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The monthly update on Emergency Department Management

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Drug-seeker lists are dangerous at best, require tight administrative controls

Attorney says avoid them altogether, others urge limited use

After you have security escort patient Joe Jones out of the ED for causing such a ruckus when he couldn't get any Vicodin, you're thinking you'd like to avoid this obvious drug seeker in the future. So maybe you should add his name to the list of frequent flyers or the kook book your staff keep at the nursing station.

Good idea? Not really. Though all EDs struggle with drug seekers and other disruptive patients, keeping a list can be the wrong way to go, say legal and ED experts. The list and how it's used can create tremendous legal liabilities and may not accomplish much for your ED anyway, they say.

At the very least, you should implement strict controls on how that list is kept and used, says **Joel Geiderman**, MD, FACEP, co-chair of the ED at Cedars-Sinai Medical Center in Los Angeles. The Cedars-Sinai ED keeps a list but only with tight restrictions.

"There are a lot of ethical problems with the way these lists can be used," he points out. "These things kind of creep into EDs, and you have a list before you realize it. They're fairly widespread, but people just don't talk about them much."

Many EDs keep such lists, but it is usually done informally, without official approval or disapproval from management, says **Frederick Schiavone**, MD, FACEP, professor of clinical emergency medicine and associate dean of clinical education at Stony Brook (NY) University Hospital. Schiavone discourages keeping such lists

Executive Summary

It is extremely risky to keep lists of people who show up frequently in your ED seeking drugs, and the lists may not accomplish much anyway. If you allow staff or physicians to keep such lists, you should establish tight controls.

- Lists can pose confidentiality concerns.
- Never use a list before a patient is properly screened.
- Take a hard-line approach with obvious drug seekers to diminish repeat visits.

because of all the difficulties they pose with confidentiality concerns and the potential for distracting providers from proper treatment.

"Any time you label patients, the labeling ends up working against us, because you label someone to deny them resources, not to give them more resources," he explains.

Stony Brook's ED does not keep lists of drug seekers. Schiavone says the lists tend not to be very useful for EDs anyway, so the risks and difficulties probably aren't worth the trouble. It is more likely that the list will lead you to deny pain medication to those patients when they really need it or misdiagnose a legitimate complaint just because you have that person on a list.

After all, he points out, drug seekers and frequent flyers can have an aortic dissection or back injury, just like everyone else. If you fail to detect the problem and treat it, you're not off the hook just because you thought the patient was crying wolf again.

According to Geiderman, the lists probably aren't needed as much as some people think. Drug seekers and other frequent flyers aren't as common as most ED staff believe, he says. It's just that they're especially frustrating and so they make an impression on staff.

Establish tight controls

Geiderman and Schiavone say they're not necessarily in favor of keeping lists, but they acknowledge that ED staff tend to keep them informally if management doesn't say otherwise. That's why they recommend prohibiting the practice outright or instituting tight controls on how such lists can be kept.

The first rule, they say, is that only physicians can put someone on the list.

The biggest problem with letting staff keep a list is that you lose control of what goes on the list, notes Schiavone.

"All you have to do is have one person put something egregious in the list, and it becomes part of a legal document; and you have tremendous legal and ethical issues that will arise," he says. "Keep it to only physicians, and make it very clear that only factual information can be included — no judgments or personal criticisms."

The list also should be secured in a way that only physicians can consult it, with a computer password, for instance. The goal is to make the list a resource that will help physicians provide better care, not a blacklist that cuts the person off from proper care, Schiavone says.

The list can help improve care if it keeps track of what physicians have already done for the patient, what recommendations and referrals already have been made, and what medications work and don't work for the patient's pain.

Those are some of the precautions taken with the list at Cedars-Sinai, Geiderman adds. Any process you establish should be approved by your hospital's legal counsel, he advises. **(For more on the protocol**

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Formalize drug-seeker list; minimize who can access

The first step in formalizing your list of drug seekers or other frequent visitors to your ED is to avoid any disparaging names for them or the list, says **Joel Geiderman**, MD, FACEP, co-chair of the ED at Cedars-Sinai Medical Center in Los Angeles.

Don't call it a "kook book" or "problem patient file." Instead, use a more neutral term such as "habitual patient file," he suggests.

"The labeling is important because you start off on the wrong foot if you use a disparaging term for these patients," he says. "The list should be free of personal judgment or nasty remarks about the people, so start by giving it a name that doesn't label them that way."

