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IN THIS ISSUE

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Overcrowded Emergency Department Leads to Lawsuit Over EMTALA

By Robert A. Bitterman, MD, JD, FACEP, *Contributing Editor*

A patient, Scruggs, presented to Danville (VA) Regional Medical Center (DRMC) ED about 2 a.m. complaining of two days of prolonged dry heaves. He was triaged in the usual manner, prioritized as "non-urgent," and instructed to wait in the waiting area until his name was called. The court pointedly noted that the triage nurse failed to document the patient's "diabetic ketoacidosis condition or his history of diabetes."[1]

Almost 12 hours later, Scruggs was finally examined by the emergency physician on duty, who learned of the history of diabetes, conducted a full examination, and noted the patient to be tachycardic. The physician ordered intravenous fluids, oxygen, a cardiac monitor, and laboratory tests, which included a blood glucose. An hour later, an ED nurse found Scruggs unresponsive and in cardiopulmonary arrest. He was successfully resuscitated, admitted to the hospital, and recovered to be eventually discharged home.

Plaintiff Scruggs sued and alleged that the hospital violated EMTALA for "failing to provide an appropriate *and prompt* medical screening examination," claiming that the hospital staff ignored his repeated pleas for help.[1] *(Emphasis added.)* Furthermore, he asserted that triage alone is not a medical screening exam (MSE) and the nurse's triage of him was insufficient to meet the hospital's screening duty under the law.

The defendant hospital moved to dismiss the lawsuit and argued that the complaint failed to set forth facts sufficient to establish that it failed to provide an "appropriate" medical screening examination, as that term is defined under EMTALA by the federal courts. The hospital asserted that Scruggs' claim was simply one for negligent triage and that EMTALA is not a substitute for state law medical negligence claims.[1]

The court's opinion

The court agreed with the hospital that an "appropriate" medical screening exam (MSE) refers to the hospital's process of screening patients and whether it was applied uniformly to all patients presenting with similar complaints. The court also acknowledged that "triage is a necessary part of emergency care utilized to determine the priority by which patients are examined," but then emphasized that

"triage is not the equivalent to a MSE and merely determines the order by which patients are seen in the ED."[1]

Furthermore, the court accepted established precedent of the Fourth Circuit, affirming that "EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence."[2]

However, the court cited the same case law that makes it clear that EMTALA requires hospitals to provide ***some*** medical screening, which is reasonably calculated to determine "whether a patient with acute or severe symptoms has a life threatening or serious medical condition."[1,2] Thus, the court determined that it is possible that the hospital's screening procedures could be so substandard as to amount to no screening at all.[1]

In essence, the court was stating that Scruggs might be able to prove that the extensive delay in screening him essentially amounted to denial of an adequate or appropriate MSE in violation of EMTALA, i.e., the prolonged delay constituted "constructive denial" of his federal right to an "appropriate" medical screening exam.

The district court also focused on language in the seminal case of *Baber v. Hospital Corp. of Am*. and stated "whether the hospital's screening is 'appropriate' is inherently a factual determination and is not a candidate for determination on a motion to dismiss."[3] Because the hospital moved to dismiss the case pursuant to federal rule 12(b)(6), the court was required to take the facts as alleged in the complaint to be true.[4] Thus, the court assumed, as the plaintiff asserted, that the hospital ignored his pleas for help and provided absolutely no medical treatment for 11½ hours subsequent to the time he presented to Danville's emergency department. The court held that Scruggs could possibly make out a claim under EMTALA for failure to provide an "appropriate" MSE. Therefore it denied the hospital's motion to dismiss and allowed plaintiff Scruggs to proceed with his litigation against the hospital.

Procedural legal analysis

Before physicians at all overcrowded backed-up EDs in the country start hyperventilating, it must be pointed out that this was a federal "12(b)(6) motion" to dismiss for failure to state a claim and not a motion for summary judgment.[4] A motion to dismiss under Rule 12(b)(6) is disfavored in law and rarely granted.[5] The court must accept all the pleaded facts as true and view them in the light most favorable to the plaintiff; then it will dismiss the claim only if it appears beyond doubt that the plaintiff can prove no set of facts that would entitle him to relief.

Thus, the hospital's contention that the allegations were unsubstantiated and therefore warrant dismissal was not relevant, since a Rule 12(b)(6) motion merely tests the adequacy of the pleadings and not plaintiffs' ultimate evidentiary burden. If the plaintiff fails to substantiate the allegations with admissible evidence though the discovery process, then the hospital would be entitled to summary judgment.[6]

Substantive legal analysis

The real issue of this case is whether an "appropriate" MSE should be construed to mean a reasonably prompt MSE.[7] Said another way, does the EMTALA statute or regulations require the MSE to be performed within a certain period of time after the patient's arrival to the ED?

