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INSIDE

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Legal Implications for ED, Hospital if Triage Nurse Orders Testing

At some EDs, triage nurses order certain tests to speed care. "Triage nurse-ordered testing seems beneficial in theory," says **Michael Gottlieb**, MD, RDMS, FAAEM, FACEP, associate professor in the department of emergency medicine at Rush University Medical Center in Chicago.

By ordering tests while the patient is waiting for an emergency physician (EP) evaluation, length of stay presumably shortens. Hopefully, test results return by the time the patient sees the EP. "This would be very useful, given high ED volumes and overcrowding. However, what seems beneficial is not always borne out in practice," Gottlieb observes.

The authors of a recent analysis examined 13 studies about nurse-ordered testing at triage.[1] Ten studies were about length of stay or time to diagnosis. The authors of the other three compared tests ordered at triage with tests ordered by EPs. There were some surprising findings. "In cases where no testing was actually indicated, it can increase length of stay," notes Gottlieb, one of the authors of the analysis.

Likewise, some patients need additional testing that was not ordered at triage. "This negates the time benefits, and also means a second blood draw," Gottlieb explains.

For example, triage nurses may order a chest X-ray and some basic lab work for a patient with difficulty breathing. However, when the EP evaluates the patient, a D-dimer is added to evaluate for pulmonary embolism.

Another unexpected finding was the variation in time benefits found in the studies. Some showed no difference or a clinically insignificant difference in length of stay, but others revealed a significantly shorter stay. Most studies did not show any time benefit at all, but the reason is unclear. "It is worth exploring whether the studies that did find a benefit were simply aberrations, or if there were unique strategies and factors present at those institutions that allowed them to capitalize on this model to maximize ED efficiency," Gottlieb offers.

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Notably, there was only moderate inter-rater reliability between the triage nurse-ordered testing protocols and physician orders. "In these cases, it is possible that some patients may receive testing that wasn't indicated. Therefore, it is important to review protocols and ensure sufficient training, education, and oversight," Gottlieb says.

For some patients, longer waits for tests to be ordered results in delayed diagnosis and treatment. Sometimes, those delays contribute to poor outcomes and lawsuits. "In general, we see absence of triage testing as a higher risk than the presence of triage testing," says **John Burton**, MD, chair of the Carilion Clinic's department of emergency medicine in Roanoke, VA. In general, says Burton, "the U.S. ED experience has demonstrated very few adverse outcomes due to the use of triage test-ordering protocols."

Overall, says Burton, triage testing makes legal action less likely because care is quicker. One concern is triage testing could result in overuse of diagnostic tests. Burton says in his experience, this has not been the case. "We do not see overtesting as a consequence of thoughtfully derived triage order protocols," he reports.

There always are times when tests ordered by EPs end up different from what was ordered at triage. "The 'fringe' tests tend to be things like D-dimer, brain natriuretic peptide, sedimentation rates, and perhaps even troponins," Burton notes.

These are tests the EP might choose to order during the evaluation, which are not usually included in a triage nurse order set. "One must also reflect on who is at triage," Burton adds.

Some larger-volume EDs place a physician assistant or EP at triage. This reflects a shift toward adding resources to triage to alleviate crowding and rapidly identify low-acuity patients who can be discharged quickly. "All triage order sets are not alike," Burton explains. "One has to look at the providers for whom they are intended."

Sometimes, tests are ordered at triage, but the patient is stuck in the waiting room anyway. Test results could return before the patient is assigned to an EP. "It's certainly possible that an abnormal test result may go unnoticed for hours as the patient waits. This is an area of exposure for EDs," Burton cautions.

A process to ensure review by a provider in the ED is essential in the thoughtful design of triage test-ordering protocols. Typically, this would entail test result alerts to EPs, either by the lab, radiology, or a triage nurse. "Tests that are deemed abnormal must be identified through this process and presented to the physician," Burton says. Then, the EP can determine the next step.

If an ED does not use triage orders, and a lawsuit alleges delayed care, it is questionable whether a plaintiff could successfully argue the legal standard of care required triage testing. "I have not seen this argument employed in a plaintiff case," Burton says.

Plaintiffs would face an uphill battle arguing triage test-ordering protocols are standard of care for EDs. "No authoritative bodies that I am aware have taken the position that triage protocols are an expectation as a standard," Burton says.

It is conceivable attorneys could argue the plaintiff received subpar care compared to other, similar patients for whom tests were ordered at triage. However, such a case appears fairly unlikely. "The specifics would all have to line up for such

a case to have any traction," Burton explains.

