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Advanced Practice Providers See More Complex Patients, Sued More Often

More ED patients are visiting physician assistants (PAs) or advanced practice nurses (APRNs).¹ Of 54,722 closed malpractice claims analyzed in a recent study, about 75% of claims naming advanced practice providers also named physicians.² Other key findings:

- Malpractice claims naming PAs and APRNs were more likely to be paid on behalf of the hospital (38% and 32% respectively), compared to 8% of malpractice claims naming just physicians.
- Payments were higher when APRNs were defendants, for claims involving procedures, and for claims involving when patients died.

"ED advanced practice providers used to be sued infrequently, mainly because their practice pattern was more restricted to simpler patients," says **Mark Spiro**, MD, chief medical officer of the Walnut Creek, CA-based The Mutual Risk Retention Group.

Typically, advanced practice providers saw children with earaches

and patients with mild trauma such as lacerations or simple fractures. Today, advanced practice providers are caring for medically complex patients in the ED, those with chest pain, sepsis, and stroke. "This is because of the physician shortage and because there are more complex patients and less minor ones. It is also partly that the advanced practice providers want a more interesting and challenging practice," Spiro offers.

In turn, advanced practice providers are named in lawsuits more frequently. "They are taking on more complicated patients, and we are seeing them get sued much more often," Spiro reports.

Supervising EPs typically are named, too, even if they never saw the patient. The question for the co-defendants then becomes: Why did the advanced practice provider not consult with the supervising EP? "It's a chance for another person to look at the patient and, hopefully, to catch what got missed," Spiro notes.

Possibly, the advanced practice provider saw a patient with a dislocated



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knee and failed to order an angiogram of the popliteal artery. In that kind of case, the plaintiff attorney would focus on why the supervising EP never intervened and missed the chance to avoid a bad outcome.

In one case, an inexperienced plaintiff attorney named only the supervising EP without even realizing that an advanced practice provider was the one who saw the patient. Eventually, the lawyer realized the supervising EP had not cared for the patient. By that time, the statute of limitations had expired. “The supervising EP was held liable for the care that the advanced practice provider gave,” Spiro says.

Usually, both providers are named, at least initially. “Our experience has been that eventually, the supervising physician is usually dropped,” Spiro observes.

Ultimately, it is determined the supervising EP did not provide the care at issue. There may be no reason for the plaintiff attorney to keep the supervising EP in the case. “If it’s a \$200,000 case, and each provider has a \$1 million policy limit, there’s no need for the plaintiff attorney to go after the supervising physician,” Spiro explains.

Some ED policies list specific chief complaints that always require the supervising EP to be consulted. These can be problematic, legally speaking, according to Spiro. He prefers EDs offer general guidance on which categories of patients need the supervising EP involved, such as “any patient older than age 80” or “any patient younger than three months.”

For one thing, that kind of guidance is easier to remember than a long list of complaints. Also, if the patient’s complaint is on the list, and the advanced practice provider did not involve the supervising EP, there

is additional liability exposure for failing to follow the policy.

Ideally, the communication between the advanced practice provider and the supervising EP is “very open and inviting,” Spiro says. If the perception is that a grumpy, short-tempered supervising EP just does not want to be bothered, it puts everyone at risk. “The supervising EP should encourage them to come forward, as opposed to the attitude, ‘Can’t you handle this?’” Spiro says.

That attitude might be expressed verbally, or the supervising EP might just come off as unapproachable. Either way, the advanced practice provider is reluctant to “bother” the supervising EP, even if he or she is unsure about a high-risk patient. “Ultimately, it’s not about malpractice; it’s about what’s best for the patient,” Spiro says. “What’s best for the patient is for the supervising EP to get involved.”

Sometimes, the problem is patients do not understand why they are seeing a PA or NP. In other cases, the patient just assumes they are seeing an EP, or the NP or PA did introduce themselves, but the patient did not understand. “It could be that the patient just hears the word ‘physician,’ and assumed the PA was a doc,” Spiro suggests.

Occasionally, patients complain to attorneys that they were never told they were seen by an advanced care provider as opposed to an EP. “Older patients tend to assume that advanced care providers are physicians and refer to them as ‘doctor,’” says **Amy Evans, JD**, executive vice president of business development and liability claims division at Intercare Insurance Services in Bellevue, WA.

