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Sexual Comments, Behavior Create Minefield in the Health Care Setting

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Interactions in the clinical setting that involve sexually related comments or behavior, personal relationships, or physical examination of private areas of a patient's body must be handled with sensitivity and good judgment to avoid potential liability. In this article, the authors will address what constitutes sexual harassment, sexual battery during a physical exam, and unacceptable relationships with patients. These cases address environments and situations that emergency department (ED) clinicians encounter regularly.

Allegations alone can kill careers

The mere allegation of sexual harassment is one that can haunt a clinician through the rest of his or her practice, and has the potential to end a career. A health care provider subjected to a sexual harassment suit could suffer significant financial, professional, and personal loss. Because physicians are considered to be in a position of authority and in possession of "deep pockets," they are at increased risk of being targeted by such accusations, whether or not there is a factual basis for the claim. Physicians are often identified as supervisors and leaders, as well, and may be held accountable if they don't stop witnessed behavior by those they supervise.

The financial and personal cost of defending a sexual harassment suit could be so excessive that an attorney will invariably advise a physician client to attempt to settle a suit, even if no harassment occurred and the lawsuit is defensible, rather than risk incurring further losses in attorney's fees. Malpractice insurance may not cover the cost of defending such an allegation, therefore personal assets could be at risk.

As with malpractice claims, it is best to do everything one can to be informed about and avoid high-risk situations to prevent becoming a defendant in a sexual harassment suit. Understanding the legal definition of sexual harassment and awareness of behaviors that may predispose you to this allegation are crucial to not being

caught in this situation. Sexual harassment is a type of gender discrimination which employees are legally protected from under the federal statute Title VII of the Civil Rights Act of 1964. As defined by law, sexual harassment occurs when an employee is subject to unwelcome advances, to the extent that the employee's compensation, privileges, or employment terms and conditions are tangibly affected.

There are two types of sexual harassment that are recognized:

- ***"Quid Pro Quo:"*** This is a Latin phrase meaning "something for something," which in legal usage refers to an exchange of an item or service for something else of value. In the setting of sexual harassment *quid pro quo* refers to, for example, a supervisor offering an employee professional advancement in return for sexual favors.
- **Hostile Work Environment:** This situation is created when unwelcome conduct results in an intimidating or offensive work environment, and unreasonably interferes with an employee's job.

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The alleged behavior must be "severe or pervasive" to support the claim of a hostile work environment.

It is often challenging in court to decide exactly what crosses the line in creating a hostile work environment. This is an area that is difficult to define and is decided on a case by case basis. The following cases illustrate examples where the court has determined whether or not harassment has occurred.

Cases that the courts have labeled "severe or pervasive." One example of a case that was determined by the court to have met the requirement of "severe or pervasive" behavior is *Rorie v. UPS,* in which a supervisor frequently told a plaintiff she smelled good, patted her on the back, brushed up against her, called her at home, and made comments to her concerning the size of his penis. He also told the plaintiff she looked better in her UPS uniform than any other woman.[1]

Another suit that the court found to demonstrate the "severe or pervasive" condition was *Wilson v. Chrysler Corporation,* where a female worker complained of being subjected to verbal assault and obscene cartoons. She received a lewd greeting card signed by 38 employees, including her supervisor. A co-worker placed a fake penis between his legs and yelled to her, "[L]ook what I got for you, bet you can't handle this." A male colleague repeatedly looked at the plaintiff's breasts and said, "ummm," and on one occasion touched her breast.[2]

In *Bailey v. Runyon,* a male homosexual co-worker asked the male plaintiff repeatedly for sex over a 45-month period of time, on one occasion grabbed the plaintiff's genital area, and exposed himself to the plaintiff in the men's room.[3] In another case, a court allowed a male meatpacker to proceed with a harassment claim against same-sex co-workers who verbally harassed him, pinned him down, grabbed and hit him, and simulated sexual acts.[4]

As the latter two cases show, the victim and harasser do not have to be of the opposite sex for the claim of sexual harassment to be pursued.

