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INSIDE

AHC Media

Did Advance Practice Provider Commit Malpractice? EP Could Face Negligent Supervision Claim

Patients often assume they saw EP

The fact that an ED patient with neurological complaints was never seen by an EP became a central issue in recent malpractice litigation.

The man initially presented with an unstable fracture of the cervical spine.

"A decision was made by the neurosurgeon to treat this with a special collar, and he was eventually sent home, doing well," says **Stephen H. Mackauf**, JD, an attorney at Gair, Gair, Conason, Steigman, Mackauf, Bloom & Rubinowitz in New York City.

A few days later, the patient returned to the ED with new and worsening neurological complaints. A physician's assistant (PA) saw the patient and discharged him home; no EP ever saw the patient.

"He returned some hours later, much worse. A different PA saw the patient and decided the symptoms were due to a stroke," Mackauf says. "By the time a physician saw the patient, he was irreparably quadriplegic."

Mackauf is seeing an uptick in claims involving patients seen by advance practice providers (APPs) instead of EPs.

"We currently have several cases involving PAs and NPs [nurse practitioners] who have committed malpractice," Mackauf reports. "Of course, the issue becomes, 'Who else is also liable for their negligence?'"

Negligent Supervision Is Common Allegation

If APPs employed by the hospital are involved in the care of an ED patient in any way and a malpractice suit occurs, they are likely to be named as defendants.

"If nothing else, doing so puts the hospital's professional liability coverage on the hook," says **Robert J. Milligan**,

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Reliance on an APP exposes the EP to allegations of negligent supervision, Milligan adds. EPs can help to defend themselves by demonstrating that the APP was fully qualified to treat the patient, and the EP's past experience with the APP provided the EP with assurance of that fact.

"This would only be possible, of course, if the EP had a history of working with the midlevel, and had confidence in the midlevel's ability," Milligan notes.

Claims alleging negligent supervision are stronger if it can be demonstrated the EP knows or should know an APP is not qualified to treat a particular patient, Milligan says.

For example, an EP might be exposed to a negligent supervision claim for allowing an APP with little work experience to have primary responsibility for the care of a patient who presented with a complex medical condition, such as an elderly, obese, hypertensive diabetic in congestive heart failure who presents with worsening shortness of breath.

"Obviously, if the midlevel is employed by the ED practice, the practice is vicariously liable for the midlevel's conduct," Milligan explains.

The more unqualified or incompetent the APP is, Mackauf says, the better the case against the EP.

"This, however, misses the point," he adds. "No matter how well-qualified a non-physician is, patients come to the hospital expecting to be seen by a physician, and in my opinion, they are entitled to that."

In some EDs, there is no requirement for patients to be seen by an EP; it is sufficient if the APP discusses the case with an EP.

"There is a problem with this practice," says Mackauf. "That is, the only facts learned by a physician who does not see the patient themselves are the facts told to them by the paraprofessional."

The EP cannot really know what questions were asked, what answers were given, what examination was done, or what the examination should have revealed.

"The law in many states is that a paraprofessional can only practice if they are supervised by a physician," Mackauf notes.

The question then becomes what constitutes "supervision."

"In two recent cases of ours, the paraprofessional in the ED testified that being supervised meant that supervision was 'available,'" Mackauf says. When asked who decides whether they should consult with an EP about a particular patient, the answer was that the paraprofessional makes that decision.

"The problem with that should be obvious," Mackauf adds. "The fact a paraprofessional sees no need for physician consultation does not prove that no consultation was needed."

In Mackauf's experience, paraprofessionals frequently testify they know just as much as EPs, that they are just as well-trained as EPs, and that they therefore do not need supervision any more than an EP does.

"When asked why the law requires that they be supervised, their only explanation tends to be that such laws are politically driven by physicians," Mackauf says.

Patients Not Informed

In malpractice claims involving ED patients seen by APPs, Mackauf

often sees these fact patterns:

• Patients left the ED without an EP knowing the patient was ever there.

• Patients assumed, incorrectly, they had seen an EP.

Plaintiff's attorneys can argue the failure to advise a patient of the APP's status or licensure creates an informed consent claim, Milligan notes.

"I can think of no good reason why midlevels should fail to advise patients of that information when they introduce themselves," he says.

Mackauf recently handled a malpractice claim against an APP who saw a patient at the office of an OB-GYN.

"No physician saw that patient, no physician was consulted about the patient, and no physician even knew the patient was in the office and had been seen," Mackauf says.

In fact, the patient left the office thinking the person she saw was an OB-GYN.

"It was only when the patient saw me about a potential medical malpractice case and I looked up the 'doctor' that we learned together that the person who committed the malpractice was not even a doctor," Mackauf notes.

