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EDs Face Legal Trouble if Patient's Advance Directive Not Followed

Emergency physicians (EPs) worry about litigation because they did not save a patient's life. However, few realize there are considerable legal risks if aggressive end-of-life care is provided against the patient's wishes.

Several recent million-dollar settlements have involved ED patients who were resuscitated or intubated against the documented wishes in their advance directives.[1] "As the front line, the ED providers would be considered more culpable than anyone else in the situation," says **William Hopkins**, JD, a partner at Austin, TX-based Spencer Fane.

ED providers are the first ones to encounter the patient, and the first ones with the opportunity to find out if there is an advance directive — and, if so, to make sure it is in the medical record. "Wrongful prolongation of life lawsuits are a fairly new phenomenon, based on the expansion of our society's acceptance that patient choice and decision-making is paramount in healthcare," Hopkins says.

For years, courts routinely dismissed such lawsuits, ruling plaintiffs had no cause of action.[2-7] "The old concept of healthcare was that failing to do something that results in someone's death is bad and punishable, but doing something that results in life being extended should not be punished, even if it is not what the patient wanted," Hopkins says.

Courts took the view that providing extra life cannot be an injury to a person. But recent successful lawsuits have opened the door to this litigation.[8-11] "In the past decade or so, we've seen courts more willing to recognize that patients who are treated without their consent actually suffer a legally compensable injury," says **Nadia N. Sawicki**, JD, co-director of the Beazley Institute for Health Law and Policy at Loyola University Chicago School of Law.

The publicity surrounding these cases, especially those with significant financial settlements, means patients, families, and clinicians are on notice

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that "wrongful prolongation of life" is something that can be addressed through the legal system. "It's likely that healthcare providers will see more of these claims in the coming years," Sawicki predicts.

The recent successful wrongful prolongation of life lawsuits reflect a greater appreciation of a patient's right to choose. "That includes the termination of that life or not trying to save that life with extraordinary measures," Hopkins explains.

State and federal administrative agencies also are paying attention to the issue of advance directives. Under the Patient Self-Determination Act (PSDA) of 1990, Medicare-participating hospitals are required to establish policies and procedures for documenting whether a patient presents with an advance directive, and informing patients of the hospital's policies regarding those directives. "There have been several instances where administrative action has been taken against facilities that violate the requirements of the PSDA," Sawicki reports.

Emergency providers should familiarize themselves with hospital policies to ensure their departments are in compliance. Patients, if conscious and competent, can refuse treatment. Liability for failing to honor advance directives is in some ways a logical extension of this. Wrongful prolongation of life lawsuits argue if a refusal of treatment should be honored when provided verbally, it should be equally honored when provided in writing in the form of an advance directive. "Failure to do so violates patients' rights and may be actionable," Hopkins cautions.

Additional legal exposure is possible because of physical harm caused by unwanted life-saving interventions. Ribs can be broken during resuscitation efforts. "I have seen 'life-saving' actions, contrary to an advance directive, being characterized criminally as assault and battery based on the definition of an 'unwanted, harmful, or offensive touching by another,'" Hopkins recalls.

Hopkins says ED providers should ask themselves this question: If this patient were conscious and refusing these actions, would I still be comfortable performing them against the patient's wishes? "Most ED staff would answer very quickly that the answer is no," Hopkins offers.

EPs are likely to be named in advance directive lawsuits, even if the actual interventions happened in the ICU. "As the top of the healthcare decision-making pyramid, it is the physician who issues the orders regarding how to proceed with treatment, including life-saving measures," Hopkins notes.

EPs also are obligated to ensure patient records are reviewed for advance directives before proceeding with a treatment plan. "Failure to do so is no different than a physician making any other medical decision without all of the relevant information first," Hopkins observes.

If the advance directive is never found or it is ignored, and the patient ends up in the ICU, any resulting malpractice lawsuit probably is going to name everyone involved in the care. "The argument is that the ICU staff are continuing the abuse of the patient, because the patient is still being treated after the violation has occurred," Hopkins says. Most of the blame and liability might focus on the ED. "It was their initial failure that led to all of the subsequent actions and allegations," Hopkins explains.

Hopkins says training is the best way to avoid these lawsuits.

Triage staff should be seeking as much information as possible from the patient and/or family about any possible advance directive, and document what they find. "No matter what the response to the questions, make sure that it is documented," Hopkins stresses.

That way, if the patient or family later claims nobody ever asked them about an advance directive, the record proves otherwise. This can shift the liability from the ED to the family member or patient who failed to disclose that information, because the ED can establish that an effort was made to find out. "ED staff will have a defense to a potential lawsuit when the advance directive is later discovered," Hopkins says.

