

ER PHYSICIAN HOTLINE

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Thanks to Dr. Dillard and Dr. Way for contributing these articles. Questions or comments may be directed to them at:

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NEW CLARIFICATIONS ON EMTALA

BY PETER WAY, MD

Because of an inquiry by the Supreme Court to the Department of Health and Human Services requesting clarification of several EMTALA rules in a legal dispute, EMTALA was revised and clarified. The changes to into effect November 10, 2003.

I have included an ER pertinent summary based on an extensive review by hospital administration, legal firms, and physicians.

An On-Call physician must come in to evaluate a patient if called. He cannot come in at his convenience. Age over 65 is not an excuse if it affects patient care. A Physician's Assistant may be sent to evaluate at the discretion of his supervisor.

In any dispute between the ER physician and any other physician, EMTALA policy will defer to the judgment of the ER physician.

The ER cannot deny appropriate screening exam by a physician using any necessary tools at his disposal. Any sug-

gestion of reluctance, inuendo that it may be costly or discouragement to obtain ER screening will be considered a violation of EMTALA.

If an appropriate screening finds the condition to be non-emergent without possibility of becoming so, medical stabilization can be deferred to a follow-up physician. Examples given include physical exams, work releases, non-medical requests, suture removal, elective cosmetic procedures, "I just got scared," or obvious minor colds. Missed diagnosis is not addressed and presumably is on a case by case basis.

The standard used to guide policy is the "prudent layperson" statute. You may ask about insurance if it is relevant to care, and does not impede the screening exam and stabilization. Any questions about cost should be addressed to a trained hospital staff designee and should not discourage evaluation or treatment.

Any hospital based ambulance is deemed part of the ER, and cannot be diverted or sent to the nearest other ER unless covered by a written hospital policy approved by medical staff, a non-affiliated EMS medical director directs the EMS elsewhere, or the patient signs/states a Refusal of Treatment.

All clinics, satellites, OB-GYN or Psych wards directly accepting ER patients, minor emergency clinics or medical offices affiliated with a hospital are deemed to be part of the ER, and must stabilize and transport to the actual ER immediately.

No transfer arrangements are necessary as they are deemed part of the ER already. They cannot be sent elsewhere unless written policy approved by the medical staff covers it, or the patient signs/states a Refusal of Treatment. Ancillary services run by a hospital are not considered part of the ER. Any-

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RISK MANAGEMENT SUGGESTIONS

BY DR. LEIGH DILLARD

Sometimes it may be worth repeating facts we already know. The current number of medical liability suits out there make it more important to be mindful of areas where other physicians have encountered problems with plaintiffs and attorneys. With

that in mind, I will list some areas of common traps we can easily fall into in busy ER settings.

Many of the following scenarios are based on my 28 years of experience. I invite you to share other scenarios

that we can include in future newsletters based on your experiences. You may fax or e-mail them to Shonda. Include no identifying data; these are for education and

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RISK MANAGEMENT SUGGESTIONS (CONTINUED FROM PAGE 1)

information sharing purposes only.

If the patient is female, she might be pregnant

What is childbearing age anyway? I personally diagnosed an ectopic pregnancy on a female who was one-year post hysterectomy. Her ovaries remained, and she conceived in the broad ligament.

If it can bleed, it might have:

- How many of us have heard of the chronic ER abuser with headaches who has a subarachnoid hemorrhage?
- Many subarachnoid hemorrhages have initially negative CT brain scans.
- Many acute severe GI bleeds have initially negative fecal occult blood tests and normal Hgb. and Hct.
- Many placenta previas and abruptio placentas have only minimal initial bleeding.
- Many ruptured internal organs do not present in shock.
- Fractured bones can lacerate blood vessels.

- Drunks can have all of the above and more.

If it can break, it might have:

Follow-up x-rays don't hurt anyone.

If you consider a lumbar puncture, do one:

This is so difficult in an ER where the family does not know you and are afraid of giving permission. They can refuse, but this protects you only if you request permission, and document their refusal after you informed them of the potential consequences.

If you are too busy, slow down:

If you need help due to excessive patient volume, call the back-up physician. If the back-up physician is unavailable, notify administration and put the ER on diversion. If you are too busy because of personal matters, eliminate them. If you are too busy because you are too slow, speed up.

