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INSIDE

RELIAS
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More Than Half of ED Claims Diagnosis-related

However, many EPs believe legal risks lie elsewhere

Misdiagnosis continues to be one of the most common reasons for ED claims, according to a recent report from Coverys, a Boston-based medical liability insurer.[1] Investigators analyzed 10,618 closed medical professional liability claims from 2013-2017. Of 1,412 ED claims, 57% were diagnosis-related.

"There was very little in the ED data that surprised us," says **Robert Hanscom**, co-author of the report. However, the prevalence of misdiagnosis in ED claims often comes as a surprise to practicing emergency physicians (EPs).

"We find that when we present this data to ED physicians, they seem somewhat surprised that ED malpractice cases are so dominated by missed diagnoses," says Hanscom, vice president of business analytics at Coverys.

The EPs often express that they thought they were more at risk for other issues. These include wait times leading to adverse outcomes, failure to monitor patients who are waiting for beds, and crisis-response issues (such as a patient suddenly "crashing" and an insufficient response to that event).

"That's what [EPs] thought might be where the liability is, ahead of our data being presented to them. But it's not actually true. They do a really good job in those situations," Hanscom says. The Coverys analysis shows that missed and delayed diagnoses are EPs' main liability risks." Hanscom says these two issues usually become key areas of focus in these ED claims:

- How long was the patient in the waiting room, both before and after triage?
- Was the patient reassessed while he or she was waiting to be seen?

"The 'timer' should be started on any patient who enters the ED," Hanscom offers. "Once in the inner core of the ED, the 'timer' should be reset."

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: **Arthur R. Derse**, MD, JD, FACEP (Physician Editor), **Kay Ball**, PhD, RN, CNOR, FAAN (Nurse Planner), **Stacey Kusterbeck** (Author), **Jonathan Springston** (Editor), **Jesse Saffron** (Editor), and **Terrey L. Hatcher** (Editorial Group Manager).

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AUTHOR: Stacey Kusterbeck
EDITOR: Jonathan Springston
EDITOR: Jesse Saffron
EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

It's especially important in the ED setting that timing is documented throughout the entire duration of a patient's visit. For instance, if a patient is in the ED for a few hours, providers must document accurately time spent in triage, time spent in the treatment room, and the amount of time before treatment was administered.

"This process is beneficial for several reasons," says Hanscom, identifying patient satisfaction as one reason. "It makes providers much more aware of their patients' journey, and prevents patients from feeling forgotten about, which is a frequent pain point in healthcare," Hanscom explains.

Additionally, timeframes often become critical during litigation. Good documentation gives a much more specific window into everything that occurred during the ED visit. "It provides detailed and established care intervals that are much more legally defensible," Hanscom adds.

Plaintiff attorneys often make an issue of how long the patient waited for a full evaluation. This is where documentation of reassessment at regular intervals becomes important. "Depending on their symptoms, somebody should be checking on them every 15 or 30 minutes, just to ensure that their clinical presentation has not deteriorated or changed in an unexpected way," Hanscom says.

Plaintiff attorneys also make an issue of how much time the patient waited for treatment. "One of the things that we often see in the ED is that people lose track of the amount of time that has elapsed in the triage, evaluation, diagnosis, and then treatment of each individual patient," Hanscom says.

EMRs provide the ability to track time through each phase of ED care. "That should be done on a routine basis. An added benefit is that it would also lead to improved patient satisfaction scores," Hanscom notes.

Do Not Hide Uncertainty

Contrary to what some EPs believe, documenting uncertainty about a diagnosis does not create greater liability exposure. In fact, just the opposite is true. "If a provider is uncertain but the documentation does not reflect that, it is more difficult to later defend a malpractice case," Hanscom warns.

It's not enough for the EP just to document uncertainty. It also needs to be conveyed to all concurrent and subsequent providers. "In so doing, the ED physician is preventing others from getting anchored in a diagnosis that is tentative," Hanscom explains.

This encourages other providers to weigh in on what is really going on with the patient. Hanscom says that documenting uncertainty not only leads to better care and more accurate diagnoses, but also aligns with a tenet from the legal system: Juries and judges do not expect physicians to know everything. They *do* expect the EP to acknowledge uncertainty and consult with specialists as appropriate.

"If it can be shown that all reasonable steps were taken in response to uncertainty, juries will be favorable to physicians," Hanscom offers.

Documentation becomes especially critical if the EP is describing a potential diagnosis that has yet to be officially confirmed. "Often, along the way, providers will go through a number of potential ailments and conditions based on the patients' symptoms," Hanscom says. To make the diagnosis, the EP must receive final confirmation

through an additional test, such as an X-ray, CT scan, or blood test. Until then, EPs must avoid documentation that appears as though the diagnosis is already definite. They can do this by noting it as a "working" or "tentative" diagnosis, or using similar terminology to convey uncertainty.

"This ensures any caregivers or physicians reading the report are aware that nothing has been set in stone," Hanscom explains.

