ED LEGAL LETTER™

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INSIDE

RELIAS MEDIA

ED Violence Often Unreported, Ignored by Prosecutors, Dismissed by Judges

Police responded after a patient's family member assaulted an ED provider at Beaumont Hospital in Royal Oak, MI.

"The police hauled him out, took him to jail, and he was out on bond in a couple of hours. The prosecutor never brought the case," says **Bradford L. Walters**, MD, FACEP, assistant program director for Beaumont's emergency medicine resident program.

The assailant later claimed he was highly stressed because his brother was injured, which the prosecutor found sympathetic. This kind of response from the legal system is one reason so many ED assaults go unreported, according to Walters. "If nothing happens, people say, *'What's the point?'"*

Walters has seen many other assaults against his ED colleagues go unpunished, including an ED nurse whose finger was broken. "Prosecutors have the attitude that *'This is not something we're going to go after,'"* says Walters, noting assaults and threats have caused many people waiting for care to forgo treatment. "I have seen other patients leave the ED because of the violence."

State felony laws do not affect ED practices and policies at all, according to **James Phillips**, MD, assistant professor of emergency medicine at the George Washington University School of Medicine and Health Sciences. "After years of researching healthcare workplace violence, most emergency physicians probably cannot tell you if they work in a state where it is a felony to assault a physician versus a misdemeanor."

Even in states where it is a felony to assault a nurse, it is not always clear whether emergency physicians (EPs) are protected under the same law. "Nurses' unions and advocacy groups have worked tirelessly to get protected person status for nurses, making physical violence against them a felony," Phillips notes. "I know of no such physician groups who have done the same."

It is unclear what percentage of ED assaults are reported or how many

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remain unreported. "These types of data are not tracked by any agency," Phillips adds.

When he was a disaster medicine fellow in Boston, Phillips called the police after a patient assaulted him, resulting in a felony charge against the assailant. "In my 14-year career in medicine, I have never seen another physician or nurse call the police on a patient who assaulted them. I have witnessed numerous assaults during that time," Phillips says.

The legal system is a barrier to reporting ED violence. "Police often downplay such assaults. This alone deters providers from calling, as they feel it is a waste of their time since the patient will not be arrested or ticketed," Phillips offers.

If an arrested patient requires ongoing medical care, a police escort must be present in the ED with the patient the entire time. "This functions as a very strong deterrent to arrest, even when legally justified," Phillips says.

At least one patient's family filed a suit against the hospital instead of the assailant. The patient was choking an EP and was restrained by other ED staff and security. The patient suffered cardiac arrest during the attack. ED staff could not revive the patient. "There is currently a large lawsuit against the hospital alleging they are liable for the death of the attacker," Phillips notes.

Even when ED providers involve law enforcement and perpetrators are arrested, prosecutors sometimes decline to file charges. "There's fairly clear law on what a prosecutor is supposed to do when they are faced with certain crimes. Violence in the ED is not so clear," Walters laments.

If prosecutors file charges, judges often dismiss them. This was the case when Walters was assaulted during an ED shift. "Are stressed plaintiffs and lawyers allowed to punch out the judge? I dare say no, but it's OK in the emergency department," Walters says. "We make excuses; people are stressed, they're waiting a long time, they're intoxicated."

Of 3,539 EPs surveyed, 62% reported someone assaulted them in the previous year. About one-quarter said they had been assaulted two to five times, according to the results of a 2018 survey from the American College of Emergency Physicians (ACEP).[1] The most common response of hospital administrators or security was to put a behavioral flag in the patient's chart. In only 21% of cases, hospital security arrested the patient for the assault or enlisted law enforcement to do so. Hospital administrators advised EPs to press charges in just 6% of cases.

"Emergency docs are not only reluctant to prosecute, but also reluctant to even report the violence," says **Leigh Vinocur**, MD, a Baltimore-based EP and former chair of ACEP's committee on ED violence. Vinocur is no stranger to workplace violence: While seeking treatment for a drug

EXECUTIVE SUMMARY

Assaulting ED providers is a felony in many states. However, it is rare for anyone to press charges against assailants. In these cases, hospitals face potential legal exposure if leaders fail to:

- provide de-escalation training;
- address security needs;
- take precautions to protect providers and patients from violent patients.

overdose, a patient grabbed and choked her.

Many EPs in who participated in ACEP's 2018 survey indicated that their hospital's response was to simply remove or restrain the assailant. Thirty-four percent of EPs said the biggest contributing factor to ED violence was no consequences for the attacker. Just 3% of respondents said their hospital pressed charges against the individual. EPs do not want to stigmatize patients who are acting out while ill or impaired; "do no harm" is their ethical duty, Vinocur adds.

