ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

JULY 2020 Vol. 31, No. 7; p. 73-84

INSIDE

RELIAS MEDIA

Longer Treatment Time Frames for ED Stroke Patients Mean More Potential Plaintiffs

Future stroke-related litigation against emergency departments (EDs) is likely to be fueled by greater numbers of possible plaintiffs, due to updated recommendations for expanded treatment time windows.[1]

"New guidelines do create risk. Our pool of potential candidates is larger, and we are moving faster," says **Bryan E. Baskin**, DO, FACEP, associate quality improvement officer at the Cleveland Clinic Emergency Services Institute and an attending emergency physician (EP) at Fairview Hospital.

The guidelines are relevant to ED litigation that alleges missed stroke or a delayed diagnosis of such. "It's good medically, for better outcomes. But it also creates higher expectations from patients," says **Renée Bernard**, JD, vice president of patient safety at The Mutual Risk Retention Group in Walnut Creek, CA.

Outdated practices in EDs are legally problematic. "ED providers may be hindered by hospital systems and processes that are typically slow to change. This leaves them in a vulnerable position," Bernard explains.

The earliest possible administration of tissue plasminogen activator (tPA) is recommended, assuming patients meet criteria. "This can be used to support plaintiff arguments that the EP should have given tPA without consulting neurology," Bernard offers.

If there is no time to wait for neurology, perhaps because the treatment window is closing fast, it is an easy decision to make. "But if there's more time to wait, emergency providers may choose to do so, and limit their legal risk," Bernard counters.

The problem is that every minute the EP waits for neurology, this delays possible life-saving treatment interventions and could lead to worse patient outcomes. Malpractice claims often center on the fact that a stroke patient came to the ED within the treatment time frame, but treatment was administered too late. "The argument is that had it been offered, the outcome would have been better," Baskin notes.

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: **Arthur R. Derse**, MD, JD, FACEP (Physician Editor), **Michelle Myers Glower**, MSN, BSN, RN, NEA-BC, CNEcl (Nurse Planner), **Stacey Kusterbeck** (Author), **Jonathan Springston** (Editor), **Jill Drachenberg** (Editor), **Leslie Coplin** (Editorial Group Manager), and **Amy M. Johnson**, MSN, RN, CPN (Accreditations Director).

ED LEGAL LETTER

ED Legal Letter (ISSN 1087-7347) is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *ED Legal Letter*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.

GST Registration Number: R128870672.

SUBSCRIBER INFORMATION
(800) 688-2421
customerservice@reliasmedia.com
ReliasMedia.com

ACCREDITATION
Relias LLC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Relias LLC designates this enduring material for a maximum of 1.5 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

Opinions expressed are not necessarily those of this publication, the editors, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

AUTHOR: Stacey Kusterbeck
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS DIRECTOR: Amy M. Johnson, MSN, RN, CPN

More patients are candidates for both intravenous (IV) and intra-arterial tPA, as well as endovascular therapy, due to expanded time frames. This means more potential plaintiffs if ED delays happen. Baskin has seen malpractice cases center on these recommendations:

• IV tPA is indicated within three to 4.5 hours (for select patients) from the last known well time;

• For certain strokes, endovascular therapy is indicated for time frames even beyond 4.5 hours.

Baskin says to limit legal risks, EPs should "make sure to consider therapies beyond IV tPA when the patient is a candidate." This might call for vascular imaging and/or transfer of the patient to a primary stroke center. "Stroke is missed more often in subtle presentations," Baskin adds.

An example would be a patient presenting with dizziness and subtle neurological changes. Other tricky cases are patients with profound changes such as lethargy and aphasia, who are treated as altered mental status cases instead of acute stroke cases. "When strokes are missed or undertreated, attorneys make the case that acute intervention was not considered due to lack of a thorough history and physical," Baskin observes.

The plaintiff expert looks for these things in the ED chart: Identification of risk factors, efforts to establish the last known well time, a thorough neurological exam, and a National Institutes of Health Stroke Scale Score. If any of that is missing, it helps the plaintiff attorney to demonstrate that poor care was given. On the other hand, good documentation on these points could discourage the attorney from pursuing a lawsuit in the first place. "Even under tort reforms where non-economic caps exist, these cases hold high indemnity, as long-term care for stroke is costly," Baskin notes. These are a few issues that arise repeatedly in stroke-related ED malpractice claims:

• ED charts include incorrect time frames for important events. "Time is everything in these cases," Bernard stresses.

The appearance of any kind of delay (in transfer, treatment, or referral) is problematic for the defense. The precise time of an initial exam, a repeat exam, or when someone noted a change in the patient's condition can make or break the outcome of a lawsuit.

Time-stamping in the electronic health record (EHR) appears to be exact, but can be misleading. "Providers should not rely on the EHR technology to time their entries for them. This can lead to inaccuracies," Bernard cautions.

One reason is that EPs often start their documentation at the time of the case, but finalize it hours later. Based on that final timestamp, an egregious delay in care seems to have happened. "Later, when deposed, the provider will recall that there was not a delay in the exam. But there is no evidence in the medical record to support that testimony," Bernard says.

