Medical-Legal Considerations

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Objectives

1. Discuss the importance of good communication and proper documentation when caring for pediatric patients and their families in the emergency department.
2. List common diagnoses that lead to malpractice lawsuits and identify methods to reduce malpractice actions in emergency care.
3. Describe issues of confidentiality and consent related to children in the emergency department.
4. Explain the requirements of the Emergency Medical Treatment and Labor Act with regard to evaluating and transferring patients.
5. Outline the pros and cons of having family members present for emergency procedures.
6. Develop an approach to a family whose child has died in the emergency department.

Chapter Outline

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CASE SCENARIO 1

A 12-year-old boy is hit by a car while bicycling. He is brought to the emergency department (ED) and found to be hypotensive with abdominal distention and a swollen left thigh. The staff begins fluid resuscitation, and blood is ordered for possible transfusion. The child's condition worsens, and perfusion cannot be maintained with saline alone. His parents are told about his serious condition and the need for surgery and blood transfusion. The parents reply that they cannot consent to a blood transfusion because of their religious beliefs.

1. What should you do now?

CASE SCENARIO 2

Paramedics bring in a 4-year-old boy who was rescued from a house fire, along with his uninjured mother. The child is awake and responds to questions but is mildly tachypneic despite receiving supplemental oxygen. Other vital signs are stable. The physical examination reveals scattered first- and second-degree burns to less than 5% of the body surface area but involving regions on the face and lips. Carbon deposits are noted in the oropharynx. Concern for inhalational injury prompts the decision to perform endotracheal intubation. The child's mother asks to stay with her son as the intubation is performed.

1. How should you respond to the mother’s request?
Introduction

Legal issues are especially important in the ED. There are guidelines, rules, and laws that govern the relationships among the pediatrician or emergency physician, the patient, the child’s family, other medical staff, and community agencies. Children have unique and sometimes complicated medical conditions. They might present with problems, such as child abuse or neglect, which pose difficult medical and legal questions. Issues of consent for minors add further legal burdens. The rights of the patient, physician, hospital, and public are intertwined in complex relationships. Physicians and other health care professionals must be aware of these relationships and legal guidelines if they are to safeguard the patient, hospital, community, and themselves.1

They must also be trained to recognize the pediatric diagnoses that pose the highest risk for litigation, such as the febrile child and the child with abdominal pain.2-4 They also should be adequately prepared for court when legal proceedings are forthcoming.

Medical Malpractice and the ED

Providing emergency care to children is a challenging endeavor. Emergency physicians are at particular risk for claims of medical malpractice because patients presenting to the ED often have high acuity illness and delivery of emergency care is complex.5 There are several other reasons that lawsuits seem to originate in the ED. Emergency physicians rarely have an ongoing relationship with their patients. Frequent patient handoffs and communication breakdowns can contribute to errors and malpractice lawsuits.5,7 Overcrowding also makes the ED a legally risky environment.8,9

In addition, lack of supervision of trainees in the ED contributes to medical errors and malpractice lawsuits.7 Furthermore, in the ED, privacy is often limited, and overworked staff might be impatient at times. Sometimes the encounter with the physician can seem impersonal if the overwhelmed physician hurries off to see another patient. Perhaps most importantly, patients can become frustrated when they endure long waiting times before they get to see the emergency physician.10

Most malpractice lawsuits result in out-of-court settlements, or they are dropped altogether. Only approximately 10% reach a jury verdict. Still, these legal actions can be burdensome and emotionally draining.1,12 They are also expensive. Between February 1, 2004, and December 31, 2005, there were more than 30,000 malpractice payments made on behalf of practitioners in the United States, and these totaled $8.8 billion. Of this, $1.7 billion was paid on behalf of children younger than 19 years, for just more than 4,000 claims.11 The average payment for a pediatric case was $422,000 (vs $247,000 for an adult-related case). Understandably, children younger than 1 year of age who had a diagnosis that required care for their entire life were awarded the highest payments.11

A bad outcome might trigger a lawsuit. The bad occurrence might be compounded by poor communication on the part of the physician or unrealistic expectations on the part of the patient or family. Some families sue to seek revenge against physicians with whom they are unhappy. Others sue to obtain resources they will need to care for a handicapped child. Others sue to relieve their own guilt and some to “save another patient from the physician” (Table 23-1). Often the lawsuits are instigated by a relative (perhaps a physician) who implies that the treatment given to a child fell below the standard of care.12 The ED staff members can unintentionally precipitate a malpractice lawsuit. Raising the eyebrows, shaking the head, or making comments such as “I wish you had brought the child here first” might convey to...
Statute of Limitations

If there is a poor outcome, parents (or the patient) might find fault with the care provided many years later. Each state has its own statute of limitations that sets the maximum length of time in which a person can bring a lawsuit for an alleged injury. For most states, the statute of limitations for adult patients is 2 or 3 years from the time an injury that resulted from alleged negligence is discovered or should have been discovered. When this time has passed, a lawsuit can no longer be brought, regardless of its merits. With children, the period is extended because they cannot initiate legal action on their own behalf. In many jurisdictions, the period does not begin for an injured child until he or she has reached the age of majority (18 to 21 years old). Thus, a pediatric patient can bring a lawsuit against a physician for events that took place 20 years earlier.1,5,10

For example, suppose an infant, only a few months old, presents with meningitis that is not promptly diagnosed and results in complications, including delayed development. The family is not obligated to initiate a lawsuit within 2 years of the illness but rather within 2 or 3 years after the injury (delayed development) is discovered. This could be when the child begins school 5 years later. Some states limit this period, but it usually extends 7 to 8 years or more after the injury should have been discovered. If the parents do not file a lawsuit, the patient can still decide to sue when he or she becomes an adult.1,10 In one case, a Kentucky dentist extracted the wrong permanent tooth from his 11-year-old patient in 1998. The girl’s parents elected not to sue the
dentist. However, when the girl reached the age of majority, she successfully sued her dentist for malpractice and was awarded $71,000. It can be difficult to defend such a case years later, when memories have faded and complete records cannot be located.

**High-Risk Cases in Pediatric Emergency Medicine**

Consider the following case: a 15-year-old girl is taken to an ED with symptoms of severe abdominal pain. She is evaluated and discharged to home with medication. She returns 3 days later with persistent symptoms. At the second visit, a perforated appendix and peritonitis are found.

The patient sues the hospital and the physicians who treated her initially. She contends that her condition had worsened and that complications developed because the hospital failed to make the correct diagnosis on the first visit. The hospital claims that the patient was sent home with instructions to see a private physician the same day. She allegedly ignored those instructions, and thus her condition worsened. A jury returns a verdict in favor of the physicians and the hospital.

Consider a second case: a 7-month-old boy is brought to the ED because of lethargy, irritability, decreased appetite, uncontrollable crying, and stiffening of his extremities. The physician who examines the infant diagnoses an upper respiratory tract infection and discharges him with a prescription for amoxicillin. Two days later, the infant is taken to another hospital and is given cough syrup. The next day, the infant develops seizures and is rushed to the first ED. He is found to be in a coma and is transferred to a local children’s hospital 4 hours later. Bacterial meningitis is diagnosed. The infant has brain damage and now has a chronic seizure disorder. It is believed that the infant will not be able to live independently. The family sues the physicians and hospitals that treated the infant initially, claiming that they should have performed a spinal tap when he first presented, before he had the seizure.

The physician at the first hospital claims the infant did not have meningitis at the time of the visit and that a complete examination was performed but negative findings were not noted in the record.

A jury finds in favor of the first physician and hospital that provided treatment. The other physicians and hospital settle with the family for more than $900,000.