When Mackauf deposed the paraprofessional, he asked if she would be surprised to find out that the patient left the office thinking that she was an OB-GYN.

"Her response, under oath, was, 'That's her problem!'" he says. "In the ED setting, exactly the same problems may occur. Patients should not be misled, even by silence."

Clear Policies Needed

If a bad outcome occurs after an ED patient is seen by an APP, the plaintiff's attorney may allege the patient's triage level was inaccurate, and that if the triage level had been accurate, the patient would have been seen by an EP.

"They then allege the APP should have notified the EP, or the EP should have known the patient needed a higher level of service," says **Rade B. Vukmir**, MD, JD, FACEP, FACHE, chairman of education and risk management at ECI Healthcare Partners, a Traverse City, MI-based provider of emergency, hospitalist, and acute care practice management services. Vukmir also serves as chief clinical officer of National Guardian Risk Retention Group, the ECI Patient Safety Organization, and as an adjunct professor of emergency medicine at Temple University.

> THE EP AND THE APP SHOULD MAKE IT CLEAR TO PATIENTS THAT PHYSICIANS WORK TOGETHER ON A CASE AS A TEAM TO MEET ALL NEEDS.

To guard against such allegations, Vukmir advises, EDs need to establish clear policies and procedures for how APPs operate in the department.

"Most importantly, does the EP see all patients, some patients as needed, or is there no patient contact, with the EP only signing off on the medical record?" he asks. He says ED policies should specifically address these operational questions:

• How is the APP supervised?

• What is the interaction with nursing staff?

• What is the interaction with the EP?

• What is the procedure when a patient needs to be transferred or admitted?

• What patients are seen by the EP?

• What are the EPs' documentation requirements?

If the EP is working in a different area of the ED, Vukmir advises periodically checking with the APP and asking if there is anything the EP can do to help with the patient care needs.

In his own practice, he attempts to greet every patient seen by the APP, and states, "I'm Dr. Vukmir, the emergency physician seeing you in conjunction with our advance practice provider. Can I do anything to help you? Do you have any questions for me?" When appropriate, he does a focused exam.

Vukmir says simply being approachable can reduce legal risks for EPs.

"Make it clear that you work as a team. Establish dialogue with the APP," he suggests. The EP can say, for example, "I'm here for you. If you have any questions or concerns, feel free to come to me."

"Visit with the APP periodically during the shift to make sure there are no unmet needs," Vukmir advises. ■

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This Documentation in ED Chart Got EP Dismissed from Med/Mal Suit

Excellent documentation of a telephone consultation with a specialist was a key factor in an EP defendant's dismissal from a recent malpractice case. The specialist remained a defendant in the case.

"The EP was dismissed, presumably due to the fact that the plaintiff's expert felt it was appropriate for the EP to rely on the advice of the specialist," says **Ellen M. Voss**, JD, a medical malpractice defense attorney at Portland, OR-based Lewis Brisbois Bisgaard & Smith LLP.

Several days after an outpatient procedure performed by a specialist, the patient presented to the ED with complaints of fever and pain at the surgical site. The EP performed an appropriate work-up, and consulted with the specialist who performed the procedure.

"The EP's documentation of the substance of the call with the specialist made it clear he was relying on the specialist's opinion that additional work-up was not needed," Voss says.

Once the specialist confirmed the discussion had happened as documented, the EP was dismissed from the case.

Here are some other pieces of documentation that often become critical in malpractice litigation against EPs:

• The time of important events — review of vital signs, reassessments, physical exams, discussions with patient and/or family members, discussions with specialists, and the last discussion before the patient is discharged.

"Although there is a time stamp associated with everything in the EMR [electronic medical records], if an interaction or actual care occurred well before the physician is able to document the encounter, it can be very helpful to document the actual time of the event in the summary note," Voss advises.

If an EP does not document in the EMR contemporaneously, she explains, but instead prepares a summary note at the end of or after the patient's care, it can be difficult to determine when each event described in the note occurred.

"EPs then have to rely on the charting of other events captured in nursing notes, orders sign-off, lab records, or imaging records to reconstruct a timeline," Voss explains.

> DELAYS LONGER THAN AN HOUR OR TWO CAN BE A PROBLEM IN A LAWSUIT.

• Acknowledgement of abnormal vitals.

Voss has seen many malpractice claims in which the last set of vitals taken before an ED patient's discharge was abnormal. Often, none of the parties involved documented whether the EP was notified.

"EPs can protect themselves by always documenting if they were notified of abnormal vital signs taken before discharge," Voss proposes.

By consistently documenting every notification of abnormal vital signs, the EP will be able to testify that, based on his or her practice, there was no notification of abnormal vital signs if there is no documentation stating otherwise.

