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INSIDE

RELIAS
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The Fourth Amendment: Coming to an ED Near You

By Diana Nordlund, DO, JD, FACEP, Deputy Compliance Officer, Emergency Care Specialists, PC, Grand Rapids, MI

The highly publicized arrest of an on-duty nurse in Utah has reignited the conversation about search and seizure, constitutional rights, and the interaction between law enforcement and healthcare providers in the healthcare setting.

Nurse Alex Wubbels was arrested by a Salt Lake City police detective after she refused to allow him to obtain a blood sample from a patient without his consent. Most of this interaction was recorded by bystanding officers' body cameras. The patient, unconscious after a fiery crash in which his vehicle was struck by a vehicle whose driver was fleeing from police pursuit, was not under arrest, nor did the officers arrive with a warrant. Wubbels relied on hospital system policy that required either a warrant, patient consent, or that the patient be under arrest. Because none of these criteria were met, Wubbels blocked the forensic blood draw. Subsequently, body cam footage shows officers forcing Wubbels out of the hospital in handcuffs and placing her in an unmarked squad car.[1] Forensic blood draws are the proverbial tip of the search-and-seizure

> THE ARREST OF AN ON-DUTY NURSE IN UTAH HAS REIGNITED THE CONVERSATION ABOUT THE INTERACTION BETWEEN LAW ENFORCEMENT AND HEALTHCARE PROVIDERS.

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iceberg in the healthcare setting.[2] In the courts, the constitutionality of a search typically is evaluated on a continuum of invasiveness. Searches can range from tactile physical examinations, specimen collection, and X-ray and other imaging to much more invasive examinations such as body cavity searches and endoscopic or surgical procedures.

Recent lawsuits regarding body cavity searches for illicit drugs include one brought by David Eckert, an adult male who eventually underwent several non-consented enemas and a colonoscopy, and two adult females who were subjected to rectal and vaginal examinations against their will (one of whom was 18 years old and was not allowed to contact her parents).[3] The settlements in these cases ranged from $475,000 to $1.6 million.[4]

An even more extreme example is a recent case involving a patient who was sedated, paralyzed, intubated, and ventilated against his will to facilitate a rectal examination for illicit drugs. Even though illicit drugs were found, such evidence was excluded from trial later based on the violation of the plaintiff's Fourth Amendment rights.[5]

Although venipuncture is less invasive on the continuum of bodily integrity than cavity searches, the same legal and ethical ramifications apply to forensic blood draws for registered patients in the ED, prompting the question: In what instance, if ever, is it appropriate to perform an examination, test, or procedure that is requested for evidence-collection purposes and also is a procedure to which the patient does not consent?

Easy answer? Never. Although statutes in several states *may* allow physicians to perform a search according to a valid search warrant, none (to this author's knowledge) compel it.[6] Although a degree of immunity is provided by these statutes, it is not absolute, and certainly does not bar the filing of a lawsuit.

Even though several lawsuits allege that a healthcare provider has wrongly performed an examination, the same is not true for providers who have refused. Pragmatically speaking, one must consider the scenario in which law enforcement is disinclined to take "no" for an answer. Unless the laws in your state expressly state otherwise, Wubbel's experience in Salt Lake City notwithstanding, you are not required to and cannot reasonably be compelled to gather evidence for law enforcement.

Ultimately, Wubbels was released. The arresting officer was fired, the watch commander was demoted, and the parties reached a $500,000 settlement.[7] Although the patient, a reserve officer with the Rigby, ID, police department, ultimately died from his injuries, the Rigby Police Department made a public statement thanking Wubbels for protecting her patient.[8]

We in the ED work closely with municipal and state law enforcement officials as well as in-house security staff. That relationship is critical to patient, public, and provider safety. The maintenance of a cordial and functional relationship is imperative. However, it cannot happen at the expense of our patients' health, dignity, and constitutional rights. ■

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ED Staffing Scrutinized if Patient Experiences Bad Outcome in Waiting Room

EP's legal obligation to patients waiting to be seen is at issue

A man collapsed at a convenience store and was brought by ambulance to the ED, but apparently was neither triaged nor treated. "The emergency physician was in the back, treating other patients, and had no knowledge of the patient being in the waiting area," says **Christine Oliver**, CPHRN, assistant vice president of Western Litigation in Houston.