Assaults on EPs increased from about 28% annually in 2005 to about 38% in 2018, according to the results of a recent Michigan survey that compared survey data from 2005 and 2018.[2,3] Researchers found that rates of ED violence were similar regardless of the practice setting. "It didn't matter whether the hospital was rural, suburban, or urban, an academic medical center or a community hospital," says Walters, who was involved in both studies.

Since the 2005 survey, more respondents reported seeing security personnel assigned to the ED, police in the ED, and the installation of metal detectors. Despite this, more EPs reported feeling "constantly fearful" of becoming a victim of violence (8.1% in 2018 vs. 1.2% in 2005). "EPs don't feel particularly well-supported by their administration or the legal system," Walters says. "That seems to be a prevalent opinion, and adds to a feeling of discomfort."

Laws making assaults against ED providers a felony are not, by themselves, a solution, says **Lisa A. Wolf**, PhD, RN, CEN, FAEN.

"In order for [these laws] to have any effect, someone has to prosecute. What we hear from emergency nurses is that they are discouraged from filing charges by both hospital administrations and law enforcement." Police or prosecutors convey this attitude with statements such as *"the patient was impaired," "this is just part of working in the ER,"* or *"you weren't badly hurt."*[4]

"The most effective thing hospitals can do is to provide a simple, streamlined, actionable process for reporting incidents of violence," says Wolf, noting most hospitals require some kind of de-escalation training. "If a nurse is injured, the hospital can claim it provided training." Wolf adds one more warning: "In the case of a violent patient who has a history with the facility, failure to take precautions to keep providers, other patients, and the patients themselves safe could also result in legal responsibility on the part of the organization." ■

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Measles Case in Waiting Room? Liability Exposure if Diagnosis Missed

Measles outbreaks have alarmed public health officials in many states. Many infected people end up in ED waiting rooms. If providers miss the measles diagnosis, there are potential liability risks for both ED providers and hospitals.

"The implications of a measles case can be pretty severe," warns **Stephen Y. Liang**, MD, MPHS, an assistant professor of medicine in the divisions of infectious diseases and emergency medicine at the Washington University School of Medicine in St. Louis. Serious complications such as pneumonia or brain infections can occur. If an ED patient is misdiagnosed with an upper respiratory infection and discharged, that patient could sue for failure to diagnose. Liang is unaware of any recent lawsuits involving failure to diagnose measles.

"But I do think there are potential legal risks if the emergency physician evaluated the patient and it was clearly missed," Liang notes. There are obvious public health implications if measles, a highly contagious disease, is missed. Undetected in the ED, a measles patient can go on to expose others in the waiting room and the hospital (and, if discharged, the community). According to Liang, plaintiffs may allege the following if measles is misdiagnosed:

• The hospital was notified of cases in the community; therefore, the ED providers should have had

a higher index of suspicion for measles. For some EDs, the 2014 missed Ebola case in a Dallas ED was a wake-up call to fine-tune infection control procedures.

"Measles should be in the purview of emergency physicians. It's been in the news over and over again with several large outbreaks," Liang says.

• EDs had not instituted any procedures for identifying and isolating patients with strong suspicion for a highly contagious disease such as measles.

• ED providers failed to notify the local jurisdiction of measles cases. "It should be simple and easy. It should not be something that needs multiple phone calls," Liang says.

• ED providers failed to isolate the patient properly. "If someone was exposed to a contagious disease in a hospital setting because a person wasn't isolated according to best practice infection control measures, I think people have a case for that, just as we see lawsuits for other types of hospital-acquired infections," Liang says.

It is important to note that many EPs have not seen measles in their careers, notes **Amesh Adalja**, MD, an infectious disease and emergency medicine specialist and senior scholar at the Johns Hopkins Center for Health Security.

"We don't have recent memory of it, to fear it like we used to. We almost forget that measles was a major infectious disease threat several decades ago before we had a good vaccine," Adalja explains.

Ideally, Adalja says, EPs and ED nurses should receive updates on all ongoing outbreaks of measles, not just in the immediate area but around the country. "Having situational awareness of measles outbreaks would enhance patient safety and, consequently, reduce liability," Adalja says.

If ED providers fail to recognize measles, they also will fail to isolate the patient. This means that others may be exposed.

To what extent, says Adalja, "will depend on whether the patient is symptomatic in the waiting room and how many people in the waiting room are unvaccinated."

Improved identification by ED nurses and triage nurses becomes "very important," Adalja adds. "Often, they are the first people to physically see the patient."

(Editor's Note: For much more information and news about measles, check out the April issue of Hospital Infection Control & Prevention*, available at https://bit.ly/2Uip5LM, and the upcoming May issue of* ED Management.*)* ■

Patients Want a Diagnosis, But a Premature One Can Fuel Lawsuit

Patients do not like leaving the ED without receiving a definite diagnosis, according to the authors of a recent study.[1]

However, this kind of closure is not always possible in the ED, where many people are sent home with a symptom-based diagnosis such as "abdominal pain."

