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Untwisting the Myths: A Medicolegal Review of Testicular Torsion

By Kyle Couperus, MD, Physician, John Bass, MD, Physician, and Gregory Moore, MD, JD, Attending Physician, Madigan Army Medical Center, Tacoma, WA

Testicular torsion (TT) is a urologic emergency with potentially devastating consequences and costs for providers and patients alike. With an annual incidence of approximately 4.5 per 100,000 males aged 1-25 years, TT is an uncommon medical condition, yet is the third most common cause of medical malpractice suit in this demographic.[1] Because of varying presentations and physical exam findings, along with diagnostic imaging subject to individual interpretation, ED providers may miss this time-sensitive diagnosis. Delays in identification and management of this surgical emergency significantly increase the morbidity associated with TT. Between 31.9% and 41.9% of such cases result in testicular loss.[2] Accordingly, error in diagnosis is the most common major liability in paid TT malpractice suits, with an average reported settlement of $60,000.[2] When encountering genitourinary and lower abdominal complaints in male patients, ED providers must

DELAYS IN IDENTIFICATION AND MANAGEMENT OF TESTICULAR TORSION SIGNIFICANTLY INCREASE ASSOCIATED MORBIDITY.

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maintain a heightened suspicion for TT. Below are medical-legal cases that highlight potential errors in the evaluation, work-up, and management of this high-risk condition.

Patient History and Age

Case 1. A 12-year-old boy was referred to the ED by his pediatrician for a testicular ultrasound after sliding into base during a baseball game, resulting in a swollen and painful testis. On exam, the ED physician noted the testicle was three times larger than the other testis, albeit without scrotal ecchymosis or evidence of hernia. An ultrasound was interpreted by radiology as showing testicular contusion with interstitial edema, an epididymal head cyst and hydrocele, and slightly decreased vascularity in the left testis pole. The ED physician discussed these results with a urologist, who recommended a follow-up ultrasound in two weeks. Four days later, the patient returned with increased testicular pain and swelling, and repeat ultrasound revealed no flow to the testis. Following orchiectomy, a lawsuit was filed for failure to diagnose TT on the first evaluation, and a settlement of $662,500 was reached.[3] It is likely that the physicians providing care in this case anchored on the trauma present and did not consider TT.

Although classically associated with abrupt onset and excruciating scrotal pain, there is no standard presentation for TT. The TT presentation can resemble epididymitis. A significant number of proven TT cases present with gradual onset discomfort, whereas alternative causes of scrotal pain, such as epididymitis, can present with sudden discomfort in up to 51% of cases.[1] Furthermore, nonspecific complaints, such as nausea or vomiting, offer little in differentiating the cause of scrotal pain. Approximately one-third of patients with confirmed TT complained of nausea or vomiting upon initial evaluation, compared to 12.5% of epididymitis patients.[1] Finally, circumstances surrounding a presentation may not reveal the ultimate diagnosis. TT is attributed to direct trauma in only 4-8% of reported cases, and more frequently occurs during sleep because of spontaneous cremasteric contractions.[4] Since there are varying symptoms and circumstances surrounding TT, it is imperative to maintain a high suspicion for this diagnosis, and not rely on historical features in isolation to guide further evaluation.

Case 2. A 53-year-old male presented to the ED initially complaining of right lower quadrant pain, and later right testicular pain. A genital exam performed by the intern and attending physician was believed to be normal. The patient was discharged after an abdominal CT scan for appendicitis was read by radiology as normal and the pain had resolved. The patient returned later that day with right testicular pain and swelling, and an ultrasound showed TT with infarction. An orchiectomy was performed. The plaintiff later claimed that an ultrasound should have been performed during the first visit, while the defendant stated that there was no evidence of TT on the first visit, which included a normal exam and pain abatement. The defense also asserted that no harm occurred as there was no effect on reproductive ability, sexual performance, or testosterone levels. A jury ruled for the defense.[5]