• What was on the EP's differential, and why certain diagnoses were excluded.

"Generally speaking, the more a note reflects the medical judgment of the physician, the more difficult it is for plaintiffs to present evidence of alternate theories that the physician should have been pursuing," Voss says.

If an EP notes why a certain diagnosis was excluded at the time of the ED visit, it can make a malpractice suit easier to defend if the patient in fact ends up having that particular diagnosis.

"Listing everything that was considered and why each particular diagnosis was ruled in or out, is considered unlikely, or is still on the differential, is an excellent self-preservation technique," Voss says.

Including a short paragraph explaining the EP's decision-making can be legally protective for EPs, advises **Charles A. Eckerline, Jr**. MD, FACEP, an EP at University of Kentucky Hospital in Lexington, KY, and associate professor in the Department of Emergency Medicine at the University of Kentucky.

"With every complaint, there are certain worrisome high-risk diagnoses that are relevant," he explains. "State why you decided to order, or not order, a particular test. You want to have some documentation that makes your thought process clear."

In one malpractice case, a patient was discharged home from an ED, but returned with full-blown cauda equina syndrome.

"The patient ended up with a reasonably good result from surgery, but some neurological deficits," Eckerline recalls. "The documentation on the first ED visit was good enough

so that the lawsuit was eventually dropped."

The EP specifically noted the absence of bowel or bladder symptoms, normal rectal tone and sensation, and intact ankle reflexes at the time of initial evaluation.

"The plaintiff's own experts admitted under oath that if the findings were as documented, then there was no indication for a neurosurgery consult, admission, or emergency MRI," Eckerline says.

• That risks were explained to patients who refused a procedure, refused admission, or left against medical advice.

A recent malpractice case involved a patient who presented with chest pain; the ED workup was negative. However, the EP still thought the patient was high-risk, and recommended the patient be admitted, but the patient refused admission.

"The patient ended up having a bad result, and sued the EP," Eckerline says.

The EP's notes specifically stated the risks had been explained to the patient, including stroke, heart attack, or out-of-hospital death, and that the patient's wife and ED nurse were present during the discussion.

"The final disposition is pending, but the documentation puts the ED physician in a much better position," Eckerline notes.

Another factor strengthening the EP's defense was that the documentation was done contemporaneously with the ED visit.

"Documentation delays longer than an hour or two can be problematic in a subsequent lawsuit," Voss notes. ■

SOURCES

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Did Patient Deteriorate After Discharge? Suit May Allege Failure to Get a Consult

After a patient who presented to an ED with chest pain, diaphoresis, and shortness of breath was discharged and later suffered a myocardial infarction (MI), the family sued the EP, alleging failure to obtain a cardiology consultation. The case was quickly settled.

"I don't think most jurors would believe an ED physician is in as good of a position to diagnose a cardiac condition as a cardiologist," says **Russell X. Pollock**, Esq., an attorney at Bergstresser & Pollock in Boston, MA, who represented the plaintiff.

Another factor complicating the EP's defense was that the patient had signs and symptoms of an MI, and that a cardiac consultation most likely would have led to a timely diagnosis and treatment of the condition.

"Most jurors would believe that a cardiac consult should be available, if needed, at major medical centers and even most smaller hospitals," Pollock says. The same arguments could be made with respect to stroke and neurology consultations, he adds.

A malpractice case with a similar fact pattern, still pending, involves a patient with stroke symptoms who was discharged from an ED without receiving a neurology consultation. The patient later suffered a severe stroke.

"If a condition requires work-up from medical specialties, the ED physician should put in a timely request for the consultation," Pollock advises.

If an imaging study reveals free air, for example, a patient should not be discharged without further consultation and likely emergency treatment, Pollock says.

"A presumed diagnosis of enteritis will not carry the day," he notes.

Similarly, a patient with abdominal pain, hypotension, and lethargy should not be discharged without further consultation and diagnosis of the cause.

"The patient reporting they might have gotten food poisoning does not carry the day," Pollock explains.

Pollock is handling several malpractice claims alleging that the tissue plasminogen activator should have been administered to minimize injury from clots.

"A claim that a neurology consult was not timely obtained can be made in those cases in which there was a therapy that could have resolved or mitigated the results," he notes.

Pollock says EPs should be particularly mindful of the timeline from arrival to diagnosis.

If a patient comes to the ED with a severe condition, is not seen or diagnosed rapidly because a consult is delayed, and then dies or is seriously injured by the condition, he warns, "one could envision a case of negligence stemming from the delay."

Weigh Risks and Benefits

If a consult is considered but not ultimately ordered, EPs should document the reason why not, Pollock recommends. "Of course, this presumes good medicine is being practiced," he notes. "If you document poor judgment, the documentation is not going to help defend the physician's actions."

