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INSIDE

RELIAS MEDIA

Most-Often Missed Serious Neuro Conditions: Ischemic Stroke and Intraspinal Abscess

The authors of most studies on diagnostic error in the ED use a "look back" approach. Researchers start with the misdiagnosis, then examine the factors associated with it. Other investigators recently used a different method.[1]

"We took a 'look forward' approach in our analysis. We took common symptoms and looked to see the misdiagnoses from these," says study author **Nicole Dubosh**, MD. The researchers investigated misdiagnosis of neurological emergencies in the ED for two common complaints: headache and back pain.

"Our methodology is different than many studies about misdiagnosis. It's a 'needle and haystack' phenomenon," says **Jonathan A. Edlow**, MD, FACEP, another of the study's authors.

In this case, the researchers studied the whole "haystack" (for example, all patients presenting with back pain) with the goal of finding only those "needles" (patients with epidural abscess, for instance) who were misdiagnosed in the ED. "Many other papers look only at the pile of needles [only the abscesses], and then see what proportion had been misdiagnosed," explains Edlow, a professor of emergency medicine at Harvard Medical School and vice chair of the department of emergency medicine at Beth Israel Deaconess Medical Center in Boston.

Researchers analyzed 2,101,081 ED discharges with a nonspecific diagnosis of headache and 1,381,614 ED discharges with a nonspecific diagnosis of back pain. Of all patients with back pain, only a small proportion had an epidural abscess. "Whereas the other type of study methodology may conclude that 30% of epidural abscesses are missed in the ED," Edlow notes. "The difference in approach is key."

Using the same "look forward" approach, researchers examined all patients presenting with headache. "Very few have strokes, and only a proportion of these are missed," Edlow adds.

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Dubosh and Edlow did not look at how many of the undiagnosed cases became malpractice claims. However, Edlow says "these cases do tend to have large payouts due to high disability."

A typical plaintiff in a missed epidural abscess malpractice case: A patient with persistent back pain and bilateral leg radiation, with or without fever, who has a major risk factor (such as IV drug use or a recent bacteremia). The neurological exam is normal, and the patient is diagnosed with simple sciatica. However, the patient returns two days later paraplegic with bladder dysfunction that is permanent.

"Besides the obvious risk factors, sciatica is almost never a bilateral process," Edlow says. It is also important to know that patients with epidural abscess can go from a normal neurological exam to a serious deficit rapidly due to cord infarction from a septic arteritis or thrombophlebitis, Edlow adds. Some key findings:

- In both populations, male sex, non-Hispanic white, advanced age, and comorbidities (such as HIV/AIDS, malignancy, or neurologic disorders) were associated with higher odds of a bad outcome in both groups.
- Overall, 0.2% of back pain patients and 0.5% of headache patients returned to the ED and were hospitalized for primary diagnosis of a serious neurologic condition or died in hospital within 30 days of ED discharge.

"In terms of percentages, emergency physicians are actually doing a decent job based on our results. However, there is always room for improvement," says Dubosh, an assistant professor of emergency medicine at Harvard Medical School.

The miss rate was lower than in previous studies.

"The surprise was how low the misdiagnosis rate was. However, it is still significant because even though it's a very small percentage, it's a very small percentage of a very large number," Edlow cautions. "The total number of patients affected is important."

HOW TO REDUCE MISDIAGNOSIS

For stroke, **Jonathan A. Edlow**, MD, FACEP, a professor of emergency medicine at Harvard Medical School, offers these potential ways to reduce misdiagnosis:

- Establish whether the onset of symptoms is abrupt;
- Always document the reason that tPA is not given, even if obvious;
- Perform a systematic neurological exam;
- Close the knowledge gap about testing for and interpreting nystagmus;
- Know the limitations of early imaging.

Usually, CT in the first hours of stroke is negative. "But less well-recognized is that for patients with posterior circulation stroke, even MRI with diffusion-weighted imaging can be negative in the first 48 hours," Edlow notes. This is particularly true for patients presenting with isolated dizziness.[3]

For epidural abscess, Edlow recommends the following:

- Use a checklist to ask about risk factors;
- Use inflammatory markers.[4]

"It is important to understand the unpredictable time course of the neurological deficit, which is often sudden," Edlow adds. ■

• The most often missed condition for headache was ischemic stroke (18.1%). The most common missed condition for back pain was intraspinal (epidural) abscess (41%).

