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INSIDE

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Claims Involving Physician Assistant Care Continue

Malpractice claims involving physician assistants (PAs) in the ED have increased in recent years and are continuing to come up, according to legal experts interviewed by *ED Legal Letter*.

"There are more cases coming in involving PAs now than there were five or 10 years ago, likely due to expanding scope of practice of the PAs," says **Mark Spiro**, MD, chief medical officer of the Walnut Creek, CA-based The Mutual Risk Retention Group.

Several states are pushing for more practice autonomy for PAs.[1-3] Of an estimated 1 billion ED visits between 2010 and 2017, 5% were seen by a PA and 8.2% by a PA with physician involvement, according to the authors of a recent study.[4] Spiro says that in his experience, emergency physicians (EPs) are somewhat concerned about their liability risks regarding working with PAs. "It is a topic that has come up with our medical group many times," he shares.

Most EPs who voice concerns are worried about finding themselves defendants in lawsuits — when they never saw or even knew about the patient. "It becomes uncomfortable sometimes, depending on the risk tolerance of the EP," Spiro explains.

PAs may be reluctant to consult with supervising EPs on too many cases for fear of receiving the label of incompetent. Such hesitance raises legal risks for all parties.

Allegations against PAs are similar to those made against EPs: failure to appropriately diagnose and failure to treat, says **Julie C. Mayer**, JD, a partner in the Virginia Beach office of Hancock, Daniel & Johnson. If something bad happens because a PA failed to consult the supervising EP, generally, the plaintiff sues the EP and the PA. "The hospital would only be involved if it employed either the PA or ED physician," Mayer says.

Hospital policies will be examined during litigation. Of particular interest is what the policy says regarding which patients the PA needs to consult the EP. From a defense standpoint, says Mayer, "the more general the supervision

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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

agreement, the better." If the policy is more general, it is easier to defend the PA's actions as reasonable and appropriate under those specific circumstances. "It is helpful to have solid triage systems in place to identify high-risk patients upon arrival," Mayer offers.

Some hospital policies prohibit PAs from seeing "high-risk" patients. The problem with that is that by the time the lawsuit is filed, the poor outcome already is known to everyone. "It is not always easy to determine high-risk patients vs. those who are not," Mayer says. "That's one of the biggest challenges in emergency medicine."

After the fact, it is easy for a plaintiff to argue the patient was clearly high-risk. After all, the patient suffered a heart attack shortly after leaving the ED. But at the time of the ED visit, the patient's symptoms and presentation might well have been consistent with a non-life-threatening GI issue.

"There needs to be strong communication between the PAs and EPs to ensure that the EP does see truly high-risk patients," Mayer suggests. Including these items in the chart can help the defense:

• **For PAs: A thorough description of evaluations and findings, and when a supervising EP was consulted.** In a recent malpractice claim, the plaintiff alleged the PA failed to diagnose subarachnoid hemorrhage in a patient with severe headache. The PA's documentation of the physical exam became a focus. "The plaintiff argued that based on that note, the ED physician was required to perform a lumbar puncture," Mayer says.

• **For EPs: Evidence showing the PA's documentation was reviewed carefully.** Often, EPs sign an attestation indicating they agree with the care provided by the PA — without closely reviewing the care. "When they are presented with the chart to review later during litigation, they will see something that they do not 100% agree with," Mayer observes.

Carefully reviewing the PA's notes is one way to guard against this. EPs also could consider writing their own summary of the patient's presentation and their recommendations. "Good communication and a good working relationship among PAs and physicians are absolutely necessary to minimize risks," Mayer stresses.

PAs work under a supervisory model, meaning the PA works under the direct or indirect supervision of the EP. This means the EP can be held liable for the PA's negligence and, potentially, for negligently supervising the PA, says **John C. West**, JD, MHA, DFASHRM, CPHRM, principal at West Consulting Services, a Signal Mountain, TN-based risk management and patient safety consulting firm.

The hospital could be held liable for the PA's negligence or the EP's negligent supervision on either a respondeat superior basis (if they are employers) or an ostensible agency basis (if they are independent contractors).

If the EP is named in a suit arising out of the PA's actions, and the EP remains in the case when it settles and money is paid, the EP will be reported to the National Practitioner Data Bank, West cautions.

In one malpractice case, the PA discharged the plaintiff with a diagnosis of cellulitis and a prescription for antibiotics.[5] Twelve hours later, she was brought by ambulance to the ED with acute arterial occlusion and ultimately

underwent amputation of both legs below the knee. The patient sued the PA, the EP, and the hospital.