Since EPs cannot order consults on every patient, they need to weigh the risks and benefits of an emergent workup vs an outpatient work-up, says **Bobbie S. Sprader**, JD, an attorney at Bricker & Eckler in Columbus, OH. She says these are important things for EPs to consider to minimize the risk of future liability, should a patient deteriorate before a work-up is completed as an outpatient:

• How likely is it that the patient's condition will deteriorate before an outpatient workup can be performed?

"The EP will need to take into account the expected disease progression, and the speed with which that patient can reasonably be expected to complete the needed workup," Sprader says. Once the EP has considered these factors and makes a recommendation, the EP's thought process should be explained to the patient, and the patient's understanding documented.

"This discussion should include recognition that there is a risk the disease could progress faster than the EP currently predicts," Sprader notes.

She gives this example of good documentation: "Patient understands that Dr. Jones believes that his condition does not require an emergent work-up, and is discharging him for an outpatient work-up with Dr. Smith that should occur within the next 7-10 days. Patient understands there is no guarantee his condition will not progress or deteriorate in the next 7-10 days. Patient will immediately return to the ED if symptoms change or progress or if he has any concerns that may warrant an emergent work-up."

• What degree of morbidity and mortality is likely to result if the disease does progress before an evaluation is completed and treatment implemented?

"It goes without saying that if the EP thinks the patient is at risk for a disease that would result in significant morbidity and/or mortality if not evaluated and treated before it progresses, then this needs to be factored into the decision," Sprader explains.

If the EP decides it is appropriate to proceed with an outpatient work-up, the patient should be made aware of the importance of timely follow-up, she adds, and be given specific instructions as to what symptoms to look for that would warrant a return to the ED.

• What is the likelihood the patient will follow through with the recommended outpatient work-up?

"This is really an assessment of patient compliance, which is hard for an EP to do reliably with just the one isolated encounter with the patient," Sprader says. If an EP suspects the patient requires further evaluation or treatment and is likely not going to follow-up either timely or at all, this may weigh in favor of ordering a consult to get the work-up done emergently.

"At a minimum, the EP should document having made the recommendation for an outpatient work-up and having emphasized the importance of getting that work-up done and done in a timely fashion," Sprader says.

ED patients who are being discharged should be told their condition could deteriorate faster than expected, Sprader warns. "The importance of a timely work-up should be explained," she adds. "Ideally, this discussion should be witnessed and documented." ■

SOURCES

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Is ED Discharge Followed by Sudden Death? Plaintiff's Attorneys Will Be Interested

Of 47 unexpected deaths following hospital admission from the ED, half were preventable, according to a recent study.[1] The most common process breakdowns were incorrect choice of treatment (47% of patients) and failure to order appropriate diagnostic tests (38% of patients). The most common medical error was a severe delay or absence of recommended treatment for severe sepsis, which occurred in 10 (42%) patients.

The researchers weren't surprised by the findings.

"Our hypothesis was that the rate of preventable deaths among unexpected deaths was high. Previous studies on unexpected deaths among discharged patients reported a similar rate of preventable death," notes **Yonathan Freund**, MD, PhD, one of the study's authors and an EP at France's Assistance Publique-Hopitaux de Paris.

Jury Will Be Sympathetic

Any unexpected death that occurs a short time after an ED discharge is bound to get the attention of a plaintiff's attorney, according to **Michael M. Wilson**, MD, JD, a Washington, DC-based malpractice attorney. "Anyone is sympathetic to the family of a person, particularly a young breadwinner with children, who is sent home from an ER and then drops dead a few hours later," he says.

Wilson says the best way for EPs to avoid being a target is to show that they carefully evaluated the person's complaints, established a reasonable differential diagnosis, and then provided appropriate care with reasonable follow-up.

"Then if the patient dies from an undiagnosed zebra, the ED physician will be able to show reasonable care, and that the unusual disease would not have been diagnosed with standard and ordinary medical care," Wilson notes.

He explains these practices can mitigate risks for EPs:

• Carefully documenting the history, physical examination, differential diagnosis, and medical decision-making;

• Having a reasonable follow-up plan, documenting that plan, and communicating that plan to the patient orally and in writing;

• Having a physician or nurse document the appearance and status of the patient at the time of leaving the ED, particularly if the time spent in the ED was lengthy;

• Consulting with another EP or a specialist if the ED visit raises questions.

If there are unusual findings, or an unusual event, such as travel to a remote part of the world, "do this even if you think that you know the answer," Wilson advises.

If a malpractice suit occurs, it will help the EP's defense to show that the extra effort was made to consult with another physician.

