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INSIDE

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The Opioid Minefield

By Diana Nordlund, DO, JD, FACEP, Deputy Compliance Officer, Emergency Care Specialists, PC, Grand Rapids, MI

Opiate overdose deaths have quadrupled in the past 18 years. The CDC reports a daily death toll of 91 in the United States alone.[1] This issue has become not only a public health crisis, but also a political one. Thus, legislative activity at the state and federal levels of government has reached a fever pitch, the ramifications of which certainly will affect the practice of emergency medicine.

> LEGISLATIVE ACTIVITY AT THE STATE AND FEDERAL LEVELS OF GOVERNMENT HAS REACHED A FEVER PITCH.

For some time, the DEA and Office of the Inspector General have been increasing enforcement actions against so-called "pill mills" and racketeering rings.[2] Case law decisions have permitted plaintiffs to sue for opiate-related injuries despite plaintiffs' participation in criminal drug-diversion activity.[3] More recently, criminal prosecution of prescribers has extended beyond profit-based drug diversion. In February 2016, a California physician was convicted of second-degree murder for the opiate-related deaths of three patients and sentenced to 30 years to life in prison.[4] The following month, a family physician in Nevada pleaded guilty to involuntary manslaughter for the overdose death of a patient to whom he had prescribed oxycodone. Subsequent to the plea, the physician was sentenced to 10 years in prison followed by three years of supervised release and a $25,000 fine.[5] It is in this context that one examines legislative responses to opiate prescribing practices and their effect on the daily practice of emergency medicine.

Six major categories are targeted across the nation: prescription drug monitoring programs, prescribing

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EDITORIAL EMAIL ADDRESS:
jspringston@reliaslearning.com

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AUTHOR: Stacey Kusterbeck
EDITOR: Jonathan Springston
EXECUTIVE EDITOR: Shelly Morrow Mark
EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

guidelines and limits, provider training and education, rescue drugs and Good Samaritan laws, regulation of pain management centers, and other measures, such as public school education, mandatory disclosures to patients, parental consent for minors, and formal informed consent/signed treatment agreements for patients. A discussion of the key points that are most germane to emergency care follows.

Prescription Drug Monitoring Programs

A prescription drug monitoring program (PDMP) is a statewide database for monitoring controlled substance prescriptions. Requirements vary from state to state, but the CDC recommends providers consider checking the PDMP prior to every prescription for opioids.[6]

As of mid-2017, the only states that do not *require* checking the PDMP in at least some circumstances and/or provide for disciplinary action if the prescriber fails to query the database are Florida, Hawaii, Iowa, Idaho, Illinois, Kansas, Michigan, Missouri, Montana, Nebraska, Oregon, South Dakota, and Wyoming.[7] Lawmakers in some of these states, including Michigan, are considering legislation pending that, if passed, would mandate a PDMP query.

State laws vary as to exceptions, the degree of documentation required, and associated penalties. Existing penalties include lost reimbursement, fines, and state licensing board sanctions that may include licensure suspension or revocation.[8]

The CDC has set forth prescribing guidelines for opiate-based treatment of chronic pain. At first blush, one might think these guidelines do not apply to emergency medicine, particularly because the guidelines refer to a "focus" on primary care clinicians.

However, the CDC defines chronic pain as pain that "typically lasts > 3 months or past the time of normal tissue healing."[9] Further, the CDC guidelines cite a 2012 study showing that 43% of U.S. adults experience common pain complaints such as arthritis, back or neck pain, and recurrent headaches, all of which are seen frequently in the ED.

Finally, the same guidelines state that their purpose is "to inform clinicians who are considering prescribing opioid pain medication for painful conditions that *can* or have become chronic."[9] When the *possibility* of a chronic condition is added to their application, it is clear that EPs must take note of these guidelines.

In broad strokes, the guidelines suggest that before prescribing opioids, clinicians should:

- perform and discuss a risk/benefit analysis and establish realistic treatment goals with the patient;
- use only the lowest effective doses of immediate-release formulations;
- prescribe the smallest quantity expected to treat severe pain, typically three days or less;
- consider offering naloxone;
- review the PDMP and determine whether patient is at risk for opioid-related harms;
- avoid co-prescribing benzodiazepines whenever possible.

