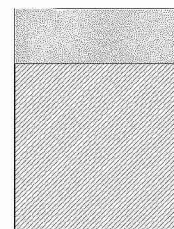


Endless waits, beds crowded into hallways, no specialists on call—in today’s emergency rooms, you can’t trust you will get the right care. But you can improve your chances. Here, insiders share what just might save you or your family

On June 1, 2004, Norma Jean Chiulli was doing errands in her hometown of Rockland, MA, when she became so ill—with nausea, abdominal pain, and an overall “horrible feeling”—that she had her mother drive her to a nearby clinic. Doctors thought it was acute appendicitis and called for an ambulance to take Chiulli, then 42, to the hospital. It was 6 P.M. when she arrived. A nurse asked a few questions, then—despite Chiulli’s likely diagnosis—



wheeled her into the ER waiting room.

Hours dragged by. Other patients came and left. And though her pain steadily worsened, and she was vomiting repeatedly, Chiulli was told to keep waiting. "I was curled up in a fetal position on a couch, writhing in agony," she recalls.

Around 9 P.M., her father asked for help, but the nurse at the desk said they'd have to wait. At midnight, he became more insistent, and Chiulli finally saw a doctor.

It was just in time—her inflamed appendix had burst. "This woman needs an operating room ASAP!" the doctor called out, and within minutes nurses were rushing Chiulli to surgery. Because of her long wait, what should have been a straightforward operation became perilous, as the surgeon had to mop infected spatter off organs surrounding her ruptured appendix. "The doctor said I almost died," she reports.

The problems plaguing emergency rooms date back to the 1990s, when multiple studies first described overcrowding and miserable wait times. But today the situation has become even more serious. The latest study, from the Cambridge

Health Alliance, a Harvard Medical School teaching affiliate, was released in January, and documented frightening treatment delays for all patients, especially those who are critically ill.

That's sobering, considering there's a one-in-five chance you'll find yourself in the emergency room this year—one-in-four if you have children under 6. Besides long wait times, what are the problems you're likely to encounter? How can you prevent a disaster for your family? And what other options do you have besides the ER? For answers, we've turned to the experts—medical insiders who know what will get you the best treatment and ensure you and your family survive a trip to the ER.

Killer Waits

Every minute, 219 people, on average, pass through the doors of an ER. In 2005, there were an estimated 115.3 million visits, an average increase of more than 1.7 million each year during the previous decade, ac-

ording to the latest figures from the Centers for Disease Control and Prevention. And all those patients had to squeeze into fewer facilities, since nearly 10 percent of ERs closed during the same decade.

By law, ERs must evaluate everyone who comes in—seriously ill or not, insured or not. Patients who use emergency facilities for ordinary ills, such as sore throats and cuts and scrapes, are often blamed for clogging the system. But that's not a big problem, experts say, especially since those visits tend to take a modest amount of time. More critically, the growing number of elderly patients—who often come with complicated medical

problems—contributes to the logjam. Between 1993 and 2003, visits by people 65 and older went up 26 percent; that number is expected to double in the next five years, a situation the American College of Emergency Physicians (ACEP) has deemed "catastrophic."

But the biggest reason behind those long waits is "boarding." Once a doctor decides you need to be hospitalized, you have to wait for a bed to open up in the appropriate department. It can be a very long wait—there have been reports of up to five days—especially for beds in specialty areas like cardiac care or psychiatry. Officially, waiting ER patients have been admitted as inpatients at the hospital, but in reality they are cared for in the ER—often on stretchers lined up in crowded hallways.

Meanwhile, new ER arrivals are backed up in the waiting room. "Inpatients who belong upstairs are taking space and using the doctors, nurses, lab techs, supplies, and X-ray facilities that are meant to handle just the ER patients," says Sandra Schneider, M.D., a Rochester, NY, emergency physician and ACEP board member.

Boarding has become a frequent or near-constant problem in 69 percent of ERs, an ACEP survey reported last October. One physician in Maryland arrived to start his shift, only to find that

every single ER bed was occupied by a patient being boarded. And while they're waiting to go upstairs, these patients may receive less than ideal care, in part because nurses are overwhelmed. While some states set a limit on the number of patients a nurse can oversee, those limits almost never apply to the ER. "A hospital department may refuse to accept someone new because a nurse is caring for five others on the floor. That

leaves the patient in the hands of an ER nurse who has 10 to 12 other sick people," says Dr. Schneider.