The man was in the ED for over an hour before someone alerted the triage nurse that he was not moving. The man was rushed to a treatment room. "The emergency physician attempted to revive the patient; however, the patient's skin was already mottled and some indications of rigor mortis were already settling in," Oliver says. During initial stages of the case, the plaintiff attorney obtained a triage record for the man. However, the patient had not been triaged. This was evidenced by the hospital's own security video, which showed no evidence of anyone bringing the patient to the triage room, nor did ED nurses (or anyone else) ever check on him. "The triage record appears to have been falsified," Oliver says. The lawsuit against the hospital and the emergency physician (EP) included these allegations:

• The EP had an obligation to know what was going on in the entire ED, including the waiting room.

The defense countered that it would not have been possible for the EP to monitor the entire ED, and that is why triage nurses and other ED staff are needed. "Until the patient is triaged, that patient is not going to be put up on the board for the EP to know about," Oliver says. The plaintiff's side responded that the EP should have been checking with nurses on which patients were waiting to be seen.

• Triage staff were inadequately trained.

The plaintiff attorney alleged that the triage nurse was an LPN, not an RN, and wasn't properly trained to perform triage duties.

• Both the hospital and the defendant EP had a duty to ensure the ED was appropriately staffed, and that the hospital was aware of staffing problems.

It was difficult for the hospital to claim it was unaware of the situation, since the ED's staffing problems had

EXECUTIVE SUMMARY

Plaintiff attorneys allege inadequate ED staffing contributed to patients' bad outcomes in medical malpractice cases. Typical allegations include:
- The hospital allowed dangerously low staffing levels despite concerns;
- The triage nurses were inadequately trained;
- The EPs have a duty to ensure adequate staffing.

been reported in the local news. "The EP can't go back and forth between treating patients and going out to see who is in the waiting room," Oliver says.

EPs, Hospitals at Odds

Bad outcomes for patients waiting to be seen have put ED staffing practices under legal scrutiny. Despite this, many hospitals continue practices that result in crowding and understaffing.

"A lot of hospitals have made policy decisions to let their EDs be overcrowded and malfunctioning in order to protect the rest of the hospital," says **Andy Walker**, MD, FAAEM, a Signal Mountain, TN-based EP who offers legal consultation on the defense of EPs. "Hospitals have chosen to accept some liability exposure for understaffed EDs."

Boarding admitted patients in ED hallways is a common practice, with well-recognized risks. "The cost of fixing that problem is higher than the cost of lawsuits," Walker notes. "What really costs them a tremendous amount of money is canceling elective surgeries so they won't move admitted patients upstairs from the ED."

Walker says EPs avoid many malpractice suits by becoming experts at workarounds. "Even though the hospital ought to be fixing the problem and doesn't, the EDs come up with creative ways to get around the hospital's malfeasance," he adds.

Some EPs have reported concerns about understaffed EDs to no avail, then find themselves defendants in a lawsuit when the inevitable bad outcome occurs. The ED defense team can convincingly argue that the EP was doing everything possible, but the hospital had made providing good care impossible because the ED was understaffed. "There are lots of situations where the EP and the hospital end up being antagonists," Walker laments.

Some EPs might even find themselves testifying against the hospital on behalf of the plaintiff. Suddenly, the hospital has a big incentive to settle the case, on the condition that the individual EP is dismissed. "That is probably why we aren't hearing about some of these lawsuits, because of confidential settlements," Walker adds.

> BAD OUTCOMES FOR PATIENTS WAITING TO BE SEEN HAVE PUT ED STAFFING PRACTICES UNDER LEGAL SCRUTINY.