Most wrongful prolongation of life claims center on resuscitation of a patient with a DNR or Do Not Intubate order. "These are usually treated like negligence cases, with the usual rules for standard of care, expert testimony, and the like," says **Thomas William Mayo**, JD, professor of law at SMU in Dallas.

Claims can be brought against an EP who performs the resuscitation despite an unmistakable order in the chart or bracelet. "Liability will turn on the factual details of individual cases," Mayo says. There are important fact issues to consider:

• How emergently did the patient need resuscitation — immediately upon arrival, or several hours later? "A possible defense for ED providers is that an extremely urgent emergency presentation made it impossible to check for an out-of-hospital DNR," Mayo notes.

• Would a reasonable ED team have noted the patient's resuscitation status (if any) and shared it among the treatment team? "Some courts are reluctant to entertain these claims because, as with wrongful life claims on behalf of infants, the courts are reluctant to consider life to be a legal harm," Mayo explains.

Under some circumstances, unconsented resuscitation may give rise to a battery claim.

"This is an intentional tort and as such, it may give rise not only to compensatory damages for an unconsented harmful or offensive touching but also to punitive damages," Mayo says.

In the ED, many patients who need resuscitation are unconscious. "Presumed consent" to life-saving interventions is the general rule. "Battery will be difficult to prove unless the team overlooked a DNR bracelet or other obvious indication that the patient does not consent to resuscitation," Mayo offers.

Ryan R. Nash, MD, MA, has reviewed multiple "wrongful prolongation of life" cases as an expert witness, and advises hospitals on how to avoid these lawsuits. Nash says the transition between the ED and ICU or inpatient floor is the root of the problem in some cases. The EP does put the DNR status in the notes, but somehow it never is conveyed to the physician who is writing the admit orders.

"Even when the ED does its job and the DNR status is documented all over the chart, it gets lost in the transition between the ED and the inpatient side," says Nash, director of The Ohio State University Center for Bioethics.

In other cases, everything is handled correctly. The DNR order is in the chart, the bracelet is on the patient — but clinicians panic in the heat of the moment. "When they resuscitate someone who has a DNR bracelet on their body, that's called malpractice," Nash says.

In one such episode, clinicians noticed the DNR bracelet, but it was 45 minutes after resuscitating the patient. Nash suggests a few tips to avoid problems:

• **Everyone caring for the patient must take responsibility to check DNR status.** "Whose responsibility is it to check the chart and verify the bracelet? Everybody who enters the room," Nash stresses.

• **Clinicians can categorize patients who are likely to need resuscitation as a "predicted code."** That way, ED staff anticipate the need for CPR, and can decide on a plan of action based on the patient's code status.

• **ED clinicians can become familiar with protocols and policies on DNR status.** "You can make a lot of good policies, but the failing is the education of the staff," Nash notes.

One good way to educate staff is by sharing information on recent successful advance directive lawsuits. "I encourage hospitals to tell these stories as cautionary tales," Nash says. "It's a surprise to many people who didn't think that resuscitating someone who's DNR opens them up to liability." ■

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'Total Breakdown in Communication' Led to Settlement of Advance Directive Case

An 89-year-old New Jersey woman had put in place both "do not resuscitate" and "do not intubate" orders. Despite this, ED providers resuscitated and intubated her anyway.

Her daughter sued the hospital, the EP, and several nurses for disregarding the patient's wishes. The lawsuit alleged the providers either did not know about the advance directive or ignored it.

A superior court judge ruled the defendants violated the patient's "fundamental right to refuse unwanted medical care."[1] **Timothy L. Barnes**, Esq., represented the plaintiff, and says three issues led to a settlement for an undisclosed amount:

• Providers failed to carefully review the documentation about the advance directive in the medical chart. "The ED staff, both nurses and doctors, must read the entire chart and specifically familiarize themselves with any advance directives," says Barnes, an attorney with Morristown, NJ-based Porzio, Bromberg & Newman.

• The nurse failed to tell the resident about the advance directive, who failed to tell the attending in the ED, who failed to tell the hospitalist on the floor after admission. "There was a total breakdown in communication," Barnes says.

• No provider acted on the advance directive, despite the fact it was documented in multiple places. Instead, the providers relied on a brief version of the history taken by previous providers, without taking their own history, and without reading the documents in the chart. "Everyone was at fault, so they were all named in the suit. They all contributed to the settlement," Barnes reports.

EDs can learn a lot from this particular case about how to avoid litigation for disregarding advance directives. "We learned, through discovery, that the hospital revised many protocols as a result of the mishandling of this patient's DNR," Barnes says. ■

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When Urgent Care Center Refers Patient to ED, Reasons Might Be Unclear

Some patients present to the ED without really knowing why. They come not of their own accord, but because an urgent care center referred them.