"More education and awareness is needed on these specific conditions in order to reduce malpractice claims," Dubosh offers. Edlow says, "The medical/legal implications are tough because there is no magic way to improve this low miss rate." Knowledge gaps are one known issue.[2]

Alan Gelb, MD, a professor of emergency medicine at University of California, San Francisco, and chair of the medical risk management committee at Zuckerberg San Francisco General Hospital, commonly sees these three allegations in missed stroke cases:

• Missed focal findings (because of lack of a careful neurological exam or lack of documentation of one);

• Focal findings wrongly attributed to pain, migraine equivalent, pain that is limiting movement, or unresolved Todd's paralysis postseizure; and/or failure to consult a neurologist in this scenario;

• Speech problems thought to be psychiatric, leading to an incomplete exam and "anchoring" diagnosis of conversion reaction.

A recent malpractice case involved an elderly patient who came to the ED with confusion and inability to walk.

"It was assumed by the emergency physician to be psychiatric because the patient had a psychiatric history," Gelb says, noting only a cursory neurologic exam was performed, which was documented as "grossly normal" and "unable to test."

"The patient had a fairly classic left middle cerebral artery stroke with aphasia and right hemiparesis," Gelb explains. The patient presented just two hours after onset of symptoms, but because stroke was not diagnosed, no therapy was offered. Aphasia was misunderstood to be psychiatric conversion, depression, or lack of cooperativity. Hemiparesis was not diagnosed because the patient was not following verbal commands because of aphasia.

"The patient was diagnosed the next day as an inpatient, too late for intervention," Gelb notes. ■

DEFENDING MISSED STROKE CASES

If well-documented, the following factors make missed stroke cases more defensible, according to **Alan Gelb**, MD:

• Detailed serial exams;
• Use of the National Institutes of Health Stroke Scale;
• Obtaining history from family or friends;
• Discussion with a neurologist;
• Providing evidence for the alternative diagnosis made, when the diagnosis is not stroke;
• Recommendation of close follow-up and administration of medication such as aspirin and clopidogrel (if symptoms resolve in the ED and the patient is discharged with a diagnosis of transient ischemic attack).

On the other hand, Gelb says these factors make it more likely the plaintiff attorney will decide to pursue a missed stroke malpractice claim:

• A bad outcome;
• A young patient;
• A patient with multiple risk factors;
• Failure to use the hospital's stroke activation protocol;
• Delay in obtaining a CT scan or MRI;
• Conflicting documentation between the nurse and the emergency physician (EP) as to whether there were focal findings;
• A patient who presented early after onset of symptoms (within six hours for tPA or 12 hours for interventional radiology);
• A patient who was a candidate for tPA, but was not offered treatment;
• Failure to consult with a neurologist in decision-making (if required by the hospital);
• Failure to transfer the patient to a stroke center for interventional radiology despite early presentation;
• No documentation on the timing of onset of symptoms.

"This allows the plaintiff to say there was time for intervention to improve outcome," Gelb explains. ■

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Patients' Insurance Status Affects ED Disposition

Of 215,028 patients seen in EDs for three common conditions (asthma, pneumonia, or COPD) in 2015, 66.5% were discharged from the ED, 32.1% were admitted, and 1.5% were transferred to another hospital, according to the authors of a recent study.[1] Compared with privately insured patients, those without insurance were more likely to be both discharged and transferred.

"A more innocuous explanation for this trend is that individuals without insurance or with Medicaid may not have a primary care physician," offers **Timothy C. Gutwald**, JD, a healthcare attorney in the Grand Rapids, MI, office of Miller Johnson. With so many patients with non-urgent problems using the ED as a primary care practice, lower admission rates would make sense.

"Others would argue that hospitals want to avoid running up large inpatient bills when Medicaid is the payer or when a patient has no insurance," Gutwald says. Other cultural and socioeconomic factors also come into play, such as Medicaid and uninsured patients more likely to check in to the hospital to treat avoidable conditions.[2] "This is a complicated issue the health system has been attempting to address for decades," Gutwald notes.

Whatever the case, repeatedly discharging or transferring patients with certain conditions that are more prevalent in low-income patients may draw the wrong kind of attention from the Centers for Medicare & Medicaid Services. "Patients returning to the ED shortly after discharge may also result in scrutiny from state and federal regulators," Gutwald warns.

However, plaintiff attorneys probably would face an uphill battle trying to establish this kind of pattern in an ED. "I think a court would be hesitant to allow an attorney to engage in a fishing expedition and give them access to the records of enough patients to establish a pattern of disparate treatment," Gutwald predicts.