TT often is considered in a bimodal distribution, with a peak

incidence during the perinatal period, and again during puberty. Most cases occur in males under the age of 25 years, and 65% of these cases involve males between the ages of 12 and 18 years.[4] However, approximately one-third of torsion malpractice cases involve adult plaintiffs, which suggests a possibly higher rate of misdiagnosis in this demographic.[6] In fact, one study showed that the odds of orchiectomy effectively doubled for every decade of patient life in TT cases.[1] Although factors such as delayed evaluation and anatomic changes associated with age likely contribute to this likelihood of orchiectomy, ED providers must consider TT high in their differential diagnosis for acute scrotal pain, regardless of patient age.

Physical Exam

Case 3. A 16-year-old male arrived at the ED complaining of right lower quadrant abdominal pain with some associated nausea and vomiting. The ED physician obtained labs and completed an abdominal exam, abdominal ultrasound, and a CT of the abdomen and pelvis. These were all unremarkable. Nevertheless, a surgical consultation was obtained to further evaluate for appendicitis. The surgeon did not believe appendicitis was present, and the patient was discharged without anyone performing a genital exam.

The following day, the patient returned with right testicular pain. He was immediately taken to the operating room for scrotal exploration and required a right orchiectomy. The patient sued for failure to perform a genital exam and failure to consider testicular torsion in the diagnosis. Before trial, the parties reached a settlement.[7]

Isolated abdominal pain is a frequent chief complaint associated with TT. In one review, failure to complete a testicular exam was associated with 19% of TT malpractice cases.[2] It is imperative to consider this diagnosis and complete a scrotal exam any time lower abdominal pain is present.

Case 4. A 17-year-old male awoke in the middle of the night with testicular pain and came to the ED. The physician considered a TT diagnosis, but says he ruled it out based on physical exam. The patient was discharged with treatment for epididymitis. Five days later, the patient presented to his primary care physician with persistent pain. The patient was immediately referred back to the ED, where staff diagnosed TT. The patient subsequently underwent an orchiectomy. The patient sued, claiming an ultrasound should have been performed on the first visit. A medical review panel unanimously ruled that the standard of care was not met. The physician claimed he met the standard of care by conducting a thorough history and genital exam. The jury delivered a defense verdict.[8] This physician was fortunate to obtain the jury outcome rendered.

ED physicians should be hesitant to decide the absence (or presence) of TT based solely on clinical exam. Presence or absence of cremasteric reflexes, scrotal edema/erythema, pain along the upper pole of the testicle or epididymis, enlarged epididymis, transverse lie, and retraction of testicle all fail to give a definitive answer.[1] Even when experienced urologists combine all these exam findings, their initial impressions frequently are wrong.[1]

Historically, the presence of a cremasteric reflex has been cited to rule out TT. Unfortunately, this is a black pearl. Although mostly small case series, several have reported TT with intact cremasteric reflexes.[1] Specifically, patients who were later diagnosed with TT exhibited intact cremasteric reflexes in 12-40% of cases.[1] This percentage is unacceptably high; thus, cremasteric reflex is unreliable. Additionally, cremasteric reflexes are absent in 30% of males with normal testicles, and also absent in patients with other scrotal pathology such as hydatid torsion and epididymitis.[1]

Other physical exam features of TT exhibit much overlap with other diagnoses. Scrotal erythema, edema, and testicular swelling also are reported frequently in patients with TT at indiscernible rates from other causes.[1] Isolated pain along the upper pole of the testicle or epididymis has been reported to occur in 18.7% of patients with TT and 40.8% of patients with torsion of the testicular appendage.[1] Enlargement of the epididymis also has been seen in 40% of patients with TT and 77% of patients with epididymitis.[1] A transverse testicular lie has been reported in 17-83% of TT cases, while a vertical lie has been observed in up to 54% of TT cases.[1] Lastly, testicular retraction (high-riding testicle) is only present in 33-80% of TT cases.[1] Sadly, it is not possible to rule TT in or out based on physical exam findings.[1,6]