Cases that the courts have labeled as not "severe or pervasive." In some cases, the standard of severe or pervasive was not met, as in *Minor v. Ivy Tech State College,* when a college chancellor talked to an employee in a sexually suggestive tone, told her he had been watching her through the window, and on one occasion put his arm around her, kissed her and squeezed her, and said, "[N]ow is this sexual harassment?"[5]

In *Cowan v. Prudential Insurance Company of America,* a female insurance agent was unable to prove hostile work environment when male co-workers actions were occasional and sporadic. The men called each other crude names, discussed regular trips to a strip club, and used a picture of a provocatively dressed cheerleader in promotional materials.[6]

A female plaintiff alleged sexual harassment when male colleagues stared at her and her breasts, a male co-worker touched her on the arm, and a male employee told her not to wave at squad cars in front of the police station because passers by would mistake her for a prostitute. In this case, *Adusumilli v. City of Chicago*, the court decided this was not severe or pervasive enough to be considered sexual harassment.[7]

Sexually stereotyped insults, jokes, and innuendos may create a hostile work environment if there is a pattern of this language such that a "reasonable person" would find such language to interfere with an employee's ability to perform the job. The U.S. Supreme Court has recognized that some amount of flirtation or teasing is a common workplace occurrence and thus not actionable. However, the distinction between actionable and non-actionable conduct is a fine line that is safest not to walk. When verbal harassment is accompanied by unwelcome physical contact, the situation is more likely to meet an actionable standard.

So what behavior is acceptable, and what steps are too far over the line? To be safe, one suggested rule of thumb is that all workplace conduct should be measured against what would be appropriate for a Walt Disney movie, or rated "G" for general audiences.

Sexually related liability in clinical practice

Health care providers are placed in a position of trust by their patients, and professional conduct is mandatory. Deviation from this by engaging in a sexual relationship with a patient, even if the formal doctor–patient working relationship was terminated, will be viewed negatively by a jury. The following cases highlight this issue.

Sexual Involvement with Patients

In *Anonymous Female v Steve Rosenthal MD,* a 23-year-old woman was treated by a psychiatrist for more than two years. She claimed the psychiatrist sexually abused her by cuddling, hugging, fondling, and watching pornography. She claimed this led to emotional distress and a suicide attempt. The psychiatrist admitted the relationship existed, but argued that the patient suffered no harm. The jury awarded a $400,000 verdict.[8]

A 13-year-old girl was exhibiting sexually dangerous behavior with teenage boys and she was admitted to a psychiatric hospital. On the last day of admission, she engaged in sex in the bathroom with a 27-year-old employee. She revealed this to her mother two weeks later, and police were notified. The employee was arrested, convicted, and sentenced to three years in prison. The mother of the patient said that her daughter had openly stated that she intended to have sex with the employee; nevertheless, they were allowed to come in contact. The mother also claimed the male staff had prior misconduct and was not properly supervised by the hospital. The hospital claimed that this employee had an exemplary record and that the patient initiated the contact to get revenge on her mother, who forced the admission. A settlement was reached, including $900,000 for the patient and $350,000 for her mother.[9]

The courts have been consistent in finding that a physician or therapist who engages in sexual activity with a patient may face civil sanctions and criminal liability. Common defenses which the courts have rejected include claims that the patient consented to sex and that the practitioner's treatment was finished before sexual relations began.[10] Physicians and other health care providers would be wise to never become sexually or personally involved with their patients.

Physical Exam of Private Body Areas

Besides being liable for sexual harassment in the workplace, providers can be held liable when they examine patients' personal physical areas. Cases that illustrate the issues are now presented with recommendations.

Case 1: A 31-year-old woman went to see a doctor for replacement of her intrauterine device. Her scheduled physician was unavailable, and she was seen by the defendant. The plaintiff claimed that the medical assistant left the room for a period of time and that she was molested during the procedure. The physician denied the charges and the defendant medical group claimed that a medical assistant was present throughout the examination. The plaintiff sought recovery for sexual harassment, sexual assault, sexual battery, and medical malpractice, and her husband sued for loss of consortium. It was found that the charges were fabricated and that the medical assistant was present in the room at all times. A defense verdict was returned.[11]

Case 2: A 34-year-old woman underwent a myomectomy to remove fibroids from her uterus. She claimed that after surgery, the anesthesiologist fondled her breasts and vagina. The plaintiff sought recovery for sexual battery, as well as negligent supervision by the hospital. The hospital was released from the case prior to trial, and the defendant denied the charges, also citing inconsistencies in the plaintiff's story. After investigation by the hospital and police, a defense verdict was returned.[12]

Sexual Battery During Physical Exam of Patients

One of the charges that is likely to be made when a physician exams a private area of a patient's body in an unacceptable manner is a charge of battery. This is evidenced by the cases above. Battery is unlikely to be

covered under a provider's malpractice policy and opens the clinician up to extreme personal risk. A provider must be very careful to avoid committing battery in the process of a patient exam encounter.

Battery has the following legal elements: 1) It involves invasion of a person's bodily integrity without their consent; 2) Criminal actions, or even an attempt to harm, need not be present; 3) One can actually be trying to help the patient and still lose a battery suit. Intent is immaterial.

