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September 2013
Vol. 24 • No. 9• Pages 97-108

Drugs, Alcohol, and Disposition

By Kevin Klauer, DO, EJD, Chief Medical Officer, Emergency Medicine Physicians, Canton, OH

There is much myth, controversy, and misunderstanding surrounding the safe and medical legally sound disposition of patients who are under the influence of drugs or alcohol. Notwithstanding the importance of defining what "under the influence" truly means, there are several clinical scenarios associated with drugs, alcohol, and the emergency department that are commonly encountered. There are many opinions on these matters. Most are worth exactly what was paid for them.

I'll attempt to bring some clarity to these issues and dispel the myths regarding discharging patients after receiving opioid analgesics, refusals of care while intoxicated, and discharging intoxicated patients.

Background: Intoxication and Intent

Whether in a criminal or civil (tort) liability context, intoxication has been described in two contexts: voluntary and involuntary. Although our discussion focuses strictly on the liability of the negligence tort, it may be of value to recognize the similarities in definition with criminal law. Voluntary intoxication is just how it sounds. When people intentionally use an intoxicating substance, they are responsible for their actions. When people are given an intoxicating substance unknowingly, or are not informed of the side effects of a substance (i.e., opioid analgesics, sedative-hypnotics, etc.), they may claim involuntary intoxication as a defense to a general-intent crime.

The complex issues surrounding criminal law are rooted in the accused person's ability to formulate intent and what intent is required for such a crime. Although not universally utilized in all jurisdictions, most distinguish between specific-intent and general-intent crimes. The tortious (tort liability) corollary will become fairly clear. So, to be convicted of a specific-intent crime, such as first-degree murder, a person must meet all of the elements of the crime, beyond just the general intent to perform the act. For example, if you intended to kill someone with your vehicle, you could meet the statutory requirements of first-degree murder (depending on the jurisdiction and specific required elements). However, if you killed someone with your car, but had no specific intent to do so, it would be unlikely that the prosecu-

tion could meet the burden for a first-degree murder charge, but the general intent to drive the car, and with reckless disregard due to voluntary intoxication, would certainly meet the burden of a lesser crime, requiring only general intent (i.e., reckless homicide, vehicular manslaughter.)[1]

Although criminal charges could be filed against an intoxicated patient who commits a crime, it is unlikely for criminal charges to be filed against the health care providers and institutions that cared for the accused. However, the exposure to civil (tortious) liability for negligence in these cases is very possible. Certainly, a defendant's claim of involuntary intoxication due to a lack of information/warning or instruction by a health care provider or institution could prove problematic in a civil case.

Dram shop statutes have been adopted in many states. Such statutes are invoked as a matter of public policy to avoid unnecessary risk to the *unnamed* third party (those who may be injured by an intoxicated patron if that person drives). It is important to note that these statutes are narrowly crafted and are not utilized in medical negligence cases in which a patient received a sedating medication or the intoxicated patient was discharged and injured someone. These statutes traditionally are limited in scope to alcohol and vendors selling alcohol to minors or intoxicated patrons.

Although traditionally alcohol has been the primary intoxicant noted in legal definitions, challenges have been made that other mind-altering substances should be treated similarly. The Model Penal Code § 2.08 defines intoxication as, "A diminished ability to act with full mental and physical capabilities because of alcohol or drug consumption;" drunkenness. Thus, the medications we provide in the emergency department may be easily included in the legal definition of intoxicating substances. This inclusion could come into play when patients are discharged and deemed to be intoxicated, based on medications provided while under the care of medical personnel.

Discharging Patients after Receiving Opioids and the "Duty to Warn"

Is there liability associated with discharging a patient after he or she receives opioid analgesics, for instance? Yes, but the alleged negligence is ordinary negligence, as opposed to medical malpractice. However, if certain steps are taken, the liability exposure is minimal. What seems evident in many EDs is that some have misinterpreted and inflated the concerns of liability in these cases, and in order to protect themselves, have adopted defense strategies that are both unreasonable and inefficient. Some behaviors that seem both unreasonable and unwarranted are refusing to provide patients with opioid analgesics until after their ride can present to the emergency department, as well as attempting to detain the patient if it appears that person may be getting into a vehicle as the driver, despite showing no signs of impairment. Although there is certainly no prohibition to doing these things, they are unnecessary from a legal perspective. If a hospital or provider would like to notify the police, they should do so. However, there is no requirement of obligation to do so. Also, pain management shouldn't be delayed until the patient's ride is present. The discharge can be delayed for their arrival, but withholding treatment may be deemed unethical.

The common law roots of "duty to warn" by health care providers is defined in *Tarasoff v. Regents of the*

ED Legal Letter™, ISSN 1087-7347, is published monthly by AHC Media, LLC, 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.