There were three important factors during the litigation: The supervising EP never examined the patient, the PA did not order an arteriogram, and the patient was triaged as non-urgent. Ultimately, a jury returned a $5 million verdict in favor of the plaintiff. "The case does have overtones of requiring heightened scrutiny when care for a potentially high-risk patient is provided by a PA," West notes.

It is entirely possible that even if the supervising EP had examined the patient, the patient might have been discharged regardless. "I do not fault the PA here. An MD/DO could have made exactly the same mistake," West offers. "But $5 million later, this was an expensive mistake to make."

For EDs using PAs, says Spiro, "the challenge is to make the environment safer, both for patients and for providers."

Some hospital protocols try to do this with a long list of criteria that require the PA to consult with an EP (e.g., when blood pressure or heart rate levels are above certain thresholds).

"That will capture a lot of people. The problem is, in practice, who can remember everything on the list?" Spiro asks.

If a patient records a heart rate of 125 bpm, and the protocol says the EP should see all patients with heart rate faster than 120 bpm, "it increases liability because the protocol wasn't followed," Spiro says. Ideally, electronic health records (EHRs) would give "hard stops" if a PA put in certain vital signs or information. For those cases, PAs would have no choice but to consult the EP. "EHRs are not yet sophisticated enough to do that," Spiro laments.

EPs should not be overly worried about legal risks of working with PAs, according to Spiro. Although it is true the supervising EP is likely to be named in the lawsuit, in the end it is likely to be the PA who is held liable. "It's usually the person who provides the care that ends up with the liability," Spiro observes.

In part, it hinges on whether the PA's policy limits cover the jury verdict or settlement. "Most probably have $1 million limits, and most cases are below that limit. But some aren't," Spiro says. The downside is EP defendants will have to report the lawsuit, even if there is no payout on their behalf.

Sometimes, EPs do not want to be involved with patients seen by PAs specifically because they are wary of legal exposure. Some just do not want their names on the chart indicating they served as a case consultant. "I've seen that situation, where the PA could use some assistance and the EP is reluctant to be involved. It's bad for the patient," Spiro says.

However, those cases are in the minority. For the most part, EPs and PAs maintain good working relationships based on mutual respect. "The focus should be on creating a collegial environment so there is no hesitation for the PA to consult with a supervising EP and no resistance on the EP's part," Spiro says.

In a broader sense, PAs reduce risks because patients are seen who otherwise might languish in ED waiting rooms due to overcrowding. "The benefits definitely outweigh the risk. But there is risk," Spiro says. ■

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Acute Myocardial Infarction Most Likely to Result in Payout

Almost 40% of acute myocardial infarction (AMI) malpractice claims result in payment, a higher percentage than any other condition, according to the results of a recent analysis.[1]

"It means that those should be considered as a higher prevalence of claims, among other conditions," says **Mark Zonfrillo**, MD, MSCE, the study's senior author and an associate professor of emergency medicine and pediatrics at Brown University.

AMI was the medical condition cited in 4% of the 6,779 claims from 2001-2015 that were analyzed in adult EDs or urgent care settings. Zonfrillo and colleagues observed an average indemnity payment of $306,487. "It's difficult to know the specifics of why," Zonfrillo says. "Further study of this is an important next step."

Katherine Anderson, JD, an attorney in the Memphis, TN, office of Baker Donelson, says the top factor in defending this type of case is documentation. The most common allegation is failure to timely diagnose. "With a ST-elevated MI [STEMI], there is only so much time allowed from door to lab," Anderson notes. Usually, the standard of care is considered to be putting the patient in the cath lab within 90 minutes so the tissue damage is minimalized. If the EP fails to interpret the ECG correctly and fails to consult with a cardiologist, then the EP would be liable, according to Anderson. "Unfortunately, this results in a lot of myocardial infarctions being called STEMIs when they are not," Anderson adds.

Then, the patient undergoes a needless catheterization, and there is possible damage that can occur. One malpractice lawsuit involved a patient for whom a STEMI was called, but the catheterization revealed the arteries were clear and open. "The patient actually had sepsis and ending up losing his legs from the blood clots formed by the sepsis," Anderson reports.

The cardiologist was sued, but was let out of the case on a motion for summary judgment. "The allegations were that the cardiologist signed off after the cath, instead of following the sepsis," Anderson says.