Even if a plaintiff did get access to other patient charts, the court will not necessarily allow the charts to be admitted. This prevents the attorney from showing that other uninsured patients or Medicaid patients were treated similarly to the plaintiff, or that privately insured patients were treated differently. "Such evidence may be more prejudicial than probative," Gutwald explains. ■

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With or Without Gag Clauses, It Is a Hurdle for ED Defendants to Blame EHR

Are EPs well-aware of a glitch within the electronic health record (EHR) that has almost harmed many patients? They might be wary of calling attention to it publicly due to vendor "gag clauses." These are an example of "risk management gone wrong," says **Michael S. Victoroff**, MD, a consultant on health IT in the department of patient safety and risk management at Denver-based COPIC.

Gag clauses prohibit EHR users from publishing reports of flaws, defects, malfunctions, error-inducing processes, usability problems, and other hazardous conditions. From the ED provider's perspective, lack of clarity on the legalities of what is allowed leads to fear of speaking up. "Users may even feel they are contractually forbidden to discuss such things with any external party, including their insurance carriers. The fact that this is probably mistaken does not reduce the chilling effect," Victoroff says.

Medical malpractice insurance carriers have not seen the volume of EHR-related claims they have been expecting over the past two decades, Victoroff notes. "Plaintiff attorneys have not figured out that EHRs play a role in many medical errors and could plausibly be named as part of the causation pathway in some cases," he says. Despite gag clauses in some contracts, generic observations of EHR flaws (without specific attribution) are widely published. "The vendors have deep pockets, and it wouldn't take a whistleblower to draw attention to the technology," Victoroff says. "All it takes is a plaintiff to ask the right questions in the defendant's deposition."

The "learned intermediary" legal doctrine may be providing substantial

protection to technology vendors, offers Victoroff. This protects suppliers by placing liability on licensed practitioners.

"It is not clear how much weight a trial court would give a nondisclosure agreement in a case where a patient came to harm because a physician felt inhibited from taking remedial action in the face of an obvious safety hazard," Victoroff says.

Jurors are unlikely to sympathize with an EP who put a vendor contract ahead of a patient's welfare. "In practice, most [health information technology] hazards fall in a grey zone where 'user error' can almost always be invoked," Victoroff adds.

This gives cover to vendors no matter how poorly designed the EHR. "There is even a perverse liability to consider if users repeatedly raise concerns about the number of errors they intercept and yet continue to use the system," Victoroff says. "This is a true lose-lose situation."

New proposed rules from the Department of Health and Human Services' Office of the National Coordinator for Health IT would forbid vendors from enforcing gag clauses.[1] "The removal of these clauses would mean that EDs, and provider organizations more generally, can more easily share explicit examples of usability and safety challenges, which could decrease liability risk," says **Raj Ratwani**, PhD, director of the MedStar Health Research Institute's National Center for Human Factors in Healthcare in Washington, DC.

There is growing concern that gag clauses prevent anyone from airing problems with EHRs before people are harmed. "EHR usability issues create many dangerous situations that require extra work and careful attention to do the right thing, when doing the right thing should be the easiest thing to do," says **Dean Sittig**, PhD, a professor in the School of Biomedical Informatics at the University of Texas Health Sciences Center in Houston.

EXECUTIVE SUMMARY

Proposed rules would eliminate gag clauses in electronic health record (EHR) vendor contracts to encourage airing of safety concerns. Some known issues cropping up in ED malpractice claims:

- Some EHRs make it difficult for ED providers to view the most current test results.
- The correct medication order is not always listed in the EHR.
- Sometimes, orders entered in free text are not carried out.

Research on the usability of EHR interfaces in ED settings has shown that errors such as ordering X-rays on the wrong side or ordering medications with the wrong dose can occur with rates ranging from 16.7% to 50%.[2] "During this study, we collected videos of the physician interactions with the EHR. We have posted these examples on EHRSeeWhatWeMean.org," says Ratwani, the study's lead author. The videos show that some EMR interfaces can be difficult to use and may contribute to errors.