Also important is for EPs to note any other conditions that a patient might exhibit. This protects patients by ensuring they do not receive a clear bill of health prematurely. "It also protects the provider from being accused of definitively giving an incorrect diagnosis," Hanscom adds.

At Issue: Medical Decision-making

Two common allegations in the ED claims included in the Coverys analysis include failure to get a complete history, and failure to conduct a thorough examination. **Joseph P. Wood**, MD, JD, a Cave Creek, AZ-based EP and past president of the American Academy of Emergency Medicine, says frequent interruptions also contribute to misdiagnosis in the ED setting.

"The emergency physician has less time to do some medical decision-making on all the possibilities that could account for the patient's symptoms, and then systematically work through it," he explains. "There's a confirmation bias toward grabbing on to a diagnosis that's readily available. Subconsciously, you don't want to entertain one that is not common, or more difficult, or time-consuming." For example, an EP might admit a chest pain patient with an atypical, non-diagnostic ECG for observation for suspected coronary syndrome. In fact, it could be an aortic dissection, a diagnosis that requires a more involved workup, but one in which a timely diagnosis could prevent a bad outcome.

"It's reality, and it's part of the culture in the ED, that nurses and others like to work with an emergency physician who's quick and doesn't seem to get bogged down with a lot of tests," Wood explains.

Of course, ED patients see the situation from a different perspective. Most would prefer a more thorough EP who obtains a complete history and considers all possibilities. "When you are a patient, you want the one that's a little slower but almost always right, not the one who's quick and usually correct," Wood says. "But if you are working in the ED, you like the one that gets them in and out."

EPs need to be mindful of this, always asking themselves, "What else could this be?," and consult colleagues as needed, Wood advises. "A fresh set of eyes is always helpful."

Anna Berent, JD, claims counsel for Houston-based Western Litigation, says most ED misdiagnosis cases fall into one of these three categories:

• "Monday-morning quarterbacking" cases. In these cases, the patient has visited the ED one or more times. Their symptoms have changed or evolved, making the correct diagnosis possible. "I would put [in this category] cases concerning transverse myelitis, whose symptomatology does not become readily apparent until more severe consequences such as loss of sensation in the legs, for example, occurs," Berent says. In such cases, it's important for ED providers to show two things:

• The physical exam was well-documented;

• All symptoms at that time were part of the differential, and were addressed and investigated. "The case of misdiagnosis then becomes weak," Berent adds.

• "Miscommunication" cases. This is a case in which the ED provider makes a diagnosis based on an imaging study, which someone misread or read inconclusively. For instance, a patient is discharged because there is no fracture, yet the next day a final read of the X-ray reveals fracture. The radiology department notifies the ED.

"The communication breaks down at that point, and the patient never learns of the X-ray results," Berent says.

• Cases that are "so close." An ED practitioner puts the correct diagnosis on the differential. But for whatever reason, the diagnosis is ruled out or put at the bottom of the list of possibilities. Missed pulmonary embolism, aortic dissections, and stroke are common examples.

"These 'so close' cases are most difficult for practitioners to accept, as they directly speak to their professional medical judgment," Berent says. ■

REFERENCE

1. Hanscom R, Small M, Lambrecht A. Diagnostic accuracy: Room for improvement. Coverys, 2018. Available at: https://bit.ly/2qlmVtz. Accessed June 29, 2018.

SOURCES

- **Anna Berent**, JD, Claims Counsel, Western Litigation, Houston. Phone: (713) 358-5964. Email: anna_berent@westernlitigation.com.
- **Robert Hanscom**, Vice President, Business Analytics, Coverys.
- **Joseph P. Wood**, MD, JD, Emergency Physician, Cave Creek, AZ. Email: soxdoc6@yahoo.com.

If Family Gets Only Silence After Bad Outcome, Plaintiff Attorney Likely Next Call

Answers can prevent some litigation

An ED nurse inadvertently put a nasogastric tube into a patient's lung and administered charcoal. The 35-year-old man, who had come to the ED because of a barbiturate overdose, died within minutes. The nursing supervisor's advice was, "Don't tell the family anything."

"But I thought it was very important that the family know exactly what happened and why,'" says **John Tafuri**, MD, FAAEM, regional director of emergency medicine at Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland. One reason was that the family would likely find out, since an autopsy was probable. Shortly after the patient's death, Tafuri, who was director of the ED at the time the incident occurred, told the family exactly what occurred. "There was never any lawsuit filed, and I think that was because of the communication that occurred at the time," Tafuri offers.

When a patient dies unexpectedly, either in the ED or shortly after discharge, "the traditional thing to do is not tell the family anything. That creates suspicion," Tafuri says.

To the family, it appears the ED is hiding something. Some file a lawsuit because there's no other way to find out what really happened. "If they don't get answers from the physician or the hospital, they will call a plaintiff attorney and say, 'No one will talk to me,'" Tafuri notes.

If the family is too emotionally distraught at the time of the ED visit for this kind of conversation, it should occur shortly afterward, within a few days, Tafuri offers.

"If you are not honest with the family at the time of the incident, you are setting yourself up for the family to be very angry and vengeful," Tafuri warns.