Although these are only guidelines, several states have enacted legislation based on these tips, including statutory limits on prescription duration for *acute* pain, ranging from as few as three days to as high as 10 days.[10]

By mid-July 2017, naloxone accessibility laws had been passed nationwide. Although details vary,

these laws include some degree of immunity for prescribers, dispensers, and laypersons and provide for third-party prescriptions or allow laypersons to obtain reversal agents without a prescription. Additionally, Good Samaritan laws were passed in 40 states (and Washington, DC) to provide legal protection to persons reporting an overdose.[11]

Other Measures

In addition to states mandating training for prescribers, some medical schools are initiating opioid training for medical students.[12] Further, providers may be required to provide certain information to patients prior to prescribing, develop a treatment plan, and complete formal informed consent.[13] Lastly, some states require documentation of certain elements of these discussions in the medical record.[14]

Expectations and Action

Given the above, it seems highly likely that every state will regulate at least some aspects of opiate prescribing by EPs. States that have not passed PDMP laws are in the process of creating such legislation. Further, both civil and criminal case law is amassing rapidly. One needs only to conduct an online search using the keywords "narcotic lawsuits" to be besieged with a plethora of solicitations for litigation representation related to addiction- and/or overdose-related injury. Successful lawsuits to date include a high-profile case in St. Louis in which a jury awarded $17.6 million to a 45-year-old municipal employee who ultimately entered addiction treatment.[15]

In addition to lawsuits levied against individual prescribers and clinics, there is a growing number of actions brought against drug manufacturers. At least two states (Mississippi and Ohio) have filed lawsuits directly against manufacturers, and at least 40 states have joined an investigation of manufacturers headed by a coalition of state attorneys general.[16,17]

As more plaintiffs litigate successfully and as more states pass laws regulating prescribing practices, there is a significant increase in provider risk. Practice groups that respond with prescribing policies and guidelines will find that those documents are discoverable and may be used as evidence of malpractice if a provider does not adhere to them. Practice groups that do not implement such measures will find that failure to do so can be held up as evidence of negligence as well. Furthermore, deviation from state law can carry significant civil and criminal penalties, including license censure or revocation, fines, and imprisonment. Thus, prioritizing responsible prescribing and patient safety in a manner that adheres to state law and respects national guidelines is important for patients and providers alike.

AS MORE PLAINTIFFS LITIGATE SUCCESSFULLY AND AS SOME STATES PASS LAWS REGULATING PRESCRIBING PRACTICES, THERE IS A SIGNIFICANT INCREASE IN PROVIDER RISK.

EPs would be well-served to become familiar with their relevant governing state law and develop compliant opiate-prescribing practice patterns. Regardless of the requirements of state law, a responsible prescribing practice likely includes the following: perform and document informed consent, prescribe the lowest effective dose in the smallest effective quantity of an immediate-release formulation, avoid co-prescribing benzodiazepines whenever possible, consider naloxone, and review (and document such a review) the PDMP.

Conclusion

Prescribing opiates is now an extremely high-risk aspect of the practice of emergency medicine. National public service messages and state-based efforts will produce lasting effects. Individual providers are well-served by familiarizing themselves with existing state law as well as pending legislation. From a proactive perspective, if pending legislation can be improved by provider input, it behooves EPs to advocate at the state level of government before the bill becomes law.

At the individual practice level, ensuring adequate provider education and facilitating uniformly responsible prescribing practices improves safety for both patients and providers. As always, EPs are on the front lines of patient care and uniquely poised to effect positive change approximately 356,000 times per day.[18] This crisis presents another opportunity to improve the quality of life for patients and the quality of care delivered in the United States. ■

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ED-based EHR Errors Caused More Significant Harm to Patients Compared to Other Settings

More than half experienced high-severity outcomes

Electronic health record (EHR)-related errors in the ED resulted in more significant patient harm than errors that occurred in the inpatient or ambulatory settings, according to a recent analysis.[1]

Seeking to obtain more information on health IT-related problems, researchers analyzed EHR-related cases occurring between 2011 and 2015 submitted to CRICO Strategies' Comparative Benchmarking System, a database of malpractice cases. Researchers found 420 cases in which the EHR was a contributing factor. Of this group, 50 cases occurred in the ED.

