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JANUARY 2016 Vol. 27, No. 1; p. 1-12

INSIDE

The Rise of Drug-seeking Behavior in the ED and Strategies to Manage Such Behavior

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As the prevalence of opioid dependency and abuse continues to increase, managing individuals exhibiting drug-seeking behavior has become an important issue for ED personnel. This article examines the various approaches recommended for dealing with drug-seeking behavior in the ED and also evaluates and considers issues in implementing such approaches.

The Rise of Opioid Abuse

The number of overdose deaths related to an opioid addiction currently outnumbers the amount of overdose deaths due to all other illicit drugs. In 2009, the incidence of overdose deaths due to opioid abuse surpassed the amount of deaths associated with motor vehicle accidents for the first time in the United States. An estimated $72 billion is spent on medical costs related to opioid abuse. As opioid dependency and addiction increases, the number of ED visits by individuals seeking opioids has also grown.[1]

Although the majority of prescriptions for opioids are written by primary care physicians and internists, an estimated 45% of all opioids utilized in a non-medical manner are derived from prescriptions written in the ED.[2] Therefore, identifying individuals exhibiting drug-seeking behaviors, and curtailing the ability of those individuals to access opioids, has become an important issue for ED personnel. Since ED visits typically involve brief interactions, with little or no follow-up appointments, it can be difficult to effectively identify and manage drug-seeking individuals. Even when EDs can and have identified so called "frequent fliers" who rou-

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: **Arthur R. Derse**, MD, JD, FACEP (Physician Editor); **Kay Ball**, PhD, RN, CNOR, FAAN (Nurse Planner); **Stacey Kusterbeck** (Contributing Editor); **Shelly Morrow Mark** (Executive Editor); **Jonathan Springston** (Associate Managing Editor); **Mary Malone** (Author); **W. Clay Landa** (Author); and **Megan Dhillon** (Author).

ED LEGAL LETTER

ED Legal Letter™,
ISSN 1087-7347, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
ED Legal Letter
P.O. Box 550669
Atlanta, GA 30355.

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This activity has been approved for 18 nursing contact hours using a 60-minute contact hour. Provider approved by the California Board of Registered Nursing, Provider #CEP14749, for 18 Contact Hours.

This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

tinely exhibit drug-seeking behavior through multiple ED visits, the ED must develop proper procedures to manage such patients and provide treatment. In addition, certain prescribing practices in EDs exacerbate this difficultly, namely "prescriptions for high daily doses of opioids, overlapping ED prescriptions for opioids or opioids and benzodiazepines, and receiving long-acting/extended-release opioids for acute pain conditions."[1] However, several states and cities have sought to address the rise of opioid abuse drug-seeking behavior plaguing EDs by formulating guidelines for prescribing opioids.

Guidelines for Opioid Prescribing

As opioid abuse has increased, many localities have imposed restrictions on the availability of opioids and the ability to prescribe painkillers. Ohio was one of the first states to curb opioid accessibility.[3] Ohio's guidelines stress that healthcare practitioners must evaluate the potential for non-pharmaceutical and non-opioid therapies before considering opioids. The Ohio guidelines caution healthcare providers against treating chronic pain with opioid therapy and against prescribing opioids with benzodiazepines given the potential adverse effects, including the increased risk of overdose. The guidelines recommend that opioids should only be prescribed when a "favorable risk-benefit balance" can be achieved. Ohio also crafted a policy statement to be posted in EDs, which states that staff may contact the primary care physician of an individual who presents to the ED, and staff may ask to see the individual's driver's license. The policy statement says that narcotic pain medication may not be prescribed unless ED staff can talk directly with the individual's primary care physician. The policy statement also says that before prescribing narcotics, ED staff should check the Ohio Automated Rx Reporting System to track an individual's narcotic and controlled substances prescription. Finally, under Ohio's guidelines, EDs can develop care plans for frequent users of the ED to attempt to address issues with addiction and abuse.[4]

Arkansas' Prescribing Guidelines state that before providing a prescription for opioids, an ED patient should be screened for substance abuse. ED personnel are advised to use the Arkansas Prescription Drug Monitoring Program. EDs should "perform screening, brief interventions, and treatment referrals for patients with suspected prescription opiate abuse problems." Arkansas' guidelines also caution ED personnel against providing replacement prescriptions for controlled substances and suggest that providers contact the patient's primary opioid prescriber. If the patient's chronic pain is exacerbated, the ED provider should only provide medication to last until the patient is able to see the primary care provider. The Arkansas policy stresses that only one medical provider should provide opioids to treat a patient's chronic pain, as a means to prevent opioid abuse.[5]

