ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

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

AHC Media LLC

IN THIS ISSUE

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: Larry Mellick, MD, MS, FAAP, FACEP, (executive editor) Professor of Emergency Medicine and Pediatrics, Residency Program Director, Department of Emergency Medicine, Medical College of Georgia, Augusta; Theresa Finerty, MS, RN, CNA, BC, (nurse planner) Director, Emergency and Trauma Services, OSF Saint Francis Medical Center, Peoria, IL; Staci Kusterbeck (contributing editor); Jorge A. Martinez, MD, JD, Director of Clinical Emergency Medicine Services at Charity Hospital and Professor of Clinical Medicine at Louisiana State University School of Medicine, New Orleans, LA; Allison Weaver (Editor) and Lee Landenberger (Associate Publisher). Robert Bitterman, MD, JD, FACEP, (contributing editor) discloses that he is President, Bitterman Health Law Consulting Group, Inc., Charlotte, NC; and he serves on the Board of Governors and committees of the Emergency Physicians Insurance Co., Inc., Auburn, CA.

APRIL 2007
VOL. 17, NO. 4 • (pages 37-48)

Interactions with admitting or on-call physicians: Documenting discussions and utilizing physician extenders

by Robert A. Bitterman, MD, JD, FACEP, Contributing Editor

A host of medical and legal issues arise when the emergency physician contacts the patient's private physician or the hospital's on-call physician to get a patient admitted to the hospital. This article will address two of those issues: first, the everyday question of what constitutes appropriate and adequate documentation of the conversation with the admitting physician; and second, the relatively new but increasingly common issue of dealing with an on-call physician's physician extenders.

Documentation of conversations with admitting physicians

How much of the conversation with an admitting physician should the emergency physician document in the emergency department (ED) medical record? Everything — well, almost everything. The purpose of the discussion with the admitting physician is twofold: First, to transfer responsibility for the patient from the emergency physician to the admitting physician; and second, to provide sufficient clinical information necessary for the admitting physician to appropriately care for the patient from that point forward. Your job is to ensure the patient's safety, and consequently avoid liability, by effectively communicating to the admitting physician the relevant clinical data, your working diagnosis, and any concerns you harbor regarding the patient's condition. *(See Table 1.)*

Transfer of Responsibility. Document the time you initiated a call to the admitting physician and the time you discussed the case with him or her. You want to create a bright line, with no uncertainty, of the time you transferred responsibility and liability for the patient. You should place a note in the medical record stating, "Patient's care transferred to Dr. Smith at 1500 hours." (Incidentally, this applies equally for "change-of-shift turnovers" from one emergency physician to another.)

It doesn't matter if the transfer occurs by phone or to the admitting physician at the bedside in the ED. It also irrelevant if the patient remains boarded in the ED awaiting an inpatient bed; it is NOT true that emergency physicians remain responsible or liable for any patient still physically present in the ED. The admit-

ting physician's hospital privileges and duty to the patient do not magically start after the patient leaves the confines of the ED; they begin when he accepts the patient from the emergency physician. (If the emergency physician writes the initial admitting orders, this becomes a much more complicated issue; the medical-legal issue of the emergency physician writing admitting orders is a topic for another time.)

The phone conversation with the admitting physician should also end with a mutual understanding of when the admitting physician will come to the ED or the hospital to see the patient. If a patient with routine pneumonia can be started on antibiotics and seen in the morning, then morning is a reasonable time for the admitting physician to be expected to come into the hospital to see the patient on the inpatient service. If the patient needs to go to the operating room ASAP, then ASAP is the time the physician should be expected to appear in the ED to assume care of the patient. Federal regulations require that the expected "response time" for an on-call physician to come to the ED when asked to see a patient with an emergency condition must be written down, in minutes, in the hospital rules and regulations or medical staff bylaws.[1] State law also may govern an on-call physician's response time; Missouri, for example, requires the on-call physician to come to the ED within 30 minutes in certain circumstances.[2]

You want to avoid the scenario, for example, where you call the surgeon for a patient with acute appendicitis, he says he's on his way, but doesn't show up until many hours later; then, after examining the patient, screams to the family, "Why didn't the ED call me much sooner?"

If an admitting physician or surgeon gives you grief about agreeing to come to the ED within a set time frame, then document your request and the supporting facts in the ED record. Failure to consult the patient to a general surgeon in a timely fashion is a very common source of litigation against emergency physicians in appendicitis cases (or any other serious disease case); you want a clear record that you didn't cause the delay. Don't make inflammatory comments about the admitting or on-call physician in the record, but your notes should accurately reflect the conversation, your concerns, and the subsequent course of events. These are high-risk cases and litigation frequently follows if the patient's appendix ruptures and leads to complications or an adverse outcome, especially if after a prolonged stay in the ED without diagnostic and/or surgical intervention.

As an emergency physician, you must be willing to take heat from the difficult-to-deal-with or "incompetent" admitting or on-call physician on behalf of your patients.

