ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

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INSIDE

EP Failed to Obtain Consult? ED Malpractice Claims Can Include This Allegation

Some patients need to be evaluated by a specialist at the time of the ED visit. However, for whatever reason, the evaluation does not happen.

It turns out that a significant number of ED claims involve this scenario — about one in five, according to an analysis of closed malpractice claims.[1] There are some relevant case examples:

• A patient with an eye injury was not referred to an ophthalmologist. The emergency physician (EP) failed to correctly diagnose the patient with a corneal ulcer that required immediate treatment. Later, a second EP correctly diagnosed the patient and referred him to an ophthalmologist. "The incorrect diagnosis led to a delay in treatment by an ophthalmologist," says **Darrell Ranum**, JD, CPHRM, vice president of the department of patient safety and risk management at The Doctors Company.

The plaintiff attorney alleged that if the eye injury had been diagnosed correctly, the patient would have been referred to the appropriate specialist. "The patient, therefore, would have been treated immediately and would not have suffered a corneal ulcer that required corneal transplants," Ranum explains.

• A cardiologist was not called for a stat review of an ECG. The patient presented with chest pain, but the initial set of cardiac enzymes were normal. "There were some changes to the ECG. A second set of cardiac enzymes were ordered later than protocol required," Ranum says.

The cardiac enzymes were elevated. The patient was admitted to the hospital under the care of a hospitalist, but the patient remained in the ED. Neither the EP nor the hospitalist contacted a cardiologist until the patient was transferred to an inpatient unit, delaying necessary interventions. "The patient suffered extensive cardiac damage due to the delay. It was determined to be substandard care," Ranum reports.

• A patient with an upper respiratory illness was not referred

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to a pulmonologist. The patient presented to the ED with fever, body aches, vomiting, and chest pain. A rapid flu swab test was negative, but a chest X-ray showed COPD with right lower lobe pneumonia.

After receiving medications, the patient felt better and was discharged home. Shortly after, the patient returned to the ED, was diagnosed with bilateral pneumonia, and was admitted to the hospital. "His condition continued to deteriorate. The family insisted on transferring the patient to a larger hospital," Ranum says.

There, the man was intubated for respiratory failure. The patient died a short time later. "The failure to consult with appropriate specialists may have caused the patient's death and was found to be below the standard of care," Ranum notes.

• **A patient with a bowel obstruction was not referred to a surgeon until the patient was severely septic.** A patient with shortness of breath, chest pain, abdominal pain, and constipation presented to the ED and was discharged with laxatives. The man soon returned to the ED with worsening symptoms.

"Multiple tests, including X-rays of the small bowel, showed dilated loops and air in the abdomen, which is an ominous sign," Ranum says. The patient arrested and was resuscitated. He was taken to surgery to remove ischemic portions of his small bowel. "The patient was septic and experienced multiorgan failure. He expired," Ranum says. The lawsuit alleged the EP failed to diagnose a bowel obstruction and failed to refer the patient to a surgeon.

• **A man with stroke-like symptoms was not referred to a neurologist until the patient suffered permanent paralysis.** This patient presented to an ED with garbled speech, headache, elevated blood pressure, and difficulty walking. The patient's glucose level was high. He was diagnosed with transient ischemic attack and diabetes. A CT scan was negative for intracranial hemorrhage.

After three hours, a neurologist finally was consulted. He diagnosed stroke, but by that time the time-frame to give tPA had run out. "The patient suffered permanent disabilities due to the delay in diagnosis of stroke and referral to a neurologist," Ranum says.

Malpractice claims alleging the EP should have involved a consultant "are always based on looking back," says **Rodney K. Adams**, JD, a visiting assistant professor at the University of Richmond (VA) School of Law. The questions become: Why did the EP not obtain a cardiac consult for the chest pain patient? Why did

EXECUTIVE SUMMARY

About one in five ED malpractice claims include the allegations that the EP failed to obtain a consult. Documentation of these items is helpful to the defense:

- A thorough ED evaluation;
- What was communicated to the consultant regarding the urgency of the case;
- Specifics on symptoms and complaints at the time the patient presented to the ED.

no one call a neurologist for a possible stroke? Why did no one summon a neurosurgeon for a back pain patient? Why did no one consult a surgeon for abdominal pain?

"Unfortunately, an EP has to make such decisions for many patients each day," Adams observes. The EP needs to decide whether a condition needs specialist care and, if so, how urgently? "Usually, the cases boil down to documentation," Adams adds. In litigation, a few issues arise frequently:

• **Thoroughness of the ED evaluation.** Adams defended an EP in a lawsuit involving a firefighter who reported back and leg pain after lifting a heavy person. The EP carefully documented a thorough neurological exam, and ordered a CT scan to rule out spinal cord compression.

"This exceeded the guidelines for back pain evaluation," Adams notes. The EP even called the radiologist to discuss the CT scan interpretation. The plaintiff was later diagnosed with cauda equina syndrome. The resulting malpractice lawsuit alleged that a neurosurgeon should have been consulted at the time of the ED visit.