"What's interesting about the ED cases is that 57% of them ended up in a high-severity outcome," says **Penny Greenberg**, MS, RN, CPPS, editor of the report. This compares to 45% in the inpatient setting, and 39% for the ambulatory setting. Greenberg is senior program director of patient safety services for CRICO Strategies, a division of CRICO, which provides medical professional liability coverage for the Harvard medical community. As a group, the EHR-related ED cases

cost $18 million to resolve. Here are some case examples:

• A 48-year-old woman's X-ray was read by the EP as normal, but the radiologist's report the following day revealed an incidental finding of a pulmonary nodule and recommended a chest CT scan.

"The EHR did not flag the result for the EP to look at it, and it wasn't reported to the patient," Greenberg says. Two years later, the patient discovered she had advanced lung cancer and sued, alleging that the cancer should have been caught at the time of the ED visit. The case was settled.

• A man presented to an ED with severe substernal chest pain radiating to the left chest and shoulder. The first troponin level, the CT scan, and the chest X-ray were all normal, and the man's pain decreased after he received morphine.

The plan was to admit the patient, who was moved from the acute section of the ED to the urgent section because of crowding. This affected the way in which the second troponin level, which came back high, was documented in the EHR.

"Neither the EP nor the ED resident looked up the value, or made the diagnosis of [myocardial infarction], because the value was in the 'acute' results section in the EHR, instead of the 'urgent' section," Greenberg explains.

The patient coded and could not be resuscitated. The case was settled for $1.2 million.

• A 39-year-old woman with a history of migraines presented to an ED with severe pain, which resolved before discharge. The following day, she returned with vomiting and worsening pain.

The EP ordered 50 mcg of fentanyl, to be given 25 mcg at a time. However, the EHR was set up for single doses of fentanyl of 25 mcg, or ranges of 50 mcg to 100 mcg. The EP entered a 50 mcg order into the EHR, but did not specify this should be given as two single doses of 25 mcg. "The EHR automatically translated the EP's order from 50 mcg to a range of 50 mcg to 100 mcg," Greenberg explains.

Based on the severity of the patient's pain, the ED nurse administered the higher dose of 100 mcg of fentanyl to the patient. After the fentanyl was administered, the patient used the bathroom, and the pulse oximetry was likely disconnected at this time.

Shortly afterward, the patient was found unresponsive. Resuscitation was successful, but a CT revealed an anoxic brain injury. The patient was removed from life support and expired. The case settled for $450,000.

• A patient with a history of unresectable brain meningiomas was transferred to an ED for evaluation of swelling and bleeding from one of her brain masses. She also reported a headache and left-sided facial numbness.

The ED resident evaluated the patient and prescribed the steroid dexamethasone, selecting the "taper and take" fields in the EHR. The "take" field automatically defaulted to a "1" in the printed prescription.

"The ER resident didn't know this would occur," Greenberg says. "It was unclear if this was included in EHR training." The resident verbally reviewed instructions on how to taper the medication with the patient. "However, the first line of the written instructions, due to the EHR default, were to take '1 tab by mouth 1x daily for 35 days,' which was not intended," Greenberg notes.

The instructions should have read, "Take 4 tabs q 6 hours x 7 days." The patient was discharged home, and took the medication according to the incorrect instructions.

Shortly afterward, the patient returned to the ED with continued headaches and left-sided facial numbness. "Her facial droop was unchanged from the prior visit. It was discovered that the patient was not taking the correct dosage of Decadron," Greenberg says.

The problem was that the EHR default error resulted in the patient's steroid prescription being too low. "The patient's symptoms improved once she was taking the correct dose," Greenberg adds. The case settled for $1,700.

EXECUTIVE SUMMARY

Electronic health record (EHR)-related errors in the ED resulted in more significant patient harm than errors that occurred in the inpatient or ambulatory settings. To reduce risks, EPs can:

- configure the ED's EHR with end users' input and in ways that improve care;
- know who to call for help if there's a problem with the EHR;
- probe further if information about an ED patient seems incorrect.