The EP's defense is bolstered if there is good documentation on diagnoses considered, tests performed, and patient's complaints. "It is best if you even had an inkling of thought that the patient might have heart problems to send the patient to a cardiac floor on telemetry," Anderson offers.

EPs should note they informed the admitting physician of past heart problems and/or any sign there might be one in the future (e.g., the patient is on oxygen at home). Whether the patient saw a cardiologist in the past is important information. In one malpractice case awaiting trial, the patient had gone to another hospital a week before and was diagnosed with heart disease. "The patient did not divulge this information to the ED physician. The patient died the next morning," Anderson says.

What follows are issues that can result in successful malpractice claims involving AMI:

• EPs fail to consider AMI as a possibility due to lack of a thorough history. "The easiest way to be successfully sued in a malpractice claim regarding AMI is to not consider the diagnosis," says **Daniel LaLonde**, MD, medical director of the ED at Ascension Providence Hospital (Southfield Campus) in Southfield, MI.

It is easy when a middle-aged man with a history of tobacco abuse, diabetes, hypertension, high cholesterol, and cardiac family history presents to your ED sweating, nauseous, and holding his chest in discomfort. It is the cases with nonspecific symptoms (e.g., vague abdominal pain) that make it difficult to consider AMI in the differential. "A complete and focused history of present illness is crucial in someone with these types of symptoms," LaLonde stresses.

Failure to obtain a thorough history could, in and of itself, lead to a successful malpractice claim. "Documentation of pertinent negatives and positives will aid any successful defense," LaLonde explains.

A good example is a patient who reports a history of reflux, but omits the fact this particular episode was different because antacids provided no relief. "These details are essential in creating a proper differential of chest pain, and eventually may lead to a diagnosis of AMI," LaLonde says.

• EPs fail to review something pertinent that is accessible somewhere in the electronic medical record. At some point, the ED patient may have undergone cardiac catheterizations, ECGs, stress testing, or cardiac consultations. "You should review the past records, and document that you did," LaLonde suggests.

• EPs fail to involve the patient's own cardiologist or a cardiology consultant. "Many patients who present with chest pain also have an outpatient cardiologist who likely knows the patient better than you do," LaLonde observes.

Involving the patient's cardiologist in no way absolves the EP from allegations, but it does help the defense of a claim. The same is true of an on-call cardiology consultant. "A cardiologist may be able to take your patient directly to the cath lab after an abnormal ECG, perform a stat echocardiogram in the ED, or involve the cardiac fellow to evaluate the patient at the bedside," LaLonde suggests.

• The right diagnosis was ultimately made in the ED, but treatment was delayed for some reason. "It is well-known that hospitals aim for a specific door-to-balloon time. The old adage that 'time is muscle' still matters," LaLonde says.

Most EDs maintain a list of criteria of nonspecific symptoms (e.g., dizziness, nausea, or abdominal pain with history of diabetes) that facilitate an immediate ECG on arrival. "Each patient presenting with chest pain should have a prompt ECG performed at triage, with immediate review by an EP," LaLonde says.

That initial ECG might be worrisome enough for a cardiologist to immediately take the patient for intervention. Sometimes, there are delays because the ECG is not performed quickly enough. "The ED provider could overlook a subtle finding on the ECG and later make the diagnosis of AMI," LaLonde adds.

Whatever the reason for the delay, the plaintiff's attorney can use it to allege the bad outcome could have been prevented if treatment was timely.

• The EP fails to perform proper testing (e.g., obtaining cardiac troponin levels). Obviously, a patient with AMI should not be discharged. "But proper risk stratification of someone with chest pain is also crucial," LaLonde says.

A 19-year-old patient with chest pain with no risk factors and a normal ECG probably can be discharged home (assuming the patient is encouraged to come back to the ED if worse).[2] "The patient with at least a moderate HEART score should be observed with further testing," LaLonde says. ■

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Malpractice Insurer Can Bolster Defense, Even Before Lawsuit Is Filed

If ED providers receive a notice of intent to sue, most would not put off calling their professional liability carrier. "However, they may have known that a lawsuit was possible sooner, but hesitated to make that same call," says **Bobbie S. Sprader**, JD, a partner in the Columbus, OH, office of Bricker & Eckler.

One reason for this hesitation is EPs are concerned about negative consequences — namely, higher insurance premiums or even loss of coverage. Additionally, some insurance companies only assign a lawyer after a lawsuit is filed or a deposition is requested. Others are willing to be more proactive. "It really varies by insurance carrier," Sprader explains.