Specific diagnoses are particularly troublesome and are often the subject of malpractice lawsuits in acute pediatric care. For example, febrile children and those with abdominal pain pose high-risk situations. Failure to diagnose meningitis and appendicitis are the leading pitfalls for those treating children. This is not surprising because these conditions can result in serious illness or death if not diagnosed and treated promptly. In addition, both of these conditions can have subtle presentations. Many infections progress rapidly, and the diagnosis might not be obvious when the patient first presents to the clinician. Other errors, such as missed fractures, might not result in serious illness but are common triggers for malpractice lawsuits.

In these cases, the public simply expects the physician to make the diagnoses. The public is aware of great advances in medicine. They expect a good outcome when they seek medical care. Anything less “must be someone’s fault.”

Failure to diagnose testicular torsion often results in litigation. This fact underscores the need to carefully examine the genitalia of all boys who experience abdominal pain or scrotal pain. Medication errors often go unrecognized, but if they cause symptoms, a malpractice claim can result. Finally, complications of lacerations, especially those involving the hand and fingers, are often involved in malpractice claims. A careful approach to these conditions is warranted. Juries are generally sympathetic to children and award large sums when a physician is found negligent. Table 23-2 summarizes the pediatric diagnoses commonly involved in ED malpractice actions.

**Documentation**

The importance of careful documentation cannot be overemphasized. Good documentation prevents lawsuits. The patient’s medical record...
is generally the first document reviewed by parents, attorneys, and expert witnesses. Its content and appearance could be the difference between being sued or not in those cases where there is a perception of incorrect treatment. A record that demonstrates a thorough examination and testing can suggest to the plaintiff’s attorney not to proceed further. A record that does not clearly document the performance of an important test or portion of the examination can lead counsel to assume it was not done. The record will often sway the consulting physician who advises an attorney whether the case has merit and should be pursued. Because it is difficult to predict which patient will have a bad outcome and pursue litigation, each medical record should be prepared as if it were to serve as the basis for defense in a lawsuit.1,10,20

Electronic medical records are thought to reduce medical errors and can reduce malpractice lawsuits. A study of office-based physicians showed users of electronic health records were less likely to pay malpractice claims (over 10 years) than nonusers (6.1% vs 10.8%), but the difference was not statistically significant.23 However, there are new risks associated with electronic medical records. For instance, using dropdown lists in a hurry can result in errors.22 Also, quickly clicking through a template without noticing that the language is inappropriate for a particular patient could compromise a physician’s defense in a malpractice suit.24

The history of present illness must be described completely but concisely in the medical record.1,10,20 Any information relevant to the chief symptom should be included. It is especially wise to record details about the child’s diet, level of activity at home, and medications received. The physical examination finding should be described in detail, including vital signs. Abnormal vital signs deserve careful attention.1,10,20 It is particularly important to note the child’s general appearance, state of hydration, and level of activity or playfulness in the

### TABLE 23-2 Common Pediatric Diagnoses Involved in Emergency Department Malpractice Claims

- Appendicitis
- Child abuse
- Dehydration
- Fractures
- Medication errors
- Meningitis
- Meningococcemia
- Myocarditis
- Slipped capital femoral epiphysis
- Testicular torsion
- Wounds and lacerations (foreign bodies and other complications)


### TABLE 23-3 Crucial Elements of Emergency Department Medical Record Documentation

- Address chief symptom.
- Include pertinent positive and negative findings.
- Carefully describe general appearance and state of hydration.
- Record allergies, immunizations, medications, and medical history.
- Record neatly; note should reflect professional approach.
- Include progress or discharge note.
- Document your thought process.
- Avoid derogatory statements.
- Avoid self-serving statements.
- Establish agreement with notes of others (emergency medical technician, nurse).

A second note or progress note is essential if the child remains in the ED for a significant amount of time. Detailing patient improvement is very important; otherwise the medical record reflects only the initial, unstable, or uncomfortable condition of the patient. Procedures must be documented in a detailed note. The medical record must include the diagnostic impression of the physician, and this should be consistent with the treatment rendered.

The medical record should provide meaningful information to another physician if further care is required. The record should display a concerned and professional attitude toward the patient. Only comments that a physician would be comfortable reading in front of a jury should be included. The content and neatness of such a record can greatly affect the way a jury feels about a physician. It should not contain insensitive terms. Avoid derogatory statements or descriptions of the patient’s parents.

The notes of other professionals caring for the child in the emergency setting are also important. Physicians should carefully read the notes of nursing staff, consultants, and out-of-hospital care providers. Emergency medical technicians (EMTs) who transport the child can provide pertinent information, such as the patient’s name, the condition in which he or she was found, vital signs, and a description of services rendered, such as the administration of oxygen or attempts to establish vascular access. This information can be very helpful in caring for the patient. For example, if a child is involved in a motor vehicle crash, a description of how the patient was found can help the physician determine the most likely type of injury and the appropriate diagnostic studies to obtain. An EMT’s description of the crashed vehicle can help determine the magnitude of the injuries sustained. A patient might have related important information to the EMTs, such as drug allergies or medications taken. Copies of the EMT’s medical records should be presented to the ED staff, and important information should be shared verbally and entered into the patient’s hospital record. The physician’s notes should be consistent with those of other professionals who record in the medical record.

Record-keeping is particularly difficult in the ED. Frequent interruptions and extraneous noises are the norm, and physicians understandably make mistakes while record-keeping. Errors should be corrected appropriately. In written or paper records, there should be no attempt to cover up mistakes by blacking out words or phrases because this tends to arouse suspicion. A single line drawn through the error, which is then initialed and dated, is more appropriate at the time of the encounter.

If any portion of the record is later found to be factually incorrect or unclear, any changes in the medical record made after the date of service to correct this should be made as addendums (rather than altering the original entries) and should include the date of the entry into the medical record rather than the date of service.
Good communication among the medical staff, patient, and family is also extremely important in the ED. There is a direct relationship between good communication skills of the physician and fewer malpractice lawsuits. Physicians who generate patient concerns are more likely to be sued. The patient and family must perceive a caring attitude, openness, professional integrity, and standards of excellence. Patients are not always aware of a physician’s competence, but they are keenly aware of his or her manner. In other words, when treating children in the ED, accuracy helps. Professional appearance, honesty, and a kind, compassionate attitude are vital.

Consider a case: a 1-week-old infant was taken to an ED by ambulance. The infant’s mother and uncle, who spoke little English, came to the ED with the infant. The triage nurse took a history from the uncle, who conveyed information using “broken English” and hand signs or gestures. The uncle demonstrated to the nurse that he had tapped on the infant’s chest, but when asked if the child had stopped breathing he stated, “No, no, I don’t know.” The nurse did not request a translator. A first-year pediatric resident later obtained a history and thought that a translator was not required but documented that the history was “limited by language.” The infant was later discharged from the ED. Within hours, she stopped breathing, and she died 4 days later from respiratory syncytial virus bronchiolitis.

The family sued and claimed that because of a language barrier a detailed and accurate history was not obtained. They argued that this resulted in failure to recognize that the infant had experienced a life-threatening event at home and should have been admitted to the hospital. They contended that it was the duty of the hospital’s personnel to determine when an interpreter was needed and that translation services were required if there was any doubt. A judge found in favor of the family and awarded them $400,000.

If a family speaks a foreign language, it is imperative that the hospital obtain a translator to assist with communication. It is not acceptable to merely record history was “limited by language.” The physician is expected to ask for an appropriate translator and the hospital is obligated to provide one.