"The jury had no problem returning a verdict in favor of the emergency physician, despite the subsequent treating spine surgeon trying to lay all kinds of blame on him," Adams recalls.

• **The timing of the consultant's response.** Sometimes, the EP calls a specialist, but the specialist decides not to come until later — sometimes, much later, or not at all. In these cases, who has the best documentation can determine which physician — the EP or the consultant — is held liable.

In one case, an intoxicated patient arrived with a cut to his buttock following a fight. The EP closed the wound, but the patient's blood pressure fluctuated. "The patient was lethargic and combative at times," Adams says.

Fluid resuscitation was initiated, and the EP called a surgeon to admit the patient to the ICU for observation. The surgeon agreed, but did not come to the hospital until four hours later. "The EP and the surgeon disagreed as to the sense of urgency conveyed in the phone call," Adams says. Neither documented the contents of the conversation.

When the surgeon finally arrived, the patient was coding. Once resuscitated, the patient was immediately taken to the OR. "The surgeon explored the buttock wound but couldn't control the bleeding," Adams says. "Realizing that the injury was in the pelvis, he had to flip the patient and enter from the front."

The internal iliac artery had been severed. "Several liters of blood were hidden in the pelvis. The patient didn't survive," Adams says. Despite the terrible outcome, a jury returned defense verdicts for both the EP and the surgeon. One reason was that the plaintiff attorney decided to file separate lawsuits against the defendants. "Thus, the potential conflict of the EP and the surgeon pointing the finger at each other was avoided in front of the jury," Adams explains.

When called to testify in the trial of the other, each physician had far less at stake in defending his care. "Similarly, the defense counsel for the defendant on trial was able to argue more strongly as to the impact of the absent physician's care since he wasn't in the courtroom," Adams adds.

Karen Clouse, JD, an attorney in the Columbus, OH, office of Bricker & Eckler, says these are the most common fact patterns in claims alleging failure to obtain a consult in the ED:

• chest pain, where the cardiologist is either not called at all or not called stat;

• head trauma that is considered minor by the EP, and no neurological consult is obtained;

• abdominal pain not recognized as representing a surgical abdomen requiring prompt intervention.

The plaintiff will focus on the bad outcome that happened after the ED visit. The defense's job is to draw attention to what happened at the time of the ED visit. "It is important to look at the patient's symptoms and complaints *when* they presented to the ED," Clouse says.

For instance, these kinds of questions become important for chest pain cases:

• What type of chest pain did the patient report at presentation?

• Did it resolve with a GI cocktail or with nitroglycerin?

• Were serial cardiac labs and ECGs ordered? If so, were they abnormal? If they were not ordered, did the EP explain why not?

Not every chest pain patient will undergo a full cardiac workup. "But the ED physician needs to have testing and documentation to back up the decision *not* to call in a cardiologist," Clouse stresses.

One malpractice case involved a 63-year-old woman with a history of

COMING IN FUTURE MONTHS

- Defense responses if plaintiff expert gives false testimony
- Actions that can lead to subpoenas for ED colleagues or family members
- Even slightly abnormal vital signs complicate malpractice defense
- How plaintiff attorneys prove ED patient was discharged prematurely

abdominal pain and no bowel movement for four days. Bowel sounds were present in all four quadrants, and the abdomen was soft but tender to palpation. The patient was progressively tachycardic and hypertensive in the ED. A CT was obtained that showed pyelonephritis. "This was likely a missed read by the radiologist, who was not named," Clouse offers.

The patient was admitted to her family physician without a surgeon in the ED seeing her. "Pain that was out of proportion to the findings should have been concerning but wasn't picked up as such by the EP," Clouse says.

The family physician saw the patient the next morning and consulted general surgery. By that time, the patient was in excruciating pain. "She was taken for exploratory laparotomy where she was found to have extensive necrosis of the small and large bowel," Clouse reports. The patient died the following day. The plaintiff's expert testified that the patient had occlusion of the superior mesenteric artery and would have survived with prompt surgical intervention. "In this case, the EP had a very wide differential diagnosis and may have been led astray in part by the CT report," Clouse notes.

However, the reading of pyelonephritis probably was not consistent with the patient's presentation and complaints. "This should have led to consultation with a surgeon or urologist, rather than routine admission to the primary care physician," Clouse says.

ED patients may present with complaints that initially do not point to the correct diagnosis, such as gastric symptoms. "An astute ED physician should think: 'Could this be cardiac related?'" says **Kay M. Anderson**, JD, an attorney in the Memphis, TN, office of Baker Donelson.

Without a cardiac workup, the patient probably will be discharged with instructions to follow up with the primary care physician, or he or she will be admitted, but on a general floor without cardiac telemetry. "There is no urgency, as this is a patient merely complaining about gastric upset and nothing else," Anderson says. "Then, the patient is found dead in the morning having suffered a myocardial infarction."

