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INSIDE

RELIAS MEDIA

Study: Electronic Medical Record Design Flaws Can Hurt Patients

Patients can be harmed when there are problems in electronic medical records (EMRs) related to how information is conveyed to other providers and how test results get displayed, according to a recent study."[1]

"Suboptimal usability may contribute to safety issues. Providers may be held liable for those issues," says **Jessica Howe**, MA, the report's lead author. Howe is a senior research specialist and system safety specialist at MedStar Health's National Center for Human Factors in Healthcare in Washington, DC.

Of more than 1.7 million reports of safety issues researchers analyzed, 1,956 indicated the EMR as a cause of patient harm, and 557 reports contained language explicitly suggesting EMR usability contributed to possible patient harm. Of those, 80 caused temporary harm, seven may have caused permanent harm, and two may have been fatal. About 8% of the harm events occurred in the ED.

"It is critical that ED leadership understands that how EMRs are designed, developed, and implemented does contribute to patient harm," Howe cautions. There is growing recognition that some bad outcomes result from EMRs that were designed or implemented poorly. "We can't continue to blame providers or 'user errors' for these EMR-related harm events," Howe advises.

In the ED, as in other settings, says Howe, "if the EMR is not designed, developed, implemented, customized, and maintained appropriately, the EMR can promote errors." Two common ED examples:

- **Pending lab results are not detected by ED providers.** If there are 11 results and 10 come back, the displayed results do not always show that there is still one result pending. The risk: An ED patient is discharged before an abnormal finding returns.
- **Lab results or medications are never ordered because the EP doesn't realize an additional click is needed.** The risk: Delayed care contributing to a bad outcome.

The question *"Would any other reasonable provider in the same conditions make the same error?"* is the key to determining liability in such cases, Howe explains. "If the answer to this question is 'yes,' then this is indicative of suboptimal usability."

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This is one way a plaintiff can bring the hospital into ED malpractice litigation. "If the healthcare system is involved in the customization decisions that impact usability and safety of the EMR at their sites, they could potentially be liable," Howe notes.

Under certain circumstances, the ED defense team could use a poorly designed EMR to deflect liability away from the EP. However, if the hospital also is named in the lawsuit, the co-defendants likely will be pointing fingers at one another. "That is the plaintiff's dream," says **Robert B. Takla**, MD, MBA, FACEP, medical director and chief of the emergency center at Ascension St. John Hospital in Detroit. Takla offers a better strategy: "Work together on a strategic approach for defense. Even better is to fix the EMR before it causes issues."

Lorraine Possanza, DPM, JD, MBE, program director for the Partnership for Health IT Patient Safety, curated by ECRI Institute, says these are important issues regarding EMRs in the ED setting:

• **The way information looks.** For instance, it is not always clear whether lab results are from a current or previous visit.

• **How information flows to other providers, both within the hospital and externally.** One reported safety event involved a patient admitted from the ED who needed constant supervision due to mental health issues. The ED nurse documented this in the EMR.

"But when the patient went to the floor, that wasn't readily evident. So no one knew they needed one-on-one supervision," Possanza says. The patient was unharmed. "But the event demonstrated a concern that information is not always readily visible to those needed to act upon that information," Possanza adds. Possanza says the main question ED providers should ask is: *"Am I communicating information clearly to people who need to know it?"*

• **Where information is located.** Often, ED providers are frustrated because the EMR gives them no easy way to document certain pieces of information. "We still face that free-text issue," Possanza laments. "If I'm putting something in a free-text area, it's not necessarily being communicated to the next person. Sometimes, that information is lost."

It may be that an EP tried to order a medication in a certain dose, but the system only listed six dosages because the drop-down menu only allowed for six boxes.

"The ED provider then has to pick one of the others or free-text it," Possanza notes.

Possanza says EDs should continually test how information flows. This is especially important after an upgrade or the addition of new modules to see if anything looks different or any information is in a different location. "There are a lot of people who flex in and out of the ED," Possanza adds. "Maybe they work three days and are then off. They may not have been there the day you did an upgrade."

It is equally important to encourage ED providers to report problems with the EMR that are affecting patient care adversely. "You want people to tell you when things aren't working as anticipated. You also need a mechanism so they can learn what was done about the issue," Possanza offers.

