ED LEGAL LETTER™

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INSIDE

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AHC Media

Plaintiff Attorney Could Have Tough Time Proving Causation in ED Med/Mal Suit

It is often very difficult for the plaintiff's attorney to prove causation — one of the four elements of a medical malpractice claim, along with duty, breach, and damages — against an emergency physician (EP), says **Ken Zafren**, MD, FAAEM, FACEP, EMS medical director for the state of Alaska and clinical professor in the Department of Emergency Medicine at Stanford University Medical Center.

"The burden of proof rests with the plaintiff," Zafren says.

The plaintiff's attorney must prove that the EP breached the standard of care, and that the breach caused the alleged damages.

"A common way of stating this is, 'But for the physician's breach of the standard of care, the patient would not have sustained the alleged damages,'" Zafren adds.

It is generally easier for a plaintiff's attorney to establish causation in cases of commission, where it's alleged that the EP did something that harmed the patient, than in cases of omission, where it's alleged that the EP's failure to do something harmed the patient, Zafren says.

"The defendant's attorney can still claim that there were mitigating factors," he explains.

There are two common mitigating factors: delay in the patient's presentation and the seriousness of the patient's condition.

"These sometimes occur together," Zafren notes. "A case in which the patient had a critical illness or injury that led to major morbidity or death can pose great difficulty for a plaintiff's attorney."

In cases of serious conditions causing death, the mitigating factor is sometimes referred to as the "dead man (or woman) walking" defense.

"The defendant's attorney can argue that the condition was so serious at the time of initial presentation, that the EP could not have done anything to prevent the patient's inevitable death," Zafren says.

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customerservice@ahcmedia.com.
AHCMedia.com

EDITORIAL E-MAIL ADDRESS:
jonathan.springston@ahcmedia.com.

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EDITORIAL/CE DIRECTOR: Lee Landenberger
EXECUTIVE EDITOR: Shelly Morrow Mark
ASSOCIATE MANAGING EDITOR: Jonathan Springston
PHYSICIAN EDITOR: Arthur R. Derse, MD, JD, FACEP
CONTRIBUTING EDITOR: Stacey Kusterbeck

Zafren was the plaintiffs' expert in a malpractice claim against an EP who misdiagnosed bacteremia due to a painful septic prosthetic hip joint as pyelonephritis.[1]

"The patient was admitted when the blood culture from the first visit, ordered by an alert physician's assistant, came back positive for MRSA," Zafren says.

Two hospitalists failed to diagnose the source of the bacteremia for several days.

"By the time the hospitalists consulted an infectious disease specialist who identified the hip joint as the source, the patient had irreversible multi-organ system failure that led to his death," Zafren says.

The defendant EP's attorney claimed that the patient would have died from MRSA septicemia even if the EP had made the correct diagnosis and consulted an orthopedic surgeon at the initial visit.

The case resulted in a defense verdict for the EP, largely due to the testimony of an emergency medicine expert who testified that infections of long-standing prosthetic joints are so rare that the EP could not have been expected to make the diagnosis.

"In other words, that there was no breach of the standard of care," Zafren says.

Another malpractice case involved a patient who developed compartment syndrome of the hand after extravasation of radiocontrast dye that was administered for a CT of the abdomen and pelvis with contrast.[2] The EP discharged the patient with compartment syndrome. The patient subsequently required fasciotomy.

"The case settled for a relatively low amount because the patient recovered substantial function in the affected hand," Zafren says. "In this case, the mitigating factor involved damages rather than causation."

Breaches of omission are more common than breaches of commission, Zafren notes. The plaintiff's attorney might allege that failure to diagnose appendicitis on the patient's first ED visit led to damages because the appendix perforated.

However, Zafren adds, "the defendant's attorney may counter that the initial presentation was not clearly that of appendicitis, and that it was not a breach of the standard of care to send the patient home with close follow-up and return precautions."

Technical Jargon Is Challenge

Juries typically place more weight on an EP's breaching the standard of care than on causation, according to **Stephen A. Barnes**, MD, JD, FACLM, a trial attorney at McGehee Chang Barnes & Landgraf in Houston.

"Causation is often a murky area replete with esoteric expert witness testimony," he says. "Jurors are not doctors. The technical jargon associated with pathophysiology is hard to understand."

The science behind even the most basic disease mechanisms is often hotly contested.

"In causation analyses, timing is everything," Barnes says, providing an example of a patient who arrived at the ED 40 minutes after the onset of a heart attack but lost a critical amount of muscle after only 30 minutes. "The doctor wins even if he delayed the diagnosis. But if the critical timing is 120 minutes, the doctor loses," Barnes warns.

Therefore, to establish causation, experts often argue over issues such as "At what time, to the hour and minute, did this patient's heart suffer permanent damage during a

myocardial infarction?" or "What is the mechanism involved for irreversible septic shock and multi-system organ failure, and at what time did that irreversibility occur?"