It gets worse. After beds and waiting rooms are full, emergency departments may go "on diversion"—shunting incoming ambulances to other hospitals. Nationwide, more than a third of ERs close their doors at least once a week. At one in 20 hospitals, it happens daily or almost daily. And sometimes, ambulances are diverted from more than one ER.

Looking for McSpecialist

As Mary Stone, a prekindergarten teacher from Tequesta, FL, pulled into the school parking lot in October 2003, she developed a fierce headache. Parking her car, she ran over the curb because her left leg wasn't working properly. Luckily, a coworker spotted her and a maintenance worker immediately called 911. Paramedics quickly transported Stone, age 52, to a nearby ER, where a CT scan was performed within 30 minutes. So far, so good. The scan revealed a hemorrhagic stroke, with bleeding in the brain that required emergency surgery.

That's when things broke down. The medical center had no neurosurgeon on call—and no transfer plan to send patients like Stone to a facility that could treat them. From 7:30 A.M. until 6 P.M., an ER physician and others frantically called around the state to find a neurosurgeon and hospital to take the case. During that time, Stone, who earlier had been talking and walking in the ER, de-

teriorated to the point where she was paralyzed and unconscious. Finally, 11 hours after she'd arrived at the ER, she was taken by jet helicopter to Gainesville, nearly 260 miles away, where she had surgery to decrease swelling in her brain. But by then, the damage was extensive and irreversible, and she died 18 days later.

"They kept telling us there were no beds available at any of the hospitals they tried to reach," says her husband, Sam Stone. "What they weren't telling us was that the deck was stacked against the patient—they had a neurosurgeon on call only 15 days out of the month and Mary happened to need one on a day that no one was on call."

There's often talk of a shortage of specialists in ERs, but "shortage" is really a misnomer, Stone's attorney, Gary M. Cohen, argues. "There were at least 12 brain surgeons in the area, plenty to cover all the ERs. But the neurosurgeons had asked hospitals to pay them for their on-call time and to include them in the hospitals' malpractice coverage, and the hospitals refused," he says. "Worse, the hospitals ignored laws requiring them to have an agreement to transfer patients when they didn't have a specialist on call."

Stone's case isn't unusual. Within a two-year period, at least three other women in their 50s died of bleeding strokes under similar circumstances in Palm Beach County, FL, alone. Finally, in 2006, the county health department stepped in, enforcing the requirement for neurosurgical coverage for any hospital accepting stroke patients.

Across the country, specialists like neurosurgeons—or orthopedists or ob-gyns—are trying their best to avoid being on call at ERs. They have good reasons, they say. For one, they may not be paid for seeing these patients; also, they worry that they're more likely to be sued because emergency operations often occur under difficult circumstances.

“ERs have big problems getting coverage for many of the surgical specialties,” says Linda Lawrence, M.D., president of ACEP. In the group’s recent survey, 44 percent of emergency departments scored inadequate on coverage. At some ERs, doctors from certain specialties might be available, but not all the time, while in others, no one from particular specialties is on call.

That’s precisely what one Arizona woman encountered about a year and a half ago when she fell and cut her lip severely. At a top-level Phoenix trauma center, the doctor who evaluated her, Todd Taylor, M.D., realized that she needed a plastic surgeon to repair the gaping wound or she would be permanently disfigured. But there were no plastic surgeons on call at the hospital, and none of the six he phoned would see her. So he patched the woman up as best he could and sent her home, hoping that her primary-care doctor would *continued on page 246*

have better luck finding a plastic surgeon the next day. “That was one of my last patients,” says Dr. Taylor, who no longer practices. “I had to stop pretending I could take good care of people in this system.”

Strategies for Smart Patients

Doctors like Taylor may become so disheartened that they drop out of the system. But sick people can’t. And while real improvement in ER care will require broad and imaginative solutions on the part of health specialists and lawmakers, you may need treatment before changes are in place. What you can do now:

- **Find out about specialists when you’re feeling fine** If there are several ERs in your area, ask your doctor which would be best for each family member or under different circumstances. A hospital that has an out-

standing heart center is more likely to have cardiologists on call, for example, while a children’s hospital would have more success summoning a pediatric neurologist.

- **Follow up with the ER yourself** If you’re told, “Oh, yes, we have neurosurgeons on call,” find out if that’s 24/7 or every other Thursday. You can also take an extra step and ask for names, then check the info with each doctor’s office.

- **Ask which hospital your doctor is affiliated with** and try to use that ER. He or she will know specialists connected with the hospital and can ask them to see you.