Geiderman's research shows that most EDs keeping lists do so without much control over who goes on the list or how it is used.[1]

If you keep a list, which he doesn't necessarily support, you must employ tight controls to keep it from being misused, he notes.

Here are some of the steps employed by the ED at Cedars-Sinai:

- Names of suspected drug seekers are forwarded to a semiweekly meeting of attending physicians, where they are discussed confidentially. The physicians discuss the patient and decide whether to place the name on the habitual patient list.
- The file is maintained on the computer system, and physicians can access it with a password from any ED workstation. Unlike medical records, only physicians can access the file.
- The list is used as a resource only. Physicians are free to exercise their own judgment in determining how to provide treatment for the patient, using the information in the file as supporting data.
- Cedars-Sinai does not share information from the file with other institutions. The only exception is for a private physician who has an established relationship with the patient.

Reference

1. Geiderman JM. Keeping lists and naming names: Habitual patient files for suspected nontherapeutic drug-seeking patients. *Annals of Emerg Med* 2003; 41:873-881. ■

Cedars-Sinai uses for keeping a list of drug seekers, see box, at left. For tips on how to deal with drug seekers, see related article, p. 28.)

Huge legal risk

Lists of drug seekers, or any other type of frequent flyers, can lead to serious legal problems, says **Grena Porto**, RN, ARM, DFASHRM, a health care risk manager and principal with QRS Healthcare Consulting in Pocopson, PA, and past president of the Chicago-based American Society for Healthcare Risk Management.

Keeping a list is "hazardous at best," she says.

Though such records could, in theory, improve patient care by alerting physicians and staff to a patient's background and particular needs, they more often will lead to a bias against the patient, she says.

And that situation relates to another problem with lists: You're creating a record that can be used against you. No one can stop your staff from keeping a mental record of who shows up often asking for drugs, but when you put it on paper or the computer, you create a record that can be subpoenaed.

Defamation is another potential problem. Porto says a plaintiff could make a good case that being on the list amounts to defamation because you are accusing him or her of abusing drugs.

If you decide to keep such a list despite the legal risks, you absolutely never should share that list with anyone else, she advises. Don't share lists with your sister hospital across town, and don't confirm to anyone else that someone is on your list.

"It's bad enough having the list in your own ED, but when you start broadcasting it to the community, you're just asking for trouble," Porto says.

Though most EDs would not use the list to keep people from even being triaged and examined, Porto points out there still is a risk that the list could lead to violations

Sources

For more information on keeping lists of drug seekers, contact:

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- **Grena Porto**, QRS Healthcare Consulting, P.O. Box 142, Pocopson, PA 19366. Phone: (610) 430-7393. E-mail: gporto@earthlink.net.

of the Emergency Medical Treatment and Labor Act (EMTALA) or other charges of discrimination.

Even if your staff are savvy enough to provide the required medical screening examination for drug seekers, just like anyone else, being on the list could give them ammunition if they allege an EMTALA violation.

Geiderman underscores Porto's point that a list of drug-seeking patients must never be used to keep those people from obtaining a proper evaluation.

Most EDs wouldn't make that mistake, he says, but it might not be a big leap for a staff member to realize that someone is on the list and then give him or her short shrift during the evaluation.

That's why educating staff and physicians about proper use of the list, including what it does and doesn't mean, is so important, he says. But no matter how hard you try to manage the list, don't expect your hospital's risk manager to be happy about it.

Porto says her bottom line recommendation is that EDs not keep lists of drug seekers or other frequent visitors.

"Each patient and each case has to be evaluated individually," she says. "Even patients who you know are drug users and trying to get drugs from you, each time they come they are entitled under the law to an unbiased, brand-new assessment of their situation." ■

Get tough with drug seekers, know methods

Ex-cop advises EDs to be aware

Whether you use a list or not, the best way to deal with drug seekers in your ED is to get tough with them, says **John Burke**, commander of the Warren County (OH) Drug Task Force in Cincinnati, and a former police officer.

Burke is an expert on prescription drug diversion in health care, and he says ED managers can discourage drug seekers from visiting their EDs over and over again by sending a message that they won't coddle them.

Source

For more information on stopping drug seekers, contact:

- **John Burke**, Pharmaceutical Diversion Education, P.O. Box 146, Bethel, OH 45106. Phone: (800) 566-2049. E-mail: burke@rxdiversion.com.