One of Many Factors

It's easy to simply blame the EHR for the adverse outcomes. However, for every one of the malpractice claims in the database, the EHR was only one of multiple contributing factors. "It's never just the EHR. Adverse events happen generally because of

many factors colliding at once," says **Trish Lugtu**, CPHIMS, senior manager of advanced analytics at Minneapolis-based MMIC, a Constellation company.

Assessment failures by the EP, or lack of communication between providers about the patient's condition, also are to blame.

"The EHR is intended as a tool to support the care team," Lugtu says. "It is not meant to replace critical thinking or sound medical judgment. It can't take the place of the provider."

Malpractice cases involving EHRs close faster than the average claim, Lugtu explains. "After all, EHR is documentation. Wrong or right, it provides attorneys with immense documentation and built-in time stamps."

Engage EPs

Lugtu says that problems with EHRs generally fall into a few simple categories: Information is not seen, information is wrong, or information is missing. Therefore, EPs' training is very important. "The number one thing is to get emergency providers engaged, to collaborate on workflow design, and to learn how to use the EHR well," Lugtu offers.

Many EDs have yet to take advantage of the EHR capabilities that can support improvement of care. For instance, automated reports can provide audits of incomplete tests or undelivered results open at the time of discharge. "Not only is it important to configure the EHR well to avoid mishaps, but there is such a great opportunity to leverage the EHR to improve care," Lugtu notes. Greenberg recommends EPs use these practices to reduce EHR-related risks:

> "THE NUMBER ONE THING IS TO GET EMERGENCY PROVIDERS ENGAGED, TO COLLABORATE ON WORKFLOW DESIGN, AND TO LEARN HOW TO USE THE EHR WELL."

- Know who to call for help if there's a problem with the EHR;
- Include questions about potential EHR involvement in every event report and root cause analysis;
- Combine information from root cause analyses and incident reports with medical malpractice data;
- Be sure you are in the right record before documenting;
- Use critical thinking.

"If there is information that doesn't seem correct, ask questions. If the data are not accessible, that does not mean it's not available," Greenberg says. ■

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- **Trish Lugtu**, Senior Manager, Advanced Analytics, MMIC, a Constellation company, Minneapolis. Phone: (952) 838-6844. Email: Trish.Lugtu@ConstellationMutual.com.

Liability for EP if Admitted Patient's Condition Deteriorated

Evidence of conveyed information helps ED's defense

An ED patient might be stable when the decision is made to admit, but the patient's condition can deteriorate suddenly while he or she is "boarded."

Rodney K. Adams, JD, has handled several malpractice cases involving this scenario. In each case, the attending physician agreed to admit the patient, but the patient remained in the ED. During that period, a complication arose.

"There is always some ambiguity as to who is in charge," says Adams, an attorney at Richmond, VA-based LeClairRyan. Since the EP is the one who is physically present, he or she often is presumed to be primarily responsible for the patient. This is the case even if hospital bylaws state that the attending is responsible once the

patient is accepted for admission. "As the one who is standing right there, it's hard for the EP to wash their hands of the whole thing," Adams says.

One recent malpractice case involved an intoxicated patient who was brought to an ED after being stabbed in a fight. The EP asked the surgeon to come examine the patient because of concerns about the patient's fluctuating blood pressure. The surgeon agreed over the phone to admit the patient.

However, the patient remained in the ED for several more hours waiting for the surgeon to arrive and finally collapsed. What the EP believed was a simple laceration turned out to be a penetrating wound of the internal iliac artery. By the time the surgeon finally arrived, the patient was already in the ICU. "The EP had actually gone up to run the code," Adams notes.

The patient subsequently died after a lengthy ICU stay. The family sued both the EP and the surgeon. The litigation focused on the communication between the two physicians — specifically, what was stated regarding how quickly the surgeon had to get to the ED.

The EP testified that it was the surgeon's responsibility, not the EP's, to determine how quickly the surgeon needed to get to the ED. The surgeon countered that the EP stated that the patient was currently stable. Since no emergency was communicated, the surgeon simply came to the ED to check on the patient during his usual morning rounds.