Communication of Clinical Information. You want the admitting physician to appreciate the patient's clinical status at the time of the call, and assure that his understanding coincides with your impression of the patient's condition. Be sure to relate your diagnosis, any significant abnormal physical findings, and your clinical impression of the seriousness of the patient's condition. You should also inform the admitting physician of any abnormal laboratory or X-ray studies. The scenario you want to avoid here is an assertion by the admitting physician such as, "If the ED had only told me the glucose was 1,000 and the arterial pH 6.9, I'd have gone to the ED immediately to see the patient."

The medical record should reflect the full scope of your conversation about the patient. Document that you gave to the admitting physician the diagnosis, any abnormal physical findings, and the current condition of the patient. Also, specifically document which lab and X-ray data were provided to the admitting physi-

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. **POSTMASTER:** Send address changes to ***ED Legal Letter,*** P.O. Box 740059, Atlanta, GA 30374.

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

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

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

Approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit.

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

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

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

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

Senior Vice President/Publisher: Brenda Mooney
Associate Publisher: Lee Landenberger

Contributing Editors: Robert Bitterman, MD, JD, FACEP, Staci Kusterbeck, Jorge A. Martinez, MD, JD.

Questions & Comments
Please contact **Lee Landenberger,** Associate Publisher, at lee.landenberger@ahcmedia.com.

Table 1

Documentation of Discussion with Admitting Physicians — Key Elements

- Time initiated call for admission
- Time discussed case with admitting physician
- Time transferred responsibility of the patient to the admitting physician
- Time admitting physician is expected to physically come to the ED or hospital to personally examine and care for the patient
- Patient's diagnosis, abnormal physical findings, and present clinical condition
- Pertinent lab and X-ray data, especially critical values

cian. Placing in the ED medical record that "told glucose over 1000 and pH 6.9" or "told potassium 8.5" eliminates misunderstandings and minimizes liability of the emergency physician; it also enhances patient safety. *(See Table 2.)*

If you don't think the admitting physician understands your concerns or appears somewhat confused at the moment, as often happens when you awake a physician in the middle of the night, then ask him or her to get a cup of coffee and call you back in few minutes. Also, it is wise to review the admitting orders of the physician to be sure the orders make sense, especially at night, since you have a much greater understanding of the patient's condition at that time.

Midlevel providers involved in on-call services to the ED

Physician assistants (PAs) and nurse practitioners (NPs), often called midlevel providers or physician extenders, are now commonly involved in providing emergency care. Many admitting physicians, including pediatricians, orthopedic surgeons, internists, and cardiologists, frequently use PAs or NPs in their practices and interactions with the ED. However, federal law, the Emergency Medical Treatment and Active Labor Act (EMTALA), and Center for Medicare and Medicaid Services (CMS) regulations distinctly require the hospital to provide on-call physicians, so it is clear that the hospital may not allow a midlevel provider to take ED call instead of a physician.[3] Critical access hospitals (CAHs), however, as defined by federal regulations, while subject to EMTALA's requirements, may allow PAs or NPs to take ED call in certain circumstances.[4]

Additionally, all states, the District of Columbia, and the majority of U.S. territories have laws governing the practice of PAs and NPs.[5,6] Each state defines and/or limits the scope of practice allowed by each type of provider and addresses the required level of supervision.[5,7] Thus, state laws as well as federal law must be reviewed and considered before a hospital allows a midlevel provider to be involved in providing admitting or on-call services to the ED.

The real issue for emergency physicians, however, is whether the admitting on-call physicians may permit one of their associated midlevel providers to answer the call from the ED or evaluate the patient in the ED on their behalf. One of the government's "guidance" comments has confused the issue. CMS states that:

> "...circumstances [exist] in which a physician assistant may be the appropriate practitioner to respond to a call from an emergency department . . . that is providing screening or stabilization mandated by EMTALA. . . . However, any decision as to whether to respond in person or direct the physician assistant to respond should be made by the responsible on-call physician, based on the individual's medical needs and the capabilities of the hospital, and would, of course, be appropriate only if it is consistent with applicable State scope of practice laws and hospital bylaws, rules, and regulations."[8,9]

This language has been misinterpreted by some to mean that the on-call physician may decide whether the midlevel provider can answer the page from the emergency department, or respond in person to the ED, instead of the on-call physician.

Table 2

Sample documentation of conversation with an admitting physician:

> *"*Case discussed and care transferred to Dr. Jones at 1600 hours. Explained diagnosis of COPD/pneumonia, T 103, RR 28, pulse ox 90% on room air/95% on 2L, WBC 19,000, and patchy RLL infiltrate. Patient alert/comfortable/stable now, BP and HR fine, and first dose of antibiotics given in ED. Dr. Jones gave verbal admitting orders to the nurse and said he'd be at the hospital within an hour to see the patient."

