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Update on State Medical Malpractice Wars – Part II of II

By Robert Bitterman, MD, JD, FACEP, Contributing Editor; President, Bitterman Health Law Consulting Group, Inc.

Last month's ED Legal Letter *analyzed some recent tort reform court battles.[1] This month, we review cases where physicians are suing state governments to stop them from pilfering the cash in patient malpractice compensation funds, and a few more cases litigating state and federal tort laws.*

Court Orders Pennsylvania to Repay $800 Million to Physicians' Malpractice Insurance Fund

The Pennsylvania Medical Society and the Hospital Associations of the state won the first legal battles in their war with Gov. Ed Rendell (D) and his administration regarding the state-run medical liability coverage fund. A trial court ordered the commonwealth to repay over $800 million into its Medical Care Availability and Reduction of Error Fund (MCARE) fund,[2] which provides excess malpractice liability coverage to physicians and other health care providers in the state.[3] The court held that Pennsylvania did not have the right to siphon money from the physicians to balance its massive budget deficit. Gov. Rendell's administration formally appealed the decision a few days after the court's ruling.

Pennsylvania physicians must carry $1 million in malpractice insurance. The first $500,000 must be obtained from private insurers, and the MCARE fund provides the second $500,000 of coverage.[2] Pennsylvania assesses physicians and other health care providers approximately 20% of the cost of their private insurance annually to finance the MCARE fund.[2] However, unlike a traditional insurer, MCARE is a pay-as-you-go plan; it sets aside absolutely no reserves to pay future claims. It simply charges physicians, hospitals, and other health care providers the annual assessment to pay current claims and operating expenses.[4]

To help physicians fund MCARE during the malpractice crisis of the early 2000s, the legislature created a "Health Care Provider Retention

Account" financed by cigarette taxes and motor vehicle violation surcharges.[5,6] The purpose of this account was to provide abatements (subsidies) to physicians to reduce their annual MCARE assessments, in hopes of keeping physicians from abandoning Pennsylvania. The court found that the state administration inappropriately transferred $100 million from the MCARE fund to the state treasury, and that the state failed to transfer around $616 million from the Health Care Provider Retention Account to the MCARE fund to provide the liability premium abatements. The court held that the physicians had a vested right to the fund's assets that could not be overturned by a subsequent act of the legislature.[3]

The legislature has since terminated the Health Care Provider Retention Account, so all of MCARE's funding must now come solely from assessments on health care providers. Furthermore, since MCARE is a pay-as-you-go system, without the cushion of the money the state tried to siphon off from the fund there would have been essentially no reserves whatsoever to actually pay the unfunded liabilities of its outstanding claims that still need to be settled or litigated. The outstanding liability is estimated to be $1.7 billion.[7] Thus, the annual assessments for MCARE will continue long after physicians no longer obtain coverage from the fund, and even physicians who never obtained coverage via the fund will be stuck paying the assessments ad infinitum.[8]

Pennsylvania Medical Malpractice Losses Continue to Decrease

There is some additional good news on the medmal front in Pennsylvania. State Supreme Court Chief Justice Castille recently released the court's data on medical malpractice filing and verdicts for 2009. For the fifth year in a row, since the court instituted two significant procedural rule changes, the number of lawsuits and the amounts of damages awarded has decreased. In 2003, the court required attorneys to obtain a medical professional certificate of merit that the care provided fell below accepted standards, and it also required medical malpractice actions to be brought only in the county where the case took place, eliminating the contemptible practice of "forum shopping" that was so common in Pennsylvania.[9,10] At the same time, the high court required all counties in the state to methodically track medical malpractice cases to obtain accurate data on the litigation occurring within the state.[11]

Wisconsin Physicians Seek to Follow Pennsylvania, Restore Money Taken from State Patient Compensation Fund

Wisconsin also has a catastrophic fund to provide medical malpractice insurance to health care providers in excess of their primary insurance coverage limits (the Injured Patients and Families Compensation Fund, or "IPFC Fund"). Current law requires physicians to carry minimum yearly coverage amounts of $1 million per claim and $3 million in the aggregate. Claims in excess of these amounts are paid out of money from the IPFC Fund, which is funded solely by the health care providers through annual assessments.[12]