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University of California. In this case, Mr. Poddar, a student at the University of California, was romantically interested in Ms. Tarasoff. She didn't share the same interest, and he became depressed and sought counseling. He made statements to his counselor that he had thoughts of hurting Ms. Tarasoff. However, the therapist didn't initially report these statements. When Mr. Poddar failed to return to counseling, the counselor notified campus police, who questioned Mr. Poddar. No further action was taken. Mr. Poddar killed Ms. Tarasoff two months later. The Supreme Court of California held that providers have a duty to warn potential victims. This could be accomplished by notifying the police of the threat or by admitting the patient. This mental health case has direct implications for emergency medicine. The duty owed to a *named* third party, someone that the patient states he or she intends to harm (i.e., "when I leave here I am going to kill so and so"), can be fulfilled by notifying law enforcement and by hospitalizing the patient, if mental illness is the cause.

To avoid liability regarding the discharge of a patient who has received potential intoxicating substances from the ED, a duty is owed to the patient and to the *unnamed* third party. The duty owed to the patient is to adequately and reasonably inform the patient about the side effects of the treatment provided and any limitations on his or her activities to prevent unintentional self-harm. The duty owed to the *unnamed* third party is very similar, but the goal is to prevent harm of the *unnamed* third party by the actions of the patient. Patients *must* be told not to drive or operate machinery, etc. This should be clearly documented in the after care instructions and the nursing documentation. For the sake of completeness, this duty is usually owed to the *unnamed* third party when the patient poses risks to others for different reasons, such as driving while at risk of having a seizure or driving with an eye patch.

In general, once the duty to third parties has been met, the health care provider's responsibility ends. However, it is still possible that someone could get in the car, drive away, and injure someone. It's even possible that a lawsuit could be filed against the institution or providers. A Massachusetts case from 2009[2] established a strong legal basis that health care providers have no obligation to detain or otherwise control a patient to avoid potential harm to *unnamed* third parties. An additional holding was that medicated patients are not deemed inherently dangerous purely because they have been medicated.

Documentation that the patient has been adequately informed of the effects of medications provided and of any restrictions (e.g., driving or operating machinery) is essential to a good legal defense and to avoiding a lawsuit altogether.

Intoxication and AMAs

Despite the patient's disinterest in seeking medical care, intoxicated patients are frequently brought to the emergency department by family, friends, or law enforcement. Also, alcohol intoxication may result in behavioral issues in patients who initially do want and consent for treatment, but subsequently change their mind.

So, when may an intoxicated patient refuse medical care? This is another complex question. First, it is imperative to recognize that most courts will give great deference to a physician attempting to provide reasonable care to a patient. Furthermore, stories of physicians being sued for torts such as false imprisonment, assault and battery, and criminal charges filed for kidnapping are nothing more than urban legends. Think this through. In order to file a lawsuit, a prospective plaintiff will need an attorney. Quite honestly, individuals who report being mistreated in an emergency department by health care professionals attempting to care for the patient while they were intoxicated, spitting, being verbally abusive, etc., just don't make good witnesses or clients. Most attorneys see no benefit in taking on such cases. Having said that, it is important to respect a patient's right to refuse care, and intoxication does not absolve a provider from allowing a patient to make his or her own decisions when capable of doing so.

As with any other patient, the ability to consent and refuse is based on medical decision-making capacity. If you don't have decision-making capacity, you can't refuse. Competence is determined by a court and cannot be established by a physician or at the time of patient care delivery. Medical decision-making capacity can be established by making certain the patient is oriented to person, place, time, and situation, and that the patient understands the risks and benefits of the proposed treatment, and alternatives to treatment, including no treatment at all. It is very possible that someone under the influence of alcohol or other substances may still have medical decision-making capacity. However, the decision to allow a "drunk" patient to refuse care should be approached with great caution. When in doubt, err on the side of providing medical care. The chances of being sued for missing a subdural hematoma in an intoxicated patient you allowed to sign out against medical advice (AMA) are exponentially greater than being sued for detaining the patient. Furthermore, the exposure for third-party injury by an intoxicated patient who argu-

ably didn't understand the informed refusal is likely greater than the previously discussed scenario of the unimpaired patient who was discharged following the delivery of opioid analgesics. In both cases, the duty to the third party must be met. However, in the obviously intoxicated patient attempting to leave, some jurisdictions or courts may apply a higher standard on the health care worker for the duty to *unnamed* third parties than for the patient who received therapeutic doses of analgesics and exhibits no signs of impairment. Again, in the obviously intoxicated patient, it may be prudent to take extra steps, such as calling law enforcement, when a patient is clearly a risk to himself or others.

It is recommended that this be a team decision. If the physician and nurse caring for the patient are in agreement that this patient has decision-making capacity and the patient shows no signs of impairment, they should both document this in their respective records when allowing a refusal. Exercise great caution with intoxicated patients who may have pathology altering their decision-making capacity. For instance, if a patient who has consumed alcohol seems mildly intoxicated (i.e., slurred speech, mild somnolence, etc.), he or she may actually have traumatic brain injury or a diabetic complication. The physician's evaluation and documentation should reflect attempts to identify any such medical etiologies that would preclude safe refusal and discharge. Of course, the best strategy is to convince to patient to consent to treatment. All such attempts to do so should be documented.