Massachusetts has also instituted guidelines for developing strategies to address opioid misuse. The guidelines suggest that providers consider alternative methods for pain management prior to prescribing opioids. Recommending that a patient with "chronic and complex pain" be referred to a pain specialist, the guidelines emphasize that ED providers should not prescribe long-acting or controlled release opioids. Whenever possible,

ED staff should consult with the patient's primary care physician, and emphasize the importance of follow-up care. Additionally, the Massachusetts guidelines recommend that ED staff cultivate a process to screen, identify, and address interventions for individuals who could be prescribed opioids. The guidelines recommend that ED providers review the Massachusetts Prescription Monitoring Program before prescribing opioid medications. Although Massachusetts law exempts ED personnel from checking the monitoring database when prescribing less than a five-day supply of a controlled substance, the guidelines advise checking the database whenever possible to identify patient prescription histories that indicate drug-seeking behavior. However, the guidelines counsel that a "concerning pattern of prescriptions" in the database is not an adequate reason to withhold opioids if a patient possesses an obvious source of pain. Given the importance allocated to the database by the Massachusetts guidelines, it is no surprise that the guidelines also contemplate the formation of a system for all hospitals to immediately disseminate and share ED patient histories with other EDs and urgent care centers.[6]

New York City also instituted guidelines for ED opioid prescriptions, which caution that only short-dose opioids should be prescribed, such as limiting prescriptions to a time period of three days. The guidelines suggest that follow-up care should be expedited if a longer supply is required. Further, ED staff should not replace prescriptions for lost or stolen medication. ED personnel should provide a prescription for a one- or two-day supply only after confirming the necessity of the medication with the patient's physician. The guidelines also recommend ED personnel communicate to patients the risks associated with opioid medication, as well as strategies for ensuring that the medication is not shared or stolen.[7]

The New York City guidelines, as well as the guidelines for Ohio, Arkansas, and Massachusetts, echo the policies released by the American Academy of Emergency Medicine (AAEM). AAEM states that discharge prescriptions should be limited to a supply of seven days. The AAEM guidelines also recommend that narcotics should not be prescribed for back pain, routine dental pain, migraines, and chronic abdominal or pelvic pain.

A COMMONALITY AMONG ALL GUIDELINES AND POLICIES IS A RECOMMENDATION TO UTILIZE A PATIENT DRUG MONITORING PROGRAM, CONSIDERED TO BE AMONG THE MOST PROMISING TOOLS TO ADDRESS PRESCRIPTION DRUG ABUSE.

For patients who frequently appear in the ED, AAEM suggests sending a certified letter stating that the patient will no longer be prescribed narcotics in the ED and the addition of an internal code, identifying the patient as exhibiting drug-seeking behavior, in the patient's medical record.[8]

Patient Drug Monitoring Programs

A commonality among all the guidelines and policies designed to deal with drug-seeking behavior exhibited in the ED is a recommendation to utilize a patient drug monitoring program (PDMP). PDMPs are considered to be among the "most promising clinical tools to address prescription drug abuse."[1] Most PDMPs require retail pharmacists to enter data regarding prescriptions pertaining to controlled substances into a centralized database.[9] ED staff can access the information in the database to determine a patient's prescription history, including whether the patient has obtained medication from multiple providers, whether prescriptions were filled at different pharmacies, and the frequency in which prescriptions were filled.[6] PDMPs are deemed an effective vehicle to screen and identify patients exhibiting drug-seeking behavior because the data from PDMPs supplies objective standards, allowing providers to better identify patients with a potential to abuse or misuse opioids.[10]

However, research regarding the effectiveness of PDMPs has been mixed. Research has indicated that utilizing a PDMP reduces "the prescribing of Schedule II opioid analgesics, lower[s] substance abuse treatment admission rates, and result[s] in lower annual increases in opioid misuse or abuse in states with PDMPs compared to those without them."[1] Another study, on the other hand, has shown that states with robust PDMP programs did not have lower rates of consumption of opioid drugs for the period examined. However, the study postulated that PDMPs are

most effective when used in combination with other tools to combat opioid abuse, such as tamper-resistant prescription forms.[9]