When it comes to user issues with EMRs, says Takla, "Liability will always exist. 'How can we minimize it by improving the design?' is the question we should be asking." ED clinicians and leaders need to work together to modify EMRs to be more user-friendly, Takla says. One example: "nuisance" alerts that ED

providers often ignore. This is because the alerts don't make sense clinically. "They assume they are providing us with a 'helpful' alert, but that is not the case. The end result is we ignore them," Takla notes. Clinical impressions should "pop out" to ED providers, Takla says. Ascension St. John Hospital's ED has implemented these changes to its EMR based on input from ED providers:

• Request to build mandatory "hard stops" when discharging a patient with abnormal vital signs. This would require the provider to acknowledge any abnormal vitals before discharge. (Takla notes this change was requested, but has not been implemented yet.);

• Critical values are displayed in different colors;

• Eliminate duplicate computerized physician order entry of radiological tests to avoid unnecessary radiation and longer ED length of stay. "This has reduced diagnostic testing by 11%," Takla reports. If a duplicate test is ordered, the system alerts providers as follows: *"This test was conducted on [date], here is the result. Do you want to order it again?"*

In some EMRs, the most recent test results always appear at the top of the list. Unfortunately, that's not true of all EMRs. Further complicating matters, ED providers sometimes work in multiple hospitals. "When they go to find information, it's not in the same place," Possanza says. Likewise, allergy information may have a designated location in one record, but no field for entry in another EMR. ED providers are forced to record the information as free text. The bottom line is that every EMR is different, and those differences expose EDs to liability. "The differences multiply when hospitals or medical systems adapt or modify EMRs to fit their specific needs," says **Brandy A. Boone**, director of risk resource for ProAssurance Companies in Birmingham, AL.

ED nurses likely are employees of the hospital, whereas EPs often are independent contractors working at multiple health systems. "A major risk in the ED regarding EMRs is lack of consistency in training and use," Boone notes. ED providers don't always know where to look for important critical information in the system they are using, such as the most recent test results. Thus, providers lose critical time in providing the appropriate care for patients, delays that can lead to bad outcomes. "When staff develop workarounds and shortcuts within a system, those may not be consistently applied," Boone adds. "This can threaten the flow of communication."

Appropriate training is needed for everyone entering or viewing information in the EMR, Boone emphasizes. It is not enough for EDs to establish appropriate usage guidelines for EMRs. "They should also consider how those guidelines are going to be enforced, to ensure more consistent use across the board," Boone says. Hospitals can do this in these ways:

• For employees, require mandatory training and compliance through orientation and annual performance reviews;

• For non-employed medical staff, through the credentialing process, including initial credentialing and any renewal of privileges.

The idea is to tie compliance to the ability of the medical and nursing staff to continue practicing at the ED. "This can lead to better overall communication, more effective treatment, and more positive patient outcomes," Boone says. ■

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Is ED Patient's Conduct a Viable Defense Strategy?

The plaintiff in one malpractice claim had been seen in the ED for injuries he sustained while fleeing the scene of a crime. However, it was unclear whether a jury would ever get to hear about the patient's criminal conduct.

"The EP believed that the jury would certainly rule against the patient if they knew how he was injured," says **Keith C. Volpi**, JD, an attorney at Kansas City-based Polsinelli who defended the EP.

The parties settled the case before the admissibility issue could be decided, but it raised a question ED defendants ask commonly: Can an ED patient's pre-treatment conduct be used as a viable defense strategy?

"The short answer in most jurisdictions is: It depends," Volpi explains. There are two types of pre-treatment conduct that defense attorneys and defendant EPs want a jury to know:

• Pre-treatment conduct by a patient that is medically relevant.

Did a patient wait too long to go to the ED, or fail to follow a provider's instructions? The general rule is that medically relevant pre-treatment conduct is admissible.

"I recently defended a case that provides a great example of this," Volpi says.

The plaintiff presented with a knee dislocation. The lawsuit alleged that too much time passed before the EP ordered a CT angiogram to diagnose an occluded popliteal artery, and that the delay resulted in acute compartment syndrome.

"However, we learned that nearly three hours passed between the injury and the patient's presentation in the ED," Volpi notes. That pre-treatment conduct was "absolutely, directly" medically relevant to the patient's claims, Volpi says.

In this case, the patient's delayed presentation for medical treatment was acutely important.

"As anticipated, evidence of the patient's delayed presentation was admissible and heard by the jury," Volpi recalls. The defense got this message across ... both during the opening statement and also through expert testimony. "Our theme was that the patient, not the EP, made this a time-sensitive case," Volpi says. "We told the jury during opening that the patient took his sweet time before going to the hospital."

