

# ED Legal Letter™

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## Intoxicated patient in the ED can be a sobering experience

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**E**ditor's note: *An intoxicated person trips and falls while exiting a local tavern and has difficulty getting up, not due to physical trauma, but rather from overconsumption of alcohol. An overzealous bystander calls 911, and the uncooperative patient is rushed to the emergency department (ED). This is an all-too-familiar scenario for emergency physicians (EPs) and nurses. EDs have become the "drunk tank" and the health care safety net for society. Intoxicated patients found in alleys, along roadways, and wandering the streets are brought to the ED for evaluation. This burden, whether EPs and nurses like it or not, has become routine. The reasoning behind it is simple — intoxicated patients are high risk. Management of these patients can be both complicated and frustrating. An intoxicated, violent patient can bring down morale in an ED and turn a shift into havoc faster than any other patient encounter. This issue of ED Legal Letter will outline risk management strategies aimed at reducing both litigation and stress for the EP and nurse.*

*To properly manage the alcohol-impaired patient, the EP and nurse must understand several important clinical and medicolegal principles. The intoxicated patient represents a high-risk emergency presentation, and the emergency clinician must be extremely diligent to provide the highest quality of patient care; diagnose coexisting, life-threatening disorders; and protect the patient's constitutional rights. A review of the literature indicates that there are no clear-cut guidelines for the management of the intoxicated patient.<sup>1</sup> These patients present to the ED with altered mental status, often express suicidal ideation, and at times are belligerent and physically violent. Frequently, police, family, or friends bring these patients into the ED against their wishes. These patients often refuse medical care, leaving the EP with very difficult "refusal-of-care" issues.*

*The alcohol-impaired patient often lacks insight into his condition, making it difficult for the physician to accurately diagnose and treat any underlying medical illness. ED clinicians must be careful not to assume that a patient who has been seen before merely is intoxicated again. One must be suspicious that the alcoholic patient is hiding some potentially life-threatening pathology until proven otherwise. To ensure patient and staff safety, the EP must be prepared to apply physical or chemical restraint and isolation when warranted. An understanding of the medical and legal issues associated with these patients will assist the EP in acting confidently and competently in providing optimal patient care and protecting the patient against the risk of injury and subsequent litigation. Several key points will be discussed in this issue, including whether blood alcohol content (BAC) levels are required in all patients; general management of the intoxicated patient; "against medical advice" (AMA) in the*

*alcohol-impaired patient; physician use of restraint and forced treatment; clinically clearing patients for discharge; and high-risk cases and risk management discussions.*

## Chemical Overview

Ethanol is a selective central nervous system (CNS) depressant at low doses and a general depressant at high doses. At the highest BAC levels, there is loss of protective reflexes, coma, and increased risk of death from respiratory depression.<sup>2</sup> There is a narrow margin between the anesthetic and fatal dose; deeply intoxicated patients are near death and must be managed aggressively.<sup>3</sup> Chronic alcoholics with a developed tolerance may appear sober at a BAC level of 300 mg/dL, whereas an adolescent with a level of 200 mg/dL may present with respiratory arrest.<sup>4</sup>

A "standard drink" (equivalent to a glass of wine, a shot of liquor, or a 12-oz beer) increases the BAC by 25-35 mg/dL. Lethal doses of ethanol are reported to be 5-6 mL/kg in adults and 3 mL/kg for children.<sup>5</sup> The LD 50 (the "lethal dose" level at which half of those patients with this BAC level would die) in the nonhabituated patient is approximately 500 mg/dL.<sup>6</sup> In general, the BAC level will fall by 15-45 mg/dL/h.<sup>7</sup>

Ethanol is a dialyzable substance in cases of potentially lethal ingestion.<sup>8</sup> There is no antagonist to alcohol currently available. Neither naloxone nor flumazenil has been shown to reduce or reverse the effects of alcohol.<sup>9</sup> There is a new direct alcohol dehydrogenase inhibitor, 4-methyl pyrazole (4-MP), for toxic ingestions of methanol or ethylene glycol. Studies have shown that 4-MP in a dose of 10-20 mg/kg produces a 40% reduction in the rate of elimination of alcohols.<sup>10</sup> It is unlikely that a true ethanol antagonist ever will be discovered.<sup>11</sup>

## General Management of the Intoxicated Patient

*Feeney vs. New England Medical Center Inc.*<sup>12</sup> At 10:16 p.m., Dec. 1, 1987, an ambulance team of the Boston Department of Health and Hospitals found 26-year-old Brian R. Feeney manifestly very drunk, sitting in the open on a street corner in South Boston.<sup>12</sup> Feeney admitted to alcohol abuse but denied drug use. He was physically and verbally combative and had trouble walking and speaking intelligibly. His condition interfered with his evaluation. Vital signs were not

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taken. He was picked up by ambulance and arrived at the hospital at 10:45 p.m. General observations that were noted described that there was no doubt that the patient had consumed significant amounts of ethanol.