An example would be a surgeon who performs a non-emergency surgery that he or she feels is needed without first getting consent. A patient's consent can also be withdrawn at any time, without good reason, and even if sedated. If an exam is being done and the patient says "stop" or "I don't want this," the physician should immediately cease the exam.

Courts often use key phrases when rendering decisions regarding a charge of battery. Statements such as "sanctity of the person," "bodily integrity," and "personal autonomy" are used, as the Constitution protects all from invasion.

If a provider loses a case of battery, then several types of damages may be awarded. First, general damages may be given for the invasion itself. Subsequently, special damages may also be awarded. These damages compensate a patient for the expenses accrued, such as hospital bills and lost wages.

Case 3: A 41-year-old woman was involved in a serious car accident, for which she began receiving chiropractic treatment with the defendant. She was treated for three weeks with customary adjustments, massage, and exercise. After three weeks without improvement, the defendant recommended an intra-rectal coccygeal adjustment to correct a stress condition within the meninges surrounding the spine. The plaintiff claimed that she was not informed that the procedure would entail entering the rectum, and that she was not told the risks or other treatment options. She claimed that the procedure cause post-traumatic stress disorder, aggravation of pre-existing emotional instability, and personality adjustment disorder. She also claimed that the procedure was unlawful and was therefore intentional assault and rape. The defendant contended that the procedure was fully explained, as were risks and other treatment options. A defense verdict was returned.[13]

Recommendations for exams involving patients' private body areas

The cases just described illustrate that patients are not hesitant to bring legal action against physicians who examine private areas of the body. This may occur despite chaperones, other professionals, or family presence during the exam.

One way to avoid this litigation is to use optimal communication skills and sensitivity. Many patients are uncomfortable when a professional, often a stranger, examines them. It is important to explain the reasons for examination or procedure and the likely feelings and sensations that may be present before proceeding. Then the patient should be asked for permission. The physician's exam should not be more invasive than necessary for a given complaint. Despite the need to have a patient undressed for most thorough exams, the patient's modesty should be respected by providing adequate coverage with gowns and sheets. In addition, the body area being examined should be uncovered only long enough to permit the necessary evaluation.

Another way to avoid litigation is to ensure consent is obtained. It is not necessary to sign formal consent for the exam. Most ED "permission to treat" agreements that patients sign before care allow for exams and procedures without more specific consent. The patient's simple actions of giving permission, or assuming the required examination position, gives implied consent, as well. If an unusual procedure/exam is done, formal consent should be considered, as in the instance of coccygeal manipulation.

A chaperone provides a direct witness to vouch for the behavior during the exam. It is optimal to have a chaperone present for every personal (breast, rectum, genital) exam, regardless of the sex of the provider and patient. Documenting the actual witness/chaperone present or having the observers themselves note their presence on nursing charts is invaluable, also, as clearly evidenced by the defense verdicts above.

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Could photographing an ED patient get you sued?

Without consent, you are asking for a lawsuit

Photographs of ED patients' clinical findings are being taken more frequently, due to the ubiquity of digital cameras, increasing use of electronic medical records, and their recognized value in medical education, according to **Lawrence B. Stack, MD**, associate professor of emergency medicine at Vanderbilt University in Nashville, TN, and co-editor of *Handbook of Medical Photography.*

However, patients who are to be photographed should be informed of the photography and given an opportunity for informed consent, says **Matthew J. Walsh, MD**, associate professor in the department of emergency medicine at the University of New Mexico in Albuquerque.

"Random photography with the ubiquitous cell phone camera is asking for a legal suit and should be forbidden," he says. Educational uses are of insufficient value to society to permit the violation of patient privacy without explicit informed consent, Walsh argues.

There are many issues surrounding consent for taking clinical photographs, says Stack, including purpose, privacy, confidentiality, trust, patient care, and identifiability.

What if your patient can't give consent because he or she is unconscious, incompetent, or deceased? Stack says that in these cases, photographs can be taken, but they should not be used without permission of the patient when he or she becomes competent, or from the family. If consent is denied by the patient or family at a later time, the images must be destroyed.

Stack says that clinical photographs should not be taken if a minor patient's guardian objects, though an exception to this is when photographs will be used in the record as evidence of a possible criminal act.

Consent generally serves as an agreement between the patient and all persons associated with the medical institution where the image is taken, which gives permission to take the photograph, defines the scope of its use, and releases institutional personnel from any liability related to the stated use of the photographs, says Stack.

"Most patients feel that use of images for medical education is a gallant purpose and will grant permission for taking and use of their photographs of clinical findings to 'help someone else,'" says Stack.

