ED LEGAL LETTER™

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INSIDE

Analysis: Radiology Malpractice Claims Much More Likely to Involve ED Than Other Sites

About half (46%) of radiology malpractice claims involve ED patients, according to the results of a recent analysis.[1]

"There are a disproportionate number of actions arising out of the ED," says **Jeffrey Robinson**, MD, MBA, FACR, the study's lead author and an associate professor in the department of radiology at University of Washington.

As president and founder of Cleareview, a malpractice review consulting company, Robinson noticed many cases involved ED patients. "As I was entering case after case into the Cleareview intake database, it occurred to me that there seemed to be an awful lot of ER cases," Robinson recalls.

Researchers set out to learn if this anecdotal impression was supported by hard data. Robinson and colleagues analyzed 149 imaging exams occurring during a six-year period from 2012 to 2019. There were 68 claims from the ED, compared to 56 in the outpatient setting and 25 in the inpatient setting. Investigators wanted to verify the prevalence of ED-related malpractice claims truly was disproportionate to the total number of exams performed in the ED. To do this, they used the 2016 Medicare Part B claims database, which is assumed to closely approximate the general population. "We found it was four or five times more likely to have a malpractice action arise out of an ED exam compared to an inpatient or outpatient exam," Robinson observes.

Previous studies of radiology and malpractice have focused on the type of exams involved in claims. "None talked about whether it was inpatient, outpatient, or ER," Robinson notes. "This is the first paper to focus on the ER as an independent risk factor."

Radiologists lacking specific ED expertise are one potential reason for the disproportionate number of claims involving ED patients. "Anytime there's a malpractice lawsuit involving radiologists, it's almost always over

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misinterpretation," says Robinson, a practicing emergency radiologist at Harborview Medical Center in Seattle.

Expertise and background of radiologists reading ED cases varies widely. Some are subspecialists in neuroradiology, while others are breast imaging specialists.

"A lot of the studies are being read by people for whom ER exams are not in their sweet spot," Robinson explains.

It is not that ED exams are unusually difficult; rather, they vary widely and come at all hours of the day and night. Many radiologists are at the end of an extended day when the late evening head CT comes in. "But that exam is part of the normal workload of someone on a dedicated emergency radiology service," Robinson adds.

Robinson hopes the study's findings will raise awareness of emergency radiology as a distinct subspecialty.

"Somebody really ought to be focusing their attention on these providers and these patients," he offers.

One possible approach is for radiology groups to develop a section that is focused primarily on emergency medicine. "They don't necessarily need to be fellowship-trained," Robinson suggests. "But a section whose primary customer is the ED is needed."

Rodney K. Adams, JD, has defended multiple malpractice radiology claims, representing both emergency physicians (EPs) and radiologists. While facts of the cases vary, there is one prevailing theme. "Often, it has to do with lack of communication both ways — between the ER doctor and the radiologist," says Adams, a visiting assistant professor at the University of Richmond (VA) School of Law. Ideally, the EP gives a relevant clinical context so the radiologist understands what he or she is looking for. However, the way orders are entered in some EDs hinders this. For instance, the EP might ask a nurse or a clerk to obtain a chest X-ray. The order is entered without any clinical history or context on why the X-ray is indicated, other than a generic symptom like "chest pain."

"If the EP gives the radiologist a specific question, that would draw their attention to it," Adams says. Even if EPs handle their own ordering, many use template charting, which makes the clinical history difficult to ascertain.

Radiologists may try to access the chart in the electronic health record (EHR), but their systems are not necessarily integrated with the ED's system. Even if they can view it, time often will not permit a lengthy chart review. "If the radiologist calls to get the history, the ER doctor will likely be tied up with another patient or in the middle of a procedure," Adams adds.

The same kind of communication gaps exist on the radiology side. For various reasons, radiologists do not always verbally convey the urgency of a finding to the EP. "That's becoming more of a problem with the EHR," Adams notes.

The radiologist assumes the EP is going to look at the report at some point prior to discharge. The report is in the EHR, but there may not be anything drawing the EP's attention to it.

"Sometimes, there is something critical in there that the radiologist has identified, but nobody ever picks it up," Adams says.

Plaintiff attorneys will name both the EP and radiologist, hoping

the two defendants will blame one another. In some cases, radiologists testify that if the EP really had a specific concern, the EP should have given a better clinical history.

"Given that they don't know what else is going on with the patient, the fact that the chest X-ray looks normal doesn't mean much without the big picture," Adams explains. In response, EP defendants say they would have expected a call from the radiologist if there was an important finding. "The other thing is that radiologists, trying to hedge their bets, will put in a few disclaimers," Adams says.

