GEOFFREY C. MITCHELL, MD, JD, FAAEM
3847 Olentangy Blvd.
Columbus, Ohio 43214
Tuesday, November 10, 1998

Richard Shonk, MD, Ph.D.
Vice president, Medical Affairs
Grant/Riverside Methodist Hospital
3535 Olentangy River Road
Columbus, OH 43214

RE: CPIT Referral - Mrs. XXXX XXXXX, 11/09/98, MR # XXXXXX

Dear Dr. Shonk:

I believe you are the appropriate individual to review this case. I understand that you are the ultimate agent of quality medical care and chair of the hospital wide CPIT committee.

Mrs. XXXXX is another unfortunate victim of the gross overcrowding of our department. It is my contention that this is a significant quality of care issue.

Mrs. XXXXX presented to our ED in the early afternoon. Because the ED was in its usual * overcrowded state, she was triaged to a hallway bed. It spite of the fact that she had complained of chest pain, no EKG was done because she was in the hallway. It was not until she dropped dead (V-Fib = "cardiac sudden death") that she was moved into a room. There she was vigorously resuscitated by 4 or 5 physicians and subsequently placed on cardiac bypass and transported to the cath lab. Her left main trunk lesion was then opened.

There is currently a great deal of discussion regarding the implementation of policies, protocols and clinical pathways in our institution. Many times such written guidelines are useful. Sometimes they are just so much hot air, as in this case. Any good physician knows that it is a good idea to obtain an EKG on a middle-aged patient with chest pain. We already have written chest pain policies which stipulate that a physician should have had Mrs. XXXXX's EKG in his hand within 5 minutes of her arrival. Unfortunately this protocol didn't do her any good.

At the time of this writing, Mrs. XXXXX is cardiologically alive. Her neurological prognosis remains uncertain. Even if she does make a full recovery, this is simply an attestation to the great skill of Drs. Taylor and Yakubov. The use of cardiac bypass in the ED is not to be encouraged. The concept of triage by arrest should be unthinkable. It doesn't even make sense from a financial perspective. I suspect that the money spent on this ED resuscitation would go a long way to offset the cost of a new room in the ED.

Believe me, I am well aware that bad things happen in the ED. I have spent 17 years there. I do understand. I think I also understand the role of QA/QRM/CQI/TQM etc. I believe your goal should be to prevent unnecessary deaths. This is the ultimate function of any QA committee, whatever its new name. This sort of review activity has a long and honorable role in American medicine. For generations it was called M&M. It has been repeatedly emphasized that modern QA committees want to address "systems" issues. The perpetuance of "hallway medicine" in the RMH ED is a "systems" monster of the highest order. For 17 years the only solution has been various permutations and recycling of the "catapult" plan. I.e. simply send patients upstairs to their rooms faster.

I realize I'm not making friends by lobbying to spend more money in the current environment. I'm all in favor of saving money and improving medical care. As you know, I have invested thousands of hours of my own time to develop workable ways to do so. I am also aware that we are spending $150 million to purchase two more hospitals. I suspect that these two hospitals are fraught with problems or they would not be for sale. The assumption of a huge debt burden and the responsibility of reforming problematic hospitals virtually guarantee that the quality of care in our ED will decline further. Until we expand our facility and eliminate the practice of "hallway medicine" this nightmare in the ED is destined to continue.

If not for the reputation of this institution than at least for the health and safety of your patients, your neighbors and families, please stop neglecting the patients on our front doorstep. **I beg you to take a stand against hallway medicine**. Thank you for you time and consideration.

Sincerely,

Geoffrey C. Mitchell, M.D.

cc: Ron Taylor, M.D.