Good communication is especially important at the time of discharge from the ED. The physician should give written, detailed discharge instructions and go over these carefully with the parent or other caregiver and with the patient if he or she is old enough to understand. Non-specific instructions to “give fluids” or return “as needed” are not helpful. Abbreviations and difficult medical terms should be avoided. The instructions should always include a few examples of worrisome signs to look for at home. Although it is not feasible to list every possible complication, the parents must have a clear notion of when to see their personal pediatrician and what warrants an immediate return to the ED. Patients and parents should be told how and when to obtain test results if these are pending at the time of discharge. The ED staff should be sure the patient comprehends the instructions. In one study, 78% of patients interviewed after leaving the ED had deficient comprehension of their discharge instructions. Asking them to repeat the instructions given can help confirm their understanding. The parent should be asked to sign the record to indicate that he or she has received the discharge instructions. The diagnosis should be written down for other caregivers at home, and the parents should be asked if they have questions before they leave.

It is also important to explain the thought process to a parent at the time of discharge and why follow-up care is crucial, especially if the child’s symptoms change. Unfortunately, one pediatric study showed only 60% of patient guardians complied with discharge instructions to follow-up with a physician after leaving the ED.

It is also essential to acknowledge uncertainty. Patients often think highly of physicians and believe that a clinical evaluation provides absolute certainty that the child’s condition is benign. However, symptoms of serious illness can develop later (eg, appendicitis, meningitis), and parents might be reluctant to return to the ED because they were told that the child’s condition is benign. Acknowledging that the diagnosis is never totally certain permits patients...
or parents (in fact, they should be encouraged) to call the ED or return if the child’s condition worsens or fails to improve as expected. In addition, parents might perceive the physician to be arrogant when they are told emphatically that the child’s condition is benign, and if it turns out to be serious, they might be more likely to sue. Physicians and patients together must be able to accept some degree of uncertainty. If any party is uncomfortable with this, the risk of litigation and dissatisfaction is higher. Direct discussions and communication with the family can improve this situation. Optional diagnostic studies can reduce the level of uncertainty.

**Consultants**

Consider the following case: a teenaged boy is stabbed with an ice pick during an altercation and is brought to an ED. The physician diagnoses a superficial wound and discharges the patient with instructions to return if his condition changes. The patient returns to the ED 3 hours later with vomiting and abdominal pain. At this time, the chief of surgery is called, and the patient is taken to the operating room. An exploratory laparotomy reveals that the patient has a perforated duodenum, which is repaired. However, a second perforation is not noted or repaired and neither is a laceration to the right kidney and renal vein. Four hours after surgery, the patient experiences cardiac arrest and dies due to blood loss from the vascular injury that was not found.

The surgeon is sued for deviating from the standard of care. However, the family also sues the first physician for failing to call the surgeon earlier and for releasing the patient from the ED, which caused a delay in surgical intervention. They argue that the surgery was more difficult because of the delay and that this might have led to the misdiagnosis. The hospital settles with the family for $100,000 before trial. A jury returns a verdict in favor of the physicians.

In a second case, a 14-year-old boy is injured in a motor vehicle crash. He is trapped in a vehicle with his legs under the dash for 30 minutes before he is extricated and brought to an ED. The child has bilateral hip pain and cannot stand or bear weight. An emergency physician evaluates the child, obtains radiographs of the hips, and reads their results as normal. The boy is admitted to the hospital for pain management. The next day, the hospital radiologist reviews the radiographs and diagnoses bilateral posterior hip dislocations. The report is not placed into the child’s medical record for 2 days, and no action is taken. The patient undergoes “therapy” in the hospital, and his pain worsens. Orthopedics is consulted when the radiology report is discovered, and the dislocations are reduced. Additional radiographs taken at this time reveal fractures of the femoral heads.

He subsequently develops bilateral hip necrosis. He requires multiple surgical procedures, and 1 year later, he requires bilateral hip replacements. He is expected to have more hip replacements as he ages. The family sues the hospital, emergency physician, radiologist, and primary care physician who managed the

**Key Points**

**Communication of Physicians With Families in the ED**

- There is a direct relationship between good communication skills of the physician and fewer malpractice lawsuits.
- The physician should give written, detailed discharge instructions and go over these carefully with the parent and the patient (if old enough to understand).
- It is important for the physician to explain his or her thought process to a parent at the time of discharge and why follow-up care is crucial, especially if the child’s symptoms change.
- Parents can perceive the physician to be arrogant when they are told emphatically that the child’s condition is benign, and if it turns out to be serious, they might be more likely to sue.
- Acknowledging that the diagnosis is never totally certain permits patients and parents (in fact, they should be encouraged) to call the ED or return if the child’s condition worsens or fails to improve as expected.
hospital admission. They claim that poor communication among the physicians led to a delay in diagnosis and treatment. The case is settled for $1.6 million.38

No physician works in isolation in the ED. Frequently, there is a need to consult other physicians and specialists while caring for ill and injured children. Emergency physicians should call for help whenever they believe that the care required is beyond their expertise or when it appears that another opinion will be helpful. Pediatricians, emergency physicians, critical care specialists, trauma surgeons, radiologists, and other experts must work together to manage illnesses and injuries appropriately. Usually, these interactions proceed smoothly and consultation leads to improved patient care.1

Consultation in a timely manner is expected.39,40 The more unstable the patient, the more urgent the need for rapid consultation. If there is a true surgical abdomen, for example, it is unwise to delay consultation by waiting for a urinalysis or other study. Likewise, if a child has a clinical picture of testicular torsion, it is appropriate to call for consultation promptly rather than ordering Doppler studies or other tests that might delay definitive care.39 If the consultant does not arrive in a timely manner, other options should be pursued, including calling the consultant’s supervisor, specialty attending physician, or other sources for help.40 It is important to document the time the specialist was called, the time he or she arrived, and, if applicable, the time he or she assumed care of the patient.

If a family insists on consultation (eg, a plastic surgeon to suture a facial laceration), it might be wise to comply whenever the request is reasonable. A request for a second opinion should also be honored if at all possible.31

Often the emergency physician calls a patient’s primary care physician to discuss the need for admission, to obtain special studies, or to get approval for specialty consultation. The opinion of an outside attending physician should be considered advisory only.31 If the physician providing the care believes admission to the hospital is warranted and the consultant disagrees, then the consultant must come to the ED to evaluate the child. Responsibility for the disposition often rests with the emergency physician, but this responsibility would probably be shared if both have evaluated the child.

If simple, limited information is needed from a consultant, it can be appropriate to obtain this by telephone without direct examination by the consultant. In those cases, it should be made clear that the consultant is being asked solely for advice and there is no request for the consultant to see the patient directly.1,39 The essence of the telephone conversation should be recorded in the patient’s medical record. Both the consultant and the emergency physician accept some risk with this type of consultation because miscommunication on the telephone is possible.1

Radiology consultation is common in the ED. The emergency physician should seek radiology consultation if it is available and if there is doubt about the interpretation of a radiograph. In the event of a trial, the emergency physician might be found liable for misreading a child’s radiograph. The emergency physician might not be held to the same standard as a radiologist, but a jury will have to determine the level of expertise that the physician should possess.1 If a radiologist is not available in the ED, the family should be told that the interpretation by the ordering physician is preliminary and that they will be contacted if there is a discordant reading.1 Because this procedure is not always followed perfectly, it might be preferable to recommend that the parent follow up through the primary care physician’s office. A preprinted instruction sheet could provide a standardized set of instructions that describes how parents can do this.

Good communication with consultants is essential (Figure 23.1). Understandably, there are sporadic disagreements about patient treatment. Consultants are not always correct, and their actions, or inaction, can sometimes result in harm to the pediatric patient. The emergency physician can be sued with a specialist when a patient is harmed by the improper actions of another physician, as illustrated in the case.42

Emergency physicians are not legally bound to accept the advice of consultants. Blind acceptance of a consultant’s advice can leave the emergency physician liable if an issue occurs.41 However, it is not advisable to reject the advice.
Medical-Legal Considerations

of a specialist without careful consideration of the consequences. If there are questions about care, it is best to discuss the case personally with the consultant. If recommendations are not followed, the emergency physician should document why suggested studies were not obtained.1,40 Disputes about care should not be discussed in front of the patient or family. Instead, it is best to try to resolve these amicably, away from the patient, before discharge.1 Table 23-4 reviews the physician-consultant relationship in the ED.