Root Cause Analysis

At Fairview Hospital, a team of people communicates bad outcomes to the family. The group includes a risk manager, an ombudsman, and usually one clinician (a director or another physician who is experienced in communicating bad news).

"In general, we like to have directors involved. It gives a little more gravitas to the situation," Tafuri says.

Before the team approach was implemented, a director was the designated person to communicate with the family. "He or she was not directly involved in the case, and presents less of an issue from a legal standpoint," Tafuri explains. The purpose of the meeting is to acknowledge that there was an unexpected bad outcome, to explain how it occurred, and to answer all the family's questions.

"We put any unknowns to rest, so the family understands what really happened," Tafuri says. This means the family has no reason to file a lawsuit just to find out. Once the family files suit, and the plaintiff attorney has invested time and money in the case, everyone has an incentive to continue pursuing the claim. Sometimes, this is true even if it becomes evident that no negligence occurred. "If you can avoid an attorney being involved in the first place, that is much better," Tafuri adds.

The meeting usually occurs three to five days after the ED visit. This allows the team to gather all the facts before talking with the family.

"Sometimes, the details of what happened are not immediately known," Tafuri says. Multiple caregivers are involved in complicated cases. "We often will get all of the caregivers in a room and perform a root cause analysis of exactly what happened. Because of scheduling, this can take some time."

Concerns that talking openly about the bad outcome will plant the idea to sue are unfounded, according to Tafuri. Since the bad outcome was unexpected, the family already is curious about what happened. "We are not fanning the fire, or starting a fire that doesn't already exist," Tafuri says.

People usually appreciate the honesty. Few are inclined to seek legal recourse after meeting and learning the facts. "It's the right thing to do for the patient and family, but also for the hospital as well," Tafuri says. "We firmly believe it helps reduce our legal risks, and does not seem to stir up any issues."

Teams are trained to communicate about bad outcomes by role-playing with mock scenarios, with local actors playing the part of distraught family members. "One scenario that was used was an incidental lung nodule that was not noticed and turned into cancer six months later," Tafuri recalls. EPs are encouraged to contact risk managers after an unexpected bad

outcome for guidance as to the best course of action, communication-wise. "Every situation is a little bit different," Tafuri notes. In the case of the misplaced nasogastric tube, it was very clear what had happened, so the decision was made to tell the family right away. "I felt it was important to get it out there right away, so the family would go home with a clear understanding of what happened," Tafuri reports.

Other cases are more complicated. If it's less clear what occurred, the family is told, "We're going to look into this for you, and will call you to set up a meeting so we can discuss it in a lot more detail."

However, EPs are not prohibited from speaking directly with the family right at the time of the bad outcome. One reason is that the state's apology statute offers some legal protection. "Sometimes, everything was done exactly as it was supposed to be, but the EP can still say, 'We are very sorry that your family member passed away,'" Tafuri says.

The family meetings have challenged the long-standing belief that anything the ED provider says to the family can be used against them legally, so it's better not to tell them anything.

"That's what the lawyers have said for years. Maybe legally that's correct, but emotionally I don't think it's correct," Tafuri offers.

Once families have all the facts, "many times they can move on," Tafuri says. "But if they don't get the answer, they will keep pursuing it." ■

SOURCE

- **John Tafuri**, MD, FAAEM, Chairman, Regional Emergency Medicine, Cleveland (OH) Clinic. Phone: (216) 476-7312. Email: jotafu@ccf.org.

Legal Implications for ED if Scribes Used for Documentation

By relying on scribes to document, EPs presumably can spend more time focusing on the patient and include more detailed documentation in the ED chart. On the other hand, scribes can potentially increase legal exposure for EPs. One obvious concern involves accuracy.

"I have heard from emergency physician colleagues that consistency of documentation is highly dependent on the individual scribe and physician and their relationship," says **P. Divya Parikh**, vice president of research and risk management for the Rockville, MD-based Medical Professional Liability Association.

In essence, scribes replace one problem with another. "It's inherently a balancing act. But most EPs find that, on balance, practice is better with them than without them," Parikh adds. Inadequate training, poor supervision or oversight, and use of the scribe beyond his or her role and scope of responsibilities are the biggest legal risks with scribes in the ED setting, according to **Denise Shope**, RN, risk management consultant at RCM&D, a Towson, MD-based insurance advisory firm. "The ED clinician is ultimately responsible for the care of the patient and accuracy and integrity of the medical record documentation," Shope says. This includes the documentation entered by a scribe. Potential errors include sound-alike words, especially with medications; confusion about laterality (left vs. right) or numeric values, such as 10.8 vs. 0.8.