However, he adds that "medical education" is a concept not fully understood by patients. Case conferences, lectures both in and outside the medical institution, patient education, medical-legal education, web-based education, photography competitions, commercial educational products, and journal publication, both print and electronic, are all venues which could fall under the heading of "medical education."

"This should be carefully explained to the patient," says Stack.

While many hospitals have a "consent for photographs/video" form as part of their routine registration procedure, Stack says that the photographer should be sure the patient is "truly informed" as to the intended use of the photograph.

Patients should also clearly understand that their decision won't change their care in any way. "They should also be aware that placing their clinical photograph into their electronic medical record may enhance their care by allowing consultants to provide real-time input on their care—a form of telemedicine—and for follow-up," says Stack.

Is written consent needed?

Consent serves as some protection for the photographer and institution from being sued for damages from violations of privacy, defamation, or anguish, says Stack.

"While written consent does not prevent a lawsuit, it may make it more difficult to prosecute," Stack says.

For this reason, Stack recommends that with any photograph where a patient is identified, particularly the face, written consent should be obtained and placed in the medical record, even if the photo is being used only for educational purposes.

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Sources

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SPECIAL REPORT

Smoothing Legal Rough Waters with Mediation

*By **Richard J. Pawl, MD, JD, FACEP,** Associate Professor of Emergency Medicine, Department of Emergency Medicine, Medical College of Georgia, Augusta.*

***Editor's note:** The format of this article deviates somewhat from the usual style of footnotes sustaining the assertions of the article, because the purpose of this essay is to provide an introduction to alternative methods of dispute resolution in the healthcare field, which will be further examined in future articles. The author takes an editorial approach to the topic, followed by an exemplary example of what one innovative institution has developed to manage a selection of their medical malpractice suits to provide a taste of what can be done when parties have open minds and are motivated to expedite a resolution to litigation outside of the traditional malpractice suit.*

Many physicians' first encounter with a formalized dispute resolution process occurs when they are first sued for a medical malpractice action. Given that the traditional malpractice action offered by our civil justice system is, by its nature, an adversarial approach to resolving allegations of medical malpractice, it is no wonder that this experience inevitably leads to a very dysphoric experience for the physician. One needs only to have read the initial complaint in a filing for a medical malpractice action, where the defendant physician is described as what seems to be the most negligent physician who ever existed prior to that point in time. Being in the "hot seat" during one's first deposition as a defendant is an experience that is seared in one's memory forever, as the defendant is raked over the coals as he or she explains what happened during the patient encounter where the alleged malpractice occurred. However, just as the defendant physician resigns himself or herself to the inevitability of the malpractice action, it becomes clear that the plaintiff's attorney will have to prove to a judge and jury the allegations asserted against the defendants—often not an easy task even for experienced plaintiff attorneys, and certainly always an expensive task for plaintiffs and defendants alike in terms of money and the time invested in the action. But once a malpractice action has been filed, there may be alternatives—couched in the category of settlement discussions—that offer a more timely, less expensive, and more satisfactory resolution. An example of such an alternative will be discussed below.

In areas of dispute within the healthcare arena outside of malpractice, alternative and formalized methods of dispute resolution have been used successfully. A common venue for such formalized processes occur when medical institutions offer formalized mediation processes to patients, their family members, and the patient's healthcare team members when ethical, cultural, and religious beliefs are in conflict in situations such as end-of-life decision-making. To be sure, most disputes—if they are really disputes at all—are resolved successfully in an informal fashion. However, there are times when interested parties have such conflicting interests and values that only a formalized process of resolving the differences between parties would have any hope for resolving the issues. Most typically, the resolution process offered is mediation, where the parties involved are guided to resolving their own problems with a trained mediator (or mediators) whose only role is to facilitate the parties into coming up with their own solutions. What is unique about mediation, as opposed to other formalized forms of dispute resolution, is that the mediator is powerless to impose any decisions upon the parties. If mediation fails, and disputes are still present, parties may still have to resort to the formalized, adversarial process of the lawsuit, but if the parties arrive at a settlement of their differences, they have complete ownership in their solution. Mediation offers a more comfortable and empathetic approach to solving problems between parties that may still need to relate to each other after a dispute has been resolved, such as family members and a patient's healthcare team.

Another process that has been crossing over from the financial service arena into contracts with independent contractor emergency physicians is that of the mandatory arbitration clauses that are found more frequently in contracts between emergency service corporations and their doctors. This author cannot state unequivocally that it is an industry trend, but from personal experience over the past two decades, I have seen an increasing frequency of contracts that contain clauses that require the parties to seek resolution of any disputes about the contract from an arbitration process rather than a civil contracts litigation approach.