Fired Without Due Process

Walker once became aware of problems with order entry software that put patients at risk. He informed a hospital administrator, "If I'm the unlucky doctor whose patient is injured or killed because of this software, I'm going to be an enthusiastic witness for the plaintiff."

As part of an independent, democratic ED group, Walker had some protection from termination by the hospital. However, EPs who are employees of the hospital or an ED staffing corporation "can be fired at the drop of a hat without peer review or due process," Walker says. "So, they absolutely cannot speak their minds."

If the ED group is an independent, physician-owned group, and the hospital has contracted with it to staff the ED, that physician group might be held liable for understaffing, Walker adds. This is because the physician partners in that group decide how many EPs and midlevel providers to hire, and how many people to put on duty at any one time. "On the other hand, if the EPs are hospital employees and have begged the hospital for more staffing without success, then staffing levels are completely beyond their control," Walker says.

The same is true if the ED is staffed by a large national contract group or staffing company. That company decides how many providers to put on duty at any one time, usually, but not always, in consultation with the hospital. Therefore, the group carries liability exposure for understaffing. "But the EPs who work in that ED have absolutely no decision-making power, and cannot fairly be held liable for understaffing," Walker says.

Most EPs can be fired without cause, without any peer review, or without due process. The exceptions are those who work for a democratic physician-owned group, where bylaws typically dictate that an EP can't be fired without a majority vote of the partners. "Unfortunately, very few EPs own their own practices and the number is dropping," Walker laments. "The fundamental problem is almost no EPs have the job security they need to stand up for patients."

"Whistleblower" employee protections are available for EPs who are employees of the hospital for issues related to the federal False

Claims Act or Medicare or Medicaid fraud. If an EP reports that the hospital is fraudulently billing, or that the hospital is pressuring the EP to upcode for billing purposes, the EP can sue the hospital if he or she is terminated as a result. "But even then, they can fire us without cause," Walker cautions. "If we report an understaffed ER, it would be the right thing to do ethically. But there is no legal protection." ■

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Did EP Override Safety Prompt for No Apparent Reason? It's a Hurdle for Defense

Explanation of thought process is crucial

Emergency physicians (EPs) routinely override safety prompts in clinical decision support systems for very good reasons. However, a skilled plaintiff attorney can depict it as a rogue physician's negligence.

"A liability exposure can be presented if there is no field in the electronic record for the physician to explain the reason he or she overrode the prompt," says **Kenneth N. Rashbaum**, JD, a partner at New York City-based Barton.

If a complication occurs, such as an adverse drug reaction, failure of efficacy of the dosage, or other untoward event, the ED defense team has a problem. "How will the emergency physician be able to recall the basis for that decision when a lawsuit or investigation arises months or years later?" Rashbaum asks. "The difficulty this can pose for the defense can be stark."

'Easier Sell' if Documented

Ideally, the electronic medical record contains a field to document the rationale for the override of a safety prompt. If so, the EP "should do so, with all pertinent information at his or her hands at the time the decision was made, and the clinical basis for the decision," Rashbaum offers.

Documentation of the EP's thought process is critical to the defense. However, not all electronic health records contain such fields. In this case, advises Rashbaum, "be sure to explain the reason for the override in another part of the record." For example, the EP might include this documentation in progress or consultation notes.

After assessing the patient, the EP may conclude that the chest pain is not cardiac in nature. "They don't follow the prompts that would send up the signal that it's a serious situation, because in their professional opinion, it doesn't warrant those actions," says **Joan Cerniglia-Lowensen**, JD, an attorney at Pessin Katz Law in Towson, MD. The EP might conclude the chest pain is [gastrointestinal] or musculoskeletal in nature.

