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Patient Can't Pay for ED Care? EPs Must Protect Themselves Legally

Offer patients options for follow-up care

"I can't afford that test," "Don't bother giving me an appointment for a specialist because my insurance won't cover it," "I can't pay for that medication."

When an emergency department (ED) patient makes statements such as this, the emergency physician (EP) is often faced with few or no financial assistance options for the patient to achieve the recommended course of care, says **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney.

"Despite the political hype surrounding the Affordable Care Act, the situation is not likely to disappear in the foreseeable future," says Frew.

There is no specific cause of action for patients who are unable to pay and claim they were not treated or were discriminated against, except under the Emergency Medical Treatment and Labor Act (EMTALA), and that cause of action is against the hospital. "The issue often is subsumed in allegations of substandard care or perhaps discrimination," says Frew.

As with any emergency plan, the hospital must assess all of the available community resources and be in a position to deploy them to assist patients with financial needs, advises Frew.

"While resources in many hospitals are limited, the ED should be aware of all options and how to access them," says Frew, adding that in larger facilities, the EP may be able to rely upon a patient service representative to work with the patient.

There is no specific legal obligation for the EP to be an expert on the financial aspects of care. However, says Frew, "a successful plan of care that the patient can and will follow always leaves the physician in a less vulnerable position for future claims of malpractice or EMTALA violation."

Don't Ignore Concerns

"The risk for the EP is if a plaintiff's attorney can prove that the physician knew that the patient could not afford follow up, and thus, would not," says **Michael Blaivas**, MD, FACEP, professor of medicine at University of South Carolina Medical School and an ED physician at St. Francis Hospital in Columbus, GA.

If the patient or family specifically stated that they cannot follow up due to finances, this would typically be documented in the medical record by the EP or ED nurse. "Then, in court, it sounds like the EP effectively suggested no follow up," says Blaivas. "While this is not in fact true, the fear is that a crafty plaintiff attorney will convince the jury of that."

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This is especially problematic if follow up was critical. "Many of us never ask patients about money, look at the patient's insurance, or document payer status, as we should not," says Blaivas. "However, if you heard from the patient or family about this concern, it cannot be ignored."

To protect themselves legally, EPs can address the concern and document the discussion, says Blaivas. Otherwise, the EP may be surprised later to find such documentation in the nursing notes after the patient is discharged. "The nurse did not mean anything malicious by this, but simply did not have time to catch up on charting until later, and was diligent enough to document family and patient concerns," says Blaivas.

Blaivas recommends that EPs have a "ready response" of resources for indigent patients, such as clinics or social services that can serve as a backup for the patient. "Ask them to follow up with the referral, but if for some reason they need the backup, here it is," says Blaivas. "Also, they should always be reminded to return to the ED."

Documenting these efforts does not have to be burdensome for the EP, he adds — just a summary is needed. "This will be important to stand up to a challenge by the plaintiff that the EP did not give plausible options, such as a facility too far or without capability," says Blaivas. EPs should know the location and capability of the backup "referrals," he adds, and should be able to explain why they thought it was a reasonable place for the patient to go if the patient was unable to get into the referral that was made based on the hospital call list.

"The EP can also explain in court that he or she is required to refer by the call list, but took the extra step of giving additional options in response to the patient's concern about finances," says Blaivas.

Non-standard Course of Care

If the patient is in the ED with a condition that, left untreated, may cause a deterioration in the patient's condition, EMTALA requires the hospital to provide the necessary care regardless of means or ability to pay. "Medical malpractice liability generally follows the EMTALA requirements," says Frew. "That care is required to be consistent with the care provided to fully insured patients with the same or similar conditions."

If the patient refuses care, the only option for EPs under EMTALA is to document a detailed discussion of risks and benefits, and to obtain a written refusal of services from the patient. "'Risks

and benefits discussed with patient' is wholly inadequate documentation," adds Frew.

EPs should specify that they discussed alternatives with greater risk and potentially less effectiveness to prevent the patient from going completely untreated, says Frew. This documentation establishes that the EP is proceeding "under duress" to achieve some level of care for the patient by prescribing the non-standard course of care, he explains.

