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IN THIS ISSUE

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Inpatient Transfers and Community On-Call Programs: New Rules Finalized

By Robert A. Bitterman, MD, JD, FACEP, *Contributing Editor*

In August of this year, the Centers for Medicare & Medicaid Services (CMS) published final rules revising the Medicare hospital inpatient prospective payment system (IPPS). These regulations also contain policy changes related to a hospital's obligations under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA).[1]

First, CMS rejected its own proposed rule which would have required referral hospitals to accept inpatients in transfer from other hospitals if the patient remained unstable after admission under EMTALA. Moreover, it severely limited the scope of EMTALA's transfer acceptance mandate by eliminating its application to inpatients entirely. Second, CMS affirmed its proposal to allow hospitals to band together to provide "community call" to meet their on-call duties under the law.[1]

The CMS proposed regulations[2] and their potential ramifications were discussed earlier this year in the June and July issues of *ED Legal Letter*.[3,4] This article will address the final rules, which become effective on Oct. 1, 2008, on the transfer acceptance requirement, and the new "community call" program intended to alleviate the nation's on-call crisis.

While the "final rules" address particular aspects of these two EMTALA obligations, it is highly likely that CMS will promulgate still more regulations on both issues, particularly the on-call requirement, since it has yet to address many of the recommendations made by the "Technical Advisory Group" (the EMTALA 'TAG') established by Congress to review and advise CMS on the EMTALA regulations.[5,6]

EMTALA's transfer acceptance requirement

Back in 2003 CMS took the position that a hospital's obligation under EMTALA ends when that hospital, in good faith, formally admits an individual to the hospital. However, CMS never directly addressed the question of whether EMTALA's transfer acceptance requirement applied if a hospital needed to transfer the patient after admission.[7]

Many attorneys and hospitals (particularly tertiary/academic medical centers) believed since EMTALA ended for one hospital upon admission, that no other hospital had any EMTALA obligation to accept an inpatient in transfer. Others believed

that EMTALA imposed an independent duty upon accepting hospitals, and that their duty to accept transfers is not derivative or dependent upon the EMTALA duties of the other hospital. In other words, just because EMTALA ends for one hospital when it admits the patient does not mean the law does not apply to a different hospital when it is asked to accept an appropriate transfer of a patient who needs further emergency care.

In its April 2008 proposed regulations, CMS agreed that once the individual is admitted, admission only impacts the EMTALA obligation of the hospital to which the individual first presented, not the EMTALA obligations of other hospitals.[2] It proposed to expand the duty to accept transfers to included patients admitted under EMTALA who remained unstable, and solicited comments on whether or how the transfer acceptance mandate should apply to all inpatients.

After reviewing the many comments it received and reconsidering the issues, CMS reversed itself and stated:

> "Although we believe that the language of section (g) of the Act can be interpreted as either applying or not applying to inpatients ... we have serious concerns about the impact the proposed policy would have had on patient care and the possibility that it may overburden many hospitals that are currently having difficulties providing sufficient emergency care."[1]

In summary, CMS believed that applying the transfer acceptance mandate to inpatients (in addition to ED patients) would negatively impact patient care due to an increase in the number of inappropriate transfers; result in overcrowding academic medical centers, tertiary care centers, and public safety net hospitals; and "further burden the emergency services system and may force hospitals providing emergency care to limit their services or close, reducing access to emergency care."[1]

The end result is that CMS has created two distinct classes of patients with life-threatening emergency conditions, one class protected by EMTALA from economic discrimination by hospitals, and one class against whom it is fair game for hospitals to overtly discriminate and deny access to emergency care based solely on their insurance status.

Access to emergency care is now determined on what door someone enters the hospital! If an individual develops an emergency condition at home and seeks care at a local ED, but that ED can't manage the emergency, other hospitals that can manage the emergency have a legal duty under EMTALA to accept the person in transfer to provide the necessary care. However, if an individual is already admitted to a hospital and then develops an emergency that the hospital can't treat (think acute neurosurgical emergencies in hospitals without neurosurgeons on staff), no other hospital has a duty to accept the patient in transfer. Other hospitals can accept or reject inpatients in transfer based entirely on economic considerations alone.

(Ironically, it was CMS and the courts that originally expanded a hospital's duty to provide medical screening and stabilizing care when interpreting the statute's "comes to the ED" language, stating explicitly that "access to emergency care shouldn't depend upon which door you enter the hospital.")

Impact of the courts

However, CMS may not have the last word on whether the transfer acceptance mandate applies only to ED patients and not to inpatients. It is inevitable that an inpatient will develop an emergency medical condition and proceed to die or suffer severe damages because no other hospital would accept the patient in transfer due to lack of insurance. (One recent actual example: an unfunded inpatient developed an epidural abscess and was refused transfer for neurosurgical care, leaving the patient permanently paralyzed and incontinent.) The patient or family will sue the hospi-

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tal that refused to accept the patient in transfer, claiming that the hospital had a federal duty under EMTALA to accept appropriate transfers of patients with emergency conditions if the transferring hospital couldn't treat the emergency.

