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INSIDE

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Cardiology-Related Misdiagnoses Frequently Alleged in ED Malpractice Claims

Malpractice claims naming emergency physicians (EPs) differ from claims involving other specialties in many ways, according to an analysis.[1] "We were able to compare claims to highlight the differences among the specialties," says **Laura C. Myers**, MD, MPH, CPPS, the study's lead author.

Myers and colleagues analyzed closed claims from 2007 to 2016 from CRICO Strategies' Comparative Benchmarking System database. Of 54,772 claims analyzed, 2,760 involved EPs, 5,886 involved internists, and 3,207 involved surgeons.

"We wanted to provide an updated look at malpractice risk for EPs," says Myers, who conducted the study as a Harvard quality/safety fellow at Massachusetts General Hospital and currently is a research scientist at Kaiser Permanente Northern California.

As a group, the researchers brought to the table a great deal of expertise in patient safety and quality improvement. "We understand the huge opportunity that exists to improve patient care by understanding the insights that live in malpractice data," says **Emily L. Aaronson**, MD, MPH, another study author and assistant chief quality officer at Massachusetts General Hospital. Aaronson also is an assistant professor of emergency medicine at Harvard Medical School. "In emergency medicine, very little had been done to glean the insights from this data," she adds.

One group of researchers had tried, but their work was more than a decade old.[2] Other investigators had looked at narrow disease-oriented data sets.[3,4] "We knew there was more to learn, and we had the data to learn from it," Aaronson says.

The frequency of emergency medicine claims increased steadily over the 10-year period. "We were surprised to see just how much the frequency of claims and indemnity payments had increased," Aaronson offers. These are some important findings:

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• Most claims (58%) against EPs resulted from misdiagnosis. Misdiagnosis is "the biggest driver of claims and settlements in ED litigation," Aaronson notes. "This is incredibly important from a patient safety and risk mitigation perspective."

The findings confirm the need for focused attention on misdiagnosis in the ED.

"No emergency medicine society has explicitly carved out strategies aimed at this in the same way they have for stroke or STEMI or sepsis," Aaronson adds.

• Diagnosis-related allegations were more common in emergency medicine-related claims (58% of claims) than in claims involving internists (42% of claims). "Internists have the opportunity to follow patients longitudinally, as opposed to having to make quick, triage-based decisions," Myers says.

• The most common final diagnoses were myocardial infarction, pulmonary embolus, and cardiac arrest. "These are diagnoses that are well-known to emergency medicine providers," Myers observes.

Failure to obtain consultations with on-call specialists was a factor in some claims. "Engaging with medicine subspecialists in cardiology and pulmonology may help to affirm diagnoses made by emergency medicine providers," Myers suggests.

It is unclear if the missed diagnoses happened because of uncommon presentations, high comorbidity burden that complicated the diagnosis, provider fatigue, provider bias, or poor access to advanced diagnostic testing.

"Further investigation should try to dissect the factors associated specifically with diagnosis-related claims," Myers says.

• Acute myocardial infarctions (MIs) made up only 2% of all claims. "This is an area that many ED providers carry around fear about," Aaronson reports.

Some ED providers, keenly aware of the malpractice risk posed by misdiagnosis of MI, made practice changes to improve care of suspected MI patients.

"It's also possible that other safety improvements and more sophisticated diagnostics have made this less treacherous territory, and that the fear is, in fact, not as well-founded as we think," Aaronson says.

• EP defendants' median age (44 years) was younger vs. internists (52 years) and general surgeons (51 years).

• Claims involving EPs were filed in a median time of 15 months vs. internists (18 months) and surgeons (16 months).

• For claims naming EPs, the median open claim time was longer (23 months) vs. claims naming internists (20 months) and claims naming surgeons (22 months).

• Most (72%) claims naming EPs also included the hospital as a co-defendant. In contrast, ED nurses rarely were included (only 4% of the time).

"Nurses are often not named as individuals on claims; rather, the institution is named," Myers explains.

• Procedural complications were involved in one-quarter of claims involving EPs.

The most common procedures involved in the malpractice lawsuits were intubation, suturing, and lumbar puncture. Procedural competency already is addressed heavily in emergency medicine training. "But it's possible that alternative approaches to teaching these skills may further reduce the

likelihood of claims," Myers offers. Procedure-related claims were associated with increased likelihood of a payment compared to other malpractice claims. Simulation could decrease the risks of procedure-related claims.

