Current Studies Focus on Access to Emergency Care and Medical Malpractice

Kathleen Ream
Director of Government Affairs

According to a recent study by the RAND Corp, approximately 28% of emergency department (ED) visits were first contact for a new health concern that could have been provided at an alternative site. In the past, general practitioners were considered the providers of first contact in the United States. The authors[1] found that today only 42% of the 354 million annual visits for treatment of a new health problem are made at the office of a patient's primary care provider. The rest of the visits are made to EDs (28%), specialists (20%), and outpatient care departments (7%).

This study further found that time of day had an influence on the site of care. As one might expect, more than 95% of acute-care, office-based primary care providers and specialist visits occurred on weekdays. Also, outpatient care departments received 89% of their acute care visits on a weekday. EDs, due to the availability of 24-hour access, saw 30% of their acute care visits on weekends. On weekdays, after standard office hours, EDs saw 37% of acute care visits.

Timely access to primary care is a continuing problem in this country. In 2009, 28% of Medicare beneficiaries and a similar number of privately insured individuals had difficulty finding a primary care provider. This suggests that individuals, out of necessity, will continue to seek primary care in a different setting than a primary provider's office.

Another recent study[2] explored the potential use of urgent care centers and retail clinics to decrease ED acute care visits. While care at these sites does not help to address the issue of continuity of care that is lost by a patient's use of the ED and these less conventional sites, use of these alternate care sites could realistically reduce the numbers of non-urgent primary care visits seen in EDs. The authors report that 27% of ED visits could be seen in these sites. This would include care for sore throat, sinus infection, pink eye, ankle sprain and simple fractures. Urgent care centers and retail clinics are viewed by patients as more convenient as well as saving money for the patient and payer.

Medical liability reform is an important topic that was not addressed in the ***Patient Protection and Affordable Care Act***. Health care reform will have the effect of extending health care benefits to more individuals; the ability to decrease the national cost for health care is an important concern. One area that is identified for national health care cost reductions is medical liability reform.

In a study entitled "National Costs of the Medical Liability System," the authors analyzed the components cost of the medical liability system.[3] The overall costs, including defensive medicine, were found to be an estimated $55.6 billion in 2008, representing 2.4% of total national health care spending. The study concluded that while medical liability is unlikely to "bend the health care cost curve significantly," it may be important for other reasons. While liability reform represents a very small part of national health care costs, it is still a significant amount of "real" money. In another study[4] that was released recently, the authors addressed the fear of litigation that drives providers to practice defensive medicine. The study found that defensive medicine practices were widespread within almost all clinical areas and in 28 out of 35 physician specialties.

Policymakers and regulators will be forced to deal with many issues during the implementation of health care reform. With the expansion of coverage, more individuals will move from the uninsured to the insured category and begin to seek services. The question is how will we deal with access and how can we move medical liability reform.

References:

1. Pitts, SR, Carrier, ER, Rich, EC, Where Americans get acute care: Increasingly, It's not at their doctor's office. *Health Affairs* 29, No. 9 (2010): 1620.
2. Weinick, RM, Burns, RM, Mehrota, A, Many emergency department visits could be managed at urgent care centers and retail clinics. *Health Affairs* 29 No. 9 (2010): 1630.
3. Mello, MM, Chandra, A, Gawanda, AA, Studdert, DM, National Costs of the medical liability system. *Health Affairs*, 29 No. 9 (2010): 1569.
4. Thomas, WJ, Ziller, EC, Thayer, DA, Low costs of defensive medicine, small savings from tort reform. *Health Affairs* 29 No. 9 (2010) 1578.

Summary Judgment Granted in Claim of Emotional Distress

On July 16, 2010, the U.S. District Court for the Northern District of California granted a medical center's motion for summary judgment in a suit alleging emotional distress damages from a denial of treatment at the medical center's ED resulting in an EMTALA violation (Pugh v. Doctors Medical Center, N.D. Cal., No. 08-4159, 7/16/10).

The Facts

On February 19, 2008, Tommie Pugh, accompanied by his wife, Willia Pugh, sought emergency medical care from the Doctors Medical Center's (DMC) ED, in Oakland, California. Pugh was immediately assessed by a triage nurse. Pugh complained of burning from the knees down and stated that he had diabetic neuropathy. He told staff to "hurry up," because he wanted pain medication.

Pugh was then examined by Malcolm Johnson, MD, a contract employee hired by California Emergency Physicians. Johnson reported in the record that the patient "was argumentative and noncompliant" and that Pugh reported a history of hypertension, diabetes and high cholesterol. While Pugh complained that he could not move his right lower or upper extremities, Johnson noted that the patient had walked into the room without difficulty and that he also used his right hand and arm to remove EKG leads from his chest. Johnson did not find on physical examination or by observation that Pugh was having right-sided or lower extremity weakness. Johnson noted in the chart that all Pugh said he wanted was methadone.

Johnson reported that Pugh "became upset when he was informed that methadone was not available in the ED. At that point, Mr. Pugh got up from the table and told Dr. Johnson that he wanted to leave. Dr. Johnson tried to keep Mr. Pugh from leaving, but…Mr. Pugh signed a form verifying that he was leaving against medical advice."

The Pughs returned to their home where Tommie Pugh took his methadone. "Mr. Pugh testified in his deposition that after he drank the methadone, he 'blacked out,' and that he had no recollection of any events that occurred during the next few weeks – until 'a month or so later when I came to.'" Because Tommie Pugh was feeling weakness in his right side and Willia believed Tommie was having a stroke, she drove her husband back to DMC. Upon arriving at the

continued on page 5

medical center, Willia Pugh asked two ambulance attendants sitting outside the ED entrance for assistance in getting her husband inside.

