ED Legal Letter™

The Essential Resource for Emergency Medicine Malpractice Prevention and Risk Management

From the publishers of *Emergency Medicine Reports* and *ED Management*

AHC Media

Get Free Salary/Career Guide by Filling Out *ED Legal Letter* Survey

This year, we're going digital with our annual *ED Legal Letter* reader survey — and giving away a free publication to subscribers who take it. To participate, go to the Web address at the bottom of this message and enter your responses. When you're done, you'll receive a PDF of our new 57-page publication, *2012 Healthcare Salary Survey & Career Guide*.

Thanks in advance for sharing your thoughts about *ED Legal Letter* and how we might better meet your needs as a subscriber.

Here's the Web address for the survey: https://www.surveymonkey.com/s/EDLsurvey2013

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), Director and Professor, Center for Bioethics and Medical Humanities, Institute for Health and Society, Medical College of Wisconsin, Milwaukee, WI; Robert A. Bitterman, MD, JD, FACEP (Writer); Stacey Kusterbeck (Contributing Editor); Shelly Morrow Mark (Executive Editor); and Leslie Hamlin (Managing Editor). Kay Ball RN, PhD, CNOR, FAAN, Consultant/ Educator, K&D Medical Inc., Lewis Center, OH (Nurse Planner) is a speaker for AORN and a stockholder for STERIS, Inc.

July 2013
Vol. 24 • No. 7 • Pages 73-84

The Federal Government Blocks South Carolina Hospitals from Posting 'Pain Management Signs' in their Emergency Departments

By Robert A. Bitterman, MD, JD, FACEP, President & CEO, Bitterman Health Law Consulting Group, Inc., Harbor Springs, Michigan
Contributing Editor

All across the country, states, hospital associations, communities, and emergency departments (EDs) are attempting to deal with the growing incidence of prescription pain medication abuse, overdoses, and deaths.[1] Opioid pain medications now kill more Americans than cocaine and heroin combined, and over the past five years, there have been more drug-induced deaths than motor vehicle accident deaths.[2]

Mayor Michael Bloomberg and the city of New York just announced to much fanfare new opiate prescription limits on the city's public emergency departments.[3,4] The U.S. Food and Drug Administration has also recently moved to tighten controls on narcotics, and almost all states have prescription drug-monitoring database programs in place or in various phases of development and implementation.[5]

As part of their opioid prescription initiatives, states such as Washington, Oregon, Colorado, and Ohio developed and displayed posters in their emergency departments to "educate" patients regarding the ED's restrictions concerning opioid administration in the ED or in providing pain prescriptions via the emergency physicians. In Washington, which has been a leader in addressing prescription drug issues, the state chapter of The American College of Emergency Physicians (ACEP) believes strongly that the posters have been instrumental in reducing prescription opioid overdoses over the past three years.[6]

In South Carolina, however, the state hospital association (SCHA) sought prior approval of its proposed "Prescribing Pain Medication in the Emergency Department" signage from the Atlanta Regional Office of

The Centers for Medicare and Medicaid Services (CMS) out of concern that the sign could be viewed as violation of federal law, The Emergency Medical Treatment and Labor Act, EMTALA. (*See Table 1.*)

Opinion of CMS

CMS responded first by citing the statutory definition of an emergency medical condition (EMC) under EMTALA,[7] implying that "severe pain" is an emergency as defined by the law:

"The term 'emergency medical condition' means … a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) … etc."[8]

However, "severe pain" alone is not sufficient to be an EMC.[9] CMS left off the last part of the EMTALA definition of an EMC, which states, "[severe pain] such that the absence of immediate medical attention" could reasonably be expected to result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.[10]

For example, the chronic back pain patient with "severe pain" that's a 12 out of a possible 10 does not have an EMC if he does not need immediate medical attention for an aortic aneurysm that's ruptured, an epidural abscess, a herniated disc that's producing serious neurological loss, or some other true EMC. No matter how "severe" the back pain, if it is not a manifestation of serious disease, the patient does not have an EMC as defined by EMTALA.[11] But the only way to know if the chronic back pain patient has an EMC is for the ED to put the patient through its usual medical screening examination (MSE) process; that's the whole purpose of EMTALA's mandated MSE — to determine if the patient's presenting medical complaint, in this case back pain, is an EMC.

Therefore, all patients requesting pain medications for acute exacerbations of chronic pain syndromes, such as herniated disks, fibromyalgia, trigeminal neuralgia, or migraine headaches, must be examined — provided a medical screening exam — to determine if their pain is indicative of an EMC. Furthermore, the MSE must be provided no matter how well the "frequent flyer" patient is known to the ED, and even if the patient had just left the ED a few hours ago.