The decision of who to speak to by phone or who must present to the ED must be left to the emergency physician or other medical staff member requesting the services of the on-call specialists. The government agrees, stating:

"We believe any disagreement between the two [emergency physician and the on-call specialist] regarding the need for an on-call physician to come to the hospital and examine the individual must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual and is currently treating the individual."[9,10]

Thus, it's perfectly appropriate to list the name of the on-call physician on the call panel and the name of the physician's midlevel provider. For routine admissions or follow-up care, the emergency physician can contact the midlevel provider to arrange the necessary services. However, for true emergencies or other instances where the emergency physician wants phone consultation from the on-call specialist directly, or needs the specialist to come to the ED to evaluate and treat the patient, the emergency physician must be able to contact the specialist directly at any time. The choice of which on-call individual to contact and which one must come to the ED must always rest with the physician examining the patient in the ED.

Every hospital needs its admitting medical staff and the emergency physicians to define the role of a PA or NP in providing on-call services to the ED and draft written policy and procedure regarding the admitting or on-call physicians' duties to supervise their midlevel providers and respond to the ED when requested by the emergency physicians.

Both the American College of Emergency Physicians and the American Medical Association offer policies and procedures regarding the role of PAs and NPs in the ED.[11-13]

References

1. 42 CRF 489.24; See reference #9: CMS Interpretive Guidelines, May 2004.
2. MO. 19 C.S.R.30-20.021.
3. 42 USC 1395cc(a)(1)(I)(iii); 42 CFR 489.20(r)(2).
4. 42 CFR 485.618(d)(1): Personnel Standards.
5. An extensive summary of each state's laws and regulations relating to physician assistants is available at www.aapa.org/gandp/StateLawsandRegulations.htm. Accessed February 6, 2007.
6. See also www.aanp.org for laws related to NPs. Accessed February 6, 2007.
7. For a list of PA regulatory agencies with addresses, phone numbers, and web links see www.aapa.org/gandp/statereg.html. Accessed February 6, 2007.
8. 68 Federal Register 53256 (2003).
9. CMS Interpretive Guidelines. Issued in May 2004 for state surveyors and CMS Regional offices regarding the enforcement of EMTALA. Available on line at http://www.cms.hhs.gov/manuals/Downloads/som107ap_v_emerg.pdf.
10. 68 Federal Register 53255 (2003).
11. ACEP Policy #400117, Guidelines on the Role of Physician Assistants in the Emergency Department, Approved by the ACEP Board of Directors February 2002. Accessed February 6, 2007 and available at: http://www.acep.org/webportal/PracticeResources/PolicyStatements/hlthwrkforce/guidelinespanursepract.htm.
12. ACEP Policy #400123, Guidelines on the Role of Nurse Practitioners in the Emergency Department, Approved by the ACEP Board of Directors June 2000. Accessed February 6, 2007 and available at: http://www.acep.org/webportal/PracticeResources/PolicyStatements/hlthwrkforce/guidelinespanursepract.htm.
13. AMA Policy H-35.989: Physician's Assistants; AMA Policy H-160.947: Physician Assistants and Nurse Practitioners; AMA Policy H-160.950: Guidelines for Integrated Practice of Physician and Nurse Practitioner; AMA Policy H-360.987: Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice. See also AMA Policies H-135.975; and H-425.997. ■

Family's presence in ED may lower liability risk

If anything, patients are less likely to sue, say experts

by Staci Kusterbeck, Contributing Editor

A growing number of emergency departments (EDs) are allowing family members to be present during resuscitation, as a result of multiple research articles that consistently report that families want to be present and generally have a positive experience. However, some ED providers refuse to allow this, fearing lawsuits by family members who misinterpret what they see and hear.

What are the liability issues in this new and controversial area? Several authorities who have both published and practiced in this area were asked their opinions.

Many people "focus too much" on the likelihood of lawsuits in these situations, says **Gregory P. Moore,** MD, JD, an ED physician with Kaiser Permanente in Sacramento, CA. As a general rule, patients are more likely to file suit if they think that are secrets being kept from them, since the lawsuit serves as a conduit to obtain answers to questions about what happened, he explains.

Key Points

To reduce risks if family members are allowed to be present during resuscitation:

- Have a nurse or physician explain what is being done.
- Inform the ED team before the family comes in.
- Perform major procedures before the family enters the room.

"If they witness good medical care, they will likely feel a sense of appreciation and satisfaction," says Moore. "There is no data that I am aware of but I would guess that the possibility of a lawsuit is decreased by family presence."

There is no question that family presence is becoming an increasingly accepted practice in EDs nationwide, says **Eric T. Boie**, MD, vice chair and clinical practice chair for the department of emergency medicine at Mayo Clinic in Rochester, MN. Rather than increasing legal risks, the practice improves the ability of a family member to cope with death, and reduces overall liability, he says.

"Family members leave with the understanding that everything possible was done, and that the team worked hard to save the patient, rather than wondering with no insight whether any more could have been done," says Boie.

Matthew J. Walsh, MD, FACEP, currently chair of the department of emergency medicine at the University of New Mexico, says that he has occasionally allowed families in the resuscitation room. "I feel that it's rare to have the right staff, sufficient resources, and a family that is present at the right time, but I have personally done it a couple of times," he says.

