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Inside

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What if your ED misdiagnoses a public figure? Here's how to handle VIPs

'Within 24 hours, the whole world will know how incompetent you are'

It's every ED manager's nightmare. A former U.S. president comes to your ED complaining of pain in his face and tongue and is given a diagnosis of sinus infection by your staff. Only a few hours later, he returns and is admitted to the hospital with a stroke. That's exactly what happened to ED managers at Hahnemann University Hospital in Philadelphia who treated former President Gerald Ford for facial pain while he was attending the Republican National Convention this summer.

Soon after, national media outlets were reporting that Ford was misdiagnosed. Even though Ford himself never questioned the ED's diagnosis and said the care he received was "fabulous," the public relations damage was done. (The hospital refused to comment for this article.)

While your ED might not have cared for movie stars or presidents, every ED occasionally treats "local VIPs," says **Norman J. Schneiderman**, MD, FACEP, chief of staff for the emergency and trauma center at Miami Valley Hospital in Dayton, OH.

Those VIPs include family members, administrators, physicians, and members of the hospital's board of trustees, he notes. When you're caring for high-profile patients, errors are magnified many times over, he warns. "If something goes wrong, within 24 hours the whole world will know how incompetent you and your hospital are. Bad press is not as important as a patient injury, but no one wants it if you can avoid it."

While no experts interviewed by *ED Management* suggested VIPs should receive better care than other patients should, many sources thought they should be managed differently. "There is more at stake, so you want to be extra

Executive Summary

When caring for local or national VIPs, take extra steps to ensure the correct diagnosis is made without giving preferential treatment.

- Consult with colleagues to double-check your decision making in person or over the telephone.
- When asking for a second opinion, don't give the consultant your diagnosis.
- If you fill out an incident report, never allude to that in the patient's chart.

cautious and conservative," advises Schneiderman.

Here are ways to manage the treatment of VIPs in the ED and reduce the risk of misdiagnosis:

• **Get a second opinion.** Consult liberally and ask for a second opinion, suggests **Steven J. Davidson**, MD, MBA, chair of the department of emergency medicine at Maimonides Medical Center in Brooklyn, NY.

"Call your chief and tell him or her what's going on, and ask for advice," he says. "Ask a colleague to double-check your decision making in person or over the telephone at least."

It never hurts to get a consultation, Schneiderman advises. For example, with an orthopedic patient, "after you have done the evaluation, call the orthopedist and make them aware of what is going on," he says. "Run it by them and arrange follow-up to make sure it's for the next day."

Or have the radiologist look at the X-ray to be 100% sure, as Schneiderman recently did when treating actress Carol Channing's spouse for a fall. "I didn't want to read an article two days later in the news saying that we totally missed a fracture her husband had," he says.

Always do this with a VIP if there is any question at all, urges Schneiderman. "We are never 100% sure in most of our diagnoses," he says. "But I like to approach 100% with a VIP, just so we're not unlucky."

Don't prejudice the consultant by giving your diagnosis, advises **Stephen Colucciello**, MD, FACEP, assistant chair and director of clinical services for the department of emergency medicine at Carolinas Medical Center in Charlotte, NC. "Nothing obscures the truth as much as a diagnosis. Once the patient is labeled, the thinking stops," he says. "All subsequent care providers work from that assumption, which may be wrong."

Your system should be set up so that specific chief complaints always are passed on for specialist consultation, recommends **Gregory L. Henry**, MD, FACEP, vice president of risk management for Emergency Physicians Medical Group in Ann Arbor, MI.

• **Never reference in the patient's chart if you fill out an incident report.** This practice may allow the patient's attorney to obtain a copy of the report, warns Henry. "The risk management issues of the system problem and/or individuals involved are discussed in the incident report. The patient's chart discusses the patient's care," he says. "The two reports should never be cross-referenced."

Quality assurance materials usually are protected from discovery and admissibility, explains Henry. "This is where we can be candid within the hospital. If you drop a patient off the stretcher in X-ray, that's not a desirable thing. But it's recorded differently in the patient chart and the incident report."

In the patient's chart, record facts such as "at 10:52, the patient slipped off the X-ray table and now has a tender, swollen wrist," says Henry. In the incident report, it may be documented that "John Jones, the third-shift X-ray tech, has now dropped people off the stretcher 10 times because he doesn't call to get help," he explains.

• **Develop relationships with your community leaders.** Take the lead in public relations by knowing who your community leaders are and making sure they know you, says Davidson.

To increase your visibility in the community, do the following, he suggests:

— Have volunteer ambulance companies come to the ED for instruction.

— Participate in community health fairs or other activities.

— Adopt a school.

— Provide clinical rotations for community emergency medical technician training programs.

— Speak to community organizations.

If a misdiagnosis occurs, you should make your statements directly to your community leaders and use local neighborhood venues to communicate, he advises.

Get in touch with your "communities of interest," which include volunteer ambulance services, distinct ethnic communities, and local organizations, Davidson suggests. "Do this *before* something awful happens," he says. He recommends conveying the following points:

— ED medical care is done by humans, so mistakes will happen.

— Your ED does everything possible to keep mistakes from happening. When they do, you learn from them and improve so they don't happen again.

COMING IN FUTURE MONTHS

- How to reduce risk of patients who leave without being seen
- Controversy over ambulance restocking
- Effective ways to evaluate safer needle devices
- Start a telephone follow-up program

— Your ED is never satisfied with the status quo but is always working to improve. Only when patients, families, or others tell you about your mistakes can you learn from them and improve.

Get your message out through the local neighborhood weekly newspapers, suggests Davidson. "All of this depends upon building relationships with the community *before* you need [them]," he stresses.

Build a relationship with leaders focused on what the community needs and wants from the ED, says Davidson. Ask leaders how the ED can help, he suggests. "For example, the volunteer ambulance corps may want a fast way of getting patients off their stretcher, [taking the] report, and [getting] them out the door because they are unpaid and they have jobs and families. Or they may want training time in the ED."

Likewise, community organizations may want an opportunity to have young people volunteer at the hospital, or they may want a lecture on "what to do before you go to the ED," says Davidson.

Then, as the relationship matures, raise the points listed above, he advises. "If you have done your work well, when the inevitable disaster hits, these community organizations and their leaders will criticize you to your face and not in the press."

Maimonides' ED has relationships with more than 100 neighborhood community organizations, including church and synagogue-based organizations, schools, and groups for the elderly, Davidson reports. "I personally talk to representatives from five to 10 organizations every month, but the hospital CEO, COO, patient representative, and many others have many more relationships that are tended carefully," he says.