Unfortunately, lawsuits are filed with the benefit of hindsight. "This is a luxury the ED physician does not have. If there is even a small iota of question in your mind, consult," Anderson advises. ■

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Analysis Reveals Slight Decrease in Frequency of ED Claims

Emergency medicine malpractice claims have decreased slightly over the past decade, according to the authors of an analysis of closed claims from 2009-2018.[1]

The frequency of ED claims fluctuated somewhat from year to year. "This may be due to the small number of claims that we receive each year for emergency medicine physicians," offers **Darrell Ranum**, JD, CPHRM, vice president of the department of patient safety and risk management at The Doctors Company.

A few findings on ED claims included in the analysis stand out:

• About 8% of malpractice cases involved the ED setting. Of these, 54% were diagnosis-related; 49% involved a severe permanent injury or death;

• In the hospital setting, 9% of claims emanated from the ED. This compares with 8% for labor and delivery, 6% for the ICU, 5% for radiology/imaging, and 4% for ambulatory or day surgery.

"Emergency department claims were third in frequency behind operating rooms and patient rooms," Ranum notes. Emergency medicine claims were more frequent than internal medicine and anesthesiology, but less frequent than obstetrics and general surgery;

• As for who is named in claims involving ED care, it is the EP 84% of the time, the hospital 44% of the

EXECUTIVE SUMMARY

ED malpractice claims decreased slightly in frequency over a 10-year period, comprising 8% of total claims, according to the authors of a recent analysis. Some issues that arise often in ED claims:

- Failure to establish a differential diagnosis;
- Failure to appreciate and reconcile relevant signs, symptoms, and test results;
- Failure or delay in ordering diagnostic tests.

time, and other ED employees 2% of the time;

• At least 10% of claims that named EPs involved selection and management of therapy (such as mismanagement of medical treatment or invasive procedures or failure to order medications);

• A total of 76% of ED cases involved breakdowns in clinical judgment.

Patient assessment, selection and management of therapy, patient monitoring, failure to ensure patient safety, and conditions affecting the caregiver (such as heavy workload or understaffing) were common issues in these claims.

"A majority of those cases tend to involve a missed diagnosis," Ranum notes. "Those cases involve a higher-than-average injury severity."

The malpractice analysis revealed there is progress regarding risk in the ED, but opportunities to improve remain, says **Dana Siegal**, RN, CPHRM, CPPS, director of patient safety for CRICO Strategies, which conducted the analysis. "We, in looking at malpractice claims, can see that there are still scenarios where we are not ordering the right tests, we are not following up on tests, we are discharging patients before we complete their assessment," Siegal says.

Sometimes, ED patients are discharged appropriately, but no one follows up when additional information is available. In one case, an overread X-ray revealed a cervical spine fracture the following day — but the information never reached the discharged ED patient. EPs often do not become aware of such diagnostic failures until there is a lawsuit.

"The patient comes back on a different shift and the connection isn't made. Or, the patient seeks care elsewhere, and the organization never gets to know it happened," Siegal offers, adding that this is why an analysis of closed malpractice claims is so important for EDs. "The biggest vulnerability in diagnostic failure is getting the data and knowing it happened."

What follows is a closer look at some issues identified in ED malpractice claims that were part of the CRICO analysis:

• **Triage failures.** Claims involving inadequate triage represent just 1.1% of ED claims where hospitals were named as a defendant, and less than 1% for claims naming EPs. "When they do happen, it's usually serious, and we missed something big," Siegal says. *(See sidebar box at bottom of this page for more information.)*

• **Diagnostic failures.** In 21% of claims against EPs, the plaintiff alleged failure to establish a differential diagnosis. Failure to appreciate and reconcile relevant signs, symptoms, and test results was alleged in 18% of claims that named EPs. Failure or delay in ordering diagnostic tests was another common allegation (included in 23% of claims naming EPs).

None of this is surprising to Siegal: "That's what people are going to the ED for. They are going for a diagnosis, or to treat a known diagnosis that has complications of some kind." Litigation centers on whether the EP gathered the right information, ordered the right tests, and drew the right conclusion. Sometimes, patients are poor historians; the EP may attempt to call a treating physician but never makes the connection. "Family history might have come into play, or some previous event the patient did not tell us about," Siegal says.

• **The patient decompensates while in the ED.** "The patient's condition evolves before we actually realize what it is," Siegal notes. The ED patient presents with signs of an impending myocardial infarction (MI) or serious infection, but nobody puts the entire picture together. "The nurse has a part of the story and the emergency physician has another, but those two stories don't always come together in a timely manner," Siegal notes.

