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INSIDE

AHC Media

Court Rules on Standard of Care for Pediatric Patients in "General" EDs

Recent malpractice litigation involving an infant who died of complications of enterovirus infection after being discharged from an ED centered on a controversial allegation.

"In addition to the usual alleged deviation from standard of care, the plaintiff alleged that a general EP was not qualified to staff a pediatric ED," says **Michael J. Gerardi**, MD, FAAP, FACEP, president of the American College of Emergency Physicians (ACEP). The hospital had created and marketed a pediatric ED within its general, busy ED.

"A particularly aggressive plaintiff counsel tried to seek further damages accusing the hospital of false marketing," Gerardi says. "He posited the pediatric ED should be staffed only by pediatric EPs. We fought it tooth and nail." Gerardi is an attending physician and faculty member in the Department of Emergency Medicine at Morristown Medical Center and director of Pediatric Emergency Medicine at Goryeb Children's Hospital in Morristown, NJ.

ACEP filed an amicus brief on behalf of the defendant EP, stating that general EPs are well-qualified to treat children in EDs and summarizing numerous programs and initiatives to assure competency of general EPs in handling pediatric emergencies.

"In my years as a medical legal expert and now as an ACEP board

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member, I am not aware of many cases when plaintiff's counsel questions a general EP's training and competence to treat children like this and said, 'You are not prepared just because you are a general EP,'" Gerardi says. "When ACEP learned of this, we had to fight back just as aggressively and find ways to support the defendant."

After a prolonged trial, the case resulted in a verdict in favor of the defense. The plaintiff appealed, but recently lost in a decision rendered in April 2015.

"The case was based on a false accusation that the general EP wasn't competent to take care of children. That is defamatory to general EPs and our specialty," Gerardi says. "The undeniable fact is that most kids present to general EDs, and that we are well-prepared to handle their emergencies."

Although some studies suggest that general EPs are more conservative than pediatric EPs, and tend to order a few more tests when working up certain maladies, Gerardi adds, there are no demonstrable differences in outcome.

"But if there is a bad outcome, you can be sure you will be attacked because you are a general EP," says **Alfred Sacchetti**, MD, FACEP, chief of emergency services at Our Lady of Lourdes Medical Center in Camden, NJ, and assistant clinical professor of emergency medicine at Thomas Jefferson University in Philadelphia, PA.

If the plaintiff had prevailed, Gerardi says, it would have set a dangerous precedent suggesting general EDs are not safe for children. "When plaintiffs, the media, or even physicians cast aspersions on general EDs, there is a lot of damage that is done," he says. "It's a danger to the public, and it's not based on fact."

The standard of care does not require the EP to be an expert in pediatric care, such as fellowship-trained pediatric EPs, but rather a competent EP who is prepared to treat pediatric emergencies. "This is where your defense attorney really has to step up to the plate," Sacchetti says.

The defense attorney can question the pediatric emergency medicine expert testifying for the plaintiff about where they practice, for instance. Sacchetti suggests the defense attorney might say something like, "You practice with every resource known to medicine in your facility. Have you ever practiced where you had no backup?"

Demonstrate You Met SOC

Some hospitals market their EDs as specializing in certain populations, such as cardiac care. "Hospitals have their own product lines, but that said, you can't let the other populations, children especially, fall below the standard of care," Sacchetti warns. "For a number of departments, the focus is on adults, and pediatric care is almost on a second tier. It's not a priority."

If a bad outcome in a pediatric patient results in a lawsuit against the EP, Sacchetti says the EP's defense can be strengthened with evidence of the ED's commitment to pediatric patients. One way to demonstrate this is to show compliance with the American Academy of Pediatrics (AAP)/ACEP/ Emergency Nurses Association guidelines on the care of children in EDs, which were updated in 2009.[1]

Sacchetti participated in the development of the guidelines. "Some of the other guidelines out there are very onerous and have ridiculous expectations to meet," he says. "This is a nuts and bolts set of recommendations, which any community ED can easily meet." If the EP can truthfully state the ED has met every one of the recommendations, "it's a nice way to bulletproof your department," Sacchetti adds. "On the other hand, if someone pulls out this document and the ED is missing half of the things that are recommended, that's difficult to defend."

