Medicolegal Issues in Emergency Medicine

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A 24-year-old man was brought to the emergency department in police custody for psychiatric evaluation. His mother called 911 because he was hearing voices and threatening to shoot her. He reportedly had a history of schizophrenia and had not been receiving his medications. On arrival, he was attempting to leave the ED. “Let me go! I know my rights!”

Learning Objectives

- Discuss common pitfalls in emergency medicine documentation that increase risk of poor outcomes
- Explain the significance of EMTALA in the care of patients presenting to the emergency department.
- Identify common themes in patient care scenarios that have resulted in bad outcomes
- Discuss the significance of patients who "bounce-back" to the ED with same complaint from a medicolegal standpoint
- Describe best practices in ending patient encounters to mitigate risk of patient dissatisfaction

Agenda

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History of Medical Ethics

Decisional Capacity

Informed Consent, Refusal of Treatment, & Discharge Against Medical Advice

Standard of Care & Negligence

Working with Consultants

Sign outs/Hand-offs

Summary

Medical Ethics

History of Medical Ethics

- *Epidemics I*- generally thought to be written by Hippocrates
  - "Declare the past, diagnose the present, foretell the future. As to diseases, make a habit of two things- to help and not to harm"
- Primum non nocere
- AMA Code of Medical Ethics- adopted 1847
- Declaration of Geneva- 1948
- Hippocratic Oath-1964

Hippocratic Oath

- I swear to fulfill, to the best of my ability and judgment, this covenant:
- I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.
- I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.
- I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.
- I will not be ashamed to say "I know not", nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

Hippocratic Oath (con.)

- I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.
- I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.
- I will prevent disease whenever I can, for prevention is preferable to cure.
- I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.
- If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Four Basic Principles of Medical Ethics

Autonomy

Justice

Beneficence

Non-maleficence

“Prima facie”

Ethics in the Emergency Department

- Patients often brought in involuntarily via EMS
- No relationship exists between patient and clinician
- Uninsured or indigent patients
- EMTALA
  - Any individual who presents to an ER and requests treatment must have a medical screening exam
  - If an emergency condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized.
  - Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack capability

Decisional Capacity

Capacity

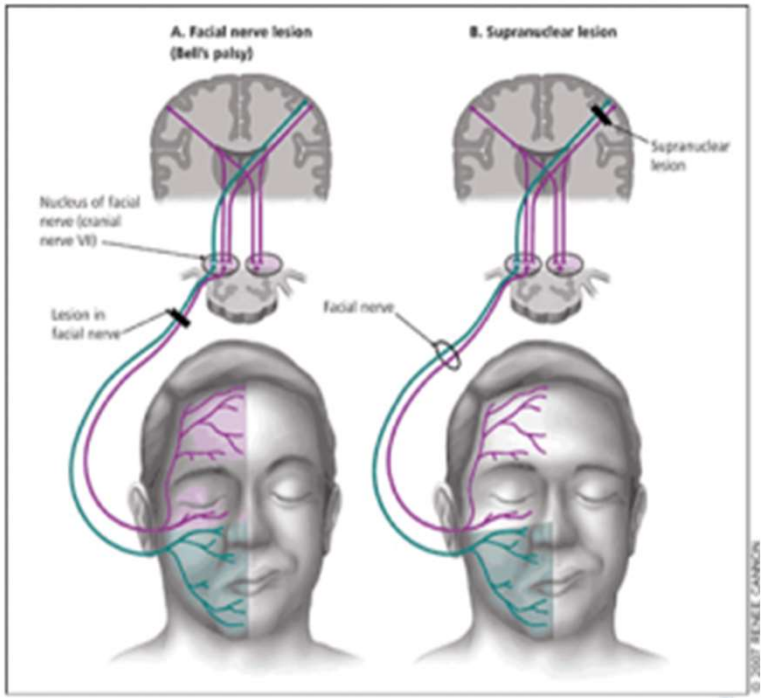
- Competence is a legal term about an individual's ability to make decisions
- Capacity is an individual's ability to make decisions about their medical care
- Capacity involves the ability of an individual to:
  - Understand the information needed to make a medical decision
  - Appreciate consequences of their decisions and apply them to their own life
  - Evaluate, compare risks and benefits, and make a rational choice
  - Communicate that choice

Capacity

- Capacity is dynamic and task specific
- Individuals may have impaired capacity from a reversible condition at one point and may have full decisional capacity when the condition has resolved
- The need to assess competency is inversely proportionate to the degree of agreement with the medical opinion or the preferred medical option
- The patient who chooses an option that carries significantly higher risk or an expected treatment choice requires a greater need to explore the extent to which they have decisional capacity.

Informed Consent

- 48-year-old male with slurred speech, left-sided facial droop, dizziness, unsteadiness, left leg weakness



Informed Consent

- Mohr v. Williams (1905)
  - Battery – offensive or harmful bodily acts against consent

- Canterbury v. Spence (1972)
  - Negligence – when one party does not act in a reasonable manner and damages occur

Right to receive information about the condition

Right to Refuse Treatment
&
Discharge AMA

- A 45-year-old man presented “feeling sick.”
- h/o dialysis, missed one week of treatment
- K = 7.4, BUN = 88, Creat = 9.9
- CXR = pulmonary congestion
- “Let me go home. I’ll be all right.”

