Physician & PA Alert

Premier Health Care Services, Inc. May 2005

Monthly Physician & PA Alerts are intended to provide you with relevant and timely tips to reinforce excellent clinical care, reduce medical-legal risk, and improve customer service. Your feedback is welcome.

— Tom Syzek, MD, FACEP, Director, Risk Management

PATIENT TURNOVERS: TICKING TIME BOMBS

I call it the "Fred Flintstone Syndrome." At the end of a work shift, your replacement arrives, the clock strikes 5 p.m. (or 11 p.m., 7 a.m., whatever), the whistle blows, and the voice in your head screams "Yabba-Dabba-Do!" The temptation is give a 2-second report to your partner about the patients you are turning over, and get OTD, OTB, and HFH (out-the-door, on-the-bus, head-for-home). **STOP RIGHT THERE!** You and your partner have just entered one of the most dangerous areas in all of medicine – the "Change of Shift Transition Zone." One false move in this Zone and your turnover patients may suffer a preventable bad outcome, while you and your partner are transported to the next level – the Malpractice Zone.

Change of shift in the emergency department is a time of great potential danger to the patient and emergency practitioners. For the practitioner who is ending his shift, it can be difficult to effectively communicate to his partner all the details of a patient's workup, his medical reasoning, and working diagnosis. For the newly arrived practitioner, the temptation is to quickly label and disposition the turnover patients, and move on to the rack full of new patients to be seen. Patient safety can be ensured and conducting an orderly and careful process at the change of shift can minimize risk to practitioners.

TIPS FOR THE DEPARTING PRACTITIONER

1. Minimize the number of patient turnovers if at all possible.
2. Consider a period of staffing overlap to avoid turnovers and maximize communication.
3. Avoid turning over patients whose evaluation and ED course are highly complex.
4. Sometimes the best course of action is to stay and finish the difficult patient – regardless of compensation.
5. Consider making bedside "rounds" with your replacement and introduce him/her to your turnover patients.
6. Communicate the key details of each turnover patient to your partner; including at least the chief complaint, brief history and exam, diagnostic results ordered and pending, treatment provided, differential and working diagnoses, likely consults, and anticipated disposition.
7. Consider developing a template "change of shift" report on which you record these key details for each patient.
8. Tell the patient, patient's family, and the primary nurse you are leaving and who will be assuming care of the patient.

Side 1 of 2

9. Document your history, exam, test results, ED course, and medical reasoning up to the point of turnover.
10. Document who is assuming care of the patient, and the time of turnover.

TIPS FOR THE ONCOMING PRACTITIONER

1. Arrive a few minutes early to allow time for the turnover process.
2. Listen carefully and respectfully to your departing partner – you will have turnovers also!
3. Accept the fact that you are now the practitioner of record, responsible for completing the patient encounter.
4. Mark the patient tracking board to reflect that you are now the responsible practitioner.
5. As soon as feasible, introduce yourself to each turnover patient and family, informing them that you are now the practitioner responsible for their care.
6. On each turnover patient, take a history and perform an exam sufficient for you to be comfortable that you know each patient.
7. Avoid tunnel vision – use an open mind and high index of suspicion to form a differential diagnosis for each patient based on your own observations.
8. Follow up on the result of EVERY test ordered by you AND your departed partner.
9. Document your own evaluation, test results, medical reasoning, and disposition plan for each patient.

A poorly conducted "change of shift" process can result in patients being forgotten and delays in evaluation, diagnosis, treatment, and disposition. A cavalier attitude by either the departing or oncoming practitioner can contribute to patient dissatisfaction, bad outcomes, and malpractice litigation. An orderly, systematic, well-documented process results in improved patient safety and reduced liability. Remember that turnover patients are ticking time bombs – they must be handled with great care to prevent disaster.

Source: Premier Health Care Services, Dayton, OH.

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AMA: Patients Who Leave Against Medical Advice

The first impulse most practitioners have when faced with an ED patient who wants to leave **against medical advice** (AMA) is to simply let him leave. "Hit the road, Jack. One less work-up and one less hassle." The prevailing wisdom in ED Risk Management would say to resist this understandable impulse and instead take a calm and reasoned approach to the AMA patient. Failure to do so can spell medical tragedy for the patient and malpractice disaster for the practitioner. The outcome of many suits actually hinges on what was said and done when a patient leaves the ED, especially AMA. The following list of **"Do's and Don'ts"** is offered as a guide to avoid medical-legal catastrophe when dealing with AMA patients.

- **Don't** ignore the patient who wants to leave AMA. If at all possible, stop what you are doing and prepare to address the issue.
- **Do** your best to find out from the ED staff, the patient, and his family why he wants to leave and what you can do to convince him to stay.
- **Don't** blame or berate the patient or anyone else for his desire to leave.
- **Do** apologize if the patient has been waiting, or there have been delays in the ED process. Apologies are free. Suits cost millions.
- **Don't** just ask the nurse to have a patient sign a generic AMA form and leave. This course of action provides little protection for the practitioner.
- **Do** explain the benefits of your treatment plan and the potential risks to the patient if he declines your recommendation. For example, if a patient with chest pain wants to leave despite your advice to be admitted, it should be clearly explained to the patient that he may suffer a heart attack, heart or brain damage, acute or chronic pain, permanent disability and even death.
- **Don't** express your frustration and anger to the patient. Instead, earnestly convince him that your overriding interest is his well-being. Make sure he knows that you are on his side against a potential threat to his health.
- **Do** enlist the patient's family and friends in your attempt to convince the patient to stay.

