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Assessment, Documentation, and Protocols: All Tied to ED Malpractice Payouts

Malpractice claims are more likely to succeed if documentation is insufficient, if an assessment was inadequate, or if something was not handled according to policy or protocol, according to the authors of a recent analysis.¹

In all care settings, including the ED, “these particular issues increase the odds for closing with an indemnity payment,” says **Jock Hoffman**, senior editor at Boston-based CRICO.

Researchers analyzed 37,000 claims and lawsuits from the CRICO Strategies’ Comparative Benchmarking System. Of the 3,081 cases that involved the ED, about 8% included a policy or protocol as a contributing factor. Some case examples:

- The emergency physician (EP) read a chest X-ray and discharged the patient. Later, the radiologist identified pneumonia, but did not follow the notification protocol. Neither the patient nor the EP was informed. The patient died of pneumonia.

- No one informed an EP, per hospital policy, of positive blood culture results that returned after discharge, resulting in the patient’s death.

- A patient leaving the ED against medical advice was not asked to sign the required paperwork.

Almost three-quarters of the claims involved a patient assessment as a contributing factor. Some case examples:

- ED providers failed to consult cardiology to assess a patient’s chest pain. The patient later died of cardiac arrest.

- A patient with chest pain never received a cardiology consult, despite symptoms that went unrelieved during the ED visit. Thus, everyone missed acute coronary syndrome.

- An EP focused on kidney stones as the cause of the patient’s symptoms. The EP failed to review the chest X-ray or consider worsening symptoms, including back pain, and missed an aortic dissection.

- A 45-year-old patient died of sepsis after a work up for flu-like symptoms.

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The EP failed to order a lactate blood test, which the plaintiff attorney alleged would have raised concern for sepsis.

Insufficient documentation was a contributing factor in 12% of the ED cases. Some case examples:

- The plaintiff was discharged with a diagnosis of urinary tract infection, perineal/rectal pain, and urinary retention, and died of postpartum sepsis. An ED provider later stated the patient had refused admission, but no one had documented this in the chart.

- An ED patient's popliteal artery injury was misdiagnosed. In part, this was because of inadequate documentation of numbness and tingling and failure to review emergency medical services notes, which described symptoms of vascular compromise.

- An EP diagnosed stroke, but there was nothing in the ED chart showing that tissue plasminogen activator was considered.

Diagnostic failure in the ED often can be traced to an incomplete picture of the patient's presenting story. Both the physician and the nurse know some information. "But if they aren't communicating, the full picture does not come together in a way that fully supports the diagnostic process," says **Dana Siegal, RN, CPHRM, CPPS**, director of patient safety for CRICO Strategies.

Misdiagnosis also can be linked to a failure to document. "It is important to recognize that in the age of the electronic medical record, documentation is a primary form of communication, especially in the ED," Siegal stresses.

The nurse takes vital signs and notes a decline in the patient's condition. But the nurse is interrupted and forgets to chart the information. Sometimes, the

problem is the ED nurse does not give the information verbally to the attending EP, who does not view the nursing documentation until the patient is discharged. "Failure of team interaction and communication, or missed information or failure to access available information, are the most common drivers of assessment failures," Siegal explains.

To mitigate this and improve team communication, Siegal suggests EDs focus on:

- clearly defined expectations of communications between EPs, ED nurses, and other ED patient care associates;
- diagnosis and discharge huddles, during which team members can convene in person to review cases before a diagnosis is made, or before the patient is discharged;
- chart reviews to assess documentation processes and identify trends in ineffective documentation (e.g., checking for consistent documentation of discharge vital signs taken at discharge);
- review of cases that show the link between documentation failures and problems with patient assessment.

"ED leadership should consistently encourage staff to identify appropriate cases for debrief and/or case review as a standing learning methodology," Siegal offers.

EDs must ensure policies and protocols reflect actual staff capabilities and available resources. For instance, some policies do not take into account that availability of services such as radiology or ultrasound may be different on weekends, nights, or holidays.

"While it is imperative to recognize the use of workarounds by staff, it is equally important to understand the underlying system issues that create the workarounds," Siegal notes.

Failure mode and effects analyses and root cause analyses can determine if policies are followed inconsistently, and, if so, why.

“Determining if it is staff choice or system failure when policies are not adhered to will determine the

appropriate intervention,” Siegal says. For example, some policies state an ED nurse is supposed to accompany patients admitted to the ICU. “With limited night resources, an in-person handoff may not be feasible,” Siegal adds. ■

REFERENCE

1. CRICO Strategies. *The Power to Predict: Leveraging Medical Malpractice Data to Reduce Patient Harm and Financial Loss*. CRICO 2020 CBS Benchmarking Report. <https://bit.ly/2ELXziK>

Essential ED Documentation Often Missing from Chart

Certain pieces of information, if omitted from the ED medical record, instantly raise concerns about the quality of the care provided.

These missing items in particular complicate malpractice defense, according to **John Tafuri, MD**, FAAEM:

- **Vital signs that were taken at the beginning of the ED visit.**

“When I look at a chart, I look at the vital signs first. That gives me an idea how sick somebody is in a general way,” says Tafuri, regional director of emergency medicine at Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland.