At 10:45 p.m., as the patient was received at the hospital, he was judged responsive to pain and able to speak and move his extremities. There was no apparent trauma; however, there was no record that vital signs were taken. The patient was placed on his side on a stretcher in a hallway between the ED and waiting rooms. The documentation for the period between 10:45 p.m. and 11:30 p.m. is “sparse and contradictory,” as one of the experts put it. On the ED record, the next entry after 10:45 p.m. was at 11:30 p.m., when the patient was brought to the examining room. At that time, he was without respirations, was cyanotic, and his pupils were fixed and dilated. On the physician documentation record, in which the EP wrote out the course of the case to the end, he reported that a nurse returned at 11:05 p.m. and found the patient unresponsive and without respirations. However, this record goes on to report that the patient was pronounced dead at 12:07 a.m. after about 30 minutes of resuscitation efforts. If (as stated in the ED record) the nurse returned to the patient at 11:30 p.m., then it may be inferred that the patient had not been monitored for 45 minutes. On the other hand, if one refers to the physician documentation record, which states that the patient was seen at 11:05 p.m., then there is room to infer that a lapse of 25 minutes transpired between that visit and the commencement of “code.” One expert suggested that the former was the “more probable scenario.” On either basis, a gap appeared that needed explanation.

The court inferred from expert testimony that, “The minimum standard of care on the nursing side called for monitoring the respiratory rate of this patient every 15 minutes; this more likely would have permitted the nursing staff to observe changes in this patient’s breathing patterns and/or the onset of respiratory arrest.” Experts for the plaintiff argued that “(f)ailure of physician to evaluate the patient within the first few minutes of Mr. Feeney’s entry into the emergency facility and to initiate care, even absent any nursing-initiated contact” breached the standard for the emergency room physician. “(T)he emergency physician has an obligation to determine who is waiting for physician care and how critical is the need for that care,” plaintiff’s experts argued. The experts maintained that had the standards been

maintained, respiratory arrest might have been averted or treated effectively. According to the autopsy report, respiratory arrest was the sole cause of death. The autopsy report, in fact, revealed an ethanol blood level of 390 mg/dL.

The final outcome of this case is unknown because on appeal it was sent back for retrial against the hospital, treating nurse, and EP.

## Discussion

The case illustrates a common ED presentation of an intoxicated individual who is brought to the ED for evaluation. Unfortunately, an unsuspecting EP is defending a lawsuit that is premised upon the physician not evaluating a patient he was not even aware was in the ED. In general, the intoxicated patient warrants a thorough history and physical. It is imperative that these patients should be undressed, and the EP should view all body surface areas.

Intoxicated patients may present with a wide variety of life-threatening conditions, including trauma, hypoglycemia, hypothermia, hepatic encephalopathy, sepsis, electrolyte abnormalities, ethanol withdrawal, Wernicke-Korsakoff syndrome, or coingestions. Despite intoxicated patients’ objections and a common physician bias against these patients, they warrant rapid, meticulous evaluation and aggressive treatment when indicated. Physicians must not assume that intoxication is the etiology of a patient’s altered mental status. There is little debate about the management of the patient with a severely altered level of consciousness or in a comatose state. Attention to the ABCs (i.e., airway, breathing, and circulation) is the first priority. If the airway is occluded, unprotected (i.e., no gag reflex), or there is poor respiratory effort, these patients must be intubated. When possible, patients should be positioned in the left lateral decubitus position to prevent aspiration (after clearance of the cervical spine). Understandably, positioning is difficult and often impossible in these patients. It may be prudent to obtain cervical spine x-rays in those patients who are mild to moderately intoxicated with a possibility of trauma, including ground level falls, as evaluation of neck tenderness is unreliable. In addition, these patients will not lie supine for prolonged periods of time without significant physician and nurse intervention.

A full set of vital signs, including a core temperature, is essential. Thiamine 100 mg IV should be

given, as Wernicke's encephalopathy is suspect in the malnourished alcoholic patient. Patients with pinpoint pupils or depressed respiration should receive 2 mg of naloxone, given in consideration of a possible concomitant narcotic overdose. Ethanol intoxication classically dilates pupils; however, patients with very high ethanol levels (> 400 mg/dL) may present with pinpoint pupils that are unresponsive to naloxone. A blood glucose check always should be performed, as alcoholics are prone to develop hypoglycemia. Fifty milliliters of 50% glucose IV should be given if the blood sugar is low, a common state in chronic alcoholics due to depletion of glycogen stores.