If you’re going by ambulance, you may not have to be taken to the nearest ER. Local regulations vary, but if you’re not critically ill or injured, EMS can often drive you to the hospital of your choice. To find out about the policy in your area, call your fire department or local EMS organization (do not call 911).

GET ON THE FAST TRACK

Before you’re confronted with a medical emergency, find out whether any ERs near you have separate units (often called fast-track areas) where patients with non-life-threatening injuries or illnesses can be moved in and out more quickly. If so, you’ll know where to go when your daughter has a cut that needs stitches or your husband throws out his back.

You might be able to avoid the ER altogether if there’s an urgent-care center near you. Laura Meyer, 47, a high school teacher on Long Island, and her two children have had plenty of reasons to seek medical treatment outside regular office hours—like the time she sliced open her hand. Or the weekends her kids have had sore throats and needed strep tests. Meyer relies on a nearby urgent-care center that’s open through the evening

and on weekends, one of more than 10,000 such centers in the country.

These clinics are a less stressful alternative for minor problems. But if you have chest pain, dizziness, or any of the other symptoms listed in "11 Signs to Get to the ER—STAT!" (page 184), you need the more sophisticated care of a hospital. "Go to the ER for anything that might require hospital admission," says David Stern, M.D., an internist who practices urgent care in Illinois. Not sure? Call the urgent-care center for advice.

CALL 911!

Not only will an ambulance get through traffic faster, but (Norma Jean Chiulli's ordeal notwithstanding) if your condition is serious, you'll get quicker attention once you arrive at the ER. Overall, patients who arrive by ambulance are seen about 25 percent sooner than walk-ins, but only if their situation warrants—coming by ambulance doesn't automatically bump you to the front of the line. Stroke victims who come by ambulance wait less time to have imaging performed—essential to determining whether the stroke can be treated with clot-busting medication (which must be given within three hours of onset).

What's more, care can start in the ambulance, on the way to the ER. "The paramedic can assess your condition and call ahead to mobilize services you may need—like having the cardiac catheterization lab ready for a patient who seems to be having a heart attack," says Michael Richards, M.D., chairman of the department of emergency medicine at the University of New Mexico.

And don't delay. A couple of years ago, researchers from the VA Medical Center, Baltimore, reported that visits to ERs declined about 30 percent while a major sports event was on TV, then surged in the hours after. Ap-

parently, men felt that their stomach-aches or even chest pain (!) could wait until after the fourth quarter.

Big game or no, people try to avoid ERs on weekends. The reality: Mondays are probably the most crowded, as the ER fills with people who suffered through the weekend and patients sent from nursing homes after doctors do morning rounds. In general, ERs get busier as the day goes on (until a drop-off in the wee hours), so you may want to think twice about waiting to see "how you feel later."

No matter what, if your gut (or heart or broken leg) tells you that → you need to get to an ER, then go. You don't want to end up sicker than you would have been or with complications that could have been prevented because you were worried about long wait times, says Dr. Lawrence.

When Rebecca Riley, 36, of Anderson, IN, developed chest pains and palpitations in 2006, she headed for the Internet, not the hospital. "The year before, I'd waited at the ER for seven hours with my husband," says Riley. "Plus I didn't want them to tell me it was just a panic attack." Finally, though, she was anxious enough that she went to the ER and learned that she had an easily corrected potassium deficiency.

But if Riley had been having heart trouble, the delay could have been dangerous: Getting to the hospital within one to two hours of the start of heart attack symptoms betters your chances of receiving the proper treatment by nearly 70 percent over waiting 11 to 12 hours for help, a recent Mayo Clinic study found.

To help avoid a wait, call your own doctor as you head for the hospital. He or she can then phone the ER staff and give them your medical history. And at teaching hospitals, your physician may be able to summon a resident to meet you, shortening or

even eliminating your wait time.

BE READY FOR QUESTIONS

Unless it's clear your problem is life-threatening, your first contact in the ER is likely to be with a triage nurse who will evaluate the seriousness of your case. Triage needs to know:

- **What's going on** When did your symptoms start? How much does it hurt? What steps have you taken? "There's no bad information," says Donna Mason, 2007 president of the Emergency Nurses Association.

- **A brief medical history** You'll save time—and maybe get routed to more appropriate care—if you write up health problems in advance. (See "Your Emergency Grab-and-Go File," page 185.)

BE PREPARED TO WAIT

There's no way around it. If you're not deathly ill, you're likely to spend some time—maybe a lot of time—in the land of sticky vinyl sofas and year-old magazines. Is there a book you've been dying to read? Now may be the time to start it. Or bring your iPod or knitting—or all of the above.

