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Patient Could Allege Opioids Given by EP Sparked Addiction

Receiving an opioid at just one encounter, such as in the ED setting, is linked to future adverse outcomes, including addiction, according to a recent study.[1]

"We were surprised by the magnitude of variability in opioid prescribing, even within the same ED, as well as how persistent the effect of one exposure to a high opioid-prescribing physician was," says lead author **Michael L. Barnett**, MD, MS, an assistant professor of health policy and management at Harvard T.H. Chan School of Public Health in Boston.

The ED patients had not used prescription opioids in the six months before the ED visit, yet the intensity of the EP's opioid prescribing was linked to the patient's likelihood of becoming a long-term opioid user during the subsequent 12 months.

"Acute treatment of pain, either postoperatively or in the setting of acute injury, is now felt to represent one of the primary gateways to chronic use of pain medications, opioid use disorder, and addiction and/or overdose," says **Michael D. Anderson**, a risk specialist and supervisor of patient safety and risk management at Medical Insurance Exchange of California (MIEC) in Oakland, CA.

Malpractice litigation against EPs is likely to rise commensurately. "We expect EPs to be increasingly included as potential targets of claims in which it is alleged that opioids were prescribed acutely either without adequate indication, or in excessive amounts," Anderson says.

False Marketing Alleged

In May, Ohio's attorney general filed a lawsuit alleging opioid manufacturers engaged in fraudulent marketing.[2] This could trigger increased opioid-related litigation for all prescribers, including EPs, says **Renée Bernard**, JD, vice president of patient safety at The Mutual Risk Retention Group in Walnut Creek, CA. However, it's unlikely EPs could

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point to alleged fraudulent marketing practices as a defense for inappropriate prescribing practices.

"I can't see how any medical malpractice defendant prescriber could successfully argue false marketing practices at this point in time, when we have so much more knowledge about this issue," Bernard says.

When litigation commences against a product, manufacturers typically defend the product unless and until test cases result in large losses, says **Mollie K. O'Brien**, Esq., director of claims at Coverys, a Boston-based provider of medical professional liability insurance.

"In these matters, the treating physicians, those using the allegedly dangerous or defective products, are called upon as witnesses in litigation, as opposed to being named as party defendants," O'Brien explains. Typically, this is the case because treating physicians could not be said to have foreseen the danger to the patient.

"In the case of opioid addiction, however, the tide may change," O'Brien notes, adding that advocates for addicted patients may allege that addiction was foreseeable to the prescribing physician. "EPs don't want to be the guinea pigs for such a case. Many are erring on the side of caution — not prescribing — to avoid that possibility."

Reduce Likelihood of Lawsuit

There has been a consistent rise in costs from opioid-related litigation since 2005, according to the PIAA Data Sharing Project.[3] Emergency medicine notched the second-highest "paid to close" ratio, after psychiatry.

Bernard warns, "It's imperative for EPs to educate themselves on new drug monitoring regulations and best prescribing practices to reduce their likelihood of being involved in litigation."

John Burton, MD, chair of Carilion Clinic's department of emergency medicine in Roanoke, VA, says, "The big picture here is the growing sensitivity of the public to the dangers of prescribed opiates." He sees these two groups as highest risk for EPs legally:

- Patients prescribed long, multiweek courses of opioids;
- Patients co-prescribed opioids and benzodiazepines.

Although prescribing of opioids during the ED visit always carried the potential for legal risks, such cases were uncommon.

"However, the game changer is the potential for suits by discharged ED patients who receive prescribed opiates for therapy following the emergency encounter," Burton explains. Here are some possible allegations involving ED prescribing of opioids:

- **The EP's prescribing practices are not consistent with either institutional policies or state statutes.**

EPs must be "hypervigilant" in this regard. Burton warns: "Follow local policies and state statutes very closely to assure your practice remains aligned with these practice changes." A recently passed statute in Virginia requires all physicians to offer a prescription of naloxone to any patient for whom benzodiazepines and opioids are co-prescribed in any encounter. "The statute brings up an entirely long list of unintended consequences," Burton laments. Two obvious questions: What specific instructions must the EP give to the patient regarding the use of naloxone, and what counseling should the EP give to the patient regarding risk of addiction and risk of respiratory depression with the co-prescribed medications?