Imaging

Case 5. A 14-year-old male was taken to the ED after awakening with abdominal pain. Laboratory studies, an abdominal CT scan, and a scrotal ultrasound were performed. The CT scan was read as suggestive of appendicitis; thus, ED staff called for surgical consultation. The surgeon did not believe that appendicitis was present. The

radiologist reviewed the ultrasound and diagnosed epididymitis. Based on the studies, the ED physician discharged the patient on antibiotics. Three days later, the patient awoke with testicle pain and was taken to a different ED where he was diagnosed with testicular torsion and received an orchiectomy. A review of the original ultrasound revealed there was decreased blood flow to the testicle. The patient litigated, claiming that the diagnosis should have been made on the first visit and the testicle could have been salvaged. The case was solely against the ED physician and not the radiologist. There was testimony from the ED physician that he ordered the "gold standard" test and he relied on the interpretation by radiology. After trial, the jury awarded a $500,000 verdict.[9] This case is typical of others. When a radiologist misreads the testicular ultrasound, often the radiologist pays out less than the ED physician, or the ED physician pays out alone. The thought process is that the ED physician had the ability to make a "clinical correlation" that the radiologist didn't.

The test of choice, a scrotal ultrasound, can be very helpful, although it is not failproof. First, the fact "one simple test" could make the diagnosis factor is hard to contest. Nevertheless, and perhaps more importantly, upon review of cases that were involved in litigation, obtaining an ultrasound did not correlate with a more successful defense.[2,6] This possibly is because most of these associated cases produced false-negative results.[2,6] Specifically, they were read by a resident, technician, or ED physician as (inaccurately) negative. The ultrasound is only as good as the user. Generally, high-resolution ultrasonography has a sensitivity of 96% but is not perfect.[6] When a provider obtains an ultrasound in search of TT, it is important to ensure the individuals reading the exam are skilled at such a task. If a negative ultrasound is reported, in the situation that a high clinical suspicion remains, a urologist should be consulted. Historically, involving a consultant has created a very defensible position.[6]

Prognosis

Case 6. A 12-year-old male presented to the ED with lower abdominal and testicular pain. His exam was normal, and he was treated with morphine and ondansetron. A CT of the patient's abdomen and pelvis was normal, and he was subsequently discharged. The following day, he presented to his pediatrician's office with an edematous left testicle. The physician referred him for an immediate ultrasound, which revealed TT. A detorsion was completed in the operating room. One month later, the same patient returned with progressive pain. A testicular ultrasound revealed no flow, and an orchiectomy was performed. A claim was placed indicating an ultrasound should have been obtained on the first visit. A jury awarded the plaintiff $2 million.[10]

TT is a time-sensitive diagnosis. Testicular salvage rates are 85-97% — if intervention is initiated within six hours of symptom onset.[2] If suspicion for TT is high, a urology consult should be obtained before (or concurrently) with the ultrasound. If a patient presents with symptoms greater than six hours, they should be managed just as urgently.[1] Several case series have described good salvage rates up to 12 hours after symptom onset, and other isolated cases even several days out.[1]

In conclusion, TT is an uncommon, time-sensitive diagnosis, with high rates of successful litigation against emergency physicians.[2,6] The use of history, physical, and imaging stand as diagnostic pillars; however, they are fallible. Care must be taken when relying on ultrasound findings. If there is any doubt in the diagnosis, consulting a urologist has been shown to allow for a more defensible position in court.[6] ■

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Plaintiff Attorney Could Depict 'Early Adopters' of New ED Treatment Approaches as Reckless

Be clear why EP chose to depart from traditional approach

An emergency physician (EP) is aware of a new treatment approach in the literature and believes it's a reasonable option for a particular patient — possibly even better than the traditional approach. What are the legal risks in this situation?

"If it's the best thing for the patient, you should do it. But it doesn't necessarily change the standard of care," says **Kevin Klauer**, DO, EJD, FACEP, chief medical officer of Knoxville, TN-based TeamHealth's emergency medicine division. Klauer also is chief risk officer at TeamHealth.