"And, that other physician, be it another ED physician or a subspecialist consultant, can be an extremely valuable witness in the event a lawsuit is filed," Wilson adds.

These Fact Patterns Are Common

Laura Pimentel, MD, vice president/chief medical officer at Maryland Emergency Medicine Network in Baltimore, MD, is familiar with several malpractice cases against EPs involving unexpected deaths of discharged patients. Here are common fact patterns in these claims:

• Patients with chest pain are evaluated and discharged from the ED, followed by sudden death.

Common allegations in these claims include failure to obtain troponin levels in the ED, failure to properly interpret an EKG showing findings suggestive of ischemia or infarction, and failure to admit a patient for observation or obtain cardiology consultation.

• Patients with subarachnoid hemorrhage (SAH), carotid dissection resulting in stroke, or missed cervical spine fractures are discharged, with missed or delayed diagnosis.

"Neurological cases are particularly difficult, and very high risk for EPs," Pimentel says.

Missed SAH claims often allege the EP failed to consider the diagnosis and obtain proper diagnostic tests.

"Patients may be mistakenly diagnosed with migraine or other benign etiology for headache, and discharged after symptomatic treatment," Pimentel notes.

Another common allegation is the patient was discharged after a normal head CT scan was obtained, but the EP failed to perform a lumbar puncture to assess for blood in the cerebrospinal fluid.

"With respect to cervical spine fractures, image with CT scans in patients with concerning mechanisms of injury and those over 40," Pimentel advises. "It is common for plain radiographs to miss cervical spine fractures."

Evaluating patients clinically and only ordering a non-contrast head CT is a common pitfall in missed stroke cases against EPs, in Pimentel's experience.

"Depending upon individual circumstances, patients with suspected stroke should either be admitted for observation and neurology consultation, or evaluated with CT angiography or MRI of the head and neck," she says.

Cerebellar strokes may be misdiagnosed as peripheral vertigo, with patients mistakenly discharged resulting in death.

"It is incumbent on the EP to obtain proper imaging of the posterior fossa to avoid this fatal pitfall," Pimentel warns.

In a recent case, an MRI of the cervical spine was ordered for

a patient suspected of having an epidural abscess. The study was mistakenly read as normal, and the patient was discharged. He subsequently died of sepsis.

"I am familiar with a disturbing number of cases in which the EP did consider the diagnosis and ordered the appropriate imaging studies, only to have them misinterpreted by the radiologist," Pimentel notes.

• An EP correctly diagnoses a disease process, such as pneumonia, but misjudges the severity of illness and discharges a patient who subsequently dies.

"The allegation may be that the physician failed to admit and aggressively manage a patient who subsequently develops sepsis or respiratory failure," Pimentel says.

EPs should utilize clinical decision support tools embedded in most EMRs, such as the pneumonia severity index, Pimentel recommends.

"As this technology continues to improve, one may find that a diagnosis not initially considered is identified by the differential generated by the EMR," she says. She suggests EPs consider these practices to reduce risks:

• Obtain a consult, observe, or admit patients with concerning but unclear presentations.

"I have found that an order for regular neuro checks on patients with early or subtle neuro complaints in the ED is very helpful in identification of strokes in evolution," Pimentel says.

• Follow your instincts even if a test result such as an MRI or CT angiography does not confirm your clinical suspicion.

"Strongly consider observation if the patient still looks sick or you are uncomfortable discharging the patient," she advises.

• Ensure patients and families are comfortable with your disposition.

"Even if the outcome is poor, if the family thought you were diligent and sincere in your management, the likelihood that you will be sued is far lower," Pimentel says. ■

REFERENCE

1. Goulet H, et al. Unexpected death within 72 hours of emergency department visit: Were those deaths preventable? *Crit Care* 2015;19:154.

SOURCES

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What Did Transferring EP Tell Receiving EP? If Bad Outcome Occurs, Stories May Differ

Finger-pointing between transferring and receiving EPs benefits only the plaintiff's attorney, warns **Jonathan D. Lawrence**, MD, JD, FACEP, an EP and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

"Suppose the patient dies upon arriving at Hospital B and Dr. B. gets sued. What could be better for the plaintiff attorney than for Dr. B to say it was all the fault of Dr. A?" Lawrence asks. "EPs would be well-advised to keep those sorts of criticisms to themselves."

Documentation of the time and date of the conversation, who the EP spoke to, and the acceptance of the patient by the receiving EP are required by the Emergency Medical Treatment and Active Labor Act, Lawrence notes, "but certainly, the more complete description of that conversation, the better."

Here are some items that, if not properly communicated by the transferring EP, can complicate the defense of a subsequent malpractice lawsuit:

• Pending test results.