"In my ED, patients are commonly referred by urgent care centers. This can be frustrating if there is no call and the patient is unsure why they have been sent," says **Laura Pimentel**, MD, an EP at University of Maryland Medical Center.

Sometimes, the discharge instructions are helpful in clearing up the situation, sometimes not. Certain patients are unhappy because studies performed at the urgent care center (e.g., X-rays, ECGs, or lab work) are not available and must be repeated in the ED. "When the referral is unclear and information is omitted, the EP should call," suggests Pimentel, clinical professor of emergency medicine at University of Maryland.

The goal is twofold: to learn why the patient was sent to the ED, and the results of workup already completed. "There is risk if there is poor communication and the ED physician is unsure why the patient was referred," Pimentel says.

In essence, the urgent care center is "escalating the urgency of care needed by that patient by referring them immediately to the ED for a further workup of their presenting issue," says **Heather L. Brown**, DMSc, PA-C, DFAAPA, owner and CEO of Roswell, GA-based HL Brown and Associates.

If the ED determines nothing more is needed, or the additional assessment did not indicate anything more serious, "it certainly opens the door for a missed opportunity for diagnosing something that could develop after discharge," Brown

cautions. Emergency providers can cut risk by following a few practices:

• The EP should explicitly address the concern of the referring provider, even if the EP does not agree the patient is emergent. "Good documentation is the best defense against the risk of litigation on the basis of disagreement with a referral," Pimentel offers.

Red flags are created when it appears as though the EP just ignored the concerns of the urgent care provider. If a patient is referred because of possible appendicitis, the EP is not obligated to order an abdominal CT scan. "But she should perform a careful clinical evaluation," Pimentel cautions.

The EP also should specifically address why a CT scan is not indicated for the patient. "This indicates that she understood the reason for the referral and addressed the question specifically," Pimentel adds.

• The EP should avoid making negative comments such as, "They don't know what they are doing over there" or "This is a ridiculous referral." Badmouthing the urgent care center to the patient is not a good idea.

"If a complication later arises, those feelings toward the provider can play into initiating litigation," Brown explains.

Disparaging the urgent care center "is unprofessional, unnecessary, and upsetting and confusing for patients," Pimentel says. "If an emergency is missed, it sets the EP up for embarrassment and litigation."

• The EP should conduct a thorough evaluation, even if an urgent care center routinely refers patients who are not emergent. "Treat every patient as a new case and start from scratch," Pimentel suggests.

• If there is a conversation with the urgent care center, the EP should document it (in the medical record or on a standard form used to document call-ins from referring physicians). "These are now primarily within the EMR, so [they] can be reproduced if necessary for defense purposes," Pimentel notes.

There also is possible legal exposure if the EP does not continue the plan outlined at the urgent care center. For instance, patients often are sent to the ED to rule out pulmonary embolus. "The ED provider must be sure the patient understands whether this was ruled out — and, if not, why not," says **Daniel Pallin**, MD, MPH, an assistant professor of emergency medicine at Harvard.

The single most important factor in avoiding malpractice liability is the patient's clinical outcome. It stands to reason patients referred to the ED by other providers are more likely to experience bad outcomes than walk-ins. "They've already been triaged," says Pallin, research director in the department of emergency medicine at Brigham and Women's Hospital in Boston.

Lawyers, expert witnesses, and juries must determine if the standard of care was breached. If the patient experiences a bad outcome that is relevant to the reason for referral, concluding the standard was breached is easier. "If the outcome is bad, and you did not adhere to the standard of care, no amount of warm conversation or defensive charting will save you," Pallin explains.

The key to avoiding malpractice lawsuits, says Pallin, is to ensure all ED patients experience the best attainable outcomes, and devote extra thought to scenarios in which mistakes are less likely to be forgiven. For patients sent by urgent care centers, "be sure you fully understand why the patient is there," Pallin says. "Think about the worst possible outcome."

If a patient was sent to the ED from an urgent care center, another provider has categorized the patient as high-risk. It is possible the ED provider does not share the same view of the problem as the referring clinician. "Call the referrer if you don't understand the referral," Pallin suggests.

That is especially important if the EP does not understand why the referrer thought it was an emergency. "If things are not crystal clear, go the extra mile for this small group of patients," Pallin says. ■

Communication and Resolution Programs Are Alternative to Malpractice Claims

Considering signs of financial uncertainty in liability insurance markets, it is an excellent time for EDs to study communication and resolution programs as an alternative to malpractice litigation, the authors of a recent paper argued.[1] "We wrote this paper to encourage the medical community, and the insurance industry that serves it, to see the challenges of a hardening insurance market differently this time around," says **Richard C. Boothman**, CEO of Boothman Consulting Group.