"Outlier" EDs Unprepared

A recent assessment of EDs' compliance with the updated 2009 guidelines indicated that EDs are better prepared than they have been in the past to care for children.[2] "The results supported our contention that ED managers and directors are paying attention, and that the quality of care is improving," Gerardi says.

Some EDs, however, operate under a false sense of assurance that they won't see pediatric emergencies because of their proximity to a children's hospital. "The outliers are the ones who say they don't treat children, because parents and ambulances know not to bring children there," Sacchetti says. "I have seen instances where providers did not have any of the recommended equipment and were completely unprepared. 'We are not supposed to get pediatric emergencies' is a very weak defense."

Any malpractice case against an EP involving a child with a bad outcome is difficult to defend at trial. "It doesn't necessarily mean you are going to automatically lose the case. But the case is more likely to be settled, even if the care is perfect," Sacchetti says. He is aware of multiple claims involving pediatric patients seen in EDs where the EP clearly met the standard of care, and the caretakers were clearly at fault for not following instructions, but were settled anyway due to the emotional component.

"Part of the problem is the inability of the house of medicine to police its experts," Sacchetti notes. "There are a number of bad actors in this area who have made a living out of inappropriately criticizing general EPs because of their credentials."

Children May Present in Early Stages

In many malpractice claims involving pediatric patients seen in EDs, an appropriate assessment was done and a reasonable decision to discharge the child was made. "Then the child comes back with an evolution of their disease, and the claim is made that the EP should have recognized it at that time," Sacchetti says. For instance, a child who is wheezing but otherwise appears fine may be discharged from an ED, but three days later develops a cardiomyopathy.

"The problem is that children have so much physiologic reserve that it is very possible to be fooled into thinking the child is healthier than they are, when they are in the early stages of something," Sacchetti says. "Be sure to close the loop in terms of follow-up."

If it's early in Sacchetti's shift, he sometimes asks parents to call back in eight hours to tell him how the child is doing or return to the ED. "One of the classic lines that the parent always says in a deposition is, 'The doctor said nothing was wrong,'" Sacchetti notes. He recommends instead saying, "We are not finding anything at this time."

Before discharging pediatric patients who are potentially in the early stages of an evolving illness, Gerardi offers to observe the child longer in the ED or get another opinion if parents aren't comfortable leaving the ED. "If it's 3 a.m., offer to observe the child for a few hours until the light of day when there is another colleague or a consultant available to take a look," he says. "Time is a great diagnostic aid." ■

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Unique Legal Risks Posed by ED "Bridge Orders"

When a 61-year-old woman presented with heavy cough, rib pain, and difficulty breathing, the EP suspected a possible pulmonary embolus (PE). "The ED physician was unable to get a CT scan completed until the following day," says **Brandon K. Stelly**, corporate director of Enterprise Risk Management Legal Division and internal counsel for the Schumacher Group in Lafayette, LA.

Accordingly, the EP had the patient admitted under the care of an admitting physician. The EP's "bridge" orders included an order for a therapeutic dose of enoxaparin sodium injection every 12 hours to cover the patient against the possibility of PE until the patient could be seen by the admitting physician.

The following day, the CT ruled out an active PE. However, the admitting physician failed to adjust the dosage, so the patient continued to receive a therapeutic instead of a prophylactic dose. "Ultimately, the patient developed a large hematoma in the anterior abdominal wall with active bleeding," Stelly says. "She was administered IV fluids, blood transfusions, and was intubated, but ultimately expired."

The patient's family sued both the EP and the admitting physician. The case went before a medical review panel, which found that the EP did not breach the standard of care by ordering a therapeutic dose to cover the patient. However, the panel found that the admitting physician did breach the standard of care by failing to review and revise the bridge orders. "The EP got out on a motion for summary judgment, based on the panel opinion," Stelly says.

The panel wanted to know why the EP ordered a therapeutic dose instead of a prophylactic dose. The EP explained that because a CT scan was unavailable, he wanted to cover the patient for a possible active PE instead of a prophylactic dose, which is only designed to prevent an impending PE. "The panel agreed that was reasonable, and the buck stopped with the admitting physician who failed to review and revise the bridge orders," Stelly explains.

This raised the question of why the bridge orders continued to be followed for days without revision or new orders by the admitting physician. "The EP's position was that he had explained the orders and the admitting physician agreed with them, but unfortunately failed to adjust them appropriately once PE had been ruled out," Stelly says.