CMS then noted that hospitals may not "unduly discourage" individuals from remaining in the ED to receive an MSE and stabilizing treatment for EMCs, as is their federal right under EMTALA.[7] Furthermore, CMS stated that "patients may leave the ED of their own free will, but they should not leave based on a 'suggestion' by the hospital or through coercion."[7]

Consequently, the Atlanta Regional Office of CMS opined that the language proposed by the SCHA for its pain management sign, and any similar language the hospital might choose to post in patient waiting rooms or treatment rooms, "might 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." CMS added that "Our concern is that some patients with legitimate medical needs and

ED Legal Letter™, ISSN 1087-7347, is published monthly by AHC Media, 3525 Piedmont Road N.E., Bldg. 6, Suite 400, Atlanta, GA 30305. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ED Legal Letter, P.O. Box 105109, Atlanta, GA 30348.

Subscriber Information: Customer Service: (800) 688-2421. Customer Service E-Mail Address: customerservice@ahcmedia.com. Editorial E-Mail Address: leslie.hamlin@ahcmedia.com. World Wide Web: http://www.ahcmedia.com. Subscription Prices: United States: $499 per year. Add $17.95 for shipping & handling. Multiple Copies: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Canada: $529 per year plus GST. Elsewhere: $529 per year. Back issues: $83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date. GST Registration Number: R128870672.

AHC Media is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media designates this enduring material for a maximum of 18 *AMA PRA Category 1 Credits*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for a maximum of 18.00 hour(s) of ACEP Category I credit.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

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

AHC Media

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

Table 1: The Proposed ED "Pain Management Sign" Submitted by the SCHA to CMS[7]

Prescribing Pain Medication in the ED

Our emergency department staff understands that pain relief is important when one is hurt or needs emergency care. However, providing pain relief is often a complex issue, especially when pain is a chronic or recurrent process. Mistakes or misuses of pain medication can cause serious health problems and even death. Our emergency department will only provide pain relief options that are safe and appropriate.

The primary role of the Emergency Medicine provider is to look for and treat an emergency medical condition. We will use our best medical judgment when treating pain, following all legal and ethical guidelines.

- You may be asked about a history of pain medication use, misuse, or substance abuse before prescribing any pain medication.
- We may ask you to show a photo ID, such as a driver's license, when you check into the emergency department or receive a prescription for pain medications. We may also research the statewide prescription database regarding your prescription drug use.
- We may only provide enough pain medication to last until you can contact your doctor. We will prescribe pain medications with a lower risk of addiction and/or overdose when possible.

For your safety, we do not:

- Give pain medication shots for sudden increases in chronic pain, or aggravation of chronic pain syndromes.
- Refill lost or stolen prescriptions for medications. You must obtain refill prescriptions from your primary care provider or pain clinician.
- Prescribe missed methadone doses, or provide prescription refills for chronic pain management.
- Prescribe long-acting pain medications, such as OxyContin, MSContin, fentanyl patches, or methadone for chronic, non-cancer pain.
- Prescribe pain medications if you already receive pain medication from another doctor or emergency department.

legitimate need for pain control would be unduly coerced to leave the ED before receiving an appropriate medical screening exam."[7]

CMS went on to say that the issues raised in the proposed sign are important and appropriate points for discussion between the patient and the emergency physician, but "they should be discussed in the context of an appropriate medical screening exam rather than posted in the ED before patients are provided an appropriate medical screening exam. Blanket statements or protocols should not supersede professional medical judgment in individual cases."[7]

Comment

The response from the chief medical officer of the Atlanta regional office is consistent with CMS' long-standing position that any action or sign that discourages a patient from completing the medical screening process is a violation of EMTALA. There is no question that the intent of these signs, at least in part, and particularly for the earlier drafts that include the South Carolina proposal, is to encourage a select patient population to leave the ED.

Photo ID

It is a near certainty that CMS would consider the requirement that patients produce a photo ID prior to receiving narcotics in the ED or via a prescription to "unduly discourage" particular individuals, such as undocumented immigrants, other non-citizens, or just anyone without a photo ID — all of whom have a "federal right" to an MSE under EMTALA — from staying in the ED for the medical screening.

Query to a State Prescription Database or 'Checking the Patient's Drug History'

During triage, can the triage nurse or a hospital case manager inform patients that they have X number of ED visits this year and they are being monitored by a statewide ED visit management system? Can the sign posted in the ED state that "before prescribing a narcotic, we will check the state database that tracks your narcotic or other controlled substance prescriptions," or "ask that you give a urine sample before prescribing narcotic pain medication?" (These statements are present, for example, on Ohio's ED pain management

Table 2: An EMTALA-compliant "Prescribing Pain Medication in the ED" Sign[13]

Our emergency department staff understands that pain relief is important when someone is hurt or needs emergency care. However, providing pain relief is often complex. Mistakes or misuse of pain medication can cause serious health problems and are a major cause of accidental death. Our emergency department strives to provide pain relief options that are safe and appropriate.

Our main job is to look for and treat an emergency medical condition. We use our best judgment when treating pain, and follow all legal and ethical guidelines.