Fortunately, most emergency ser-

vice corporations and emergency clinicians will often resolve any issue amicably without a formalized process, even when the resolution is merely parting company under the terms of the contract. But the fact that most of these disputes are resolved without resorting to arbitration begs the question as to how much a physician who has signed such a contract really knows about the process of arbitration. If a contracting physician ends up having to resolve a contract dispute via arbitration, does that physician know what to expect from the process, and what are the advantages and disadvantages of that process for his or her interests?

A more detailed discussion about alternative dispute resolution methodologies used in the healthcare arena can be deferred to more in-depth reviews of each method. But to exemplify how one such methodology, co-mediation, has been successfully used in the process of settling malpractice suits, a thumbnail sketch of Rush University's Co-mediation Program will be discussed; space precludes a full description of the Rush process.

As of 2007, Rush University Medical Center in Chicago is a tertiary care academic facility that operates approximately 900 beds, and has some 2,000 members on its medical staff. At any given time, Rush is a defendant in roughly 150 medical malpractice suits, with an average of 40 new cases being filed with Rush as a defendant each year. About 50% of the malpractice claims filed against Rush are voluntarily dismissed by the plaintiffs after about four years. About one third of the cases filed against Rush are considered by their legal analysts to be completely defensible. About one case every other year is considered to be indefensible. The remaining cases represent cases that are less clearly defined and may have aspects favorable to either the plaintiffs or the defendants.

Given that pursuing a traditional approach to malpractice litigation towards trial can take up to 3–5 years in the Cook County jurisdiction (Chicago), and that huge damage awards were appearing more frequently in the early 1990s, Rush began looking for alternatives to being forced into the trial process for the resolution of select malpractice suits that would offer them more control over the results more quickly. What emerged was the Rush Co-Mediation Program.

The plaintiff first selects co-mediators from a bank of mediators who are experienced plaintiff or defense medical malpractice attorneys—one from the defense side and one from the plaintiff's side. After the selection of the two mediators, the parties enter into mediation with the intent of creating their own solution to the litigation with the assistance, guidance, and insight of the co-mediators. Critical to the process is that all interactions amongst the parties are considered settlement discussions that are undiscoverable to the outside litigation. The requirement that the co-mediators are experienced malpractice attorneys is also considered to be a critically important aspect of the Rush co-mediation process. The complexities of medical malpractice litigation become more manageable when the mediators themselves are inherently familiar with the arena.

Since 1995, Rush has participated in approximately 110 mediations. Ninety percent of the mediations were considered to have resulted in settlements. One clear benefit to the parties of the successful mediations was savings in their time investment. Mediations often resolved cases in a matter of hours, rather than the months or years that the litigation process would require. And while settlements achieved via the co-mediation process were not always at or below the reserves set for each case previously, Rush has found that the results have been consistently in line with their reserves, making budgeting for expected losses and overall expenditures more predictable.

Additionally, Rush found that their overall expenses for the defense of all malpractice cases have stabilized since the initiation of their co-mediation program. Through the co-mediation program, in-house counsel and risk management have been able to exert greater control over the negotiation of settlements. Other benefits have been realized, and will be further explored in a future issue of *ED Legal Letter*.

Disputes will always occur in medicine. Alternative dispute resolutions methodologies are available for use in resolving such disputes and should be seriously considered before running to the courthouse. However, to take advantage of such methodologies, they need to be in place and functional at the time the disputes present themselves. Being aware that the methods exist is the first step. Establishing active alternative dispute resolution processes that stand ready to handle disputes is the next step and will likely involve an investment of time and money from our institutions for these systems to come to fruition.

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Stack notes that photographs originally taken in or converted to a digital format can be manipulated to render a patient's features relatively unidentifiable. "This has been done traditionally by placing a black box over the eyes, a marginally effective method," he says. "Placing coarse pixilation over the eyes or a larger portion of face seems more effective, but may hide important clinical findings or may be distracting."

While the image shown for educational purposes may have this "mask" placed, the original image, if it demonstrates identifiable features, should be obtained with written consent when possible, notes Stack.

"I do not feel that consent is needed in the situation where the patient cannot be identified, such as the oral cavity, hand, or close-up of the skin," says Stack. "Publishers do not require consent where the patient is not identifiable."

Stack says that components of written consent should include:

- The patient's name, medical record number, and date;
- Purposes for which the photographs will be used; for example, entry in the medical record, legal evidence, educational/training purposes, publication in an electronic or printed medical journal, Internet, and/or advertisement for profit;
- An agreement to hold harmless the person taking the photographs and any person associated with the facility where the photographs are taken or used for educational purposes; and
- Patient signature, date, and witness signature.

