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INSIDE

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Closed Claim Malpractice Data Reveal Actual Legal Risks for ED Providers

Many emergency physicians (EPs) worry about malpractice lawsuits, but without much data on the actual risks they face in clinical practice.

"It is important for emergency medicine providers to be aware of the most common medical conditions and factors involved in malpractice suits. It is important to understand what the current landscape is," says **Mark Zonfrillo**, MD, MSCE, an associate professor of emergency medicine and pediatrics at Hasbro Children's Hospital and the Alpert Medical School of Brown University in Providence, RI.

Zonfrillo and colleagues analyzed 6,779 closed claims for adults in the ED and urgent care center settings logged between 2001 and 2015.[1] "We wanted to have a nice, big snapshot in time, and just get an idea of where we see the top risks in emergency medicine and what we can do to hopefully mitigate it," says **P. Divya Parikh**, MPH, CAE, study co-author and vice president of research and risk management for MPL Association, a Rockville, MD-based industry trade association representing medical professional liability insurers.

Error in diagnosis was the most frequently cited medical error in the claims (36.4%). The top five diagnoses in ED claims were: cardiac or cardiorespiratory arrest, acute myocardial infarction, aortic aneurysm, pulmonary embolism, and appendicitis. "Those are all diagnoses that we know can be very challenging in the ED," Zonfrillo says. "I don't think that the list of diagnoses will come as a great surprise to anybody. But it reinforces what people may have already assumed." Some specifics:

- Aortic aneurysm claims generated the highest average indemnity ($369,872);
- Acute myocardial infarction had the highest ratio of paid-to-closed claims;
- Cardiac or cardiorespiratory arrest was the most common medical condition cited in claims with a payout.

All these findings would be expected for the ED. Yet despite years of risk

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

management and patient safety initiatives targeting these conditions, EDs still face claims with similar fact patterns. "Something we are really looking at is why we are still seeing these issues come up in claims," Parikh says.

Data on payouts and settlements do not reveal what is fueling these lawsuits. Knowing that cardiac arrest is a common diagnosis in malpractice claims does not tell ED providers how to avoid litigation if they miss it. "It doesn't give you a lot of information to guide your care. But it gives you an idea of what's out there," Zonfrillo says.

Zonfrillo's primary area of research is studying the epidemiology of injuries in children. He says the same fact-driven approach applies to ED malpractice risks. "Understanding the facts and the prevalence is a good first step," he says.

That includes medical students. Medical education is about more than just evidence-based medicine and procedural competency. "There are a lot of ancillary topics that should also be reviewed from time to time. One of those is understanding medical liability," Zonfrillo explains.

It is particularly important in the ED, where providers lack longstanding relationships with patients, and sometimes lack medical history. Many people present with signs and symptoms that can either be benign or immediately life-threatening. "Data on the types of cases that are highest risk in terms of malpractice can inform efforts to educate ED providers or provide clinical decision support," Zonfrillo says.

What is different about the ED is "it's everybody under the sun. You get such a broad spectrum of patients and diseases," Parikh observes.

Even with the best intentions and good care, ED providers are likely to be sued at one point during their careers.[2,3] "That you might see a lawsuit just because of the exposure of being in a certain specialty is kind of frightening. It's not something you are taught in med school," Parikh says.

Zonfrillo, Parikh, and colleagues categorized claims according to injury severity, ranging from insignificant (emotional injury only) to death.[1] Of about 2,600 claims resulting in a patient's death, 770 resulted in a payout. The next highest category was minor temporary injury. "Those are also an area to target and delve into deeper," Parikh says. "They may not be giant in terms of indemnity payments or defense costs, but there is still an opportunity to reduce those."

The central questions are "How do we take these findings and really mitigate risk further? What more can we do?" Parikh asks.

Claims are not just about clinical mistakes. Lawsuits often center around miscommunication (e.g., failure to explain the treatment plan or patient expectations that were not met). "Looking at what type of claims we are seeing presents an opportunity to see where the risks are, especially if there are new medical conditions coming into the mix," Parikh says.

Things change over time. "You want to see which conditions remain there over decades. You also want to see which ones are appearing," Parikh notes.

Medical liability claims data "can provide direction for where EDs need to focus attention," Parikh says.

At the end of the day, the most legally protective thing EPs can do is to meet the standard of care to all patients. Unfortunately, there are

obstacles. "There are very busy EDs and very sick patients. Sometimes, there are system issues," Zonfrillo says.

Quality assurance initiatives and clinical practice guidelines are important tools.