Guideline Considerations and EMTALA

Although the guidelines seek to formulate effective approaches to address non-legitimate opioid-seeking behavior, the guidelines also represent recommended strategies. All the guidelines emphasize that ED staff must be permitted to exercise medical judgment regarding the prescription of controlled substances. ED personnel must balance the goal to curb access to opioids to reduce rates of addiction and misuse against the need to ensure patients with legitimate pain receive access to necessary treatment.[1] Pain is one of the most common complaints among ED patients.[2] Managing pain presents a difficult dilemma for ED staff, given the lack of objective support in identifying and addressing pain symptoms.[11]

Adding to the complexity of pain management, many of the undesirable behaviors associated with drug seeking can also be attributed to the undertreatment of legitimate pain. In a study of drug-seeking patients in the ED, the generally accepted common characteristics of drug-seeking behaviors were rarely exhibited. The study found that the "behaviors most frequently used (headache, back pain, and 10/10 pain) are extremely common complaints in the ED, and are likely not very specific for the diagnosis of drug-seeking behavior."[12] Therefore, while the guidelines suggest methodologies to identify and manage drug-seeking patients, in practice, it can be difficult for ED staff to effectively determine whether a patient is seeking legitimate pain relief.

Another consideration that ED personnel must consider is that the guidelines may present issues regarding compliance with the Emergency Medical Treatment and Labor Act (EMTALA). In 2013, the South Carolina Hospital Association requested guidance from the Centers for Medicare & Medicaid Services (CMS) regional office in Atlanta regarding whether proposed signage addressing prescribing pain medication in the ED would violate EMTALA.[13] The proposed language in the signs mentioned that ED personnel would ask the patient about any prior history of pain medication use, ask to see a photo ID, may check the statewide prescription database regarding the patient's prescription drug use, and would only provide enough pain medication to last until the patient's physician could be contacted. The sign also stated that lost or stolen prescriptions would not be refilled, long-acting pain medications would not be prescribed, and pain medications would not be prescribed if the patient already received pain medication from another doctor or ED.[14]

> PERSONNEL MUST BALANCE THE GOAL TO CURB ACCESS TO OPIOIDS TO REDUCE RATES OF ADDICTION AND MISUSE AGAINST THE NEED TO ENSURE PATIENTS WITH LEGITIMATE PAIN RECEIVE ACCESS TO NECESSARY TREATMENT.

In response, CMS noted EMTALA's definition of an emergency medical condition (EMC) by specifically highlighting that an EMC manifests itself through acute symptoms of sufficient severity, which includes severe pain.[13] Thus, CMS implied that severe pain alone meets the definition of an EMC, even though the remainder of the statutory and regulatory definition of an EMC indicates the pain must be caused by an underlying medical condition such that the absence of immediate medical attention would place the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.[15]

CMS stated that the Interpretative Guidelines indicate that patients should not leave the ED based on a suggestion by the hospital or through coercion. CMS found that the language in the South Carolina hospital sign "or any similar language" that a hospital may post that is viewed by the patient prior to receiving an emergency medical screening exam could be "considered to be coercive or intimidating to patients who present to the ED with painful medical conditions, thereby violating both the language and the intent of the EMTALA statute and regulations." Although CMS acknowledged that the issue of drug-seeking behavior was an important problem facing EDs, CMS stressed that such signs may lead to the possibility that patients with a legitimate need for pain relief might be unduly coerced to leave the ED. Instead, CMS stressed that the issues raised in the sign were appropriate for discussion between the patient and the ED physician in the context of a

medical screening exam and that after performing the screening, a physician may make a decision based on professional medical judgment to withhold prescribing opioids.[13]

Conclusion

ED personnel face an increasingly difficult environment regarding the proper treatment of patients exhibiting drug-seeking behavior in the ED. Opioid abuse and overdoses are continuing to increase, many of which are related directly to prescription controlled substances. ED personnel have long been on the front lines of witnessing patients arriving at the ED in an attempt to gain access to opioids. In this role, ED personnel are put in the difficult position of having to screen and potentially treat and stabilize such patients under EMTALA while also weighing patient safety and professional concerns after prescribing pain medications to patients who appear only to be seeking such drugs for ulterior purposes.