"It's understandable that jurors often are confused about causation testimony," Barnes says. "After all, which expert should they believe?"

Causation testimony stands in stark contrast to testimony and evidence regarding breaches in the standard of care. Those are much easier for a jury to understand, Barnes says, because standard of care questions concern physician examinations, testing, and treatment plans, which all jurors experience at some time in their lives.

"Having been patients themselves, jurors are very adept at recognizing arguments about what a doctor should or should not do during a patient encounter," Barnes says.

For instance, the plaintiff attorney might state, "Had the doctor simply ordered a CT scan, we wouldn't be here today."

In Barnes' experience, if there are clear breaches in the standard of care, a jury will often disregard the technical jargon associated with causation arguments, which may have been in favor of the EP, and find the EP liable.

One lawsuit alleged permanent paralysis due to a delay in treating a spinal abscess. "The jury, interviewed after the verdict for the plaintiff, gave little weight to the battle of the experts regarding when a spinal cord abscess creates permanent injury — hours versus days," Barnes says.

Instead, the jury concentrated on the fact that the EP did not document a basic lower extremity neurological examination when the patient's presenting complaint was extreme weakness in her legs.

"While experts battled at trial over whether it was already too late to save the plaintiff when she arrived at the hospital — a causation dispute — the jury instead was bewildered by the negligence of an absent neuro exam," Barnes says.

If the EP clearly failed to provide a thorough evaluation pertinent to the patient's complaint, any problem with causation usually shifts in favor of the plaintiff, Barnes notes.

"Juries will be hard pressed to reverse their findings against a doctor because paid experts argue about microcirculation or blood flow, timing of inflammatory reactions, and other scientifically 'heavy' causation elements," Barnes explains.

Barnes advises EPs to rely on a causation defense only as a last resort, and instead, always perform a complete and thorough assessment and treatment of a patient.

"If you can tell a jury that you did all you could to try to diagnose and treat the plaintiff, you are in a far better position to present a causation defense as an additional reason to find in favor of the EP than those doctors who cannot say that they did every-

Standards Vary on Causation Evidence

The standard for causation does not vary from state to state regarding the legal theory that it was foreseeable that a negligent act could cause a bad outcome.

"States do vary, however, in the doctrine of causation 'risk.' Also, states vary in what they will allow in as causation evidence," says **Stephen A. Barnes**, MD, JD, FACLM, a trial attorney at McGehee Chang Barnes & Landgraf in Houston.

Some states are very strict with the allowable science. The causation testimony must be based on reproducible peer-reviewed studies and accepted by at least some respected portion of the medical community. In other states, the evidentiary standard for causation is lower.

"Publications that are not peer-reviewed, such as case reports, may come in. A physician's own personal experience can come in," Barnes says. For instance, an EP might testify "In my experience, the appendix perforates three days after acute appendicitis develops."

"The logic behind each state's causation evidentiary requirement varies between 'hardcore' states that treat the judge like a scientific gatekeeper, and 'softer' states that believe that judges are not scientists and the jury can figure out the science based on rigorous cross-examination of the experts," Barnes explains.

Some states allow, and others do not allow, lawsuits based on "loss of chance." Barnes provides an example of a patient who arrives at the ED with cough and sputum production. An EP misreads a chest X-ray as normal, when in fact there is a lung mass. Months later, the patient is diagnosed with a form of lung cancer that now has a 5% five-year survival rate. Had the EP not misread the chest X-ray months earlier, the survival rate would have been 40%.

"In some states, the patient can sue for his lost 35% chance of survival," Barnes says. In other states, the patient may sue under this "lost chance" doctrine only if the likelihood of survival would have been greater than 50% at the time of that chest X-ray. "In still other states, no such 'lost chance' applies at all," Barnes adds. ■

thing for the patient," Barnes says. ■

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- **Stephen A. Barnes**, MD, JD, FACLM, McGehee Chang Barnes Landgraf, Houston. Email: sbarnes@lawtx.com.
- **Ken Zafren**, MD, FAAEM, FACEP, Alaska Native Medical Center, Anchorage, AK. Phone: (907) 346-2333. Fax: (907) 346-4445. Email: kenzafren@gmail.com.

High-risk ED Abdominal Cases Involved These Diagnostic Errors

Diagnostic errors occurred in 35 of 100 high-risk cases of patients presenting to the ED with abdominal pain, according to a recent study.[1] Researchers developed an electronic tool to identify patients who presented to the ED of an urban academic hospital with acute abdominal pain who were discharged home, had a return ED visit within 10 days, and were admitted to the hospital when they returned.

The researchers identified 100 patients who fell into this category, and found that 35 diagnostic errors occurred during the initial ED visits.

"Many errors fell into a few categories. Remembering these may help physicians avoid the common pitfalls," says **Laura Medford-Davis**, MD, the study's lead author and a Robert Wood Johnson Foundation Clinical Scholar in the Department of Emergency Medicine at the University of Pennsylvania in Philadelphia.