"Many programs across the country have simulation centers, and staff trained to run scenarios with learners," Myers says.

More safeguards are needed to protect patients from poor outcomes and ED providers from litigation related to procedures. "This may be related to training, supervision, assessments of ongoing competency, or to shared decision-making around the consent process itself," Aaronson says. ■

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Documentation Can Determine Outcome of Missed Myocardial Infarction Lawsuit

Missed myocardial infarction (MI) is one of the most common and costly reasons for ED malpractice claims.[1,2]

"Careful documentation is important in any malpractice case, but especially so in missed MI cases," says **Julie C. Mayer**, JD, a partner in the Virginia Beach office of Hancock, Daniel & Johnson.

Mayer's firm has represented several EPs who were sued by a patient who experienced an MI shortly after discharge. In each case, the narrative notes became vital areas of focus.

Often, the plaintiff's lab results were borderline or technically abnormal, but not enough to definitively indicate cardiac problems. In those cases, the EP's charting on their evaluation and thought process became "key in defending against the plaintiffs' claims that the emergency department physician had ignored obvious signs of a cardiac event," Mayer reports.

Some charts indicated there was chest pain and an abnormal ECG, but the patient was discharged with no explanation. "Plaintiffs use this to make a case that the EP missed classic presentation of MI," Mayer explains. EPs can counter this allegation with specific documentation:

• **The EP's thought process regarding why it was safe to discharge the patient, even though some signs were consistent with MI.** "It is important for the physician to make it clear in their documentation that they have reviewed all findings, but believe based on the presentation that the patient is not suffering from an MI," Mayer stresses.

• **Specific reasons why the EP does not believe it is an MI.** "This may include referencing objective test results or other potential conditions that are higher up on the differential diagnosis list," Mayer offers. The chart should include a thorough description of the symptoms, history, and potential non-MI causes of the symptoms.

• **Specific details on the location and nature of the pain.** Only documenting "chest pain" is problematic because it allows plenty of room to later claim the pain suggested an MI. Good specifics can shut down this argument. With details noted in the medical record, "the plaintiff cannot embellish or change the nature of the pain once litigation has started," Mayer explains.

• **Test results (including lab results), vital signs, and ECG strips.** "It is imperative that the providers document vital signs are within normal limits during examinations, and to make sure that any cardiac monitoring goes into the chart," Mayer says.

In some malpractice cases, ED providers testified about continually checking the telemetry strips and vital signs. However, there was no proof in the chart. If the providers had written "Reviewed vitals and telemetry monitoring, which were normal," it would have made defending the case years later in court much easier. "Be sure to explain why any abnormal results are not the result of an MI," Mayer adds.

• **Discharge instructions (including specifics on when to return to the hospital and who to follow up with).** Often, plaintiffs testify they had no idea they needed to return to the ED if they felt worse. Others insist no one mentioned the need for additional follow-up from a primary care provider or a cardiologist.

• **Any refusals of diagnostic tests or treatment.** Sometimes, patients (either for financial reasons or personal reasons) refuse to undergo any additional testing. It is important for the provider to document the patient's refusal and his or her reasons for the refusal. "After the fact, nearly all plaintiffs will claim that the test was not offered and that if it had been, they would have agreed to the testing," Mayer says.

If the chart is vague on any of these points, plaintiffs can use these deficiencies as further evidence indicating providers never took the patient's complaints seriously. Reviewers studying the chart after the fact already know the outcome — the patient experienced an MI right after leaving the ED.

"Their opinions may be impacted by hindsight bias," Mayer says. "This can be minimized by careful documentation by the providers at the time of care." ■

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Knowing More About Super-Users Prevents Unnecessary ED Visits

Some ED patients are well-known to staff because they visit the department often. "ED super utilization may represent an inefficiency in the healthcare system," says **Eric Goralnick**, MD, MS, medical director of the Brigham Health Access Center. Investigators recently studied characteristics of ED "super-utilizers," defined as those with four or more ED visits a year.[1] "Super-utilizers account for 10% to 26% of all ED visits, and are responsible for a growing proportion of healthcare expenditures," says Goralnick, the study's lead author and assistant professor of emergency medicine at Harvard Medical School.[2]

Goralnick and colleagues analyzed claims data from the Military Health System Data Repository collected between 2011 and 2015 for all adults with at least one ED visit. Researchers wanted to learn more about how to improve quality in the ED while lowering costs. Some important findings:

• The risk of ED super-use was more likely for older patients and those in poorer health.