Sittig has reviewed multiple malpractice lawsuits alleging ED providers missed abnormal test results that in some way involved EHR usability. In one case, a patient's X-ray results were sorted in chronological descending order of the date, with the oldest tests listed first. The most recent X-ray report was not visible unless the EP scrolled down to locate it. The EP did not realize a new result was available and decided to send the patient home based on a previous X-ray taken before the accident. The patient, who had a broken bone, sued the EP. "There was really no excuse on the part of the doc, although the EHR made it really hard to see the new result," Sittig says. The lawsuit was settled prior to trial. Other ED malpractice claims have revealed dangerous problems with entering orders into the EHR. Sometimes, the EP cannot find the appropriate order from a long list of medications in the EMR and enters a different order — one that is listed. Then, the EP tries to enter the correct order in free text, but the incorrect order is carried out. "Sometimes, the free text does not cross the interface," Sittig explains. "Again, in the lawsuit, the doc has very little to stand on since she clearly ordered the wrong item."

When unambiguous product defects are at fault, there likely will be cases in which vendors become defendants. "But one defense that is not generally going to be helpful is simply jousting at the vendor," Victoroff says.

However, sometimes it takes a malpractice lawsuit to air dangerous issues. "These so-called gag clauses only apply to people who want to talk about these problems before there is a legal issue. Once the subpoena comes through, everything is fair game, including screen prints," Sittig says.

Even once someone is harmed, it is still not easy for the EP defendant to point the finger at a faulty EHR. "Defendants often try to blame the EHR. But this is difficult for many reasons," Sittig notes.

The system may be quite cumbersome in the hectic ED setting with multiple high-acuity patients in the mix. However, in the courtroom, it does not look that way. "A good EHR user — say, a trainer — can easily

show a jury how the EHR should be used, and it does not look hard at all," Sittig says. This depicts the EP defendant as incompetent or uncaring. Even blatant safety problems with EHRs can be hard for any individual ED provider to pinpoint. "EHRs are very complex, with many interacting components, any of which may not be functioning properly," Sittig explains. "The doc may not be aware that something is wrong."

It is not just vendors that try to prevent people from talking about problems with the EHR. Healthcare organizations also put restrictions on their employees. "For example, a hospital wouldn't want a doc saying that the EHR was not safe at the hospital where he works," Sittig says. "What patient would go to an ED with a known unsafe EHR?"

ED providers must feel free to speak up about EHR concerns, says **Lorraine Possanza**, DPM, JD, MBE, program director of the Partnership for Health IT Patient Safety at ECRI Institute. "There are multiple ways that errors could occur," Possanza says. Questions to consider about ED care may include: How was the test ordered? Was there a drop-down menu or a default order that needed to be changed in each instance? Was there an issue when images or reports appeared across systems? How were items displayed?

"It is important to include technology safety in any risk and safety programming within an organization," Possanza says.

Sittig recommends that hospitals, in conjunction with their EHR vendors, create easy ways for users to quickly report safety concerns. Further, he suggests IT departments carefully review comments that users enter routinely when they override clinical decision support alerts. "Researchers have demonstrated that these comments often contain excellent suggestions for improving patient safety," Sittig says.[3] Workarounds are dangerous, too. "If someone else then later reports that issue and there is no communication that a change occurred, that very workaround used previously may cause a safety issue to occur," Possanza cautions. Possanza says these are important questions to answer on ED care:

• If a patient requires a certain level of care identified by the ED provider, is that readily visible after the patient is admitted? For instance, the ED patient may require 1:1 monitoring, but it is not clear to inpatient providers.

• Is there a verification process to determine that the information sent was actually received? For instance, if three prescriptions are sent to an outside pharmacy, the ED should be able to verify that all three were received.

• Is the information received by the patient in their aftercare summary complete and accurate? For instance, medication dose and strength should be displayed, along with directions on how and when to take it.

"Organizations should encourage reporting and not punish providers for reporting safety issues, as it can have a chilling effect," Possanza warns. ■

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Liability Exposure if Communication Is Poor Between ED and Consultant

When EPs and consultants are codefendants in malpractice claims, finger-pointing is sure to follow. The EP insists the urgency of the situation was totally clear; the consultant claims the whole story was not told.

"Expectations of whether and when a patient will be evaluated, and who will order tests, must be clear," says **Mamata Kene**, MD, chief of medical legal affairs at Kaiser Permanente Fremont (CA) Medical Center. "Consultants also must know to ask for specialty-specific information that may not be on an ED physician's radar." An EP discussing a patient with fever and flulike symptoms with the infectious disease specialist does not mention a previous splenectomy — and the specialist does not ask. Thus, the patient does not receive antibiotics, and invasive bacterial infection is not considered as the cause of fever. Similarly, the patient with appendicitis whose chronic

steroid use is not mentioned can go into adrenal crisis with the stress of surgery. If steroids are not continued and potentially augmented at a stress dose (high-dose steroids needed during acute illness for patients on chronic exogenous steroid therapy), the patient can develop life-threatening symptoms, Kene warns.