Each individual keystroke is not timestamped, only the time the note was completed. Judges or juries must decide what to believe: the EP's version of events, or what the ED medical record shows. Bernard offers two simple options to clear up the situation: "Providers should be aware of how their EHR timestamps [are entered], or — even better — enter the time themselves as part of their note."

• Family members change their recollection of the last

known normal time during their depositions. "We have seen a cluster of these cases," Bernard says.

Stroke malpractice cases often hinge on the exact time the patient was last seen normal. Plaintiff attorneys use it to prove that the treatment window for tPA ran out during the ED visit.

Defense attorneys use it to show the opposite, that the time frame already ran out by the time the patient arrived at the ED.

"Getting a definitive answer is often difficult," Bernard admits.

Stroke patients' cognition may be abnormal, or family members may be unsure when symptoms first started. To be sure nothing is missed on this crucial point, EPs can consult with colleagues to see if anything relevant was stated or charted at any time during the ED visit.

"Not only is it better clinical care, it is also a stronger malpractice defense to have a medical record documentation in alignment with other providers," Bernard explains.

In one malpractice case, a family member at the bedside gave the last known normal time as 8:00 p.m. The ED nurse documented that time. "At the time of deposition, the family member testified to a different time, which helped the plaintiff's case," Bernard recalls.

No other providers documented the 8:00 p.m. time. At deposition, the family member claimed that onset of symptoms occurred hours later.

The new time put the patient squarely in the treatment window for tPA during the ED visit. The case was resolved with a confidential settlement.

"It would have helped our provider to have corroborating documentation from the bedside nurse or another provider," Bernard adds.

• Some missed stroke claims have involved younger patients who also were intoxicated at the time of the ED visit. "These cases are less common, but they can have devastating outcomes," Bernard says.

An intoxicated patient makes obtaining an initial neurological exam difficult. "Physicians can miss pertinent findings that would create suspicion for a head bleed," Bernard says.

• Delays happen because the ED has limited access to imaging or neurology consults. The problem is the EP cannot determine if a stroke patient is a candidate for tPA or surgical interventions. "Rural treating areas are obvious for these hurdles," Bernard reports.

However, malpractice cases alleging delayed transfer can happen in any ED.

"We also see this in systems if the hospital has outsourced neurology consultation services that may not be as responsive in off-hours or on weekends," Bernard says.

• Charts lack any kind of answers on why a particular test was not obtained. One recent malpractice case involved a patient discharged from an ED with a diagnosis of vertigo. The patient reported blurry vision, eye pain, and dizziness. A head CT revealed no acute abnormalities. The EP noted some mild ataxia with slight unsteady gait, but the neurological exam was otherwise normal.

The next day, the patient collapsed and was brought to another ED. There, staff performed an MRI; stroke was diagnosed. In subsequent litigation, the plaintiff alleged some neurologic deficits, including problems with gait and cognitive function, occurred.

"Ultimately, the patient's condition stabilized. It was vigorously disputed as to what injury and/or loss of cognitive function, if any, was truly suffered by the patient," says **David A. Depolo**, Esq., an attorney with Walnut Creek, CA-based Donnelly Nelson Depolo Murray & Efremsky.

One of the main issues in the case was whether an MRI should have been ordered at the first ED visit, in addition to the CT scan. At the first ED, the ED resident did order an MRI but never was performed because the neurology service deemed the procedure unnecessary. The defense team said it would not have mattered anyway.

"The defense argued that there was no treatment option that would have arrested the further development of problems that occurred," says Depolo, who represented both the EP and hospital.

The plaintiff attorney contended the standard of care required the MRI to be performed at the first ED visit, based on the patient's history and clinical findings. The defense countered that the patient was outside the treatment window for tPA, and that the poor outcome could not have been stopped regardless.

Initially, the EP was the main focus of the litigation. "It morphed into a case against the neurological team, because they made the decision to cancel the MRI," Depolo reports.

The plaintiff's expert, a well-respected neurologist, testified that the MRI should not have been canceled because it would have showed signs of stroke. Also, the neurologist testified that immediate treatment would have minimized the bad outcome. Finally, had the stroke been diagnosed, the neurologist said blood pressure medications (which the ED team decreased) would have been kept at the same level to maintain adequate perfusion, thereby preventing further injury.

"Ultimately, the case settled for an amount substantially below the plaintiff's original demand, and consistent with the costs that would have been incurred had the matter been taken to trial," Depolo says.

The lawsuit focused on why the ordered MRI was canceled. The ED chart was silent on this point, with no documentation of the conversation between the EP and neurologist.

"There was no recall of the discussion, and poor documentation to support the reasoning behind the discontinuation of the MRI order. This would have been immensely beneficial to the case," Depolo explains.

Even a minimal statement such as "Discontinued MRI order, Clinical exam does not warrant study" could have helped the defense. From the EP's perspective, it points to the importance of explaining why a test that was considered never happened.