It should be noted that less expensive care is much more effective than no care, says Blaivas. "Best treatments are not always agreed upon, and the person with the largest wallet may end up with testing and procedures they do not need," he adds.

Blaivas says the best approach for EPs is to recommend and document their recommendation for reasonable and effective care.

"The key in court is that if you believe it was a reasonable referral — and you should if you made it — do not waver, no matter how much the attorney presses, and do not let yourself be tricked with hypothetic scenarios," he says. In this scenario, Blaivas says EPs should "stand their ground and repeat, 'As I have already said, I believe this was reasonable because ...'"

If a patient is unwilling to accept the EP's recommendations due to cost, and threatens to refuse all care as a result, "only then should a discussion ensue about less costly and effective alternatives," says **Michelle Myers Glower**, MSN, RN, NEA-BC, a clinical instructor at Loyola University, Chicago. Myers Glower is former ED director at Elmhurst (IL) Hospital and former ED case manager at NorthShore University Hospital in Evanston, IL. Before this discussion begins, however, she says these steps should occur:

- The mental competency of the patient should be determined.
- The EP should make it clear to the patient that he or she is now acting against the EP's best medical advice.
- Lastly, a conversation about the benefits, risks, and costs of alternative care should ensue.

"Excellent documentation that covers the above conversation from practitioner to patient is a must," says Myers Glower. "This cannot be overstated."

Offer Options to Reduce Risk

Myers Glower recommends that ED nurse case managers facilitate the discussion about options in follow-up health care at the point of entry.

"This does work. I did it, and the patients loved the information," says Myers Glower. "This new type of discharge planning should be happening at the point of entry."

In one case, a patient who presented to the ED with a pelvic fracture wanted to be admitted under inpatient status for three overnight stays in order for Medicare to pay for her to go to a skilled nursing facility.

"However, she did not qualify for inpatient status; she qualified for observation status," says Myers Glower.

The patient was given the option of being transferred from the ED to a skilled nursing facility at a negotiated rate that the hospital arranged with several facilities in the area, or to be admitted overnight and discharged to a skilled nursing facility, which would result in higher out-of-pocket costs.

"This way, the patient who can pay the significant reduced rates for a short skilled nursing facility stay is managed appropriately, and not sent home to be unable to care for herself," says Myers Glower.

Similarly, uninsured patients with no primary care physician who need follow up in a clinic can be given a referral and, hopefully, an appointment before they leave.

"Many EDs are now doing this 24/7, which is smart thinking," says Myers Glower. "Identifying the risk at the door with a plan makes everyone happy." ■

Sources

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Suits Against EDs Unlikely to Involve Over-ordering of Tests

Failure to order test is far easier argument for plaintiff

Over-ordering of diagnostic tests is a key focus of policymakers and insurers, but is unlikely to come up during malpractice litigation, according to health care attorneys and risk management experts interviewed by *ED Legal Letter*.

"You are much more likely to hear a complaint of that nature from a third party payer than from a plaintiffs' attorney," says **Joseph P. McMenamin**, MD, JD, FCLM, a Richmond, VA-based health care attorney and former practicing emergency physician (EP).

The reality is that the EP may someday have to explain to a plaintiffs' attorney why he or she didn't order a diagnostic test, says McMenamin.

"As a society, we are somewhat hypocritical, by criticizing physicians for exposing patients to needless risk and then turning around and suing them if they don't diagnose every disorder," says McMenamin.

It's far easier for a plaintiffs' attorney to make the argument, "The EP saved the hospital $300, but cost my client his life because he didn't get a CT scan," than to make the case that a patient was harmed because the EP subjected him or her to an unnecessary diagnostic test, he notes.

"This is because the amount of radiation in a single CT is so modest that the likelihood it could cause malignancy or any other harm is minimal," says McMenamin. "The criticism will more commonly arise from those that pay the bills than the lawyers that sue doctors."

McMenamin says that for this reason, the temptation is strong for EPs to "err on the side of diagnostic thoroughness. Obviously, you don't want to miss a diagnosis, and many medical conditions do lend themselves to more successful treatment when detected early."