"In one recent conversation in our ED, a patient in whom we were counseling for this specific circumstance was very confused as to the proper use of naloxone," Burton says. The patient asked if she should use it daily when she takes the other medications, how she could afford the drug, and whether she should receive an intranasal or injection form of the drug. "The conversation prompted us to reflect on the complexities of prescribing this drug for patients who we encounter in a single visit to the ED," Burton says.

This is just one example of a state statute in response to the opiate crisis that has direct implications for emergency medicine practice. "As state legislators derive their own statutes, there are a number of possible legislative efforts that could similarly impact emergency medicine practice," Burton adds.

• The ED prescription caused long-term substance addiction.

"Sooner or later, a plaintiff attorney or family will desire to pursue such an allegation," Burton warns.

Anderson says the primary liability concern around opioid treatment is the risk of overdose and death due to respiratory suppression. However, MIEC has seen, and paid indemnity on, cases in which a patient's opioid addiction is the claimed injury. "As focus on the potential liability associated with opioids continues to increase, we expect to see more of these types of cases," Anderson predicts.

One way EPs can mitigate liability risks is by acknowledging and discussing the risks of opioids with patients. Barnett says, "Some patients may decline opioids if they are more informed about the risks of addiction or overdose. This conversation could be documented in high-risk situations."

In Burton's view, EPs should be "very hesitant" to prescribe opiates in volume or duration that would exceed brief, acute pain management periods.

"To be very blunt, now is not the time to be prescribing one-month refill for patients who allege they have lost their monthly supply of opiates for chronic pain," Burton says. For instance, the plan for an acute fracture patient should be a multi-day prescribed course of pain medication as opposed to a multi-week prescription. Many state statutes now limit the days of prescribed therapy for opiates, particularly in the ED setting. "Law enforcement has specifically focused on 'pill mill' physicians," Burton notes. Thus far, the focus has been on chronic pain management clinics or primary care physicians prescribing multi-month, large-dose opioids to patients.

"To date, I have not seen suits or law enforcement focused on ED prescribing, unless there is some allegation of an unusual pattern or circumstances for prescribing," Burton says.

Many more cases brought against physicians are expected. "The courts and public have certainly lost their patience with excessive opiate prescribing by physicians," Burton adds. "We have seen very aggressive penalties for physicians convicted of malfeasance, including jail time."

• Opiates prescribed in the acute care setting harmed the patient.

"As the public becomes more sensitive to the potential for these events, one would expect to see an increase in these types of suits," Burton says. Typically, the patient suffers a stroke, cardiovascular event, or respiratory arrest after discharge from the ED.

"These tend to be uncommon cases and are frequently challenged with proving causation between the prescription action in the acute care setting and the patient event," Burton says.

• The patient drove while under the influence of controlled substances received on discharge from the ED.

California law requires physicians to report patients with disorders characterized by lapses of consciousness to the Department of Motor Vehicles. Generally, this is interpreted to refer to seizure disorders. "But recently, we've noted plaintiff claims alleging negligence where an opioid use disorder was not timely reported by a physician per these regulations," Bernard says.

EPs should seek clarification on their state reporting requirements, says Bernard, including whether the EP can delegate the report to be performed by another member of the care team.

• The EP failed to conduct a thorough history, including checking the state's prescription drug monitoring database.

"EPs frequently encounter patients who are attempting to access opioids through more than one provider and pharmacy," Bernard notes.

EPs write 5% of all opioid prescriptions, typically providing about a five-day supply, according to researchers who analyzed medical examiner reports of prescription drug-related deaths in San Diego County during 2013.[4]

Although EPs appear to provide fewer prescriptions to patients who die because of prescription drugs, EPs accounted for a high proportion of total providers, according to the study. These results highlight the need to use prescription drug monitoring program data to monitor prescription patterns closely, the authors argued. Eleven states currently have such programs in place. "These programs are one useful resource to help guide EPs in determining how to manage pain in the time between an ED visit and the referred outpatient appointment," Bernard says.

Failure to take a full history, including checking the prescription drug monitoring program database, could lead to an ED patient receiving a dangerous cumulative opioid dose. Anderson says, "It is also important to perform morphine-equivalent dosing calculations to determine the cumulative effects of concurrent opioids being prescribed to a given patient."

Opioid abusers often arrive at an ED after experiencing a suspected overdose. These patients subsequently may return to the same ED for acute opioid medications.