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In 2007, Gov. Jim Doyle (D) approved a legislative act to transfer $200 million from the fund to finance deficits in various Medicaid-related health care programs, none of which had anything to do with excess malpractice claims.[13]

The Wisconsin Medical Society sued to prevent the state from pilfering the fund to plug its budget deficit, claiming the monies were protected dollars to be used exclusively to decrease malpractice premiums and compensate injured patients.[14] The Medical Society lost the case at the trial court level, despite the fact that the statute which created the fund explicitly stated that "moneys in the fund may not be used for any other purpose of the state," and that "the fund is held in irrevocable trust for the sole benefit of the healthcare providers participating in the funds and proper claimants."[15]

The physicians appealed. Their case is currently before the Wisconsin Supreme Court which is expected to rule later this summer on whether to allow the transfer or require the state to pay the money back.[16,17]

Just before the state Supreme Court heard the case the Wisconsin Legislative Audit Bureau audited the finances of the fund. Not surprisingly, at least to the Medical Society, the fund has an estimated $109 million less in assets than its projected liabilities, thereby jeopardizing its ability to pay expected future malpractice claims.[18] The Chair of chair of the Medical Society's board, Dr. George Lange, was quick to comment: "The fact that the fund no longer has enough money to pay projected claims ... erodes confidence in a system designed to protect the interests of injured patients and their families and undermines the integrity of Wisconsin's medical liability climate."[18,19]

The state auditor, in a letter to lawmakers, stated that "The fund's financial position has declined significantly in the last two years," and predicted its finances would continue in the coming years unless the fund raises the annual assessment amount. The assessment was increased nearly 10% in 2009.[18]

The auditor cited a number of reasons for the precipitous drop in the fund's assets, including but not just the $200 million transferred out by the state. The fund lost millions of dollars from the collapses of Lehman Brothers and Washington Mutual Bank in 2008, and millions more from the stock market crash. Claims payments increased every year for the past four years, and several multimillion dollar hits resulted in the fund's liability to cover future medical expenses of plaintiffs to bounce from $5.5 million in 2006 to $31 million in 2009.[18]

The claims increases were in part attributed to the nullification of the state's non-economic damages cap by the Wisconsin Supreme Court in 2005. In the case of *Ferdon v. Wisconsin Patients Compensation Fund,* the Court determined that the states' $350,000 non-economic damages cap (which was indexed to inflation) violated the Wisconsin constitution.[20] The legislature enacted a $750,000 cap in 2006, but the *Ferdon* ruling left no limits on such damages for injuries occurring between 1991 and 2006.[21]

Interestingly, when it struck down the non-economic damages cap, the Wisconsin Supreme Court concluded that, "The cap would not protect the solvency of the Wisconsin Patient Compensation Fund" and that "the non-economic damages cap does not decrease malpractice awards or decrease malpractice insurance premiums."[20] At the time, not even the Wisconsin Insurance Commissioner bought into the Court's conclusions, stating in writing that the non-economic damage caps helped control medical malpractice awards and create a stable legal environment in Wisconsin. Furthermore, a non-partisan legislative actuary study and audit done before *Ferdon* had estimated that "if Wisconsin's cap on non-economic were to be declared unconstitutional, the potential fund liabilities may be increased by an estimated $150-200 million." That audit specifically cited the legislature's re-establishment of a limit on non-economic damages in 1995 as one of the reasons behind the stabilization of the fund's finances.[20]

Wisconsin's history has borne out the predictions of the auditors, actuaries, legislature, and health care providers, disproving the "conclusions" of the state's Supreme Court — just as the history of other many other states has proven the effectiveness of non-economic damages caps in lowering malpractice insurance costs and improving access to care.