It is important for advanced care providers to correct patients who refer to them as doctors to eliminate

any confusion on this point, Evans says. Ideally, ED patients are told they are talking to an advanced care provider and hear a brief explanation of the provider's role.

In most malpractice claims naming advanced practice providers in the ED, the care provided was good, Evans notes. Those cases are fairly straightforward to defend because the supervising EP's testimony supports the care at issue. The claims that are tough to defend feature this fact pattern:

- The advanced practice provider is faced with a subtle or unique presentation;
- The advanced practice provider fails to consult with an EP before discharging the patient.

Evans has seen malpractice claims involving advanced practice providers with these allegations:

- Failure to recognize early signs and indications of sepsis;

- Failure to diagnose concussions;
- Missing subtle indications of myocarditis.

These claims are problematic if the supervising EP cannot support the care provided. "They usually testify that if they had been contacted, they would have recommended a different course of treatment," Evans says. That pits the supervising EP against the advanced practice provider, making a unified defense impossible.

Also problematic are cases in which the advanced practice provider failed to involve specialty consults when, in hindsight, they should have.

If the advanced practice providers are employees of the hospital, then the hospital can be held vicariously liable. This is the case even if they are not employees, if "apparent agency" laws are strong in a particular venue. "Hospitals also may face exposure if they are staffed primarily with advanced practice providers

without sufficient physician staffing to adequately support and guide the advanced practice providers," Evans notes.

This kind of arrangement might be cost-effective for financially struggling hospitals. Yet hospitals need to keep in mind how it would look to a jury. "While advanced practice providers are inherently qualified, optics still matter to juries," Evans adds. "There still needs to be a visible physician presence." ■

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Crowding Tied to Higher Mortality Rate, Even After Discharge

While working at various academic medical centers as a researcher, **Lindsey Woodworth**, PhD, noticed that many patients in the ED waited hours to be seen.

"Along with that, I would hear stories of patients crashing and occasionally dying in the waiting room," says Woodworth, an assistant professor in economics at the University of South Carolina.

Woodworth suspected there was a strong relationship between how crowded an ED is at a patient's time of arrival and that patient's likelihood of surviving. She decided to see whether data supported this by looking at existing South Carolina EDs in locations where a new ED opened recently. "There is an

instantaneous reduction in crowding in existing EDs when a new ED opens nearby," she explains.

Woodworth used hospital records to determine how many patients visited the EDs each day, and analyzed the patient volume and death rates. She found that if ED patient volume is alleviated by just 10%, it significantly lowers the average patient's chance of mortality.¹ Woodworth observed decreased

mortality rates both during the ED visit and after discharge.

"What was surprising was the suggestive evidence that patients are more likely to die after their visit when they are exposed to more crowding," Woodworth says.

Patients are more likely to leave without being seen when care is delayed because of ED crowding.^{2,3} "It could be that some of the increased mortality is due to patients

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walking out of the ED, going home, and then dying,” Woodworth offers.

Considering this unexpected finding, says Woodworth, “EDs could focus on reducing their rates of patients leaving without being seen. Clearly, lowering wait times would be one way to encourage patients to stay.”

The first step is for EDs to be aware of the direct link between patient volumes and patient

outcomes. “EDs can then take steps to improve patient flow when crowding is high,” Woodworth explains. ■

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Stroke Care Not Significantly Delayed Despite Crowding

There were no significant delays in stroke care associated with ED crowding, according to the results of a recent study.¹

“As emergency department crowding has become more pervasive, we were curious to explore how crowding has impacted the care of time-critical illnesses,” says **Todd Andrew Jaffe, MD**, the study’s lead author and a clinical fellow in emergency medicine at Massachusetts General Hospital in Boston.

Jaffe and colleagues decided to examine stroke because diagnosis and treatment is time-dependent. “Our additional question centered around how the processes of care surrounding these time-dependent illnesses, such as stroke, could potentially be protective against

ED crowding,” Jaffe says. They analyzed the level of crowding at the time acute ischemic stroke patients presented to an urban academic ED between 2016 and 2018. Of 1,379 patients, 78% presented at times of normal capacity, 15% presented during times of high crowding, and 7% presented during severe crowding.