• The most common diagnoses were low back pain, nausea and vomiting, chest pain, headache and migraine, urinary tract infection, and abdominal pain.

Identifying super-user patterns is important to reduce preventable ED presentations. "Next steps might include listening to patients to understand barriers to primary care access," Goralnick suggests.

EPs might learn the patient keeps coming to the ED because they cannot receive care elsewhere because of limited office hours, geographic location, language barriers, or inability to pay.

It is necessary to evaluate each ED visit as a new, separate episode, despite the fact the patient has been seen recently for the same complaint. "We need to make sure we are not missing critical diagnoses, even if we've seen this patient many times," says **Jordan Selzer**, MD, a disaster and operational medicine fellow in the department of emergency medicine at George Washington University School of Medicine. What follows are some characteristics of ED super-users:

• **Patients staff perceive as difficult.** "Some frequent ED visitors are very demanding, and take up a lot of time," Selzer observes.

This can cause staff to want to discharge these patients as quickly as possible instead of providing a thorough workup. "It's important to not fall into that trap of inertia," Selzer cautions.

If a frequent ED patient is verbally abusive to staff, switch providers if a particular nurse or technician is visibly exasperated. Give the patient a chance to express what he or she is upset about. Try to redirect the patient with a statement such as, "We're trying to help you, but it's important that you communicate respectfully to our staff."

"Verbal de-escalation is the first choice," Selzer explains. "But if things continue to progress, the patient is sometimes so aggressive that you have to involve security."

• People with unmet social needs. "It may not be a medical need. It can be that they are just lonely. To them, chatting with people and being cared for is a reward, and they don't have that support anywhere else in their lives," Selzer observes.

A group of researchers screened 210 ED patients and found 61% reported one or more social needs, such as transportation, housing, utilities, mental health or addiction services, or food assistance. Fifty-two percent of this group indicated they would like follow-up. Patients with social needs visited the ED more often in the subsequent three months than ED patients without social needs.[3]

Certain patients are upfront about the fact they came to the ED because of unmet social needs. In other cases, a comprehensive workup already is underway when staff discover the patient is living in an unsafe environment or has nowhere to go. The next step is to involve social workers. "An example of a time to get social workers involved would be an individual suffering from homelessness who presents repeatedly for the same complaint or numerous minor complaints, particularly when environmental conditions are extreme, such as heat or cold," Selzer explains.

• Individuals who are intoxicated. "They are intoxicated, but maybe they hit their head," Selzer reports.

It always is possible something else is causing the patient's altered mental status. The question is whether a head CT is needed every time the intoxicated patient visits the ED. "That's always a big question. Sometimes, they come in intoxicated, and had maybe 10 head CTs in the previous year," Selzer says. Each care episode has to be evaluated individually.

• Anxious patients who consistently arrive for the same issue. Patients with anxiety might visit the ED often to report chest pain or abdominal pain. "Those complaints can be anything from very mild causes to absolutely life-threatening diagnoses," Selzer observes.

Just because an anxious patient reports chest pain for the tenth ED visit, and nothing was wrong during previous nine visits, does not rule out an MI for the current visit. "It's important to look at each individual visit with fresh eyes," Selzer stresses.

EPs must ensure the anxious patient is cared for safely, but also have to consider judicious use of resources. "Every physician has their own clinical practice style and risk tolerance as far as their clinical decision-making," Selzer notes.

Even if the EP is risk-averse, admission of every anxious patient is not appropriate. "It will fill up a lot of bed space, and you will potentially not have room for really sick, crashing patients because they are all filled up with low-risk chest pain patients," Selzer says.

Crowded waiting rooms during a pandemic make this even more of a pressing consideration. "You have to decide [if] the chest pain [is] because of their anxiety or cardiac disease. How far down the treatment algorithm do you go for this particular care episode?" Selzer asks.

Generally speaking, Selzer says if anything is new, worse, or changed compared to the anxious patient's previous visits, that is more of a trigger to advance the workup further. For example, if the chest pain usually feels sharp and non-radiating, it is worrisome if the patient describes the pain this time as pressure radiating to the jaw and is associated with nausea.

On the other hand, if the anxious patient says nothing has changed, or that symptoms are a little better but not altogether gone, "it's more reassuring," Selzer says. It suggests the current visit is part of the same episode as the previous encounters. In those cases, it probably is OK to take a "watchful waiting" approach.

"That patient needs very clear and good guidance on when to return and who to follow up with, with a chance to ask questions," Selzer adds.