The Centers for Medicare & Medicaid Services (CMS) specifically instructs its state survey investigators to examine "emergency department visits where the patient is logged in for an unreasonable amount of

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time before the time indicated for commencement of the medical screening examination."[8] CMS has cited hospitals for unreasonably delaying the provision of MSEs to indigents when no other emergencies were being treated, based on the premise that delay of access is equivalent to denial of access. But in each case there was obvious discrimination or disparate treatment; it was not a situation in which someone, as did all others in the same triage category, had to wait an inordinate amount of time simply because the ED was overwhelmed.[9]

The Office of the Inspector General (OIG), which enforces EMTALA along with CMS, is on record stating it believes the immediacy of the MSE is part of what is "appropriate" under EMTALA's screening duty. Therefore, under the OIG's reading of the statute, the amount of waiting time from presentation to actual screening in the ED could conceivably be a factor in judging whether a hospital provided an appropriate MSE.[10]

In a November 1999 *Special Advisory Bulletin*, CMS and the OIG warned hospitals as follows: "It is our view that hospitals should be very concerned about patients leaving without being screened. Since every patient who presents seeking emergency services is entitled to a screening examination, a hospital could violate the patient antidumping statute if it routinely keeps patients waiting so long that they leave without being seen ..."[11]

Scruggs didn't leave the ED, fortunately, but he was kept waiting a very long time. CMS and the OIG could construe an "appropriate" MSE to mean one that is reasonably prompt.

The appellate courts, to my knowledge, have not yet opined on the exact scenario of the *Scruggs v. DRMC* case. One appellate court, in the case of *Correa v. Hospital San Francisco*, held that a hospital's delay in screening constituted a constructive refusal to screen a patient, in violation of EMTALA[12] The patient presented with chest pain but still was not triaged after waiting more than two hours. The court interpreted the word "appropriate" to mean that patients should be examined within a reasonable period of time depending on the nature and circumstances of the complaints for which they presented. The court held that the excessive delay constituted a constructive denial of the MSE on behalf of the hospital, stating that: "EMTALA should be read to proscribe both actual and constructive dumping of patients."[12]

However, in the *Correa* case, the court's decision stemmed from the hospital's failure to follow its own policies, not that the patient was constructively denied screening due to non-discriminatory delay. The hospital's written policies required the emergency department to "promptly take the vital signs of every patient who visited the facility, make records of all such visits, triage patients complaining of chest pains as critical cases, and to refer all critical cases to an in-house physician immediately."[12]

Policy and procedure considerations

Hospitals must be careful how they define their own reasonable time frames in policies and procedures. If a hospital commits to performing an MSE or triage examination within a certain period of time, it will be held to that standard, as in the Correa case. Failure to complete those procedures within the stated time frame will be a violation of federal law. For example, a Florida hospital's EMTALA policy stated that all patients would be triaged within three minutes of their arrival to the emergency department. One patient was not triaged until well over 45 minutes after arrival and died of a ruptured abdominal aneurysm that was not diagnosed in a timely fashion. The hospital was held to have violated EMTALA because it failed to triage the individual within the 3 minutes specified in its own policies.[13]

Hospital policies should state that triage or the MSE will be done "as soon as reasonably possible" or "within a reasonable time frame depending upon the circumstances," but never guarantee performance within a set period of time. The practice of emergency medicine is simply too unpredictable.

A semi-analogous situation arises when a hospital is asked to accept a patient in transfer under EMTALA's non-discrimination clause.[14] It is not uncommon for the requested hospital to take an inordinate amount of time to respond to the request, typically because of difficulty locating the hospital's on-call physician who must accept the patient in transfer. Such delays are really a "no" answer; a *constructive denial* of the request to accept the patient in transfer. A potential accepting hospital should respond within a reasonable time frame so that the transferring hospital can arrange proper care for the emergency patient in a timely fashion. The expected "standard of care" should be that an accepting hospital has addressed the issue in its policies and procedures and is able to asses its capacity and capabilities, including its on-call physician expertise and availability, in a reasonably prompt time frame.

What is a reasonable amount of time for a patient to wait before the hospital conducts the MSE? Obviously, wait times in emergency departments vary from day to day. Longstanding Medicare Conditions of Participation require hospitals to be adequately staffed to meet the reasonably anticipated ED volume.[15] If the hospital commits resources and staffing personnel to

the ED judged reasonable for the expected volume and acuity under ordinary circumstances, it should be adequate under EMTALA. Only if patients *routinely* wait egregiously long times should the government or the courts be allowed to claim that the hospital constructively denied patients appropriate MSEs.[16] Occasional long waits, such as those that occur in flu season or during a night of multiple auto crashes after an ice storm, shouldn't be an issue under the law.