A time-dependent therapy would have to be delayed, for one thing. Most patients undergoing time-dependent treatments (e.g., tPA for stroke) are not sent back to the waiting room. "Patients deemed high risk — trauma or heart attacks, for example — are often moved to the front of the line in priority, thus not really being the subject of triage testing protocols," Burton notes.

Another potential legal pitfall is that ordering incorrect tests at triage could cause the EP to go down the wrong diagnostic pathway. An example of this would be a triage nurse ordering an ultrasound for a patient with an acutely swollen, painful leg without considering rhabdomyolysis or compartment syndrome. "I have not seen this in a claim to date," Burton reports.

Hopefully, EPs would notice the error during the patient evaluation. "However, one could envision the triage test-ordering overly influencing the physician's thinking, resulting in a bias in their medical decision-making," Burton offers.

That could result in a missed diagnosis or treatment delay. "As a result, the physician provider must be alert to this potential in their practice, and guard against this proclivity toward bias in each encounter," Burton says.

The same holds true for every ED patient. Theoretically, any notes triage nurses document could mislead EPs. For this reason, triage testing, according to Burton, "does not represent any real change in a potential bias pitfall that has been present historically in emergency medicine." ■

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Few Hospitals Violating 'Good Faith' EMTALA Requirements for Admitted Patients

An ED patient is admitted, but then is transferred almost immediately. This kind of situation can call into question whether the admission was "good faith" or if the hospital was just trying to work around federal EMTALA requirements.

"Any scenario where a patient is admitted, when it is clear that the hospital does not have the appropriate inpatient services that could be reasonably expected to stabilize the patient's emergency medical condition, could be questioned as a good faith admission," says **Mary C. Malone**, JD, a partner at Hancock Daniel in Richmond, VA.

Usually, suspect cases are those in which patients are transferred shortly after admission. "Like most other healthcare situations, the documentation of medical decision-making becomes key," Malone says.

Investigators will want to see evidence that shows an admission was made with the intent of providing stabilizing treatment within the hospital's capacity and capability at the time the decision to admit was made. Problematic cases involve questionable admissions — those for which the hospital lacked the capacity and capability to provide the needed stabilizing treatment.

"However, to the extent that the patient's condition unexpectedly worsens soon after admission and a transfer is necessitated, that should not create issues with the good faith nature of the initial admission," Malone notes.

Good documentation shows the medical judgment used in the initial decision to admit and the reason for the unanticipated need to transfer. To avoid problems with EMTALA good faith admission requirements, the chart should be clear on the reason for admitting the patient in the first place, as opposed to just documenting the reason for transferring the patient.

A recent case makes this clear. The plaintiff sued the hospital for an alleged EMTALA violation, claiming the facility just admitted the patient to meet EMTALA requirements with no intention to treat — and then immediately transferred the patient elsewhere.[1]

The court ruled there was no evidence the hospital improperly admitted the patient. "As the court pointed out, the plaintiff did not show any facts to establish that the intent of the admission was to avoid providing EMTALA-mandated care," says **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney.

The plaintiff alleged the hospital could have provided better care or could have transferred him sooner. "Those issues are malpractice-type allegations, not EMTALA liability issues," Frew notes. The court had ruled against the plaintiff on the

issue of inadequate screening under EMTALA. "The bad faith admission theory appears to have been an attempt to maintain an EMTALA theory of liability for a tactical legal advantage, instead of reverting to a malpractice cause of action," Frew observes.

In the early days of EMTALA, some hospitals would try to work around the regulation by admitting the patient. The on-call specialist would try to manage the patient later by phone, or would enter a phone order to transfer without ever responding to the bedside. "Hospitals thought they could avoid making the on-call specialist come in," Frew explains.

Some patients received little or no actual care during the period of admission, and either died or were transferred without care.

"This further complicated the situation, because a number of hospitals felt they did not have to accept transfers of admitted patients," Frew says. In recent years, Frew has not seen this practice of bad faith admissions intended to avoid EMTALA compliance. Still, there are situations where the patient is admitted and deteriorates, so a transfer becomes necessary.

"But these are the exact situations where the good faith admission rule is meant for — to avoid EMTALA liability," Frew adds. ■

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Shortness of Breath in Older Adults Is Challenging Diagnosis in ED

Diagnosis of older adults with dyspnea is particularly challenging in the ED setting for many reasons. "Some ED decision tools, and also chest X-rays, aren't quite as accurate in older patients as they are in younger patients," says **Katherine Hunold Buck**, MD, an assistant professor of emergency medicine at the Ohio State University Wexner Medical Center.