For starters, he advises, EDs should have a policy of calling the police whenever a drug seeker attempts to obtain prescription drugs illegally, whether by using a forged description, false identification, or any other clearly improper means.

"I guarantee you that if people get the idea you're going to call the police when they try to scam you out of drugs, they won't keep coming back to your ED," Burke stresses.

They may go across town to the ED that doesn't contact the authorities instead, he says.

"Word spreads, and you want your ED to have the reputation as one that isn't going to just roll over and take that kind of misbehavior when you have real patients to treat," Burke adds.

He also urges ED managers to institute a policy that staff will not tell people by phone which physicians are on duty.

Drug seekers often will call the ED to see what doctors are working because they want to avoid someone who has busted them before or they want to see a physician they know is a soft touch.

Also be cautious with medical residents or any staff and physicians new to emergency medicine, Burke says. Drug seekers will take advantage of their inexperience.

"They know that some doctors have seen their kind for years and won't fall for it," he notes. "But when they spot someone who might not be so experienced, they'll pull out all the tricks." ■

Head injury, stroke require speed to avoid malpractice

(Editor's note: This is the last of a three-part series addressing the top five issues that lead to malpractice claims in the emergency department and how you can reduce the risk. In the last two issues, we addressed chest pain, headache, and abdominal pain. This month, ED Management *looks at head injury and stroke.)*

Head injury is one of the most time-sensitive of all conditions treated in the ED, making staff and physician response pivotal in avoiding malpractice claims, says **Diane M. Sixsmith**, MD, MPH, FACEP, chairman of emergency medicine at New York Hospital Medical Center of Queens in Flushing.

Brain damage was the second most frequently claimed injury (9%) in medical malpractice cases between 1994 and 2000, according to a report,

Medical Malpractice: Verdicts, Settlements and Statistical Analysis from Jury Verdict Research in Horsham, PA. The most frequently claimed condition in those cases was death (23%), according to the report.

With head injury, reducing your risk of liability is all about making sure the patient gets treatment fast, she says. A computed tomography (CT) scan should be done within 30 minutes, and there must prompt neurosurgical response.

Sixsmith's advice is based on 25 years as an expert witness and malpractice consultant, in addition to her years in the ED. She spoke on the topic at the recent meeting of the Chicago-based American Society for Healthcare Risk Management (ASHRM), along with **Andrew S. Kaufman**, JD, a partner with Kaufman Borgeest & Ryan LLP in New York City, a prominent law firm defending health care malpractice claims.

If the patient will be transferred, reduce your liability by requiring that the ambulance provider will guarantee a prompt response. That guarantee must be secured in advance, not when you have a patient to transfer, Sixsmith notes.

The inebriated patient poses a particular malpractice risk for EDs, she says. Encourage ED staff to assume a serious head injury in an inebriated patient until you can determine otherwise. Those patients can be difficult to evaluate for head injury and are more likely to have one, Sixsmith points out.

Frequent, careful observation by nurses is another important protection for EDs. If the patient sues, you want to be able to show that a nurse performed a neurological check frequently.

That often is not the case, especially at shift change. "I can't tell you how many times I've seen records with the nurse documenting that the patient's neurological status was all normal and then the next nurse documents two hours later that the patient was unresponsive," she says. **(For case study illustrating Sixsmith's advice about head injuries, see box, below.)**

Speed also is of the essence in treating stroke patients, according to Sixsmith. Tissue plasminogen activator (TPA) should be administered within three hours of symptom onset, but she also cautions that TPA must be administered only when the patient has a neurological deficit that is not improving and is severe enough to warrant the risks of TPA.

Any delays in treatment can lead to irreversible damage, so the ED must have a system for fast-tracking stroke patients, she points out.

"The [ED] should be structured so that patients with stroke symptoms can be rapidly triaged and get a CT of the head within 45 minutes of arrival," Sixsmith advises. She warns that consults should not be done over the phone.

Kaufman agrees. The hospital is at extreme risk if the consulting physician gives an order that proves to be unwise. "Tell the doctor that he either comes in to

Case history shows how head injury is easily mistreated

To illustrate how EDs set themselves up for malpractice liability when treating head injuries, **Diane M. Sixsmith**, MD, MPH, FACEP, chairman of emergency medicine at New York Hospital Medical Center of Queens in Flushing, tells the story of a 22-year-old boxer who was knocked out in a training session.