In comatose patients or those patients with severely altered mental status, BAC level should be checked to determine if alcohol intoxication is the likely etiology of the altered mental status. The BAC level should correlate roughly with the level of consciousness. Physicians must be aware that coma due to ethanol alone is rare at blood levels less than 300 mg/dL.<sup>13</sup> As a few of the following cases illustrate, attributing an altered mental status due to intoxication when the BAC is not high will delay accurate diagnosis and delay proper treatment.

After a thorough history is obtained and physical examination is completed, if the EP determines that there is no apparent traumatic or other life-threatening illness or injury, then a period of observation is reasonable. The emergency staff should agree upon a reasonable observation protocol. Once a protocol is established, it should be followed and documented. This would include, at a minimum, repeat vital signs, check of the patient's mental status, and neurologic checks. There is no widely accepted time interval for physician re-evaluation. This should be determined on a case-by-case basis. ED managers and directors should avoid developing protocols that may be setting up the physician and nursing staff for failure. For example, requiring rigid time standards applied to vital signs and neurologic checks at brief intervals (such as every 10 minutes) will prove impossible when the ED is busy, and will give the plaintiff's attorney ammunition if there is an adverse outcome. This is not to say that frequent vital signs and neurologic checks would not be required if the patient has a moderate to severe decrease in level of consciousness.

In general, the patient's clinical condition should begin to improve in a three- to six-hour time frame.<sup>14</sup> In a study done at Detroit Receiving

Hospital, to distinguish patients with uncomplicated ethanol intoxication from intoxicated patients with other causes of mental status depression, researchers found an average of 3.2 ( $\pm 3.6$ ) hours were required to normalize mental status scores in patients with uncomplicated ethanol intoxication. While the authors recommend searching for an alternative cause for continued altered mental status after three hours, they noted considerable individual variation in the duration of mental status depression caused by uncomplicated ethanol intoxication (21% took seven or more hours to normalize, and 4% took as long as 11 hours).<sup>15</sup>

Another study reported that 16% of patients with traumatic intracranial hematomas had recognition of their head injuries delayed more than 12 hours due to ethanol ingestion, and that 45% of those dying from undiagnosed head trauma had been intoxicated.<sup>16</sup>

Whatever the time frame, further investigation is indicated if the patient's mental status does not improve during a reasonable period of observation (i.e., the patient does not "come up" or "sober up" as expected) or in those patients whose mental status does not correlate with the BAC level. Further work-up is indicated if there is any deterioration in mental status and/or new patient complaints as the patient approaches sobriety. Alcoholics are prone to trauma and coagulopathies, and the threshold for computed tomography (CT) scanning should be low.<sup>17</sup>

A history from family, friends, and paramedics is essential, and coingestions as well as recreational drug use should be suspected. Although ethanol is absorbed rapidly by the body and poorly adsorbed by activated charcoal, the possibility of recent ingestion (within one hour) and coingestion make gastrointestinal evacuation and the administration of activated charcoal a reasonable approach to the extremely intoxicated patient.<sup>18</sup> EPs should be aware of the possible presence of cocaethylene, a toxic metabolite of cocaine and ethanol, which is more toxic than either drug alone and has been reported to be present in more than half of subjects who tested positive for cocaine in one study.<sup>19</sup> Furthermore, chronic alcoholics may suffer from low magnesium and other electrolyte abnormalities, clotting disorders, hepatic encephalopathy, and untreated infections.

It is impossible to detect every traumatic injury, coexisting medical problem, or every coingestion

during the initial evaluation of the intoxicated patient. The observation period is necessary to identify hidden or subtle problems. This highlights one area in emergency medicine where physician/nursing teamwork is critical. The entire staff must recognize this as a high-risk situation. Staff may feel that managing the intoxicated patient is distasteful, but they must be convinced that it is not nearly as bad as malpractice litigation.

### Indications for Drawing Alcohol Levels

Generally, when alcohol levels are indicated, the use of a breath-testing device rather than a blood sample is acceptable. Studies have shown breath analysis to be as accurate as blood testing, particularly when the level is greater than 100 mg/dL.<sup>20</sup> However, breath analysis does require a certain degree of ability on the part of both the patient and the technician. Patients must be able to follow directions and cooperate while intoxicated. Breath testing is limited to those patients who can cooperate.

Breath testing can afford physicians an immediate level to work with, thus permitting rapid correlation of the level and clinical assessment. Waiting for a BAC level may delay immediate treatment and aggressive management of underlying or coexisting problems. Therefore, use of breath analysis is a rapid and acceptable alternative to BAC levels in a limited clinical setting. Those patients who are severely intoxicated or uncooperative prohibit breath testing; BAC levels should be obtained when clinically indicated.