The courts do not blindly accept CMS's regulations or interpretations of the statute, though they are given great weight and a high degree of deference. (The U.S. Courts have established complex legal precedents for interpreting statutes and regulations implementing them.) See, for example, the legal reasoning in the cases of *Preston v. Meriter* and *Anderson v. Kindred Hospital*,[8,9] where the courts upheld CMS's regulations ending the application of EMTALA and the liability under the law for hospitals that admit the patient from their ED. Contrarily, the U.S. appellate courts have rejected CMS's interpretation of the meaning of an "appropriate" medical screening exam (MSE). When enforcing EMTALA, CMS determines whether a hospital or the emergency physicians provided an "appropriate" MSE based on ordinary medical "negligence standards" — did the physician meet the acceptable standard of care? The courts uniformly reject the negligence standard, and instead hold the hospitals and physicians to a "process standard" — did the hospital and physician put the patient through their usual screening process to determine if an emergency condition existed?[10]

Note the language of the transfer acceptance section, section (g), of EMTALA:

> "*Nondiscrimination.* A Medicare participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units …) shall not refuse to accept an *appropriate transfer* of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual."[11]

That word "appropriate" is once again used, this time to define the type of transfers that a hospital must accept. The language is broad and does not condition the acceptance of such patients on their location in the transferring hospital (ED vs. inpatient), or even whether they entered the hospital via the ED.

Remember too, that section (g) was not part of EMTALA originally. Congress amended the law in the late 1980s to add this requirement because referral hospitals were refusing to accept patients in transfer from other hospitals because of their insurance status and the patients were dying in the ED and dying in the inpatient settings. Congress' intent when it passed section (g) was to prohibit our more capable hospitals from refusing for economic reasons transfers of patients with emergency conditions that the original hospital couldn't handle. Hence the title of the section: "*Nondiscrimination.*"[12]

Section (g) and its "appropriate transfer" language should be interpreted to mean that higher level facilities must accept medically indicated transfers of patients with emergency conditions when they can do so, regardless of the location of the patient in the sending hospital, and on a nondiscriminatory basis.

It will be interesting to see if the courts allow our nation's hospitals to revert to the pre-EMTALA days of openly discriminating against patients in the throes of life-threatening medical emergencies based on insurance status, only this time against inpatients, placing them at risk of death, instead of against ED patients.

Community on-call programs

As expected, CMS confirmed its commitment to allow "community call" programs to be established by groups of hospitals in self-designated referral areas to help address the shortage of ED on-call specialists.[1,2]

The final rule permits a group of hospitals to designate one of the hospitals in their geographic area as the "on-call facility" for a specific time period, such as weekends, or for a specific service, such as neurosurgery or hand surgery.[1]

The involved hospitals must establish a formal written plan, with formal written agreements recognized in their policies and procedures, and comply with set minimum criteria determined by CMS; however, no advanced approval from CMS will be required. Each hospital in the program must still medically screen, stabilize, and arrange an appropriate transfer when sending the selected patients to the "community call" facility.

CMS adopted all of its proposed requirements for community call except one. CMS dropped the section mandating that participating hospitals in the community call plan "analyze the specialty on-call needs of the community" for which the plan is effective.[1,2]

Therefore, under the final rule, hospitals must incorporate the following minimum criteria into a community call program for the plan to be acceptable to CMS:[1]

1. The community call system must be a formal plan among the participating hospitals, signed by an appropriate representative of each hospital participating in the plan, and with written policies and procedures in place.
2. The community call plan must include a clear delineation of on-call coverage responsibilities, that is, when each hospital participating in the plan is responsible for on-call coverage.
3. The community call plan must define the specific geographic area to which the plan applies.
4. The community call plan must ensure that any local and regional EMS system protocol formally includes information on community on-call arrangements.
5. The community call plan must include a statement

specifying that even if an individual arrives at the hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability, and hospitals participating in community call must abide by the EMTALA regulations governing appropriate transfers.

6. Each hospital participating in the community call plan must have written policies and procedures in place to respond to situations in which the on-call physician is unable to respond due to situations beyond his or her control.
7. There must be at least an annual reassessment of the community call plan by the participating hospitals.

CMS expects these on-call changes to help hospitals attract more physicians, afford additional flexibility to provide on-call services, and improve access to specialty physicians for emergency care in their communities.[1,2] Time will tell if it works out as CMS, emergency physicians, and the general public hopes. ■

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MRSA: An evolving, high-risk area for the ED

Can treatment choices get you sued?

Editor's Note: *This is a two-part series on liability risks regarding antibiotic choice in the emergency department. This month, we report on liability risks involving methicillin-resistant* Staphylococcus aureus.

The issues involved with treating community-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) in the ED are complex, says **John Burton,** MD, residency program director for the Department of Emergency Medicine at Albany (NY) Medical Center.

"There are a great deal of public fears and misconceptions about this bug and its subsequent infections that create near panic in some communities," he says.

This makes caring for a MRSA patient ripe for "confusion, failed expectations, and uncertain causes and effects," says Burton. In other words, it's a perfect combination of factors to provoke legal action against treating physicians. To make things more difficult, "the treatment of these infections is a moving target," adds Burton.