Previous research on this subject was mixed. “Some studies found delays in stroke care associated with ED crowding, whereas others did not,” Jaffe observes.

Jaffe and colleagues hypothesized they would see delays in care associated with more crowding. “Yet we were also curious to see how our defined robust processes of care surrounding stroke may be protective,” Jaffe says. The researchers

expected some factors (e.g., higher stroke severity) may mitigate delays during heavier crowding. Overall, Jaffe and colleagues found no significant delays associated with ED crowding, which means the systems in place might be protective against crowding.

“As many studies have documented associations for other conditions and ED crowding, it was interesting to not find these delays related to stroke,” Jaffe offers.

These findings provided some assurance EDs can address time-critical illnesses even when crowded, at least when it comes to stroke care. “What is potentially concerning is hypothesizing that other patients may have significant delays in times of crowding,” Jaffe shares. For example, patients presenting with

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time-sensitive illnesses, but more vague complaints, may experience significant delays during times of ED crowding as resources are dedicated for more protocolized illnesses. “Although we found no delays in

stroke care, many other studies have found delays for other illnesses,” Jaffe says. “Further studies may help identify what patient population poses these risks during times of increased crowding.” ■

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Partly Driven by Defensive Medicine, ED Imaging Orders Rise Dramatically

Some EPs err on the side of ordering imaging tests because they do not want to miss something — or be sued for malpractice.

“Many radiologists attribute increasing volumes of imaging studies to defensive medicine ordering practices,” says **Alexander Villalobos**, MD, a diagnostic radiology resident at Emory University School of Medicine in Atlanta.

Villalobos and colleagues set out to answer the compelling (and controversial) question: “Does the litigation environment affect the way doctors order imaging tests?”¹

“Before our study, no one had thoroughly evaluated the multiyear impact of the malpractice environment on imaging practice patterns at a national or even regional level,” Villalobos offers.

Researchers analyzed advanced Medicare imaging use and paid malpractice claims, examining claims data for a 5% sample of Medicare beneficiaries from 2004 to 2016 and the National Practitioner Data Bank. For every 1% increase in the number of paid malpractice claims, there was a corresponding 0.20% increase in advanced imaging use.

The increase might seem small, but it amounts to much additional imaging. One paid malpractice claim was associated with an average of 1,389 additional advanced imaging

exams in the subsequent year, and that is just in the Medicare population, Villalobos reports.

“Imaging utilization in the ED setting has grown considerably, and disproportionately, compared to other sites of service,” Villalobos notes.^{2,3}

The authors of one study found that cervical spine imaging for Medicare patients in EDs more than tripled between 1994 and 2012.⁴ Radiography declined by 27% during this period, but CT scans increased dramatically — more than 8,000%.

“While our recent paper shows that part of this increase in CT utilization is driven by the litigation environment, it is more likely that improved access, scanning efficiency, and overall outcomes have predominantly driven this huge increase,” Villalobos notes.

Another study revealed the use of advanced imaging (defined as CT scans or MRIs) increased significantly from 1996 to 2014. For patients with a headache, the percentage increased from 17.5% to 33.3%. For those with urinary calculus, the percentage increased from 0% to 48.5%.⁵

All this advanced ED imaging is adding to, rather than replacing, other imaging modalities. Radiography and ultrasound use rates remained grossly unchanged within this period.⁵

“Advanced imaging has significantly increased in the ED

setting, and its use has unfortunately not been displaced by similar decrease in the utilization of non-advanced imaging,” Villalobos laments.

Many ED patients undergo both non-advanced imaging and advanced imaging. An example would be a patient who comes to the ED with minor trauma to the neck. The EP may decide to obtain a CT of the cervical-spine (C-spine) without contrast first, and it clearly shows no acute fracture or traumatic malalignment of the C-spine.

This might be unnecessary. It is unlikely to add more information about an acute fracture or traumatic malalignment than what the CT C-spine without contrast has provided. “One could argue that a flexion and extension C-spine radiograph may be worth pursuing after a CT C-spine without contrast to evaluate for more subtle pathologies,” Villalobos offers.