"EPs may increasingly face liability for failing to recognize opioid use disorder or addiction based on previous ER visits and prescribing additional opioids to addicted patients," Anderson cautions.

Potential Addicts

O'Brien says, "EDs have been plagued for years by addicts and chronic pain patients seeking opioid medication." As a result, EPs have long been savvy at identifying these high-risk individuals, even before the more recent onslaught of media attention to the opioid epidemic.

"Recently, there have been a number of studies published about a new at-risk population: potential addicts," O'Brien says. These are patients who are prescribed a course of treatment with opioid medication and develop a dependency as a result.

"Although the media hasn't targeted only EDs, the discussion regards all opioid prescribing, and, as such, applies to the EP directly," O'Brien explains. "The result is that the EP must be circumspect about any opioid prescribing." This is true even for the legitimate patient suffering from moderate pain, O'Brien adds.

"Previously relied-upon practices of prescribing only enough medication to bridge the time between the ED visit and an appointment with the patient's primary or consulting physician is now deemed dangerous," O'Brien explains. If one of those patients should develop an addiction, she warns, "the EP could, under the current landscape, certainly become a target in litigation."

Whether EPs ultimately will end up as defendants in litigation alleging that improperly prescribed opioids led to addiction remains to be seen. "But the risk-averse EP won't, and shouldn't, wait to find out," O'Brien notes. "Smart practice will include significant safety measures and conservatism in the prescription of opioids." ■

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Test Ordered in ED, but Patient Discharged or Admitted?

Experts warn not to assume someone else followed up

The EP reads a chest X-ray as normal, and the patient is discharged. However, the radiologist's report the following day tells a different story: "0.5 cm pulmonary nodule. Recommend clinical correlation and repeat imaging in six months."

Alan Gelb, MD, clinical professor in the department of emergency

medicine at University of California, San Francisco School of Medicine, has reviewed multiple malpractice lawsuits alleging that the EP failed to follow up on such incidental findings.

"If there is no reconciliation process, and the patient has lung cancer that goes undiagnosed, everyone gets sued," Gelb says. The EP can be held liable for failure to "close the loop" on non-emergent abnormal findings. The hospital can be held liable for not instituting a reconciliation process to flag discrepancies between the EP's readings and those of the radiologist.

"Most of these cases I have reviewed have settled," Gelb notes. "There are lots of 'horror stories.'"

In one ED malpractice case, a patient's urinalysis revealed a urinary tract infection, but the patient was discharged without it being identified. The patient was not contacted about it. "The untreated urinary tract infection becomes *E. coli* and claims the patient's life," recalls **Amy E. Goganian**, Esq., an attorney at Goganian & Associates in Needham, MA. "The ED doctor was sued, and the case settled during discovery."

The hospital needs a process to ensure follow up if abnormal results are not acknowledged during the ED visit, Gelb advises. This should include X-rays and labs that include blood and sexually transmitted disease cultures. Gelb recommends these approaches:

• Systems to prompt the EP when there are abnormal results, and when X-ray findings by the radiologist are different than the preliminary findings of the EP.

"The EMR might also prompt a different provider than the one who discharged the patient, but is responsible for these follow-ups," Gelb adds.

• In the event the patient cannot be contacted, an "alert" in the medical record system that pops up whenever and wherever in the system the patient is seen.

"This is difficult to set up in many systems, but can be done," Gelb says.

• Documentation of attempts to notify the patient, and how the results were eventually communicated to the patient.

Goganian says these practices reduce legal risks for EPs:

• Whoever requests the test should review the results;

• Patients should be instructed to call for results;

• Patients should be contacted with results, and the ED record should reflect this;

• Rapid follow up should be scheduled;

• Discharge instructions should instruct the patient to return if symptoms do not improve or get worse.

"A significant adverse test result with no or delayed follow up or plan of care makes it easier for the plaintiff to prevail," Goganian warns.

Admitted Patients Are High Risk

Failure to follow up on abnormal test results of discharged ED patients "remains a significant and preventable area of patient harm and liability," according to **Alan Lembitz**, MD, chief medical officer at Copic, a Denver-based medical professional liability insurance provider.

Typical allegations in malpractice cases involving discharged ED patients include:

• failure to follow up on incidental findings on imaging studies;

• discordant findings in the final radiology report from what was acted on by the EP;

• failure to follow up on studies that did not return prior to discharge, such as cultures or pathology.