Nan Gallagher, JD, an attorney at Kern Augustine Conroy & Schoppmann in Bridgewater, NJ, has seen failure to communicate pending test results cause legal problems for transferring EPs.

"That's probably the number one reason why EPs remain in the case," she says. "There may be an administrative snafu or clerical error, and the EP wrongly assumes the results made their way into the chart and the next EP received them."

A recent malpractice case involved a 38-year-old patient who presented with chest pain. The patient opted to transfer to a hospital closer to his home before troponin levels came back.

"They showed clear evidence of coronary infarction, which would have precluded the transfer altogether," says Gallagher.

The patient was transferred by

ambulance, and the EP did not communicate the test results to the receiving EP.

"The patient died of coronary dissection upon arrival to the second ED," Gallagher says. "The original EP remained in the case and settled for his $1 million policy limit."

• The patient's condition at the time of transfer.

How the transferring EP describes the patient's condition can become a key issue in malpractice litigation.

"It makes a difference on what they are prepared for on the receiving end," Lawrence says.

Lawrence recently reviewed a malpractice case, which is still pending, involving a patient who presented to an ED with a knee dislocation who was at risk for a vascular injury to the knee. The hospital didn't have a vascular surgeon on call, so the patient was transferred.

"The receiving EP asked the transferring EP to describe the patient's circulation," Lawrence says. "The transferring EP replied that it was dusky previously, but the color was a little better, and the patient now had a weak pulse."

The receiving EP asked this question to determine whether it was necessary to have a vascular surgeon waiting to take the patient to the OR immediately.

"But the first EP is the only one who described a pulse at all," Lawrence says. "The paramedic felt no pulses and described a dusky blue foot."

As a result of the transferring EP's report, the vascular surgeon was not waiting for the patient.

"When the patient was re-evaluated, it was determined the patient needed immediate vascular surgery. He went to the OR but lost his leg," Lawrence says.

The defense attorney's experts claimed the additional 90 minutes it took to get the OR ready didn't make a difference in the patient's outcome, but the plaintiff's experts argued otherwise.

If the EP's initial assessment revealed a weak pulse, the fact that the patient's condition changed between the time of the phone call and the actual physical transfer required the transferring EP to notify the receiving EP, Lawrence says.

"The EP could have rechecked the leg, called back, and said, 'Hey, we talked about this patient earlier. I think he's lost his pulse and his foot looks duskier than when we first talked,'" Lawrence explains, adding that this simple communication might have prevented both the bad outcome and the lawsuit.

In another malpractice case involving a patient who was brought to an ED by ambulance after losing consciousness and falling while golfing, a CT scan indicated a questionable vascular tear involving the right iliac artery.

"Arrangements were made one hour later to transfer the patient to a regional medical center," says **Lizabeth Brott**, JD, regional vice president of risk management at ProAssurance Companies in Okemos, MI.

The following day the patient's blood pressure dropped to 85/40, with a pulse of 50; it appeared the patient was going into shock, and he was taken to the OR. "Shortly after surgery commenced, the patient had a cardiac arrest," Brott says. "Attempts to resuscitate the patient were without success."

In the subsequent malpractice litigation, plaintiff experts were critical of the cardiac surgeon's response, but the transferring EP was not named in the malpractice lawsuit. One factor was the EP's good documentation. "The transferring EP contacted the ED at the receiving hospital and spoke to the cardiac surgeon, indicating the patient had a ruptured iliac artery," Brott says. "This was included in the ED record."

Brott suggests EPs consider these practices to reduce risks involving patients transferred from one ED to another:

For receiving EPs:

• Upon arrival, conduct an immediate assessment of the patient's condition and stability and any clinical diagnostic data, so appropriate actions may be taken.

For transferring EPs:

• Document all care, treatment, and diagnostic results, and discuss these with the receiving physician in an SBAR (Situation, Background, Assessment, and Recommendation) format.

"Assess the patient immediately before the patient is sent to the receiving EP," Brott says. "Call the receiving EP to ensure they have the most current information." ■

SOURCES

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Patient 'Bounced Back' to Your ED? It's an Opportunity to Stop Bad Outcome, Lawsuit

A dismissive attitude could cause an EP to miss a life-threatening condition in a patient who returns to the ED, warns **Michael B. Weinstock**, MD, adjunct professor of emergency medicine at The Ohio State University College of Medicine and ED chairman at Mount Carmel St. Ann's Hospital in Westerville, OH. Weinstock is author of *Bouncebacks! Medical and Legal* (Anadem, 2011).

Bounce backs are a second chance for EPs to "get it right," Weinstock says. "Don't say, 'This patient is annoying because they are back again.' Instead, thank the patient for coming back to your ER."