The work by Villalobos and colleagues suggest defensive medicine is driving at least some of the surge in ED imaging. “It is our hope that highlighting the impact of medical malpractice on actual physician practice patterns will be beneficial to the design of targeted policy and delivery system interventions aimed at helping control the ED imaging volume and costs,” Villalobos says.

Several clinical decision algorithms have been created to curb the unnecessary use of imaging, such as the National Emergency X-Radiography Utilization Study and the Canadian C-Spine Rule.⁶

Potentially medically inappropriate CT C-spine scans decreased from 45% to 22% after a clinical decision-making tool was added to the EHR and ED clinicians were educated on the criteria.⁷

“Nevertheless, clinical decision support systems are not widely implemented into daily clinical practice at this time, or at least not as wide of a scale as it should be,” Villalobos says.

EPs may perceive the information provided by the tools is not valid, relevant, or convenient to use.

“Many physicians and researchers are working on understanding the reasons for why physicians are not adopting clinical decision support systems as much as they should,” Villalobos says.

Villalobos suggests EPs become aware of all available tools for

imaging use decision-making. It is not only software that can be consulted. Simply getting to know the radiology group can help reduce unnecessary imaging. Radiologists might note that a prior study can answer the EP’s clinical question.

“Sometimes, radiologists can save you time and your patients money by recommending a single study that answers multiple clinical questions at once,” Villalobos adds. ■

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Angry Encounters Can Adversely Affect Clinical Decision-Making

A patient screams and spits at the EP and ED nurse who are trying to determine if a life-threatening emergency exists. Another patient is extremely grateful, cooperative, and respectful. Assuming both patients presented with the exact same clinical situation, would ED providers treat them any differently? The authors of two recent studies examined this interesting question.

Researchers studied how emotional patient encounters affect clinical decision-making in the ED. In the first study, researchers asked

94 ED providers (50 EPs, 44 ED nurses) to write about three patient encounters: one that caused anger, irritation, or frustration; one that led to appreciation, happiness, or satisfaction; and one that involved a patient with a mental health condition.¹

ED providers said their emotions affected clinical decision-making most often during angry situations (e.g., patients displaying manipulative or abusive behavior, poor self-care, or frequent ED use). Emotions during mental health and angry situations

were connected to more perceived risk to patient safety. In contrast, ED visits eliciting positive emotions were associated with perceived better care quality.

In a second study, researchers conducted in-person interviews (averaging about one hour in length) with 45 EPs and 41 nurses from four academic medical centers and four community hospitals.² ED providers indicated they were aware negative emotions could adversely affect their clinical decision-making. Many described specific ways they regulated

their emotions, such as distraction, suppression, and cognitive reappraisal.

“They believed that they employ strategies that can effectively mitigate risk. But in the heat of the moment, they might still make poor judgments,” says **Linda M. Isbell**, PhD, lead author of both studies.

In fact, in the first study, more than 75% of EPs acknowledged they had done something that could have adversely affected at least one of the patient encounters they described because of an emotional response to that patient. ED providers acknowledged spending less time with the patient, acting less compassionately, and failing to provide a necessary exam or treatment. Survey participants offered these specific examples:

- An EP said it was possible that a full history and physical exam had not been obtained because of anger at the patient;
- An ED nurse described feeling “overcome with anger” and not wanting the patient to be seen;
- An EP recounted feeling angry at a patient and that he had “probably prematurely closed my thoughts to them having anything bad”;
- An EP stated if patients are verbally abusive and manipulative, that she “tends to not go any length to provide them with extra services, consults, etc.”

On the other hand, positive emotions affected patient care beneficially. Providers spent more time with the patient and provided extra testing, consultation, or treatment. One ED nurse put it this way: “Since she was so pleasant and appreciative of everything I did for her, I was happy to enter the room to help her.” An EP said, “In that the patient was a very kind, articulate person, I may have been more motivated to go the extra mile

to make the correct diagnosis.” As a social psychologist, Isbell researches how emotions affect decision-making. The Institute of Medicine’s *To Err is Human: Building a Safer Health System* motivated her to consider this in a medical context.³

At first, Isbell was mainly focused on identifying disparities that put patients with mental health conditions at risk in the ED. After spending time with ED providers, her perspective evolved.