EPs typically are well-versed in the importance of good discharge instructions, however, and many EDs do have systems in place to reconcile abnormal imaging and labs post-discharge. For this reason, says Lembitz, "The higher risk is now the admitted patient."

No discharge instructions are given to patients admitted from the ED. EPs simply assume that the next provider (a hospitalist, surgeon, or admitting physician) will follow up and act on the results of tests or labs ordered in the ED.

In one case, a 45-year-old female with right upper quadrant pain was direct-admitted to the surgeon, who scheduled a laparoscopic cholecystectomy for the following morning. "During the surgery, major bleeding is encountered from many sources, and during conversion to open procedure, she arrests and dies," Lembitz recalls.

It was discovered later that the patient was taking warfarin, and that at the time of the ED visit the patient's international normalized ratio was 6.5. "No one on the inpatient service was alerted of the abnormal finding in the ED, which was assumed to be communicated to that service. Hence, no direct contact was made," Lembitz says.

Lembitz has seen multiple malpractice lawsuits involving ED patients who undergo CT imaging to rule out pulmonary embolism. An incidental lung nodule is noted, the patient gets admitted for other reasons, and no one ever follows up on the lung nodule. "The EP is named on the CT order, he or she assumes the inpatient service will see it, yet they only see that pulmonary embolism or whatever the indication for CT was has been ruled out," Lembitz explains.

Another case involved a 60-year-old man whose CT scan ordered

in the ED revealed appendicitis. The EP told the patient of an incidental kidney mass, but the patient received no further follow up of it after the successful appendectomy. "The patient assumed that when the surgeon was 'in there,' he checked it out," Lembitz notes. In reality, the surgeon was never aware of the finding. "Despite the report being in his office records for post-op care, he never saw it," Lembitz recalls. "The patient dies of metastatic kidney cancer two years later." Multiple factors contribute to these terrible outcomes. "Poor handoffs, EHRs that are 'noisy,' lots of extraneous information but [records] are unclear about important follow up, and insufficient communication lead to these preventable harms," Lembitz says. One solution is a "built-in redundancy" to the system, Lembitz suggests. "The EP could directly communicate significant findings that they know are likely to lead to harm if missed by a direct communication with the subsequent provider." ■

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Some Plaintiffs Face Higher Burden of Proof

Is this long overdue, or is it unfair to injured patients?

More than a decade ago, Texas, South Carolina, and Georgia enacted tort reform that changed the malpractice standard for emergency care. To prevail in malpractice litigation in Texas, plaintiffs must demonstrate that the EP acted "with willful and wanton negligence, deviated from the degree of care and skill that is reasonably expected of an ordinarily prudent physician or healthcare provider in the same or similar circumstances."[1]

Simply put, plaintiffs must prove EPs acted with gross negligence rather than simple negligence. How has this higher burden of proof affected ED malpractice litigation? For one thing, there is no longer much of it.

"We do not see a lot of emergency care cases, since there is a higher standard of proof," says **Vicky Gould**, vice president of claims in the Austin, TX, office of ProAssurance Companies.

Appellate courts are considering several issues regarding the construction of the statute and situations in which they apply. "We are hopeful that the current tort reform in Texas will continue to withstand challenges through our courts," Gould says.

Tort reform hasn't put a stop to all ED malpractice lawsuits. "We are finding that plaintiff's experts are increasingly willing to testify that emergency physicians were grossly negligent [so as] to meet the heightened burden of proof," Gould notes. However, this alone isn't enough for an injured plaintiff to prevail.

Attitudes about tort reform vary widely among EPs, defense attorneys, and plaintiff attorneys. *ED Legal Letter* spoke with two Texas physicians on how tort reform, in their view, has affected the practice of emergency medicine and malpractice litigation there.

Relationship Less 'Adversarial'

***Arlo F. Weltge**, MD, MPH, FACEP, clinical professor of emergency medicine at McGovern School of Medicine at the University of Texas at Houston*:

The liability climate has improved dramatically. It has been a huge boon to emergency medicine.