Does it violate HIPAA?

Photographs are protected health information under the Health Insurance Portability and Accountability Act (HIPAA), which means that they should be treated just as any medical record would be treated, according to **Erin McAlpin Eiselein, JD,** a health care attorney with Denver, CO-based Davis Graham & Stubbs.

HIPAA permits photographs of patients to be used for internal educational activities, such as onsite teaching and training programs. However, photographs cannot be used for external educational activities without first obtaining patient consent to do so.

Under HIPAA, verbal consent is not sufficient—written consent is required. "The best practice is always to obtain a written consent or authorization from the patient specifically allowing the use of photographs for educational purposes," says Eiselein. "Such authorization provides the maximum protection to the physician and the hospital."

HIPAA also allows individually identifiable health information to be de-identified, which means removing all information that could identify the subject of the medical record—in this case, the photograph.

"If individually identifiable health information is de-identified, then it falls outside of the HIPAA regulations," says Eiselein. "With respect to photographs, the regulations state that if the full face is removed and the individual cannot be identified from the remaining image, the photograph is not subject to the HIPAA regulations."

That said, however, Eiselein advises that the most prudent course of action, especially considering state laws that may be more stringent than HIPAA, is still to obtain patient consent for any use of a photograph.

As for what liability risks an ED physician or hospital would face if photographs were used in violation of HIPAA, Eiselein notes that there is no private right of action under HIPAA, which means that the individual could not sue the physician or hospital for a HIPAA violation. However, Eiselein adds that the patient could make a report to the United States Department of Health and Human Services' Office for Civil Rights ("OCR"), as that is the agency charged with enforcing HIPAA.

If the OCR concluded that use of the photograph violated HIPAA, it could impose civil or even criminal penalties, depending on the circumstances, on the physician or hospital.

"In addition, the patient could file a lawsuit against the physician or the hospital based upon state tort law, such as a claim for invasion of privacy," says Eiselein. "Some states may have more stringent laws addressing photographs, and those laws may create independent causes of action, as well."

Risks rising for 'delayed diagnosis' ED litigation

Size of claims often are substantial

Editor's Note: *This is the first of a two-part series on delayed diagnosis in the ED. This month, we cover general liability risks and documentation. Next month, we'll report on why legal risks involving time-dependent medications and interventions are increasing.*

A growing number of ED malpractice lawsuits are alleging that a patient was harmed due to delayed diagnosis—and risks are reportedly increasing. Failure to diagnosis is "one of the most common causes of ED malpractice litigation," says **Matthew Rice, MD, JD, FACEP**, an ED physician

with Northwest Emergency Physicians of TEAMHealth in Federal Way, WA.

High-risk areas, says Rice, include vascular-related problems (coronary artery disease, pulmonary embolism, and stroke, aneurysms/dissections, and intra-abdominal ischemia); infections (sepsis, meningitis, appendicitis, and cellulites/fasciitis); and trauma-related problems (fractures and foreign bodies).

Other scenarios that have a growing potential for litigation, says Rice: Failing to recognize medication-related problems; failing to recognize abuse of spouses, the elderly, and children; and failing to diagnose increasing incidences of unusual infectious problems.

Many ED "delayed diagnosis" cases involve patients with devastating outcomes—death or substantial disability, notes **John Burton, MD**, residency program director for the Department of Emergency Medicine at Albany (NY) Medical Center. "As a consequence, the size of claims are often substantial—routinely in the hundreds of thousands and millions of dollars per case."

One potential malpractice lawsuit for delayed diagnosis in emergency medicine results from a misdiagnosis. "An example of this would be missed acute coronary syndrome," says **Jesse M. Pines, MD, MBA**, MSCE, assistant professor of emergency medicine and epidemiology at the Hospital of the University of Pennsylvania in Philadelphia. "In this case, a patient may be discharged from the ED and later comes back and another physician identifies the diagnosis, or in the worst case scenario, the patient goes home and dies from a cardiac arrest."

In other scenario, the patient may also be misdiagnosed in the ED, and then gets a correct diagnosis while in the hospital. An example would be a patient who is admitted with a diagnosis of pneumonia, but has hypoxia that remains persistent despite antibiotics. A chest computerized tomography (CT) scan is ordered, and the patient is shown to have a pulmonary embolism.

"Diagnostic delays can cause worse outcomes, in some cases on the order of hours in, for example, meningitis. Other delays can be on the order of days to years, such as a missed diagnosis of cancer," says Pines.

Pines says that he thinks that rates of diagnostic delays due to misdiagnosis are likely to decline, as a result of greater use of radiography and laboratory testing.