For your safety, we:
- Avoid giving pain medication shots for sudden increases in chronic pain.
- May not refill stolen or lost prescriptions for medication.
- Do not prescribe missed methadone doses or long-acting pain medication that has a high risk of addiction or overdose.
- Review your health and prescription history to determine the best approach to managing your pain.
- Prescribe pain medication with the lowest risk of addiction or overdose, and for no longer than necessary.
- Take into consideration whether you already receive pain medication from another health care provider or emergency department, and whether you have a doctor who can follow up on your condition.
- Will help you find treatment for any pain or medication problems that you may have.

sign.) Of course not, and this may surprise many emergency departments! Only after the MSE has been completed and no emergency identified can this type of information be given to the patient. Such language will certainly "unduly discourage" a patient from staying in the ED to receive the MSE.[12] Obviously, the hospital's intent in providing this information, at least in part, is to discourage the patient from being seen in the ED in the first place. Moreover, from a medical or patient safety perspective, how can the ED be sure that the patient doesn't have a real EMC at this moment in time without conducting a proper medical examination? Even individuals who cry wolf experience a life-threatening event eventually.

Similarly, language on the sign such as "We may ask you about a history of pain medication misuse or substance abuse before prescribing any pain medication" can be viewed as stigmatizing and discouraging patients from staying for the MSE if they know they are going to be grilled about their drug habits. CMS considers patients with substance abuse problems to be a "protected class" under EMTALA (i.e., more likely to be discriminated against by the ED). Note that it's perfectly appropriate to conduct this type of questioning, but it should be done *after* the MSE, not before.

Contacting the Patient's Physician

Can a chronic pain patient be told in advance of the MSE by the emergency department that their regular doctor has left instructions with the ED not to use opioids? Can the posted ED sign state, "We will not prescribe narcotic pain medicine if we cannot talk directly with your primary care provider?" (For example, this is what Ohio's ED pain management sign says.) No, it cannot, for the same reasons noted above.

Drafting an EMTALA-compliant Pain Management Sign for the ED

If a hospital wants to post pain signs in its ED, the language of the sign must be crafted in a manner that does not appear to imply that services will be denied, that the patient's pain may not be treated, or in any way intimidate or "discourage" patients with painful conditions from staying in the ED to receive their "federal right" to an MSE. The language should be couched in terms of patient safety, and when read in total confers the impression that the ED is indeed acting in the patient's best interest.

A sign believed to be compliant with EMTALA (in the author's opinion) is provided in Table 2.

However, it may be hard to convince CMS that there is no intent to discourage, at least to some degree, particular patients from seeking examination or treatment in the ED when posting such signs.

Recommendation

Even if a posted sign would survive EMTALA scrutiny, the prescription drug issues would be better addressed to the general populace through

community outreach, web sites, and in other educational literature, as well as with the individual patient during the interaction with the physician or on their way out of the ED, instead of potentially deprecating language found on the walls in the ED entry areas.

The wisest course is to create, implement, and follow sound department-wide drug-use policies, rather than post signs. For example, some hospitals years ago quietly adopted policies whereby the emergency physicians would never write prescriptions for methadone or replace lost or stolen pain prescriptions. It only took a few weeks for the methadone seekers to cease coming entirely, and the "lost prescription" crowd nearly disappeared, too. The grapevine will disseminate the ED's drug policies fast enough.

Another advantage of having a written departmental policy is that the emergency physician has something to refer to as coming from "a higher power," stating that "no opioids will be prescribed for x, y, or z conditions," which allows the physician to demonstrate that he or she is not being arbitrary or discriminatory to that individual patient.

Dealing with chronic pain patients or drug-seeking patients is always difficult. To help hospital emergency departments deal with the issue, a number of states convened emergency provider workgroups to establish opioid management protocols for the emergency department. For example, see the Washington State ACEP Chapter/Washington State Department of Health opioid prescribing guidelines, available at www.washingtonacep.org/painmedication.html. ■

REFERENCES

1. For example, see the Washington State ACEP Chapter/Washington State Department of Health opioid prescribing guidelines at www.washingtonacep.org/painmedication.html.
2. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2012). Results of the 2011 National Survey on Drug Use and Health: Summary of National Findings. HHS Publication No. (SMA) 12-4713. Rockville, MD.
3. Huffman A. Controlling opioid abuse in the emergency department: Legitimate public policy or 'legislative medicine'? *Ann Emerg Med.* 2013;61:13A-15A.
4. The New York City Department of Health and Mental Hygiene issued guidelines January 2013 for opioid analgesic prescribing to patients discharged from the ED. (http://on.nyc.gov/YZVuhf)
5. According to the White House National Drug Control Policy web site: http://www.whitehouse.gov/ondcp/2013-national-drug-control-strategy.
6. Personal communication with Washington ACEP Chapter leaders.
7. February 6, 2013 letter from Dr. Richard E. Wild, Chief Medical Officer for the CMS Atlanta Regional Office, to Diane Paschal, Director of Corporate Compliance, South Carolina Hospital Association. ("CMS Letter")
8. CMS Letter, citing 42 USC 1395dd(e)(1).
9. Bitterman RA. Is 'severe pain' an emergency medical condition under EMTALA? *ACEP News* 2013;32(4):17-18.
10. 42 USC 1395dd(e); 42 CFR §489.24(b). Emphasis added.
11. The courts have interpreted the "serious bad things happening to patient" phrasing in EMTALA to mean "imminent danger of death or serious disability" or "imminent danger of death or a worsening condition that could be life threatening." E.g., *Thornton v SW Detroit Hospital*, 895 F2d 1131 (6th Cir 1990), or *Camp v Harris Methodist Fort Worth Hospital*, 983 SW2d 876 (Tex App. 1998).
12. 42 CFR §489.24(d)(4)(iv); CMS Interpretive Guidelines §489.24(d)(4)(iv).
13. With assistance, credit, and thanks to the Washington Chapter of ACEP.