Washington Supreme Court Voids Statute Requiring 90 Days Notice Before Filing Malpractice Suits

Last month we discussed a Washington case, *Putman v. Wenatchee Valley Medical Center*, where the state Supreme Court struck down the legislature's certificate of merit requirement for medical malpractice cases.[22] Another Washington

tort reform statute just went down in flames in the case of *Waples v. Yi*.[23] The 90-day notice requirement was one of the other changes the state legislature made to the medical malpractice system in 2006 in an effort to encourage potential malpractice plaintiffs to settle cases before resorting to court. The court said the waiting period "conflicts with the judiciary's power to set court procedures," and thus violates the separation of powers between the legislative and judicial branches of government.[23]

U.S. Supreme Court Declines to Review 6th Circuit Decision on EMTALA and Inpatients

In late June, the high court declined to accept the *Moses v. Providence Hospital* case, in which the 6th Circuit held that admitting a patient for stabilization did not end the hospital's obligations under the Emergency Medical Treatment and Labor Act (EMTALA).[24] The 6th Circuit Court of Appeals had invalidated the Center for Medicare and Medicaid Services (CMS) regulation that had effectively ended a hospital's obligations under EMTALA after a patient is admitted,[25] because the regulation "appears contrary to EMTALA's plain language."[26,27]

This means hospitals located in Michigan, Ohio, Tennessee, and Kentucky (the 6th Circuit) now have more civil liability under EMTALA than the states in the rest of the country. Families upset that the hospital "discharged grandma too soon" can now sue the hospital under EMTALA for "failure to stabilize the patient before transfer" (since all discharges from the hospital, whether from the ED or the inpatient setting are legally defined as "transfers" under EMTALA). This would include any inpatient who developed an emergency condition while in the hospital, not just those admitted through the ED.

Fortunately, however, EMTALA's duty to stabilize applies *only* at the time of transfer/discharge. Whether the emergency medical care provided in the ICU or the hospital complied with the standard of care is irrelevant for compliance with EMTALA; what matters is whether the patient's condition is stable when the patient is ultimately sent out of the hospital. As the Sixth Circuit explained: "EMTALA requires a hospital to treat a patient with an emergency condition in such a way that, upon the patient's release, no further deterioration of the condition is likely."[26]

Unfortunately, the Sixth Circuit's interpretation also voids (at least for purposes of civil litigation against hospitals) CMS's 2008 regulation holding that hospitals are not required to accept inpatients in transfer from other hospitals.[28] Now academic and tertiary hospitals in these four states must accept inpatients with emergency conditions in transfer from nearby hospitals which are unable to stabilize the patient's condition.[29] Under the rather cross-purposes CMS regulation, a higher-level hospital could have refused to accept an inpatient with an emergency condition in transfer solely on account of insurance status, which is exactly the type of economic discrimination that EMTALA was originally enacted to prevent.

The U.S. Solicitor General wrote a brief on the case recommending that the Supreme Court not accept the case.[30] The Solicitor General believed that interpreting EMTALA to extend beyond the emergency department, as the court of appeals did, raised other questions not answered by Congress which are best suited for "expert agency (CMS) consideration" on how best to effectuate Congress's intent.[30] Apparently, CMS intends to initiate a rulemaking process in 2010 and 2011 that will reconsider its prior regulations articulating the "admission defense" for hospitals.[30] Thus, CMS will reexamine the application of EMTALA to inpatients, addressing such questions as "Does the law apply to ALL inpatients, or only those admitted via the ED?" "If EMTALA's reach extends beyond the point of admission in some circumstances, does that liability extend until the time of discharge or should there be some temporal limitation apart from the point of admission?" "Do other hospitals have to accept inpatients in transfer, and if so, under what circumstances?"

Conclusions

Tort reform remains an active battlefield in both the state and federal arenas. Emergency physicians and hospital ED providers need to remain ever vigilant and actively involved to defend against assaults on existing beneficial tort protections or enact new reforms necessary to ensure continued access to quality care for all.

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What Are the Actual Legal Risks if You Did It, but Didn't Document?

Any piece of information could be critical

[Editor's note: This is the first of a two-part series on documentation and ED liability. This month, we explore the legal risks of inadequate documentation and information that should not be omitted. Next month's issue will cover liability risks when the ED physician or nurse's documentation is inconsistent with documentation by other caregivers.]

Despite the adage, "If it wasn't documented, it wasn't done," not everything that ED nurses and physicians do is actually documented. The fact is, documentation omissions and errors do occur. The question is, what piece of information is likely to become crucially important from a legal perspective?

Steven J. Davidson, MD, MBA, FACEP, FACPE, chairman of the Department of Emergency Medicine at Maimonides Medical Center in Brooklyn, NY says that in his opinion, the conventional wisdom of "If it wasn't documented, it wasn't done" is really a consequence of the breakdown of trust between patients and physicians. "This is a real phenomenon I've observed over my 35 years in the ED," he adds.