If Tafuri sees vital signs are missing from the ED chart, he asks the ED nurse about it. Sometimes, nurses obtained the vital signs but just forgot to document them. “It’s surprising how often things like that are missing from the chart,” Tafuri says.

Depending on specific allegations in the lawsuit, missing vital signs can appear suspicious. A chart without a pulse oximetry level in someone presenting with shortness of breath, or no temperature for a patient who died of sepsis, are “very problematic,” Tafuri cautions. “That’s a big issue, because it directly relates to the problem and the complications.”

- **The fact the patient was informed of incidental findings.**

In one case, the EP noted a nodule

on a woman’s chest X-ray, and documented it in the ED chart. “But there was no documentation that the patient was informed,” Tafuri notes.

Subsequently, there was a lawsuit alleging delayed diagnosis of cancer. The plaintiff attorney insisted the EP never mentioned the worrisome finding. The EP insisted he had told the patient and her husband about it. “A year into the litigation, during his deposition, the husband eventually admitted the EP did tell them about it,” Tafuri relates.

This came as a big surprise to the plaintiff attorney, who had by that time invested thousands of dollars pursuing the claim. The lawsuit hinged in large part on the EP’s alleged failure to inform the patient of the incidental finding, which turned out to be a false allegation. The case was dismissed days after the bombshell testimony. “Interestingly, the plaintiff probably had a cause of action against the follow-up physician. But, because of the poisoning of the case, everyone was dismissed,” Tafuri says.

Plaintiffs may not always tell their attorneys the full story. “They then get nervous under oath, and tell the truth,” Tafuri observes.

In this particular case, if the EP had simply documented that the patient was informed, it is likely no malpractice lawsuit would have

happened in the first place. “It’s extremely difficult to say the patient was never informed when it’s in the discharge instructions,” Tafuri explains.

If the finding has nothing to do with the reason the patient came to the ED, it is easy to put off a discussion. That is why whenever an incidental finding requiring follow-up is noted, Tafuri documents it in the discharge instructions without delay. “As soon as you see it, you put it in. Otherwise, you’re likely to forget,” Tafuri says.

- **The ED chart does not indicate the patient’s chief complaint ever was addressed.** In one malpractice case, the plaintiff was a young man who was in a bicycle accident a few days earlier. The ED chart noted a chief complaint of left calf pain. The nurse practitioner (NP) documented a detailed examination of the patient’s knee, but made no mention of the calf pain. The patient died of a pulmonary embolism shortly after the ED visit.

“The NP never addressed the chief complaint that was clearly documented in the medical record — in big letters in the chief complaint box,” Tafuri says. The claim settled for an undisclosed amount before trial.

- **The EP does not address conflicting statements made by others.** “It’s important to address

everything that's in the chart by other providers that you do not agree with," Tafuri stresses.

ED nurses may chart the patient has peritoneal signs or rebound tenderness. If Tafuri disagrees, he charts, "Nurses notes noted."

"That gives me license to say, in the event of some type of legal proceeding, that I saw what the nurses wrote, but I disagreed — on my exam, it wasn't there," Tafuri offers.

• **Abnormal vital signs are noted, but go unexplained.** "Plaintiff attorneys can use this to show that there is disorganization or that you missed something that someone else picked up on," Tafuri says.

This often happens at discharge. ED nurses chart a vital sign that clearly is abnormal. It could be there is a good explanation. For instance, a bronchodilator might be causing a patient's tachycardia. "Document that you noted the vital signs and your

explanation for the abnormalities — and why you felt that it was still OK to discharge the patient," Tafuri suggests.

Many times, there is no explanation in the chart on what the EP was thinking at the time. It appears as though the abnormal finding was ignored. "It's important to acknowledge things that could make it appear that the plaintiff was sicker than they really were at the time," Tafuri says. ■

Many Charts Lack Any Evidence of Thorough H&P

Often, a portion of the history, assessment, or evaluation was handled, but for whatever reason does not make it into the emergency medicine (EM) record. "A thorough H&P, simply stated, is often lacking in EM charts," says **Bryan Baskin**, DO, FACEP, assistant professor of medicine at Cleveland Clinic Lerner College of Medicine and associate quality improvement officer for Cleveland Clinic's Emergency Services Institute.

This makes it appear as though a poor or incomplete assessment was conducted. Baskin often sees ED charts missing these important items:

• **Review of risk factors for coronary artery disease, acute coronary syndrome, pulmonary embolism (PE), stroke, or spinal infections.** For instance, if PE is on the differential, Baskin says the chart

should show the EP reviewed PE risk factors, and used a decision rule such as the Pulmonary Embolism Rule-out Criteria (PERC).

• **Specific exams that are relevant to the patient's chief complaint.**

No evidence of abdominal and vascular exams in a patient with chest pain or no evidence of a thorough neurological exam in a patient with headache can lead to legal trouble.

• **Medical decision-making.**

Many charts lack appropriate rationale for the care that was rendered, or any insight on why the EP decided on a specific workup, treatment, or disposition. "This is an area where ED charts typically fall short," Baskin observes.

