

Report Examines Recession's Impact on Emergency Departments

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To determine what impact the recession is having on hospital EDs, the Kaiser Family Foundation's Commission on Medicaid and the Uninsured conducted a set of interviews in July 2009 with ED heads and officials of groups representing emergency physicians and nurses. The EDs in which they practiced reflected a broad spectrum of settings across the country. The product of those interviews, a policy brief entitled *Emergency Departments under Growing Pressures*, indicates that the recession may be pushing EDs to their breaking point.

Key Findings

Strained ED Capacity and Rising Volume

While ED capacity has been strained for some time, nearly all the EDs surveyed reported rising volume. The recession, with its negative impact on health coverage and patients' ability to afford needed care, was widely viewed as the cause of the volume increases. To deal with such increases, EDs are raising the number of patients that doctors see per hour and adding to work shifts and staff. The situation is worrisome, as the pressure on staff to do more in less time increases the risk of errors.

Economic Pressures Produce New "Recession" Population

ED doctors and nurses report seeing more people who lost their jobs and became uninsured. They also report higher numbers of insured patients seeking primary care in the ED because they can no longer afford to pay deductibles and out-of-pocket costs at their doctor's office.

No Other Options for Uninsured Patients

Except for one ED, which was part of a large area health care system that included clinics for poor and uninsured people, all others surveyed cited sharp inadequacies in access to primary care in their communities, giving uninsured patients no other options. They reported that few private practices accept uninsured patients and waits for new-patient appointments at community health centers and clinics range from four to six weeks to four to six months. Also, when they have no other access to physician care and have run out of their medicines, uninsured adults come to the ED to get a refill, often having gone without the medications for weeks. The visit is likely to be repeated a month later, as few ED doctors will prescribe for more than a month. Several interviewees said that doctors' offices in their communities had directed uninsured clients, clients with Medicaid and insured clients whose benefits had run out to the ED for care.

No Access to Timely or Affordable Care

Faced with full primary care practices or unacceptably long waits for appointments with private physicians, insured patients turn to the ED for primary care. For some, their deductible or the co-pay required up-front in doctors' offices is a deterrent. They come to the ED instead where they receive needed care, but do not have to pay right away.

Long Waits

Whether insured or uninsured, patients face long waits due to ED overcrowding. In one large, urban hospital, the wait was 18 to 24 hours. One ED physician said, "It is only a matter of time before people are dying in the waiting room." It is expected that patients who give up waiting and leave will come back in worse shape. No inpatient capacity for those who need admissions leads to boarding.

Repeated Visits and Sicker Patients

Patients not receiving primary care come to the ED repeatedly as problems flare or they get sicker. As a result, the ED is burdened, and the patient faces higher costs and possibly more difficult treatment.

Costs Lead Patients to Decline Recommended Care

The interviews elicited numerous accounts of both insured and uninsured patients choosing not to follow medical advice because of the cost, including the cost of missing work. Such decisions put patients' health in jeopardy, leading to repeated ED visits and even costlier treatment.

ED Visits Linked to Stress from Job Loss/Financial Worries

Interviewees reported increases in complaints of anxiety, depression and stress due to joblessness and financial worries. When no physical cause can be found for such somatic complaints as stomach or chest pains, the symptoms may be stress-related.

Follow-up Care Unlikely

Interviewees described follow-up care for uninsured patients as an enormous problem, with fees and long waits for referred appointments the impediments. When ED physicians realize their patients are unlikely to get follow-up care, they practice differently to ensure the patient's safety – doing more extensive and costly work-ups, or admitting them in some cases. The effects of no follow-up, including worsened conditions, are seen at intake.

Inadequate Resources to Meet Mounting Pressures

In order to handle the increasing volume, EDs need additional staff, ancillary services capacity and greater inpatient capacity. If the H1N1 pandemic hits, EDs will have even more pressure. That could be more than EDs can handle.

The complete policy brief (publication #7960) is available at <http://www.kff.org/uninsured/7960.cfm>.