Nine Percent to 30% of Strokes Misdiagnosed in ED

However, dizziness less associated with med/mal suits

Diagnostic errors are the most common, most costly, and most deadly medical errors, according to a recent analysis of 25 years of malpractice payouts from the National Practitioner Data Bank.[1]

Missed strokes and related neurological conditions account for many cases of diagnostic error resulting in serious, permanent disability.[1] Patients presenting to an ED with stroke have about a 9% risk that the stroke will be misdiagnosed, compared to less than 2% for patients with heart attacks.[2]

However, the risk of missed stroke varies widely depending on the patient's initial manifestations; the risk increases to more than 30% if the patient's presenting symptom is dizziness or vertigo.[1]

"Dizziness, though a very common symptom, is very frequently misdiagnosed," says **David E.**

Newman-Toker, MD, PhD, the study's senior author and associate professor in the Department of Neurology at Johns Hopkins Hospital in Baltimore, MD. "Strokes causing dizziness look a lot like inner ear conditions causing dizziness if you don't know what to look for."

The ED is the highest-risk site for liability claims related to diagnosis, he adds, because the level of illness severity and complexity is as high as any other practice setting, but the timeframe to make a diagnosis is much shorter.

"The ED is probably the toughest place to practice medicine in general because of the high variability of illness manifestations, wide range in illness severity, and heavy patient volume," he underscores.

Dizziness is among the most common complaints in the ED.[3] When The Ottawa Hospital Research Institute surveyed emergency physicians (EPs) about which clinical decision rule they needed most for adults, the number one answer was when to obtain neuroimaging in patients with dizziness or vertigo to exclude stroke.[4]

"There are four million ED visits for dizziness every year, and we know that clinical practice is not well-aligned with the evidence," says Newman-Toker. The cases that do end up as lawsuits typically involve very obvious presentations in which the patient presents with additional signs and symptoms, he says. One such case involving a former basketball player who left the ED with neurological complications after a stroke was misdiagnosed as a sinus infection resulted in a $217 million jury verdict.[5]

"Ironically, dizziness is probably less often associated with malpractice suits because the standard of care is so low," he says. "It's more often that suits are brought for headache misdiagnosis because the standard of care is higher."

Nearly one in four ED patients with dizziness leave with no diagnoses, notes Newman-Toker, and many diagnoses given aren't correct. In one study, he and colleagues found that more than 80% of ED patients said to have specific benign inner ear conditions causing dizziness were given an incorrect diagnosis.[6]

Newman-Toker says that ED physicians often focus on the *type* of dizziness — spinning, fainting, or wobbling — but should instead be focused on whether the dizziness comes in spells and is triggered by particular movements.

"This leads them down a faulty line of diagnostic reasoning that often ends in misdiagnosis and incorrect treatment," he says. If the patient complains of vertigo, the EP is likely to diagnose an inner ear condition and give the patient a medicine to suppress the symptoms, rather than treat the underlying cause.[7]

"When a patient is older or has vascular risk factors, ED physicians often rely on CT scans of the head to look for stroke," he says. "Unfortunately, these scans miss more than 80% of new strokes, and almost all of the new strokes are in the part of the brain that controls balance and present with dizziness."

More than 40% of all ED patients with dizziness now get CT scans, but most of this imaging is not indicated, adds Newman-Toker. "The test is costly, it exposes the patient to radiation that risks causing cancer, and a normal scan can end up being falsely reassuring that a stroke has been 'ruled out,'" he says.

William J. Meurer, MD, assistant professor of emergency medicine at University of Michigan Health System in Ann Arbor says these practices can help to prevent stroke misdiagnosis in cases of dizziness:

• EPs should check and document visual fields along with coordination and gait testing.

"These additional examination pieces are quite helpful in preventing misdiagnosis in the case of the isolated dizziness presentation," he says.

EPs should be very cautious when assigning a diagnosis of benign paroxysmal positional vertigo, unless there are objective exam findings such as nystagmus patterns or a positive Dix-Hallpike test that are consistent with those diagnoses.

