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Policies and Guidelines Bury Hospitals and Physicians

Michigan appeals court allows use of hospital's internal policies and ACEP's Clinical Chest Pain policy as evidence against hospital and urgent care physician in malpractice case.

By Robert Bitterman, MD, JD, FACEP, Contributing Editor; President, Bitterman Health Law Consulting Group, Inc.

The pros and cons of writing explicit hospital policies and procedures and/or adopting specialty approved clinical guidelines have been heavily debated in the medical-legal literature. Do they minimize practice variability? Do they improve patient care? Do they increase or decrease medical malpractice liability? Case law suggests ever-increasing litigation against hospitals and physicians related to such written policies or clinical guidelines. A recent chest pain wrongful death lawsuit in Michigan highlights the risks to providers.

Jilek v. Stockson, et al.[1]

Mr. Jilek presented to the Maple Urgent Care Center (UCC) complaining of flu-like symptoms that had not resolved after a course of antibiotics. He did not complain of chest pain at triage, but the physician documented in the medical record that he had "chest tightness" and "trouble breathing" that "interfered with his ability to run;" and that Mr. Jilek appeared in "moderate distress."[1] Judging the patient symptoms to be respiratory in origin, not of cardiac origin, no EKG, enzyme biomarkers, or cardiology referral was done. The physician prescribed an albuterol inhaler and discharged Mr. Jilek from the Urgent Care Center.

Five days later, Mr. Jilek died while exercising, just after using the albuterol inhaler. (A typical ED chest pain discharge/"go home and die" case.) Autopsy revealed the cause of death to be an acute myocardial infarction due to an hours-old clot obstructing a severely diseased left main coronary artery.

Mr. Jilek's family and estate sued the urgent care physician and the hospital that owned the UCC. They asserted that the physician fell below the standard of care for emergency medicine by failing to take a more detailed chest pain history, failing to do an EKG or undertake a cardiac work-up,

and/or failing to refer the patient to a cardiologist for timely evaluation of his chest pain complaints. Additionally, the plaintiffs alleged that until a cardiac etiology was ruled out, the physician should have instructed Mr. Jilek to refrain from exercise and should not have prescribed albuterol.

The case went to the jury. After hearing the experts testify on whether Dr. Stockson should have investigated the patient's condition to comply with the standard of care, the jury found in favor of the physician. The hospital reached a settlement with the plaintiffs the day the trial began.[1]

The family appealed the jury decision on a number of grounds, one of which was that the trial judge had improperly excluded from evidence some internal hospital urgent care policies and guidelines, and the American College of Emergency Physicians' Clinical Policy for Initial Approach to Adults Presenting with Chief Complaint of Chest Pain with No History of Trauma (ACEP Chest Pain Policy).[1] This article will focus on the "policy" issue of the case, but before delving in, it is worth noting one of the other grounds for appeal decided by the court.

Standard of Care for Urgent Care Center

The physician working in the UCC was a board-certified family physician, ineligible to sit for the emergency medicine boards. The trial judge had instructed the jury that the applicable standard of care was that of "a physician specializing in family practice and working in an urgent care center." Logical though that may seem, Michigan law requires the court choose "the one most relevant specialty" to set the standard of care, and the appellate court decided as a matter of law that the specialty should be emergency medicine, not family practice.[2] The court held that the locus of the practice and the substance of the medicine being practiced at the time of the alleged malpractice defined the relevant specialty.[1,3] The court granted the plaintiffs' appeal, stating that the governing standard of care to be employed at the new trial was emergency medicine. Thus, at least in Michigan, it appears that physicians working in a typical UCC will be held to the standard of emergency medicine, regardless of their past specialty training or board certification status.[1]

Admissibility of Policies and Guidelines as Evidence at Trial

The appellate court divided the issue into the hospital's *internal* rules, policies, or guidelines and *external* guidelines, such as ACEP's Chest Pain Policy or those of the Joint Commission on Accreditation of Healthcare Organizations.[1] The court noted that no state statute bars use, and no state privilege shields use of such guidelines as evidence in medical malpractice trials.[1] However, there was long-standing, well-established, existing Michigan court precedent which stood for the proposition that "an institution's internal rules and regulations do not add to its obligations to the public or establish a standard of care."[1,4] The appellate court sidestepped that doctrine, recognizing that "*a hospital's rules could be admissible as reflecting the community's standard where they were adopted by the relevant medical staff and where there is a causal relationship between the violation of the rule and the injury.*"[1] (*Emphasis added*)

It noted that the policies "did not set or define

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Director of Marketing: Schandale Kornegay

Questions & Comments
Please contact **Leslie Coplin, Managing Editor**, at leslie.coplin@ahcmedia.com.

the standard of care, only that they may be considered as relevant to the jury's determination, based on expert testimony, of what that standard is."[1]