The most frequently missed diagnoses were gallbladder pathology (10 cases) and urinary infections (five cases). More than two-thirds of the cases had breakdowns involving the patient-provider encounter. Most of these involved history-taking or ordering additional tests and/or follow-up and tracking of diagnostic information, such as abnormal test results.

The fact that a large number of errors involved EPs' failure to address abnormal test results surprised Medford-Davis.

"It seems relatively simple, but providers who made errors often did not mention these abnormal results in their charts," she says.

One patient had liver enzymes three times the normal level, but it was not mentioned in the ED chart or discharge instructions. The patient was discharged from the ED with an impacted gallstone.

Medford-Davis says EPs should make a habit of reviewing all results one last time before discharge to make sure that they haven't overlooked anything.

"If there is something abnormal, like liver tests, but the physician still thinks it is appropriate to discharge the patient, they should be sure to document their thought processes," she says.

It is also important to document a discussion with the patient about the follow-up plan for that abnormality.

Inconsistent Charting

In one case, nursing notes for a patient who did not speak English stated that the patient was vomiting so much that she had been unable to keep anything down. The EP's notes did not document use of an interpreter, and stated "no nausea or vomiting."

"When the patient returned, those provider and physician notes again documented an inability to tolerate oral intake since onset of symptoms — including during the first ED visit," Medford-Davis says.

In another case, nursing notes documented right upper quadrant abdominal pain, but the EP's notes did not.

"The patient was misdiagnosed as kidney stones but the true diagnosis was cholecystitis, consistent with right upper quadrant pain," Medford-Davis says.

In cases where failure to order the proper test led to errors, usually the missing test was an imaging test.

"This is similar to most malpractice literature, and a frequent cause of litigation," Medford-Davis notes.

For the study, researchers did not use the legal standard of care, which allows for the consideration of the final diagnosis.

"This allows plaintiff attorneys to argue, for example, that a CT scan should have been ordered that would have diagnosed appendicitis," Medford-Davis explains.

Researchers relied solely on the symptoms, exam, and results documented during the initial visit to determine if a diagnostic error occurred.

"But even using the more lenient standard, failure to order imaging on a patient with abdominal guarding or grossly abnormal labs and

suspicious symptoms still was seen frequently," Medford-Davis adds.

Researchers also utilized an electronic "trigger algorithm" to identify the 100 high-risk abdominal cases.

"Group practices could adopt this for quality review, to capture and address or learn from many of these high-risk cases in their own practices," Medford-Davis suggests.

Rush to Diagnosis

EPs must always maintain a high level of suspicion with any abdominal pain patient, warns **John Tafuri**, MD, FAAEM, regional director of emergency medicine at Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland.

"We see so much abdominal pain; most is a benign process that doesn't need an acute intervention, but every once in a while the patient needs immediate surgery," Tafuri says. "That poses medical risks for that patient and legal risks for us."

Appendicitis cases may be settled for $100,000 or $150,000, he notes, so it may be cheaper to settle than to go to court.

"Abdominal cases are always tough because so much depends on the examination," Tafuri says. "But you always have to anticipate that you may go to court."

Tafuri offers some strategies to reduce these risks:

• Avoid rushing to a diagnosis of gastroenteritis or stomach flu.

"Patients don't like to be told that they just have a virus and then have something serious after the fact," Tafuri says. If the EP conducts a very brief exam and the ED nurse tells that patient they have stomach flu and can go home, "we are right almost every time," Tafuri says, adding, "but when you are wrong, it gets complicated from a medical/legal standpoint."

EPs sometimes feel pressure to offer a diagnosis.

"It's OK to give 'non-specific abdominal pain' as a diagnosis," Tafuri says.

If a malpractice suit occurs, that would be more defensible for the EP than a diagnosis of "stomach flu," he adds.

Instead, after conducting a thorough evaluation, including a pelvic and rectal exam, EPs can tell patients, "Right now, the tests look OK, but how you feel going forward is more important than the tests and there could still be something serious that did not show up. It's very important to come back if symptoms worsen or fail to improve so we can reexamine you."

Tafuri usually provides patients a 12-hour window for this, since most gastrointestinal complaints will improve in that timeframe.

"It plays a lot better with the patient if they do end up with appendicitis," Tafuri says.

If the patient returns a few hours later and the physical exam is then suggestive of an acute process, Tafuri feels a lawsuit is less likely. This is because the patient wasn't falsely reassured and was told that it was still possible that a more serious process may be occurring.

"The worst cases are when the patients don't come back for two or three days, and the ulcer, diverticulitis, or appendicitis is perforated, leading to a much more complicated course," Tafuri says.

• When possible, keep abdominal pain patients in the ED for a period of time and document a second examination.

"I've had patients who looked fine when I initially examined them. But by the time I rechecked them a few hours later, after labs and X-rays were back, the exam changed," Tafuri notes.

• Perform and document repeat exams.