“I realized that the ED is a very difficult work environment, where people’s needs far outweigh the resources that are available. It is where all societal problems end up,” says Isbell, professor of psychology at the University of Massachusetts.

Most EPs truly appreciated the chance to explain to someone outside the healthcare field what they deal with daily. Participants displayed empathy, care, and concern. Some became emotional as they spoke about how their own negative emotions could have played a part in a patient’s poor outcome. To encourage candor, Isbell and colleagues emphasized confidentiality would be strictly respected, and that cases would be de-identified.

“These results would probably be shocking to anyone who doesn’t work in an ED, but would not surprise any ED provider,” Isbell offers.

One problem is EPs’ emotions, and the adverse effect on patient care, are unlikely to be aired during root cause analyses or morbidity and mortality conferences. “It’s really hard for an EP to say, ‘I was really angry at the patient. That’s why I discharged them early,’” Isbell notes.

Peers and administrators are likely to be unsympathetic to a statement like that. EPs also are concerned such a statement could be used against them in malpractice litigation. “From

a liability perspective, that kind of admission is really bad. The attorney can say, ‘What’s wrong with your physicians? They can’t control their anger?’” Isbell suggests.

Recently, Isbell showed 82 EPs a video of an actor playing the role of an ED patient interacting with a physician while giving a medical history. Some videos included patient behaviors Isbell found to produce frustration and anger in EPs (e.g., making demands, insulting remarks, and using profanity), while other videos did not include these behaviors.

Preliminary data show EPs who saw the anger-inducing behavior did not trust the patient as much as the EPs who saw the other videos. “This has important clinical implications. It means that physicians might discount part of the history provided by the patient, which may lead to medical errors,” Isbell cautions.

Isbell says possible solutions are pop-up warnings in EHRs for patients identified as high-risk for emotional encounters, such as patients with mental health conditions and substance use disorders. EPs also could use cognitive interventions to remind themselves to process information more carefully if they feel their emotions are affecting their decision-making.

Emotions during ED encounters “are not all bad,” according to Isbell. “A long history of research demonstrates that emotions are highly adaptive and often lead us to make good decisions,” she says.

For example, the anxiety an EP feels when discharging a patient can trigger a re-evaluation on whether it might be a safer, better idea to observe the patient in the ED for a few additional hours. Isbell says it is not realistic — or even desirable — for ED providers to expect medical

decision-making to be devoid of emotion.

A better, more realistic approach is to simply acknowledge emotions do play a factor. “Open communication about emotions could promote better outcomes. It could also have a downstream effect on the legal situations that emerge,” Isbell says.

Andrew Lawson, MD, FACEP, says, “any stressful encounter, angry or otherwise, has a direct effect on our decision-making in the ED.”

During an angry patient encounter, an EP’s brain functioning has been “hijacked and shut down by our primitive, survival brain functioning. With this shutdown, our decision-making suffers,” says Lawson, says director of patient satisfaction and service recovery for the ED group at Mission Hospital Mission Viejo (CA).

Lawson recommends EPs perform breathing exercises whenever they recognize they are reacting angrily to a patient. “This moves our primitive brain from ‘fight or flight’ mode to ‘rest and digest’ mode,” Lawson says. “Elite military teams such as the Navy SEALs use tactical and box breathing methods while in combat.”⁴

Lawson uses both methods before a stressful patient encounter, during the encounter, and afterward. “It is an easy exercise to ‘hide’ from staff and patients that you are actually doing it,” Lawson adds. “But it provides immediate calming of your body’s stress response.” ■

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Report Links ED Boarding to Worse Clinical Outcomes

Boarding critically ill patients in EDs is associated with worse clinical outcomes, according to the authors of a recently published white paper.¹

“Boarding in EDs occurs because the hospital beds are full. Patients are the ones who suffer,” says **Nicholas Mohr**, MD, FACEP, FCCM, co-chair of the ED-Critical Care Medicine (ED-CCM) Boarding Task Force that authored the paper and former chair of the American College of Emergency Physicians’ Critical Care Section.