The family filed two separate lawsuits against the EP and the surgeon, both of which resulted in a defense verdict. Since the lawsuits were filed separately, the physician defendants weren't in the position of pointing fingers at each other. If the specialist and the EP are at odds, documentation probably is going to be the deciding factor as to who's held liable. "Juries tend to believe what's written down," Adams says.

The EP can testify that he or she strongly recollects something he or she told the admitting physician. This is tough for the jury to swallow if that piece of crucial information is nowhere in the ED record.

"Jurors have told us, 'If it was that important, the doctor would have written it down,'" Adams notes.

A patient presented to a Texas ED with an ST-elevation myocardial infarction. He was admitted to the cardiology service, but remained in the ED awaiting transfer to the cardiology catheterization lab. It took more than two hours for the patient to be transferred. "In that time, the patient deteriorated to the point of having widespread heart muscle death, losing his ability to work and requiring aide and attendant care for the rest of his life," says **Stephen A. Barnes**, MD, JD, FACLM, an attorney at McGehee, Chang, Barnes, Landgraf in Houston.

The EP was sued, along with the hospital and cardiologist. A jury found all three defendants liable. "The reason for such co-liability, including the ED physician, is because the common practice of ED physicians to 'wash their hands' of a patient, once that patient is transferred or admitted, is not founded in medical or ethical principles," Barnes explains. It's easy for a jury to understand that the EP, as the doctor physically present, could have done something. In the above case, for instance, the EP could have called the cardiologist back, called the catheterization lab back, transferred the patient to another hospital, or even given thrombolytic medication. "Keeping even a distant eye on patient flow may save the ED physician a lawsuit," Barnes offers.

Even if a boarded ED patient's condition remains stable, there are other legal risks that arise just by virtue of the patient remaining in the department.

"Patients may fall off a cart, pull out an IV, or fall. Often, they aren't being watched that closely," Adams says. ED staff face legal risks if they disregard the boarded patient's safety. "They've got to make a judgment call about whether the patient needs an aide with them when they go to the bathroom, or needs some type of restraint," Adams explains.

Also, there is the question of how much care the ED should provide while the patient remains in the ED. Both insufficient care, and going above and beyond, pose legal risks for EPs. "There is always that tension between providing only emergency care, and providing whatever care the patient needs," Adams says. Some EPs believe they should provide whatever

EXECUTIVE SUMMARY

EPs are not absolved of legal responsibility for admitted patients who remain in the ED while waiting for an inpatient bed to become available.

- Juries rely on documentation to determine what information was communicated to the admitting physician.
- Providing treatment to admitted patients can lead to the EP being held to a higher standard of care.
- Undocumented interactions are problematic for the defense.

care is possible while the admitted patient is in the ED. This can lead to "assumption of responsibility," meaning the EP could be held to a higher standard of care.

"Let's say they decided to lance a boil themselves instead of having the surgeon do it. Then the EP has to meet the [surgical] standard of care," Adams notes.

On the other hand, if the EP provides only minimal care to the boarded patient, this opens the door for a plaintiff attorney to allege that more should have been done. The fact that many interactions aren't recorded in the ED chart makes the defense team's job tougher.

"All of that stuff, in the ideal world, would get captured, but it doesn't," Adams says. "This can be a problem with ED cases."

A busy EP might duck his or her head into the room of a boarded patient, engage in a quick conversation with an ED nurse about the patient, or look at the boarded patient's X-ray. If none of this is mentioned in the chart, it's easy to paint a picture of a patient who got ignored. "A brief note at regular intervals by a nurse or physician would go a long way toward proving the attentiveness of the staff," Adams says. ■

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- **Stephen A. Barnes**, MD, JD, FACLM, McGehee, Chang, Barnes, Landgraf, Houston. Email: sbarnes@lawtx.com.

Psych Patients Elope or Are Discharged? Either Way, It's a Wrongful Death Lawsuit

Damage done 'becomes the liability of the ED staff'

If a family member reports that a teenager overdosed on pills after an argument, but the patient, now in your ED, adamantly denies intent to harm himself or herself, can the patient be discharged safely?

"It becomes a judgment call," says **Bruce Janiak**, MD, a professor in the department of emergency medicine at Medical College of Georgia in Augusta.