Even something as benign as "correlate clinically" leaves wiggle room for radiologists to argue the EP should have acted.

"We can never win a case when the defendants are fighting amongst themselves, with both trying to exculpate themselves," Adams says. ■

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ED Malpractice Claims: Finger-Pointing, Insufficient Information

ED staff over-rely on the radiology report, or give insufficient information to the radiologist. **Anna Berent**, JD, has seen these two issues come up repeatedly in ED malpractice claims. These are the fact patterns in actual cases:

• An EP treated a patient who reported hearing his foot make a "pop" sound after a fall. An X-ray report referenced a possibly old calcaneal fracture.

"Dismissing the significant findings of the physical exam and the history, the ED doctor attributed the pain to a soft tissue injury, and did not stabilize the foot upon discharge," says Berent, claims counsel at Western Litigation in Houston.

Several days later, the fracture became displaced. Eventual surgical intervention was complicated by intractable infections and concerns over possible foot amputation.

"The case assessment through outside experts revealed that had the ED physician heeded the physical exam, he would have at least stabilized the foot upon discharge or ordered a follow-up with an orthopedic specialist," Berent reports.

• A young woman came to the ED with severe abdominal pain. The EP suspected a ruptured cyst, which was the only diagnosis on the differential. Once the ultrasound confirmed there was no ruptured cyst, the patient was discharged. She returned the next day with a diagnosis of a ruptured appendix. "While the radiologist is also named in the suit that stemmed from the incident, their role was quite limited, and they will likely be dismissed from the case," Berent explains.

• An elderly man injured his knee when he shattered a flower pot. After cleaning the wound, the ED physician wanted to confirm there were no shards remaining in the wound, and ordered an X-ray. However, the physician told the radiologist only that the patient had fallen, without mentioning the broken flower pot. The co-defendant radiologist noted no fractures, but missed the presence of shards in the wound.

The patient sued the EP and radiologist. The lawsuit alleged a severe infection developed due to failure to remove the shards. The EP claimed he relied on the interpretation of the X-ray to confirm the wound did not need further cleaning. The radiologist claimed he would have noted the presence of the shards if the EP had indicated it. "Both physicians are locked in, and their adjusters recognize the potential for finger-pointing," Berent notes.

• A routine chest X-ray revealed a widening mediastinum, suggestive of an aortic aneurysm. The radiologist defendant contended that a slightly widened mediastinum in an elderly patient is not unusual and often not mentioned in a radiology report.

However, the EP was using the chest X-ray as an initial screen for aortic aneurysm in addition to looking for other pulmonary pathology. "The patient's aortic aneurysm was not diagnosed before death," says **Rodney K. Adams**, JD, a visiting assistant professor at the University of Richmond (VA) School of Law.

• A young man presented to the ED with complaints of severe abdominal pain, and a CT scan was ordered. The patient stated he had been seen previously in other EDs several times over the past few weeks.

During litigation, it was discovered the patient had undergone several abdominal CT scans. "When all of the CT scans were collected and reviewed, they showed a clear progression of bowel dilation and fat stranding," Adams says.

• **A routine post-intubation X-ray revealed the endotracheal tube probably was positioned improperly.** The radiology report was entered in the electronic medical record timely, but the patient was in the process of transferring from the ED to the ICU at that point.

The ICU physician assumed the EP had repositioned the tube. The EP did not review the report because the patient was already in the process of transferring. "She assumed the ICU physician would be reviewing the report," Adams says. ■

Pooled Malpractice Data Show True Prevalence of ED Claims

A decade's worth of malpractice claims data allowed three Phoenix-based ED groups to improve care of spinal epidural abscess patients.

Each group had captive insurance, and decided to share their claims data. "What we started doing was aggregating our data over a decade's worth of claims," says **Terrence Brown**, MD, JD, FACEP. At the time, Brown was counsel to the Emergency Physicians Insurance Program, and ED chairman for Banner Estrella Medical Center.

The claims data included both actual malpractice lawsuits and incidents in which there was the potential for litigation.

"If there was an adverse event, or if a provider thought there was an opportunity to improve care, they would let us know about it," Brown says.

By pooling their data, the ED groups figured out the true prevalence of claims. "What first appeared to be a handful of claims involving outlier behavior turned out to have some common themes," Brown notes.

Spinal epidural abscess is not a common diagnosis, and it is a difficult one to make. "When there is a bad case, it's usually very high-dollar litigation, potentially millions of dollars," Brown explains.

Taken as a whole, the claims showed EPs often were on the right diagnostic track. They were considering a spinal cord emergency or a spinal infection. The problem was they did not image the entire spine.