"These can help to consistently meet the standard of care for all patients who present to the ED," Zonfrillo says. "That should always be on the minds of the providers in the ED." Other key findings on the outcome of closed ED claims:

- 22.8% of the claims resulted in a settlement, with an average payout of $297,709 and an average defense cost of $55,260.
- Few (7.6%) of the claims went to trial. Of that group, the defense prevailed 92.6% of the time. For those cases, the average defense fee was $111,446.
- Of the small group of claims (just 38 cases) in which the plaintiff prevailed at trial, average indemnity was $816,909. The average defense cost for those cases was $159,716.

Even though plaintiff verdicts in ED claims are rare, high payouts command outsized attention. "A lot of effort is spent targeting this small bucket of claims, because you don't want those large payout situations," Parikh says.

Interestingly, 65.9% were dropped, withdrawn, or dismissed. Most claims in this group were found to have no merit, meaning the EP met the standard of care.

"The claims really have very little to do with medical care delivery. It raises the question of why we see so many claims like that," Parikh says.

Even though those claims did not result in any payout, there still was a financial cost. Average defense fees totaled $25,996 for these cases. There also is the issue of emotional trauma.

"When a claim is filed, I don't think there is a general understanding of how traumatic and demoralizing that can be to a caregiver," Parikh says. "It really hits them in a personal and professional way."

Even if the claim is dismissed, "there is impact from all of those claims. These aren't insignificant," Parikh adds.

The finding suggests some people are bringing claims because they are unhappy with the ED outcome, even though nothing wrong happened. "When something that shouldn't have happened did happen, that patient needs to have support," Parikh says.

Improving the patient experience in that type of situation could help prevent malpractice claims. One example is early communication and resolution approaches to adverse events. Another is meeting with patients or family before a claim is filed.

Ideally, this occurs whenever ED providers recognize something unexpected happened. "By intervening early, EDs can get ahead of the problem before there is a claim," Parikh says. ■

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Aortic Aneurysm Claims Generate Highest Average Indemnity for ED

ED malpractice claims involving aortic aneurysm generated higher average indemnity ($369,872) than any other medical condition, according to a recent analysis.[1]

"Failure to timely diagnose is the most common allegation in malpractice actions, followed closely by poor communication between providers," says **Amy Evans**, JD, executive vice president of business development and liability claims division at Intercare Insurance Services in Bellevue, WA.

Evans says the following included in documentation can refute allegations of failure to timely diagnose abdominal aortic aneurysm (AAA): a current, negative CT; a note indicating AAA was a part of the differential; and the specific reasons the EP believed the diagnosis was unlikely. Consider the following AAA cases involving these scenarios:

- Patients with sudden abdominal pain that waxes and wanes with a GI cocktail. "We see several cases every year where that patient later ruptures and dies," Evans reports.

In those cases, plaintiffs' counsel seized on the fact the GI cocktail masked the symptoms of the deadly AAA. The attorneys argued the EP treated a life-threatening condition as nothing more than a "belly ache." Ideally, the EP noted that AAA was

considered, but not likely due to low BMI, no history of hypertension or smoking, and lack of any corroborating symptoms. "If the symptoms wax and wane, EPs can consider monitoring the patient long enough to see if the symptoms truly resolved or are just in the waning part of the symptom cycle," Evans says.

• AAA was missed without documentation of provider-to-provider discussions. "This is especially pertinent if the patient is being discharged or admitted to a specialist who did not see the patient in the ED," Evans says. The plaintiff attorney focuses on whether the EP covered the size of the aneurysm, the patient's vitals, lab results, and symptoms.

Sometimes, the patient told the EP he is aware of the AAA, which another physician is following. In those malpractice cases, the EP called the other provider who confirmed awareness of the AAA. The second provider agrees the patient can be discharged for later office follow-up. Then, shortly after discharge, the patient ruptures and dies. "At deposition, the other provider often testifies that they were not told the size of the AAA and/or they did not approve of discharge," Evans explains.

For successfully defended cases, documentation includes specific information conveyed by the EP and the specific instructions provided by the treatment provider.

• Some lawsuits involve dissections that happen after admission from the ED. The admitting or consulting specialist does not round on the patient immediately, and later testifies the EP never told them the patient was acute or unstable.

Evans gives this example of a documentation note that can help refute this: "Surgeon Dr. Johns confirmed she will see the patient within an hour to determine whether emergent surgery is necessary. Ordered NPO status just in case."

"If urgency is conveyed verbally, it should be documented in the chart, along with exactly when the consulting said they would see the patient," Evans says.

Stephen Colucciello, MD, FACEP, has reviewed multiple claims involving missed or delayed diagnosis of leaking AAAs. In one case of an elderly woman with sudden, severe back pain, a lumbar film showed degenerative disease. She was discharged without anyone evaluating the aorta.

"The plaintiffs later argued that the wrong test was ordered — a lumbar film instead of an abdominal CT with contrast," Colucciello says.