The frequent use of the breath analyzer, even if a BAC level was obtained previously, offers the emergency clinician a convenient and rapid determination of the alcohol level to determine if alcohol content is rising or falling. Although rising ethanol levels are uncommon, they may occur in patients who ingest a large amount of alcohol prior to the ED visit with ongoing gastric absorption, or if the patient still is drinking in the ED. These rechecks will assist in correlating alcohol level with clinical improvement. The level obtained by breath analysis should be documented in the chart. If the Breathalyzer is capable of printing, the printed number should be attached to the chart. If a printed copy is not available, then the physician or those delegated to administer the test should document the time and the level obtained.

It is not practical to draw a BAC level on every patient who presents to the ED with suspected alcohol consumption. In patients simply suspected of consuming alcohol, a clinical assessment by history and physical exam with particular focus on mental status and neurologic exam is sufficient. A determination of alcohol level is not always necessary. It is acceptable simply to observe patients who are intoxicated and lack signs of significant trauma, traumatic mechanism, focal neurologic deficit, or other problems for a period of observation, without an alcohol level. These patients require serial exams to establish clinical improvement of their mental status over time. In this patient group, for clinical purposes, a numerical BAC level has little use. If the patient does not deny alcohol intake, the patient's clinical capacity is more important than the specific level of alcohol. A low BAC level does not guarantee competence. Other variables may not have been measured, such as drugs ingested or abused by other routes of administration, hypoglycemia, acidosis, medical illness, blood loss, etc.

A determination of the alcohol level is indicated if there is apparent intoxication and the patient is comatose, is in respiratory distress, has a severely altered mental status, or an altered mental status with signs of significant trauma or a significantly traumatic mechanism. In patients with signs of minor trauma alone, a determination of alcohol level should be based on the case history and physical exam, particularly the mental status and neurologic exam. In the patient who did not receive an initial level and then fails to improve clinically over time or whose condition deteriorates, an alcohol level is indicated.

### Disclosing BAC Levels

*Mellow v. Medical Malpractice Joint Underwriting Association of Rhode Island.*<sup>21</sup> The Supreme Court of Rhode Island held that a medical malpractice insurer had a duty to defend an EP against allegations that he improperly disclosed a patient's BAC level to the public.<sup>21</sup> In this case, the patient was treated by the EP for injuries to his head and body. In the course of treatment, the patient's BAC level was tested. The results of that test became public knowledge when published in the local newspaper. The patient brought suit against the EP for revealing this information without his consent. The patient complained that plaintiff had invaded his privacy and

caused him to incur “humiliation, shame, emotional distress, and mental anguish.”

## Discussion

First, the good news is that even though the malpractice insurance carrier attempted to avoid the obligation to defend the suit, the court found that it had a duty to defend the EP in this situation. Second, EPs must know when and to whom BAC levels can be released, to prevent this type of litigation. Recent studies have indicated that patients involved in motor vehicle accidents (MVAs) with illegal BAC (as identified by the hospital) were less likely to be convicted of driving under the influence (DUI).<sup>22</sup> Problems with legal constraints regarding to whom this information can be released and lack of chain of custody were identified as potential reasons. These problems have led to more specific legislation regarding when BAC results can be released. In Illinois, for example, the results of blood or urine tests performed for the purpose of medical treatment in a hospital ED for injuries resulting from an MVA *shall* be disclosed to the local or state police. The confidentiality provisions of law pertaining to medical records and medical treatment shall not apply and no person shall be liable for civil damages or professional discipline as a result of such disclosure (625 ILCS 5/11-501.4-1). This language mandates that physicians report the information to police upon request.

A more complex scenario would be if an EP does not order a BAC level because he or she does not believe it to be clinically relevant to treatment of the patient. Under section 11-501.1(a) of the Illinois vehicle code, any person driving a car who has been arrested and issued a traffic ticket for DUI is deemed to have given consent to a test of blood or urine for the purpose of alcohol and drug testing (625 ILCS 5/11-501.1[a]). However, a person may withdraw his or her consent to these tests.

There have been several debates over whether hospital ED staff are *required* to draw blood or collect urine at the request of the police officer, over the objection of the person to be tested. Section 11-501.2(c) of the Illinois vehicle code specifically addresses this question. It states in pertinent part that if a law enforcement officer has probable cause to believe that a motor vehicle driven by or in actual physical control of a person under the influence of alcohol, other drugs, or intoxicating compounds caused death or personal injury to another,

that person shall submit to testing. This section does not impose an obligation on the hospital to participate in the collection of the blood or urine sample over the objection of the patient. There is an immunity section (11-500.1) that protects hospital staff from liability in performing such blood draws upon request of police, as long as they are acting in good faith and not willfully and wantonly. Physicians in other states should request that the hospital attorney assist in outlining a risk management strategy based on the pertinent laws in each state. If the EP is in question about the authority of law enforcement in performing blood draws against the patient’s wishes, then a court order may be indicated. Judges are on call for just such emergencies, when a delay in testing or obtaining evidence adversely would affect the state’s case.