"If you are going to make an important decision on a study, the reason for your decision-making is always a good thing to document if you can," Depolo says. ■

REFERENCE

1. Powers WJ, Rabinstein AA, Ackerson T, et al. Guidelines for the early management of patients with acute ischemic stroke: 2019 update to the 2018 guidelines for the early management of acute ischemic stroke: A guideline for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke* 2019;50:e344-e418.

Survey Identifies Ways to Improve Transfer of Stroke Patients

If any delays or glitches happen in transferring a stroke patient for time-sensitive treatment and the family sues, a plaintiff attorney is sure to make a huge issue of it.

To learn more about stroke transfer processes, researchers interviewed 45 staffers, nurses, and physicians at three emergency departments (EDs).[1]

"We focused specifically on the organizational aspects of the transfer, because they have received less attention than medical protocols," says **Tim Vogus**, PhD, professor of management at Vanderbilt's Owen Graduate School of Management. Participants explained what specifically made transfers go smoother:

• Protocols that standardize transfer processes, reducing unnecessary communication.

Researchers were struck by "the incredible importance of pre-structuring the interaction," Vogus says.

Auto-accept protocols focused conversations on the most important pieces of information. This way, ED staff did not have to waste valuable time convincing the receiving center to accept the patient in the first place.

• Direct communication with the neurology team at the receiving center.

It turned out that relationships between the sending and receiving centers mattered a great deal. "It's not just about sending a patient to a better-resourced facility," Vogus notes.

A nice rapport between the two people initiating and receiving the transfer sped up the process. "Clear conversation, where there was clarity about what needed to happen, was easier," Vogus explains.

ED staff reported that they rarely, if ever, learned anything about how things went after the patient arrived at the receiving facility. Without post-transfer feedback, the sending ED has no way to know if they made a good decision to transfer the patient. They also will not know if anything they did in the ED helped the patient experience a good outcome.

"This is a missed opportunity for the people working at the transferring center," Vogus says. Some examples of helpful information for the transferring ED:

• data (e.g., test results) that the receiving facility wishes they would have had;

• how long it took for the patient to arrive at the receiving hospital;

• the patient's outcome.

If it took too long to arrive at the receiving facility, Vogus says the transferring hospital could explore alternate modes of transport. Understanding travel times can help everyone learn how that could positively or negatively affect patient outcomes.

The receiving hospital could automatically provide feedback via a link to a report on how things went. "Alternatively, transferring hospitals could opt in to whether they wanted the feedback," Vogus says. ■

REFERENCE

1. Hayes M, Schlundt D, Bonnet K, et al. Tales from the trips: A qualitative study of timely recognition, treatment, and transfer of emergency department patients with acute ischemic stroke. *J Stroke Cerebrovasc Dis* 2019;28:1219-1228.

Analysis Reveals Malpractice Risks When Providing Pediatric Care in ED

Pediatric emergency medicine physicians are at greater risk for malpractice claims than general pediatricians and nonhospital-based pediatric subspecialties, according to the authors of a recent analysis of survey results gathered between 1987 and 2015.[1] "The ED [emergency department] is a 24-hour, fast-paced environment with rapidly changing acuity, no prior physician-patient relationship, and patients who often can't verbalize their symptoms," says **Jonathan M. Fanaroff**, MD, JD, FAAP, one of the study's authors.

Each of those factors contributes to the higher malpractice risk identified in the study. "ED providers may feel that a lawsuit won't happen to them, when in fact lawsuits related to ED care are common," says Fanaroff, a professor of pediatrics at Case Western Reserve University School of Medicine in Cleveland. Staying current, good documentation, and communicating effectively, not only with other healthcare providers but also the patient and family, alleviate legal risks.

"Additionally, not locking into a diagnosis too soon to the exclusion of other potential diagnoses can help decrease the risk of a diagnostic error," Fanaroff adds.

It is important to note that general EDs are, in fact, qualified to take care of children, says **Michael J. Gerardi**, MD, FAAP, FACEP, director of pediatric emergency medicine services for Atlantic Health at the Goryeb Children's Hospital in Morristown, NJ. The vast majority of children are, in fact, cared for in general EDs, which care for both adults and children.[2,3] Gerardi says these practices can help general EDs defend against malpractice litigation — or prevent it in the first place:

• **Designate a champion (ideally, on both the nursing and physician side) who ensures all appropriate pediatric equipment and protocols are in place.** "Every ED really needs a champion for children to keep abreast of the latest developments in pediatric emergency medicine," Gerardi says. "If you don't have that, you're opening yourself up for liability."

For instance, the champions can consult with emergency physicians (EPs) facing tough calls on whether to transfer a child with abdominal pain or acute pneumonia or bronchiolitis.

• **Put transfer agreements in place ahead of time (and staff who are familiar with them).** "It's a simple phone call to get a pediatric patient to a tertiary center, if that's what they require," Gerardi says.

• **Document exactly what is discussed with consultants.** "Once a bad event happens, you can't add the discussion to the chart. It then becomes a 'he said/she said' situation," Gerardi notes. These kinds of specifics can be essential to the defense team: "Talked to GI specialist. Due to the fact that bicarbonate level was low, have decided to transfer." "Kid is smiling, blowing bubbles, and playing with my iPad. Decided to discharge with f/u tomorrow, as discussed with peds GI." "Peds hospitalist examined the child again. We all agreed child can go home."