Based on the allegations in lawsuits, Colucciello says EPs can make successful claims less likely with these specific practices:

• Remember that in older patients with back, flank, or abdominal pain, normal distal pulses and normal abdominal exam does not rule out the diagnosis. "Hypotension is an especially ominous sign, but is not always present," says Colucciello, a professor of emergency medicine at Wake Forest School of Medicine.

• Set a low threshold for performing bedside ultrasound of the aorta (or, if the patient is stable, for obtaining an abdominal CT).

• Check the medical record to see if the patient has undergone an abdominal CT in the past several years. "Since abdominal aortic aneurysms grow at the rate of about 1 cm per year, a normal aortic diameter in the past several years on CT makes a new AAA unlikely," Colucciello says.

• Consider AAA in the older patient with apparent renal colic. "In one study, up to 87% of patients with leaking AAA had hematuria," says Colucciello.[2]

• Follow current guidelines for management of AAA. These suggest avoiding aggressive fluid resuscitation (as long as the systolic blood pressure is between 70 mmHg and 90mmHg, and the patient demonstrates a normal mental status).[3] "Do not over-resuscitate, especially with crystalloids," Colucciello says. "If the patient is in frank shock, resuscitate with blood and get the patient to the OR as soon as possible."

• If the hospital does not offer vascular surgery, establish a transfer protocol, such as "Code Rupture," with a center that routinely handles AAA repair. "Time to operation is key in the management of ruptured AAA, preferably less than 90 minutes, and sooner if possible," Colucciello offers.

• Instead of sending a hemodynamically unstable patient to CT scan for suspected AAA, perform bedside ultrasound, and call the vascular surgeon. "If the surgeon insists upon CT first, document this in the medical record," Colucciello says. The EP might chart, "Suspected AAA. Case discussed with vascular surgery, who asked for a CT scan for operative planning. Aware that BP systolic was 70 mmHg at the time of consult." ■

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Most ED Malpractice Lawsuits Are Dropped, Withdrawn, or Dismissed

When an EP is sued for malpractice, many immediately envision testifying in court before a jury. In reality, few ED claims (7.6%) make it that far. Most cases (65%) actually end up dropped, dismissed, or withdrawn, according to a recent analysis.[1]

"The vast majority of professional liability claims are aggressively defended at every stage of litigation," says **Richard F. Cahill**, Esq., vice president and associate general counsel at The Doctors Company in Napa, CA.

An adverse jury verdict, arbitration award, or settlement carry serious implications for EP defendants. These may include personal financial exposure, adverse publicity, protracted mental duress, medical board investigations, limitations on hospital privileges, access to third-party payor networks, reports to the National Practitioner Data Bank and specialty medical societies, and costlier malpractice premiums. Defense lawyers will do all they can to demonstrate the claim is legally insufficient and should be dismissed as a matter of law. "Such motions frequently prevail and not uncommonly are sustained on appeal, thereby reducing the parties available to pursue," Cahill says.

The following are some reasons ED malpractice claims are dropped:

• Plaintiff's counsel decides to focus more distinctly on the most culpable defendants. For that particular case, it does not include the EP. "Peripheral or less responsible providers, especially physicians practicing in the ED setting, are commonly dismissed once the deposition is taken as the date for trial or arbitration approaches," Cahill notes.

• Plaintiff attorneys might drop claims solely because filing deadlines were not met. "Deadlines are state-specific, and may require precise calculation based upon the statute of limitations and any mandatory presuit administrative proceedings," says **Maryann G. Hoskins**, JD, an associate at Degan, Blanchard & Nash in New Orleans.

Some states require a claimant to submit an administrative complaint before filing a malpractice lawsuit. Inexperienced attorneys, unaware of this requirement, might file the malpractice lawsuit near the deadline without submitting the administrative complaint. In certain cases, Hoskins has called the plaintiff attorney to share this news, and the case was dismissed shortly afterward. It is unknown whether the client is told the actual reason (i.e., failing to file timely). "Did they dismiss it because it's a weak case, or was it because they don't want their legal malpractice brought to light?" Hoskins asks.

• Plaintiff attorneys might drop the claim when they discover the EP is not a hospital employee. "Many plaintiff attorneys erroneously believe that the EP is employed by the hospital," Hoskins reports.

More often, EP defendants are employed by a group that staffs the hospital's ED. "If they sue the hospital and the EP, they might dismiss the EP when they find out the EP is not an employee," Hoskins explains.

When a claim is filed, plaintiff attorneys often name multiple defendants to ensure the named party is correct. For example, a malpractice lawsuit might name the EP, the charge nurse, and a radiologist.