WV Court Finds No Evidence Supporting EMTALA Screening and Stabilization Claims

On August 7, 2009, the U.S. District Court for the Northern District of West Virginia dismissed claims brought by a driver involved in a racetrack accident, alleging that a hospital violated EMTALA screening and stabilization requirements (*Ramonas v. West Virginia University Hospital-East, N.D. W.Va., No. 3:08-cv-136, 8/7/09*).

The Facts

George Ramonas crashed his car on September 19, 2005, into a wall at a racetrack in West Virginia. The force of the impact broke Ramonas' safety helmet, and both airbags deployed, yet he managed to remove himself from the wreck. Ramonas was transported by ambulance to the trauma center at Jefferson Memorial Hospital (JMH) where he was triaged as "urgent" by a nurse. The nurse noted his pain level at "5" on a scale of 1 to 10, but decided that it was unnecessary to give Ramonas a full chest, abdomen and neurological evaluation because his vitals were within normal limits. The nurse's assessment also found Ramonas to be "cooperative and calm; his facial features symmetrical; oriented motor response and speech; limited movement due to pain; and abnormal numbness in three toes on his left foot."

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After triage, Ramonas was examined by the on-duty physician in the ED. The physician, understanding that Ramonas had a history of lower back pain, gave Ramonas a physical exam upon belief that the car wreck had aggravated the existing back pain. The physician noted that Ramonas did have "spasms in the left buttock," so he ordered X-rays of Ramonas' lumbosacral spine and pelvic region, but did not perform straight-leg-raising tests, and "never, ever evaluated the patient's ability to ambulate." Ramonas reported "pain with deep breaths," but the ED physician did not order X-rays of the chest or palpate the chest wall.

Upon reviewing the X-rays, the ED physician "concluded that Ramonas was only suffering from 'muscle spasms,' and ordered that Ramonas be given an injection of Toradol for his pain as well as prescriptions for Percocet, Flexeril, and Motrin." Orders were left for Ramonas' discharge. Ramonas asked to be admitted to the hospital, but the ED physician refused.

Ramonas returned to his home, and on September 23, 2005, an ambulance was sent to Ramonas' home to take him to George Washington University Hospital (GWH). An examination at GWH discovered a fractured left seventh rib, a left transverse process fracture, a fracture of the body of S2 and bilateral fractures of the sacral ala. The GWH physicians "also noted that Ramonas had a kidney injury, vision floaters, hematuria, and abdominal pain." Ramonas was discharged from GWH on October 3, 2005.

Ramonas filed suit against JMH for the alleged negligence of its ED staff and for "violating EMTALA by failing to provide an appropriate screening examination, failing to stabilize an emergency medical condition, and for transferring Ramonas in an unstable condition." Defendant JWH filed a motion for summary judgment.

The Ruling

With respect to the negligence claims, this federal court determined that JMH may be held vicariously liable for alleged negligent acts of a non-hospital employee, such as an ED physician, because such physician was an "actual agent" of the hospital, where the only real difference between this ED physician "and the other staff physicians was the duration of their appointments." Stating that the "existence of an agency relationship is a question of fact to be determined by the jury – not on summary judgment," the court denied the defendant's motion for summary judgment to the extent that a triable issue of fact did exist as to whether [the ED physician] was an "actual agent" of JMH.

The court also denied JMH's motion for summary judgment on the defendant's contention that the plaintiff failed to provide admissible expert testimony that the ED nurses strayed from the applicable standard of care. Rather, the court determined that the plaintiff "presented a report and deposition testimony by a board certified emergency medicine physician who appears . . . qualified to testify as to the standard of care for emergency room nurses. It is well established that physicians can opine as to the standard of care applicable to nurses."

In regard to EMTALA claims, to survive the defendant's motion for summary judgment a plaintiff has the burden of "proffering sufficient evidence from which a reasonable jury could find, by a preponderance of the evidence, that '(the defendant) actually knew of that (emergency medical) condition . . .'" The federal court in this case determined that Ramonas' claim fell short, because the "[d]efendant and its agent failed to actually appreciate Ramonas's condition as an 'emergency medical condition.'" "If the emergency nature of the condition is not detected," the court explained in its decision, "the hospital cannot be charged with failure to stabilize a known emergency condition."