Sometimes, EPs and ED nurses spend entire shifts crossing paths without ever verbally sharing what they see and hear. "Because we rely so heavily on the EMR, we really miss the opportunity to be huddling. We've missed the human interaction that triggers people to think outside the box in the urgency of emergency

TRIAGE-RELATED CASES

In the CRICO analysis, the authors looked closely at several ED cases related to triage, including:

• A patient with severe vomiting and diarrhea waited hours to see the EP because the patient did not meet the criteria for sepsis, resulting in septic shock and death;

• A patient with a hand laceration was not diagnosed with nerve damage, delaying surgery and resulting in loss of function;

• A patient with abdominal pain and significant comorbidities (malignant hypertension and kidney disease) waited hours for care, leading to sepsis, pneumonia, and death;

• A patient with pelvic inflammatory disease waited several hours before vital signs were reassessed. Only then was it recognized that she was in respiratory distress from sepsis. ■

care," Siegal laments. In this way, ED providers can miss important pieces of the clinical picture. "People have bits and pieces of the information," Siegal adds. "But they don't share it in a way that makes the story whole."

• Lack of resources for patients with psychiatric symptoms. "So many patients who land in the ED are dealing with depression, anxiety, and alcohol and drug issues," Siegal notes. Often, psychiatric patients are boarded for long periods in the ED. This group of patients needs another level of care, but there are no resources available. "The struggle is moving them into a system that can care for them properly. They become boarders waiting for our weakened mental health resources to have a place for them," Siegal explains.

• Boarding ED patients waiting for an available inpatient bed. "The ICU nurses come down and do the assessment. But there's no bed to move them to," Siegal says. Confusion can occur over who is responsible for the patient — the EP or the attending — during this period.

"We have a diagnosis and we know the next level, but we can't move them through the system," says Siegal, adding that although this wreaks havoc with patient flow, it does not appear to be a major cause of malpractice lawsuits. "Interestingly, ED boarders are not producing the majority of malpractice claims. But they certainly produce some, and it is a burden on the system."

ED boarding poses indirect risks to other ED patients. If there are two or three beds held up, says Siegal, "one might be the very bed that we might have moved the MI [patient] sitting in the waiting room into, had the bed become available."

• Premature discharge. Twelve percent of claims naming EPs alleged the patient was discharged too soon. "Perhaps we didn't appreciate the findings of the acuteness we were seeing," Siegal says.

Some ED claims in the analysis involved patients discharged home who went on to experience an acute event without anyone appreciating the urgency of the situation. "We don't take their blood pressure and pulse again before they leave, and don't appreciate that the pulse has increased or that the blood pressure has dropped," Siegal observes.

Premature discharge, says Siegal, "is the outcome of a series of other things. It means we arrived at a diagnosis and determined we could manage it as a nonacute issue." In hindsight, the true situation becomes clear: The patient has an MI at home or an infection evolves rapidly.

The resulting lawsuit alleges the EP should have waited for cardiac troponins to come back, should have performed an MRI while the patient still was in the ED, or should have obtained a cardiac consult. Instead, a decision was made to send the patient for these tests or consults the following day. Siegal says it is not enough to simply document discharge vital signs; changes must be acted on. "Are we comparing it to the admission vital signs and finding that everything looks good? Or, if not, are we having a new conversation?" Siegal asks.

• Hand-offs at shift changes. Three percent of claims naming EPs involved the EP relying on a previous provider's diagnosis. A typical scenario: The outgoing EP tells the oncoming EP that they are just waiting for one more lab to come back. If the lab is fine, the patient probably can go home. "You've already set up the next shift to kind of dismiss that patient," Siegal notes. Even if the lab test does not quite fit the picture, the oncoming EP still might rely on the previous EP's interpretation. The question, says Siegal, is, "Are providers going to reopen the query, or just rely on somebody else's diagnosis?"

If a poor outcome happens to an ED patient, says Siegal, "the most important thing we can do is talk about it. We need to understand why things do fall through the cracks."

Siegal would like to see EDs take the malpractice data in the CRICO report and consider whether it sounds like something that could happen in their own department. "Look at the past day, week, and month. Would you say, 'Yeah, that could happen here,'" Siegal asks. "If so, think about what would stop it from happening."

Too often, action is taken only after a terribly bad outcome. "Sadly, sometimes it takes one case to go really sour and hit an organization's reputation that causes them to make the change, when data way earlier told them the vulnerability was real," Siegal laments.

ED providers can tell hospital leaders about the issues they are seeing that expose patients and the organization to risk, but they cannot do it alone. "We need senior leaders and risk managers to say, 'This is a vulnerability in our system, and we need to find the resources, the dollars, and the commitment to fixing it,'" Siegal says.

For instance, the ED team might determine on its own that every patient needs discharge vital signs. "But if senior leaders don't make a policy, [hire] staff to support it, and measure whether it's happening, there's no guarantee that good plan will go anywhere," Siegal cautions. ■

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ED's Claim of Unusually Large Patient Volume Could Backfire on Defense

After triage, a patient waited seven hours for treatment for acute pancreatitis, despite clinical presentation of systemic inflammatory response syndrome (SIRS).

"Certain stat orders took over four hours to execute," says **David Sumner**, JD, a medical negligence specialist with a multistate trial practice. The ED defense team claimed that unusually high patient volume caused the delay. The approach backfired.