Since the bridge orders were documented on a form with the heading "Emergency Department Physician Admission Orders," it was necessary to explain to the panel that the orders were merely holding orders and that the EP did not have admitting privileges to the facility. Stelly recommends having a policy requiring such orders to be revised or expire within a certain period of time.

"Within the physician handoff, there is always room for error, and that's what happened in this case," says Stelly, adding that it would have helped the EP's defense further if he had a progress note that explained the plan of care with the admitting physician and that the dose was to be revisited following the CT scan.

Clear-Cut Guidelines Needed

Bridge, or transition, orders are best developed to guide physicians in assuring effective communication and continuity of care, says **Laura Martinez**, BSN, RN, MS, CPHRN, FASHRM, vice president of risk management at MagMutual Patient Safety Institute in Atlanta, GA. "Failure to establish clear-cut guidelines for provider roles and responsibilities is the biggest concern," she says. The American College of Emergency Physicians has provided guidance for EPs with regard to the use of bridge orders as an effective means for hand-off communication to admitting physicians.[1,2]

"The expectation of everyone involved should be that 'bridge' orders are just that — a bridge to fill the gap from when the EP relinquishes care and the admitting physician actively assumes care," Stelly stresses. To protect themselves legally, EPs can write the bridge order in such a way that ensures it isn't continued indefinitely. For instance, the EP could simply order two doses of enoxaparin sodium injection for the patient, ensuring that the order will be revisited, instead of writing for one dose every two hours under the assumption that the admitting physician will see the patient the next day and revise the order as needed.

"If that doesn't happen for any reason, the risk is that the orders will be carried out indefinitely to the patient's detriment," Stelly warns. ■

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Simple Actions Before Discharge Can Prevent Some ED Claims

Lack of specific personalized discharge instructions and no indication of the EP's rationale complicated the defense of a recent malpractice claim involving a 38-year-old woman who presented to an ED with abdominal pain, nausea, and a fever which resolved in the ED. The patient ultimately developed sepsis.

"The claim was reviewed and ultimately denied because the standard of care was met. But better documentation would have likely prevented the claim from being brought in the first place," says **Scott O'Halloran**, JD, a medical malpractice attorney in the Tacoma, WA, office of Fain Anderson VanDerhoef Rosendahl O'Halloran Spillane.

Standard electronic medical record (EMR) discharge instructions regarding abdominal pain were given. "There was no medical decision-making summary given by the physician," O'Halloran says. The patient failed to follow up with her primary care physician as indicated in the discharge instructions and was later treated emergently for sepsis. In the resulting claim, the patient's lawyer alleged that the EP did not properly evaluate and treat the patient, resulting in delay in diagnosis and treatment for sepsis.

"This case exemplifies the inadequacy of the EMR to provide a clear record of the medical decision-making and specifics of personal patient instructions," O'Halloran says. It also underscores the necessity that the EP clearly document the rationale for the diagnosis and the content of the discussion.

"An optimal way of managing this patient's case might include a note that discusses the medical decision-making at the time of the visit, including the diagnosis considered, and a documented discussion with the patient about the findings, assessment, and plan," O'Halloran says.

Relying on printed patient instructions as a method of communication with an ED patient can be problematic. Studies have shown that patients don't always read them.[1] "When they do, the language may be too medically sophisticated for the patient to comprehend or too broad for the patient to apply to their situation," O'Halloran says.

Patient Doesn't Fit the Mold

Malpractice claims alleging premature discharge from an ED generally involve a failure to take an adequate history or failure to perform adequate examination and imaging, according to **Armand Leone, Jr.**, MD, JD, MBA, a medical malpractice attorney at Britcher, Leone & Roth in Glen Rock, NJ.

"Typically, there is a disconnect between the patient's profile and the stereotypical patient for the underlying condition," Leone says. "The common fact pattern is that the patient doesn't fit the prototypical patient for the disease or condition."

This causes the EP to commit a representative bias error and subconsciously to exclude a more serious condition since the patient "doesn't fit the mold," Leone says. "These errors occur especially when the ED physicians are busy, tired, or distracted."

A recent malpractice claim involved an athletic, non-smoking young man under 35 who reported chest pain after playing sports. A chest X-ray was normal, but an EKG was not obtained.

