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CA Court Determines State's Damage Cap Does Not Apply to EMTALA Claim

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

In a series of questionable decisions, a California federal court allowed a plaintiff to bring a "failure-to-screen" claim under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) against a hospital for what was really an ordinary state malpractice claim for "failure to diagnose," and then held that California's $250,000 damages cap wouldn't apply because the EMTALA claim was not a "professional negligence" claim as contemplated by the state's tort reform law — the Medical Injury Compensation Reform Act (MICRA).[1,2,3]

Facts of the Case — Romar v. Fresno Community Hospital

Plaintiff Christina Romar, a toddler, presented to the emergency department (ED) of Fresno Community Hospital and Medical Center (FCH) with cold symptoms and a fever.

The clinicians noted the child had fever, cough/congestion, fussiness, pulling on the ears, runny nose with clear drainage, and a red, infected left ear. They diagnosed otitis media, prescribed acetaminophen and amoxicillin, and provided appropriate discharge instructions.[2,3]

Two days later, the child returned to the ED with bilateral periorbital swelling and a complaint of "mother thinks possible medication reaction." There was no fever, and examination of the ears and throat were normal (no signs of the ear infection). No diagnostic studies (such as a complete blood count [CBC], sedimentation rate, blood culture, or computed tomography [CT] scan) were obtained during this visit, which would be a major point of contention in the subsequent litigation. The child was diagnosed with an allergic reaction with acute angioedema and administered Decadron (steroid anti-inflammatory agent) and Benadryl™, (an antihistamine). The amoxicillin was discontinued, and instead she was prescribed Prelone (steroid) and the antihistamine.[2,3]

Another three days later (five days from original presentation), the child was taken to a different hospital, where she was found to have orbital cellulitis, sinuses abscesses, and sepsis. She recovered after multiple surgeries, but suffered significant, permanent, debilitating injuries.[2,3]

Allegations and Claims / Theories of Liability

The child's mother sued the treating physician for malpractice, and the hospital and the physician for violating EMTALA by failing to provide an "appropriate" medical screening exam (MSE).[1,2,3]

Plaintiff's expert, Dr. Peggy Goldman, stated that the possibility that the child was suffering from a virulent bacterial infection "should have been recognized" by competent emergency medical practitioners. She also asserted that the hospital's medical screening exam was inappropriate under EMTALA because an acceptable "appropriate" MSE had to include, at a minimum, a CBC, blood differential, blood and urine cultures, a CT scan, and a sedimentation rate — none of which were ordered as part of the patient's screening examination. She asserted that the standard of care also required the hospital to conduct all these tests and to consult with a specialist and administer IV antibiotics at the time of the second visit.[2]

(Dr. Goldman also claimed that the hospital violated EMTALA because it failed to provide stabilizing treatment to the patient's emergency condition; despite the fact that every appellate court in the country has held that the hospital must have "actual knowledge," i.e., actually diagnose the emergency medical condition (in this case orbital cellulitis and/or sepsis), before it can be held liable under EMTALA for failure to stabilize that emergency condition.)[2]

The physician's standard of care expert, Dr. George Sternbach, opined that since there was no fever at the second visit, the child's ear was all better, and the periorbital swelling was bilateral (not unilateral, which is typical of an infectious process), it was reasonable and within the standard of care to diagnose the child with an allergic reaction to the amoxicillin at the time of the second visit.[2] (Not to mention that most of our younger emergency physician colleagues have never seen orbital cellulitis due to the effective *Haemophilus influenzae* vaccine introduced in 1987.)

The hospital's EMTALA expert, Dr. Eric Weiss, stated that no diagnostic studies were necessary to screen the patient to comply with EMTALA. He stated that the child wasn't screened any differently than any other patient perceived to have the same or similar symptoms as the child. Whether the clinicians should have considered a more serious condition than an allergic reaction was a medical malpractice question under state law, not a federal question under EMTALA.[2]

The Court's Rulings

Medical Malpractice. In a legal snafu, the plaintiffs never actually had their medical expert opine at deposition that the emergency physician violated the standard of care. Therefore, since California law requires a plaintiff to produce expert medical testimony that the standard of care was breached, the involved physician was granted summary judgment and dismissed.[1] Additionally, since a plaintiff can't sue physicians under EMTALA (they can only sue hospitals), the physician was gleefully out of the case entirely.[4]

EMTALA Failure-to-Screen Claim. To succeed on a failure-to-screen claim under EMTALA, the plaintiff must prove that the hospital provided no screening, screening so cursory that it was not reasonably calculated to detect emergency medical conditions, or disparate screening — a screening process that was not comparable to that offered other patients presenting with similar symptoms.