The hospital's internal urgent care policy, "Process for Transferring Urgent Care Patients with Chest Pain" provided that "Adult patient with chest pain arrives at urgent care; vital signs and EKG obtained." The court noted this could be interpreted to mean that all adult patients presenting to the UCC with chest pain must have vital taken and an EKG performed, in which case it's admissible to support plaintiff's claim that Mr. Jilek's "chest tightness" should have been assessed with an EKG. Contrarily, the court also noted the policy could be interpreted to mean that only those adults who actually had an EKG would be considered for transfer, in which case the policy would be inapplicable to Mr. Jilek and thus inadmissible at trial. The trial judge's determination on admissibility would depend on the expert testimony on the applicability of the policy to the appropriate standard of care.[1]

The court ruled that the trial judge erred in excluding plaintiffs from introducing the ACEP Chest Pain Policy. It noted that Michigan courts, as well as most state courts, routinely allowed external guidelines to be used as evidence in determining whether the hospital or physician met the standard of care.[1,5]

The court also noted that the ACEP policy was admissible since it specifically had been adopted by the hospital and Dr. Stockson's contract physician staffing group for use in its emergency department and urgent care clinics, including Maple Urgent Care at the time that Dr. Stockson treated Mr. Jilek.[1,4,6] It held that the physician defendant certainly can argue that Mr. Jilek's chest pain was not of the type to which the ACEP Chest Pain policy would be relevant, but since the plaintiffs presented evidence that Mr. Jilek's chest pain was of that type, the ACEP document was relevant to the standard of care and therefore admissible at trial.

Thus, the court decided that internal hospital policies and guidelines and external guidelines do not in and of themselves set the standard of care, but they should be admitted so long as they are relevant to the applicable specialty's standard of care and to the injury alleged by the plaintiffs. The case was just appealed to the Michigan Supreme Court on September 9, 2010.[1]

Different Ruling Under EMTALA?[7,8]

Unlike under state malpractice law, where the courts hold that internal or external policies or guidelines adopted by the hospital do not "set or define the standard of care," under EMTALA such policies can establish a duty and set the standard of care. Plaintiffs now routinely try to prove hospitals provided "disparate treatment" in violation of EMTALA by showing that the hospital deviated from its established medical screening policy.[9]

If the hospital has a policy that states all chest pain patients must have an EKG done within 10 minutes of arrival, then failure to do the EKG, or failure to perform an EKG within 10 minutes is a violation of EMTALA. If the plaintiff can prove the violation proximately caused harm, then he can recover damages in a civil action against the hospital under EMTALA. The hospital could argue over whether "chest tightness" constituted "chest pain" for purposes of complying with the chest pain/EKG policy, but it could not argue that its internal 10-minute rule did not set the standard for purposes of complying with the federal law. Under EMTALA, the hospital sets its own medical screening standards and it will be held to those standards, even if they are higher or different than the prevailing standards in the community.

For example, in the case of *Bode v. Parkview Health System*, a 6-year-old child with multiple congenital anomalies died from dehydration one day post-discharge from the hospital's ED after presenting with vomiting and diarrhea.[10] An Indiana federal court ruled the hospital could be liable under EMTALA for failing to provide an appropriate medical screening when it deviated from its standard policies, which required the ED to take the blood pressure of children aged 6 and older and reassess vital signs before discharge. The policies were admissible to demonstrate that the hospital provided disparate treatment by failing to comply with its self-imposed standards. The jury then would decide if the failure to meet that standard, by failing to take the child's blood pressure or reassess vital signs before discharge, was a proximate cause of the child's death from dehydration the next day.[10]

Case Comment and Summary

Hospitals should undertake proactive reviews of their ED policies and procedures, particularly those centered on the EMTALA-mandated medical screening examination requirement. Liability for "failure to follow your own rules" is growing, and decisions like the Jilek case just increase the likelihood that a health care institution's internal policies and procedures will be used against it in medical malpractice and EMTALA litigation.

Plaintiff lawyers certainly will attempt to use the hospital's internal policies and external guidelines, particularly if adopted by the hospital or its emergency physicians, to define the applicable standard of practice at trial.

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3. See *Reeves v. Carson City Hosp.*, 736 N.W.2d 284 (Mich. App. 2007) ; see also *Gonzalez v. St John Hosp. & Med. Ctr.*, 739 N.W.2d 392 (Mich. App. 2007).
4. Citing *Gallagher v. St. John Hosp. & Med. Ctr.*, 739 N.W.2d 392 (Mich. App. 1988).
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6. Citing *Owens v. Allis-Chalmers Corp.*, 326 N.W.2d 372 (Mich. 1982).
7. 42 U.S.C. § 1395dd
8. This section sets aside the issue of whether EMTALA applies to hospital owned and operated off-campus urgent care centers, which CMS believes does apply, while many practicing legal experts believe it does not.
9. E.g., *Clark v. Baton Rouge Gen. Med. Ctr.*, 657 So.2d 741 (La. App. 1995); *Correa v. Hosp. San Francisco*, 69 F.3d 1184 (1st Cir. 1995); *Scruggs v. Danville Reg'l Med. Ctr.*, No. 4:08CV00005 (W.D. Va. 2008).
10. *Bode v. Parkview Health Sys.*, No. 1:07-CV-324 (N.D. Ind. Mar. 23, 2009).