"However, as discovery progresses, plaintiff attorneys often dismiss one or more defendants — often the EP — in order to proceed with a more straightforward claim against one defendant," Hoskins adds. ■

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Expert Panel Is Low-Cost Way to Determine Strength of Med/Mal Claim

In certain states, the law requires an expert medical panel to review malpractice claims. In Louisiana, after the malpractice claim is filed, a medical review panel gathers. The plaintiff and the defense name one physician expert each. Together, the two experts name a third panel member.

"Most of the time, they find no deviation from the standard of care," says **Maryann G. Hoskins**, JD, an associate at Degan, Blanchard & Nash in New Orleans. The plaintiff still can file a lawsuit. "But it is enough to discourage many claims," Hoskins notes. Either side can introduce the panel's opinion as evidence at trial. If the panel finds nothing wrong with the care, says Hoskins, "the defense attorney can say, 'Three doctors looked at this and said there was no deviation from the standard of care.'"

The medical review panel process is a relatively inexpensive way for

claimants to determine whether the case has merit. "Medical malpractice claims are notoriously expensive because you have to get experts," Hoskins explains.

If a plaintiff attorney realizes he or she needs to invest $10,000 to $15,000 on experts and depositions in a likely unwinnable case, "that changes a whole lot of things," Hoskins notes. "Just because it was a bad result doesn't mean it was malpractice."

If the panel finds the EP deviated from the standard of care, a malpractice lawsuit is likely. On the other hand, if the panel finds the ED care was reasonable, "there is a fair chance that the claimant will not file suit against the EP," Hoskins observes.

Sometimes, the plaintiff attorney declines to pursue the claim, will do so only if the plaintiff pays on an hourly basis, or will agree to file suit to protect the statute of limitations on the condition the attorney will be permitted to withdraw as counsel of record thereafter. Hoskins has represented many EPs during the medical panel review process. Often, the EP's own testimony resonates most.

"The EP's explanation of why there was no malpractice is more compelling than an explanation filtered through an attorney. It's more credible coming from the emergency physician as opposed to the attorney," Hoskins explains.

One claimant alleged an EP committed malpractice by failing to diagnose septicemia, resulting in septic shock and a 30-day hospitalization. The patient presented to the ED with severe neck pain radiating down to the left shoulder and arm, along with chills, vomiting, and diarrhea. The EP discharged the patient home with gastroenteritis and cervical radiculopathy. The claimant returned to the ED later that day with severe symptoms, and was hospitalized. At one point during his hospital stay, the claimant told a physician he had used a pocket knife to scrape a corn off his foot.

In his affidavit, the EP stated he was not given that information during the ED visit. Therefore, infection was not included on the differential diagnosis.

The expert panel stated the ED diagnosis was reasonable based on the medical facts and history related by the patient. "In this case, the statement from the EP bore significantly more weight than any such assertion filtered through his counsel," Hoskins says.

After the panel issued an opinion of no malpractice, the plaintiff did not file suit. ■

Checkbox Charting Is Problem for ED Malpractice Defense

Charting consisting solely of checkboxes is a thorn in the side of ED malpractice defense attorneys. "It creates some real problems in terms of documentation, which is the 'story' for what happened during the care at issue," says **Jesse K. Broocker**, JD, an attorney at Weathington in Atlanta.

The first problem is checkboxes inevitably create discrepancies in the medical record. A common example is with a required field of "similar to typical chest pain." Sometimes, there are just two options — yes or no. "But what if this is acute onset new chest pain? If you check 'not typical chest pain,' it looks like you've contradicted yourself," Broocker cautions.

Many EPs rely on templates to fill in the chart quickly and easily, in lieu of going through every system during the physical exam. "It streamlines having to fill in a bunch of superfluous information," Broocker admits. "But if you become too reliant on that, you inevitably will create discrepancies."

At deposition, the plaintiff attorney can ask the EP defendant, "Your neuro exam was all normal, but the chief complaint was headache. How is that possible?"

By calling attention to things like this, plaintiff lawyers can argue the sloppy charting also reflected subpar care. "Checkboxes create rushed charting and a dereliction of attention to the narrative boxes," Broocker says.

Many ED charts contain just one or two brief sentences in the history or disposition notes. It does not tell the story of the ED visit. "Lawyers can tell if you just plugged in an algorithm vs. actually documenting specific to the patient," Broocker says.

Broocker cautions against using auto-templates in any capacity outside the most routine care (e.g., a twisted ankle). "It is usually in the context of rushing through the patient," Broocker observes.

EPs say they use auto-populated templates because the exam was normal, but plaintiff attorneys point out how little time was spent charting on the patient. Timestamping shows when the EP started and stopped documenting. "It's simple math at that point. 'The doctor was bedside at 10:01, the note was opened at 10:06 and completed at 10:08. There is no way they performed a sufficient exam on my client,'" Broocker notes.