In response to the drastic increase in overdose deaths and opioid abuse, many states have enacted guidance regarding how EDs can treat patients who may be exhibiting drug-seeking behavior. While many of these guidelines may be seen as common sense measures that will protect both the ED personnel, as well as the patients, CMS has indicated that such measures may violate EMTALA because they could unduly coerce a patient to leave the ED prior to receiving an emergency medical screening exam and any necessary stabilizing treatment. Therefore, measures put in place by EDs should stress a discussion between the physician and patient regarding the prescription of opioids in the context of the medical screening exam and treatment, but should by wary of measures that provide information to patients prior to the screening exam that could be seen as discouraging patients from receiving treatment. ■

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Here Are Common Allegations in Missed Sepsis ED Claims

A patient presented with symptoms indicative of sepsis, and the emergency physician (EP) failed to recognize it or appropriately respond, directly leading to unnecessary morbidity or mortality.

This is the most common allegation in missed sepsis claims against EPs, says **William M. McDonnell**, MD, JD, clinical service chief of pediatric emergency medicine and medical director of the emergency department (ED) at Children's Hospital & Medical Center in Omaha, NE.

"As with all medical malpractice cases, it is far easier for EPs to defend themselves if their medical decision-making is recorded in the chart," McDonnell says.

Simple check boxes, orders, and diagnoses do not provide a legally protective explanation of why a particular course of diagnostic studies and/or treatment was, or was not, pursued.

"When the record does not provide an explanation, a plaintiff's attorney is always ready to provide an explanation," McDonnell notes.

Formalized Approach

Ultimately, a malpractice claim premised on missed sepsis depends on the plaintiff establishing that the defendant EP failed to do what a "reasonable" provider would have done in similar circumstances.

"Therefore, it is much easier for EPs to defend themselves if they can point to a formalized approach that was put into place to identify and treat sepsis, and if they can show that they followed this previously established process," McDonnell says.

Juries understand that occasionally any disease process might go unrecognized, despite the EP's good faith efforts.

"But, they want to know that the EP and the institution had a plan for identifying and treating sepsis, that they followed their own plan, and that they made reasonable efforts in good faith," McDonnell says.

McDonnell says that a defense attorney would be pleased to see an explanation in the ED chart describing how the EP considered sepsis, followed the institutional approach to sepsis in accordance with the established protocol, and chose the particular action taken based on the findings and on the guidance in the sepsis pathway.

A missed sepsis claim is more difficult to defend if the ED chart includes abnormal vital signs and abnormal physical exam signs suggestive of severe sepsis, and a complete absence of any discussion about a sepsis protocol or consideration of sepsis.

"It then becomes quite easy to demonstrate that the EP 'missed it completely,'" McDonnell says.

SIRS Criteria Is Issue

Scott O'Halloran, JD, a medical malpractice attorney in the Tacoma, WA, office of Fain Anderson VanDerhoef Rosendahl O'Halloran Spillane, has seen multiple claims alleging that an EP failed to admit a patient who met the Systemic Inflammatory Response Syndrome (SIRS) criteria, "but it's usually a very strict interpretation and they didn't strictly meet it."

Another common scenario is a patient with elevated white blood cell count or elevated band count with one other indication of infection, such as fever, chills, nausea, vomiting, diarrhea, or tachycardia, where the EP failed to admit, order cultures, or prescribe prophylactic antibiotics.

"There is a lot of good research and support for not giving prophylactic antibiotics, which is what the lawsuits usually allege they should have done," O'Halloran says.

Documentation showing that the EP considered whether a patient met SIRS criteria is helpful.

"If white blood cell or bands are elevated, documentation of why this is not indicative of an infection for this particular patient can be helpful," O'Halloran says.

If a patient meets SIRS criteria, the EP should clearly document medical decision-making, advises **Larry D. Weiss**, MD, JD, FAAEM, MAAEM, clinical professor of emergency medicine at the University of Maryland School of Medicine, Baltimore.

"State why you believe the patient has, or does not have, bacteremia or sepsis," Weiss says, adding that compliance with the new Centers for Medicare & Medicaid Services (CMS) Severe Sepsis/Septic Shock Early Management Bundle (SEP-1) will show that the EP acted within the standard of care.

"If the patient possibly has bacteremia or sepsis, document your compliance with the SEP-1 guidelines," says Weiss. The guidelines recommend:

- obtaining a blood culture, serum lactate level, and administration of antibiotics within three hours of arrival in the ED;
- repeating the lactate level within six hours;
- administering a fluid bolus of 30

mL/kg of isotonic fluid if the patient presents in a state of septic shock.

Some patients with simple upper respiratory infections fulfill some of the SIRS criteria.