ED Could Be Liable if Patient Harms Self Post-Discharge

Chart's contents take center stage

If a psychiatric patient harms himself or someone else after being transferred or discharged from your ED, can he or she successfully sue for malpractice? If so, would a jury agree that the ED was at fault? That depends, in large part, on the details contained in the patient's chart.

"If the examining physicians documented the patient's history and suicidal tendencies well, removed any potentially lethal objects, and made referrals to consulting physicians, all the better for defending the lawsuit," says **Robert D. Kreisman**, a medical malpractice attorney with Kreisman Law Offices in Chicago.

The medical chart will serve as the basis of the ED's defense, according to Kreisman, "and, as such, needs to document that the patient was medically stable at the time of discharge." He says that the ED chart should include these items:

- Evidence that the ED physicians, nurses, and clinicians were alert to the possibility of suicide attempts and carefully laid out the follow-up treatment plan.
- A detailed medical evaluation documenting the patient's subjective complaints and the physician's observations. "This can help support the ED's decision to discharge or transfer a psychiatric patient," says Kreisman.
- Resources for follow-up given to the patient, including telephone numbers for a suicide hotline, doctors, and therapists.
- Non-subjective reports, such as appropriate laboratory tests, radiology exams, or even a patient's vital signs. "These provide the hard evidence that can make or break a case where an underlying medical emergency had been missed," says Kreisman.

Risks Increasing

Eight percent of all ED visits in 2007 involved a mental health condition, according to the Agency for Healthcare Research and Quality's Nationwide Emergency Department Sample. "The number of psychiatric patients are increasing in the ED. This is a high-risk patient population," says **Mariann Cosby**, RN, principal of MFC Consulting, a Sacramento, CA-based legal nurse consulting firm.

Andrew Garlisi, MD, MPH, MBA, VAQSF, medical director for Geauga County EMS and codirector of University Hospitals Geauga Medical Center's Chest Pain Center in Chardon, OH, says that the "supply and demand imbalance" faced by EDs is increasing risks in this area.

"There is a growing and seemingly unlimited demand placed on the emergency teams, and a relative dearth of emergency department manpower and resources," says Garlisi. "Given this, it is no surprise that patients with certain psychiatric illnesses and emergencies may stress an already overburdened emergency system. They may fall through the proverbial ED cracks."

The biggest legal risks involving discharge of a psychiatric patient are anything that shows that the ED physician "knew, or should have known, that the patient was at risk," says **Gregory P. Moore**, MD, JD, an attending emergency medicine

physician at Madigan Army Medical Center in Tacoma, WA.

Moore says that a plaintiff's lawyer will look for "clear evidence of danger that was not acted upon by the physician. ED physicians are notoriously *not* experts at predicting violence."

Subtle Presentations

Cosby says to remember that only a small percentage of psychiatric patients present to the ED with *overt* signs and symptoms of emotional or behavioral disorders, such as attempted suicide.

"The majority present with other issues, such as alcohol abuse, depression, or anxiety," says Cosby. "To reduce liability risks, ED nurses should be aware of these *other* signs of a potential underlying psychiatric problem, and intervene appropriately."

If the patient is deemed to be suicidal or homicidal based on the screening, then a safe environment must be provided to ensure the safety of the patient, staff, and visitors.

"The nurse should err on the side of caution if there is any doubt, and perform the screening rather than not," says Cosby. "Using this methodology, the ED nurse's legal risks associated with these type of patients can be reduced."

Psychiatric patients "can and do present with a constellation of signs and symptoms," notes Garlisi. "These presentations can be flagrant, such as violent acute psychotic episodes, suicide attempts, hallucinations, or delusions, but they can be relatively subtle."

Examples are mental status change in an elderly patient, anxiety symptoms masked as a physical complaint, and patients with vague symptoms caused by depression. "One of the biggest challenges and risks to the emergency staff is the assessment, diagnosis, risk stratification, and disposition of the patient who may be suicidal," says Garlisi.

The suicidal patient also may have coexistent alcohol and/or drug intoxication, adds Garlisi, or may deny suicidal ideation or intent in order to gain the freedom to follow through on the suicide plan. "Document the patient's remarks, using quotes whenever appropriate," he advises. To reduce risks, consider these practices:

Take precautions to prevent the patient from harming self or others.