"It's important to document positive findings, but equally important to document negative findings," Tafuri says.

An EP's documentation of a benign abdomen during a second examination can be of great help to the defense if the plaintiff attorney later alleges the patient should not have been discharged.

"Documentation of repeat exams shows that you are not blowing off the patient — that the patient was not examined just once but also a second time, just to see if anything changed," Tafuri says.

Tafuri says the vast majority of abdominal patients will improve and not return to the ED. Good discharge instructions can catch those with an evolving disease process.

"Of the patients that do come back, only a handful won't have something serious," Tafuri says. ■

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- **Laura Medford-Davis**, MD, Robert Wood Johnson Foundation Clinical Scholar, Department of Emergency Medicine, University of Pennsylvania, Philadelphia. Phone: (215) 573-2574. Fax: (215) 573- 2742. Email: Lmedfo@mail.med.upenn.edu.
- **John Tafuri**, MD, FAAEM, Regional Director, TeamHealth Cleveland Clinic. Phone: (216) 476-7312. Fax: (440) 835-3412. Email: jotafu@ccf.org.

Are Missed Abdominal Pain Claims Against EPs Defensible?

Many claims involving misdiagnosis of abdominal pain in the ED involve multiple visits to the ED, or to other providers such as primary care physicians or urgent care centers, says **Justin Corcoran**, JD, an attorney at O'Connor, O'Connor, Bresee & First in Albany, NY.

"Many claims hinge on whether the clinical picture required more intervention such as imaging or consults with surgery," he says.

Common allegations include failure to accurately obtain relevant history, failure to appreciate changes in the presentation during the ED visit, and failure to conduct and document an appropriate physical examination — including details of the abdominal exam beyond just the presence of rebound tenderness or guarding.

"In many cases, there were signs that, in hindsight, should have increased suspicion for an etiology that required more workup," Corcoran says.

Corcoran defended two EPs who saw a patient, later diagnosed with a perforated appendix, who presented on consecutive days for nonspecific, diffuse abdominal pain without any overt peritoneal signs. The patient reported that she and a friend vomited after eating at the same ice cream stand the day before her first visit. The EPs performed a CT scan on the first visit and reported the scan negative for appendicitis, with the caveat that it was difficult to visualize the appendix.

The patient presented with fever and elevated white blood cell count.

"But the absence of right lower quadrant pain pushed the EPs to consider nonsurgical diagnoses," Corcoran says. No one performed another CT scan in the ED, and the EPs requested a GI consult instead of a surgical consult.

"The unusual presentation led the EPs away from surgical diagnoses, and probably contributed to their sparse documentation of detailed serial exams and bias against additional imaging," Corcoran says.

The jury returned a verdict in favor of the EPs. Corcoran says these two factors likely played a role in their decision making:

• That the patient received detailed discharge instructions, which prompted her to return after the first presentation;

• That she was referred to a specific specialist, rather than simply discharged, after the second ED presentation.

This likely persuaded the jury that while both EPs were uncertain of the precise diagnosis, they felt assured that the patient would seek further care if she did not improve. "Even though they 'missed' the diagnosis, they kept the ball rolling with their discharge instruction and referral," Corcoran says.

Complicating Factors

What is the EP's best defense in cases in which a patient with abdominal pain is discharged from the ED, only to return with a serious or surgical diagnosis? In Corcoran's experience, it's "a factual note that shows a careful physical exam, consideration of appropriate diagnoses, the rationale for the disposition, and discharge instructions that highlight for the patient what to do if she does not improve."

Here are some factors that Corcoran has seen complicate the defense of claims involving abdominal pain patients:

• The ED chart contains only ambiguous documentation.

"The most common shortfall is omitting details about pertinent benign or negative findings on exam like palpation and auscultation, and reassuring history — when the patient last ate, passed stool, or exercised," Corcoran says.

In Corcoran's experience, it's much easier to convince a jury that the EP provided an appropriate evaluation if these details are explicitly mentioned. If they're not, EPs are forced to claim it's their "custom and practice" to perform a thorough exam but only document positive findings.

"If the EP attributes abdominal pain to foodborne illness, it's more defensible if the suspected food source is identified and the chronology of signs/symptoms documented," Corcoran says.

This strong documentation can sometimes dissuade a plaintiff's lawyer evaluating an ED chart from taking the case in the first place.

"Similarly, it's easier to defend the EP who details her impression after touching, pressing, and listening and, if appropriate, noting how these findings differ from another provider's findings," Corcoran says.

• The EP selected an unsupported diagnosis, instead of a diagnosis that reflects uncertainty.

For instance, the EP documents a diagnosis of "gastroenteritis" instead of "abdominal pain."

"In some cases, the diagnosis recorded in the chart is not really supported when details of the history are

investigated," Corcoran says.

• The EP failed to document informal discussions with other ED providers or on-call specialists.