• **Reassessments.** "These are an important part of EM charts. They show thoroughness," Baskin says.

Examples include repeat abdominal,

respiratory, or neurological exams. These often are completed, but are not documented, so it is questionable whether they occurred.

• **Discharge instructions.** Many charts are light on specifics. Nowhere does it indicate exactly who, where, and when the patient should be following up. This can be stated simply, according to Baskin. For example, the EP might chart: "Follow up with cardiology in one week's time."

Charts also omit specifics on signs and symptoms to watch for, and what should bring them back to the ED in a hurry. Baskin likes to see specifics such as "If headache reoccurs, changes, or worsens, or you develop weakness or numbness."

"Interestingly, in many medical cases, the discharge instructions are a highly reviewed portion

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of the medical review,” Baskin reports. Demonstrating that a good assessment was conducted can be more challenging if the ED visit is brief. Leaders view a short length of stay positively, an indication of efficient processes and good patient flow.

“However, in the event of a bad outcome, a plaintiff may later allege a short length of stay means the evaluation was rushed or incomplete,” says **Melanie Heniff**, MD, JD,

FACEP, FAAP, assistant professor of clinical emergency medicine at Indiana University School of Medicine.

Good documentation of discharge instructions shows the opposite was true. “The chart should convey that enough time was spent with the patient,” Heniff offers.

The discharge instructions should show the EP explained what the patient needed in terms of further evaluation and treatment, even

though this was not immediately necessary at the time of the ED visit.

Some ED patients are initially described as “in distress” or “ill-appearing,” but eventually improve enough to be discharged. For these patients, documentation of re-assessment and improvement (in symptoms and in abnormal vital signs) is “critical,” according to Heniff. “This is particularly true when a patient is in the ED for a long period.” ■

Telehealth Booming in EDs, but Poses Some Unique Liability Risks

Since the COVID-19 pandemic began, “there has been a dramatic uptick in the use of telemedicine in the ED,” says **Angela Russell**, JD, managing partner in the Baltimore office of Wilson Elser.

EDs are using telehealth for screening visits before arrival or for follow-up re-evaluations on COVID-19-positive patients.¹ Expanded coverage and relaxed requirements allowed for reimbursement of these visits.^{2,3} At both the state and federal levels of government, some changes are expected to become permanent.^{4,5}

“It appears that medical-legal risk to the provider and hospital is still relatively low, assuming that the provider is making every effort to meet the standard of care,” says **Adam Hennessey**, DO, an EP at Our Lady of Lourdes Medical Center in Camden, NJ.

The standard of care remains the same whether the ED provider is seeing a patient in person or virtually. “If a provider is unable to perform a virtual evaluation that is essentially equal to that of an in-person evaluation, and subsequently fails to refer the patient to an in-person clinical setting, then he or she has

potentially breached the standard of care,” Hennessey explains.

It is important to know what can be excluded safely in a telemedicine consult, and what requires urgent and/or emergent in-person follow-up. “As clinical conditions become more complicated, the risk to the provider would theoretically increase, and also would make telehealth evaluation more difficult,” Hennessey says.

Richard Cahill, JD, sees these specific liability risks for hospital-based telehealth providers, including those in the ED setting:

- insufficient confirmation of patients’ identity;
- incomplete history-taking;
- inadequate visual examinations;
- the possible inconsistent nature and extent of triaging (by both administrative and professional staff);
- deficient charting, discharge instructions, and follow-up instructions.

“Above all, practitioners must appreciate that telehealth encounters are evaluated by the same community standard applicable to traditional onsite visits,” says Cahill, vice president and associate general counsel for The Doctors Company.

Russell says there are certain risks unique to the ED when it comes to telehealth. These include an inability to attend to serious conditions as quickly as would happen during an in-person ED visit, failure to appreciate presenting symptoms, and performing a telemedicine exam when it should have been performed in person given the patient’s condition.

When using telemedicine for ED encounters, Russell says liability risks can be minimized with proper screening. Some patients may need to be seen in person for an ED provider to adequately assess them. “Failure to do so could be considered malpractice,” Russell cautions.

On the other hand, some known ED risks can be lowered with telemedicine. “This assumes the patient can be adequately treated virtually, and that they do not need to be seen in person,” Russell explains.

ED wait times declined with a hybrid telehealth program at one hospital.⁶ Offering telehealth at odd hours decreased the number of patients who leave without being seen, according to a study at an urban academic ED.⁷ Telemedicine consults speeded interhospital

transfers for severely injured patients.⁸ Telehealth also shortened wait times for behavioral health patients at rural EDs.⁹

Notably, all these studies were conducted well before the COVID-19 pandemic. “This is a trend in medicine that has been gaining interest over the past decade, to address ED concerns such as wait time, congestion, and adequacy of treatment,” Russell says.

To reduce liability risks of telehealth, Cahill encourages EDs to develop policies and procedures for determining the types of circumstances and conditions appropriate for virtual care. Mandate healthcare providers to follow specific requirements in preparation of every encounter (such as chart review, if possible). Adopt guidelines to be used during the patient evaluation to comport with community standards for history, diagnosis, specialty referrals, pre-procedure informed consent, refusal of care, medication prescriptions, and post-visit instructions. Finally, establish clear directions for documentation created as a result of any telehealth visit.

