ED Legal Letter™

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IN THIS ISSUE

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ED overcrowding and ambulance diversion cause potential liabilities

By Jay Weaver, MD, EMT-P, Attorney, Private Practice, Paramedic, Boston Public Health Commission, Boston, MA

Emergency medicine practitioners have little control over the flow of patients into their facilities. Federal law requires them to examine and treat virtually everyone who comes through the door. Traditionally, ED directors have eased congestion by diverting ambulances to other hospitals. Now, though, with hospitals everywhere filling to capacity, this practice may create more problems than it solves.

Emergency physicians who provide medical oversight to EMS agencies have a duty to manage ambulance diversion responsibly. So, too, do physicians and nurses who have the authority to order ambulance diversion on behalf of the facilities in which they work. In fact, all ED practitioners should know something about ambulance diversion because of the profound logistical and economic implications it can have on their hospitals. To make sense of this practice, however, one must first understand why it is used.

ED Overcrowding: The Basis for Ambulance Diversion

ED utilization has increased steadily in recent years. Between 1958 and 2000, the number of ED visits grew by approximately 600%.[1] During the past decade alone, ED visits have increased by 26%. Today, more than 114 million Americans seek care at these facilities annually.[2] This has caused 90% of the EDs at large hospitals and level I trauma centers to operate at or above capacity.[3]

It would be easy to blame this phenomenon on the excessive, inappropriate use of EDs by patients who don't require emergency treatment. While it is true that the poor and uninsured have increasingly turned to EDs for routine medical care, this is not the principal cause of ED overcrowding.[4] Rather, ED overcrowding is primarily a byproduct of hospital overcrowding, representing a backup of seriously ill patients who cannot be admitted due to a shortage of inpatient beds.[5] *(For examples of how some EDs handle high patient flow, see triage story, page 101.)* To compensate for reductions in Medicare and Medicaid reimbursement, hospitals eliminated nearly 40% of all inpatient beds between 1981 and 1999. With the remaining beds filled almost constantly, ED practitioners have found it increasingly difficult to admit patients requiring unscheduled care.[6] At hospitals with overcrowded EDs, the average wait for admission now exceeds five hours.[7]

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Adding to this problem is the fact that fewer EDs now exist. Between 1993 and 2003, one out of every eight EDs closed as hospitals merged in an effort to contain costs.[2] Obviously, this leaves more patients for each remaining ED to treat.

Faced with unprecedented numbers of patients, and no place to send them after they've been stabilized, some EDs have resorted to the practice of "boarding" admitted patients in the ED—sometimes for days. This is not an ideal solution, of course. Boarding ties up staff and ED beds, slowing the rate at which patients may be processed, and thereby delaying the examination and treatment of subsequently arriving patients. This adds to the burden of already-overworked ED personnel, increasing the likelihood of diagnostic and treatment errors, and delaying some patients from receiving specialized treatment available only in a critical care unit.[8]

The American College of Emergency Physicians (ACEP) has defined ED overcrowding as "a situation in which the identified need for emergency services outstrips available resources in the ED."[9] This has proven an elusive concept to measure. Some authorities consider an ED to be overcrowded when the waiting time to see a physician becomes excessive. Others look at patterns of movement from ED to inpatient beds, or the relationship between patient acuity and staffing. Indeed, in some studies, ambulance diversion itself has been used as a measure of ED overcrowding.[4]

By any standard, the nation's EDs are now overwhelmed. A decade ago, only one ED director in ten expressed concern about overcrowding. Today, nearly all ED directors consider it a serious problem. More than half report that their EDs are overcrowded several times each week, while 39% report that this happens daily. Even more troubling is the fact that one-third of the respondents have witnessed poor patient outcomes directly linked to overcrowding.[10]

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires EDs to provide screening examinations and stabilizing care to all who present with an emergent condition.[11] This makes it illegal for ED personnel to turn patients away once they have arrived at the hospital. To cope with overcrowding, doctors and nurses must act sooner, turning patients away *before* they get to the ED. Ambulance diversion represents one of the few ways to accomplish this legally.

The Nature of Ambulance Diversion

Ambulance diversion refers to the rerouting of incoming ambulance traffic by a hospital that cannot handle additional patients. In some parts of the country, this has become an "all or nothing" proposition, with hospitals either "open" or "closed" to ambulances. Others make a distinction between hospitals that would prefer not to accept additional emergency patients and those that have been completely overwhelmed. Similarly, some regulatory authorities allow hospitals to declare themselves "closed" due to a lack of inpatient beds, while others allow hospitals to divert ambulances only when their EDs become full.