If there's any question whether a new approach is the patient's best option, or if it's more of an alternative to the traditionally accepted approach, the EP shouldn't offer it without a thorough informed discussion, Klauer advises. If the EP uses a new approach and a bad outcome occurs, the plaintiff's attorney is likely to build a case around the fact that the new approach was not the standard of care.

"If you decide to take a certain pathway — traditional or alternative — with a high-risk presentation, always document your rationale for doing so," Klauer says.

Documentation of the EP's reasoning, and of existing evidence to support the new approach, helps to defend the claim.

"It's really important for every emergency physician to recognize what reasonable standards are — and that there are circumstances where it's reasonable to deviate from the more traditional approach," Klauer says.

Acceptance of new ED clinical practices begins with a small number of "innovators" who propose new ideas supported by science.

"If those ideas are compelling, a larger number of early adopters take the idea and run with it," says **William Sullivan**, DO, JD, FACEP, an EP at the University of Illinois in Chicago and a practicing attorney in Frankfort, IL. Practices then may gain wider acceptance in the emergency medicine community.

Not all EPs change their practice, and not all hospitals change their policies, even after a "new" practice becomes mainstream. Some will adopt it sooner, while others take longer.

"At the end of the bell curve are the 'laggards' who just don't like adopting new innovations," Sullivan offers.

Practicing "reasonably" amounts to working within the middle of the bell curve, Sullivan says.

"Being a laggard and not keeping up with technological advances is difficult to defend if there is a proven innovation that has been generally adopted," he says.

Case in point: A Philadelphia jury returned a $78 million verdict in 2012, partly stemming from the hospital's use of outdated equipment that caused a doctor to misinterpret the images.[1] On the other hand, "early adopter" EDs face legal exposure, too.

"Innovations are great when they improve patient outcomes, but if an innovative treatment causes a bad outcome, it is likely that the early adopters will be labeled as reckless," Sullivan cautions.

A recent example involved a surgeon who used a stent, and then a suturing device, to attempt to repair a leak in a child's esophagus, which the plaintiff alleged were unproven and inappropriate practices. The case resulted in a $30 million settlement.[2]

Another possibility is that plaintiffs will allege that new and potentially unproven innovations studied at tertiary care centers are "standard practice." Such an approach, says Sullivan, "turns the standard of care on its head by holding all physicians to the high-level, cutting-edge treatments practiced at specialized tertiary care centers."

EXECUTIVE SUMMARY

New treatment approaches may be good options for a particular ED patient, but a bad outcome can trigger malpractice litigation alleging the standard of care was violated. The ED defense team must:

- refuse to acknowledge any particular guidelines as authoritative;
- document that patients were aware the treatment is one alternative;
- ensure the EP is held to the standard of care that existed at the time care was delivered.

Since the standard of care is defined as what a reasonable physician would do in the same or similar circumstances, alleging that all EPs should be performing at the level of the specialized centers, Sullivan says, is "similar to saying that an average person is negligent if they can't cook like a master chef or handle a car like a stunt driver."

'General Acceptance'

In some cases, expert testimony as to the standard of care ends up inadmissible because it doesn't meet a "general acceptance" standard. Generally, court determinations as to whether an expert's testimony is admissible are based on two Supreme Court cases: *Daubert v. Merrell Dow Pharmaceuticals, Inc.* and *Frye v. United States*. The *Daubert* standard is used by federal courts and by most state courts.

"It basically states that evidence is admissible if the judge determines that it is relevant, reliable, and derived from sound scientific methodology," Sullivan explains.

In contrast, the *Frye* standard says it's admissible if the judge determines it has gained "general acceptance" within the field. "While both standards seem similar, there are some subtle differences," Sullivan notes.