ED staff fielding phone calls should be trained appropriately on which individuals should be directed immediately to an in-office visit, urgent care, or the ED, or to hang up and call 911 without delay. “Healthcare providers should perform a similar function as additional information is obtained during their

virtual encounter concerning the patient’s medical condition, and as the degree of exigency becomes better understood,” Cahill offers.

This could minimize potential liability exposure in the event of an adverse outcome. It may reduce the likelihood of other risks, too, such as an administrative investigation by a state medical board for infractions of licensing laws, an inquiry by federal regulatory agencies for compliance violations, civil litigation seeking monetary damages for professional liability, a report to the National Practitioner Data Bank, or a CMS billing audit that could lead to sanctions.

Cahill says ED telehealth policies “should be periodically reviewed and audited for purposes of consistency, uniformity, and compliance with the prevailing standard of care for facilities similarly situated in the community.” ■

REFERENCES

1. Chou E, Hsieh Y, Wolfshohl J, et al. Onsite telemedicine strategy for coronavirus (COVID-19) screening to limit exposure in ED. *Emerg Med J* 2020;37:335-337.
2. Weigel G, Ramaswamy A, Sobel L, et al. Opportunities and barriers for telemedicine in the U.S. during the COVID-19 emergency and beyond. KFF Issue Brief, May 11, 2020. <https://bit.ly/3gSzAvl>
3. Centers for Medicare & Medicaid Services. Trump administration proposes to expand telehealth

benefits permanently for Medicare beneficiaries beyond the COVID-19 public health emergency and advances access to care in rural areas. Aug. 3, 2020.

<https://go.cms.gov/3jGoMmc>

4. Guth M, Hinton E. State efforts to expand Medicaid coverage & access to telehealth in response to COVID-19. KFF Issue Brief, June 22, 2020. <https://bit.ly/2QQxqSK>
5. Verma S. Early impact of CMS expansion of Medicare telehealth during COVID-19. Health Affairs Blog, July 15, 2020. <https://bit.ly/3i3a73O>
6. Reddy S. Can tech speed up emergency room care? *The Wall Street Journal*, March 27, 2017. <https://on.wsj.com/355q9qd>
7. Rademacher NJ, Cole G, Psoter KJ, et al. Use of telemedicine to screen patients in the emergency department: Matched cohort study evaluating efficiency and patient safety of telemedicine. *JMIR Med Inform* 2019;7:e11233.
8. Mohr NM, Vakkalanka JP, Harland KK, et al. Telemedicine use decreases rural emergency department length of stay for transferred North Dakota trauma patients. *Telemed J E Health* 2018;24:194-202.
9. Fairchild RM, Ferng-Kuo SF, Laws S, et al. Telehealth decreases rural emergency department wait times for behavioral health patients in a group of critical access hospitals. *Telemedicine J E Health* 2019;25:1154-1164.

For EDs, Simulation Is Not Just for Training, It Is a Risk Management Tool

Some procedures are high-risk, but low-volume. Thus, ED staff need to find a way to keep rarely used skills current. “Skills deteriorate with time. If you don’t use them, you

definitely lose them,” says **Barbara M. Walsh**, MD, director of pediatric emergency medicine in situ and mobile outreach simulation at Boston Medical Center.

For EDs, “simulation is an obvious source of risk mitigation,” says **Stephanie Stapleton**, MD, assistant professor and director of emergency medicine simulation at Boston

University School of Medicine.¹ Unlike EDs, simulation is used commonly in OB/GYN, anesthesia, and surgery. Multiple studies have shown reduced malpractice risks in those fields.²⁻⁵ When it comes to linking simulation to lower liability, “other specialties are way ahead of emergency medicine,” Stapleton observes.

Simulation is a way for ED providers to practice uncommon procedures such as intubation, central lines, umbilical vein catheters in neonates, cricothyrotomy, pericardiocentesis, pediatric resuscitation, and vaginal deliveries. Heart attacks and strokes are commonplace in EDs. “But critically ill kids are few and far between,” Walsh notes.

Most children present to general EDs.⁶ True critical emergencies in pediatrics are uncommon, even at children’s hospitals. “If we don’t keep up those skills, we aren’t going to be prepared and ready when a really critically ill child comes,” Walsh warns.

The health system’s malpractice insurer helped fund a state-of-the-art simulation center so ED providers could practice low-volume, high-risk procedures. “If a bad outcome happens, we can help the team figure out how to investigate it and prevent it from ever happening again,” Stapleton reports.

Of course, not all EDs have access to a fully staffed simulation center. “There are huge simulation labs that are very fancy, but it’s not what everybody needs,” Stapleton explains.

EDs can make do with a mannequin, an available resuscitation room, and a skilled debriefer. “It’s not perfect, but it’s good enough,” Stapleton adds.

The right mindset is more important than access to specific

resources. “You need to have a culture [in which it is] OK to practice rare procedures and reflect on your mistakes in a meaningful way,” Stapleton says.