• EPs should document evidence that supports a peripheral cause for the patient's symptoms.

For instance, the EP's documentation of "horizontal nystagmus only, completely normal neuro examination otherwise," can be helpful if someone else is looking at the chart later after a bad outcome.

• EPs should not rely on CT scanning to exclude brainstem or cerebellar strokes.

"CT is also relatively inaccurate when obtained early, and in many cases won't give a clear answer regarding small lacunar stroke anyway," Meurer says.

"EKG for dizziness"

Newman-Toker and colleagues have developed a new approach to prevent stroke misdiagnosis in

patients with dizziness or vertigo. This approach relies on experts examining eye movement physiology at the bedside to differentiate inner ear causes from brain causes of dizziness.

They have shown that this approach picks up more than 99% of all strokes causing dizziness, and is far more accurate than other methods, including what is currently considered the "gold standard" test, brain magnetic resonance imaging.[8]

Recently, their team has shown that a new device measuring these same eye movements could help non-specialists do the same. The device, recently approved by the Food and Drug Administration, perfectly discriminated between strokes and inner ear disorders, according to a small study led by Newman-Toker.[9]

Newman-Toker believes this approach will soon transform clinical practice in the evaluation of patients with dizziness.

"It still requires some expertise, but we hope this will soon become the EKG for dizziness," he says. "In the next couple of years, it will become standard practice in EDs, and will knock out a huge number of these diagnostic errors." ■

REFERENCES

1. Saber Tehrani AS, Lee H, Mathews SC, et al. 25-year summary of US malpractice claims for diagnostic errors 1986-2010: An analysis from the National Practitioner Data Bank. *BMJ Qual Saf*. 2013 Apr 22. [Epub ahead of print]
2. Newman-Toker DE, Robinson KA, Edlow JA. Frontline misdiagnosis of cerebrovascular events in the era of modern neuroimaging: A systematic review [abstract]. *Ann Neurol*. 2008;64(Suppl 12):S17-S18.
3. Tarnutzer AA, Berkowitz AL, Robinson KA, et al. Does my dizzy patient have a stroke? A systematic review of bedside diagnosis in acute vestibular syndrome. *CMAJ*. 2011;183(9):E571-E592.
4. Eagles D, Stiell IG, Clement CM, et al. International survey of emergency physicians' priorities for clinical decision rules. *Acad Emerg Med*. 2008;15(2):177-182.
5. Associated Press. $217 million awarded in malpractice case: A misdiagnosed Tampa man was left brain-damaged and disabled. *Florida Times Union* 2006.
6. Kerber KA, Morgenstern LB, Meurer WJ, et al. Nystagmus assessments documented by emergency physicians in acute dizziness presentations: A target for decision support? *Acad Emerg Med*. 2011;18(6):619-626.
7. Newman-Toker DE, Camargo CA, Jr, Hsieh YH, et al. Disconnect between charted vestibular diagnoses and emergency department management decisions: A cross-sectional analysis from a nationally representative sample. *Acad Emerg Med*. 2009;16(10):970-977.
8. Newman-Toker DE, Kerber KA, Hsieh YH, et al. HINTS outperforms ABCD2 to screen for stroke in acute continuous vertigo and dizziness (in press). *Acad Emerg Med*. 2013.
9. Newman-Toker DE, Saber Tehrani AS, Mantokoudis G, et al. Quantitative video-oculography to help diagnose stroke in acute vertigo and dizziness: Toward an ECG for the eyes. *Stroke* 2013;44(4):1158-1161.

Sources

For more information, contact:

- William J. Meurer, MD, Assistant Professor, Emergency Medicine, University of Michigan Health System, Ann Arbor. Phone: (734) 615-2766. E-mail: wmeurer@medi.umich.edu.
- David E. Newman-Toker, MD, PhD, Associate Professor, Department of Neurology, Johns Hopkins Hospital, Baltimore, MD. Phone: (410) 502-6270. E-mail: toker@jhu.edu.

Restraining Violent Patient? Consider Malpractice Risks

Too often, ED staff don't report violence due to onerous reporting processes, according to **Terry Kowalenko**, MD, clinical associate professor in the Department of Emergency Medicine at University of Michigan Health System in Ann Arbor. Research suggests that violent incidents occurring in EDs are far more frequent than statistics reveal.[1-3]

"Clearly, this is a big problem, and it is probably much bigger than we know," says Kowalenko. He recommends that EDs make reporting processes quick and easy to get as much information as possible about when and how incidents are occurring.

"If you really get the numbers on who are the victims and perpetrators in your ED, then you can tailor an intervention that is aimed at controlling that," says Kowalenko. For instance, the researchers were surprised to learn that physical assaults by ED patients were perpetrated roughly equally by men and women.

"It stands to reason that if you have a violent patient, it increases risks of injury to not only the workers but also the person themselves — and as a result, there could be some liability risks involved," says Kowalenko.

