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WSJ NEWS EXCLUSIVE

Children Are Dying in Ill-Prepared Emergency Rooms Across America

Hospitals and regulators have done little to ensure E.R.s are ready to treat children in emergencies, while researchers prove taking basic steps can save lives

By Liz Essley Whyte Follow *and Melanie Evans* Follow

Oct. 1, 2023 5:30 am ET

Hundreds of children die or are left severely injured around the country each year after they are rushed to hospital emergency rooms that are poorly prepared to treat them.

Only about 14% of emergency departments nationwide have been certified as ready to treat kids, or are children's hospitals specializing in treating young patients, The Wall Street Journal found.

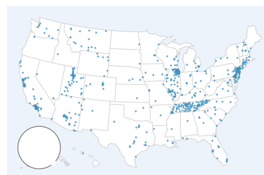
Many emergency doctors don't treat enough children to be able to spot life-threatening illnesses obscured by run-of-the-mill symptoms, or conditions more common in kids. Some E.R. staff default to drug doses and protocols meant for adults and either don't have or don't know where to find child-size gear in a crisis.

Doctors, health authorities and policy makers have known—and warned—of these failures for decades. Research in recent years has quantified the lack of readiness and number of child deaths that could have been avoided, and pointed to basic steps for solving the problem.

Yet most hospitals haven't taken action, according to the Journal's investigation of certification levels in all 50 states, reviews of medical records and interviews with doctors, health officials and researchers.

Parents in many places can't make an informed decision about where to take a child in a medical emergency. More than 70% of emergency departments have completed a federally funded assessment gauging whether they are ready for kids, but results for individual hospitals are confidential. Meanwhile, 25 states don't check E.R.s' pediatric preparedness at all, and even some that do check don't publish names of the hospitals that earned recognition for being prepared.

HEALTHCARE



Find Hospitals Deemed Ready to Treat Children in Your Area

Only 14% of U.S. emergency departments are certified as pediatric ready or specialize in kids

The Journal put together the first comprehensive list of hospitals nationwide that have received state certification of some level of readiness for pediatric emergencies, or are children's hospitals or pediatric trauma centers expert in taking care of young patients.

The fraction of hospitals that are deemed ready have varying levels of requirements. Some haven't done much more than identify weaknesses and promise improvements, the Journal found.

The lack of preparedness costs lives, research shows. About 1,440 children died from 2012 to 2017 because the emergency rooms that treated them weren't well prepared, according to a study of 983 E.R.s published in January by JAMA Network Open.

Children are four times as likely to die in less-prepared emergency rooms, a 2019 study published in the journal Pediatrics found. In addition to avoidable deaths, large numbers of children have been left with severe, long-term health conditions, doctors and researchers said.

"All E.R.s are not created equal," said Phyllis Rabinowitz, who started a foundation to improve emergency care for children. Her infant daughter died of Coxsackie B virus in 2006 after an E.R. sent her home. "This is a real crisis. I am living proof."

Ascension Seton Highland Lakes hospital in Burnet, Texas, hasn't been recognized by a Texas program that evaluates pediatric readiness.
JORDAN VONDERHAAR FOR THE WALL STREET JOURNAL

Dr. Chris DeRienzo, chief physician executive of the American Hospital Association trade group, said hospitals are committed to treating young patients well, and the doctors who most often staff E.R.s have some pediatric training.

He said it is unreasonable to expect every emergency room to have the pediatric expertise of a state-of-the-art children's hospital.

Emergency rooms don't need to have the resources of a children's hospital to take good care of kids, according to pediatric-emergency experts. Rather, studies have recommended simple steps that all hospitals can and should take.

Among them: assign a doctor and a nurse to coordinate improvements, stock appropriate supplies and train emergency staff to ensure they keep pediatric skills.

But most hospitals haven't done enough. Nationwide, they scored a median 69.5 on a 100-point test measuring pediatric readiness, according to a study published in JAMA Network Open in July. The assessment was developed by a group of doctors, health researchers, government officials and professional societies including the American Academy of Pediatrics. A score of 88 is considered well prepared.

"Our emergency care systems were never designed with children in mind," said Dr. Katherine Remick, co-director of the federally funded Emergency Medical Services for Children Innovation and Improvement Center.

Avoidable deaths

The first breathing tube that staff handed the doctor treating Avery Guzman-Mendez was too large for the 37-pound toddler.

Three-year-old Avery, who was epileptic, had been suffering a seizure when an ambulance brought her in March 2020 to the emergency room at Ascension Seton Highland Lakes hospital in Burnet, Texas. There, the doctor moved to install the tube to make sure neither the girl's seizing nor a seizure medicine stopped her lungs from getting oxygen.