Sources

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• **Use the term "clinical impression" instead of diagnosis.** The end of the ED visit should only be viewed as a "moment in time," argues Henry. "It's well-documented that 50% of the time, we don't have a specific diagnosis for patients with abdominal pain, but that doesn't mean we don't know important things," he says. "The worst thing to do is to convince the public that every time a patient leaves the ED, there will be an exact diagnosis." **(For additional information on treatment of VIPs, including an ED protocol, see *ED Management*, August 2000, p. 90.)** ■

How to avoid 'VIP syndrome'

Are you suffering from "VIP syndrome"? Treating celebrities differently often results in worse care, warns **Steven J. Davidson**, MD, MBA, chair of the department of emergency medicine at Maimonides Medical Center in Brooklyn, NY.

"Physicians are human and are all too easily cowed by the trappings of celebrity," he says. "If you are distracted by these trappings and the VIP's entourage, you may omit routine components of the evaluation."

Problems arise when you start making exceptions to the rules, argues **Gregory L. Henry**, MD, FACEP, vice president of risk management for Emergency Physicians Medical Group in Ann Arbor, MI.

"The first thing you should remember is you are dealing with a human being. If a rectal exam is good for anyone else, it's smart for a former president," he says. "Don't avoid doing things because these are somehow special people."

Celebrities do not deserve better care, but you may inadvertently provide worse care, says **Stephen Colucciello**, MD, FACEP, assistant chair and director of clinical services for the department of emergency medicine at Carolinas Medical Center in Charlotte, NC. "That's because you aren't doing what is tried and true, what you know to be good medicine," he says.

Here are some ways to avoid VIP syndrome:

• **Follow routine procedures with the history and examination.** Don't cut corners by avoiding asking potentially embarrassing questions about alcohol and drugs or avoiding important tests such as rectal exams, says Colucciello. Don't worry that you are going to offend VIPs by taking a thorough history, he advises. "Don't skirt any of the tough questions. Don't avoid the routine exams just because you want to avoid inconveniencing the patient."

• **Have an ED physician treat the patient.** The biggest mistake you can make with a VIP is to have the patient seen by someone other than an ED physician, says **Norman J. Schneiderman**, MD, FACEP, chief of staff for the emergency and trauma center at Miami Valley Hospital in Dayton, OH.

"If you call in the orthopedic chairman of the department, that individual may not have been seeing patients for a number of years," he emphasizes. "Therefore, he or she is not in tune with the common problems we see every day in the ED."

ED patients need a physician who is experienced and comfortable and knows the routine, explains Colucciello. "Calling upon an esteemed, white-haired celestial figure who is out of the tumble of day-to-day clinical practice is doing a disservice to the patient," he stresses.

That practice also might lead to a misdiagnosis, he warns. "Assuming the most obvious explanation is a diagnostic pitfall. The ED physician needs to at least consider the worst, and work down from there." ED physicians are trained to ask themselves, "In what way could this patient fool me and die?" he adds.

ED physicians also are generalists and consider the overall picture, notes Schneiderman. "An ED physician will look at an injury and ask, 'Why did this patient fall?' It may be that the patient had an arrhythmia which caused the fall," he says.

When treating a VIP, it's important that the ED physician be experienced, he recommends. "It's not unusual, if I am working and a member of the board of trustees comes in, for the nurse to let me know so I can see [that patient] personally," he says. "[Such patients] are reassured because I am the chief of staff and know them personally." Other ED staff members still can be involved in the patient's care, he explains.

With high patient volumes and overcrowding, the ED can't possibly be at its best 100% of the time, but you should try to make sure your "best face" is seen when treating VIPs, urges Schneiderman.

• **Don't allow a celebrity's entourage to interfere with care.** Public relations people and aides who come in with celebrities interfere with medical care at times, says Colucciello. "A classic example of this is a football player who comes to the trauma center with the team doctor. That individual may start to give orders, when he really does not know how to manage multiple trauma," he notes.

You may need to instruct the entourage to step back and be quiet, or if need be, remove them, Colucciello says. "They need to be ignored by the medical staff," he urges. "You cannot have your best judgment corrupted by nonexperts or people who have their own agendas." ■

Here's how to admit you made a mistake

If a mistake was made in your ED, what would your first plan of action be? If you're like many ED managers, your instincts might be to downplay, overlook, or attempt to conceal the error, but those are major mistakes, says **Steven J. Davidson**, MD, MBA, chair of the department of emergency medicine at Maimonides Medical Center in Brooklyn, NY.

Instead, you must own up to the problem and state the truth immediately, urges Davidson. "Then you must say what you are doing about it," he advises. "Even if you can't fix the specific occurrence, you must specifically state what you are going to do so that it doesn't happen again."

Who should you tell?

Here are ways to acknowledge and address an error:

• **Don't make a public apology.** Hospital administrators and risk managers advise against making public acknowledgments of mistakes, says Davidson. "In medicine, we are not accustomed to acknowledging mistakes publicly," he notes.

Regardless of the usual prohibition on "going public," one still must own up to the problem internally, he says. "It is extremely important to notify others in the hospital as soon as the mistake is discovered."

Notify risk management, the patient's current treating physician, the chief operating officer or chief executive officer, and the hospital's public relations department, Davidson says.

• **Have a plan to correct the problem.** Tell those you notify what you've discovered and what its effect on the patient is or might have been, advises Davidson. "Then tell them what you are going to do about it in your area," he says, suggesting the following as an example of what to say:

"We are investigating. We are scheduling a critical incident review meeting with physicians, nursing, and the consulting services on this date: _____ at _____ a.m./p.m. From that meeting, we will develop our corrective actions and we will plan for the implementation and monitoring of those corrective actions. We will report the case for review at the next housewide performance improvement meeting and the medical staff executive committee."

It is always better to be in the position of reporting a mistake with your own first impressions and recommendations for actions, says Davidson. "It's much harder to be in the position of reacting to accusations

from others, especially when those accusations are valid," he notes.

• **Don't apologize for missing a diagnosis if your care was appropriate.** Disease is not always easy to define, says **Gregory L. Henry**, MD, FACEP, vice president of risk management for Emergency Physicians Medical Group in Ann Arbor, MI. "Not all patients will be diagnosed in one shot during an ED visit, but that doesn't mean you haven't done the right things," he explains.

• **Be as candid as possible.** Never attempt to hide a mistake, Henry advises. "It's how you package the product and the face you put on it," he explains. "If you say, 'We know the following things, but this part of disease has not yet declared itself,' most people can handle that kind of honesty."