- **Don't** refuse to provide treatment — this could be considered abandoning the patient. Provide whatever treatment, prescriptions, follow-up appointments, and specific discharge instructions the patient will accept.
- **Do** make it clear that the patient is welcome to return to the ED anytime he gets worse or changes his mind.
- **Don't** let a mentally incompetent patient leave AMA. This applies to intoxicated patients. Remember your risk in a malpractice suit is much greater than your risk of holding an incompetent patient against his will.
- **Do** document the patient's "informed refusal" of crucial diagnostic testing (i.e., blood work or x-rays), procedures (i.e., LP to rule out meningitis or subarachnoid hemorrhage), or treatments (i.e., medications or transfusions) in the same detail as you would an AMA.
- **Don't** worry about whether or not the patient's insurance will deny payment if he signs out AMA. His insurance is not your problem but a malpractice suit will definitely be your problem.
- **Do** always document (dictate) the details of the AMA patient encounter. Include documentation of the patient's competence, the specific benefits of your proposed treatment and risk of leaving AMA, what you did to get the patient to stay, and your compassionate interest in having the patient return to the ED for any reason. Without an AMA form which addresses these details, signed by the patient and witnessed by a family member and/or ED staff member, the only defense you will have in a suit will be your word against that of everyone else.

— Tom Syzek, MD
Director, Risk Management

Source: Premier Health Care Services, Dayton, OH.

Side 2 of 2

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THE DECEPTIVE PIED PIPERS: "BEDSIDE MANEUVERS" FOR CHEST PAIN

Malpractice claims related to the chief complaint of chest pain continue to represent the most frequent and costly in Emergency Medicine. Foremost among these claims is the allegation of "missed MI," which has now been expanded to include missed unstable angina as well as actual myocardial infarction. Although the ED evaluation of the adult with chest pain is fraught with many pitfalls, one of the most glaring yet avoidable errors is the reliance upon "bedside maneuvers" to exclude the diagnosis of coronary etiology.

More so than any others, the use of two classic "bedside maneuvers" tends to mislead practitioners. The first is the "GI Cocktail," and the second is the elicitation of "chest wall tenderness." These two bad actors alone are to blame for dozens, if not hundreds, of malpractice suits in emergency medicine across the nation. Let's expose each of these sinister characters in turn.

THE CURSE OF THE GREEN SLIME: THE GI COCKTAIL

A 47-year-old man enters the ED with chest pain and is given a mixture of Mylanta, viscous lidocaine, and Donnatal, and was discharged "feeling better." He collapses in cardiac arrest at home and dies. During the malpractice trial, expert witnesses were critical of the emergency physician for not performing an EKG or obtaining cardiac enzymes, and for allowing the results of the GI cocktail to "guide his decision making." The jury awarded $1 million to the surviving spouse in a verdict against the ED physician.

Several key points can be made about the use of a GI Cocktail in chest pain patients:

1. Before 1912, when Dr. James Herrick first described the syndrome of coronary thrombosis, thousands of people who died while vomiting and clutching their chests had their cause of death listed as "acute indigestion." Nobody dies of indigestion – these were all acute coronary syndromes!
2. There is considerable overlap in the symptoms produced by gastrointestinal and coronary disease. Patients who complain of pressure, burning, or "indigestion" either in the chest or abdomen certainly might have GI disease, but it is incumbent on the emergency provider to consider and rule out an acute coronary syndrome.

Side 1 of 2

3. Relief of chest or abdominal pain following administration of the "Green Slime" is frequently and mistakenly misinterpreted by physicians as confirming a diagnosis of esophagitis thus ruling out cardiac ischemia.
4. The response to a GI Cocktail is simply not a sensitive or specific indicator of GI disease or coronary ischemia.

Consider the following caveats regarding the use of a GI cocktail in the evaluation of patients with chest or abdominal pain:

1. The use of a GI Cocktail as a diagnostic test to differentiate between gastrointestinal and cardiac causes of patient's symptoms is inappropriate because it frequently leads to erroneous conclusions.
2. A surefire recipe for disaster is to discharge a patient with chest pain after administering a GI Cocktail without ruling out an acute coronary syndrome.
3. Before discharging an adult patient home with the diagnosis of gastritis, gastroenteritis, GERD, or just plain "vomiting," stop and ask yourself if this patient could be having coronary ischemia and needs an EKG and further evaluation.
4. Join "GI Cocktail Users Anonymous" to kick the bad habit of relying on this concoction to tell you anything useful during your evaluation of adult patients with chest and/or upper abdominal pain.

THE MYTH OF CHEST WALL TENDERNESS

During a busy shift in the Emergency Department, you see a 48 year-old man with dull central chest pain and feel that, although he is clinically stable and the initial EKG is normal, myocardial ischemia ought to be ruled out. He is a busy and inpatient man. On examination you elicit chest wall tenderness. You wonder if this sign is sufficiently reliable to allow the exclusion of an acute coronary syndrome.

In patients with acute chest pain, the literature shows that chest wall tenderness suggests that acute coronary syndrome is less likely but it does not rule out the diagnosis. Two observations to consider:

1. Using chest wall tenderness as an independent rule out strategy in patients with chest pain would lead to an unacceptably high rate of missed MI.
2. Unless the physical exam shows a large Gila Monster attached by its teeth to the patient's sternum, it is unwise to conclude that the presence of chest wall tenderness alone will reliably exclude coronary ischemia.

THE BOTTOM LINE

Neither the response to a GI Cocktail nor the presence of chest wall tenderness provide reliable data to rule out coronary ischemia in patients with chest pain. Many malpractice cases result (and are lost) from the use of these dangerous "Bedside Maneuvers." Emergency practitioners would do best to avoid following the misleading melodies of these Pied Pipers.

Source: Premier Health Care Services, Dayton, OH.