Five years ago, skin abscess infections weren't very common, and the general consensus was that uncomplicated infections did not require antibiotic coverage in an immunocompetent patient. If antibiotics were given, cephalexin was a typical choice.

"As MRSA began appearing in our communities and ED wound cultures, this management view began to come apart at the seams," says Burton. Initially, there were recommendations to culture all wounds, and subsequent opinions ranged from treating all

Key Points

If the ED physician chooses an antibiotic that does not cover methicillin-resistant *Staphylococcus aureus* (MRSA), there is potential liability exposure. To reduce risks:

- Consider local sensitivities when choosing an antibiotic.
- Give empirical coverage with vancomycin or another MRSA-active parenteral drug for patients who appears sick and may be infected with MRSA.
- Advise patients to obtain follow-up care with a primary care physician or via a "wound check" in the ED.

wound patients with antibiotics to treating only those with larger and more inflamed wounds.

Current antibiotic coverage for these patients has increasingly emphasized trimethoprim/sulfamethoxazole as a first-line agent, says Burton, with doxycycline or minocycline as an alternate for sulfa-allergic patients.

"Physicians should certainly be aware of the sensitivities of this bug, as well as prevalence, in their treatment populations," says Burton.

How to cover for MRSA?

Regarding community-acquired MRSA, the most likely scenario for an ED physician to be sued is if antibiotics such as keflex are used that do not cover it, and MRSA has been well-documented in the area, according to **James R. Miner,** MD, FACEP, associate professor of emergency medicine at University of Minnesota Medical School and faculty physician in the ED at Hennepin County Medical Center, both in Minneapolis.

"The clinical presentation of MRSA is not different from other staph strains, so it's no more likely to be missed than any other infection," adds Miner. "Adding bactrim to keflex or using clindamycin covers the MRSA in most communities to account for this."

But community-acquired MRSA is now common enough in many areas that standard medications like keflex may not be suitable first-line agents anymore. "A lot of community-acquired MRSA is sensitive to bactrim or clindamycin. Local susceptibilities are important to know," says Miner. "We cover for MRSA in anybody with sepsis, no defined source, those who are at risk for MRSA, and ill pneumonia patients. The overwhelming majority of these patients are being admitted."

Inpatients should be covered with vancomycin for 24 to 48 hours until the source or organism is identified, adds Miner.

David A. Talan, MD, FACEP, chairman of the department of emergency medicine and faculty in the Division of Infectious Diseases at Olive View-UCLA Medical Center, says he is aware of lawsuits that have come forward contending negligence regarding choice of antibiotic for skin and soft tissue infections that progressed to sepsis because antibiotics active against MRSA were not given. "This is an evolving high-risk area for docs," says Talan.

Even with MRSA now recognized as the leading cause of skin and soft tissue infections, many doctors still prescribe cephalexin despite the fact that it lacks in vitro activity. Since this is still a widespread practice and there is a lack of clinical trials proving this is ineffective, however, it could be contended that this practice is within the standard of care, says Talan.

"On the other hand, for a patient who appears sick and may be infected with MRSA, I think most emergency medicine docs would give empirical coverage with vancomycin or another MRSA-active parenteral drug," he says.

Incision and drainage may be adequate for simple uncomplicated abscesses, but antibiotics should be given for ill patients and those with cellulitis or deeper infections, says Talan.

"I think prescribing keflex for likely MRSA skin infection at this point is still 'defensible,' as in a defense can be made. But of course, it all comes down to a jury's decision," says Talan. "There are plenty of guidelines now that say this is frankly wrong, but there continues to be use of keflex despite these guidelines."

No clinical outcomes "proof" on keflex yet

At present, there is no clinical trial "proof" that keflex is inferior to MRSA-active drugs in terms of clinical outcome. "We are conducting a $10 million NIH study to answer this question," says Talan. The results of the NIH study are expected to be available in about three years. "The wheels of progress turn slowly," says Talan. "However, it will be the largest randomized clinical trial of uncomplicated skin and soft tissue infections conducted that will evaluate off-patent antibiotics active against MRSA."

"Of course, there are a boatload of examples in infectious disease that substantiate that if you use a drug that kills the bug in the test tube, then the patient will do better than using one that does not. Even juries get that," Talan says.

Physicians should routinely culture wounds that undergo incision and drainage in the ED to contribute

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Sources

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SPECIAL REPORT

Common Mistakes in the ED

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In an age of high patient volumes, overcrowding, and prolonged patient stays in emergency departments (EDs), the clinician is challenged to be both efficient and effective on a daily basis.

In the ED, clinicians are required to apply a careful, diligent approach to each patient that still may sometimes lead to a missed diagnosis. In this article, we discuss certain common mistakes that may cause clinicians to overlook devastating disease processes or consequences. Avoiding these omissions may help protect against both misdiagnosis and the potential for subsequent civil action.

CASE 1, Patient with back and neck pain. A 51-year-old male presented to Hospital A (a free-standing ED facility) with complaints of back and neck pain.[1] He arrived via EMS on a backboard, had no past medical history, and was medicated en route with fentanyl. Cervical-thoracic-lumbar plain films of the spine were negative and he was transferred to Hospital B due to continuation of his pain.