"That's a bulletproof chart," Gerardi says. "And what does it take you — two minutes?" ■

REFERENCES

1. Bondi SA, Tang SS, Altman RL, et al. Trends in pediatric malpractice claims 1987-2015: Results from the periodic survey of fellows. *Pediatrics* 2020;145:e20190711.
2. Agency for Healthcare Research and Quality. Healthcare Cost and Utilization Project. Statistical Brief #242. Overview of pediatric emergency department visits, 2015. August 2018. https://bit.ly/2XwmqOy
3. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee; Emergency Nurses Association, Pediatric Committee. Joint policy statement: Guidelines for care of children in the emergency department. *J Emerg Nurs* 2013;39:116-131.

6 Common Fact Patterns in Pediatric-Related ED Lawsuits

Certain fact patterns arise repeatedly in malpractice cases involving pediatric patients presenting to the emergency department (ED).

ED Legal Letter interviewed medical/legal experts, who identified and explained six of these patterns:

• The emergency physician (EP) does not consult a tertiary center or specialists, even though the diagnosis is unclear. "Kids have had untoward outcomes because they were not referred in a timely manner to get the specialty care that they need," says **Michael J. Gerardi**, MD, FAAP, FACEP, director of pediatric emergency medicine services for Atlantic Health at the Goryeb Children's Hospital in Morristown, NJ.

In some cases, there is no communication, even when the child was seen recently at the tertiary care center. When the EP needs advice but fails to consult with specialists, says Gerardi, "that's where people get into trouble."

If the EP is unsure whether transfer is needed, contacting specialists always is an option. The idea is to talk through the case and receive a recommendation on whether care can wait or if the child really needs to be transferred right away. "That level of expertise is really widely available now. It's just a matter of picking up the phone and asking for help," Gerardi notes.

• The ED transfers a critically ill child, but it does not happen quickly enough to prevent a bad outcome. "Smaller, rural hospitals are especially at risk, as they are the place of last and first resort for pediatric emergencies," says **Anna Berent**, JD, senior director of claims at MCIC Vermont in New York City.

Often, transfer timeliness is the pivotal issue in pediatric ED medical malpractice lawsuits. "Frankly, these types of claims unfairly impact the ED provider," Berent offers.

An example of this kind of malpractice case involved a 14-month-old patient who presented to a rural hospital ED with vomiting and fever. The EP ordered a CT scan, which took some time to complete and ultimately was inconclusive. "Out of abundance of caution, the physician proceeded to effectuate a transfer to a level I trauma center," Berent reports.

Upon arrival, the infant was in multiorgan failure, and was diagnosed with intussusception. The infant died several days after admission to the receiving hospital.

The plaintiff argued the ED provider should have recognized the infant's acute condition. The lawsuit also alleged the EP should have ordered the transfer without waiting for completion of the imaging studies to avoid delays caused by minimal staffing during off-hours in the smaller ED. "The matter ultimately settled, with the ED physician and radiologist sharing in the contribution toward settlement 60/40, respectively," Berent reports.

Multiple factors contribute to terrible outcomes, some of which are outside the individual EP's control. EPs do not control policies at receiving and transferring facilities, relationships between the hospital and other institutions, or practices used by transportation providers. "As much as the EP is the 'captain of the ship' in provision of care to said pediatric patient, there is an inextricable dependency on the infrastructure," Berent explains.

• The child comes to the ED in the early stages of a life-threatening condition, but it is too early to make the diagnosis. "I've seen a lot of cases with delayed diagnosis of sepsis and bad outcomes," Gerardi says.

At the time of the ED visit, the child does not appear seriously ill. Many present only with mild symptoms and slightly abnormal vital signs. "Then, when they get to a shock level, they crash, and bad things happen," Gerardi adds. It takes time for these dangerous cases to evolve. "You are not going to make every diagnosis in the ED. That's why we admit patients for further workup in the hospital," Gerardi says.

The EP cannot always make the diagnosis at the time of the ED visit. The EP does need to recognize if there is a sudden change, if further workup is needed, or if the child needs a higher level of care. "As an [emergency medicine] physician, that's your obligation," Gerardi says.

In one malpractice case, the EP consulted with a pediatric hospitalist, who recommended giving an oral food challenge. If tolerated, the child would be cleared for discharge. The child kept a few ounces of fluid down, was discharged home, but died four hours later.

Both the EP and pediatric hospitalist were sued. As an expert witness, Gerardi argued the EP was responsible as the physician of record in the ED who made the decision to discharge. The plaintiff attorney argued the hospitalist was legally obligated to come back to examine the child again before discharge. The hospitalist ended up settling.

"If the EP was concerned, the EP should have admitted the kid to the hospital — and then let them discharge the kid if they disagreed with the admission," Gerardi says.

• A parent says the child "just is not acting right," but the child is discharged home from the ED without a clear diagnosis. "If you really can't find anything, it's then incumbent on you to observe them for a longer period. Or, get some help, get a second pair of eyes on them," Gerardi offers.