Right to Refuse Treatment

- Providing treatment against a competent patient's refusal may result in a suit for battery, medical negligence, and lack of informed consent – Anderson v St Francis- St George Hospital (1996)
- The right to refuse treatment even includes life saving or life sustaining treatment- *In re Quilan* (1975), Cruzan v Director, Missouri Dept of Health (1990)

- 24-year-old intoxicated patient brought in by police for medical clearance
- Patient initially refusing care
  - Later consented to blood tests & imaging
- Discharged AMA

Discharge Against Medical Advice (AMA)

- No formal definition
- 1-2% of emergency department visits
  - Increasing numbers during the pandemic
- High risk population
- Documentation

AMA Myths

- Insurance will not pay
- Must discharge AMA if refusal of procedure or treatment
- AMA forms are beneficial

Standard of Care & Negligence

- 36-year-old man with chest pain
- Turkey sandwich for dinner “Didn’t taste right.”
- H/o stomach ulcers, but no cardiac risk factors
- EKG, CXR, blood work performed but not recorded on chart
- RN reports c/o breathing problems and dizziness in ER
- Dx “Food Poisoning”
- ER “bounce back” 48 hours later, Dx “Viral Syndrome”
- Roommate finds him unresponsive
- Autopsy confirms aortic dissection w/ undiagnosed Marfan’s Syndrome

Evolving Definition of Standard of Care

Prior to 1900's- "Customary"

- If a business practiced in a certain way in order to eliminate hazards, this practice could be used to determine standard of care

1932- The case of T.J. Hooper & Helling v Carey

- If a practice is reasonable, but not universally "customary" it may still be used to determine standard of care

1985- Hall v Hilbun

- Minimally sound medical judgment and render minimally competent care

Negligence

- Negligence requires four conditions to be met for plaintiff to recover damages:
  - Duty
  - Breach of Duty
  - Harm
  - Causation

Plaintiff must prove that the defendant was negligent, that this negligence was a direct and “proximate cause” of the plaintiff’s injuries and that the plaintiff was damaged by the defendant's negligence

Consults & Sign Outs

- An elderly man presents to the ED at 4am with the complaint of chest and abdominal pain
- ED physician – ACS workup
- On-call cardiologist – “does not sound cardiac in nature”
- Patient discharged home

Consults

- EMTALA and on-call consultants
- Official consults vs “Curbside” consults
- What happens when the ED PA and consultant disagree?
  - ED PAs remain responsible for the care of the patient
- Documentation
  - Who do you speak to? At what time?
  - What was the recommendation?

Sign out

- Poor communication increases patient adverse events
  - 30% of malpractice cases have a breakdown in communication
  - More than 1700 deaths
  - $1.7 billion paid out in malpractice claims
- Standardized hand-offs
  - I-PASS
  - ISBAR
  - PSYCH

A PA's Story

Tim Scanlon's Very Bad Shift

Tim Scanlon's Very Bad Shift

- 28-year-old male presents to the ED with abdominal pain.
- Patient diaphoretic, tachycardic, and slightly confused.

- "You've got this, right?"
- Overlapping PA/MD shifts
- Handoffs/patient ownership
- When do you ask for help?
- Difficult patient with unclear diagnosis
- Laboratory Error

Best Practices

Best Practices

- For patients who want to leave AMA…
  - Focus on redirection, mitigation and education over filling an AMA form
  - Involve family member, friends, SW’er early
  - Think about underlying factors that may be driving patients' decision
- Informed Consent
  - Assess
  - Present
  - Document
- Consider using a handoff evaluation tool
- Reassess frequently(ish) and document
- Ensure provider and nursing documentation align

Best Practices

- Frame “bounce backs” as second chance to get it right
- Be assertive and ask for help
- Consider the use of a “magic minute” at the end of each patient encounter.

Magic Minute

- This is what I heard…
- This is what I saw…
- Putting it all together, I thought about…
- This is our plan…
- These are your return precautions…

Magic Minute

- Ms. Jones, I heard you tell me today that you have had a cough and fever for 3 days. Your cough is so severe it keeps you up at night and you are concerned you have pneumonia.
- On exam, your nasal passages are congested, your throat is a bit red, but your lungs are clear and your chest x-ray shows a viral pattern.
- While I considered more serious causes of your symptoms like pulmonary embolism and pneumonia in my work up, in the end I think you have bronchitis. I'm going to treat your symptoms with a prescription cough medicine. I suspect within 10-12 days your immune system will take care of this illness.

Magic Minute

- I would like you to follow up with your PCP in 3 days for a recheck.
- If you develop severe chest pain, fever more than 103, difficulty breathing or coughing up blood, I would like you to return to the emergency room.
- What questions do you have for me?

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