"When we started looking at the cases, we would see that the EP concluded too early that the patient didn't have the diagnosis, because they didn't get a complete workup," Brown reports.

For instance, EPs would order a lumbar spine MRI for a patient with low back pain and leg weakness. "But, in fact, [patients] had pathology at multiple levels, and it's not until they have a full neurosurgical evaluation that the pathology is appropriately detected," Brown explains.

Patients were discharged from the ED, only to bounce back with worsening symptoms. The EP then would image the entire spine, revealing the pathology that was not seen in the previous MRI. "Clinical literature is now making it more evident that you need to image the entire spine," Brown adds.

The ED groups implemented an MRI cord compression screen protocol. When EPs are ordering emergent MRIs of a single level of the spine, the system alerts the EP that it is not sufficient to rule out a spinal cord emergency. It prompts the EP to order a new MRI order set, as well as antibiotics, blood cultures, and early neurosurgical consult. "It pooled all the other things you tend to not necessarily remember when you are in the midst of an emergency," Brown says.

The claims data helped the ED groups secure buy-in from radiology. "What made it easier to sell this idea was being able to show that these kinds of errors happen more frequently than we might realize," Brown says.

Looking at the data in aggregate made a bigger impression than only hearing about one of these cases once in a while. "Instead of just saying, 'We had a bad case,' we instead could say, 'We are all seeing the same pattern,'" Brown offers.

EPs can make diagnoses for spinal epidural abscess and other cord emergencies faster. "It forces the clinician early on to look for multilevel pathology. It saves everybody time, and, ultimately, is better for the patients," Brown says.

Every ED has somewhat unique risks in terms of malpractice, Brown notes. Some handle many claims regarding certain diagnoses; others handle a high percentage of missed over-reads by radiology.

"But when it comes to the more common claims, spinal epidural abscess or subarachnoid hemorrhage or stroke, the common theme that doesn't change is diagnostic error," Brown stresses. Without data, EDs cannot know how they are performing compared to peers. "There's a tendency to presume they're doing a better or worse job than they

actually are. In reality, if you look at claims data from other systems, you can see that the patterns are the same," Brown observes.

This suggests malpractice risks are tied to cognitive errors all EPs make. "When you're able to show that it's not just our health system, but rather it's a cognitive error we are all prone to make, it's a little easier to get people to buy into change," Brown offers.

Institutions remain wary of opening their malpractice claims data to external scrutiny or research. "You have to have a health system and risk management department that's interested in getting over the fear that the data will be used against them in some way," Brown says. More health systems are trying to use malpractice data for quality improvement, Brown notes. States vary as to whether the information is going to be legally discoverable during litigation. "Depending on what legal protections you have, there is a risk, still, when you are looking at this data, that it can be used by a plaintiff attorney to prove negligence," Brown says.

Nonetheless, health systems are moving toward more transparency with claims data. "The benefits of preventing litigation down the road are probably worth the potential costs associated with this information being used in current litigation," Brown shares.

ED providers, ED groups, health systems, and insurers first need to become comfortable their malpractice claims data will not be used against them.

"People are thinking differently about the information, instead of keeping it bottled up in a risk management silo for years," Brown adds. ■

Malpractice Claims Information a Powerful Patient Safety Tool for ED

At the UMass Memorial Medical Center ED in Worcester, analyzing medical malpractice data has become a powerful patient safety tool.[1]

"We periodically look at a variety of reports that identify what we are seeing relative to cases arising out of the ED," says **Timothy Slowick**, director of claims management for UMass Memorial Health Care, the parent company of the Worcester facility. This includes adverse event data, root cause analysis, reportable events, and malpractice claims data.

The ED can compare itself to peers in the academic medical center world in terms of malpractice, and learn whether the ED is an outlier, better-performing, or if specific areas are problematic. Once all the data are considered, says Slowick, "we develop a plan of action to move forward from there." These are some of the changes that were made in the UMass Memorial Medical Center ED:

• Ultrasound coverage is now 24/7. The ED handled four malpractice cases that alleged failure to recognize, evaluate, or treat testicular torsion. All involved teenagers who had lost a functioning testicle from torsion. Three of four cases involved patients who came to the ED at a time of day when ultrasound was not immediately available, which delayed diagnosis and treatment.

An analysis (using data from the Controlled Risk Insurance Company [CRICO] Strategies' National Comparative Benchmarking System database of malpractice claims) showed that UMass Memorial was an outlier compared to its peers.