If the EP is not really sure what is going on, and the parent details concerning symptoms (e.g., intermittent abdominal pain and lethargy), the EP is obligated to work that up, Gerardi says. Sometimes, symptoms disappear altogether during the ED visit. "That's where time is your diagnostic friend," Gerardi notes.

If a child reports three hours of diffuse abdominal pain, but the pain subsides with no tenderness and the child is well-appearing, it is probably reasonable to discharge the child. "You know you have 24 to 36 hours after the onset of symptoms before you have to worry about perforation from missed appendicitis." Gerardi explains.

To guard against worst-case scenarios, the child can be brought back in eight to 12 hours. "That is another diagnostic technique, to bring them back for a re-evaluation," Gerardi suggests.

This requires good communication on an important point: Discharge from the ED does not always mean things are fine. "Just because you're being discharged doesn't mean I won't see you again," Gerardi cautions. "We saw the trailer, but we didn't see the whole movie. That will take time to develop."

Parents hear about specific symptoms that warrant a return visit: for instance, pain that persists after eight hours, or a rash develops. To make this point crystal clear, Gerardi gives parents his cellphone number and tells them, "I want to hear from you tomorrow. If symptoms are abating, then all is good. If things are worsening, I am going to recommend that you come back."

"They are so appreciative that I care and that they have a contact," Gerardi adds.

• Plaintiff lawyers allege a pediatric ED should be staffed with pediatric EPs all the time. Pediatric EDs may be staffed with pediatric EPs some (or most) of the time, but not all the time. This became the entire focus of a recent malpractice case.

A well-appearing newborn with some congestion and mild fever was discharged with instructions to follow up with a pediatrician. The next day, the pediatrician examined the infant, and also sent the infant home. The third day, the child came back to the ED in shock and was immediately sent to the intensive care unit, but ultimately died of myocarditis and overwhelming viremia. "That very bad outcome led to a very public lawsuit," Gerardi notes.

The lawsuit named the EP, the ED group, the hospital, and the pediatrician. A major allegation was the hospital advertised its pediatric ED, but staffed it with general EPs. The pediatrician quickly settled.

That meant a jury did not hear about the fact the pediatrician sent the child home the day after the ED visit. The lawsuit alleged the EP prematurely discharged the child. The defense team obtained an amicus brief from the American College of Emergency Physicians stating general EPs are, in fact, qualified to treat children in a pediatric ED. "This all went to trial, and we won. It was appealed, and on appeal, we won again," Gerardi says. Allegations involving staffing of pediatric EDs can bring the hospital into the litigation. If the plaintiff prevails, says Gerardi, "the hospital could be on the hook for punitive damages, which could be huge."

• EPs conducts only a cursory evaluation of a child referred by a pediatrician or urgent care center. "When a child is referred to you by another venue, you've got to give it even more attention," Gerardi stresses.

In one tragic case, a child was referred to the ED by a nurse practitioner at an urgent care center. "The ED doctor did a cursory exam that showed the belly wasn't tender, and sent the kid home. The kid ended up going into shock and dying," Gerardi reports.

• A child has complained about symptoms (e.g., abdominal pain or neurological issues) for weeks with no answers from other providers. By the time the frustrated, worried parents arrive at the ED, they are going to expect to leave with a clear diagnosis. "If you don't give them a diagnosis, they're going to be enraged — and you can see that coming," Gerardi says.

It is best for the EP to be upfront in these cases. For example, the EP might state, "I am not a neurologist (or GI specialist). I can make sure your child is stable to go home. If not, we will find that out. I will give you a diagnosis plan for you to call one of the best specialists I know."

This way, the parents do not leave the ED feeling as though nothing was done for them. Facilitating outpatient follow-up care is a way to demonstrate the EP cared, and that good care was provided.

The EP could call a neurologist colleague to talk through a relevant case and let the colleague know the child really needs to be seen in the next day or two. "If we can't make the diagnosis, at least we can create and initiate a plan of action," Gerardi says. ■

Poor Outcomes More Likely if ED Is Ill Prepared for Children

Critically ill children die at a lower rate if they present to an emergency department (ED) with a higher pediatric readiness score, according to the authors a recent analysis.[1]

The motivation for conducting the study came from the researchers' own clinical experience.

"As pediatric intensivists and emergency physicians, we noted a variation in care provided for critically ill children at different emergency departments," explains **Stefanie G. Ames**, MD, the study's lead author and a pediatrician specializing in critical care medicine at UCLA Mattel Children's Hospital in Los Angeles.

Previous research showed a large variation in EDs, based on the National Pediatric Readiness Survey.[2] Therefore, it was already clear EDs varied in how prepared they were for children.

"We wanted to determine how it impacted outcomes for children presenting with a critical illness," says Ames, an assistant professor in the division of pediatric critical care at University of California, Los Angeles medical school.

Ames and colleagues analyzed data from 20,483 critically ill children presenting to 426 hospitals. They fully expected pediatric readiness to be associated with better care quality and outcomes. Indeed, that was the case.

