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Hospital-Based Violence Intervention Programs Gain Momentum

By Dorothy Brooks

As COVID-19 pandemic-related concerns begin to recede, long-standing health issues that were overshadowed during the crisis have re-emerged — in particular, the number of patients presenting to medical facilities with violence-related injuries.

A new report indicates nearly 1.5 million people age 2 to 17 years seek medical care each year as a result of some form of violence, a figure 4.5 times higher than prior estimates that included only ED data.¹ Further, research suggests that up to 40% of all patients who present to the ED with violence-related injuries return to the ED with a repeat violence-related injury within five years.²

In response, there are calls for hospitals and EDs to take steps to break this cycle by bringing appropriate resources to bear when any patient presents with a violence-related injury. Naturally, emergency medicine practitioners are taking the lead on many of these efforts. Experts in this arena note that even with many competing priorities in healthcare, funding and support for this work is

much easier to come by these days than it has been in years past.

One of the newest such programs is Project HEAL (Help, Empower, and Lead) at Hackensack Meridian Jersey Shore University Medical Center in Neptune, NJ. **Aakash Shah, MD**, the program’s medical director and an emergency medicine physician at the hospital, says a driving motivation for the program was the growing recognition that violence tends to be cyclical.

“I have lost count of the number of times that I have had conversations with patients who are victims of violence, whether that is domestic violence or gang violence,” he explains. “One of the things that has always struck me is that all too often I find myself having these conversations with [the same victims] more than once.”

Consequently, a primary goal of Project HEAL, which works in coordination with the hospital’s department of psychiatry and behavioral health, is to break that cycle by recognizing and intervening with

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patients when they first present to the ED with a violence-related injury. Shah emphasizes such patients will receive the same prompt medical care for their injuries that they have always received — with an added element to their care.

A tech, a nurse, or the treating physician will notify the charge nurse that a patient with a violence-related injury is in the ED. The charge nurse will contact Project HEAL to send over a violence intervention specialist to meet with the patient while he or she is in the ED.

Typically, at Project HEAL, violence intervention specialists are peers who come from the same communities as the patients. Many of these peers have experienced violence-related injuries. They become hospital employees, undergoing several weeks of training for the role.

The offices of Project HEAL are close to the hospital. When a charge nurse calls about a consult, it does not take long for the specialist to connect with the patient at the bedside. Once there, the specialist will obtain the patient's permission to work closely with hospital case managers and social workers to develop an individualized service

plan and coordinate wraparound services that will continue beyond the point of discharge.

Shah says he and colleagues have moved away from the “treat and release” approach. “Instead, we are continuing to work with [violence victims] for weeks, if not months,” he says.

For example, if case managers and social workers realize the patient needs not just care for wounds but also educational opportunities, Project HEAL partners with the local community college to meet those needs. Similarly, there are resources for training and placement, housing, mental health, and treatment for substance use disorder. The latter is a condition that applies to about half of all of Project HEAL patients, according to Shah.

To optimally meet the needs of patients who have been injured by violence, it helps to develop strong connections with the community. For instance, Shah recalls the case of a patient who was shot in a gang-related incident.

“A fellow gang member came up to us and said that he appreciated all that we were doing for [the patient] in the hospital, but he said that the minute [the patient] touched the

EDITOR'S NOTE

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street, he would be shot again,” Shah says.

The gang member indicated what the patient really needed was a one-way bus ticket to North Carolina where he could stay with his grandmother and be safe. “In the absence of us providing the patient a one-way bus ticket to North Carolina, all that would have happened, based on the estimation of [the patient’s] own peer, is that he would have wound up, best case scenario, back in the ED,” Shah observes.

Before Project HEAL began connecting with patients in the ED in March 2021, there was plenty of prep work. For instance, program supervisors spent weeks going to every ED huddle to ensure each staff member was aware of the program, what it does, and how to contact the organization. “It is a process of continual reinforcement. We join for department meetings to discuss which patients we should be called about, and to provide examples of patients that staff members have already called us about and what the outcomes were,” Shah says. “This is so everyone gets a more granular sense of what we are doing and how, so that [the program] is always in the front of their minds in case they see someone who might benefit.”

One of the challenges program developers have encountered is many people assume Project HEAL only works with victims of domestic violence. The reality is the program works with victims of all types of violence. “I would argue that our work with [the victims of gang violence] is just as important,” Shah says. “Today’s victims can be tomorrow’s perpetrators.”

Project HEAL is only months old, but Shah is hoping to drive home this message regarding the wide scope of the program, not only to ED staff but

also to community neighbors. In fact, Shah still takes a handful of shifts in the ED every week, which allows him to nurture existing relationships there. “This program is designed in a way so that it really does minimize the lift for the ED team ... so that they are not doing anything extra,” he says. “When I am on shift in the ED, I appreciate that ability to know that I can put out a call and solve some of those toughest and most important issues facing my patient, issues that until now the ED was not designed to resolve.”

Established in 2012, The Violence Intervention Program (VIP) at Children’s Hospital of Philadelphia (CHOP) shares many of the same goals as Project HEAL. **Joel Fein**, MD, MPH, the emergency physician who founded the program, continues to direct the VIP while also serving as co-director of CHOP’s Center for Violence Prevention.

Usually, a social worker in the ED will spot young people who present with violence-related injuries, but other clinical staff members can refer these patients to the VIP. “If the patient is admitted or is in the ED for a long enough time, one of our violence prevention specialists, [all of whom are] hired through the hospital, can see the patient [at the time of presentation],” Fein explains. “Oftentimes, the patient is sent home before the violence prevention specialist can get to the ED. [In that case], we make sure that we connect with the patient in the next few days.”

There are several mechanisms in place to ensure patients with violence-related injuries who present to the ED are identified and contacted by the VIP. Fein notes the VIP has asked its fellows and the nurse practitioners who work in the ED to be aware of any patient who is violently injured and to refer each to the program.

“Even if the patients don’t have any interest in our program, they may need help reporting to the police or even just navigating the healthcare system after their ED visit,” Fein says.