Emphasis on over-ordering of diagnostic tests, however, "is going to become more pronounced in the future, not less," says McMenamin. "There will come a point where doctors' freedom to order diagnostic studies will be curtailed. To a degree, in fact, it already is."

EP Is "the One on the Front Line"

There is a feeling among some EPs that the need to eliminate even low-probability disorders is a high priority for liability protection, says **James Scibilia**, MD, a Beaver Falls, PA-based pediatrician and member of the American Academy of Pediatrics' Committee on Medical Liability and Risk Management.

"Some of this comes from prior 'near miss' experiences of physicians or colleagues, or information learned about particular malpractice cases in the community," he says.

Another factor, says Scibilia, is the current mechanism in malpractice litigation in which opposing experts provide perspectives on care to non-medical court members who may not be savvy concerning the medical issues.

"The possibility of an 'expert' second guessing your assessment, even when appropriate, leads to the increase in a variety of diagnostic tests and referrals," he says.

Regarding the possibility of increased long-term cancer risks in patients receiving CT scans, Scibilia says most EPs tend to look at the overall risk to a single patient as negligible compared to their potential liability risk of missing a rare finding.

"The problem is, if a patient comes in with a severe headache, the likelihood that it's due to a subarachnoid hemorrhage [SAH] is remote — it's probably less than 1% — and yet, if the EP says, 'you don't need a CT scan, we can just watch it,' and it turns out to be SAH, then there are big problems," says **Leonard Berlin**, MD, FACR, professor of radiology at Rush University and University of Illinois, both in Chicago, and author of *Malpractice Issues in Radiology*.

In one case, a defendant EP told the plaintiff attorney that he didn't order a CT scan because the likelihood of an SAH was less than 1%. "The attorney said, 'But in this patient, it was 100%, wasn't it, doctor?'" says Berlin. "That is the issue."

The EP will pay the consequences if he or she makes the wrong decision, says Berlin. "It's very easy for politicians or policymakers to say we could cut down on the utilization of CT scans if EPs were far more conservative. But the EP is the one on the front line," he says.

If the EP believes a test isn't indicated and the patient agrees, "that's wonderful, but by all means, the EP should document it," says Berlin. "Otherwise the patient can say, 'You never explained that to me. You just refused to do the screen.'"

On the other hand, says Berlin, if a parent demands

a head CT for a child with a minor head injury even after the EP recommends a "wait and see" approach, "the EP will be very foolish if he doesn't agree to do it, because if there turns out to be an injury later on, there's going to be a big problem."

Data Prevent Duplicative Testing

EPs sometimes order diagnostic tests simply because they're unaware that duplicative testing has already been done, says **Brian Dawson**, MD, MBA, FACEP, an EP at Johnston Memorial Hospital in Abingdon, VA.

"EPs are chief complaint-oriented, and don't always have the time to spend looking through all the charts and data that exist in the EMR," says Dawson, co-founder of Abingdon, VA-based Brily Innovations, whose Align system gives EPs data on recent diagnostic tests obtained by frequent ED visitors.

"We've found that this has reduced testing in a certain subset of patients," says Dawson. In a pilot test of 100 patients followed over 14 months, ED visits were reduced by 2000 compared to the previous 14-month period.

One patient in the pilot study had 36 brain natriuretic peptide levels done. All were negative, and it was determined that the patient had chronic obstructive pulmonary disease, not congestive heart failure. "So ordering that test again on subsequent visits is likely to be of no benefit to that patient," says Dawson. "But without knowing that information, many EPs might order it as part of their work up for shortness of breath."

Another patient had multiple EKGs, all of which showed an ST-elevation myocardial infarction (STEMI) pattern. The patient actually had pulmonary disease and an abnormal baseline EKG.

"Before our program, that patient went to the cath lab three times unnecessarily," says Dawson. "No one did anything wrong because when he showed up, the EKG had the STEMI pattern and quick action was indicated. But because we provided the EP with meaning from prior data, we removed what could be called an unnecessary test in retrospect."

One patient had almost 30 CT scans in a five-year period at the same institution. "The problem is that the EPs don't find out until after the fact," says Dawson. "If the patient comes in and has a history and exam consistent with appendicitis, many EPs will just order the scan and move on." With the patient's imaging history, the EP can discuss other options with the patient, and document "patient's report was reviewed. We had a discussion and the patient chose not to proceed with another CT scan at this time."