The boxer regained consciousness and was transported to the ED. His examination was unremarkable except for amnesia for the event and somewhat slowed mentation.

A computed tomography (CT) scan was ordered, but 90 minutes later the patient was found unresponsive, with a Glasgow coma score of 4.

The CT was done and showed an acute subdural bleed. He was intubated, and the ED physician spent the next 70 minutes on the phone trying to arrange for neurosurgical care. The patient was accepted for transfer to another hospital, but the ambulance didn't arrive for two hours later. He survived surgery but remains severely disabled.

Sixsmith notes that patients with head injury often will have a period of normality after their injury and then rapidly deteriorate, so "it is important not to be fooled into thinking that the normal-appearing patient is fine.

"Careful nursing observation at 15 minutes intervals and nurses who are trained to observe subtle changes in neurological status can alert the physician to a patient who is going downhill before that process is irreversible," she adds.

Sixsmith also stresses the need to evaluate each patient "with a sense of urgency" and to obtain a diagnostic CT of the head as soon as possible.

"Even more than in patients with major trauma, patients with head injury have the golden hour to be stabilized," she says.

Prompt neurosurgical response is crucial, adds Sixsmith. "Every head injury malpractice case will hinge on how quickly the diagnosis was made and how quickly the neurosurgeon intervened," she continues. "Transfers to tertiary care facilities must be done stat, since every minute delay increases the liability of the transferring hospital." ■

Sources

For more information on ED malpractice risks, contact:
- **Diane M. Sixsmith**, MD, MPH, FACEP, Chairman of Emergency Medicine, New York Hospital Medical Center of Queens, 56-45 Main St., Flushing, NY 11355-5045. Phone: (718) 670-1231.
- **Andrew S. Kaufman**, JD, Partner, Kaufman Borgeest & Ryan, 99 Park Ave., 19th Floor, New York, NY 10016. Phone: (212) 980-9600.

examine the patient, or you have to make the decision yourself," he says. "The liability lies with the hospital, not the physician on the phone."

Rapid administration of TPA is a growing concern. Sixsmith says her experience suggests there has been "a remarkable increase" in suits for failure to treat stroke with thrombolytic therapy since the Food and Drug Administration approved TPA for that usage in 1995.

Many neurologists and ED physicians do not agree with the American Heart Association and the American Stroke Association, which call for administering TPA within three hours of symptom onset to patients whose neurological deficit is severe enough for the benefit to outweigh the risk, she notes. But that action is what she advocates.

"TPA should be given to patients who have more than just a mild deficit," she says.

No TPA leads to lawsuit

Sixsmith says hospitals should have a policy that allows ED physicians to administer a treatment or perform a procedure (assuming that they have been appropriately credentialed to do so) once it has become the standard of care. She considers the rapid use of TPA to be the standard of care, though some clinical experts would disagree.

Alternatively, Sixsmith notes, the hospital can insist that the appropriate subspecialist come to the hospital to do it within 30 minutes of consultation.

"Enable your ED physicians to do what's best for the patient, whether that is administering TPA or admitting the patient to the hospital, and overrule the doctor on the phone," she says. ■

Satisfaction climbs with smiles, other soft skills

Executive Summary

Patient satisfaction can be improved with more attention to interpersonal skills and catering to the concerns that most patients have about emergency care. Staff may resist the idea at first but can be convinced to try it.
- Simple things such as how a nurse talks to a patient have a significant effect.
- Managers should role model the changes they want.
- The environment of the waiting room and other areas also is important.

Patient satisfaction improves dramatically if your staff pay more attention to the soft skills of ED care, such as the way you talk to people, while simultaneously improving the physical surroundings.

That was the experience of managers at one ED in Arkansas, who also found that staff morale improved significantly.

The ED at the University of Arkansas for Medical Sciences (UAMS) in Little Rock, has been trying to improve patient satisfaction for about two years, using a multipronged approach, says **Glenn H. Raup,** RN, MSN, director of the ED, which sees about 31,000 patient visits a year. When Raup took over as director in 2001, overall patient satisfaction scores were in the mid-60s.

He reviewed the primary complaints from patients and staff. They were the same problems that many EDs face, such as waiting times and the difficulty of conveying information adequately to patients during busy periods.

"We focused on the perceptions that nurses weren't taking problems seriously, weren't taking time to listen, and weren't attentive to [patients'] needs," Raup explains. "We've shown dramatic improvements in those areas, going up one to four percentage points for all nursing areas."