At Hospital B, he arrived with his family and reported that three days prior to presentation he was lifting a sofa and felt some back pain. Then on the day of presentation, he woke up with severe back and neck pain, left knee discomfort, and right shoulder discomfort. Review of systems was negative for gastrointestinal or genitourinary symptoms, chest pain, and shortness of breath. He also denied any upper respiratory symptoms or other injuries.

He had no relevant past medical or surgical history. On arrival, he was febrile with a temperature of 102.6 degrees F. His pulse was 116, blood pressure was 130/82, and respiratory rate was 16.

Pertinent negatives on physical exam included a normal cardiac and pulmonary exam, and his abdomen was soft, non-tender/non-distended with appropriate bowel sounds. Examination of his neck and spine showed right paracervical tenderness with bilateral diffuse lumbar pain. Neurological exam showed normal strength, sensation, and reflexes, but he was unable to ambulate without experiencing intense pain in his neck and lumbar spine.

The differential opined by the evaluating provider included back spasms, meningitis, or a viral syndrome. The work-up included CT scan of the brain and cervical spine, urinalysis, and lumbar puncture. All were normal except for the lumbar puncture, which had an opening pressure of 38 mmHg. The patient was given pain medication and was asked to ambulate, which he did with moderate pain. He reported that his neck hurt with ambulation and he was given a soft cervical collar and discharged to home. Prior to discharge, the patient's wife voiced concerns about her husband's inability to walk, stating "My husband has never taken a day off in his life. He is in good shape and is a hard worker. He doesn't complain and this is not like him." In response to the wife's concerns, the evaluating resident relayed a story about her uncle who had back spasms that were accompanied by back and neck pain. The wife responded that she did not care to hear about the resident's family history and that her only concern was for her husband as "something is clearly wrong with him." Despite this, the patient was discharged and advised to follow-up with his primary care physician (PCP) and neurologist within 2-3 days.

The patient presented to his PCP three days later and was sent immediately to the ED for neurological changes. Emergent MRI revealed a 5cm abscess in the cervical epidural region and he was taken urgently to the OR for decompression.

CASE 2, right lower quadrant pain. A 43-year-old registered nurse arrived in triage at 23:55 with complaints of right lower quadrant pain for eight hours prior.[2] She had a recent history of ovarian cysts and also had been experiencing nausea, decreased appetite, and urinary frequency/dysuria. She stated "I had a D&C in September and my period is late, so I don't know if my ovaries are twisted or if it is my appendix." She was seen by the ED physician who noted the history above. In addition, the patient stated her pain began suddenly at 12 p.m. on the day of presentation. Her review of systems was negative, and her exam showed a temperature of 97.8 degrees F, pulse of 70, respiratory rate of 20, and a blood pressure of 107/66. She rated her pain as a 10/10.

Findings on exam included a normal cardiac and pulmonary evaluation, and her abdomen was non-tender and non-distended with normal bowel sounds. Pelvic exam showed a normal perineum with blood tinged discharge in the vaginal vault and external cervical os. Her uterus was normal sized and her cervix was normal as well. On bimanual exam, she was noted to have severe adnexal pain, right greater than left.

Her labwork showed an elevated white cell count of 15.2, with a nor-

mal urinalysis and a negative serum pregnancy test. Her pelvic ultrasound showed a normal uterus and right adnexa, with two cysts (each 2cm in size) on the left ovary. Normal flow was noted to both ovaries and there was a trace amount of free fluid.

The patient was informed of her results, including the leukocytosis. She asked why it was elevated. The explanation given to her was the concept of white cells increasing in the blood stream as a result of stress, which can be painful. She was instructed to follow-up with her gynecologist in 2-4 days and the ED nurse caring for the patient requested that the patient receive acetaminophen and oxycodone hydrochloride since "she is one of us."

The patient took her pain medication and saw her gynecologist as instructed 3 days after her initial ED presentation. Her gynecologist immediately sent her back to the ED and a diagnosis of a perforated appendix was made. She was treated by interventional radiology for drainage of an appendiceal abscess and underwent appendectomy thereafter.

CASE 3, right lower leg pain. A 21-year-old male with a history of migraine headaches arrived to the ED with complaints of pain in the right lower leg.[3] Per the triage note, the patient stated he injured his right lower leg while playing basketball the day prior. He complained of pain to the right shin that he described as 7 out of 10. The family reported he mentioned numbness in his lower leg and pain with movement; he was unable to ambulate unassisted into the ED.

He was afebrile with normal vital signs and his exam revealed minimal tenderness over the distal third of the anterior lateral tibial region with minimal swelling and slight muscular spasm. He was neurovascularly intact and an X-ray of the region was negative. He was discharged home with a diagnosis of shin splints.

The patient returned to the ED 12 hours later with worsening pain. On the second presentation, he reported constant pain and an inability to bear any weight on his right leg. His vital signs remained stable and an exam noted tenderness at the mid right tibial surface with a 4mm hard nodule. There was no fluctuance or drainage, and it was not warm or erythematous. He still had an intact neurovascular exam, but no reflexes were tested and there was no documentation of palpable distal pulses.