Misunderstandings on when the ED patient should be seen also can lead to lawsuits. For instance, a patient with a corneal ulcer needs close follow-up with ophthalmology. "The timeframe for follow-up is important to establish prior to the patient leaving the ED," Kene says. Likewise, a patient with suspected retinal detachment may need to be seen the same day or within 24 hours. "Both of these conditions could result in vision loss if not promptly evaluated, treated, and followed up," Kene says.

Both the patient and the consultant could claim later that the EP was at fault. "Clear communication of expectations, in read-back format, can be helpful," Kene offers.

For example, the EP might state: *"What I'm hearing you say is that patient X needs to be re-evaluated in 24 hours. Are you coming in to see him, is your office going to call for an appointment, should patient X call your office, or can I give him an appointment date and time right now?"*

EMRs with complete medical histories, immunization records, and medication lists also can mitigate risks. "The onus to review the EMR for these critical details falls on both the ED physician and the consulting physician," Kene explains. ■

Policies Can Quickly Complicate Defense of ED Claim

Does an ED clinical policy state that all chest pain patients must undergo an ECG within 10 minutes of arrival, but it took somewhat longer? The slight delay might have had nothing to do with the plaintiff's terrible outcome. But that does not matter; plaintiff attorneys can use it to paint a picture of substandard care, says **William J. Naber**, MD, JD. The policies become one more hurdle for the ED defense to overcome.

Naber, an assistant professor of emergency medicine at UC Health, has seen these issues relating to hospital policies come up during ED malpractice litigation:

• **The provider deviates from a policy, and the ED chart offers zero explanation as to why.** "When signing up for medical staff privileges, you agree to follow the policies and procedures of the hospital you work at. Most emergency physicians don't think about that," Naber says.

The defense team now has the added challenge of proving that the deviation from the policy was within the standard of care. "That's really hard because usually policies are written around the standard of care," Naber notes.

Guidelines from specialty organizations differ somewhat. From the perspective of the defense team, this means wiggle room. The same is not true of ironclad hospital policies. "If the hospital says, *'We're going to do it this way,'* and you deviate from it, you need to address that in your medical decision-making," Naber offers.

There may be an acceptable alternative that is medically appropriate for a smaller group of patients.

"The 'alternative school of thought' theory says that just because 85% of people do it one way and 15% another way, it doesn't mean the 15% are wrong," Naber explains.

There are many valid reasons for EPs failing to follow a policy to the letter. "Policies or accepted guidelines of care are written for the most common situations," Naber notes. For example, the Surviving

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Sepsis Campaign's updated 2018 recommendations call for an initial bolus of 30 mL/kg fluid bolus for patients with suspected sepsis. For a 100-pound patient, this may not be appropriate.

"If that person is 85 years old and has a bad heart, you may put them in congestive heart failure by giving them that much fluid," Naber notes. In this case, the EP who gives less than the recommended amount of fluids might document: *"Because the patient had unknown volume status and unknown cardiac function, I was cautious with fluids and reassessed the patient every hour."*

• **The EMR does not contain all relevant policies.** "When somebody comes in with pneumonia, sepsis, or a stroke, you want the EMR to have a built-in order set that helps you follow policies," Naber says. For instance, this facilitates obtaining a National Institutes of Health Stroke Scale score for all patients with suspected stroke.

• **Some policies are outdated.** "Sometimes, a policy is written, it goes into some database, then people just forget about it," Naber says. During discovery in malpractice litigation, the policy is produced, one that has not been updated in a decade. The hospital faces accusations of failing to update its own policies. Equally problematic are multiple policies on the same issue. This happens occasionally when new hospital leadership decides a policy is needed on something without realizing one already exists. "Now, you have two inconsistent policies," Naber adds.

• **Sometimes, providers are unaware of policies and procedures.** "If it's 3:00 a.m. and you don't know how or where to find a policy, that's a problem," Naber cautions. An accurate database with good search functionality helps providers avoid this issue.

• **Some policies are created by administrators without any clinical expertise.** Unrealistic requirements lead to legal problems when they are not followed by well-meaning EPs. "When you're creating a policy, you need a variety of people in the room, including frontline clinicians, to make sure it's going to work," Naber says.