"Psychiatric patients should not be able to complete a suicide while on the hospital premises, especially when in an ED 'safe' room," says **Scott I. Palumbo**, a health care attorney with Palumbo Wolfe in Phoenix, AZ. "EDs should consider having a designated security officer to watch the patient." The room should have no windows, no curtains, no call light cord, no sharps in the room, no sheets, and no access to roof through air vents, says Palumbo.

Garlisi says these interventions may be needed:

- Close observation in a room designed for safety;
- Removal of clothing;
- Searching the patient for weapons or drugs;
- Notifying security and/or police officers for added protection;
- Sedation or physical restraints.

Perform a thorough medical screening examination to rule out coexisting traumatic and/or medical conditions.

"Beware of the intoxicated violent patient with head injury, or the inebriated patient with hypomagnesemia, hypoglycemia, or a mixed drug overdose," says Garlisi.

Educate staff on how to safely search and restrain a psychiatric patient.

"Many psychiatric patients are combative, or arrive with sharps on them," says Palumbo. "During these efforts, the staff is exposed to injury. This creates significant workers' compensation liability for the institutions."

Ensure proper credentialing of mental health providers.

An ED may not have an in-house or on-call psychiatrist who can evaluate the patients *and* prescribe medications, says Palumbo. Instead,

Sources

For more information, contact:

- **Mariann Cosby**, MFC Consulting, Sacramento, CA. E-mail: smfc@deepwell.com. Web: http://www.juris-pro.com/mem/MariannCosby.
- **Andrew Garlisi, MD, MPH, MBA, VAQSF**, University Hospitals Geauga Medical Center, Chardon, OH. Phone: (330) 656-9304. Fax: (330) 656-5901. E-mail: garlisi@adelphia.net
- **Robert D. Kreisman**, Kreisman Law Offices, Chicago, IL. Phone: (312) 346-0045. Fax: (312) 346-2380. E-mail: bob@robertkreisman.com. Web: www.robertkreisman.com
- **Gregory P. Moore, MD, JD**, Emergency Department, Madigan Army Medical Center, Tacoma, WA. E-mail: GMoore4408@aol.com.
- **Scott I. Palumbo**, Palumbo Wolfe, Phoenix, AZ. Phone: (602) 265-5777. Fax: (602) 265-7222. E-mail: spalumbo@PalumboWolfe.com. Web: www.palumbo-wolfe.com

some hospitals contract with the local Regional Behavioral Health Authority to have masters-level social workers and counselors evaluate patients.

"Many of these providers do not have experiences with danger-to-self or danger-to-others patients," says Palumbo. "Many do not know the variables involved in the 24- to 48-hour hold options, restraint options, ability to transfer, and involuntary admission."

They also cannot prescribe medications, so they have to work with ED doctors to medicate those patients requiring medication. "To avoid liability exposure when treating a psychiatric patient, it is critical that the facility have a properly credentialed mental health provider reasonably available at all times," says Palumbo.

What if Psych Patient Attempts to Leave AMA?

Delays make it more likely

Margaret Bergin, an attorney with Palumbo Wolfe in Phoenix, AZ, and a former hospital risk manager, says the longer the psychiatric patient is allowed to remain in an ED without mental evaluation, the higher the possibility that the patient will leave against medical advice (AMA).

"In some rural facilities it can take up to two hours to have a Mental Health Provider respond to a call for evaluation," says Bergin. "During that time, the patient may try to leave AMA. This presents a sticky situation for the ED facility and staff."

One problem is that ED physicians may not feel qualified to determine if a patient is a danger to self or others, unless the patient admits this is the case. Also, if there is a delay in getting the Mental Health Provider to the ED, the ability to hold a patient becomes more difficult. This can lead to violations of the Emergency Medical Treatment and Labor Act.

"A medical screening exam is not complete until a Mental Health Provider has evaluated the patient," warns Bergin.

If a psychiatric patient, deemed to be dangerous to self or others, elopes from the ED, all efforts must be made to find and return the patient to the ED for a complete evaluation, says **Andrew Garlisi**, MD, MPH, MBA, VAQSF, medical director for Geauga County EMS and codirector of University Hospitals Geauga Medical Center's Chest Pain Center in Chardon, OH.

"This includes notification of law enforcement officers," says Garlisi. "The ED is liable for consequences if the patient injures him or herself or others during the elopement time frame."

Can Patient Legally Be Held?

If ED physicians and staff aren't clear on when they can hold a psychiatric patient against their will and for how long, this poses legal risks.

"Many times, the ED staff has not witnessed the behavior that led to ED visit," says Bergin. "The patient won't talk, thereby requiring the ED staff to rely on third-party accounts from friends or family of what occurred."

The ED is then required to weigh the accounts and determine whether to hold or release the patient. "If the patient is released and is then successful at suicide or harming others, the facility and provider can be held liable for improper release," says Bergin.