The patient was once again diagnosed with tendonitis and discharged with orthopedic referral and instructions to return to the ED with worsening symptoms. He was seen by the consultant orthopedic surgeon the next day and was diagnosed with acute anterior compartment syndrome and taken immediately to the operating room for fasciotomy.

Case Review. After careful review of these cases, through the benefit of hindsight, what common threads are woven through each one? Are assumptions made in dealing with difficult, puzzling cases that can be scrutinized for future learning? And, what important information can be picked up from an initial visit that can help to solidify the correct diagnosis at that time?

ABCs. We must be aware of the many facets that encompass the care we provide. It is imperative that the history given by the patient and family members or acquaintances is carefully noted and analyzed, as well as to the patient's presenting vital signs. The temptation to ignore or downplay patient complaints and presenting symptoms must be avoided, and a plausible, rational explanation for any abnormality in vital signs should be sought. These very crucial factors can play a significant role in the appropriate disposition of any patient.

Customer Service. On many occasions, patients who have experienced poor outcomes have been asked why they did not pursue legal action against the treating physician. Almost universally, the response centered on the individualized, compassionate care that the patient and family members perceived throughout their experience. As Sir William Osler once stated, "people do not care how much you know, as long as they know how much you care."

Fred Lee, author of "*If Disney Ran Your Hospital, 9 ½ Things You Would Do Differently,*" states "compassion also creates loyalty to physicians."[4] He also notes the strong relationship between physician communication and malpractice lawsuits. He has found that patients tend to become angry about something other than clinical outcomes. The most common thread of medical malpractice suits dealt with physicians not validating or empathizing with patients and not showing them warmth, compassion, and concern for their worrying. He also added that "family members need empathy too."[4]

Close Follow-up. One crucial piece of the complete evaluation is to make sure to arrange timely follow-up for a patient, especially for those diagnoses that are less certain or when the addition of 24-48 hours of time could aid in making the correct diagnosis. While it would be nice to insure every patient has timely follow-up with their PCP or the appropriate consultant specialist, sometimes the only option is to instruct the patient to follow-up in the ED. While some patients may express reluctance to do so due to inconvenience or ED wait times, it has been found that a careful explanation of why you are making the follow-up recommendation goes a long way in persuading a patient to come back. As always, documentation of this discussion and recommendation is paramount for the emergency care provider.

Outcomes. Case 1: Diagnosis — Spinal Cord Compression Syndrome. A patient who presents with fever and midline vertebral ten-

derness and a diminished ability to ambulate should automatically raise a red flag in the mind of the provider. Although this patient did not have a history of high-risk behaviors, he was unable to ambulate in the ED secondary to significant cervical spine and neck pain. The "red herring" was the patient's own voluntary admission that he thought his pain was related to the sofa he had lifted prior to coming to the ED. While this sort of activity can produce significant musculoskeletal injury, this act alone does not explain his febrile condition or his inability to ambulate out of the ED.

Should an MRI of the cervical spine, looking for something beyond a musculoskeletal injury, have been ordered? In hindsight this seems obvious. In real time, an MRI would have allowed the clinician to investigate the potential for cervical spinal pathology that could account for a fever and a diminished ability to ambulate. Our goal is prevention of further neurological demise while intervention is still feasible and not to intervene after subsequent paraplegia and/or bowel and bladder dysfunction.

If we as clinicians do not know the exact diagnosis, it is imperative to acknowledge this fact. We are never going to diagnose every patient correctly the first time we evaluate them. "The biggest mistake is thinking that one visit is going to have all the answers," explains Greg Henry, MD, of Medical Practice Risk Assessment Inc. and past President of ACEP.[5] However, this is where the reasonable physician can arrange for follow-up that is time and action specific, especially when an observation unit for serial exams is not available. In this case, one could argue that if a patient who normally is able to ambulate cannot walk out of the department without significant assistance, especially with an unknown etiology, he or she probably should not be discharged.

In this particular case, why did the family take legal action? One motivating factor was to recoup money from lost income related to the missed diagnosis. However, the patient regained almost full functionality and was not off of work for a lengthy recovery. During discovery, it became clear that this primarily hinged on the lack of customer service. The patient's wife stated that the resident physician was not empathetic to her and her husband. In addition, she commented that the doctor was flippant about her husband's case. In fact, the wife stated she was very upset that the resident physician tried to compare her husband's condition to her own family member. The wife held the resident responsible for the missed diagnosis. The patient filed a lawsuit,[1] and after thousands of dollars spent in discovery the case was settled for $175,000.