Based on the malpractice lawsuits, and a series of root cause analyses, it was determined the ED did not have enough ultrasound coverage ensure these patients were a high priority and seen and screened quickly. "We used our claims data and the significance of the injury to do a risk/benefit analysis to push for 24/7 coverage of ultrasound for that particular population," says **Janell Forget**, RN, BSN, JD, senior director of risk management for UMass Memorial Health Care. The ED now provides full-time, in-house ultrasound services to address torsion and other emergencies.

• Several claims involved incidental findings on ED patients who were not followed up on. The findings were either not properly flagged, or were not properly sent for follow-up. An ED follow-up nurse was responsible for test results, such as blood cultures, that come back after patients leave the ED. "We added the follow-up of incidental findings in the ED into that person's workflow," Forget says.

The nurse now sends electronic notifications in real time to primary care physicians, even if they are not within the health system.

"But there is still a human who does the follow-up and makes sure the results get to where they need to be," Forget adds. If the patient is homeless and cannot receive the results through traditional methods, it is the follow-up nurse's responsibility to make sure the patient is notified or brought back in.

• **Airway management training is provided to ED providers.** The training covers practical skills training for intubation and surgical airways. Initially, the code airway curriculum was focused primarily on the OR and anesthesia providers. "This past year, it was extended to the ED," Forget reports.

Data were used to justify the health system's multimillion-dollar investments in ultrasound coverage and airway management training, and the process continues. Recently, risk management performed a 10-year look back on all its data to decide on a focus for 2020. "Not surprisingly, it's diagnosis-related," Forget says. "We found that 75% of our diagnosis-related cases come out of the ED and the ambulatory areas."

The claims department delineates issues that really need significant intervention, and issues that need more minor interventions. Organizations sometimes take a "wait and see" approach with malpractice risks. "For the one case that you get a year, it could be that no one pursues litigation, or it could be a $5 million hit. It's a gamble," Forget says.

Remaining transparent with malpractice claims data helps all stakeholders be proactive. "We feel so strongly about getting the information out that our chair of emergency medicine is a member of our claims committee and self-insurance program committee," Slowick reports. ED clinicians learn the ultimate outcome of malpractice lawsuits, both for the patients and the financial payout. "Some of the data I produce is older, three to five years, by the time it becomes actionable," Slowick says.

ED providers may fail to see the urgency, or assume they have addressed it already. To show the issue is current, claims managers incorporate event reporting data with malpractice data. "We can say, 'Not only did this happen in 2017, but it also happened yesterday,'" Slowick explains.

Risk managers go to the ED unannounced routinely. "We look at corrective actions that are not so grandiose, in-the-moment, small things happening, for continuous improvement," Forget says. Two recent examples:

• An investigation of some cases of patient misidentification, which resulted in new processes;

• Development of code teams for pulmonary embolism and gastrointestinal bleeds. The teams arrange phone consults quickly so patients can be discussed in real time.

"There is a close relationship between the claims people who handle ED cases, risk managers who manage the ED cases, and ED clinicians," Slowick says. This makes it more likely clinicians will share information on what is going wrong in the ED. Risk managers carry responsibilities specific to departments. "You are able to do better risk mitigation when you have alignments like that," Forget says. For smaller hospitals that cannot assign a dedicated risk manager to the ED, an alternative is to put a leader trained in risk management within the ED.

"If you don't have that relationship, you have no idea what's going on," Forget says. "You can't really do proactive mitigation. You are always behind the eight ball — and sometimes really far behind."

By spending time in the ED, risk managers hear about problems right as they are happening. "There are things we do on a daily basis, based on interactions with the ED, to minimize near misses and the likelihood of their becoming a huge situation," Forget says.

ED providers air concerns about boarding of admitted patients, such as pressure ulcers for patients who are held for long periods. Risk managers then share the concern with hospital administrators. "We hear about serious quality events that may not end up as formal claims," Forget says.

Risk managers and claims managers encourage ED providers to reach out. "Staff must be willing to put it all out there, air their dirty laundry, and freely converse with the people who can help them," Forget says. ■

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Solid Documentation Refutes Premature Discharge Allegation

After discharge from an ED, did a patient experience a bad outcome serious enough to result in a malpractice lawsuit? The plaintiff attorney is going to argue the EP should have ordered more tests, observed the patient, sought out more consults, or admitted the person.

"That's a given," says **Stephen Colucciello**, MD, FACEP, vice chair of the department of emergency medicine at Carolinas Medical Center in Charlotte, NC. Colucciello shares some issues he has seen become problematic during ED claims alleging premature discharge:

• Abnormal vitals are noted, but go unaddressed. The EP takes a look at the chart and decides to discharge the patient. "The vital signs are then taken, after the EP is done with the chart, and they're abnormal," Colucciello says.