"The physician mentally ruled out cardiac ischemia based on an erroneous assumption that the patient is too young and too healthy to have coronary disease," Leone says. "This mental bias caused the physician to misdiagnose cardiac ischemia and to prematurely discharge a patient with an unstable and potentially lethal condition." In this case, misdiagnosing the condition as reflux esophagitis led to a non-fatal heart attack with cardiac arrest that also caused significant hypoxia and permanent brain damage. "The failure to order an EKG was pivotal in this case, which resulted in a settlement for the plaintiff," Leone says.

Other malpractice claims involve the EP's failure to recognize early signs of a stroke that present with minimal symptoms. "Depending on the age, sex, and associated co-illnesses of the patient, an EP may fail do a complete neurological workup or request a neurology consultation

because the patient does not create an index of suspicion that stroke may be the cause," Leone says.

A recent case involved a 45-year-old woman who presented to an ED within 90 minutes of developing facial droop. "Since the patient did not have any cardiovascular risk factors and had Lyme disease, the facial droop was attributed to that, without any further consideration of other etiologies, neurological workup, or consultation," Leone explains. Later that night, after being discharged from the ED, the patient went on to have a completed stroke. This case ultimately settled after discovery was completed.

Leone says EPs can protect themselves legally by recognizing that they are vulnerable to various cognitive biases that can lead to wrong diagnoses. "Just because a patient is not at high risk for a condition based on demographics does not mean the patient is not at any risk," he underscores. "If it is flu season and five patients have come in with respiratory symptoms, malaise, and fever consistent with the flu, it doesn't mean that the sixth patient doesn't have a bacterial pneumonia."

Leone suggests EPs take a moment to think critically about what else could be causing the patient's problems and ask, "What is the worst that could be going on?"

"These mental time-outs allow a physician to step back and look at the whole patient and not just the salient features that created her first impression of the problem," Leone says. "If a physician fails to consider a diagnosis or fails to provide a relevant treatment, that creates an omission rising to a deviation."

Abnormal vital signs in ED patients at the point of discharge is a major focus at TeamHealth Patient Safety Organization, says associate director **Nathaniel Schlicher**, MD, JD, FACEP. Schlicher is also attorney of counsel in the Seattle office of Johnson, Graffe, Keay, Moniz & Wick.

"We need to be thoughtful in the way that we approach abnormal findings. It is a last opportunity for us to double check the chart for a safe course," Schlicher says. Abnormal vital signs have been linked to unexpected deaths after discharge from the ED.[2]

The ED chart ideally shows the provider has reviewed the vital signs and considered them in the context of the differential and the treatment plan. For instance, discharging a febrile child with an upper respiratory infection who is tachycardic may be a reasonable approach. "If the same child is younger, unimmunized, and has labored breathing, it may present a very different picture," Schlicher says.

The ED chart should include the EP's reason why the patient had abnormal vital signs. "If a patient has an unexpected return, the presence of abnormal vital signs often implies that something was missed on the first visit," he says.

An anxious teenager who is discharged with tachycardia and a panic attack, for instance, might return three days later with a pulmonary embolism. "It's important to document why you did not find the abnormal vital signs to be a concern, just as you would document why an abnormal lab is not a concern," Schlicher says. Good documentation will identify the abnormality, discuss its implication on the diagnosis, explain away other potential diagnoses in the differential, and indicate how the plan has been affected.

TeamHealth encourages its EDs to have a protocol for checking vital signs within 30 minutes of discharge, holding the discharge if any vital signs are abnormal, and then notifying the EP. This provides EPs the opportunity to document their rationale if they proceed with the discharge.

"Discharging an asthmatic that is mildly tachycardic but breathing well, moving good air, and without evidence of respiratory distress may very well be OK. But sometimes the double check may change your course," Schlicher advises. In some cases, EPs decide against discharging the patient.

"The tachypneic and tachycardic patient that is using accessory muscles that you had not seen on your initial evaluation may have a more severe presentation and require observation and hospitalization if they do not improve," Schlicher notes.

Just as with abnormal labs, the EP needs to consider why abnormal vitals did, or did not, change the treatment plan. "You don't ignore the data that's in front of you," Schlicher says. "You don't necessarily need to act on that data. But it's important that prospectively, we have a reason for why we did something." ■

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High Payouts Make Missed Meningitis Cases Very Appealing to Plaintiff Attorneys

A patient has flu-like symptoms and is discharged from the ED; shortly afterward, the patient is diagnosed with meningitis and sues the emergency physician (EP) for malpractice. Such cases are becoming rarer due to the decreased incidence of meningitis, but claims that do occur are likely to be settled, says **John Tafuri**, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland.