Case 2: Diagnosis — Appendicitis. Mrs. Jones, a health care professional herself, is aware that misdiagnosis can occur in caring for patients. In her case, her exam was consistent with right adnexal pain but the misdiagnosis hinged on the disconnect between two cysts with minimal pelvic fluid as the source for her "10 out of 10" pain. In addition, she did have an elevated white blood cell count. Although we know this does not diagnose acute appendicitis, this lab value must be strongly considered in the differential. An elevated total white blood count >10,000 cells/ mm^3, while statistically associated with the presence of appendicitis, has very poor sensitivity and specificity and almost no clinical utility.[6] In this scenario, the elevation in white cell count was reviewed with the patient and explained by demargination due to her level of pain. Anchoring onto this explanation led to a missed diagnosis. The key to this case was the need for close follow-up that was required to provide a plausible, reasonable diagnosis for her right lower quadrant abdominal pain. Patients with an unclear diagnosis that could include appendicitis should have follow-up in 12-24 hours, and they must be advised that appendicitis has not been ruled out and that is why the follow-up is critical. The provider must clearly document that this discussion took place with the patient as well as documenting any family members or nursing personnel who also may have been present at the discussion.

Ultimately, the patient sought legal counsel and sent a demand letter to the physician that indicated her dissatisfaction with her care.[2] She stated "I told her I thought I had appendicitis but the doctor just wouldn't listen. She kept trying to tell me that it was my ovaries but I knew that wasn't the case. If someone had just addressed my concerns this would have been handled correctly from the start and I wouldn't have had to go through what I went through." She further stated that as a nurse she did not think an elevated white count correlated with a problematic ovarian cyst. The patient blamed the ED physician for ignoring the white count of 15,000 and not being told to follow-up sooner. In addition, she pointed out that the Percocet she was taking for her pain should have been recognized as an agent that could mask a fever and/or worsening pain. In the end, this patient settled with the physician for $25,000.

Case 3: Diagnosis — Compartment Syndrome. The concept of anchor bias, meaning a situation in which a provider anchors onto a diagnosis, is used to describe a scenario in which the provider holds steadfast to a particular diagnosis while rationalizing its validity to the particular situation at hand. This case involves a young, healthy male, a demographic that generally doesn't tend to complain. He arrived to the ED to the presenting physician with the "red herring" of shin splints. In this situation, the physician anchored onto this diagnosis as a means of explaining this patient's condition. In evaluating this case retrospectively,

there were many unusual factors that were overlooked. A patient with shin splints usually will not complain of an inability to feel parts of his foot and will usually be able to move his foot. A red flag should have been raised when it was noted that the patient could not ambulate into the ED the second time because of the severity of the pain. It can further be argued that the diagnosis of "shin splints" could have represented the earliest form of compartment syndrome. This layman's term is technically referred to as "medial tibial stress syndrome." Shin splints are almost always on the medial tibia. Compartment syndromes of the lower leg (which are actually uncommon), are typically along the lateral aspect of the lower leg. In the scope of medical practice, this nuance of medial versus lateral is often not differentiated. As a result, the term "shin splints" is often used as the name for overuse of muscles of the anterior lower leg. Taking a step back and looking at the presenting signs and symptoms and physical findings, a patient who is experiencing severe pain and neurological changes on exam should not be sent home with a diagnosis of shin splints. This patient returned to the ED again; the second treating physician anchored onto the initial diagnosis and failed to provide close follow-up that was time and action specific. This case was settled without formal litigation.[3] During discussions, the patient and family expressed that "they were treated poorly in the ED and that on both visits they were not taken seriously by either physician." The patient's sister told the triage nurse and evaluating physician that she had never seen her brother in so much pain. In addition, he was an athletically active young man and he never should have been discharged if he could not ambulate out of the ED. The family filed suit and settled out of court for $250,000.

Summary. In conclusion, all of these scenarios depict the need for practitioners to use dynamic thought processes and to be aware of the various thinking errors that can occur.[7] In many cases, he or she must decipher and diagnose. It is important that emergency physicians take the time to listen, to not rationalize, and more importantly to show compassion. Adhering to these principles may still result in a missed diagnosis, but the clinician will have established a bond of caring and empathy toward the patient and family that may diffuse the situation and avoid litigation. ■

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to the monitoring of drug-sensitivities for this bug, recommends Burton.

"There is little evidence to guide one's understanding and practice in these patients," says Burton. "Despite approximately half a decade of a startling increase in prevalence of this bug in ED patient populations, we have very little definitive data that clarify the effect on outcomes for either end of the spectrum — no antibiotic coverage with emphasis on wound care, versus aggressive, comprehensive antibiotic coverage in all patients."

The concept of "double coverage" is a confusing in itself, adds Burton. "If the prevalence of community-acquired MRSA in these wounds ranges from 35-70% in our patients, do we ignore the potential coverage of methicillin-sensitive bugs?" he asks. "This is further confused by the view that we typically were not utilizing antibiotic coverage in the pre-MRSA era of skin abscess patients."

Clear and documented wound care instructions are essential for MRSA patients. The plan should include advising the patient to follow-up with a physician for wound assessment or, in some settings in which access to a primary care physician is limited or absent, a plan for a "wound check" in the ED, advises Burton.

"Culture of debrided wounds has now evolved to be a routine, advised practice in these patients," says Burton. "This is a clear departure from a historical practice that viewed pus cultures as nonessential and noncontributory to any meaningful patient outcome. The landscape has changed. These wounds should be routinely cultured."