Corcoran has seen many cases in which "curbside" consults informed the EP's clinical judgment and patient disposition, but weren't noted in the chart — and the consultant denies any recollection of the conversation. One such case involved an infant, later diagnosed with appendicitis, who was triaged to the fast track. A physician assistant (PA) saw the patient. The PA then asked the EP to examine the patient.

"The EP performed an independent exam and called an on-call surgeon, who opined that appendicitis or other surgical diagnosis was very unlikely given the presentation," Corcoran says. Neither the EP nor the PA documented the EP's exam. The PA only wrote one clinical note.

All parties agreed the standard of care required the EP to examine the patient after the PA asked for help. However, the patient's parents insisted that no EP examined the patient.

"The EP prevailed at trial, but likely could have avoided the suit entirely if the PA had noted the EP's involvement or, preferably, if she had documented her own exam," Corcoran says.

• The EP failed to appreciate and reconcile available contradictory evidence.

Discrepancies are often noted between the observations of different ED providers, such as different descriptions of pain in the nursing or emergency medical services charting.

"One aspect that we find in defending almost all these claims is a discrepancy between the patient's description of pain and other signs or symptoms, and the recorded description by the ED clinicians," Corcoran adds.

Here are four factors, in Corcoran's experience, that made missed diagnosis claims more defensible:

1. Evidence of the EP's rationale.

"The electronic medical record has actually discouraged the type of documentation that is most helpful to the doctor's defense," Corcoran says.

This is because it tempts the EP to rely on a template instead of an original, individualized assessment of the history, physical exam, and, most importantly, the reason why the EP has decided that the patient's abdominal pain does not require admission or referral.

2. Conducting and documenting serial exams, and the patient's responses to questions.

"This can help justify clinical decisions to discharge, especially when they detail specifically how and when improvement was noted," Corcoran explains.

3. Explicit and detailed discharge instructions.

These should ideally include the name of the physician to see for follow-up care, the date by which such follow-up should occur, and the specific circumstances under which the patient should return to the ED.

"This can rescue an otherwise difficult case, because it can place some responsibility back on the patient," Corcoran says.

This strategy can also bolster the argument that the EP was always open to the possibility that the true diagnosis was not apparent at discharge, but could be detected if things changed at a later point in time.

4. Documentation showing that the EP explained to the patient that a more serious diagnosis cannot be ruled out.

"This can demonstrate that the uncertainty in making a concrete diagnosis was part of the exercise of clinical judgment at the time of treatment — not just after a lawsuit has been filed, as is so often claimed by plaintiffs' counsel," Corcoran says. ■

SOURCE

- **Justin Corcoran**, JD, O'Connor, O'Connor, Bresee & First, Albany, NY. Phone: (518) 465-0400. Fax: (518) 465-0015. Email: corcoran@oobf.com.

Patient Doesn't Appear Seriously Ill? Bad Outcomes Can Occur in ED Waiting Rooms

Numerous recent, highly publicized cases and malpractice suits involved patients who died in ED waiting rooms.

"Don't buy into the myth that the patient can't die in the lobby, that the waiting room is a safe place regardless of the presenting complaint," warns **Nathaniel Schlicher**, MD, JD, FACEP, associate director of the Patient Safety Organization for Knoxville, TN-based TeamHealth. Schlicher is also attorney of counsel in the Seattle office of Johnson, Graffe, Keay, Moniz & Wick.

Patients sometimes don't appear as ill as they actually are.

"There seems to be a bias that patients can't die in the lobby," Schlicher says. "Tragedy has told us all too often that that is not the case. We only need to open a newspaper or news feed to see that."

The risk of open court litigation in

highly publicized cases can increase the pressure on defendant EPs to settle — and at a potentially higher cost than otherwise might occur.

"Any high-publicity case increases the risk of high-cost litigation — and the risk of the multiplier effect of public condemnation and punitive damages in jurisdictions that allow it," Schlicher adds.

Crowding Is Root Cause

Schlicher says the root cause of ED waiting room deaths is crowding stemming from unavailability of inpatient beds.

"There are inpatients taking up ED beds in every institution," he says.

Inpatients boarded in EDs aren't necessarily receiving the ideal care they deserve, he notes, and patients in the waiting room have even less supervision than patients in hallways.

"Sometimes we see the 'easy' things in hallway beds, while the sick and septic patient sits in the lobby," Schlicher says.

If patients miss out on life-saving treatments due to systems problems, the plaintiff might argue "what we might call a lost opportunity doctrine," Schlicher says. "There is risk for the hospital, as well as ED providers."

If tests ordered for a patient in the waiting room come back abnormal, the EP might not even know because he or she hasn't seen the patient yet.

"'Standing order' protocols are running into challenges with CMS," Schlicher notes. While the EP's risk of litigation decreases if the EP's name isn't on the chart, "the right thing is to start care — whether it means protocols allowing nurses to initiate orders, or the EP going out into the lobby," Schlicher advises.

In some cases, EPs order tests for patients before the patient is officially "their" patient.