"If this is the case, then the EP should document the clinical impression of an upper respiratory infection, obviating the need for institution of the SEP-1 guidelines," Weiss says. ■

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Surprising Research on Ultrasound-related Lawsuits Against EPs

A 2012 analysis of lawsuits involving ultrasound in the ED found just one malpractice case — for failure to perform an ultrasound.[1] A group of researchers decided to see if the legal landscape had changed for emergency physicians (EPs).

"With a dramatic increase in point-of-care ultrasound use by physicians since the prior study, an update was in order. We were curious if we would find far more cases," says **Lori Stolz**, MD, RDMS, director of emergency ultrasound at Banner University Medical Center Phoenix (AZ).

The researchers conducted a retrospective review of all reported state and federal cases between January 2008 and December 2012 in the Westlaw database.[2]

"We were surprised to find no cases in which EPs were involved in lawsuits involving ultrasounds that were performed," Stolz says.

Cases were included if an EP was named, the patient encounter was in the ED, the interpretation or failure to perform an ultrasound was a central issue, and the application was within the American College of Emergency Physicians' (ACEP) ultrasound core applications.[3] Five such cases were identified.

"Failure to perform an ultrasound study or failure to perform it in a timely manner was involved in all the identified cases," Stolz says. Four cases resulted in patient death.

In one case, the patient was discharged from the ED with a follow-up right upper quadrant ultrasound scheduled for the next day. She was found to have acute cholecystitis and suffered several complications from it, which she alleged was secondary to the delay in diagnosis.

"This is an exam type that could have been performed at the time of the visit by the ED physician, had they had the training, as it is an ACEP core application," Stolz says.

Another case involved an adolescent male involved in a motor vehicle accident. He presented to an ED, where no abdominal imaging was performed, and was discharged.

"The young man died later that night in his sleep, found to have hemoperitoneum with a liver laceration," Stolz says. "In this case, a FAST [Focused Assessment with Sonography for Trauma] exam could have been performed at the time of the visit."

All malpractice cases that were identified were within the ACEP core emergency ultrasound applications, and could have been performed by the EP but were not.

"This is new technology. Physicians who trained before ultrasound and were heavily taught in residency may feel inadequately prepared to perform and interpret ultrasound," Stolz says.

EPs may lack equipment, continuing education, quality assurance, image archiving, or hospital policies that support the use of point-of-service ultrasound.

"Each of these elements are needed for ED physicians to use ultrasound routinely in their practice," Stolz says.

Because point-of-care ultrasound is relatively new to the field, legal risks remain unclear, Stolz says.

"Radiology is traditionally a high-risk specialty, so one could foresee potential for increased risk for EPs performing an imaging procedure," she says.

Based on the study's findings, however, learning and using ultrasound doesn't seem to put EPs at risk for legal liability, Stolz says; instead, "failure to use the skill may confer more risk."

Point-of-care ultrasound can potentially decrease risk by aiding EPs in making faster diagnoses.

"There is potential for malpractice lawsuits when EPs fail to perform point-of-care ultrasound in situations where they could," Stolz says. ■

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SOURCE

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New Data on ED Malpractice Claims: 42% Involve Diagnosis

Of ED malpractice claims that closed during a 10-year period, 42% involved diagnosis, according to CNA's Hospital Professional Liability Claim Report 2015. CNA is a Chicago-based provider of professional liability insurance. (*The full report is available at* ***www.cna.com/healthcare.***)

"Examples of allegations related to diagnosis include delay in establishing a diagnosis, failure to or delay in obtaining or addressing diagnostic test results, and failure to diagnose and misdiagnosis," says **Joyce Benton**, CNA's assistant vice president for risk control. Here are some actual cases, all of which settled for $1 million:

• A patient was evaluated in the ED three separate times and discharged home after complaints of progressive back pain. Later, at another facility, she was diagnosed with a spinal epidural abscess and underwent surgical intervention. "The ultimate, and unfortunate, outcome was paraplegia," Benton says.

• The emergency physician (EP) did not appropriately follow-up with a patient after receiving a CT scan report. "The delay in diagnosis resulted in a worse prognosis, and the patient required additional surgery and chemotherapy," she says.

• A patient experienced bleeding following thyroglossal tumor surgery. She was evaluated in the ED by a mid-level provider, who discharged her home with pain medicine. "Shortly afterward, she returned to the ED in respiratory distress, was resuscitated, and taken to surgery for control of active bleeding," Benton says. "The patient sustained significant brain injury."

