Consultation for Simple Laceration Repair When On-Call in the Emergency Department: Potential Quagmire

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Summary: What are the forces obligating a plastic surgeon who is on-call for the emergency department to respond to a consultation request for repair of a simple laceration? Although the duties are clear in cases of obvious surgical emergency, ambiguity and subsequent conflict may arise when the true nature of the emergency is less clear. Does the consultant’s clinical discretion dictate the obligation in the case of a simple laceration; or is it subservient to either the discretion of the requesting health-care provider or even the patient? Do federal statutes such as the Emergency Medical Treatment and Labor Act, or perhaps more local rules apply, such as the by-laws of the hospital? It would behoove all medical practitioners to familiarize themselves with both the legal and moral implications of these issues. Having legitimate policies in place which actively address those situations where the consultative obligation is unclear is critical to resolve potential conflict. (Plast Reconstr Surg Glob Open 2017;5:e1428; doi: 10.1097/GOX.0000000000001428; Published online 12 July 2017.)

When an injured patient presents to the emergency department of a hospital requesting a plastic surgeon repair a simple laceration, an intricate cascade is initiated with competing interests. Emergency department staffing models and teaching affiliations play a critical role in determining how a simple laceration is repaired: whether by a medical student or resident, allied health professional, or an attending physician. Alternatively, the administrative team of the hospital may desire the plastic surgeon provide this service as a community benefit to improve public relations. The patient may personally believe the plastic surgeon delivers a better aesthetic outcome than other health-care providers. The emergency physician might look to decrease his or her case load during a busy shift by having the plastic surgeon repair a simple laceration which otherwise might be repaired by personnel in the emergency department. The plastic surgeon may be attracted to the potential boost to practice revenue. Even the definition of what constitutes a simple laceration may be open to debate.

In an affluent neighborhood, the emergency department may be well staffed with on-call plastic surgeons willing to serve the community to build business. These plastic surgeons may make themselves readily available for simple laceration repair even though the actual procedure is within the skill set of the emergency physician. Moreover, these plastic surgeons may be out of network with insurance; therefore, commanding charges which are higher than those of the emergency physician who may be in network with insurance. This price differential does not reflect any difference in inherent ability but only reflects participating status with insurance by the health-care provider. On the other hand, a rural facility may have a dearth of plastic surgery coverage, where there may be only the emergency provider to repair the simple laceration. Generally, the standard of care is the level at which the average, prudent provider in a given community would practice or how similarly qualified practitioners would have managed the patient’s care under the same or similar circumstances. Therefore, the repair of a simple laceration falls well within the purview of the emergency physician or qualified allied health professional. By inference, the standard practice and policy should reflect any difference in inherent ability but only reflects participating status with insurance.

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of care in emergency medicine requires the emergency physician recognize wounds, where the complexity falls outside the scope of practice and therefore obtain appropriate consultation. However, what are the obligations of the plastic surgeon consultant when an injury clearly falls within the skill set of the emergency physician and therefore may be considered elective?

**TRIGGERING EMERGENCY MEDICAL TREATMENT AND LABOR ACT**

Emergency Medical Treatment and Labor Act (EMTALA) is a federal statute that requires any patient presenting to the emergency department of a hospital to be provided with an appropriate medical screening examination determining if he or she is suffering from an emergency medical condition. An emergency medical condition is defined as manifesting itself by acute symptoms of sufficient severity (including pain) such that absence of immediate medical attention could easily be expected to result in serious impairment to bodily functions. If these indications are met, the hospital is required to provide stabilizing treatment. The original intent of this law was to prevent transfers of uninsured patients.

If a patient does not have an emergency medical condition, the statute imposes no further obligation to the hospital. In the interest of protecting the public, courts broadly interpret what constitutes an emergency. However, a straightforward and isolated laceration—diagnosed after an appropriate health screening—is not life threatening. The federal court has recognized such. Therefore, it is safe to assume that an on-call plastic surgeon cannot be forced into the emergency department if the laceration falls within the scope of practice of the emergency physician through the requirements of EMTALA.