Usually, to prove a disparate screening claim, the plaintiff tries to show that the hospital didn't follow its own policies or procedures and thereby provided "disparate" care to the plaintiff. *Romar* didn't take that route, but instead alleged that the hospital's emergency

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physicians ordered diagnostic tests on other patients with similar presenting signs and symptoms but did not order such tests on the plaintiff, and thereby provided "disparate" screening in violation of the law.[2]

During discovery, the plaintiffs requested, and the court mandated the hospital to produce, "the emergency room records of all patients treated for a fever, possible infection, or other condition you deem similar to plaintiff's" in the month in question.[2] After much bantering with the court over which medical records were deemed relevant, the hospital produced 287 ED medical records, of which the plaintiff claimed 30 presented with similar symptoms as the plaintiff but received superior screening exams.[2] Essentially, the plaintiffs claimed that those 30 patients received diagnostic studies and the plaintiff did not, and therefore the hospital violated EMTALA because it provided "disparate screening" to the plaintiff.

The hospital's emergency physician EMTALA expert examined all 287 ED records and concluded that none revealed a similarly symptomatic patient screened differently than the plaintiff.[2]

The plaintiff's expert, Dr. Goldman, reviewed the same 287 cases and determined that numerous similarly situated patients received screening examinations that were, in crucial respects, more extensive and superior to those received by the plaintiff. She therefore opined that the MSE provide to the plaintiff was inappropriate and not in compliance with EMTALA. She noted that other cases received one or more of the studies she recommended and therefore the plaintiff did not receive the MSE she was entitled under EMTALA. (Interestingly, it appeared that none received all the tests she claimed were required by the standard of care.) Yet, Dr. Goldman readily admitted to the court that none of the cases reviewed presented the same as the plaintiff; i.e., none had bilateral periorbital edema without fever two days after initiation of antibiotics for a probable ear infection that was deemed to be allergic, not infectious, in origin.[2]

The court chose to let the decide jury the credibility of the experts and what weight to give their opinions on whether the records reviewed were sufficiently similar to determine the hospital provided the plaintiff with a disparate screening exam.[2]

The court failed to recognize that it is the process of the screening that needs to be disparate to violate EMTALA, not whether the physician's medical decision-making was different in patients with apparently similar symptoms or conditions. EMTALA requires the medical screening process to be uniform for all patients, not that the physician's judgment will be the same or correct in each case. The process refers to how the hospital goes about taking care of the patient: triage, vital signs, placement in a room, interaction with the emergency physician or mid-level provider sanctioned to provide the MSE on behalf of the hospital, material compliance with hospital policies and procedures, and that the physician undertakes medical decision-making based on medical indications (including testing, consulting, and disposition decisions), not based on any discriminatory reasons. EMTALA doesn't govern the accuracy or competency of the physician's medical decision-making; that's an issue for state malpractice law.[5]

Furthermore, the screening required is for the symptoms or condition as perceived by the examining physician, not for the symptoms or condition that actually existed or "should have been" diagnosed.[6] If the physician judges a patient's back pain to be from a pulled muscle from lifting a heavy box, the standard screening exam would be limited to the history and physical exam; it wouldn't include a CT scan to rule out an aortic aneurysm or obstructing urinary tract stone. Only if the physician perceived the patient's symptoms to point to a possible ruptured aneurysm would the standard screening exam include a diagnostic study such as a CT or ultrasound. On the same line, is there any emergency physician who would order a CBC, blood culture, sedimentation rate, and CT scan for periorbital edema if the physician truly believed the etiology was a straightforward allergic reaction?

If the court's ruling is correct, it means every testing decision made by emergency physicians is subject to liability under EMTALA. If 287 headache patients present to the ED each month and on 30 of them the emergency physician orders a CT scan to rule out a bleed or tumor, does that mean he violates EMTALA in each of the other 257 cases for failure to conduct an "appropriate" MSE by providing "disparate" screening? Or does the emergency physician violate the law in the 30 cases by actually ordering the study, which is still "disparate" screening compared to the other 257 cases? Note that "disparate" just means "different," not necessarily "less extensive"; thus, more extensive screening when ordering tests is equally as "disparate" as less extensive screening.

Plaintiff's allegation was nothing more than a garden variety "failure-to-diagnose" claim. The plaintiff was simply questioning the medical judgment of the hospital's medical staff regarding whether diagnostic testing was medically indicated during the ED visit at issue.

The judge should have dismissed the EMTALA screening claim at this stage of the proceedings, in which case the plaintiff's end-run on California's medical malpractice tort reform would have been averted.

California's Damages Cap. In a civil action under EMTALA, the plaintiff can only recover those dam-

ages available for personal injury under the law of the state in which the hospital is located.[4] Thus, the damages available are subject to the limitations set by each state's tort reform legislation.