Think worst case scenario and work backward:

I particularly remember a child with a bulging TM and fever of one day. A typical presentation of acute otitis media, and he did not have a

stiff neck. He later was diagnosed with H. flu meningitis. He did not develop a stiff neck until the third ER visit with the third physician who made the diagnosis. I was the first physician in this chain. I was not the second or third physician.

Act as though you were being filmed:

The eyes of the patients, their families, and the ancillary staffs of the ER are filming us. Their playback in front of a jury can be crystal clear, as convincing to a jury as if on film.

Sick people don't always have great personalities:

I remember diagnosing a frontal lobe brain tumor on a patient who was so rude, I wanted to kick him out of my ER. I ordered a CT brain scan on the belief that no one could be that uncouth naturally. If he had not had the tumor, I was considering inviting him out to the parking lot for an attitude adjustment.

This is educational, and cathartic. More will follow in future newsletters to include your submissions. Till then....
Godspeed. ●

"I ordered a CT brain scan on the belief that no one could be that uncouth naturally. If he had not had the tumor, I was considering inviting him out to the parking lot for an attitude adjustment."

NEW CLARIFICATIONS ON EMTALA (CONTINUED FROM PAGE 1)

one collapsing within 250 yards from an ER door is considered within the ER.

All transfers by an ER must be by EMS unless the patient signs/states a Refusal of Treatment (which can be an AMA form), or the condition is specifically allowable under a written hospital policy approved by medical staff. If the patient is stable, it is permissible to discharge the patient to outpatient follow-up.

All patients admitted in "good faith" to a hospital are not subject to EMTALA rules, and is deemed covered by Medicaid/Medicare rules. ●

PEDIATRIC RESPIRATORY EMERGENCY UPDATE BY PETER WAY, MD

Soon influenza season will be upon us, and as a result, so will croup along with a whole host of mimics that cause airway strider. Last year, we had about 20 cases where the diagnosis or treatment was reviewed, questioned, and criticized by medical staff, usually having been diagnosed with a minor cold. This year, I think we should all review the basics of diagnosis and treatment. I have included a basic and hopefully pertinent review.

Croup is due to subglottic and vocal cord swelling, is the viral form of laryngotracheobronchitis and causes a classic "seal bark" cough and sore throat. A "steeple sign" on soft tissue films is characteristic. Initially, it presents with low WBC followed by an elevated WBC around 15K with moderate fever. Classically, the cold air outside on the way to the ER decreases subglottic swelling and the strider. Admission criteria is persistent oxygen saturation below 95%, continued croupy cough despite two doses of racemic epinephrine given one hour apart, or age less than three months. Remember that airflow is proportional to the radius of an airway to

the third power, so a little edema in a small airway can compromise an infant's respiration. Most facilities recommend you transfer the infants. Outpatient therapy consists of steroids, cool mist humidifier, fluids, and low temperatures around 70 degrees F. You may elect to recommend cough medicines, fever medication, or broad spectrum prophylactic antibiotics to prevent secondary infections. Close follow-up and a 4 day release from school are recommended as recurrence is frequent.

Bacterial laryngotracheobronchitis differs in a higher WBC, higher fever, and a "sicker" looking child. It is usually due to Strep pneumonia or H. flu or Mycoplasma. These patients need high dose steroids, antibiotics, both beta-agonists and racemic epinephrine, and usually admission, sometimes intubation.

RSV is a virus that can cause a number of upper respiratory illnesses, including croup. Please obtain RSV cultures on suspicious cases, especially infants. Traditionally, children under 3 months of age need transfer, but over the last two years, Cook's

Children and Dallas Children's Hospital have been using a one month cut-off criteria. Sick looking infants with RSV often require admission, IVF, oxygen, and a cool mist tent. Ribavirin is seldom used now due to high cost, poor efficacy, and teratogenicity. Intubation should be done based on clinical necessity.