A complete and accurate record of the ED patient's medical history and current plan of care "mitigates the potential for miscommunication and error," Shope says. "But I don't think we have clear evidence yet that there is a direct correlation with the use of scribes and the reduction of litigation." Shope shares some practices that could limit risk and liability for EDs. She says these practices should be included in the hospital's written policies:

- Scribes accompany the attending provider into the exam room and enter information in real time;
- The scribe remains with the provider during the entire visit, except in an emergency (if the provider asks the scribe to leave), or at the patient's request (for privacy reasons);
- All entries made by a scribe regarding a patient's health information are completed in the presence and at direction of EP;
- Scribes are responsible for capturing an accurate and detailed description of the ED patient encounter in the provider's words;
- Scribes may not interject their own observations or impressions into the medical record;
- Scribes may assist the provider in navigating the EMR and locating test or lab results for review during the patient visit;
- Staff cannot ask scribes to leave the room to perform other duties (such as running errands or assisting with procedures) that would

take scribes away from their scribing duties;

• The scribe brings to the provider's attention any advisories or alerts that appear on the EHR screen and records the provider's response as appropriate;

• All orders for patient care are communicated by the provider, not the scribe;

• Scribes use their own unique login to perform their scribe duties;

• Scribes document the words, actions, physical exam findings, and procedures as performed and dictated by the provider.

"The scribe is only entering the provider's words for them and not inserting their own comments or judgments into the record," Shope notes.

• The scribe must attest in the medical record that he or she acted as the scribe for the provider using the following statement: *"I acted as a scribe of the services personally performed by the clinician, and the medical note documents those services and medical decisions made by the clinician and recorded by me as a scribe."*

• The provider must attest to using a scribe using the following statement: *"I have personally performed the services documented here and agree that the documentation accurately represents the services and medical decisions I made. I have reviewed the documentation and made changes or additions as needed. The encounter was documented by the clinic staff acting as my scribe."*

• At the conclusion of the patient visit, as soon as reasonably possible, the provider reviews all documentation completed by the scribe, makes any necessary amendments, and signs and dates the record.

Shope says the scribe's clinical training should include hospital policies and regulations on confidentiality and privacy. "ED scribe documentation should be managed with the same quality assurance expectations of any other patient documentation," she adds. Scribes can present an additional hurdle for the ED defense team: It's one more way for the plaintiff attorney to place the quality of ED documentation into question.

"The use of scribes is ripe for attack in the litigation scenario. It invariably introduces a further opportunity of what we call failure to communicate," says **Kevin J. Kuhn**, JD, a partner at Wheeler Trigg O'Donnell in Denver.

Scribes may even find themselves named as witnesses in a malpractice case against the EP. The plaintiff attorney may ask questions like, "The EP testified he told the patient to go see his primary care physician tomorrow. Did you hear him say that? If you did hear him say that, would you have made a note?"

"Then, they throw the scribe back in the physician's face to say, 'Well, the scribe doesn't remember you saying anything like that,'" Kuhn reports.

In this way, the scribe is used to challenge both the credibility of the EP and the accuracy of the ED chart. The best-case scenario from the defense perspective, according to Kuhn, is for EPs to handle their own documentation. "Then, I know it's accurate, and he or she is the one who entered it."

Involvement of scribes opens the door to suggestions that the ED record can't really be trusted, with differing recollections coming into play. This complicates the defense of any ED malpractice claim.

"I call it the multiplier of confusion," Kuhn explains. He acknowledges that scribes can help with patient throughput, and that some EPs feel they are legally protective because it allows the EP to spend more time on medical decision-making. However, the defense team's mission is to protect EP defendants from allegations that they failed to meet the standard of care.

"Frequently, I have to rely on documentation to carry out that mission," Kuhn notes. "My best source of defending a case is from the emergency medicine physician, not diluted through a scribe charting."

EDs may say or do something the scribe doesn't observe directly, such as giving discharge advice, answering a patient's question, or reminding a family member of the need for follow-up. This won't be entered into the record, since the scribe is unaware of it.

"That distorts the advice that was given and also the compassion that was shown to the patient," Kuhn notes.

It's also not unheard of for an EP to ask the scribe to tell a patient something or remind them of discharge instructions.

"A physician may say, 'I would never do that,' but in a busy ED, it's possible," Kuhn predicts. "This could open the door to a negligent training allegation." ■

SOURCES

- **Kevin J. Kuhn**, JD, Partner, Wheeler Trigg O'Donnell, Denver. Phone: (303) 244-1841. Email: kuhn@wtotrial.com.
- **P. Divya Parikh**, Vice President, Research & Risk Management, Medical Professional Liability Association, Rockville, MD. Phone: (301) 947-9000. Email: dparikh@mplassociation.org.
- **Denise Shope**, RN, Risk Management Consultant, RCM&D, Towson, MD. Phone: (443) 421-5053. Email: dshope@rcmd.com.

Beware Exposure if 'Bouncebacks' Don't Return to Same ED

Most EDs track return visits — cases in which patients come back with new or worsening symptoms. But what if that patient goes to a different ED? Investigators recently examined this question.[1]

"Our research group undertook this study to better understand how patients moved between different hospitals after an initial ED discharge," says **Bradley Shy**, MD, the study's lead author. Researchers analyzed more than 12 million return visits (sometimes called "bouncebacks") occurring within 72 hours of initial presentation at 31 EDs over a five-year period. These included 841,259 same-site visits and 107,713 different-site return visits.