Restrained ED patients pose significant malpractice risks for emergency physicians (EPs), however. "Once the patient does go into restraint, there are several potential allegations that EDs should be aware of and be cautious about, from a risk perspective," says **Karyn Finneron,** RN, BSN, MA, BC-HN, senior risk management representative for Boston, MA-based Coverys, a provider of medical professional liability insurance.

Here are some allegations against EPs involving restrained patients that Finneron has seen:

• Lack of informed consent.

An agitated patient might have consented for treatment with certain drugs or dosages, but has escalated to the point at which the patient is a danger to him- or herself or others.

The drugs used for escalating behavior may be in the same class of drugs the patient is presently taking, but a higher dose may be prescribed to treat the patient in an emergent situation, adds Finneron.

"An emergent situation can circumvent the patient's right to consent," she says. "Once the patient is more manageable and the crisis has passed, the patient must be offered the opportunity to consent to the drugs or refuse them."

• Lack of appropriate monitoring.

"Some of the elements of how much checking on the patient is required are dictated by state statute," says Finneron. When safety checks regarding the patient are made, the EP needs to consider what is required by regulatory and accrediting bodies such as the Centers for Medicare & Medicaid Services, The Joint Commission, and/or state statute.

"In addition, standards of care dictated by the American College of Emergency Physicians and psychiatric societies must all be considered with regard to patients in restraints," says Finneron.

An ED patient could sustain an injury to various joints from fighting restraints. These injuries could be simple sprains or strains, or more complicated such as a dislocation of the joint.

"If these injuries occurred as a result of inappropriate application of restraints or lack of monitoring the patient, the result could be allegations against the provider and/or the facility," says Finneron.

• Failure to restrain a homicidal or suicidal patient.

Once there has been an assessment of potential homicidal and/or suicidal ideation, the facility must be on alert for a potential elopement of the patient or for the patient to leave against medical advice (AMA), says Finneron. The ED has a "duty to warn" potential victims or to involve law enforcement, as needed, to protect the patient from suicide.

"As an insurance company, we have seen claims brought against institutions or health care providers for lack of proper assessments, lack of documentation of the assessments, or not following through on the duty to warn issue," says Finneron.

• Inappropriate use of restraint.

To defend against this allegation, good documentation is needed to show why restraints were needed, when applied, when the patient was checked, and an assessment of the patient's condition before, during, and after restraints are removed, says Finneron.

"Any and all regulatory requirements regarding these issues, including time frames for documentation, must followed," she says. "There needs to be good documentation, especially involving any behavioral health issue. This cannot be stressed enough."

Finneron says anyone reading the chart should be able to see "a good flow of the situation from when you first noticed the patient's behavior changing. Even subtle changes are important to document."

For instance, a back pain patient waiting a lengthy period to be seen might also have a mental health history and, at one point, become agitated.

"If there's not a good continuum of assessments, care, and documentation from the time the patient enters the ED to the time the disposition of the patient occurs, the result will often be gaps, where the defense of any allegations can and will most likely be compromised," she says.

Finneron recommends that triage nurses monitor the waiting room as part of an ongoing process to note any potential behavioral changes in patients that can result in a patient's perception of a long wait time to be seen or a sense of a lack of caring by the staff.

"Once the patient is brought into the ED exam area, the nurse attending to the patient needs to do an accurate and updated assessment," she advises. "It should be noted if there are any changes, not only in physical condition, but also in behavioral issues."

The ED nurse might document that the patient is demonstrating anger and frustration due to a long wait, for instance.

If the chart notes the patient was assessed at 9:45 a.m. and a follow-up by the EP at 11:15 a.m. with no substantial changes in behavior noted, it would be difficult to validate the patient being placed in restraints at 11:30 for a violent outburst.

If there is a lack of documentation to support treatment or a validation of escalating behavior, Finneron explains, "it would be very difficult to defend the rationale of a crisis that may have ensued, requiring the patient be placed in restraints." ■

REFERENCES

1. Kowalenko T, Walters BL, Khare RK, et al. Workplace violence: A survey of emergency physicians in the state of Michigan. *Ann Emerg Med* 2005;46(2):142-147.
2. Gacki-Smith J, Juarez AM, Boyett L, et al. Violence against nurses working in US emergency departments. *Journal of Nursing Administration* 2009;39(7-8): 340-349.
3. Gates D, Gillespie G, Kowalenko T, et al. Occupational and demographic factors associated with violence in the emergency department. *Adv Emerg Nursing J* 2011; 33(4):303-313.

Sources

For more information, contact:

- Karyn Finneron, RN, BSN, MA, HNB-BC, Senior Risk Management Representative, Coverys, Boston. Phone: (617) 526-0371. E-mail: kfinneron@coverys.com.
- Terry Kowalenko, MD, Clinical Associate Professor, Department of Emergency Medicine, University of Michigan Health System, Ann Arbor. Phone: (734) 763-7919. E-mail: terryk@ed.umich.edu.