"Willful and wanton" has restored competition with (and availability of) medical malpractice liability. The out-of-control litigation that was going on led to all but three liability carriers leaving the state. We now have insurance companies coming back to the state. They are willing to write policies, and the cost of the policies of the companies that did remain have dropped substantially. The tort climate was very out of control before the law passed in 2003. EPs were getting hammered for all sorts of peripheral issues that we had been involved in at some point. That has dropped off dramatically with the gross negligence standard. But we are starting to see the pendulum swinging back, where there are challenges to what constitutes a freestanding ED, and what constitutes emergency care.

Tort reform is not something that gets floated easily without some precipitating event or crisis in the state. Before the law passed, we had entire specialties leaving regions of the state

uncovered. It was the rural part of the state that recognized that this law was needed to provide access to care. That's the way it was sold to the citizens of Texas. Whole areas of the state were losing access to medical care. Texas saw a dramatic increase in EPs coming to the state, recognizing that these protections provide a much nicer practice environment. The allegation from some is that there will be no controls on the practice of medicine. Part of the tradeoff in Texas was the recognition that the appropriate control on the practice of medicine is the licensing agency. There are an increased number of investigations going before the Texas Medical Board. The fears that this would turn loose a "Wild West" lack of quality has not been founded.

I personally believe that in some respects, the quality of ED care has improved. We have consultants available who are willing to see these patients, who are often times without established physicians, who are among the sickest, on holidays and weekends. Part of it is recognizing that there is some protection, that in seeing these severe cases the consultant is not going to be sued and punished for doing their job. Before this law was passed, I heard many physicians express concerns of being blamed for an adverse outcome out of their control, fear of losing their practice, of losing their homes, just by doing what they consider to be the appropriate medical response.

What this law has allowed me to do is to carry on a much better informed consent discussion with patients. I don't feel obligated to order a CT scan on every child who bumped his head, because I not only have good clinical guidelines stating I don't need to do that, but I also don't have to be afraid of the one out of 1,000 or one out of 10,000 results. I feel much more comfortable explaining to the parents that the likelihood of serious injury is extremely low, and that there are legitimate risks associated with the radiation. I have the Texas law to support me in providing this reasonable care. Before the law passed, I really couldn't count on that. I couldn't assume that doing the right thing would necessarily stand up in court, or prevent a case from being filed. Many times, it wasn't negligence we got sued for, it was a bad outcome. There is a little bit of a herd mentality. When everybody sees that suing is the response to any less-than-ideal outcome, that is not healthy for the patients, or for physicians, or for our society.

We have an effective system in place. The medical board is not tolerant of people who are sloppy or not doing their job well. The solution is not five years of litigation and an adversarial relationship. We have a profession that can be regulated. These issues can be addressed in another mechanism, rather than taking it to court with a long-term litigation process that's very disruptive to physicians — and, in many respects, to patients — and doesn't effectively meet anybody's needs. Now, I've got the ability to deliver a good quality of care without the unreasonable fear of the risk of an extremely unusual bad outcome forcing me to do things that in many respects are not in the patient's best interest. It has restored a better integrity to the practice of taking care of patients with emergency medical conditions.

'Almost Impossible to Win at Trial'

***Brant Mittler**, MD, JD, a practicing cardiologist for 40 years and a litigating attorney for the past 15 years*:

It's very clear to me, in Texas, as a practicing attorney, that we are just not taking ED cases. I would be surprised if many lawsuits against ED doctors have been filed in Texas in recent years. The "willful and wanton" negligence standard is just too hard to overcome for plaintiffs. I think it's almost impossible to win at trial. Defense counsel have bragged that even if we win at trial, they will appeal, and the Texas Supreme Court will probably take away or reverse our verdict.

My trial partner and I did try an ED case in state court in San Antonio. A woman named Jennifer McCreedy accidentally stepped off her back porch at night and shattered her ankle.[2,3] She was taken to the ED at one of the largest urban hospitals in San Antonio. The ED physician admitted under oath that he had treated fractures like this before, and in every other case he had reduced the trimalleolar fracture, and called an orthopedic surgeon to the ED. The patient's treating board-certified foot and ankle surgeon came to court, at no charge, and testified that the ED doctor's treatment was below the standard of care. A well-credentialed Texas emergency physician who not only practiced but taught in an emergency medicine training program testified that there was gross negligence. The ED doctor tearfully admitted during the jury trial that he was negligent, that he failed to meet the standard of care, but that he wasn't grossly negligent. We thought we had a good case, but the jury gave the doctor a pass after deliberating less than an hour. The only real threshold question was: Was it gross negligence?