"In many cases, patients are discharged without a sufficient explanation of what's occurred during the visit and what to do about their symptoms," notes **Kristin Rising**, MD, one of the study's authors. Rising is an EP at Thomas Jefferson University Hospital and associate professor of emergency medicine at Thomas Jefferson University, both in Philadelphia.

In their analysis of 30 recently discharged ED patients, Rising and colleagues found that most patients' primary reason for coming to the ED is to receive a diagnosis.

"This study was focused on what struggles patients have when they haven't yet received a 'real' diagnosis, and the diagnosis they receive is a re-statement of their symptoms," Rising explains.

Even if a clear-cut diagnosis is not possible, ED personnel can address the patient's associated needs, Rising and colleagues suggested. Many patients voiced the need for better explanation for *why* they did not receive a diagnosis. They wanted to know why it was safe to leave the ED without one.

"Patients repeatedly highlighted a need for more effective communication with providers," Rising says. This includes identification of who was in charge of their care or discharge, test results, and reasons why certain tests were not ordered. Currently, Rising is developing a standardized approach for patients who are discharged without a definite diagnosis, including:

• a clear statement to patients that a definitive diagnosis has not been identified;

• a description of alternative diagnoses that were considered and how they were ruled out.

Without this knowledge, when bad outcomes happen, it is easy to suspect the ED provided poor care. A call to an attorney is not far behind.

One patient discharged without a diagnosis stated, *"I think because of the type of healthcare that I have, I was not given the best of services."* Others reported that lack of information made them feel inadequately treated and generally dissatisfied. "All of these things potentially decrease patient trust in providers and the system as a whole and may increase their desire to seek legal action in the setting of bad outcomes," Rising adds.

The fact that EPs do not know "the whole story" often becomes a defensive tactic during malpractice litigation. A defense attorney will remind jurors that EPs cannot be responsible for what they are not told or what clinical information they cannot quickly access.

"This, many times, will resonate with jurors," says **Robert Hanscom**, vice president of business analytics at Coverys, a Boston-based provider of medical professional liability insurance. However, it is the EP's duty to ensure the patient receives the correct treatment. If this standard of care is not met, the plaintiff's case is stronger.

"This is true even though the ED physician's relationship with the patient is compacted into a relatively short period of time," Hanscom notes. Typically, EPs rapidly treat a substantial volume of patients, making many time-pressured decisions throughout their shifts. "It is an intense environment; sometimes, they are dealing with limited information," Hanscom says. "The ED defense team often cites the nature of the ED as a big part of their case."

Often, EPs are wary of speaking up about uncertainty, fearing it will expose them legally. "It, in fact, does quite the opposite," Hanscom argues. "I'm a big believer in being completely candid with the patient."

Hanscom suggests this wording: *"Your symptoms are somewhat unusual. If they were just [blank], we could quickly say it is [blank]. But you also are experiencing these problems. Those do not usually present themselves with this diagnosis. To be candid, it is not exactly clear what is going on here. But we will make sure there are steps taken to get to the bottom of this. Here's the plan to move that forward."*

Documenting the uncertainty, the discussion, and the plan in the ED chart is helpful to the defense. Conversely, remarks such as *"it is just a sprain"* when the X-ray is less than definitive are going to be legally problematic if it turns out to be a fracture. The EP then must admit at trial or deposition that, in fact, the diagnosis was uncertain. "Uncertainty should always be communicated, documented in the record, and should be followed up by next steps to get to a more certain state," Hanscom adds. Patients then become more engaged in their own care. This becomes very important for time-sensitive diagnoses such as myocardial infarction, stroke, or aneurysm.

"If a physician conveys confidence surrounding a diagnosis when they're actually unsure, they set themselves up for liability," Hanscom says. This is because the EP is providing potentially incorrect and damaging information. "By acting with full transparency, you lower the risk of adverse results and create a path to the correct diagnosis," he adds.

According to Hanscom, these are categories of diagnoses that cause the most trouble for EDs legally:

• Emergent issues that are potentially life-threatening if not resolved. "Doctors must be on especially high alert for potential symptoms of these conditions, as the severity of the potential injury is extremely high," Hanscom warns.

• Missed fractures, such as a minor break miscategorized as a sprain. "While these are often not as high value, if an injury results in permanent impairment, it could certainly result in a substantial payout," Hanscom cautions.

• Situations in which EPs order tests to determine a diagnosis, but the patient is discharged before results return. If someone is sick enough for the EP to order tests such as blood cultures, the patient ideally should not be discharged until the test results have been received and reviewed.