Dr. Johnson came outside. According to Willia Pugh, "she told Dr. Johnson that Mr. Pugh was ready to come back to the hospital, but Dr. Johnson told her that he…was tired of their 'shucking and jiving and lying,' and…allegedly threatened to have the Pughs arrested for trespassing if they did not leave the hospital area." Johnson stated that "he took three or four steps out of the ED entrance toward the Pughs' vehicle, but did not approach the van, or see who was in it. He concedes having spoken with Mrs. Pugh, but maintains that Mrs. Pugh did not want or request care or treatment…Johnson denies that he ever argued with Mrs. Pugh or that he refused to treat Mr. Pugh."

Willia Pugh took Tommie to another facility, Alta Bates, located 25-30 minutes away from DMC. Medical records indicate that upon evaluation in the Alta Bates's ED, Tommie Pugh "was alert, awake, and oriented…a CT scan of his head showed a 2.4 cm left thalamic and basal ganglia hemorrhage with some mild edema. A neurological evaluation concluded that no surgical intervention was required." Tommie Pugh was admitted to the ICU for further treatment, and two weeks later, Pugh was transferred to another facility for subacute treatment.

On September 3, 2008, the Pughs filed suit with a claim of negligence per se against DMC, based on a violation of EMTALA, and a claim of intentional infliction of emotional distress against Johnson. On December 16, 2009, both defendants filed motions for summary judgment. In March 2010, the federal district court denied Johnson's motion as to the intentional infliction of emotional distress claim, but for the negligence per se claim against DMC, the court granted the motion insofar as "Mr. Pugh was seeking damages based on physical injuries, and denied it insofar as he was seeking damages for emotional distress…the court also noted that the pleading of the EMTALA claim as a claim of negligence per se was problematic, as an EMTALA violation does not give rise to a negligence claim, and Mr. Pugh had alleged no other viable underlying claim of negligence" (57 HCDR, 3/26/10).

In a second amended complaint, Tommie Pugh stated a cause of action against DMC for a violation of EMTALA, and as a result of the EMTALA violation, alleged a claim seeking emotional distress damages. DMC sought summary judgment on the EMTALA claim.

The Ruling

The court wrote that under EMTALA, a plaintiff can recover "those damages available for personal injury under the law of the state in which the hospital is located…In California, where a plaintiff seeks damages for violation of a statutory duty, the general rule of tort damages – that all detriment proximately caused by a breach of a duty is compensable – applies…in order to recover damages for emotional distress where there is no physical injury, the injury suffered must be "severe" – that is, substantial or enduring, as distinguished from trivial or transitory."

The court then determined that "plaintiffs lack sufficient evidence to raise a triable issue with regard to whether Tommie Pugh suffered severe emotional distress as a result of DMC's alleged violation of EMTALA." Moreover, finding no support for plaintiffs' position that "severe emotional distress can be inferred from an EMTALA violation absent any direct evidence that plaintiff actually suffered emotional distress," the court granted the motion for summary judgment. However, the court also added that Willia Pugh's claim against Johnson for intentional infliction of emotional distress remained in this case.

View from the Fishbowl

Joel M. Schofer, MD RDMS FAAEM
Member, AAEM Board of Directors
Lieutenant Commander, Medical Corps, US Navy
Emergency Ultrasound Director, Emergency Department
Naval Medical Center Portsmouth, Portsmouth, Virginia

I'm floating around the Persian Gulf, alternating between stints on the USS Pearl Harbor and USS Dubuque. During my most recent stay on the Dubuque, or "the Dub" as we affectionately call it, I had a roommate who is a "GMO" or General Medical Officer. He has completed his internship and is now serving as a primary care physician for a battalion of Marines while he tries to figure out what residency he wants to pursue.

Part of his role as a GMO…actually the majority of his role as a GMO…is to listen to young Marines complain about various musculoskeletal aches and pains associated with what they call "PT" or physical training. PT consists of lifting weights, running, doing CrossFit, Marine Corps Martial Arts Program or "McMAP" training, and all other things that involve perspiration and just being a Marine. The inevitable knee, ankle, back and shoulder pain is usually met with the same simple prescription: a Motrin, more trips to the water fountain and more PT.

There is nothing wrong with a Marine that cannot be cured by Motrin, a full canteen, more PT or any combination of these. Nothing.

I remember him relating to me one day that he had become less empathetic to the musculoskeletal complaints of his Marines due to the constant stream of orthopedic injuries.

I frequently encounter a similar attitude in the ED when a patient presents for something deemed "nonurgent" by the ED resident or provider seeing the patient. It is usually a 2 a.m. fever in a child, a patient with a "cold" or some other true non-emergency. I imagine all of us think these things from time to time.

Well, as luck would have it, guess who hurt his back doing PT? Deadlifting did him in.

He didn't look too bad the first day. There was a definitive loss of mobility and a slight limp.

"Oh, I just hurt my back deadlifting. No big deal."

"Did you take any Motrin?"

"No, I don't think I need it."

The next day he couldn't get out of his bed. Granted, this was no normal bed. We call them "coffin racks" (beds on a ship are called racks) because the fit for anyone over 5'10" tall is tight, coffin-like. If you are about 6'3" or taller and have any upper body strength, you have no ability to even roll without dislocating a shoulder. He is 6'2", and we've already established he does PT, so moving in a coffin rack

continued on page 11