EPs can conduct a thorough evaluation, document "no evidence of homicidal or suicidal ideation," and contact a psychiatrist to consult on the patient to support the decision to discharge the patient.

"But no one can predict the future," Janiak adds.

When a woman was brought to an ED by her husband due to the recent onset of bizarre behavior, the EP correctly diagnosed acute psychosis. The treatment plan was appropriate: admit the patient to a psychiatric facility. Yet, the patient was discharged home from the ED at her request and that of her husband.

"Unfortunately, the patient ended up beating their 16-month-old son to death," says **Scott L. Zeller**, MD, chief of psychiatric emergency services at the John George Psychiatric Hospital of the Alameda Health System in Oakland, CA.

The family sued the hospital and the EP, alleging that the EP failed to properly diagnose, treat, and hospitalize the patient.[1]

The trial court granted summary judgment for the defendant hospital and physicians, but this was reversed on appeal. The South Carolina Court of Appeals held that the EP's inadequate treatment of the patient's psychosis in the ED was the proximate cause of her fatal assault on the child. During the litigation, the plaintiff attorney focused on the EP's failure to obtain a psychiatric consultation.

"Assessment and diagnosis of acute psychiatric conditions is

EXECUTIVE SUMMARY

If psychiatric patients are discharged or elope from the ED and harm themselves or others, a wrongful death lawsuit is possible. To reduce risks, EPs can:

- document that there was no evidence of homicidal or suicidal ideation at the time of the ED visit;
- contact a psychiatrist to support the decision to discharge;
- keep the patient secure until the evaluation is complete;
- take reasonable precautions when patients are transported to another facility.

complicated and involves a multitude of specific criteria," Zeller explains. He encourages EPs to consider consulting a psychiatrist when a patient presents to the ED with a mental health crisis. If an in-person psychiatric consult is not available, telepsychiatry is another good option. "A board-certified psychiatrist, who might be many miles away, can evaluate the ED patient at practically the speed of light," Zeller offers.

The process works this way: Within an hour, the psychiatrist responds and speaks to the patient via secure two-way video conferencing. After a thorough evaluation, the psychiatrist advises the EP on diagnosis, treatment, and disposition.

"This lends itself to decreased ED length of stay, short evaluation times, and earlier diagnosis and therapy," Zeller adds.

Lack of security to keep psychiatric patients from eloping is a significant legal risk for EDs. "If that isn't in place, the patient can escape. And whatever damage the patient does to himself, herself, or others then becomes the liability of the ED staff," Janiak warns.

One ED group found itself named as defendants in a highly publicized lawsuit that involved a patient who left an ED before a mental health evaluation was completed.[2] The patient presented to a small community ED and told the triage nurse he was suicidal. The EP conducted a brief evaluation and called a psychiatric technician, who evaluated the patient and left to consult his psychiatric supervisor. After about an hour of waiting, the patient stated he wanted to go out for some fresh air.

"The staff let him do that, which was the big error," Janiak says. The patient got behind the wheel of a running fire engine and killed a pedestrian. The man's family sued, alleging that the EP failed to keep the patient secure until the psychiatric evaluation was completed. "They were actually planning on admitting the patient to a psychiatric unit in an accepting hospital," Janiak notes. "However, he eloped before that because they just let him go."

The case illustrates the ED's significant legal exposure during the period when patients are under evaluation for suicidal or homicidal ideation.

LACK OF SECURITY TO KEEP PSYCHIATRIC PATIENTS FROM ELOPING IS A SIGNIFICANT LEGAL RISK.

"In a small ED without security, this means keeping the patient in the room and not allowing him or her to leave until such time as the patient is deemed capable of taking care of himself," Janiak says.

Once a patient reports suicidal or homicidal ideation, "the person is no longer in charge of themselves. But the patient may not voluntarily agree to be hospitalized," Janiak notes. If the patient becomes violent when the ED attempts to initiate the commitment process, the patient or others may be injured. "When a patient is fighting back against people trying to hold them down, the patient can become acidotic and go into cardiac arrest," Janiak adds.