Thus, it is important for the ED staff to be trained and educated regarding when, and for how long, a patient can be held against his will. ED staff should also document all efforts made to evaluate and treat the patient.

"Should a lawsuit ever arise, the records will be the best evidence to show that the treatment provided was reasonable under the circumstances," says Bergin.

To justify forced detention and psychiatric evaluation of the potentially suicidal patient, Garlisi says that the ED physician "must track down witnesses, relatives, police officers, or others to supply information."

In addition, the ED physician should be made aware of the arrival of a psychiatric patient right away. Failure to document the statements of witnesses as to the reason for forced detention could create legal complications for the ED if the patient sues for false imprisonment, explains Garlisi.

"Speak with the paramedics and police officers when they arrive with the patient, in order to establish the need for forced detention sooner rather than later," says Garlisi.

Have you heard statements made by police officers, emergency medical services personnel, witnesses, friends, and family members regarding the circumstances that resulted in the patient's ED visit? Carefully document these in the patient's medical record. "These statements by reliable witnesses can justify the physician's forced detention of a patient," Garlisi says.

5 Major Lawsuit Risks with Psych Patients

Leslie S. Zun, MD, chairman of the department of emergency medicine at Rosalind Franklin University of Medicine and Science in North Chicago, IL, says that if a patient discharged from the ED later commits suicide, "there are a number of issues that can place the emergency physician at risk." Zun gives these five major areas of risk involving ED psychiatric patients:

1. Consent for treatment.

"At times, these patients may need a mini-mental state examination, assessment of drug or alcohol impairment, or glucose check during the triage process," says Zun. "It is essential to err on the side of treatment of these patients."

Psychiatric patients may present to the ED but do not wish to be treated. "For some, this is part of their disease process," says Zun. "Implied consent is presumed until a complete evaluation is performed."

2. Medical problems.

An appropriate medical clearance process needs to be performed on all patients who present with psychiatric symptoms to ensure that medical problems are properly addressed.

"A history provides information on prior psychiatric illness, and a physical examination provides evidence of medical illness," says Zun. "A mental status examination determines consistency with medical or psychiatric disease and clinically directed laboratory testing looking for medical problems."

Zun notes that it is the obligation of the ED physician to determine whether the patient who presents with psychiatric symptoms has a medical problem that is causing or exacerbating his psychiatric presentation.

3. Suicide assessment.

"Emergency departments do a poor job assessing a patient's suicide risk unless the patient presents with a psychiatric illness," says Zun. "Many of these patients presenting with medical complaints have occult suicide ideation that is not identified unless a proper assessment of suicidality has been completed."

Collateral information from patients, friends, or others may assist in determining the suicide risk determination. "Just mentioning that they have thought about suicide is different than someone who has a plan and means to complete it," says Zun.

Like other medical complaints, the emergency physician must determine the patient's probability of suicide. "Use of suicide scales or assessment of suicidality based on certain risk factors will assist in this determination," says Zun.

4. Signing out against medical advice (AMA).

A mental status examination must be performed and documented prior to sending a patient out AMA, whether a psychiatric patient or otherwise, says Zun. "Just because a patient presents with a psychiatric complaint does not mean they do not have the capacity to understand the risks and benefits of treatment," he adds. "There is a liability risk in forcing treatment on competent patients, as well as letting patients leave AMA who are unable to make medical decisions."

5. Suicide contracts.

Some EDs have social workers or mental health personnel who evaluate patients. These individuals may develop a safety plan, including a contract not to commit suicide. Zun notes that a recent malpractice case involved an emergency physician sending a patient home with a suicide contract; the patient committed suicide a day after discharge. "Unless the patient is placed in a controlled, environment with close observation and known therapeutic alliance, I would recommend against using a contract," says Zun. "There is no way one can ensure that a patient will commit to such a contract."

Source

For more information, contact:

- **Leslie S. Zun, MD**, Chairman, Department of Emergency Medicine, Rosalind Franklin University of Medicine and Science, North Chicago, IL. Phone: (773) 257-6957. Fax: (773) 257-1770. E-mail: leslie.zun@sinai.org.

Do Others Say Patient Is Dangerous?

Take it seriously and track down witnesses

A 25-year-old male patient is brought to an ED because of suicidal statements made to his ex-wife. The patient arrives via police escort and is placed in a room. The ED nurse assesses the patient, who denies suicidal ideation or intent. Although the man admits to drinking alcohol, he does not appear to be overtly intoxicated and is coherent. The ED is extremely busy, and the physician assistant (PA) picks up the chart.

After the police officers leave, the patient tells the PA there was a "misunderstanding" and assures the PA that he is not suicidal. The PA briefly mentions the patient to the ED physician and orders a basic medical screening evaluation. The intent is to request a formal psychiatric assessment of the patient once he is "medically cleared."