AMA forms are frequently utilized, but the protection they provide is often overrated. Just like a consent form, the AMA refusal form should outline what treatment is proposed, any alternatives, and the patient's understanding of the informed discussion. Signing an AMA form, in the absence of documenting that a true informed refusal was obtained, is a recipe for disaster. It is evidence of a signature, but not true understanding of the risks of refusal. The most important documentation of the refusal is the assessment of decision-making capacity and the informed discussion. Documenting this in the medical record is much more valuable than an AMA form, particularly when AMA forms contain little more than a signature. Strategically, providers may want to avoid the use of AMA forms, as they frequently result in confrontation. "If you don't want to … then you have to sign this form accepting responsibility for your bad decision." The conflict created may not be worth the protection provided by such forms, particularly when a well-documented informed refusal in the medical record accomplishes so much more. All patients should be made aware that they are welcome to return anytime should they change their mind, and this notification should be noted in the record.

DWI (Discharged While Intoxicated)

The discharge of intoxicated patients can be safely accomplished after completing treatment if the patient is medically stable. If the patient shows signs of intoxication, then providers should confirm that the patient has a safe means of transportation and will not be left unattended. So, if a patient suffered a hand laceration from a broken glass and experienced no other injuries, but is intoxicated (i.e., slurred speech, mild disequilibrium, etc.), it is acceptable to discharge the patient if someone can drive him home and will be available to stay with him. Being intoxicated and alone may not be a medical emergency, but recommending that a drunk patient under your care stay home alone is a risky proposition. If the appropriate resources are not available to safely discharge the medically stable, intoxicated patient, then hold the patient until he or she is sober or when such resources become available. This topic leads us to a very important issue: How do you know when someone is intoxicated?

Who's drunk and who isn't? Traditionally, providers have relied on blood alcohol levels to determine a patient's level of intoxication and to estimate when the person will no longer be intoxicated (e.g., hepatic clearance). This rationale for this approach is horribly flawed. First, ethanol intake produces different levels in every patient, which, in turn, result in different, and very individual, effects. Second, ethanol metabolism and clearance is variable and very individual. Traditional thinking holds that certain rates of clearance, such as 0.2-0.3 mg/dL per hour, are predictable and reproducible. In addition, different rates were reported for chronic versus occasional users. Although these numbers may have some validity when considering large populations, attempting to apply them to individual patients is nearly worthless. In a 2010 article published in the *Journal of Medical Toxicology*, the authors stated, "Attempting to relate observed signs of alcohol intoxication or impairment, or to evaluate sobriety, by quantifying blood alcohol levels can be misleading, if not impossible."[3]

The final ace in this house of cards is that managing blood alcohol levels is medically managing with a legal definition of intoxication, as opposed to using more appropriate clinical indicators of intoxication. We have all seen and cared for the patient with an alcohol level of 230 mg/dL who can carry on a normal conversation, ambulate without ataxia, and show no obvious signs of intoxication.

So, is the patient intoxicated? It will depend on

whom you ask. If you ask the plaintiff's attorney hired by an injured third party, a judge, law enforcement officer, etc., most will say that patient is intoxicated because his or her ethanol level is above the legal limit. However, this has nothing to do with the patient's clinical state of intoxication. As a clinician, how can you refute their claim and assertion? The easiest way is to stop ordering blood alcohol levels on patients who don't need them. From a clinical perspective, any test that is ordered to answer a question you already know the answer to is probably unnecessary. For instance, when a patient tells you he has been drinking and he appears mildly intoxicated, what useful clinical information does an ethanol level provide? In most cases, none. Of course, there may be regulatory/logistical reasons to obtain such a test (i.e., required by mental health professionals to screen for admission, court order following a motor vehicle accident, etc.). However, there is little to no medical utility in ordering these tests.

So, when is an ethanol level of value? As mentioned previously, when a test helps answer an unanswered question, it's a useful test. When alcohol ingestion has not been confirmed, and its presence or absence will help guide the management of the patient, this test may be essential. For instance, a seemingly intoxicated patient is being treated for a scalp laceration and his ethanol level is "0," suspicion for other etiologies of somnolence or behavior, such as intracranial injury or other toxicological exposures, should be prompted. An ethanol level may also be helpful when a complete history is not available and the patient presents with a mental status change.

Impairment is a clinical diagnosis or assessment, not one made by the laboratory. To that end, a well-documented examination including mental status, speech, and motor function is very effective for determining whether or not the patient is impaired. Remember, our goal is not to determine if they have substances on board, but if they are impaired. This is akin to a roadside sobriety test. Law enforcement officers don't use their Breathalyzer on every traffic stop. They perform their roadside testing, and if no signs of impairment are present, the DUI evaluation is usually complete. Why should we be held to a different standard? Fortunately, we aren't. However, when an alcohol level is recorded in the chart, it opens Pandora's box when the patient is deemed unimpaired clinically. If the only sobriety/impairment test in the record is a detailed and well-documented examination by the physician (or other primary provider) corroborated in the nursing documentation, then it is very difficult to refute that the patient wasn't impaired. Using ethanol levels when not indicated can create serious legal exposure for clinicians.