"The ER tried to defend extraordinarily lengthy registration to treatment intervention delays on the date of presentation by asserting the ED had an unprecedented number of patients the day of the occurrence," Sumner explains. This opened the door for the plaintiff to obtain the ED daily census reports.

"The defense contentions placed the daily census reports for the ER at issue in the case, including acuity designations and time to disposition," Sumner notes.

Armed with the ED's daily census reports, the plaintiff refuted the claim that the ED was unusually busy. The census reports showed that during a 75-day period preceding the events, the ED saw even more patients on 47 separate days compared to the day the plaintiff presented. Overall acuity levels were no higher on the day the patient presented, either. This revealed that "the center was slow to enhance staffing to address historical greater ED patient volumes," Sumner explains.

The plaintiff contended that, in fact, the ED was understaffed for expected patient volumes. "The defense that the ED was uniquely overwhelmed with patients on the day of the occurrence was largely discredited," Sumner adds.

An ED's staffing data are not necessarily going to be admissible. However, in this case, the ED made that data relevant by including patient volume in its defense.

"You have to be careful about what doors you are opening up to much more expansive discovery by asserting certain defenses," Sumner cautions.

The defense team placed adequacy of staffing at issue by asserting that their patient volume was exceptional on the day the plaintiff presented. "You cannot assert that the ER was too busy to provide more timely care without opening up for discovery the daily patient census, acuity information, and data on adequacy of staffing," Sumner warns.

The plaintiff argued the ED did not have designated staff to review labs before patients were brought back to a room. Thus, the patient's abnormal lab results (a white blood cell count of 21,000 accompanied by hemoconcentration, severely elevated lipase, and creatinine of 1.4) went undetected for hours.

"The hemoconcentration was a critical element to demonstrate why he needed earlier aggressive IV hydration and why a seven-hour delay in treatment influenced his outcome," Sumner says. "He languished in the ER to his considerable detriment." The patient developed multiple organ system failure. He survived a lengthy hospital admission, but was so compromised from the severity of his pancreatitis that he required numerous additional admissions related to his earlier critical care course. He died within months of the initial ED visit.

The lawsuit alleged the ED's "surge" staffing policies were ignored. ED nurses admitted staff were not adhering to the surge plan. Further, the nurses admitted the surge plan probably was inadequate for their volumes even if invoked. "Any deviation from hospital policies and procedures can sink the defense of the case," Sumner says.

Later, the hospital developed more effective surge plans to address the consistently higher volumes in its ED. "The case was settled at mediation for a confidential amount after expert witness opinion disclosures but before any expert witness depositions," Sumner reports.

Typically, ED staffing is outside the control of an individual EP. Thus, it is a way to bring the hospital in as a defendant, says **Bradley Shy**, MD, medical director of the adult ED at Denver Health and Hospital Authority. Highlighting systemic problems

EXECUTIVE SUMMARY

Defense claims that unusually high volumes led to delayed care can result in expanded discovery, including census reports. If admissible, the plaintiff can use staffing data to:

- show the ED was, in fact, not experiencing unusually high volumes on the day the plaintiff presented;
- demonstrate a pervasive pattern of understaffing;
- show that the hospital had not reacted quickly enough to increasing ED volumes.

with staffing and wait times could help an EP defendant to deflect liability by placing blame on the hospital's shoulders.

"The hospital and the physician would have competing interests with regards to how crowding should be considered as a mitigating factor in that case," Shy explains.

The EP might want to testify that the ED was understaffed constantly, which caused delayed care. The hospital, on the other hand, would want to place blame on the individual EP's shoulders. "Crowding could be an important tool that plaintiff attorneys may use going forward," Shy offers.

But first, the attorney would need data on ED wait times and staffing. "It can be difficult for an attorney to truly understand how busy an ED was at any given point, particularly a case that's several years old," Shy says.

Such data can paint a picture of ED providers who delayed care, rushed through an evaluation, or missed a diagnosis.

"It could be used against hospitals if a bad outcome occurred during a particularly crowded time for the ED," Shy explains.

If an ED was understaffed on just one random day, this information is not of much use to a plaintiff attorney. However, it is a different story if the attorney can show it happened routinely.

"It's not enough that in flu season the waits are too long. If a year's worth of data suggests there is a systemic, persistent practice of understaffing, that potentially might be admissible," says **Rade Vukmir**, MD, JD, FCCP, FACEP, FACHE, president of Critical Care Medicine Associates and clinical professor of emergency medicine at Temple University and Drexel University.

If the attorney obtained the log from the date of the plaintiff's ED visit, and 120 patients were seen, but the ED was staffed for approximately 80 patients, it seems like a smoking gun. But it might be that the ED's average volume was 80 patients, and there was a larger-than-normal patient volume on that particular day. Juries will understand that "you've got to staff for the average; you can't always staff for the busiest day," Vukmir says.

Of course, EDs should have a system in place to adjust to sudden volume surges. "But if understaffing doesn't happen every day, and you had a plan and a surge protocol in place, you're generally OK," Vukmir says.