In some cases, it may be appropriate to scan the patient again, acknowledges Dawson. "It doesn't stop the EP from ordering the test," he says. "It just gives the EP a better, faster way of getting meaning from the existing medical data, and that understanding allows us to reduce some tests." ■

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Is EP Liable if Patient Fails to Disclose Substance Abuse?

Documentation makes claims more defensible

When a patient arrived at an emergency department (ED) and reported chest pain, he failed to notify the emergency physician (EP) that he was addicted to opiates. The case involved a patient who suffered a cardiac event while visiting relatives. The family had no knowledge of the patient's medical history or current medications he was taking.

"In fact, the patient's cardiac event was actually a symptom of opiate withdrawal," says **Justin S. Greenfelder**, JD, Buckingham, Doolittle & Burroughs, Canton, OH. "He alleged that the physicians failed to provide him with the proper treatment for his condition."

In order to learn as much about this patient as they could, the EPs determined the names of the patient's physicians at home and immediately faxed them requests for the patient's medical records.

The case is still pending, reports Greenfelder, but the EPs' actions in immediately obtaining the patient's medical records and evaluating his condition has made the case more defensible. "The EPs' actions were reasonable under the circumstances, and have basically eliminated any claim for breach of the standard care on that specific issue," he explains.

Question Often Isn't Asked

Patients presenting with fever and constitutional symptoms such as myalgias and malaise without a localizing source are often diagnosed with viral syndrome and, particularly when the patients are young, may be sent home from the ED with minimal work up.

"However, patients with a history of intravenous drug abuse (IVDA) who present with fever are at risk of endocarditis," says **Darien Cohen**, MD, JD, an attending physician at Presence Resurrection Medical Center and clinical assistant professor in the Department of Emergency Medicine at University of Illinois, both in Chicago.

The signs and symptoms of endocarditis can be particularly difficult to diagnose, and if a history of IVDA is not obtained, this diagnosis may not be considered. "If the patient were to return critically ill with a subsequent diagnosis of endocarditis, it would be important to have documented that the patient denied any illicit substance abuse at the initial visit," says Cohen.

Similarly, young patients with chest pain are generally thought to be at relatively low risk for coronary artery disease. However, says Cohen, one of the many risk factors for coronary artery disease is cocaine use.

"Patients who have a history of cocaine abuse presenting with chest pain generally require a more extensive work up, and there is a lower threshold for admission," he says. Failure to obtain and document a history of substance abuse can put the physician at risk legally if the patient subsequently presented with a cardiac event, says Cohen.

Certain prescriptions may be contraindicated in a patient with a history of substance abuse. "Generally, physicians would not prescribe narcotics to a patient with history of heroin abuse," says Cohen. "However, if there is no social history documented, and the patient subsequently overdoses on prescribed narcotic pain medication, the physician could be at risk."

While patients are not always honest about their illicit drug and alcohol use, EPs should at least ask the question and document the response, advises Cohen.

"It is much easier to defend a chart in the above scenarios wherein the physician documented that the patient denied illicit drug use, than a chart where no mention is made of the patient's social history," says Cohen.

Stephen A. Barnes, MD, JD, an attorney at McGehee Chang, Barnes in Houston, TX, says that in his experience, it is more common that an EP doesn't properly inquire about substance abuse than it is for a patient to fail to disclose when proper inquiry is made. For instance, patients are typically asked, "What medications are you currently taking?"

"They answer appropriately with prescription medications. The inquiry into substance abuse is an entirely different ballgame and usually not asked by doctors," says Barnes.

Electronic medical records (EMRs) make it more likely that ED nurses will skip asking about substance abuse and simply check the "none" box, he adds. "For EPs, it's rare for them to ask at all, and if they are asking, it's due to a suspicion of abuse," says Barnes. "And if there is a suspicion of abuse, the standard of care is to get a toxicology screen."