This is true even if the EP's care was entirely appropriate and well-documented, says Tafuri, because of the extremely high payouts associated with meningitis cases. Plaintiff attorneys are more likely to pursue the claim, even if they are uncertain they can prevail.

"If the case is a $5 to $6 million case based on damages, even if the attorney thinks there is only a 10% chance of winning it, they are willing to roll the dice and pursue the claim," says Tafuri.

According to the PIAA Data Sharing Project, of 75 closed claims involving meningitis in pediatric patients in 2001 to 2010, the majority of cases involved death, major permanent injury, and grave injury. Claims involving major permanent injury had the highest total indemnity of $10.2 million and highest paid-to-closed ratio of 52.4%. Of 48 closed claims involving diagnostic errors, 22 were paid, totaling more than $12 million.[1]

Two days later, she was brought by ambulance to the ED and diagnosed with bacterial meningitis, and suffered permanent severe brain injuries. The case settled due to lack of support from experts, who felt that discharging the patient without lab results, cultures, a spinal tap, and intravenous fluids may have been interpreted as outside of the standard of care.[1]

Since many EPs only have $1 million of malpractice insurance, there is a possibility the payout will exceed the policy limits. A plaintiff attorney can use that as a negotiating tool to pressure the EP into settling what otherwise might be a defensible case.

"The attorney might say, 'I'm going to take this to trial if you don't settle for your policy limit, and if you lose, I'm going to come after your personal assets,'" says Tafuri. "That is a tactic they will take if there is a devastating illness that results in long-term care needs where damages are in the millions."

Meningitis often presents with non-specific, common signs and symptoms such as fever, headache, vomiting, and poor appetite.

"Missed cases often involve a failure to exclude meningitis, even when it has been considered, as well as a failure to perform timely follow-up to ensure the patient remains clinically stable," says **Jonathan M. Fanaroff**, MD, JD, associate professor of pediatrics at Case Western Reserve University School of Medicine and co-director of the Neonatal Intensive Care Unit at Rainbow Babies & Children's Hospital, both in Cleveland, OH.

Early on, meningitis can resemble flu-like illness. "That is problematic for EPs, particularly for certain kinds in meningitis that can come on very quickly and be devastating," says Tafuri. "Identifying meningitis can be very difficult at an early stage."

Tafuri says a typical fact pattern in a missed meningitis claim is a patient who presents to an ED early in the disease process and is discharged without a clear diagnosis.

"The EP is not paying attention to how sick the patient is," he says. "The patient may be confused, having a severe headache, or not acting the same."

Patients may also have signs of sepsis, tachycardia, or abnormal blood pressure.

One malpractice case involved a 13-year-old girl who presented to an ED with headache, fever, and vomiting. Nursing notes described the patient as pale and sleepy, and the patient history filled out by the patient's mother noted stiff neck, change in alertness, and abnormal behavior. The EP discharged the patient with a diagnosis of fever and nonspecific vomiting.

Two days later, the patient was brought by ambulance to the ED, diagnosed with bacterial meningitis, and suffered permanent severe brain injuries. The case settled due to lack of support from experts, who felt that discharging the patient without lab results, cultures, a spinal tap, and intravenous fluids was below the standard of care.[1]

Documentation that the patient was re-evaluated in the ED will become important in the event a lawsuit is filed.

"This demonstrates that you didn't just see the patient for five minutes and then blow the patient off," says Tafuri. "That is helpful in any claim, but particularly in meningitis claims."

Of 521 children who were hospitalized with a final diagnosis of meningitis or septicemia in Ontario between 2005 and 2010, 21.9% had repeated ED visits before admission, according to a recent study.[2]

Documentation of the EP's thought process allows the EP to demonstrate that meningitis was considered during the initial ED visit. However, stating this outright might become problematic during the course of litigation.

"Sometimes, when you say, 'I don't see any evidence of meningitis,' it looks a little defensive," Tafuri explains. "The attorney may say, 'Well, you were thinking of it, that's why you wrote it there.'"