Further, there are research assistants associated with the VIP who are in the ED often for many hours a day. They can refer patients to the program, along with providing some initial information. “We also track every violently injured patient who comes to the ED through an electronic medical record [EMR] review,” Fein says. “Within a week of that patient being in the ED, having not been referred, we will still call them and try to recruit them into the program ... we have a backup system for recruiting patients that way, and quite a number of patients are recruited through EMR surveillance.”

VIP is voluntary, but if the patient and family agree to participate, the first step is to conduct an assessment. “We try and go to the patient’s home; obviously, over the last year, this has been done virtually,” Fein reports. “That assessment establishes mutual goals for the patient and the family ... we also think about what the family may need to both recover and heal from the event, and also what they may need in general for this [violent injury] to not happen again.”

Currently, all violence prevention specialists at CHOP hold a master’s degree in social work. They are highly trained in setting up wraparound care to meet the goals established during the assessment. For instance, the family may need assistance setting up an individualized education program (IEP) at the patient’s school while the youth recovers from his or her injury.

“The family may also need special circumstances or a safety plan, which is the most important thing we do, both in the community and in the school,” Fein notes. This requires an

assessment of the potential for future violence, such as the possibility of retaliation.

Some families may need help with court proceedings or reporting to the police. Many people need help finding new housing because it is dangerous for them to stay in their current homes. Fein says all the social determinants of health, including food, water, and shelter, are considered.

Patients engaged in the VIP often require mental healthcare. They may be suffering from PTSD following the violent incident that caused their injury. Fein notes these patients also might present with other mental health needs that led to the injury or were concurrent with the reasons staff saw the patient in the ED. “We can connect them with mental healthcare providers, but we can also connect them with certain therapies through our program,” Fein explains.

For example, some older kids in the program participate in a trauma-informed therapy group called Building Resilience After a Violent Event (BRAVE). “We have been holding these sessions virtually [in recent months], but we [generally] hold them in person every month,” Fein says. “This is a 10-session program that patients go through to help them identify their own trauma, understand what is called the self-awareness around trauma, and then heal as a group from their injuries.”

How do program leaders know their approach is working? Fein explains they determine if the mutual goals that have been established as part of each patient’s individualized plan have been achieved. “For example, probably 75% of our patients have mental health goals, and we have been able to meet 80% of those needs,” he says. “We meet almost 100% of the safety and

danger goals because that is the most important thing we can do for the family.”

It is harder to gauge how patients who engage with the VIP fare in terms of avoiding violent injuries well into the future. “For each kid, that is the goal — for them not to be reinjured,” Fein says.

However, because many of these patients are adolescents, it is challenging to obtain a statistical read on how they perform once they leave the pediatric healthcare system.

The VIP’s multitude of resources may seem unrealistic to other facilities with similar needs, but Fein stresses the program began with one part-time person, and then gradually expanded from there. Further, he notes there is growing advocacy and support for such programs. For instance, Fein serves on the advisory board for the Health Alliance for Violence Intervention (HAVI), a national network of programs that serves as a go-to resource for hospitals interested in building or improving their own violence intervention efforts.³

“We started [HAVI] with eight programs in the country, and now there are 42 members with 40 more that are trying to become members,” Fein reports. “This is a burgeoning area of intervention. As we get more and more programs, we are getting more and more evidence.”

The HAVI offers training and technical assistance to new violence intervention programs. It is a source of expertise on many issues ranging from how to work with traumatized individuals to community engagement and safety planning. Fein’s advice to administrators interested in establishing a violence intervention program is to scope out what internal and external resources are in place that could be leveraged.

“Every program exists in a different location. See if there are community programs that you can utilize to do some of the work by forming agreements with them,” Fein says.

While hospital-based violence intervention programs can differ in many respects based on community characteristics and available resources, there are some components that are non-negotiable.

“There has to be some trauma-informed training or at least the hiring of trauma-informed personnel,” Fein stresses.

Secondly, such programs need to extend well beyond the ED encounter or hospital stay. “The hospital visit is an important time to connect ... but you can’t just be making a referral from the hospital and then saying goodbye to the patient,” Fein says. “The kernel of the program is working with patients and maybe their families. They become clients because they are no longer patients, but they are people who are in the community with you.”

Finally, Fein advises new programs start collecting data on their efforts immediately. “The way you get more funding is to provide the data to show that there is a need and that you are doing good things,” he says. “If you don’t start that from the beginning, and you forget about the expense and need for collecting your evaluation data, then you are going to have more challenges getting increased funding.”

In fact, Shah argues the need for information-gathering begins even before there is a program.

“I think those who feel passionately about this, those who have an intuitive sense that something about the traditional approach to cycles of violence in the ED needs to change, I would encourage them to start keeping track of the data,” he says.

For example, Shah suggests tallying the number of patients who present to the ED with injuries from assaults, gun violence, and stab wounds. Note where these patients come from and how often they return over several years. Use these data to make the case for change to hospital leaders, perhaps in a memo to the chief medical officer.

Perhaps there are 200 victims of gun and knife violence each year, 30% of whom return to the ED with repeat violent injuries. The vast

majority of these are uninsured or underinsured.

“Is there an opportunity here to intervene on these cycles of violence in a way that not just makes clinical sense but also makes economic sense?” Shah asks. “I think leveraging that insight can go a long way, even for those who might not have a ready-made funding opportunity before them.” ■

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With STDs at an All-Time High, Advocates Push Expedited Partner Therapy

By Dorothy Brooks

In its latest report on the incidence of sexually transmitted diseases (STDs), the CDC reported the number of cases reached an all-time high for a sixth consecutive year.

The agency indicated there were more than 2.5 million cases of chlamydia, gonorrhea, and syphilis reported in 2019. Further, the data show there was a 30% increase in reportable STD cases between 2015 and 2019.¹

While STD clinics and primary care clinicians detect and treat many of these cases, there is no question EDs play an outsize role in caring for patients with STDs, particularly among disadvantaged populations. However, evidence suggests many EDs are not using all the tools at their disposal to facilitate treatment and curb transmission.

In particular, researchers note most EDs have not embraced expedited partner therapy (EPT), a practice that involves providing patients who have been diagnosed with an STD with prescriptions/treatment for their partners as well as themselves.