"We were surprised by the degree to which presentation to a pediatric-ready emergency department was associated with a decreased, risk-adjusted mortality," Ames reports.

Risk of mortality was four times as likely if the child presented to an ED with low readiness score, compared to an ED with a high score. "These findings support the need for increased pediatric preparedness in some emergency departments," Ames says.

To mitigate risk, Ames says EDs should, above all, follow appropriate evidence-based guidelines.[3] "The guidelines detail the appropriate training, staffing, and equipment needed for quality care of pediatric patients," Ames notes.

The National Pediatric Readiness Project was developed to support the implementation of these guidelines.[4] "This can help hospitals be more prepared to care for pediatric patients as well as meet accreditation goals and decrease liability," Ames offers.

Notably, about half of all ED visits happen in rural and low-volume EDs.[2] "What that means is that the frequency of seeing critically ill children may be few and far between," says **Katherine Remick**, MD, FAAP, FACEP, FAEMS, executive lead for the Emergency Medical Services for Children Innovation and Improvement Center.

Statewide pediatric facility recognition programs identify EDs that adhere to a standard level of readiness for children. The programs are linked to higher pediatric readiness, according to the results of a recent study.[5]

Over the past few years, more hospitals have specialized in stroke, ST-elevation myocardial infarction, and trauma. This kind of specialization is linked to fewer adverse events and lower rates of mortality and morbidity.

"It comes as no surprise that centers that maintain critical pediatric capabilities are going to perform at a higher level," says Remick, one of the study's authors. For EDs, the pediatric facility recognition program is a way to differentiate the care they provide to children. "It's a real nice way for an ED to be recognized, and be able to display signage that speaks to their pediatric capabilities," Remick says.

If EDs are not seeing critically ill children often, it is more difficult to maintain a constant state of readiness. Placing blame on individual ED providers is not the answer. "There's been a real shift in focus from the providers to a system perspective," Remick observes. "Our performance is only as good as what the system was designed to support."

As individuals, ED providers can only do so much. "Regardless of how good a single nurse or physician is, if you're in a system that's broken, it's really hard to achieve high-quality care," Remick laments. ■

REFERENCES

1. Ames SG, Davis BS, Marin JR, et al. Emergency department pediatric readiness and mortality in critically ill children. *Pediatrics* 2020;145:e20200542.
2. Gausche-Hill M, Ely M, Schmuhl P, et al. A national assessment of pediatric readiness of emergency departments. *JAMA Pediatr* 2015;169:527-534.
3. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee; Emergency Nurses Association, Pediatric Committee. Joint policy statement — Guidelines for care of children in the emergency department. *J Emerg Nurs* 2013;39:116-131.
4. Emergency Medical Services for Children Innovation and Improvement Center. National

Pediatric Readiness Project Toolkit. https://bit.ly/2U6bYes
5. Whitfill TM, Remick KE, Olson LM, et al. Statewide pediatric facility recognition programs and their association with pediatric readiness in emergency departments in the United States. *J Pediatr* 2020;218:210-216.e2.

EDs Brought into Litigation Alleging Misinterpreted CT Scans

Misread scans and films are the leading cause of patient injury involving diagnostic radiologists, according to a recent analysis of closed malpractice claims.[1]

"Radiology as a specialty has been experiencing higher-than-anticipated losses," says study author **Darrell Ranum**, JD. Ranum is former vice president of patient safety and risk management at the Doctors Company, a Napa, CA-based medical malpractice insurer, which sponsored the analysis.

More claims and higher indemnity payments were happening than in the recent past. The insurer decided more data were needed. The analysis revealed poor communication between providers was one of the key contributing factors to the lawsuits. "We expected that the communication problem would be between the radiologist and attending physician when reporting important findings," Ranum says.

Those communication breakdowns do occur. But the study showed a different communication problem. Communication between ordering emergency physicians (EPs) and radiologists was problematic. The issue is the ordering EPs are unclear on the reason for ordering the imaging studies. "Radiologists were often left guessing as to what the attending physician was trying to learn," Ranum explains.

The American College of Radiology recommends ordering clinicians include a working diagnosis, pertinent clinical symptoms, and specific questions to be answered.[2] For the emergency department (ED) in particular, Ranum recommends the following:

- EPs should provide clinically relevant information when ordering imaging studies;
- EPs should consider calling radiologists for suspected conditions that are unusual to help radiologists reach accurate findings;
- When radiologists discover serious findings for ED patients, they should call EPs to make sure the information reaches them;
- If the ED patient has been discharged already, radiologists and EPs should determine who will convey the information to the patient's personal physician and/or the patient;
- When receiving calls from radiologists, EPs should repeat the findings to confirm the information was understood.

The analysis also revealed patients themselves contributed to the problem by not showing up for scheduled appointments or follow-up studies. Ranum could not determine why. "We can only speculate that patients either did not understand the findings, did not comprehend the importance of the follow-up studies, or they could not afford to pay for additional studies," Ranum offers.