Two hours later, the physician goes into the room to examine the patient, but the patient is gone. The PA and nurse inform the physician that the patient denied suicidal thoughts, and the physician dictates a note that the patient "did not appear to be actively suicidal and eloped from the department against medical advice."

Several hours later, toward the end of his shift, the ED receives a call from the paramedics who inform him that the patient, who had been in the department the same evening, shot and killed himself in the front lawn of his ex-wife's house. The patient's parents successfully sue the emergency department and hospital.

Andrew Garlisi, MD, MPH, MBA, VAQSF, medical director for Geauga County EMS and codirector of University Hospitals Geauga Medical Center's Chest Pain Center in Chardon, OH, says that the main lesson learned from this case is that it behooves the emergency physician to take the time to "track down" witnesses to the behaviors and statements made by the potentially suicidal patient *prior* to the ED presentation.

"Police officers and paramedics could be a valuable resource, either through personal observation, or as a lead to others who witnessed the patient's suicidal remarks or gestures," says Garlisi.

Garlisi acknowledges that this can be a time-consuming and often frustrating exercise for the ED physician. However, he says that these efforts often will yield the "evidence" necessary to justify forced detention of the patient. This eliminates the risk of elopement, and allows for medical and psychiatric evaluation and safe, appropriate disposition of the patient.

"Physician failure to perform this 'due diligence' in the assessment of a potentially suicidal patient leaves the door open for adverse clinical outcomes and medical-legal complications," warns Garlisi.

Mariann Cosby, RN, principal of MFC Consulting, a Sacramento, CA-based legal nurse consulting firm, was an expert witness on a case involving a patient transferred from an ED to an inpatient psychiatric facility. Although the patient was a suicidal risk and on a 5150 hold, he was cooperative in the ED and didn't appear to be acting out or volatile.

When he was placed in the ambulance for transfer to the inpatient mental health facility, the ambulance attendants did not restrain the patient's arms or legs. "The patient ended up escaping out the back of the ambulance while it was at a signal. The patient fled and ended up killing himself," says Cosby. "The lesson learned, of course, is that the ambulance staff should have restrained him."

ED staff should be sure to clearly convey and document the patient's status—a 5150 hold due to suicidal threats—to the transport staff.

Include Family Members

Andrew Slutkin, an attorney with Silverman Thompson Slutkin & White in Baltimore, MD, says that he has seen several "failure to prevent suicide" cases involving the ED. "In my cases, interviews with the family members who brought the patient into the ED would have revealed information that the patient did not disclose to the ED. This would have prevented the ED from discharging the patient," says Slutkin.

In one case, a young man had no history or mental illness, yet over a few days he became psychotic. He complained of people who were coming after him and trying to kill him, to the point where he said he wanted to kill himself. On admission to an ED, a psychiatrist evaluated him and recommended admission because of the suicidal

Source

For more information, contact:

- **Andrew G. Slutkin**, Silverman Thompson Slutkin & White, Baltimore, MD. Phone: (410) 385-2786. Fax: (410) 547-2432. E-mail: ASlutkin@MdAttorney.com. Web: www.MdAttorney.com

and paranoid thoughts. Lorazepam, a short-acting anti-anxiety drug, was prescribed.

After the patient calmed down, a psychologist interviewed him and recommended discharge because the boy told him that everything was fine and that he just wanted to go home.

"He killed himself the next afternoon by jumping off of a bridge. Our experts said he never should have been discharged," says Slutkin.

The experts stated that the medication calmed the patient down enough to tell the psychologist exactly what he wanted to hear—that everything was fine—when in fact nothing had changed since admission. Their position was that once the lorazepam wore off, the boy was going to be in exactly the same position as when admitted to the ED.

The failure of the psychologist to consider that the short-acting lorazepam was not going to change things and cure a psychosis was a very important factor in the case.

"Also, the psychologist effectively overruled the psychiatrist, which we said should not occur," says Slutkin. "If the psychologist had talked to the family members present, he would have learned that they had watched him severely deteriorate into paranoid delusions over a few days, such that no reasonable person would have sent this kid home."

Slutkin adds that he isn't sure that an ED's documentation stating that the patient is not a suicide threat really matters, if in fact the patient really is a continuing threat. "In this case, they said he wasn't a threat, but the facts and circumstances indicated otherwise," he says.

Clinical Pitfalls

Testicular Torsion Pitfalls and Challenges

By Larry Mellick, MD, MS, FAAP, FACEP,
Editor-in-Chief;
Professor of Emergency Medicine and Pediatrics,
Medical College of Georgia, Augusta

A common diagnostic dilemma for emergency medicine physicians is the patient who presents with a painful testicle. Frequently, the presentations of the various conditions that cause scrotal pain and most frequently testicular torsion fail to "conform to the accepted clinical picture."[1] Accurately sorting through the various conditions that can cause a painful testicle can be challenging. In fact, experts admit that their initial clinical impressions frequently are flawed.[1,2,3] Even authors who continue to express confidence in the physical examination report a significant number of patients with misdiagnoses of their testicular torsion (12.5%).[4]

Conditions that commonly present as a painful testicle range from kidney stone pain referred to the scrotum to a testicular torsion. Various diagnostic tools and modalities, including physical examination, doppler ultrasound, nuclear scintigraphy, and surgical exploration, are available to assist with sorting through the diagnostic possibilities.