Many EDs don't have a psychiatric facility in their hospital. This means psychiatric patients are held for extended periods while waiting for a facility to accept the patient. "There is a lot of pressure on EPs to discharge these patients because they are occupying beds in the ED," says **Alan Gelb**, MD, clinical professor in the department of emergency medicine at UCSF School of Medicine. EPs face significant legal exposure in this all-too-common scenario.

"If you let someone like that go, not only do you risk a med/mal case, but some of these cases have gone to federal court because of perceived EMTALA violations," Gelb says. A recent record $1.29 million EMTALA fine involved psychiatric patients boarded in the hospital's ED for extended periods.

In Janiak's experience, it's not unusual for psychiatric patients to be held in EDs for several days. "Sometimes, you are working your next shift, and the patient is still there days later." The question is how to ensure safe custody of the patient until a definitive disposition can occur. "This is one of the biggest problems in emergency medicine right now," Janiak laments.

Pediatric psychiatric patients are particularly challenging because few institutions accept them. "We'll have a kid who is just sitting there for three or four days doing nothing," Janiak explains. "It's a very rare shift when my ED is not boarding a psychiatric kid."

Safety During Transport

A suicidal patient is medically cleared in the ED and is finally accepted by psychiatry. However, there is still a legal landmine to navigate: the timeframe from when the patient leaves the ED to the patient's arrival at the psychiatric facility. "You send the patient with

transport by whatever means, and the patient escapes," Gelb says.

As the sending facility arranging the transportation to the receiving facility, he explains, the ED is responsible for taking reasonable precautions to ensure the patient is not going to escape. "These are not the kind of cases where you discharge the patient to the family to take the patient somewhere else," Gelb notes.

Gelb uses the analogy of transporting a critical care patient, who would require a critical care transport ambulance as opposed to a basic life support ambulance. The same is true for a psychiatric patient who required restraints in the ED setting to prevent the patient from eloping or harming self or others.

"Whatever was in the ED should be available in the transport," Gelb says. "You wouldn't take them out of restraints and have them in the ambulance unrestrained."

It's important to remember that the psychiatric patient still is under medical care during transport, Gelb explains. However, this period often is overlooked by ED staff.

"The mindset is that the ED staff are so glad the patient is finally leaving they don't think about the transport," he says. "Transfers have to be safe for the patient."

At Zuckerberg San Francisco General Hospital, the psychiatric ED is located in a separate building from the main ED. When psychiatric patients are transferred there, a sheriff's deputy escorts them.

"A lot of the patients are on an involuntary hold because they are suicidal," Gelb notes. "If they elope and kill themselves, it's a wrongful death lawsuit." ■

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SOURCES

- **Alan Gelb**, MD, Clinical Professor, Department of Emergency Medicine, UCSF School of Medicine, San Francisco. Phone: (510) 790-2784. Email: alan.gelb@ucsf.edu.
- **Bruce Janiak**, MD, Professor, Department of Emergency Medicine, Medical College of Georgia, Augusta. Phone: (706) 721-1005. Email: brjaniak@gru.edu.
- **Scott L. Zeller**, MD, Chief, Psychiatric Emergency Services, John George Psychiatric Hospital of the Alameda Health System, Oakland, CA. Email: szellermd@gmail.com.

Did ED Patient Threaten Violence? EP Might Have Legal Duty to Warn

Statutes vary not only between states but also across time

EPs frequently encounter patients who were involved in violent acts or who threaten violence. "This raises questions about provider-patient confidentiality, and the circumstances in which that confidentiality can and must be broken," says **Edward Monico**, MD, JD, assistant professor in the section of emergency medicine at Yale University School of Medicine in New Haven, CT.

State "duty to warn" or "duty to protect" statutes vary. "Furthermore, the duty to protect not only varies between states but across time," Monico notes.[1]

EXECUTIVE SUMMARY

EPs might have a legal "duty to warn" individuals if a patient threatens violence against them.

- State statutes vary.
- EPs are shielded from allegations of breach of confidentiality if they warn someone of a threat.
- EPs can be held liable if their failure to warn leads to a violent act.

The legal precedent behind state duty to warn statutes stems from the landmark 1976 case of *Tarasoff v. Regents of the University of California*. That case involved a graduate student who killed a woman after disclosing the threat to do so to his therapist. The therapist informed the campus police, but no one warned the eventual victim. The California Supreme Court stated that therapists have a duty to warn others who are in foreseeable danger from the therapists' patients.