As hospital capacity is stretched, patients wait in ED beds for hours or days until a bed finally becomes available. “ED boarding has increasingly been shown to be dangerous for patients who are

critically ill,” says Mohr, a professor of emergency medicine, anesthesia critical care, and epidemiology at the University of Iowa Carver College of Medicine.

The task force found ED boarding is linked to longer duration of mechanical ventilation, higher mortality, and longer length of stay (both in the ICU and the hospital overall). Some findings from studies that were included in the literature review:

- Longer boarding times are associated with deteriorated organ dysfunction and make it more likely stroke patients experience poor neurologic recovery.
- Boarding can cause low-quality process-related care of critically ill patients who waiting to be admitted

to the ICU. Emergency medicine critical care (EMCC) is a relatively new subspecialty, concerning the care of critically ill patients in the ED and other settings.

“We get to see the downstream impact of ED care on the critically ill,” says **Brian T. Wessman**, MD, FACEP, FCCM, co-chair of the ED-CCM Task Force.

Initial ED care includes mechanical ventilator set-up and management, sedation, timely administration of antimicrobials, and ongoing decisions regarding type and amount of fluid resuscitation. “We have data showing that a large majority of initial ED care impacts downstream patient management and outcomes,” says Wessman, division chief of emergency medicine/

critical care medicine at Washington University's School of Medicine in St. Louis.

Improving hospital throughput means critically ill patients are not stuck in EDs waiting for ICU beds. "No matter where critically ill patients are, though, they need the same intensity of care to have the best outcomes," Mohr says.

Some hospitals have found a novel solution in the form of resuscitative care units (RCUs), which are ICUs based in EDs.² Approaches vary, but the basic concept is patients who need time-sensitive respiratory, metabolic, neurologic, or hemodynamic critical care can receive it in the ED. This prevents these patients from waiting so long for a bed to finally open in the appropriate specialty ICU.

"Regardless of physical location, critically ill patients need similar resources," Wessman notes.

Critically ill patients need ICU-level nursing in an appropriate patient ratio, access to supplies, continuous monitoring, and available physicians who are directly providing their care. "By definition, this will be difficult in an already-taxed ED location that is continuing to provide appropriate care and stabilization to newly arriving patients — unless the system allocates more resources and support," Wessman explains.

The ED-CCM Boarding Task Force found it was surprisingly hard to measure the prevalence of

boarding. "Even though we think it's common, there's no standard way that it's measured or reported from hospitals across the country," says Mohr, noting that makes it hard to track changes over time.

Additionally, the task force found no uniform definition of ED boarding. "This is an underrepresented and underreported issue," Wessman says.

Researchers used all kinds of different definitions and time frames in examining ED boarding. Some studies categorized the admitted patient as "boarded" only if the patient spent a certain amount of time in the ED. Other studies counted the total amount of time spent in the ED as the "boarded" period. Still other researchers used the time frame that elapsed only after the decision to admit was made.

Regardless of the exact criteria used, the overall implications are clear. "Managing critically ill patients in the austere environment of the ED with limited support/resources makes it difficult to provide critical care," Wessman stresses.

A recent review of 12 studies did not reveal clear evidence of a link between ED boarding and in-hospital mortality.³ Six studies indicated an association, five studies showed none, and one study produced conflicting results. One limitation was that the various studies used different time frames.

"The problem is that there were many different cutoffs used. It was

not possible to deeply study the relationship," says **Abdelouahab Bellou**, MD, MSc, PhD, one of the study's authors.

More research is needed to determine if there is a specific time cutoff linked to higher in-hospital mortality.

"We need a very big study, using the same definition and the same population," says Bellou, director of quality and safety, administration and leadership, and international emergency medicine fellowship at Harvard.

The inconclusive finding conflicted with the researchers' clinical experience in the ED. "We are not happy when our patients are staying in the ED for many, many hours," Bellou says. "We have this feeling we are not doing a good job for the patient. But feeling is not science." ■

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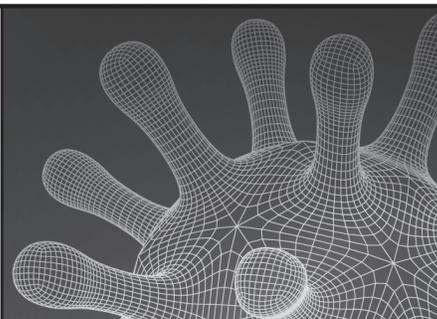
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Hospitals Mistakenly View Boarding as an 'ED Problem'

Many ED hallways are filled with patients who have been admitted, but cannot move out of the department because no inpatient bed is available.