If the EP waits until a lawsuit has been filed, the plaintiff will have performed at least an initial investigation. Likely, experts will have reviewed the records and analyzed the care provided.

"This can put the EP at a distinct disadvantage. There can be great value in speaking with an attorney early in the process," Sprader offers.

EPs should consider these reasons for contacting their liability carrier and requesting to speak with an attorney if there has been an unexpected bad outcome:

• There may be an opportunity to preserve evidence that could help the defense that otherwise would be lost.

Some audio and video recordings in various locations and formats, along with handwritten logs, are maintained only for short intervals (days to weeks) — if someone does not intentionally preserve them.

"While EPs can work with the owners of this information — frequently, hospitals — to have it preserved, this is rarely something that occurs to them," Sprader says. "It will, however, occur to the attorney, who can help the EP find the best approach to preservation."

• EPs can record their own recollections about the case.

If the lawsuit is filed, it will be months or years later. By then, the EP probably will not be able to remember the specifics of the case.

"A defense attorney can help the EP consider how to best preserve their recollection of events above and beyond what is in the hospital record," Sprader says.

• It is a chance for the attorney to advise the EP about applicable protections.

Understandably, an EP who is involved with a case where the outcome was not what anyone had hoped for seeks reassurance from others. "However, depending on who the EP speaks to, they could be creating evidence and witnesses, possibly even adverse witnesses," Sprader cautions.

For example, if an EP speaks with another ED provider who finds fault in the care that was provided, that conversation could end up disclosed in a future lawsuit. Now, that ED colleague is a witness for the plaintiff, regardless of whether they like it. "If the EP speaks with an attorney, they will at least know which conversations are protected and which are not so that they do not engage in conversations where there is no protection," Sprader says.

• EPs can review the ED chart without going into the EMR.

Plaintiff attorneys are going to look closely at the EMR audit trail to see what an EP looked at, when, and even from what location. "Of more concern is the implication that the EP may have done more than just look. Now, the validity of the charting is in question," Sprader says.

Unless the EP has been counseled not to do it, it is a natural reaction to go into the chart to see what went wrong. "This can complicate the defense of the claim and distract from the actual care that was provided, which should always be the focus," Sprader says. Through an early consultation, the attorney can request a hard copy of the ED medical records. "This gives the EP full access to their documentation, without creating ancillary issues that have nothing to do with the clinical care that was provided," Sprader says. ■

Evidence Shows Boarding Harms All Admitted ED Patients

Patients who are admitted, but held in the ED waiting for an inpatient bed to become available, are known to be at risk for increased morbidity and mortality.[1-4] However, it was unclear how boarding affects admitted patients generally.

"We aimed to understand patient boarding from the experience of ED patients by evaluating the variables known to influence ED throughput each day," says **Leslie A. Laam**, PhD, lead business intelligence analyst at Steele Institute for Health Innovation in Danville, PA.

Laam and colleagues analyzed 466,449 encounters in two large EDs that occurred from 2015-2019.[5] "Our results confirmed the sense that ED boarding harms all admitted patients, not just boarded ones," Laam reports.

The median length of stay for all admitted patients increased 12.4 minutes in one ED and 14 minutes in the other ED for every boarded patient. In addition to boarding, Laam and colleagues studied other variables, such as quality improvement efforts and hospital capacity. "ED boarding is the result of larger system factors. The ED is where the problem is felt, but it's not necessarily where it begins," Laam observes.

It is not just the ED. Inpatient units, patient placement, and environmental services also are involved. "Teams must understand their role in the larger process," Laam says. "All should be working toward the same goal, held accountable by leaders throughout the organization."

David Ledrick, MD, says ED boarding means the system is "broken somewhere." Possibly, the hospital lacks available beds because of an inability to discharge inpatients. ED boarding also happens if housekeeping is understaffed, making bed turnaround difficult. "Hospitals are built for a set capacity, but not necessarily for surges in volume," says Ledrick, associate residency director and clinical clerkship director in the department of emergency medicine at Mercy St. Vincent Medical Center in Toledo, OH.

When administrators create a budget for a daily schedule, staffing is based on historical trends. "But in a tight economy, having additional staff around 'just in case' is difficult to afford," Ledrick says.

During the COVID-19 pandemic, as many as 25 patients might be boarded at one time in Mercy St. Vincent Medical Center's ED. Boarding that many patients "is inefficient, full of communication errors, and has unclear lines of responsibility," Ledrick says.