The patient admitted on the stand that he decided to wait to see if symptoms improved before going to the ED.

"Our experts testified that the outcome would have been much different if the EP had another few hours to work with," Volpi adds.

• A patient's pre-treatment conduct that is only tangentially medically relevant.

The general rule is that this type of "socially relevant" pre-treatment conduct is inadmissible. "I see this most commonly in my practice when patients present in the ED intoxicated and then file a claim for negligent treatment by the EP," Volpi says.

For obvious reasons, ED defendants want the jury to know the patient was drunk and belligerent. But unless the patient's intoxication is medically relevant to the alleged negligence, it often is inadmissible.

"In other words, pre-treatment conduct is inadmissible for the sole purpose of 'smearing' the patient," Volpi explains. In a recent decision in Maryland, a trial court determined that the amount of time that passed before a patient presented for treatment after experiencing severe abdominal pain was inadmissible.

The lawsuit alleged that the patient's common bile duct was injured during a cholecystectomy.[1] The court held that the patient's pre-treatment conduct is irrelevant in determining whether the physician is liable for violating the standard of care.

"The amount of time during which the patient experienced abdominal pain was not medically relevant to the performance of the surgical procedure," Volpi notes.

Contributory negligence is still a viable defense in Maryland when it comes to the plaintiff's conduct *after* the relevant care and treatment, says **Ronald V. Miller, Jr.**, JD, an attorney at Baltimore-based Miller & Zois.

"But the door is now closed, assuming the court of appeals does not speak to this, on the plaintiff's conduct before the alleged negligence," Miller says. ■

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ED Misdiagnosis Case Alleged Failure to Use Decision Tool

Failure to obtain an ordered ECG, failure to use a decision tool, and anchoring bias were factors in a recent ED malpractice claim alleging missed pulmonary embolism (PE). **Ken Zafren**, MD, FAAEM, FACEP, clinical professor of emergency medicine at Stanford University Medical Center, reviewed the case as an expert witness.

The plaintiff was an otherwise healthy 30-year-old male who had been ill with cough and shortness of breath for several weeks. He had been diagnosed with bronchitis at a clinic, for which he was prescribed azithromycin.

The following day he was seen in the ED, where he was found to be tachycardic with an oxygen saturation of 94%. A chest X-ray was read as normal. An ECG was ordered but never obtained.

The oxygen saturation improved to 98% without treatment, but the tachycardia did not resolve. The patient was given a dose of azithromycin and told to fill the prescription from the day before.

The next day, the patient experienced sudden shortness of breath. Someone called 911. The paramedics found the patient hyperventilating with a heart rate of 130 beats per minute, a blood pressure reading of 110/76, a respiratory rate of 48, and oxygen saturation at 93%. The paramedics helped the patient slow his breathing and transported him to the same ED in which he had been treated the previous day.

Initial vital signs in the ED were: Heart rate of 125, respiratory rate of 28, blood pressure of 116/97, and oxygen saturation at 95%. The lungs were clear. Lower extremities were neither swollen nor tender. The ECG showed tachycardia, inverted T waves in leads V1-3, and a biphasic T wave in V4, with an S1Q3T3 pattern. The machine reading gave the axis as indeterminate, although visual inspection showed a rightward axis. "The patient's mother asked if her son could have a blood clot, and mentioned that she had a history of a blood clot," Zafren notes.

The patient was sent home with diagnoses of cough and shortness of breath and with instructions to continue azithromycin. "Unfortunately, he was found dead the next morning on his bathroom floor," Zafren says. The autopsy showed a saddle pulmonary embolus and a lower extremity deep venous thrombosis (DVT).

At the first ED visit, the physician misdiagnosed the patient with bronchitis despite abnormal vital signs that suggested PE. "A normal chest X-ray in a patient without underlying disease who is short of breath and hypoxemic is virtually diagnostic of PE," Zafren says.

The EP likely demonstrated anchoring bias stemming from the initial misdiagnosis of bronchitis at the clinic, Zafren adds. The EP also failed to follow up on the ECG that was not performed. Zafren says that errors at the second ED visit included:

• **Failure to interpret abnormal vital signs.** In a healthy patient with clear lungs, hyperventilation should result in an oxygen saturation of 99-100%. "The oxygen saturation of 93% strongly suggested PE, especially when associated with sudden onset of shortness of breath," Zafren explains. Persistent tachypnea and tachycardia also should have raised concern for PE.