Unanswered Question Is Red Flag

A plaintiff attorney might allege that the EP failed to seek the information because the ED history doesn't ask about at-risk behaviors. "That would probably pose liability for the ED corporation and/or hospital. But in some circumstances, the doctor might also be culpable for not having insisted that they use such a protocol," says **Kathleen M. Roman**, MS, a Greenfield, IN-based risk management consultant.

Roman recommends that all EDs use a written health history that asks every patient about substance abuse, with at least two people reviewing the document — the physician assistant (PA) and the EP, for example. "If the patient answers the question in the affirmative, then the treatment plan needs to be adjusted, if necessary, to take into account the patient's risk," she says.

If the EP makes no notation of the patient's affirmative response, and the patient suffers an injury that appears to be related to the at-risk behavior, a plaintiff attorney might allege that

the EP failed to pay attention to the information.

For example, the PA might ask the patient verbally, note the information, and pass it along, either in writing or verbally, to the EP, who might forget about it or fail to review the notes before examining the patient. In other cases, patients leave the question blank on a paper health history form.

"A blank space becomes an immediate red flag for assertive follow up with the patient, including additional testing if the doctor thinks it is beneficial," says Roman. "If there is any suspicion that the patient has attempted to mislead the ED team, the ensuing conversation should include two members of the ED team, one of whom is there as a witness."

If the patient lies on the form and there are no significant signs that he or she might be lying, the EP is likely to be protected, says Roman, because the patient's risk of injury is self-triggered. "The record is the physician's biggest protection," she says. "And in an ED, where doctors are unlikely to know their patients, it is critically important."

Document Patient's Denial

Stephen G. Reuter, JD, an attorney with Lashly & Baer in St. Louis, MO, gives the scenario of an ED patient denying alcohol use who is then given a medication in the ED that causes acute liver failure. "The best way to prevent a plaintiff lawyer from taking the case is to document the patient's denial of alcohol use," he says. Drop-down checkboxes in EMRs are not as strong a defense as the EP actually writing a note, adds Reuter. "If there is a heightened suspicion for whatever reason, the EP can be specific without being accusatory," says Reuter. For instance, the EP can ask the patient, "Are you taking any narcotics or pain medications?" or "Are you currently using any recreational drugs?"

"It takes longer to do this, but if the EP is concerned, it's a good idea to go ahead and type in, 'Patient denies use of pain medications or recreational drug use,'" says Reuter. "That way it's more specific to this patient, as opposed to a rote checklist."

If the EP has access to the patient's previous records indicating the patient's history of alcoholism, the plaintiff attorney is likely to argue that the EP had an obligation to access these records. "If the EMR contains the patient's previous records, that is creating a potential new standard of care for EPs," Reuter explains. "If the EP doesn't look at those, and the answer is there, then the plaintiff attorney now has something to talk about."

An EP can have a nurse or unit secretary access the part of the EMR that contains the patient's medication history. "The problem with that is it's ivory tower stuff — as a practical matter, it's very difficult to do," says Reuter.

EPs should check the triage and nursing notes to see whether these are consistent with the EP's documentation about the patient's substance abuse or alcohol use, recommends Reuter.

"It's going to be harder for a plaintiff attorney to take the case when you have three health care providers in one record documenting that the patient said they weren't taking any pain medications," says Reuter. ■

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These Successful Claims Involved Inappropriate Discharge of ED Patients

EP failed to consider changes in patient's condition

A 42-year-old female presented to the emergency department (ED) with a complaint of a constant headache that began the day before arrival. The patient was seven days postpartum, having undergone an epidural block and cesarean section.

The initial emergency physician (EP) ordered labs, including a urinalysis, and requested an anesthesia consultation to determine if the headache was related to the epidural block. An anesthesiologist determined that the headache was not caused by the epidural puncture, and suggested that other possible causes be investigated, such as preeclampsia, and recommended an OB/GYN consultation. According to the first EP, this consultation took place over the phone, and the OB/GYN dismissed the possibility of preeclampsia since the cesarean section had been performed one week earlier.

"The emergency physician failed to document the conversation. Later, the OB/GYN testified that he could neither confirm nor deny that the conversation took place," says **David Long**, senior vice president of risk management at Phoenix Physicians in Durham, NC.