When dealing with patients who are potentially impaired, either by their own choosing or by our treatments, great caution should be taken to make certain they are stable for discharge, and that such discharges can be carried out safely. It is critical to make certain that providers have met their duty to *unnamed* third parties, informing patients of their restrictions and documenting their understanding. Avoid the unnecessary use of alcohol levels and meticulously document your clinical evidence that your patient is unimpaired. When in doubt, err on the side of treating the intoxicated patient, even if detaining the patient is necessary. ■

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Did Frequent ED Patient Sue? Thoroughness of Workup Is Issue

Was a frequent ED patient discharged after complaining of chest pain, and later suffered a myocardial infarction (MI)? In this scenario, "the emergency physician (EP) can expect a lawsuit if she sent the patient home without assessing and treating the patient as she would any other patient with the same complaint," says **Jonathan T. Brollier**, JD, an attorney at Bricker & Eckler in Columbus, OH.

Brollier has represented several EPs who sent frequent ED users home after concluding that the patients presented simply to get drugs or attention. Lack of documentation made these cases more difficult to defend, he says.

"If the physician brushes the patient off, or sends the patient home just because the patient's been a drug-seeker in the past, this can constitute a deviation from the standard of care," says Brollier.

It might feel like a "waste of time" to workup chest pain or unusual epigastric pain in a chronic pain patient, acknowledges **Timothy A. Peterson**, MD, MBA, FACEP, assistant professor and chair of the ED Complex Care Program at the University of Michigan in Ann Arbor.

"But it is better for them, and for you, if you catch the acute MI while they are in the ED and before the autopsy," warns Peterson. "Typically, the patients who are in the ED the most frequently are viewed by EPs as the least likely to be sick."

Robert B. Takla, MD, MBA, FACEP, medical director and chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI, says frequent ED users embody "the classic story of the boy who cried wolf too many times. The biggest concern is missing something that turns out to be serious and truly results in damages."

Examples include chronic back pain patients with a cord compression or abdominal aortic aneurysm, patients with an intracranial bleed, or patients with acute alcohol intoxication with a subdural bleed or internal bleeding.

"Eventually, something will be seriously wrong, but the entire staff becomes jaded and desensitized to these 'frequent flyers,'" Takla says.

EPs at St. John Hospital and Medical Center frequently care for a sickle cell patient whose complaints included headache on a recent ED visit. The following day when the patient returned to the ED, a CT scan of the head showed a subdural hematoma.

"He still comes in with sickle cell pain, and he also complains of a headache," says Takla. "On the visit where [the subdural hematoma] was missed, I am not sure if we just became complacent because he is there all the time asking for [hydromorphone hydrochloride] and [diphenhydramine]."

Meet SOC Every Time

When caring for frequent ED patients, EPs must take care to meet the standard of care each time they present to the ED. "The brushing off of a patient with a new complaint, which is later associated with a serious adverse outcome, can result in patients becoming plaintiffs," says Brollier.

Successful claims for medical negligence brought by frequent ED patients have involved EPs failing to diagnose a new illness and, instead, writing the patient off as a "frequent-flier" or drug-seeker without an adequate assessment and workup.

"These cases arise because of inadequate treatment and workup in the ED," adds Brollier. "EPs or staff sometimes acknowledge that less time was spent on the patient because the patient is known to present frequently either under the influence or seeking drugs."

In University of Michigan's ED, the patients with the highest volume of repeat visits are chronic alcoholics found intoxicated in public and patients with substance use disorders.

"It is easy to say EPs must maintain a high index of suspicion for dangerous conditions in this patient population," says Peterson. "But it is very difficult to do in real practice, when your department is busy and you are trying to see all the patients as efficiently as possible."

Takla notes that chronic alcoholics often present with cortical atrophy, coagulapathy, unsteady gait, and their behavior is often risky, offensive, or aggressive, which could result in an assault or trauma.

"All of this increases their risk for a subdural hematoma," he says. "We often attribute their altered status to being intoxicated and just wait for them to establish sobriety."

After adequate time passes so that the alcohol level is low enough not to be affecting the patient's behavior, but the altered status continues, EPs begin to suspect something more serious might be going on. "You get a CT scan of their head — and surprise — a subdural hematoma," Takla says. "But the alternative is to CT every chronic alcoholic who presents every time, and that is not appropriate."

The University of Michigan's ED Complex Care program works with frequent ED users and their primary care physicians to create care plans to manage their ED use. "In fact, in our population, patients who are in the ED the most often have some of the highest mortality rates," says Peterson.

To avoid claims involving frequent ED users, EPs should specifically look for what is *different* in the patient's presentation each time, advises Peterson.

"If the patient really is drunk with no bruises, can move their limbs equally, and just needs to sleep it off, so be it," says Peterson. "But if the patient has never complained of a headache before, and is vomiting, then maybe they do need a head CT this time."

Demonstrate Thorough Workup

Accurate and complete documentation from the time of treatment can help an EP defend against malpractice claims asserted by frequent ED users. "Merely noting that the patient is well known to the ED is insufficient," says Brollier. "The physician should include that fact, but also document that the patient's complaint was taken seriously."

Review the patient's prior medical records, if possible, says Brollier, and document what prior information assisted you in reaching a disposition of the patient during the present visit.