This is not a new concept. A quarter-century ago, in a story about Long Island's packed EDs, a *New York Times* reporter wrote that "hospitals often ask ambulance drivers, by means of two-way radios used to alert emergency rooms to imminent arrivals, to go elsewhere."[12] For many years, diversion occurred only in urban areas during winter influenza outbreaks.[4] But as ED overcrowding has exploded into a nationwide, year-round phenomenon, smaller hospitals—including those in rural areas—have been forced to divert ambulances as well.

Diversions now occur more than half a million times each year, or roughly once every minute.[2] A study of Washington hospitals revealed that EDs typically close to ambulance traffic 18 times each month

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for an average of 7.5 hours per day.[9] In major American cities, where ED overcrowding remains most prevalent, hospitals remain on divert status as much as half of the time.[3]

Of the 16 million patients transported by ambulances to EDs each year, 70% are triaged as emergent or urgent, meaning that they require treatment within one hour.[5] These people need to receive care in a hospital, not in an ambulance. Diversion adds to transport time, thereby delaying the onset of care. This becomes a critical consideration when the patient suffers from myocardial infarction, stroke, respiratory failure, or other conditions requiring immediate intervention. According to one Congressional study, ambulance diversion now impedes timely access to emergency care in the metropolitan areas of 22 states, affecting 75 million Americans.[13]

Diversion also impedes access to emergency medical services (EMS). Long-distance transports occupy ambulances and their crews for prolonged periods of time, leaving them unavailable for subsequent emergencies. This exposes the public to delayed emergency responses, thereby placing the entire community at risk.[14]

Since overcrowding rarely exists at just one hospital, ambulance diversion by one ED may cause surrounding EDs to overflow, forcing them to divert ambulances, as well. Simultaneous diversion by multiple hospitals in contiguous areas poses an especially serious problem, because it leaves ambulances with no destination at all. When this happens, EMS authorities may refuse to honor diversion requests, or public health authorities may order rotating diversion.[4] Such was the case in Phoenix, Arizona, several years ago, when EMS had to override diversion requests virtually every day for an entire month—an experience that prompted one physician to conclude that "the concept of ambulance diversion decompression is failing."[15]

For a while, ambulance diversion served a useful purpose. By halting the flow of seriously ill patients, it gave ED personnel an opportunity to admit some patients and discharge others, thereby clearing hospitals of gridlock. But now there are just too many patients, and not enough places to treat them. Diverting ambulances at will is no longer a suitable option.

Diverting Ambulances Responsibly

In today's competitive healthcare environment, ED practitioners and administrators sometimes succumb to pressure to divert ambulances as a cost containment measure, ensuring that inpatient beds will remain open for high-paying elective surgery candidates. To do so constitutes a grave mistake. Such practices are illegal under EMTALA, and carry a penalty of $50,000 and possible exclusion from the Medicare and Medicaid reimbursement programs—plus a risk of civil liability.

The Centers for Medicare and Medicaid Services (CMS) has stated in its Interpretive Guidelines that "[a] hospital may divert individuals when it is in 'diversionary' status because it does not have the staff or facilities to accept any additional emergency patients at that time."[16] No other EMTALA provision permits a hospital to deny emergency care to any patient. Thus, a hospital may not rely on a shortage of inpatient beds to justify diversion. Only after the ED's resources have been exhausted may a hospital turn away ambulances.

When care begins. These guidelines go on to say that "if any ambulance disregards the hospital's instructions and brings the individual on to hospital campus, the individual has come to the hospital and the hospital has incurred an obligation to conduct a medical screening examination for the individual."[16] Moreover, CMS has informed hospitals that an EMTALA obligation arises when the patient arrives in the emergency department, not when care is "accepted" by hospital personnel from EMS personnel.[17] It should be clear from these statements that a hospital does not enjoy an absolute right to divert incoming ambulances. Rather, diversionary status amounts to a request—a request that may be honored or ignored by area EMS agencies and ambulance companies.

A Hawaii physician learned this lesson the hard way. In *Arrington v. Wong*, the Ninth Circuit Court of Appeals held that he may have violated EMTALA by turning away an ambulance by radio when his hospital was not on diversionary status. The court went on to suggest that he would have had an obligation to accept the patient even if his hospital *had* been on diversionary status if the EMTs had ignored the diversion and continued to his hospital.[18]

Patient choice. To some extent, then, patient autonomy trumps a hospital's diversionary status. A patient may demand to be transported to a "closed" ED, and if EMS personnel agree to bring him there, the hospital cannot legally turn him away. The patient should be made to understand, however, that he accepts the risk of delayed care by overriding the diversion. EMS personnel have a legal obligation to provide sufficient details to permit informed consent. Once the patient reaches the ED, hospital staff have a similar duty to provide information about the anticipated waiting period.