The importance of simulation to reduce risks is underscored because many community hospitals closed their pediatric and obstetric units.^{7,8} This means EPs need to independently manage these patients, and stabilize for transfer. “This is within our scope of practice. But sick children and obstetric emergencies are high-risk and low-frequency events,” Stapleton says.

Most academic centers use simulation, as it is standard practice for trainee and student education. “Community EDs use simulation variably,” Stapleton reports.

Some do not use any simulation; other EDs use it in a limited way for nursing or procedural skills. A few EDs run simulation cases. “Simulation is really a huge part of medicine for education and training,” Walsh says. “But its most powerful use is risk management and safety.”

This distinction becomes important when justifying an investment of time and money in simulation. “No one wants to pay for training and education. But if you call it risk management, which is really what it is, that changes how people look at it,” Walsh offers.

At Boston Medical Center, simulations are conducted in the trauma bay several times a month. “We run very high-level cases that really tax our systems. It makes us think about how we designed our rooms, or if something isn’t right or is missing,” Walsh explains.

Cases cover neonatal, pediatric, adult, obstetrics, and airway emergencies.

“With simulation, we are able to look at where errors might occur,

where things didn’t happen that should have,” Walsh says.

The ED team finds the deficits, and makes the necessary changes. “The goal is to have a good outcome for any type of patient who walks through the door,” Walsh adds.

There are some issues that were identified in simulated cases:

- **ED providers cannot give fluid or antibiotics as quickly as needed to a pediatric patient.** “They are not thinking about how to maintain access, or not prioritizing things in the right order,” Walsh suggests.

- **Some EDs are unprepared for deliveries with complications.** “Deliveries in the ED are a high-risk area for liability,” Walsh notes.

Walsh is developing a simulation of a dual resuscitation of a mom and baby who both need resuscitation simultaneously. EPs in rural areas rarely see women who deliver with complications. EDs in large academic centers see these cases more often. “But we have obstetric and pediatric colleagues to help us, so we rarely handle these cases solo,” Stapleton explains.

- **Some EDs cannot administer a large volume of fluid to a septic child quickly.** Many ED providers assume they can put fluids in a pump like they do with adults. “If you just run the fluids, the child is not going to do as well,” Walsh cautions. “We teach them to use a three-way stopcock, and it’s key to resuscitating that kid.”

- **Supplies take too long to locate.** In one simulated case, nobody could locate the Magill forceps to remove a foreign body from a child’s airway. In another case, an intraosseous device was needed to resuscitate a critically ill patient, but it was locked up in the automated medication dispenser. Staff needed to pull the item, then rush back to the

trauma bay. “That is inefficient and adds to the stress,” Walsh says.

The solution was simple: stock the device on the code cart. Another identified problem involved a medication that took too long to make up. “There might be a different medication they can use to buy time while the drip is made up,” Walsh suggests.

• **Communication is too vague.** “Simulation isn’t just for muscle memory and hands-on stuff. It’s also used for how to communicate,” Stapleton says.

Teams find some things do not work as well as they assumed. Something stated was not heard, was too vague, or was misunderstood. A page is not sent appropriately to the OB team during a neonatal resuscitation, or verbal orders are unclear. In one case, the EP asked a nurse to turn the sedation “up,” but the nurse heard “off.” The EP saw the problem and pointed up, stating “Increase.” This led to the use of “increase” instead of “up.”

During a simulated resuscitation, a nurse stated, “I need epi.” Several team members looked for the drug simultaneously, while others did not react at all. The problem was the nurse needed to identify a certain person to find the epinephrine, and instruct them what to do next.

Good communication would sound something like this: “Jill, I need you to get me code dose epi.” “I have the epi. Do you want me to push it?” “Yes, I want you to push it.” “OK, the first dose of epi is in.”

“This gets everybody on the same page during the resuscitation,” Walsh says.

During another simulated resuscitation, multiple people on the team were unclear on whether certain medications had been given, and if so, when. “The team members need to state what they think is going on,” Walsh stresses.

For instance, if a patient is in septic shock, some team members might wrongly assume they are dealing with a pneumonia patient with stable vital signs. A team member should state clearly, “This is uncompensated septic shock.”

“That changes the whole focus. It means the patient is critically ill, and we have to act now,” Walsh says.

Ideally, simulation keeps terrible mistakes from happening in the first place.

“Simulation might cost tens of thousands upfront, but it could help you avoid a \$20 million payout in the future,” Stapleton says. ■

REFERENCES

1. Walsh BM, Wong AH, Ray JM,

et al. Practice makes perfect:

Simulation in emergency medicine risk management. *Emerg Med Clin North Am* 2020;38:363-382.