Novel treatment or research that's admissible under the *Daubert* standard (because it's undergone reliable scientific testing and is relevant to the issues in the case) may be excluded under the *Frye* standard because it has not reached "general acceptance" in the medical community. An expert's opinion was thrown out in a 2015 malpractice case for this reason.[3] The case involved a patient who alleged that two prescription medications had caused cardiac arrhythmia resulting in placement of a permanent pacemaker. Case studies and articles were submitted, but none linked the drugs to the patient's atrioventricular block. The court found that the expert's opinion was not accepted in the medical community.

"The case was dismissed because the 'general acceptance' standard was not met," Sullivan adds.

Push Back Against Plaintiff

Since malpractice litigation often occurs months or even years after the ED visit, the standard of care may well have changed during that time. Klauer has seen plaintiff attorneys inappropriately attempt to hold the EP to that new standard of care.

"When the EP is defending a claim, both sides need to consider what the standard of care was at the time the care was delivered, not at the time the claim is being defended," Klauer says.

The ED defense team also needs to push back against assertions that certain guidelines constitute the standard of care.

"The jumping off point for the allegation that the plaintiff is going to make will oftentimes be based on what a guideline says," Klauer says. A typical deposition question is: "Do you consider guidelines from this society to be authoritative?" By answering affirmatively, the EP defendant has just acknowledged that the guidelines are the standard of care.

"What you have done is agreed that everything in that guideline should be followed and that you should be familiar with its recommendations in detail," Klauer cautions.

A better response is that no guidelines are authoritative, because every patient presentation is different.

"Every responsible specialty society should make it very clear that it's not appropriate to apply guidelines in a black and white manner," Klauer adds. The EP's clinical judgment is needed on a case-by-case basis, regardless of what any guidelines say.

Klauer suggests EPs exercise caution before mentioning a specific guideline in their documentation if they did *not* follow it.

"You have to be careful. If you reference a guideline, make certain you used it correctly," Klauer says.

Specificity can help if a guideline influenced the EP's decision-making. For instance, the EP could document that the HEART Pathway for Early Discharge in Acute Chest Pain was used to determine that admission wasn't required, or that he or she clinically cleared the cervical spine based on the National Emergency X-Radiography Utilization Study (NEXUS) criteria. Generally speaking, says Klauer, "If you use evidence

in the literature to inform your decisions, you should refer to that, and that will help to defend you."

If the EP defendant points to research supporting an alternative treatment approach, the plaintiff attorney's expert can challenge the validity of the study.

"The expert might say, 'this journal article was based on just 25 patients and it's really not statistically significant — and even though it worked on those patients, it hasn't been tried and tested, so therefore it's not really the standard of care,'" says **Mark Kadzielski**, JD, a partner at BakerHostetler in Los Angeles. There may be a good reason why the traditional approach is just not appropriate for a particular patient.

A well-documented rationale can help the defense, says Kadzielski, "but that doesn't mean you are going to be right in the second guessing of a jury." ■

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Will Antibiotics for Appendicitis Become Standard of Care for ED?

It's reasonable 'in the right patients, and in experienced hands'

Antibiotics instead of surgery is a reasonable approach for patients with early uncomplicated appendicitis, according to the authors of a recent small pilot study.[1] Of 30 patients, 16 were randomized to antibiotics first and 14 underwent an appendectomy. Participants in the antibiotics group were discharged only after at least six hours of observation in the ED, with next-day follow-up.

Some key findings include the following:

• Of the 15 antibiotic-treated adults, 14 were discharged from the ED and all demonstrated symptom resolution;

• At the one-month mark, major complications had occurred in two appendectomy patients;

• Antibiotics-first patients experienced less hospital time than appendectomy patients as well as less pain and disability;

• At the one-year mark, two of the 15 patients treated with antibiotics had developed appendicitis. One was successfully treated with antibiotics, and one underwent an appendectomy.