The EP has moved on to other patients, and never goes back to check on the patient who is about to be discharged. "There needs to be a policy that ED nurses verbally approach EPs for abnormal vital signs," Colucciello offers.

Some abnormal vitals are not terribly concerning. "If we already knew the patient was febrile, if the temperature goes up or down, for the most part it's immaterial," Colucciello observes.

The same is true if blood pressure is a little high. The EP would want to know if it is low, less than 90 mmHg for an adult who is not elderly, or any patient has a shock index of 1 or higher, or a heart rate over 100, Colucciello notes.

Some ED systems hold up discharges until an EP responds to an alert he or she received. "This happens so often that it needs to be fixed in a 'Stop, don't go any further,' manner," Colucciello suggests.

It may be that an anxious patient with slight tachycardia is OK to discharge if previous records show that same patient is frequently tachycardic in the ED and it appears to be stress-related, not pathologic. "The emergency physician should document this explanation in the chart," Colucciello adds.

• High pain levels at discharge are used to argue the patient was assessed or treated inadequately. "Elevated pain scores do not automatically mean opioids," Colucciello notes.

If pain medication is not given, the EP should document the reason why not. For instance, the EP might chart: "I do not believe opioids are appropriate for this patient with chronic low back pain. Encouraged patient to get physical therapy. Community resources provided."

"Those patients are unlikely to have a problem they are going to sue for," Colucciello predicts. "Not many plaintiff lawyers are going to take a case where the patient is saying, 'They didn't give me opioids, and I want a million dollars.'"

More concerning, both clinically and legally, are unexplained increases in pain scores, particularly if pain is acute as opposed to chronic. If a patient with cellulitis arrived with a pain score of seven but is about to be discharged with pain at a level of 10, maybe something was missed. "That's an opportunity for reflection," Colucciello says. "The EP should ask, 'Am I missing something? What haven't I done?' In this case, it's a CT scan to look for fascial air."

• ED nurses chart something as the patient is discharged — and the EP never addresses it. "The EP must review the nurse's notes, all of them, including ones made during the ED stay," Colucciello stresses.

Many times, the statement "have reviewed the nursing notes" is checked off too early in the ED encounter. The EP sees the patient's chief complaint was mild nausea or lightheadedness. Then, at the point of discharge, the nurse documents substernal chest pain radiating up the left arm. That kind of inconsistency can be used to incite finger-pointing, Colucciello cautions. "The plaintiff wants us to accuse each other. That rarely leads to a good outcome," he says.

If EPs do notice an inconsistency like that, says Colucciello, "we don't ask nurses to change their notes. We comment on their notes."

Educating nurses on the nuances of various terminology is a good idea, according to Colucciello. While "fussy" can describe any sick child, the words "irritable," "inconsolable," or "lethargic" carry another connotation. "These are code words for meningitis or sepsis, and all need to be addressed if the child is to be discharged," Colucciello says.

If EPs see a child about to be discharged described as "lethargic," they can chart something like this: "Child is not lethargic on my exam. Interactive and playful. Do not have concerns for serious bacterial illness such as meningitis or sepsis."

• ED discharge instructions are too vague to help the defense. Many instructions state the patient should follow up with a primary care physician within 48 hours. The obvious problem is many patients do not know a doctor they can or want to visit regularly. Colucciello says better

discharge instructions are more specific, as in: "Follow up with a primary care physician by Wednesday. If unable to see a doctor by then, return to the ED."

"The reality is that the ones who come back are getting sicker, or you missed the diagnosis in the first place," Colucciello explains. Although not always possible, it is ideal to direct somebody to actually make an appointment before the patient leaves the ED.

About 70% of Colucciello's patients are underinsured. There may be a clinic these patients have visited, but they do not see a private doctor. "Many have no medical home at all. If you say, 'Get in this week,' it's not going to happen," Colucciello observes. "Follow-up is a huge issue in emergency medicine."

The health system's clinics save a certain number of slots just for these kind of follow-up appointments. An ED scheduler also gives the patient a reminder call. "The number of appointments you need a day depends on the size of your ED," Colucciello offers.

Another option is for the ED to make follow-up calls. Most of the time, these calls are made to a random sample of patients to gauge patient satisfaction. "But you can also do targeted callbacks on patients you had clinical concerns about," Colucciello suggests. The hope, he adds, is that "[patients] return to the ED, and you get a second chance rather than hearing from a lawyer months later."

• **There are no serial exams documented.** "This is a common theme in inappropriate discharge cases," Colucciello notes.