As his shift was ending, the EP ordered a CT scan of the brain to rule out an intracranial bleed. He discussed the patient with the oncoming EP, and advised her of the consultations with the anesthesiologist and the OB/GYN.

"He also told her that the patient was having a CT scan, that everything else looked fine, and the patient could be discharged if the scan was negative," says Long. The CT scan was negative and the patient was discharged by the second EP.

When the patient returned 24 hours later unresponsive, a second CT scan revealed a subarachnoid hemorrhage. The patient was taken to surgery but did not survive, and an autopsy revealed hemorrhages in the brain and lungs.

"The medical examiner concluded that postpartum preeclampsia was the cause of the hemorrhages," says Long. There was a multi-million dollar settlement of the ensuing lawsuit.

"Although there are a number of concerning issues with this case, many are related to the second emergency physician relying on the first emergency physician's judgment and the completeness of his assessment," Long says.

The second EP was still on duty when the patient returned unresponsive. Upon reviewing the records from the first visit, she noted that the urinalysis showed a very elevated protein — a strong indicator of postpartum preeclampsia.

"Had she reviewed this previously, the emergency physician said she would not have discharged the patient," he says.

EP Charted Ahead for Discharge

A recent malpractice case involved a 4-year-old child seen in the ED for complaints of diarrhea, nausea, and vomiting. The EP noted signs of dehydration, but the exam was otherwise unremarkable, and the physician started intravenous fluids and ordered lab work and blood cultures.

As a courtesy to the relieving physician, the first EP prepared the chart for discharge with a diagnosis of viral syndrome. "The relieving physician interpreted the child's lab values as normal, and discharged him at 7:30 p.m. with the viral syndrome diagnosis," says Long.

The relieving physician did not evaluate the patient before discharge. The nursing notes indicated that the child had become more lethargic and that his vital signs had deteriorated.

"During ensuing litigation, it was disputed as to whether or not the nurses had brought the changes to the attention of the discharging emergency physician," says Long.

At approximately 4:45 a.m. the following morning, the child was taken back to the ED unresponsive, with fixed and dilated pupils. He was intubated and a code was called.

"The child could not be resuscitated, and he was pronounced dead. An autopsy revealed that the patient's death resulted from septic complications due to acute appendicitis," he says. A lawsuit was filed, and the case was settled for several hundred thousand dollars shortly before trial.

"There are several aspects of this case that created higher risk," says Long. Charting ahead for discharge showed that the first EP was making assumptions without all the facts.

"Even if the course is later reversed and the patient is admitted, it appears presumptuous — because it is. It makes a case more difficult to defend," he says.

In addition, the discharging EP failed to take into account that a patient's condition can change while he or she is in the ED.

"Diseases evolve and new signs and symptoms appear," says Long. "Patients are often in the ED long enough for such changes to manifest themselves."

Avoid "Double Sign Outs"

Discharged patients are often neglected because no one EP takes full responsibility for the patient, says **Dickson Cheung**, MD, MBA, MPH, an attending physician at CarePoint in Denver, CO, and former instructor in the Department of Emergency Medicine at Johns Hopkins School of Medicine.

"The early afternoon doc signs out at 8 p.m. to the late afternoon doc, who leaves at 10 p.m., when the night doc comes out and picks up all the remaining patients," says Cheung.

This results in a "double sign out." "In a game of telephone, it is the third provider that assumes responsibility of the patient without directly hearing from the first provider who saw the patient," says Cheung.

The second EP is prone to just "babysit" the patient and not fully invest in the patient, says Cheung, because he or she knows another handoff will occur very shortly, often within the hour. "The third EP is often left clueless because he or she is hearing third-hand about the patient," he adds. Cheung suggests these practices to reduce legal risks:

- Every EP coming on should take full responsibility for the patient, as if the patient was their own to begin with.
- EPs should explicitly assign remaining tasks, such as checking the patient's second lactate or consulting the cardiology service for a stress test if the patient's second troponin level comes back negative.
- EDs should arrange shift schedules such that "double sign outs" are eliminated or reduced.

"Give cell phone numbers out, in case providers have questions after they leave," advises Cheung. ■

Sources

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Should EP Comply with Blood Draw Requested by Law Enforcement?