Emergency physicians are trained to repair simple lacerations and it is indeed part of their scope of practice. In fact, privileges granted by hospitals to emergency physicians nationwide include multilayered repair of lacerations. Even the scope of practice granted by many state licensure boards for both physician assistants as well as advanced practice nurses include suture repair of simple lacerations. Few, if any, would assert that the standard of care requires that only plastic surgeons repair simple lacerations. But what is the actual obligation, if any, of the on-call plastic surgeon when a consultation occurs from the emergency department for repair of a simple laceration?

If the request for a plastic surgeon originates directly from the emergency physician, it is critical that the underlying reason be elucidated. Additionally, this reason should be clearly documented within the medical record. If the emergency physician feels the laceration repair is within his or her scope of practice, but requests a plastic surgery consultation, the consultation might be considered “elective” undertaking in the absence of any institutional expectation to the contrary. A parallel situation would be if an emergency department patient with urinary retention required Foley catheter placement. No one would expect a urologist to receive a de novo consultation for Foley catheter placement unless there was something that made catheterization beyond the routine (e.g., a history of urethral stricture requiring cystoscope-assisted catheter insertion). The same logic applies to simple laceration repair.

**OTHER FACTORS FORCING TREATMENT OF A SIMPLE LACERATION BY A CONSULTANT**

However, there are confounding factors which may obligate a plastic surgeon manage a simple laceration. For instance, hospital administration may feel that offering the services of a plastic surgeon, no matter how simple the injury, is in the public benefit and reflects well on the facility. Parents of a young child may desperately want a plastic surgeon to close the injury. Or the emergency physician may simply not feel technically skilled in suture repair, despite being board certified in emergency medicine.

As reimbursement declines, many emergency departments are utilizing allied health professionals (physician assistant, advanced practice nurse) to repair simple lacerations. This is permitted if both the appropriate state licensing board and the facility grant this privilege. But how can an allied health professional, who is privileged to repair a simple laceration, force a plastic surgeon who is on-call perform the same task? This scenario illustrates the illogical rationale that may currently exist.

In those situations where stakeholders insist that a plastic surgeon treat a simple laceration, hospital administration may cite the by-laws of the medical staff as a compelling reason for the on-call plastic surgeon to manage the injury. Departmental policies or medical staff by-laws may exist, which compel honoring a consultation even if EMTALA does not. Additionally, employment contracts (if applicable) may require the physician to answer all consultations. Because policies and by-laws vary in each hospital, providers must be cognizant of these rules or possibly face the menace of peer review.

On the other hand, if the Department/Division of Plastic Surgery has specific guidelines addressing management of simple lacerations, which are within the scope of practice of the emergency physician, the outcome of any subsequent peer review process will be more predictable. It is recommended that these guidelines become part of Department/Division policy and undergo the appropriate process for approval by the medical staff. These guidelines should outline what process is followed by the plastic surgeon when a consultation request is made for repair of a simple laceration, which is within the scope of practice for the emergency physician.

**DEVELOPING A DEPARTMENTAL/DIVISION POLICY REGARDING SIMPLE LACERATION REPAIR**

A clear policy established by the Department/Division of Plastic Surgery—and approved by the medical staff—stating how consultations for simple lacerations are triaged is in the best interest of all parties. The policy should be uniform. Patients must be educated about these policies before engaging the services of an on-call plastic surgeon for a simple laceration.
Although repair of the simple laceration by a plastic surgeon on-call can be viewed as an elective undertaking; federal guidelines regarding discrimination cannot be ignored in these policies. For example, the emergency department may request a plastic surgeon repair a simple laceration on a young girl’s face due to parental concern about her long-term appearance. However, in the current politically charged climate, this can be viewed as gender discrimination. Does not a young boy or transgender girl deserve the same consideration? Or for that matter, does not the 75-year-old salesman, who feels that he relies on appearance, deserve the same treatment? One can easily see that if a pattern emerges whereby only certain classes of patients receive more favorable treatment, legal challenge is possible by a disgruntled patient. Therefore, a uniform policy will protect all those involved in the process. If ability to pay is used as a criterion for treatment of a simple laceration by the on-call plastic surgeon, this too will eventually fall prey to legal action. In the case of the Medicare patient, it is one thing to visit a plastic surgeon regarding facial aging when considering a rhytidectomy. This is considered a cosmetic procedure, which health insurance does not provide coverage. On the other hand, because a simple laceration is a medical condition, health insurance does provide payment for treatment. Therefore, based on the federal rules of our current health-care system, the plastic surgeon cannot quote prices and directly charge the patient in the emergency department for treatment of this medical condition, which is covered by insurance if the consulting plastic surgeon otherwise participates with Medicare. Only if the consulting plastic surgeon has completely opted-out of Medicare, is direct patient negotiating permitted. However, fewer than 3% of plastic surgeons have done so. Although the rules are not as stringent with commercial insurance, many states are adopting laws that cap out-of-network charges. The treatment of the simple laceration by the on-call plastic surgeon may be elective, but it is never cosmetic. It is the moral duty of the plastic surgeon on-call to make sure the patient is aware of these facts before engaging treatment of the simple laceration. If the plastic surgeon on-call typically refuses to treat simple lacerations sustained by persons covered by Medicare or Medicaid but attends to other individuals with commercial insurance, a case of discrimination could be argued.