## Informed Consent, Refusal of Care, and AMA

*Oates v. The New York Hospital.*<sup>23</sup> In this case, the plaintiff, a 49-year-old male with alcohol on his breath (BAC level was later tested to be 0.232), was brought to the ED of the defendant hospital with multiple stab wounds. Upon his arrival, the plaintiff requested treatment. However, after defendants informed the plaintiff that they wished to perform a surgical procedure on him, he refused to consent. Believing that plaintiff was incompetent to consent and in a life-threatening situation, and since attempts to obtain consent from plaintiff’s family members failed, “consent” was obtained from a hospital administrator. An exploratory laparotomy was performed. After it was determined that plaintiff had not suffered intraperitoneal injury, plaintiff was brought to the recovery room. Shortly thereafter, he was discharged from the hospital in a greatly improved condition. As a result of the nonconsensual operation, plaintiff sued defendants for assault, punitive damages, and malpractice. The defendant physician and hospital won on all three counts.

## Discussion

In general, patients who present to the ED with a significant alteration in mental status are deemed incompetent to make medical decisions. Technically, only the legal system can declare incompetence. However, physicians often are placed in the difficult position of making rapid decisions about intoxicated patients refusing care or attempting to leave the ED

AMA. The EP must have special expertise in addressing this complex medical and social problem.

The alcohol-impaired individual who refuses treatment often is not capable of understanding the risks, benefits, and alternatives of treatment; therefore, an informed decision cannot be made. An analysis of state legislation and case law strongly suggests that the EP may err well on the side of caution by restraining and treating when necessary. However, intoxication is not synonymous with incompetence. Therefore, the EP must make an individual determination on a case-by-case basis regarding the patient's ability to provide informed consent or refusal. The EP carefully should document the presence of altered mental status and the need for application of restraint to protect the individual from harm.

Although this is a complex problem, there clearly is a duty to protect patients who cannot make an informed decision and may be a danger to themselves or others. From a legal standpoint, it is better to err on the side of paternalism. In some states, the EP also may have a legal duty to protect third parties, outside of the patient-physician relationship. **(See *ED Legal Letter*, June 1995, pp. 95-102.)** For example, if an intoxicated patient leaves the department and drives home in an automobile and injures a pedestrian en route, the third-party pedestrian may have a cause of action against the EP for negligent discharge of an intoxicated patient.

The AMA defense is an extremely strong defense when used in the appropriate circumstances. If a patient has a normal mental status and makes an informed refusal of care, then the AMA defense wins in almost every case. Although these issues must go to a jury, the jury tends to support the EP. However, if there is a question about the individual's ability to provide an informed refusal and, thus, an informed AMA departure, the juries are not nearly as lenient. Judges and juries often think of intoxication as anything over the local legal limit for intoxication. The legal limit typically is used for DUI cases, and should have no bearing on our medical management of the intoxicated patient. However, judges and juries often use this level as a threshold for decision making. In recent years, the legal limit has become a moving target. The legislative limits of intoxication have been reduced in several states recently. Regardless, if the patient's BAC level is above the legal limit, judges and juries often

conclude that the patient cannot make an informed decision. Certainly, the plaintiff's attorney reinforces that point.

As EPs, we know that some of our regulars can walk into the ED and have a normal mental status with a BAC level well over the legal limit of intoxication. In these cases, it is appropriate to discharge a patient, having documented a normal mental status through a mental status examination, and to document that the patient understands the risks of leaving the ED (i.e., an informed refusal). If there is no documented serum alcohol level, then the judge and jury must rely upon your clinical assessments, which is appropriate. If you've ordered a blood or serum alcohol test, a judge or jury may be swayed by the level and not by your clinical judgment.

Some states, such as Florida, specifically have legislated that there shall be no legal recourse against physicians for examining and treating a patient without his or her consent if the patient is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent.<sup>24</sup> In Mississippi, the law defines who may consent to medical treatment. It excludes those of unsound mind, related to "natural state, age, shock, anxiety, illness, injury, drugs or sedation, intoxication, or other causes of whatever nature."<sup>25</sup>

In states without such statutes, case law (similar to the *Oates* case) supports the underlying philosophy that intoxicated patients are incapable of giving consent. In *Miller v. Rhode Island Hospital*,<sup>26</sup> the Rhode Island Supreme Court held that a patient's intoxication may render him incapable of giving informed consent and, in emergency situations, that consent may be waived. In this case, the plaintiff, Miller, had a BAC level of 0.233 and was involved in a multiple vehicle accident. Due to the nature of the accident and the patient's intoxication, the attending surgeon determined diagnostic peritoneal lavage was indicated. Over the patient's objection, the surgery was performed. In *Blackman v. Rifkin*,<sup>27</sup> the Colorado court found that intoxication coupled with head trauma permits EPs to restrain a patient and imply consent necessary to treat his or her condition.