Broocker says that instead of checkboxes, EPs should tell the story in substantive sentences. The disposition note should state what the

EP saw, what he or she was thinking, and why. "If the documentation shows that, we have a leg up," Broocker offers. "We are in a good position to tell the jury, 'We tried, and we were thoughtful.'"

The ease of checkbox charting "requires provider attention and care in order to avoid potential exposure to a malpractice claim," says **Elizabeth A. Harris**, an associate attorney in the Health Care and Life Sciences practice in the Washington, DC, office of Epstein Becker Green.

In malpractice cases, the ED medical record is a critical piece of evidence. The chart establishes whether the EP met the standard of care. The statute of limitations for medical malpractice cases ranges anywhere from one to five years, depending on the state. EP defendants testify about a patient from years ago. "The treatment in question may have been provided on a single occasion in a busy ER," Harris notes.

EP defendants typically do not have an independent recollection of individual patients. Instead, they rely heavily on the chart when testifying. Details about the patient's care can make or break the outcome of a claim. Checkboxes are not going to jog anyone's memory.

"Lack of individualized detail can make describing the patient's treatment more difficult for both the physician defendant and the expert witness," Harris says.

Checkbox charting complicates the defense of any medical malpractice claim, but there are other problems. "It can also present issues from a regulatory and reimbursement perspective," Harris warns.

To receive reimbursement from Medicare and Medicaid, the medical record must support the level of service provided and demonstrate medical necessity.

"The use of checkbox charting can present the risk of a claim that the charting does not support the level of medical necessity required for reimbursement," Harris says. This can lead to audits, investigations, or even False Claims Act liability, with possible hefty penalties. Harris recommends EPs clearly document their medical decision-making and provide individualized and detailed narratives to clarify or explain information, especially when pertinent to the patient's chief complaint. For example, it is not enough to check the appropriate boxes for a chest pain patient. An individualized narrative about the cardiac exam performed and the results is needed.

Make sure the ED uses modified templates to allow EPs to add free-form text. Carefully review the record for accuracy before signing the note (including automatically populated checkboxes), either contemporaneously or close in time to the encounter. Finally, maintain a strong compliance program with regular medical record audits, including a review of electronic health record systems.

"This can improve clinician documentation, defend against medical malpractice claims, and decrease the risk of liability related to fraud and abuse," Harris says. ■

Most Sickle Cell Disease Patients Avoid EDs During Pain Attacks

Sixty percent of patients with sickle cell disease say they "very much" or "quite a bit" avoid going to the ED during a pain attack because of a previous bad experience.[1]

Researchers gathered input from 51 patients with sickle cell disease regarding the care they receive in EDs. Many reported experiencing stigma because of providers' suspicions of drug-seeking behavior. Half said they waited at least two hours for treatment. In terms of how sickle cell disease is managed in the ED setting, "there is a lot of attention on it, but there is still a lot of need for education overall," says **Paula Tanabe**, PhD, RN, FAEN, FAAN, one of the study's authors. Tanabe is vice dean for research at Duke University. In many EDs, sickle cell pain episodes continue to be managed poorly. "There is still a lot of concern about opioid addiction and a mindset that patients don't have real pain. Timely and adequate pain medication is still the No. 1 problem," Tanabe says.

The hope is that with rapid and aggressive treatment, pain can be controlled enough to allow for discharge. "That can result in a lower hospital admission rate, which is good for the patient, good for the hospital, and good for costs," Tanabe says.

Previous research showed ED nurses could safely administer high-dose opioids for sickle cell disease pain.[2] The National Heart, Lung, and Blood Institute (NHLBI) guidelines for sickle cell disease recommend using individualized opioid dosing to treat acute pain in the ED.[3] Hematologists or sickle cell disease specialists enter the individualized dosage in the electronic health record. "That's not always possible, as not everybody has these great support programs with hematologists to write these protocols,"

Tanabe says. An alternative approach is weight-based treatment, with redosing occurring in 30 minutes.[3] Tanabe and colleagues are conducting a randomized, controlled trial using the same protocols in six different EDs.[4] They are testing both approaches, safety outcomes, hospital admission, and repeat ED visits or readmissions within seven days.

Previously, this research group published a pilot study at two EDs using the same protocol.[5] Patients who received individualized dosing reported a greater reduction in pain than those who received a weight-based protocol, without safety concerns.

Posting dosage information in the electronic health record allows patients to walk into any ED with a treatment plan already in place. "This time, it will look real. In the past, physicians would write a letter and give it to the ED, and was sometimes disbelieved," Tanabe says.

Tanabe and colleagues are studying the success of this approach in eight EDs.[6] "This is an important trial that could dramatically change the way vaso-occlusive episodes are treated in the ED," Tanabe offers.