However, virtually no EPs in the United States have experience with this approach, according to **David Talan**, MD, FACEP, FIDSA, who led the study. A previous paper found that one-fifth of Irish surgeons routinely treated uncomplicated appendicitis with antibiotics.[2]

"Most practice experience is from Northern Europe rather than the U.S.," notes Talan, chair emeritus of the department of emergency

EXECUTIVE SUMMARY

Antibiotics instead of surgery is a reasonable approach for some patients with early uncomplicated appendicitis, according to the authors of a recent study; however, it is not the standard of care. To reduce legal risks, EPs considering this practice should:

- direct the patient to consult with a surgeon for recommended treatment;
- inform the patient of the risks of refusing an evaluation by the surgeon and/or refusing surgery;
- consider offering antibiotics as an alternative if patients refuse surgery.

medicine and faculty in the division of infectious diseases at Olive View-UCLA Medical Center in Sylmar, CA.

In the ED setting, the EP would first advise the patient with suspected appendicitis to allow a surgeon to evaluate him or her, Talan says. If the surgeon concurs that the patient has appendicitis, the surgeon would guide treatment options. Most will recommend an appendectomy.

"But there are surgeons in the world, and even a minority in this country, who offer antibiotics to patients," Talan notes. "And those providers are often the ones who have experience doing it."

Next Best Alternative

Talan says that a similar approach is used routinely for ED patients with uncomplicated diverticulitis who are discharged with antibiotics with next-day follow-up. A growing number of providers, though not in the ED setting, are taking the same approach with appendicitis patients.

"Some offer it as an equal alternative to surgery. Some offer it as a secondary alternative, describing it as something new that appears to be safe," Talan explains.

EDs might consider this approach if appendicitis patients refuse surgery. It's a rare occurrence, but it does happen, Talan says.

"There are certainly circumstances when even when the surgeon is called, and we talk with the patient and say they need surgery, they refuse," Talan reports.

A GROWING NUMBER OF PROVIDERS, THOUGH NOT IN THE ED SETTING, ARE TAKING THE SAME APPROACH WITH APPENDICITIS PATIENTS.

In such cases, the EP is obligated to inform the patient of the risks of refusing an evaluation by the surgeon and/or refusing surgery.

"But you also have an obligation to treat them with the next best alternative," Talan adds. "That would be antibiotics."

If the EP has no prior experience with this approach, the patient ideally would remain under observation in the hospital. On the other hand, the patient might request to be treated with antibiotics and go home, and is well enough to be discharged. "There's certainly enough evidence that the EP can do that, and that the patient would be fine," Talan offers.

In more than 1,700 patients with uncomplicated appendicitis treated with antibiotics and described in 21 published studies, none has gone on to develop diffuse peritonitis or severe sepsis, and no patient has died, Talan adds. Some patients are adamant that they don't want surgery; others may have heard of the option of antibiotics.

"The patient has the right to direct their care. This is safe in the right patients and in experienced hands," Talan says.

The study's findings pave the way for a multicenter U.S. trial comparing antibiotics first to appendectomy. The authors of the Comparison of Outcomes of Antibiotic Drugs and Appendectomy (CODA) trial will enroll and randomize 1,600 patients with early appendicitis to surgery or antibiotics.[3] The study will shed light on long-term outcomes and which patients are likely to experience better outcomes with either antibiotics or surgery.

"We know that it's safe. We are now going to see how this plays out in different centers and in different types of patients," says Talan, co-principle investigator of the trial. **Ken Zafren**, MD, FAAEM, FACEP, clinical professor of emergency medicine at Stanford

University Medical Center, says, "For EPs, nonoperative antibiotic treatment of appendicitis is neither standard care, nor should it be viewed as standard of care." Zafren adds that asking a surgeon to see the patient and provide treatment, either with an appendectomy or with antibiotics, would likely prevent legal exposure for the EP. If a patient with uncomplicated appendicitis refuses to see the surgeon, Zafren would recommend as a next best alternative:

- treating the patient with antibiotics with a period of observation in the ED (if the patient agrees);
- documenting that the patient refused to see the surgeon;
- discharging the patient against medical advice (AMA). This process includes giving the patient an open invitation to return to the ED at any time, instructing the patient to obtain close follow-up, and specifically warning the patient to return to the ED for any worsening of the condition, or if there is not marked improvement by the next day.