Video recordings of the ED patient encounter would be one remedy to the issue of documenta-

Essential Elements of Documentation

- Presenting symptoms and complaints
- Care rendered prior to arrival (self-medication or emergency medical services medications or treatments)
- Pertinent positives and negatives relative to the history of the present illness
- Pertinent positives and negatives relative to the physical examination
- Review of ancillary data (EKG, arterial blood gas, blood panels, radiology studies, etc.)
- Discussion with patients and family members regarding treatment plans and options
- Reassessment of the patient's response to therapies and interventions
- Decisions regarding why treatments were not rendered, as with "Do Not Resuscitate" situations
- Discussions with primary care and consultants
- Procedure notes
- Any unusual occurrences such as elopements, leaving against medical advice, disruptive behaviours, or refusal of suggested procedures such as lumbar puncture for severe, sudden headache
- Acknowledgment of review of vital signs, recheck of abnormal vital signs, and interventions of patient education or instructions provided for follow-up of abnormal vital signs
- Explanations of unexpected results, with explicit instructions on when, how, and with whom to follow up. These include high creatinine, suspicious nodule on chest X-ray, proteinuria, low hemoglobin, heme occult positive stool, abnormal EKG, abnormal liver functions, and hypokalemia
- Reasons for transfer (or not to transfer) to another facility
- Psychiatric patients in general — children and adult, suicidal patients, forced detention issues, and restraints

Source: Andrew Garlisi, MD, MPH, MBA, VAQSF, University Hospitals Geauga Medical Center, Chardon, OH.

tion on the medical record, says **Andrew Garlisi, MD, MPH, MBA, VAQSF**, medical director for Geauga County EMS and co-director of University Hospitals Geauga Medical Center's Chest Pain Center in Chardon, OH.

"Short of this, the only reliable way to support, confirm, or authenticate the completion of a task is through documentation of the medical record," he says.

Memories fade and cannot be relied upon in a courtroom situation months or years after an encounter with a patient. "But the medical record can stand as de facto evidence of the truth," says Garlisi. "After all, why would a physician falsely document the medical record in real time, since he or she would have no knowledge that a lawsuit would be forthcoming?"

In reality, there are constraints to documentation of the ED medical record. One is that the expectations and responsibilities for emergency physicians "have seemingly exponentially expanded," says Garlisi. He points to "time is muscle" and "time is brain" initiatives, electronic health record physician order entry, 30-minute guarantees by EDs, and "one-hour door-to-door" fast track initiatives.

"All of these have placed pressure on emergency staff to see patients faster, and complete the evaluations and treatments in shorter time frames," says Garlisi.

An ED physician may be deluged with several patients simultaneously, with unstable or critical care patients in the mix. In that scenario, it is difficult for the physician to document every phase of each encounter accurately and precisely, if at all, in real time.

"Documentation takes a back seat to the task at hand—managing the sick and dying patients in a

safe manner," says Garlisi. "The emergency staff is under the proverbial gun to deliver faster care and achieve a score of 5 on Press-Ganey patient satisfaction surveys—all in the face of staff cuts and dwindling resources."

At the same time that demands on the emergency physician have increased, there may be insufficient staff and other resources. "It is easy to understand why documentation can be, and often is, substandard, even with the template documentation systems which are in widespread use," says Garlisi. *(See Table, "Essential Elements of Documentation," p. 90)*

"Unfortunately for the emergency physician, any and all aspects of documentation could be a critical piece of information which could make or break the defensibility in malpractice case," says Garlisi.

To the question "Which piece of documentation is critically important?", Garlisi responds, "The critically important piece is the one not done properly or missing completely from the medical record," he says. "In my experience, almost every aspect of medical record documentation can be subjected to scrutiny, and be a significant determining factor in a medical malpractice decision."

Gabor D. Kelen, MD, director of the Department of Emergency Medicine at The Johns Hopkins University in Baltimore, says that there is no doubt that good document can "save the day" in the event of a malpractice lawsuit alleging poor ED care.

"But I would like to seriously challenge that documentation is everything," he says. "I've seen some cases saved by lack of documentation, and I've seen some cases flushed down the toilet, rightfully so, because of documentation."