Intubating a child is just one of the procedures that can be especially tricky for doctors who don't treat kids often.

Children's airways are smaller than adults' and positioned differently. Doctors must also do the work more quickly in kids because children lose oxygen faster than adults do, pediatric specialists said.

In 2000, 20 years before Avery arrived at the hospital, 6-year-old Matthew Melancon had died from lack of oxygen after the Highland Lakes emergency team tried but failed to intubate him, according to his mother and court records.

Avery died on Matthew's birthday. Matthew would have been 26 years old.

The hospital hasn't been certified under a Texas program that recognizes facilities working to upgrade their crisis care for kids.

The following account of Avery's care is from the recollections of her aunt, medical records and court records in the family's lawsuit against the hospital, the doctor and two physician staffing agencies.

The sides settled the lawsuit earlier this year. Terms weren't disclosed.

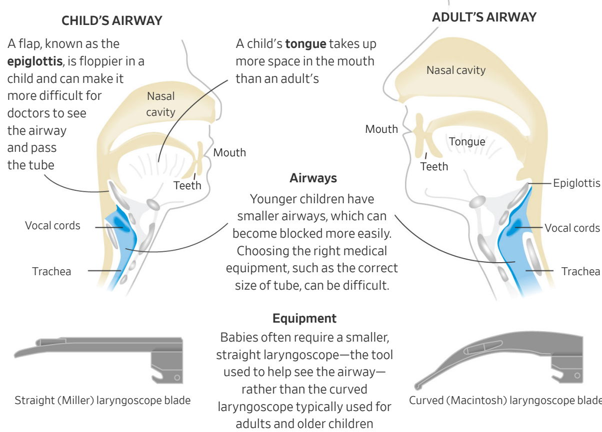
Ascension, the health system that owns Highland Lakes, didn't respond to requests for comment, but in court records issued a blanket denial of all the lawsuit's allegations.

After staff handed the doctor a breathing tube sized for a small woman, the doctor attempted to intubate with the large tube, medical records said and the doctor told lawyers. The doctor tried again multiple times with smaller tubes and failed, finding it difficult to spot Avery's airway.

Avery began losing too much oxygen, and her heart stopped.

The Complexity of Intubating a Child

Doctors must use special techniques and equipment to insert a breathing tube into a child's airway —and do so more quickly, since children lose blood oxygen rapidly.



Note: Not to scale
Sources: Harvard Medical School; The Royal Children's Hospital Melbourne; Dr. Marc Auerbach; Dr. Joshua Nagler

The team attempted CPR at least six times. A nurse recorded their efforts by hand on a hospital record that displayed adult drug doses, which the team gave to Avery.

The nurse found the adult record in the drawer of the trauma room. She said later she wasn't sure if there were pediatric versions available.

The team finally stabilized Avery. But her oxygen had dipped to life-threatening levels at least five times.

Avery was flown to the children's hospital about 50 miles away in Austin, and doctors there intubated her on their first attempt. But her brain was already damaged. She died six days later.

Most pediatric-readiness programs require hospitals to have the equipment, training and protocols necessary for intubating kids and other emergency procedures.

The 10-bed emergency room at Grand River Health hospital, in Rifle, Colo., nearly doubled its readiness score to 97.5 this past spring after it trained its nurses to use equipment for children and color-coded its emergency pediatric supplies.

The Grand River Health emergency department, at the base of the mountains in Rifle, Colo., roughly doubled its score on an assessment measuring its readiness to treat kids after it trained its nurses to use equipment for children and color-coded its emergency pediatric supplies.

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Grand River Health nurse Amber Hill, left, learned to use a device for delivering air to infants. Jeff Wold, a hospital director, taught her during a pediatric-care training in September.

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As long ago as 1984, after a U.S. Senate staffer's child received poor treatment in an emergency room, Congress began funneling some funding to address the shortcomings. Since then, medical groups including the American Academy of Pediatrics, the American College of Emergency Physicians and the National Academy of Medicine (formerly the Institute of Medicine) have issued reports bemoaning the state of children's emergency care.

Yet hospitals have had little incentive to improve care for kids because many government agencies and professional groups haven't required action. State efforts to help hospitals have limited federal funding, and child emergency care isn't in as high demand or as lucrative as other services.

Federal funding to states for improving child emergency care amounts to roughly $190,000 per state each year—enough to pay for one or two staffers and some free training for hospitals and emergency responders, state program officials said.