"Ultimately, during the rehearing of the case, the 'duty to warn' enunciated in the first ruling was expanded," Monico says. The court stated that

the therapist has a duty to "use reasonable care to protect the intended victim against such danger."[2]

"Since the initial *Tarasoff* ruling, subsequent courts have expanded the duty to warn a potential victim into a more onerous 'duty to protect,'" Monico explains. This may involve warning the potential victim, telling the police, or taking other steps that are reasonably necessary under the circumstances.

"There is no blanket federal duty to warn or protect. Instead, these duties are defined and codified into three distinguishable categories of state laws," Monico says. These are:

• laws that mandate some duty to warn or protect;

• laws that allow a warning by protecting healthcare providers from liability for breach of confidentiality if they do so, but issue no requirement to issue a warning;

• those that offer no statutory or case law guidance.

"Interstate variability has resulted in a 'duty to warn' landscape fraught with legal risk and immunity limits, navigated by practitioners that typically seek to find the path of least resistance," Monico says.[3]

EPs are shielded from allegations of breach of confidentiality if they do warn someone. EPs can be held liable if their failure to warn leads to a violent act, Monico adds.

"At least 20 states seem to extend the duty to include physicians who are not necessarily credentialed in psychiatry, as long as the physician purports to offer mental health treatment or represent a frequent point of contact for persons with psychiatric disorders," Monico notes.[4] ■

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SOURCE

- **Edward Monico**, MD, JD, Department of Surgery, Section of Emergency Medicine, Yale University School of Medicine, New Haven, CT. Phone: (203) 785-4710. Email: edward.monico@yale.edu.

CME INSTRUCTIONS

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CME 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

- How hospitals are held liable for ED triage mistakes
- Conflicting documentation complicates defense of ED claims
- Deposition questions that stump even the most well-prepared EPs
- ED chart can refute allegations of delayed diagnosis

ED LEGAL LETTER™

CME QUESTIONS

1. **Which is true regarding malpractice litigation and electronic health records (EHR)?**

   a. In malpractice claims in which the EHR is an issue, the EHR typically is one of multiple contributing factors that led to a malpractice claim.
   b. Malpractice cases involving EHRs take significantly longer to settle than other malpractice claims.
   c. Automated chart audits are the most common aspect of EHRs that result in malpractice claims.
   d. Evidence shows that claims are significantly easier to defend if the EP has copied and pasted all the previous information available regarding the patient's previous visits into the ED record.

2. **Which of the following is true regarding admitted patients boarded in EDs?**

   a. EPs are not legally responsible for patients who remain in the ED while waiting for an inpatient bed as long as an admitting physician has accepted the patient.
   b. If the EP provides treatment to admitted patients above and beyond the care typically provided in the ED setting, the EP might be held to a higher standard of care.
   c. Documenting specifics on what was conveyed to the admitting physician about the patient complicates the EP's defense because it makes the charting appear defensive.
   d. The EP cannot be held liable if a hospital's bylaws state that the attending is the one who is responsible once the patient is accepted for admission.

3. **Which is true regarding risks of a malpractice lawsuit alleging discharge of a psychiatric patient?**

   a. Consulting a psychiatrist when a patient presents with a mental health crisis can be legally protective for EPs.
   b. The EP cannot be held liable if the patient refuses hospitalization as long as it's clearly documented that the patient was discharged in the care of a responsible family member.
   c. Court rulings indicate that, in most cases, the use of telepsychiatry does not meet the legal standard of care.
   d. Once the medical evaluation is completed in the ED and the patient is accepted by psychiatry, the EP is not legally responsible for the patient during transport.

4. **Which is true regarding transport of a psychiatric patient from the ED setting?**

   a. The receiving facility, not the ED, is responsible for ensuring appropriate transport.
   b. Having patients on involuntary holds escorted by law enforcement is advisable to prevent elopement.
   c. Use of restraints during transport generally is a violation of the standard of care, even if the patient required restraint in the ED setting.
   d. Suicidal patients can be discharged to a family member for transport to another care setting as long as they are medically cleared.