For most complaints that require diagnostic imaging and lab tests, such as neurological complaints or abdominal or chest pain, "you write a minimum of one follow-up note," Colucciello says. This could be as simple as "Re-examined the patient. Patient appears better" or "Patient smiling and calm, not feeling weak."

Simply put: Whatever the chief complaint was, it is addressed in the repeat exam. "Based on that, you do more tests, consults, admission, observation — or, if the complaint has improved, then discharge," Colucciello says.

Joan Cerniglia-Lowensen, JD, has defended multiple lawsuits in which the patient complained of chest pain, but just a single cardiac troponin is conducted. The patient is discharged without going through follow-up enzymes. "By the time the patient returns, treatment is delayed by several hours," says Cerniglia-Lowensen, an attorney at Pessin Katz Law in Towson, MD.

Sometimes, the ED chart states the patient appeared stable, with no abnormal vitals, no continuing chest pain, an adequate cardiology consult, and adequate follow-up instructions. Even with all this great documentation, the lack of follow-up cardiac enzymes makes for a difficult defense. "Most of these cases are settled," Cerniglia-Lowensen says.

The plaintiff's argument goes like this: If the patient had been in the hospital waiting to submit the next series of enzymes, they would have experienced myocardial infarction (MI) while on a monitor. Therefore, the patient could have been resuscitated. The plaintiff's expert will testify that the nature of the MI was such that it would have been amenable to early treatment, and that the patient could have been moved to the cath lab in time. "That's not necessarily true," Cerniglia-Lowensen says. "But that is the argument."

It is hard to counter assertions about an outcome that could have happened, since it really cannot be disproven. "The deceased patient and their family are a lot more sympathetic than an EP who is being painted as sloppy," Cerniglia-Lowensen observes.

The chart is more defensible if it states there was no abnormal findings suggestive of a cardiac event, with meticulous follow-up instructions given to the patient. "Then, it doesn't look like we are throwing the patient into the great abyss," Cerniglia-Lowensen explains.

Some patients are going to be discharged with abnormal vital signs. For example, many ED patients have high blood pressure; not all can be admitted. "The biggest challenge is patients who haven't seen a doctor in 10 years who come to you with extremely elevated blood pressure, and you are trying to provide appropriate follow-up," Cerniglia-Lowensen says.

For the EP, the best course of action is to treat the patient by giving them a week's worth of medication, and to document a discussion with the patient about the importance of follow-up. Specific names of providers in the area also are helpful.

When a bad outcome happens shortly after the patient leaves the ED, litigation is likely to follow. "You can't insulate yourself from a lawsuit," Cerniglia-Lowensen laments. "What you can do is make sure you are not an easy target." ■

COMING IN FUTURE MONTHS

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'Copy and Paste' Can Legally Compromise Entire ED Record

When information is copied and pasted into the ED chart, it can improve patient care because all providers are aware of the patient's history — or it can legally compromise the entire medical record.

"The most important thing is to recognize that copying and pasting has both benefits and risks," says **Lorraine Possanza**, DPM, JD, MBE, program director of the Partnership for Health IT Patient Safety, a collaborative convened by ECRI Institute. The collaborative developed safe practice recommendations for copy and paste in 2016 and an implementation guide in 2019.[1,2]

"Here we are in 2020, and the issue is still coming up constantly," Possanza laments. "People need to know: This is something I've got to be paying attention to."

These are some pitfalls for ED providers:

• The information pasted into the chart could lead providers to incorrect conclusions. The risk is the provider could mistakenly believe that a note taken from a visit years earlier that summarized a condition is describing the patient's current condition.

"Knowing where the information came from is something to consider," Possanza observes. "If the information was already copied from someplace else, though, it may get muddled."

If the patient has been in the hospital recently, EPs can capture that history so it can be considered during the ED visit. Certain parts of a history do not change: the year a gallbladder or tonsils were removed or the age of the patient's parents when they died. Similarly, a patient may have presented with a complex medical condition that requires a significant amount of associated care. A patient may have been undergoing chemotherapy for the past several months with many complications, and is now presenting to the ED for evaluation of a new complication. "That information can be best captured accurately and completely by copying it from another part of the record," Possanza says.

Used in this manner, copy and paste is "time-saving, and allows you to capture a large amount of complex information," Possanza adds.

If not noted correctly, though, it could be unclear to someone reading the chart later what was happening at the current encounter vs. a previous encounter. "This could lead to a billing problem, a compliance problem, or a treatment problem," Possanza cautions.