In one study, researchers found only 19% of academic EDs reported using EPT. Even when the option was available, many clinicians did not realize the practice was legal in their states.² This was the case even though EPT is supported by the CDC as well as multiple professional organizations, including the American College of Emergency Physicians.³

Advocates of the approach stress this gap represents a clear opportunity for improvement in ED care, pointing to studies that show EPT is effective at both curbing the spread of STDs and preventing reinfection rates.⁴

Rachel Solnick, MS, MSC, a clinical lecturer in the department of emergency medicine at the University of Michigan, says EPT has existed for more than a decade, primarily in clinic and public health settings. She contends EDs should adopt the practice, considering the high number of patients presenting to EDs who could benefit from EPT.

However, she notes ED medical directors frequently cite the logistical

complexity of implementing the practice as a barrier. “We all use electronic medical records now and that creates a little bit of a challenge in terms of how you actually write a prescription ... for someone who is not in the patient’s chart at all,” she explains.

Many states have worked around this problem by passing laws that allow clinicians to write a prescription even if the patient’s partner is not physically there. Other ED providers simply write the prescriptions for patients’ partners on paper. “There have been a number of workarounds, but more than those issues is just the fact that a lot of people don’t even know about EPT,” Solnick shares.

In the wake of COVID-19, with interest high in transmissible diseases, Solnick believes the timing is right for the emergency medicine community to adopt EPT, especially when it is explicitly legal in most states.⁵ “South Carolina was one of the last states in which [EPT] was prohibited, and it just changed that in the last few months.⁶ Now, in every state in the

U.S., EPT is either likely permissible or it has specific laws supporting the practice,” Solnick shares.

For clinicians interested in learning about the potential for EPT in their EDs, Solnick advises bringing departmental leadership on board with the practice. Then, establish a clear written policy regarding EPT.

“People will be more supportive of [EPT] if they feel there is a policy that is supporting them,” Solnick suggests. “Having it written down as something that the ED does so that people don’t feel like they are going rogue when they are offering EPT would be very helpful.”

Some clinicians may find their systems already instituted a policy in support of EPT. That was Solnick’s experience when she came to the University of Michigan.

“I found that we actually had a policy here since 2016. It is just that we weren’t really aware because it wasn’t something that we were in the practice of doing,” she explains.

Since then, Solnick has delivered brief presentations about EPT and its importance to staff. “I think it is important for everybody to understand when a department adopts a policy,” she adds.

Experts note it is important for ED leaders to think creatively about how they can most effectively implement EPT. For instance, **Gabrielle Jacknin**, PharmD, BCPS, clinical specialist and lead pharmacist at the University of Colorado Hospital in Aurora, explains the EPT policy in place there is primarily driven through pharmacy services.

“When the providers see a patient that they decide to treat for an STD, they are able to offer partner prescriptions at that time and can physically write a prescription,” she explains. “We have a 24/7 physical pharmacy attached to our ED. They

are able to write a prescription on a prescription pad and give it to the pharmacy with the patient’s information for the partner’s information or as an anonymous prescription without the partner’s information. Then, that can be picked up at the time of discharge.”

Usually, a positive STD result will flow into the inbox for the pharmacy group. The pharmacists will call the patients about the positive results.

“Then, the standard of care is to offer the partner prescriptions at that time,” Jacknin says. “The pharmacists are the ones who write the prescriptions, and about 50% to 60% of patients elect to have their partner treated.”

Jacknin says the ED sees about 110,000 patients a year, and the pharmacists receive seven to 10 positive STD cultures every day. That means there are many conversations happening about EPT.

Most partner prescriptions are paid for through Medicaid or a commercial insurer. When insurance is unavailable, the prescriptions are provided through a hospital program that provides certain medications to high-risk patients.

This approach to EPT removes any logistical burdens from the treating clinicians, and it is a natural extension of how many pharmacists are acting already.

“Pharmacists are calling patients with positive results in general, especially ED pharmacists. There is a precedent for this to be on their radar,” Jacknin says.

However, she acknowledges not all EDs maintain physical pharmacies on site. Providing the medicines to partners would need to follow a different pathway for those facilities.

Jacknin’s advice to other EDs interested in developing a similar approach is to start with a

stakeholder meeting that includes whoever is handling the callbacks for STD results through the ED, a representative from the physician leadership group, and someone from pharmacy. Come equipped with the knowledge of what is required in terms of state laws and hospital regulations. Determine how to best execute EPT given the resources available.

Jacknin is unsure why more ED-based pharmacists have not branched into providing partner prescriptions for STDs, but it has worked well in the ED at the University of Colorado Hospital.

“It seemed like a very obvious step at our site, which is why we added it here,” she says. “We are fortunate to have a physical pharmacy here, too, so that made it very seamless for us to be able to prescribe.” ■

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Researchers Make the Case for STD Screening in Pediatric EDs

By Dorothy Brooks

Considering the prevalence of sexually transmitted diseases (STDs) in adolescents and young adults, should pediatric EDs screen for STDs when these patients present to the ED? From a cost-effectiveness standpoint, the answer is yes, according to a team of researchers who examined this issue recently.¹

In a simulation study, investigators compared three screening techniques for a hypothetical population of 10,000 patients age 15 to 21 years who presented to the ED: no screening, targeted screening (which involves the completion of a sexual history survey to estimate STD risk), and universally offered screening to every patient.

Assuming under a conservative estimate that 3.6% of all these patients presented with either chlamydia or gonorrhea, the researchers concluded targeted screening resulted in the detection and successful treatment of 95 out of 360 STDs. The incremental cost-effectiveness ratio (ICER) for targeted screening when compared to no screening was \$6,444 per detected and treated case.

Under universally offered screening, 112 STD cases were identified and successfully treated, and the ICER per identified and treated case when compared to no screening was \$12,139.

The investigators concluded both targeted and universal screening approaches for STDs are cost-effective, although universal screening detects more cases. Further, they noted cost-effectiveness improves substantially when the prevalence of STDs is roughly tripled, a figure

some analyses suggest is closer to the actual incidence of STDs in this population.