"An EP can demonstrate a thoughtful workup

of a patient, even if that patient has a history of frequently presenting to the ED," Brollier says. For instance, the EP could chart: "Reviewed electronic medical records from patient's prior presentations to ED on April 17, May 12, May 27, and June 4, in which patient expressed complaints identical to current presentation, and requested Percocet. Completed additional workup, including physical examination and lab studies, to rule-out _____. Identified a clinic where patient could receive more cost-effective primary care, and provided the patient with contact information for that clinic. Patient expressed understanding of referral."

This shows conscientious concern for the patient's complaint and illustrates that the EP reviewed the patient's prior documentation and found evidence of a drug-seeking pattern. "It also shows that the practitioner ruled out emergent causes of the patient's complaints and referred the patient to a clinic that could better serve the patient's primary care needs," says Brollier.

Helping frequent ED users find access to care that does not involve the ED demonstrates that the EP took the patient's problems seriously, says Brollier.

Efforts to rule out life- and limb-threatening conditions need to be done each and every time, emphasizes Takla. An incomplete history and/or superficial exam makes such claims more difficult to defend.

"This gives the appearance to a jury of being judgmental and uncaring, and not paying attention to abnormalities because the physician attributes them to chronic complaints or attention-seeking, drug-seeking, or psychiatric behaviors," Takla says. ■

Sources

For more information, contact:

- Jonathan T. Brollier, JD, Bricker & Eckler, Columbus, OH. Phone: (614) 227-8805. E-mail: jbrollier@bricker.com.
- Timothy A. Peterson, MD, MBA, FACEP, Assistant Professor/Chair, ED Complex Care Program, The University of Michigan, Ann Arbor. E-mail: timopete@med.umich.edu.
- Robert B. Takla, MD, MDA, FACEP, Medical Director/Chief, Emergency Center, St. John Hospital and Medical Center, Detroit, MI. Phone: (313) 343-7398. E-mail: rtakla@comcast.net.

Chart Discrepancies: Basis for Legal Claims

Unaddressed discrepancies damaging

According to the nursing notes, a 15-year-old boy presented to the ED with headache, neck pain, nausea, and vomiting. "The emergency physician (EP) used a template for abdominal pain and crossed off the neurology section, including headache, in the review of systems," says **Ken Zafren**, MD, FAAEM, FACEP, FAWM, who reviewed the case. Zafren is EMS medical director for the state of Alaska and clinical associate professor in the Division of Emergency Medicine at Stanford (CA) University Medical Center.

The patient was discharged from the ED with a diagnosis of gastroenteritis, and died at home a few days later from a ruptured arteriovenous malformation (AVM). This had been diagnosed as an apparent incidental finding on a CT scan done to rule out a soft-tissue mass of the neck a few days before he presented to the ED. The case was settled.

"Even without the history of the AVM, the patient's symptoms as described by the nursing notes should have mandated a CT and a lumbar puncture if the CT did not show bleeding," says Zafren.

Do the ED nursing notes mention an abdominal patient's "guarding and rebound," but the EP's documentation makes no mention of it? If the patient is later found to have an acute abdomen and a malpractice suit is filed, "the plaintiff attorney will allege the nurse had it right and the doctor didn't," says **John Tafuri**, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland.

Inconsistencies in the chart often serve as the basis for a legal claim against EPs, says Tafuri, such as abnormal pulse oximetry or blood pressure that is not addressed at the time of discharge or admission.

There will always be discrepancies in charts, but it's the *unaddressed* discrepancy that is damaging to EPs in the event of a lawsuit, warns **Kevin Klauer**, DO, EJD, chief medical officer at Canton, OH-based Emergency Medicine Physicians.

"It's not that the other provider is always wrong," he says. It may be that the patient told a nurse that the current headache is the worst of his life, but omitted the fact that he's had the same "worst" headache every month for years.

"If a different provider gets a different answer, the EP can say, 'I'm the primary provider, when I talked to

the patient, this is what they said, and this is the right answer,'" Klauer says.

Other providers sometimes get different information from the patient than the EP, even if they ask the very same questions. "I've had experienced providers say, 'I asked them that question and they said no,'" says Klauer. "Well, maybe you gave the patient a chance to think about it." Patients also don't know what pieces of information are critical, such as chest pain that radiates to the left arm.

Klauer has reviewed claims where EPs defended themselves by claiming a nurse didn't give them important information.

"That is a golden gift to the plaintiff attorney," says Klauer. "Because when you point fingers and say you would have done something differently, what you are saying is *someone* is negligent — we are just deciding who."

Flag Abnormal Vitals

The electronic medical record (EMR) at Fairview Hospital's ED flags abnormal vital signs charted by nurses so these are easily visible by EPs. In addition, if EPs are discharging a patient with abnormal vital signs, the EMR alerts the EP.

"It doesn't stop you from discharging the patient, but it calls your attention to it," says Tafuri. "The EP can then determine if it is something that is critical to address, or something they want to comment on in the chart."

In some cases, EPs decided to admit the patient after being alerted to abnormal vital signs that they'd overlooked, such as a patient who is persistently tachycardic without explanation and ultimately diagnosed with pulmonary embolus.