"This work may raise important malpractice implications for the second ED involved in a two-hospital bounceback," says Shy, associate medical director and director of quality assurance and process improvement in the department of emergency medicine at Mount Sinai School of Medicine in New York City.

The data showed "a huge variability" in how frequently patients from any particular ED will return to a different hospital within 72 hours, Shy says. The ED most likely to have patients return to another site saw a 52% increase in the number of 72-hour returns identified when other hospitals were included in this analysis.

"This work highlights the perils of using 72-hour return frequency as a surrogate measure for quality of care," Shy notes.

Health information exchanges could allow ED physicians to learn in real time the nature of a patient's recent visit to an outside hospital.

"There are countless examples — access to blood culture results, avoiding redundant CT scans, knowledge about patients' allergic drug reaction history — of how this technology can be potentially life-saving," Shy says.

As Health information exchanges grow, ED physicians could conceivably be liable for not reviewing data from outside hospitals. "If EDs have access to these records from outside hospitals and do not access these, these physicians and hospitals could be taking on significant risk," Shy warns.

Shy stresses that EPs should look for ways that this can improve their patient care.

"It is very likely health information exchanges will become substantially larger and more robust over the next decade."

Encourage Patients to Return

The traditional understanding of a 72-hour bounceback was based on identifying patients who had returned to the same facility. "But it is logical to consider the possibility that if the initial visit resulted in a return, the patient may want their repeat evaluation to be done by a different center," says **Michael B. Weinstock**, MD, co-author of *Bouncebacks! Emergency Department Cases: ED Returns*.

Investigators did not seek to determine if there was a medical error resulting in the return.

"In fact, there are some patients who will have a progression of their disease or new symptoms. We *want* these patients to return," says Weinstock, associate program director of Adena Emergency Medicine Residency and director of medical education and research at Adena Health System.

Factors that increased the likelihood that the patient would return to the same ED included age of 65 years or older, and the existence of an emergency medicine residency program at the hospital.

"Risk management factors to consider when discharging a patient are to anticipate patients who may have progression of disease and to ensure they understand the importance of returning for a recheck," Weinstock says, noting that patients should know they are welcome to return to the ED any time. "But going to the closest ED, even if a different ED, should not be discouraged."

The need to return to the ED is not always clear to patients.

"A patient's presentation is a question that sometimes only we understand — for example, a thunderclap headache or left lower quadrant pain in an amenorrheic woman," Weinstock offers. It is important that both the ED provider and the patient understand the question that needs answering. "This will help with encouraging the patient to return if their symptoms progress or change," Weinstock notes.

When seeing a "bounceback" patient, there's a risk EPs will fall into "diagnosis momentum," according to Weinstock. "One of the biggest impediments to making an accurate current diagnosis is to attribute undue importance on the previous diagnosis," he says.

When a patient returns to a different ED, Weinstock says, "the previous ED visit should be explored for complaints not explored, lab

abnormalities not acted on, and abnormal vital signs not recognized."

Some EPs may be inclined to blame the initial doctor for a misdiagnosis.

"This may prompt the patient to initiate a lawsuit," Weinstock warns.

The presentation may seem obvious on the return visit, but the diagnosis may have not been so clear at the time of the first ED visit. A common example is a patient presenting with the earliest symptoms of appendicitis (mild nonfocal abdominal pain and nausea). If the patient feels better with conservative treatment, exhibits good vital signs, and shows improvement during a follow-up physical exam, discharge may be indicated, provided that good ED return precautions are understood by the patient.

"Although appendicitis would be possible at this point, other diagnoses, such as gastritis, may be more likely," Shy says. On a return visit to the same or different ED, symptoms may be more severe and consistent with appendicitis. "At this point, this diagnosis can be readily made," Shy adds.

EPs should keep in mind that the previous ED evaluation and management might have been entirely appropriate based on the information available at the time.

"We should never cast blame on a previous provider," Weinstock advises.

For example, a patient with complaint of headache may have told the initial provider that it was identical to past headaches. But with the additional information of unintentional weight loss given to an EP at the second ED, now primary or metastatic malignancy moves up on the differential.

"Keep the encounter focused on the patient's symptoms and making a diagnosis and management plan," Weinstock offers. "Leave litigation for someone else." ■

REFERENCE

1. Shy BD, Loo GT, Lowry T, et al. Bouncing back elsewhere: Multilevel analysis of return visits to the same or a different hospital after initial emergency department presentation. *Ann Emerg Med* 2018;71:555-563.

SOURCES

- **Bradley Shy**, MD, Associate Medical Director/Director of Quality Assurance and Process Improvement, Department of Emergency Medicine, Mount Sinai School of Medicine, New York. Phone: (646) 537-8703. Email: brad.shy@gmail.com.
- **Michael B. Weinstock**, MD, Associate Program Director, Adena Emergency Medicine Residency; Director, Medical Education and Research, Adena Health System; Professor, Emergency Medicine, Department of Emergency Medicine, Wexner Medical Center, The Ohio State University, Columbus. Phone: (614) 507-6111. Email: mweinstock@mweinstock.com.