The most time-limited diagnosis is testicular torsion, which is the twisting of the spermatic cord with subsequent loss of blood flow to the testis as well as impaired venous drainage. Unless the condition is recognized and managed in a timely manner, the resulting edema and ischemia eventually end in testicular necrosis.

Although the timely and accurate diagnosis of testicular cancer or epididymitis is clinically important, torsion of the testicle is the condition that presents with the clock ticking. In fact, the phrase "time is testicle" is commonly used. The failure to diagnose testicular torsion in a timely manner results in significant morbidity to the patient and generally includes loss of the endangered testicle. In adolescent males 12 to 17 years of age, testicular torsion is the third most common cause of a malpractice lawsuit.[5]

Difficulties Diagnosing Testicular Torsion

So, just how reliable is the physical examination in the diagnosis? The answer is that it is not reliable. The overlap of physical findings between testicular torsion and epididymitis, the condition most commonly mistakenly confused for torsion, is impressive. Although clinically it may be possible to make the diagnosis of torsion or epididymitis without an ultrasound or a nuclear scan, the health care provider needs to understand that a gamble is being taken. The stakes are high; and unfortunately, when the clinician is wrong, both the patient and the physician can lose big.

Although the onset of pain in testicular torsion frequently is sudden, it can be more gradual in nature and suggestive of epididymitis.[1] In one series, although 90.7% of testicular torsion patients had a sudden onset, almost 60% of epididymitis patients also reported a rapid onset.[6]

The loss of the cremasteric reflex is commonly

described with testicular torsion. Nevertheless, it remains present in a significant number of patients and cannot be relied upon to rule out torsion of the testicle. Van Glabeke et al reported that 40% (10 of 25) of testicular torsion patients demonstrated a persistence of the cremasteric reflex.[6] Murphy et al reported a normal cremasteric reflex present in three of the eight patients requiring orchiectomy due to necrotic testicles.[2] In a published abstract, Paul et al reported that the cremasteric reflex was present in 12% of their small series of 17 testicular torsion patients; and these authors described the cremasteric reflex as "suboptimal" in diagnosing testicular torsion.[7] In a moderately sized series reported by Ciftci et al, the cremasteric reflex was reported as present in 8% of patients with testicular torsion.[8] Eaton et al described a series of patients with intermittent torsion in which the cremasteric reflex was present in 20% (3 of 15) of patients.[9] Karmazyn reported that 10% of their series of 31 patients with testicular torsion had a cremasteric reflex.[10]

Pain around the upper pole of the testicle or epididymis is thought to be consistent with epididymitis, but it also occurs with torsion. In a review of 543 surgical explorations of children and adolescents, Van Glabeke et al reported the pain was restricted to the upper pole of the testis in 40.8% of patients with torsion of the testicular appendage and almost 18.7% of patients with testicular torsion.[6] The epididymis also can be enlarged on ultrasound in patients with testicular torsion. Karmazyn et al reported that 43% of the children with testicular torsion had a swollen epididymis as compared to 77% of the children with epididymitis and torsion of the testicular appendix.[10]

Scrotal edema and testicular swelling are common in torsion of the testicle, appendix of the testicle, and in patients with epididymitis.[1,4,6,11]

Nausea and vomiting occur more frequently with torsion of the testicle. However, the signs and symptoms often are not reported and they also can occur with epididymitis.[4] Sessions et al reported nausea and vomiting in only 60% (90 of 150) patients with testicular torsion.[12] Lyonis et al reported nausea and vomiting in 62.8% of patients with testicular torsion and 12.9% of patients with epididymo-orchitis.[11]

Although the lie of the testicle in torsion is frequently transverse, a vertical orientation is also common. In a small series by Kadish et al, a normal lie was described in 54% of the testicular torsion patients.[3] Ciftci et al found 17% of patients with testicular torsion had a normal or vertical orientation of the testicle.[8] Eaton et al reported a horizontal lie in 46% of their patients with intermittent testicular torsion.[9] Murphy et al described an abnormal position of the torted testicle in 52% of their 31 patients with testicular torsion.[2] In that series, abnormal testicular position was reported as a horizontal lie in 26% of those patients.[2] Karmazyn et al reported an "abnormal orientation" in 21 of 41 patients with testicular torsion.[10]

Complications and Testicular Survival

Just as with the reliability of the physical examination, testicular survival is an issue more complicated than what frequently is stated. It is commonly taught that the torted testicle has six hours before becoming nonviable. Although there have been dead testicles noted at surgery or atrophy at follow-up when symptoms have been present for fewer than six hours,[2,12] many papers and series in the literature describe longer time periods after which significant percentages of testicles have gone on to survival.[2,4,11-18] Significant numbers of reports describe survival up to 12 to 24 hours.