**Issues of Consent**

Consider the following case: an 11-month-old girl is brought to an ED by her aunt because of difficulty breathing. Her mother is at work. The family claims that an ED clerk told the aunt that the infant could not be treated without the mother’s consent. The hospital denies this and says another patient or visitor in the waiting area misled the aunt. The woman leaves the ED with the child and goes to find the mother. The three return to the ED, but the infant is then in cardiac arrest and dies soon after.1 Federal law (Emergency Medical Treatment and Labor Act [EMTALA]) requires a medical screening examination for all patients presenting to the ED regardless of consent or who brings the child in.

When a child is not in the care of the parents, consent and determination of guardianship should not delay the medical screening examination. Most states have laws that permit treatment of minors (children younger than 18 years) for an emergency and for other selected cases. Treatment without parental consent is required to prevent death or serious injury. The greater the risk of medical malpractice litigation.

**TABLE 23-4 Emergency Physician-Consultant Relationship**

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<tr>
<th>Emergency Physician’s Role</th>
<th>Consultant’s Role</th>
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<tr>
<td>• Request consultation when appropriate.</td>
<td>• Provide timely consultation.</td>
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<tr>
<td>• Consult in a timely manner.</td>
<td>• Document time of arrival.</td>
</tr>
<tr>
<td>• Document time of call.</td>
<td>• Address specific questions.</td>
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<tr>
<td>• Consult a competent physician.</td>
<td>• Communicate well with emergency physician.</td>
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<tr>
<td>• Communicate important information succinctly.</td>
<td>• Document findings.</td>
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<tr>
<td>• Request specific advice or ask management questions of the consultant.</td>
<td>• Attempt to resolve disagreements.</td>
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<td>• Attempt to resolve disagreements.</td>
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of serious harm to a child, the more justified it is to act without delay in the absence of the legal guardian. The hospital staff should attempt to locate the legal guardian and obtain consent for treatment, but treatment should not be delayed so as to risk the child’s life or health. If a physician is not sure if a patient’s medical condition justifies immediate yet unconsented treatment, it is best to err on the side of treatment rather than to withhold care. A good general principle to follow is to act as a reasonable person would expect a reasonable physician to do.

Adolescents who present for care pose additional dilemmas. Courts in almost all states have agreed that there are some situations in which a minor can be treated in the ED without parental consent or knowledge. Most states recognize an emancipated minor as one who has been married, has been pregnant, graduated high school, served in the armed forces, or is otherwise independent of parental care or control (Table 23-5). State laws vary; clinicians are advised to become familiar with local statutes. Most states permit adolescents to seek medical care for reproductive health (including sexually transmitted disease), substance abuse, and human immunodeficiency virus without parental consent.

Furthermore, several states allow “mature minors” to give consent for treatment. The mature minor doctrine allows minors older than 14 or 15 years to consent for care if they are “sufficiently mature to understand the nature of the procedure and its consequences.” The treatment must not involve serious risks. For example, in some jurisdictions, a 15-year-old boy who is assessed to be mature enough to understand can give his own consent to have a finger laceration sutured. The physician must determine that the minor is competent to understand and give consent.

Physicians should be aware of problems in treating adolescents who present for care without their parent (Figure 23.2). Their medical histories might be incomplete, and knowledge of important facts, such as immunizations or allergies, can be lacking. Also, their ability to understand directions might be limited, and compliance with treatment can be poor. Consequently, medical care can be compromised, and the physician faces additional liability risks. The right of confidentiality is extended to a minor who consents to his or her own care. If a minor adolescent is treated in the ED without parents (under a state’s mature minor statute) and insists on privacy, this must be respected unless it is believed that failure to inform the parents will harm the patient.

It is wise to discuss confidentiality as it applies to billing issues with the adolescent patient in the ED. Most hospitals send the bill to the legal guardian (a confidentiality breach), and the parents would then be likely to ask questions about the visit. In general, parents are not responsible for contracts made by their children, so the adolescent who consented for his or her own care is legally responsible for the bill. Ideally, hospital billing and medical record-keeping should be performed in a manner that protects the adolescent’s right to privacy. Unfortunately, this is not always easy to do.
Informed Consent

Parents, legal guardians, or emancipated minors have the right to know and make an informed decision about the care to be delivered. They must give informed consent for treatment and significant procedures unless an emergency exists such that there is no time to involve the patient or guardian. To make an informed decision, the patient or parent must be autonomous, that is, free of coercion or manipulation by the physician, family, or other forces. Next, the patient or parent must be capable of making the decision. The physician must determine that medications or disease have not impaired his or her ability to decide. Third, there must be adequate disclosure. Physicians are obligated to reveal the significant risks of treatment and of withholding treatment. It is expected that the physician will tell parents whatever information a reasonable person would need to make an informed decision. Alternatives must be disclosed. Many patients and parents want to know the physician’s opinion and will follow his or her recommendations if the physician seems trustworthy. Finally, the patient or parent must comprehend the information. It is wise to ask the patient or parent to repeat the information given in his or her own words.44 Table 23-6 summarizes the important features of informed consent to be reviewed with patients or parents.

KEY POINTS

Consent for Emergency Care of Children

- Treatment without parental consent is permissible when it is needed immediately to prevent death or serious injury.
- Treatment in the ED should not be delayed to obtain consent if doing so would pose a risk to the child’s life or health.
- Although in some situations adolescents can consent for treatment without their parents’ knowledge, adolescents might not be fully aware of their previous medical histories and adherence to treatment can be poor.

THE BOTTOM LINE

- Consent and confidentiality laws vary between states.
- Consent and confidentiality issues are complex and can conflict with each other.
- Required immediate medical care should be provided even if a parent or guardian is unavailable for consent.
- Adolescents (mature, emancipated, and others) present special complex consent and confidentiality issues.
Refusal of Care

In general, parents have the right to make decisions about their child’s care, and it is presumed they will act in their child’s best interests. Some patients or parents refuse treatment or leave the ED against medical advice. This usually occurs when the patient or parent is angry, is afraid, feels guilty, is disoriented, or has certain religious beliefs. In some situations, a hostile patient or parent is actually invited or encouraged to leave by an angry or frustrated staff member. When a patient or family leaves the ED without evaluation and treatment, everyone involved is affected. The child, of course, might have persistent or worsening symptoms from a medical problem that has not been addressed. Likewise, the staff usually feels a sense of failure and frustration when their advice and recommendations are not heeded. Worse yet, the hospital and physicians can be exposed to a lawsuit if the patient experiences serious illness or dies after leaving against medical advice, even voluntarily.1

The physician should try to understand why the patient or family wants to leave. If the patient or parent seems angry, allow him or her to express concerns without interruption.43 If a staff member made the family angry, that individual should apologize or avoid contact with the patient. It is never a good idea to challenge a patient to sign out against medical advice, and they should not be threatened with a call to the security officers. Further agitation will accomplish little. Security should be called only if needed to maintain order. Instead, the staff should remain courteous and flexible in the treatment plan. If the situation reaches an impasse, offer the parents an opportunity to speak to another physician. Involving the primary care physician can often be helpful in such situations. If all attempts to convince the family to stay for treatment are unsuccessful and the family leaves the ED against medical advice, the encounter must be carefully documented and should conclude with an offer for the family to return any time should any of the family members change their mind (Table 23-7).1,43

TABLE 23-7 Required Documentation When Patients Leave Against Medical Advice

- History, examination—any parts completed
- Clinical impression
- Treatment risks, benefits explained
- Alternative treatments explained
- Reasons family wanted to leave
- Offer of help to transfer the child
- Invitation to return to emergency department later
- Signatures of parents (if possible), physicians, witness


In some cases, the patient might not be permitted to leave under any circumstances. A disoriented or impaired teenager or parent should...
not be permitted to leave the ED. A patient or parent who cannot understand the risks and benefits of treatment or the risks of leaving the ED should not be permitted to make a decision to refuse care. Likewise, any medical problem that presents a life-threatening problem for the child justifies immediate medical care. Most courts in the United States will not allow a parent to impose his or her religious beliefs on a minor, especially in a life-threatening situation. If a blood transfusion is considered essential for treatment, it should be given. A court order will be necessary and should be sought simultaneously with the initiation of treatment. In most cases of leaving against medical advice or refusal of care, it is best to win the cooperation of the parents, but if they refuse, the staff is justified in treating the child. They should report the case as medical neglect and attempt to obtain a court order while emergency care is delivered. If it is unclear whether a life-threatening situation is present, the staff should err on the side of treatment. Similarly, in the case of suspected child abuse, when the perpetrator is unknown, the child should not be released despite the parents’ wishes or protests.