If the family member is accompanied by a physician or nurse who can explain everything being done, Walsh believes there is no significant risk of liability. "I never worried about legal issues of this type," he says. "Some folks I know feel everything is a risk and they would do nothing beyond the absolute ordinary. Others, like me, are less concerned and don't feel any significant risk."

Most of the time, the family didn't arrive in the ED until the code had been called and the patient was pronounced, notes Walsh. "In my current position, the present rooms are too small for the care team and the family, so I couldn't do this at present," he adds.

Moore says that in theory, one legal risk would be a suit for negligent infliction of emotional distress. This is a controversial legal theory not accepted in many jurisdictions, but the underlying concept is that one has a legal duty to use reasonable care to avoid causing emotional distress to another individual. If one fails in this duty and unreasonably causes emotional distress to another person, that person will be liable for monetary damages to the injured individual.

In contrast with intentional infliction of emotional distress, there is no need to prove intent to inflict distress — an accidental infliction, if negligent, is sufficient to support a claim.

To avoid this possibility, ED staff should discuss beforehand with the family what they are likely to encounter in the room and then ask them if they want to proceed, similar to the process for informed consent, advises Moore. "It would be very hard later for them then to sue and say 'You exposed me to something horrible and now I suffer from the experience,'" says Moore. The response would then be, "I warned you of what you would encounter and you wanted to be present."

Is it a factor in lawsuits?

What if an emotional family member hears or sees something that they misinterpret, and later tearfully tells a jury that the staff were unprofessional or uncaring? To reduce the chance of this happening, Moore says that the ED team should be addressed and warned of the family's impending arrival before the family comes in, and encouraged to behave professionally.

To minimize malpractice exposure, perform major procedures before the family enters the room, Moore suggests. "When I have let family members in during resuscitation, it is usually after the initial procedures and evaluation has been done," he says. This often is a moot point, however, as the family typically arrives some time after the patient has come by ambulance, and the initial care has been provided.

This practice not only reduces legal risks, it also gives you an opportunity to share some information with the family when they arrive, such as what was done, what was noticed, and what is about to be done. "But most procedures have known complications," says Moore. "When a bad outcome develops, juries are made aware of that, and thus they understand that a complication, in and of itself, is not a breach in the standard of care."

It's difficult to determine whether family presence was a factor behind many ED malpractice lawsuits,

—continued on page 44

SPECIAL REPORT

Reduce risks in patients with shortness of breath

by Jorge A. Martinez, MD, JD

The checklist below, developed by ***Jorge A. Martinez,*** *MD, JD, Director of Clinical Emergency Medicine Services at Charity Hospital and Professor of Clinical Medicine at Louisiana State University School of Medicine, both in New Orleans, reminds us of potential steps or options that should be considered to reduce risks when caring for patients with shortness of breath in the emergency department (ED).*

- ❒ Carefully listen to the patient. Allow the patient to describe their illness and symptoms in their own words. Seek additional information from family, caretakers, or paramedical personnel as needed.
- ❒ Be careful not to overlook the nurses' notes and emergency medical services' documents that contain supplemental information regarding the patient's medical history and present clinical presentation.
- ❒ Don't forget the basics — make sure your patients with severe shortness of breath rapidly receive supplemental oxygen, are placed on a cardiac monitor, have an intravenous line established, and have a pulse oximeter applied.
- ❒ Pay attention to the patient's vital signs. Repeat them liberally or follow the monitored vital signs closely to look for early indicators of change in the patient's condition.
- ❒ Initially, the physical examination should be aimed at finding physical signs and manifestations consistent with disease or injury of the respiratory tract. In the absence of such findings, the physical examination should be expanded to uncover physical signs and manifestations that suggest which organ system, environmental factor, or injury is causing or contributing to the shortness of breath.
- ❒ Carefully and thoughtfully develop your differential diagnosis based on your historical information and physical examination.
- ❒ Based on your most likely diagnoses with an eye towards the life-threatening conditions, prioritize laboratory and radiological studies.
- ❒ If the cause of the shortness of breath can be addressed and the respiratory status stabilized in the ED, the patient may be discharged. In addition to written instructions and appropriate medications to manage the non-life-threatening cause of the shortness of breath, instruct patients to return to the ED if the outpatient treatment fails or if the shortness of breath worsens. For those patients with potential high risk or life-threatening etiologies, consultation should be obtained and hospital admission to the appropriate unit should be carried out.

ED cases involving shortness of breath

Moore v. St. Joseph's Hospital, 538 S.E.2d 714 (W. Va. 2000).

On March 28, 1995, the patient was taken to St. Joseph's ED complaining of muscular and skeletal pain, and was treated conservatively and released. Two days later, the patient was taken back to the ED complaining of sweating and shortness of breath, and was diagnosed with pneumonia, treated and released.