Two researchers involved with this study, **Jennifer Reed**, MD, MS, director of scientific review and development in the division of emergency medicine at Cincinnati Children's Hospital Medical Center, and **Monika Goyal**, MD, a pediatric emergency medicine specialist and associate division chief of emergency medicine and trauma services at Children's National Hospital in Washington, DC, jointly responded to questions about the implications of their findings and remaining barriers in terms of getting more pediatric EDs to adopt either targeted or universal screening approaches for STDs.

"Because many adolescents often use the ED as their only access to healthcare, the ED is now being viewed as a strategic setting for the provision of preventive health services, especially to high-risk populations. However, it can be challenging to provide sexual health services in the ED because it is fast-paced, with many competing priorities, and there are adolescent confidentiality issues," they explained. "Therefore, developing a process for efficient screening in an ED setting without interfering with patient flow and acute care is of utmost importance. We are in the process of studying several approaches for gonorrhea/chlamydia screening in the ED that would not impact the clinical workflow."

Reed and Goyal noted there are significant clinical and financial consequences from undetected

and untreated STDs. "Patients can develop pelvic inflammatory disease [PID], orchitis, and chronic pelvic pain, which may ultimately lead to infertility issues, if left untreated," they said. "From a cost perspective, over \$1 billion is spent yearly on PID treatment, which could be avoided with appropriate screening and treatment of gonorrhea and chlamydia infections."

Screening techniques also are important, considering some STDs, especially chlamydia, can be asymptomatic for extended periods.

"Patients may not be aware of their health status until they have developed complications from the untreated infection. Further, if left undiagnosed and untreated, adolescents may be unknowingly transmitting the infection to their partners," the researchers said.

Reed and Goyal acknowledged it is difficult today to offer guidance on whether a targeted or universal screening approach would be best for a specific ED. However, they are working to shed more light on this question.

"We are currently enrolling adolescents at six pediatric EDs across the country into a study that evaluates the clinical and cost-effectiveness of targeted vs. universally offered gonorrhea and chlamydia screening," they shared. ■

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Patient Complaints Can Reveal Surprising ED Safety Concerns

By Stacey Kusterbeck

Do ED patients complain because they are seeking some type of compensation, or is it really about wanting to be heard? “In fact, most people who complain are doing so because they want to see improvement,” says **David Chaulk**, MD, MPH, an associate clinical professor of pediatrics in pediatric emergency medicine at the University of Utah School of Medicine.

Typically, EDs respond to complaints by offering some type of service recovery (e.g., waiving charges or expediting follow-up). This might resolve the problem for the individual patient, but the underlying issue might remain. “Patient complaints should be a key part of the department’s approach to improvement,” Chaulk says.

Complaint data are a good way to identify failures in the diagnostic process, according to a recent analysis.¹ “Healthcare systems are already collecting complaint data. But it’s unclear how that data can be used to improve care,” says **Traber Davis Giardina**, PhD, MSW, a patient safety researcher and assistant professor at Baylor College of Medicine.

Giardina and colleagues reviewed 1,865 patient complaints submitted to Geisinger in 2017, and found 177 complaints were likely to be linked to diagnostic errors. After conducting an additional analysis, the researchers identified 39 diagnostic errors (22 of which occurred in the ED). In 2018, researchers reviewed a second group of 2,423 complaints, and identified 310 concerning reports. Further analysis uncovered five diagnostic errors (three of which occurred in the ED). “It is interesting that patients

are reporting diagnostic concerns via the complaint system,” Giardina offers. Some patients specifically reported they were misdiagnosed. Others complained about returning to the ED multiple times before receiving a correct diagnosis.

Finding diagnostic errors within patient complaints is “very labor-intensive,” Giardina notes. “We need to be more thoughtful about the way we collect and categorize patient complaint data so we can address diagnostic safety issues as they emerge.”

Ideally, ED providers should be gathering feedback right away on diagnosis-related complaints. “These types of errors can have serious consequences for patients,” Giardina cautions.

Communication breakdowns are the underlying reason for most ED complaints.²⁻⁴ “In particular, cases where a diagnosis was missed or delayed should be reviewed,” Chaulk suggests. EDs often view misdiagnosis complaints as “one-offs.” This limits the opportunity to learn from them. “Unintentionally, the local response to patient complaints without systematic analysis can actually limit the power of the patient’s voice,” Chaulk says.

An ED’s approach to complaints should include viewing complaints as a failure of a process, instead of blaming an ED provider. “It is hard to receive a complaint,” Chaulk observes. “Sharing these data is hard, as it can be viewed as airing your dirty laundry.”

If complaints are tracked at the ED level, and also the hospital level, the complaint becomes less about an individual’s shortcoming, and more of

a process failure. Patients often complain about how they were stuck in an ED waiting room for hours without anyone checking in, or they had no idea who or what they were waiting for. “When this is reviewed as an individual complaint, it may appear to be a failure of the individual nurse or provider,” Chaulk explains.

If a trend of similar-sounding complaints is noted, there is a process or staffing issue standing in the way of timely reassessment and good communication. “The response should be targeted improvement, rather than reprimand,” Chaulk advises.

Bear in mind that patients from minority groups, or from lower socioeconomic groups, are less likely to complain about the ED visit. It is not because they have less to complain about than other patients. “We know that there are health disparities in healthcare. These disparities also exist in patient complaints,” Chaulk notes.

Understanding the ED patient experience requires multiple sources of information. “This may include getting feedback before the patient leaves the ED,” Chaulk suggests. Unsolicited complaints about ED visits probably are the tip of the iceberg. “The complaints that are formally submitted by patients represent only a small fraction of the patients who feel that something went wrong in their care,” says **Thomas H. Gallagher**, MD, a professor of medicine, bioethics, and humanities at the University of Washington School of Medicine.

Gallagher and colleagues found 48% of hospitalized patients thought a harmful breakdown occurred in their care, but only 30% of those patients felt comfortable enough to

speak up about what happened.⁵ “The lack of established doctor/patient relationship in the emergency department may actually make it less likely that patients will share their concerns with providers,” Gallagher laments.