EP's Independent Contractor Status Doesn't Always Limit Hospital Malpractice Exposure

Often, hospitals and EPs are named jointly in malpractice litigation. The EP defendant's status, as either a hospital employee or independent contractor, can determine whether the hospital is liable.

"A hospital's potential liability when named in a suit along with an ED provider can vary due to a number of factors," says **Megan Kures**, JD, director at Hamel Marcin Dunn Reardon & Shea in Boston.

If the EP is an employee, plaintiff's counsel usually will proceed under a *respondeat superior* theory of liability. "This typically requires the plaintiff to prove that the provider was acting within the scope of his or her employment at the time of the negligence in question," Kures explains.

In some jurisdictions, many hospitals are charitable corporations with statutory protections in the form of caps on damages. "Some counsel will make a strategic decision not to name the hospital due to application of the cap and the possibility that the jury might find against the hospital rather than the provider," Kures says.

Whether the EP defendant is legally considered to be an independent contractor or an employee is not always clear. "There may be an entire separate legal analysis that goes into that determination," Kures says. Courts may consider:

- the language of any applicable agreement;
- the degree of control that the hospital exercises over the provider;
- how benefits are handled;
- how patients are assigned;
- how schedules are made.

"Nurses, nursing assistants, social workers, therapists, and other nonphysician providers are more likely to be legally defined as employees than physicians," Kures says.

EPs are less likely to be subject to the direct control of the hospital because they have to exercise

independent judgment in treating patients based on their education, training, and experience. "For example, a hospital is not going to have a specific policy that tells a physician how he or she should treat a patient with a fractured tibia," Kures explains.

Other providers may be more likely to be subject to specific policies and procedures that guide their clinical interactions with patients. For instance, a written policy that instructs a nurse how to insert an IV may exist.

EPs also are more likely to have a direct say in their schedules, shifts, and time off compared to other nonphysician providers. "These factors may push against a finding that the physician is controlled by the hospital," Kures notes.

If the provider is not an employee, then a plaintiff will find it difficult to proceed under a *respondeat superior* theory of liability against the hospital, Kures offers. This is true, although there may be a claim against a different entity or a different theory of liability. If the EP is not an employee of the hospital in question, he or she might be an employee of a different corporate entity or practice group. "The plaintiff may elect to then go after that entity or group," Kures notes.

Frequently, issues related to the EP's employment status are sorted out in the discovery phase of the case. "At this time, you may see amended pleadings filed to reflect the legally accurate status of the defendants," Kures adds.

Whenever an EP or a physician assistant (PA) employed by a staffing company is named in malpractice litigation, it's a safe bet to assume the hospital will be named, too. "The presumption is that the hospital is vicariously liable for the actions or inactions of the ED provider," says **Jason Newton**, senior vice president and associate general counsel at Medical Mutual in Raleigh, NC.

If the EP is a hospital employee, it increases the hospital's liability exposure for vicarious liability related to the alleged negligence of the EP defendant. If the EP is an independent contractor, the opposite is true; the hospital's exposure for the EP's alleged negligence decreases, Newton says.

State law determines whether the EP is legally viewed as a hospital employee or independent contractor. Newton says courts consider many factors, including (but not limited to): billing structure, verbal and written patient instructions, insurance coverage, and contract language.

Hospital administrators may believe using independent contractors in the ED limits the facility's exposure in malpractice cases. However, Newton cautions this often is not true because hospitals didn't conduct due diligence up front.

Newton says hospitals can limit their liability by writing contracts carefully. He recommends contracts spell out several stipulations, including (but not limited to):

- facility cannot fire the independent contractor without cause;
- hospital pays fixed prices for independent contractor services rendered;
- independent contractor uses separate billing for services rendered;
- independent contractor can work at other facilities and treat other patients;
- hospital forfeits supervisory rights;
- facility does not dictate number of vacation and sick days;

When it comes to determining the EP defendant's status as employee or independent contractor, the patient's perception "definitely weighs into the equation," Newton says, noting that courts often focus on what the patient *believed* about the EP's employment status.

Typically, plaintiffs claim they did not see signs nor read the details of consent forms, which they signed while in the ED anyway. Newton says it is vital that hospitals ensure patients understand clearly that an independent contractor is not a hospital employee, which means the hospital is not liable for that contractor's care.

To make it more difficult for plaintiff attorneys to argue that the patient thought the EP was an employee, Newton suggests hospitals hang colorful signs with large font in many places, including triage, treatment areas, and waiting rooms.

Newton suggests this sample wording for such signage: *The emergency physicians who staff the ED at the hospital are not employees of the hospital. They are independent contractors. That means they have their own liability insurance and the hospital is not responsible for any action or inactions in which the patient is dissatisfied. The emergency physician will send the patient a separate bill.*

Other tactics include:

- Direct independent contractors to wear name tags or badges without the hospital's name or logo;
- Do not assign independent contractors email addresses that contain the hospital's domain name;
- In all authorizations and consents, list the independent contractor's employer;
- In any information available to patients online and in printed form, avoid any "team" references when highlighting services that include services independent contractors provide.