"There may be potentially serious consequences for the patient, especially if the ER physician cannot get in contact with them right away," Hanscom explains.

• Misreporting, or not reporting, incidental findings. For instance, a routine chest X-ray may reveal a lung spot that requires further tests. "If the ED physician fails to ensure that the finding is seen by the provider following the patient on an ongoing basis, they could be named in a suit should that result in a failure to diagnose," Hanscom says. ■

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COMING IN FUTURE MONTHS

- Legal exposure if ED overlooks critical lab finding
- Efforts underway to help ED defendants cope with litigation
- Legal risks for hospitals if staff divert drugs
- Publicly reported data used in malpractice litigation

Multiple Allegations Against EPs in Airway Management Cases

Airway management in the ED setting "has been, for decades, an area with high liability," says **Mark Spiro**, MD, chief medical officer of the Walnut Creek, CA-based The Mutual Risk Retention Group.

There are several common allegations in these claims:

• ED providers did not act quickly enough. "When a patient is doing poorly, taking a *'Let's see what happens over the next hour or two'* approach can have devastating consequences," Spiro warns.

Plaintiff attorneys may allege that ED nurses failed to monitor the patient adequately, or that ED nurses noted problems with ventilation, such as lower oxygen saturation levels, without alerting the EP. One malpractice case involved a woman who presented to the ED with unstable vital signs and respiratory distress after vaginal delivery. The EP put the patient on biphasic positive airway pressure (BiPAP) for several hours, but the patient continued to decompensate. The EP intubated the patient, but the patient was unable to recover and died.

The plaintiff attorney alleged the EP was looking at a critical patient who needed immediate airway intervention but chose to put the patient on BiPAP instead of definitive airway management, which was needed. "It may or may not have made a difference, ultimately," Spiro says. "But the lack of immediacy created an obstacle that the doc was not able to overcome." The EP defendant settled the claim out of court.

• The endotracheal (ET) tube was placed incorrectly. Intubation has improved over the years, with various tools used to confirm placement. "But sometimes in a code situation, those tools are not as effective as you'd like. You have to be sure you are actually in the trachea," Spiro notes.

• The correct equipment, such as pediatric-sized ET tubes, was not available (or, if it was available, ED providers lacked the ability to use it). These are two issues that potentially can bring the hospital into the claim, Spiro says.

• Someone other than the most qualified person in the ED performed the intubation. In one case, the respiratory therapist thought the tube used to intubate an infant was too small, and the EP was outside the room. The respiratory therapist thought the EP had asked the respiratory therapist to replace the tube, but the EP's testimony contradicted this.

"In the height of a very critical case, it's easy at times to misinterpret things," says Spiro. The hospital policy stated that it was acceptable for respiratory therapists to perform intubation. The respiratory therapist replaced the tube, and the infant ended up with encephalopathy. The EP and hospital were both sued, and both settled out of court. "If the EP had done it, would the outcome have been different? We'll never know," Spiro says.

Certain documentation tends to become important in ED airway claims, including the EP's thought process and a timely assessment of the adequacy of ventilation (not just oxygen saturation, but also blood gas). Also, it is important to document whether the patient was alert and speaking in sentences and whether the EP anticipated the case as a potentially more difficult airway to manage. If so, the EP should note how he or she prepared, either by obtaining additional equipment or asking for assistance from anesthesia.

"As emergency physicians, we don't have to be perfect. Errors in judgment are not necessarily malpractice. But we have to be able to justify what we did and why we did it," Spiro says.

Failure to secure the airway prior to transfer, even when specifically requested by the transferring EMS agency, is a common allegation. **Darren Braude**, MD, has reviewed multiple malpractice claims with this scenario: The sending EP appropriately anticipates airway difficulty but does not appreciate the risk of transport and assumes the patient will be OK all the way to the receiving facility. The flight crew then feels compelled to take matters into their own hands, either while at the sending facility or en route.

"If subsequent complications occur, the plaintiff can allege negligence by both the flight crew and the ED provider," says Braude, chief of the

EXECUTIVE SUMMARY

Airway management cases involving devastating outcomes are a significant source of liability for EDs. Some common allegations:

- The wrong-sized equipment was used.
- Clinicians failed to act quickly enough.
- ED providers failed to verify tube placement after transport.

division of prehospital, austere, and disaster medicine and professor of emergency medicine and anesthesiology at the University of New Mexico Health Sciences Center. This pits the two parties against each other. Braude also has seen cases where no one prepared for the possibility of airway difficulty.

"Common themes include failure to appreciate the impact of patient physiology (hypoxia, hypotension, acidosis) on time for airway management and either a rush to remove an extraglottic device or failure to insert one," Braude says.