• A patient presented to the ED with complaints of respiratory distress and heaviness in his arms. Following a chest X-ray, the patient was incorrectly diagnosed with pneumonia and discharged home. "The patient returned to the ED a few hours later in cardiac arrest and died," Benton says.

The ED was one of the top three locations in regard to frequency, and was one of the top five in regard to average total paid claims by location. The top five average total paid claims by clinical service, in order, were perinatal, behavioral health, surgery, medicine, and emergency medicine.

"We were surprised that claims occurring in the ED were not one of the top three locations in regard to average total paid for closed claims by location," Benton says. Here are other findings:

• The data set of 107 closed claims involving the ED had an average total payment of $276,879 by location. The closed claims were paid by CNA on behalf of organizations with professional liability coverage insured through the primary hospital program. Indemnity and expense payments included only monies paid by CNA on behalf of its insureds, Benton says.

"Self-insured retentions and other possible sources of payment for other parties, such as noninsured physicians, in response to a claim cannot be determined, and therefore, are not included in this report," she says.

• ED claims range considerably in terms of severity, with many claims having a paid indemnity less than $100,000.

• At the opposite end of the spectrum, six of the 20 $1 million paid indemnity claims involved the ED.

• Assessment and monitoring-related allegations included failure to properly or fully complete a patient assessment, failure to assess the patient's concerns or symptoms, delayed or untimely patient assessment, failure to monitor patients who are identified as an elopement risk, failure to monitor and address vital signs, and failure to monitor per order or protocol.

"These allegations have the highest average severity," Benton says. In one such case, a patient was evaluated in the ED and determined to meet the criteria for involuntary commitment.

"While waiting for admission, she eloped and could not be found. Soon after, she was struck by a car and sustained fatal injuries," Benton says. ■

Poor Communication with Physician Assistants Resulted in These Successful Lawsuits

EDs are increasingly relying on physician assistants (PAs) and nurse practitioners (NPs), but this raises the possibility of more malpractice lawsuits, according to medical and legal experts.

In one case, a 58-year-old male presented to an ED complaining of abdominal pain.

"He was seen primarily by a PA who ordered labs and X-rays and medicated the patient with hydromorphone and ketorolac before the ED physician saw the patient," says **Laura Pimentel**, MD, vice president/chief medical officer at Maryland Emergency Medicine Network in Baltimore, MD.

The labs came back with a white blood cell count of 14,000.

"When the ED physician saw the patient, he was much more comfortable. The PA did not communicate the elevated white blood cell count," Pimentel says. Because the patient felt better, and the physician was told that the workup was negative, the patient was discharged. "Six hours later, the patient presented to another ED and was diagnosed with perforated appendicitis," Pimentel says.

In another case, a 26-year-old man presented to an ED complaining of a cough and fever.

"He was seen by a PA whose clinical evaluation revealed no concerning findings," Pimentel says. The patient was discharged before the ED physician had an opportunity to see him. "When the physician later reviewed the chart, he was concerned that the temperature was 102 and the respiratory rate was 26," Pimentel says. Twelve hours later, the patient was brought by ambulance to another ED in severe respiratory distress; he was diagnosed with multi-lobar pneumonia and intubated in the ED.

Here are common fact patterns in ED claims involving PAs and NPs:

- There is an absence of a defined scope of practice.

FAILING TO DEFINE WHAT TYPES OF PATIENTS PHYSICIAN ASSISTANTS CAN SEE INDEPENDENTLY AND WHICH REQUIRE CONSULTATION IS RISKY.

"This is surprisingly common," Pimentel says. In many EDs, PAs practice nearly independently and only consult with EPs if they believe it is necessary.

"Some states encourage this unsafe practice because the law allows PAs to bill as long as there was a physician available to answer questions," Pimentel says.

In many EDs, it's unclear when the PA needs contemporaneous supervision and when the PA can discharge patients, says **Joseph Wood**, MD, JD, vice chair of the Department of Emergency Medicine at Mayo Clinic Arizona. "I have first-hand knowledge of a claim in which a PA discharged somebody with chest pain and high blood pressure, and the person went on to have a heart attack and died," he says. Part of the problem was that the supervising EP did see the patient, who had been in an automobile accident, but only to check the patient's abdomen. "The EP was unaware that the patient had also complained of chest pain," Wood says.

Failing to define what types of patients PAs can see independently and which require physician consultation is "extremely risk-prone," Pimentel warns.