2. McCarthy J, Cooper JB. Malpractice insurance carrier provides premium incentive for simulation-based training and believes it has made a difference. *Anesthesia Patient Safety Foundation Newsletter* 2007:22. <https://bit.ly/3hKzWpt>
3. Ecker E, Moller J, Lagnese J, et al. A twofold approach: Integrating simulation and risk management training. *Obstetrics & Gynecology* 2016;127:415.
4. Riley W, Meredith LW, Price R, et al. Decreasing malpractice claims by reducing preventable perinatal harm. *Health Serv Res* 2016;51:2453-2471.
5. Hanscom R. Medical simulation from an insurer's perspective. *Acad Emerg Med* 2008;15:984-987.
6. Ames SG, Davis BS, Marin JR, et al. Emergency department pediatric readiness and mortality in critically ill children. *Pediatrics* 2019;144:e20190568.
7. Hung P, Kozhimannil KB, Casey MM, Moscovice IS. Why are obstetric units in rural hospitals closing their doors? *Health Serv Res* 2016;51:1546-1560.
8. Chang WW. The rapidly disappearing community pediatric inpatient unit. *The Hospitalist*, July 12, 2018. <https://bit.ly/3buc0nR>

Lawsuits Allege Abnormal Findings Were Missed After ED Patient was Admitted

Some malpractice lawsuits allege significant incidental findings discovered after discharge were never communicated to patients.

“With more and more imaging being done, it’s become more prevalent. It’s a huge patient safety issue,” says **Alan Lembitz**, MD, chief

medical officer at COPIC, a Denver-based medical professional liability insurance provider.

Many EDs have created fine-tuned processes to keep this from happening. “We don’t miss many of those because we’ve been harping on our EPs so much to say, ‘This is the

only chance this person will ever get to find out they’ve got an incidental nodule or lesion that needs further workup or surveillance,’” Lembitz explains.

COPIC instructs its ED clients to give patients the imaging disk when possible. At a minimum,

patients should receive the results and instructions on how and why to follow up.

“Our ED doctors are getting that message and are doing very well,” Lembitz reports.

Education on structured handoffs and closed loop communication “is bearing fruit for people discharged from the ED,” Lembitz notes.

However, malpractice claims are occurring with admitted patients. The fact patterns all are similar: Tests are ordered while the patient remains in the ED. Results come back after the patient is upstairs — and no one ever follows up.

One such lawsuit involved a patient whose CT scan showed acute appendicitis and a renal lesion. The patient underwent a successful appendectomy, went home, and attended a postoperative follow-up visit with the surgeon — and never heard anything about the renal lesion.

A year and a half later, the patient was diagnosed with advanced renal cell carcinoma.

“The assumption is: I admit you for sepsis, appendicitis, or another acute condition, and the subsequent accepting surgical or hospital service is going to look back on all the tests in the ED that I did. And they don’t,” Lembitz observes.

The patient is physically upstairs and out of the ED. The EP believes the admitting physician is going to see the incidental findings and inform the patient at some point before discharge. In reality, only the findings pertinent to the hospitalization are discussed.

“Surgical services manage the surgical problem. They don’t always look back and see an incidental finding from a test ordered in the ED,” Lembitz notes.

COPIC has seen multiple recent cases of missed cancer where neither

the hospitalist nor the surgical service caught significant incidental findings from tests ordered in EDs. “In the heat of being admitted for their primary diagnosis, these other things just don’t come up,” Lembitz shares.

EPs do not handle discharge summaries with patients who are admitted. “That step is omitted. We are trusting somebody down the line,” Lembitz says.

The assumption is that if something is in the EMR, it is going to be seen by other providers. In reality, the worrisome finding is lost in the voluminous record.

“When you talk to hospitalists or services, they’re totally frustrated. They say they can’t go back and re-view everything that was done in the ED,” Lembitz reports.

If nobody ever informs the patient of the abnormal finding, both the EP and the admitting physician are likely to be named in malpractice litigation. “The EP takes part of the hit because the EP’s name is on the study that was done in the ED,” Lembitz says.

It is not enough to caution EPs to “just be more careful.” EHRs can flag abnormal findings appropriately without creating “alarm fatigue.” Reviewing cases where things went wrong, without blaming individual ED providers, can raise awareness.

“This can lead to a cultural shift among providers, that abnormal results need to be brought to the patient’s attention whenever anyone sees them,” Lembitz offers.

Daniel LaLonde, MD, says if these test results return after the patient makes it to an inpatient bed, legal problems could emerge:

• **The band count included in a differential of a complete blood count is missed because it comes back after other results.**

This tends to lag behind the reporting of the white blood cell

count and hemoglobin levels. “But it can contain some very important information,” LaLonde notes. “Increased bands are a marker of sepsis and can be easily missed.”

• **Imaging study results are missed because the ED patient goes straight to their inpatient bed from radiology.**

“It is the responsibility of the ordering physician to follow up on these results,” says LaLonde, associate medical director of the ED at Ascension Providence in Southfield, MI.

The EP must communicate to the admitting team that the study is pending, and that the admitting team is responsible for following up on the results. “The admitting physician most certainly assumes care of that patient when they are transferred to the floor,” LaLonde says. “But good closed-loop communication leads to better patient care.”

Once the patient leaves the ED and the admitting physician assumes care, the responsibility lies with the admitting physician.

“At that point, it is on that physician to use all of the testing and information that was garnered in the ED, and report to the patient any of the incidental findings,” LaLonde explains.

• **Patients are discharged from the ED after a chest X-ray or CT scan without finding out they have a pulmonary nodule.**

LaLonde typically documents these conversations in the patient’s chart, includes the information in discharge paperwork, and recommends to patients they see their primary care physician.