Older adults might present with atypical symptoms, such as "just not feeling right." Some experience a decreased sensation of dyspnea itself, so they do not even report feeling short of breath when they present to the ED. Older patients also may present with various comorbid conditions that are causing shortness of breath, such as congestive heart failure or COPD. "This leads to misdiagnosis, or diagnostic uncertainty," Buck says.

If older patients with dyspnea are misdiagnosed, higher admission rates, longer stays, mortality, or rehospitalization within one year all are possible outcomes. "We really wanted to look at this group in particular. There is a potential for high reward for the ED," Buck says. Buck and colleagues enrolled 81 ED patients age 65 years or older who presented with dyspnea.[1] The ED attending physician diagnosed pneumonia in 16 patients, COPD in 12 patients, and heart failure in 30 patients. "Based on expert review of the patient record and subsequent tests, we calculated under- and overdiagnosis rates for these diagnoses," Buck explains.

The EPs' diagnosis was correct in 89.9% of pneumonia diagnoses, 91.1% of the COPD diagnoses, and 73.4% of heart failure diagnoses.

"We need tools that can help improve ED diagnostic accuracy," Buck offers.

Certain tests that would give more information to complete the diagnostic picture are not available in the ED, such as bronchoalveolar lavage. Blood culture results also are unavailable. "On the inpatient side, we can watch the patient over time and see how the disease progresses," Buck notes.

In contrast, ED providers are seeing a snapshot in time of the illness. Thus, it is not always possible to make the diagnosis in the ED. Buck says diagnostic uncertainty needs to be communicated, whether to the patients or family at discharge, or to inpatient providers (if the patient is admitted), or to outpatient providers who may follow up with the patient. "We need to be sure that we are clear that we haven't definitively ruled out certain conditions," Buck stresses.

In verbal handoffs and in the ED chart, EPs must be clear on this point. The differential diagnosis should be accompanied by medical decision-making that explains the diagnoses the EP believes are definitively ruled in or out, says Buck, as well as diagnoses about which information is lacking. "That way, the assumption is not that we have ruled something out when we are unsure," Buck explains. "This may help prevent diagnostic momentum and early closure." ■

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Discrepancies in Overread of Radiology Studies Pose Legal Risks for EDs

Radiology studies receive a preliminary read in the ED. Later, the radiology overread might conflict with the original findings. If a radiologist is available overnight, any problems can be caught while the patient still is in the ED. "Benefits of in-house, overnight attending radiologists are disputed by some, stating that costs do not outweigh benefits," says **Ferco Berger**, MD, EDER, FASER head of the emergency and trauma radiology division, department of medical imaging at Sunnybrook Health Sciences Centre in Toronto.

Berger and colleagues wanted to know how an overnight radiologist affected return callbacks for ED patients.[1] They studied patients with imaging completed overnight in the two years before an overnight radiologist was added, and compared that information with the following year. In 2016 and 2017, the number of patients who underwent overnight imaging was 13,883 and 14,463, respectively. Fifty-four patients in 2016 and 61 patients in 2017 were called back regarding the imaging. After an overnight radiologist was added in 2018, 15,112 overnight imaging studies were performed in the next year. Of that group, only seven patients were called back. "This paper provides new evidence that there is benefit to having this service," Berger says.

Not many patients are called back to the ED in relation to overnight imaging findings. However, the reduction in this number after introducing overnight attending radiologists "is significant, and does help reduce costs, overcrowding in the ED, and patient discomfort involved in having to return to the hospital," Berger says. The sooner a patient receives appropriate treatment, the better. "We should do everything we can to improve patient safety and reduce the risk of error," Berger stresses.

Berger and colleagues did not examine the specific diagnoses of patients involved in the study. Risks for individual ED patients range from nonexistent to significant, depending on the diagnosis. "Based on the results of our study, we see a benefit of having an attending radiologist cover overnight reporting in the emergency department setting whenever possible to reduce recall numbers as low as possible," Berger says.

EPs are responsible for the results in any study they order. "If something is either missed on the EP's read or noted on the formal read and not relayed to the patient, there is an opportunity for medical malpractice," says **Adam Hennessey**, DO, medical director and chair of emergency medicine at Roxborough Memorial Hospital in Philadelphia and Lower Bucks Hospital in Bristol, PA.

A relatively common example is missed lung nodules that were lost to follow-up until someone identifies a large, advanced malignancy. Sometimes, this happens because the patient is admitted, and the ED providers assume inpatient providers will convey the findings. "It is not prudent to assume that an inpatient provider will notice a small discrepancy on a radiology read," Hennessey cautions.

EDs need protocols for how to handle radiology discrepancies. Exactly how that happens will vary depending on the facility. Some make a point of verifying patients' personal cellphone numbers or their preferred contact method. Others make a practice of contacting the patient's primary care physician, either by phone or electronically. Still others use certified mail to inform patients of the need for follow up on abnormal findings.