Consider area hospital capacity/specialty. Hospital diversion decisions should take into account the capabilities of surrounding hospitals. A community hospital may divert ambulances to other community hospitals, for example, with relatively little impact on patient care. When a regional trauma center closes to ambulance traffic, however, EMS personnel may be

left with no alternative destination. Specialty centers should, therefore, divert ambulances rarely, if ever. If only for ethical reasons, these facilities should consider adopting a policy that permits diversion of routine ambulance traffic while remaining open to patients requiring specialized care.

It's difficult to say just how badly an ED must be overwhelmed before diversion is justified. Diverting too frequently imposes an unfair burden on surrounding facilities, which may spark a community-wide public health crisis. But waiting too long may cause problems as well. Several years ago, a Maryland hospital effectively refused to close, accepting ambulance traffic regardless of conditions in its ED. The facility soon filled, and EMS personnel had to wait hours with patients until a bed became free. After many such incidents, the county gave paramedics the authority to decide for themselves whether to bypass the hospital since the facility had proven itself unable to perform its public duty.[19]

Who should have the authority to place a hospital on diversionary status?

Opinions vary. Some hospitals give this authority to the senior on-duty emergency physician. Others give it to an administrator, ED charge nurse, or hospital nursing supervisor. ACEP recommends vesting this authority in an ED physician with the cooperation of the administrative and nursing staff.[20] Regardless of position or title, the person who authorizes diversion must have an appreciation of the legal, medical, logistical, and financial implications of such a decision.

When advising EMS agencies, ED practitioners must know when to honor diversion, and when to ignore it. An ambulance service that ignores a hospital's diversionary status may incur liability if a patient suffers harm from a delay in treatment. At the same time, EMS personnel have an obligation to deliver patients to a hospital within a reasonable time. This becomes something that's difficult to accomplish when all area hospitals have closed to ambulance traffic. It is not unreasonable, then, for an EMS agency to adopt a policy under which a specified number of diversions triggers the re-opening of all area EDs. The Metropolitan Boston EMS Council has entered into an agreement with Boston hospitals, for example, that permits no more than two EDs to divert ambulances simultaneously.

Conclusion

ED personnel have long relied on ambulance diversion to reduce overcrowding. With the demand for emergency care rapidly outpacing demand, this practice has become less effective and more problematic. Better methods exist for controlling patient flow—methods that include the use of observation units for short-term admissions, "fast track" facilities for patients requiring little care, and a "bed czar" to coordinate bed utilization throughout the hospital. ED practitioners who persist in diverting ambulances should realize that this may create legal problems, as well as ethical and logistical ones. ■

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Poor triage processes can get you sued, criminally charged

Los Angeles case reflects increasing anger toward EDs

by Stacey Kusterbeck, Contributing Editor

The news stories shocked many Americans: ED staff ignored a dying woman's pleas for help as she bled to death of a perforated bowel on the floor of their waiting room. That is what the family of a Los Angeles woman claim happened in May 2007 at Martin Luther King Jr.-Harbor Hospital's emergency department.

The family has since announced it will file a wrongful death and medical malpractice lawsuit against both the hospital and the triage nurse involved.

Delay in care leading to what may have been a preventable death is nothing new to emergency medicine malpractice litigation, says **Edward Monico,** MD, JD, assistant professor in the section of emergency medicine at Yale University School of Medicine in New Haven, CT. "Failure to recognize a medical or surgical emergency has always been a source of liability for triage personnel, hospitals, and emergency physicians," he says.

However, malpractice lawsuits involving adverse outcomes *before* ED patients were seen by a physician are particularly difficult to defend, according to **James J. Augustine,** MD, FACEP, director of clinical operations for Canton, OH-based Emergency Medicine Physicians. "I have had to try to defend cases where people had a bad outcome in the front end, and they are not easy to defend," says Augustine. "I don't think that the circumstances of this case are that unusual, unfortunately."

Both this case and a July 2006 Illinois case involving a woman who had an acute myocardial infarction caused by acute coronary thrombosis and died in an ED waiting room were both looked at by officials as potential criminal actions.

A coroner's jury ruled the woman's death a homicide, saying that the ED's decision to triage the woman back to the waiting room was a "gross deviation from the standard of care, which a reasonable person would exercise in the situation." No ED staff were ultimately criminally charged in that case.

At presstime, it was not yet announced whether criminal charges will be in fact be filed against ED staff at the Los Angeles hospital. Regardless, if prosecutors felt that the actions taken by ED staff may have cost these patients their lives they would be potential criminal matters. It is a wake-up call for EDs, says Augustine.