We learned our lesson. We have since turned down many ED cases, including bad death cases. Yes, patients and their families can file complaints with the state medical board. I don't know how often that occurs. I suspect rarely. Even though I sue doctors, I also represent doctors in hospital credentialing, peer review, and state

medical board matters. Some of those cases have involved ED care. In one instance, a large hospital system was critical in peer review actions against an independent physician in the ED, but at the same time was not critical of the conduct of its own contracted ED doctors in the very same case. Another hospital refused to take action against a cardiologist who was associated with a large group that had essentially an exclusive contract with the large hospital system, despite repeated criticisms over the misreading of a diagnostic study in an ED that resulted in patient harm. Hospitals seem to see the ED as a place to make money, punish competitors, and support doctors they have a business relationship with. Patient safety appears to be way down their list of concerns.

Texas courts have said the gross negligence standard represents a lower standard of care.[4] I don't think that when someone goes to an ED with an acute heart attack they want a lower standard of care. They probably expect a higher standard of care.

Most of the time, if the story the family or patient tells sounds egregious, I'll look at the medical records. Often, I have to explain that we can't take the case because it happened in the ED, and there is a gross negligence standard that will be impossible to meet in court. I have had more than one conversation where people expressed outrage and alarm. I tell them to call their state legislators or the governor. But in red state Texas, that's a futile process.

In one surprising case, the Texas Supreme Court upheld a gross negligence award against an ED for failing to provide a stat echocardiogram in a patient with an acute heart valve problem.[5] The court said that because the hospital had entered into a contract to provide stat services, and didn't have it available, there was gross negligence. But that's a rare case. In general, I think most plaintiff attorneys feel that even if by chance you get a jury verdict, which would be a rare event, the defendants would certainly appeal it so as to never have the gross negligence standard changed. The business community and the Texas Medical Association have very effective lobbies. They have convinced Texans that unless we rein in those dangerous plaintiff attorneys, they won't be able to find a doctor. A study in *The New England Journal of Medicine* showed that after tort reform, the rate of ordering CTs and MRIs in ERs didn't change a bit in Texas Medicare beneficiaries.[6] The cost of care came down just a bit in Georgia, and didn't even change in Texas and South Carolina.

So, this idea that tort reform is going to save money and reduce unnecessary testing — that is nonsense. And why is that? Doctors order those tests because of uncertainty. We get a lot of information from those tests. Other legal scholars have also shown that Texas tort reform did not increase doctor migration to Texas or to rural areas, and, in fact, increased the occurrence of adverse patient safety indicators.

In the *McCreedy* case, people may say, "We saved money from a frivolous lawsuit. That greedy plaintiff, we showed her." But what was the reality? This woman, a single mother raising a son, who was a hard-working, solid citizen before her freak injury? She now walks with a limp, uses a cane, has a chronic pain syndrome, and is disabled. She went on Social Security disability, rightfully so, and after two years went on Medicare. So, the risk for negligent ED care got shifted from the doctor's and hospital's insurance companies to the U.S. taxpayer. The insurance companies didn't have to pay. The taxpayers are paying for it. That's a really important point. Hospital EDs may dodge the risk. But it shows up in other parts of the economy, as the U.S. taxpayer gets handed the bill — a classic risk shift. ■

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Missed Spinal Epidural Abscess: 'Lightning Rod for Litigation'

In these cases, EPs are the second most commonly sued physicians

Missed or delayed diagnosis of spinal epidural abscesses is a "lightning rod for litigation," says **J. Mason DePasse**, MD, an orthopaedic surgery fellow at Brown University's Warren Alpert Medical School in Providence, RI. DePasse recently analyzed 56 malpractice cases involving spinal epidural abscesses.[1]

"Epidural abscesses are a challenge. The symptoms are often nonspecific; as any emergency physician can tell you, countless people present with back pain," he says.

Unfortunately, this condition can be as devastating as it is difficult to diagnose. Patients may be left paralyzed or with a range of neuropathic symptoms, including weakness and pain, that never go away. "Frustrated patients wonder if something could have been done sooner," DePasse says.

Investigators searched the literature for research on lawsuits associated with epidural abscesses. They found only one small study with limited data for analysis. "We were surprised to find that there was very little information available. So we decided to perform our own study," DePasse says. Some key findings:

• Of the 56 cases, 17 were settled, 22 resulted in a defendant ruling, and 17 resulted in a plaintiff ruling. Internists were the most commonly sued physicians (named in 13 suits), followed by EPs (named in eight lawsuits).