"It is probably not legally defensible for the EP to give antibiotics as an alternative to surgery without consulting a surgeon," Zafren cautions.

In previous studies, patients treated with antibiotics were hospitalized, Zafren notes.

"The multicenter CODA trial may be large enough to show whether the approach is safe — and to confirm or change current practice by EPs," he adds. ■

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ED Malpractice Claims Allege Failure to Obtain Translator

Who serves as a translator and how that is documented are two huge factors

A triage nurse's notes indicated that a 27-year-old man had a significant family history of cardiac disease, yet the EP's documentation made no mention of this. The patient died of an aortic dissection several days later, and the family sued. One of the principal allegations was that the ED failed to obtain a translator for the patient. ED nursing documentation included a checked box indicating the patient needed a translator. "The plaintiff attorney made a big issue of this," says **Christopher M. Bracci**, Esq., an attorney at Boston-based Ficksman & Conley.

The plaintiff attorney alleged that if a better history had been taken by the EP, the patient's bad outcome could have been prevented. Family members testified that the patient had stated that he'd requested an interpreter but didn't get one. The defendant EP testified that he was able to get all the information he needed from the patient. "The doctor swore up and down that he had no problem conversing with the patient and had no reason to get a translator," Bracci says.

The defense contended that even if the patient's family history of acute coronary disease was known, it would not have changed the treatment plan because it is not linked to increased risk of aortic dissection. The plaintiff alleged that if a CT scan had been performed, it would have shown the dissection, and the patient would have been brought in for emergency surgery.

The defense's cardiology expert countered that even if a CT had been performed, it wouldn't have shown the dissection at the time of the ED visit.

Thorough documentation by the EP suggested that good communication with the patient took place. Also convincing was the EP's own assertion that if he had any concern whatsoever that a translator was needed, he would not have hesitated to pick up the phone and request one.

"The jury must have concluded that the patient spoke enough English that he didn't require a translator," Bracci notes.

Without the checkbox indicating the translator was needed, the allegation would probably have never been made, Bracci adds. "An entire case can be brought around one inadvertent slip-up."

ED Nurse Translated

Another recent malpractice case alleged that ED nurses and the EP failed to appropriately translate medical instructions. The patient was instructed to return to the ED or see a healthcare provider if he began to experience a fever or other symptoms. The discharge instructions were given to the patient in English. However, a Spanish-speaking nurse translated the information to the patient and his wife before asking the patient to sign off on the discharge instructions. The patient did not return or seek further care, even though he developed a fever and worsening symptoms. Thus, he became seriously ill and died.

"The theory against the defendants was that they were negligent in the discharge instructions and allowed the patient to be at risk," says **Linda M. Stimmel**, JD, an attorney at Wilson Elser Moskowitz Edelman & Dicker in Dallas.

The patient's wife alleged they did not understand the importance and the details of the discharge instructions. She testified that had they understood, they would have sought treatment for her husband.

"Unfortunately, the Spanish-speaking nurse was not certified to translate, and did not chart her name or any details," Stimmel says. The plaintiff also made an issue of the fact that the instructions were not in Spanish, and that there was no follow-up call by the ED.

"It is risky to have a family member or friend of the patient be the translator," Stimmel cautions. "The ED cannot rely upon such a person to translate accurately." She recommends:

• using a certified translator or telephone interpretation services to translate. "The transaction number or the translator's name and certification must be in the chart," Stimmel says;

• maintaining a backup log. "The ED must have evidence that they acted in a reasonable manner in providing appropriate translations," Stimmel says.