"But because ED crowding appears to be worsening across the U.S., I think that cases related to ED delays on the order of hours will probably increase," says Pines.

Why are risks increasing?

"With each year, it seems that emergency physicians are increasingly expected to be the physician of record in ordering medications and therapy, and holding the responsibility for screening patients for suitable therapy or diagnostic testing," explains Burton.

Emergency physicians are expected to identify patients who will benefit from timely antibiotic administration or revascularization therapy, for example. "In recent years, the access and involvement of specialists in identifying these patients has decreased in nearly every hospital practice," says Burton.

Burton says that one bright spot is that most states have adopted legislation regarding the qualifications of plaintiff's experts with requirements that the "standard of care" be specialty-specific. In other words, emergency physicians are held to the standards as characterized solely by other emergency physicians, not by physicians practicing outside the specialty.

In some states, moreover, the standards can only be attested to by a physician in similar practice as well as practicing actively in that state.

The lesson for emergency medicine, says Burton: There is a need to actively debate diagnosis and treatment standards at the specialty level, "with local and state groups of emergency physicians facilitating communication of expected practice standards."

Timing may be beyond your control

Timing issues can sometimes result in significant damages, "even if the factors involved are not always under the emergency physician's control," according to **Steven Davidson, JD,** a partner with Omaha, NE-based Baird Holm. One particularly high-risk scenario: If a patient's outcome is altered because of an ED physician's inattention. "That is a dangerous subject matter, in my view," says Davidson. "ED physicians can sometimes get drawn into things that aren't necessarily their fault—they may be more a victim of circumstances than anything else—but at the end of the day, the physician in charge of the patient is responsible for making sure they get the care they need in a timely way."

It's a difficult situation if things "turn south" when closer attention by the ED physician sooner in the process might have made a difference, says Davidson. "Plaintiff lawyers look for that. Where time of treatment is important—cardiac care or stroke are good examples—I've seen cases get some legs under them and go somewhere," he says. "ED physicians have a higher level of attention paid to their decisions, sometimes, than other doctors do."

However, **Joseph J. Feltes, JD,** a partner with Canton, OH-based Buckingham, Doolittle &

Burroughs, notes that the delay in diagnosing a patient's condition must have caused some injury. "For example, an Alabama court recently reversed a verdict for a patient with hydrocephalus because the patient failed to show that she suffered any actual injury by the ED physician's failure to order an [magnetic resonance imaging] or transfer her to another hospital," he says.[1]

Delays to diagnosis are frequently cited in acute myocardial infarction and stroke cases. "These types of cases often have very bad outcomes for patients—disability or even death—which lead patients and their families to ponder the impact of delays to diagnosis, perceived or real," says Burton.

Risk is mitigated in this scenario

One "delayed diagnosis" risk area for ED physicians involves a case where the ED diagnosis translates to a treatment plan or series of interventions that would affect a patient's outcome. For example, if a pulmonary lesion found on a CT scan is not adequately followed up, the patient may have a delay to diagnosis of lung cancer of weeks, months or longer.

"At some point, there is an important interval that ultimately affects therapy for the disease and then survival," says Burton. "With the cancer analogy, weeks don't matter, months often do, and a year most certainly would in most cancers."

Another example might be subarachnoid hemorrhage, says Burton, well-known as a disease with "sentinel bleeds" occurring in many patients as a precursor to major hemorrhages. "While the sentinel bleed event may not typically cause morbidity or mortality, it acts as an essential opportunity to make the diagnosis before a more devastating bleed or sequelae, such as vasospasm or hydrocephalus, occurs," says Burton.

In this case, there is no time-dependent immediate intervention in the ED—rather, there is an opportunity to make a diagnosis that is important to the patient's well-being. "When missed, these can translate to delays and problems for the patient at some point," says Burton.

Other examples would be aortic aneurysm or dissection. "Both of these diagnoses have a shorter timeframe for nailing the diagnosis," says Burton. "In these cases, the ED physician is sued for a delay to diagnosis that often translates to delays in therapy on the order of days, months, or years."

However, Burton notes that in this type of scenario, the emergency encounter is often one of many physician encounters-the patient has likely seen other ED physicians, primary care physicians and medical specialists, so the risk to the individual ED physician is mitigated.

Sources

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"Additionally, there is typically a great deal of doubt in these cases-both as to the impact of the specific delay to diagnosis on the patient's outcome, and also, at whose hands the responsibility for the delay should rest," adds Burton.

Interventions can reduce risks

Pines says that interventions that may be able to reduce the likelihood of a misdiagnosis are better training (including board certification in emergency medicine) and also the more liberal use of ED-based testing.