Radiology malpractice claims in the ED usually are made for one of two reasons, says forensic consultant **Jonathan D. Lawrence**, MD, JD, FACEP. Either the EP misreads the study, and is never picked up by the radiology overread, or the radiologist finds something incidental, but never contacts the EP to recommend a follow-up. "The key to both of these is communication. ERs [emergency rooms] and radiology need an ironclad procedure for X-ray discrepancies," Lawrence stresses.

In some EDs, the EP never sees the actual X-ray and relies solely on the radiology report. "The ER doctor is off the hook as far as misreading the X-ray, but will still be named in the lawsuit," Lawrence explains.

Since the EP had nothing to do with the misread, relying entirely on the radiologist's reading, the defense attorney probably can find a way to dismiss the EP from the litigation. "But nonetheless, time, energy, and anxiety still accompanies being named in the lawsuit," Lawrence cautions.

If the EP reads the X-ray, then the radiologist overreads it, a few things need to happen to reduce risks. The EP's reading needs to be clear to the radiologist. "I have reviewed many charts of ED colleagues where the X-ray reading is not documented. The radiologist can't see it," Lawrence recalls.

If a discrepancy is noted, the radiologist needs to make sure the EP knows about it. The next question is what the EP does about it. If the radiologist picked up a missed fracture for a discharged ED patient, that patient needs to be told about the finding. "Even if it's picked up relatively quickly — the next day — the attorney will say that the delay

caused worsening of the injury," Lawrence reports.

The disclaimer ED discharge instructions typically state radiology will review X-rays and that patients will be notified if there is any discrepancy. "If this doesn't happen, then the hospital is on the hook because of the promise they made to the patient," Lawrence says. ■

REFERENCES

1. Ranum D. Diagnostic and interventional radiology closed claims study. The Doctors Company. https://bit.ly/3071C1Q
2. American College of Radiology. ACR practice parameter for communication of diagnostic imaging findings. Revised 2014. https://bit.ly/304yOH9

Wrong Box Checked in Chart? Common, Careless Error Complicates Defense

An emergency physician (EP) defendant's documentation — specifically, a checked box indicating a baby's lungs were clear — was hotly debated during malpractice litigation. The problem was another box also was checked — one indicating the patient, a six-week-old infant, was "speaking in complete sentences."

"When the infant died unexpectedly a few days later, the error became significant," says **Ashley Dobbin Calkins**, JD, an attorney in the Richmond, VA, office of Hancock Daniel.

The status of the patient's lungs at the time of the emergency department (ED) visit became a central issue in the ensuing litigation. "While everyone could agree the selection was a mistake, it called into question the veracity of other selections in the EMR [electronic medical record], especially when attempting to assess potential causes of death," Calkins says.

The mistake even called into question whether a physical exam had been performed at all. "It made the ED providers look sloppy. It made both their care and the record seem unreliable," Calkins reports.

Andy Walker, MD, FAAEM, has seen two types of discrepancies cause major problems for the ED defense during malpractice litigation. One is a discrepancy between the EP's documentation and nursing documentation.

"The other is between the EP and obvious reality," says Walker, a Signal Mountain, TN-based EP who offers legal consulting services for the defense of EPs.

One ED patient with amyotrophic lateral sclerosis was ventilator-dependent and underwent a tracheostomy. Yet the EP checked a box indicating "normal motor functions."

"Either he never performed the medical exam, and everything else in the medical record can't be believed, or he clicked the wrong box out of habit," Walker says.

In this particular case, the glaring error did not devastate the EP's defense. At trial, the EP defendant was calm and matter-of-fact about how it happened.

"The EP said, 'I just clicked the wrong box.' Even the plaintiff attorney accepted it, and moved on," Walker says. Eventually, the EP was dismissed from the case.

The real issue in this case was an airway problem, one the EP addressed properly. "He clearly knew the patient could not move and could not breathe on his own. There was no doubt about that," Walker notes.

If it was not so clear, the wrongly checked box could have caused major problems for the defense.

"That kind of discrepancy can discredit everything else in the ED record," Walker cautions.

One defense tactic is to elucidate just how common checking the wrong box really is. "If EPs hover their cursor over a text box a couple of millimeters off, they're going to check off the exact opposite of what they intended to document," Walker observes.

The defense attorney can ask, 'Has this ever happened to you?' The defense expert can answer truthfully, "Practically every day. It's an easy mistake to make."

Even so, EP defendants will face questions about their responsibility to ensure accuracy in the ED medical record. "Plaintiffs' lawyers are fond of pointing out that the hospital record is likely to be relied upon by subsequent treating providers who are assuming the record to be correct," says **Jason Newton**, JD, associate general counsel and senior vice president of claims at Raleigh, NC-based Curi.

Further legal complications can happen if subsequent treating physicians relied on an incorrect entry to the patient's detriment. If an ED nurse inaccurately recorded a patient's reported pain to be at a 10/10 (when it actually was reported to be a 2/10), it might seem unlikely to cause any serious issues. Yet if the patient suddenly reports pain at 10/10 at some point after arriving on the floor, the mistake could produce devastating consequences.

"A subsequent provider would not necessarily realize the patient's condition had changed significantly and could require urgent intervention," Calkins explains.