Kelen has also seen charts where the documentation was lacking, but the ED physician "fell on their sword." "They said that they were lousy documenters but it doesn't mean they didn't do the right thing. Then they testify as to what really happened."

In that situation, it comes down to who is more credible—the plaintiff who claims the doctor ignored them or the doctor who says he gave good care but just didn't document it.

"The physician may say, 'I had a lot of patients to see. I didn't shortchange this patient, but I didn't get around to documenting everything I did.' If they give a credible account of what happened, often the case either settles for a much smaller amount than it otherwise would have, or they win in court," says Kelen.

Sources

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Does Your Charting Explain Your Medical Reasoning?

Gabor D. Kelen, MD, director of the Department of Emergency Medicine at The Johns Hopkins University in Baltimore, says that one area of documentation he feels is too often shortchanged involves the ED physician's medical reasoning.

"This takes the longest to document," he says. "I might not remember every piece of history I asked, or every part of the physical exam that I did, even with computer guidance," he says. "But I spend most of my time on medical reasoning."

Medical reasoning explains the ED physician's thought process. "I document, 'the conditions and situation I considered, why I do think it's this or why I can't exclude a certain important consideration, and here's why I don't think it's various other conditions,'" says Kelen. "I believe that if something should go wrong, if in my documentation I explain that I considered a condition and why I didn't pursue it, at least I have given a good medical opinion."

Following this format will explain, for example, why an ED physician discharged a patient after

arranging for outpatient follow-up, or cautioned the patient that while he couldn't be 100% sure about a certain outcome, he believed it was very low risk.

Another good reason to document medical decision making is better communication with other health care providers. "Sometimes the inpatient guys [based on charting] have no idea why we admitted the patient. The medical decision making helps them know what I have already considered, and what my real concerns were," says Kelen.

The same is true if the patient was discharged from the ED. "If I sent the patient out, the outpatient doctor can see that my workup reasonably excluded or addressed some conditions," says Kelen. "They have some way to understand what your thinking is. That's probably the most important part of documentation."

Another common problem area is the failure to document your acknowledgement of vital signs. "Sometimes people look at the very first vital signs and fail to note an abnormality," says Kelen. "It's not like you can't send the patient home with an abnormal vital sign. You certainly can, but you better explain in your notes why it's okay."

Never omit an explanation of any and all critical abnormalities that you find. A patient may come in with chest pain and during your examination you find abdominal pain.

"Just because they came in with chest pain doesn't mean that somewhere in your notes you don't have to explain what you think the abdominal pain is about," says Kelen. "Otherwise it just looks like you didn't look at it, or if you did look at it, you didn't understand its implications."

It should be obvious to anyone reading the chart that you acknowledged an abnormality, looked at it and had some understanding of the implications, says Kelen. "Every acute abnormality should be explained somewhere in your notes," he says.

Source

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These Items Can Prove Important in Lawsuits

Linda M. Stimmel, JD, a partner with the Dallas, TX-based law firm of Stewart Stimmel, says that it is difficult to know with certainty what type of information documented in a chart by an ED nurse or physician may become critical if a lawsuit ensures regarding the care of that patient.

"Many times, something as simple as a check mark as to whether the patient had anything to eat or drink while they were in the ED may become an important fact in the defense of a lawsuit," says Stimmel. Here are some of Stimmel's recommendations:

Consider that a comment made by a family member or the patient may be important to chart.

For instance, a comment such as "I haven't been following up with my medication from my primary care provider," is important to note.

Be specific about what you tell consultants.

Stimmel has defended many hospitals and EDs in lawsuits alleging they did not follow the appropriate chain-of-command process when a physician was needed to consult on the pateint.

"It is very important to document your chart objectively and not subjectively," says Stimmel. "This can be particularly important when defending an allegation of a hospital or ED not invoking the appropriate chain-of-command."

Stimmel says she would advise the ED staff to chart in detail what was told to the consulting physician and not just "I informed the physician of the status of the patient."

If a lawsuit is filed, she explains, it may be two years later. Many times, the consulting physician will testify they were not given the appropriate information by the ED staff.

"If the ED staff had documented exactly the details told to the physician, it would be much easier to defend," says Stimmel.

Put important statements by patients in quotation marks.