In the pre-hospital setting, some states have provided legislative protection from liability for emergency medical service (EMS) personnel and police in restraining intoxicated patients who are under the influence of drugs or alcohol. In Illinois, the Alcoholism and Other Drug Abuse Dependency Act provides that a person

who appears unconscious or in immediate need of medical services while in a public place and shows symptoms of impairment brought on by alcoholism or other drug abuse may be taken into protective custody and brought to emergency medical care.<sup>28</sup> This type of statute helps alleviate EMS and police fears of potential future lawsuits when the intoxicated patient is refusing.

In summary, these cases and statutes demonstrate support of physicians in treating intoxicated patients without their consent. The documented inability to understand the risks, benefits, and alternatives of treatment creates a presumption of incompetence in regard to making medical decisions. Physicians who render reasonable care to intoxicated patients historically have been afforded protection from civil and criminal liability in providing necessary evaluation and treatment.

### Discharge Recommendations

The medical, legal, and social issues related to discharge are complex. The EP has to consider the patient's clinical condition and conduct following discharge; the patient's support network of family or friends; community resources for follow-up care; the potential for injury to third parties exposed to the patient post-discharge; and other issues. The following case examples are illustrative:

- Patient A presented clinically intoxicated, with no other apparent clinical problem. The patient has been observed over a period of time, has "come up" as expected, and wants to leave the hospital. The EP does not feel that an initial or follow-up alcohol level is necessary. On re-examination, the EP has documented a normal neurologic exam and normal mental status with decision-making ability. This patient may be discharged safely from the hospital, after careful documentation of the re-examination. Optimally, the patient leaves the ED with a family member or friend, with an appointment with a family doctor or an alcohol treatment program.
- Patient B presented similarly, but the EP decided to order an alcohol level. Whether this is a blood or Breathalyzer sample, the thought process is the same. Legally, the decision to discharge should be based upon the patient's

clinical condition. When the patient has a normal neurologic and mental status examination, and is not a danger to self or others, the patient may be discharged from the ED. However, in this scenario, the EP now has a documented alcohol level, and there may be a repeat level that remains above the state's legal limit of intoxication, or the physician may not have ordered a repeat level.

It is important to note that the state legal limit of intoxication is not a measure of patient competence. The legal limit for driving has very little to do with the capacity to make informed decisions. Intoxication is not used to indicate a level that increases the risk of injury while driving; but rather is a term used to describe a level that produces clinically identifiable impairment that may alter sensation, coordination, judgment, and insight.

Without clear documentation of neurologic status and mental status, a judge or jury may deem discharge inappropriate based on popular perceptions of the legal limit. If the patient is agreeable, we recommend holding the patient until the alcohol level is below the legal limit of intoxication. If the patient wants to leave, the EP must discharge when the patient has a normal examination, and can understand the risk of leaving. However, if the EP or staff are aware that the patient intends to get into an automobile, and therefore deems the patient a danger to himself or others, the EP should order patient restraint, or local law enforcement should be contacted.

To summarize, patients who show no evidence of concurrent, significant illness or injury and are functionally sober probably can be discharged safely.<sup>29</sup> These patients are not clinically intoxicated, and discharge is appropriate. For those patients who are to be discharged and have a documented BAC level above the legal limit, extensive documentation of the patient's clinical condition with focus on capacity needs to be done, and special discharge arrangements must be made. In this situation, assuming subsequent patient injury and a lawsuit, the jury may rely on the numerical value rather than the physician's assessment of functional sobriety or clinical intoxication. Therefore, if a level is drawn, the potential for exposure to liability would be reduced if discharge is delayed until the BAC is at or near the legal limit. Assist the jury — the fact

finder — with excellent documentation prior to discharge.

### Evaluation of the Trauma Patient

*Conyers v. Dr. Rufus K. Nimmons Jr., and the Oconee Memorial Hospital.*<sup>30</sup> The patient was a 21-year-old male who was involved in a car accident. He was thrown 20 feet. The patient was intoxicated when paramedics took him to the ED of Oconee Memorial Hospital. The paramedics recorded that the plaintiff had good movement in his extremities.

The EP, Dr. Nimmons (a general surgeon), removed the cervical collar and other immobilizing devices to take x-rays. The physician took the plaintiff's arm and, holding the back of the plaintiff's neck, lifted him into a sitting position. The patient yelled out that his neck was in pain. He subsequently became quadriplegic.