Hospitals get much more revenue from adults because the facilities care for more older patients. Meanwhile, hospitals often lose money treating children, including the many covered by Medicaid, which pediatric experts say doesn't pay enough to cover all the costs.

Most of the safety standards set by the Centers for Medicare and Medicaid Services, the nation's primary hospital regulator, and the Joint Commission, a private organization that sets standards for hospitals, apply to people of all ages, rather than children specifically.

CMS does regulate confining or restraining children, an agency representative said. The Joint Commission discussed adding pediatric-equipment requirements in 2019. Some hospitals criticized the standards, and the organization decided that emergency departments needed a stronger consensus, a spokeswoman said.

About 700 out of 5,085 emergency rooms nationwide either specialize in children or have been recognized by states for their efforts to improve emergency care for kids, according to the analysis by the Journal, which surveyed all 50 states, Washington, D.C., and more than 600 hospitals.

Some states, local agencies and nonprofits have designated pediatric trauma centers, which are meant to be staffed with experts able to treat the most critical patients, but these are limited in number so they see enough child emergency cases to maintain their skills.

Only Tennessee, Illinois and New Jersey require and check that the rest of hospitals are equipped to provide emergency treatment to the youngest patients.

The Illinois mandate only applies to major hospitals. A state official said roughly 40% of hospitals there don't take part in the readiness program. And two New Jersey doctors involved with efforts to improve children's emergency care there said the state doesn't enforce its requirements. A state agency spokeswoman said the federal government has signed off on its verification program.

Twenty-two states have programs that are voluntary. Among the states without a program is Michigan.

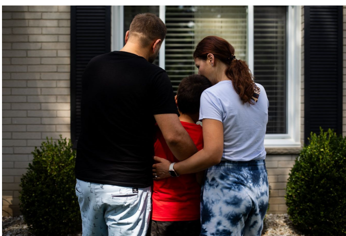
Severe injuries

On the outskirts of Detroit, emergency staff gave 4-year-old Mason Seitllari apple juice and Tylenol after his parents brought him to an emergency room for vomiting and stomach pain.

It took four hours for the St. Mary Mercy Livonia emergency department to order an X-ray of Mason's bowel.

A dangerously crumpled bowel is more common in kids than adults. The condition, known as intussusception, can be easily missed by emergency rooms that lack experience treating children, pediatric specialists said. It can be easily confused with constipation or a stomach bug. Yet if caught early, an enema can treat it.

This account of Mason's treatment is based on depositions, medical records and other documents that were part of the family's lawsuit against St. Mary Mercy and others. It is also based on interviews with Mason's parents.



Mason Seitllari with his mother Nisjeta Seitllari and father Dorjan Seitllari outside their home in Livonia, Mich. An emergency room took four hours to order an X-ray that revealed a bowel obstruction. Mason then spent nearly four months in a different hospital.

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Trinity Health Livonia hospital, formerly St. Mary Mercy Livonia hospital, on the outskirts of Detroit, where Mason came for emergency treatment. Michigan has no program to evaluate E.R.s' readiness to treat kids.

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Mason's parents, who moved to the U.S. from Albania, took him to St. Mary Mercy in April 2017 because it was close to their home in Livonia. "I thought every hospital in U.S.A. is good," said Nisjeta Seitllari, Mason's mother.

St. Mary Mercy, which is owned by Trinity Health, had discussed sending Mason home before it got the X-ray results. Mason was rushed to the University of Michigan Health C.S. Mott Children's Hospital. Doctors there quickly diagnosed his intussusception.

Mason's oxygen dropped. He went into septic shock. Doctors rushed him to emergency surgery. In the operating room, Mason's heart stopped.

“It was a nightmare,” Nisjeta Seitllari said. “That is the worst thing that can happen to a parent.”

Mason needed about a dozen surgeries and procedures on his bowel and lungs. He spent nearly four months in the hospital. When he finally left, he had one tube in his throat to get oxygen and needed another tube through his nose for feeding.

The negligence lawsuit filed by Mason’s family is scheduled for trial in March.

The hospital and doctors denied the lawsuit’s allegations in court documents. A Trinity Health representative declined to comment, citing ongoing litigation.

Mason’s lungs suffered long-term damage. Now 10 years old, he depends on inhalers and is shaken by a device to keep his lungs clear.

He has been hospitalized several times for pneumonia, a complication from the lung damage. His parents won’t go to St. Mary Mercy, now named Trinity Health Livonia, and instead take him to Mott Children’s.

“We just don’t want to take the risks,” Nisjeta Seitllari said.

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Appeared in the October 2, 2023, print edition as 'Children Are Dying in Unprepared Emergency Rooms Across America'.