

Pain Management in the Emergency Department (ED)

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Purpose Statement

The purpose of this activity is to introduce physicians to risk management techniques that will enhance their pain management strategies.

Target Audience

This activity is intended for physicians and allied health-care professionals involved in emergency department and urgent care settings.

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INTRODUCTION

Numerous challenges face emergency departments (EDs) nationwide, including overcrowding, fragmented coordination with local ambulance services, shortages of on-call specialist coverage and lack of disaster preparedness.¹ In addition to these pressures, recent federal guidelines have prompted a paradigm shift in patient approach, changing the focus from immediate diagnosis of the underlying cause of pain to immediate relief of the pain itself.²

Pain is the most frequent chief complaint of ED patients.^{2,3} However, despite increased awareness, research, and improvements in pain

management, pain continues to be undertreated in emergency medicine. The following barriers to effective pain management in the ED have been listed:^{2,4}

- Ethnic, cultural and gender bias on the part of physician and nursing staff (e.g., some reports suggest that Hispanic and African American patients with fractures are less likely than non-Hispanic white patients to receive analgesia in the ED, and that female patients describe more pain and are more likely to receive analgesics than male patients in the ED).

(continued on page 2...)

- The ED environment and culture (e.g., distribution of physicians and nursing staff per patient, frequent interruptions in tasks, the transient nature of treating emergency patients, the large number of independent steps between patient presentation/registration and the administration of pain medication, a one-size-fits-all attitude toward dosing, preprinted discharge instructions that are not tailored to the individual patient's needs).
- The stigma of opioid analgesics (e.g., the suspicion of drug-seeking behavior, lack of knowledge about opioids and opioid choices, negative views of patients with chronic pain, the belief that opioid prescription should be managed exclusively by primary care).
- The lack of formal education regarding pain management, particularly the treatment of acute pain.
- The problem of assessing pain in patients where communication is difficult or impossible (e.g., children, cognitively-impaired patients, traumatized patients, unconscious patients).

The consequences of inadequate treatment of acute pain can include the following:²

- Increased patient suffering
- Development of chronic pain
- Feelings of mistrust and dissatisfaction regarding care rendered

The Medical Malpractice Angle

From a professional liability perspective, inadequate pain management by itself is not responsible for a statistically meaningful number of malpractice allegations against emergency physicians. However, poor pain management has surfaced as a *factor* in adverse outcomes that eventually resulted in lawsuits. The following pain management-related problems have been identified in an analysis of closed claims against EDs and physicians:

- Oversedation

- Lack of appreciation of patient self-report
- Inadequate discharge instructions (especially the use of preprinted instructions)
- Poor communication between providers
- Improper application and documentation of informed consent, informed refusal and leaving against medical advice (AMA)

Consider the following case examples, which represent two situations in which inappropriate pain management harmed the patient.

Case Example #1

Allegation: Oversedation of minor with Down syndrome and premature discharge from the hospital resulting in respiratory arrest and residual neurological injuries.

The Event

After falling while kicking a soccer ball with her friends, a 9-year-old girl with Down syndrome was transported by ambulance to the ED. During transport the patient received 30 mg of morphine sulfate and 1 mg of diazepam. Once admitted to the ED, within one hour of her arrival, the ED physician ordered an additional 6 mg of morphine.

X-rays showed dislocation of the right patella with no obvious bone fractures. Following the diagnosis, the patient received two 1 mg injections of midazolam by IV. The physician then reduced the dislocated patella, and placed a knee immobilizer.

Shortly after the knee was set the patient sustained a period of respiratory arrest. She was promptly given supplemental oxygen, Naloxon® and flumazenil and seemed to recover. The patient remained in the ED for an additional 50 minutes and was discharged home with her parents. No vital signs were recorded in the period between her recovery and discharge from the hospital. The preprinted discharge instructions that were given to the patient's parents warned that medications may cause drowsiness and advised against activities that require alertness (e.g., operating heavy

machinery and other nonapplicable advice). Neither physician nor nurse provided any warning to the parents to watch the child for signs of narcotic overdose and immediately call the ED if the child appeared abnormal.

Outcome

Later that night the parents heard the girl the vomiting in her sleep. Her mother noted that her lips were blue and tried to wake her, but she was unresponsive. The parents took the child by car to the ED, and on arrival she was in critical condition. Oximetry reflected 74 percent saturation, and respirations were 4-6 per minute. The patient was given Naloxon®, lorazepam and was intubated. For the following 3 months the patient continued treatment in the intensive care unit (ICU) and then at the rehabilitation center. Her discharge diagnosis included aspiration pneumonia, hypoxic brain injury and cortical blindness.