Instead, he suggests describing the aspects of the patient's condition that are inconsistent with meningitis presentation, as follows: "There is no change in mental status, no rash, no nuchal rigidity."

Fanaroff says good documentation of a thorough clinical exam, including pertinent positive and negative findings, education of the patient and family of the importance of close follow-up, and what signs indicate that the patient is getting sicker and needs to be seen immediately, can make missed meningitis claims more defensible.

EPs should have "a low threshold for work-up and early treatment when indicated," he adds.

Fanaroff says these factors make a missed meningitis claim a strong candidate for settlement:

- Poor documentation, which does not include pertinent negative findings.
- Lack of education of the patient and family with no follow-up plan in place.
- Failure to consider meningitis in the differential.
- Late initiation of treatment after the patient has begun to deteriorate.

It is advisable for EPs to clearly instruct patients with symptoms that could be an early presentation of meningitis, "This may be early in the course of illness. Should your symptoms progress, it is mandatory that you come back for a repeat evaluation," Tafuri says.

"The importance of that can't be overemphasized," he adds. "Don't tell them, 'It's just the stomach flu.'" ■

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How Can Emergency Physician Counter Patient's Claim that Exam Was Rushed?

In the course of malpractice litigation, EPs commonly find themselves on the receiving end of claims that the ED visit was rushed or incomplete. To the frustration of defense attorneys, the ED chart often offers nothing to counter these assertions.

A nurse may tell the EP that a patient is complaining of a headache. When the EP goes in to re-evaluate the patient, the patient says, "I always get headaches like this."

"Instead of being a worrisome red flag, it turns out to be a benign finding," says **Douglas Segan**, MD, JD, FACEP, a Woodmere, NY-based medical-legal consultant.

Since the plan of care isn't changing, EPs typically won't document the fact that they went in to see the patient. The nurse, however, has likely documented the patient's complaint. If a bad outcome occurs, "the last thing you see in the chart is that the patient is now complaining of a headache," Segan says. The assumption, even if the EP re-evaluated the patient and decided it was something innocuous, is that the EP either didn't know about the new complaint or did nothing to address it.

"When the physician's deposition is being taken a year or two later, the worst possible interpretation is given

to the chart because there is nothing to contradict that," Segan says. The EP may have actually checked the patient and discussed the care plan with the family several times during the course of an ED visit.

"There is a big difference between a nursing note saying 'At 17:00, patient complains of increased abdominal pain,' and one adding that 'and the physician is in to re-evaluate the patient,'" Segan says.

While both notes may be factually accurate, "the latter sounds so much better than the former," he adds.

Documentation showing the patient appeared well before discharge "can make or break a case," Segan notes. Frequently, an ED patient will present with significant symptoms, and is discharged, but the chart doesn't reflect the patient's improvement at the point of discharge. "It may be that their abdominal pain, chest discomfort, or headache went away, and that there were no serious findings on the workup," Segan explains. "But there needs to be a progress note, which is frequently lacking, showing that."

Because of time pressure and other patients who require the EP's attention, "we don't always do as good a job as we should documenting in the chart that the patient was better when they left the ED," Segan says. In an infant with fever, for example, the ED chart should ideally include a discharge note by the EP such as, "The patient is happy and playing and drinking well. Parents state the infant is acting normally."

"This becomes important if it's the unfortunate situation of the infant developing meningitis or sepsis. People will have different memories of the patient's condition on discharge when these cases go poorly," Segan warns.

Set Clear Expectations

Laurie Marcum, RN, senior risk consultant at Coverys, a Boston-based medical professional liability insurance provider, often sees ED charts that fail to document these things:

- A complete and accurate patient history and physical examination.
- That the problem list or medication list entered by a nurse or imported from the last visit via the electronic medical record (EMR) was reviewed by the EP.
- Clinical decision-making related to the diagnosis and treatment plan.

"Extensive use of algorithms, protocols, and T-sheets add to the appearance that little time was spent with the patient," Marcum says. Such documentation gives the impression that care was provided via a prescribed pathway, rather than being individualized for the patient.

"Best practice risk mitigation strategies for ED physicians include using a clinical narrative to describe the patient's clinical presentation and the care that was provided," Marcum offers. A thorough documentation of the ED physician's thought process will reflect the quality care that was provided.