On April 3, 1995, the patient was taken to St. Joseph's ED for a third time, and during the visit, he again complained of sweating and shortness of breath. At that time he was diagnosed as suffering from congestive heart failure, and was transferred to another hospital the following day, and died two days later. The cause of death was attributed to pulmonary embolism.

A wrongful death action was filed alleging negligence by St. Joseph's for failing to diagnose and treat the patient for pulmonary embolism. The case was heard by a jury, who returned a verdict finding St. Joseph's 75% liable for the death of the patient. The jury awarded the patient's wife $50,000 in non-economic damages and $100,000 in economic damages.

Possible lessons learned:

- ❒ Consider patients who return to the ED with the complaint of ongoing shortness of breath at high risk for a wrong diagnosis or inadequate initial therapy. Be sure to carefully evaluate these patients as a new patient and search diligently for an occult pulmonary or nonpulmonary cause of shortness of breath.
- ❒ Always repeat the history and physical examination while paying special attention to changes in the patient's symptoms and clinical examination.
- ❒ Don't forget that a pulmonary embolus can parade as more

common conditions such as hyperventilation syndrome or asthma and should be considered in cases where the cause of shortness of breath is not apparent after repeat laboratory and radiological studies.

Holly v. Huntsville Hospital, 865 So.2d 1177 (Ala. 2003).

A mother took her 11-month-old son to the ED at Huntsville Hospital because he had a high fever, a rapid pulse rate, and trouble breathing. The ED physician treated the child for croup, observed him for three hours, and gave the mother a prescription and discharged the child.

While the mother was at the pharmacy getting the prescription filled, the child suffered a respiratory and cardiac arrest. Emergency medical technicians transported the child to Huntsville Hospital, where he was pronounced dead. An autopsy indicated that the child died of necrotizing tracheobronchitis, a severe infection of the trachea and bronchi that obstructed his airway.

The jury returned a verdict in favor of the defendants. The plaintiffs moved for a new trial. The trial court denied the motion and entered a judgment on the jury verdict in favor of the defendants. The plaintiffs appealed the trial courts denial of a new trial arguing that the trial court erred in 1) excluding the plaintiffs' experts' testimony to standard of care and breach of that standard, and 2) in instructing the jury on the plaintiffs' experts' competency and on the applicable standard of care.

The Alabama Supreme Court ruled that the trial court erred in instructing the jury that the plaintiffs' experts were not qualified to testify to standard of care and breach of that standard. The Court also ruled that the trial court erred in instructing the jury that the standard of care applicable to the defendant doctor was the standard of care for family practice physicians rather than physicians practicing emergency medicine.

Finally, the Court held that the trial court erred in denying plaintiff's motion for a new trial and ordered a new trial on the merits of the case. In a subsequent trial, the jury returned a verdict in favor of the plaintiffs. The defendants moved for a new trial, which was granted by the trial court. The trial court's decision was affirmed by the Alabama Supreme Court in 2005, and the case has been remanded back to the trial court for a new trial.

Possible lessons learned:

- ❒ Shortness of breath in children has many benign etiologies, but don't forget life-threatening conditions such as bacterial tracheitis, myocarditis with congestive heart failure, overwhelming pneumonia, toxic exposure/ingestion, anaphylaxis, or aspirated foreign body.
- ❒ A detailed history should be taken from family members or friends who witnessed the child's shortness of breath. Questions may include:

  What was the child doing when he developed the shortness of breath? (Keep in mind the possibility of a foreign body aspiration.)

  Was the onset of shortness of breath acute or gradual?

  Does the child have any medical illnesses, or has he or she undergone surgical procedures?

  What medications is the child taking? (This may help clarify if the child has any underlying medical problems.)

  Does the child have any allergies?

  Has the child developed fever, choking, cough, nausea, vomiting, diarrhea, or a change in mental status or level of consciousness?

  Does the child make any noises while breathing? (Clarify if patient has stridor or wheezing or both.)
- ❒ The physical examination must include visualization of the child's nasopharyngeal airway, mouth, throat (with caution if epiglottis is suspected). The chest should be inspected for intercostal retractions and accessory muscle use. The physical examination must also include meticulous auscultation of the neck, trachea, and chest.
- ❒ Monitor the child's oxygen saturation and administer oxygen liberally.
- ❒ Consider a soft-tissue lateral X-ray of the neck if the upper airway is involved. (If epiglottitis is a consideration, the X-ray should be performed as a portable or the child should be accompanied by the physician to the radiology suite and airway equipment goes along.)
- ❒ Monitor carefully the child's overall clinical condition and vital signs. If the child's condition and vital signs do not stabilize with treatment, the child should be admitted for further evaluation, treatment, and consultation. ■

continued from page 41
says **Ken Braxton**, a health care attorney and partner at Dallas, TX-based Stewart Stimmel. "This is because any court opinions are going to address the underlying medical facts of the case — not whether or not the family was present," he says.

