

Emergency department overcrowding: ambulance diversion and the legal duty to care

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In January 2000 hospital emergency departments across Canada were overwhelmed with influenza patients. In the early hours of Jan. 14, when Joshua Fleuelling was in severe respiratory distress, no advanced life-support paramedics were available and the emergency department only 3 to 4 minutes from the Fleuelling's house was on critical care bypass. The basic life-support ambulance crew was directed to transport him to another hospital 4 times farther away. He ultimately died despite efforts to resuscitate him en route to the second hospital.

The flu epidemic ended, but overcrowding in emergency departments continues and hospitals still go on critical care bypass or redirect consideration when resources in the emergency department are being overwhelmed. The resources lacking may be physical, such as monitors, stretchers or rooms, or they may be people, such as nurses.

"Critical care bypass" means that the hospital cannot admit even one more critically ill patient without compromising the care of patients already in the department. Thus the emergency department is essentially closed to patients coming by ambulance. Hospitals typically go on critical care bypass for only brief periods, such as 30 minutes. "Redirect consideration" is a request that the ambulance dispatch centre send all but critically ill patients to another hospital. At such a time, resources in the emergency department are being stretched, but another critically ill patient could be accommodated if necessary. Redirect consideration is a way for the emergency department to buy some time so it does not have to go on critical care bypass. The decision to go on either mode of patient redirect is usually made in the emergency department by the charge nurse and the physician on duty.

In this issue (page 465) Anne Walker discusses the Fleuelling case and whether it is legal or ethical for hospital emergency departments to go on critical care bypass.¹ The short answer is No. She also discusses how courts might look at the issue of duty to care if that care were compromised as a result of overcrowding and lack of resources.

Physicians have a duty to care for their patients, but in general they have a right, even in an emergency, to refuse to care for someone when there is no pre-existing professional relationship. Emergency physicians rarely have a pre-existing relationship with their patients, but by virtue of be-

ing on duty in the emergency department, they have contracted with the community to provide medical care. The community has a right to rely on that care being available.

The whole purpose of an emergency department going on critical care bypass is to divert ambulances away from it. If the emergency physician really did not expect any more critically ill patients to arrive in the next 30 minutes, he or she would not bother to have them redirected. So the patients are foreseeable, but is the harm? If the nearest neighbouring hospital is only 2 minutes farther down the road, it could be argued that an extra couple of minutes of transport time would not have a significant effect on patient outcome. This may be true for many mid-sized communities with more than one hospital, but transport times between institutions may be much longer in large urban centres because of traffic, and in rural areas because of distance. We know from outcome studies involving patients in cardiac arrest that the longer the transport time, the poorer the outcome. The harm is foreseeable, and thus going on critical care bypass is a breach of the physician's duty to provide care. In 2000 the Canadian Medical Protective Association's annual report² stated: "Nor is it appropriate for a physician to redirect or delay transfer of an emergency patient where this would pose a danger to the patient. In such a case, physicians may have no choice but to treat the patient to the best of their ability even if the available resources are not optimal."

Walker also argues that it is unethical for physicians to refuse to provide emergency care, that public policy arguments have been used in court to support a duty to treat and that hospitals cannot legally accept patients who arrive by private vehicles while refusing patients transported by ambulance. In Quebec, legislation requires hospitals and physicians to provide emergency care.³ In Ontario, the Public Hospitals Act could also be interpreted as mandating a duty to provide emergency care.⁴

Because harm is foreseeable or at least potential, a decision to go on critical care bypass is not made lightly. It is made when the emergency department's resources, both physical and human, cannot be stretched to care for another critically ill patient without the risk of harm to someone already being cared for in the department. There is no case law to know how the courts will look at this issue.

Walker suggests that “[the courts] are willing to adjust the standard of care when personnel or equipment are limited as a result of an actual scarcity of resources beyond the control of the physician or the hospital.” Certainly patient volumes in the emergency department are beyond anyone’s control. If, however, the physician or hospital has limited resources for reasons of cost containment alone, or the available resources are not managed well, the courts would be less forgiving. With their million dollar budgets and constant readjustment of funding priorities, hospitals probably have more reason to be concerned about liability arising from resource allocation than do physicians who are working hard with what they have available.

In response to public concern and the coroner’s recommendations from the inquest into Joshua Fleuelling’s death, the government of Ontario convened a multidisciplinary working group of people involved in prehospital care.⁵ The group’s recommendation was that critical care bypass and redirect consideration be replaced with the comprehensive Patient Priority System. This new system was piloted last summer in the Hamilton area and implemented on Oct. 3, 2001, in the rest of the province. Ambulance services and hospital emergency departments now assess patients and communicate with each other using the 5-level Canadian Triage Acuity Scale (CTAS).⁶ In summary, CTAS level 1 is assigned to patients requiring immediate resuscitation and level 2 (emergent) to those needing assessment within 15 minutes; levels 3 (urgent), 4 (less urgent) and 5 (nonurgent) are assigned to patients whose conditions require assessment within 30 minutes, 1 hour and 2 hours respectively.

Under the Patient Priority System, if a particular emergency department is becoming overwhelmed, the physician on duty can request “consideration” from the ambulance dispatch centre to divert patients who are not critically ill. This is similar to the old redirect consideration. If the emergency department is so busy that the physician on duty decides he or she cannot safely care for another critically ill patient, he or she can request “time consideration.” This is similar to the old critical care bypass in that the dispatch centre can direct ambulances to another hospital, but only if the other hospital can be reached in the same length of time. If all the other hospitals in a community are farther away and the patient is CTAS level 1 or 2, the ambulance will be directed to continue to the first (and closest) hospital regardless of how busy the receiving emergency department is, unless the patient requires specialized services available elsewhere only (e.g., pediatric trauma care).

In theory, the ambulance dispatch centre will monitor the number of patients received by the hospital and the patients’ CTAS levels, to be better able to direct ambulances

carrying less ill patients elsewhere without being asked. However, the dispatch centre has no way of knowing how many seriously ill patients have arrived at the emergency department by private vehicle. Only 7%–20% of all emergency visits arrive by ambulance.⁵

In practice, several critically ill patients can arrive at an emergency department within minutes of each other. Ambulance attendants have to care for their patients in hospital hallways because there are no beds or staff available. Decisions have to be made about which patient to take off a monitor prematurely so that it can be used for someone else. Physicians and nursing staff feel increasingly frustrated and exhausted as they try to care for many ill people at the same time.

Both from Walker’s discussion and the Canadian Medical Protective Association’s annual report,² physicians and hospitals have a legal duty to treat all patients who come to the emergency department and cannot divert ambulances if doing so would potentially harm the patient. In Ontario the new Patient Priority System could work, but there needs to be better communication between emergency departments and the ambulance dispatch centre, or else ambulances will arrive on the doorstep of hospitals with no available stretchers, monitors or staff to provide care. When that happens, the system deficiencies that existed at the time of Joshua Fleuelling’s death will be transferred from the streets to the emergency department. Whether physicians, hospitals or the government will be held responsible by the courts remains to be seen.

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