California's well-known and envied MICRA imposes a $250,000 limit on non-economic damages for professional negligence, among other limitations on the types of damages allowable and attorney fees.[7]

Plaintiff, however, contended that the screening claim under EMTALA was not a professional negligence claim and therefore the state caps didn't apply to the case.[8]

The court first noted that MICRA specifically defines "professional negligence," for purposes of enforcing the caps, as "a negligent act or omission to act by a health care provider in the rendering of professional services," which is the proximate cause of the plaintiff's injury.[9]

It then noted that under California law, "when a cause of action is asserted against a health care provider on a legal theory other than medical malpractice (such as EMTALA), the courts must determine whether it is nevertheless based on the 'professional negligence' of the health care provider so as to trigger MICRA." [10] In other words, the analytical approach adopted by the California Supreme Court for determining whether the MICRA cap applies to a particular EMTALA claim is to examine the nature of the health care provider's conduct itself to determine whether it would constitute "professional negligence" under California law.[11]

The court then made this astounding statement:

> "Although a medical screening may be a service provided by a hospital, the provision of a screening is not governed by the standards of knowledge, care, and skill of members of the medical profession; a disparate screening claim is based on disparate treatment."[2]

The court decided the issue was whether the patient "received a materially different screening that that provided to others in her condition."[12]

How did the court think that question could be answered in this case? Whether to order diagnostic tests, and which tests would be indicated in a particular clinical scenario, is clearly determined by the professional judgment of the examining physician. Neither the court nor a lay jury would have sufficient knowledge or expertise to determine whether ordering tests was "disparate" treatment; that conduct is clearly medical decision-making — medical judgment — and requires expert testimony to assist the jury.

In fact, the Sixth Circuit, in the case of *Smith v. Botsford General Hospital*[13]. which was cited by the *Romar* court, specifically identified the need for expert testimony as the key distinguishing feature of claims involving professional negligence. The Sixth Circuit also looked to the conduct of the physician to determine if a plaintiff's EMTALA claim would constitute a professional negligence claim under Michigan law and come under the state's cap law.[13,14]

The *Romar* court, however, didn't accept the expert testimony argument or agree with the hospital that the screening standard clearly depended upon how the reasonable medical professional (standard of care) would act in the particular situation in question.

Therefore, the court concluded that disparate screening, in this case failure to order a diagnostic test, is not a "negligent act or omission," and thus not based on professional negligence as defined by the MICRA legislation.[3] Therefore, the court held that MICRA's $250,000 non-economic damages cap does not apply to a failure to screen claim under EMTALA.[3]

Comparison to the California Supreme Court ruling in Barris v. County of Los Angeles

In *Barris*, the court had held that in order to violate EMTALA a hospital or physician would have to act negligently and fail to conform to professional standards, and therefore the MICRA cap applied.[11] However, the *Romar* court declined to follow the California Supreme Court's ruling in *Barris* because it was a failure to stabilize case, not a disparate screening case.[11] *Romar* simply ignored the concurring opinion in *Barris,* which stated, "a hospital's demonstrated failure to act in accordance with EMTALA is, in and of itself, 'a negligent . . . omission to act by a health care provider in the rendering of professional services' under the MICRA definition of professional negligence."[11] This justice concluded that any liability claim based on EMTALA, a screening or stabilization claim, constituted an action based on professional negligence subject to MICRA.[15]

Under the rationale of the California Supreme Court, the *Romar* court wrongly decided this case.

Ramifications of the Court's Decisions

The court's decisions have the potential to markedly expand hospital liability and void state legislative caps for non-economic damages. The precedent the court set by allowing failure-to-screen claims under EMTALA for the routine medical decision-making regarding ordering diagnostic tests in the ED is a dangerous one. Plaintiffs' attorneys will now try to fit all sorts of ordinary medical malpractice claims into an EMTALA failure-to-screen cause of action: first, to sue the hospital directly for the actions of the emergency physicians; and second, to circumvent the states' non-economic

damages cap law. This is was not what the U.S. Congress intended when it enacted EMTALA, which was designed to prevent hospitals or physicians from refusing to treat patients or treating them in a disparate manner due to discriminatory reasons.

Also, this case clearly illustrates the need for careful and artful drafting of tort reform legislation. While MICRA was drafted prior to EMTALA's passage,[16] the same issue has been litigated in many states that have more recently enacted tort reform and damages caps.[17] The California legislature and that in other states should reconsider the language in their reform laws to explicitly include civil liability claims under EMTALA.