"We are at the point in our system development where we have prosecutors who are making these kinds of judgments. That is very, very much a call for us to look at the design of our entire system," says Augustine.

"Both of these cases said that you are not only liable in a civil action, but there is a potential that your activity could be viewed as something criminal. That is a huge transition and reflects the anger that the community has toward the ED," he says.

There is no question that anger and frustration of patients toward EDs are increasing, says Augustine. "It blows me away that we have to get to the point where a prosecutor is considering criminal actions against a department before we say 'Maybe the process that we've been using is not correct,'" he says.

Triage nurses at risk

Prolonged wait times in EDs have become a pervasive problem that increases liability of triage nurses, says **Vickie Halstead**, RN, CVNS, CCRN, CEN, CLNC, principle of Circle Pines, MN-based The Critical Difference, a consulting firm specializing in emergency and critical care education.

Once a patient arrives and is waiting in the triage area, that patient is the responsibility of the triage nurse, says Halstead. Document the status of patients waiting according to the hospital's standards, which often advocate hourly vital signs and status reports, she advises.

"This is extremely difficult to accomplish when there are 20 or 30 patients waiting and more patients constantly arriving," she says. "Hospitals need to staff the triage area adequately to allow this ongoing assessment of patients who are waiting."

Remember that when you document patient care, you are writing a record of how well you met the standards of care, which only dictate the minimum expected, says Halstead. "Courts may interpret a lack of documentation as a lack of patient care. If triage nurses are monitoring the status of patients waiting, they must take the time to document their findings," she says.

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SPECIAL REPORT

Use caution when buying medical malpractice coverage

*By **Layton C. Severson, ARM, AIC,** President, L. C. Severson Company, Inc.*

Summary: Physicians should not purchase medical malpractice insurance from the surplus lines insurance markets unless there is no coverage available to them from the admitted markets. Physicians should use the surplus market only as a last resort when buying medical malpractice coverage. Moreover, physicians should be concerned regarding two other insurance pitfalls — limits of liability for each physician within a group and whether the expenses of claims are inside or outside of the limits of liability of their policy.

I have encountered several recent situations when reviewing coverages for physicians that have made me wonder if they truly understood how the insurance market works and how policies are constructed. Here are three issues in professional liability insurance that the physician should understand when purchasing professional liability coverage.

Coverage in the Surplus Insurance Markets

Generally speaking, coverage should not be placed with the surplus insurance market unless there are no admitted insurance markets available to quote your coverage.

For the last several years, the healthcare industry has experienced a hard insurance market, meaning that for some physicians, insurance has been difficult to obtain at any price, and for almost all other physicians, the pricing has increased dramatically. In the insurance world, this leads to the entry of surplus lines insurers who can quote conditions, terms, and pricing on almost any basis they feel like offering when they review your application. They know that your agent has (or should have) received declinations from admitted markets before going to them, and they may be your last hope for coverage.

There are indications that some practice managers and physicians have had the misfortune to trust an agent who has placed them with a surplus lines company when an admitted carrier would have issued them an insurance policy. In some cases, physicians and practice managers were not given full information about what it means to be insured by a surplus lines carrier instead of one that is licensed to do business in their state (an admitted carrier). Before you pay a premium to have an unauthorized carrier protect your reputation and your assets, consider the following issues:

- Each state's law regulating the conduct of insurance agents usually prohibits them from soliciting or placing liability business on behalf of an unauthorized carrier unless there has first been a good faith effort to obtain such coverage from properly authorized carriers in their state. In other words, an agent may not place business with unauthorized insurers unless a number of the companies licensed in the state to provide the coverage have been given the opportunity to evaluate the risk and have refused to offer such coverage. While most insurance agents and brokers are professional in their activities, some of them are closely associated with unauthorized carriers and may not be making the required effort to present their clients to the "standard" market before guiding them to a surplus lines carrier.
- You should expect your agent to advise you, preferably in writing, of all the markets they have contacted on your behalf and to advise you of the results of those contacts. They should also advise you of their commission or fee arrangements with each market to be certain you are fully informed and can make an intelligent business decision about an issue that is both critical and costly to your practice.
- Be aware that no agent is licensed with all markets, so there may be other markets that can quote your business from other agents or brokers.
- Your state Department of Insurance laws usually prohibit an insurance company that is not licensed in your state from transacting insurance business within the state. Agents procuring coverage from surplus lines carriers are involved in out-of-state transactions that are not regulated by your state Department of Insurance (DOI). If you elect to go with one of these insurance carriers, you should ask your agent for a complete briefing on their agency's relationship with each surplus carrier proposal presented and their associated compensation plans. In some instances, agents have the option to adjust the commission or fee with the insurer. Be certain that your agent shares his/her fee or commission structure with you before you buy.
- Important protections afforded by your state's Department of Insurance will not be available to those insured by unauthorized carriers, including protection

against such things as: policy language and coverage that does not meet minimum standards for approval; unreasonable or short notice cancellations; non-renewal without adequate notice; mid-term cancellation by the insurance company; and unreasonable terms for extended reporting endorsement ("tail") coverage.