EMR time stamps are not necessarily indicative of the actual time spent with a patient, but plaintiff attorneys may use these to demonstrate the EP spent only a minute or two with the patient. "The quality of the care provided is the best defense against a time stamp that may, on the surface, suggest that not enough time was spent with the patient," Marcum says.

She recommends EPs set clear expectations for nurses to timely notify EPs of assessment abnormalities and critical vital signs and lab values, and appropriately document that they have notified the EP and the EP's response.

"If an ED physician spends an extended period of time at a patient's bedside or in a 1:1 scenario, such as during a code or procedure, this should be documented by the ED physician and the involved nurses," Marcum adds. ■

SOURCES

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- **Laurie Marcum**, RN, Senior Risk Consultant, Coverys, Boston, MA.

Informed Consent Can Become an Issue During ED Medical/Malpractice Litigation

Emergency physicians (EPs) overestimated the risks of myocardial infarction and the potential benefit of hospital admission to chest pain patients, according to a recent study of 425 patient-physicians.[1]

"We were vaguely aware that communication in these scenarios was incomplete, and we hoped to characterize and quantify this. We did not expect to find that the information being exchanged was often inaccurate, or that the gaps in perception were this big," says

David H. Newman, MD, FACEP, the study's lead author and associate professor of emergency medicine and director of clinical research in the Department of Emergency Medicine at Icahn School of Medicine at Mount Sinai in New York City.

EPs often fail to discuss risks of treatments and interventions, Newman notes. However, failure to obtain diagnostic tests is a far more common allegation in malpractice lawsuits.

"One of the reasons that there have been few, if any, ramifications for physicians in these scenarios is that our legal system tends to reward 'doing,'" Newman explains.

Overtreatment, a common problem with distant consequences that are easy to defend as a best effort by the EP, is an uncommon source of legal review, he says.

"Undertreatment, a much less common problem that is easily conjured in retrospect and emotionally simpler as a source of blame, is a far more common reason for legal finger pointing," Newman notes.

If immediate treatment is required in order to prevent death or other serious harm to an ED patient, treatment may be provided without consent.

"However, this does not mean that informed consent should not play an important role in the activities of the ED physician," says **Sue Larsen**, co-founder and chief operating officer of Astute Doctor Education in Laguna Niguel, CA.

"During litigation, patients often say they were rushed into signing informed consent forms but did not really understand what they were signing," Larsen says.

She gives the scenario of a patient presenting to the ED with a dislocated hip and fractured ankle who was told she'd be given morphine for the pain, and was also given the sedative midazolam without consent or knowledge.

"The patient was medicated twice, and woke up confused and scared. Hospital personnel refused to tell the patient what she had received, and told her she had experienced a 'normal' reaction,'" Larsen says.

The patient then fought the hospital for her medical records, and when these were received, discovered that she had stopped breathing during her treatment and had required resuscitation.

The hospital advised the health department that informed consent had been received; the patient experienced anxiety and depression, which she believed was due to the sedative medication.

"The patient then requested an audience with the hospital to discuss her care, but this was ignored," Larsen says. "She is now considering legal action for incapacitation as a result of the lack of informed consent."

A patient may have a viable informed consent case against an EP, even if there is no viable medical malpractice claim, says **Gregory Dolin**, MD, JD, co-director of the Center for Medicine and Law in Baltimore, MD.

"You can show the physician violated informed consent by not presenting the patient with alternatives and the risks and benefits of each," he says.

If a physician recommended amputating a patient's leg to save his or her life, but failed to present alternatives, the patient wouldn't have a viable malpractice claim if amputation fell within the acceptable standard of care, he explains, "but informed consent is viable if the patient isn't given information about alternatives."

Informed consent cases "usually arise in conjunction with a traditional medical malpractice claim, but they don't necessarily rise and fail together," Dolin notes.

He says EPs should consider these questions: Is there more than one option? Would a reasonable person want to know about the other options? If so, did you present all the options to the patient?

"The default position should be that we tell the patient as much as possible, given the situation," he says. ■

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1. Newman DH, et al. Quantifying patient-physician communication and perceptions of risk during admissions for possible acute coronary syndromes. *Ann Emerg Med* 2015. DOI: http://dx.doi.org/10.1016/j.annemergmed.2015.01.027

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Diagnostic Tests and Disposition Decisions

A patient was assigned to an EP who was not on duty in the ED at the time. As a result, a critical test result was not reported. This is a de-identified example of an actual event reported by EDs to Pennsylvania's Patient Safety Authority involving the time period between diagnostic testing and disposition decision. The authority's March 2015 advisory analyzed 2495 events that occurred during this phase of the ED visit.