Return visits to the ED are twice as common as was previously reported, according to a recent study.[1] Nearly one in 12 patients who visited an ED in six states returned to an acute care setting within three days. The revisit rate rose to nearly one in five patients 30 days after the first ED visit.

"It is hard to be correct all the time without doing tons of overtesting," Weinstock says. "The fact is we want to try to localize patients who might bounce back with a life-threatening or life-ending illness." He gives these two examples:

• Patients with unexplained vital sign abnormalities. "If a patient's heart rate is 120 and you don't have a good explanation, like dehydration or pain, you need to localize that patient as a bad outcome soon to occur," Weinstock says.

• Patients with symptoms that could be a potentially life-threatening condition, such as shortness of breath, headache, fever, or chest pain, combined with diagnostic uncertainty. To reduce risks, Weinstock recommends EPs:

• Write a medical decision note about why certain high-risk conditions aren't suspected. This not only protects the EP legally if the patient ends up having the condition — in some cases, it could change the EP's treatment plan. "It might make you think, if I can't even convince myself that nothing bad is going on, there is no way I can convince a jury," Weinstock says.

• Recruit the patient and family to watch for specific concerning signs that would warrant a return ED visit. "Inform the patient of diagnostic uncertainty," Weinstock advises. "It's important the patient knows you haven't figured it out. Sometimes an accurate diagnosis can't be determined in one visit."

• Perform an independent assessment. In many "bounce back" cases reviewed by Weinstock, the EP relied on the diagnosis of a previous physician. "Maybe the diagnosis was appropriate based on the symptoms the patient had at that time; maybe not," Weinstock warns. "You need to make your own diagnosis."

In one case, a woman presented to an ED with a headache. She had been prescribed antibiotics for a sinus infection by her primary care provider. The EP prescribed stronger antibiotics, even though the patient's symptoms weren't consistent with sinus infection, while failing to diagnose pre-eclampsia. "The patient ended up with a horrible neurological outcome and was paraplegic," Weinstock says.

Keith C. Volpi, JD, an attorney at Polsinelli in Kansas City, MO, is currently defending an EP in a lawsuit involving a patient who returned to the ED. A pregnant woman presenting with abdominal pain and a history of multiple coagulation disorders was discharged home after a telephone obstetrical consult and instructions to return to the ED if symptoms worsened. "Approximately 36 hours later, the patient returned to the ED with a significantly expanded hematoma and a fetal demise," Volpi says. "The patient's allegations included that she should not have been discharged after her first ED visit."

These factors helped the EP's defense: testing and documentation to show the fetus was not in distress, an appropriate consult, and labs demonstrating there was no evidence of internal bleeding. However, the plaintiff alleged that the EP:

• failed to send the patient to labor and delivery for monitoring and observation, per hospital protocol;

• failed to communicate with the patient's attending obstetrician;

• failed to perform a repeat abdominal ultrasound to determine whether the potential hematoma was expanding, particularly in light of the patient's coagulation disorders.

"At the end of the day, the ED physician's care and treatment is defensible," Volpi says.

The medical evidence indicates the patient's hematoma did not start expanding until after she was discharged home after her first trip to the ED. "But this is a case in which perception will be difficult to defend," Volpi notes. The perception is that a woman nearing the end of a high-risk pregnancy presented to the ED and was sent home after no obstetrical care and with no explanation for her pain and symptoms. "In hindsight, the ED physician would have best served herself by insisting on labor and delivery observation and in-person OB and hematology consults," Volpi explains.

There are certain populations of patients, including high-risk pregnancies, that EPs must be very careful treating without consultation, regardless of acuity, Volpi warns. "This is particularly true where there is not a clear explanation for the patient's presenting symptoms," he adds.

A bad outcome and return ED visit will predictably result in an unhappy patient, says **Dan Groszkruger**, JD, MPH, principal of Solana Beach, CA-based rskmgmt.inc. "The patient and his or her attorney will suspect that a missed diagnosis may have occurred during the initial visit," he says.

However, Groszkruger says that whether or not a lawsuit occurs probably depends more on the quality of the EP's documentation of the first visit. "Plaintiff's attorneys tend to evaluate damages before looking at liability," he explains. "The value of 'delay' damages varies." If the second ED visit results in care and treatment that might have been provided during the initial visit, Groszkruger notes, damages mainly represent solely the value of the delay in providing necessary care. "This often consists of transient emotional distress, worry, and physical pain, which may not represent sufficient damages to justify filing a lawsuit," Groszkruger says.