ED waiting rooms are full with patients still waiting to be seen. Meanwhile, the boarded admitted patients are cared for by nurses not trained in inpatient care. "All the medical personnel are running from one brushfire to the next, without the resources they need in a healthcare gridlock," Ledrick notes.

Boarded patients are put at risk if they miss scheduled doses of antibiotics or steroids. Other ED patients are at risk of remaining stuck in a waiting room or left off a necessary monitor. Critical lab results may go unrecognized or unreported. From the EP's perspective, says Ledrick, two things are most important: maintain clear lines of responsibility and eliminate barriers to communication between EPs and bedside nurses.

On inpatient floors, physicians are not always present. They depend on others at the bedside to carry out treatment protocols and alert them to deviations in care or a deterioration in condition. "These models break down when an inpatient is in the ED," Ledrick reports.

Often, it is difficult for an inpatient physician to learn information about an admitted patient. ED nurses must prioritize acute, newly arrived, and unstable patients. "It is difficult to use inpatient charting and ordering systems in the acute care setting of the ED," Ledrick adds.

To help, move the inpatients to a specified area of the ED with personnel who are familiar with inpatient care. Assign an EP to act as a hospitalist for the inpatient services. Staff the ED with additional nurses from the inpatient units. Finally, move boarded ED patients to inpatient floors in hallway beds. "If they are going to be in a hallway bed anyway, they may as well be upstairs," Ledrick offers.

ED boarding "isn't as much an ED problem as it is an inpatient problem," according to **Lindsey Woodworth**, PhD, an assistant professor of economics at University of South Carolina who studies health economics. Correcting the problem likely will require buy-in from hospital administrators, which is no easy task.

Part of the solution requires beds in inpatient wards to be opened — beds that are occupied by patients receiving lucrative elective procedures. "This potentially affects hospital profitability if inpatient beds are repurposed to accommodate backlog in the ED," Woodworth says.

But what happens if there is an adverse event in the ED? "A lawsuit could inflict a heavy blow on a hospital, potentially heavier than the blow that would come from pre-emptively allocating more inpatient bed space to non-profitable emergency patients," Woodworth says. ■

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Neurology Consult Delays Can Become Issue in Claims

If a stroke patient alleges failure to administer tissue plasminogen activator (tPA), whether a timely neurology consult was obtained likely will be a central issue in the litigation. The following are some issues that can arise during litigation:

• **The EP failed to request a neurology consult.** "The most common legal pitfall with neurology consults is not getting one when you should," says **Kenneth Alan Totz**, DO, JD, FACEP, a Houston-based attorney and practicing EP.

A good example is a patient with cerebrovascular accident symptoms who does not meet the National Institutes of Health Stroke Scale criteria for tPA administration. "That patient may be aggressively treated with tPA by the consulting neurologist, or the neurologist may suggest a transfer to an institution with interventional neurology care, or provide some other diagnostic considerations to further evaluate the patient," Totz says.

In his own practice, Totz pre-emptively involves (time permitting) any consulting service that will be assuming care of a procedure started in the ED (e.g., tPA for stroke or myocardial infarction with ST-segment elevation). "This is especially true when my care may drastically impact the care to be rendered by the specialist consultant," Totz reports.

• **The EP requested a consult, but it happens too late.** When difficult neurologic cases arise, or the care will be complex and require ongoing neuro consults, "consider getting them on board sooner than later," Totz offers.

Most emergent neurological issues include some component of time dependency. If the neurology consult is delayed, the EP should document in the chart the reason why. Otherwise, the plaintiff attorney can paint a picture of a patient who presented for care, but unacceptable delays closed the window of treatment opportunities.

Totz stresses that "it is extraordinarily critical" to document the time the patient was seen, the time of consultation, and the time care was initiated. "This is crucial to legally protecting yourself when time-critical treatment is being considered," he cautions.

• **The EP, for whatever reason, chooses to deviate from the consulting neurologist's recommendations.** "If the consultant's recommendation, neurology or otherwise, differs from your anticipated treatment, consider asking the neurologist to come in to personally see the patient, consulting another neurologist, or transferring the patient," Totz says.

Recently, a neurologist sent a pregnant patient to the ED for a lumbar puncture. The patient reported headache and fever on a Friday afternoon. The neurologist never saw the patient. After seeing the patient, Totz believed she clearly had sinusitis, without any suggestion of meningitis and without any clinical justification for a lumbar puncture. "I conveyed my thoughts to the neurologist, who then belittled me with his authority as a board-certified neurologist," Totz recalls.