The idea is to be honest without being inflammatory, Henry says. For example, a patient was supposed to be given a shot of Solu-Medrol (Sanofi Winthrop Pharmaceuticals, Morrisville, PA), an anti-inflammatory steroid for a severe inflammatory throat that was causing swelling, and mistakenly was given a shot of Demerol (Abbott Laboratories, Abbott Park, IL), Henry recalls. "That was a clear error. However, the truth is, he needed pain relief anyway, although it wasn't what the nurse intended to give," he says.

Henry explained to the patient that the steroid is usually given first, but he happened to get his pain medication first. "There was no harm done. Don't build in the mind of the patient something that didn't happen. What you want is the facts and no editorializing."

• **Meet with the patient and/or family.** If an obvious error is made, you should meet directly with the family to explain it, recommends Henry. "The meeting should not be held with risk managers. It should be a doctor, not necessarily the one who had the problem, meeting with the family to explain what happened."

• **Consult with risk management.** You might fear that if you apologize to a patient, you'll be promoting a malpractice lawsuit, says **Stephen Colucciello**, MD, FACEP, assistant chair and director of clinical services for the department of emergency medicine at Carolinas Medical Center in Charlotte, NC. To reduce that risk, consult with risk management before you speak to the patient, he advises. However, Colucciello stresses that it's always the clinician's call whether to accept or reject that advice. "They may tell you to give minimal information, but you may think that's wrong," he says. "But even in that case, they may give you help in understanding how to say something."

• **Document mistakes and how they were handled.** When an error is made, document it immediately, says Henry. "Everybody makes mistakes. It does happen. The question is, did you try and correct it?"

Henry suggests the following as an example of good documentation: "Medication X was given instead of medication Y. The patient was informed and re-examined. The nature of the medication is not expected to have side effects, but we will monitor the patient.' That is a very clear statement that hides nothing," he says. "It shows that when you found out about something, you took steps to ensure the patient's safety." ■

Use algorithm to avoid EMTALA violations

Are you confident that everyone on your staff understands how to comply with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA)? If you're like most ED managers, the answer is a resounding "no," says **Todd Taylor**, MD, FACEP, an attending ED physician at Good Samaritan Regional Medical Center in Phoenix.

"Even today, experienced hospital staff continue to violate EMTALA due to a lack of basic understanding of the law," he explains. **(See common causes of EMTALA violations, p. 126.)**

An algorithm can help convey basic EMTALA compliance information, according to Taylor, who developed an EMTALA algorithm. **(See sample, p. 127.)** "The use of an algorithm may help in providing at least basic understanding and illuminating cases that need further consultation when the algorithm does not seem to resolve the issue," he notes.

Every ED employee needs to understand EMTALA requirements, stresses **Denise Casaubon**, RN, owner and president of DNR Medical-Legal Consultants, a Fountain Hills, AZ-based company specializing in health care corporate compliance. "All staff have the potential for violations," warns Casaubon, who also developed an algorithm for EMTALA.

Executive Summary

- An algorithm can help convey basic EMTALA compliance information to ED staff.
- An algorithm can instruct staff to perform duties in the correct order.
- Every ED staff member needs to understand EMTALA requirements, because all employees have the potential for violations.
- Complex EMTALA issues call for personal consultation with the hospital's EMTALA coordinator or risk manager.

Here are items that cause violations

Violations of Emergency Medical Treatment and Active Labor Act (EMTALA) occur frequently, although relatively few are ever reported and investigated, according to **Todd Taylor**, MD, FACEP, an attending ED physician at Good Samaritan Regional Medical Center in Phoenix.

"They generally occur when some event occurs that interrupts the usual process for evaluating patients in the ED," he explains.

Taylor recommends watching out for these common "red flag" scenarios:

- Managed care requests input into how the patient will be managed. For instance, managed care makes a request to "triage" the patient to a primary care doctor's office or demands prior authorization for elements normally considered part of the medical screening exam.
- The patient requests assurances that his or her insurance will cover particular services and then refuses to consent to evaluation if assurances are not provided.
- Simple or what appear to be obvious nonemergency complaints are dealt with at triage by a person not designated as a "qualified medical provider."
- Physicians alter their usual medical screening exam due to notification of denial of payment by the health plan. ■

EMTALA violations can yield significant penalties, she stresses. The fine for a hospital that negligently violates EMTALA can be up to $50,000 or, for hospitals with fewer than 100 beds, up to $25,000. Civil money penalties also apply to physicians.

The algorithm format guides the ED staff to make proper decisions for patient care that comply with EMTALA regulations, says Casaubon. "An algorithm is easier to understand because the format is a 'picture view' that walks you through the steps, making it easier to comprehend," she explains.

The verbiage in the federal regulations can be difficult to understand, she says. "But remember, an algorithm cannot address all of the situations that arise in the ED related to EMTALA. An algorithm is only a guide to assist staff to perform duties in the correct order."

Algorithms have limitations, explains Taylor. "Algorithms often do not help with cases for which you really need guidance," he says. "Some cases are more complicated than any algorithm can address." **(See case study, p. 128.)**

However, Taylor developed the EMTALA algorithm because so many ED managers requested it. "I believe its best use would be in the basic EMTALA education for ED nurses, physicians, and registration staff on how to manage a patient in the ED with respect to EMTALA," he says.

The algorithm probably would not be the best tool to deal with complex EMTALA issues that arise from time to time, he cautions. "Such issues are best dealt with by personal consultation with the hospital's EMTALA coordinator or risk management."

The algorithm is straightforward and accounts for the various steps required by the federal EMTALA law, he says. "The overriding principle of EMTALA is to 'take care of the patient,'" he notes. If anything interrupts your ability to accomplish this (for example, the patient refuses treatment), have the patient read and sign your documented understanding of the situation, Taylor advises.

Consider this example

An example in which the algorithm probably would not help involves a woman who suffers an intracerebral hemorrhage and is initially seen at a rural ED without neurosurgery capability, says Taylor. Arrangements are made with a referral hospital to transfer the patient, and the neurosurgeon and family are expecting the patient to arrive at that hospital. The ambulance crew inadvertently takes the patient to a different hospital with equal neurosurgery capability as the original referral hospital.

The patient arrives at the ED, is unconscious, and no family is available. What should that ED do? There are only two options, according to Taylor:

1. Keep the patient, make alternative arrangements with the neurosurgery staff at the hospital, and run the risk of the family's objection.
2. Transfer the patient to the hospital originally designated, where the neurosurgeon is standing by ready to receive her, but run the risk of transferring an unstable patient under EMTALA without consent of the patient/family.