The ED's overall patient satisfaction scores now are consistently in the mid-70s, and Raup expects them to continue climbing. Eventually, the ED's goal is to reach 95% patient satisfaction and stay there. "That is a very lofty goal, and we all realize that, so we're taking incremental steps like focusing on soft skills: eye contact, a smile on the face, all of those things that demonstrate we care what [patients'] needs are," he says.

Can be a tough sell

The idea of telling overworked ED staff to smile more may seem unrealistic, and Raup confirms that it is no easy task.

Role modeling by managers was important in convincing staff to give it a try, says **Colleen Jordan**,

Source

For more information on patient satisfaction, contact:
- **Glenn H. Raup,** RN, MSN, Director of the ED, University of Arkansas for Medical Sciences, 4301 W. Markham, Slot 600, Little Rock, AR 72205. Phone: (501) 686-8998.

RN, a care delivery facilitator in the UAMS ED. Jordan's managerial position was created to continually monitor patient care, ensure resources are allocated properly, and provide constructive feedback to nurses — all with the goal of improving care and satisfaction levels.

"They're accepting it, and I think part of that comes from seeing that others can smile and still get their jobs done, can take a few minutes to say something nice to a patient, and keep up with the patient load," she adds.

UAMS also convinced staff of the importance of soft skills by having them meet in small groups to discuss other situations they may have experienced outside the ED in which soft skills made a difference.

"We ask them to think about times in restaurants or hotels or airports where they were having a stressful time and the other person's demeanor made a difference in whether that experience got worse or better," Raup continues. "It helps them understand that this is something that has real impact on our patients and isn't just a crazy idea from management."

He also asks staff to consider how much time they would have to spend with one angry patient vs. smiling at 10 patients who were on the verge of being dissatisfied, and which one they would prefer to do. They always choose the latter.

Avoid judging patients

ED staff members are encouraged to read patients' comments and read between the lines to see what's at the root of the dissatisfaction. Many times, the problem is that the patients felt staff members were judging them, based on things such as the tone of voice, facial expressions, and standing over instead of sitting with the patients, Raup says.

Nursing rounds also were implemented to improve patient satisfaction, Jordan points out.

"All the nurses go to the bedside every four hours and talk to the patient, let them know what we're doing, what's going on with their treatment, and ask simple things like whether they want a blanket," she says.

"That way the nurses stay in contact with the patient. We also have some patient liaisons that round with us to help handle issues that might not be nursing-related."

Look for total immersion

To make a soft skills approach work, Jordan says ED managers have to employ it with staff, not just patients. And you have to back up the smile on your face with a sincere desire to make things better. "They need to see that your intent is genuine, and you're not just going into a patient room and putting on a fake face because you want your scores to go up," she notes. "Some of the nurses look at me and say, 'If you can do this after being here 14 years, maybe I can, too.'" ■

Fish tanks and fresh paint help improve mood in ED

Another strategy for improving patient satisfaction in the ED at the University of Arkansas for Medical Sciences (UAMS) in Little Rock is the "calming effect," which aims to create an environment that is less stressful for the patient.

The appearance of the ED can have an important effect in creating a calm environment for patients and helping them cope better with their injuries and illnesses, not to mention any delays and other difficulties they encounter in the ED, says **Glenn H. Raup,** RN, MSN, director of the ED. To achieve a better environment, cleanliness in the patient waiting area was deemed a top priority, along with sufficient reading materials.

UAMS also repainted the ED with soft colors and installed two fish tanks: one in the patient waiting area and one at the nurses' station.

The tank in the patient area is 600 gallons, a huge freshwater aquarium that Raup says patients and staff alike find to be beautiful and relaxing. The initial cost of the setup for both tanks, several thousand dollars, was covered by a donation from the hospital's auxiliary. The ED contracted for an outside company to maintain the tank at a cost of about $100 per month. He notes that large but a more typically sized aquarium of 100 gallons, the size in the staff area, can be established for $500 to $1,000.

Raup says it is important to include staff in any efforts to improve the ED environment. "Their satisfaction with their work will affect how they interact with each other and also with patients," he adds. "Their morale is a big part of a patient's experience." ■

'Gridlock page' helps clear crowded ED

Sometimes, you have to look beyond the walls of your ED for solutions to your overcrowding problems, says **Sandy Vecellio**, RN, BSN, clinical manager of the ED at Gwinnett Medical Center in Lawrenceville, GA. And when things really get rough, she advises, send out an SOS.