It helps to have a friend or relative come with you, not just for company, but to act as your advocate. Deborah Davidson, 55, went to the ER with an excruciating attack of diverticulitis—potentially life-threatening because an inflamed pocket of intestine can burst. During the wait, she was doubled over in pain and couldn't really talk. "My boyfriend believed I was dying. After an hour, I thought he was going to strangle the nurse to get me help," says Davidson.

Strangling the triage nurse—or yelling or threatening—assuredly won't help. One ER insider points out that if you have a "horrible attitude," the health-care staff may be less likely to help you—maybe not medically, but in terms of other needs, like

keeping you updated.

While triage nurses may give you dark looks if you interrupt them, they need to hear if:

- **There's a change in your condition** If your pain skyrockets or moves from your abdomen to your chest, for example, let them know.

- **You're hungry or thirsty** You may be so bored that putting quarters in the vending machine will seem entertaining. Ask first: If you need surgery, your care can be delayed further if you've had anything to eat or drink.

- **You need to use the restroom** It sounds icky, but if there's a chance that the doctor will need a sample of your urine, feces, or vomit, ask before you use the facilities. If, for example, you're there for a urinary tract infection, the diagnosis depends upon a urine sample, and you don't want to add extra time waiting until you have to go again, points out James Augustine, M.D., an emergency physician in Atlanta.

In the end, though, there is only so much you can do yourself to get the best care in the ER. As a start to rescuing the system, the House and Senate have introduced bills that would establish a commission to find solutions to crowding, specialist coverage, boarding, ambulance diversion, and other issues. Info on the proposed law (Access to Emergency Medical Services Act) is available at acep.org (go to "advocacy").

11 Signs to Get to the ER—STAT!

1 Difficulty breathing, shortness of breath

Can be anything from pneumonia to a heart attack

2 Chest or abdominal pain or pressure

May be a heart attack

3 Fainting, trouble talking, dizziness

Can be signs of a stroke

4 Changes in vision

May be a stroke or an eye emergency

5 Confusion

Again, possibly a stroke

6 Sudden or severe pain

What it may signal depends on location, but it always needs to be checked

7 Uncontrolled bleeding

Continuous bleeding can lead to collapse and death

8 Severe or persistent vomiting or diarrhea

May be food poisoning or an infection. In small children and the elderly, can lead to dehydration

9 Coughing up or vomiting blood

Sign of internal injury or illness

10 Suicidal feelings

Mental-health pros can evaluate and start to treat

11 Unusual abdominal pain

Can be a sign of gastrointestinal or gynecologic emergency

TIME SAVER

Your Emergency Grab-and-Go File

Having your medical information with you will speed things in the ER. But you may be distracted as you head out or unable to gather it all. So in advance, create a file for each member of the family that includes:

- A short medical history, including past surgeries or major problems
- Current medical conditions
- Doctors and their phone numbers
- Medications
- Immunizations
- Allergies (especially drugs, latex)
- Insurance information

If an emergency strikes before you've prepared a file, grab the patient's medicine bottles (if any) and insurance info. It's also crucial to give signed medical consent forms for your kids to babysitters or anyone who might need to bring the kids to the hospital, says **ACEP** president Linda Lawrence, M.D.

Print out a medical-history form for each family member at goodhousekeeping.com/healthform

The Waiting Game

Numbers that are enough to drive up your blood pressure:

4 hours

Average time spent in the ER (from arrival to discharge or admission to hospital)

6+ hours

Average time at the slowest emergency rooms

5.3%

Number of patients who leave without being seen by a doctor

8 minutes

Median wait for heart attack patient to see a physician in 1997

20 minutes

Median wait for heart

attack patient in 2004

TIP SHEET

3 Things Never to Say to the Triage Nurse

1 "We're on our way to the ER"
 "If we're answering 200 'we're coming in' calls a day, that's a lot of time we can't attend to the patients who are already there," says Donna Mason, 2007 president of the Emergency Nurses Association.

2 "How much longer will it be?" Same problem—it just delays your care if you're asking every 10 minutes why you haven't been seen.

3 "That person came in way after us" It's not the bakery—patients are seen in order of urgency, not arrival time. If it were your loved one having a heart attack, wouldn't you want to go in ahead of the patient with the sprained finger?

There's a one-in-five chance you'll visit an ER this year; one-in-four if you have kids

Photograph by Andrew I eyente/Getty Images