Transfer of Care

Interfacility transfer of patients involves a number of medical and legal considerations. The ability to transfer patients represents a vital component of the health care system. Transfer of patients can occur to provide care not available at the sending facility (both emergent and non-emergent) or as a result of the patient’s or primary care physician’s request. Discussion of the medical responsibilities involved in transferring patients should be coupled with a discussion of the federal statute governing this process.

Emergency Medical Treatment and Labor Act (EMTALA) was originally designed to prevent the so-called dumping of uninsured patients from private to public EDs; however, its scope has broadened considerably. EMTALA applies to all US hospitals that receive Medicare funds. Failure to comply with EMTALA can result in fines to the physician that are not covered by malpractice insurance, and the hospital can be terminated from the Medicare program. Despite this, many physicians are unaware of their obligations under EMTALA. EMTALA imposes essential duties on hospitals. A medical screening examination is required for all individuals who present for evaluation of a medical condition to determine whether an emergency medical condition exists. Triage assessment is not considered a medical screening examination. An emergency medical condition is defined as a condition of “acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to the pregnant woman, the health of the woman or her fetus) in serious jeopardy, serious impair-

\[CASE\ SCENARIO\]

A 3-year-old child presents to a small, rural ED with a 24-hour history of abdominal pain. The patient also has fever and vomiting but is clinically stable. The child has a medical history of developmental delay, cerebral palsy, and epilepsy. The ED physician establishes a diagnosis of appendicitis and consults a general surgeon. The surgeon agrees with the diagnosis of appendicitis but recommends transfer to a tertiary care center given the patient’s complex medical issues. Citing a lack of bed availability within the hospital, the physician at the tertiary care center refuses to accept the patient. The emergency physician disregards the refusal and sends the patient by ambulance to the tertiary care center.

1. Should the patient have been transferred under these circumstances?
2. Is such a refusal justified?
Emergency physicians are also routinely faced with issues regarding transfer of care within their own institutions. Transfer of care can occur within the ED itself or to inpatient care units. With a transfer of any nature, there is a potential for lapses in patient care and legal ramifications. Special attention should be awarded to these issues despite the fact that they might represent routine and seemingly benign events in ED care.

The patients in the ED are the primary responsibility of the ED attending physician. This can only change when medical orders are written that identify another physician willing to oversee the care of the patient. However, there can be cases in which the patient’s primary physician and the emergency physician disagree with the disposition of the patient. The emergency physician is ultimately responsible for arranging the appropriate level of care for admitted patients.\(^1\) In accepting a lower level of care, the emergency physician implies that the patient’s condition is such that more intensive or specialized care is not indicated. Other potential conflicts can arise with the decision to admit or discharge a patient. This is particularly troublesome if the discussion occurs over the telephone. Again, while in the ED, the patient is the responsibility of the emergency physician. If the conflict cannot be resolved, the primary physician must come to the ED and assume responsibility for the care of the patient. However, this approach might not completely absolve the emergency physician and the hospital if the patient deteriorates after discharge. All parties might ultimately share responsibility to varying degrees in the event of a poor outcome. A more cooperative attitude will reduce legal exposure and might ultimately benefit the patient.

Change of shift is accepted as a high-risk situation for patients. Sentinel events involving treatment delays are usually associated with communication errors and often are associated with change of shift.\(^{51-53}\) Complicating matters is that there is little supporting research to develop evidence-based guidelines to guide change of shift practices.\(^{54}\) Patients are often transferred to the incoming emergency physician with a diagnosis and plan of care. As a result, there is...
the tendency not to reevaluate these patients. Physicians should be aware of the potential for medical errors associated with change of shift. A formal transfer of care with supporting documentation and complete reassessment by the incoming physician will improve patient care during this high-risk situation.22,51 The physician of record is the physician who discharges the patient, but all involved in the child’s care will likely be held accountable in the event of a poor outcome.

**THE BOTTOM LINE**

- All patients who present to the ED requesting evaluation of a medical condition must receive a medical screening examination.
- Transferring (sending and accepting) patients must be performed according to clinical necessity and EMTALA regulations.

**Family Presence**

The concept of family member presence during invasive medical procedures continues to develop. Early literature identified parental preference for presence during routine procedures, such as venipuncture. Focus then expanded to include parental presence during more invasive procedures and even medical resuscitations. More recently, some institutions have adopted family presence during trauma resuscitations.55 These changes stimulated significant discussions regarding potential benefits and problems associated with family presence. Support for the concept has expanded beyond the individual institution levels and now includes organizations such as the American Academy of Pediatrics, Emergency Nurses Association, and Emergency Medical Services for Children.56–58

Most parents want to remain with their children during medical procedures.59–62 The reasons for this preference vary and are unique to each individual. However, most parents believe that their presence reduces their own anxiety and allows them to comfort their children. In most cases, parents believe that their presence will assist the individuals performing the procedures. As procedures become more invasive, parental desire to be present decreases. Despite this “hierarchy of invasiveness,” most parents want to be present during invasive procedures, such as lumbar puncture and endotracheal intubation.63 Most families believe that the physician should not make the decision regarding their presence.

Medical personnel have traditionally displayed reluctance toward family member presence. The reasons against parental presence include increased patient and parent anxiety, lack of parental understanding of the procedure, anticipated parental interference, and increased nervousness of the medical staff member performing the procedure. Although a decrease in pain has not been demonstrated in cases of parental presence, similarly no differences have been noted in the number of attempts or time to complete the procedure.62 Medical personnel experienced with family presence for procedures are known to be more supportive of this concept.

The issue of family presence during resuscitation deserves special consideration because it often generates the most intense emotions and is the setting in which the request for parental presence is most likely to be denied. Data suggest that a large proportion of parents want to be present during resuscitations,61,63 and this number might increase if the child is likely to die during the resuscitation.63 The family’s presence might help in the acceptance of the child’s death. The presence of family members during resuscitations prompts consideration toward medical-legal issues, self-confidence of the medical personnel in their abilities, effects on education, and concern regarding the emotional effects of witnessing the death of a child. As with other procedures, the experience of medical personnel with family presence during resuscitation correlates with their support for the process.64 The effect of family presence with respect to medical-legal issues has yet to be described. Many institutions have policies to facilitate family presence. These policies vary but include the identification of appropriate personnel to stay alongside the family and serve as a liaison. Other policies are
related to the safety of family members, such as requesting that family members remain seated during their child’s procedures. Structured programs for family presence at trauma resuscitations are associated with few complications and do not delay care.55,65

Family presence might not be appropriate in all circumstances. In some cases, the family members are too emotionally distraught to remain with their child or might interfere with the procedure. Others have different reasons for not remaining with their child.