However, that's not to imply the family's testimony would not be a key part of the case — it certainly would, says Braxton. "In most emergency department cases that I have defended over the past twenty years, the testimony of family members who are with a patient in the ED is always a significant part of the case, especially if their testimony is different than the care providers," he says.

He gives the following example of a malpractice lawsuit involving a difficult intubation of a patient with chest trauma. In front of a family member, the physicians discussed whether the endotracheal tube was placed correctly into the lungs, and questioned each other's findings from auscultation. "The family member, not understanding the 'checks and balances' approach to insuring correct placement, and allowing the junior physician to learn from the senior's placement of the tube, interpreted that 'the first physician didn't know how to do it and had to have someone check it,'" says Braxton.

A key concern is the level of understanding a "layperson" family member really has about how ED providers go about their work. Braxton has represented academic physicians as defendants in many malpractice cases, ranging from residents to faculty with decades of experience. "When we take a family member's deposition with the four or five defendants sitting in the room, the family member will testify that a medical student or junior resident was 'in charge' from what they saw," says Braxton. "And they will describe the senior faculty as not being really involved 'hands on' with the patient."

In this case, the family member clearly didn't understand how the ED team functioned, with a senior faculty directing the actions of all the various team members. "The junior resident physician may do much of the hands-on work, and discuss the situation with this family member after, so they think the resident must have been the senior member of the team," says Braxton.

In several lawsuits involving traumatic intubations, insertion of chest tubes, and head trauma interventions, family members have misinterpreted the "controlled chaos" of saving a life as callousness, says Braxton. "In a crisis, the ED team must be able to function without having emotions play a role in their care, and this can be interpreted as indifference by a layperson," he says.

To avoid misunderstandings, if the family is allowed to stay in the room during resuscitation or any other lifesaving maneuvers, a health care provider from the ED should be assigned to communicate what is going on to the family, says Braxton. "Communication between health care providers and patients is always the best way to alleviate problems," he says. "For lifesaving maneuvers, the ED team must focus their total attention on the patient, without having to worry about liability as even a remote consideration." ■

Sources

- **Eric T. Boie**, MD, Vice Chair and Clinical Practice Chair, Department of Emergency Medicine, Mayo Clinic, Rochester, MN Phone: (507) 255-2216. Fax: (507) 255-6592. E-mail: Boie.Eric@mayo.edu
- **Ken Braxton,** Partner, Stewart Stimmel, 1701 N. Market St., Suite 318, Dallas, TX 75202. Phone: (214) 615-2013. Fax: (214) 752-6929.
- **Gregory P. Moore,** MD, JD, Emergency Department, Kaiser Permanente, 2025 Morse Ave.Z, Sacramento, CA 95825. Phone: (916) 973-1627. E-mail: gregory.p.moore@kp.org.

ED observation units mean fewer missed diagnoses

Less risk of patients discharged inappropriately

by Staci Kusterbeck, Contributing Editor

Observation units significantly decrease an emergency department (ED) physician's liability risk, primarily because fewer patients are discharged home inappropriately, according to **Michael A. Ross**, MD, FACEP, director of the emergency observation unit at William Beaumont Hospital in Royal Oak, MI.

In a landmark study, Ross and other researchers compared the rate of missed myocardial infarction (MI) diagnosis in EDs with and without a chest pain observation protocol. In EDs without an observation unit, the rate was 4.5%, and in EDs with an observation unit, the rate was less than 0.5%.[1]

"For chest pain, observation units led to a tenfold decrease in missed MI — that is huge," says Ross.

Key Points

Liability risks are lower for EDs with a chest pain observation protocol because:

- There is a missed myocardial infraction rate of less than 0.5%, compared with 4.5% for EDs without an observation unit.
- Patients are more satisfied in ED observation units than inpatient units.
- A physician's threshold for completing a diagnostic evaluation for patients at risk for a serious condition is lower.

Sources

- **Louis G. Graff,** MD, FACEP, FACP, Associate Chief, Emergency Medicine, New Britain General Hospital, 100 Grand St., New Britain, CT 06050. Fax: (860) 224-5774. E-mail: louisgraff4@aol.com.
- **Sharon E. Mace,** MD, Department of Emergency Medicine, Cleveland Clinic, 9500 Euclid Ave., E-19, Cleveland, OH 44195. Fax: (216) 444-1703. E-mail: maces@ccf.org.
- **Michael A. Ross,** MD, FACEP, Chair, Short Term Observation Services Section, American College of Emergency Physicians; Director, Emergency Observation Unit, William Beaumont Hospital, 3601 W. Thirteen Mile Road, Royal Oak, MI 48073-6769. Phone: (248) 898-3080. Fax: (248) 898-2017. E-mail: maross@beaumont.edu.

"And I am positive they do the same thing for appendicitis and stroke." Other studies have reported similar findings, showing that with observation units, missed MI incidence is less than 1%.