Plaintiffs will want access to any and all procedures and protocols that are generated by hospitals and promulgated to their staff and credentialed providers. "This is a challenge we always fight on the defense side. It is a constant debate," says **Parisa Tabassian**, Esq., an attorney in the Richmond, VA, office of Hancock Daniel.

The defense team argues that, legally, the policies cannot be the basis for establishing the standard of care for EPs; therefore, the policies should not be discoverable as relevant or reasonably likely to lead to admissible evidence. For example, in a malpractice case including allegations relating to wound care provided by hospital-employed nurses, a plaintiff may ask for all hospital policies relating to wound care.

"The court may rule these are properly discoverable, though not necessarily admissible in court," Tabassian says.

Hospital policies do not constitute the legal standard of care.

"But they can implicate the entity for not adequately training or supervising their personnel or not delivering optimal care," Tabassian warns.

If ED providers failed to comply with the policy, the hospital is criticized during litigation for not meeting their own expectations.

"In some cases, ED defendants have testified that they have no idea where the policies are located," Tabassian says. ■

Legal Problems if ED Overlooks Critical Lab Finding

Critical lab results are missed because ED patients are discharged already. Other times, results are never communicated to the EP who is caring for the patient. "Reasons include ED overcrowding, ineffective physician communication between leaving and oncoming physicians, or protocols allowing for triage ordering of testing the treating physician was not aware of," says **Edward Monico**, MD, JD, assistant professor in the department of emergency medicine at Yale University School of Medicine.

Despite the importance of critical values in ED care and requirements that hospitals provide for the identification and timely communication of critical results, there is little standardization of procedures.[1,2]

"The lack of such standardized procedures has resulted in treatment delays and injury to patients," Monico says. Regardless of the reason, a malpractice lawsuit is likely. "Plaintiffs will have to demonstrate a causal relationship between the missed lab value and the harm realized," Monico adds.

Chris Messerly, JD, has handled many sepsis cases over the past three

decades. A 2017 case involving an overlooked critical lab value turned out to be the largest wrongful death verdict in Minnesota history. The jury awarded $20.6 million at trial.[3] The highly publicized case involved the death of a woman a few days after she delivered her first child. She died as the result of a missed sepsis diagnosis from endometritis.

"The nurse practitioner [NP] in the ED at a major hospital simply disregarded a key lab finding," says Messerly, a partner at Minneapolis-based Robins Kaplan.

The patient's platelets at presentation were 50. The lab report flagged the finding as low. However, when the NP spoke on the phone with the on-call OB/GYN, the NP failed to comment on the platelets. Also, the NP did not tell the patient and her husband of the dangerously low levels. As a result, the EP agreed with the NP's conclusion that the patient simply had a urinary tract infection and could be discharged safely.

"By the time the patient returned to the same ED many hours later, it was too late, despite an emergency hysterectomy," Messerly says.

The case underscores the importance of ED providers carefully reading lab reports and acting on them.

"While that states the obvious, sadly, it does not always happen," Messerly laments. The defense team admitted the NP's negligence but claimed that it played no role in the patient's death. "They claimed it was a rare case of necrotizing fasciitis, which the jury did not buy," Messerly reports.

At trial, the nurse practitioner testified that she told the patient and her husband about the alarmingly abnormal platelet count. "I don't think that anyone believed she was telling the truth, including the jurors," Messerly says. EPs are responsible for reviewing any tests they order.

"If another provider placed orders, the case becomes murky," says **Catherine Vretta**, MD, MPH, an EP at Ascension St. John Hospital in Detroit.

Certain EDs have standing orders for specific complaints, such as troponin orders in chest pain patients. "If the facility allows ED nurses to place orders, ideally, this should be communicated to the physician of record," Vretta says.

Some ED patients have left the department already by the time culture results are available. In this case, says Vretta, EPs should "be prepared to disposition the patient without these results." There must be a plan in place for evaluation of the culture results. For patients who are admitted, it is reasonable for EPs to expect that the physician managing the patient's care in the hospital would be responsible for reviewing the culture results when they become available.

"The case is more problematic if the patient is being discharged without cultures resulted," Vretta notes.

Certain ED policies state that a designated person (a quality control coordinator, nurse, or EP) follows up on all cultures obtained in the ED on discharged patients.

"If no such policy exists, the physician of record would be responsible for these results," Vretta cautions.

Sometimes, EPs handle the issue by contacting the patient's primary care physician or specialty physician to arrange outpatient follow-up on the test results. If so, Vretta cautions that the EP should only discharge the patient with results pending if these test results would not change the immediate care of the patient.