Although there is considerable variation with regard to acceptance and appropriateness of family presence among medical personnel, family members show a strong preference for this model. Medical personnel should be mindful of these preferences with even critically ill patients. Table 23-9 summarizes the pros and cons of having family members present for procedures and resuscitation.

### Table 23-9 Family Presence During Invasive Procedures and Resuscitations

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Most families prefer to be present</td>
<td>• Can increase patient anxiety</td>
</tr>
<tr>
<td>• Can reduce parent anxiety</td>
<td>• Can increase parent anxiety</td>
</tr>
<tr>
<td>• Allows parents the opportunity to</td>
<td>• Potential for parental interference</td>
</tr>
<tr>
<td>comfort the child</td>
<td>with the procedure</td>
</tr>
<tr>
<td>• Can assist individual performing the</td>
<td>• Can increase nervousness of individual</td>
</tr>
<tr>
<td>procedure</td>
<td>performing the procedure</td>
</tr>
<tr>
<td>• Can help in acceptance of a child’s</td>
<td>• Can limit teaching opportunities</td>
</tr>
<tr>
<td>death</td>
<td>• Emotional effects of witnessing a child’s</td>
</tr>
<tr>
<td></td>
<td>death</td>
</tr>
<tr>
<td></td>
<td>• Medical-legal concerns</td>
</tr>
</tbody>
</table>

### Key Points

#### Presence of Family During the Delivery of Care in the ED
- Family members often prefer to be present during procedures on their children.
- The family’s presence can help in the acceptance of the child’s death.

### The Bottom Line
- If reasonable, permit parents to be present during procedures if they want to be.

---

A 3-month-old infant is brought to the ED with no pulse and no respirations. The mother had fed the infant at 6:00 pm and put her back in her crib. She found the infant lifeless at 9:00 pm and called emergency medical services (EMS). The mother attempted cardiopulmonary resuscitation (CPR) before the paramedics arrived, and the paramedics intubated the infant’s trachea and continued resuscitation en route to the hospital. In the ED, the infant is noted to have an asystolic rhythm. The temperature is 36°C (96.8°F). Pupils are fixed and dilated.

The ED staff confirm correct placement of the endotracheal tube, place an intraosseous needle, and give the infant epinephrine (adrenaline), three doses during 15 minutes. The infant has no spontaneous respirations and remains asystolic.

1. Does the literature support termination of CPR in this case?
2. In what clinical situations can prolonged resuscitation be justified?
Death and Dying

Termination of CPR

All patients in cardiac arrest in the ED should undergo CPR unless the patient has signs of irreversible death, such as rigor mortis, dependent lividity, or decapitation. Also, CPR should not be initiated if an attempt to resuscitate would put the rescuer at risk (this is unlikely in the ED setting but can apply to out-of-hospital care providers).66–68 Finally, CPR can be withheld if there is a valid do not resuscitate (DNR) order or other advance directive. An advance directive is an expression of a person’s thoughts or wishes for end-of-life care. The Patient Self-determination Act of 1990, revised in 1991, requires hospitals to inform adults of their right to prescribe limits on CPR and lifesaving treatment.69 Under some circumstances, minors can also express the wish to have life support withheld. This is controversial in children, and laws vary from state to state. Only a few states allow out-of-hospital care providers to apply advance directives to children.70

Advance directives are always difficult for emergency physicians. They generally do not know the patient or his or her personal wishes about resuscitation. Family members often change their minds when a child approaches death and call EMS because they are ambivalent. Some regions use a bracelet to identify patients who do not want CPR. Several recent court cases have authorized physicians to recognize decisions made by older adolescents regarding the right to withhold resuscitation attempts. Legal uncertainty exists, but if a patient has a living will, it should serve as evidence of the patient’s wishes.71 In the ED, DNR orders should be considered one element of the treatment plan and should not limit other forms of treatment, such as admission to an intensive care unit.66

In the absence of these findings, and even when the prognosis is dismal, it is still prudent to initiate resuscitation efforts immediately until a more thorough assessment can be made. Cardiopulmonary resuscitation can be discontinued if no benefit can be expected because the patient’s vital function has deteriorated despite maximal therapy for a specific condition, such as shock. Prolonged resuscitation for children with pulseless arrests is not likely to be successful.70 In general, resuscitative efforts can be discontinued if a child has not responded with spontaneous circulation after 20 to 30 minutes.67,72 It has been noted that failure to respond to two doses of epinephrine (adrenaline) greatly decreases the chance of survival for a child. After such attempts and in the absence of ventricular fibrillation, ventricular tachycardia, toxic drug exposure, and primary prearrest hypothermia, resuscitation can be discontinued if there is no return of spontaneous circulation. However, there are cases of intact survival after prolonged in-hospital resuscitation.73,74 Hospitals should develop policies on brain death and how this pertains to resuscitated patients in the ED.66 Nonreactive pupils have little predictive value in the outcome of a case and might not be a criterion in itself to halt resuscitation. In one study of pediatric resuscitation, 33% of children with nonreactive pupils survived.75

KEY POINTS

Termination of CPR

• All patients in cardiac arrest in the ED should receive CPR unless the patient has signs of irreversible death.
• CPR should not be initiated if an attempt to resuscitate would put the rescuer at risk.
• CPR can be withheld if there is a valid DNR order or advance directive.
• Honor parental decisions to withhold CPR or other life-sustaining treatment if this seems to be in the best interest of the child or if the treatment is futile.
• In cases of cardiopulmonary arrest in children, discontinue CPR if there is no return of spontaneous circulation after advanced life support maneuvers, including airway management and the delivery of two doses of epinephrine (adrenaline), and in the absence of ventricular fibrillation, ventricular tachycardia, toxic drug exposure, and primary prearrest hypothermia.
If at all possible, the physician should talk with the parents about withholding CPR or avoiding further treatment that might be futile.\textsuperscript{66} Parents, if present at the time of resuscitation, have the right to select among medically appropriate options. Parental decisions to withhold CPR or other life-sustaining treatment can be honored if this seems to be in the best interest of the child or if the treatment is futile. In some circumstances, adolescents are granted the authority to decide to withhold resuscitation efforts. Hospital policies should guide practitioners in the ED.\textsuperscript{66} When there is doubt about the authority or reasonableness of a guardian’s request to withhold CPR, resuscitation should continue until the conflict can be resolved.

**Approach to the Deceased Child and Family**

The death of a pediatric patient in the ED places an enormous strain on the medical staff and obviously the child’s family (\textit{Figure 23.3}). Most deaths in the ED are unexpected, and the patients were well children only minutes before a tragic incident. Dealing with such situations takes great skill, compassion, and poise. Knowledge of policies, procedures, and local laws is essential. The American College of Emergency Physicians and the American Academy of Pediatrics Committee on Pediatric Emergency Medicine created a joint policy statement, “Death of a Child in the Emergency Department.”\textsuperscript{76,77} This statement outlines the issues to consider when dealing with a death of a child in the ED. In 2005, the American Academy of Pediatrics issued a Technical Report to support those policy recommendations.\textsuperscript{78} Clinicians must support family members, including the siblings of the deceased child. They must minimize any misunderstandings and inform the family about the cause of death, whether the death was preventable, whether the child experienced any pain, and perhaps whether the child’s condition is contagious to others. They must guide them about practical issues, such as funeral arrangements. Answers should be provided with truth and compassion.\textsuperscript{76–78}

Protocols and written policies for the investigation of a pediatric death in the ED, with accompanying checklists, are important to aid the staff. This will help ensure a thorough examination and notification of proper authorities. It will also contribute to the understanding of sudden infant death syndrome, child abuse and neglect, undiagnosed genetic diseases, and cases of inadequate health care.\textsuperscript{76,77} Accurate documentation of the history and physical examination and resuscitation efforts is essential. Investigation at the time of death or at postmortem might include a skeletal survey, drug screen, cultures, photographs of injuries, and forensic evaluation for sexual assault. The ED staff is often responsible for notification of others, such as the medical examiner, primary care physician, additional family members, and perhaps a religious leader. The primary care physician can have an important role in supporting the family and reviewing autopsy reports in the future. Child protective services or the police should be notified as appropriate.\textsuperscript{76–78}

The hospital should provide a team of physicians, social workers, nursing personnel, and clergy or chaplain who can respond...
immediately to a sudden death in the ED. They are especially important in the ED if there is a language barrier and they are needed to provide initial and long-term support and assistance.78 Someone experienced in supportive care should remain with the family for as long as they remain in the ED, even if the nursing and medical staff must depart to take care of other patients.78 Grief counselors and support groups are available in some communities.