Case Analysis

Physician reviewers testified that 36 mg of morphine sulfate administered over the period of an hour was an excessive dose for a 50 kg child. It was generally agreed that all signs pointed to oversedation, and that the administration of midazolam on top of morphine triggered the respiratory arrest. Furthermore, experts testified that children with Down syndrome require an extra cautious approach to pain management because they generally have thickened tongues and shortened elastic airways, which can result in sleep apnea. In such cases the administration of morphine may considerably increase the risk the patient will develop hypoxia.

The fact that the patient was discharged 50 minutes after the administration of Naloxon®, and during this period no vital signs were recorded, was strongly criticized by reviewers of the case. At the time of discharge the child was under the effect of the reversal agents and appeared to be fully recovered. However, reviewers commented that Naloxon® and flumazenil tend to wear off more quickly than

the drugs they are reversing, and agreed that the ED physician should have anticipated that this level of functioning would not be sustained given the heavy sedation the patient had received.

Many reviewers felt that given the circumstances, the child should have been kept overnight or at least observed for a few hours longer in the ED. At minimum, the risks of oversedation should have been discussed with the parents at discharge, and instructions should have specifically advised them to watch for episodes of vomiting and any evidence of progressive sedation such as unrelenting drowsiness or inability to awaken the child. The parents should also have been advised when and how to contact the ED in the event of a problem.

Case Example #2

Allegation: Delayed diagnosis of L3-L4 disc herniation resulting in delayed surgery and residual neurological impairment.

The Event

A 38-year-old truck driver suffered a lifting injury to his back. He did not initially seek medical care for the injury, but his condition gradually worsened, and one month later he presented to the ED with low back pain radiating down both legs, and numbness in his legs and feet. Physician #1 noted both upper extremities as neurovascularly intact, and that the patient had good motor function. Deep tendon reflexes were 1+ and equal bilaterally, and leg-raising did not increase the patient's pain. A sensation test revealed bilateral hypesthesia in the L5-S1 area.

After administration of meperidine (100 mg), promethazine (50 mg), lorazepam tablet, prochlorperazine (10 mg), and then additional meperidine (50 mg), the patient demonstrated no real improvement and was still writhing in pain. Physician #1 questioned the patient whether he was "coming off drugs," which he denied. Thereafter the patient became angry

(continued on page 4...)

and agitated and Physician #1 instructed the nurse to discharge him. While attempting transfer from gurney to wheelchair, the patient collapsed on the floor in pain, and was given IV midazolam, which did not bring him much relief.

At the shift change care was transferred to Physician #2. The physician checked deep tendon reflexes, which were 2+ bilaterally. He prescribed IV morphine sulfate to control the pain and ordered a urine analysis and complete blood count (CBC). At this point the patient was thrashing in pain and very frustrated. He refused lab work and IV medication and called his wife to drive him home. The nurse gave him written discharge instructions prepared by Physician #1 earlier that morning, and witnessed him crawling painfully into the car.

Later that day the patient's leg numbness had progressed and he had no sensation in his toes. His wife brought him back to the ED and he was seen by a third physician (Physician #3). During examination, Physician #3 documented weakness in the plantar flexion and dorsiflexion of the right foot. Achilles nerve reflex was difficult to obtain bilaterally, and the examination revealed motor weakness, which had not presented before. Physician #3 suspected lumbar disc herniation, and wanted to order an MRI scan; however, MRI was not available at that time, and he scheduled the patient for later in the week. He advised the patient on his choices of staying in the ED or going home, and after administering pain medication (fentanyl patch), he discharged the patient.

Outcome

The next day the patient stayed home, the fentanyl patch providing some pain relief. However, the numb sensation progressed and by that evening the patient was unable to walk and had lost control of urinary function. The following morning he was brought by ambulance to the hospital and an MRI revealed "spinal stenosis with a disk herniation at L3-4 and obliteration of the spinal canal." Medical

examination revealed that the patient had diminished sphincter tone, loss of ankle jerks, loss of sensation to the plantar aspects of both feet, increased weakness in his right foot and some weakness in the left foot. The patient was diagnosed with Cauda Equina Syndrome and an urgent surgery was performed to decompress nerve roots. However, as a result of extensive nerve damage, the patient developed urinary incontinence and impaired bowel function, and became unable to sustain his balance while standing unsupported.