Patients with abnormal vital signs at the time of discharge are more likely to have bad outcomes than patients discharged without abnormal vital signs, adds Tafuri.

In some cases, the EP still discharges the patient but is able to acknowledge the patient's abnormal vital signs in the chart. "If relevant, the EP writes a note explaining that they saw the nursing notes, and why they feel it's O.K. for the patient to go home," Tafuri. "Should there be a legal issue down the road, you are in a far better position if you acknowledge the nurse's notes."

Notes Can Help or Hurt EP

Nursing notes have the potential to help or harm EPs in malpractice litigation, says Zafren. Zafren is currently reviewing a claim involving a patient with frostbite who arrived in the ED early in the morning and who was not seen by the EP on duty at that time.

The frostbite was allowed to thaw spontaneously rather than receiving the correct treatment, which would have been rapid thawing in warm water, resulting in increased tissue damage.

There was one EP's name on the patient's record, but care was given by a different EP. "The nursing notes and metadata make it clear that the patient was seen only by a second emergency physician after change of shift," says Zafren. "This was confusing until I reviewed the nursing notes."

Zafren recommends these practices involving nursing notes to reduce liability risks:

• Read nursing notes during the patient visit and just before discharge.

"I make sure I am not missing something important that the nurses didn't tell me or, more likely, that they did tell me but I failed to pay sufficient attention," Zafren says.

• Don't sign the note until after the patient has left the ED.

This allows Zafren to review the nursing notes once more so no late entries are missed. "EPs should never lose sight of the fact that they would be nothing without the nurses," says Zafren. "Nurses have bailed out every practicing EP many times by calling their attention to things they might otherwise have missed."

• Never criticize nursing notes in the patient's chart.

"It always looks terrible when one health care provider criticizes another in the medical record," says Zafren.

Zafren says that while EPs are viewed favorably by juries, he believes that ED nurses are viewed even more favorably. Thus, an EP who criticizes a nurse would be viewed very unfavorably.

"I learned long ago to write on nursing notes 'appreciate nursing notes' to show that I had read them," says Zafren. "The EMR version of this is a check box that says 'nursing notes reviewed.'" ■

Sources

For more information, contact:

- Kevin Klauer, DO, EJD, Chief Medical Officer, Emergency Medicine Physicians, Canton, OH. E-mail: kklauer@emp.com.
- John Tafuri, MD, FAAEM, Regional Director, TeamHealth Cleveland (OH) Clinic. Phone: (216) 476-7312. E-mail: jotafu@ccf.org.
- Ken Zafren, MD, FAAEM, FACEP, FAWM, Alaska Native Medical Center, Anchorage, AK. Phone: (907) 346-2333. E-mail: zafren@alaska.com.

Crowding Doesn't Change Legal Standard of Care

Negligent staffing allegations could arise

Did an emergency department (ED) experience a sudden surge in volume at the same time a particular patient presented, who later filed a malpractice suit?

"Almost every ED doctor thinks this should be something considered in their defense," says **Charles R. Grassie**, MD, JD, an emergency physician (EP) at St. Joseph Mercy in Ann Arbor, MI.

While crowding does not change the standard of care, juries appear to take the fact that an ED was excessively busy into some consideration, according to **Mark Spiro**, MD, president of CEP America, an Emeryville, CA-based partnership of acute care physicians.

For that reason, defense counsel sometimes ask the defendant EP at trial or in depositions if the ED was excessively and unexpectedly busy. "Crowding could come up during malpractice litigation in the context of extraordinary wait times, and can arise in the context of missed or late treatment due to competing urgencies," adds Spiro.

Crowding as a Defense

In some cases, sudden volume surges can provide an effective defense for an EP. "If you called the disaster and followed all the rules, it would be a very good defense," says Grassie. "A busy disaster situation does change the standard of care dramatically."

For this to be the case, however, the EP would need to have called a disaster and followed hospital protocol. "But that almost never happens, absent a bomb going off," says Grassie. "It is not usually the case, in retrospect."

Persistent ED crowding without physician or hospital intervention would likely not mitigate any particular claim, according to **Donald M. Yealy, MD**, chair of the Department of Emergency Medicine at University of Pittsburgh Medical Center.

"It might actually aggravate the situation," he says. "The plaintiff attorney will say, 'You are always crowded. You knew you couldn't handle this.'"

Even in a crowded ED, EPs have to prioritize their activities. "That's another reason why it almost never eliminates the standard of care issue," Yealy explains. "Crowding will rarely, if ever, relieve you of meeting the minimum standard of care, even if you trigger an internal mechanism because the ED is busier than expected."

EPs should be clear in their documentation about how they prioritized individuals to be seen, advises Yealy, such as patients with an immediately life- or limb-threatening injury.

For example, the EP could chart, "I spent 20 minutes resuscitating this patient" in the first patient's chart, coupled with "While stabilizing another patient, the staff did XYZ, and I returned immediately once available," for the next patient.

"I think judges and juries recognize when a physician did the best they could with multiple competing demands," Yealy says.