"Often, EPs are dragged into a case because the nurses need orders and the EPs are intervening with patients without even seeing them," Schlicher says. "When you put orders in under your name, you are responsible."

Another issue is patients who leave without seeing anyone, before test results are back. When someone doesn't follow up on critical abnormalities for these patients, Schlicher says, "that puts everyone at risk."

EDs need a quality oversight program that ensures follow-up on all test results for patients in the waiting area and for patients who leave without being seen.

EPs need to be aware of patients in the waiting room, going so far as to possibly walk in the lobby, Schlicher stresses.

"Even if you are not seeing them physically, EPs need to look at the patient complaint and know their story," he says. "EPs oftentimes can be a second set of eyes for a sick patient."

Schlicher notes that from a fiscal standpoint, the hospital loses revenue when the patient leaves without evaluation or treatment.

"Many patients will see your ED in chaos and not even bother to register," he says, noting EPs can use this to justify additional resources to administrators.

"There are real risks to the patient — and liability for the EP and the hospital — when we don't prioritize the ED and instead put dollars into the operating room," Schlicher says.

As with any other type of negotiation, he says, EPs need to understand the other side's perspective.

"Frame your story in a language they can understand," Schlicher says. One way of doing this is to share actual cases in which patients were put at risk in the ED waiting room, such as a patient who sat in the lobby for hours while having a heart attack.

"The emotional impact of powerful stories will often drive administrators to make difficult choices," says Schlicher. "No one should have a loved one cared for in a lobby because there is not even a hallway chair."

Lawsuits Stem from Delayed Care

Regardless of whether a bad outcome occurs in a waiting room or after the patient is brought back to a treatment room, EPs face liability risks whenever care is delayed and the patient has a time-sensitive diagnosis, "no matter how well you chart it or explain it," says **Charles A. Eckerline Jr.** MD, FACEP, an EP at University of Kentucky Hospital. Eckerline is also an associate professor at the University of Kentucky's Department of Emergency Medicine.

Eckerline has served as an expert witness in many claims against EPs in which delayed care was a central issue.

"The majority of EDs are experiencing increased crowding. Medicaid patients are flooding EDs, and long waits are not unusual for patients believed to be non-urgent," he says.

Claims involving patients waiting in the ED lobby often stem from incorrect triage, sometimes due to atypical presentation of a time-dependent problem.

In a current malpractice case, the patient presented with what appeared to be minor shortness of breath and died in the ED shortly after staff brought the patient to a room.

"The allegations are that the patient should have been brought back more quickly and started on appropriate anticoagulants, and that the triage nurse should have identified

that the patient was at higher risk," Eckerline says.

Good documentation of the patient's initial presentation can justify the decision not to bring the patient back sooner.

"If there are long waits and patients don't seem to be in any distress, at the time it may have been a reasonable decision," Eckerline explains.

In some cases, the patient died right before, or shortly after, arriving in the treatment room. The EP had not yet seen the patient, but was still named in the lawsuit. In one such case, Eckerline says, "the patient seemed stable, until suddenly he crashed." The EP hadn't seen the patient, but was still named as one of the defendants.

"The plaintiff attorney argued that the EP should have had some role in determining who comes back and is legally responsible for the patient's outcome," Eckerline says.

Other malpractice claims with a similar scenario involve patients who present with what appears to be a relatively minor febrile illness who, as it turns out, suffer from a life-threatening infection. The plaintiff typically alleges that delayed antibiotics and intravenous fluids exacerbated the patient's outcome.

In such cases, Eckerline says the EP's best defense is good documentation of regular assessments and decision making.

"But juries are not sympathetic to long waits, no matter the reason," he says. "It's very hard to explain why a patient who had a bad outcome waited for six to eight hours."

This opens the door for the plaintiff's attorney to ask questions at the EP's deposition such as, "Did you call in other resources?" "Did you reassess the patient?" or "Did you recognize that crowding was a problem?"

"To reach the deeper pockets, the plaintiff attorney will try to make the case that the hospital should have been aware of the crowding before it became such an issue," Eckerline says. Patient flow plans that seemed appropriate a year ago might not reflect the ED's current situation.

"It's a continually moving target," Eckerline says. ■

SOURCES

- **Nathaniel Schlicher**, MD, JD, FACEP, Associate Director, Patient Safety Organization, TeamHealth, Knoxville, TN. Email: nathan_schlicher@teamhealth.com.
- **Charles A. Eckerline Jr.**, MD, FACEP, Associate Professor and Vice Chairman, Department of Emergency Medicine, University of Kentucky Medical Center, Lexington. Email: caecke1@uky.edu.

Examining Legal Pitfalls for EPs When Treating Patients with Time-Sensitive Diagnoses

Plaintiff attorneys commonly claim that the emergency physician (EP) did not perform an appropriate workup or respond to diagnostic test results in a timely manner, and that this delay significantly contributed to a poor outcome, says **Jonathan M. Fanaroff**, MD, JD, associate professor of pediatrics at Case Western Reserve University School of Medicine in Cleveland.