Case Analysis

Physician #1

Reviewers of the case agreed that instead of keeping the patient in the ER for over six hours, Physician #1 should have admitted the patient into the hospital, possibly with a referral for orthopedic or neurology/neurosurgery opinion. The physician's remarks about the patient "coming off drugs" were targeted by the plaintiff's attorney as demonstrative of this physician's blatant disregard for the patient, and intention to dismiss the patient without a complete work-up or final diagnosis.

Physician #2

Physician #2 was criticized for knowing that the patient had not been diagnosed and was experiencing severe pain, and then not taking appropriate action. While it was appropriate for this physician to order labs, it was generally agreed that he should have admitted the patient to the hospital for observation and further testing while waiting for results. Furthermore, when it became clear that the patient intended to leave against medical advice, he neither discussed the risk involved with such a decision, nor made any attempts to convince him to stay for further evaluation and treatment.

Physician #3

When the patient was seen by Physician #3 it was his second visit to the ED on the same day. This was a red flag that the patient had a

serious and unrelenting problem that required a prompt diagnosis. By the time the patient saw this physician he had developed new symptoms indicative of progressive neurological deficit. Reviewers opined that the physician should have performed a rectal examination and determined whether a saddle anesthesia was present, and he should have ordered an emergency MRI or a CT study and/or prompt orthopedic or neurosurgical consult to avoid further neurological impairment (e.g. Cauda Equina Syndrome, which eventually developed).

In sum, the case was settled out of court, with most reviewers agreeing that had these essential steps been taken, the surgery would have been performed earlier and the final outcome would have been different.

A Risk Management Approach

The previous ED case scenarios—along with others that have been presented in NORCAL's series on pain management—underscore the importance of appropriate assessment, monitoring, documentation, communication and informed consent. General professional standards of care for pain management in the ED are set by organizations such as the American College of Emergency Physicians (ACEP) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and are upheld in part by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) statute. In addition to these guidelines, consider incorporating the following risk management-based strategies to augment the management of acute pain patients and reduce professional liability exposure:

- Appreciate variability between patients in their experience (including their expression, reporting and expectations for treatment) of pain. Do away with the one-size-fits-all model of pain assessment and treatment.
- In the event that the hospital has written protocols for pain management and procedural sedation, adhere to such protocols.

When diverting from a policy or protocol, spend extra time documenting decision-making rationale and treatment plan in the medical record.

- Develop communication and listening skills with regard to pain. The use of pain scales has become commonplace, but should not take the place of truly listening to the patient report and asking pointed and compassionate questions.
- Document in objective and factual terms. Do not write personal judgments about the patient in the medical record.
- Assess and document pain at the point of transfer or discharge.
- Seek continuing medical education (CME) opportunities on the topic of pain management.

The Drug-Seeking Patient

An ED treating 75,000 patients per year has as many as 262 visits from fabricating drug-seeking patients. Drug seekers may demand specific medications, claim that no other medications work (or that they are allergic), or may seem otherwise preoccupied with obtaining opioids during the ED visit.⁵ It is not always easy or even possible to distinguish such patients (especially in the acute care setting) and physicians are challenged with the task of devising a balanced pain management plan that relieves the patient's pain enough for the patient to function, and does not contribute to abuse of prescribed medications.

Complicating matters is the existence of "pseudoaddiction," which can be a possibility in patients with undertreated pain. Pseudoaddiction includes patients with a painful condition who require opioids to function normally. Such patients may exhibit behaviors such as complaining about the need for higher doses in order to find sufficient relief from pain and fully participate in life. Healthcare professionals may label such behavior as manipulative, obsessive or "drug-seeking."

(continued on page 6...)

However, these behaviors can resolve when the patient receives adequate treatment. Questionable behaviors may be deemed legitimate if the following can be confirmed and documented:⁶

- A diagnosis can be confirmed that is consistent with the condition for which the patient is presenting.
- The ED physician is able to communicate with the patient's primary care physician regarding the patient's history, recent examinations, tests and current condition.
- The patient is not demanding about the need for medication.