"The usual miss rate for MI is maybe 5% for EDs. So that is a major decrease," says **Sharon E. Mace,** MD, director of the observation unit at Cleveland (OH) Clinic. "If you take not just chest pain but asthma and other things and do this appropriately, you can markedly decrease liability for those conditions as well." Cleveland Clinic, which sees about 6000 patients a year, has had an ED observation unit since 1994.

Several studies have shown that patients are more satisfied in ED observation units than inpatient units. "Patient satisfaction is another thing that has an impact on liability," says Mace. "Patients are much happier in an observation unit than being in an in-house floor. And if you have happier patients, they are less apt to sue you," she says.[2,3]

Having an observation protocol lowers a physician's threshold to complete a diagnostic evaluation for ED patients who are at risk for a serious condition, and in doing so, captures patients who might have been missed. "Having said that, though, litigation is a fact of life. Between 5 and 10% of ED visits are eligible for observation units. So with that volume, litigation is inevitable," says Ross. "There is no system or diagnostic protocol in medicine that is 100% foolproof."

Mace says she is not aware of any lawsuits filed as a result of a patient being in an ED observation unit. "I think there is enough experience out there now that we know the pitfalls and the issues so we can avoid them," she says.

In a 2002 study, researchers looked at academic institutions with an ED residency program and found that 36.1% had observation units and 44.9% were planning to open a unit. A 2003 follow-up study that looked at all types of hospitals indicated that 18.8% of EDs had an observation unit, with 11.6% more planning to implement one.[4,5] There are no more recent statistics available, though Mace says that she expects the percentage has increased significantly since the studies were done.

Reduced liability risks are one reason why EDs are opening observation units, and overcrowding is another — which in itself is a liability issue, says Mace. "It limits our ability to take care of patients in a timely fashion and because of that, there are increased risks," she says. "There is just no place to put patients, and the observation unit is a very quick way to process patients."

Select right patients

Without an observation unit in the ED, there is a "threshold" issue. "The physician has to decide to call and get somebody admitted and go through that whole process. A lot of the patients that go to the observation unit are just a little bit shy of that threshold," says Ross. The observation unit makes it easier to complete the patient's workup without having to reach that threshold, he explains.

Many of these patients may actually be fine going home, but there are clearly misdiagnoses that would also be sent home if observation were not an option, says Ross. Avoiding misdiagnosis is hard to quantify or prove, but there is plenty of anecdotal evidence of this from ED physicians, according to Ross. "When we opened our unit, several of my partners thought we shouldn't be doing this, that we should just make up our minds to admit or discharge people," he

recalls. "But over the course of a year, every one of them came to me and said, 'If it wasn't for the observation unit, I would have sent this guy home and missed this diagnosis.'"

No research has been done on the rate of malpractice claims per observation case, says Ross. "Observation patients are a peculiar case mix. They are not your most straightforward group of patients in the ED," he says. "They are people that often pose a diagnostic dilemma. They fall above the threshold for discharge but below the threshold for admission." The following are principles for management of an observation unit that, if adhered to, minimize risks:

• *Have a focused patient care goal with a clearly defined reason for observation.* "Patient selection is a very big issue," says Ross. The main pitfall to avoid is putting an inappropriate patient in observation, warns Mace. "If somebody is an ICU type of candidate or seriously ill, they probably should not be in an observation unit," she says.

The observation unit should not be used to manage a patient that the ED physician knows should be admitted as an inpatient, but the admitting inpatient physician refuses to accept, says Ross. "That is really beyond the scope of the observation unit," he says. "When you start to do that, you take on risks because you are caring for a patient in a setting not designed for that patient."

• *Limit duration and intensity of service.*

• *Select an appropriate hospital location.*

• *Provide appropriate staffing skills and equipment.*

• *Provide continuing care in an outpatient setting which includes appropriate transfer care from one physician to another.* "This is critically important," says Ross. "There has to be a very clear delineation for who is responsible for the patient in the observation unit." There should be no question in anybody's mind at any minute of the day as to who the responsible physician is, and what their participation in the patient's care will be, he explains.

• *Provide intensive managerial review.* There needs to be a clear definition for how to deal with indeterminate results, such as equivocal stress test results, cardiac markers, and electrocardiogram changes for chest pain patients, says Ross. A system must be in place to ensure timely recognition of changes in a patient's condition. For example, if a transient ischemic attack patient goes on to develop a stroke, that has to be recognized within the three-hour time frame during which thrombolytics can be given.

• *Use predefined protocols outlining physician, nursing, and consultant responsibilities.* Between 20 to 30% of observation patients will be admitted to the hospital, because they will either fail treatment or have a serious medical condition recognized, says Ross. "That is the intent of observation," he adds.

It is important to have clear follow-up for observation patients who are discharged, in the rare event that everything was done right but an emergency condition exists and the patient is discharged, says Ross.

Observation units come in many different designs, including open units where a physician anywhere in the hospital can admit the patient to the unit. "The nurses often have a hard time identifying when patients can be discharged, or even who to contact," says Ross. "That is a high-risk situation, as opposed to a well-defined unit with clear protocols."