Totz countered with the fact he was board-certified in emergency medicine, and, in addition, was the only physician who had actually examined the patient. Totz requested the neurologist come see the patient. The neurologist declined. Totz responded that he would start the patient on antibiotics for presumptive sinusitis and observe the patient under the neurologist's service so the neurologist could perform a lumbar puncture if the neurologist believed it was indicated.

The patient was discharged the next morning on oral antibiotics, without undergoing a lumbar puncture. In the chart, Totz noted a lack of fever, lack of meningismus, and lack of any other signs of meningitis that normally would prompt a lumbar puncture recommendation. "These are very high-risk situations, whether you comply with the consultant's recommendations or depart from them," Totz explains.

There is legal risk if the EP does not follow what the consultant recommends and the patient actually is living with the disease of concern. If the EP does follow the consultant's advice and orders the lumbar puncture, there also are legal implications.

"If you don't document a reasonable rationale for the exam, you could be in trouble if there are complications from an unnecessary procedure," Totz explains.

Just documenting "the consultant wanted the procedure" is not enough for a strong defense. "Meticulous documentation of the discussion with the consultant and the rationale for departing from their recommendations must be noted," Totz says.

• **The EP discharged a patient after the neurologist refused to come in to evaluate the patient.** "One of the hardest obstacles for young EM docs to hurdle is knowing when to request — or demand —

the consultant perform a bedside evaluation," Totz says.

If the consultant refuses to come in, Totz says to document this and call the chief of staff or chief medical officer. If the EP cannot do so, he or she can consider transferring the patient, noting the reasons in the medical chart, along with the EMTALA form that asks why the patient is going to be transferred despite the fact the specialty exists at the hospital.

"Do not discharge a patient if you feel strongly about a necessary consultation," Totz says.

Christopher B. Colwell, MD, chief of emergency medicine at Zuckerberg San Francisco General Hospital and Trauma Center, says that in terms of ED consults, neurology is "one of the higher-risk areas. In cardiology, it's clear when the patient is going to have to get to the cath lab. There are pretty clear criteria, similar to surgical and trauma patients."

Neurology cases are less clear because patients often present with vague, non-specific symptoms (e.g., dizziness). "You want to have neurology involved early if patients are having a stroke to maximize everything we can do for them," Colwell offers.

EPs have to determine whether to contact the neurologist for a patient with subtle symptoms that also could be something completely unrelated to stroke.

"Where I see medical-legal cases, almost inevitably it's because you didn't recognize stroke soon enough, you didn't initiative tPA soon enough, and you didn't get neurology involved soon enough," Colwell observes. When the EP calls neurology for a patient with unclear symptoms, the response might be "Why are you getting us involved?"

"It is much less clear when the right time to get a neurologist involved, prospectively. It's always clear in retrospect that the numbness in the finger of the left hand was a sign of a stroke," Colwell says.

EPs know what to do if someone suddenly lost the use of his or her left arm and leg, but other stroke cases just are not that clear. "Very few patients are crystal clear," Colwell notes.

The ED chart should be transparent on the outcome of the discussion with the neurologist (e.g., there was a mutual agreement that it probably is OK for the patient to be seen the next morning). If the consultant declines to come in, the EP should be explicit on that, too, while avoiding inflammatory comments such as "consultant refusal to come in."

"When plaintiff attorneys see that, they start counting the zeros on the check. It's a battle that nobody wants to be in," Colwell cautions.

At deposition, the neurologist's typical response is, "If only the EP expressed the appropriate amount of concern, I would have been more than happy to come in. That's what I do all the time. It was only because the EP didn't describe the story appropriately, or express to me the true findings on exam."

"The defense is going to be the same every single time," Colwell says. "It's not that they are bad people. It's just that at that point, they are defending what they did, which is not come in." It is much better to reach an agreement up front on when neurology will be called, with set criteria for when neurologists will come in to see the patient. That might include a stroke scale score so that both the EP and neurologist are speaking the same language. "It should be discussed ahead of time," Colwell says. "At 2 a.m., it is almost never going to work out well."

Early in Colwell's career, he saw a 67-year-old man with hypertension and dizziness and was reluctant to discharge the patient because something just did not seem right. The neurologist refused to become involved in the case. The patient was sent to family practice, and suffered a devastating stroke. "They didn't go forward with a lawsuit, but we did get a notification of intent to sue," Colwell recalls.