- Unauthorized carriers are not permitted to be members of your state's Insurance Guaranty Association. In the recent past, many professional liability writers have become insolvent, including companies that once enjoyed an A rating by A.M. Best. Regardless of a company's current rating, if you purchase from an unauthorized carrier, you will not be protected by your state's guaranty association if that carrier becomes insolvent.
- Surplus lines carriers have historically been a "court of last resort," charging higher premiums over time, insuring physicians with challenging claims histories, and paying higher-than-average commissions to agents. While there may be a role for these surplus lines carriers in placing physicians who are "high risk" for any number of reasons, surplus lines carriers have not been the insurance companies preferred by doctors with good claims histories and who present an acceptable risk.

While the vast majority of insurance agents have performed admirably and with great integrity through the hard market (see "coverage in the surplus markets" section), there are always a few bad apples that give any profession a bad name.

There may come a time when a high-quality unauthorized or "surplus lines" insurance carrier might be your only option—a time when your claims history or a lack of insurance options forces you to make an informed choice to obtain insurance through such a carrier. We have seen some excellent examples over the past few years in the hard market. However, as the market has stabilized most states now have several admitted carriers available to the vast majority of physicians, and their agents should first look at these admitted carriers for their clients. Any suggestion to the contrary should be scrutinized closely before acceptance.

Lesson Learned. Require that:

1) your agent or broker fully disclose all of the insurance coverage and carrier details;
2) the agent or broker fully disclose their total remuneration for representing your interests;
3) they provide you with a list of the licensed insurers available within your state;
4) they disclose which carriers have been solicited by them (or others they may have contacted with other agents or brokers); and
5) you know what other options you might have regarding your coverage.

Your Policy's Limits of Liability

The limit of liability of an insurance policy indicates the amount of coverage. However, this limit can be modified later within the policy in several ways.

In most professional liability policies, the Limit of Liability (LOL) is stated in a flat amount, such as $1,000,000 per medical incident and $3,000,000 per annual aggregate. The one million per medical incident would seem to be simple to understand, as would the three million annual aggregate. If you are a solo practitioner, there is little doubt for concern regarding these limits.

However, if you practice within a group, such as most ED physicians do, there may be some hidden complications of coverage within the insurance policy. Several policies I have reviewed from surplus lines carriers have indicated that the limit of liability applies, in total, to all physicians within the insured group or corporation.

Let me give you one extreme example. I was recently asked to review one ED group's professional liability policy and determined that for the entire 14-member group, the limit of liability was one million dollars per medical incident, with an annual aggregate of one million dollars. Thus, there was only one million dollars of coverage for the entire policy year for the entire group—and the annual premium approached one million dollars. In this case, there was essentially no insurance, just a trading of dollars for which the agent was receiving 20% of the premium.

Lesson Learned. Make certain that the limits of liability of your policy apply to each physician in the group and not to the group as a whole.

Factors Eroding the Limits of Liability

While there is not enough space here to identify all of the potential approaches insurers might have to affect the LOL of your insurance policy, I want to note that the major concern is whether the allocated loss adjustment expenses (ALAE) of a claim are covered inside or outside of the LOL.

The ALAE in a complex medical malpractice claim can be substantial. Most admitted insurers cover these expenses as an additional or supplemental coverage within their policies. However, many surplus lines carriers may place these expenses within the LOL of the policy, thus reducing the amount of coverage available to settle claims.

Most hospitals requiring specific limits, such as one million per claim and three million per annual aggregate, have not addressed this issue.

However, as time goes on with the continued escalation of claim costs, they will ultimately focus on it. Currently, it is more important that the physician or practice group understand that the limitation of this LOL can pose a significant problem of inadequacy of limits to resolve claims.

When dealing with non-admitted carriers (surplus lines carriers), other conditions and restrictions may apply that admitted carriers routinely provide for.

Lesson Learned. Be careful to get the full limits of liability you applied for. Require that your insurance agent or broker fully explain your coverage and its limitations.