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3. *Romar v. Fresno Comm. Hosp. et al.*, 2008 U.S. Dist. LEXIS 85080 (E.D.Cal. Oct. 10, 2008).
4. 42 USC 1395dd(d)(2)(A).
5. Eg., *Baker v. Adventist Health, Inc.*, 260 F.3d 987 (9th Cir. 2001).
6. *Vickers v. Nash General Hosp., Inc.,* 78 F.3d 139, 144-45 (4th Cir. 1995).
7. Cal. Civ. Code § 3333.2 et seq. *See* http://www.micra.org/about-micra/micra-history.html. (Accessed 11/30/2008.)
8. California Civil Code § 3333.2(a).
9. *Romar v. Fresno Comm. Hosp. et al.*, 2008 U.S. Dist. LEXIS 85080 (E.D.Cal. Oct. 10, 2008). Plaintiff argued that two federal district courts held that EMTALA claims are not subject to the severe non-economic damage limitations applicable to medical malpractice claims under MICRA. See *Jackson v. East Bay Hosp.,* 980 F.Supp. 1341 (N.D. Cal. 1997); *Burrows v. Redbud Community Hosp. Dist.,* 188 F.R.D. 356 (N.D. Cal. 1997).
10. Citing *Smith v. Ben Bennett, Inc.*, 133 Cal.App.4th 1507, 1514 (2005).
11. *Barris v. County of Los Angeles,* 972 P.2d 966 (Ca. 1999).
12. *Romar v. Fresno Comm. Hosp. et al.,* 2007 U.S. Dist. LEXIS 25959 (E.D.Cal. Mar. 21, 2007). The court noted that EMTALA was a statutory liability claim for disparate screening and not a negligence claim, in accord with other jurisdictions, and that Congress did not intend to impose a federal malpractice standard when it passed EMTALA.
13. *Smith v. Botsford General Hospital* 419 F.3d 513 (6th Cir. 2005).
14. Mich. Comp. Laws §600.1483.
15. *Barris v. County of Los Angeles,* 972 P.2d 966 (Ca. 1999), concurring opinion and citing *Power v. Arlington Hosp. Ass'n.* 42 F.3d 851 (4th Cir. 1994); concluding that an EMTALA claim based on alleged disparate medical screening by a hospital was subject to Virginia's cap on medical malpractice damages even though the claim did not allege a breach of the prevailing standard of care.
16. MICRA was passed by the California legislature in 1975.
17. E.g. See *Power v. Arlington Hosp. Assoc*., 42 F.3d 851 (4th Cir. 1994); *Smith v. Botsford Gen. Hosp.*, 419 F.3d 513 (6th Cir. 2005); *Brooks v. Maryland Gen. Hosp.*, 996 F.2d 708, 715 (4th Cir. 1993); *Valencia v. St. Francis Hosp. & Health Ctr.*, 03-cv-0252-LJM-WTL, 2004 U.S. Dist. LEXIS 7929 (S.D. Ind. Mar. 1, 2004) (agreeing with *Power*); *Hughes v. PeaceHealth,* No. A123782 (Or. Ct. App. Mar. 15, 2006); and *Jeff v. Univ. Health Servs., Inc.,* No. Civ.A.04-1507 (E.D. La. July 27, 2005).

Could giving 'unequal' care to inpatients get your ED sued?

Differences in care revealed during lawsuits

(This story concludes a two-part series on liability risks of boarding admitted patients in the ED. This month, we report on the problem of EDs providing an unequal level of care compared to what patients would have gotten on inpatient units. Last month, ED Legal Letter *covered liability risks of holding admitted patients in ED hallways.*

Admitted patients held in EDs are required by The Joint Commission to receive the same level of care as they would get on inpatient units. A jury hearing about a patient's bad outcome would presumably expect this as well. But what if this is just not realistic for an understaffed, overcrowded ED?

It would be difficult for a plaintiff's lawyer to prove that the care provided during the time the patient spent boarding in the ED was inferior across the board, according to **Jesse M. Pines, MD, MBA, MSCE**, assistant professor of emergency medicine and epidemiology at the Hospital of the University of Pennsylvania in Philadelphia.

However, if a medical error occurs while a patient is boarding, attorneys may look to how the hospital systematically treats boarders, says Pines. For example, if a medication error occurs while a patient is boarding and the order entry system is different in the ED and on hospital floors, attorneys might focus on the difference.

Despite the Joint Commission requirements, many hospitals lack policies to ensure that boarders receive the same level of care, such as having inpatient physicians care for their own patients in the ED. "The problem is that most hospitals still require emergency nurses to care for the admitted patients," says Pines. "This can put both the boarders themselves and the other patients waiting to be seen at risk."