Waiting times have increased all across the country. Hospitals have no control over the volume entering their doors due to the EMTALA mandate and, in some states such as Massachusetts, the decision by state or local authorities to prohibit ambulance diversion. Public "safety-net" hospitals are known to have prolonged waiting times, particularly for patients triaged as non-urgent. How many minutes or hours are too long before a MSE is not "reasonably prompt"? Will every mistaken categorization of a patient's acuity status by the triage nurse that delays necessary emergency care, whether negligent or not, become an EMTALA violation? If such cases are allowed to routinely go to a jury, the plaintiff's bar will have a field day claiming "egregiousness" of ED wait times and engendering outrage to inflame the jury.

The ultimate outcome of the *Scruggs v. Danville Regional Medical Center* case could send some serious reverberations through our nation's emergency departments.

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Lawsuits may arise from ED 'boarding' practice

There's proof it harms patients

(This story is Part 1 of a two-part series on liability risks of boarding admitted patients in the ED. This month, we'll report on liability risks of holding admitted patients in ED hallways. Next month, we'll examine the legal risks if patients get unequal or inadequate care in the ED, as opposed to what they would have gotten on the inpatient floor).

An emergency physician is managing an acute myocardial infarction, arranging for a patient transfer, sewing up a laceration, and putting in a chest tube, with 20 people still waiting to be seen in the waiting room. This is probably not the best person to provide routine inpatient care for multiple patients being held in the ED, says **William Sullivan**, **DO**, director of emergency services at St. Mary's Hospital in Streator, IL.

"Chances are that it's been a while since an emergency physician has ordered a colon preparation prior to a patient's colonoscopy, or done an in-depth work up to determine the cause of a patient's anemia," Sullivan says. "Those just aren't things we routinely do. Having admitting physicians handle admitted patients is better for patient care."

Holding admitted patients in EDs was always known to be bad for patient flow, but there is a growing body of research showing that it also harms patients.[1-4] There's no question that the risk of a poor outcome increases when patients board for long periods, particularly when those patients are critically ill,

according to **Jesse M. Pines**, **MD, MBA**, assistant professor of emergency medicine and epidemiology at the Hospital of the University of Pennsylvania in Philadelphia.

"This certainly increases the legal risk to the physicians caring for these patients," says Pines. "In many hospitals, it is the ED physicians and nurses caring for these boarders, so the risk falls squarely with them. It may be impossible to avoid getting roped into lawsuits if there is an error attributed to boarding."

Pines says that he doesn't know of any lawsuits that have involved ED boarding specifically. "But when a bad outcome does occur, I'm sure that attorneys will scour the chart to see what happened while the patient was boarding, if there is any link," says Pines. "This is especially true now that there is clear evidence that boarding is hurting people."

ED leadership must be patient advocates, says **Robert Broida**, **MD, FACEP**, chief operating officer of Physicians Specialty Limited Risk Retention Group, the professional liability insurer for Canton, OH-based Emergency Medicine Physicians. His recommendations:

• Consistently and respectfully remind administration and medical staff leadership of the responsibility of the hospital, and ultimately, the hospital board, to ensure reliable, quality care under its roof.

• Provide hospital leadership with the report on boarding from the American College of Emergency Physicians' (ACEP) Task Force, titled Emergency Department Crowding: High-Impact Solutions. **(To access the report, go to www.acep.org. Under "Practice Resources," click on "Practice Resources," and under "Issues by Category," click on "Boarding and Crowding." Scroll down to "2008 Boarding Task Force Report.")**

• Use examples, especially near-misses, from your own hospital to emphasize the risks involved.

Crowding caused by boarding harms patients

"There is plenty of research that demonstrates emergency department crowding due to boarding is responsible for poor outcomes," says **Tom Scaletta**, **MD**, president of Emergency Excellence, a Chicago-based organization that improves patient care and efficiency in the ED while controlling costs. Scaletta is also medical director of a high-volume community hospital in a Chicago suburb.

Scaletta says that most lawsuits will involve delayed diagnoses in time-sensitive problems such as myocardial infarction, ischemic stroke, peripheral vascular disease/ischemia, intracranial bleeding, and hemorrhagic shock. It's likely that attorneys will target ED physicians if an adverse outcome occurs and a patient was boarded, says Scaletta. "In the Chicago area, we are still reeling from a highly unusual move by a local coroner who declared a patient's death in an ED waiting room was a homicide," he says. "She presented with chest pain and was not brought into the ED immediately because of crowding." **(See "Chest pain patient waits two hours in ED, ruled 'homicide,' *ED Legal Letter*, December 2006, p. 136.)**

In the event of a lawsuit, Scaletta recommends showing the jury a log of patients seen that day, with names redacted, and the number of ED physicians and midlevel providers that were working. "There are published statements published by professional societies that dictate reasonable staffing levels," he says. For instance, of the American Academy of Emergency Medicine says that the rate of patient influx should not exceed 2.5 patients per physician per hour on average. **(To access this position statement, go to www.aaem.org. Click on "AAEM Position Statements," and scroll down to "Position Statement on Physician-to-Patient ED Staffing Ratios.")**

Scaletta believes this is safely increased by 50% (to 3.75) when a physician works as a team with a midlevel provider. "Emergency physicians need to have due process so that they can speak up about problems like under-staffing and not get fired, which has happened," adds Scaletta. Your documentation needs to be "factual and not accusatory," says Scaletta. "I also think emergency physicians need to be aware of the waiting room load and call in reinforcements when the number/acuity is high," he says. "Hospitals need to have a crowding action plan, akin to internal disaster activation."