With multiple trials underway, there is momentum to improve ED care of sickle cell disease. "We're going to have a lot of data coming out to hopefully strengthen the evidence base around individualized dosing," Tanabe says. The changing mindset also is reflected in a 2019 Emergency Nurses Association resolution, which called for disseminating treatment recommendations and other educational resources nationally to all EDs. *(Read the resolution online at: https://bit.ly/3vEEfJe.)* "Fifteen years ago, that never would have passed," Tanabe says. "It does show that attitudes are shifting."

However, delays caused by poor management still happen. "There are still places that are incorrectly triaging patients so they end up in a lower category," Tanabe reports.

In overcrowded EDs, that means a long wait to see a provider and delays in receiving pain medication. "That triage nurse has so much power. If you don't get that right, the patient's pain treatment can be very delayed," Tanabe underscores.

Putting patients in the right triage category still comes down to the individual ED and the individual triage nurse. If they are wrong, the sickle cell disease patient sits in the waiting room for hours. "If the ED is super crowded, they may sit there anyway, which is a whole other problem," Tanabe laments.

The NHLBI guidelines recommend the first dose of pain medication should be given within 60 minutes of arrival.[3] "If anybody was going to try to improve, I would say look at your triage scores," Tanabe suggests. "That is a good place to start." ■

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Medication History Often Inaccurate on Inpatient Side

When patients are admitted through the ED, the medications they are taking do not always make it to the inpatient side.[1-3] "The medication reconciliation process is important to ensure that critical chronic medications are continued at hospital admission," says **Lawrence Frazee**, RPh, PharmD, pharmacy residency program director at Cleveland Clinic Akron (OH) General. Medication histories were more accurate when obtained by pharmacy technicians, according to a recent study.[4]

Of 183 patients admitted through the ED in 2017 and 2018, medication histories were accurate just 38% of the time with the usual process (typically, a nurse reviews the medication list and updates it accordingly) and 70% of the time with pharmacy technicians. "Medication discrepancies exist in the ED, and can be identified and

resolved by dedicated and trained pharmacy personnel using multiple sources," says Frazee, one of the study's authors.

These include electronic health records, the patient, family members, community pharmacies, and extended care facilities. "Having an accurate medication list is critical for both diagnostic and therapeutic decision-making," Frazee says. In the ED, providers need the best possible medication history for several reasons:

• Providers will know if a medication could be causing the patient's presenting symptoms. This can prevent misdiagnosis. For example, a patient who recently started a new diabetes medication in the SGLT2 inhibitor class presents with nausea, vomiting, lethargy, and an anion gap acidosis. There are relatively normal blood sugars, but the patient could be experiencing euglycemic diabetic ketoacidosis. "This is a known side effect of this class of agents," Frazee notes.

• Providers can avoid serious drug interactions when choosing a treatment for a presenting problem. For instance, a patient taking the skeletal muscle relaxant tizanidine should not receive ciprofloxacin, which can lead to significantly elevated tizanidine levels and a possible severe reaction.

• Providers can recognize a medication on the patient's list was discontinued. Often, this is because of an adverse effect. "If the patient shows up in the ED with that medication still on the list, there is a possibility that the medication could be resumed in the ED," Frazee says. Perhaps an elderly patient with urinary incontinence is taking an anticholinergic, but an outpatient provider recently discontinued this course over concerns about delirium. "If the provider is not in the same health system, the medication may not have been removed from the list and could be continued for admission," Frazee explains.

There are many situations when ED patients' medications are not fully conveyed to inpatient units. In code situations, medications are pulled out of the box on verbal orders. Designating a specific person to document these medications is a good practice, says **Monika Smith**, DO, MBA, chief of the ED at Virtua Our Lady of Lourdes in Camden, NJ.

Medications, such as lidocaine, might start in the prehospital setting, but no one communicates this to the inpatient side. Smith suggests assigning a specific person to obtain all the prehospital data and document it in the system.

Once on the inpatient unit, a patient's chronic medications might not continue. "Patients on medications such as chronic steroids, if interrupted, can go into adrenal crisis and hemodynamic instability," Smith cautions.

One way to reduce these risks is for ED providers to walk up to the inpatient units with patients taking medications such as heparin, insulin, or pressors, and directly sign off on the patient with the intake nurses.

In the ED, medications might start, but perhaps no one from the ED informs the inpatient unit staff. "High-priority meds, such as insulin, sedatives, and pressors, need frequent reassessment, adjustment, and titration — as often as every five to 15 minutes," Smith says.