Some facilities have come to use "narcotic contracts" with opioid users, or pain management letters that refuse opioids to frequent visitors unless they present a letter from their personal physician. Other hospitals have a designated "care manager" who tracks frequent visitors and helps to direct abusers and addicts away from the ED toward treatment programs and community services, while helping the department provide appropriate care for legitimate therapeutic users.⁵

The following risk management recommendations may help physicians prevent drug-seeking patients from taking advantage of them to obtain drugs:

- Obtain a thorough patient history, including possible or potential illegal drug use or abuse. If the patient requests or is a known user of a particular drug, or is exhibiting a tolerance, ascertain how long the patient used/has been using a substance, how frequently the patient used/is using and what result the patient wanted/wants from the substance.
- Maintain thorough medical records documentation:
 - Document in the patient's chart all medications prescribed, including drugs prescribed by other clinicians.
 - Document the rationale for the drugs prescribed.

- Document discussion about the likelihood of physical dependence occurring, as well as a plan of action to address physical dependence. (State laws impose requirements to protect the confidentiality of information pertaining to diagnosis and/or treatment of drug or alcohol abuse. Federal law also imposes confidentiality requirements for federally assisted drug and alcohol treatment programs. Hospitals can protect patient confidentiality by keeping patient drug and alcohol abuse information in a separate section of the medical record.⁷ Physicians should seek legal counsel about confidentiality regulations in their own states, as well as their obligations to protect patient confidentiality under federal law. California Medical Association (CMA) members can obtain further guidance from CMA On-Call Document #1110, *Confidentiality of Sensitive Medical Information*, at www.cmanet.org.
- When providing the patient with a written prescription, write out the quantity of the drug in longhand in addition to using a numeral, so that quantities cannot be altered.
- If no refills should be made, place a line or large zero in the refill space on the prescription.
- Do not leave blank prescription pads on desks or on exam room counters.
- Implement "compassionate refusal" when appropriate. Compassionate refusal allows physicians to express compassion for the patient's problem or condition while at the same time communicating that fast-acting opioids may do more harm than good for long-term pain control, and that working with a pain clinic/specialist may be the most appropriate course of action.⁵ Again, document all discussions with patients, including referrals made, in objective terms in the medical record.

CONCLUSION

Despite federally regulated mandates to aggressively treat patient pain, the ED setting presents myriad challenges and barriers to proactive pain management. Notwithstanding these barriers, physicians can better establish control over the pain management process by first appreciating the importance of timely pain relief, and then instituting a pain management approach that includes performing a comprehensive initial assessment and ongoing reassessment, understanding the individual patient's circumstances, administering medication in a prudent manner, ensuring clear and empathetic communication with the patient

and adhering to sound documentation practices. The goal is to treat the ED patient's pain safely and effectively and as a parallel process to diagnosing the underlying condition. The challenge of drug-seeking patients is unlikely to disappear completely, but physicians can feel more empowered in their response to potentially drug-seeking patients by applying thorough history-taking, improved communication about risks and benefits of opioid use (including utilization of a therapeutic agreement or contract, when applicable), enhanced communication with primary care, and appropriate referral to community services and treatment programs.*

* For more information about establishing written therapeutic agreements regarding opioid use, refer to NORCAL's CME course titled *Managing Pain with Opioid Analgesics*. Available at: www.norcalmutual.com/cme.

Notes

- ¹ Institute of Medicine (IOM). The future of emergency care in the United States Health System. Report Brief. June 2006.
- ² Fosnocht DE, Swanson ER, Barton ED. Changing attitudes about pain and pain control in emergency medicine. *Emerg Med Clin N Am* 23(2005)297-306.
- ³ Burt CW, McCraig LF. Trends in hospital emergency department utilization: United States, 1992-1999. *Vital Health Stat* 2001;13(150):1-34.
- ⁴ Johnson SH. The social, professional, and legal framework for the problem of pain management in emergency medicine. *J Law Med Ethics*. 2005 Winter;33(4):741-60.
- ⁵ Hansen GR. The drug-seeking patient in the emergency room. *Emerg Med Clin N Am* 23(2005)349-365.
- ⁶ National Headache Foundation. The emergency room guide to distinguishing the legitimate headache sufferer from the drug seeking-patient. Available at: www.headaches.org/professional/educationresources/erprotocol.html. Accessed: 6/17/05.
- ⁷ California Medical Association (CMA) Legal Counsel. CMA On-Call Document #1110: Confidentiality of sensitive medical information. January 2004. Available at: www.cmanet.org. Accessed: 6/17/05.

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