• **Failure to interpret diagnostic tests correctly.** A normal chest X-ray in a patient with shortness of breath and hypoxemia should have led to the diagnosis of PE, Zafren says. Additionally, the ECG, which strongly suggested PE, was read as "nonspecific."

• **Premature elimination of the correct diagnosis from the list of differential diagnoses.** The EP at the second ED documented, "Although patient is tachycardic with a family [h/o] DVT, low suspicion of PE given that his legs are nontender, symmetric, no chest pain, not hypoxic, and no recent travel or immobilization. VS otherwise stable and his tachycardia and RR improved somewhat after he rested here in the ED."

• **Failure to consider all pertinent elements of the history.** Although the EP's note stated that the patient's mother mentioned her own history of DVT, she actually had a history of PE for which she was treated at the same hospital many years previously.

"The misdiagnosis could have been avoided had the physicians correctly interpreted the vital signs and diagnostic testing been carefully interpreted," Zafren concludes.

At trial, it was clear that the second EP had misread the abnormal ECG as nonspecific. Consultation with a cardiologist, another physician, or a web resource regarding the ECG likely would have led to the correct diagnosis.

"Failure to obtain expert consultation is a common failing in malpractice cases, including those involving misdiagnosis," Zafren notes. The patient's presenting complaint also strongly suggested the correct diagnosis of PE. "Pulmonary embolus without the classic findings of chest pain or leg swelling is common," Zafren notes.

The patient was hypoxic, but the physician testified at trial that 93% and 95% were normal oxygen saturations for this patient. "An SpO_2 of 93% or even 94% is not normal for a

healthy 30-year-old patient with clear lungs. It screams PE," Zafren says.

Zafren notes that premature closure of the diagnostic process was caused by:

- anchoring on the previous diagnosis of bronchitis;
- deciding that the diagnosis was hyperventilation despite evidence to the contrary;
- dismissing findings that did not support the diagnoses of bronchitis and hyperventilation.

"The process of documentation might have helped in this case by clarifying the thought process, leading the physicians to the correct diagnosis," Zafren says.

Although the claim was defended successfully, the fatal outcome and great personal cost to the defendant ED could have been avoided if either EP had made the correct diagnosis.

"The successful defense hinged on the fact that the EP at the first visit and the emergency medicine resident at the second visit, who were not named in the lawsuit, had also missed the diagnosis," Zafren says. Investigators recently studied whether the Pulmonary Embolism Rule-out Criteria (PERC) in ED patients with low clinical probability of PE safely exclude the diagnosis of PE.[1] PERC criteria are safe for very low-risk ED patients, the researchers concluded.

"Although you could theorize that the findings support EPs if a bad outcome occurs despite the use of PERC, the fact is that patients with a negative PERC will always have a very low risk," Zafren says. The components of PERC are very similar to the components of PE risk scores. "It is very unlikely that a patient with a low risk of PE and a negative PERC score will have a bad outcome," Zafren adds.

In the above case, there was no evidence that the EP used a decision tool in her decision-making. "Instead of clearly imperfect clinical gestalt, the second physician could have chosen to use a decision tool such as the Wells or Geneva PE score," Zafren offers. In either case, the patient would have had moderate risk. Even if the Wells score had been applied improperly, by failing to award points for the fact that there was no more likely diagnosis, the patient still would have been classified as low probability.

"The next step in both cases would have been to order a D-dimer, which would almost certainly have been positive, leading to the diagnosis of PE," Zafren says. ■

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No One Saw ED Nursing Notes? Jury May Not Like It

An ED patient was very specific during the nursing evaluation of his chest pain: It worsened during exertion. He also reported an extensive family history of cardiac problems.

Both worrisome pieces of information were carefully documented in the ED nursing notes. However, they were mentioned nowhere in the EP's documentation. This became a key issue during malpractice litigation.

"Patients are frequently more comfortable with nursing staff because nurses spend more time with individual patients. The picture they get is sometimes more complete," says **Joan Cerniglia-Lowensen**, JD, an attorney at Towson, MD-based Pessin Katz Law who represented the EP.

At the time the EP evaluated the patient, the patient minimized the chest pain. The patient also suggested it might be caused by eating certain types of foods, and that antacid improved the pain. "This caused the EP to conclude it was a gastroesophageal problem," Cerniglia-Lowensen says. In contrast, the ED nursing documentation indicated (correctly) concern that the problem was cardiac.