A current malpractice case involves an ED patient who was seen only by an NP, with a presentation of severe abdominal pain of sudden onset.

"The patient sees an NP who he thinks is an EP," says **Gary Weiss**, JD, the Louisville, KY-based attorney representing the plaintiff. A CT report indicated "a small amount of extraluminal gas," but the patient was discharged with a prescription for antibiotics. By the time the patient returned to the ED, "peritonitis had set in. The patient had a stormy course, had a colostomy, and multiple surgeries," Weiss says.

Both the hospital and the ED group employing the NP were named in the resulting lawsuit.

"The basis of the claim against the hospital was that they failed to have a proper protocol, which would have required that a board-certified EP see the patient. Instead, it was left up to the NP's discretion," Weiss says.

Expert witnesses testified that the hospital should have had a protocol requiring an EP to see a patient who presented with such symptoms. "When asked how it's determined if an EP needs to see a patient, the NP responded that it was completely discretionary to the NP," Weiss says.

Pimentel says EPs are protected

by policies and procedures that define the scope of practice of the PA and the supervisory responsibilities of the EPs.

"In my practice, we require a conversation between the PA and the attending prior to patient discharge," she says. "EPs are required to sign the chart and assume responsibility for the disposition."

• EPs sign charts of patients that they did not see or discuss prior to discharge.

"This is another common practice with which most physicians are not comfortable, and places them at significant risk," Pimentel says. "Some groups encourage and expect this for billing and regulatory purposes."

Generally speaking, EPs aren't fully aware of what's expected of them when they sign a PA's chart, Wood says. "If you sign the chart, it's reasonable to interpret that to mean that you reviewed the chart and agreed with all the care that's documented."

Sometimes EPs sign the chart on the next shift, or even days later.

"Those are dangerous practices," Wood says. "If you are signing the chart at a later point, put the date you signed it. Otherwise, it leaves the impression that you contemporaneously supervised the PA."

In one malpractice case, a patient with a septic knee was diagnosed with cellulitis and discharged by the PA.

"Litigation included the supervising physician, who signed the chart after the fact," Pimentel says. The case was not discussed, nor was the patient seen prior to discharge. In another case, a patient with necrotizing fasciitis was discharged with the diagnosis of cellulitis. "The result was an untimely death," Pimentel says.

EPs often fail to fully appreciate the responsibility they have for the decisions made by PAs — until they find themselves a defendant in a malpractice lawsuit, warns **Armand Leone**, Jr., MD, JD, MBA, a Glen Rock, NJ-based attorney.

Leone sees change-of-shift handoffs and oversight gaps between PAs and EPs as especially legally risky.

> EMERGENCY PHYSICIANS OFTEN FAIL TO FULLY APPRECIATE THE RESPONSIBILITY THEY HAVE FOR THE DECISIONS MADE BY PHYSICIAN ASSISTANTS — UNTIL THEY FIND THEMSELVES A DEFENDANT IN A MALPRACTICE LAWSUIT.

"You'll have an ED patient who is clearly not an ESI Level 1 or 2, as determined by the ED triage nurse," he says. The PA then assesses the patient, orders labs, and checks in with the EP.

"The problem is that EPs need to get some confirmatory check on the information they're given," he says. The PA may discuss the case with the EP, who does nothing to confirm the information they're being given. "It's not enough for the EP to just rely on the PA's verbal summary on the patient and then sign off." Critical aspects of the patient evaluation that underlie the diagnosis and treatment plan should be confirmed by the EP, Leone says.

"If you are working together for months and the PA is pretty good, it's easy to develop a false sense of security," he says. "But you are the EP, and you have the responsibility."

• The EP discharges the patient without a final check.

If the EP does review a PA's care at some point during the ED visit and a significant amount of time passes, the EP should go back and conduct a review at discharge, Leone advises. The patient's condition could change in the interim, resulting in the discharge of an unstable patient.

"There needs to be a last check before such a patient leaves the ED," Leone says. He recalls one case in which the patient had an unstable condition but was not exhibiting obvious symptoms. The initial information obtained in the ED by various providers was not consistent, went unnoticed, and no further inquiry was made to resolve the discrepancies. As a result, further testing was not done, and a consultation was not called.

The patient returned to the ED about two weeks later with permanent injury.

"The EP missed it because of overreliance on the PA and failing to perform a last check prior to discharge. When the patient returned with neurological injury, it was too late," Leone says. In such a case, liability extends to both the PA and the EP.