Burton recommends having an agreed-upon wound care plan for patients in your community. "This will close the gaps between opinions of treating physicians, and thereby reduce the risk inherent to disparate practice plans if patient outcomes worsen instead of improve," he says.

Incorporate infectious disease expertise into this strategic planning, to formulate treatment strategies based on local prevalence and sensitivity data, says Burton.

Be wary of medical experts who advocate that this issue is simple and that there are clear standards of care, warns Burton. "It's a fast moving and evolving issue that requires formulation of a treatment plan specific to each wound and patient, with recognition of local practice patterns based on the prevalence and sensitivities of this bug," he says. ■

When, if ever, can you divulge your ED patient's HIV status?

ED physician may have a duty to warn others

A man with chest pain tells you that he uses cocaine and is positive for human immunodeficiency virus (HIV), then asks you to not tell his girlfriend who is about to enter the room. What are you most likely to be sued for: if you disclose the patient's status, or if you don't tell and his partner gets infected?

A patient's status as HIV-positive is protected by federal and state law, says **Erin McAlpin Eiselein,** a health care attorney with Davis Graham & Stubbs in Denver, CO.

You may only disclose this confidential and protected health information if there is an exception to the federal or state law, says Eiselein.

However, in light of the California Supreme Court's 1974 decision in *Tarasoff v. Regents of the University of California,*[1] involving a patient who killed a specific agency about a possible HIV infection would not violate HIPAA for the additional reason that there is an exception for disclosures to avert a serious threat to health or safety.

Steinberg points to a Wisconsin case which found that an emergency medical technician invaded the privacy of an overdose patient when she told the patient's co-worker about the overdose.[1]

And in a Michigan case involving a pharmacy employee who loudly blurted out a patient's HIV status in a crowded waiting room, the court of appeals upheld a jury verdict of $100,000 for slander, invasion of privacy, intentional infliction of emotional distress, and violation of a Michigan statute that protects the confidentiality of HIV results.[2]

Before HIPAA, physicians had been sued for failure to disclose to third parties in limited instances, such as the *Tarasoff* case, notes Steinberg. Also, a physician was successfully sued in a case involving the failure to warn family members of the possibility that they also had been exposed to Rocky Mountain spotted fever when a relative had died of the disease.[3]

"With HIPAA now in effect, these lawsuits probably not be successful if filed today," says Steinberg. ■

What if HIPAA conflicts with your state's law?

Disclosure isn't always prohibited

According to **Jill M. Steinberg,** a health care attorney with Baker, Donelson, Bearman, Caldwell & Berkowitz in Memphis, TN, the Health Insurance Portability and Accountability Act (HIPAA) would prevent an ED physician from discussing a patient's HIV status with any other person, even if that person could be potentially exposed to an infectious disease.

Instead, the ED physician should do what he or she can to obtain permission from the patient to disclose the information, and/or make a strong recommendation to the patient himself to disclose his HIV status.

"The physician should also document in the patient's record that he was counseled to avoid unprotected intercourse, stop using drugs, and warn all of his sex partners of their potential exposure," she says.

It is unlikely that a successful lawsuit could be maintained against the emergency physician for failure to tell a patient's girlfriend of his HIV status even if she becomes infected, since HIPAA prevents the disclosure, says Steinberg.

"Without permission or a Health Care Power of Attorney, there are very few, if any, scenarios wherein an ED physician or nurse would be legally able to divulge patient information unless the patient is incompetent or comatose," says Steinberg.

There appears to be no private right of action for a HIPAA violation. Patients complaining of violations are required to file their grievance with the Office of Civil Rights. However, suits may be filed by patients alleging a breach of confidentiality based upon state law rights of privacy.

Laws may conflict

There may be situations where state law and federal law are in conflict, such as states that require the physician to notify a sexual partner or local health organization of the patient's status as HIV-positive. "Failure to notify may put the physician in violation of state law. But notifying a non-patient of the patient's status would be in violation of federal law," says Steinberg.

However, ED physicians likely will not violate HIPAA by complying with a state statute that permits or requires reporting known contacts of a HIV-positive individual to a public health agency. "Such reporting probably would fall under the HIPAA exception for public health activities, so those state laws would not be contrary to HIPAA," says **Erin McAlpin Eiselein,** a health care attorney with Davis Graham & Stubbs in Denver, CO.

Eiselein adds that there is a "good argument" that an ED physician notifying a contact or a local health

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individual after informing his psychologist that he intended to do so, physicians also have an obligation to warn a party in clear or imminent danger.

"The intersection between the physician/patient privilege and the physician's duty to warn raises a number of legal and ethical considerations," says Eiselein. "If an ED physician encounters this situation, he or she should immediately contact the hospital's legal counsel, as controlling laws vary widely by state."

Many states allow, but do not require, notification to third parties, while a few states require the notification. "In those states, the disclosure would be permissible," says Eiselein.

Michigan, for example, has enacted a statute requiring physicians to notify the contacts of an HIV-positive patient, if this disclosure is necessary to prevent further transmission of HIV.

"The ED physician can also discharge this duty by notifying a local health officer," adds Eiselein.