"This can be seen in a variety of conditions, from appendicitis to stroke," he adds.

Fanaroff says it is far easier to defend these cases when the EP appropriately documents that he or she considered the diagnosis in question, initiated and responded to diagnostic testing results without delay, and obtained appropriate consults, such as a surgical consult for suspected appendicitis, in a timely fashion.

"Poor documentation can make these cases very difficult to defend," Fanaroff says. If the electronic medical record (EMR) shows that no one checked abnormal laboratory or X-ray results, he adds, "the case will likely need to settle."

A recent malpractice lawsuit highlights several pitfalls an EP can encounter when treating a patient with a time-sensitive diagnosis. The case involved a patient who injured his knee in a water skiing accident. The EP's physical evaluation was very limited, due to the patient's intense pain.

"The physician took a history and ordered X-rays of the injured knee, with no indication that they should be performed 'stat,'" says **Keith C. Volpi**, JD, an attorney at Polsinelli in Kansas City, MO, who defended the EP in the resulting lawsuit. The X-rays showed a spontaneously reduced dislocation. The EP consulted with the on-call orthopedic surgeon, who requested a CT angiogram of the knee to evaluate potential vascular injury. This showed an occluded popliteal artery.

The EP advised the on-call orthopedic surgeon of the results. The orthopedic surgeon and a vascular surgeon operated shortly thereafter.

"The patient alleged that he sustained permanent vascular injury in his knee due to the delayed diagnosis and resultant compartment syndrome," Volpi says.

Here are three factors that became

central issues in the decision to settle the malpractice suit:

• The EP failed to recognize the potential for a time-sensitive injury.

"It goes without saying that the most common pitfall in diagnosing a time-sensitive injury is recognizing the potential for a time-sensitive injury," Volpi says.

The defendant EP failed to appreciate that the most common knee injury associated with water skiing is dislocation, that dislocation very commonly causes vascular injury, and that vascular injury in the knee must be treated within approximately six hours of acute injury to avoid permanent damage.

"Had he appreciated these facts, he most certainly would have acted with a greater sense of urgency," Volpi says. "Plaintiffs' counsel hammered this home during the EP's deposition."

The defendant EP was very well-prepared for the deposition.

"But great deposition testimony can't change the fact that the records showed no sense of urgency in his care and treatment," Volpi notes.

Volpi counsels his ED clients to ask specialists for details regarding the most common time-sensitive injuries.

"Then create a flow chart of symptoms and acute events that one can walk down, to quickly rule in or out this type of injury," he advises.

• The EP failed to designate orders as "stat."

Nearly an hour passed before the patient was taken for X-rays of his injured knee, because the X-ray order was not denoted "stat."

"Many ED physicians have told me that they expect that every order from the ED is treated as a 'stat' order. But I've not seen this play out regularly," Volpi says, adding that ED orders, particularly for labs and imaging, should always be denoted "stat."

"This gives the ED physician the best chance of timely diagnosing a time-sensitive injury," Volpi says.

• The EP waited too long to obtain specialist consultation.

The orthopedic surgeon ordered the CT angiogram to explore vascular injury as soon as he learned of the nature of the injury. The problem was that the EP waited more than an hour after the patient arrived in the ED to contact the orthopedic surgeon.

"In the eyes of the general public, this is simply too much time for an ED physician to diagnose a dislocated knee and the need for specialty care," Volpi says. ■

SOURCES

- **Jonathan M. Fanaroff**, MD, JD, Associate Professor of Pediatrics, Case Western Reserve School of Medicine, Cleveland. Phone: (216) 844-3387. Fax: (216) 844-3380. Email: jmf20@case.edu.
- **Keith C. Volpi**, JD, Polsinelli, Kansas City, MO. Phone: (816) 395-0663. Fax: (816) 817-0210. Email: kvolpi@polsinelli.com.

Many Crowded EDs Have Not Adopted Proven Solutions that Address Problem

The most crowded EDs in the United States have not adopted proven interventions to address crowding, a recent study found.[1] Some key findings:

• 19% did not use bedside registration;

• 94% did not use surgical schedule smoothing, which helps plan surgical schedules to match inpatient bed availability.

Leah Honigman Warner, MD, the study's lead author and an attending emergency physician (EP) at Long Island Jewish Medical Center in New Hyde Park, NY, had hoped to see more EDs addressing crowding.

"I worry instead that a crowded ED is now the new status quo, which reduces the incentive to change," she says.

Jesse Pines, MD, one of the study's authors, was not entirely surprised by the findings. Pines is director of The Office for Clinical Practice Innovation at George Washington University School of Medicine and Health Sciences in Washington, DC. Addressing ED crowding is "time-consuming, costly, and requires leadership locally in the ED and within the hospital, along with staying power over time to sustain any gains in efficiency," Pines says.