Is EP Legally Required to Obtain Patient's Consent?

Consent to an intervention or treatment is generally implied when a patient comes to the ED, but there are some exceptions to this, according to **Andrew H. Koslow**, MD, JD, an assistant clinical professor of emergency medicine at Tufts University School of Medicine in Boston, MA, and an emergency physician (EP) at Steward Good Samaritan Medical Center in Brockton, MA.

"As for which procedures EPs need to do the complete informed consent process, there are some general guidelines, but not all EPs agree in this area," he adds.

Koslow says that EDs should obtain consent for procedures that have considerable risks, and procedures that the average patient wouldn't expect to happen during the ED visit, such as conscious sedation.

For the procedures for which EDs do obtain informed consent, EPs need to be very careful they are disclosing the proper information, he adds.

"We see a lot of boilerplate forms, which lack key elements of informed consent, and are often difficult to understand," says Koslow. "We often see just the form on the chart, sometimes not completely filled out, without any discussion of alternatives or other key elements of informed consent."

While some EPs have patients sign a consent form for procedures, others just document the discussion in the chart.

"The value of the patient's signature is very much debated. There are a lot of people who believe there is no value in the signature itself. What is really important is what was discussed with the patient," says **Alfred Sacchetti**, MD, FACEP, chief of emergency services at Our Lady of Lourdes Medical Center in Camden, NJ, and assistant clinical professor of emergency medicine at Thomas Jefferson University in Philadelphia, PA.

If a bad outcome occurs, the patient can easily claim that he or she was in too much pain or too nervous to understand the form he or she was signing. Sacchetti says a note stating, "I discussed this with the patient and the patient agrees we are going to proceed," is more legally protective for EPs.

"If you say in the chart, 'We had a conversation and they understood what I was saying,' that is a whole lot different than just having them sign a piece of paper," he says.

Sacchetti is aware of a case involving a pneumonia patient, in which the EP obtained informed refusal for admission to the hospital. The patient signed the standard forms, but when the patient returned in respiratory failure, the family claimed that they didn't understand that the pneumonia could get worse and the patient could end up on the ventilator and die.

"In that case, the EP's only note was, 'Patient signed out AMA [against medical advice],' with the signed form. There was nothing to show that a conversation occurred, or what that conversation included," says Sacchetti. Here are practices that could reduce liability risks for EPs:

• Document that the patient or his or her surrogate was able to repeat back or explain the key concepts involved, ideally in the presence of witnesses.

This might dissuade a plaintiff's attorney from pursuing an informed consent claim, says Koslow.

• Know state requirements for what the EP is legally obligated to disclose to the patient.

"Various courts have weighed in on this. It is generally accepted that you need to talk about alternatives, including doing nothing at all," says Koslow.

Koslow points to a 2012 Wisconsin case[1] involving a man who came to an ED with neurologic symptoms and was diagnosed with Bell's palsy, was discharged, and returned with a major stroke days later, with a nearly completely occluded carotid artery.

"The court decided that the physician needed to tell the patient about the possibility of having a stroke, and that tests such as a carotid ultrasound were available — even though the physician didn't think the patient was having a stroke," he says.

This caused a lot of controversy, and Wisconsin lawmakers are currently trying to nullify the court's decision, he notes. While an extreme case, Koslow says it illustrates the point that state requirements vary for informed consent.

• Have a way to document the patient's partial refusal of care.

While most EDs have an AMA form, these are typically meant for patients leaving the ED altogether, as opposed to refusing just one aspect of their care.

For instance, a patient might refuse a lumbar puncture, but doesn't want to leave the ED. "EPs are often not sure how to handle that situation, especially the documentation of it," Koslow says. "Most EPs don't have a good premade form for that."

This means that EPs will either have to cross out statements and add addendums on the AMA form or document from scratch.

"That is a very vulnerable area," says Koslow. "If the patient who didn't want the lumbar puncture actually had a subarachnoid hemorrhage or meningitis and they didn't sign an AMA form, then what could the EP have done instead? Often, they don't have much to rely on."

• Be specific about risks.

For example, instead of stating that risks of infection were discussed with the patient, the EP might document that the patient was informed of the risk of a specific type of infection.

Be clear that risk of death is a possibility, if that is the case, but that alone may not be sufficient if loss of function and other serious risks exist, Koslow says.

"Include all the bad things that could happen," advises Sacchetti. "There's been cases where the patient said, 'The doctor told me I could have died, but I didn't realize I could be severely handicapped.'"

• Learn why patients are refusing care and attempt to address their concerns.

"I'm a big believer in using quotes whenever possible," says Koslow. "Really paint the picture so that when someone is reading the chart two years later, they can get a sense of the circumstances and the patient's reasons for not wanting something."

For instance, if pain is the reason for a patient refusing a lumbar puncture, the EP should document if additional anesthesia was offered, or that the process was explained more carefully.

"When the patient talks about their reasons for refusal, you often find out it's based on a misconception that you can clear up. Once you do that, the whole potential legal issue goes away," says Koslow.