ED's Legal Obligation

Edward Monico, MD, JD, assistant professor in the section of emergency medicine at Yale University School of Medicine, offers this evolution of the ED's legal obligation to provide language interpreters to limited English proficiency (LEP) patients:

• Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, or national origin.[1]

"In interpreting Title VI, the Supreme Court has treated discrimination based on language as equivalent to national origin discrimination," Monico says.[2] This means that in federally funded programs and activities, people who speak a language other than English are entitled to treatment equal to that of English speakers.[3]

• In 1980, the Department of Health and Human Services issued a notice stating, "No person may be subjected to discrimination on the basis of national origin in health and human services programs because they have a primary language other than English."[4]

"Furthering this notion, President Clinton issued Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, in August 2000," Monico adds.[5]

• In response to this, the Office for Civil Rights (OCR) issued an extensive policy guidance to assist

EXECUTIVE SUMMARY

Malpractice litigation is possible if EDs fail to obtain a translator and, as a result, the patient is injured. Recent claims have shown that:

• inadvertently checking a box indicating the need for a translator can lead to serious legal repercussions;

• EDs should use a certified translator or language line instead of a family member;

• discharge instructions also should be translated.

healthcare providers and other federal fund recipients in meeting their obligations to LEP individuals.[6]

"Revisions of the Policy Guidance under the Bush Administration resulted in four factors that institutions, programs, and providers should consider in determining the extent and types of language assistance that should be pursued," Monico says. The third factor in the OCR Policy Guidance suggests that given the nature and importance of healthcare services, healthcare providers carry a special obligation to ensure language access for their patients.

If failure to provide the necessary language interpretive services resulted in injury because a misunderstanding caused inaction or delay in care on the part of the provider, it could result in medical malpractice (for the delay or inaction), Monico says.[7,8] A civil rights lawsuit also is possible — for failure to provide Title VI Civil Rights Act obligations.

"Triage nurses can mitigate the possibility of injury arising as a result of language barriers between patients and providers by proactively activating institutional language interpretive services early in the course of a patient's presentation to the emergency department," Monico advises. ■

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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.

COMING IN FUTURE MONTHS

- How plaintiff attorneys decide to pursue malpractice claims against ED
- Increasing legal risks for EDs if psychiatric patient is discharged
- Legally protective charting if ED patient is seen by physician assistant
- Liability for hospitals if ED clinician is impaired by drugs or alcohol

ED LEGAL LETTER™

CME/CE QUESTIONS

1. **Which is recommended to reduce risks if the ED is using a newer treatment approach?**

   a. EPs should only offer a treatment if the medical literature supports it as the standard of care.
   b. Hospital policies must clearly state that the treatment can be offered only as an alternative.
   c. ED documentation should specifically cite any guidelines that were not followed, regardless of the reason.
   d. If a specific guideline influenced the EP's decision-making, it should be noted in the chart.

2. **Which is true regarding standard of care in the ED setting?**

   a. Only peer-reviewed journals are truly authoritative in terms of the standard of care.
   b. In some cases, expert testimony about the standard of care can be ruled inadmissible because it doesn't meet a "general acceptance" standard.
   c. EPs should practice using only those standards widely accepted in the emergency medicine community as the standard of care.
   d. EPs are legally held to the standard of care that exists at the time the case goes to trial.

3. **Which is true regarding antibiotics as a treatment option for appendicitis?**

   a. Antibiotics are considered to be the new standard care for uncomplicated early presentations.
   b. Surgical consultation is no longer recommended for most appendicitis patients who want an alternative to surgery, unless patients cannot decide on treatment options.
   c. Antibiotics are a next best option if patients refuse surgery and are informed of the risks.
   d. Offering antibiotics as a potential treatment for appendicitis is a clear violation of the current standard of care because there is no scientific evidence to support its safety.

4. **Which reduces legal risks involving translators in the ED setting?**

   a. Allowing family members to translate for the patient when possible, since they know the patient best.
   b. Asking onsite healthcare providers to translate, even if uncertified, because they can see the patient in person.
   c. Including the translator's name and certification in the ED chart.
   d. Documenting the translation in a single place without a backup log.