A growing number of hospitals, including EDs, have implemented communication and resolution programs (CRPs). The law is slowly evolving to support these alternative approaches. So far, 39 states have instituted some form of apology law.[2] These apology laws are "creating a fertile environment for communication and resolution programs to be adopted," says **Michelle M. Mello**, JD, PhD, a professor of law and medicine at Stanford. Apology laws "do tend to have some reassurance value for physicians, which might help them be a bit more candid with patients," she adds.

When things go wrong in any healthcare setting, including the ED, "there are better ways than adversarial litigation to care for patients, ways that also help prevent harm to future patients," says **William M. Sage**, MD, JD, chair for faculty excellence at the University of Texas at Austin School of Law. In the post-COVID-19 pandemic period, the financial uncertainty in liability insurance markets "might grow into a full-fledged crisis of the sort not seen in nearly two decades," Sage observes. "We wanted to talk about possibilities, such as communication and resolution programs, before people are too panicked to consider them."[1]

In emergency medicine, as in all healthcare fields, "openness, compassion, and engagement are essential aspects of liability prevention," Sage continues. "This is the right time to implement systems of error response that emphasize them."

Boothman is frustrated by the slow pace of adoption. "Lawyers have been serious impediments to the spread of CRPs for various reasons. But it's finally dawning on the legal profession that they need to know about CRPs and get involved," says Boothman, a visiting scholar at the Vanderbilt University Medical School Center for Patient and Professional Advocacy.

These programs also have been proven to reduce claims; shorten the time for claims to be resolved; and decrease total liability, patient compensation, and non-compensation-related legal costs.[3] "We reached this conclusion more than a decade ago, and still, authentic spread of this approach remains slow and incomplete," Boothman laments. Historically, tort reforms have been the response to hardening professional liability insurance markets. "These reforms, in one form or another, simply make malpractice claims harder to bring or less lucrative or both," Boothman says.

For emergency medicine in particular, tort reform involved attempts to immunize providers delivering emergency care. Boothman says these efforts are counterproductive. "They would shelter shoddy practices, invite dangerous practitioners, and lead to greater patient harm," he argues.

EPs do face some unique challenges in terms of malpractice risks. "They see patients in isolated vignettes of their patients' lives and patients' illnesses," Boothman offers. "EPs diagnose, treat, counsel, and refer around illnesses that are often not clear at the time of presentation."

Communication and resolution programs can help reduce risks for both EPs and their patients. "The best thing we can do to help our caregivers realize their own professional goals is to create a culture that stimulates learning and improvement," Boothman says. ■

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Template Charting on Nursing Notes Complicates Med/Mal Defense

Many EPs use boilerplate documentation to indicate they saw, and agreed with, everything ED nurses charted, such as, "Nursing notes reviewed and agreed unless discussed."

"Blanket statements like that, in general, are not good practice. If something bad happens and you end up in a deposition, it's very difficult to talk your way out of it," says **William J. Naber**, MD, JD, associate professor of emergency medicine at the University of Cincinnati.

One problem is patients might give a different history to ED nurses and EPs. A patient tells the nurse about chest pain. When the EP comes in to evaluate the patient, she only mentions abdominal pain. If the chest pain is not investigated, and the EP's chart states he or she agreed with the nursing notes, "it creates a very challenging position for the EP to be in if something goes awry," Naber explains.

Another issue is nurses might document after the EP discharges the patient. "They may do an entry, based on the last thing they talked about, and it may be something unique or different about the visit that the provider would not know," Naber observes.

The EP has discharged the patient, and assumes the interaction with the patient is finished. If the patient came in with chest pain, labs and ECG returned normal, and is discharged home, the patient may mention something to the nurse on the way out about the pain returning or changing. If the EP does not see the nursing note, and does not investigate further, but the chart indicates the nursing notes were reviewed, "that's a very difficult statement for a provider to talk around," Naber cautions. In one recent deposition, an EP defendant indicated disagreement with the nurse. The plaintiff attorney noted the EP had "agreed" with the nurse in the templated statement. "I'd much rather be in a situation, if asked in a deposition by counsel if I reviewed the nursing notes, to say, 'My standard practice is to review the nursing notes,'" Naber offers.

> "IF THE DOCTOR DID NOT ACTUALLY REVIEW THE NURSING NOTES, STAY SILENT ON IT."