Because of those "gut feeling" cases, Colwell says one criterion has to be the EP simply believes a neurology evaluation is necessary. If it turns out a particular EP is calling for consults needlessly all the time, that can be addressed separately. "The beginning of the conversation with neurology can be, 'This is really a high-risk situation. It's high risk for all of us,'" Colwell suggests.

The EP can discuss the reality of stroke lawsuits — namely, that both the EP and the neurologist are likely to be named. It also is important to consider the fact that plaintiff attorneys build cases based on the perception that strokes can be 100% cured if medication is given early enough.

"Their first question is, 'Did they give you the clot-busting medication?' If not, we have a lawsuit on our hands," Colwell says.

One approach is to ask neurologists to agree to a six-month trial of coming in when EPs request it, based on agreed-on criteria. If, at the end of the six months there really are too many inappropriate consults, the criteria always can be re-evaluated. Both sides need to trust the process.

"They've got to be confident that you may look at it and conclude that some EPs are just not good at neurology and are making calls on

every dizzy patient," Colwell says. It gives neurologists a chance to educate ED providers on which cases they are more worried about. The culture at the institution also matters.

"If the neurologists are constantly critical and unpleasant, whether intentional or not, they've created a culture of 'don't call me,'" Colwell observes. Creating a "culture of collegiality" with good communication is what is needed, says Colwell. "If that's set up ahead of time, these discussions are so much easier." ■

ED Violence Means Possible Liability Exposure for Hospital

Violence is common in the ED, and can lead to legal problems.

"In-hospital injury is an easy target for both plaintiffs' attorneys and regulatory bodies," says **Daniel Pallin**, MD, MPH, an EP, consultant, and former Harvard faculty. "Security guards often default to an argumentative or combative relationship with the patient or visitor."

Plaintiff attorneys will look at the response to the incident. Hospitals can be criticized for overreacting or underreacting. An example of a "too aggressive" response would be if security guards restrained someone who posed no threat to anyone. If a patient attempts to elope from the ED and is persuaded to return, but is then not put on a security watch, the hospital is legally exposed for not using enough aggression. "In my opinion, protocols often supplant careful, individualized judgment," Pallin says.

Just because someone has a history of violent behavior, that does not necessarily mean there is a need for aggressive management. "Each case has to be considered according to its unique characteristics," Pallin says.

Protocols can cause staff to treat all patients the same. "What is needed is good training, careful thought about individual cases, and physician leadership," Pallin adds.

Caitlin Lentz, JD, an associate attorney at Hamil Little in Augusta, GA, says if one patient injures another, the hospital or ED staff may be held liable under negligence theories (simple negligence, professional negligence, or premise liability).[1-4]

If the act or omission that "allowed" the patient-on-patient violence is on the hospital staff, then there may be a claim against the hospital for negligent hiring and supervision. "When it comes to patient-on-staff liability, we get more into the regulatory world," Lentz says.

Specifically, EDs could be hit with violations of OSHA's workplace safety standards. "There have been huge penalties against hospitals for violence against medical staff," Lentz notes.

A pending federal bill would direct OSHA to add new standards to protect healthcare and social services workers.[5,6] "It depends on the jurisdiction's laws, but generally there is some duty owed to patients who present to a hospital's ED," Lentz explains.

That could be painted as a basic duty, which in some jurisdictions is "measured by the capacity of the patient to provide for his or her own safety," Lentz says. In other jurisdictions, it may be argued the duty owed was that of a professional to a patient. "What will be looked at is what the hospital and its staff did to perform the duty it owed," Lentz says.

During litigation, two important questions will arise: How did the hospital keep the patient safe? Was the hospital not doing reasonable things that other hospitals were doing?

Liability also depends on whether the injury of the ED patient was foreseeable. "This is more of a fact-specific issue," Lentz notes.

To determine this, attorneys will look at factors such as whether the hospital is in an inner city, high-crime area. They also will consider whether there were previous similar incidents in the ED. If so, how did the hospital prevent future incidents? "If the hospital met its duty and there was still an injury, the hospital likely won't be liable under a negligence theory," Lentz suggests.

To show the hospital met its duty, the defense can point to some specifics. Perhaps the hospital is doing the same things as other similarly situated hospitals in terms of security, training, policies, and oversight. Facility leaders may have taken steps to prevent the occurrence of violence, if similar incidents occurred before.