If a patient files a malpractice lawsuit, the plaintiff attorney will explore whether the ED provider had the option for an official radiology read but went with a preliminary read instead.

"For example, if the ED physician makes a disposition or other clinical decision based on a technician's read of an ultrasound rather than waiting for the official read, their actions could be considered negligent," Hennessey explains.

For cases in which EPs are reading their own studies, Hennessey says it is a good idea to engage in a conversation with the patient to explain the process (and to document that conversation). EPs can explain their interpretation is a preliminary read, that a formal read will occur shortly afterward, and that any variances will be conveyed directly to the patient. Ideally, EDs maintain radiology coverage for all studies.

"It is reasonable to assume that an EP would assume less liability if they are operating within the structure established by their individual hospital," Hennessey says.

From a medical/legal perspective, there are two reasons for a radiology overread, says **Eric H. Weitz**, JD, a Philadelphia-based medical malpractice attorney. One is to confirm or clarify the EP's findings. "ED physicians' standard of care requires a certain level of ability to interpret tests that they order. But when the findings become more

nuanced or less common, a trained radiologist is needed," Weitz says. A second reason for the overread is to identify incidental findings that may not be within the EP's scope of training. "The most common source of liability arises out of what happens, or does not happen, next," Weitz says. "Failing to communicate a potentially lethal incidental finding is indefensible."

ED staff need a consistent, clear, and simple way to communicate discrepancies to the patient and subsequent providers. Two crucial questions: What happens to the discrepancy report if the patient is no longer in the ED? Who is ultimately responsible to close the loop on reporting and acting on the discrepancy? "These are the real sources of considerable liability," Weitz says.

Lack of good documentation makes it easy for plaintiff attorneys to assert that inadequate follow-up, or none at all, happened.

"There was a purpose the test was ordered," Weitz says. "Failing to close that loop is a very attractive trial story." ■

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Considerable Legal Risks for EDs if Discharged Patients 'Bounce Back'

Patients with a history of substance abuse or chronic pain were most likely to "bounce back" to the ED, according to the authors of a study.[1]

"Patient bounce-backs are a part of emergency medicine, and occur for many different reasons — system-related, patient-related, and disease-related," says **Janine E. Curcio**, DO, the study's lead author and an EMS fellow at OhioHealth Doctors Hospital in Columbus.

Curcio and colleagues analyzed 732 charts for ED visits from 2015 to 2017. They found 4.65% of patients returned within 72 hours. The authors expected training level (i.e., residents vs. attending physicians) might affect bounce-back rates, but this was not the case. "It's important to look at bounce-backs as a second chance to look at the problem again and to help the patient. It's when our bias starts creeping in that we open ourselves up to more liability risks," Curcio offers.

Multiple visits to an ED "are always challenging in a lawsuit," says **Susan Martin**, RN, JD, executive vice president of litigation management and loss control at AMS Management Group in Plano, TX.

Virtually everyone discharged from an ED receives instructions along the lines of "Return if there is no improvement, or if symptoms worsen." When patients follow those instructions, though, it needs to be taken seriously.

"It should raise a red flag for physicians to consider that it may be a missed opportunity for a more definitive diagnosis, or an indication of a more serious medical emergency," Martin says.

A recent malpractice case involved a young man who arrived in the ED after a car accident with a puncture wound on his lower arm. The patient reported the air bags deployed and glass broke, but denied sustaining any other injuries. The EP cleaned and dressed the wound and discharged the patient.

Two days later, the patient returned to the ED complaining the wound was painful. During the second ED visit, the EP did not review the record from the first visit. The second EP simply examined the wound and instructed the patient to change the dressings and keep the wound clean.

During the second ED visit, a dangerous (and incorrect) assumption was made.

"The ED physician assumed the prior ED physician performed X-rays on the arm and examined the wound," Martin says.

The patient was discharged again. Four days later, the man returned with an obviously infected wound. Upon exam, the third EP noted the wound was swollen with purulent material. The third EP ordered an X-ray, which showed a large foreign body in the deep tissue, likely a piece of glass. The patient started antibiotics, was admitted to the surgical floor, and eventually underwent surgery to retrieve the foreign body.

His arm eventually healed, but the patient sued the first EP and second EP for malpractice after incurring significant medical expenses and lost wages. The case was settled for an undisclosed amount. "The lesson is that you never assume what occurred on an earlier visit," Martin says. Ideally, the EMR automatically flags

return visits within a certain period of a previous ED visit, such as 48 or 72 hours. That should prompt the EP to scrutinize the original visit and the return visit to be sure nothing is missed.