Delivering bad news to a family, especially informing them of the death of their child, is an extremely difficult task. Generally, ED staff members have no previous relationship with the family and now must give news to them that they will remember forever. The responsible physician should find a private area to meet with the family and review the events and outcome.79 A designated room in the ED is most helpful. The room should have comfortable seating and only basic accompaniments, such as tissues, a telephone, and perhaps water.

The physician who is delegated to deliver news of the child’s death should sit at eye level with the family members. He or she should be sympathetic and say he or she is very sorry. An empathetic staff member will be remembered long after the child’s death. It is important to use the child’s name and not refer to the deceased as a “patient” or even “your child.”80 Use clear words such as “died” or “dead,” so there is no misunderstanding of the child’s condition. Avoid terms such as “passed on” or “expired.” Speak clearly in a soft, sympathetic voice. Allow the family members to absorb the initial information before proceeding with additional details. Listen and do not falsely reassure them. While saying you are sorry, avoid trite expressions such as “I know how you feel.” There is no way to know how the family feels. Do not offer hope with expressions such as “You are young and can have other children.” Such comments would be inappropriate because the child is not replaceable. Allow the parents time to react or even to sit in silence. Offer help in informing siblings or other family members. Offer information about the next steps, such as contacting a funeral home and the medical examiner. Explain that autopsy is mandatory (usually). Explain in simple terms what this involves and that it will not interfere with funeral plans. Try to reduce the family's feelings of guilt if appropriate.81

The ED staff should be prepared for a variety of reactions to the news of a child’s death. Some will deny the news, others will be distraught. Some will be violent or angry with themselves, family members, or the medical staff. Family members should be offered the opportunity to see or sit privately with the deceased child and hold the child, regardless of whether they were present in the ED for the resuscitation. Some families have religious or cultural norms that alter their behavior at the time of death. Discuss the merits of seeing their child in a nonjudgmental way.81 This is a chance to confirm the reality of death, say good-bye, and begin separation.81,82 Prepare them for the child’s appearance beforehand. Many parents would like a memento, such as a lock of hair, a handprint, or a footprint, and staff should consider offering such to families.79 Make certain the family has transportation and support at home before they leave.83 Table 23-10 highlights the important features of the approach to the family after the death of a child in the ED.

The medical staff is generally emotionally and physically drained after the death of a child in the ED. Ideally, the staff should be allowed

**TABLE 23-10 Discussion of Death With Family in the Emergency Department**

- Find a private area to deliver news and discuss events.
- Sit with the family at eye level.
- Use a calm, sympathetic voice.
- Show genuine concern; say you are sorry.
- Use clear terms ("died" or "dead").
- Offer explanation—possible cause of death.
- Be a good listener; do not hurry off.
- Relieve guilt if appropriate.
- Avoid giving false hope; avoid reassurance about their future.
- Offer help in contacting others and speaking to siblings.
- Offer opportunity to see or hold the deceased child.
a brief time to recover from such a traumatic event. Even taking a short walk or a moment outside the ED can be helpful. Unfortunately, the pace of the ED does not often allow an immediate recovery time. Critical incident debriefing often helps the medical staff cope with sudden death of a child in the ED. This is best done within 24 hours of the child’s death. At such sessions, the medical care can be reviewed and feelings can be shared with professionals who can offer guidance. Studies have shown that emergency physicians often feel guilty or inadequate after an unsuccessful pediatric resuscitation, and a significant number admit to feeling impaired during the remainder of their shifts. Many members of the staff have a need to know that they acted properly and what they could do differently in the future. Table 23-11 summarizes the responsibilities of the physician after a pediatric death in the ED.

<table>
<thead>
<tr>
<th>Table 23-11 Physician Responsibilities After Death in the Emergency Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complete physical examination of child.</td>
</tr>
<tr>
<td>• Document carefully.</td>
</tr>
<tr>
<td>• Consider forensic investigation (not extensive) for cause of death.</td>
</tr>
<tr>
<td>• Notify local organ procurement organization.</td>
</tr>
<tr>
<td>• Assemble support team for family.</td>
</tr>
<tr>
<td>• Contact medical examiner, police, and child protective services if indicated.</td>
</tr>
<tr>
<td>• Contact primary care physician.</td>
</tr>
<tr>
<td>• Complete death certificate.</td>
</tr>
<tr>
<td>• Help console and inform other staff members.</td>
</tr>
<tr>
<td>• Arrange critical incident debriefing.</td>
</tr>
<tr>
<td>• Take time for self.</td>
</tr>
</tbody>
</table>

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The office of the medical examiner should be notified soon after a child’s death. Organ procurement in pediatric patients is often coupled with medical and forensic investigations related to the cause of death. In some cases, the medical examiner will advise against organ donation. However, in many cases, through cooperation of personnel in multiple disciplines, organ donation can still be achieved while preserving important medical and forensic evidence. This cooperation can substantially affect the supply of pediatric organs. For many families, organ donation is very important. Despite their tragic loss, a family might derive significant comfort from the knowledge that their child’s organs are being used to benefit others.

The Medical Examiner

The medical examiner or coroner should be notified of all deaths in the ED. Many states require the medical examiner to investigate all deaths that occur as a result of violence, sudden deaths when the patient is in apparent good health (such as sudden infant death syndrome), a suspicious, unusual, or unnatural manner of death, deaths that occur when the individual is not under the care of a physician for a potentially fatal illness, or any death otherwise unexplained. A death certificate must be filled out accurately in the ED. This serves to identify high-risk populations and
geographic trends. Funding for research and illness or injury prevention is often allocated based on death certificates.87

KEY POINTS

• A child’s death in the ED results in substantial social stress and is associated with legal requirements and additional legal risk.

THE BOTTOM LINE

• Establish policies for the death of a child in the ED.
• Present news of a child’s death to parents professionally and clearly in a quiet environment.
• Physicians must be aware of and comply with legal requirements, such as notification of organ procurement services and the medical examiner.
Check Your Knowledge

1. In many states the following are characteristics of an emancipated minor, EXCEPT:
   A. college graduation.
   B. high school graduation.
   C. married.
   D. military service.
   E. pregnancy

2. When parents are present during procedures and resuscitations, which of the following is correct?
   A. Children cry more when parents are present because they do not understand why the parents are not helping them.
   B. Most parents are at risk of fainting during the procedure.
   C. Most parents prefer to be present.
   D. Most parents provide technical assistance during the procedure.
   E. Studies have demonstrated that procedure success rates are lower when parents are present.

3. Do not resuscitate (DNR) orders are difficult to carry out in emergency departments (EDs) for all of the following reasons EXCEPT:
   A. parents frequently change their minds as deterioration approaches.
   B. parents have called 911 in a panic and resuscitation efforts have already begun.
   C. parents have not previously established a relationship with the emergency physician, who does not know about the child’s chronic condition.
   D. primary care physician for the child cannot be reached immediately.
   E. there is no written DNR order, but the parents communicate “do not resuscitate” orally.