"The emergency physician should also carefully document the conversation with the physician to whom the patient's care will be followed up by," she adds.

By the time a malpractice lawsuit is underway, everyone knows the bad outcome happened. Typically, plaintiff experts look for anything the EP could have done to prevent it, and then they argue that it was the standard of care to do so.

"That is very difficult to get around. You are basically working backward," says **Joan Cerniglia-Lowensen**, JD, an attorney at Pessin Katz Law in Towson, MD.

The defense position is that the EP can be judged only by what was reasonable at the point the patient presented. The plaintiff's side counters that in light of the bad outcome, it clearly was not enough. Some plaintiff experts have testified that instead of calling a patient when critical test results came back, that law enforcement should have been sent to the patient's house. In hindsight, most jurors would agree; after all, a person's life was at stake.

"But if nobody is there, then what? Does it increase the provider's obligation?" Cerniglia-Lowensen asks. "You have to look prospectively at the case, not retrospectively."

This issue came up during malpractice litigation involving an ED patient who was sent home before an elevated D-dimer result returned. At the time of discharge, the EP believed it was safe to send the patient home. As soon as the result came back, ED providers attempted to contact the patient, who had already suffered a stroke.

The plaintiff attorney argued that the patient was prematurely discharged from the ED. Further,

the plaintiff attorney argued the ED failed to communicate the critical value in a timely manner.

The plaintiff attorney focused on the fact that stroke must have been on the EP's differential, or the EP would not have ordered the D-dimer. The ED chart lacked any explanation of *why* the EP thought stroke was unlikely enough to discharge the patient. With differing expert opinions on whether the bad outcome could have been prevented if the patient had been in the hospital at the time it occurred, the case settled out of court.

Even consulting with specialists will not necessarily insulate the EP from liability.

"It might bring others into the case. But what they'll say is, *'In the ED, you had the first opportunity to intervene for this patient,'"* says Cerniglia-Lowensen. What if a critical lab finding is simply missed, and the ED patient is discharged? This is another dangerous situation.

"This can occur when incomplete labs are resulted," Vretta notes. For example, an electrolyte panel is ordered and is partially resulted without a potassium level. The EP notes that none of the results are abnormal, so everything looks fine. It is not apparent that the potassium level is missing.

"A patient could inadvertently be discharged with a critically dangerous lab value and have a potentially disastrous outcome," Vretta says. "Ultimately, the emergency physician would likely be held responsible."

It helps avoid confusion if lab results are designated as "pending" rather than simply absent from the partially returned results. This could allow the ordering EP to avoid a premature discharge.

"The EP should confirm that all orders were completed and resulted prior to any discharge," Vretta advises. ■

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Facial Trauma Lawsuits: Half of Cases Involve Delayed or Missed Diagnosis

Of 53 claims involving facial trauma, 10 out of 69 named defendants were EPs, according to a recent analysis.[1] Complaints of delay or failure to diagnose accounted for half these lawsuits.

Lawsuits stemmed from a variety of issues, but when EPs were sued, it was usually for failure to diagnose a fracture.

"One of the main issues we found is someone comes in with an injury, and the emergency physician gets an X-ray but misses the fracture," says **Boris Paskhover**, MD, one of the study's authors and an assistant professor in the department of otolaryngology at Rutgers New Jersey Medical School. Often, the plaintiffs underwent an X-ray, which the EP or someone else read as negative. "But the honest truth is if you don't do it often, you can easily miss a small fracture. Even a small fracture often needs some sort of management so it doesn't become a big deal," Paskhover explains. If missed, small, midfacial fractures typically heal with no major consequences.

"But the mandibular fractures have implications as a stress-bearing bone. If you miss a small fracture and it gets infected, you have consequences," Paskhover cautions.

The one practice change EPs should consider, according to Paskhover, is that if there is suspicion of a fractured jaw, "a CT scan's going to pick it up. An X-ray may not." A recurring fact pattern in the lawsuits involved EPs who relied on the X-ray they (or someone else) misread as normal, without getting a CT scan. In some cases, patients themselves gave a clue that something was missed.