The most dangerous cause of strider is Epiglottitis. These children are very quiet, sick appearing, drooling, with fever and decreased oxygen saturation. Unless they need urgent intubation, the patient should be kept calm, no labs or IVs should be attempted and urgent transfer obtained. If the child remains calm, you should consider oxygen and a lateral soft tissue film of the neck. A swollen epiglottic area ("thumb printing") is classic, where the size of the swelling is >40% of the 3rd vertebra width. If the child undergoes respiratory failure, intubation should be attempted by the most experienced person in airway management. Often a needle cricotracheostomy will be required. Then IVF, labs, antibiotics, oxygen and steroids should be administered. ●

"Last year, we had about 20 cases where the diagnosis or treatment was reviewed, questioned, and criticized by medical staff, usually having been diagnosed with a minor cold."

ER CHORES AND NOTICES

BY PETER WAY, MD

There are certain unpleasant duties expected of all our ER physicians which must be done. Failure to do them reflects poorly on ESS, physicians in general, and mostly on that ER doctor personally. I have spoken extensively to other doctors, nurses, patients, and administration, as well as reviewing the charts, and I find sloppy work reflects very badly on the ER physician's dedication, character,

work ethic, and professional competence. It will lower a lawyer's threshold of filing a lawsuit, or tarnish a physician's reputation. Sloppy work makes negotiating for higher pay difficult, and could get an ER physician's privileges removed by the Medical Staff despite my best efforts for leniency.

I know all of you must be very dedicated to have endured so much to practice the

healing arts, and I must make some requests to try to improve our reputations and perceived worth. They are as follows:

- Fill out the chart completely as possible, regardless of how you may personally feel about it. Lately, we have had areas in the ROS and HIP left completely blank. Fill them even if the nurse

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THE NURSE'S VIEW OF THE PERFECT ER PHYSICIAN

By Dr. Leigh Dillard

I have surveyed nurses at various hospitals to get their opinion of the perfect ER physician. This is not a scientific study, but conveys the general idea. Some of their responses were left out since physical appearance, marital status, etc., have nothing to do with ESS. The following are the most common responses:

The Perfect ER Physician...

- Examines the patients in a timely manner
- Acts and dresses professionally
- Speaks to the patients compassionately—not as subhumans
- Treats the nursing and ancillary staff in a civil manner
- Acts concerned about the patient and their illness
- Refrains from putting down the staff or facility in front of the patient
- Respects the opinion of the staff even if they don't agree

I invite ER physicians to submit their views of the perfect ER Nurse. Again, comments regarding physical appearance, marital status, and other personal data will not be printed. We will read those comments as we did from the who responded. You may fax or mail your views to ESS, attention Shonda Rupe.

ER HOUSE CHORES AND NOTICES

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does not. If you have not filled them, I will request that the chart be sent back to you for completion. Then please e-mail your grievances to me at pcway1962@yahoo.com and I will try to resolve the issue or discuss what is being done, perhaps elicit your help. Leaving them blank makes it impossible to defend you against complaints from anyone or from legal challenges.

- When admitting a patient, please make as accurate an assessment as possible when determining Observation verses Admission. If a person is really ill, please admit them. Reserve Observation for healthy appearing "Rule Outs." If you do use Observation, make sure the patient receives either IVFs, IV medications, serial set of 3 enzymes and 2 EKGs in 24 hours for Chest Pain.

- Please review the Updates in Emergency Medicine in any fields you may not feel quite comfortable with. They are available for your viewing at Glen Rose, Breckenridge, Bowie, and Grand Saline. Hopefully, they will be available at other facilities soon. Please do not take them home, and return them if you have, so others can use them.
- Please do not "vanish" from the ER. Take any necessary precautions to ensure the ER can always get in contact with you or find you. If you carry a cellular phone, you might consider giving the nurse the number in case she cannot find you.
- Practice "Multi-Tasking" in the ER. See a patient and prioritize the condition, briefly assess the relevant signs and symp-

toms, discuss your plan with the patient, and order appropriate studies and medications. When everyone is seen, begin the charting and plan your strategy on who needs consultation and procedures. Then go back to perform procedures, finish examining every patient, reassess the medication's effect, and add orders. See any new patients, make the consultation calls, and continue reviewing labs while charting. In this way, you can optimize your time and stay organized. You simply cannot effectively "see one patient at a time" in the ER. At first, it may be challenging, but within 2-3 weeks, it becomes much easier.

This is my laundry list. I hope it will help all of us become better physicians and face our challenges honestly.