytime only. I have seldom had as much fun as when I coached my son's Little League games in the 80's and 90's. Ellen and I used to have a partial season ticket to the Giants when we lived in Palo Alto.

But I can honestly say I have never seen a more fun baseball game, or any sport for that matter, than when going out to a Crabs game. They even have a really good pep band, the Crab Grass Band, who are also volunteers and play a great brand of music.

There are many unique pleasures of living here on the North Coast, but the Crabs are one of the best. The season extends into the first week of August. Go out and watch a game! §

Hospice Update

JOHN NELSON, M.D.

Medical Director



It is not an uncommon scenario. The Patient with chronic illness had been declining for some years. Now an acute event has sent him to the hospital, the family has gathered, and a referral to Hospice has been made. A Hospice of Humboldt nurse has talked with the family, explaining the services available to them through the Medicare Hospice Benefit. The family wants to bring their loved one home and care for him with the help of Hospice for the short time remaining.

Previously, I have seen this scenario end in one of two ways. If the patient could be stabilized enough to survive the trip home, Hospice would have met him at his home and enrolled him.. Most likely he would die within a few days, while his family received the support and help of the Hospice interdisciplinary team, including individualized bereavement counseling.

But over 20% of patients referred to Hospice while in the hospital die before they can be enrolled. It is not uncommon for hospitalized patients to be too unstable to be discharged, and to spend their last days in the hospital.

Now a new partnership between Hospice of Humboldt and St. Joseph Hospital, Eureka, provides an alternative – admission to Hospice while the patient remains in the hospital.

The Medicare Hospice regulations allow for patients receiving hospice care to be hospitalized for the control of symptoms that cannot be adequately addressed in the

home setting. This is called GIP care – general inpatient care. Hospice of Humboldt uses the GIP level of care to manage patients who are already enrolled in Hospice whose symptoms remain uncontrolled in the home environment. The new partnership allows patients who qualify to be enrolled directly into Hospice at the GIP level of care while remaining in the hospital.

Under GIP care Hospice manages the patient’s Plan of Care for symptom control, as well as providing emotional and spiritual support for the patient and family by Hospice social workers and chaplains. As Hospice Medical Director, I will visit patients enrolled while in the hospital and serve as the attending physician, just as I do for other hospitalized Hospice patients.

Other Hospices with similar programs find that patients remain in the hospital after hospice enrollment for an average of about 5 days. About 40% of those patients are able to return home; the others die while remaining in the hospital, receiving care from hospice.

The purpose of providing hospice services to patients while they are hospitalized is to provide focused, expert end-of-life palliative care, including specialized supportive care to the patient’s family and friends.

If you have questions about this service or any other aspect of Hospice care, I can be reached at Hospice of Humboldt, 445-8443 §



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"Opinion" Continued from page 3

Epidemiology

50% of DNR orders are written within 2 days of death.

TV Series Resuscitation Rates

In 1996 the NEJM reported a study of the CPR survival rates of three TV series: ER, Chicago Hope and Rescue 911. The study showed an average CPR success rate of over 77% with 57% of those successfully resuscitated leaving the hospital.

Survival Rates for subpopulations receiving CPR, by primary diagnosis (recall that survival of CPR is defined simply as getting a pulse back):

Metastatic CA	0%
AIDS	0%

GI Bleed	0%
COPD	0%
Pneumonia	0%
Acute CVA with deficit	0%
Class IV CHF	0%
All resuscitations >15 minutes	0%
Septic Shock	0.9%
Pre-existing renal failure	0-1%
Nursing home residents	0-2%

(In-hospital CPR)

1995 VA Hospital Study of 340 codes over a 2-year period:

0% of the survivors living over 30 days returned to full function

Final thoughts:

We need to stop using the term DNR when discussing Code status and writing

orders. Its use is both dysfunctional and misleading. Use DNAR instead.

Be prepared to discuss the realities of CPR efficacy and appropriateness. Patients need to be informed as to the potential risks and benefits of CPR. For many patients, there are fates worse than death.

Remember that a Code, just like all surgical and diagnostic procedures, has established indications and contraindications. CPR was never intended to be an option extended to every patient in all circumstances. Medical ethicists and hospital system legal counsel both agree that as a profession we are not obligated to acquiesce to a patient's request for CPR, but rather to implement only those requests that are reasonable, appropriate and medically sound.§

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