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SPECIAL REPORT

Sleep Deprivation and Fatigue

*By **Mitchell C. Sokolosky, MD,** Associate Professor and Residency Director, Department of Emergency Medicine, Wake Forest University Health Sciences Center, Winston-Salem, NC; and **Randall Best, MD, JD**, Assistant Professor, Division of Emergency Medicine, Department of Surgery, Duke University School of Medicine, Durham, NC.*

The dangers of sleep deprivation and fatigue can no longer be ignored. There is a large body of mounting evidence that demonstrates that fatigue impairs human performance. In fact, fatigue has been shown to have similar effects to alcohol intoxication.[1] Fatigue may result in unintentional medical errors, motor vehicle crashes, mood disturbances, somatic complaints, and job burnout.[2]

Despite the fact that other high-risk industries (e.g., airlines) adopted restricted work hours decades ago to combat the negative effects of sleep deprivation and fatigue, the medical profession has only recently adopted similar restrictions for physicians in training. In 2003, the Accreditation Council for Medical Education (ACGME), the agency responsible for overseeing graduate medical education in the United States, instituted work duty hour restrictions for all U.S. residency programs.[3] The rules limit the resident physician's weekly work hours, maximum continuous duty hours, and require at least one full day off duty each week on average. Although practicing physicians currently have no such restrictions on work hours, recent state legislation addressing the criminal effects of fatigue could affect sleep-deprived physicians.

Legal Consequences. Fatigue resulting from the long and irregular hours of health care shift workers has obvious harmful physical and mental consequences that are all too well known to emergency physicians and has been the subject of numerous scholarly articles and vigorous public debate.[4] Less well known are the potential legal ramifications and effects of this problem. As first espoused in the Massachusetts Constitution and oft repeated, we are a government of laws and not of men.[5] Once the public becomes aware of adverse effects of any social problem, legislation is sure to follow.

Most emergency physicians have heard of Libby Zion, the young woman who died after admission to New York Hospital in 1984, presumably from serotonin syndrome.[6] As her distraught journalist father, Sidney Zion, investigated the circumstances surrounding her death, he was shocked to discover that the residents who cared for her had been working at the hospital for at least 18 hours. His efforts to draw attention to the long work hours of resident physicians led to widespread regulations limiting resident work hours.[6] Ironically, it never was shown conclusively that her death was proximately caused by doctor fatigue; rather, an overwhelming workload or lack of proper supervision are equally plausible culprits.

Less well known, but similar in terms of the eventual legal ramifications, is the case of Maggie McDonnell. She was a 20-year-old New Jersey woman killed in 1997 by a driver who admittedly had been awake for 30 hours when he crossed the median and struck her vehicle.[7]

At his criminal trial, the driver was found guilty of mere careless driving rather than the harsher offense of vehicular homicide, and the driver received only a $200 fine.[7] At that time, New Jersey law did not allow intentional and knowing sleep deprivation to fulfill the requisite mens rea or mental state necessary for a vehicular homicide conviction.[7] Her family's grief, along with public outrage, led to "Maggie's Law," an amendment of the New Jersey vehicular homicide statute that provides that "proof that the defendant fell asleep while driving or was driving after having been without sleep for a period in excess of 24 consecutive hours may give rise to an inference that the defendant was driving recklessly."[8]

Thus, one who drives and causes a fatal accident knowing that he is sleepy or has been awake for a long period could be found guilty of the charge of vehicular manslaughter with resulting harsher criminal penalties than a charge of careless or reckless driving would bring. Analogous to the Libby Zion case, the focus of this tragedy was on the deleterious effects of driving while sleep deprived. The fact that the driver had been smoking crack cocaine prior to the accident was mostly overlooked, while public scrutiny honed in on the fear that dedicated, but fatigued shift workers could cause for deadly motor vehicle accidents.

A statutory law such as Maggie's Law has significant implications for all emergency physicians, not just resident doctors. Without a nap prior to an isolated night shift, an emergency physician easily could be awake for 24 or more hours. So far, New Jersey is the only state with a

law such as Maggie's Law, but other states have considered it. In fact, a federal bill focusing on drowsy driving was introduced in the United States House of Representatives in 2002 and again in 2003, but each time it failed passage.[9] Each of these bills focused on incentives for states and communities to develop traffic safety programs related to the problems of sleep-deprived drivers.

While criminal penalties for injuries caused by sleep deprivation might be justifiable, a more efficacious solution would combine a greater understanding of the physiologic effects involved and development of effective countermeasures to the problem.

Sleep Physiology. Sleep is a natural state of bodily rest that is necessary for survival. Sleep is a dynamic process of a complex series of sleep stages (stages 1–4 and REM [rapid eye movement]) that repeats itself several times throughout the sleep period. Sleep requirements change throughout life. However, the average person requires at least eight hours of sleep each day to be restorative. Long and short sleepers have been shown to have increased mortality.[10] Sleep is regulated by the circadian rhythm (internal clock). The circadian rhythm is an approximate 24-hour cycle of reoccurring biochemical, physiological, and behavioral processes that are essential for life. Sleep loss is characterized as either acute, total sleep deprivation (recent 24-hour sleep loss) or as chronic, partial sleep deprivation (less than six hours of sleep per night on average for at least one week).