In Scaletta's view, the chief cause of ED crowding is the failure of inpatient hospital services to take responsibility for admitted patients. This problem could be resolved, he says, by hospital leaders facilitating the success of inpatient hospital services with flexible and ample staffing, and regulatory agencies mandating the timely movement of admitted patients to inpatient areas. **(See related story, p. 141, on who is legally responsible for admitted patients in the ED.)** "Unfortunately, hospitals are being severely stripped financially, and the business of inpatient medicine is not profitable. From a fiscal perspective, hospitals stay afloat from their outpatient services," says Scaletta. "The ED is a hospital's largest bridge between inpatient and outpatient medicine."

The ED is accustomed to handling volume fluxes, but when the inpatient areas cannot reciprocate, crowding occurs. "Even though only 20% of ED cases

(Continued on page 140)

SPECIAL REPORT

The Difficult Airway: Part 2. *Preparing for Failure*

By Mark J. Greenwood, DO, JD, FAAEM, FCLM, *Flight Physician, Aero Med Spectrum Health, Grand Rapids, MI*

Managing a patient's compromised airway involves preparing for the possibility of not being able to complete the intubation procedure in a timely manner. To avoid ongoing hypoxia and hypercapnea, management should include being ready to use alternative or "rescue" methods, including a surgical airway.

In this article, part two of a two-part series on airway management, alternative airway measures are discussed, as well as the liability involved when they are not used expediently and efficaciously. Several case examples are presented below that illustrate the importance of timely decision making, equipment familiarity, technical proficiency, and creating optimal conditions for success in the use of alternative airways.

Case Example: Timely Alternative Airway. Following an otherwise uncomplicated tonsillectomy, a 3-year-old male experienced recurrent episodes of bleeding from the pharynx over a period of days.[1] On his third visit to the ED for bleeding, he was taken to the operating room (OR) in an attempt to locate and stop the bleeding. He was first examined in the OR by the anesthesiologist, who observed no active bleeding. About the time that rapid sequence intubation (RSI) was performed, the patient experienced rebleeding. At that time, the patient's airway was being managed by both a CRNA as well as the anesthesiologist. At least two attempts at oral intubation were unsuccessful. After some delay, which included a failed attempt at cricothyrotomy and after the patient arrested, a tracheostomy was begun. At the moment the scalpel entered the trachea, the anesthesiologist was able to orally intubate the patient. The patient later had a return of spontaneous circulation and survived, but with hypoxic brain injury. He is enrolled in a special needs program and requires physical, occupational, and speech therapies. According to the plaintiff's attorney, "The defense attorneys and claims representatives ... appreciated that this child's injuries were due to negligence, and it was their obligation to provide for his future."[2] The case was settled for $5.335 million.

The value and critical importance of alternative techniques and devices for "rescue" of an otherwise uncontrolled airway and their timely application have been well established over the last decade and has become the expected standard of care. Consequently, practice guidelines for healthcare providers in the ED, OR, and out-of-hospital setting have been established and reflect these expectations.

Case Example: Familiarity with Alternative Airway Equipment.[3] In this case, an anesthesiologist was required to spend a specified amount of time "on call" to the hospital's ED to maintain hospital privileges. He was contacted by an ED physician for help treating a patient who had suffered a head-injury and was comatose, but who was still breathing on her own. The ED physician had been unsuccessful securing the airway after several attempts, both using laryngoscopy and fiberoptic nasal intubation. The ED physician, and later a respiratory therapist, called the anesthesiologist and requested his assistance in managing the airway. The anesthesiologist never responded to the ED. In anticipation of the patient's need of a surgical airway, the ED physician also contacted an on-call surgeon, who came to the ED and secured the patient's airway by performing a tracheostomy.

The next day, the ED physician filed a complaint regarding the anesthesiologist's failure to respond. After a hospital investigation, his hospital privileges were revoked. He filed charges with the Illinois Department of Human Rights and with the Equal Opportunity Commission, alleging that his privileges were revoked because of his religion and national origin. Both entities found no evidence of discrimination. He then filed suit in federal court, claiming that revocation of his privileges was in violation of the Civil Rights Act.[4] He was unsuccessful in his claim.