"Such policies, and careful review and thoughtful re-examination, are in the best interest of the patient and may deter a lawsuit," Martin says.

Patients who return to the ED after discharge within a day or two "represent a unique challenge from a patient safety standpoint," says **Andrew P. Garlisi**, MD, MPH, MBA, VAQSF, EMS medical director at Cleveland-based University Hospitals EMS Training & Disaster Preparedness Institute.

One problem is ED providers sometimes look at return visits as annoying. "Emergency physicians and nurses should avoid the tendency to consider these patients an attention-seeking nuisance," Garlisi cautions.

In reality, the return visit is a red-flag warning that something was missed or evolved since the first visit. "A careful review of the prior medical record should ensue," Garlisi suggests.

ED providers should find out if the patient's history or physical exam changed in any way since the first visit. Prior lab and imaging results also should be reviewed. "The team should approach the patient encounter with fresh eyes and a critical thinking process unencumbered by judgmental bias," Garlisi says.

Frequently, abdominal pain complaints are encountered on repeat visits. "This is no surprise, as abdominal pain has a huge differential diagnosis," Garlisi observes.

Often, the specific etiology of abdominal pain cannot be identified on the first (or even subsequent) visit. The patient's immediate safety is ensured as long as the EP considers and rules out a surgical emergency (e.g., testicular or ovarian torsion, appendicitis, perforated bowel, bowel ischemia, or aortic aneurysm leak) or medical emergency (e.g., acute coronary syndrome, pancreatitis, GI bleed, or pyelonephritis).

EPs must decide whether to admit a bounce-back patient for observation, symptom management, further testing, or consultation.

"Patients who continue to have abdominal pain despite multiple doses of pain medication, or persistent vomiting despite [ondansetron] and [prochlorperazine], should be hospitalized," Garlisi says.

Discharging a bounce-back patient a second time in a short period "invites close scrutiny and increased risk of malpractice action if the patient dies or has serious negative health consequences," Garlisi warns. This documentation helps the defense:

- The EP considered various life-threatening conditions but believed these were unlikely.
- The patient had improved/was stable.
- Follow-up was not just recommended, but arranged, for the patient. For instance, ED staff can schedule next-day follow-up with the surgeon, a specialist (e.g., a cardiologist for chest pain), or the primary care physician.
- The ED provider spoke directly to the doctor following up with the patient.

"Arranging a scheduled, short-term follow-up announces to the world that the emergency physician realizes that the patient's condition could deteriorate," Garlisi says.

It also is an opportunity for the consultant to make further recommendations for ancillary testing, which could be handled before the patient leaves the ED. "This strongly supports that the emergency physician did everything reasonably possible to ensure a positive clinical outcome," Garlisi says.

Not all ED bounce-backs indicate a patient safety concern. EPs are "often in the position of using a reasonable amount of resources to explore a chief complaint, and then advising a patient who looks well enough to go home to return if symptoms worsen," says **Renée Bernard**, JD, vice president of patient safety at The Mutual Risk Retention Group in Walnut Creek, CA.

If the patient returns per the ED discharge instructions, that is appropriate; it is how the system is intended to work.

"There are nonmedical, social access reasons that EDs see the same patients multiple times. A lot of malpractice cases involve multiple ED visits and complex care issues," Bernard explains.

The challenge becomes showing the standard of care was met, even though a patient experienced a bad outcome. "The actions of a provider on the second visit become a bit more critical than on the first," Bernard notes.

The second EP must review the first visit and explore in detail with the patient what changed since then. "It's very important to document a thorough exam and history on the chief complaint," Bernard adds.

In retrospect, ED providers often wish they had addressed a lab result that was not quite normal. The second EP also must be clear on the timing of their own documentation about reassessments and differentiate that from prior exams.

"That will help tell the story more clearly, as not all EMRs make it easy to track progression of symptoms or exams," Bernard says.

The second EP also should take the trouble to document the bounce-back visit in real time as opposed to hours later. "Though this is not always practical, it is essential in a patient who is at higher medical risk," Bernard adds. ■

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Legal Standard of Care Is Evolving for ED Patients with Opioid Use Disorder

Patients with opioid use disorder often present to the ED, sometimes after overdosing, and other times with completely unrelated conditions.

"The emergency medicine community is certainly at the forefront of this patient struggle with narcotic use disorder," says **Rade Vukmir**, MD, JD, FCCP, FACEP, FACHE, president of Critical Care Medicine Associates.

Failure to adhere to established care protocols is the most significant legal risk for ED providers. "This may manifest as a broad range of allegations, typically including standard negligence theories — failure to diagnose or failure to treat," Vukmir says.