Neurocognitive Effects. The effect of sleep deprivation on cognitive performance has been well studied in sleep laboratories. Neurocognitive impairment is similar for both acute, total sleep deprivation and chronic, partial sleep deprivation. Performance testing of vigilance (responsiveness to simple repeated tasks) and serial mathematical calculations were equally affected by 24 hours of total sleep loss and one week of sleep restriction to five hours of sleep per night.[11] Mean cognitive performance of young healthy adults who are sleep deprived (both short-term and chronic) are 1.3 standard deviations below the mean.[12] Verbal processing and complex problem solving is impaired with acute and chronic, partial sleep deprivation.[13] While most people recognize their limitations after acute, total sleep deprivation, the effects of chronic, partial sleep deprivation may go unrecognized. Even more worrisome is the fact that the effects of chronic, partial sleep deprivation are cumulative (sleep debt), and one cannot become acclimated even though many think they can. Adequate recovery sleep is necessary to correct sleep debt.

Clinical Implications. Recent studies have demonstrated the adverse effects of fatigue on patient care. Interns made substantially more serious medical errors when they worked frequent extended periods (24 hours or more) than when they worked shorter periods.[14] Interns made 35.9% more serious medical errors, 20.8% more serious medication errors, and were 5.6% times as likely to make serious diagnostic errors when working extended work periods. Eliminating the extended work periods in an intensive care unit significantly increased sleep and decreased attention failures during night work hours.[15] Night shift workers are particularly at risk. Total sleep time for emergency physicians on night shift duty are significantly less than their daytime counterparts.[16] Performance also has been shown to decrease among night shift emergency physicians. Both completion time in a simulated intubation task and clinical accuracy in a triage task were worse for night shift physicians.[17] Results appeared to be related to insufficient sleep and circadian rhythm disturbances.

Countermeasures. The most effective counter-measure to combat sleep deprivation and fatigue is simple: sleep. Adequate sleep is essential to healthy living and to being an effective physician. The goal is to come to work well rested and attentive. Clockwise shift schedules (e.g., days to evenings to nights) is preferable to counterclockwise schedules because of circadian effects.[18] The timing of sleep for night shift workers is important to consider. Sleeping as soon as possible after a night shift is desirable. This allows for some sleep to occur during the normal sleep period. Splitting the sleep cycle (sleeping for 3–4 hours immediately after and before a shift) is acceptable for short stretches (a few days) following night shifts. The concept of "anchor sleep" (sleeping during the same period each day) is important to consider when working long stretches (weeks) of night shifts. A study performed on individuals in an isolation unit illustrates the effectiveness of anchor sleep.[19] Individuals slept either as a single random eight-hour period or two randomly arranged four-hour sleep periods. Circadian rhythms were stabilized in the four-hour group if anchor sleep was taken at the same time each day regardless of the timing of the second half of the sleep as compared to the single random eight-hour group. Day

sleep environments should be dark, quiet, and cool to facilitate adequate sleep. Naps are an effective countermeasure for combating fatigue. Naps as short as 20 minutes can be effective, but naps should not exceed two hours to avoid sleep inertia (period of drowsiness upon awakening).[20] A nap taken before driving home may reduce the chances of an accident.[21] Other effective countermeasures include the use of low-dose caffeine (avoid within four hours of sleep)[22], aerobic exercise, and the use of bright lights during the circadian nadir (between 2 a.m. and 9 a.m.).[23]

Conclusions. Preparing for work by getting adequate sleep should be viewed by physicians as a professional responsibility to our patients. Fatigue may result in unintentional medical errors, motor vehicle crashes, mood disturbances, somatic complaints, and job burnout. The most effective countermeasure for fatigue is obtaining adequate sleep. We must obtain adequate daily (at least eight hours) and weekly recovery sleep (for sleep debt) as needed. We must understand our limitations when sleep deprived and plan accordingly. Fatigue must be viewed as an unacceptable risk with dire consequences to our patients and ourselves.

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Also, even when inpatient physicians care for boarders, emergency physicians still have the ultimate responsibility for patients who are physically in the ED. "From both a patient safety and legal perspective, this is high-risk," says Pines. "If a patient becomes unstable and emergency physicians need to step in to care for a critically ill patient who has been admitted for hours, lawyers may place the blame on emergency physicians for what was really an inpatient complication."