Guidelines ensure that patients with certain complaints, such as shortness of breath, chest pain, abdominal pain, or patients with abnormal vital signs, aren't discharged unless the EP sees the patient. PAs might be reluctant to be seen as "pestering" a busy EP with multiple critical patients.

"That's where guidelines can help," Wood says. "If you can't

discharge somebody unless they run it by the EP, both the PA and the EP know they're just following the policy."

Leone says it's prudent for EPs to see the patient prior to discharge and confirm the history, physical examination, assessment, and plan, then document the same. This is much more defensible than the entry, "Spoke with PA and agree with assessment and plan."

"That is a typical entry that we see. And to me, that's a slim reed to stand on," Leone says.

Broader Liability Analysis

State laws vary as to whether an EP can serve as an expert witness to judge a PA's conduct.

"In New Jersey, we need to have a PA opine on the standard of care for the PA, and an EP assess the EP's conduct, including their oversight of the PA," Leone says.

The PA's liability is determined according to the standard of care the midlevel provider is held to, and the EP's liability is determined by the standard of care the EP is held to.

Midlevel providers in EDs have added "an additional dimension of liability," Leone says. "Some cases require three separate emergency medicine experts to review the care — an ED nurse, a PA with ED experience, and an EP — before I know what claims, if any, exist."

This makes the investigation of the case more complicated for plaintiff attorneys, who have to cover all aspects of potential liability and obtain positive and/or negative opinions regarding probable merit as to each defendant. "Defense attorneys, on the other hand, do not have the burden of proving deviations at all," Leone says. Each defense attorney looks at the case from the perspective of her individual client's area of practice. "Each defendant only is concerned as to opinions by a matching expert, and has no affirmative duty to produce expert testimony until the plaintiff has," Leone says.

PLAINTIFF ATTORNEYS HAVE TO COVER ALL ASPECTS OF POTENTIAL LIABILITY AND OBTAIN POSITIVE AND/OR NEGATIVE OPINIONS REGARDING PROBABLE MERIT AS TO EACH DEFENDANT.

If the EP is the sole named defendant, but months into the litigation the evidence shows that the PA was also at fault, it could be difficult for the plaintiff attorney to add the PA to the lawsuit. For this reason, Leone addresses all potential claims by provider type prior to filing the lawsuit.

"The EP may have a legitimate defense that the PA messed up or improperly relayed information, and that person is not named in the suit," Leone says. ■

SOURCES

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CME/CNE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

COMING IN FUTURE MONTHS

- Legal disasters involving bad outcomes in ED waiting rooms
- Mitigate legal risks if psychiatric patients are boarded in ED
- Disprove allegations of inadequate mental health evaluation
- How plaintiff attorneys prove causation in ED med/mal suits

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CME/CNE QUESTIONS

1. **Which is true regarding an EP's defense against allegations of missed sepsis?**

   A. Checkboxes provide a legally protective explanation of why a particular course of treatment was pursued.
   B. If a patient with a simple upper respiratory infection fulfills some, but not all, of the Systemic Inflammatory Response Syndrome (SIRS) criteria, EPs should document only the clinical impression of an upper respiratory infection.
   C. Documentation showing the EP followed formalized approaches that were put into place to identify and treat sepsis cannot be utilized to show the EP met the standard of care.
   D. If a patient is discharged and later alleges missed sepsis, the absence of any documentation about sepsis protocols helps the EP's defense by showing the EP did not consider sepsis in the differential.

2. **Which is true regarding lawsuits involving ultrasound in the ED, according to a recent study?**

   A. Malpractice lawsuits have increased commensurately with the increase in point-of-care ultrasound use in the ED.
   B. EPs are at particularly high risk for lawsuits involving ultrasounds that were performed and interpreted negligently.
   C. Failure to perform an ultrasound study, rather than a negligent EP interpretation, was alleged in all identified malpractice cases involving ultrasound in the ED.
   D. Courts have ruled that EPs cannot be held liable for performing point-of-care ultrasounds because it is outside of their scope of practice.

3. **Which is recommended to reduce liability involving care provided by physician assistants (PAs) in the ED?**

   A. Define scope of practice for PAs informally.
   B. Having written guidelines that state that the PAs are to consult with EPs only if the PA believes it is necessary.
   C. Avoiding written guidelines as to what types of patients a PA can see independently and which require physician consultation.
   D. Having policies that define the PA's scope of practice and the EP's supervisory responsibilities.