It is different if ED understaffing occurs continually. That is something the plaintiff can use to bring the hospital in as a defendant. Whether it is admissible is another matter. "A basic principle of evidentiary law is that if the probative value of the evidence is more than the prejudicial effect, it probably will be allowed to be considered," Vukmir explains.

The first question is whether extrinsic evidence (such as ED staffing data) is admissible in that particular legal venue. If so, and the plaintiff expert testifies that the ED continually staffed at significantly less than the recommended staffing levels for their patient volume, "that could potentially be an issue," Vukmir cautions. ■

Texts Can Hurt Defendant EP, Even if Messages Were Sent Off Shift

It may seem like no big deal to text a colleague about a tricky ED case. However, that message could become a major issue during malpractice litigation.

"That little cellphone in your pocket can be very helpful in caring for a patient but very harmful in a lawsuit. It's not something to be taken lightly," says **Jesse K. Broocker**, JD, an attorney at Weathington McGrew in Atlanta.

Even just answering a text while off shift carries important legal implications for EPs. One recent malpractice case involved a patient who underwent a total knee replacement. The next morning, the physician rounding learned that the patient had lost feeling in his foot. That physician texted a colleague about the situation.

"My doctor had no obligation to respond to that text message. He was not on call. It was purely a favor to his colleague — and, really, the patient — that he engaged in decision-making," Broocker says. The physician texted back, *"Wow, that's weird. You might want to do a nerve conduction study."* Shortly after, the first physician texted back, *"The patient can move his foot again, and is fine."*

"It ended up [the patient] had a popliteal artery injury, which caused intermittent symptoms," Brooker says, noting the patient sued the doctor who had rounded. "But, in that doctor's deposition, he whipped out these text messages."

The plaintiff attorney added the doctor who had responded to the text to the lawsuit, arguing that the physician should have realized the

seriousness of the situation and taken appropriate action. "He was probably out on the golf course just trying to be friendly and ended up getting dragged into the case," Broocker suggests.

EPs often want to know: *"Are you telling me that if someone texts me with one question, and I answer it, that I can be brought into a lawsuit?"* It's certainly possible, according to Broocker: "There are no hard and fast rules. But you may be brought in. You just have to be careful."

Even texts and calls of a nonclinical nature cause problems during litigation. EP clients sometimes tell Broocker, *"I'm on shift right now."* He instructs the doctor to end the call immediately.

"If a bad outcome happens during the shift, the plaintiff attorney can get ahold of the phone records," Broocker says. The plaintiff attorney will be able to say, *"You were on the phone with your lawyer when you should have been seeing patients."*

The same goes for sending text messages during an ED shift. The question *"Were you sending text messages during your shift?"* is common in depositions. Broocker advises his EP clients to turn off their phones while working a shift. "They can get [cellphone records] now," Brooker notes. "I'm surprised, quite frankly, that they don't ask for it in more ER cases."

So-called "curbside" consults performed informally in hallways or over the phone are nothing new in ED litigation. "For an ER doctor, a consult can be massive insulation in malpractice. If you get the right consult for an issue, that's a very defensible case if that consultant gives you the wrong advice," Broocker says.

In a typical case, the EP pages a cardiologist for input on an ECG read. The cardiologist thinks it is just an informal exchange, but the EP documents it as a consult. "I've had cases where there was miscommunication on the level of the consultant's involvement," Broocker says.

What is new is that curbside consults are happening with text messages. The EP might text a radiologist, *"Let me know what you think"* about an X-ray. The radiologist texts back, *"It looks normal."* The EP thinks the radiologist has reviewed the X-ray in its entirety and has cleared it. The radiologist's text was referring to something being looked for specifically, such as checking to see that a tube was placed correctly. This miscommunication can pit one defendant against another.

Despite the potential legal risks, it probably is unrealistic to stop curbside consults altogether. "Curbsides are quicker, and consultants will be more responsive," Brooker says.

The key is for all parties involved to realize that anything they say on a cellphone call or text is potentially admissible in the event of malpractice litigation. "I can't promise that anything is *not* coming in. Whether or not a text ends up being admissible is the judge's call," Broocker cautions.

In one court of appeals case, texts exchanged between two physicians became an issue. The messages included disparaging remarks about a consultant, which had no relevance to the facts at issue in the malpractice case. Nonetheless, the texts were ruled admissible.[1]

It is safe to assume plaintiff attorneys will try to obtain any texts sent during the EP defendant's shift to use against the EP in some fashion. "It behooves them to muddy up the case," Broocker adds.

In a medical malpractice case, any text about the patient's condition, treatment decisions, or prognosis likely is admissible as a statement made by the defendant physician, according to **Ryan M. Shuirman**, JD, an attorney at Yates, McLamb & Weyher in Raleigh, NC. Similarly, the content of a phone call, particularly statements made by a defendant, likely will be admissible as admissions.

"Statements of nonparties in such a phone conversation may be admissible if offered to prove why an EP took a certain action based on information conveyed by a colleague," Shuirman explains.