The plaintiff contended the following: The defendant had mistreated patients who were intoxicated; the defendant regularly removed cervical collars from ED patients; the defendant improperly lifted the plaintiff into a sitting position; and the patient's paralysis resulted from the treatment received in the ED. The defendant contended that the plaintiff was injured in the automobile accident and there was no relationship between the ED treatment and the plaintiff's injuries. The jury returned a \$5 million award for the plaintiff.<sup>30</sup>

### Discussion

The alcohol-impaired patient may have a serious traumatic injury with no complaint of pain. In fact, one study of patients involved in MVAs found that a positive BAC increases the chance that the final diagnosis will include more injuries than initially documented.<sup>31</sup> The EP should assume that the intoxicated patient brought in from the scene of an accident has suffered traumatic injury until proven otherwise. Palpating the cervical spine and asking the patient if he has pain is not a good screen for cervical spine injury in the intoxicated patient. A review of alcohol-related lawsuits suggests that, at times, the EP's feelings about the intoxicated patient get in the way of clinical decision making. The EP must recognize that intoxicated patients are a high-risk group for serious injury, and should make these patients a priority.

*Joseph Johnson v. United States of America.*<sup>32</sup> The patient presented to the ED of the McGuire Veterans Affairs Medical Center requiring assistance to

walk and under the influence of alcohol. He complained of tingling in his arms and weakness in his legs. He also complained of severe pain in his neck and shoulders. He initially was combative and verbally abusive, but calmed down later. The patient cooperated with the medical examination in the ED by allowing his blood to be taken and his upper motor strength to be tested.

When asked to move his legs, however, he indicated that they were sluggish to move. The patient had a history of a cervical spine injury 16 years earlier in a helicopter crash. The diagnosis was possible cervical spine injury, but the physician felt that a repeat exam would be necessary when the plaintiff was sober.

The patient/plaintiff claimed that no cervical magnetic resonance imaging (MRI) or x-ray studies were performed for 16 hours. The MRI studies revealed an acute herniated disc at the C6-7 level causing his neurologic symptoms. The plaintiff claimed that surgery was performed 19 hours after admission, which resulted in his becoming a C-7 quadriplegic. According to accounts, a settlement with a present cash value of \$1 million was reached.<sup>32</sup>

### Discussion

Once again, the EP aggressively must work up all potential life or limb threats in the patient who is under the influence of intoxicants. The inebriated patient who has blunt head trauma has an intracranial bleed until proven otherwise. The inebriated patient with neck pain has an unstable cervical fracture until proven otherwise. This patient should have been completely immobilized and should have had a hard cervical collar and backboard applied pending further diagnostic evaluation.

If the physician felt the need to repeat the exam prior to radiographic evaluation, complete immobilization in the interim may have avoided this lawsuit. The plaintiff would claim that movement during the 16-hour delay caused or aggravated the injury. Optimally, this patient would have been sent immediately for CT. If the physician felt strongly that repeat exam was indicated, further testing should not have been delayed beyond the suggested three to six hours. If for any reason the diagnostic evaluation had to be delayed, complete immobilization or transfer to a facility that could carry out the evaluation was indicated.

*Steve v. Gilbert M.D. and Spectrum Emergency*

**Care Inc.**<sup>33</sup> The patient was a 16-year-old boy who was taken to the defendant Emergency Care Center after his friends found him abandoned in a parking lot. He was disoriented, lethargic, semicomatose, and unresponsive, except to painful stimuli. His BAC level was 53 mg/dL. The patient exhibited poor verbal skills, sluggish pupils, contusions on the back of his skull, upper back abrasions, and an inability to communicate rationally.

The defendant EP examined the patient at midnight. The primary diagnosis was alcohol abuse with a possible head injury. The ED staff checked on the patient periodically throughout the night. The patient's condition deteriorated between 5 and 6 a.m., and he was transferred to another medical center. En route, the patient died as a result of a massive intracranial epidural hematoma.

The plaintiff claimed that the defendant immediately should have transferred the decedent to the medical center for a CT scan for further evaluation since it was not available at the emergency clinic. The defendants contended that the decedent had been treated appropriately given his conditions and symptoms. They also maintained that immediate transfer of a patient in the decedent's condition for a CT scan was not within the standard of care.<sup>33</sup> The jury returned a verdict for the defendants.

## Discussion

The defendant in this case was extremely fortunate that the jury did not equate his delays with negligence, particularly with the death of the patient. It appears there was a delay in diagnostic evaluation. However, remember that the jury is asked to measure the physician's conduct not against the highest quality practitioner, but against the reasonably trained practitioner. Here, the jury believed that it was reasonable to observe rather than aggressively evaluate. Although this was a defense verdict, the case demonstrates a critical element regarding management of this patient group. The alcohol level of 53 mL does not explain the long list of neurologic signs and symptoms. Alcohol levels in this range may begin to cause problems with judgment, but would not cause obvious neurologic changes. If the alcohol level is not consistent with the patient's presentation, the EP must dismiss alcohol as the cause and aggressively pursue the diagnostic evaluation.