Pines says practicing EPs can reduce liability risks associated with ED crowding by:

• ensuring that documentation is complete and timely, even when it's busy;

• recognizing which patients are higher risk for harm during episodes of crowding, such as the elderly and the critically ill.

Entire Hospital Affected

ED crowding can adversely affect the entire hospital, according to Warner. This calls for systemic solutions and collaboration between EPs and hospital leadership.

"There are many evidence-based interventions, both which we evaluated, as well as others that should be considered," she says.

Some solutions simply require a change in protocol, such as EDs implementing a "full capacity" protocol to address inpatient boarding, while solutions such as surgical schedule smoothing require changes in staffing. Other interventions require more capital investment, creation of observation units, or fast tracks.

"Once we can improve crowding, we should also see better outcomes, which should reduce risk for liability," Warner says. ■

REFERENCE

1. Warner LSH, et al. The most crowded U.S. hospital emergency departments did not adopt effective interventions to improve flow, 2007–10. *Health Aff* 2015;34:2151-2159.

SOURCES

- **Jesse Pines**, MD, Director, The Office for Clinical Practice Innovation, George Washington University School of Medicine and Health Sciences, Washington, DC. Email: jesse.pines@gmail.com.
- **Leah Honigman Warner**, MD, Emergency Department, Long Island Jewish Medical Center, New Hyde Park, NY. Email: lwarner2@northwell.edu.

Plaintiff Attorney Could Argue ED Was Unprepared for Mass Shooting

With the increasing incidence of mass shooting events, it is important to consider appropriate ED preparedness, says **William M. McDonnell**, MD, JD, clinical service chief of pediatric emergency medicine and medical director of the ED at Children's Hospital & Medical Center in Omaha, NE.

"Failure to prepare for such events might not only risk patient safety, but could also result in liability risks to the hospital and EPs," he warns.

If a mass shooting occurs, with multiple victims subsequently brought to an ED, a plaintiff attorney could allege that the ED was not reasonably prepared for this scenario.

"Disaster-preparedness cases brought against hospitals in Louisiana after Hurricane Katrina suggest how possible future plaintiffs in mass shootings might attempt to sue hospitals and physicians," McDonnell says.

In one such case, plaintiffs sued for negligence and wrongful death of family members who died after Katrina. They alleged that the hospital failed to properly anticipate the natural disaster and have in place appropriate preparations for patient evacuation and transfer.[1]

EDs are expected to be "reasonably" prepared for foreseeable disasters, McDonnell says, such as tornados in Kansas or earthquakes in California.

"As mass shootings become more and more common, it also becomes more foreseeable that any ED might encounter such a situation," he says.

Although not every ED has the ability to provide definitive care for multiple gunshot victims, McDonnell says, every ED can develop a plan for how it will address such a situation if it occurs.

"It is becoming difficult for hospital EDs to claim that they could not have foreseen a mass shooting in their community," McDonnell adds.

Hospitals and EPs, therefore, should incorporate a plan for responding to a surge of shooting victims into their disaster policies.

"Having such a plan will be invaluable if tragedy occurs, and will be a powerful defense against subsequent negligence claims," McDonnell says. ■

REFERENCE

1. *LaCoste v. Pendleton Methodist Hospital*, 966 So.2d 519 (2007).

SOURCE

- **William M. McDonnell**, MD, JD, Clinical Service Chief, Pediatric Emergency Medicine/Medical Director, Emergency Department, Children's Hospital & Medical Center, Omaha, NE. Phone: (402) 955-5140. Email: wmcdonnell@ChildrensOmaha.org.

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

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CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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2. Scan the QR code to the right, or log onto **AHCMedia.com** and click on My Account. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

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CME/CE QUESTIONS

1. **Which of the following statements is true regarding proving causation in an ED medical malpractice litigation?**

   A. The burden of proof rests with the defendant.
   B. The plaintiff's attorney must prove either that the EP breached the standard of care, or that the breach caused the alleged damages, but is not required to prove both.
   C. It is generally easier for the plaintiff's attorney to establish causation in cases of commission than omission.
   D. In cases of omission, the defendant's attorney is barred from using the patient's delayed presentation as part of the defense.

2. **Which of the following statements is true regarding the standard for causation?**

   A. States vary as to what they will allow as causation evidence.
   B. Causation testimony must be based on reproducible peer-reviewed studies.
   C. "Loss of chance" lawsuits are allowed in all jurisdictions.
   D. A physician's personal experience is not allowable as causation evidence.

3. **Which approach is recommended to reduce legal risks of patients in ED waiting rooms?**

   A. EPs should bear in mind that waiting rooms are safer for patients than hallways.
   B. The risk of initiating care with standing orders before the patient is "officially" the EP's patient far outweighs the benefits.
   C. EPs should understand that they have no legal obligation to follow up on critical abnormalities if patients leave without being seen.
   D. EPs should be aware of patients in the waiting room and at times go out into the waiting room to start care.