Other factors can complicate the ED defense, including lack of a procedure note, conflicting details between physician and nursing documentation, ED providers' assumption that anyone can be intubated with video laryngoscopy, and providers blaming one another.

"I have seen cases where providers in one unit suggested to families that providers in another unit had mismanaged the case," Braude recalls.

In other cases, providers at the receiving hospital made off-hand comments about care at the sending facility, or EMS made such comments to families during interfacility transport. "The immediate presumption by family was that the ED physician or staff had been trying to hide something," Braude says. "That's where the seed of the lawsuit began."

The correct placement of an ET tube, confirmed with an $EtCO_2$ detector, usually is well-documented in ED charts immediately after intubation.

"But from a legal perspective, it's just as important to make sure it *stayed* in the right spot," says **Scott DeBoer**, RN, MSN, EMT-P, founder of Pedi-Ed-Trics, a Dyer, IN-based pediatric emergency education and consulting firm.

DeBoer has reviewed multiple EMS, transport, and ED malpractice claims alleging negligent airway management as an expert witness. Almost always, the tube was confirmed to be in the trachea initially. The bad outcome happened because at a later point in time, the tube moved from the trachea to the esophagus, which went undetected.

"If you want to stay out of court when it comes to an intubated patient, verify it's in the right spot not only right after you put in the tube, but also any time something bad happens with your patient or there is a major move," DeBoer offers.

This does not necessarily mean the patient is transferred to a different institution. It also could mean the patient is moving from the ambulance to the ED stretcher or leaving the ED to go to X-ray or the ICU. Often, ED charts do not include information about whether the tube placement was verified at these crucial points.

DeBoer looks for this kind of documentation in the ED chart whenever the patient was moved or the patient's condition deteriorated: Evidence of positive color change on the CO_2 detector, evidence of good end-tidal CO_2 wave form, or statements such as *"patient moved to ER stretcher, end-tidal CO_2 37."*

These specifics tell the expert who is reviewing the chart that the tube was most likely in the right spot. They also show the ED provider knew the tube placement needed to be verified after the patient was moved or deteriorated. "Documentation such as this gives you credibility as a provider," DeBoer adds.

A patient intubated in the ambulance may die minutes after arriving at the ED. With no document proving otherwise, a plaintiff attorney can argue that the patient's bad outcome happened because the paramedics misplaced the tube at the time of intubation. Or, the plaintiff attorney can argue that the tube became dislodged when the patient was placed on the ED stretcher.

"Nobody has any documentation as to where the tube was at that specific point in time, so it turns into a he said/she said," DeBoer explains. "It's one of those utterly preventable issues that doesn't need to happen."

The ED provider will face questions at deposition and/or trial as to what he or she learned regarding not only initial verification but also regarding ongoing verification that the tube was in the right spot. DeBoer has seen plaintiff attorneys ask these questions:

- What were you taught regarding how to initially confirm an endotracheal tube is properly placed?
- What were you taught regarding documentation of correct endotracheal tube placement?
- What were you taught regarding ongoing verification of correct endotracheal tube placement?
- Are you familiar with the DOPE [Displacement, Oxygen or Obstruction, Pneumothorax, Equipment] mnemonic?

"This mnemonic frequently appears in airway courses or publications as a reminder that when bad things happen — an intubated patient is unexpectedly crashing — to check the tube placement first," DeBoer says.

Many ED protocols specify the need to verify and document initial placement. However, many do not address reverification, which opens the door to bringing the hospital in as a defendant.

"The plaintiff attorney will blow up hospital protocols and put them on a big screen while you are on the stand," DeBoer warns. ■

When ED Is Crowded, Hospital Admission Becomes Less Likely

Patients are less likely to be admitted when the ED is crowded, according to the authors of a recent study.[1] However, patients discharged during periods of crowding are not more likely to return to the ED within two weeks of discharge.

However, the fact that fewer patients are admitted when EDs are crowded does not necessarily mean patients are put at risk, says **John Tafuri**, MD, FAAEM. Some patients boarded in the ED for hours or even days find their condition improves during the lengthy wait. This allows them to be discharged safely.

"If you have somebody who you believe needs to be admitted, and you keep them in the ED until a bed becomes available, they may get better while in the ED," explains Tafuri, regional director of emergency medicine at Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland.

Evidence that the ED was crowded will not help the defense, Tafuri says. It is more likely to benefit the plaintiff. During a recent busy day, Tafuri apologized to a woman who had arrived for evaluation but had to wait a long time before anyone could see her. Tafuri said that he was caring for a seriously ill cardiac patient simultaneously. The patient's response was: *"I don't care about everybody else in the ED. I only care what happens to me."*

Tafuri says he believes jurors are likely to feel similarly if they are asked to consider that the EP was caring for multiple high-acuity patients at the time the plaintiff presented. The plaintiff attorney could respond to this by pointing out that the EP has a duty to every patient. For the plaintiff, the EP failed in that duty.