• Patients who are intentionally misleading. "Some people know that certain complaints will allow them to skip the line. They'll come up with a complaint, knowing they will get to see an EP," Selzer reports.

It is only after an extensive workup that the patient admits there is nothing medically wrong. Perhaps they just wanted to come in out of the cold. Document what the patient says in these cases. If someone reviews the chart later, it will note the patient's chief complaint at triage. If the patient admits nothing is really wrong, but the statement is not documented, it looks as though a worrisome complaint was ignored for no apparent reason.

"In these cases, I will often document what the patient says verbatim," Selzer offers.

These objective data also are documented: The patient can clearly articulate understanding. The patient does not appear distressed, intoxicated, or altered.

"Maybe they said they no longer have the complaint, or were not being truthful, and are well-appearing with no injuries," Selzer suggests. "All of that needs to be documented." ■

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Overusing CT Scans: Evidence of Decision-Making Helps Defense

There is continued focus on preventing unnecessary CT scans in the ED.[1-3] Nevertheless, the practice remains prevalent.

"In the short term, ordering CT scans liberally may protect against litigation. But that is not necessarily good resource utilization or in the best interest of the patient," says **Genevieve Santillanes**, MD, an associate professor of clinical emergency medicine at the University of Southern California.

Researchers reviewed 154 CTs and 154 ultrasounds ordered in the ED for abdominal complaints for appropriateness, based on American College of Radiology recommendations.[4] More than one-third (36.3%) of the CTs and 84.4% of the ultrasounds were inappropriate.

Isolated minor head trauma; other blunt trauma, such as motor vehicle collisions; abdominal pain; and seizures all lead to overuse of CT scans in children. "Missed appendicitis is one of the more common reasons for malpractice lawsuits after pediatric emergency visits," Santillanes notes.[5]

Appendicitis can be difficult to diagnose during the initial ED presentation.[6] "Utilization of alternate forms of imaging can be helpful if the indications and limitations are understood," Santillanes explains.

For example, ultrasound can be useful in the evaluation of pediatric abdominal pain. "But clinicians must understand that if the appendix is not visualized, the ultrasound is nondiagnostic," Santillanes cautions.

Appendicitis remains a possible diagnosis for that patient. Some hospital appendicitis pathways use ultrasound, followed by focused MRI if the ultrasound is nondiagnostic. "Such pathways can decrease the need for CT scans without increasing liability," Santillanes explains.

A good shared decision-making discussion between the EP and the family offers some additional legal protection. When children present with undifferentiated abdominal pain or vomiting, Santillanes explains it this way to parents: "While most abdominal pain and vomiting in children is not dangerous and will improve without specific intervention, appendicitis and other abdominal emergencies can present just like a viral illness in the first day or so. But appendicitis or other emergent conditions will declare themselves over the next day."

Next, she explains what would warrant additional diagnostic testing so families know what to look for (e.g., pain that consistently is in the right lower abdomen, pain that makes it difficult for the child to walk, or any worsening or lack of improvement in a day or two). "Similarly, after trauma, I talk to families about the risk of injury that is not immediately evident," Santillanes adds. Other recommended interventions:

- Tell families what should lead them to return;
- Document the conversation in the chart;
- List specific return precautions on discharge paperwork.

This makes it clear to families (and to anyone who reviews the ED chart later) why the CT was not ordered during the initial visit. If the provider takes the time to explain this, the family is less likely to be angry if there is a delayed diagnosis. "Without a discussion at the first visit, the family may feel that a CT scan wasn't ordered because the physician didn't take the complaint seriously, didn't care, or rushed the visit," Santillanes warns. Providers also should document these specifics:

- A clinical decision rule was used (e.g., the Pediatric Emergency Care Applied Research Network for children with minor head trauma or the Pediatric Appendicitis Score).
- The provider believes the long-term risk of radiation is greater than the risk of a missed injury or missed emergent pathology. This makes it clear the provider did not forget to order the CT; in fact, the provider was carefully considering what was best.

"Families, and lawyers, may forget that CT scans can also cause

harm, and that we are weighing the potential harm of radiation when making decisions," Santillanes observes.

• The EP decided to observe the patient for a period. If this is not noted explicitly in the chart, it appears the patient was ignored. Without mention of the need for observation, the chart misleadingly describes a long visit without any interventions or testing. "Time can be a very valuable diagnostic tool," Santillanes adds.