Newton says a team-oriented statement used for marketing purposes, such as "Our emergency physicians are the best in the

business," may be used against the hospital. This is because it allows the patient to argue that it sounded like the EPs were hospital employees. Even with all these measures in place, Newton says an administrator should assume his or her facility somehow represented itself as the provider of all care, thus putting legal responsibility on the facility. The hospital can reduce this likelihood if it can prove evidence to the contrary existed at the time the patient received treatment in the ED. These include dated photos of the signage that was posted and the patient's signature on informed consent or care authorization forms, with the independent contractor language initialed.

It's also important for the EPs who are independent contractors, and the companies that employ them, to make this distinction. If the hospital is deemed vicariously liable, in actions in which the hospital really should not have been named as a defendant to begin with, "the hospital will then threaten to revoke the contract of the emergency medicine staffing company or will want the litigation settled to avoid hospital exposure," Newton warns. Thus, both the hospital and ED staffing company have a vested interest in making sure the relationship is clearly delineated. Ideally, says Newton, "there can be no ambiguity when a court looks at what the patient would have signed or seen before treatment." ■

SOURCES

- **Megan Kures**, JD, Director, Hamel Marcin Dunn Reardon & Shea, Boston. Phone: (617) 482-0007. Email: MKures@hmdrslaw.com.
- **Jason Newton**, Senior Vice President/Associate General Counsel, Medical Mutual, Raleigh, NC. Phone: (919) 878-7603. Fax: (919) 878-7592. Email: Jason.newton@mmicnc.com.

Is Intoxicated Patient 'Just Another Drunk,' or Someone With Unsuspected Critical Illness?

About 1% of patients who arrived to the ED for uncomplicated alcohol intoxication required critical care resources during their encounter, according to a recent study.[1]

"The purpose of this study was to identify the frequency at which patients who presented to the ED for uncomplicated alcohol intoxication had underlying critical illness," says **Lauren Klein**, MD, MS, the study's lead author.

Researchers analyzed 31,364 ED visits of patients from 2011 to 2016. The initial assessment for these patients was uncomplicated alcohol intoxication without other acute medical or traumatic complaints. A few factors were associated with increased odds of critical illness, including chemical sedation, hypoglycemia, and abnormal vital signs. Common diagnoses included infection or sepsis, acute hypoxic respiratory failure, intracranial hemorrhage, and alcohol withdrawal. Three patients went into cardiac arrest.

"While working in the ED, in patients who arrived to the ED 'just intoxicated,' we would often find additional serious pathology," says Klein, faculty in the department of emergency medicine at Hennepin County Medical Center in Minneapolis. Sometimes, these patients would even go on to require critical care interventions, such as endotracheal intubation for respiratory failure. The findings correlated with the researchers' clinical experience.

"This validated our concern that the population of patients presenting with alcohol intoxication is a high-risk cohort," Klein reports. "These encounters should be treated with the utmost respect and attention to detail."

If busy EPs see a patient on the tracking board listed as there for "alcohol intoxication," the patient may not get their full attention compared to the other patients who seem sicker. "This study suggests that intoxicated patients need a comprehensive evaluation," Klein offers. "Intoxicated patients can hide serious pathology, and it is our job to find this pathology."

In the ED, "we still stigmatize people who are intoxicated. There's a lot of frustration and skepticism, a mindset that 'You're just drunk, get out of my ER,'" says **Andrew Lawson**, MD, FACEP, acting director of quality assurance & quality improvement for the emergency physician group at Mission Hospital Regional Medical Center in Mission Viejo, CA.

EPs must overcome this bias, approaching the interaction with an open mind, Lawson says. "If you treat them as you would treat anybody else, you will order the appropriate tests and treat appropriately."

Mindset "plays a huge factor in this," Lawson adds. "Seeing the patient as 'just another drunk' vs. a patient just like any other patient is the number one cause of getting into medical/legal trouble."

The following are issues involving intoxicated ED patients that can lead to litigation:

• ED providers may miss serious medical conditions because of a less-than-thorough evaluation. "Often, we get jaded, and go down a line where we do very little testing or do the wrong tests," Lawson laments.

Frequent ED users who visit the ED for acute alcohol intoxication demonstrated higher rates of medical and psychiatric comorbidities compared to non-frequent users. Researchers noted that these comorbidities included liver disease, chronic kidney disease, ischemic vascular disease, dementia, COPD, history of traumatic brain injury, schizophrenia, and bipolar disorder.[2]

Of 32,121 patient encounters, 325 patients were defined as frequent users for alcohol intoxication, comprising 11,370 of the encounters during the study period. The number of ED visits per patient ranged from 20-169.

"Downplaying what's going on will get you into trouble," Lawson warns, reporting that he has seen EPs miss spinal cord injuries and broken bones in intoxicated patients. "The patient could have a broken neck and not act like they do."