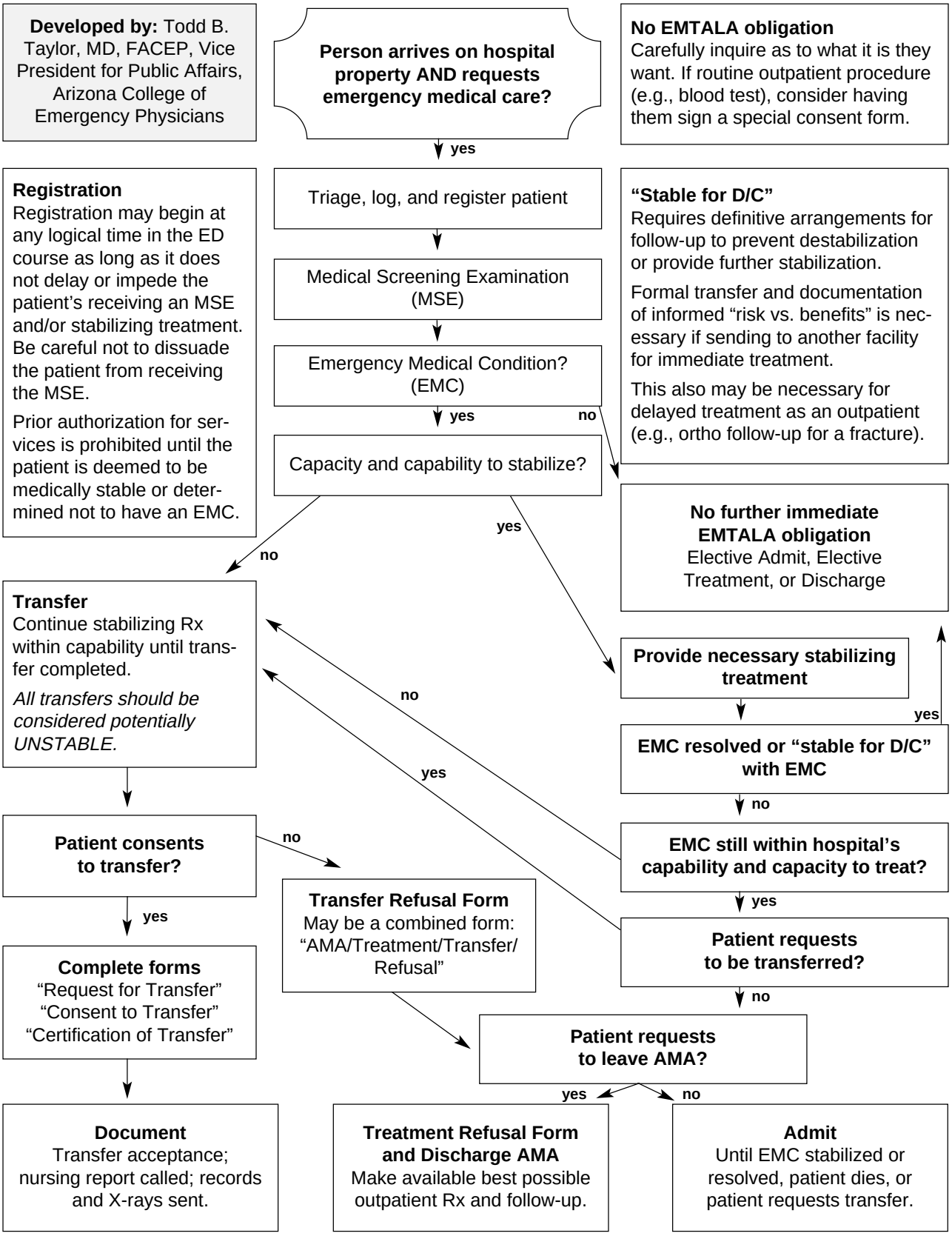
Two national EMTALA experts have given opposite opinions on how to handle that situation, Taylor notes. "In this type of instance, an algorithm does not help."

Here are key points conveyed in the algorithm:

- **Emergency medical condition.** It is important for ED staff to understand that a medical screening exam

(Continued on page 128)

EMTALA/COBRA Algorithm



Source: Todd Taylor, MD, FACEP, Good Samaritan Regional Medical Center, Phoenix.

must be done to determine if the patient has an emergency medical condition, says Casaubon. "This includes patients with psychiatric disturbances and/or substance abuse and women in labor," she explains.

• **Prior authorization.** The key thing to remember is not to obtain prior authorization before the medical screening examination is completed, period, she says.

• **Patient refusal of transfer or treatment.** Documentation in the clinical record of all of the events surrounding the patient's treatment up to the refusal is paramount, says Casaubon. That would include the following, she notes:

— patient notification of the risks and benefits of the treatment the patient is refusing;

— the treatment that had be administered up to the point of the refusal;

— the attempt to obtain written refusal.

Reasonable measures must be taken to obtain the written informed refusal of the transfer or treatment by the patient or the patient's representative, she says.

• **Patient transfer:** The sending facility must be sure the receiving facility agrees to accept *and* treat the patient, she explains. If the recipient facility does not agree to accept and treat a patient who was transferred, the receiving facility has an obligation to report the sending facility to the Health Care Financing Administration in Baltimore or the state agency for an EMTALA violation.

• **Registration:** The ED staff must know what information can be collected and when it can be collected, Casaubon says. "To perform registration functions that discourage an individual from remaining in the ED for treatment is a violation."

[Editor's note: American Health Consultants, publisher of ED Management*, is offering a telephone seminar, The Expanding Scope of EMTALA: Why Every Hospital Department Must Learn the Rules and Comply, Nov. 15, 2000, at 2:30 EST. For more information or to register, contact customer service at (800) 688-2421 or customerservice@ahcpub.com.]* ■

Sources

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You can learn from this difficult EMTALA case

An algorithm can be used for basic decision making within the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations and in sorting through difficult EMTALA situations as they occur, says according to **Todd Taylor**, MD, FACEP, an attending ED physician at Good Samaritan Regional Medical Center in Phoenix.

Algorithms tend to break down, however, when difficult situations arise, Taylor acknowledges. "Judgment calls must be made at decision points in the algorithm that could completely change the process," he notes.

Taylor provides the following case study that illustrates the way the algorithm is used in the decision-making process. **(The bracketed points are taken from the algorithm, p. 127.)**

A 43-year-old electrician sustained a 220-volt shock when he stood up and contacted a bare wire across his upper back. The ground point consisted of both hands as he was holding onto a metal bar. He arrived by ambulance to a level I trauma center (Hospital A), but as a "routine" ED patient.

The patient was quickly evaluated and noted to have second- to third-degree burns across the upper back and palms of the hands. Both arms were "dusky," beginning to swell, but pulses were present. A trauma consult recommended transfer to the regional burn center.

The patient had arrived at the hospital and, even if he had been unconscious, there would be an implied request for medical care [arrived and requests care = yes]. The patient was triaged, logged, and registered simultaneously. Note that the medical screening examination was not delayed by any of those procedures.