**USING ROOT CAUSE ANALYSIS TO DETERMINE REASONS FOR CONSULTATION**

Root cause analysis should be used to elucidate why the patient is requesting a plastic surgeon in the first place and efforts put in place to make positive changes in misconceptions. A patient with back pain seen in the emergency department after lifting a heavy object does not insist upon a neurosurgical evaluation. Additionally, the emergency physician would never think to obtain such a high-level consult for initial evaluation or treatment of this diagnosis. But for some reason, the instinct for simple lacerations is extraordinarily different. The reason may be the public perception—regardless of its accuracy—that a plastic surgeon will deliver a better aesthetic result. Although there is a plethora of evidence-based guidelines for management of chronic wounds, little exists for acute lacerations. One reason for this is perhaps since so many different providers can perform this basic function, there are truly few guidelines regarding outcome metrics as it is considered a fundamental skill set. Surprisingly, few studies exist regarding outcomes based on the type of provider who sutures the laceration. One interesting study, although with significant limitations, suggests that patients are equally satisfied with the outcome of facial lacerations closed by emergency physicians versus plastic surgeons but for young women and guardians of young children. This study also demonstrates with statistical significance that the average wait time for treatment by a plastic surgeon is double that of the emergency physician and that a greater number of younger children receive treatment by a plastic surgeon. It is unclear if anxious parents drive this higher utilization of plastic surgeons or if emergency physicians prefer not to deal with the difficulty of suturing young children.

A further contributing factor to requesting an elective simple laceration repair by a plastic surgeon is that patients themselves may feel uncomfortable. This can lead to a request, generated by the patient, for an elective consultation by the on-call plastic surgeon. In these situations, it is highly encouraged that before contacting the on-call plastic surgeon, the supervising emergency physician personally inspects the laceration, especially if it is a simple laceration. It is the duty of the emergency physician to explain how a simple laceration repair falls within his or her skill set and that the outcome will meet the standard of care.

Plastic surgeons themselves are partially to blame for this situation. Out-of-network providers formerly commanded high remuneration for laceration repair. As the insurance market changes, a greater financial burden is now placed directly upon patients with higher deductibles or simply no out-of-network benefits. This has decreased the appeal for the on-call plastic surgeon to treat the elective laceration. Therefore, when an elective laceration is managed by an out-of-network plastic surgeon, the plastic surgeon should educate the patient that there may be significant costs incurred beyond which is covered by insurance. It is also important for the patient to understand that the emergency physician, who is generally in network, may result in lower out-of-pocket cost. Some states have even taken the step of forbidding out-of-pocket billing by providers for emergency services beyond what is considered usually and customary. These facts should be discussed with the patient, preferably before calling the on-call plastic surgeon. Ironically, for those plastic surgeons who are in network with insurance, the financial responsibilities of the patient are the same whether the laceration is closed by a participating emergency physician or themselves when the same Current Procedural Terminology code is utilized.

**CONCLUSIONS**

What should be a straightforward situation, the simple laceration demonstrates the complicated climate of medical care. Competing interests regarding public relations, com-
Compensation, and quality care, all juggle for attention in this situation. Although the on-call plastic surgeon cannot be forced to manage the simple laceration based upon EMTALA, he or she may indeed be required to attend the consultation request based upon local hospital by-laws. Accordingly, having clear Departmental/Division guidelines addressing this issue in a nondiscriminatory fashion, which are approved by the medical staff, will provide much needed clarity.

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