However, the Michigan statute is unusual. In the vast majority of states, such notification isn't mandated, and may not be allowed at all. "State statutes are all very different," says Eiselein. "Some allow disclosure to spouses. Others allow disclosure to sexual partners but not needle sharing partners, and others permit disclosure to anyone who may have been exposed to the virus."

In states in which notification is permitted, the ED physician will have to make a decision as to whether to notify a contact directly, or make a report to the local health agency, based upon the particular state law involved and the set of facts presented, says Eiselein.

She cautions that physicians who are statutorily authorized to notify a third party about a possible exposure to HIV should take care to strictly comply with such laws. "In many cases, this means providing the contact's name to a local health agency so that the agency can conduct the notification," says Eiselein. "Any questions about such a notification should be brought to the immediate attention of legal counsel."

Many possible scenarios for lawsuits

If you divulge a patient's HIV status, the patient could sue you for breach of physician-patient privilege, breach of confidential physician-patient relationship, invasion of privacy, and intentional or negligent infliction of emotional distress. If you fail to disclose this information, however, a third party could sue you for failure to warn, intentional or negligent infliction of emotional distress.

There also may be claims for breach of a particular statute imposing a duty of confidentiality on HIV-related information. For example, a New York appellate court held that a plaintiff could seek punitive damages from a physician for breach of the physician's duty of confidentiality and violation of a New York law prohibiting disclosure of HIV-related information.[2]

"The failure to warn cases will be most successful in states such as Michigan, that have placed an affirmative duty on the physician to notify a sexual partner or a local health organization of the patient's status as HIV-positive," says Eiselein.

Physicians have been sued for both disclosing HIV status in violation of a confidentiality statute, *and* failing to warn a third party about possible HIV infection.[3,4]

The American Medical Association's policy on HIV testing states that "Physicians must honor their obligation to promote the public's health by working to prevent HIV-positive individuals from infecting third parties within the constraints of the law. If an HIV-positive individual poses a significant threat of infecting an identifiable third party, the physician should: (a) notify the public health authorities, if required by law; (b) attempt to persuade the infected patient to cease endangering the third party; and (c) if permitted by state law, notify the endangered third party without revealing the identity of the source person."

"Another idea is to inform the patient about the criminal liability he or she will face for willful or even negligent exposure," says Eiselein.

The majority of states have some type of statute criminalizing unprotected sexual activity of a person who is HIV-positive. "Some states even criminalize a person's failure to notify a sexual partner of his or her status as HIV-positive," says Eiselein.

Otherwise, says Eiselein, ED physicians are gener-

Sources

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ally only legally able to divulge a patient's medical information when the patient consents or there is a court order compelling such disclosure. "Other than those two categories, the exceptions are very limited, and again, are heavily state law dependent," she says.

In addition, there are many state laws expressly prohibiting disclosure of a patient's status as HIV-positive. "This is an additional layer of patient confidentiality protection," says Eiselein.

Warn patients of specific risks

ED physicians should *not* disclose a patient's HIV status, except when there is a legal mandate to do so and even in this case, this is preferably done through a third party, such as a public health official, advises **Matthew Rice,** MD, JD, FACEP, an ED physician with Northwest Emergency Physicians of TEAMHealth in Federal Way, WA.

"When there is a person at specific risk of harm—a '*Tarasoff*' type of situation—then an exception might be considered. But this would be a highly unusual case," says Rice. If your patient is aware of their HIV-positive status, but indicates that he or she is going to continue to have unprotected sexual contacts with a specific person without appropriate protections, then there is a specific risk to a specific person and, thus, a potential duty for the ED physician to take action to protect this individual.

Even if this is not the case, however, clinicians should clearly document instructing the HIV-positive patient to avoid risky behaviors that could infect others, such as sharing needles and exchange of bodily fluids. Also, it should be documented that you have explicitly informed them about ways to prevent exchanges of bodily fluids. "I would be specific about this, so there is no doubt the patient has been warned of what to be careful about," adds Rice. ■

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CNE/CME *Questions*

42. Which scenario exposes the ED physician to legal risks when caring for a patient with methicillin-resistant *Staphylococcus aureus* (MRSA)?
    A. Giving empirical coverage with vancomycin
    B. Adding bactrim to kelfex or using clindamycin
    C. Using trimethoprim/sulfamethoxazole as a first-line agent, with doxycycline or minocycline as an alternate for sulfa-allergic patients
    D. Use of keflex for a soft tissue infection that progresses to sepsis

43. Which is true regarding state laws for disclosure of a patient's HIV status?
    A. No states require notification to third parties who may be at risk.
    B. Notification isn't mandated in most states.
    C. If notification is required, all individual(s) at risk must be contacted directly by the ED physician.
    D. States uniformly permit disclosure to spouses.

44. Which is recommended regarding documentation by the ED physician caring for an HIV-positive patient?
    A. Avoid documenting explicit instructions about ways to prevent transmission of the disease.
    B. Document only in general terms about avoiding risky behaviors.
    C. Be specific that you have informed the patient about ways to prevent exchanges of bodily fluids.
    D. No documentation is needed unless the patient specifically states they intend to have unprotected intercourse with specific individuals.

Answers: 42. D; 43. B; 44. C