An initial medical screening examination by the emergency physician revealed an emergency medical condition (EMC), and a trauma consult was obtained to assist in the evaluation [EMC = yes].

The trauma consult determined that, while the facility was a level I trauma center and beds were available [capacity = yes], it did not have specialized capability in burn care [capability = no]. If capacity and/or capability are a "no," then this decision point is "no" [capacity = yes, capability = no, therefore, final answer = no].

The transfer procedure was initiated with the anticipation that the patient would be transferred to the regional burn center at another local trauma center (Hospital B). The patient was advised of this recommendation but refused transfer to that hospital

because, "my father died there, and I refuse to be treated at that hospital" [consent to transfer = no].

The patient was advised of the seriousness of his injury and the need for specialized care but still refused transfer to Hospital B. A "transfer refusal form" was offered, which he refused to sign (documentation was made to that effect in the patient's chart), and he declined to leave against medical advice [request to leave AMA = no].

The trauma service was contacted again and informed of the patient's refusals. The trauma attending refused to accept the patient for admission and requested a psychiatric consult to declare him "a danger to self" and to obtain a court order to force the transfer.

'Call local EMTALA resources'

The algorithm ends at this point, because such unanticipated events cannot be accounted for in an algorithm, says Taylor. "Whenever such an event occurs, it should prompt a call to local EMTALA resources," he advises.

This resource may be a hospital administrator (EMTALA compliance officer), risk management, or an EMTALA expert if available, says Taylor. "It is also possible that hospital policies might help deal with the situation," he notes. "But for the same reasons as mentioned in the algorithm limitations, hospital policies may be insufficient for every eventuality."

In this case, Taylor was contacted initially as a local EMTALA expert, and he recommended the following actions:

- Contact the chief of trauma.
- Contact risk management.
- Contact the hospital administrator on call.
- Advise the patient that every effort to comply with his wishes would be made, but that his continued refusal to be transferred to a higher level of care could delay life- and limb-saving treatment. Documentation of those actions was made in the chart.

This case was resolved by offering the patient two options:

1. The patient could stay, possibly lose both arms, or even die. The trauma service continued to refuse to accept the patient for admission, and plans were made to admit the patient to the "ICU service." Had the patient not been accommodated somehow, a potential EMTALA situation would have occurred for Hospital A. The on-site trauma surgeon was clearly in violation of hospital policy and possibly EMTALA, Taylor says. The political realities of the situation were dealt with through the hospital committee structure.

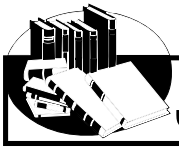
2. Ongoing attempts could be made to identify an alternative burn center in another region. Two alternatives were identified, one 250 miles (Hospital C) and one 550 miles (Hospital D) away. The closer hospital was contacted, and the burn unit director refused to accept the patient in transfer due to the situation (i.e., there was a closer center available).

Under EMTALA, the patient's refusal to go to Hospital B does not matter. In fact, that hospital was never contacted. Ultimately, the hospital administrator at Hospital C overrode the burn unit director's decision, accepted the patient in transfer, and averted an EMTALA situation.

At this point, you can return to the algorithm to the "Patient requests to be transferred?" box and complete the transfer procedure, Taylor explains.

While this case is difficult, it is not uncommon, he points out. "It illustrates when a situation 'falls off' the algorithm, it is prudent to get additional EMTALA help."

In this case, at least two potential EMTALA violations were avoided, Taylor notes. "Knowing your EMTALA resources is more important than knowing the EMTALA algorithm," he notes, "but the structure of the algorithm may assist in resolving many EMTALA situations." ■



JOURNAL REVIEWS

Schmidt T, Atcheson R, Federiuk C. **Evaluation of protocols allowing emergency medical technicians to determine need for treatment and transport.** *Acad Emerg Med* 2000; 7:663-669.

Of 277 patients determined by emergency medical services not to need an ambulance, from 3% to 11% had a critical event suggesting that, in fact, they might have needed the ambulance, according to this study from the Oregon Health Sciences University in Portland, Kaiser Permanente in Salt Lake City, and the University of Utah School of Medicine, also in Salt Lake City. Emergency medical services need to determine an acceptable rate of undertriage, argue the researchers.

The emergency medical technicians (EMTS) provided ambulance transport to 1,300 patients and categorized them as follows, according to a set of protocols developed by an expert panel:

- 1,023 (79%) needed an ambulance transport;
- 200 (15%) could go to the ED by alternative means;
- 63 (5%) could contact a primary care physician;

• 14 (1%) could be treated and released.

Using the set of protocols, EMTs determined that about 21% of patients did not need ambulance transport, and 3% to 11% of those had a critical event. Twenty-three patients (11%) had events that may not have warranted advanced life support transport, and seven (3%) had critical events in the ambulance warranting ambulance transport. The researchers explain that either the protocols don't identify all patients who might experience a critical event during transport, or the EMTs did not correctly follow the protocol.

Most of the undertriage occurred when the EMTs did not follow the protocols, except for one case that would have been missed by the protocols, the researchers say. Better adherence to the protocols might increase safety, they suggest. ▼

Washington DL, Stevens CD, Shekelle PG, et al. **Safely directing patients to appropriate levels of care: Guideline-driven triage in the emergency service.** *Ann Emerg Med* 2000; 36:15-22.

Standardized clinical criteria can identify ED users who can be safely cared for at a later date in a nonemergency setting, says this study from the VA Greater Los Angeles (CA) Healthcare System.

Using standardized criteria for deferred care, ED nurses screened 1,187 ambulatory adult patients with abdominal pain, musculoskeletal symptoms, or respiratory infection. Here are key findings:

• 226 (19%) of patients met screening criteria for deferred care. Of those patients, none was hospitalized within seven days, and none died within 30 days.

• 68 (7%) of the 961 patients who did not meet criteria for deferred care were hospitalized for related conditions, and five died.

• Patients who met the criteria for deferred care were offered the option of an appointment within one week in the ambulatory care clinic.

• The study supports the use of guidelines to triage patients for emergency care or a scheduled appointment within one week, say the researchers.

"This is a safe and timely way to approach the problem of ED overcrowding, so that explicit clinical criteria, rather than the length of the wait for care, determine which patients leave the ED," they write.

However, they caution that the deferred-care guidelines are only feasible if cost-effective alternatives to ED care exist. Patients who are safe for deferred care need to be given an appointment to be seen in a primary care setting at a later date, say the researchers. ■

Site offers tools for busy clinicians

At the Web site of the National Center for Emergency Medicine Informatics, (www.ncemi.org) users can be updated on cutting-edge research, subscribe to an emergency medicine listserv, or determine if a patient is a candidate for thrombolytics.