Court ruling affects EPs' malpractice risks

In the April 2013 case of *Missouri v. McNeely*, the Supreme Court ruled that police must generally obtain a warrant before subjecting a drunk-driving suspect to a blood test.

"At the heart of the ruling, the Court rationalized that the natural dissipation of alcohol in the blood is generally not sufficient reason to jettison the requirement that police get a judge's approval before drawing a blood sample," says **Edward Monico**, MD, JD, assistant professor in the Department of Emergency Medicine at Yale University School of Medicine in New Haven, CT.

In many states, drunk-driving suspects are typically escorted by police to local emergency departments (EDs) to procure blood samples for evidentiary reasons. "Therefore, emergency physicians will now be faced with the question of when to comply with a judicial request for blood," says Monico.

This underscores the necessity for emergency physicians (EPs) to be familiar with the law in their state, and to have a proactive plan established with the institution, legal department, and ED.

"It would be likely that a physician might be compelled to comply with a judicial order to obtain blood if that is, in fact, the law in the state," says Monico, adding that the institutional protocol should reference the state law.

"The best protection against medical malpractice is to practice good medicine," says Monico. Therefore, irrespective of the presence or absence of a warrant, if there is a medical reason to obtain blood that includes an alcohol level, the EP should obtain the blood. Documentation should reference the institutional protocol such as: "… pursuant to judicial order and hospital protocol, a blood alcohol level was obtained."

If the patient's capacity is at issue, the EP should do whatever it takes to keep the patient safe, says Monico. This may include obtaining blood against the patient's will.

"Knowing the etiology of a patient's altered mental status may foreseeably require an assessment of an alcohol level," he says. The EP could document, for example, that in the physician's estimation, the patient is incapable of informed consent and does not have the capacity to make health care decisions at this moment in time.

Monico advises EPs to document that the etiology of a patient's altered mental status includes the presence of a toxic substance and that blood analysis, in an effort to identify that substance, is indicated.

"The rubber meets the road when a patient with apparent capacity refuses blood draw in the face of a warrant demanding a blood sample be

drawn," says Monico. "A reasonable approach would be for physicians to act under color of the warrant."

Monico says liability risks for EPs are greater if patients with apparent capacity refuse a blood draw when there is no warrant. In this instance, a court could rule that blood tests obtained in this scenario violate the Constitution's prohibition against unreasonable searches and seizures.

"Emergency physicians can further protect themselves by putting in place protocols to follow that instruct health care providers on how to proceed when DUI suspects are brought to the ED by police," says Monico.

False Sense of Security

John Tafuri, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland, has reviewed a number of malpractice cases against EPs involving intoxicated patients who had an underlying traumatic injury that went undetected.

"Do not be dismissive of intoxicated patients. They still can have traumatic injuries or medical conditions," warns Tafuri. "A full and complete evaluation is mandatory."

EPs often "get numbed into a false sense of security with these patients," he says. "We all have that inclination to say, 'Oh, it's just another drunk,' but in fact, we need to have a high index of suspicion with these patients."

A recent malpractice claim involved an intoxicated patient who reported falling down, but did not complain of neck pain. "He was dismissed by the paramedics, but had a c-spine injury and ended up quadriplegic," says Tafuri. ■

Sources

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Complaint Management System Has Prevented Bad Outcomes

Malpractice claims likely averted

The day after a man came to the ED at Edward Hospital in Naperville, IL, reporting low back pain and was discharged with analgesics, he received a phone call asking how he was feeling. He reported weakness and difficulty emptying his bladder.

"This resulted in a request for him to return. An MRI showed an epidural abscess, and surgery may have prevented paraplegia," says **Tom Scaletta**, MD, FAAEM, chair of the ED. About 18 months ago, the ED implemented a complaint management system that contacts all ED patients by e-mail or text the day after a visit.

"When we first started doing this, it was only by phone. We later tested a hybrid — both phone and electronic," says Scaletta. "Now, we only send out requests electronically."

Regardless of how the patient is contacted, if the patient's condition has worsened, a notification is sent to the charge nurse, who calls the patient back.

"They confer with the emergency physician to determine if more testing is needed," he says.