There also could be EMTALA-based allegations concerning failure to stabilize or transfer. The mindset in the ED needs to change, says Vukmir, "to view opioid use disorder as a long-term, pervasive illness. Our goal is really to get people in the right treatment category."

Patients with pneumonia or chest pain are treated according to diagnostic and treatment protocols. "This situation [opioid use disorder] should be no different," Vukmir says.

However, an extrinsic regulatory requirement adds to the difficulty of treating these patients. Currently, any EP who wants to prescribe buprenorphine after discharge has to take an eight-hour educational course, apply for a license addition with the DEA, and receive an X-waiver. "Not all EPs are interested in applying for this waiver, and are limited to dispensing doses in the ED for up to 72 hours, as opposed to writing ongoing care prescriptions," Vukmir says.

Removing barriers to care for patients struggling with opioid use disorder is a priority for the American College of Emergency Physicians (ACEP). "The rate of overdose deaths during the pandemic has accelerated. Now is the time to make sure that frontline physicians are well positioned to continue efforts to reduce overdose rates and save lives," says **Jeffrey Davis**, ACEP's director of regulatory affairs. "There are clear outcome data that shows mortality is less for patients in medication-assistant treatment," Vukmir notes. This raises the possibility that EPs who do not offer medication-assisted treatment to patients who present with opioid use disorder face potential legal exposure for failing to meet a perceived standard of care.

The plaintiff could argue that a reasonable EP would have offered medication-assisted treatment to the patient. Now that there is an established treatment pathway, EPs will be held to the perceived standard of care. "However, it is crucial to realize these pathways are complicated. They require significant individualization to patients' condition, institutional resources, and significant patient compliance," Vukmir says.

In addition, the standard of care still may be regional in some respects, depending on available resources and government financial support. Some EPs met the requirements, chose to become certified, and provided medication-assisted treatment, while others opted out. Originally, the certification process was directed toward established outpatient clinics with care provided by addiction medicine specialists.

"We now have an ED care standard that may be established," Vukmir says. "It's not an individual variation situation anymore. Saying you are just not going to participate in this is probably not a viable pathway forward."

EDs will need treatment guidelines for medication-assisted treatment, just as with any other disease-driven protocol. "The sooner that the facility tackles this and gives EPs a clear pathway to approach this, the better," Vukmir offers.

Dosage is highly variable depending on the individual patient. It is not enough to come up with a one-time dose and send the patient home. "It's a brand-new, exciting area of medicine, but it's extremely complicated medicine. It will require time and investment to master and become proficient in," Vukmir observes.

ED providers still should complete the certification training, regardless of whether it continues to be required in the future, according to Vukmir. "It would demonstrate added commitment, which is always a good thing," he adds.

For a patient who presents after an overdose, ideally, the EP can give medication in the ED, then discharge the patient with an initial prescription and follow-up with an outpatient treatment source. "You can't just give the medicine and discharge the patient without adequate follow-up," Vukmir says. "It's essential that the entire facility system be geared up to treat this disease condition." That means a treatment program with addiction experts and counseling. However, the patient has to be able to access it, and the programs need to be adequately funded. If there is a three-month delay in the outpatient psychiatry network, or the patient cannot afford the treatment, "that's not going to work," Vukmir warns.

Involvement from case management and social services is needed to enhance the outpatient clinic transition and prevent frequent ED visits. "The goal is to not have the patient necessarily return to the ED every day," Vukmir says.

Some programs may use the ED to stabilize the patient on an episodic basis over a 72-hour period. "However, once they are stabilized, it's best if they are treated in an outpatient setting," Vukmir suggests.

A well-run program will allow the providers to do what they do best. That means the ED provides immediate stabilizing care, and the outpatient system provides outgoing maintenance, counseling, and psychological support. The ED is not operating in a vacuum within the hospital. "This is a bridge program. It is not the endpoint. And it's helping the patients bear responsibility here as well. We will provide medication-assisted treatment pathways under the assumption that they complete the rest of the protocol," Vukmir says.

An ED visit from someone with opioid use disorder is an opportunity to put that person in treatment. People do not present to the ED when things are going well; they present at times of crisis. "Sometimes, in that crisis, there's a little bit of a wakeup," Vukmir observes. "If the system offers some approaches and a treatment pathway, then everybody benefits." ■

New Data on Opioid Prescribing Guidelines and ED Practice

Opioid prescribing guidelines were linked to small changes in morphine equivalent units (MEU) ordered in the ED, according to the authors of a study.[1]

A suburban academic ED implemented the guidelines in September 2016. Researchers conducted a "before and after" study to determine if those would change the use of IV opioids per patient and the MEU per patient.