There are two natural times during the ED visit to encourage patients to speak up. When meeting the patient, the emergency physician (EP) can say, “Healthcare today can be very complex. Please let me know right away if you have any concerns that something has not gone well in your care.” Immediately before discharge, the EP or ED nurse can ask, “Do you have any concerns that we have not addressed?”

Gerald B. Hickson, MD, says, “it’s very important to use the eyes and ears of the people who walk through the door. They help you identify your dysfunctional systems and clinical team members who can be challenged in working with others.”

ED providers may take the attitude that everybody is the subject of complaints eventually. In fact, research has shown complaints are not randomly distributed. “We know that about 3% of physicians are responsible for 40% to 50% of reports,” says Hickson, founding director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center in Nashville.⁶

If an ED patient feels dissatisfied enough to take the time to complain, that patient is going to expect a decent response. “Some of the most loyal patients are those where we have acknowledged a problem and addressed it,” Hickson reports.

The opposite is true if a complaint goes unaddressed. “Those patients are more likely to be highly dissatisfied, seek care elsewhere in the future, share their concerns with other friends and neighbors, and — if they

experience an adverse outcome — to seek legal representation,” Hickson cautions.

Patient safety should be the overarching concern whenever there is a complaint. “A sizeable number of complaints, in the 20% range, are related to safety issues specifically,” according to Hickson, who adds that a surprising number of complaints happen because of perceived disrespect. “From a risk standpoint, it’s amazing how much time we spend talking about all of those bad lawyers, when it’s more often useful to pause and say, ‘Gosh, could I have done that a little better?’”

On the other hand, complaint-prone EPs are not necessarily doing something wrong. If ED patients are demanding antibiotics or MRIs, and the ED provider says it is not indicated, those patients might complain. The answer is not to order more prescriptions and tests; it is to communicate the decision-making better. “Many in emergency medicine may say ‘It takes too much time for that extra step.’ But in some sense, it’s pay me now, or pay me later,” Hickson says.

If the EP does not explain why the desired test is not in the patient’s best interest, an unhappy patient might assume it was negligence and call a lawyer. To avoid this kind of misunderstanding, Hickson says EPs can put it this way: “I’m doing what I feel is the right care. I respect you and your questions, but I know you would not want me to offer care that’s not in your best interest.”

Some ED complaints are not misunderstandings at all; rather, something actually went wrong. A complaint about delayed stroke diagnosis could reveal the ED nurse never informed the EP about the patient’s deteriorating condition — not because the ED nurses did not recognize

it, but because the EP routinely treats nurses with disrespect. “It is not always the disease condition. Too often, the avoidable outcome is related to team performance,” Hickson laments. “Whenever disrespect is modeled by the physician, patients are placed at risk.”

A new mindset about ED complaints is what is needed to reduce malpractice risks. Hickson puts it this way: “Instead of taking all your time thinking about how unreasonable people are, ask, ‘What could I have done differently?’” ■

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Sepsis Report Could Help ED Malpractice Defense

By Stacey Kusterbeck

Of the many different guidelines on early sepsis care in the ED, some specific recommendations remain controversial. A recently released report addresses many of these issues.¹

“While our effort was organized under the umbrella of emergency medicine, we also had other stakeholders involved. That was done for a specific reason,” says **Donald M. Yealy**, MD, FACEP, a member of the sepsis task force convened by the American College of Emergency Physicians.

This task force included key, diverse stakeholders involved in the early care of patients with sepsis and septic shock.

“Many other guidelines and metrics espoused by other groups and the government had little or no multidisciplinary input,” Yealy notes.

Specific recommended practices are not always appropriate for every ED patient. “These practices, where evidence and clinical insight differed from the recommendation or the mandate, created challenges in adhering to the guidelines, and may not have helped each patient,” says Yealy, chair of emergency medicine at the University of Pittsburgh.

The task force set out to identify areas of concern in existing sepsis recommendations or mandates, and examine current data and expert insights. “It’s not that we have concerns that any one recommendation is absolutely wrong. But [sepsis] bundles may have facets that do not serve people as well as initially intended,” Yealy explains.

Early identification and intervention for sepsis in the

ED is important. That is not in dispute. “Not every person with sepsis or septic shock has the same constellation of maladaptive effects,” Yealy notes. “Not every singular recommendation fits everyone well.”

There is no single time frame for antibiotics that is always applicable to every sepsis patient in the ED. Some patients really need immediate antibiotics, but others are better served by a more detailed evaluation first. The same is true for a specific volume of fluids to treat or prevent sepsis complications. Certain guidelines require set amounts of fluid for virtually all patients, but it varies depending on the patient.

“The ED provides initial care to roughly 75% to 80% of the people eventually diagnosed with sepsis or septic shock. EPs, ED nurses, and other people in the ED are central to the outcomes of people,” Yealy says.

The task force report acknowledges some of the differences that exist in individuals or groups of patients. The authors recognize the ED is not the final step in sepsis care. “EPs truly have a vested interest in improving outcomes, just like our intensivist, infectious disease, and pulmonology colleagues,” Yealy notes.

Yealy and colleagues confirmed some recommendations lack solid evidence. “We help clarify some of the evidence gaps that exist,” he says.

For example, the amount of IV fluid needed, the timing of the fluid, and the use of other medications to support blood pressure and organ perfusion all are under investigation to determine the best approaches. “But right now, one best approach doesn’t exist, based on evidence,”

Yealy says. The guidelines offer a more flexible range of responses for EPs to consider if sepsis is on the differential diagnosis list. “It’s not possible to name a singular standard of care,” Yealy explains.

Many ED providers worry that failure to follow any one of the existing sepsis guidelines will expand legal exposure. The task force report should alleviate this concern while improving care of sepsis in the ED. “If you care for somebody and chose a careful approach that fell outside of one of the guidelines, our paper should help you, not hurt you,” Yealy offers.

In missed sepsis malpractice cases, plaintiff attorneys frequently argue the standard of care was not met because a particular recommendation was not followed. The task force report could be used to refute this kind of argument, because it notes the challenges with many recommendations and mandates.