• The proportion of plaintiff verdicts was significantly higher in cases in which the patient became paraplegic or quadriplegic, and in cases in which there was delay in diagnosis or treatment.

• Nonsurgeon physicians, who often are responsible for initial diagnosis, were more likely to be sued than were surgeons.

"The number one way to lose a lawsuit when treating a spinal epidural abscess is to delay treatment when the diagnosis is known," DePasse stresses. Plaintiffs tend to prevail if they can demonstrate that the ED care resulted in a delayed diagnosis, and that a competent EP would have performed the appropriate workup.

Paralyzed plaintiffs are more likely to win malpractice suits, and also are more likely to receive bigger monetary awards. "This is likely due to sympathetic juries, which has implications for the risks of neck pain vs. lower back pain," DePasse says.

The patient's age and sex were not relevant. "Interestingly, whether the patient had a known infection prior to diagnosis did not matter either, despite that one might argue the physician should have had a higher suspicion for a new site of infection," DePasse notes.

Faster Diagnosis

For EPs who want to reduce legal risks, the study highlighted two important things: the need for increased awareness of epidural abscess, and the need for timely diagnosis and treatment.

"Regardless of all other factors, the key in these lawsuits is whether the plaintiff can show that a 'competent physician' would have made the diagnosis faster," DePasse says. He recommends EPs consider these practices to avoid missed or delayed diagnosis of epidural abscesses:

• Keep in mind that only a small percentage of patients present with "classic" symptoms.

Did a patient present with the classic triad of fever, back pain, and neurologic deficits? The EP will be expected to make the diagnosis promptly with imaging and laboratory workup. However, few patients present this way. On the other hand, DePasse says, "almost all patients show up with a chief complaint of neck or back pain."

Concerning additional historical factors include: the remaining "triad" symptoms, history of intravenous drug abuse, history of diabetes, history of kidney disease, and recent infection at a remote site. Of particular concern? A known methicillin-resistant *Staphylococcus aureus* infection.

• Maintain a high index of suspicion for patients with repeat ED visits for back pain.

Many patients with abscesses present two or more times to EDs with the same complaints.[2] "For patients who present with nonspecific lower back pain and no other symptoms, defendants can argue that no competent EP would have suspected epidural abscess on the first ED visit," DePasse says. This may be a more difficult argument to make if the patient returned to the ED, and the diagnosis wasn't made during that ED visit either. "Documenting the presence of spine tenderness and a thorough neurologic exam for these patients is essential," DePasse counsels.

• If there is suspicion, appropriate laboratory workup

should include blood cultures, white count, erythrocyte sedimentation rate (ESR), and C-reactive protein.

"Studies have shown that ESR is the most sensitive and specific marker for epidural abscess, and it is not very specific," DePasse notes.[3]

• If any concern remains, order an MRI with gadolinium of the entire spinal axis.

"An MRI of the area of complaint is not enough," DePasse warns. "Patients may have contiguous infection in different areas of the spine, and there were cases of catching one abscess and missing the other."

• If imaging reveals an abscess or a question of an abscess, seek urgent spine surgical consultation, or rapidly transfer the patient to a facility with spine surgery available.

"All cases in which this was delayed resulted in plaintiff verdicts," DePasse notes. ■

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Study: Individual EPs Rarely Fined for EMTALA Violations

Almost all civil monetary penalties are against facilities

Individual EPs are rarely penalized by the Office of Inspector General (OIG) for EMTALA violations, according to a recent study.[1]

"For emergency physicians, a civil monetary penalty is an often-feared consequence of EMTALA enforcement," says **Sophie Terp**, MD, the study's lead author. Terp is assistant professor of clinical emergency medicine at Keck School of Medicine at University of Southern California, Los Angeles.

A physician can be held individually liable for a fine of up to $50,000, which is not covered by malpractice insurance. Recent studies have reported that only a small proportion of EMTALA violations result in civil monetary penalties against hospitals.[2]

However, according to Terp, "Little was known about characteristics of civil monetary penalties levied against individual physicians related to violations of EMTALA." Terp and colleagues reported these findings:

• Of 196 OIG civil monetary penalty settlements related to EMTALA between 2002 and 2015, 96% were against facilities.