"If the X-ray is normal, and they still say something doesn't feel right, scan them," Paskhover says. ■

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New EMTALA Data Show Decline in Settlements

Settlements resulting from Emergency Medical Treatment and Labor Act (EMTALA) violations declined 87% between 2002 and 2015, according to a recent analysis.[1] Some key findings:

• Failure to stabilize patients in need of emergency care and failure to screen were the top violations in these settlements;

• Settlements occurred most often in urban area hospitals (74%) and hospitals in the South (48%);

• Violating hospitals incurred annual settlements of close to $32,000, on average, for a total of nearly $5.3 million over the study period.

EMTALA's status as an unfunded mandate and efforts to repeal the Affordable Care Act threaten the financial viability of safety-net hospitals, researchers warn, which could lead to more EMTALA violations.

When EMTALA first became law in 1986, "we all had a very healthy understanding and respect for the law. I have found over the years that this has diminished," says **Heather L. Brown**, DMSc, PA-C. Brown, CEO of HL Brown and Associates in Roswell, GA, recently co-authored a paper on the history that led to the enactment of EMTALA.[2]

"There is misinformation and lack of education on EMTALA," Brown says. Steep civil monetary penalties can result from violations. "Anyone working in patient care in the emergency medicine arena should be familiar with the law's do's and don'ts in order to stay on the correct side of this federal statute," says Brown, who asks ED providers to keep the following in mind:

• The provision of a mandatory screening medical exam and stabilization before discharge or transfer are the basic requirements for healthcare providers seeing patients in an emergency situation;

• It is the patient, or a reasonable layperson, who would deem a situation to be an emergency, not the trained medical professional;

• "Presenting" to the ED does not mean only patients who come in the department and register. Even those simply in proximity to the facility are deemed to be seeking care, too;

• When and where the law does not apply.

A common misconception: EMTALA applies to off-campus urgent care centers or physician offices. Sometimes, staff from the urgent care center wrongly believe that it is a violation to send a patient to the ED for evaluation without calling first to give a report or without getting acceptance for the patient to come. Likewise, staff from clinics sometimes think that informing a patient that their insurance is not accepted is an automatic EMTALA violation. This is not true.

• If the patient has presented for care at the ED, he or she needs to be given the screening exam and treatment to stabilization, not encouragement to seek care elsewhere.

"If a patient comes to the ED — by the definition, they get screened and stabilized, or the ED could be in violation," Brown says.

Well-meaning ED staff might encourage a patient to see their primary care physician because the wait is too long or the bill will be less for an outpatient location.

"The look of impropriety or coercion would not be favorable for a facility and/or provider who is investigated for a complaint," Brown warns. ■

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CME/CE OBJECTIVES

After completing this activity, participants will be able to:

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

COMING IN FUTURE MONTHS

- How ads about board-certified EPs legally expose hospitals
- Litigation after hospital security assaults ED patients
- Lawsuits alleging ED patient's fall was caused by negligence
- EMTALA used as tool in False Claims Act lawsuits

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CME/CE QUESTIONS

1. **Which is true regarding stroke identification?**
   a. CT is more reliable than MRI for ruling out stroke in the early hours of presentation.
   b. There are many false-positives with CT scans in the first hours of stroke.
   c. For patients with posterior circulation stroke, even MRI with diffusion-weighted imaging can be negative in the first 48 hours.
   d. MRI can rule out posterior circulation stroke, but only for patients presenting with isolated dizziness.

2. **Which is true regarding policies and ED malpractice litigation?**
   a. Hospital policies constitute the basis for the legal standard of care.
   b. The EP's reason for deviation from hospital policy and choosing a medically acceptable alternative is helpful to the defense.
   c. Guidelines from specialty organizations constitute the standard of care more so than hospital policies.
   d. All hospital policies are not only discoverable, but also are admissible in court, regardless of whether they are directly relevant to the care at issue.

3. **Which is true regarding liability involving critical lab findings in the ED?**
   a. Discharging an ED patient prior to review of all outstanding tests is in itself a violation of the standard of care.
   b. Standardized procedures for communicating results are linked to treatment delays and injury to patients.
   c. To prevail in malpractice litigation, plaintiffs will have to demonstrate a causal relationship between the missed lab value and the harm realized.
   d. If protocols allow triage nurses to order tests, EPs cannot be held liable for failure to communicate the results if they can prove they were unaware the test was ordered.

4. **Which is a potential EMTALA violation?**
   a. Urgent care centers sending a patient to the ED for evaluation without calling first to give report
   b. Urgent care staff sending a patient to the ED without first getting acceptance
   c. Clinic staff informing a patient that their insurance is not accepted
   d. ED staff encouraging a patient to leave the ED because outpatient care is less expensive