The EP and subsequent providers all could end up as defendants in the same lawsuit. If so, it will not take long for finger-pointing to complicate the case. "The subsequent treaters may claim their actions would have been different, and created a better outcome for the patient, if only the ED provider's note had been accurate," Newton offers. Even if the erroneous information made no difference in the outcome, plaintiffs can use it to bolster their claim. Attorneys can argue the sloppiness carried over into clinical care. "It taints the perception of what level of care the provider gave to that patient. It makes defending the clinical care that much more difficult," Newton says.

That can happen with any kind of egregious ED charting mistakes. In one memorable case, the EP copied and pasted information suggesting the patient was ambulating with a normal gait. ED nurses documented the patient was writhing in pain on the floor.

The plaintiff's lawyer used the sloppy documentation to suggest an inattentive EP was trying to create the appearance of more intimate involvement in the patient's care than actually occurred. "The physician's credibility as to what did and did not happen will be ruined," Newton explains. ■

Transfer Is Issue in Intracranial Hemorrhage ED Claims

At the scene of a motor vehicle accident, paramedics found a young woman unconscious. After she was brought to the emergency department (ED), the patient had a large contusion on her forehead, and was complaining of a headache. Nevertheless, she was alert and talking.

The treating emergency physician (EP) knew a CT scan was needed, but the scanner was out of service. It is unclear exactly when this important diagnostic test was going to be available.

"This is a dilemma for the ED physician. Although the patient is stable at the time, the patient can rapidly deteriorate," says **Susan Martin**, RN, JD.

The EP has only two choices: Transfer the patient to a facility with an available CT scanner, or wait for the out of service scanner to go live again. Calling a neurosurgical consult is not going to help much.

"The neurosurgeon is going to ask, 'What did the CT indicate?'" says Martin, executive vice president of litigation management and loss control in the Plano, TX, office of AMS Management Group, a medical professional liability insurer.

In this kind of situation, Martin says EPs must consider:

- whether the current facility's neurosurgical care and operating rooms are available if the patient deteriorates;
- the anticipated time frame for CT scans to be available at the current facility;
- whether the ED patient is stable enough for immediate transfer.

Martin says calling another facility and transferring the patient emergently is the most appropriate action. "If the patient has a sudden event in the ED, and evacuation of a hematoma or other brain surgery is immediately needed, neuro will want an emergent CT and operating room," Martin says.

Since the CT is the most definitive diagnostic test, sending her to a facility with a functional machine should be the first priority, says Martin, adding that loss of consciousness in the field and complaints of headache are concerning. "If she is not transferred, and the patient deteriorates with a neurological deficit, a lawsuit then follows," Martin cautions.

Allegations would include delay obtaining a CT scan, failure to obtain consultation, and inappropriate monitoring in the ED. Martin has reviewed multiple cases in which patients did not transfer from a community hospital. In those cases, the patient deteriorated, and no operating room was available. The plaintiffs all alleged the same thing: The EP failed to transfer the patient to a higher level of care.

The EP defendant is going to have to answer this question: "What would you expect from a same or similar facility in this situation?"

"That is always a question raised by plaintiff attorneys, whether to a witness, to the defendant, or in closing arguments to the jury," Martin observes.

Usually, the defense's argument is the patient was not stable for transfer, and the ED was waiting for the neurosurgeon to come see the patient and make the final determination on transfer.

"This is not a good position for the ED physician," Martin argues. ■

ED LEGAL LETTER™

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Log on to **ReliasMedia.com** and click on My Account. First-time users must register on the site. Tests are taken after each issue.

3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be emailed to you.

CME/CE QUESTIONS

1. **Which is true regarding recommendations emphasizing the need for early stroke treatment?**
   a. There are fewer potential plaintiffs because fewer people are candidates for intra-arterial tissue plasminogen activator (tPA).
   b. Allegations that the emergency department (ED) failed to offer endovascular therapy are harder to prove.
   c. ED providers have less legal exposure because delays now are closely tied to staffing problems.
   d. It is easier for plaintiff attorneys to argue the emergency physician (EP) should have given tPA without consulting neurology.

2. **Which should ED providers do to reduce legal risks?**
   a. Rely on electronic health records to time their entries.
   b. Enter times of actions themselves, as part of their note.
   c. Avoid asking colleagues what family members told them about symptom onset.
   d. Omit charting any specifics on why diagnostic tests under consideration were not obtained.

3. **How can EPs reduce legal risks involving pediatric care?**
   a. Consult specialists if the child was recently seen at a tertiary care center.
   b. Make a point of giving worried parents a diagnosis before they leave the ED.
   c. Wait for any ordered studies to be completed before transfer.
   d. Acknowledge at deposition that pediatric EDs should be staffed with pediatric EPs.

4. **Which is true regarding litigation focusing on misread CT scans, according to an analysis of closed malpractice claims?**
   a. Failure to report important findings was not a contributing factor in the lawsuits.
   b. Ordering EPs often were unclear on the reason for imaging studies.
   c. Calls to radiologists about unusual suspected conditions caused misreads due to anchoring bias.
   d. Giving too many specifics on the patient's clinical situation resulted in misreads.