• The patient was re-evaluated at the end of the observation period. Repeat exams on a patient with minor head trauma might include the parent's assessment of patient's mental status, whether the child is tolerating oral intake without vomiting, and presence or absence of severe headache. "It's a good time to reinforce to the family that the observation period was part of the medical care, not a delay," Santillanes stresses. ■

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Misdiagnosis Top Allegation in Aortic Dissection Malpractice Claims

Failure to timely diagnose, failure to order diagnostic tests, and failure to interpret diagnostic tests were the most frequent allegations in malpractice claims involving aortic dissection, according to an analysis of claims filed between 1994 and 2019.[1]

"Aortic dissection has a clinical presentation that is not very unique, which increases the likelihood that it might be misdiagnosed as another condition," says **Ashwin Palaniappan**, the study's lead author.

Of 135 claims analyzed, 57% resulted in a defense verdict. Allegations of failure to test, failure to refer, and failure to consent were associated with defense verdicts. Failure to diagnose was associated with plaintiff verdicts. "If patients have suspected aortic dissection in the ED, they should be referred quickly to the care of a cardiothoracic surgeon who can manage the dissection," Palaniappan says.

Aortic dissection can become fatal quickly. "Having surgeons assess patients with a suspected dissection in a timely fashion may reduce medical malpractice litigation," Palaniappan says.

A recent malpractice lawsuit involved an ED patient who presented with abdominal pain. The man stated he had experienced a pre-existing abdominal aneurysm, and was visiting a cardiologist regularly for follow-up. The EP ordered a CT of the abdomen, which the radiologist report indicated was negative for an aortic dissection, that the aortic stent had not migrated, and that the abdominal aortic aneurysm did not measure larger than what it had measured previously in serial CT imaging. "Despite this radiologic finding, his clinical complaint persisted," says **Matthew P. Keris**, JD, a shareholder in the Moosic, PA, office of Marshall Dennehey.

The family was adamant. They wanted the patient to be admitted. The EP attributed the patient's symptoms to stomach flu that was going around the community. The patient protested, and asked to be admitted. In the end, the patient agreed to discharge. "Within two hours, he coded at home, had a full-blown dissection, and later died," Keris reports.

The family sued the radiologist, the radiology practice group, the EP, the ED group, and the hospital. "The family was very angry because in their minds, had the patient been initially admitted, he would have been better monitored. A timelier intervention could have been instituted once he

coded, and he would have survived," Keris explains.

It turned out the radiologist misread the CT. Recognizing this, the radiologist and his group settled the claim. Right before trial, the attorney agreed to dismiss the hospital from the case. "This was because plaintiff's counsel did not want another defense lawyer involved," Keris notes.

If the hospital was kept in the lawsuit, there would be another defense expert testifying in support of the EP, and another cross-examination of the plaintiff's experts would take place. The plaintiff attorney also believed the EP and ED group's insurance policies, totaling $2 million, were sufficient to cover a plaintiff verdict. "They did not believe a verdict would exceed that available insurance. They made the decision to dismiss the deep pocket, which was the hospital, to go after the EP and ED group," Keris says.

Despite the damaging testimony from the family on the need for admission and the patient's devastating outcome, the jury returned a defense verdict. These two factors helped the EP defendant prevail:

• The chart indicated the EP spoke to the patient's family doctor during the first ED visit, and that the doctor agreed with the decision to discharge.

This documentation assisted the EP in showing the standard of care was met by demonstrating the EP was thorough and carefully considered the decision to discharge the patient. "It also helped because it called the plaintiff's theory of liability into question. If the EP and the family physician made the decision to discharge, why did the patient's lawyer only sue the EP?" Keris asks.

The ED chart made it appear as though the family physician, when presented with the identical medical information as the EP, agreed with the EP's decision to discharge. The family doctor was not named in the lawsuit. "Interestingly, the family physician was never deposed, and did not testify at trial," Keris adds.

If the family physician had refuted the EP's position (i.e., that they had talked before the discharge), it could have negatively affected the EP's defense. "It would have called into question the veracity of the EP's testimony and documentation," Keris says.

EPs cannot assume any doctors they consult will later recall the conversation. If the EP includes a note indicating he or she spoke with the doctor, it could be a fact issue. A good plaintiff's lawyer will follow up with that other doctor. "If the doctor later denies ever speaking with the EP, that's going to be a real issue for the defense," Keris warns.

The other doctor might not document the informal call with the EP in the patient's chart. "If they do not document it, nor remember the conversation, it may be the EP's word against the other physician regarding their involvement," Keris offers.