The patient was referred to a gastroenterologist, who also believed the problem was gastric. The patient was scheduled for an endoscopy, but died of a myocardial infarction in the interim. The patient's family sued the EP, the gastroenterologist, and the hospital; the parties later settled the claim. The case would have been more defensible if the information documented by nurses had been conveyed to all healthcare providers, Cerniglia-Lowensen offers.

"The EP still did all the right things," she says. "He got an ECG, evaluated the patient, and really believed the problem was gastric, as did the gastroenterologist." But the plaintiff experts made an issue of the information that wasn't shared between the providers.

"The difficulty becomes that memories fade," Cerniglia-Lowensen adds. The EP could not say with certainty whether he was aware of the nurses' concerns at the time of the ED visit. But the EP acknowledged it was not his routine to go through the EMR to discover what the nurses had charted. "The EP said it was just too cumbersome and not practical," Cerniglia-Lowensen says.

This admission, that the EP found it difficult to find the nursing notes in the EMR, and that he didn't review those notes routinely, was a tough hurdle for the defense. "It is a challenge for physicians to hunt through the EMR to elicit the information. In a busy ER, that is sometimes one of the things that doesn't occur," Cerniglia-Lowensen says.

Ideally, ED charts include documentation such as "Spoke with Nurse Smith. Reviewed nursing notes." If such documentation is absent from the medical record, the plaintiff attorney can argue the event never happened. "This suggests that there was a data source that was not utilized in arriving at the differential diagnosis," Cerniglia-Lowensen says.

Nursing notes became an issue in another well-known malpractice case involving a 42-year-old man who presented to an ED with shoulder strain. The patient actually had a necrotic infection that went undiagnosed. The case went to trial, and the defense prevailed. "In the end, the plaintiff was out-experted. The defense attorney had multiple national experts, and plaintiff had multiple local experts, which weren't enough," says **Michael B. Weinstock**, MD, associate program director of Adena Emergency Medicine Residency and director of medical education and research at Adena Health System.

However, the defense was complicated by the fact that nursing documentation was apparently never seen by the EP.

"I wish that the EP would have read the chief complaint and commented on it. That is the one thing about this case that could have been a game-changer," Weinstock laments.

The nursing notes indicated that the patient had a fever. "If you have shoulder strain and fever, you've got to start looking for reasons for the fever, including infection," Weinstock says.

On the stand, the EP was asked to read the nursing documentation aloud, which stated that the patient presented with left shoulder pain, fever, and chills.

"You don't have to agree with the chief complaint. But you do have to acknowledge it and comment on it," Weinstock notes.

For example, nursing documentation sometimes indicates that an infant or small child is "lethargic." If the EP disagrees, this should be indicated in the chart: *"The note has been read, appreciated, and discussed further with the family. They stated that the child had a longer nap than usual and not as active as usual. Patient is not currently*

lethargic and is active and playing." Inconsistencies between what the ED nurses document and what the EP observes while evaluating the patient are "easy to address," Weinstock says. "But we can only do that if we realize something's been written in the nursing notes."

Weinstock recommends adding a "hard stop" to ED medical decision-making.

"The idea is to monitor your own decision-making process and consider whether it was subject to some kind of bias," Weinstock says.

After reviewing all the information, including nursing notes, the EP can ask, *"Would I feel comfortable justifying my decision-making to the patient, family, or a jury if there is a bad outcome?"*

If the answer is 'no,' it means that either additional data are needed, possibly including a need to review the nursing notes, or the EP needs to reconsider his or her decision-making.

"Why wait for the patient to come back with a bad outcome?" Weinstock asks. "Why not do it before they leave, and change your course to decrease the risk of a bad outcome?"

Michelle Myers Glower, MSN, RN, NEA-BC, a Bradenton, FL-based legal nurse consultant, has reviewed many ED charts in which the EP indicated that the nursing notes were reviewed. "I applaud all physicians who document they read them. However, I know when they really *did* read the notes," Myers Glower says. "I look for evidence in the records that speaks to this." Myers Glower looks for:

- whether the notes and orders reflect the patient's chief complaint;
- what information the nurse shared with the EP;
- whether the EP's notes reflect any abnormal findings noted by nurses;
- whether ED nursing notes indicate that any abnormal findings were conveyed to the EP.