Perhaps the hospital hired an outside security company. "In that case, the security company may be liable," Lentz adds. ■

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EPs Find Ways to Mitigate Emotional Toll of Malpractice Litigation

There is increasing awareness of the negative emotional toll of malpractice litigation on EPs.[1-3] "As with many of the system factors that lead to burnout, malpractice risk is increasingly on the radar of providers," says **Martin Huecker**, MD, associate professor and research director in the department of emergency medicine at the University of Louisville School of Medicine.

Huecker and colleagues found the longer an EP practices, the more likely it is he or she will become a defendant in a malpractice lawsuit.[4] Their work revealed that, overall, EPs carried a 7.5% annual risk of litigation. "In emergency medicine, you are more likely to be named in a lawsuit than not," Huecker. "[In the ED], we practice in a setting that looks like total chaos, facing uncertainty, diagnostic time constraints, inpatient consultants, and often limited staffing."

Lack of prior patient relationships, inadequate histories, and presentation late in the disease process all present unique legal risks for EDs. "Lawsuits are very common among emergency physicians because of the nature of our practice," notes **Robert Broida**, MD, FACEP, president of Sarasota, FL-based ED Quality Solutions.

EPs who find themselves defendants do have resources — at their hospitals, from their professional liability carriers, from mental health professionals, and from specialty organizations. "Physicians should feel free to access the many support systems that are available to them," says Broida. Some examples:

• The American College of Emergency Physicians (ACEP) offers a litigation stress primer. *(Available at: https://bit.ly/3g6y6iO.)*

• The American Academy of Emergency Medicine encourages members to ask for assistance with a malpractice lawsuit, or if they are victims of unfair or inaccurate expert testimony.

• The Council of Residency Directors in Emergency Medicine offers a Medicolegal Toolkit. *(Available at: https://bit.ly/2ST6vcU.)*

As a member of ACEP's Medical-Legal committee, and his work leading two different malpractice carriers offering such services, Broida heard from many EPs who suddenly found themselves defendants. "Many docs have expressed heartfelt thanks once they availed themselves of such support services," Broida reports.

Talking with other EPs who have been sued can be helpful. "With the high incidents of lawsuits in emergency medicine, it's almost a certainty that someone else in your group has experienced this before," Broida offers.

It is not possible to talk case specifics, but it is fine to discuss the experiences and emotions involved with litigation. "Several companies have also developed peer mentorship programs specifically designed to address the concerns of emergency medicine docs in the litigation process, which can take several years," Broida notes.

Limiting stress levels also is important. "It's frequently helpful to lighten up on shifts for a month or so, but this is rarely possible," Broida laments.

EPs should practice self-care and wellness before, during, and after a lawsuit. Huecker also recommends leaning on family, friends, and colleagues, especially those who are familiar with the legal process. "Physicians should seek assistance from the people and organizations that make them feel most supported," Huecker adds. ■

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CME/CE QUESTIONS

1. **Which is true regarding legal risks involving physician assistants (PAs) in the ED?**
   a. PAs are experiencing less practice autonomy in most states, increasing the hospital's legal exposure.
   b. More frequent consults between PAs with supervising emergency physicians (EPs) is tied to higher risk of lawsuits.
   c. The hospital could be held liable for the PA's negligence or the EP's negligent supervision.
   d. Hospital policies should specify that PAs should consult with supervising EPs only on cases deemed very high risk.

2. **Which is true regarding lawsuits involving acute myocardial infarction?**
   a. Failure to timely diagnose is uncommonly alleged because it is so difficult to prove.
   b. Consulting with the patient's own cardiologist generally increases the EP's liability exposure since the cardiologist can point out an EP's standard of care deviations.
   c. Documentation of pertinent negatives and positives helps the defense of malpractice claims.
   d. Delays in obtaining an initial ECG are not enough for a successful lawsuit, as long as the correct diagnosis ultimately was made in the ED.

3. **Which is true regarding EPs contacting their professional liability carrier?**
   a. The plaintiff's attorney can use the discussion as evidence against the EP.
   b. Plaintiff attorneys can require the EP to disclose the liability carrier attorney's advice.
   c. There is no legal way to proactively preserve video recordings that could help the defense until a lawsuit is filed.
   d. A defense attorney can help the EP consider how to best preserve their recollection of events.

4. **Which did a recent study reveal regarding ED boarding?**
   a. Boarding does not affect clinical outcomes of other ED patients.
   b. Boarding extends length of stay for all admitted ED patients.
   c. Boarded ED patients are at lower risk of morbidity and mortality than other ED patients because of attentive monitoring.
   d. Boarded ED patients were less likely to leave without being seen than other ED patients.