These medications, if unchecked for an extended time, can produce a detrimental outcome. Bad outcomes also are possible if a medication was given in the ED, and the inpatient side does not know about it — and gives the drug again. "[For] insulin, blood thinners, or cardiac meds, overdose can lead to hypoglycemia, bleeding, and hemodynamic instability," Smith says. ■

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Hospitals Could Face Legal Exposure if EPs Are Not Board-Certified

In 2005, there were about 22,000 emergency medicine (EM) board-certified EPs in the United States.[1] However, investigators estimated 40,030 EPs would be needed to staff all 4,828 EDs. For years, there was not much additional research in this area. Recently, a group of investigators decided to conduct another analysis and update the data.[2]

"This felt especially important in the setting of ongoing debate

surrounding the EM board-certified EP workforce and increased use of advanced practice providers in the ED," says **Carson E. Clay**, the lead author of the most recent analysis and a research affiliate at the Emergency Medicine Network at Massachusetts General Hospital.

Clay and colleagues found improvements over the 2005 data. In 2017, there were 40,716 EM board-certified EPs, fulfilling 77% of the estimated national demand. "However, breaking the data down regionally, we found overwhelming disparities between rural and urban states," Clay says.

Many hospitals proudly advertise the fact its EPs are board-certified. What if a plaintiff in a malpractice lawsuit was seen by an EP who was not board-certified? "It demonstrates misleading or deceitful advertising. That can be a basis to argue the hospital lacks institutional honesty," says **David Sumner**, JD, a Tucson, AZ, medical negligence specialist with a multistate trial practice. Consumer protection statutes that protect people from false advertising claims could form a basis for an additional claim. Even if the false advertising statute does not give the patient the right to a direct cause of action if they relied on the ad, the hospital still can face potential civil penalties. "However, when patients are given a right to sue under the statute, it is usually an additive cause of action to the medical negligence claim," Sumner explains.

False advertising claims might require proof of reliance on the representations in the ad. Plaintiffs would need to testify that they chose to go to the ED because all EPs were board-certified. In one malpractice claim, the health system's website stating that all its physicians were board-certified became the central focus. The plaintiff testified she chose the health system specifically for that reason. The health system defined board certification as the physician possessing certification through the American Board of Medical Specialties.

The cerebrovascular surgeon held certification in neurosurgery, but only from Japanese certifying agencies. The consumer protection statute was pleaded as an additional claim. "The false advertising was highly prejudicial to the university in defending the claim," Sumner reports.

The settlement resolution required the health system to correct its website to eliminate any misrepresenting comments. The same kind of issue could come up in ED malpractice litigation. "Such a representation can result in the hospital assuming the duty or obligation to provide ER physician care consistent with what would be expected from a board-certified EM physician," Sumner says.

The legal standard of care does not require all EDs to be staffed exclusively by EM board-certified physicians. "Many communities cannot staff their ERs with only EM board-certified physicians, even if that should be an aspirational goal for all centers," Sumner notes.

If a hospital can show that not enough EM-certified physicians were available to staff their ED, it would be difficult to allege a standard of care violation because of non-EM-boarded physicians. If ED physicians are not hospital employees, but are instead provided to the hospital via large national staffing groups, it makes it easier to argue the ED could have had all EM board-certified physicians. Generally, says Sumner, "there is a wide divergence of the quality of ER care being provided at major academic centers vs. the general ER care provided in the communities nationwide."

Some academic centers mandate EM board certification. Not many community hospitals do so. "The non-EM-boarded physicians are not required to meet initial or periodic board educational or CME requirements," Sumner says.

Sumner has seen many malpractice cases in which non-EM-boarded EPs are named. In those cases, the patients were mismanaged at small community EDs and then had to be transferred to a higher-acuity center. "I have found it rare to have an EM board-certified provider in my ER cases," Sumner says. In most cases handled by Sumner, the EP defendant was a family practice- or internal medicine-trained physician without a specific EM residency in their background. Regardless, lack of board certification in EM diminishes the EP's credibility. "Skilled plaintiffs' lawyers know how to read a CV and know when credibility-enhancing training or credentials are missing," Sumner says.

Without the requirement to keep up with maintenance of certification requirements or CME specifically in EM, plaintiffs could explain why the care in the case did not meet expected standards of care. To wit: "Why did this happen? Because the physician was not suitably trained, nor did she remain current within the specialty through participation in mandatory maintenance of board certification requirements."

"That is pretty easy for any jury to understand," Sumner says. ■

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Problems When Calling Patient a 'Drug Seeker'

A patient comes to the ED frequently, always reporting pain, always asking for opioids. Before charting the words "drug seeker," ED providers should think twice, says **Bryan Baskin**, DO, FACEP, quality improvement officer at the Cleveland Clinic Emergency Services Institute.