The patient's intoxication can distract EPs from other medical conditions that require attention. Lawson says this is similar to the way an ED patient's injury can distract the EP from noting another unrelated injury.

"You have to be very careful. We almost have to order and evaluate more aggressively than you would for somebody not intoxicated," Lawson notes.

• ED providers may not be able to obtain an accurate history from the intoxicated patient. "We need to get information from everybody — paramedics, family members — to put together what really happened," Lawson advises. Questions for paramedics might include "Who called 911?" or "What did you see when you arrived?" Questions for family might include "Does the patient live alone?" or "Was this a suicide attempt?"

• Staff may fail to take appropriate precautions to prevent the intoxicated patient from sustaining an injury in the ED. "You get into trouble when you allow [patients] to walk without assistance or give them a bedside urinal rather than keeping the gurney sides up and making sure they are not able to harm themselves," Lawson explains.

• Documentation in ED charts sometimes appears judgmental. ED staff may document something like "George is drunk again."

"You want to document exactly what transpired without any derogatory comments," Lawson advises. "Be an objective observer rather than an invested, subjective person."

For example, EPs might chart, "The patient moved their arm in an aggressive way to try to punch me," or "the patient tried to attack me."

• Intoxicated patients may be harmed because of an unsafe discharge situation. "You need to provide the patient with a safe 'out,'" Lawson advises. Ideally, the patient is awake, alert, and able to ambulate — all while a family member is present.

"That's a pretty good situation for discharge," Lawson says. "But if [patients] don't have a family member with them, or you think they are not that intoxicated, and you allow them to leave by taxi, that's high risk."

• The intoxicated patient who leaves the ED against medical advice (AMA) may be harmed. "You certainly don't want to sign somebody out AMA who is intoxicated [and] who may not be competent to understand the risks and benefits of leaving," Lawson warns.

Lawson recommends getting the family involved to help convince the patient to stay for tests, and using statement such as "I don't blame you, I would want to get home, too. But if you can give us another hour of your time, we can get you some food to eat."

If the patient insists on leaving, calling the police may be necessary. In such cases, Lawson says, "We don't really want to do this, but we are concerned for your welfare, and we don't feel you are safe to go home yet. If you insist on leaving, we will need to call the police to speak with you."

If there's litigation, and the intoxicated patient signed out AMA, decision-making capacity almost certainly will become an issue.

"[Plaintiffs] can potentially find a lawyer who says the patient clearly was not capable of signing such a document in their condition," Lawson says. ■

REFERENCES

1. Klein LR, Cole JB, Driver BE. Unsuspected critical illness among emergency department patients presenting for acute alcohol intoxication. *Ann Emerg Med* 2018;71:279-288.
2. Klein LR, Martel ML, Driver BE, et al. Emergency department frequent users for acute alcohol intoxication. *West J Emerg Med* 2018;19:398-402.

SOURCES

- **Lauren Klein**, MD, MS, Department of Emergency Medicine, Hennepin County Medical Center, Minneapolis. Phone: (612) 873-7448. Email: Lauren.Klein@hcmed.org.
- **Andrew Lawson**, MD, FACEP, Acting Director, Quality Assurance & Quality Improvement, Emergency Physician Group, Mission Hospital Regional Medical Center, Mission Viejo, CA. Phone: (949) 400-5216. Email: alawsonmd@gmail.com.

ED LEGAL LETTER™

CME/CE QUESTIONS

1. **Which is the most common reason for ED malpractice claims, according to a recent Coverys report?**

   a. Misdiagnosis
   b. Wait times leading to adverse outcomes
   c. Failure to monitor patients waiting for inpatient beds
   d. Inadequate responses to "crashing" patients

2. **Which has reduced malpractice risks at Fairview Hospital, according to John Tafuri, MD, FAAEM?**

   a. Referring families to hospital risk managers whenever bad outcomes occur, with no contact with clinicians due to multiple lawsuits stemming from upfront discussions.
   b. Taking a team approach to communicate the reason for bad outcomes and answer families' questions.
   c. Discontinuing a long-standing practice of allowing EPs to apologize for mistakes that caused harm.
   d. Implementing a policy where solely the treating EP gives information about a bad outcome to the family at the time of the ED visit.

3. **Which is true regarding legal issues involving ED scribes?**

   a. If the scribe acknowledges documenting incorrectly under oath, the EP cannot be held responsible for the inaccurate documentation.
   b. There is now a strong correlation between use of scribes and decreased malpractice litigation.
   c. The ED clinician is ultimately responsible for the care of the patient and accuracy and integrity of the medical record documentation.
   d. Less extensive quality assurance is needed for scribes than other types of ED documentation.

4. **Which is true regarding the patient's perception of an EP defendant's employment status?**

   a. If hospital provides patients with written notice that EPs are independent contractors, plaintiff attorneys cannot introduce evidence that patients thought the EPs were employees.
   b. The burden of proof is on the plaintiff to prove the patient was informed that the EPs were not employees.
   c. Courts often focus on what the patient believed about the EP's employment status.
   d. Courts typically assume patients know that most EPs are independent contractors.