The court found that the ED physician's diagnosis and treatment did not violate EMTALA. Owing to "an absence in the record of any evidence suggesting that the hospital had ever treated another patient with symptoms the same as or similar to the defendant more aggressively than it treated him," the court determined that Ramonas did not establish disparate treatment in his medical screening. Iterating that EMTALA "does not provide a cause of action for routine charges of misdiagnosis or malpractice," any shortcomings in the screening or diagnosis in this case were outside the scope of EMTALA, according to the court.

The court was not convinced that the treatment Ramonas received veered from the minimum required under EMTALA and, thus, the motion for summary judgment in this part of the claim was granted.

Patient "Dumping" Claim Not Supported under EMTALA

The U.S. District Court for the Eastern District of Kentucky decided on August 24, 2009, that a hospital did not violate EMTALA screening and stabilization requirements when ED physicians transferred a patient from a hospital ED, in compliance with a court order, to a facility for treatment of suspected mental illness (*Caristo v. Clark Regional Medical Center Inc.*, E.D. Ky., No. 08-343, 8/24/09).

The Facts

On July 25, 2007, James Caristo presented himself to the ED at the Clark Regional Medical Center (CRMC) reporting that he had injured his left leg in a motor vehicle accident. The medical records completed in the ED reflect that Caristo was taking Klonopine and Lortab. An ED physician performed a complete medical examination on Caristo and ordered an X-ray of Caristo's left leg. Finding that Caristo had a fracture in his lower left leg, the physician ordered that the leg be immobilized with a splint and that Caristo be discharged to home with instructions to follow-up with an orthopedist on the following day. Caristo was also to contact his primary care provider or return to the hospital if his problem worsened or if he experienced new symptoms. Caristo was also given a prescription for Lortab. In an effort to further assist him after he was discharged, an ambulance transported Caristo to his residence.

Caristo failed to see the orthopedist on the following day, nor did he fill the prescription. But five days later, on July 30, Caristo returned to the CRMC ED, delivered by police officers responding to Caristo's mother seeking assistance for his erratic behavior. Caristo was in the ED for more than 5½ hours. The medical records contained no reference to any complaints by Caristo with respect to the prior injury to his left leg. However, Caristo was examined and treated by two ED physicians who ordered various tests and diagnostic checks in an effort to ascertain the cause of his behavior. Among the tests, Caristo underwent a consult with a licensed clinical social worker, who documented that Caristo became "angry," began to remove his IV, "and started demanding to leave." One of the physician's diagnosis of Caristo included "psychosis," "hostility," and "substance abuse." Determining that Caristo would benefit from further evaluation and treatment at a behavioral health facility, an involuntary admission was filed.

The district court judge, finding probable cause to believe that Caristo presented a danger or threat of danger to himself and/or others, ordered Caristo be transferred to Comprehensive Care, a community mental health center, for examination by a qualified mental health professional. Caristo was delivered to Comprehensive

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Care, where a certified social worker filed a certification indicating that she did not regard Caristo to be mentally ill. Based on that certification, the district judge ordered Caristo to be released, and Caristo returned to his mother's home.

On the following day, Caristo presented himself to Saint Joseph East Hospital, where he was hospitalized for five days while being treated for the broken bone in his lower left leg and for alcohol withdrawal. Caristo sued CRMC alleging that when he presented himself to the ED for treatment on July 30, CRMC's employees and agents failed to "provide needed medical care and either refused to treat him or transferred him without providing sufficient emergency care to stabilize and/or treat his emergency medical conditions," all in violation of EMTALA. Defendant CRMC filed a motion seeking summary judgment.

The Ruling

The court found that defendant CRMC did not violate EMTALA when discharging plaintiff Caristo on July 30, because Caristo was released and transferred to Comprehensive Care in compliance with a court order, "after he had been screened at the Emergency Department at CRMC where the medical staff there thought that he was experiencing some form of mental illness and concluded that CRMC did not have the resources to adequately diagnose or treat his condition." The court concluded that plaintiff was not "dumped" by CRMC.