That statement allows the EP to talk about the notes, but does not imply the EP agreed with the notes. But there are times when it becomes painfully obvious the EP never read the nursing notes at all. "Sometimes, the EHR's audit trail is pulled and it shows that the EP provider did not review the nursing notes — when that EP provider's own note states that the nursing notes were so reviewed," says **Alexandra Dare Essig**, JD, a principal at Goodman Allen Donnelly in Glen Allen, VA.

In other cases, the EP only read part of the notes, but missed an important piece of information, reviewed notes of only some nurses, or reviewed the notes hours after the patient was discharged. Essig also has seen episodes in which an EP testified the nursing notes were read, but the audit trail indicated otherwise. One EP claimed to have read the nursing notes, but was unaware the patient registered a worrisome National Institutes of Health Stroke Scale score — or that such a test was performed at all. The nurse testified the EP was informed of the results, and the documentation supported it. The Stroke Scale score was at odds with the physical exam conducted shortly before, which revealed no neurological deficits. By taking no action to rectify the discrepancy, claiming the nursing notes were reviewed appeared suspicious.

Instead of relying on template charting, systems could require the EP to type in the name of the nurse whose notes were reviewed. "The system could also flag each nursing note actually reviewed by the EP as being reviewed, whether it was a progress note, ancillary event note, or flow sheet," Essig suggests.

When EPs state "nursing notes reviewed," they are including everything contained in the notes, says **Tracie Dorfman**, JD, an attorney at Hancock, Daniel & Johnson in Fairfax, VA. "If the nursing notes contain something contrary to the doctor's own assessment, that can be fatal in a later malpractice claim," she cautions. The EP's defense might be the EP was unaware of a certain piece of information. If it was contained in the nursing notes, and the chart states "nursing notes reviewed," then "that defense goes out the window," Dorfman says.

Instead of making blanket statements about review of nursing notes, the EP should document accurately. "If the doctor did not actually review the nursing notes, stay silent on it," Dorfman warns. ■

State Malpractice Claim Rate Tied to Low-Risk Syncope Admissions

The frequency of malpractice claims is associated with higher rates of hospital admission for ED patients with lower-risk syncope, according to the results of a recent study.[1]

"There are many factors driving the decision to admit. Our goal here was to determine what effect malpractice climate may have," says **James Quinn**, MD, the study's lead author and professor of emergency medicine at Stanford University Medical Center. For example, patients with vagal symptoms, no history of cardiac disease, and a normal ECG would be low-risk patients, as determined by several of the syncope rules and risk scores available.[2-4]

Quinn and colleagues analyzed data from the Clinformatics Data Mart database on ED visits. They found 1.3% of ED visits between 2008 and 2017 were associated with syncope. Of those, 45% met criteria for lower-risk syncope. In this lower-risk group, 18.8% were admitted.

The authors also studied the rate of physician malpractice claims in the National Practitioner Data Bank during the same period. If the number of malpractice claims was higher, hospital admissions rates also were higher.

These findings suggest defensive medicine is the likely reason for the extra admissions. "The malpractice climate should not be as great a determining factor when deciding the ED disposition of low-risk patients," Quinn argues.

This raises the question of why some low-risk patients are admitted when they really do not need to be. Generally, EPs know who the low-risk patients are. For the most part, these patients do not require admission.

The issue is EPs might hesitate to discharge these low-risk patients, fearing a possible bad outcome and lawsuit alleging delayed diagnosis or premature discharge. "With decision rules and support, [EPs] should be more comfortable discharging these patients," Quinn says.

Documenting the patient's low-risk characteristics and using a risk score is helpful to the defense. From 2008 to 2017, there was an overall downward trend in the admission rate of low-risk patients.[1] "But there is still a good portion who are admitted," Quinn notes. "A thorough assessment and good judgment, supported by guidelines, can improve the management and efficiency of these patients." ■

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Safety Protocols Reduce Risk of Self-Harm for At-Risk Patients

A safety precautions protocol reduced self-harm for at-risk ED patients, according to a recently published paper.[1]

"Our ED cares for a large volume of patients at increased risk for self-harm," says **Abigail Donovan**, MD, the study's lead author and associate psychiatrist at Massachusetts General Hospital.

Even though staff took basic safety precautions, there were several episodes of self-harm in the ED. "This prompted the formation of a task force to investigate root causes, and to make self-harm a 'never event' in the ED," says Donovan, assistant professor of psychiatry at Harvard.

Donovan and colleagues compared the frequency of self-harm events before and after a protocol was implemented. "The initiation of comprehensive safety precautions correlated with lower, although not statistically significant, rates of self-harm among at-risk patients in the ED," Donovan reports.

The year before the protocol was implemented, there were 13 episodes of attempted self-harm among 4,408

at-risk patients. Six of those episodes resulted in actual self-harm. The year after the protocol was introduced, the numbers declined to six episodes and one episode, respectively.