A way to prevent a "he said/she said" situation with a consulting physician is to send a correspondence to that clinician that summarizes the conversation. "It is hard for that consulting physician to later deny what is written, especially if no objection is raised at the time of the correspondence," Keris observes.

• The jury ultimately agreed with the ED's experts, that it was reasonable for the ED to discharge the patient by relying almost solely on the radiologist's report.

The report indicated the abdominal aortic aneurysm size remained unchanged, that the stent was in place, and that there was no active abdominal bleeding. "Until trial, the EP was not averse to the radiologist's interpretation that the CT of the abdomen was normal," Keris explains.

However, the EP's defense attorney had an undisclosed report that was critical of the radiologist for misreading the study. The ED's radiologist expert opined the treating radiologist had grossly misread the abdomen CT. After the treating radiologist settled the case, and just before trial, the ED's attorney produced the report and wanted to present expert testimony to the jury indicating the radiologist misread the initial CT study. "Because this occurred so close to trial, the judge would not let the expert testify because it prejudiced the patient's case," Keris notes.

Up until that point, the EP and the radiologist had maintained a unified defense. The plaintiff attorney was not going to produce any evidence against the radiologist, since the attorney already settled the case with those defendants. At that point, the plaintiff attorney wanted the jury to focus on the EP's alleged wrongdoing.

Since part of the EP's defense was to argue the radiologist's report was incorrect, the EP had to point the finger at the radiologist. The EP wanted to argue it was reasonable to rely on the benign CT imaging report in deciding to discharge the patient, and also argue the radiologist was the one who had committed the negligence that caused the patient's death.

"Because the EP's attorney did not produce the radiologist's report sooner, they were not allowed to present the expert's testimony," Keris recalls.

The reason the EP's defense attorney did not produce the report was that if the two defendants were

averse to each other, then it made the plaintiff's case easier. Once the defense radiologist and his group settled the case, the EP's attorney did not have to worry about adverse evidence from the radiologist.

"If the EP's radiology expert was allowed to testify that the settling radiologist was negligent, that testimony would have helped the EP," Keris says. In retrospect, the decision to discharge the patient was wrong. Despite the existence of the abdominal aortic aneurysm and the patient's clinical complaints of extreme abdominal pain, the EP received a defense verdict. The defense won the case mainly because of the documented interactions between the EP, the radiologist, and the family physician. "The jury believed it was reasonable for the EP to rely on the opinions of others, despite an obvious error," Keris says. ■

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Finger-Pointing in Nurse Charting Is Opportunity for Plaintiff

When experts review ED charts for plaintiff attorneys, nursing notes almost always are an area of focus.

"The nursing notes are often the documentation that 'fills in the blanks' not covered by the physician reports," says **Andrew P. Garlisi**, MD, MPH, MBA, VAQSF, EMS medical director at Cleveland-based University Hospitals EMS Training & Disaster Preparedness Institute.

Sometimes, nursing notes seem intent on pointing out what EPs did wrong.

"This creates the opportunity for finger-pointing, a dream come true for the plaintiff attorney," Garlisi says. Some examples of this kind of problematic charting:

• "Patient became hypotensive. Physician advised, but did not immediately examine the patient."

• "Doctor informed of chest pain at 15:24."

• "Physician informed of patient's increased agitation."

"If the physician does not have a matching notation, specifically timed, addressing the nursing concern, it leaves an opening for the plaintiff in the event of an adverse outcome," Garlisi cautions. The reverse also is true. Garlisi has seen EPs document these passive-aggressive items:

• "Antibiotics ordered for patient with septic shock at 14:00, but were not administered by nurse until 16:25."

• "Patient was ordered to be on continuous cardiorespiratory monitoring. However, when I entered the room, the patient was not on the monitor and was unresponsive."

• "I ordered vital signs every 15 minutes, but vitals were not performed for over one hour, and the patient was found to be profoundly hypotensive."

Generally, a unified defense is recognized as the best approach for all defendants in ED malpractice claims, but finger-pointing notes make it difficult. Garlisi suggests EPs and ED nurses meet briefly before each shift to discuss the importance of teamwork, not only regarding patient care but also documentation.

"Combined physician-nurse staff meetings are actually not common," Garlisi observes. "This makes pitfalls in patient care and documentation more likely to occur."

ED nurses are more likely to be employed by the hospital than EPs, who often are independent contractors. This can create different chains of command.