Bayne et al reported that mean pain symptom duration in boys who were transferred but subsequently did not undergo orchiectomy (loss of the testicle) was 9.8 hours. The mathematical mean would represent that many of their patients with surviving testicles were beyond that timeframe.[17] Lyronis et al reported that the mean duration of pain at presentation was 11.4 hours, when the testis was salvaged by detorsion.[11]

There are even reports of survival beyond 24 hours. In an earlier report by Klingerman et al, the longest interval to survival was 48 hours.[14] In the series reported by Cavusoglu, the mean duration of pain at presentation was 1.35 days (range 12 hours to 3 days) when the testis was salvaged by detorsion.[18] In the series of 200 patients reported by Sessions et al, symptom duration before presentation for evaluation was 0.5 hours to 6 days (median 5 hours) in all orchiopexy cases or surviving testicles.[12] In the small series by Arce et al, the testicles of all six patients survived and one patient had a torsion of 540 degrees for 18 hours and another 360 degrees for 12-14 hours.[15] Hegarty et al described a small series of 33 patients with testicular torsion. [16] Six patients with pain for more than 24 hours had viable testes; 2 patients had subsequent testicular atrophy.[16]

And while the degrees of torsion matter, survival is documented to have occurred in patients with up to 1,080 degrees of torsion.[12] In that light, there must be other factors, such as thickness of

the cord and tightness of the twist, that contribute to the prolonged survival or quick demise of a testicle. Bentley et al described a series of patients with spermatic cord torsion and preserved testis perfusion. In their small series of 4 patients who presented with testicular torsion and preserved perfusion, the testicles were torsed 180, 360, 540, and 720 degrees.[19] Karmazyn reported normal flow on ultrasound in 10 of 41 patients with torsion and in 3 of these patients the spermatic cord was twisted from 540 to 1,440 degrees.[10] The preserved perfusion explains one reason why doppler ultrasound sometimes can be misleading and clinicians still must rely on their clinical instinct when all signs and symptoms otherwise point toward a testicular torsion. The authors conclude that the "diagnosis of testicular torsion remains a complex, often confusing challenge to the clinician."[10]

There are two important take-home lessons regarding the diagnosis and management of testicular torsions. The first is that "an absolute dependence on symptoms and signs will lead to testicular torsion being misdiagnosed."[2] The second lesson is that emergency physicians cannot and should not write off testicles as unsalvageable that present after six or more hours from onset of symptoms.

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CNE/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. ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

CNE/CME QUESTIONS

14. Which is helpful for the ED's defense in the event of a malpractice lawsuit filed by a psychiatric patient?
    A. No mention in the chart that the ED physicians or nurses were alert to the possibility of suicide attempts.
    B. A detailed medical evaluation documenting the patient's subjective complaints and physician's observations, to support the ED's decision to discharge or transfer a psychiatric patient.
    C. Avoiding written documentation of telephone numbers for suicide hotlines that were given to the patient.
    D. The absence of non-subjective reports, such as appropriate laboratory tests, radiology exams, or a patient's vital signs.
15. Which of the following will be helpful for a plaintiff's attorney suing an ED physician for malpractice regarding care of a psychiatric patient?
    A. The patient's family, emergency medical services, or nurses raise concerns that the ED physician doesn't fully explore.
    B. The ED physician wrongly believes there is no risk.
    C. The ED physician was aware of the risk, but discharges the patient without specialist evaluation.
    D. All of the above.
16. Which is true regarding liability risks of psychiatric patients in the ED?
    A. The majority of psychiatric patients present to the ED with overt signs and symptoms of emotional or behavioral disorders (e.g., attempted suicide).
    B. Only a small minority of suicidal patients present with alcohol abuse, depression or anxiety.
    C. ED nurses should not perform an emotional/behavioral screening unless a patient clearly states the intent to self-harm.
    D. The ED nurse should err on the side of caution if there is any doubt, and perform an emotional/behavioral screening rather than not.
17. Which practice is recommended to reduce legal risks of psychiatric patients seen in EDs?
    A. Do not put the patient's remarks in quotations.
    B. Have a proper credentialed mental health provider reasonably available at all times..
    C. Do not perform a mental status examination prior to sending a psychiatric patient out against medical advice, as he or she does not have the capacity to understand the risks and benefits of treatment
    D. Avoid documenting information given by witnesses to the behaviors and statements made by a potentially suicidal patient prior to ED presentation..

Answers: 14. B, 15. D, 16. D, 17. B.