ED nurses should know where to look for the EP's documentation, and vice versa. "Do not just look in one section," Myers Glower advises. "You may need to scroll to particular sections addressing the issues at hand to review critical pieces of information."

In the fast-paced ED setting where nurses and physicians work closely, much communication is non-verbal and undocumented. "Two years later, it can be difficult to prove the providers were aware of various issues, especially if not recorded in the patient's chart," says **Paul C. Kuhnel**, JD, an attorney in the Roanoke, VA office of LeClair Ryan. ■

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Hospitals Sued for False Imprisonment Due to Involuntary Holds

Recent lawsuits allege that patients who sought help at an ED for clinical reasons were held involuntarily because they were at homicidal/suicidal risk.[1]

Gail Langendorf, JD, litigated one such claim, which recently settled. The claim involved an ED patient who initially was admitted to a hospital's mental health unit voluntarily after making general statements regarding how her co-worker made her want to hit him in the head. "Her diagnosis was not homicidal, but, rather, was depression. The involuntary commitment issue arose after she wanted to leave the hospital," Langendorf says.

The mental health unit nurses testified that there was a policy that prevented a voluntary patient from leaving until the on-call psychiatrist could be reached. The hospital denied there was such a policy. "The on-call psychiatrist said to put her on a 72-hour hold," Langendorf explains. The mental health nurse testified he did not believe the on-call doctor asked any questions and that, typically, he did not ask questions; rather, he would order a voluntary patient held until the following morning. "The mental health nurses' evaluations, after voluntary admission, determined [the patient] was not a danger to herself or others," Langendorf says.

The 72-hour-hold form was erroneously signed by the doctor who

released the patient the following morning. The patient stated her doctor told her he didn't know why she had been held. "The on-call psychiatrist who was called had no memory of ordering the 72-hour hold," Langendorf notes.

The EP also was named in the lawsuit because he was listed as the admitting physician. The EP eventually was dismissed from the claim. "After taking his deposition, it became clear he had no liability. He did not have admitting privileges, and could not have admitted the patient," Langendorf explains.

State law varies regarding requirements for involuntary holds. "Before any patient is involuntarily committed, their mental status should be evaluated by a medical provider who should consider all the facts, including the evaluation of the nurses," Langendorf advises. In Kentucky, within 24 hours of the commitment, a provider must certify in the medical record that:

- the patient needs continued hospitalization because he or she is mentally ill and presents a danger or threat because of the illness;
- the patient can reasonably benefit from treatment at the hospital;
- hospitalization is the least restrictive alternative mode of treatment available.

"Certainly, an on-call psychiatrist should not make a determination, over the phone, to deprive someone of their liberty solely because they have been voluntarily admitted for treatment," Langendorf says.

Is Detention Unlawful?

Mary C. Malone, JD, a partner at Hancock Daniel in Richmond, VA, says that to prevail in a false imprisonment claim involving an ED patient, the plaintiff would need to prove that:

- he or she was held at the hospital against his or her will;
- there was no legal order in place (such as a detention order) preventing the plaintiff from leaving.

ED policies must follow state law on involuntary holds, Malone says. Policies should advise that patients who are not subject to such holds cannot be detained in the hospital against their will.

"Usually, no one is authorized to hold a patient except through the legal hold mechanism, or perhaps through law enforcement placing a patient under legal custody," Malone notes.

If the patient is not competent for medical or psychiatric reasons, it would not be considered false imprisonment, says **Leslie Zun**, MD, MBA, system chair for emergency medicine at Sinai Health System in Chicago. "This evaluation must be documented."

Scott Zeller, MD, vice president of acute psychiatric medicine at Vituity in Emeryville, CA, has encountered several malpractice claims in which EDs allowed a psychiatric patient to leave, and there was a bad outcome. Both the hospital and ED providers were sued for malpractice and/or failure to adequately assess risk.

"I have not encountered the opposite, where facilities were sued for false imprisonment, but it is certainly possible," Zeller offers. EPs must recognize that if they do not have sufficient grounds to detain individuals, they must be released, he adds.

The key is to fully understand the laws regarding involuntary detention for psychiatric evaluation in one's state, region, and/or county. "Who is authorized to detain? Does the facility have the authority to detain?" Zeller asks. These basic concepts can vary widely by state and even across county lines.

"With that being said, there is usually an understanding that a patient within the ED is not permitted to leave until the attending physician or licensed independent practitioner has evaluated the patient and determined there are no grounds to hold a patient involuntarily," Zeller says.