Not a 'dumping ground'

ED physicians typically get sued for failure to diagnose and failure to treat, with 25% of malpractice dollars paid for missing the diagnosis of acute MI, says **Louis G. Graff**, MD, FACEP, FACP, associate chief of emergency medicine at New Britain (CT) General Hospital, CT. "If you go down the list of other things, missing the diagnoses of epidural abscess, appendicitis, ectopic pregnancy, that's what we get sued for — when we falsely reassure the patient and discharge them home," he says.

Most lawsuits occur with atypical presentation, adds Graff. "Nobody misses an acute MI that presents classically," he says. "With ED observation units, you are taking patients that are atypical and saying, I don't have enough evidence to get you admitted to the hospital, but I'm going to continue doing tests for 12 to 16 hours." After that period of time watching the evolution of disease and changes on physical exam, the odds are you will be able to discriminate better, he says.

Observation units with defined protocols and good leadership are hardly a "dumping ground" for patients, emphasizes Graff. "Those arguments were debated 25 years ago and evidence and logic has proven them to be untrue," he says. New Britain's ED has had an observation unit since 1967.

"All the evidence shows that EDs with observation units have lowered their risks by having them," says Graff. "When we started [the American College of Emergency Physician's] observation section 20 years ago, this was much more theoretical, but now it's really been proven. That is why we've fought for this over the years."

He gives the example of an elderly woman who is weak and short of breath, but initial tests don't show anything. Only half of acute MI patients have a positive blood test or electrocardiogram when they come

in, and with unstable angina, only about 5% do, notes Graff. "So your tests are normal, and then you've got to tell somebody the patient might have a heart attack and they should be in the hospital, and they're going to laugh at you," he says. "But even if it's a 5% chance of having an MI, then 5 out of 100 patients will have an MI. And if you send them home, their chance of dying doubles."

There is no way you can make a definitive decision for patients with an indeterminate risk, so the observation unit gives you a "third pathway," says Graff.

If you have a patient with chest pain, and serial cardiac markers and electrocardiograms are still negative 12 to 16 hours later, then they haven't had damage to the heart, and if you do a stress test or CT angiogram, then they don't have coronary artery disease, and you have proved this in a short amount of time, says Graff.

The observation unit reduces legal risks as "more than an ED visit but less than a hospital admission," Graff concludes. "What we are trying to do is set up this third pathway so you can have your cake and eat it too," he says.

References

1. Graff LG, Dallara J, Ross MA. Impact on the care of the emergency department chest pain patient from the chest pain evaluation registry (CHEPER) study. *Am J Cardiol* 1997:80(5):563-568.
2. Rydman RJ, Roberts RR, Albrecht GL. Patient satisfaction with an emergency department asthma observation unit. *Acad Emerg Med* 1999:6(3);178-183.
3. Rydman RJ, Zalenski R, Roberts G, et al. Patient satisfaction with an emergency department chest pain observation unit. *Ann Emerg Med* 1997:29;109-115.
4. Mace SE, Graff L, Mikhail M, et al. A national survey of observation units in the United States. *Am J Emerg Med* 2003:21:529-533.
5. Mace SE, Shah J. Observation medicine in emergency medicine residency programs *Acad Emerg Med* 2002: 9(2);169-171. ■

CNE/CME instructions

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

CNE/CME objectives

After completing this activity, participants will be able to:

1. Identify legal issues relating to emergency medicine practice.
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■

CNE/CME *Questions*

13. How much of the conversation with an admitting physician should the emergency physician document in the ED medical record?
    A. Time call for admission was initiated
    B. Time case was discussed with admitting physician and the time you transferred responsibility of the patient to the admitting physician
    C. Time admitting physician is expected to physically come to the ED or hospital to personally examine and care for the patient
    D. Patient's diagnosis, abnormal physical findings, and present clinical condition, as well as pertinent lab and X-ray data
    E. All of the above

14. Shortness of breath in children always has serious etiologies.
    A. True
    B. False

15. Which of the following is recommended to reduce liability risks when families are allowed to be present during resuscitation?
    A. Do not discuss what the family member is likely to encounter in the room.
    B. Avoid informing the ED team before the family member enters the room.
    C. Perform all major procedures only after the family is present.
    D. Assign an ED staff member to communicate with the family.

16. Which is TRUE regarding ED observation units and liability risks, according to published studies?
    A. Patients are happier in observation units than inpatient units.
    B. Patients are frequently dissatisfied with ED observation units.
    C. ED physicians are more likely to be sued by observation patients.
    D. Patients in ED observation units are at high risk for inappropriate care.

17. Which is TRUE regarding observation units and missed myocardial infarction (MI) rates?
    A. In EDs with a chest pain observation protocol, missed MI rates were higher.
    B. Observation units led to a tenfold decrease in missed MI.
    C. There was no difference in the rate of missed MI for EDs with and without observation units.
    D. The missed MI rate was under 1% for EDs without observation units.

Answers: 13. E, 14. B, 15. D, 16. A, 17. B