If the patient returns to the ED with similar symptoms, pasting the history into the chart and letting it appear as though that is the current presentation "is not going to provide an accurate record," Possanza says. "No one is going to report their symptoms in the exact same way both times."

• EPs may copy and paste something, and inadvertently put it into the wrong patient's chart. This will complicate the defense of any malpractice claim, regardless of whether it had anything to do with the bad outcome. "That impacts your credibility. Once you've lost your credibility, it's very hard to get it back," Possanza says.

"The legal defense issues for copy and paste come up when it casts doubt on the truth of the record. Then, the poison often spreads beyond one single note," says **Michael S. Victoroff**, MD, a consultant on health IT in the department of patient safety and risk management at Denver-based COPIC.

The biggest lesson for EPs, says Possanza, is they need to copy and paste "discriminately." Two questions need to be considered: Is this information important to include? How can the information be attributed to its original author?

If the EP documents "copied from January 2020 hospitalization" or "information from (date)" before the EP's own documentation, there is no confusion. "It is important to add additional information, editing the copied material as needed, so that a complete picture of the current situation is in front of you," Possanza says.

Catherine Vretta, MD, MPH, says it is common practice in emergency medicine to use copy and paste. "Problems arise when it is done without thought," says Vretta, an EP at Ascension St. John Hospital in Detroit.

Not all patients warrant a complete physical exam. A patient with an isolated finger injury probably does not require a complete neurological exam. "When the same detailed physical exam is used repeatedly, it can certainly affect the validity of the entire chart," Vretta says.

If other parts of the record also are copied and pasted, it makes the entire chart look suspicious. "A plaintiff's attorney can then argue that everything is, by default, invalid," Vretta explains.

Ideally, Vretta says EPs limit the amount of clinical information covered in a "normal" physical

exam, and add pertinent positives or negatives as needed. "In this way, each exam will have some additional unique clinical information," she reports.

This would help refute the plaintiff attorney's assertion that every chart appears too similar.

"It also helps to show the physician selected unique components of the particular patient and addressed them," Vretta adds.

An EP may do everything right according to the standard of care. However, if the record shows notes copied from previous visits, "it calls into question whether the record reflects the patient interaction," says **Nathan A. Kottkamp**, JD, a partner at Nashville-based Waller. Even if the patient presentation is similar to a previous ED visit, says Kottkamp, "it's highly unlikely that circumstances will be identical. Therefore, the medical record should not be identical."

The ED medical record serves as substantiation for billing for the services provided. "If the record doesn't distinguish services provided from one visit to another, an insurance provider may reject the claim because of the lack of specificity," Kottkamp explains.

Dean Sittig, PhD, says the most egregious errors involve copying information from Patient A to Patient B.

"This can occur if, for example, an ED doc writes a beautiful note describing a particularly complex procedure — or even a simple procedure, for example, cleaning and suturing of a wound," says Sittig, a professor in the School of Biomedical Informatics at the University of Texas Health Sciences Center in Houston.

The trouble starts when that EP sees a similar case. Rather than rewrite the entire note, the EP copies the note from the first patient's chart and pastes it into the new patient's chart. The EP intends to change all the pertinent details — right to left arm, his to her, 48-year-old to 19-year-old — but it never happens. "The problem arises when the doc misses one or more key elements, and something goes wrong, and the case goes to court," Sittig says.

When the plaintiff's expert or attorney sees this obvious mistake, it is easy to make the case the EP was careless and overworked. "It is difficult to defend those accusations," Sittig says.

The same kind of copy and paste errors happen with frequent ED visitors. The EP decides to save time by copying the history and physical from a previous visit. "The ED doc forgets to change the date or specific issue," Sittig says.

There are many valid reasons for the EP copying something from an old chart. "But one always has to be extremely careful when doing this," Sittig cautions. ■

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Plaintiff Expert Worked in the ED, But Only During Residency Rotation

Sometimes, the expert who is criticizing the EP's care is a physician who never worked a single shift in the ED.

"To hold the EP to the same standard as the specialist who has specific areas of expertise is completely unfair," says **Brandon S. Kulwicki**, JD, an attorney in the Dallas office of Hall Render.

Plaintiff attorneys frequently bring in experts with specific knowledge

from whatever specialty is relevant to the condition that was missed or managed inappropriately. "It's much easier for a specialist to talk about the areas in question because that's what their focus is," Kulwicki says.

When cardiologists are called to consult on an ED patient, they are specifically looking for a cardiac issue. The problem is that at the time the EP saw the patient, he or she had to take the patient as a whole and consider every possible diagnosis.

"Unlike other specialties, emergency physicians don't get to pick and choose the kind of patients or complications that they see," Kulwicki says.