4. Which of the following situations is most likely to result in a successful malpractice lawsuit against a physician?
   A. A child is seen for abdominal pain in the office by a primary care physician, who diagnoses gastroenteritis. Later that night the child is brought to an ED and diagnosed as having acute appendicitis. The emergency physician comments that this is a very obvious case of appendicitis. After appendectomy, the child is discharged and recovers well.
   B. A child is seen for worsening abdominal pain of 6 hours’ duration. The emergency physician suspects appendicitis. Abdominal computed tomography is ordered, the results of which are determined to be normal. Still, a surgeon is consulted and the patient is hospitalized for observation. The following morning, his pain worsens and the surgeon decides to perform a laparotomy, at which time a perforated appendix is found. He develops peritonitis, requiring a prolonged hospitalization. He sustains multiple future episodes of bowel obstruction due to bowel adhesions, requiring seven hospitalizations and three laparotomies for lysis of bowel adhesions.
   C. An obese boy presents to his primary care physician with limping associated with thigh and knee pain. Radiographs of his knee are ordered, and the results are normal. A erythrocyte sedimentation rate and C-reactive protein level, measured to determine osteomyelitis, are normal. He is given a diagnosis of a knee strain and instructed to rest his knee. One week later, his pain worsens after walking down the stairs. He presents to the
ED, where radiographs of his hip demonstrate a severely slipped femoral capital epiphysis. An orthopedic surgeon is consulted, and the boy is hospitalized for bedrest, traction, and surgical pinning. He develops avascular necrosis of the femoral head and a prolonged disability.

D. The parents of a child with a forearm fracture have a long wait time to see a physician then are treated rudely by that physician. The fracture heals well with no permanent disability.

References


Chapter Review

23-27

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23-28

Medical-Legal Considerations

CHAPTER REVIEW

A 12-year-old boy is hit by a car while bicycling. He is brought to the ED and found to be hypotensive with abdominal distention and a swollen left thigh. The staff begins fluid resuscitation, and blood is ordered for possible transfusion. The child’s condition worsens, and perfusion cannot be maintained with saline alone. His parents are told about his serious condition and the need for surgery and blood transfusion. The parents reply that they cannot consent to a blood transfusion because of their religious beliefs.

1. **What should you do now?**

   In this case, you should do what is necessary to save the child’s life. If a blood transfusion is considered essential for treatment, it should be given. Most courts in the United States will not allow a parent to impose his or her religious beliefs on a minor, especially in a life-threatening situation. A court order will be necessary and should be sought simultaneously as treatment is begun.

Paramedics bring in a 4-year-old boy who was rescued from a house fire, along with his uninjured mother. The child is awake and responds to questions but is mildly tachypneic despite receiving supplemental oxygen. Other vital signs are stable. The physical examination reveals scattered first- and second-degree burns to less than 5% of the body surface area but involving regions on the face and lips. Carbon deposits are noted in the oropharynx. Concern for inhalational injury prompts the decision to perform endotracheal intubation. The child’s mother asks to stay with her son as the intubation is performed.

1. **How should you respond to the mother’s request?**

   This represents an urgent but not emergent clinical situation. The physician should discuss the decision to perform endotracheal intubation and provide the mother with a description of the procedure. Most parents want to remain with their children even during invasive procedures. After receiving the information about her child’s care, the mother’s request to stay with her child should be granted unless there are strong indications that she would interfere with the procedure.
A 4-year-old girl is brought to the ED with a history of choking on a peanut. Her medical history is unremarkable. On examination, she is in mild respiratory distress. Her respiratory rate is 44/min. She has slight retractions with decreased breath sounds on the right. A chest radiograph is consistent with foreign body aspiration. There is difficulty inserting an intravenous catheter, and the mother has "words" with the nursing staff. When bronchoscopy is suggested, the mother is visibly upset and shouts harshly at the house officer. The mother wants to sign out against medical advice.

1. How could this situation have been avoided?
2. What steps can be taken now to ensure that the child receives the best care possible?

In this case, the parents have the right to seek a second opinion for their child. However, this situation can be avoided if staff members are counseled on the importance of maintaining a professional attitude at all times. It can be difficult to deal with an irate family, but if the goal is to provide the best care for the child, then maintaining a calm and professional demeanor will help diffuse situations such as the situation that occurred in this case. The physician must also determine whether it is safe for the child to leave the ED if parents wish to sign out against medical advice. If the child is only in mild distress, the physician might allow the parent and patient to leave, only after attempts to keep the child in the ED have failed. Ensure proper documentation of the scenario, as described above. It would be wise to offer assistance to the family and help transport the child to another hospital in such situations.
A 3-year-old child presents to a small, rural ED with a 24-hour history of abdominal pain. The patient also has fever and vomiting but is clinically stable. The child has a medical history of developmental delay, cerebral palsy, and epilepsy. The ED physician establishes a diagnosis of appendicitis and consults a general surgeon. The surgeon agrees with the diagnosis of appendicitis but recommends transfer to a tertiary care center given the patient’s complex medical issues. Citing a lack of bed availability within the hospital, the physician at the tertiary care center refuses to accept the patient. The emergency physician disregards the refusal and sends the patient by ambulance to the tertiary care center.

1. Should the patient have been transferred under these circumstances?
2. Is such a refusal justified?

The emergency physician at the rural hospital established a diagnosis of appendicitis and obtained appropriate surgical consultation. The decision to transfer the patient to a more specialized center is appropriate. However, a physician at the receiving facility must be identified to provide care for the patient. In this case, the receiving facility did not have bed availability for this patient and is justified in its decision to not accept the patient. The Emergency Medical Treatment and Labor Act requires more specialized centers to accept transferred patients only if they possess the resources (including bed availability) to provide appropriate care. Transfer to a facility unable to provide necessary care is not beneficial to the patient. The discussion should then have focused on the identification of an alternative center able to provide the necessary care for this patient.

A 3-month-old infant is brought to the ED with no pulse and no respirations. The mother had fed the infant at 6:00 pm and put her back in her crib. She found the infant lifeless at 9:00 pm and called emergency medical services (EMS). The mother attempted cardiopulmonary resuscitation (CPR) before the paramedics arrived, and the paramedics intubated the infant’s trachea and continued resuscitation en route to the hospital. In the ED, the infant is noted to have an asystolic rhythm. The temperature is 36°C (96.8°F). Pupils are fixed and dilated.

The ED staff confirm correct placement of the endotracheal tube, place an intraosseous needle, and give the infant epinephrine (adrenaline), three doses during 15 minutes. The infant has no spontaneous respirations and remains asystolic.

1. Does the literature support termination of CPR in this case?
2. In what clinical situations can prolonged resuscitation be justified?
Resuscitation can be terminated because the literature demonstrates very poor to no survival rates in children receiving more than two doses of epinephrine (adrenaline) without effect.

Clinical situations that can result in meaningful survival after prolonged resuscitations (>25 minutes) include ventricular fibrillation, ventricular tachycardia, electrocution, toxic drug exposure, and primary prearrest hypothermia.

A 16-year-old cyclist is brought to the ED after being stuck by a motor vehicle. At the scene, EMS personnel arrive to find an apneic and pulseless patient. Resuscitative efforts in the field and in the ED are not successful, and the patient is pronounced dead. The patient's family arrives at the hospital just after resuscitative efforts have ceased. The nursing staff notifies the local organ procurement organization as required by law. The organ procurement service representative arrives at the hospital to discuss organ transplantation possibilities with the family.

1. Should the organ procurement service be notified before death, immediately after death, or after sufficient time for grieving has passed?

Legislation requires hospitals to refer all potential donors to local organ procurement organizations. This should take place before death has occurred, if possible. Otherwise, it should occur immediately after death. The medical examiner will help determine whether organ donation is feasible in each particular circumstance. However, at least a limited use of organs is possible in many cases, and the emergency physician should facilitate this process with early referrals to both the organ procurement organizations and the medical examiner.