“The danger of not counseling the patient in these situations is that the nodule turns out to be malignant, and the patient goes without proper follow-up,” LaLonde says. ■

'Hybrid' Medical Malpractice Lawsuits Are 'End-Run' Around Damage Caps

Some plaintiffs are using “hybrid” medical malpractice lawsuits to skirt damage caps on noneconomic damages. The cases allege both professional negligence and medical battery.¹⁻⁵

For example, in California, plaintiffs in medical liability cases can avoid the state’s \$250,000 cap for noneconomic damages. “We are seeing the ‘hybrid’ tactic more frequently,” reports **Brian Vandenberg**, JD, senior vice president and general counsel for the American Medical Association.

This controversial approach “conflates distinct legal theories, an end-run around legislative tort reform,” Vandenberg argues. “They are disingenuous, a dangerous invitation for courts to trample on legislative authority.”

Court rulings have been mixed on whether these lawsuits are allowed to go forward. “But statutory caps on non-economic damages were upheld as constitutional in most of the recent state supreme court cases,” Vandenberg reports.

To secure punitive damages in a malpractice lawsuit, “you have to show egregious, almost criminal, conduct,” says **Gregory Dolin**, MD, JD, an associate professor of law at University of Baltimore.

Those cases are rare. Damages for pain and suffering are capped, but there is no limit on economic damages. “It’s possible to get multimillion-dollar settlements or verdicts for malpractice cases even with damage caps in place,” Dolin offers.

A stockbroker with 30 more years of earning capacity, whose injuries require lifelong, around-the-clock nursing care, is an example of a case

with the potential for significant economic damages. “You could see a verdict for \$30 or \$40 million that would not be affected by the caps, that is all pure economic damages,” Dolin says. “That is one downside of caps.”

One argument in favor of caps is they remove the incentive for people to file frivolous or nuisance lawsuits. The downside is that potential plaintiffs with meritorious cases, but without large economic damages, are unlikely to find an attorney to pursue the claim. “It’s so expensive to litigate these cases, that no lawyer is likely to take the case,” Dolin says.

If the potential plaintiff is living on Social Security, a fixed income, or a small pension; is older and already past his or her life expectancy; or requires no future medical care, then economic damages are basically non-existent. “The only thing that’s left is pain and suffering,” Dolin notes. “Attorneys don’t want to take the risk when the reward at the end is very limited.”

Plaintiffs who cannot show significant economic damages are unlikely to be compensated. A good example is an ED misdiagnosing or improperly treating a heart attack or a stroke in an elderly patient. “That error may well kill the patient. But it results in very little economic damage,” Dolin says.

The patient’s earning capacity is small or zero. There are no additional ongoing medical expenses because the patient is dead.

“What will happen more and more is that attorneys will take only surefire cases,” Dolin predicts. “They want a sure bet.”

Some attorneys require potential plaintiffs to incur the cost of asking

an expert to evaluate the case.

“Not everybody is able to shell out thousands to get an opinion letter, which may end up going nowhere,” Dolin says.

It is not enough that the expert’s opinion is malpractice definitely occurred. Many attorneys will not take the case unless the expert also says it is a winnable case. The bottom line, says Dolin, is lawyers seek cases where they can win a big judgment or settlement based solely on economic damages. This leaves many meritorious malpractice cases unresolved.

“If you remove damage caps, more parties will end up getting compensated,” Dolin says. “But there will probably be more meritless lawsuits.”

Proponents of damage caps say this will raise malpractice premiums, which in turn increases the cost of medical care. Not all states have put caps in place. “Some have considered and rejected them. Others have had courts strike them down,” Dolin says.

Data suggest states with damage caps have lower malpractice premiums, without the doctor shortages that other states are experiencing.^{6,7}

“There is some evidence that caps stem the practice of defensive medicine,” Dolin says. “But there is a huge debate as to how much.” ■

REFERENCES

1. *Siebert v. Okun* (New Mexico Supreme Court, Case Pending).
2. *Condon v. St. Alexius Medical Center* (North Dakota Supreme Court, 2019).
3. *Lopez v. Ledesma* (California Appellate, 2nd District, 2020).
4. *Yebuah v. Center for Urological Treatment* (Tennessee Court of

- Appeals, 2020).
5. *DeFranko v. Poole* (Florida District Court of Appeals, 3rd District, 2019).
 6. Nelson LJ 3rd, Morrisey MA, Kilgore

- ML. Damages caps in medical malpractice cases. *Milbank Q* 2007;85:259-286.
7. Encinosa WE, Hellinger FJ. Have

state caps on malpractice awards increased the supply of physicians? *Health Aff (Millwood)* 2005; Suppl Web Exclusives:W5-250-W5-258.

Premises Liability or Malpractice Claims — Either Way, ED Falls Pose Risks

A nurse-managed, individually tailored falls prevention plan administered for at least 20 months did not significantly reduce risk of serious fall injuries in older adults at high risk for falls, according to the results of a recent study.¹

“Many factors may have played a role in the negative findings in this study,” says **Rosaly Correa-de-Araujo**, MD, MSc, PhD, one of the study’s authors and the senior scientific advisor to the director at the National Institute on Aging’s Division of Geriatrics and Clinical Gerontology.