Donovan and colleagues also discovered an interesting finding: Half of the self-harm events that happened after the protocol involved some sort of protocol breach. "While our fidelity was overall quite good, the impact of a protocol breach can be significant," Donovan notes.

The ED's protocol dictates all patients at increased risk of self-harm must use designated safe bathrooms that are ligature-resistant (i.e., free of anything that could be used for the purpose of strangulation or hanging, such as cords or ropes). In addition, the bathrooms must be observed at all times.

In one case of protocol breach, a patient used a non-safe bathroom, which included a plastic trash can liner. The patient attempted to take out the trash can liner to self-harm, but an observer intervened. "Having multiple mitigation strategies in place was critical to prevent actual self-harm," Donovan says. "But the protocol breach created an area of vulnerability."

All EDs are at risk for unwanted outcomes, including patient self-harm. "Developing and implementing comprehensive safety precautions is an important clinical and risk management strategy," Donovan says.

Protocols should be tailored to the specific ED to address their different physical environments. Some examples:

• Bathrooms may or may not be ligature-resistant. Mass General's ED designated safe bathrooms that are ligature-resistant. In an ED without ligature-resistant bathrooms, specific guidance for observers regarding particular hazards in those bathrooms would be prudent. "For example, a protocol may dictate that observers receive training on the hazards that sink handles, paper towel [holders], and toilet paper holders pose," Donovan offers.

The protocol also might require observers to visually check the bathroom after the patient leaves to verify trash bag liners, light bulbs, pull cords, or other hazards were not removed.

• Patient visibility differs depending on the ED's physical environment. At Mass General, multiple ED patients can wait in a large, open area. That gives a single observer excellent visibility of up to four patients at once. Therefore, the ED's protocol requires just one observer for up to four patients.

Not all EDs include a large, open area. Instead, staff might place each patient in individual rooms. "In this case, one-to-one observation may be necessary," Donovan explains.

• EDs may want to create individual policies on whether at-risk patient belongings are searched or stored, depending on available space and resources. "Our ED has sufficient storage space, but no surplus of police and security bandwidth to search belongings," Donovan says. The ED made the decision to store belongings, rather than require police or security to search them for contraband.

For any ED, safety events (including near-misses) should be monitored continually to allow for protocol updates. A recent example at Mass General involved patients who ask to keep a book or phone on their person — but they might have been hiding a sharp item to attempt self-harm.

"In our ED, we had several episodes of observers stopping patients from using hidden sharps to self-harm," Donovan reports.

If no one tracked these recurring episodes, it would have seemed to clinicians that each time it was just a one-off. In fact, the near misses happened multiple times. "It needed to be addressed by a safety protocol," Donovan adds.

The Joint Commission's National Patient Safety Goal 15.01.01 applies to EDs. It lays out a comprehensive suicide prevention plan.

"This includes understanding the environment patients at risk for suicide may be in, and removing objects that they may use to harm themselves from those spaces, when possible," says **Stacey Paul**, MSN, RN, APN/PMHNP-BC, clinical project director of standards and survey methods at The Joint Commission. These specific requirements pertain to EDs:

• If the environment presents risks that cannot be removed, and a patient at high risk for suicide is in that space, 1:1 monitoring may be necessary.

• All patients who present to the ED with emotional or behavioral concerns as their primary concern must be screened for suicide risk.

• For patients who screen positive, an evidence-based process must be used for assessment.

• Based on the screening and assessment, appropriate safety procedures, protocol, and treatment plan are determined.

• Staff must give counseling and follow-up instructions when discharging a patient at risk for suicide.

• All ED providers who care for patients at risk for suicide must be given training.

• Hospitals must implement a quality improvement process related to their suicide prevention program.

All this is highly likely to be scrutinized during Joint Commission surveys, when surveyors "trace" a patient's experience throughout

the hospital stay. "A surveyor will likely trace a patient who has been determined to be at risk for suicide," says **Emily Wells**, MSW, CSW, project director of surveyor management and development for The Joint Commission. The surveyor will look at everything that happened to the patient, from intake to discharge. In the ED, says Paul, that covers "the screening process and assessment process, determining what components of the environment needed to be removed for that patient to be kept safe, and monitoring procedures." ■

REFERENCE

1. Donovan AL, Aaronson EL, Black L, et al. Keeping patients at risk for self-harm safe in the emergency department: A protocolized approach. *Jt Comm J Qual Patient Saf* 2021;47:23-30.