Several recent publications have demonstrated that boarding is dangerous and that the care patients receive while boarding is inferior in many hospitals.[1-4]

"When adverse boarding outcomes do occur, lawyers will point directly to the evidence in the literature and use it against hospitals and emergency physicians," says Pines. "Unless something is done by the Joint Commission to step in and prohibit hospitals from the practice of boarding, this problem is only going to get worse."

Inpatient care should be the same wherever the patient is located in the hospital, says **Robert Broida, MD, FACEP,** COO of Physicians Specialty Limited, Risk Retention Group in Canton, OH.

"Patients on a gurney in the ED hallway do not receive the same care as those on the inpatient unit. To the extent that the patient is harmed by this, the hospital is at risk."

A plaintiff's attorney could also point to differences in policy. "Hospitals like to write volumes and volumes of policy. And in the setting of boarding, these policies become impossible to comply with," says **Peter Viccellio, MD, FACEP**, vice chairman of the department of emergency medicine at the State University of New York at Stony Brook. "Also, as the staff is stretched thinner and thinner, documentation suffers. So adequate care might be delivered, but not documented."

If a jury hears that a patient didn't get the same care he or she would have on the inpatient floor, they are likely to blame the ED physician being sued, says Viccellio. "We don't have time to document what we do, and the context in a courtroom doesn't take into account what was going on with others," he says. "Juries are not sympathetic to 'the ED was too crowded.'"

For nurses, it's 'unrealistic'

With staffing levels cut to the bare minimum, Broida says is unrealistic to expect the ED nurses to provide comprehensive "floor nursing" care to boarders on top of their already large ED patient load. "The first priority for ED nurses are the ED patients," says Broida. "Admitted patients boarded in the ED hallway may experience medication errors, delays in proper admission assessment, lack of privacy, increased risk of falling and other potential problems."

The burden of holding patients in EDs is "much more on nursing than anyone else," says Viccellio. "It's not a matter of 'do you feel like it's easy or difficult? But 'Do you think it's doable?' Nurses feel like they are failures because they can't do what they need to do. If you have an ED nurse taking care of six admissions plus eight active ED patients, it's not a mathematically doable job."

It is not possible for emergency nurses to deliver the care that admitted patients require for two reasons, 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.

"First, they are not floor nurses and definitely not specialty floor nurses," he says. "Second, emergency nurses have a full waiting room to contend with. Waiting patients need to be screened for life threats and stabilized. This is always a priority over most floor cases."

There is a significant liability risk if ED staff are not providing the same level of care, expertise and documentation as inpatient staff, according to Broida. "It would be difficult to convince a jury that the patient on a gurney in the ED hallway receives the same care as those on the inpatient unit," he says.

Broida says that once a patient is admitted, their care should be provided by the inpatient staff, not the ED staff. Hospitals should float an inpatient nurse down to the ED to care for the boarders, or place the boarder in the inpatient unit hallway to await a bed.

Some hospitals have "admission nurses" come down to the ED for patient intake, while others send ICU or floor nurses down to the ED to care for boarded inpatients. "In either scenario, the patient will receive 'typical' inpatient care from a designated inpatient nurse," says Broida. "Also, the ED nurses will not be diverted to care for inpatients and will be able to concentrate on their required ED duties."

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Do Joint Commission guidelines have a legal impact on our practice?

Reduction in liability risk not always evident

Emergency departments pour a lot of resources into compliance with the Joint Commission's standards, including the National Patient Safety Goals. But is there any evidence that compliance with The Joint Commission standards decreases liability risks for an emergency department?

"That's a big leap to make," says **Angela F. Gardner, MD, FACEP**, assistant professor in the division of emergency medicine at University of Texas

Sources

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Medical Branch, Galveston, TX and former director of risk management for Dallas-based EmCare. "There isn't any data showing that the standards have caused an increase in lawsuits, or a decrease in lawsuits."

It might not be possible to show a direct link between Joint Commission compliance and ED lawsuits, adds Gardner, unless a clear connection could be made between a Joint Commission requirement and a dramatic reduction in lawsuits, for example.

Considering all of the things that affect patient outcomes, she says, you might not ever be able to make that conclusion.

"That said, I have been not just surprised but shocked when I look at the data on something like getting a pulse oximetry reading on a patient that has a respiratory complaint," says Gardner. "My assumption was that would be a giveaway standard, but some of the early reporting shows that only 75% of people get pulse oxes. That's something very basic that is either not being done or not being documented 25% of the time. We make the assumption that it's just not being documented, but maybe it's not being done."

This is the other side of the coin, says Gardner — it's possible that Joint Commission requirements bring more attention to clinical practices, like taking routine vital signs, that affect ED patient outcomes.