A total of 108,327 IV opioid orders were analyzed. After the guidelines were adopted, the expected number of IV opioids dropped by 3.1%, with an additional decrease of 0.1% per month. The average MEU dropped by 0.3 mg, with a decrease of 0.01 mg per month. "While there have been many contributing factors to the opioid epidemic, our emergency department desired to be part of the solution," says **David A. Berger**, MD, one of the study's authors and assistant professor in the department of emergency medicine at Oakland University William Beaumont School of Medicine in Rochester, MI.

The authors of previous studies focused mainly on oral opioid prescriptions, with less attention on IV ordering in the ED.

"Our sincere hope is that by better characterizing the impact of an opioid prescribing guideline on IV ordering, we could jumpstart this aspect of opioid epidemic research," Berger offers.

The analysis by Berger and colleagues did not demonstrate a statistically significant reduction in IV opioid orders after the opioid prescribing guidelines were implemented. This finding could be because of the study's timing. "There was already increased prescriber awareness prior to implementing our guideline," Berger explains.

Another factor is patients exhibiting opioid-addicted behaviors may be

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less likely to return to the ED once they are aware of the post-guideline change in ordering behavior.

To avoid dissuading any patient from seeking care, the opioid prescribing guideline was not posted in the ED triage area. "Patients who exhibit opioid-addicted behavior in an ED setting may be receptive to discussions regarding their opioid use disorder," Berger notes.

The ED incorporated screening for opioid use disorder as part of the intake process. "We have utilized our ED-led program to provide medication-assisted treatment as a bridge to outpatient services," Berger adds. ■

REFERENCE

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Emergency Medicine Trainees More Likely Sued Than Radiology Trainees

Medical malpractice claims naming physician trainees is infrequent, and the number of lawsuits is trending downward over time, according to the authors of a study.[1]

"We have heard disparate comments from academic colleagues that working with trainees either increases or decreases malpractice exposure," says **Richard Duszak**, MD, one of the study's authors and a professor and vice chair for health policy and practice in the department of radiology and imaging sciences at Emory University School of Medicine in Atlanta.

Duszak and colleagues wanted to help academic medical centers better understand this to reduce malpractice exposure. They analyzed 580 state and federal lawsuits from 2009 to 2018 involving physician trainees. Their focus was on radiology trainees, where missed diagnoses and procedural complications were common allegations. "Radiology medical malpractice cases are often difficult to defend because of hindsight bias of both expert witnesses and juries," Duszak explains.

Individuals with knowledge about a bad outcome often expect providers to have fully understood the implications of a subtle imaging finding in real time. "To that end, we were pleasantly surprised to see that radiology trainee cases were not particularly common," Duszak reports.

When such lawsuits do proceed through the courts, radiologists prevail commonly. "Although we were most interested in studying radiology trainees, we did report their risk in the context of trainees in other specialties," Duszak says. Trainees in emergency medicine (e.g., surgery, obstetrics/gynecology) were at a higher-than-average risk of medical malpractice lawsuits. The authors did not study the persons or specialties who were co-defendants. Thus, it is unclear if EPs also were named in claims against radiology trainees. However, says Duszak, "increasing both the frequency and quality of communication between radiologists and emergency physicians about imaging studies is always a good practice to facilitate patient care and mitigate mutual risk." ■

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Lawsuits May Allege Failure to Obtain Dermatology Consults

EPs often seek consults from various on-call specialists, but not as frequently if the issue is dermatological. "It is rare to be able to get dermatology consults in the ER in most hospital systems," says **Sahand Rahnama-Moghadam**, MD, MS, assistant professor of clinical dermatology at Indiana University.

As a hospital dermatologist at the largest hospital in Indiana, Rahnama-Moghadam sees patients transferred from all over the state, specifically because there are no dermatologists to see them in EDs. "I also noted that some doctors — ER doctors, hospitalists, and infectious disease specialists — would be sued

because they had trouble identifying or managing a severe dermatologic disease," Rahnama-Moghadam says.

This seemed problematic, since these doctors are not trained to manage dermatologic diseases. "I wanted to do a study to shine a light on this," Rahnama-Moghadam says.[1]

One surprising finding: No dermatologist was sued. "In retrospect, this makes sense. ED physicians would be sued because they have to make contact with all patients; they have to manage everything," Rahnama-Moghadam says.

Sometimes, EPs call infectious disease specialists or rheumatologists for a challenging condition. Those patients have rashes, so the specialist is "roped in" to the case because he or she is available. "But this is clearly not a substitute for a hospital dermatologist. It puts everyone (the patient and the doctors) at peril, whether that is physical or legal," Rahnama-Moghadam explains.