Negligent Staffing Allegations

If an EP uses crowding as a defense, plaintiff attorneys can then ask, "If you knew that it wasn't just a sporadic, unpredictable event, why aren't you staffing differently?"

"Generally, those who bring a tort action focus their attention not only on the physician but also the hospital," notes Yealy. "Unrecognized crowding issues certainly give them a stronger entree to the hospital."

EPs should resist the urge to vent frustrations about constant crowding in the patient's chart. "The individual patient record is not the place for global operational things to be deposited. I would strongly discourage that," cautions Yealy. "It makes you feel better, but in fact, you are using the record for a different purpose than intended."

Failing to trigger internal mechanisms could be an aggravating factor in the event of a bad outcome during a crowded period. "If you don't avail yourself of mechanisms that would allow you to meet the standard of care, that's no different than not making the right choice," Yealy says.

EPs sometimes try to "tough it out" through busy periods instead of availing themselves of options that exist to mitigate crowding. "If these don't exist, then work with your director to create them," advises Yealy. "But that's a far cry from saying that using crowding as an excuse will absolve you from the standard of care."

Crowding is rarely brought up by the plaintiff or the defense, as both sides fear it can be used against them, says Grassie.

On the defense side, it could open up a question of negligent staffing, both for the emergency physician group and the hospital. If the EP and the hospital have different insurance policies, both could be tempted to point fingers at each other.

"The EP will say it's the hospital's fault for not hav-

ing enough nurses, and the hospital will say it's the EP's fault for not having enough physicians or for not calling the disaster," says Grassie. "The plaintiff just has to sit back and watch both defendants duke it out. They don't care who pays."

If the EP uses crowding as a defense, the plaintiff could claim negligence in staffing if the ED does not have back-up physicians, nurse practitioners, and physician assistants on call in case the ED becomes excessively and unexpectedly busy. "The plaintiff would have to prove crowding should have been anticipated, and a back-up plan should have been in place," says Spiro.

Grassie says crowding isn't typically brought up by plaintiff attorneys since if they ask how busy the ED was, "they are probably afraid they are putting defense ammunition in their hands, by opening up the possibility that the standard of care isn't what it otherwise would be."

EPs might be tempted to argue that the ED being understaffed at the time the patient presented contributed to the patient's bad outcome. However, it is rarely advisable for the ED group to blame the hospital for a medical claim, says Spiro.

"It can deteriorate into an argument back and forth as to who is most to blame," he explains. "Plaintiffs love that scenario, as we end up doing their work." ■

Sources

For more information, contact:

- Charles R. Grassie, MD, JD, St. Joseph Mercy, Ann Arbor, MI. E-mail: cgrassie@epmgpc.com.
- Donald M. Yealy, MD, Professor and Chair of Emergency Medicine, University of Pittsburgh and University of Pittsburgh Medical Center. Phone: (412) 647-8295. E-mail: yealydm@upmc.edu.

Is Patient's "Non-compliance" Enough to Protect EP Legally?

Chart could shift responsibility for bad outcome

Did a bad outcome occur because the patient didn't comply with the emergency physician's (EP's) recommendations?

"Non-compliance is not a 'get-out-of-jail-free card' on its own," emphasizes **Robert J. Conroy**, JD, an attorney at Kern Augustine Conroy & Schoppman in Bridgewater, NJ.

For non-compliance to provide the EP with a good defense, it needs to be founded on patients being properly educated as to what they need to do, given adequate information to impress upon them the significance of their compliance, and having the ability to comply, he says. "If the ED patient is possessed of such knowledge and ability, then there is a framework on which to build a defense based on non-compliance," says Conroy.

Conroy has used this strategy to defend many malpractice claims involving patients discharged from the ED with instructions that they failed to follow.

Several claims have involved patients seen in EDs with slight head trauma, who were discharged with instructions to call or return if they experienced vision problems or dizziness, and failed to do so to their detriment.

"Death occurred in one claim, and extended hospital stays in others with neurological injuries," says Conroy. "The claims were settled, as most claims are, but for much less value than would have been typically expected."

Many times, non-compliance won't provide a complete defense but is nevertheless useful in shifting some of the blame and responsibility to the patient for a bad outcome. In such cases, the judge or a jury will consider the patient's non-compliance and proportionately reduce the EP's share in any liability, Conroy explains.

"The more the onus for action can be shifted to the patient, the stronger the defense will be," he says. "A well-informed but lazy or willful patient would be, accordingly, the least sympathetic and most susceptible to a defense of non-compliance."

Documentation of instruction on discharge, and documentation on return that the patient did not follow prior instructions, could be valuable for the EP's defense, says Conroy.

"It bears noting, though, that a jury is not likely to penalize a sympathetic patient," he cautions. "So there can be practical limitations as to the real value of such a defense in a given set of circumstances."

If the EP learns a patient didn't follow up with the original treatment plan, **Michelle M. Garzon**, JD, a health care attorney at Williams Kastner in Tacoma, WA, says it's important for the EP to document what was done about it. For instance, the EP should document the fact that he or she reinforced the importance of the patient seeing their primary care physician, or the fact that the EP gave the patient the phone number of a clinic.

