New York Times Op-Ed: “A Winding Path to the Emergency Room”
By Paul Christopher, MD
January 4, 2011
http://www.nytimes.com/2011/01/04/health/04cases.html?_r=1&ref=todayspaper

A Winding Path to the Emergency Room

By PAUL CHRISTOPHER, M.D.

He was the first patient of the day, dropped off at the emergency room by the police or a family member — a man in his 50s, unshaved, stumbling, engulfed in the pungent aroma of alcohol.

When he blew into the breathalyzer’s strawlike tube, the readout was 0.18, more than twice the legal limit.

“I get seizures,” he said, referring to the dangerous reaction some people experience when they abruptly stop drinking. Then, as if to prove it, he held out trembling hands. Each bore the nicks and scars of a hard-lived life.

I looked at the beads of sweat on his brow, then down at his vital signs. Heart rate 120; blood pressure pushing 170/90. Despite his high alcohol level he was already in withdrawal. A medical detoxification — with drugs to counteract the sudden absence of alcohol in his system — was the right first step.

“Let’s admit him,” I said to his nurse. Because it was still early, there was a good chance a hospital bed would be available.

Her reply was apologetic but resigned: “He’s out of network.” I winced at my own naïveté. “Out of network,” a euphemism for “insurance will not pay,” was a roadblock I should have anticipated. A nuisance for many patients and would-be providers, it is ubiquitous in the second-class world of substance-abuse treatment, where insurance companies contract with selected hospitals and doctors to deliver care at bargain rates.

We called the few in-network hospitals within a broad radius. One had a bed. But before accepting my patient, the receiving doctor wanted a battery of tests, including an electrocardiogram and laboratory work, to rule out other medical concerns. It would be a day or so before the tests came back.

But the patient was already in withdrawal, I told the doctor. He couldn’t wait a day.

“Sorry,” he said flatly. “He has to be cleared first. Hospital policy.”

I hung up and made a quick calculation. An hour had passed since my patient’s arrival. If we sent him out now, he might get medically cleared in a few hours, before being transported to the in-

network hospital for admission. It would be a rough day, but with any luck, in six hours he'd be in a bed.

On the way to tell my patient the plan, his nurse caught me. "You know we'll have to get authorization, too."

And there was the second ugly truth: nearly all mental health admissions, no matter the reason, require authorization from insurance companies. Otherwise, the admitting hospital won't get paid. Although this patient wasn't coming into my facility, we were the first point of clinical contact; and because I was the one recommending admission, it fell to us to justify that decision to the insurer. The short straw was ours.

A bad situation was beginning to look worse. The insurance company wouldn't authorize an admission until my patient had been accepted to a bed, but he couldn't be accepted until he'd been medically cleared.

The sawtooth path to treatment now looked like this: after arriving at my hospital (1), the patient would be sent to a medical emergency room (2) to be cleared, then return to my hospital (1), where he would wait while we obtained insurance authorization before sending him to a psychiatric hospital (3), where, we hoped, he'd be admitted.

"Serves me right, I guess," my patient said when I gave him the news.

I smiled, wondering whether he'd misunderstood what I'd told him or was simply taking it all in stride. Perhaps he'd been through this before.

As the ambulance arrived to take him to the other hospital's emergency room, I ordered a dose of lorazepam — a sedative to ease his withdrawal symptoms — and wished him well. Then I turned to the next patient waiting to be seen.

About 10 hours later, as I was finishing my shift, my patient returned. He'd been cleared and brought back for us to get insurance authorization.

Before he stepped off the gurney, I turned to his nurse.

"I'm already on it," she said.

In the meantime I rechecked his vitals. Still sky-high, so I wrote another prescription for lorazepam. A few minutes later, his nurse approached.

"Did we get the authorization?" I asked excitedly.

She nodded once and then shook her head with a rueful smile.

"What is it?" I asked.

“The bed at the other hospital. It was already filled.”

Physicians in emergency rooms everywhere share the challenge of figuring out where their patients will get the best and most timely care — a medical or a psychiatric floor, the intensive care unit or the surgical suite? But in psychiatry more than in other specialties, it is insurance that is likely to tie a Gordian knot.

In my psychiatric residency, I spent four years learning the intricacies of mental illness and its remedies, the interactions between medications, and the ethical conundrums of involuntary treatment. Yet now that I’m in my first post-residency job, it turns out I spend much of my time wrangling with insurance companies over what I believe to be appropriate treatment.

And legislative reforms like the recent Mental Health Parity and Addiction Equity Act, while helpful, have yet to be the Alexandrian sword that so many hope for. Too many patients with substance disorders are still unable to get the prompt care they need and deserve.

The nurse and I tried once again to find an inpatient bed, this time broadening our search. But by now it was late in the day and the in-network hospitals were full.

Looking over our own census, I saw we still had two unassigned beds. I sat and wrote admission orders; we would probably end up eating the costs.

The nurse, standing behind me, said, “That seems like the right thing to do.”

Dr. Paul Christopher is a psychiatrist at Butler Hospital in Providence, R.I.