The court further stated that the "plaintiff's hospitalization at St. Joseph East and surgery on the fractured bone in his lower left

leg are of no consequence to plaintiff's EMTALA claim [based on Caristo's return to CRMC on July 30] because the subsequent care and treatment of the broken bone in plaintiff's lower left leg are related to plaintiff's visit to the emergency room at CRMC on July 25." Similarly, the court concluded that "such behavior that plaintiff exhibited on July 31 is of no consequence to his visit to the Emergency Department at CRMC on July 30, as it is unknown whether plaintiff had ingested any alcohol and/or prescription medication subsequent to his release from Comprehensive Care on July 30."

Additionally, the court stated that Caristo could not satisfy the evidentiary burden necessary to prove an EMTALA claim in the absence of expert testimony. The court defined expert medical testimony for this case as "from a trained, licensed physician and preferably from a physician who has knowledge acquired from having practiced in the emergency room setting."

The plaintiff also contended that defendant was not entitled to summary judgment because there was a genuine issue of material fact as to whether CRMC's physicians were ostensible agents of CRMC. "The record reflects," according to the court, "that when plaintiff visited CRMC's Emergency Department, he was presented with a consent form which advised him that the physicians at CRMC were not employees or agents of CRMC . . . Consequently, the court [was not] persuaded by plaintiff's argument that there is a genuine issue of material fact concerning the status of the medical personnel at CRMC." The court granted defendant summary judgment on plaintiff's EMTALA claims.

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and make publicly available certain information about licensed physicians, including "specialty board certification." The stated goals of the act include improving the quality of health care and increasing public information about health care providers, practitioners and plans.⁴ NYDOH does not currently recognize BCEM diplomates as "board certified." According to the state of New York, "Board certification means a specialty or subspecialty in which a physician is certified by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA) or Royal College of Physicians and Surgeons of Canada (RCPSC) [or The College of Family Physicians of Canada (CFPC)]."⁵

AAPS argued that NYDOH's non-recognition of BCEM diplomates as board certified violates the equal protection rights of its diplomates under the fourteenth amendment and other federal law. It presented several examples of physicians certified through their pathway who "are equally qualified to practice emergency medicine and yet have encountered various professional handicaps due to the fact that they only have specialty board certification from [AAPS]."¹ AAPS also claimed that "anti-competitive lobbying groups have misled the Department [of Health] about the importance of emergency medicine residency in specialty board certifications."¹ The defense presented documents and testimony from representatives of emergency medicine organizations, including AAEM Immediate Past President Tom Scaletta, supporting the importance of residency training in emergency medicine to board certification.

In making its decision, the court noted that "It is fair for the Department to conclude ... that physicians with residency training in emergency medicine are more qualified than those who took a practice-track to specialization."¹

AAEM's official news release on this issue adds:

"AAEM monitors the activities of AAPS, and we attempt to be present at any hearing in any state where AAPS argues that residency training in EM is unnecessary. It's embarrassing that we must still argue that EM is a legitimate specialty requiring residency training before one may call oneself 'board certified.' We expect a similar result in every state where AAPS makes a similar argument, and we will always be there to advocate for the academic integrity of EM.

Over the balance of your career, you can rely on your Academy to always stand up for your practice rights and to always stand up for the academic integrity of emergency medicine."⁶

References

1. American Association of Physician Specialists, Inc. v. Brian J. Wing et al. No. 06 civ. 14253-WGY. United States District Court, Southern District of New York. 17 Sept. 09.
2. "Eligibility Requirements." American Board of Physician Specialties. American Association of Physician Specialists, Inc. 29 Oct. 2009 <<http://www.abpsus.org/certification/emergency/eligibility.html>>.
3. Emergency Medicine Fellowship. 29 Oct. 2009 <<http://www.emfellowship.com/>>.
4. "About the Patient Health Information and Quality Improvement Act of 2000." Patient Safety Center - Center for Consumer Health Care Information. Jan. 2007. New York State Department of Health. 29 Oct. 2009 <<http://www.health.state.ny.us/nysdoh/healthinfo/about.htm>>.
5. 10 NYCRR sec. 1000.1(a)
6. "Good News from New York." American Academy of Emergency Medicine. 29 Oct. 2009 <http://www.aaem.org/media/updates_content.php?contentid=235>.