The litigation resulting from these events uncovered a factual dispute: whether the ED physician (and by proxy, the respiratory therapist as well) actually requested that the anesthesiologist come to the ED. The anesthesiologist contended that he informed the ED physician that "in light of the bleeding and swelling in the patient's throat caused by her failed intubation attempts, any further efforts to intubate could prove fatal." He also claimed that he told the ED physician that "the patient was in need of a tracheostomy, a procedure that, as an anesthesiologist, he was not qualified to perform."[3]

Also, the record is not clear as to whether the anesthesiologist was unfamiliar with the fiberoptic method in general, or more particularly, with the fiberoptic equipment available at the ED. The ED physician claimed that he "refused to assist her after apprising her that the hospital did not possess a suitable fiberoptic laryngoscope [sic] for nasal intubation. The respiratory therapist claimed that he told the anesthesiologist that "the patient was becoming increasingly unresponsive and that they had contacted [him] because of their inability to intubate, but that [he] claimed that he did not have experience with [the hospital's] flexible fiberoptic equipment."[3]

Had the litigation that resulted from this incident involved a claim of negligence, at issue would likely be the standard of care for anesthesiologists: 1) in attempting laryngoscopy despite another healthcare provider's failure with that method; 2) in being familiar with the equipment available in the hospital, more specifically with the fiberoptic equipment as that used by the ED physician; and 3) in being able to perform methods and use devices relating to the "rescue" of the failed airway, including performing a surgical airway (despite the anesthesiologist's claim that this procedure is not within his domain of practice).

Case Example: Optimal Conditions for Success. This case notes a plaintiff who was injured in a motor vehicle collision and suffered multiple traumatic injuries, including a closed head injury.[5] The plaintiff was immobilized by EMS personnel, who used a cervical collar, and was transported to the ED. Given the severity of his closed head injury, an anesthesiologist was called to perform intubation. Five attempts at intubation using the blind nasotracheal intubation (BNTI) method were unsuccessful. Standard oral intubation was then attempted. The first attempt was made with the cervical collar in place; the second attempt was made after the front portion of the collar was removed to improve visualization. Both attempts failed. The plaintiff was then given a neuromuscular blocking (NMB) agent and underwent three more intubations attempts. During each attempt, a different size of laryngoscope blade was used. As these attempts also were unsuccessful, a surgical method was then used for intubation. The plaintiff subsequently was found to have a spinal cord injury that resulted in quadriplegia. He later died from complications of the spinal cord injury.

The issue in the legal case that resulted was whether the standard of care was violated by the physicians' making multiple attempts at oral intubation, and whether these attempts — given that the plaintiff had limited movement of his upper extremities and movement of his lower extremities when he arrived to the ED — were the proximate cause of his quadriplegia and death. There was evidence that he developed neurogenic shock during the intubation attempts. Radiographs obtained after the intubation attempts, when compared with films taken when he first arrived to the ED, also showed a greater displacement between the second and third cervical vertebrae.

Intubation procedures are associated with a number of complications and adverse events. Although the risk of hypoxia is ever- present, and may result from prolonged or repeated unsuccessful attempts or from unrecognized esophageal intubation, this case demonstrates that other serious injury can occur. It also demonstrates the value of "a best attempt" at intubation.[6] This term describes creating optimal conditions for intubation so that on the first attempt there is a maximum chance of success. This is in contrast to what occurred in this case: The patient was harmed because efforts to optimize conditions were taken in stepwise fashion and resulted in several unsuccessful attempts at intubation that ultimately caused injury.

Preparing for the Failed Intubation. Managing a patient's compromised involves preparing for the possibility of not being able to complete the intubation procedure in a timely manner. This is especially critical when rapid sequence intubation is used and the patient is rendered apneic by NMB agents. The emergency healthcare provider must be prepared to use alternative or "rescue" measures to provide timely and adequate oxygenation and ventilatory support. Some measures may be temporizing or used as a "bridge" to intubation itself and include simply using bag-valve-mask (BVM) ventilations. They also may include using blindly inserted nonsurgical, supraglottic airway devices such as a laryngeal mask airway (LMA) or the Combitube (esophageal-tracheal double-lumen airway). Supraglottic devices can be rapidly and appropriately placed by airway practitioners with limited advanced skills. However, compared to standard endotracheal intubation, they provide less protection against aspiration of stomach contents or other fluids such as blood into the lungs (the LMA); and may be associated with a higher incidence of trauma to airway and esophageal structures (the Combitube). Because the extent of damage to the brain from hypoxia is measured in intervals of minutes or less, preparation for use of rescue airway materials must be made before beginning the intubation procedure.

Among alternative airways, the surgical route both is used only infrequently and carries significant risk.

Nevertheless, there are times when the surgical airway is the best or only alternative airway option. The cricothyroid membrane, because it is closer to the surface of the skin than are the tracheal rings, allows easier and quicker access to the trachea through cricothyrotomy than through tracheostomy. There are two techniques used to perform cricothyrotomy (open and percutaneous). Familiarity with both techniques is valuable.