NCEMI was founded as a not-for-profit institute in 1995 by **Craig F. Feied**, MD, FACEP, FAAEM, the organization's director, and Mark Smith, MD, FACEP.

"It was created as a way to use informatics to deliver the kinds of tools and information needed by practicing clinicians in a busy clinical environment," says Feied, director of informatics for the department of emergency medicine at Washington (DC) Hospital Center.

The Web site is a real-time resource to meet the daily needs of ED managers, physicians, and nurses, Feied explains. "Because of the immediate usefulness of its content, www.ncemi.org has become the default home page for Web browsers in many EDs around the world," he says.

Here are some of the items on the site:

• **Clinical decision-making tools.** Many of the tools deliver practical answers to specific questions, says Feied. "For example, if you need to calculate the Alveolar-arterial oxygen gradient for a patient who is intubated and breathing 60% oxygen at an elevation well above sea level, you may not have that formula at your fingertips," he notes. "But you can find a simple calculator at the NCEMI site that will give you the answer in seconds."

To decide whether a stroke patient is eligible to receive thrombolytics, you need to calculate the National Institutes of Health stroke scale score for the patient, but there are 47 distinct choices to be made in calculating that score, and the printed documentation may not be readily available, says Feied.

"NCEMI can ask you 16 questions and can calculate that score for you in two seconds," he says.

The site contains 72 clinical tools: six algorithms, 25 clinical calculators, five decision rules, nine diagrams, 18 scoring systems, and nine reference tables, Feied reports.

• **Journal update system.** The site includes a daily

selection of recent articles in the emergency medicine literature that helps clinicians and administrators stay current. The Journal Abstracts Delivered Electronically tool, accessible from a link on the page, allows visitors to sign up for a weekly e-mail that will send them links to every abstract published in the Medline-indexed literature on any topic (such as "emergency department and administration" or "observation unit") during that week. It can do the same for the articles published in any Medline-indexed journal in the past week.

Want a customized Medline search?

The journal update system, says Feied, "performs your customized Medline search every week. The results are automatically e-mailed to subscribers in a very brief format. That makes it extremely easy to stay current on a particular topic or to keep up with everything from a selected medical journal."

Links to abstracts of interest can be saved in a personal on-line "filing cabinet" for future reference whenever and wherever needed, notes Feied.

• **A free staff scheduling program.** This program is used by many EDs to handle shift scheduling needs, Feied reports. Special memo and project tracking systems provide administrative support, he says.

• **Access to Web search engines.** The site provides access to multiple Web search engines, so users can obtain medical information with a single click, says Feied. "For example, a search for clinical images of patients with a dermatologic problem or for X-rays of a particular type of fracture turns up dozens of high-quality images located at many different sites," he notes.

Other search functions permit identification of an unknown pill, delivery of drug dosing information, a Medline search, the discovery of practice guidelines, and several other commonly needed information.

• **Information on medical topics.** The site provides access to the most extensive set of medical textbooks in the world, located at emedicine.com, says Feied. "Nearly 10,000 medical authors and 1,500 editors work to write and maintain these textbooks, and all of the results are available free on-line," he explains.

In addition, more than 150 clinically useful medical topics are addressed directly on the site, including the most common simple emergencies seen in the ED, he says.

• "**Question-a-day."** The site delivers a brief daily question, answer, and citation taken from the core material of emergency medicine, says Feied. "The daily question shows up on the Web page and is also used as the basis for an on-line quiz system. But most users sign up to receive each day's question via e-mail." ■

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CE objectives

After reading this issue of *ED Management*, the continuing education participant should be able to:

1. Discuss and apply new information about various approaches to ED management. (See *What if your ED misdiagnoses a public figure? Here's how to handle VIPs*, cover, *How to avoid 'VIP syndrome,'* p. 123, *Here's how to admit you made a mistake*, p. 124, and *Journal Reviews*, p. 130.)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See *Use algorithm to avoid EMTALA violations*, p. 125.)
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication. ■

AMERICAN HEALTH CONSULTANTS®

2000 SALARY SURVEY RESULTS

ED Management®

The monthly update on Emergency Department Management

Are you offering the right benefits in your ED? If not, employees may go to a facility that is

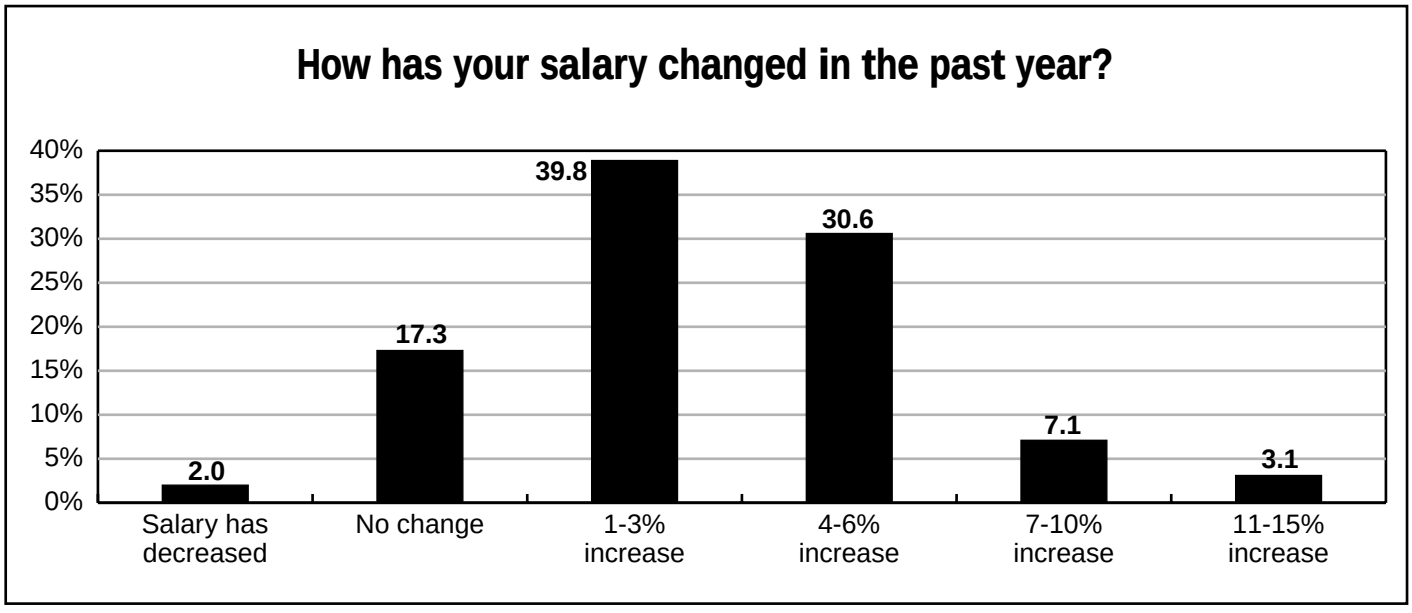
You might lose ED staff members to other facilities if you don't offer the right health insurance plan.