EPs sometimes don't have sufficient grounds to detain a behavioral health patient, but believe that the patient needs treatment. In such cases, says Zeller, "it will be helpful to document that a patient is being discharged against medical advice." Zeller would like to see EPs document as follows: *"In my medical judgment, the patient would benefit from further psychiatric treatment, but the patient is requesting to leave. In my estimation, the patient is not acutely a danger to him/herself or others, and appears fully able to care for him/herself in the community. The patient will thus be discharged against medical advice."*

In false imprisonment lawsuits, both parties usually agree that the patient was detained against his or her will. "Where most false imprisonment claims arise in connection with hospital cases is whether the detention is unlawful," says **Stephen Shows**, a senior risk resource advisor at ProAssurance Companies in Birmingham, AL.

One way for a detention to be lawful is through involuntary commitment. "Any hospital policy regarding involuntary holds should at least be consistent with whatever the state rules are for involuntary commitment," Shows says. Hospital policies should allow the ED providers to use their education, training, and experience to determine

whether those criteria are met, he adds.

In Alabama, this requires showing that:

• the patient is mentally ill;

• because of his or her mental illness, the person poses a real and present threat of substantial harm to self or others;

• the patient will continue to experience mental distress and deterioration of ability to function independently if not treated;

• the patient is unable to make a rational decision regarding treatment.

"If you can successfully petition for involuntary commitment, then the detention is not unlawful, and there is no false imprisonment," Shows says. ■

REFERENCE

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Multiple Theories of Liability Regarding ED Violence

It is not uncommon for individuals seeking narcotics or medical treatment following an off-site altercation to engage in confrontational behavior with ED staff. "These volatile situations often erupt rapidly," says **Rich Cahill**, vice president and associate general counsel at The Doctors Company.

In the ED, the potential danger of significant injury occurring is "undoubtedly greater than other healthcare venues," Cahill adds. "Proactive precautions must be implemented well in advance to minimize the potential damages."

Victims of ED violence may be professional staff, employees, patients, or third-party vendors. "Not uncommonly, assailants may include other patients, family members, visitors, or even itinerant homeless persons inhabiting the area," Cahill notes. He recommends training ED personnel on methods to help deflate volatile situations and circumstances that warrant summoning security personnel or law enforcement.

Cahill recently shared insights on third-party violence and hospital liability:

• **On hospitals' liability exposure:** Attacks often result in an arrest and criminal prosecution. Victims may separately pursue civil monetary damages for injuries sustained directly against the assailant.

According to the established common law of most jurisdictions, the enhanced risk of injury, also known as foreseeability, means that there is an increased legal responsibility on the part of hospital EDs to take appropriate precautions in advance. A facility facing civil litigation undoubtedly will need to demonstrate to a jury that due diligence had been conducted timely to identify possible risks, that protocols had been implemented to address likely scenarios, and that precautions were reviewed periodically to ensure best practices.

Often, the criminals are indigent and without financial resources to pay judgments imposed by the judicial system. Historically, the innocent bystander in those situations received no compensation. Employees injured in connection with their job responsibilities may seek redress through the state's workers' compensation system. Such recoveries tend to be limited, and often do not fully recompense an individual for the damages incurred.

Traditionally, government entities or religious groups owned and operated hospitals. Thus, those facilities were protected from civil liability by long-recognized principles of sovereign and charitable immunities. Antiquated common law rules governing the duties of landowners to persons injured on the premises made recovery by such persons even more difficult to establish. Over the last 50 years, federal and state governments have eliminated the shield of sovereign immunity. Hospitals are increasingly operated as business enterprises and purchase various insurance coverages to protect against risk.

Generally, charitable immunity is no longer necessary as a matter of public policy. The common law has gradually evolved to recognize that persons injured on the property of another, including hospitals and other healthcare facilities, may seek redress for injuries sustained on the premises, regardless of the perpetrator, even by an individual engaged in criminal activity.

• **On laws regarding recovery of monetary damages:** State laws vary significantly as to the theories of liability that are recognized to permit a person to recover monetary damages for harm sustained while on a hospital campus. Some jurisdictions have adopted a type of claim based on principles of premises liability. Others allow litigants to allege, depending on the circumstances presented, that the conduct of the healthcare provider was a form of professional negligence. Still other states have adopted the view that an injured plaintiff may assert a theory of general negligence. Here, the litigant need only establish that the facility owed the individual a duty of due care, there was a breach of that duty (often expressed as a failure to exercise reasonable care), there is a causal relationship between the negligence and the injury, and the plaintiff suffered legally compensable damages.