Conclusion

Physicians should understand that most insurance agents and brokers are reliable and trustworthy, but also be aware that, as in any other profession, there are those who will seek to take advantage of your lack of knowledge. ■

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To reduce liability when the ED is full, triage nurses must consult one of the ED physicians to assess patients who are worrisome, says Halstead. "If needed, IV access may have to be established in triage, and treatments initiated while the patient waits," she says. "This obviously requires adequate staffing of the triage area."

To reduce liability risks for patients waiting to be seen in your ED, do the following:

- **Do repeated clinical assessments.**

EDs should develop protocols and medical records to prompt health care personnel to conduct serial exams on waiting room patients, says Monico. These are necessary to recognize when a change in a patient's condition demands a change in the timing of definitive medical intervention. "Documentation of serial physical exams, patient comfort, and vital signs supports the contention that patients are not being ignored," says Monico.

Your ED could be held liable if courts find that administrators should have had protocols in place requiring triage personnel to reassess waiting room patients, says Monico.

Protocols for assessment and reassessment of patients before physician evaluation are helpful in defending malpractice allegations, but only if they are followed by ED staff, says Augustine. "Crowding of the ED is helpful for a judge or jury to understand, but may not protect the ED staff from charges of malpractice for any individual patient," he says.

- **Avoid specifying timeframes for reassessment.**

"It's better to be general and not specific, because if you don't meet that 'every hour' rule, then you hold yourself out liability-wise," says **Theresa Finerty,** MS, RN, CAN, BC, director of emergency and trauma services at OSF Saint Francis Medical Center in Peoria, IL. Instead, protocols should require staff to reassess patients frequently appropriate to their illness, she recommends. OSF's ED policy reads "The initial assessment will be performed on each patient by a licensed registered nurse. Patient diseases, condition, and presentation should direct the caregiver toward the necessary frequency of vital signs and system assessment."

- **Be sure that your electronic medical record (EMR) can identify and track high-risk patients in the waiting room.**

"The EMR should also have the ability to easily show these individuals on the tracking board," says **James R. Hubler,** MD, JD, FCLM, FAAEM, FACEDP, clinical assistant professor of surgery in the department of emergency medicine at OSF Saint Francis.

- **Utilize ED personnel to assist when appropriate.**

"Hospitals may need to adopt a flexible staffing model to address patient volume surges," says Monico. Paramedics or emergency medical technicians (EMTs) may be able to reassess patients, but they can generally only obtain vital signs, and the hospital must have a policy in place for this, says Hubler.

Patient advocates stationed in ED waiting rooms can act as liaisons between patients and triage personnel, says Monico. However, whether paramedics can be used to reassess patients in a crowded waiting room may be subject to state laws and hospital policy.

"Technicians can certainly obtain vital signs. However, vital signs represent only a part of what triage personnel use to assess the urgency of a patient's symptom complex," notes Monico. Liability might also reach hospitals and ED or nursing directors if triage personnel were found to be inadequately trained in triage techniques, he says.

Paramedics and EMTs have the skill set that is needed to greet patients, ask why they came to the ED, do a quick evaluation, and transport patients into care areas, says Augustine. "Paramedics are a natural in for greeting and screening patients, physical movement, and wayfinding," he says. "The reassessment issue is probably a better nursing skill and a core competency of nursing."

More lawsuits coming?

The huge amount of news coverage given the Los Angeles case has unfortunately added "fuel to the fire"

when it comes to increased tension between ED staff and patients, according to emergency physicians. "Media coverage of these incidents may cause further perception changes of the emergency care system," says Augustine. "The 'white hat' status of the emergency department and its staff may be darkened, and future encounters with patients and their families may become more confrontational."

The ED needs to carefully preserve an image of being caring and competent, says Augustine. "Legal actions could become more frequent if staff are viewed as uncaring," he adds.

Patients may not perceive long waits and crowded waiting rooms as the basis for a lawsuit in and of itself, says Monico. "However, when a claim of malpractice is made, the long wait usually supports a delay-in-care argument made by the plaintiff," he says. ■

Sources

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Change the "footprint" of wait areas, reduce lawsuits

It's safer for patients to wait on the "back end" of ED visit

To solve the problems that contributed to ED staff actions being considered as potentially criminal in recent cases of patient deaths in Los Angeles and Illinois, the answer doesn't lie in reducing risks of adverse events in patients kept waiting for hours, according to **James J. Augustine,** MD, FACEP, director of clinical operations for Canton, OH-based Emergency Medicine Physicians.

"I don't believe we should be working hard on establishing systems for doing reassessments," says Augustine. "We need to completely redo the greeting process, so that the patient is plugged in to treatment immediately," says Augustine.