"While the latter can be seen as a waste of resources, a lower threshold to obtain CT scans will likely result in lower rates of misdiagnosis," says Pines.

Rice says that various interventions can be useful in reducing risks of delayed diagnosis. These include proper charting, careful documentation (especially medical decision making patterns and facts) quality assurance processes, peer reviews, proper referral and documentation, appropriate practice standards, aggressively pursuing the worst-case diagnosis, and carefully informing patients of options and risks.

If your ED patient's care was delayed and you suspect the patient could be harmed as a result, Rice says that you should immediately attempt to "remediate events to try to prevent an adverse outcome, or to prevent a problem from getting worse. Honesty is critical and rapid action is necessary," he says.

It is not uncommon for an ED to have a lab test or radiographic reading reported that indicates a medical problem was not properly diagnosed, notes Rice. "Rapid review and recognition of these findings, and communication with the patient are critical to avoid potential serious outcomes," he says. For instance, a nodule on a chest radiograph needs follow up, and a positive blood culture might require the patient to get antibiotics.

"It is imperative for the patient to be contacted and appropriate treatment to begin as soon as possible," says Rice. "This helps mitigate risk and assists in service recovery. Showing patients you care, even if previous care was not perfect, is a much better risk management strategy than hoping nothing 'bad' happens to the patient."

What should you document?

If the jury hears that a patient's diagnosis was delayed, making excuses probably won't help you, says **Catherine Vretta, MD**, an ED physician at St. John Hospital and Medical Center Emergency Center in Detroit, MI. "By saying things like, 'the lab was slow,' or 'the computer being down from 3 a.m. to 5 a.m. prevented me from looking at the X-ray itself'—I just don't see how that is going to help you," she says. "People tend to look at these things as being under your control—it's your ED, you are responsible."

One exception that Vretta says should be documented: An on-call specialist's failure to come to the ED in a timely manner. "If you don't have a neurosurgeon on call, I think that would probably be viewed as out of your control-and less your 'fault,'" she says. "If you are relying on a specific specialist and you can't get ahold of them, I would absolutely document that to protect yourself to whatever degree."

Burton says that when documenting, "as is always the case, tell the truth. A fabricated record will always increase risk for any questionable event. The facts should be documented calmly, and completely, without an aggressive tone or speculation to motives for delays by consultants or staff."

If there is a clinically significant delay in care, such as a missed ST segment elevation myocardial infarction (STEMI), Pines recommends documenting what happened, including any events which might have contributed to the delay.

"For example, let's say there is a trauma code going on and an hour later, while you're catching up, you realize that there is someone with a STEMI or stroke who was initially unrecognized," he says. "While it does not completely exonerate you for the delay, if the case enters the malpractice system, you will have a better rationale as to why the delay happened, espe-

CNE/CME Objectives

After completing this activity, participants will be able to:

1. Identify legal issues relating to emergency medicine practice;
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■

CNE/CME Instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

cially if it was out of your control, such as the case of the trauma code."

Reference

1. *Crutcher v. Williams* (Ala. 1/9/09) 2009 WL 51266.

CNE/CME *Questions*

13. To prove a battery case, a plaintiff must show that the defending clinician intended to do harm.
    A. True
    B. False

14. Which scenario is an exception to the requirement of obtaining consent from an ED minor patient's guardian for photographs to be taken?
    A. The patient is unconscious.
    B. Consent could potentially be obtained at a later date from another guardian.
    C. The photographs will be utilized for the organization's internal use only.
    D. The photographs will be used in the record as evidence of a possible criminal act.

15. Which is true regarding photographing ED patients for educational purposes?
    A. Informed consent is not required if photos are used solely for educational purposes.
    B. If a patient is unconscious, photos should not be taken even if the patient and/or family members will be asked for consent when the patient becomes competent.
    C. Written consent serves as some protection against lawsuits alleging violation of privacy
    D. Under the Health Insurance Portability and Accountability Act, the patient's verbal consent is sufficient.

16. Which is true regarding ED malpractice lawsuits alleging delayed diagnosis?
    A. For a successful lawsuit to occur, the delay in diagnosing a patient's condition must have caused some injury.
    B. Documentation involving on-call specialists should include opinions about possible motives for delays, as this may help to shift the responsibility for a bad outcome to the specialist.
    C. For a patient's lawsuit to be successful, the delay in ED diagnosis must have resulted in immediate harm to the patient.
    D. Lawsuits cannot be successful if the emergency encounter involved is one of many physician encounters for the same condition.

Answers:
13. B
14. D
15. C
16. A