"If emergency directors and administrators do not see eye to eye with nursing directors and administrators, combined meetings are not likely to occur," Garlisi cautions.

As a result, many ED nurses and EPs have no idea about the liability implications of using charts to air grievances. "They may not be aware of the potential risk management complications that could ensue," Garlisi offers.

Typically, juries do not want to assess large damages against nurses, according to **Michael M. Wilson**, MD, JD, a Washington, DC-based healthcare attorney. "But when they make criticisms in the chart against the other healthcare providers, it will most likely come back to prevent the institution from mounting a successful defense," Wilson warns. These are some common examples:

• **The ED nurse documents findings that contradict the EP's findings.** One malpractice claim alleged a delay in diagnosing and treating Stevens-Johnson syndrome, a rare but serious disorder. The EP did not document a rash, but the

ED nurse did. The plaintiff attorney raised this question: Why would an ED nurse document a rash that did not exist?

The documentation created major credibility issues during litigation. "It made it inadvisable to try the case," Wilson explains. "The malpractice claim was settled by the institution that employed the ED physician and operated the ED."

• An ED nurse is upset about the EP's actions. One malpractice case hinged on the ED nurse's documentation of "multiple calls made to the on-call obstetrician, which went unanswered for a two-hour period."

The neonate was subsequently delivered through an emergency cesarean procedure. The baby sustained severe brain injury. "That case had to be settled for seven figures," Wilson recalls.

• Experienced nurses are unhappy with the performance of less-experienced residents. Some ED nurses intentionally flag the resident's perceived mistakes. That can create major legal issues — and not just for the resident, but also for the institution and everyone involved in the case. "Once the healthcare providers start blaming each other, the case frequently becomes nondefensible," Wilson says.

That is because healthcare providers have far greater credibility than any of the hired experts on either side. "Once the ED nurses start telling the jury that, for example, the resident made medical mistakes that caused injury to the plaintiff, it damages the credibility of defense counsel, their experts, and other ED providers who will all be testifying that nothing was done wrong," Wilson explains.

Unfortunately, some ED nurses view inflammatory charting as a way to protect patients from unsafe care. Ideally, there is a chain of command through which nurses can discuss what they see as inappropriate treatment decisions or incompetence. "They could report concerns without repercussions, instead of taking matters into their own hands and putting negative comments in the chart," Wilson says. ■

Providers' Misconceptions About 'Duty to Warn'

The legal concept of "duty to warn" is not new, but it is one ED providers often misunderstand.[1] "It basically covers third parties, somebody who is not warned properly. That duty goes back on the physician," says **Gregory Moore**, MD, JD, an attending physician at the Mayo Clinic in Rochester, MN, and at the Maricopa Medical Center in Phoenix.

If EPs are aware of "duty to warn," it is probably because of the landmark 1976 *Tarasoff* decision.[2] That case involved a patient who threatened to kill a specific person. The psychiatrist contacted the police about the threat, but failed to warn the intended target or her immediate family directly. "Calling the police isn't necessarily going to be sufficient to protect the EP," Moore notes.

Also, the patient does not need to name a specific person for the duty to warn to exist. "If the threat is made toward a defined group as opposed to a specific person, you need to warn the group," Moore explains.

If a patient made similar threats during previous ED visits but never acted on those, that does not mean current statements can be ignored. "Sometimes, the physician's defense is, 'He's been saying it for years,'" Moore reports.

The EP should warn the person who is threatened. If that individual cannot be reached, the EP should document their efforts, and notify law enforcement.

The *Tarasoff* case was the first to outline the requirement of duty to warn. "That was later amended to 'duty to protect,'" notes **James D. Calvert**, PhD, MSCP, LSOTP, a senior lecturer in the department of psychology at Southern Methodist University in Dallas.

If the client of a health professional (which could be an ED patient) threatens to seriously harm or kill someone else, that professional is supposed to try to find that third person, and warn them of the threat. The ED provider may not know who the person is if the patient talks about harming a spouse or co-worker without giving a name. "*Tarasoff* made it so that you would need to find and contact and warn the third party," Calvert says.

The law applies only to the state of California. "However, since it was the first and most famous case on duty to warn, it has become the most taught perspective on duty to warn. Some states have adopted that view, some haven't," Calvert reports.

The Texas Supreme Court found there is not a duty to warn a third party because of statutes on confidentiality.[3] "Indeed, they pointed out that telling a third party is a breach of confidentiality," Calvert notes.