**Shawn Davis v. Norbert Weidner.**<sup>34</sup> The patient, a

23-year-old laborer, Shawn Davis, went to a concert and had been drinking beer. Leaving the concert, the patient was struck by an automobile and knocked to the ground. He was taken to an ED, where the defendant EP, Dr. Weidner, examined him and noted that he was unsteady on his feet. Dr. Weidner did not obtain a BAC level, nor did he pursue any other diagnostic evaluation. Mr. Davis was sent home with head injury instructions.

Several hours after arriving home, Mr. Davis aspirated and was revived by his parents. A CT scan revealed a skull fracture with a subdural hematoma. The plaintiff underwent an emergency craniotomy and evacuation of the hematoma. As a result of the delay, Mr. Davis is blind in one eye and has a loss of peripheral vision in the other eye.

The plaintiff alleged that the defendant was negligent in attributing his symptoms to alcohol and in failing to diagnose the skull fracture and subdural hematoma. The defendant contended that he conformed to the standard of care in sending the plaintiff home with head injury instructions. The parties reached a structured settlement of \$120,000 cash plus \$1000 per month for life.<sup>34</sup>

## Discussion

This is a commonly recurring theme in alcohol-related emergency malpractice lawsuits. Intracranial injuries get missed in intoxicated patients who present to the ED. The EP documented that the patient was not steady on his feet. Unless proven otherwise, this represents a focal neurologic deficit. This case required more aggressive management, probably CT, and continuing observation until the patient no longer was intoxicated.

## Summary

The alcohol-impaired patient represents a high risk to the EP and nurse. These patients sometimes have occult traumatic injury, coexisting medical problems, or coingestions of other toxic substances. However, in many cases, there are no apparent problems, other than intoxication, and a period of observation is reasonable. The EP and nursing staff must maintain a high index of suspicion during the observation period.

An error on the side of missing a diagnosis in an alcohol-impaired patient may be devastating in terms of patient death or disability, with the possibility of

resulting litigation. State legislatures and courts have supported continuing patient management and erring on the side of restraint. The legal downside of this course of action would be a suit related to assault, battery, or false imprisonment, or perhaps an administrative action brought by a state Human Rights Commission or other similar entity. In general, the EP will fare far better in these latter actions, asserting his dedication and concern for the patient's well-being.

Documentation is key to preventing and defending litigation. The EP carefully should document examination, re-examination, and condition on discharge. When the patient is permitted to leave the ED, the EP must provide clear documentation of clinical capacity prior to discharge. Discharged patients always should have arrangements for support and follow-up and should be offered the option of substance detoxification.

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## CE/CME Questions

21. Which statement is *not* true regarding patients who present to the ED and have ingested alcohol?
  - A. They are a high-risk group of patients and often present with complex medical problems.
  - B. The intoxicated patient may refuse evaluation and treatment in the ED at any time.
  - C. Intoxicated patients may be chemically or

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physically restrained when they are endangering themselves or others in the ED.

- D. If a patient has consumed alcohol but is functionally sober, and understands the risks and benefits of treatment, he may refuse care even if his BAC level is above the legal limit.
22. Regarding BAC levels, all of the following statements are true *except*:
- A. All patients presenting to the ED with suspected alcohol consumption require a determination of their alcohol level.
- B. Patients with signs of trauma or severely altered mental status require alcohol levels.
- C. In the cooperative intoxicated patient, breath testing to determine alcohol level is an acceptable alternative.
- D. Patients whose BAC level does not correlate roughly with their mental and neurologic status should be evaluated immediately for another cause of their altered mental status.
23. Which of the following need *not* be included in the initial management of a comatose patient with suspected alcohol intoxication and no signs of trauma?
- A. Attention to the ABCs of airway, breathing, and circulation first
- B. Thiamine 100 mg IV; naloxone 1-2 mg IV; and blood glucose check if necessary

## In Future Issues:

- C. Determination of BAC level to determine if the level roughly correlates with the patient’s mental status
- D. Immediate head CT
24. Which of the following are *not* risks to alcoholics and intoxicated patients who present to the ED?
- A. Hypoglycemia secondary to malnutrition and depletion of glycogen stores
- B. Head bleeds from minor trauma as a result of coagulopathies and cerebral atrophy
- C. Hypothermia and coingestions of potentially life-threatening drugs
- D. Infection and sepsis
- E. All of the above

**Answers: 21. B; 22. A; 23. D; 24. E.**

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## Adverse Drug Reactions