The quality of the coverage in the specific plan is a key concern, according to **Robert Suter**, DO, MHA, FACEP, a member of the American College of Physicians Board of Directors and interim ED medical director at the Medical Center of Arlington (TX).

"People are quitting and changing jobs after changes in company health care insurance, if they do not like the new plan," he reports. "Usually, it is over very specific issues — like domestic partner coverage or specific doctors on a preferred provider list."

Doctors are focused on pension and profit-sharing, says Suter. "[They're concerned with] pension because most seem to be planning to retire early; profit-sharing because they feel philosophically that they should be entitled to it, since they are the provider of the critical component of care the patient is seeking," he explains.

Physician managers also value "flex-time," says Suter. "They do not like working in a nine-to-five framework but rather enjoy the freedom of a flexible work schedule," he notes. "In part, this is necessary for physicians to work off-hours clinical shifts. This 'freedom' is still difficult for most nurse managers to get at most hospitals, which tend not to be as tolerant of flex-time for nurse directors."



Annual Gross Income

Title	Percentage
Chairman	
$60,000 to $64,999	10%
$130,000 to $134,999	10%
$160,000 or more	80%
Nurse Manager	
$35,000 to $39,999	2.6%
$40,000 to $44,999	5.2%
$45,000 to $49,999	5.2%
$50,000 to $54,999	21.0%
$55,000 to $59,999	2.6%
$60,000 to $64,999	23.6%
$65,000 to $69,999	18.4%
$70,000 to $74,999	18.4%
$80,000 to $84,999	2.6%
Director of Emergency Services	
$40,000 to $49,999	1.9%
$50,000 to $54,999	7.8%
$55,000 to $59,999	9.8%
$60,000 to $64,999	11.7%
$65,000 to $69,999	13.7%
$70,000 to $74,999	13.7%
$75,000 to $79,999	9.8%
$80,000 to $84,999	5.8%
$85,000 to $89,999	3.9%
$95,000 to $99,999	3.9%
$100,000 to $104,999	1.9%
$105,000 to $109,999	1.9%
$160,000 or more	13.7%

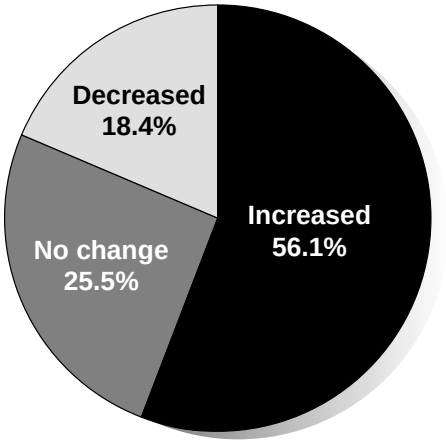
Missing categories indicate 0 responses.

Benefits were covered in the *ED Management* 2000 Salary Survey, which was mailed in July to 1,131 subscribers. There were 98 responses, for a response rate of 8.7%.

Respondents ranked the following benefits as important or extremely important **(see chart, p. 3)**:

- medical coverage: 91%;
- 401k or other savings plan: 88%;
- pension plan: 88%;

Has your staff size changed?



- dental coverage: 74%;
- tuition reimbursement: 60%;
- life insurance: 59%;
- annual or semiannual bonus: 41%;
- profit-sharing plan: 27%;
- eye care coverage: 38%;
- child care: 6%;
- elder care: 2%.

Physicians looking for traditional benefits

About 75% of ED physicians are now employees, which is a significant change over last 10 years, notes **John Moorhead**, MD, FACEP, past president of the Dallas-based American College of Emergency Physicians. "Most used to be independent contractors, so they are now looking for fairly traditional kinds of benefits," he says.

Moorhead notes that although large sign-on bonuses are being paid due to the nursing shortage, benefit packages have stayed about the same once employees are hired. Employees also are being asked to pick up more of their health care cost, so in actual dollars, the amount of benefits is less, he says.

Benefits such as tuition reimbursement are increasingly important, says **Marty Karpiel,** MPA, ambulatory care consultant for the Karpiel Consulting Group in Long Beach, CA.

"Even more so than salary, the way you are treated and the workload [are] what's important," he explains. "If we can redistribute workload so it's not as much of a burden on staff, that is important for recruiting and retention."

Based on the results of the *ED Management* 2000 Salary Survey, here are several career and salary trends for ED managers:

1. Workload has increased.

Because physicians and nurses are overworked and less able to work at nonclinical activities, the average manager's workload also has increased, Moorhead reports. According to the survey, 51% of ED managers work more than 50 hours a week.

"There is not as much support from the clinical side as we've seen in the past, so the management side is needing to pick up most of this on their own," he says. "Everyone's working harder than in the past, with not much more compensation."

The trend of working more hours likely will continue, predicts Moorhead. "An increase in acuity, a trend toward more outpatient care, and an aging population are causing a tremendous increase for unscheduled medical care, and EDs are a natural site for that," he says.

2. Salary increases are disappointing.

The highest percentage of EDM readers (39.8%) report a salary increase of 1% to 3%. **(See chart, p. 1.)** "It shows that medical managers are pretty typical of the American public, in that they are not receiving much increases in salary," says Moorhead.

The most important figure for an ED manager is the starting salary, because after that salary is set, it is difficult to negotiate upward, says Suter. He notes that due to a shortage of qualified candidates, experienced managers can demand much higher wages than their predecessors could. "But once they've started, it is difficult to get big raises without threatening to leave — and the old adage on that is that 'you can only do it once.'"