Absent any evidence that the EP considered a cardiac cause for the chest pain, it could appear later that the EP simply disregarded the

EXECUTIVE SUMMARY

Overriding safety prompts without explanation opens the door for the plaintiff's attorney to allege that the EP defendant failed to meet the standard of care. To reduce legal risks, EPs can:

- explain their clinical judgment;
- include an explanation in progress or consultation notes if the EMR lacks a field to provide decision-making notes;
- argue that safety prompts are not the standard of care, and are not mandatory.

prompt that would have resulted in a cardiac care team responding. Testimony that the EP did not believe the prompt was appropriate in this instance can appear self-serving. If there is no documentation in the ED chart, "we deal with the documentation we do have and try to expound on it," Cerniglia-Lowensen notes. "But if the documentation is there, it's certainly an easier sell."

Not Standard of Care

In most jurisdictions, malpractice is defined as a departure from accepted standards of care that proximately causes injury or death. If a court considers the safety prompt to be a standard of care, then the EP who has overridden the prompt has violated the standard of care.

"The plaintiff's case for malpractice is established to the extent that, except for an argument on causation, a motion to discuss the claim would be denied," Rashbaum says.

Plaintiff attorneys frequently contend that safety prompts represent the standard of care set by the hospital. Since the EP disregarded these, plaintiff attorneys argue, the standard of care was breached.

> THE STANDARD OF CARE IS ESTABLISHED BY HOW THE AVERAGE EP IN THE COMMUNITY ACTS IN THE SAME OR SIMILAR SITUATION.

"They will say, 'Your organization is saying you have to do this to keep patients safe, and there is a good reason for it, and you violated that,'" Cerniglia-Lowensen explains. The EP defendant is portrayed as a rogue operator who decided not to follow the safety protocols, putting the patient's life at risk for no good reason. The defense argues that the safety prompts are not the standard of care and are not mandatory. "They are guidelines to help EPs in the thinking process, but it is for the EP to make the decision," Cerniglia-Lowensen adds.

The standard of care is established by how the average EP in the community acts in the same or similar situation. The ED defense team has to educate the jury on this important point. "We have to say, 'You can't look at the outcome and work backwards,'" Cerniglia-Lowensen stresses. "You have to look at what the EP knew at the time." ■

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Settlement Likely for Missed Diagnosis Case, Even if ED Chart Shows It's 'Reasonable'

Defensible cases are settled sometimes because the plaintiff is sympathetic or because the dollar value of damages is high

Did the emergency physician (EP) consider a particular diagnosis, but rule it out for entirely valid reasons? Many such "missed diagnosis" claims end up settled.

"Frequently, EPs are finding themselves forced to settle cases where they absolutely met the standard of care," says **Marc E. Levsky**, MD, a board member of the Walnut Creek, CA-based The Mutual Risk Retention Group and an EP at Marin General Hospital in Greenbrae, CA.

Defensible cases are settled sometimes because the plaintiff is sympathetic or because the dollar value of damages is high, as with a plaintiff requiring lifelong medical care. A settlement avoids the possibility of a massive verdict in excess of the EP's coverage limits.

"Unfortunately, these factors probably have a much greater impact today on the decision to settle than does the quality of the care rendered," Levsky laments.

Here are three common examples:

1. Aortic dissections. These are catastrophic, yet frequently

missed, diagnoses. "They are relatively uncommon, and may mimic more common diagnoses," Levsky explains. Symptoms are similar to acute coronary syndrome. Patients with aortic dissection can present atypically, with few, if any, symptoms at all.

Additionally, the testing required to make the diagnosis, a contrast-enhanced CT of the entire aorta, is not only costly but poses significant risk in terms of radiation. For these reasons, Levsky says, "Missing an aortic dissection, especially one that presents atypically, is within the standard of care."

For cases in which some symptoms of aortic dissection, such as chest pain, are present, Levsky says it's especially important for EPs to document that the diagnosis was considered. One such case involved a 50-year-old man who presented to a community ED with dizziness, hypotension, and bradycardia. He denied experiencing any chest pain, and other than the vital signs, the physical exam was normal, including a nonfocal neurologic exam. The ECG showed no ischemic changes. Lab tests revealed an elevated white blood cell count, but was otherwise unremarkable.