It has become more common for plaintiffs to request the phone records of a physician. They are looking for evidence of outgoing and incoming phone calls and texts. "The rationale for requesting this information is essentially the same as the audit trail," Shuirman says. These texts and calls help establish a timeline. Such messages also identify individuals who might have knowledge beyond what is contained in the medical record.

EXECUTIVE SUMMARY

Increasingly, plaintiff attorneys are requesting EP defendants' texts and cellphone calls during discovery.

- At deposition, EPs face questions about whether they were sending texts during their shift;
- Asking colleagues a question via text could bring them into the litigation;
- EPs consulting with radiologists by text can be legally problematic for both parties;
- Humorous texts can appear inappropriate in court.

"Text messages provide more information than a call log," Shuirman says. Texts spell out exactly the information that was conveyed and, perhaps, the reaction of the recipient to the information.

Discovery in litigation often occurs years after the event. Memories of conversations can fade over time. Thus, says Shuirman, two physicians who communicate verbally via phone have plausible deniability when asked for details of the conversation at deposition.

"With a text message, however, there is no denying the information conveyed or the decisions made with knowledge of that information," Shuirman says.

In a recent malpractice case, the patient experienced life-threatening complications following a heart catheterization. The cardiology team consisted of the diagnostic cardiologist, the interventionalist, and a physician assistant who managed the patient on the floor. While the interventionalist rounded on the patient in the ICU, he was on call at another facility later in the day. Thus, he was not going to be around to receive updates on the patient's status.

"In what seemed to be compassionate inquiries into the patient's condition, the interventionalist sent text messages to the various consultants who were asked to assist," Shuirman reports.

The interventionalist jokingly wrote in a text that the consultant should give the patient a "two-for-one" discount on the various services he was receiving, or perhaps "throw in" another treatment for free. "The text was received with the levity intended, and the consultant acknowledged the joke," Shuirman notes.

In discovery, the plaintiff asked the interventionalist to produce all texts that referenced the patient. The interventionalist had to explain the appropriateness of his levity at a time when the patient's prognosis was quite guarded and severe neurologic injury likely had occurred.

"Knowing that a text message might ultimately be read by a jury should be incentive enough for a physician to think twice about the language used and tone of any message," Shuirman advises. EPs should recognize that their texts may be treated no differently than notes in a chart that contemporaneously detail facts.

"In some ways, text messages can be even more telling, in that they include a date and time stamp," Shuirman offers. "Every message alerts the reader to what was known at what particular time." ■

REFERENCE

1. *Pham v. Black*, 2018 Ga. App. LEXIS 567, *4 (Oct. 10, 2018).

Liability for Hospitals if Security Removes Disruptive Person from Waiting Room

Someone is becoming disruptive in the ED waiting room, and ED personnel decides to call law enforcement. **Scott Zeller**, MD, has seen many such cases.

"What sometimes happens is [staff will] see an individual and assume they are loitering and say, 'We need to get police and security involved,'" explains Zeller, vice president of acute psychiatric medicine at Vituity in Emeryville, CA.

When asked if a medical screening exam was performed, as is required by the Emergency Medical Treatment and Labor Act (EMTALA), the response usually is no. ED personnel often say they left it up to police to decide what to do. "The police can only assist with criminal issues. Meeting EMTALA requirements is not the police's obligation," Zeller notes.

In one such case, a patient with schizophrenia was in an ED waiting room after registering. The patient became agitated and threatening while waiting to be seen. "Security was called and felt the patient was dangerous, so they contacted police," Zeller reports.

Police officers put the patient on an involuntary psychiatric hold. Per their protocol, they arranged for an ambulance to take the patient to another hospital with a psychiatric unit. The ambulance crew arrived with a gurney, placed the patient on it, and transferred him directly out of the waiting room to the other facility.

At no time did any physician or licensed independent practitioner see the patient while in the ED waiting room. "The patient was effectively transferred to another hospital without any medical screening exam, efforts to stabilize, or even contact with the facility receiving the transfer," Zeller says.

The receiving facility contacted the original hospital, whose medical director insisted "it was a police matter, so we didn't get involved."

"However, the situation was a de facto transfer without the sending facility meeting any EMTALA requirements," Zeller says.

Under EMTALA, the hospital is required perform a medical screening exam and stabilization to the best

of its capability for anybody seeking assistance within 500 yards of the hospital. It may, in fact, be appropriate to ask police or security to escort someone off hospital grounds. "But there should be an opportunity to do at least a basic medical screening exam as part of that process," Zeller adds.

This is true even if police are putting somebody in handcuffs. "The EP attending physician should have a few moments where they can determine if this is somebody who does have an emergency medical condition," Zeller offers. With a bad outcome shortly after the episode, the hospital and responsible medical staff would be liable for both malpractice and EMTALA violations.