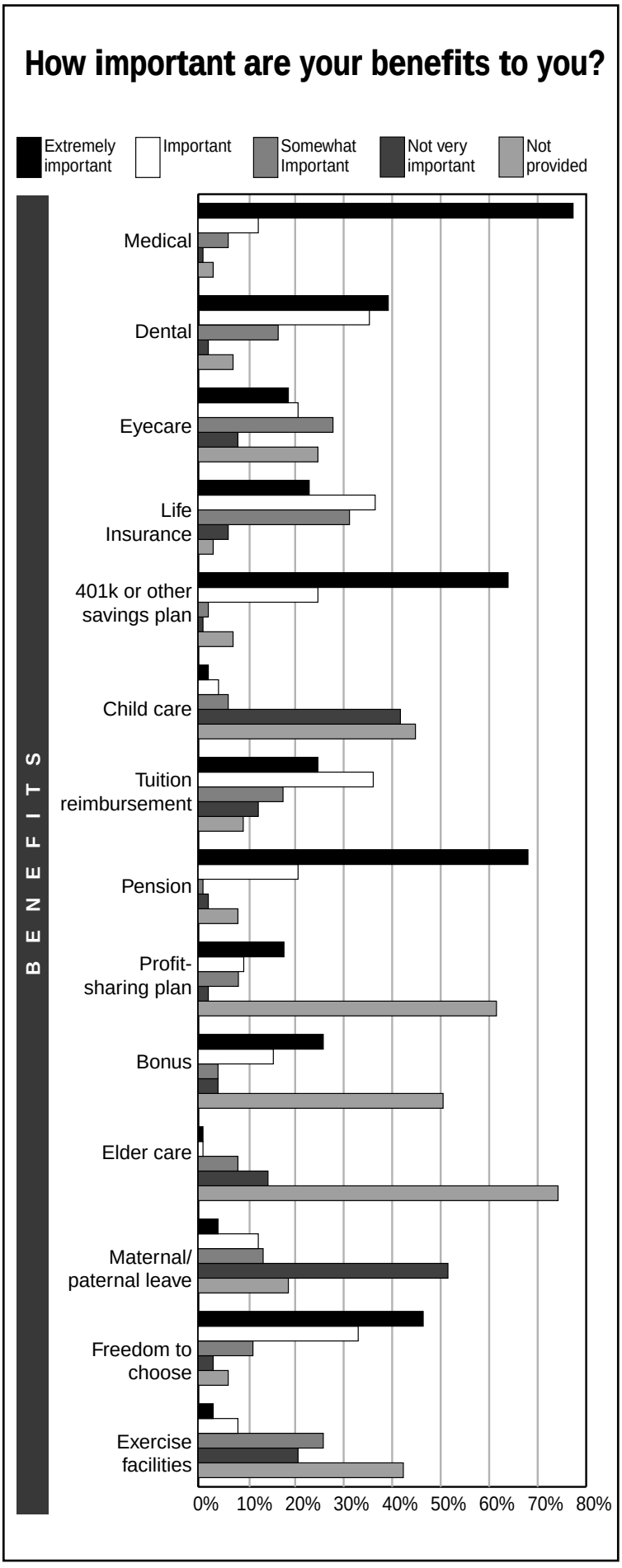
3. Most EDs have added employees in the past year.

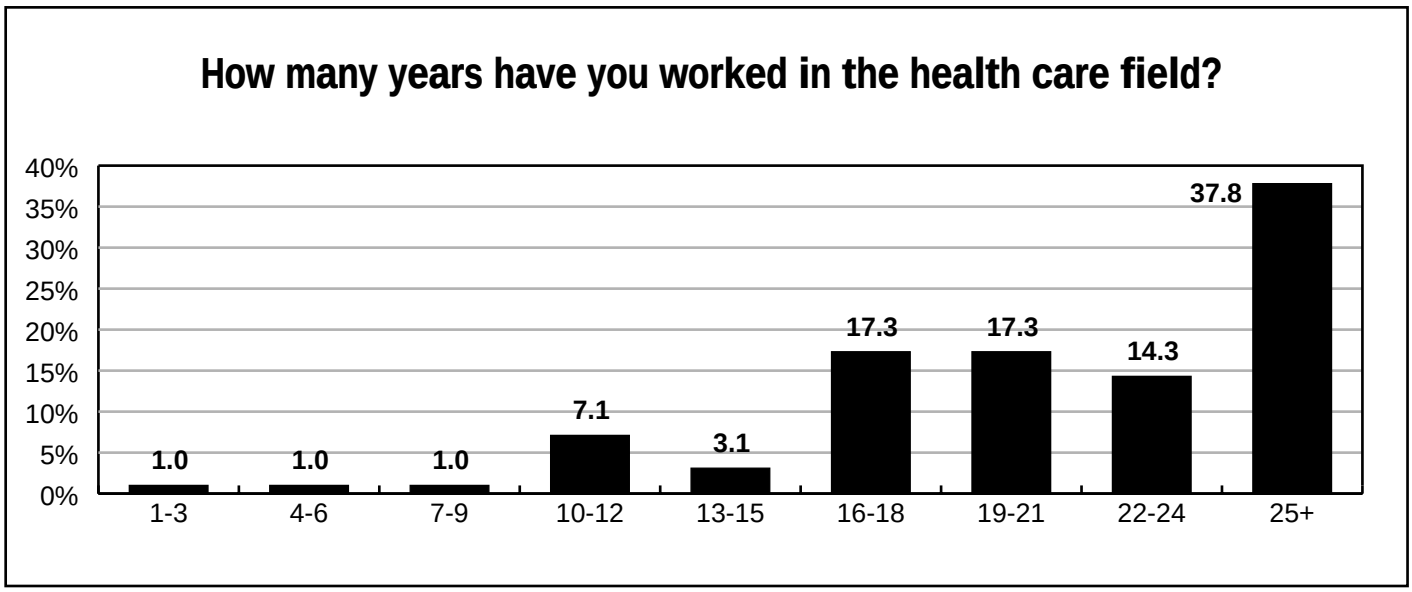
According to the survey, 56.1% of ED managers have seen the number of employees in their department increase in the past 12 months. **(See chart, p. 2.)** "This is due to increasing ED volumes across the country," says Moorhead. "We are seeing more patients, and we need more nurses and physicians to take care of them."

4. More management positions are available.

Overall, there are fewer candidates for management positions, notes Suter. "People are realizing that it is increasingly difficult work compared to what it was 20 years ago."

There is a slightly higher turnover in ED management positions and more difficulty in recruiting people into those positions, Moorhead notes. "There are still a number of young physicians who find ED





experience extremely valuable. On the academic side, it's somewhat harder to recruit managers into chair positions."

There is relatively minimal or no income benefit to a being a chair vs. working the same hours as a clinician, Suter adds. "Older physicians and nurses are stepping down or not accepting 'promotions,' and most younger folks aren't interested," he says.

This makes room for young, ambitious potential managers who are looking for opportunity, says Suter. In contrast to other fields, medical people seem to be more reluctant to relocate than in previous years, he adds.

For those who have experience and a willingness to relocate, it is a seller's market, Suter reports. "In some situations, experienced medical directors can name their own salary and benefits if willing to take difficult jobs where the contract is on the line or at risk," he says. "Proven nurse managers can be in an analogous situation." ■