"The patient was admitted to the hospital for workup of presumed sepsis. However, he coded some six hours later," Levsky recalls. The man was resuscitated successfully, and a chest CT scan showed a Type A aortic dissection. The patient's neurologic status never recovered, and he remained unresponsive. "He was deemed not to be a surgical candidate by the local tertiary care facility. Ultimately, care was withdrawn," Levsky notes.

Experts reviewing the claim believed the EP met the standard of care. Despite this, the insurance company and the EP defendant decided to settle.

"This was due to the fact that it was a high-exposure case, with a patient who was a highly compensated individual. He had young children; thus, his family would likely find sympathy with a jury," Levsky says.

EXECUTIVE SUMMARY

Malpractice claims alleging missed aortic dissection, epidural spinal abscesses, and hematomas are settled often, even if the standard of care was met. This documentation helps the ED defense:

- The EP considered the diagnosis;
- The EP believed it was sufficiently unlikely that an MRI or CT scan was not indicated;
- Patients presented *without* symptoms such as fever or severely supratherapeutic international normalized ratio.

2. Viral infections. A recent malpractice claim alleged delayed diagnosis of viral infection in an ED patient. The defense argued successfully that the ED care was not negligent, despite the patient's death. The patient presented to an ED with fever and open sores on his forehead, back, and upper extremities. Lab results showed no elevated white cell count, but the patient was admitted for observation.

"The skin eruptions did not clear up, but it wasn't until days later when the biopsy results came back that it was found that the patient was suffering from not a bacterial infection, but rather a viral infection," says **Robert D. Kreisman**, JD, a Chicago-based malpractice attorney.

An antiviral drug was administered, but the patient died several days after admission. The patient's family sued the EP, the infectious disease specialist, and the hospital. The defense argued that the diagnosis of bacterial or viral infection was not immediately possible because the biopsy results were not available until several days later. "Even though it was claimed that the viral infection was missed in the emergency department and then not correctly treated by infectious disease, there was no finding of negligence by the jury," Kreisman says.

The plaintiff attorney argued that the patient should have been started on both antiviral medication and antibiotics in the ED while waiting for the biopsy results. "The defendants were adamant that no negligence in the treatment of this patient occurred," Kreisman adds.

No offer was made to settle. "Jurors polled after the trial stated that they found the defense expert much more instructive and persuasive than the plaintiff's infectious disease expert, who really seemed to be out of his depth in this area," Kreisman notes.

3. Epidural spinal abscesses and hematomas. "These are potentially catastrophic and rare, and masquerade as something benign and ubiquitous — radiculopathy due to disc disease," Levsky explains.

MRI, the definitive test for this condition, is not available in all EDs. Even when available, an MRI is very costly in terms of time and money. "It generally involves the decision to monopolize a scarce resource, rendering it unavailable to other patients who need it," Levsky says.

EPs rely mostly on their history and physical exam to determine who needs an MRI, Levsky adds. If epidural spinal abscess or hematoma is missed, the ED chart ideally indicates that the EP considered the diagnosis but believed it sufficiently unlikely that an MRI was not indicated.

Good documentation such as this is helpful to EPs in this situation, Levsky offers. "I considered the need for emergent MRI. However, it does not seem necessary given a completely normal neurological exam, including strength, sensation and gait, and normal vital signs, including absence of fever," he says. "Also, there is no significant anticoagulation, spinous tenderness, urinary retention, or injection drug abuse. Close follow-up is arranged and feasible, and strict return precautions given."

Patients presenting with symptoms of radiculopathy, but without signs of a more serious problem such as fever or severely supratherapeutic international normalized ratio, generally are not tested with MRI. "Thus, to miss epidural spinal abscesses or hematoma in these individuals is within the standard of care," Levsky adds.