"The data showed us that this phase had multiple components to it," says senior patient safety/quality analyst **Mary C. Magee**, RN, MSN, CPHQ. The authority broke down the phase into these components:

• Treatments and procedures: Reports involved errors in ordering and executing, complications, and adverse reactions. In one case, a weight-based medication was administered based on a technician's report of the patient's weight in kilograms instead of pounds; the patient was emergently intubated and a tracheal tear surgically repaired.

• Diagnostic testing: Reports included errors in ordering, executing, and resulting, such as misidentification of patients, delays, contrast infiltrations, and laboratory or radiology test problems. In one case, a patient's EKG was misplaced, with abnormal findings discovered two days later when the final reading was done electronically.

• Monitoring and reassessments: Reports included unwitnessed falls with injury, leaving against medical advice or without treatment being completed, clinical status changes, equipment malfunctions, unplanned extubations, self-inflicted injuries, and accidental injuries during care. In one case, a patient who was found unresponsive in the bathroom required intubation and admission.

• Consults: One ED reported a delay in getting a patient in cardiac arrest to the cardiac catheterization lab caused by confusion over which cardiologist was on call.

• The diagnostic decision process: One case involved a patient discharged from an ED with a diagnosis of fractured ribs; radiology later read the patient's X-ray as positive for pneumothorax.

After identifying trends based on the events that were reported to the database, "we then looked to the literature to see if there were strategies that could help ED staff to prevent or at least minimize error," Magee says.

For example, for diagnostic testing, the report recommends simplification and standardization of specimen collection and labelling procedures and verifying patient orders before they're entered electronically. (The complete report is available at http://bit.ly/1RYeAlN.)

The de-identified narratives in the report, which are based on actual incidents, "probably ring true to every ED," says medical director **Ellen S. Deutsch**, MD, MS, FACS, FAAP. "The suggestions of what steps they might take are evidence-based and may provide new ideas for some processes they can try or test out. For other EDs, it can confirm what they already think is effective."

Magee says that EDs can benefit by comparing their own events to the advisory's data. Opportunities to improve "may be identical to what was reported in the database, or they may differ," she says. "From there, EDs can determine whether it makes sense to implement the recommended strategies in their setting, and what way to implement them," she adds.

Deutsch recommends including "non-events" in the ED's analysis, such as when a hazard was identified but did not progress to the point of impacting a patient, and when an intervention by a care provider prevented a patient from being harmed.

"Using some type of simulation can identify some opportunities for improvement before you get to the point where a near miss or event occurs," she suggests.

EDs can see the potential for something not going according to plan, and adjust the process accordingly. "Many places use simulation to improve teamwork and communication," Deutsch says. "It is less common to use simulation to examine the environment in which care is provided." ■

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CNE/CME QUESTIONS

1. **Which is true regarding the legal standard of care an EP is held to when caring for pediatric patients?**

   A. There is a well-established legal precedent that general EPs are not qualified to staff a pediatric ED.
   B. EPs are generally held to the same legal standard of care as pediatricians.
   C. The standard of care requires the EP to be an expert in pediatric care, such as a fellowship-trained pediatric emergency physician.
   D. The standard of care requires the EP to be competent in treating pediatric emergencies.

2. **Which is recommended for EPs to prevent malpractice claims involving discharge?**

   A. Rely on printed patient instructions as the sole legal method of communication.
   B. Clearly document the rationale for the discharge diagnosis and the content of the discussion involving discharge instructions.
   C. Do not include the rationale as to why discharging a patient with abnormal vital signs was a reasonable plan, as it may be used as evidence by the plaintiff.
   D. Assume patients read and comprehend printed discharge instructions.

3. **Which is recommended to reduce legal risks involving "bridge" orders written in the ED?**

   A. ED policies should not require such orders to expire within a certain period of time.
   B. It is legally risky for the admitting physician to review or revise the EP's bridge orders.
   C. EPs should write "bridge orders" so they expire on their own terms, such as once the patient is seen by the admitting physician.
   D. EPs should write "bridge orders" so that they are continued indefinitely unless the admitting physician revises the order.