Baskin says EPs should ask themselves several questions: Is this drug-seeking label truly needed to complete the chart? What message are you trying to convey, and to whom? Who is going to read that chart once you close it, and why? What does labeling the patient this way in your single encounter add to the history, examination, or medical decision-making? How does it change the plan on that day of evaluating the patient for a medical emergency? "If making this description is truly needed, there are objective ways to quantify drug-seeking behavior in the chart that other medical professionals reading it will understand," Baskin says.

An EP could chart a history of previous ED visits during which the patient demanded certain medications. Also, he or she could refer to any ED or hospital-based, patient-specific care plan already in place in relation to pain medication. For instance, the care plan might state, "This patient has had frequent visits for chronic abdominal pain. Opiates are to be avoided unless absolutely clinically indicated."

"Referencing these plans can be a way to objectively describe historical pain medication use in a patient," Baskin offers. EPs also could pull and list data from the state prescription drug monitoring program showing multiple prescriptions from multiple providers.

"Labeling the patient as drug-seeking gives the connotation they were malingering," Baskin explains. "This conveys the same message without appearing oppositional to the patient."

Clinicians should objectively describe the patient's appearance, vital signs, and demeanor, says **Alfred Sacchetti**, MD, director of clinical services at Virtua Our Lady of Lourdes Medical Center in Camden, NJ.

"Many patients with chronic pain have developed techniques to address their pain, which lead them to appear to sleep as they lay quietly on a stretcher," Sacchetti notes. However, clinicians should document when patients demonstrate rapid changes in behavior in response to the presence of ED staff. For instance, if a patient loudly vocalizes their need for pain medication between periods of laughing while talking or texting, describe that in the medical record. "The clinician should be careful not to make it appear that a pain management decision was based solely on patient behavior," Sacchetti cautions.

It is best to leave these statements as isolated observations. The justification for the treatment of pain can be stated separately. Sacchetti suggests a statement in the record to the effect of "Patient's description of pain does not coincide with my physical findings or diagnostic studies."

"Phrasing the encounter in this manner allows the clinician to express their concerns about the patient while not labeling them a 'drug-seeker,'" Sacchetti says. Patients who suffer from addiction can experience pain from real medical etiologies. An example is a patient with chronic back pain who develops an addiction to narcotics, then transitions to IV drug use, later developing a spinal abscess. "IV drug users are at increased risk for intraspinal infections. When they have this infection, they often present to the ED with a complaint of back pain," Baskin reports.

That patient's chart is going to appear suspicious because it reflects a history of drug abuse with multiple prior ED encounters for back pain. "It is easy to get biased and dismiss the presentation," Baskin admits.

The provider could easily miss a spinal infection diagnosis. "It is common for spinal infections to be missed by several providers before being diagnosed. It can be a difficult diagnosis to make, especially in its early development," Baskin laments.

Even if the provider missed the spinal abscess diagnosis on the first or second visit, it is possible the standard of care was met. "But if it appears it was missed due to bias against the patient, it increases risk for that specific encounter," Baskin warns. If any ED patient is labeled as "drug-seeking" without an appropriate workup and later experiences a bad outcome, a malpractice claim is hard to defend. "It appears as though the patient's complaint of acute pain was dismissed as drug-seeking behavior and not true medical etiology," Baskin observes. ■

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.

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CME/CE QUESTIONS

1. **Which did an analysis of closed malpractice claims in the ED and urgent care center settings reveal?**

   a. Fewer claims were dropped, withdrawn, or dismissed than in previous years.
   b. Most malpractice claims that survived a motion to dismiss resulted in a plaintiff verdict at trial.
   c. Plaintiffs usually prevailed in claims that went to trial.
   d. Error in diagnosis was the most frequently cited.

2. **Which diagnosis generated the highest indemnity payment, according to an analysis of closed malpractice claims in the ED and urgent care center settings?**

   a. Acute myocardial infarction
   b. Pulmonary embolism
   c. Aortic aneurysm
   d. Appendicitis

3. **Which documentation can help the defense of a lawsuit involving aortic aneurysm?**

   a. Documentation of a current, negative CT
   b. Documentation stating abdominal aortic aneurysm was ruled out due to normal distal pulses and normal abdominal exam in an older patient with abdominal pain
   c. Evidence of early aggressive fluid resuscitation
   d. Evidence showing a hemodynamically unstable patient was sent to undergo a CT scan instead of performing bedside ultrasound and calling the vascular surgeon

4. **Which is true regarding hospital marketing claims on board certification of emergency physicians (EPs)?**

   a. Misleading advertising on board certification of EPs could form a basis for false advertising claims.
   b. A family practice doctor moonlighting in the ED cannot be held to the same legal standard of care as an EP.
   c. Courts have long established that the standard of care requires even community EDs to be staffed exclusively by emergency medicine board-certified physicians.
   d. Whether the marketing of emergency medicine board-certified physicians affected the patient's choice on where to seek treatment is irrelevant to the success of litigation.