In the sickest patients (i.e., those with obvious septic shock, with low blood pressure, and new organ failure), early antibiotics and resuscitation efforts are key. In patients with less obvious symptoms, the timing and amount of fluid might be different. The report offers some reasonable options for ED sepsis care. “If anything, this lessens the risk while improving the care,” Yealy observes.

The following are some common fact patterns in missed sepsis ED malpractice claims:

- **The patient presents with some indicators of sepsis (fever, chills, or nausea), but is sent home without appropriate treatment.** “The patient

returns to the ED when symptoms worsen, at which point the infection has progressed past a point of recovery,” says **Annie E. Howard**, JD, an attorney in the Johnson City office of Hancock, Daniel & Johnson.

Too often, ED charts are silent on what the EP was thinking. “Checkboxes and prepopulated screening tools are no replacement for a narrative explanation,” Howard says. All that is documented is the patient presented with symptoms that were concerning for sepsis. Nevertheless, for some reason, the patient was discharged. “When an alternative explanation is not documented, to show that the provider appreciated the presentation, but reasonably

believed it to be from an alternative cause, it benefits the plaintiff,” Howard explains.

• **The patient was discharged home from the ED — without learning a blood culture returned positive.** At the time of the ED visit, the patient’s symptoms were not acute enough to warrant admission or IV antibiotics. Hours after discharge, a blood culture indicates treatment is imminently necessary.

Sometimes, the patient’s phone number is incorrect or voicemail is full.

“A simple phone call is often not enough to reach the patient,” Howard cautions. “There must be an alternative method to contact

the patient and document it was completed.”

• **The patient recorded abnormal vital signs suggestive of potential sepsis, but no screening tool was used.** “If there is no other documentation that sepsis was considered, a missed sepsis claim is much more difficult to defend,” Howard says. ■

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Artificial Intelligence Could Affect ED Provider’s Malpractice Risk

By Stacey Kusterbeck

Inaccurate artificial intelligence (AI) algorithms could harm patients and result in liability exposure, the authors of a recently published paper argued.¹

“A significant risk, in quality of care as well as malpractice, is that the clinician substitutes the AI ‘judgment’ for hers,” says **Kenneth N. Rashbaum**, JD, a partner at New York City-based Barton.

AI should be used as a tool, along with physical exam findings, narrative history, review of prior records, and clinical judgment. ED providers should document the thought process and tools used to arrive at a diagnosis, including AI, Rashbaum says.

To avoid risk management issues in the ED, Rashbaum says hospitals should be testing algorithms, using several methodologies; training clinical staff on misuses of AI (e.g., substituting AI findings for

well-reasoned clinical judgment); directing risk management, finance, and legal departments to review professional liability policies (to confirm claims based in whole or in part on allegations regarding AI are not excluded from coverage); and ensuring service agreements with the AI platform provider include indemnification provisions. “This could allow the hospital to shift some or all of the liability risks and expenses to the platform provider,” Rashbaum says.

AI adoption will require “significant time, attention, and funding to better understand the benefits in the ED setting,” says **Rick Newell**, MD, MPH, BCCI, FACEP, chief transformation officer at Emeryville, CA-based Vituity.

Currently, AI tends to reproduce existing systems with greater efficiency. If care in the ED is

problematic to begin with, AI could make it worse. Instead of addressing safety issues, AI blindly applied to the ED (or other healthcare settings) may figure out how to most efficiently recreate the safety issues. “AI in healthcare, currently, leaves much to be desired,” Newell observes.

That does not mean an EP can blame AI for negligent care. Ultimately, ED providers are responsible for the care of the patient. “As such, the malpractice risk will continue to lie with them,” Newell cautions.

AI and machine learning could affect malpractice risk for EDs in a positive way. “The ability to gain insights into disease processes in previously impossible ways is staggering,” Newell says. “We will see better care, better outcomes, and, theoretically, reduced malpractice risk.”

AI could even become the new standard of care for EDs. For instance, if AI is used at most EDs in a region, and a patient is misdiagnosed at one facility without AI, a plaintiff attorney could argue the AI tool is the legal standard of care for EDs.

“These are important questions that we’ll need to consider as AI is rolled out across healthcare more broadly,” Newell notes. AI can assist

ED clinicians in making better diagnoses. “However, it is crucial to understand both the pros and cons of AI on patient safety outcomes,” says **Cynthia A. Haines**, Esq., principal in the Harrisburg, PA, office of Post & Schell.

In the ED, faulty AI could harm patients on a broad scale.

“A system error in an AI product could lead to widespread patient injuries resulting from inappropriate

diagnosis or medication errors compared to limited patient injuries attributable to a provider’s error,” Haines says. ■

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Google Translate for ED Discharge Instructions ‘Not Ready for Prime Time’

By Stacey Kusterbeck

ED providers might be tempted to rely on family members to interpret for patients with limited English proficiency, but this practice is problematic, both clinically and legally.^{1,2} “Family members are not trained interpreters, and you have no idea what they are saying. If using a healthcare-certified interpreter, you are assured of the accuracy,” says **Breena R. Taira**, MD, MPH, CPH, FACEP, associate professor of clinical emergency medicine at Olive View-UCLA Medical Center.

One time, Taira walked by a patient’s room and heard an ED provider say, “You have a problem with your liver.” A family member then interpreted this statement in Spanish as “You have a problem with your kidney.”

“From a medical/legal standpoint, to be assured of the accuracy of your communication, you need to use tools that are reliable and accurate,” Taira says. Fortunately, most EDs maintain robust interpreter services to assist with verbal communication. However, most do not offer any translator services for assisting with written communication. Not surprisingly,

ED providers turn to automated translation software, such as Google Translate. “We see people using this because there is a gap in what hospitals typically provide,” Taira says.

Providers are trying to do the right thing — provide patients with written discharge instructions in their native language. “But machine translation is not ready for prime time in the ED,” Taira laments.

Accuracy of Google Translate is inconsistent among languages and should not be relied on by ED providers, according to a recent study.³ Taira and colleagues assessed the accuracy of Google Translate for 20 frequently used phrases in ED discharge instructions in seven languages. Translation accuracy rates varied depending on the language. “It’s not for medical use, and it’s not necessarily accurate,” says Taira.