Those Texas justices ruled that telling police or other professionals may still be a breach of

confidentiality, but would need to be assessed in another case brought before them. "However, the general application based on their wording has been that because of the ethical requirement of duty of care, getting help for a potentially dangerous client by contacting another professional to get them more intensive treatment is a reasonable and required standard of care," Calvert explains.

Contacting police or other emergency personnel would not happen to report clients for a crime. "It would be because those are the professionals in the community authorized to get clients into emergency care, such as a 72-hour hold in a hospital," Calvert says.

Not all states have adopted a position on duty to warn. Many ED providers are unaware of their state's requirements. To minimize risks, Calvert says providers should "consult with others when uncertain, do the best care you can for your patient, and document everything you do."

EPs are unlikely to realize their duty to warn obligations go beyond just threats of violence. Here are two examples:

• EPs are obligated to warn patients about the side effects of medication that could result in harm to others. In one case, a patient with a history of migraine headaches received the same medications as in many previous ED visits. No one provided a warning to the patient about side effects. Shortly after leaving the ED, she was in a motor vehicle accident that left her a paraplegic. The patient later sued successfully, winning $1.3 million.[4]

"You have to tell the patient not to drive on the medication because they might hurt somebody else," Moore says.

Since the EP cannot warn the general public of the dangers, the duty to warn is discharged when the patient is notified of the risk. This should be documented in discharge instructions.

• EPs are obligated to warn if there is a risk of infectious disease. One malpractice case involved a man who died from Rocky Mountain spotted fever after coming to an ED with headaches, fevers, and chills.[5] The patient's wife died shortly after from the same condition.

The son sued the EP successfully for failure to warn his mother she was at risk. The disease is not contagious, but infected ticks cluster geographically. The defendants appealed, but another court upheld the verdict. The court ruled that even though the wife was not in danger of contracting the disease from her husband, the EP still was legally obligated to warn her of the foreseeable risks.

"If somebody has gonorrhea and a third party might get disease from this patient, that you now know has the disease, the physician has a duty to warn that person," Moore adds.

How can the EP can warn all third parties at risk, since the EP does not know all the people who will come in contact with the patient? "You try to displace the duty to warn onto the patient," Moore offers.

ED providers must instruct the patient to warn others that he or she has been diagnosed with an infectious disease, whether it is tuberculosis or COVID-19. "It should be in the discharge instructions, that you warned them to notify people who could be affected," Moore says. ■

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CME/CE OBJECTIVES

After completing this activity, participants will be able to:

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

COMING IN FUTURE MONTHS

- EMTALA violations if ED patient is admitted
- Legal obligations if another provider sent patient to ED
- Hospitals' legal exposure if EPs are not board-certified
- Malpractice claims allege ED misdiagnosed sepsis

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CME/CE QUESTIONS

1. **Which did the authors of a recent study find regarding ED malpractice claims?**

   a. Internists received more diagnosis-related allegations than emergency physicians (EPs).
   b. The most common final diagnoses were myocardial infarction (MI), pulmonary embolus, and cardiac arrest.
   c. Most claims naming EPs also included ED nurses as co-defendants.
   d. Few claims naming EPs also included the hospital as a co-defendant.

2. **Which documentation can help the ED defense of a missed MI malpractice claim?**

   a. ED providers should not specifically mention any signs consistent with MI if they intend to discharge the patient.
   b. ED providers should specify reasons why the EP does not believe the patient is experiencing an MI.
   c. ED providers should document "chest pain" more generally, as opposed to noting overly specific details on the location and nature of the pain.
   d. ED providers should document telemetry monitoring only if there were abnormal findings.

3. **Which did a study on ED super-users reveal?**

   a. Super-users account for less than 5% of all ED visits.
   b. Younger patients are more likely to be super-users.
   c. The most common diagnoses were low back pain, nausea and vomiting, chest pain, headache and migraine, urinary tract infection, and abdominal pain.
   d. Patients with unmet social needs recorded fewer ED visits than patients without unmet social needs.

4. **Which is recommended regarding CT use in pediatric patients?**

   a. Ultrasound is not indicated for the evaluation of pediatric abdominal pain, since the appendix is not visualized frequently.
   b. Consider appendicitis pathways using ultrasound, followed by focused MRI if the ultrasound is nondiagnostic, to prevent the need for CT scans without increasing liability.
   c. Avoid using the Pediatric Appendicitis Score.
   d. Either discharge patients or admit them, but do not observe them for long periods without ordering a CT scan.