"There is a tendency to think of boarding as an 'ED problem.' But the whole system needs to be looked at. It has to come from the top. The CEO has to do what needs to be done to streamline the process," says **Robert W. Derlet**, MD, professor emeritus at the UC Davis Health department of emergency medicine.

Often, says Derlet, "the ED leadership, the nursing director, and physician director, say, 'We've got a problem here.' Too many hospital CEOs say, 'It's your problem.'"

ED providers cannot simply contact the inpatient unit to try to speed things up since they do not know for sure where the ED patient is going. "It's getting that assigned bed that's critical," Derlet notes.

Since hospitals rely on elective surgeries for financial viability, patients admitted from the ED tend to be a somewhat lower priority. Asking hospital administrators to observe the risks of ED boarding firsthand can help change this perception.

"They don't know what it's like on the front lines. Have them spend a shift in the ED, either

Friday or Saturday night," Derlet recommends. A one-time "snapshot" of a dangerously crowded ED with hallways full of patients is not nearly enough to really understand this pervasive problem. To truly grasp the reality of ED boarding, says Derlet, "CEOs, who hold the purse strings, need to spend an hour a day in the ED one or two days every week, for several weeks."

Otherwise, hospital leaders may remain largely unaware of the risks when ED patients are cared for in hallways. "Hallway care is fraught with disaster," Derlet observes.

Issues can arise regarding monitoring in crowded hallways, the fact oxygen tanks have to be used, total lack of privacy, and ED providers bumping into each other while examining patients. Derlet recommends a few practices to mitigate risks when EDs are crowded, and patients are boarded in hallways:

- **EDs need to take whatever measures are possible to avoid waits at triage.** "There should never really be a line for triage. Somebody may have a very serious condition, and 15 minutes could be the difference between life and death," Derlet stresses.

- **Triage nurses need to remember to use their best clinical judgment in determining acuity.** Derlet

cautions against overdependence on computer algorithms.

- **Triage nurses need to communicate with the EPs on anything they are unsure about.** "Unfortunately, in some EDs, there is a wall between the triage nurse and the emergency physicians, and they don't talk too much," Derlet laments.

ED boarding "threatens safety, and increases malpractice risks," Derlet adds. "I have seen increasing lawsuits being filed because of poor outcomes as a result of ED crowding."

Gelareh Gabayan, MD, an associate professor of medicine/emergency medicine at UCLA, says the problem of ED boarding could be solved by simply moving the patient upstairs, regardless of whether a bed is available.

"If the patient is able to stay in a hallway downstairs, then they are able to stay in the hallway upstairs. I promise you they won't; everyone would find a way to get the patients out faster," Gabayan offers.

Any ED visit is a high-stress situation for both patients and providers, Gabayan notes.

"Why add to the pressure by boarding patients in hallways, and not leaving any room for the patients who need to be seen?" ■

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Length of Time in ED Linked to Patient Safety Events

The odds of a patient safety event (defined as a near-miss event or adverse event) increase by 4.5% for every additional hour a patient stays in the ED, according to the authors of a recent study.¹

Researchers analyzed various risk factors associated with patient safety events in the ED, using EHR and quality assurance data collected from 2010 to 2016. Some key findings:

- Of 383,586 ED visits, 6,519 quality assurance issues were reported, with a patient safety incidence of 6.1%.
- ED waiting time, time spent boarding in the ED, and total ED length of stay all were related to patient safety events.
- The odds of a patient safety event increased by 5.2% for each additional hour spent boarding in the ED.

The added precautions taken during the COVID-19 pandemic have slowed triage processes somewhat, says **Richard F. Cahill**, Esq., vice president and associate general counsel at The Doctors Company in Napa, CA. Heavier patient volume, the use of personal protective equipment by both providers and patients, frequent cleaning of common surfaces, social distancing, and limitations on physical access mean longer waits for ED care. It is unclear what this means for malpractice risk.