Vecellio's ED is tackling the root problem of overcrowding and boarding patients by trying to get patients moving more efficiently through not just her department, but the entire hospital.

The idea is that most of the backup in her ED is caused not by anything her staff is or isn't doing, but by what's going on in other areas, she explains. When one floor is slow to discharge patients, those beds aren't available for new admissions, and eventually that slowdown will result in patients stacked up in the ED.

So the Gwinnett Medical Center ED uses a "gridlock page" to alert others that ED overcrowding is getting out of hand. The basic message is: "Hey! We've got patients stacking up here. Help us by moving your patients out faster."

"When the hospital is full and we're holding patients in the ED, we send out a gridlock page that goes to the beeper of all the managers on the floors," she explains.

Those manager confer with their charge nurses and look for patients who can be expedited with faster discharges, Vecellio says. "They might call the physician and ask if this patient can go," she says. "With the page, we're asking them to be more proactive at that point because they know we're in a critical situation."

Fax alerts doctors' offices

At the same time the managers' beepers are going off, the ED staff also sends a mass fax to physicians' offices to alert them to the gridlock. The fax asks that they come to the hospital and make rounds earlier than usual and try to discharge patients as quickly as possible.

"We get good response from some physicians, and some don't respond much at all," Vecellio adds. "That's to be expected, but any response helps."

The hospital's admissions nurses determine when to initiate the gridlock page. They consider not only the situation in the ED, but also the hospital's surgery schedule.

"We have at times needed almost 50 beds, and patients just had nowhere to go. We've had days when patients were coming out from surgery, and we were already holding 21 patients in the ED as well," Vecellio continues.

"Any time the ED is holding three or four patients and we also have surgery patients coming out, they will go ahead and do the gridlock page," she adds.

Sometimes the admissions nurses will be proactive and do just a warning page, to alert the other units that only a few beds are left.

Gwinnett Medical has been using the gridlock page for about a year employing it about twice a week. The results have been good, she says.

The ED has almost 90,000 visits per year, and the hospital has only 200 bed, "so our ED volume does not match our bed capacity," Vecellio notes. "We have to do a lot creative things."

Managers meet to brainstorm

Another strategy for clearing gridlock in the ED is the hospital's "intake capacity team," which was formed four months ago and meets monthly. Prompted by the realization that ED gridlock doesn't start in the ED, the hospital created the team to bring together managers from each treatment area of hospital, a case manager, the director of housekeeping, and leaders from radiology and the laboratory.

The hospital's chief of operations runs the meeting. Vecellio says this situation is better than the ED manager taking charge, which could breed resentment if other managers thought the ED leader was trying to boss other departments.

"We all come together and figure out where we have process issues that need to change," Vecellio points out.

One problem was beds were not being cleaned quickly enough. The hospital added positions so they had enough staff to turn over those beds quickly when the ED needed them, she says. "We also decided to keep the admission unit open 24 hours a day and increased staff to make that possible," Vecellio says,

Another change addressed the cath lab. Cardiology was admitting patients at the end of the day because

Executive Summary

Overcrowding in the ED starts in other areas of the hospital. Alert those areas and ask for help when the patient load is increasing.

- Page other departments to alert them to your patient load.
- Ask physicians to round earlier than usual and discharge patients.
- Seek ways to improve efficiency in other departments.

Source

For more information on battling ED gridlock, contact:
- **Sandy Vecellio**, RN, BSN, Clinical Manager of the ED, Gwinnett Medical Center, 1000 Medical Center Blvd., Lawrenceville, GA 30045. Phone: (678) 442-4321.

the staff of the cath lab already had gone home; the patients had to stay overnight and wait for the cath lab to open the next day. Because the situation took up precious bed space, the hospital extended the cath lab hours.

"A lot of things come out of these meetings that don't involve changes in the ED, but we change things in other parts of the hospital that have the effect of freeing up those beds and moving patients through the ED faster," Vecellio stresses. "You have to look beyond the ED for solutions."