A delay might represent high-dollar damages, however, if it led to additional harm requiring expensive treatment or permanent injury. If the plaintiff's expert indicates that signs and symptoms evident during the first ED visit were not definitive, the burden of proof to establish medical malpractice may appear to be quite formidable. "On the other hand, if the medical record demonstrates only a cursory examination, few tests, and no explanation of medical decision-making leading to discharge, then the liability threshold may be easier to cross," Groszkruger explains.

A diseased appendix may produce few or minor symptoms at the time of the first ED visit, but symptoms might quickly exacerbate. "If signs and symptoms appear to be equivocal, the ED physician may choose to keep the patient in the ED for observation," Groszkruger says.

An appendicitis patient risks rupture and complications if surgery is delayed; on the other hand, if signs and symptoms are not dispositive for appendicitis, many less serious conditions could account for the patient's complaints. "It's a balancing act decision for the ED physician, making the quality of documentation of medical decision-making all-important," Groszkruger notes.

He gives a "worst-case" scenario of a patient with equivocal signs and symptoms who is discharged home, but returns in a matter of hours. "If surgery finds a burst appendix, everyone is likely to suspect a missed diagnosis occurred on the initial visit," Groszkruger says.

However, if the medical record thoroughly documents a comprehensive work-up, and the lack of definitive signs and symptoms, then the EP's decision to discharge the patient home with follow-up instructions appears reasonable and understandable. "This illustrates the importance of the quality of documentation," Groszkruger adds.

The most common allegations **Robert D. Kreisman**, JD, a medical malpractice attorney with Kreisman Law Offices in Chicago, sees in his practice are claims the patient was "dumped" by another ED and simply discharged without treatment. "In one of our cases, a patient who was admitted, but recently discharged, returned with complaints of a severe headache and nausea," Kreisman says.

The patient had been diagnosed with a treatable benign brain tumor. "The error on return ED visit was not to rule out the brain herniation that was underway," Kreisman explains. Instead, the EP administered pain medication and discharged the patient home.

"A serious error was made in not fully understanding the condition of the patient from the earlier admission," Kreisman notes. "This was coupled with the error in judgment made by the treating neurologist who agreed by phone with the EP to discharge this patient." If a patient returns presenting with the same symptoms as before, the EP should be certain to review the chart from the previous visit, Kreisman advises, and then be sure that the most dangerous and deadly possible illnesses or injuries are ruled out first. "In all of these cases, the best defense is the well-documented chart," Kreisman recommends. "Bad outcomes are not viable lawsuits in most fact scenarios."

Kreisman handled an ED case involving a patient who presented with signs and symptoms of an infectious process. "However, the recorded vitals made a claim against the ED physicians untenable," he says. "There were no objective findings of infection." The doctors and nurses carefully recorded the patient's vital signs, which did not show the patient was becoming septic. "The only negligence in that case was alleged to have occurred later on in the admission, when the patient was misdiagnosed by an infectious disease physician," Kreisman says. ■

REFERENCE

1. Duseja R, et al. Revisit rates and associated costs after an emergency department encounter: A multistate analysis. *Ann Intern Med* 2015;162:750-756.

SOURCES

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ED LEGAL LETTER™

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CME/CNE QUESTIONS

1. **Which is true regarding malpractice lawsuits involving advance practice practitioners (APPs)?**

   A. Evidence of the EP's previous positive experience with the APP may not be used in the EP's defense.
   B. Negligent supervision claims are strengthened by evidence showing the EP was aware the APP was not qualified to treat a particular patient.
   C. There is a legal requirement for all ED patients to be seen, even briefly, by an EP.
   D. An ED group cannot be liable for the APP's conduct if the APP is employed by the ED group.

2. **Which is true regarding ED documentation?**

   A. EPs should not document timing of events that contradicts time-stamping in EMRs.
   B. EPs should not chart every notification of abnormal vital signs.
   C. A short paragraph explaining the EP's decision-making can be legally protective.
   D. Specifying which individuals were present during discussions complicates the EP's defense.

3. **Which is recommended to reduce risks of allegations the EP failed to obtain a consultation?**

   A. EPs should specify the reason why a consult that was considered was not ordered.
   B. Informing patients that their condition could deteriorate faster than expected increases legal risks, since that is always true.
   C. EPs should avoid specifying timeframes for recommended follow-up care, since patient experience varies.
   D. The likelihood of a patient obtaining timely follow-up need not be factored into the EP's decision to obtain a consult.

4. **Which is true regarding legal risks for EPs transferring a patient to another ED?**

   A. Placing blame on the receiving EP is likely to protect transferring EPs from getting named in a lawsuit.
   B. There is no legal requirement for transferring EPs to document the acceptance of the patient by the receiving EP.
   C. What the transferring EP tells the receiving EP about the patient's condition is inadmissible, since it is hearsay evidence.
   D. EPs should communicate any changes in the patient's condition prior to transfer.