"It's a difficult defense to pull off to say, *'We were busy.'* Everyone knows EDs are busy," says Tafuri. "It's a general perception of the public that EDs aren't staffed as well as they should be."

In one malpractice case, an attorney went to great lengths to prove just how crowded the ED was at the time the plaintiff, who was later diagnosed with sepsis, presented. The attorney obtained the ED log during discovery, with identifying information redacted, listing only the patients' presenting complaint. The log was used to show how many patients were receiving treatment and who was in the waiting room at the time of the plaintiff's ED visit. "The attorney did this to illustrate that there were too many people in the ED as a way to demonstrate hospital liability and bring the hospital into the case," Tafuri says. The case settled before trial.

Some EDs are routinely short-staffed on nursing or technicians due to call outs. Juries will not be sympathetic.

"If the ED couldn't take care of a patient, the jury would likely blame the hospital, and possibly also the ED provider, for not having enough staff," Tafuri says.

Understaffed EDs contribute to bottlenecks and hallway boarding, which increase liability risks. "What you don't want is to have someone boarding in the hallway have a bad outcome. They already have an impetus to be angry with the hospital and, potentially, the EP as well," Tafuri cautions.

Crowded waiting rooms raise the possibility of Emergency Medical Treatment and Labor Act complaints, too. "People leaving the hospital may allege that they did not get medical screening exams in a reasonable amount of time," Tafuri says, noting this is especially problematic if ED records show many patients leaving routinely without seeing any healthcare providers because of long waits. "This is a particular problem if ED staff tell patients that there is no waiting, or a short wait, at another hospital," Tafuri adds.

Of course, ED groups and hospitals can reduce these risks by increasing staffing. Still, this is a daunting challenge for hospitals already under financial pressure. "Hospitals and physician groups tend to staff to the mean, the average census or maybe a little bit above the average census," Tafuri explains. "But if you staff to the mean, then every other day, theoretically, you'll be understaffed."

The public's anger over long waits, delays, and hallway boarding contributes to malpractice risk as well. "Dissatisfaction is one of the primary things that drives patients to an attorney," Tafuri says.

On the other hand, excellent communication with patients, particularly if boarding or extended wait times are occurring, can mitigate risks.

"If there's confusion as to what happened in the ED, the patient or family is likely to contact an attorney," Tafuri says. "It then usually becomes a lawsuit or complaint of some sort." ■

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Higher Premiums and Payouts Possible for EPs With Restrictive Scope-of-Practice Laws

Will the EP be held liable for malpractice committed by a nurse practitioner (NP) in the department? It is more likely if the state has instituted restrictive scope-of-practice laws governing NPs, according to the authors of an analysis of the effect of these laws on the number of malpractice payments made on behalf of physicians between 1999 and 2012.[1]

"We were aware of legal reasons that physicians may bear malpractice liability risk, based on state law requirements that they supervise NPs," says **Benjamin McMichael**, JD, PhD, the study's lead author.

However, there was no empirical evidence that physician malpractice risk actually increased or, if so, to what extent. The researchers set out to pinpoint this.

"We hoped to begin important conversations around the propensity of scope-of-practice laws to interact with physicians' expected malpractice liability risk," says McMichael, an assistant professor of law at the University of Alabama.

Two key findings: The laws decreased the number of payments made by physicians by as much as 31%, and the largest decrease in physician malpractice rates occurred in states that had enacted fewer malpractice reforms.

"The legal doctrines that support the ability of injured patients to pursue malpractice claims against physicians who are required to supervise NPs have been around for a long time," McMichael notes.

The researchers found what they expected: Restrictive scope-of-practice laws increase the ability of patients to hold supervising physicians liable. "Overall, findings were consistent with our expectations, and with longstanding legal precedent," McMichael reports.

As for liability implications for EPs, there are several. "The analysis did not isolate emergency medicine or separate out any other specialty. The data source on which we relied does not provide specialty information," McMichael says. However, EPs supervise NPs at relatively high rates compared to other specialties. Thus, notes McMichael, "malpractice implications of restrictive scope-of-practice laws are potentially quite salient for EPs."

An EP in a state with restrictive scope-of-practice laws may expect to face more malpractice claims, with higher payouts, than a similarly situated EP in a state that allows NPs to practice without supervision. Another likely consequence, according to McMichael: "EPs may see higher liability costs." ■

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Testicular Torsion Claims Continue Despite Better Awareness

A young man presents to an ED with vague complaints of abdominal pain. If testicular torsion is missed, whether the EP performed a genital exam, obtained a scrotal ultrasound, or involved urology all will become important questions.