A recent malpractice case involved a 43-year-old woman who visited an ED three times over a five-day period complaining of neck pain. On the first visit, she was seen by a physician assistant, who noted normal vital signs and exam, and discharged the patient with pain medication and follow-up. On the second visit 48 hours later, a normal neurologic exam was documented again. However, the patient was noted to exhibit elevated temperature and pulse. After pain medication was administered, the vital signs had normalized and the patient was again discharged.

"On the third visit, she complained that she could not walk. The exam still showed intact strength throughout," Levsky says. Since MRI was not available at night, the patient was admitted with an MRI ordered for the next day. During the night, the patient was noted to have a deteriorating neurologic exam. "A neurosurgeon was consulted, an MRI was done, and the patient was found to have a cervical epidural abscess," Levsky recalls. The patient was taken to surgery, and thereafter demonstrated diminished strength in her extremities.

The plaintiff's expert argued that due to abnormal vital signs, an emergent MRI was indicated at the second ED visit. "Due to the high-dollar value life care plan put forth by the plaintiff, the case was settled by several involved physicians and facilities," Levsky says. ■

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Study: Constant ED Interruptions Source of Med/Mal Exposure

Researchers found EPs almost never rejected interruptions

EPs are interrupted 12.5 times every hour on average, according to a recent study.[1] "The fact that interruptions are highly disruptive and increase error is well-established in the cognitive science literature," says **Raj Ratwani**, PhD, who led the study.

Previous research has shown that interruptions produce as much as a 10-fold increase in error rates.[2] "We wanted to see how this plays out in a healthcare setting, specifically the ED, where there is high workload," says Ratwani, acting director and scientific director of the MedStar National Center for Human Factors in Healthcare in Washington, DC.

Researchers observed 18 attending EPs in three different urban academic EDs for two hours. The number of interruptions, source of interruptions, tasks interrupted, and use of interruption management strategies were analyzed. Some key findings:

• The vast majority of interruptions (87%) were in person from other staff: nurses, residents, technicians, and other EPs. Other interruptions came from phone calls (9%), patients (1%), or "other," (2.5%), including devices and pages.

• At the time they were interrupted, EPs were working on a computer 44% of the time, handling

paperwork 20% of the time, conversing with clinical staff 15% of the time, multitasking 14% of the time, and talking with patients 3% of the time.

• EPs usually (76% of the time) stopped what they were doing immediately and switched to the interruption task. "Only about a quarter of EPs continued the primary task while the interrupting task was being performed," Ratwani notes.

EXECUTIVE SUMMARY

EPs were interrupted 12.5 times every hour on average, according to a recent study. EPs rejected or delayed interruptions less than 2% of the time. Some strategies:

- Use placeholders to get back on task quickly;
- Finish the current task if interruptions are not emergencies;
- Train residents with interruptions to mimic the ED setting.

EPs' Surprising Response

The researchers were curious about strategies EPs use to cope with constant interruptions in the ED setting. "What we've seen in the past is that people have developed their own mechanisms to handle interruptions. We were interested to see if that was the case in emergency medicine," Ratwani explains.

The researchers were very surprised at the high rate at which EPs accepted the interruption. EPs almost never rejected or delayed interruptions. They did so less than 2% of the time.

"That was shocking to me," Ratwani says. The researchers expected to see EPs give themselves a moment to complete the task they were engaged in, or arrive at a good stopping point. Instead, the EPs stopped what they were doing and responded immediately to their colleagues' requests or demands.

"It shows there is a climate of trusting team members that their requests have a higher priority or higher acuity," Ratwani offers. "But at the same time, we know that has a cognitive cost."

Switching gears too quickly carries repercussions for patient safety. "Sometimes, EPs fall into a reactive mindset, where they are responding to all of the different stimuli and are not able to take a step back and prioritize as much," Ratwani laments.

Given the fact that interruptions will continue in the ED setting, better management by EPs potentially can save lives, Ratwani says. He offers these strategies:

• Reduce interruptions.

For example, EPs can avoid putting themselves in situations where someone is likely to interrupt them by documenting or placing orders while in the patient room instead of at the open workstation.