Clearly, an individual harmed by the violence of another while visiting a hospital, generally regardless of the purpose for which he or she is on the premises, must establish preliminarily that the entity sued owned the facility when the alleged incident occurred, and that the injured person was owed a duty of due care.

An attorney representing an injured person must attempt to develop those facts that support the alleged theory or theories of liability as recognized by appropriate statutory and case laws. Depending on the applicable state, questions of foreseeability of the injury and reasonableness of the defendant in operating the hospital are factors to consider. For example, is the medical center located in an inner-city area with a high crime rate? Have other attacks occurred? By whom and when? Were there training protocols in place for security personnel and professional staff on what clues might indicate a problem is imminent? What about policies regarding the presentation of a particular scenario? How do those policies and procedures compare with guidelines adopted by other similarly situated facilities in comparable locales?

Ordinarily, liability will be evaluated based on what the hospital did compared to other similarly situated facilities under the same or similar circumstances. Independent expert testimony and even surveys conducted by other providers identifying standards in the community will be presented as evidence.

Ultimately, juries or judges will determine whether the facility was reasonable and acted consistently with community norms. They also will determine whether different or additional precautions would have prevented the personal injury damages.

• **On liability exposure involving hospital security:** Not infrequently, medical centers contract with private security companies to provide surveillance and other security services on the premises. Ordinarily, the contracts state that the company is an independent contractor and will provide adequate staffing, training, and liability insurance in case of an adverse event. The contracts may contain an indemnity provision in which the security company agrees to assume defense costs and pay any monetary damages incurred by the facility in the event of a loss due to service provider negligence. Nonetheless, states are adopting the concept of ostensible agency in which even an independent contractor can be found to be the agent of the hospital, resulting in vicarious facility liability.

Also, medical facilities are entering into agreements with private companies to provide security and other on-site protection within the hospital, ED, and common areas. The contracts usually stipulate that these third-party vendors are independent contractors, and that the security company will be responsible for the conduct of its employees, including injury caused to others on facility premises. These contracts usually include a clause stating that the security provider will defend the facility in the event of litigation and will indemnify the medical center should an adverse event caused by the vendor or its employees result in plaintiff's verdict or settlement.

Medical centers often avoid such claims by posting signage in common areas that read: *"Emergency department providers, imaging, and laboratory staff and security personnel are independent contractors and are not employees of the facility."* As most facility administrators are aware, medical centers still can be sued for the conduct of independent contractors. This is true whether the suit is based on legal theories of vicarious liability and ostensible agency, or based directly on an allegation of negligent hiring, monitoring, or retention.

To limit potential financial exposure in the event of an injury and subsequent litigation, hospitals should retain insurance policies, including professional and general liability coverage endorsements, for the vicarious acts of third parties. ■

ED LEGAL LETTER™

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **Which is *true* regarding EMRs and harm to patients?**

   a. Focusing on user errors is recommended, as opposed to suboptimal design.
   b. Commercially available EMRs are legally required to flag when not all ordered test results have been returned.
   c. Unlike other information, test results are displayed identically in EMRs, regardless of the health system or vendor.
   d. When ED staff develop workarounds and shortcuts within a system, it can result in communication gaps.

2. **Which is *true* regarding admissibility of an ED patient's pre-treatment conduct?**

   a. A patient's criminal conduct always is admissible if the ED treatment was for injuries sustained during the crime.
   b. The general rule is that medically relevant pre-treatment conduct is admissible.
   c. A patient's intoxication prior to the injury always is admissible since intoxication always is medically relevant to the alleged negligence by the physician.
   d. State courts have ruled consistently that patients' pre-treatment conduct is relevant in determining whether a physician is liable for violating the standard of care.

3. **Which is *true* regarding ED claims involving false imprisonment allegations?**

   a. To prevail, the plaintiff must prove, among other things, there was no legal order (such as a detention order) in place preventing the patient from leaving.
   b. The fact that an ED patient is subject to a legally valid involuntary hold does not justify detaining such a patient in the hospital against his or her will.
   c. If the patient clearly was not competent for medical or psychiatric reasons, plaintiffs are likely to prevail in a false imprisonment claim.
   d. If hospital policies are less stringent than state rules for involuntary commitment, the ED can be held legally only to the hospital policy's requirement.