"Everybody knows about [testicular torsion]. There are tests to diagnose it, but yet we still keep missing it," says **Gregory Moore**, MD, JD, an attending physician at Madigan Army Medical Center in Tacoma, WA. Cases with "classic" presentation usually do not end up in litigation. "We get the straightforward ones, but the occasional one is still missed," says Moore, who co-authored a recent paper on this topic.[1]

Testicular torsion is a highly time-sensitive diagnosis that presents with inconsistent histories, physical exam findings, and imaging findings, says co-author **Kyle Couperus**, MD, emergency medicine clinical faculty at Madigan Army Medical Center. The classic case presents with sudden onset, severe pain, scrotal swelling/edema, a high-riding testicle, transverse lie, and an absent cremasteric reflex. "However, every single one of these factors can vary significantly," Couperus notes. The pain may come on gradually. The edema may be minimal. Rarely, a cremasteric reflex can be present. There are some other common fact patterns in missed testicular torsion cases:

• The patient experienced severe pain at one point, but it has since resolved. This can be falsely reassuring to EPs who considered the

diagnosis but believe it can now be ruled out.

"*'The patient is not hurting, so it can't be that'* is the mindset," Moore says. In these cases, Moore suggests the EP consider an ultrasound and consulting with the urologist instead of simply discharging the patient.

• Radiologists mistakenly read the ultrasound as normal. One 14-year-old patient who presented with abdominal pain was discharged from an ED on antibiotics. However, paramedics brought the patient to another ED days later. There, the diagnosis of testicular torsion was made after a scrotal ultrasound showed decreased blood flow to the testicle.

"The EP was the sole defendant in the case and testified that he had ordered the correct test and relied on radiology's interpretation," Moore says. However, the jury ruled *against* the EP and awarded the plaintiff $500,000.

• The patient does not report testicular pain. Diagnostic errors were present in all 62 closed ED malpractice claims analyzed in a recent study. Five cases involved misdiagnosis of testicular torsion.[2] Notably, two patients presented with vomiting and abdominal pain but *without* testicular pain.

If testicular pain is listed as the chief complaint by ED triage nurses, it is an obvious possibility. "But it is easy to forget when evaluating 'abdominal pain,'" Couperus adds.

This is especially important for children and adolescents who may be either confused or embarrassed by the location of discomfort. "Performing a good history and genitourinary exam on patients with abdominal pain can help mitigate this risk," Couperus says.

In one case, a 16-year-old patient complained of abdominal pain, nausea, and vomiting but reported no testicular pain. A CT of the abdomen and pelvis was unremarkable. The patient was discharged without anyone ever performing a genital exam. The following day, the patient returned with right testicular pain and required a right orchiectomy. The family sued the EP for failing to consider testicular torsion. The case settled for $300,000.

• An abnormal ultrasound is misread as normal. The average time window for possible testicular salvage is six to eight hours, with a steady decline in outcomes every hour after, Couperus notes. "If you are still concerned after a normal ultrasound, consult urology." A negative ultrasound decreases the likelihood of testicular torsion, says Couperus, "but errors in radiology reads and intermittent torsion can still occur."

Couperus says there are two steps providers can use. If suspicion is high after a workup, consult urology. If suspicion is low after a workup, discuss the continued risk of intermittent torsion, its potential complications, and strict return precautions with the patient and family.

Even if the radiologist misinterprets the ultrasound, the EP still is not off the hook legally. "The ED doctor almost universally pays out some of the award — in multiple cases I've reviewed, about two-thirds," Moore says.

One study revealed that of 52 cases of litigation involving testicular torsion, EPs were the most commonly sued medical providers (48%) and were significantly more likely to make indemnity payments than urologists.[3] The authors of another recent paper with similar findings reported that in 53 malpractice cases involving testicular torsion, EPs were the most common provider sued (35% of the time). Atypical presentations were common, with 31% presenting with abdominal pain only.[4]

Jurors' reasoning for holding EPs liable instead of radiology or urology seems to be, at least in part, the fact that the EP was physically present to evaluate the patient.

"The logic is the radiologist is looking at a machine, the urologist may have talked with the ED doctor on the phone — but the ED doctor was *there*," Moore offers. ■

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CME/CE OBJECTIVES

After completing this activity, participants will be able to:

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

Non-ED Providers Have Surprisingly Low Risk Tolerance

When it comes to acceptable miss rates of low-probability, high-risk diagnoses, non-ED providers have a surprisingly low tolerance for risk.[1] This finding conflicts with clinical practices observed by study author **Eric Chin**, MD.

"Based on what we typically see with the consultants we admit to in the hospital, you would think they would be more liberal with their miss rates. But they clearly are not, based on this study," says Chin, an EP at the San Antonio Military Medical Center.