• Avoid saying, "Come back and see me in a few minutes."

"You've just invited an interruption in a few minutes," Ratwani warns.

• Use placeholders to get back on task quickly.

For instance, the EP could place a mouse cursor where work on a screen was last updated before switching to another task. Or, the EP can place a Post-it note on the screen where the field for a medication order is located. This visual cue triggers the memory that the EP was ordering a medication for this patient.

• Delay interruptions for a few seconds by waiting for a natural break point.

Obviously, this would not work if a patient is coding. However, the vast majority of ED interruptions are not true emergencies. If the EP is interrupted in the middle of typing digits for the number of tablets or dosage, the EP is going to struggle to come back to the task. Instead, the EP can enter the dosage, turn their attention to the new task, then complete the medication order.

"Oftentimes, interruptions are not high priority and can wait a few seconds to be attended to," Ratwani adds.

• Train residents with interruptions so they get better at resuming tasks.

Medical students typically practice procedures such as intubation in simulated, controlled environments that are quiet and without any interruptions. This is nothing like the ED setting. "If you train with interruptions, you can develop strategies for how to resume tasks more easily so you are less prone to errors," Ratwani says.

Link to Lawsuits

There is no hard data to demonstrate the link between ED interruptions and malpractice litigation. However, it's still possible to discern.

"Most of the time, when we are looking at what are the contributing factors that harm patients and lead to a claim, the deep details are sometimes not available," Ratwani

explains. Even if a medication error happened because of an ED interruption, claims aren't categorized this way. Instead, lack of attention, lack of focus, or (more broadly) human error are identified as contributing factors.

"Unfortunately, it's very hard to document whether a specific interruption was a true causal factor," Ratwani says.

Still, it is well-known that interruptions increase the likelihood of error. "And they are incredibly frequent in the ED. So, I think we can draw the conclusion that they are going to lead to claims," Ratwani offers.

In analyzing patient safety event reporting systems, in which clinicians report near misses or actual harm events, Ratwani has seen a fair amount of people explicitly make note of a distraction or interruption. In one report, a nurse described lowering the side rail of a patient's bed, and getting interrupted by a resident with a question. The patient fell out of the bed and was injured.

It's not always possible to identify the exact interruption that led to an ED malpractice claim, of course. Still, the conclusion can be drawn that interruptions are linked to adverse events and litigation against EPs.

"Considering many patient safety reports have involved interruptions, there's a clear link to malpractice litigation," Ratwani says. "We know that interruptions are definitely involved in these events." ■

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SOURCE

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Overtesting for Medical Clearance Not Only Wasteful, It's Also Dangerous

Still, many psychiatric facilities won't accept patients transferred from an ED until extensive testing is complete

Many psychiatric facilities refuse to accept patients transferred from the ED unless extensive testing has been conducted. Typically, this means a complete blood count, a toxicology screen, and, in some cases, a CT scan.

"The EP is forced to do unnecessary testing, which is a terribly wasteful thing," says **Bruce Janiak**, MD, a professor in the department of emergency medicine at Medical College of Georgia at Augusta University in Augusta, GA. Of 519 consecutive psychiatric admissions that were medically cleared by EPs, the only abnormal test result found was a single urinary tract infection.[1]

"If you test everybody for everything, you are going to find something," Janiak says. "The question is: Is it worth the money to find that one thing?"

One hospital wouldn't take any psychiatric admissions unless the patient had undergone a head CT. "That's a lot of radiation and expense for no reason," says Janiak, adding that there is no clinical indication for such testing.

Researchers recently analyzed 5,606 laboratory tests for 682 psychiatric patients presenting to the ED with no physical complaints, abnormal vital signs, or abnormal physical exam findings.[2] There was a less than 1% probability of an abnormal finding changing the patient's disposition from a psychiatric admission to a medical admission. Previously, other researchers studied 789 cases of pediatric psychiatric patients presenting to the ED for medical clearance and discovered similar findings.[3] "They didn't find anything life-threatening or anything that changed much in the way of management," Janiak notes.