Confusing Presentation Could Result in Successful Missed Sepsis Claims

Despite recent emphasis on early sepsis intervention, little is known on exactly what symptoms these patients experience when presenting to EDs — and how frequently. "This knowledge is important for educating the public about what symptoms may portend a diagnosis of sepsis, as well as educating our clinicians about what symptom profiles they should be aware of when it comes to diagnosing sepsis," says **Vincent Liu**, MD, MS, a research scientist at the Kaiser Permanente Northern California division of research and critical care specialist with The Permanente Medical Group.

Without understanding what a "typical" sepsis patient looks like, it is hard for EDs to know what to watch for. Liu and colleagues analyzed 408,377 patients admitted through the ED from 2012 to 2017 with stroke, heart failure, suspected infection, or sepsis. They found there really is not a clear "typical" sepsis patient.[1] "We found that the symptoms of sepsis and infection were diffuse and heterogeneous," Liu reports. The way septic patients presented varied widely. Dyspnea, weakness, altered mental status, pain, cough, edema, nausea, hypertension, fever, and chest pain all are common signs and symptoms. Only a few patients presented with clear symptoms of infection (fevers or chills). Many presented with symptoms that overlapped with other conditions, such as pain, vomiting, or confusion. "This differed from the presentation of heart failure or stroke, which had well-defined profiles that fit with the condition," Liu explains.

Sepsis patients with typical or clear symptoms received antibiotics earlier. For those cases, the diagnosis of sepsis is clear, and the clinical workup and treatment are standardized. "However, our data confirm the challenges in clearly identifying sepsis," Liu explains.

So many symptoms with which septic patients present mimic symptoms of other conditions. The entire picture of infection is not immediately apparent. "Even without a 'typical' sepsis presentation, patients can still suffer the systemic effects of a severe infection," Liu notes.

Even young and otherwise healthy patients have succumbed to sepsis as a direct result of immune modulators, says **Andrew P. Garlisi**, MD, MPH, MBA, VAQSF, medical director of Geauga County (OH) EMS and University Hospitals EMS Institute Paramedic Training Program. Adalimumab, etanercept, golimumab, and infliximab (and many others in this class of medications) are used for a variety of conditions (e.g., rheumatoid arthritis, ankylosing spondylitis, psoriatic arthritis, Crohn's disease, ulcerative colitis, and psoriasis). "Often, these medications are not listed, or are not recognized by the emergency physician as serious risk factors for sepsis and septic shock," Garlisi says.

Garlisi is aware of two patients younger than age 50 years who were on adalimumab and died from unrecognized sepsis. "It is the obligation of the emergency staff to ensure the accuracy and completeness of the medication list," Garlisi stresses.

Unfortunately, this often is difficult or impossible. Patients cannot or will not provide the information. "It would behoove the emergency physician to consult the EMR for any information regarding patient medications, and document this effort," Garlisi suggests.

Failure to timely recognize sepsis in its early stages is a recurring issue in malpractice claims reviewed by **Heather A. Tereshko**, JD, a principal in the professional liability practice at Post & Schell in Philadelphia. "Frequently, sepsis does not present with features that are commonly associated with overwhelming infection," Tereshko says.

Underlying symptoms of infection might be masked by presenting symptoms that point to a cardiovascular issue. In a recent case, a 64-year-old man presented to the ED with a chief complaint of shortness of breath and change in mental status, accompanied by hypotension and tachycardia. He

was afebrile, but appeared cachectic. He had no significant medical history, and his family could not provide any additional history or details of the patient's condition preceding his ED presentation. His preliminary ECG was abnormal. The differential diagnosis included pulmonary embolism and myocardial infarction. The patient was seriously dehydrated, requiring multiple "sticks" to draw blood for lab work. The patient required IV fluid resuscitation before a vein could be accessed. This delayed lab results, through no fault of providers.

Labs showed a significantly elevated white blood cell count, BUN/creatinine, and lactate. "Fluid resuscitation was initiated, however, with concern for fluid overload because of the patient's abnormal ECG," Garlisi reports.

The patient was admitted and transferred to the hospital's ICU for further aggressive IV fluid resuscitation and treatment in accordance with the hospital's sepsis protocols. "Unfortunately, he was in organ failure, and required vasopressors, which led to limb ischemia, resulting in gangrene and subsequent amputations," Garlisi says. The case was settled for an undisclosed amount.

In other missed sepsis claims, patients presented with low blood pressure, shortness of breath, and tachycardia, and the focus was to rule out pulmonary embolism. Likewise, if a patient presents with shortness of breath, chest pain, and an abnormal ECG, and labs are positive for an elevated troponin level, the thought logically turns to a cardiac-related illness. "Diagnosing, or suspecting sepsis timely, is as important as diagnosing or suspecting stroke or cardiac event in a timely manner," Tereshko says.