Google Translate uses an algorithm that improves over time, but it relies on crowdsourcing feedback to do so.⁴ Even for commonly used languages with a high accuracy rate (e.g., Spanish or Chinese), accuracy of medical instructions is questionable. “All it takes is one acronym or proper

noun to throw the meaning off,” Taira warns.

ED patients could receive discharge instructions that are wildly inaccurate. Researchers found translation errors, such as “Your Coumadin level was too high today,” translated in Chinese as “Your soybean level was too high today.” If the ED does not make a certified translator available for discharge instructions, Taira recommends writing the instructions in English so the ED provider knows they are accurate. Then, go to the bedside with a certified interpreter who gives the patient instructions verbally. The patient will not have written discharge instructions in their native language. “But at least you know that the information is being conveyed accurately,” Taira adds.

As for verbal interactions, professional interpreters in the ED improve communication beyond just word-for-word translation.⁵ Researchers observed six English-proficient and nine limited English-proficient patients in the ED. Phone-based interpreters missed some information because of a lack of visual cues. “We also observed instances where telephone-

based interpreters had trouble hearing or interpreting the names of local clinics,” says **Natalie Benda**, PhD, a postdoctoral associate at Weill Cornell Medicine in New York.

Consistent use of interpreters in the ED is another legal concern. Professional interpreters are used inconsistently during pediatric ED visits.⁶ “Professional interpretation is underused in spite of federal mandate and local regulations requiring its use for families with a language other than English,” says **K. Casey Lion**, MD, MPH, assistant professor of pediatrics at the University of Washington School of Medicine.

Interventions to improve interpreter use to date in the ED “have not been terribly effective, with fewer than half of healthcare encounters that should use an interpreter actually doing so,” Lion reports.

To understand this in greater detail, Lion and colleagues recorded 50 pediatric ED visits and analyzed 312 communication events. Overall, professional interpreters were used for 36% of communications. “We should be concerned by how low interpreter use was at an institution with a strong commitment to language access,” Lion reports. “Also, everyone was likely on their best behavior, as they were being video-recorded.”

Interpreters were used most often to obtain medical histories (89% of the time). Interpreters were used least often for medication administrations (8% of the time) and for procedures (11% of the time). That is a safety concern. “There is the potential for serious errors and patient harm if the patient or parent are not able to ask questions in the moment,” Lion warns.

If the ED provider thinks the interaction will be brief (e.g., quickly checking a vital sign), it is easy to rationalize that it is not worth the

hassle to find an interpreter. “When no interpreter is used, parents are left with no way to express concerns, share relevant information, or ask questions while things are being done to their child,” Lion notes.

For example, a parent might mention to a nurse that the volume of medicine given looks different from what they give at home, or report a medication allergy. Still, finding an interpreter in the ED can be difficult, time-consuming, or complicated. Lion and colleagues identified some barriers: cannot find a video console or speakerphone, technical difficulties, needing a password to unlock a tablet or computer, or the time it takes to provide all the necessary information to the interpreter. “Each of these things may be a small annoyance on its own, but they add up,” Lion observes.

Video interpreter units in every room, quick connections, reliable Wi-Fi without dropped calls, and an easy login process all help. “Even small changes in the barriers to accessing an interpreter can translate into big differences in use,” Lion offers.

EDs that make these changes can reduce risks, both in terms of malpractice and patient safety. Patients with limited English proficiency are known to experience higher rates of serious adverse events and medical errors.⁷ Failure to use interpreters could be why. “This should be a priority for improving patient safety and decreasing the risk of communication-related lawsuits in the ED,” Lion says. ■

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COMING IN FUTURE MONTHS

- Providing COVID-19 vaccinations in the ED
- Defenses to “failure to order diagnostic test” allegations
- Recognizing and managing POTS
- Unpreparedness for pediatrics legally exposes many EDs

Diagnostic Certainty Affects ED Patients' Satisfaction

By Stacey Kusterbeck

ED patients are more satisfied if they leave with a certain diagnosis, according to the authors a recent study.¹

“This study was motivated by a lack of clear understanding of what factors drive patient experience and satisfaction during their emergency department visit,” says **Peter B. Smulowitz**, MD, MPH, the study’s lead author.

Smulowitz and colleagues surveyed 148 patients at a single academic tertiary care ED with a chief complaint of abdominal pain, back pain, chest pain, or headache. All were in the process of discharge from the ED. The patients rated how strongly they agreed with these statements: “I am sure about exactly what is wrong,” “My doctors know exactly what is wrong,” and “I am satisfied with the quality of care I received in the ED.”

Researchers were somewhat surprised to learn that patient diagnostic certainty was such an important driver of satisfaction, regardless of the number or types of tests performed in the ED.

“In other words, just doing more tests didn’t help address satisfaction,” says Smulowitz, chief medical officer at Milford (MA) Regional Medical Center.

The findings suggest the goal of an ED visit is different for patients than it is for EPs. “Physicians in the ED are looking to rule out life threats, while it appears patients may be seeking certainty. If there is such a disconnect here, then perhaps we should rethink how we actually measure and report on patient satisfaction,” Smulowitz offers.

Just remaining mindful that patients are looking for certainty is important for EPs. This does not mean ordering more tests or procedures; instead, take the time to explain any diagnostic uncertainty that may exist even after an ED evaluation.

“Diagnostic certainty is often not possible in the ED. The ED setting is for ruling out emergencies requiring urgent care,” says **Kelly Gleason**, RN, PhD, an assistant professor at Johns Hopkins School of Nursing.

Many ED patients need further testing to establish a diagnosis. “When a health problem is found not to require urgent treatment, it is often for the best that it is resolved in an outpatient setting,” Gleason notes.

A patient receives pain relief for severe chronic back pain in the ED, but the EP recommends follow-up care in an outpatient setting. Since the patient expects to leave with a diagnosis, the EP must explain why there is uncertainty. “This is the right way to go in the event where a certain diagnosis cannot be established,” Gleason says.