Factors that drive the decision to choose one technique for cricothyrotomy over the other are prior experience and equipment availability. However, the open technique may be preferred for a number of reasons. First, the equipment required for this technique (primarily a scalpel) is widely available and its use is more familiar. Second, the open technique better exposes the structures overlying the airway to visual or palpatory inspection; in patient's whose neck anatomy has been compromised, it may both allow for fewer complications and provide greater chances for immediate success. Third, unlike the percutaneous technique, the open technique may not require extending the patient's neck; therefore, it is safer in trauma patients who may have an injury to the cervical spine.[7]

Summary. In the management of any patient's airway, preparation for failure has become a standard of care. Timely decision making, equipment familiarity, technical proficiency and creating optimal conditions for success in the use of alternative airways are critical elements in alternative airway management.

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(Continued from page 137)

are admitted, admissions that become boarders block beds for the 80% of our cases that would otherwise be seen, treated, and sent home," says Scaletta. "The potential for gridlock is great and very dangerous."

Board patients on floors instead

For damages to result, the patient's long wait in an ED hallway has to be tied to some consequence, notes **Peter Viccellio**, **MD, FACEP**, vice chairman of the Department of Emergency Medicine at State University of New York at Stony Brook.

But what about the possibility of a jury being inflamed to hear that a patient was waiting for 20 hours in the hallway of an ED? "It should anger them, but the anger is misdirected. It's not the physician taking care of the patient, it's the fault of the system," says Viccellio. "But part of the problem is throwing our hands in the air and say we can't do any better, which is not true. We really cannot accept this terrible care that is provided as part of the status quo."

"Why do the patients back up in the ED? In part, it's because hospitals fail to do what they can to fix this," says Viccellio. "The ED is overwhelmed with admissions that should not be there. And you know what? They don't need to be there," he says.

If the ED is "filled to the gills" with patients, and you now have 20 additional patients to distribute, the logical answer is to put two of those patients on each unit. "But what's the current answer in many hospitals? To put all 20 in one place," says Viccellio.

He points to his own institution's practice, which sends the admitted patients to board on floor hallways when the ED is at full capacity. "It has dramatically enhanced the care of our patients. This is far more important than the consequence of that: decreasing our liability," says Viccellio. "And in terms of putting patients on the floors, we have done an exhaustive search for patient safety issues, and we can't find any."

What most institutions are asking their EDs to do is care for all the patients that come in, and staffing for those patients, but in effect, saying, 'By the way, you may have an extra 30 admitted patients that you have to care for,' says Viccellio. "What we are asking of the inpatient units is that, during times of high capacity, a nursing unit that takes care of 30 patients will care for 31 or 32," he says. "Patients are much more comfortable upstairs than downstairs. And they don't stay in the hallway for long, because magically a bed opens up once they're up there."

Anyone on a jury has likely gone to an ED and waited for hours to be seen, notes Viccellio. "And to most of them, it's not apparent why," he says. "I think there is a very legitimate moral and legal question we need to ask: Does the fact that 'that's the way things

are,' make them OK? I don't think you can fault somebody if it costs $100 million to do something. But if you can just change the way people work, at little to no cost, and it has a profound impact on the patient, why not do it?"

Juries won't be sympathetic

Pines thinks juries will be less likely to be sympathetic to hospitals that commonly board admitted patients in the ED, given the recent literature that shows that boarding actually might be profitable to hospitals.

"Hospitals are wary of cancelling more profitable elective surgeries even when the ED is unsafe," he says. "As the public comes to realize this, juries will certainly be less understanding."

ED staff are likely to be sued for medical errors when patients are boarding, Pines says. "Because there is a higher adverse event rate, this puts ED staff at great risk from a legal perspective," he says.

But regardless of the risk of getting sued, hospitals should stop the practice of boarding because it hurts patients and is not the way anyone wants to be treated, says Pines. "Imagine lying on a foam stretcher in an ED hallway for 24 hours when you're sick. It's inhumane," he says. "If hospitals choose to continue this practice because of greater economic rewards from maximizing elective admissions, it may end up backfiring in the end, because hospitals are more likely to get hit with a huge lawsuit that results from boarding."

ED physicians should advocate on behalf of their patients and urge their hospital administrators to end boarding, says Pines. "But the problem is that there are very strong forces in hospitals that promote boarding, up to the level of the CEO," he says. Because fixing boarding is likely seen as having a negative impact on profits in the short term by CEOs, it's unlikely that the practice will change unless the government or The Joint Commission steps in and puts an end to boarding.

"The problem is that the systematic dysfunction from ED boarding is created by hospital managers, not ED physicians or nurses, says Pines. "But it may be difficult for jurors to differentiate the two."

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Who's responsible for the admitted patient in the ED?

Keep the ED physician 'out of the loop'

"Quit dreaming that your patients are being watched by physicians in the ED." That's what the vice chairman of the Department of Emergency Medicine at State University of New York at Stony Brook told physicians when he sought buy-in for a process to move patients boarded in the ED upstairs during high capacity.