Researchers had long observed there were different risk tolerances between ED providers and non-ED providers when it came to admitting patients. For instance, EPs tend to want to admit low-risk chest pain patients but face resistance from internists or family medicine physicians who believe the admission is unwarranted.

"The non-ED providers might say that the fact that the chest pain is reproducible is a reason not to admit the patient. But for an ER doctor, reproducible chest pain doesn't rule out a heart attack," Chin says.

Researchers wanted to learn more about risk tolerance of providers and patients. They surveyed ED providers, non-ED physicians (including internal medicine, family medicine, and cardiologists), and patients and their family members or close acquaintances. Researchers asked about how much risk they would be willing to tolerate if a family member came to the ED for missed subarachnoid hemorrhage, myocardial infarction, cerebrovascular accident, meningitis, stroke, pulmonary embolism, ectopic pregnancy, or ruptured abdominal aortic aneurysm.

Participants were asked how often they thought it was acceptable for a healthcare provider to miss the diagnosis by selecting one of five percentages: 10%, 5%, 1%, 0.1%, or less than one millionth of 1%.

"Based on the way emergency physicians practice — we are stereotyped as wanting to admit all the low-risk patients — you'd think we'd accept no risk at all," Chin offers. In fact, ED providers said they would be willing to accept a 1% miss rate for nearly all high-risk diagnoses assessed.

In contrast, says Chin, "the hospital doctors seem to think we want to admit everyone." The researchers expected to see a risk tolerance that reflected this, but they found the opposite. Non-ED physicians said they would accept only a one-in-a-thousand risk, suggesting they would tolerate a difficult-to-achieve miss rate. To a greater extreme, the same was true of patients and families (they would accept a one-in-a-million risk).

"There is a disconnect here," Chin says. "The most interesting piece is that EPs know the actual miss rates of ED diagnoses, but most non-ED physicians and patients have no idea."

This suggests that ED providers, although they know the miss rates, act as though they do not want to miss anything. "ED providers end up admitting people others don't think should be admitted," Chin notes.

Fear of litigation is a likely reason. Malpractice outcomes do not always reflect the "acceptable" miss rate for a given condition.

"In the legal climate, if it's a really sad story or the ED provider is portrayed as uncaring, it's not uncommon for the jury to side with the patient despite the fact that the standard of care was met," Chin explains.

Chin says the best way to mitigate these risks is to involve the patient and family member in the decision-making "and show that they made an informed decision and chose, themselves, to take that higher-risk pathway." According to Chin, ED providers can do this in two ways: by clearly explaining the risks and benefits of hospitalization vs. outpatient management and by documenting the discussion carefully.

Chin offers this example of good documentation: *"I discussed with the patient and the family the risk and benefits (to include delay in diagnosis, permanent disability, and death) of evaluating X condition in the ED or hospital. However, the patient declined further evaluation at this time. The patient verbalized a clear understanding, and plans to proceed with an outpatient evaluation and follow-up."*

For patients, the expectation is that ED care "is perfect," says Chin. "We can't achieve that, so we have to mitigate the risk."

(Disclaimer: The view(s) expressed herein are those of the author and do not reflect the official policy or position of Brooke Army Medical Center, the U.S. Army Medical Department, the U.S. Army Office of the Surgeon General, the Department of the Army and Department of Defense, or the U.S. Government.) ■

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ED LEGAL LETTER™

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **Which is recommended for communicating with ED patients about diagnoses?**

   a. Emergency physicians (EPs) should not convey their uncertainty, as it has been shown to increase liability.
   b. Documentation of uncertainty complicates defense of any ED claim.
   c. If the EP fails to ensure that abnormal finding is seen by the patient's ongoing provider, the EP could be held liable in a lawsuit alleging failure to diagnose.
   d. EPs' acknowledgement to patients that providing a definitive diagnosis may not be possible in the ED markedly increases the EP's liability.

2. **Which is true regarding legal risks involving testicular torsion?**

   a. If the radiologist made a mistake interpreting the ultrasound, the EP cannot be held liable.
   b. Radiologists are by far the most commonly sued medical providers in cases involving testicular torsion.
   c. Urologists are significantly more likely to make indemnity payments for missed testicular torsion than EPs.
   d. Atypical presentations are very uncommon, such as patients presenting solely with abdominal pain.

3. **Which group expressed the highest tolerance for risk of acceptable miss rates for low-probability, high-risk diagnoses?**

   a. EPs
   b. All non-ED providers
   c. Cardiologists
   d. Patients and family

4. **Based on a recent study's findings, an EP in a state with restrictive scope-of-practice laws (in comparison to EPs in states allowing NPs to practice without supervision) may expect:**

   a. fewer malpractice claims.
   b. more malpractice claims but with lower payouts.
   c. more malpractice claims, with higher payouts.
   d. significantly lower professional liability costs.