EPs should take time to explain why they do not believe the patient is experiencing a medical emergency and why it is not possible to establish a definitive diagnosis. They also should note that to reach a conclusive diagnosis, follow-up in an outpatient setting is necessary. Finally, EPs should explain the reasons why they believe it is safe to discharge the patient.

“This is preferable to giving a patient a diagnosis when there is any uncertainty around the diagnosis,” Gleason says.

Some EPs give a diagnosis of “upper respiratory viral syndrome” to patients who present with cough and no symptoms of a bacterial illness. That may satisfy patients momentarily, but honesty is better in the long run. “Have some trust in your patient’s ability to reason and understand,” Gleason offers. “The worst thing you can do is not be transparent with the patient.”

EDs deal with uncertainty continually, even in critically ill patients. “We often admit and discharge patients with no confirmed or certain diagnosis,” says **Martin Huecker**, MD, FACEP, FAAEM, associate professor and research director in the department of emergency medicine at the University of Louisville. With many medical conditions, no lab or radiologic tests exist to confirm the diagnosis. “This leaves a so-called ‘clinical diagnosis,’ or even more nebulous, a ‘diagnosis of exclusion,’” Huecker says. These practices can reduce risks for patients with diagnostic uncertainty:

- Engage in shared decision-making as to whether a patient will be discharged or admitted.

“Document that the patient completely understands and can even recite back the areas of uncertainty,” Huecker suggests.

- Identify specific reasons to return to the ED and importance of close follow-up with primary care.

- Explain the differential diagnosis list to patients so they understand the possible causes of their symptoms and the subsequent need for further testing or treatment. “We sometimes go over what diagnoses we are considering and why they are more

or less probable,” Huecker notes. This may be a hard sell for patients who came to the ED looking for a diagnosis. “But often that’s the only answer we can give, that we have ruled out the life-threatening diagnoses, and here are the alternate diagnoses that remain that could be confirmed or ruled out by physicians in an outpatient setting,” Huecker says.

- Document the rationale for discharge in the medical decision-making portion of the chart so others can understand the EP’s thought processes. There always is the potential for liability in “uncertain diagnosis” cases. In the ED, the focus is on ruling out any life-threatening causes of the patient’s symptoms. “But some patients present early in the disease process, and some tests can be limited in these cases,” Huecker says.

Appendicitis can be missed on the CT scan of patients who arrive early in the disease process, in the first few hours that they experience pain. “Another situation can involve intermittent symptoms and intermittent diagnostic inclusion,” Huecker observes. For instance, patients can experience ovarian torsion that is intermittent in nature. This can be missed on ultrasound if the patient is not symptomatic at the time.

A misdiagnosis, lack of diagnosis, or delayed diagnosis does not necessarily demonstrate negligence. “Skilled physicians exercising reasonable care are not usually found negligent,” says **Danielle M. Trostorff**, Esq., a health law specialist at Degan, Blanchard & Nash in New Orleans. Trostorff has seen these factors determine the outcome of malpractice claims if a patient is discharged with an incorrect diagnosis (or none at all):

- Whether the patient was harmed by improper medical treatment, delayed treatment, or no treatment.
- Whether the patient’s condition worsened because the EP failed to diagnose the condition.
- Whether the patient failed to follow up as instructed, or delayed in doing so. “The delay may relieve an ER physician of negligence,” Trostorff says. If follow-up care does lead to a definitive diagnosis, but the intervening delay did not harm the patient, “then the lack of a diagnosis

at the time of discharge from the ER would not support a negligence claim,” Trostorff adds.² ■

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CME/CE QUESTIONS

1. **What percentage of patients who present to the ED with violence-related injuries return to the ED with repeat violence-related injuries within five years?**
 - a. 10%-20%
 - b. 25%-35%
 - c. 40%-50%
 - d. 50%-60%
2. **Although hospital-based violence intervention programs can differ in many respects based on community characteristics and available resources, there are some components that are non-negotiable, such as:**
 - a. external funding.
 - b. trauma-informed training.
 - c. master’s level social workers.
 - d. patient advisory boards.
3. **Under the expedited partner therapy policy in place at the University of Colorado Hospital in Aurora, what percentage of patients treated for STDs elect to treat their partners in the program, too?**
 - a. 10%-20%
 - b. 25%-35%
 - c. 40%-50%
 - d. 50%-60%
4. **How much money is spent annually on the treatment of pelvic inflammatory disease?**
 - a. \$1 billion
 - b. \$500 million
 - c. \$50 million
 - d. \$5 million
5. **Which is true regarding early sepsis care in the ED?**
 - a. Data no longer strongly support early identification of and intervention for sepsis in the ED.
 - b. Some patients need immediate antibiotics, and others are better served by undergoing a more detailed evaluation first.
 - c. There is a set amount of volume of fluids to treat or prevent sepsis complications, and this does not vary from patient to patient.
 - d. The ED provides initial care to few people eventually diagnosed with sepsis or septic shock.



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6. Which is recommended regarding artificial intelligence (AI) in the ED?

- a. Providers should document the thought process and tools used to arrive at a diagnosis, except for AI.
- b. Court rulings are clear — emergency physicians (EPs) can blame faulty AI for negligent care.
- c. Using AI for diagnosis is the legal standard of care for the ED setting in most states.
- d. A system error in an AI product could lead to widespread patient injuries resulting from inappropriate diagnosis or medication errors.

7. Which did a recent study reveal regarding interpreters in the ED?

- a. More ED providers are using family members to interpret based on evidence indicating they are more accurate than certified interpreters.

- b. Few EDs maintain robust interpreter services to assist with verbal communication, but most offer translator services for written communication.
- c. Automated translation software was highly accurate, even for uncommonly used languages.
- d. Phone-based interpreters might lose information because of a lack of visual cues.

8. Which is true regarding diagnostic certainty in the ED?

- a. ED patients are more satisfied if they leave with a certain diagnosis.
- b. Running more tests eliminates dissatisfaction stemming from diagnostic uncertainty.
- c. EPs should avoid the term “diagnostic uncertainty” as it makes patients more likely to consult an attorney.
- d. Diagnostic certainty should be the primary goal of the ED so fewer patients require outpatient follow-up.

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After completing this activity, participants will be able to:

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