"Patient responsibility is a good defense, but it has to be played pretty lightly. We can only do that when it's documented and addressed," Garzon says.

SOC Is Issue

If a patient coming to the ED reports non-compliance with treatment recommended by another provider, the EP "will then be measured with that understanding," says **Robert Shannon**, JD, a senior partner at Hall Booth Smith in Atlanta, GA.

In this case, Shannon says the questions that a plaintiff attorney will look at would be: What does the standard of care require given the presentation of symptoms? and Did the disease process or injury become worse due to the lack of compliance?

For instance, if a patient's infection worsens because the patient failed to take the required antibiotics and delayed follow-up, upon presentation to the ED the standard of care may require amputation of a limb. "Notwithstanding, the emergency physician may try to debride the infection. The patient later becomes septic and dies," says Shannon.

If the EP failed to meet the standard of care based on the patient's current presentation, the patient's previous non-compliance would not protect the EP from liability, he underscores.

Kevin Abernethy, JD, a partner with Hall Booth Smith in Atlanta, GA, says key questions will be whether the EP followed the hospital's protocol, whether discharge instructions were clearly communicated, and whether the EP instructed the patient to follow up with the patient's physician or a specialist.

"The bottom line is: Did the ED's treatment and discharge meet the required standard of care expected of physicians under similar or like conditions?" says Abernethy.

Problems With Access

Was your ED patient unable to obtain prescribed medications because of lack of insurance coverage, or because he or she was unable to obtain a follow-up appointment with a primary care physician as instructed?

If so, EPs should avoid documenting phrases such as, "patient is non-compliant" in the chart, advises **Roger J. Lewis**, MD, PhD, FACEP, a professor in the Department of Emergency Medicine at Harbor- UCLA Medical Center in Torrance, CA. "The term 'compliance,' in my mind, is a loaded term. It puts all of the responsibility of completing a recommended course on the patient," he says.

Given widespread problems with access to care, patients have many legitimate reasons for being unable to complete a prescribed course of therapy, notes Lewis.

Lewis says that it is appropriate and important, however, for EPs to document the patient's history in terms of ability to obtain medications, keep follow-up appointments, or comply with other prescribed measures, such as keeping a swollen leg elevated.

"Whenever a patient is not experiencing the hoped-for recovery, one wants to document all of the things that might have contributed to that course," he says.

When EPs give discharge instructions to patients, they have a responsibility to consider potential obstacles to compliance with these, adds Lewis.

"Even if the original plan appears appropriate, it behooves you to carefully consider the practical and logistical aspects to see that patient can successfully complete the prescribed course of therapy and follow-up," he says. ■

Sources

For more information, contact:

- Kevin Abernethy, JD, Hall Booth Smith, Atlanta, GA. Phone: (678) 539-1629. E-mail: KAbernethy@halboothsmith.com.
- Robert J. Conroy, JD, Kern Augustine Conroy & Schoppmann, Bridgewater, NJ. Phone: (908) 704-8585. E-mail: conroy@drlaw.com.
- Michelle M. Garzon, JD, Williams Kastner, Tacoma, WA. Phone: (253) 552-4090. E-mail: mgarzon@williamskastner.com.
- Roger J. Lewis, MD, PhD, FACEP, Vice Chair for Academic Affairs/Professor of Medicine-in-Residence, Department of Emergency Medicine, Harbor- UCLA Medical Center, Torrance, CA. (310) 222-6741. E-mail: roger@emedharbor.edu.
- Robert Shannon, JD, Senior Partner, Hall Booth Smith, Atlanta, GA. Phone: (404) 954-5000. E-mail: RShannon@hallboothsmith.com.

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 QUESTIONS

1. Which is recommended to reduce liability risks regarding discrepancies in ED nursing notes, says **John Tafuri**, MD, FAAEM?
   A. The most effective defense for EPs is to claim the nurse didn't give them information that would have caused them to do something differently.
   B. The electronic medical record should flag abnormal vital signs charted by nurses so these are easily visible by EPs.
   C. If EPs acknowledge the discrepancies in the chart, this always makes a claim more difficult to defend.
   D. EPs should avoid any documentation indicating awareness of abnormal vital signs if the patient is being discharged.

2. Which is recommended for EPs reviewing nursing notes, according to **Ken Zafren**, MD, FAAEM, FACEP, FAWM?
   A. Read nursing notes only once during the patient visit.
   B. Don't sign the note until after the patient has left the ED and review the nursing notes once more before signing.
   C. Always sign the note before the patient has left the ED.
   D. Criticize nursing notes in the patient's chart when appropriate.

3. Which is true regarding use of crowding as a defense to a malpractice suit, according to **Charles R. Grassie**, MD, JD?
   A. Sudden volume surges are not an effective defense for an EP under any circumstances.
   B. The standard of care always changes during sudden volume surges in EDs, whether a disaster is called or not.
   C. If EPs use crowding as a defense, this opens up the possibility of negligent staffing allegations against the hospital and/or ED group.
   D. The standard of care doesn't change due to sudden volume surges in the ED, even if a disaster is called.

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. ■