Instead of performing and documenting repeat assessment during long waits, hoping that a patient's deteriorating condition won't be missed, the goal is for the patient to be dispositioned quickly so the next patient can be seen and treated, he says.

If the patient is going to be waiting at any point, they should be waiting only after they have received their initial evaluation and diagnostic tests, says Augustine.

"If you are going to create a waiting room, it should be at the end when all the testing is done and a few results haven't come back yet, and a further discussion needs to occur," he says.

Rethink waiting areas

The root cause of the recent highly publicized patient deaths which led to lawsuits and consideration of criminal charges, says Augustine, is that EDs are designed incorrectly.

"We have decided that we need to screen people in the front end and decides who needs to wait. I don't think that is fair, and I don't think it's the right way to structure the department," he says.

Augustine points to another area of the hospital with similar challenges to the ED-labor and delivery, and says they do a much better job of accommodating patients who come in unpredictable numbers. "When a woman comes in labor, they don't tell her to sit outside and wait for 12 to 24 hours," he says. "Somehow we have designed the ED so we can make people wait. And frankly in some cases, it's done with the idea that

if we make them wait long enough maybe they will leave. That is tremendously unfair and leads to problems like what happened in these cases."

Two examples of approaches that have been shown to reduce liability risks are physician triage and team triage, says Augustine. Both these approaches aim to reduce barriers in the "front end," before a patient is seen by a physician.

"We need to make the front end a relatively small footprint in the process-just enough to know who needs to be seen in the ED, and then get them back," he says. By reducing the size of your waiting room and using the extra square footage for increased treatment space, you can "change the footprint" of your ED, says Augustine.

"You don't want to wait for a bad outcome and notoriety to make changes," he says. "You want to increase patient and staff satisfaction, and reduce the stress on the people who are otherwise out front trying to be the 'wall.' Those people have a very stressful job thinking about who should be going back and who shouldn't, when in fact everybody should be going back," says Augustine.

There is no surprise on any given day about when people are going to arrive and what services they are going to be needing, says Augustine. "It's fairly predictable in many EDs. They start arriving at 8 or 9 or 10 a.m., and stay at a constant flow until 8 or 9 or 10 in the evening," he says. "In labor and delivery, they receive patients, put them in a patient care area and begin to process them. That's the same thing we should be doing in the ED. Instead, we have fallen into a pattern where we think we need to have every patient triaged." ■

Do EM residents worry about lawsuits too much?

Safety, not lawsuits, should be priority

When a group of physicians starting emergency medicine residencies in California were surveyed, researchers found that malpractice fear markedly decreased the interns' enjoyment of medicine.[1]

"We were trying to gauge how much concern they had about malpractice, and how it affected their decision making," says **Robert M. Rodriguez,** MD, the study's lead author and research director for the department of emergency services at San Francisco General Hospital.

The interns had at least a moderate concern about malpractice at the beginning of their residency. "This concern highly affected their satisfaction and enjoyment of practicing emergency medicine," says Rodriguez. "It was something that really detracted from their experience."

By the end of the residency, their level of concern had not changed significantly, but the effect on their enjoyment seemed to decrease. "It did not affect either interns or the graduates' decision to perform procedures. But it certainly is something that is on their minds," says Rodriguez.

The researchers expected that the residents would have at least a moderate concern about being sued, but they were surprised that this did not increase over time, says Rodriguez. "We are all faculty at academic centers and we often discuss issues related to malpractice," he says. "It is a big concern for everybody."

Discourage defensive medicine

In general, malpractice concern is a negative thing, because it results in the practice of defensive medicine, according to Rodriguez. "It leads to ordering more tests just for the sake of making sure you don't get sued, which increases health care costs," he says. "The increased expenditure does not appear to lead to better patient outcomes."

Since the study showed that interns already had worries about lawsuits at the onset of their training, this leads to the question: Where do they get those concerns from? "The answer to that has to be at least partially during medical school," says Rodriguez. "And during residency itself, there may be things that we can do to alleviate some of this fear, to prevent defensive medicine from having an even greater effect."

However, other emergency physicians argue that a certain amount of concern about malpractice lawsuits is not necessarily bad. "As someone who has been a medical director for most of his career, I prefer emergency physicians with a healthy fear of getting sued," says **Tom Scaletta**, MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL and current president of the Milwaukee, WI-based American Academy of Emergency Medicine. "This helps assure careful practice and meticulous documentation."

Ideally, all emergency medicine training programs would include didactic education and simulation testing focused on improving the physician's bedside manner, says Scaletta. "Excessively defensive medicine, however, is unhealthy and can put the patient though unnecessary and sometimes invasive tests, inflate the cost of healthcare, and slow throughput so that sick patients spend too long in the waiting room," he says.