[*Editor's note: Have other ideas for battling gridlock in the ED? Send your suggestions to Greg Freeman, Editor,* ED Management, *3185 Bywater Trail, Roswell, GA 30075. Telephone: (770) 998-8455. E-mail: Free6060@bellsouth.net.]* ■

EMTALA Q & A

[Editor's note: This column addresses readers' questions about the Emergency Medical Treatment and Labor Act (EMTALA). If you have a question you'd like answered, contact Greg Freeman, Editor, ED Management, *3185 Bywater Trail, Roswell, GA 30075. Phone: (770) 998-8455. E-mail: Free6060@bellsouth.net.]*

Question: We're debating two questions in our hospital regarding when EMTALA applies. First, does the law apply to patients who only are "holding" in the ED because there are no beds available in the hospital? And does it apply when an air ambulance uses our helipad but does not bring the patient to our ED?

We sometimes let air ambulances use our helipad as a courtesy when they're transferring patients to ground transport that will take them to another hospital.

Are we supposed to do an evaluation and establish that the patient is stable before leaving our property?

Answer: EMTALA does not apply in either case, says **Daniel J. Sullivan,** MD, JD, FACEP, president of the Sullivan Group, a consulting company in Oak Brook, IL, that specializes in EMTALA interpretation. Sullivan addressed the same questions recently at the meeting of the American Society for Healthcare Risk Management (ASHRM) in Nashville, TN.

These situations were clarified in the final EMTALA rule, he says. Up to that point, most analysts agreed that EMTALA applied while the patient was still in the ED for any reason, but Sullivan says the final rule takes a more reasonable stance that recognizes the reality of how patients often are boarded in the ED.

"It is clear now that EMTALA does not apply to patients admitted to the hospital but holding in the ED," he continues. "Previously, this was dependent on whether the patient was stable; but the final regulations say EMTALA does not apply if the patient has been admitted and is only in the ED because there's no bed available elsewhere in the hospital."

The question regarding air ambulances is a little more tricky, but Sullivan says you're still in the clear. You can allow air ambulances to use your helipad without taking on an EMTALA obligation for their patients, he says. The key is that the helicopter is using your landing pad only as a practical measure to get the patient elsewhere, as opposed to bringing the patient to you for care.

"When an air ambulance uses your heliport only for convenience, the patient has not 'come to your ED,' and that is the pertinent definition that determines whether your EMTALA obligation is triggered," he explains.

"The helicopter didn't stop at your hospital because the patient was in cardiac arrest and needed to get into your ED right away. If it stopped just because you have a heliport and the destination hospital doesn't, that's just a convenience and the patient has not come to you and requested treatment," Sullivan adds.

In a similar vein, your ED has no EMTALA obligation when an air ambulance stops at your hospital to pick up blood or other needed supplies before flying on to its destination, he notes.

EMTALA should not prevent the hospital from extending that courtesy to air ambulances, Sullivan says. ■

Source

For more information on EMTALA, contact:
- **Daniel J. Sullivan,** MD, JD, FACEP, The Sullivan Group, 2000 Spring Road, Suite 200 Oak Brook, IL 60523. Phone: (630) 990-9700. Web: www.thesullivangroup.com.

Emergency physicians join call for liability reform

High premiums may reduce access to EDs

The liability crisis in many states is "an overwhelming threat to our nation's emergency care system," says **Angela Gardner**, MD, an emergency physician and board member of the American College of Emergency Physicians (ACEP) in Irving, TX.

ACEP reports that the average annual liability premium paid by emergency physicians increased by more than 50% in one year.

The average annual cost of premiums for emergency physicians rose to $53,500 in 2003, reflecting a 56.2% increase over 2002.

Organizations support legislation

High malpractice premiums and the threat of malpractice lawsuits may leave physicians and their patients without access to EDs and medical specialists, such as neurosurgeons, obstetricians, orthopedic surgeons, and cardiologists, Gardner points out.

Gardner addressed the issue in a recent press conference when ACEP joined nine other medical specialty organizations in the Doctors for Medical Liability Reform (DMLR), to unveil a national public education campaign urging U.S. senators to support federal medical liability reform legislation and protect patients' access to medical care.

According to DMLR, from 1994 to 2000, the median jury award for a medical liability case rose by 176%.

ACEP reports that between 1996 and 1999, the average jury award in medical liability cases jumped 76%. In the last 15 years, there has been a 600% rise in the number of megaverdicts in the millions, according to the organization.

Gardner says the campaign is intended, in part, to educate the public about a risk most people don't realize affects them.