When patients have questions about follow up or their discharge instructions, these are funneled to the case manager. If there is a service issue, one of the department leaders usually calls back to apologize for the negative experience.

"I have found this practice mitigates risk by identifying near-misses, correcting any misperceptions, and apologizing for service deficiencies before they fester and possibly become claims," says Scaletta. "I believe this is the origin of many frivolous lawsuits."

The system was developed as a result of feedback from the ED nursing director, says Scaletta, "who did not just want to funnel in patient complaints and create another stack of issues to deal with."

This led to the development of a way to quickly categorize complaints into 20 categories, with "complaint forwarding," if applicable, to the head of another department. For instance, a complaint about bathroom cleanliness goes to

the head of housekeeping so that it can be used to drive improvement within that department.

"The system also automatically formulates an appropriate patient response that can be edited," says Scaletta. "The system is driven by a daily data extract, of all patients seen yesterday, which is uploaded."

Direct Response to Unhappy Patients

Requests for feedback are sent to all discharged patients by text or e-mail. "We ask five questions that relate to well-being and service. We get feedback from about 30% of patients — about three times as many by text versus e-mail," says Scaletta. About 95% of patients report they are doing fine medically, and the majority give positive feedback about their care in the ED.

"We are always in the 95th percentile or better with Press Ganey benchmarking," reports Scaletta. However, the calls give nurses a chance to respond directly to the small percentage of unhappy patients. For instance, some patients experience low back pain the day after a motor vehicle accident and believe X-rays should have been done during the previous ED visit.

The first question is about the patient's well-being: "Are you better, same, or worse?" "About 1-2% of the time, the patient answers 'worse,' and a fax goes to the charge nurse," says Scaletta. "This is handled similarly to a positive culture that returns the day after discharge."

The charge nurse looks up the case, confers with the on-duty EP, if needed, calls the patient back with the plan, and documents in the electronic medical record.

The second question asks if the patient had any problems with aftercare, such as instructions, medications, and follow-up. About 3% of patients respond "yes," and the e-mail is forwarded to the on-duty case manager, who addresses the issue.

"The third and fourth questions assess physician and nurse performance," says Scaletta. "The last question is a 'catch-all' and funnels in all sorts of issues."

Several patients reported worsening abdominal pain and were told to return to the ED, where they were diagnosed with appendicitis.

This improves care continuity, says Scaletta, since EPs can compare any interval change in exams or test results and determine if any opportunity for improvement existed with the initial visit.

"While discharge instructions always state to come back if the patient gets worse, it's nice to be more proactive and make sure the patient comes back to our hospital," says Scaletta. ■

Source

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CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

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

CNE/CME INSTRUCTIONS

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. Scan the QR code below, or 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 an emergency physician's (EP's) compliance with law enforcement-requested blood draw, according to **Edward Monico**, MD, JD?
   A. Irrespective of the presence or absence of a warrant, if there is a medical reason to obtain blood which includes an alcohol level, the EP should obtain the blood.
   B. The EP's documentation should not reference the judicial order or hospital protocol.
   C. If the patient's capacity is at issue, the EP should do whatever it takes to keep the patient safe, except obtaining blood against the patient's will.
   D. If patients with apparent capacity refuse a blood draw when there is no warrant, a court cannot rule that blood tests obtained violate the Constitution's prohibition against unreasonable searches and seizures.

2. Which is recommended to reduce legal risks of ED patients who are discharged during shift change, according to **Dickson Cheung**, MD?
   A. EPs should not explicitly assign remaining tasks.
   B. Every EP coming on should take full responsibility of the patient as if they were their own to begin with.
   C. EDs should not arrange shift schedules to eliminate "double sign outs."
   D. As a courtesy to the relieving physician, an outgoing EP should routinely prepare charts for discharge.

3. Which occurred after a complaint management system was implemented at Edward Hospital's ED, according to **Tom Scaletta**, MD, FAAEM?
   A. Claims against EPs increased as a result of apologies for service deficiencies.
   B. Patient complaints increased significantly.
   C. Several patients reported worsening abdominal pain and were told to return to the ED, where they were diagnosed with appendicitis.
   D. The majority of ED patients reported serious problems with aftercare.