In residency, the focus is clinical knowledge since there is so much to learn, notes Scaletta. "Many emergency docs learn customer service techniques during

their first job—often the hard way, by being reprimanded," he says. "It is felt that some lawsuits are prevented by caring relationships and others are provoked by uncaring relationships."

According to **Carey D. Chisholm,** MD, director of the emergency medicine residency program and clinical professor of emergency medicine at Indiana University School of Medicine in Indianapolis, the amount of concern residents have is predominantly influenced by their attending physician and the faculty they work with.

"If those individuals are generally risk adverse, the resident will be more inclined to practice overly defensive medicine," says Chisholm. He points to the fact that the number one successful malpractice lawsuit that comes out of the ED is failure to diagnose.

"Obviously, to be named in a malpractice suit is rather devastating to any physician, particularly if you are successfully sued," says Chisholm. "The longer you can put off having that happen, the better."

Focus on safety, not lawsuits

Part of the problem is that fear of disclosure tends to make people cover up errors and near misses, says Chisholm. "Unfortunately, there is no reward for pointing that out. No one wants to stand out by looking incompetent or negligent," he says. "Add to that the potential for creating a malpractice suit, and I think it puts a huge braking effect on addressing systems issues that contribute to medical errors."

A recent study showed that while only 18% of physicians received education on how to disclose errors, 86% wanted this training.[1] "We are specifically going to integrate that into our curriculum this year," says Chisholm.

The legal system holds an individual accountable, but it's the system that allowed the error to be made that must be addressed, says Chisholm. "'As long as the legal system is going to hold the individual accountable as the point person and culprit, we will never have a system that is forthcoming in reporting near misses," he says.

A recent two-hour grand rounds program at Indiana University focused specifically on medical errors in the ED. "The goal wasn't to avoid lawsuits. It was to practice safe medicine for our patients," Chisholm says. "From the feedback we've gotten, the idea of looking at the system instead of the individual is something that most residents haven't been exposed to in medical school. This is a new concept for them."

As a result of this realization, Chisholm challenged both residents and faculty to identify a system issue in the ED that promotes error over the coming year.

Practicing legally safe medicine is a very different thing than practicing good medicine, says Chisholm. "Legally safe medicine," taken to the extreme, leads to ED physicians ordering tests that are potentially harmful to patients, he says. "A classic example is repeat abdominal [computerized tomography] scans with intravenous contrast, which has potential adverse effect on kidneys as well as the risk of radiation over time."

Physicians perform these tests because the legal system holds them to a zero percent error rate, says Chisholm. "It doesn't matter if there is a pretest probability of 1 in a 1000 of finding the condition. They don't want to accept that risk," he says.

There is a misconception that more diagnostic tests equals better care, but in fact, needless testing can actually harm patients, and both residents and patients should be made aware of this, stresses Chisholm. "There is a cost to the individual to have unnecessary

Sources

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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. ■

tests. For one thing, there are false positives that can result in a cascade of ongoing tests when the disease condition isn't really there."

Instead of practicing defensive medicine, residents should be learning good communication skills which decrease the likelihood that a patient will become angry, says Chisholm. "Those techniques serve you well, because angry patients are more likely to sue," he says.

Reference

1. Waterman AD, Garbutt J, Hazel E, et al. The emotional impact of medical errors on practicing physicians in the United States and Canada. *Joint Commission Journal on Quality and Patient Safety* 2007; 33(8):467-476.

CNE/CME *Questions*

35. What should ED policies require for reassessment of patients in waiting rooms to reduce liability risks?
    A. Reassessment within 30 minutes.
    B. Reassessment within an hour.
    C. That patients will be reassessed frequently appropriate to their illness.
    D. No requirements should be put in writing.

36. Which is recommended to reduce liability risks of reassessment for ED patients?
    A. Use paramedics exclusively.
    B. Take only vital signs to improve flow.
    C. Reassess only patients waiting over one hour.
    D. Use an electronic medical record to track high-risk patients.

37. Which is true regarding liability risks of triage for EDs?
    A. A process should be designed so that patients are expediently seen by a physician.
    B. Physician triage has been shown to increase liability risks.
    C. Team triage is linked to increased timeframes to see a physician.
    D. Increased waiting room size can lower liability risks.

38. Which is recommended to avoid the practice of defensive medicine by emergency medicine residents?
    A. Hold individuals, not systems, accountable for errors.
    B. Discontinue training on error disclosure.
    C. Educate residents about the potential harm of needless diagnostic tests.
    D. Avoid education on improving bedside manner.

Answers: 35. C; 36. D; 37. A; 38. C

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. ■

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