Plaintiff experts allege the EP should have ordered specific tests or conducted a more extensive workup. This may be unrealistic for the ED setting. "A lot of times, the ED doesn't have the ability to order those tests without admitting the patients first," Kulwicki notes.

The expert also has the benefit of hindsight. A cardiologist or neurologist testifying on behalf of the plaintiff already knows the problem that was identified. "Our goal is to educate them that the ED doesn't necessarily have the time or ability to gather all of the facts," Kulwicki explains.

The defense lawyer must explain how the role of the EP differs from that of specialists. "Emergency physicians are making the decision on whether to admit in minutes to hours. This is different from a hospitalist, who has days to treat the patient," Kulwicki observes.

If the plaintiff expert truly never worked in an ED, the defense could try to strike the expert for not holding the requisite qualifications. If that is unsuccessful, says Kulwicki, "you'd want to talk about why the expert's opinion doesn't hold water."

For instance, the defense attorney could tell the jury the EP had to focus on broader things than the specialist would.

"Causation is the same regardless of specialty. But the standard of care may be different because of the level of expertise," Kulwicki offers.

Most plaintiff experts, regardless of their current specialty, can truthfully state they did in fact work in the ED setting at one point in their career.

> "THEY MAY HAVE DONE AN ER ROTATION, BUT MAYBE THEY HAVEN'T BEEN IN THE ER SINCE THEN."

"They may have done an ER rotation, but maybe they haven't been in the ER since then," Kulwicki suggests.

Sometimes, experts talk at length about their presence on the call list as part of their privileges. As part of that role, experts may consult in the ED on all kinds of cases routinely. Jurors will not realize this bears no resemblance to actually working as an EP. Still, the defense attorney can always point it out. "If the expert is not being honest, it's easy to poke at that," Kulwicki says.

The expert will need to admit he or she sometimes is home in bed when called by the EP to consult on a patient, and that the specialist has a base of knowledge that is very different from the EP's. "If the plaintiff brings in a specialist instead of an EP, it's usually because a doctor from that specialty wasn't called. Something was missed," Kulwicki explains.

The best person to refute that kind of testimony is a physician from the same specialty. "That expert can say, 'These are the things I look for, and it's not because I'm a physician but it's because of my specialty," Kulwicki says.

In one malpractice case, the patient came in with classic signs of a heart attack. The EP ordered a cardiology consult, which did not occur until hours later. The patient ended up dying of an aneurysm.

The focus of the lawsuit became whether a quicker consult could have prevented this. The experts disagreed on this point. The defense expert, an EP, contended that even if the patient had been taken back immediately for surgery, the outcome would not have changed. "The expert stated that the doctor met the standard of care in triaging the patient and ordering the consult," Kulwicki reports.

The plaintiff's expert, a cardiothoracic surgeon, said earlier intervention could have changed the outcome. The fact the expert is outside the field of emergency medicine became an issue. "The defense challenged his qualifications as an expert," Kulwicki recalls. "No determination has yet been made." ■

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;
3. Integrate practical solutions to reduce risk into daily practice.

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CME/CE QUESTIONS

1. **In a recent study regarding radiology malpractice claims, the authors found:**
   a. radiologists make most interpretive errors during change of shift.
   b. misinterpretation is alleged in ED claims less frequently than inpatient claims.
   c. a disproportionate number of lawsuits involve the ED.
   d. radiologists who read a high percentage of ED studies make more interpretation errors than those who read mostly inpatient studies.

2. **Which did malpractice claims data from Phoenix-based ED groups show regarding spinal cord emergencies?**
   a. The main problem was emergency physicians (EPs) failed to consider a spinal cord emergency.
   b. EPs did not image the entire spine, so they could not detect multilevel pathology.
   c. EPs were over-ordering spinal MRIs to the detriment of patients.
   d. EPs tended to misdiagnose patients who presented with leg weakness.

3. **Which change was made to prevent delayed treatment of testicular torsion at UMass Memorial Health Care?**
   a. A prompt to document the reason for not obtaining the ultrasound
   b. A policy requiring immediate transfer to a higher level of care
   c. Protocols requiring EPs to obtain consults only if the ultrasound is not obtained
   d. 24/7 ultrasound coverage in the ED

4. **Which is an appropriate practice for copying and pasting in the ED record?**
   a. Bringing in information on a patient's recent hospitalization so it can be considered during the ED visit
   b. Using the same detailed physical examination repeatedly
   c. Aiming to make each ED chart documentation as similar as possible
   d. Copying the assessment from a frequent ED visitor's previous encounter to save time if the current presentation is similar