It may be that the patient can't afford to take off work or needs someone to care for a pet or family member. "Anytime a patient is refusing a potentially life-altering test, procedure, or hospital admission, find out why," says Sacchetti. "The more descriptive you are, the better."

A number of Sacchetti's ED patients have refused a CT scan because of the cost, for instance. "If they tell me, 'It's too much money, and this bill is already going to be too expensive,' my comment is, 'You need the test, we'll figure out a way to pay for it,'" he says.

If the EP makes every effort to address the patient's concern, but the patient still refuses care, the EP looks like a good, compassionate provider.

"A plaintiff's attorney is going to be reading that chart and thinking about what kind of person will possibly be there on the witness stand," Koslow says. "If you come off like a compassionate person wanting to do the right thing for the patient, that is hard for them to overcome."

• Show that the patient had the capacity to understand what you told him or her.

"Document that the patient was competent to understand the conversation," Sacchetti says. "You can't get informed refusal from someone so intoxicated that they can't even hold a conversation."

The EP has to be aware of all factors that could interfere with the patient's judgment, adds Koslow. "If you have sepsis or hypoxia, or have just received a large dose of pain medicine, these are all things that can make you less able to understand what's been told to you and make an informed decision," he says.

Often, the patient's reasons for not wanting to do something are strong evidence of their being able to make a rational decision.

"If the patient states that he or she read in a legitimate source that the procedure has a high complication rate and you document that, you've gone a long way toward protecting yourself," Koslow says. ■

REFERENCE

1. *Jandre v. Physicians Insurance Co. of Wisconsin*, 330 Wis 2d 50, 792 NW2d 558 (Wis Ct App 2010).

Sources

For more information, contact:

- Andrew Koslow, MD, JD, Department of Emergency Medicine, Steward Good Samaritan Medical Center, Brockton, MA. Phone: (508) 427-3034. E-mail: Andrew.Koslow@steward.org.
- Alfred Sacchetti, MD, FACEP, Chief, Emergency Services, Our Lady of Lourdes Medical Center, Camden, NJ. Phone: (856) 757-3803. E-mail: sacchettia@lourdesnet.org.

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

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.

2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME QUESTIONS

1. Which is true regarding stroke misdiagnosis in the ED, according to **David E. Newman-Toker**, MD, PhD?
   A. The risk of missed stroke is the same regardless of the patient's initial manifestations.
   B. The risk of missed stroke varies widely depending on the patient's initial manifestations.
   C. There is less risk of missed stroke if the patient's presenting symptom is dizziness or vertigo.
   D. Malpractice suits involving stroke misdiagnosis occur significantly more often when dizziness is the patient's only presenting symptom.

2. Which is true regarding restrained patients, according to **Karyn Finneron**, RN, BSN, MA, HNB-BC?
   A. An emergent situation can circumvent the patient's right to consent.
   B. EPs should generally not document subtle changes that indicate the patient's behavior is escalating.
   C. EPs have no duty to warn law enforcement, even if they have reason to believe a person who has escaped from the ED intends to harm self or others.
   D. Whether ED staff have regularly updated training in crisis prevention isn't admissible as evidence, as long as staff were trained on hire.

3. Which is recommended to reduce legal risks involving informed consent and informed refusal, according to **Andrew H. Koslow**, MD, JD?
   A. EDs should obtain consent for procedures that have considerable risks, and procedures that the average patient wouldn't expect to happen during the ED visit.
   B. The patient's signature on an Against Medical Advice (AMA) form legally protects the EP in all circumstances of refusal of care.
   C. If the patient signed an AMA form, it's not advisable for the EP to document the details of what was discussed.
   D. The plaintiff must prove the EP breached the standard of care in order for there to be a verdict for the plaintiff on informed consent.

Dear *ED Legal Letter* Subscriber:

This issue of your newsletter marks the start of a new continuing medical education (CME)/continuting nursing education (CNE) semester, and provides us with an opportunity to remind you about the procedures for earning CME/CNE and delivery of your credit letter.

ED Legal Letter, sponsored by AHC Media, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options and physician office practices. Our intent is the same as yours — the best possible patient care.

Upon completion of this educational activity, participants should be able to:
• Identify legal issues related to emergency medicine;
• Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
• Integrate practical solutions to reduce risk into daily practice.

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

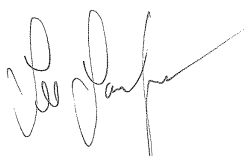
1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you instantly.

This activity is valid 36 months from the date of publication. The target audience for this activity is emergency physicians and nurses.

If you have any questions about the process, please call us at (800) 688-2421, or outside the U.S. at (404) 262-5476. You can also fax us at (800) 284-3291, or outside the U.S. at (404) 262-5560. You can also email us at: customerservice@ahcmedia.com.

On behalf of AHC Media, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,



Lee Landenberger
Continuing Education Director
AHC Media