"Patients are at risk, and they don't know they are at risk until they get to an emergency room, and the ambulance can't stop there because it is closed," she explains. "Or they do stop there, and there is no specialist on call."

In some states, many specialists are no longer taking emergency call, retiring early, or leaving for states with lower premiums, she says.

Many physicians are transferring patients from their offices to EDs to get them the medical care they need. That results in patients waiting longer in the ED and more ambulance diversions in some cases.

"Emergency physicians are dedicated to caring for everyone who seeks care, regardless of who they are, what condition they have, or their ability to pay," Gardner points out.

"However, this is not a problem that will go away on its own. It will eventually destroy the quality of medical care and patient safety nationwide," she stresses.

The main goal of the campaign is to generate pressure from the public that will urge legislators to address liability reform. **(For more information on liability reform, see "Growing ED liability crisis is spotlighted in survey," *ED Management*, December 2002, p. 141.)** ■

Source and Resource

For more information on Doctors for Medical Liability Reform, contact:

- **Angela Gardner,** MD, American College of Emergency Physicians, 1125 Executive Circle, Irving, TX 75038-2522. Phone: (800) 798-1822. Web site: www.acep.org.

For more information about the Protect Patients' Now initiatives, go to:

- www.ProtectPatientsNow.org.

COMING IN FUTURE MONTHS

- How triage nurses can reduce wait time
- Should you raise triage standards when overcrowded?
- ED educates public about overcrowding
- Portable EKGs for ambulances speed diagnosis

CE/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 with this issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

For more information on the CE/CME program, call customer service at (800) 688-2421. ■

CE/CME *questions*

This concludes *ED Management's* CE/CME semester. **(For instructions, see box, at left. For answers, see box, p. 36.)**

31. According to Grena Porto, RN, ARM, DFASHRM, a health care risk manager and principal with QRS Healthcare Consulting, when should you share information on your drug-seeker list with other institutions?
    A. When you are certain the person is improperly seeking narcotics
    B. Only after the person has made repeated visits seeking drugs
    C. Only when the other institution is part of the same health system
    D. Never

32. Who can access the "habitual patient" file at Cedars-Sinai Medical Center?
    A. Physicians only
    B. Nurses and physicians only
    C. Any ED staff
    D. Anyone who can legitimately access medical records

33. According to Diane M. Sixsmith, MD, MPH, FACEP, chairman of emergency medicine at New York Hospital Medical Center of Queens, what is one way to reduce your malpractice risk from cases of head injury?
    A. Don't assume inebriated patients have a head injury.
    B. Assume inebriated patients have a head injury until you determine otherwise.
    C. Ensure that all inebriate patients are examined by a neurologist.
    D. Avoid performing computed tomography scans on inebriated patients.

34. What does Sixsmith recommend regarding the administration of tissue plasminogen activator (TPA)?
    A. Hospital policy should allow ED physicians to administer TPA when necessary, without further authorization.
    B. Hospital policy should prevent ED physicians from administering TPA without authorization from a neurologist.
    C. TPA should be administered to all patients in whom a cerebrovascular accident is suspected.
    D. If TPA is not administered within the first hour of symptom onset, it should not be administered at all.

35. At Gwinnett Medical Center, who determines when to initiate the "gridlock page" to help clear the ED during overcrowding?
    A. The ED manager
    B. Admissions nurses
    C. Triage nurses
    D. The hospital CEO

36. According to Daniel J. Sullivan, MD, JD, FACEP, president of the Sullivan Group, what is true of the Emergency Medical Treatment and Labor Act (EMTALA) and a helicopter ambulance using your hospital's heliport to transfer the patient to ground transportation?
    A. The patient has not "come to your ED" as defined in EMTALA.
    B. EMTALA specifically excludes patients arriving by air ambulance.
    C. The helicopter's landing automatically triggers your EMTALA obligation.
    D. Your EMTALA obligation is triggered only if the patient is present for more than 30 minutes.

CE/CME objectives

- Discuss and apply new information about various approaches to ED management. (See *"Drug-seeker lists are dangerous at best, and require tight administrative controls"* and *"Formalize drug-seeker list; minimize who can access"* in this issue.)
- Explain developments in the regulatory arena and how they apply to the ED setting. (See *"EMTALA Q&A."*)
- Share acquired knowledge of these developments and advances with employees. (See *"'Gridlock page' helps clear crowded ED."*) ■

CE/CME answers

31. D 32. A 33. B 34. A 35. B 36. A