The hope is hospitals will become motivated to hire on-call dermatologists for the ED setting.

"This should be a wake-up call for hospital systems, especially ones that advertise themselves for their quality. These systems should see the value of a hospital dermatologist who supports the other specialties in diagnosing and managing these conditions," Rahnama-Moghadam says.

Without this type of dermatologist, there is a gap in the specialty care provided in the ED. It means other specialists consulting on dermatology patients in the ED choose between two bad options. Either the consultant manages conditions outside their scope, or they transfer the patient far from home and family to an academic medical center. "Transferring patients with skin disease is not good patient care, and sometimes not possible if the patient is too ill," Rahnama-Moghadam says.

EPs can pursue education to become more familiar with hospital dermatology, such as lectures or courses. "But it is not realistic to expect someone outside the field of dermatology to be proficient in managing these rare diseases," Rahnama-Moghadam cautions. To reduce patient safety and legal risks, if EPs find hospital dermatologists valuable, "they should make their voices known," Rahnama-Moghadam says. ■

REFERENCE

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Analysis: Few EMTALA Violations for Vascular-Related Issues

Few EMTALA violations involve vascular-related issues, according to the authors of a recent analysis. *(http://bit.ly/30jQBZO)*

"Our motivation for the study was to assess for EMTALA violations in our field, vascular surgery, in order to better understand how these happen," says **Jeffrey Siracuse**, MD, MBA, one of the study's authors and an attending surgeon in the division of vascular and endovascular surgery at Boston Medical Center.

Of 7,001 patients with an EMTALA violation from 2011 to 2018, only 1.4% were vascular-related.

"An example would be not adequately stabilizing or fixing a vascular emergency, such as a symptomatic or ruptured aortic aneurysm, when the capability exists," Siracuse explains.

Cases included cerebrovascular, ruptured aortic aneurisms, aortic dissections, vascular trauma, peripheral arterial disease, venous thromboembolism, dialysis access, and bowel ischemia.

"Vascular surgical emergencies can sometimes be difficult to diagnose and recognize, even by diligent and well-meaning physicians and staff," Siracuse notes.

These are the most common reasons for EMTALA violations, according to the analysis: Unavailability of specialists, inappropriate documentation, misdiagnosis, poor communication, inappropriate triage, failure to obtain diagnostic labs or imaging, and ancillary/nursing staff issues. The most frequent vascular-related violations specifically involved lack of vascular specialist availability. "This highlights an important issue. There are potential shortages of specialists, particularly outside of major cities," Siracuse says.

Early diagnosis and triage is important in a vascular surgery emergency. "Developing specialist networks and having adequate call coverage can help improve patient access to emergency services," Siracuse offers. ■

ED LEGAL LETTER™

CME/CE QUESTIONS

1. **Which did the authors of a study find regarding nurse-ordered testing at triage?**

   a. There was only moderate inter-rater reliability between the triage nurse-ordered testing protocols and physician orders.
   b. Length of stay was significantly shortened for the majority if tests were ordered at triage.
   c. The prevalence of triage testing has made it the legal standard of care for EDs in most regions.
   d. Patients who underwent triage tests were more frequently misdiagnosed than the general ED population.

2. **Which is true regarding "good faith" admissions and EMTALA?**

   a. If the patient's condition unexpectedly worsens soon after admission and a transfer is necessitated, good faith admission requirements are unmet.
   b. Patients who are admitted when the hospital lacked the capacity and capability to provide the needed stabilizing treatment are problematic.
   c. The reason for admitting the patient in the first place is irrelevant, since CMS investigators will be looking strictly at documentation on the reason for transferring the patient.
   d. Under EMTALA, hospitals do not have to accept transfers of admitted patients.

3. **Which is true regarding diagnosis of older adults with dyspnea?**

   a. ED decision tools and chest X-rays are more accurate in older patients than younger patients.
   b. Older adults present with the same symptoms as younger patients.
   c. Some tests that would help complete the diagnostic picture are not available in the ED, such as bronchoalveolar lavage.
   d. Communication of diagnostic uncertainty makes patients much more likely to leave without being seen.

4. **Which did the authors of a study find regarding legal risks of patients who return to the ED?**

   a. If bounce-back visits are electronically flagged, diagnostic errors are more likely.
   b. Abdominal pain complaints are rarely encountered on repeat ED visits.
   c. Scheduling follow-up care bolsters negligence claims because it proves the discharged patient required admission.
   d. Patients with substance abuse and chronic pain are most likely to bounce back to the ED.

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

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