“At this relatively early juncture in the pandemic, no readily identifiable increase in litigation has yet emerged from these developments,” Cahill reports.

Despite often lengthy wait times for ED patients, the same standards still apply when it comes to malpractice claims. “Plaintiff

attorneys are still confronted with proving a prima facie case of medical negligence resulting in compensable harm by a preponderance of the evidence,” Cahill notes.

Evidence would be provided to a jury pool comprised of the general public, who likely strongly support the ongoing, selfless efforts of EDs providing care under difficult circumstances. The two questions the plaintiff’s attorney should consider will be:

- Does it appear the patient suffered an injury, such as failure to diagnose, because of what the doctor apparently did or failed to do?
- Did that conduct result in compensable monetary damages?

If so, an independent expert will look at the records and see what the patient complained about, what history was obtained, what tests were ordered (if any), and whether the presentation and findings warranted additional testing. Based on all that, the independent expert will look at whether the diagnosis and subsequent treatment were appropriate and consistent with the community standard.

“How long the visit lasted, which may not be determinable from the record, really is not the issue,” Cahill says.

If the ED is overwhelmed and a bad outcome happens, a patient who felt rushed out the door might suspect negligence. “If someone feels that they were given the ‘bum’s rush,’ that patient might subjectively think they got substandard care,” Cahill observes.

That patient might seek an attorney, but it does not prove malpractice occurred. “Just saying ‘It took only 20 minutes and should

have taken longer’ does not do much to augment a patient’s claim or improve the likelihood of prevailing,” Cahill says.

There are two relevant questions: What was required by the standard of care? Would the “appropriate” care have resulted in a better outcome to a reasonable medical probability?

If a patient waited too long in the ED because of pandemic-related issues and experienced an adverse event, “it is not a COVID-19 issue. It is a triage issue,” Cahill offers.

EDs can reduce risks of adverse events and litigation by following these practices:

- Implement clear procedures for treating patients (both for in-person visits and virtual encounters);
- Follow recommendations by federal and state oversight agencies;
- Audit charts on a regular basis to better ensure compliance with established policies and the prevailing community standard for other similarly situated hospitals;
- Inform patients of the protocols at the outset (i.e., the triaging process, anticipated wait times, alternate treatment modalities such as telehealth, and the reasons for the new procedures).

“This will enhance the patient experience, decrease the risk of litigation, and help to promote optimum medical care,” Cahill explains. ■

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CME/CE QUESTIONS

- Which is true regarding malpractice and advanced practice providers in the ED?
 - Advanced practice providers are taking on more complicated patients and are sued more often than in the past when their practice pattern was more restricted to simpler patients.
 - Supervising EPs are named in lawsuits only if they saw the patient at some point during the ED visit.
 - Typically, plaintiff attorneys name only the supervising EP, not the advanced practice provider, to obtain higher policy limits.
 - Hospitals are required to list specific chief complaints that require the supervising EP to be consulted.
- Which did the authors of a recent study find regarding ED crowding and patient safety?
 - Volumes do not decrease, even if another ED opens in the surrounding area.
 - Decreased patient volume significantly lowers the average patient's chance of mortality.
 - Lower patient volumes did not affect mortality rates after discharge.
 - Patients were no more likely to leave without being seen when EDs are more crowded.
- Which did the authors of a recent study find regarding malpractice claims and advanced imaging?
 - Malpractice prevalence is associated with advanced imaging use.
 - Efforts to alleviate advanced imaging in EDs through clinical decision algorithms have contributed to more missed diagnosis lawsuits.
 - Use of radiography and ultrasound in the ED has declined dramatically due to increased use of CTs and MRIs.
 - Using clinical decision algorithms to curb unnecessary imaging are considered to be the legal standard of care for the ED.
- Which is true regarding ED boarding, according to a recent white paper?
 - Hospitals are required to use a uniform definition of boarding.
 - ED boarding is linked to longer duration of mechanical ventilation, higher mortality, and longer length of stay, both in the ICU and the hospital overall.
 - Courts consider patients to be "boarded" only if the total time in the ED exceeds six hours.
 - Stroke patients received treatment sooner if they were boarded in the ED because of quicker on-call consultant response times.

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

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