If the EP can clear the person and believes there is no medical emergency, Zeller advises documenting it as follows: *"I have conducted a medical screening exam of this individual and find that no emergency medical condition exists."*

"The EP can say, 'We've already screened this person, and they don't meet criteria,'" Zeller explains. "Then, it can be up to the police or security what happens next."

Zeller says the safest approach is to presume that anyone in the ED waiting area is presenting for evaluation and medical care, unless they indicate otherwise. "Even if an individual is not clearly stating they want help or to see a doctor, just assume that is the case. That way, you'll always be on the safe side," Zeller suggests.

Staff, especially security personnel, should be trained to approach anyone on their campus who appears to be medically or psychiatrically compromised to determine if they need help and want to see a doctor. Some people may be incoherent or unable to state their intentions. This could be because they have a psychiatric illness. It also could be an underlying medical condition that's causing an altered mental status.

"A patient with very low blood sugar can have symptoms that look like acute psychosis," Zeller says. Individuals with head trauma or an intracranial bleed, which might not be immediately obvious due to hair or a hat, can appear psychiatrically impaired.

"It's just like if somebody came to the ER and passed out," Zeller says. "We wouldn't decide that because they aren't able to ask for our help that they didn't want our help." ■

Many ED Charts Lack Explanation of EP's Thought Process

Many ED malpractice claims would be defensible except for one problem: There is nothing in the chart to explain what the EP was thinking at the time of the ED visit.

"Everyone is going to miss a diagnosis. It's inherent in emergency medicine," says **Kevin J. Kuhn**, JD, a partner at Wheeler Trigg O'Donnell in Denver.

A poor outcome does not necessarily equal malpractice. It is possible that it was too early to make a diagnosis at the time of the ED visit. For example, documentation that a headache has subsided substantially or that the patient responded to treatment is important to show *why* the EP thought subarachnoid hemorrhage unlikely. "The thought process is what we want to see to help the folks we are privileged to represent," Kuhn says. "If we can see that documented, that is so helpful." This makes it easier for attorneys to defend a malpractice claim. Consider these two common fact patterns:

• In some spinal emergency cases, the rationale for the location ordered for imaging is not documented. For instance, patient status post C-spine fusion who experiences a fall from bed at home comes to the ED. The patient presents with an onset of new neurologic symptoms that seem clinically unrelated to the surgical area. The EP obtains an MRI of the lumbar spine initially. Later, the plaintiff alleges that an MRI of the entire spine was required immediately in this circumstance.

"In a case like this, we've seen lack of documentation of medical decision-making hurt the provider's defense, especially where delay in diagnosis is alleged," says **Renée Bernard**, JD, vice president of patient safety at The Mutual Risk Retention Group in Walnut Creek, CA.

• In sepsis cases, ED providers appear to have disregarded a clinical decision tool or alert system. Plaintiffs will allege the alert from the tool should have triggered the ED to implement a treatment plan for sepsis. "The EP's clinical judgment may determine a different treatment course is appropriate," Bernard says.

Sepsis bundles do not set the standard of care for EPs making judgments as to individual patients. "Good documentation acknowledges *all* pertinent clinical data," says Bernard, noting this includes clinical decision tool alerts, which are automatically documented in the EMR. "Otherwise, it looks like a piece of information was missed or was not addressed." ■

ED LEGAL LETTER

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **Which is true if the ED defense team argues that unusual patient volume caused delays?**

   a. It opens the door for more expansive discovery, including the daily patient census.
   b. The plaintiff has no way of refuting the claim that the ED was unusually busy at the time the plaintiff presented.
   c. The defense is prevented from arguing that the ED's staffing data should not be admissible for at least 30 days.
   d. Daily census reports for EDs are inadmissible, even if the defense makes an issue of patient volume.

2. **Which is true regarding allegations that an ED was understaffed?**

   a. If the ED was staffed normally on the day the plaintiff presented, it will be automatically admissible as evidence of understaffing if there was larger-than-normal volume on that particular day.
   b. Plaintiffs cannot raise the issue of whether the ED had a system to address sudden volume surges.
   c. Data showing a systemic, persistent practice of understaffing potentially are admissible.
   d. Juries will be instructed that the ED is required to staff for the busiest day, not the average day.

3. **Which is true regarding admissibility of EP defendants' text messages?**

   a. Texts of a nonclinical nature are inadmissible.
   b. Informal consults conducted by texts cannot be used to pit one defendant against another in the event a lawsuit is filed.
   c. Texts potentially are admissible, but *only* if they are relevant to the facts at issue in the malpractice litigation.
   d. Any text message about the patient's condition, treatment decisions, or prognosis likely is admissible as a statement made by the defendant physician.

4. **Which is true regarding EMTALA and psychiatric patients?**

   a. Once police become involved, requirements for medical screening examinations no longer apply.
   b. It is safest for ED personnel to assume anyone in the ED waiting area is presenting for evaluation and medical care.
   c. If a disruptive person is placed in handcuffs, the EP no longer is obligated to determine if an emergency medical condition exists.
   d. In most cases, EMTALA does not apply to psychiatric patients.