"There was no way I could follow 15 or 20 admissions while I'm seeing 20 or 30 new patients," says **Peter Viccellio**, **MD, FACEP.** "That is a very dangerous game to play. Once they saw that, then they stepped up and took a much greater responsibility for them."

Legally, the question of "who is taking care of these patients while they are in the ED" has been frequently debated in cases. Viccellio says that hospitals need to have "crystal clear policies" on this.

"We have a very clear policy that once the patient is admitted, they are the clear responsibility of the inpatient service," he says. "If they are boarded in the ED, we will continue to provide nursing care and do minor things like blood draws. But otherwise, our physician staff have nothing to do with the inpatients, unless there is an emergency while waiting for the inpatient staff to arrive."

But even if you do have a policy stating that admitted patients being held in the ED are the responsibility of the inpatient service, this doesn't mean the issue won't come up in the event of a lawsuit. "There will still be a debate in the courtroom. The inpatient service will testify, 'Well, obviously we would have been there if they had portrayed the case differently,'" says Viccellio. "They will say, 'We weren't informed, and therefore it's their fault.'"

Every ED should have a policy which clearly delineates the transfer of patient responsibility upon admission, agrees **Robert Broida**, **MD, FACEP,** chief operating office of Physicians Specialty Limited Risk Retention Group, the Charleston, SC-based professional liability insurer for Canton, OH-based Emergency Medicine Physicians. "When the patient becomes an

inpatient, they are no longer the emergency physician's responsibility. They are the responsibility of the admitting physician, who is billing for that day of hospital care," Broida says.

Obviously, there should be a provision stating that if the patient experiences a sudden decrease in clinical status, the hospital staff caring for the patient should notify the emergency physician to provide emergency or resuscitative care, says Broida. "But the bottom line is, the boarded patient is an inpatient, not an ED patient."

William Sullivan, **DO**, director of emergency services at St. Mary's Hospital in Streator, IL, says that generally, the hospitals where he works have a policy that once a patient is admitted, even if the patient is held in the ED, the ED nurses contact the admitting physician and consultant for orders. Sullivan is also clinical assistant professor in the Department of Emergency Medicine at the University of Illinois.

"The ED physician is out of the loop," he says. "The argument that I used was that radiologists aren't responsible for patients when they are in radiology, cardiologists aren't responsible when patients are in rehab, and the Otis elevator company isn't responsible when the patient is being transported in an elevator." .

Sullivan believes that the number of EDs with this type of policy are "small but rising." "The University of Illinois in Chicago adopted this policy within the past year, and it is working very well," he says.

Sullivan notes that very few hospitals credential ED physicians to provide inpatient care. "Excepting emergency situations, a hospital that routinely allows a physician to provide care outside of what their hospital credentials allow could be subject to liability for doing so," he says. In addition, Sullivan says he is not aware of any emergency physician malpractice insurance policies that provide malpractice coverage for inpatient medicine. "A lack of malpractice coverage could be a liability for the physician, for the ED group, and for the hospital," says Sullivan.

The concerning cases are those with a change in condition that requires emergent intervention, says **Tom Scaletta, MD,** president of Emergency Excellence, a Chicago-based organization that improves patient care and efficiency in the ED while controlling costs. "Since the emergency physician is in the department, he or she will remain responsible if emergent problems are brought to their attention," he says. "If the issue is non-urgent, then it should be relayed to the admitting attending."

However, if a lawsuit occurs, Scaletta says there is nothing an emergency physician can do to prevent being named. "The responsibility issue is widely subject to interpretation and will certainly be argued bilaterally," he says. ■

Another waiting room death to bring lawsuits?

One after the other, videotapes on primetime news showed a patient, **Esmin Green**, being ignored by ED staff as she lay dying on a waiting room floor in a Brooklyn psychiatric hospital after waiting almost 24 hours for a bed. What impact will this "horror story" case, and others like it, have on ED litigation?

This incident brings into sharp focus the tragic consequences that can occur when a patient, waiting for a bed to become available, is overlooked or, in this case, ignored, in a public psychiatric ED, says **Joseph J. Feltes**, JD, a shareholder at Buckingham, Doolittle & Burroughs in Canton, OH. However, Feltes doesn't think the case will "change the landscape of ED liability in terms of theories of recovery."

Patients who are "overlooked" in the ED have long been able to bring negligence claims, when delay beyond the standard of care proximately causes injury or death, Feltes explains. "Acute care hospitals and psychiatric hospitals, as a matter of quality care and risk management, must implement effective protocols to ensure that patients are timely screened and treated," says Feltes.

Suits likely if patients overlooked

Highly publicized incidents, including another recent one in which a North Carolina patient died after having been left unattended in a waiting room chair for 22 hours, increase the probability that patients and their families will file suit if they are overlooked or ignored in the ED, says Feltes.

"The lawsuit filed by Kirkland and Ellis and the American Civil Liberties Union in New York, arising out of the Esmin Green incident, doubtless will be a case plaintiff attorneys nationwide will follow closely," says Feltes.