It is possible some participants did not mitigate all possible fall hazards, such as making changes in their home environment, exercise programs, or avoiding medicines that increase fall risk. “There are strategies to reduce fall rates, both universal measures and patient-specific measures, in the ED setting,” Correa-de-Araujo says.

When a patient comes to the ED, it is an opportunity to implement a multifactorial falls-injuries preventive program, Correa-de-Araujo offers. More than one-third of falls in hospitals result in injury, such as serious fractures, head trauma, lacerations, or internal bleeding.² “Preventing falls and related injuries in hospitals is challenging,” Correa-de-Araujo laments.

It involves managing medication side effects, confusion, and frequent toileting needs, as well as the ED’s physical design and environment. “Research is limited regarding falls

and injuries in EDs,” Correa-de-Araujo notes. “The complexity of their patient populations presents challenges.”

Eighty-four percent of 102 ED providers surveyed believe all geriatric patients should be screened for fall risk.³ Seventy-six percent also believe if a geriatric patient was identified as at risk for falls, that patient should go through an intervention in the ED.

However, ED providers were unwilling to spend lots of time on it; 46% were only willing to spend less than two minutes. “The perception is that it takes longer than it actually does,” says **Kathleen Davenport**, MD, the study’s lead author.

It does not have to be an EP or ED nurse who handles the screening. It could be a nurse assistant or other staff member. “The best screening tool is one that can be done by anyone in the department, and doesn’t require any additional equipment or space,” says Davenport, a clinical assistant professor in the department of emergency medicine at University of North Carolina School of Medicine.

Chris Messerly, JD, a partner at Minneapolis-based Robins Kaplan, has handled multiple ED fall cases. Not all turn out to be malpractice cases.

“If a plaintiff’s lawyer is giving a choice of a medical malpractice claim or a premises liability claim, it is always a much easier route to go with a premises liability claim,” Messerly says. One hospital was sued because a

patient fell on a wet floor while entering the ED. The water was from a leaky pipe. “The claim was a premises liability claim, not a malpractice claim,” Messerly recalls.

Messerly also has handled many medical malpractice claims against EDs for patient falls. Most plaintiffs were known to be at risk for falling for one reason or another. The injuries happened when the patients stood from a wheelchair or an examination bed.

“If such a person is left unattended and they fall, the ED may be responsible,” Messerly cautions. “These claims are actually quite common.”

Some ED fall cases involved serious consequences, such as fractured skulls. The plaintiff attorney’s expert will look for evidence that the ED providers knew (or should have known) the patient was at risk for falling and took no precautions. If both can be proven, says Messerly, “the healthcare provider is responsible for the harm.” ■

REFERENCES

1. Bhasin S, Gill TM, Reuben DB, et al. A randomized trial of a multifactorial fall injury prevention strategy. *N Engl J Med* 2020;383:129-140.
2. Agency for Healthcare Research and Quality. Falls. <https://bit.ly/3h1rK2C>
3. Davenport K, Cameron A, Samson M, et al. Fall prevention knowledge, attitudes, and behaviors: A survey of emergency providers. *West J Emerg Med* 2020;21:826-830.



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CME/CE QUESTIONS

1. Which is true regarding telehealth in the ED?

- a. The standard of care is higher for in-person ED visits than telehealth ED visits.
- b. There is no breach of the standard of care if an EP cannot perform a virtual evaluation that is essentially equal to that of an in-person evaluation.
- c. Some patients may need to be seen in person for an ED provider to adequately assess them, and failure to do so could be considered malpractice.
- d. Telehealth increases wait times to unacceptable levels for behavioral health patients in the ED setting.

2. Which is true regarding simulation use in the ED?

- a. Simulation is most effective in reducing legal risks if limited to improving safety of high-volume ED procedures.
- b. Since critical emergencies in pediatric patients are common at both community EDs and children's hospitals, simulation should focus on other types of cases.
- c. Simulated cases should reflect the fact that general EDs are seeing fewer obstetric patients because of more community hospitals opening obstetric units.
- d. EDs rarely see deliveries with complications, so these cases are a good choice for simulation.

3. Which is true regarding abnormal findings that return after patients leave the ED?

- a. Test results often go uncommunicated for discharged patients, but not for admitted patients.
- b. Admitting physicians have no liability for failing to inform the patient if they can demonstrate the EP ordered the test.
- c. Significant incidental findings from tests ordered in EDs are missed by the hospitalist or surgical service.
- d. EPs typically cover at least as much information with patients about to be admitted as they do if the patient is about to be discharged.

4. Which is true regarding fall injuries in the ED?

- a. Medical malpractice claims are significantly easier to defend than premises liability claims.
- b. It is irrelevant if the ED providers knew the patient was at risk for falling, since this could be true of any patient at any time.
- c. The plaintiff's expert will look for evidence that no precautions were taken to prevent the patient from falling.
- d. Lawsuits are dismissed frequently because plaintiffs lack evidence showing they were at higher risk for falls than the general ED population.

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.