Patients with sepsis often do not report initial symptoms severe enough to go to the ED. By the time they feel so ill they decide to seek treatment, timely diagnosis becomes even more critical. "Once the patient demonstrates two or more criteria for sepsis, the clock starts," Tereshko notes.

All treatment that follows is subject to scrutiny in terms of acting timely and within the hospital's sepsis protocol. "Timestamp notations in the EHR can make or break a malpractice case," Tereshko observes.

Tereshko says that plaintiff attorneys usually focus on delays in obtaining or resulting a patient's labs from the time of triage, failure to initiate aggressive IV resuscitation timely and in accordance with the clinical pathway outlined in the hospital's sepsis protocol, and failure to follow the hospital's sepsis protocol/clinical pathway. "It is incumbent upon every physician and nurse providing care in an ED setting to be acutely aware of their hospital's sepsis protocol and order sets, and to ensure that it is followed whenever sepsis is suspected," Tereshko stresses.

Ensuring adequate perfusion, and making every attempt to avoid the development of ischemic injury, which becomes more difficult when vasopressors are needed to support the patient's failing organs, also is critical to the defense. Obtaining a history from the patient regarding the severity and length of time symptoms were experienced before presenting for treatment may provide some cushion for defending the case. "The fact that the patient had to be emergently transported for treatment could be important for the defense," Tereshko offers.

Obtaining testimony from the patient and family, and analyzing the history provided to emergency responders, may be helpful in setting up a contributory negligence defense. "In sepsis cases, when the patient seeks medical treatment so late that he or she is already experiencing organ failure, the physician can only do so much to reverse that which has gone untreated," Tereshko says.

There always will be experts on both sides who disagree as to the timeliness of diagnosing and initiating the appropriate treatment in an ED. **Annie E. Howard**, JD, an attorney with Hancock, Daniel & Johnson, sees a common fact pattern in missed sepsis cases: Some indicators of sepsis are there (e.g., fever, chills, or nausea) and are initially appreciated by the nursing staff or physician. Yet the patient is discharged without appropriate treatment.

The patient returns to the ED when symptoms worsen, after which time the infection may have progressed past a point of recovery. "There is a less common fact pattern, but one that emergency departments must plan for," Howard notes.

This involves notifying patients if a blood culture returns positive after discharge. In those cases, the patient may not have presented with symptoms acute enough to warrant admission or IV antibiotics for potential sepsis. However, a blood culture indicates treatment is imminently necessary. "Well-documented procedures, and documentation those were carried out, and a formalized approach is critical," Howard stresses.

A simple phone call often is not enough to reach the patient. "If the patient's phone number is out or if a voicemail box is full, there must be an alternative method to contact the patient and document it was completed," Howard says. ■

REFERENCE

1. Liu VX, Bhimarao M, Greene JD, et al. The presentation, pace, and profile of infection and sepsis patients hospitalized through the emergency department: An exploratory analysis. *Crit Care Explor* 2021;3:e0344.

ED LEGAL LETTER™

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **Which is true regarding liability for ED providers if advance directives are not followed?**
   a. Courts continue to routinely dismiss wrongful prolongation of life lawsuits because plaintiffs have no course of action.
   b. Patients who are treated without their consent suffer a legally compensable injury.
   c. Hospitals are no longer required to document whether a patient presents with an advance directive.
   d. Unconsented resuscitation cannot give rise to a battery claim since it is a common medical practice.

2. **Which is true regarding communication and resolution programs as an alternative to ED malpractice litigation?**
   a. Apology laws are making it more difficult for these approaches to be implemented.
   b. Patients complained more about the alternative programs than the traditional litigation process.
   c. Evidence shows this approach lowers costs of total liability, patient compensation, and non-compensation-related legal costs.
   d. Communication and resolution programs result in higher payouts and more claims.

3. **Which did a recent study reveal regarding safety protocols to reduce risk of self-harm for at-risk ED patients?**
   a. A safety precautions protocol reduced self-harm for at-risk ED patients.
   b. None of the self-harm events that happened after the protocol involved protocol breaches.
   c. Ligature-resistant bathrooms presented unexpected safety hazards.
   d. Storing belongings was safer than requiring security to search belongings for contraband.

4. **Which did a study reveal regarding sepsis patients admitted through the ED?**
   a. Most patients presented with either fevers or chills.
   b. Many presented with symptoms that overlapped with other conditions, such as pain, vomiting, or confusion.
   c. Sepsis patients with clear symptoms received antibiotics later than patients with atypical symptoms.
   d. None of the patients with atypical sepsis presentation suffered the systemic effects of a severe infection.