• Only eight were levied against individual physicians. Of those, seven were imposed on on-call specialists, surgeons, and OB/GYNs. Six of the specialists failed to respond to evaluate and treat a patient in the ED. One failed to accept appropriate transfer of a patient with an emergency medical condition requiring a higher level of care.

• Only one EP was fined during the 2002-2015 period. That case involved a very clear violation of the EMTALA statute. The EP repeatedly failed to provide a medical screening exam to a pregnant teen repeatedly, based on the incorrect belief that a minor could not be evaluated or treated without parental consent.

Malpractice Suit More Likely

Continued active enforcement of EMTALA suggests that EPs are not always adhering to the statute, Terp notes. Hospitals, rather than individual EPs, typically are held responsible for EMTALA violations. The risk to an individual EP of an EMTALA fine is extremely low. "Comparatively, 7.6% of emergency physicians face a malpractice claim, and 1.4% have a claim resulting in payment to a plaintiff on an annual basis," Terp notes.[3]

Although EMTALA investigations and citations were common at the hospital level, they were rare at the

ED-visit level, according to another study conducted by Terp and colleagues.[4]

Between 2005 and 2014, investigations were conducted at 43% of hospitals with Centers for Medicare & Medicaid Services provider agreements, according to the researchers, and citations were issued at 27%. "On average, during the study period, 9% of hospitals were investigated, and 4.3% were cited for EMTALA violations annually," Terp reports.

EPs should familiarize themselves with the requirements of EMTALA, Terp advises. These include, but are not limited to:

• All patients presenting to an ED should receive timely medical screening evaluations and stabilizing care regardless of their ability to pay;

• If specialty services required to stabilize an identified emergent condition are unavailable, transfer to an alternate hospital for a higher level of care must be arranged;

• Receiving hospitals are obligated to accept transfer of patients requiring available specialized services, such as neurosurgery or burn care, if the facility has capacity to treat the patient.

"Emergency physicians should be diligent to ensure appropriate patient care, and that both they and their facilities are compliant with the EMTALA statute," Terp concludes. ■

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SOURCE

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CME/CE QUESTIONS

1. **Which is true regarding opioid-related litigation risks for EPs?**

   a. State statutes limiting the days of prescribed therapy for opiates exclude the ED setting.
   b. EPs are potential targets of claims in which it is alleged that opioids were prescribed acutely either without adequate indication or in excessive amounts.
   c. If EPs do prescribe opiates, multi-week prescriptions are not more legally perilous than limiting prescribing only to acute pain management periods.
   d. EDs are unlikely to be held liable for prescribing additional opioids to addicted patients unless the plaintiff can prove that the information was readily accessible in the state prescription database.

2. **Which is recommended regarding abnormal findings in the ED?**

   a. Maintain systems that notify the EP if the radiologist's findings differ from the EP's.
   b. Include electronic medical record prompts only for the EP who discharged the patient, since he or she is legally obligated to follow up with the patient.
   c. Exclude inpatient providers from system prompts to follow up on results of tests ordered in the ED.
   d. Rely on electronic medical records instead of direct contact between the EP and the inpatient service about abnormal findings to ensure a consistent process is followed.

3. **Which must the plaintiff prove to prevail in malpractice litigation against an EP in Texas?**

   a. Gross negligence
   b. Simple negligence
   c. Ordinary negligence
   d. Intent to harm the patient

4. **Which is true regarding liability risks of missed spinal epidural abscesses?**

   a. Documenting the presence of spine tenderness and a thorough neurologic exam for patients who report back pain is essential for liability reduction for EPs.
   b. Erythrocyte sedimentation rate is indicated clinically only if patients present with the classic triad of symptoms.
   c. Most spinal abscess patients present with the classic triad of fever, back pain, *and* neurological deficits.
   d. Courts have ruled consistently that delayed spine surgical consultation for patients presenting with nonspecific symptoms does not constitute negligence.

5. **Which is true regarding EMTALA violations?**

   a. Penalties were evenly divided between individual EPs and facilities.
   b. No penalties were levied against on-call physicians, even those who failed to respond to evaluate and treat a patient in the ED.
   c. Civil monetary penalties resulting from EMTALA violations are rarely levied against EPs.
   d. Malpractice insurance policies generally cover EMTALA fines against individual EPs.