Abnormal vital signs are used in risk management as teaching tools to improve care, Gardner adds, but in order for the vital signs to be examined, they have to be documented in the first place.

Long-term impact on liability

All Joint Commission standards are intended to enhance quality and safety, and should in the long term help the ED with liability issues in terms of preventing incidents that would result in claims, according to **Harold Bressler**, general counsel for The Joint Commission.

However, Bressler notes that the standards are not promulgated to establish a legal standard of care. "We cannot control what courts will do and it is not our business what they do with our standards," he says. "And in fact, it's an unusual case where a failure to comply with a Joint Commission standard will be directly determinate of whether an incident of care was negligent or not. But it has happened."

Failure to comply with Joint Commission standards may be cited against the ED in the event of a malpractice lawsuit, whether the organization is accredited or not. "Plaintiffs can say, here's a National Patient Safety Goal you were supposed to follow and you didn't, and it resulted in harm to a patient," says Bressler.

It can work the other way too, says Bressler, with an ED pointing out in a courtroom that care was in compliance with Joint Commission standards.

"The key point is that the standards are intended to improve quality and safety," he says. "And if you do that, you are doing well for yourself liability-wise and will have fewer claims."

Although there is no specific data showing that the number of lawsuits is less with Joint Commission compliance, liability carriers do offer specific benefits to accredited organization. These include premium discounts, or preferential coverage, and waiving required site visits before coverage is extended.

"I don't know of a solid research study, but it does make logical, intuitive sense. We have heard for years that liability insurers prefer Joint Commission-accredited organizations because of our strong focus on patient safety," says **Kathleen Goryl**, associate director of payor relations for The Joint Commission. "They look at that as a risk reduction strategy for them."

One insurer uses the National Patient Safety Goals as a screening criteria to determine whether they want to extend coverage to an organization, notes Goryl. "Accreditation in general is designed to

Source

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be a risk reduction activity. From an insurer perspective, accredited organizations are saying they have put policies and procedures in place to safeguard themselves from adverse events and liability. They have already done a lot of the work to safeguard themselves."

ED not always well represented

The Board of Commissioners is the Joint Commission's leadership and oversight body, with the mission to continuously improve the safety and quality, and "none of the 29 Board members have an emergency medicine background," says **Tom Scaletta, MD,** president of Emergency Excellence, a Chicago-based organization that improves patient care and efficiency in the ED while controlling costs.

As a result, the major emergency medicine professional organizations — the American Academy of Emergency Medicine, the American College of Emergency Physicians, and the Emergency Nurses Association — have been working together to lobby for changes regarding certain standards that are not helpful, and sometimes harmful, to achieving the goal of improved safety in the ED, says Scaletta.

"Some of the core measures make sense — giving aspirin and beta-blockers early in acute myocardial infarctions," says Scaletta. "Others, like the four-hour rule for antibiotics in pneumonia rule, are more arbitrary."

Scaletta also notes, "Unfortunately, the Joint Commission is mute on two substantial opportunities that would improve outcomes — requiring board certification in emergency medicine for physicians caring for sick patients, and disallowing boarders from overrunning the ED."

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. 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*

1. In *Romar v. Fresno Comm. Hosp. et al,* the court's decisions have the potential to:

   A. expand hospital liability and void state legislative caps for non-economic damages by skirting state damages caps.
   B. allow failure-to-screen claims under EMTALA for the routine medical decision-making regarding ordering diagnostic screening in the ED.
   C. open the door to lawsuits against hospitals directly for the actions of emergency physicians.
   D. All of the above

2. Which is true regarding care of admitted patients held in EDs?

   A. Plaintiff attorneys would find it easy to prove that the care provided during the time the patient spent boarding in the ED was inferior across the board.
   B. Emergency physicians no longer have any legal responsibility for patients who are physically in the ED if inpatient physicians are caring for the boarders.
   C. If a patient becomes unstable and emergency physicians need to step in to care for a critically ill patient who has been admitted for hours, lawyers may place the blame on emergency physicians for what was really an inpatient complication.
   D. If a medical error occurs while a patient is boarding, attorneys would not be able to examine how hospitals systematically treat boarders.

3. Which is recommended to reduce liability risks of boarded patients in the ED?

   A. Do not have inpatient nurses "floated" down to the ED to care for boarders.
   B. Avoid having policies to ensure that boarders receive an equal level of care in the ED as they would on inpatient floors.
   C. Require emergency nurses, not inpatient nurses, to take care of admitted patients being held in the ED.
   D. Once a patient is admitted, have inpatient staff provide care instead of ED staff.

4. Studies demonstrate that "anchor sleep," or a period of sleep taken during the same period each day, has no effect on the circadian rhythms of individuals working long stretches of night shifts.

   A. True
   B. False