Anyone who is familiar with the severe shortage of psychiatric beds in the United States will not be surprised by the Green case, according to **Barbara E. Person**, JD, an attorney at the Omaha, NE-based law firm Baird Holm. "Indeed, it would be nice if this case were to serve as a clarion call for all payer systems to improve the currently disfavorable reimbursement of mental health treatment," says Person. "The shortage of dedicated psychiatric facilities diverts acutely ill mental health patients to the emergency departments of general and academic hospitals."

Even hospitals with psychiatric units rely principally upon their ED physicians for assessment of mental health patients presenting to the ED, notes Person.

"Standard of care is for the ED physician to call an on-call psychiatrist to consult on the plan of care and to provide admitting orders," she says "But it is rare for the ED physician to ask the psychiatrist to come to the ED to participate in the medical screening examination [MSE]."

Increased waiting times are bad for sick patients and can lead to serious, even lethal, delays, says **Matthew J. Walsh**, MD, associate professor in the Department of Emergency Medicine at the University of New Mexico School of Medicine in Albuquerque. "That being said, each ED is responsible to develop protocols for triage and re-triage of patients in the waiting area which address local needs," Walsh says.

Psychiatric patients may pose special risks due to the inability to provide detailed, valid information about their physical complaints and history, notes Walsh. "Best practices are always to have sufficient resources to appropriately evaluate every patient as they present, to establish their relative acuity, and to provide needed care in proper time frames," says Walsh. "This is difficult, and at times, close to impossible in many public facilities." But it should always be the goal for all general EDs, he says.

Does documentation show patient was stabilized?

Many hospitals have been cited by the Centers for Medicare & Medicaid (CMS) for failure to provide an appropriate medical screening examination for mental health patients, or for discharging these patients in an unstabilized emergency medical condition, notes **Barbara E. Person**, JD, an attorney at the Omaha, NE-based law firm Baird Holm.

The CMS Interpretive Guidelines make it clear that a patient with suicidal ideation or threats is considered to be having an emergency medical condition. "That means that the patient must be stabilized or admitted. There will be a heavy burden upon the ED to demonstrate stabilization of such a patient," says Person.

Documentation of the patient's positive response to talk therapy, medication, or de-escalation might show stabilization. "However, peer reviewers will presume that an inpatient admission was necessary unless the documentation substantiates a clinical finding of stabilization," says Person.

Historically, with regard to mental health patients, CMS has distinguished between "stable for transfer" and "stable for discharge." "Obviously, chemical restraints would be more effective at stabilizing for transfer than for discharge," says Person. "It may be important to distinguish between those two conditions in documentation."

Here are additional tips from Person to reduce liability risks:

• Review nursing notes and ambulance reports to ensure that the ED physician has not missed a patient or family statement suggesting suicidal intent.

• If your ED has not implemented a mental health assessment protocol already, you should consider one, including prompts designed to identify or rule out a mental health emergency.

• Determine if your electronic health records systems require enhancement for mental health emergencies. "The prompts are often insufficient to prompt the ED physician to document a complete mental health assessment," says Person.

Older physicians who are not fully comfortable with electronic documentation, and typing in particular, should dictate to ensure that sufficient details are recorded to support their clinical decision-making and the ultimate plan of care. "Most EMTALA citations could be avoided by expanded medical record documentation so that the peer reviewer could better understand the attending's logic and rationale for the plan of care," says Person. ■

CNE/CME Objectives

After completing this activity, participants will be able to:

1. Identify legal issues relating to emergency medicine practice;
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■

CNE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. This semester ends with this issue. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

CNE/CME *Questions*

48. Which of the following is true? Under the Office of Inspector General's (OIG's) reading of the Emergency Medical Treatment and Labor Act (EMTALA) statute, the amount of waiting time from presentation to actual screening in the ED:
    A. could conceivably be a factor in judging whether a hospital provided an appropriate medical screening exam (MSE).
    B. could not conceivably be a factor in judging whether a hospital provided an appropriate MSE.

49. Which is accurate regarding liability risks of "boarding" admitted patients in the ED?
    A. There is no evidence that bad outcomes are more likely when patients board for long periods, even for critically ill patients.
    B. ED staff members are at increased risk because adverse events are more likely.
    C. Sending admitted patients to inpatient hallways when the ED is at full capacity has been linked to a significant increase in adverse outcomes.
    D. ED staff are no more likely to be sued for medical errors as a result of patient boarding.

50. Which is recommended regarding responsibility for admitted patients being held in the ED?
    A. Avoid specifying who is responsible in ED policies.
    B. Specify that ED physicians are responsible for these patients, even for non-urgent problems, because this situation is better for patient care.
    C. Never state in ED policies that admitted patients held in the ED are the responsibility of the inpatient service.
    D. Have a policy that clearly delineates the transfer of patient responsibility upon admission.

Answers: 48. A; 49. B; 50. D.