Nonetheless, such testing is commonplace. If the ED calls the psychiatrist stating that a patient needs to be admitted for exacerbation of schizophrenia, and the vital signs and physical exam are both fine, the next question probably is going to be:

"Did you get the labs?" If the ED's answer is "no," the psychiatric facility will refuse to take the patient.

"They will send the patient back to the ED for medical clearance so they don't have to suffer any liability," Janiak explains.

Dangerous Overtesting

If the psychiatrics require a urine screen to check for drugs of abuse, this poses several challenges for the ED, including legal risks. If the patient refuses to give the sample, the EP has to decide whether it's necessary to either sedate or restrain the patient, says **Alan Gelb**, MD, clinical professor in the department of emergency medicine at University of California San Francisco School of Medicine.

Even if cocaine or methamphetamine is present, the patient also may have a psychiatric problem. "It just means they have drugs on board. A lot of people who use drugs also have functional psychosis," Gelb explains. "It doesn't prove they are not psychiatric." Still, psychiatry may ask the ED to wait 12 hours until the drugs are cleared before they agree to accept the patient.

Overtesting also is dangerous for patients. False-positive results are possible. "If you get a chest X-ray on everybody for the heck of it, you're going to find little shadows that could be early cancer," Gelb says. The radiologist will write, "Suggest CT scan," which means the EP is legally exposed if the patient isn't informed of the incidental finding.

There are other ways patients can be harmed by overtesting in the ED because of the need to medically clear psychiatric patients. One example is a patient whose blood pressure is a little high, and the psychiatrist refuses to accept the patient until the blood pressure is normal.

"Instead of just waiting for the agitation to resolve, you want to control the blood pressure right now," Gelb notes. "You run the risk of overtreating the agitation." If the patient turns out to have sleep apnea, the sedative administered in the ED could make the patient stop breathing. Angiotensin-converting enzyme inhibitor-induced angioedema is another possibility.

"You don't want to do every test in the world just because that's what psychiatry wants," Gelb adds. "It's expensive. And although it's rare, you risk being accused of assault." ■

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After completing this activity, participants will be able to:

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ED LEGAL LETTER™

CME/CE QUESTIONS

1. **Which is *true* regarding ED staffing and malpractice litigation?**

   a. Court rulings are clear that emergency physicians (EPs) are legally obligated to know the status of all patients, even those who are not triaged.
   b. The standard of care has evolved to require EPs to monitor the entire ED, including the waiting room.
   c. EPs face possible liability exposure if adverse outcomes occur related to staffing, even if the EP reported concerns internally.
   d. EPs who are hospital employees cannot be fired without peer review and due process.

2. **Which is *true* regarding safety prompts in ED clinical decision support systems?**

   a. There is general agreement that overriding safety prompts is a violation of the standard of care in the ED setting.
   b. Explanation of the EP's thought process for why a prompt was overridden is helpful to the defense.
   c. Testifying as to the reason a prompt was overridden is more effective than documentation on this point.
   d. If the electronic medical record contains no field to explain the reason for the override, it is best to omit the explanation rather than document it in progress notes because it appears self-serving.

3. **Which is *true* regarding missed diagnosis in the ED?**

   a. The fact that a plaintiff is sympathetic and dollar value of damages is high can lead to the settlement of defensible cases.
   b. The fact that patients presented without certain symptoms is irrelevant to whether ED care was within the standard of care.
   c. Whether the standard of care was met is the sole determining factor as to whether a settlement offer is made.
   d. Missing an aortic dissection, even one that presents atypically, is a violation of the standard of care.

4. **Which is recommended to reduce legal risks stemming from ED interruptions, according to Raj Ratwani, PhD?**

   a. Ask the person interrupting to return in several minutes.
   b. Use placeholders to get back on task quickly.
   c. Stop tasks immediately instead of waiting for a natural break point.
   d. Train medical students in quiet environments without interruptions.