Many times, a chart will say that an ED patient is non-compliant, but give no details. "Two to three years later, you do not remember why you charted the patient was non-complaint," says Stimmel. "Be specific in the reasons for the non-compliance. Give an objective description, not a subjective one."

Be sure the history and physical is complete and accurate.

Even though it is impossible to know what small detail may become important in a future lawsuit, Stimmel says that the significant issues in any ED chart would be the history and physical.

"Many times, entries are written hurriedly, and there are mistakes in the history and physical," says Stimmel. "This helps a plaintiff's attorney paint a picture of a staff that was in a hurry and not paying attention."

Additionally, the vital signs should be clear, accurate, and written legibly. "Any consultations and any efforts to reach family also should be well-charted," says Stimmel.

Reduce Risks of Atypical Appendicitis Presentation

Though myocardial infarction is often a key area of focus when it comes to ED misdiagnoses and subsequent lawsuits, appendicitis is another common and serious misdiagnosis in the ED.

A review of the Physician Insurers Association of America's Data Sharing Project identified 2,156 appendicitis claims between 1985 and 2008, of which 48.6% were misdiagnosed and resulted in an average indemnity payment of $103,391. Among these claims, 284 occurred in the ED and had an average indemnity payment of $49,451.

The ED is among the top locations named in claims in which appendicitis was allegedly misdiagnosed, second only to the practitioner's office which resulted in an average indemnity payment of $94,769 for the same allegation.

In 2005 to 2009, there were 342 appendicitis claims, and 145 were misdiagnosed, with an average indemnity payment of $226,865. The ED ranked first by location and had an average payment of $54,375.

William Sullivan, DO, JD, FACEP, director of emergency services at St. Mary's Hospital in Streator, IL, says that it is important for ED physicians to understand the magnitude of missed appendicitis cases.

"There are more than five million ED visits each year for patients with abdominal pain," says Sullivan. "The misdiagnosis of abdominal pain accounts for between 4% and 10% of all medical malpractice suits."

Abdominal pain, in general, is often a difficult complaint to evaluate, adds Sullivan. "It is not uncommon for even the most experienced clinicians to misdiagnose appendicitis," he says.

Missed appendicitis is the leading cause of litigation against emergency physicians in patients with abdominal pain, and is the sixth most commonly missed diagnosis of all patient complaints, notes Sullivan.

"The problem with appendicitis is that the cases that are missed usually aren't typical presentations," says Sullivan. "Not too many doctors would miss a case of appendicitis when the patient has fever, migrating abdominal pain, and right lower quadrant rebound tenderness."

Sullivan says that elderly patients present even more of a diagnostic dilemma. One reason is that less than 20% of elderly patients have a "classic" appendicitis presentation.[1] Sullivan gives these strategies to avoid missing appendicitis:

- **Rely on your clinical judgment.**
  "If your suspicion for appendicitis is high, consider admitting the patient for observation regardless of what the testing shows," says Sullivan.
- **Reconsider your use of "wastebasket" diagnoses.**
  "Gastroenteritis and urinary tract infections are both common diagnoses. They can also be wrong diagnoses," says Sullivan. "If you aren't confident about what is causing the patient's abdominal pain, a diagnosis of 'abdominal pain– etiology undetermined' is better than labeling an early appendicitis as a urinary tract infection. Think about whether other medical problems may be causing the patient's symptoms."
- **Re-evaluate the patient and document that you re-evaluated the patient.**
  "I have reviewed more than one case in which a patient was evaluated for abdominal

Source

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Missed Appendicitis Cases Share Similar Features

There are many things that factor into missing a diagnosis of appendicitis, says **William Sullivan, DO, JD, FACEP**, director of emergency services at St. Mary's Hospital in Streator, IL.

Four features are often present in missed cases of appendicitis, according to a recent study. These are lack of distress, absence of rebound tenderness, a discharge diagnosis of "gastroenteritis," and lack of timely follow-up.[1] Here are Sullivan's recommendations to reduce risks:

Absence of rebound tenderness. "This is one of the classic signs of appendicitis, so it would make sense that doctors would consider appendicitis less likely if patients do not have rebound tenderness," says Sullivan. "There isn't much we can do to change the atypical presentations."

Documenting that a patient does not have rebound tenderness is a good idea, says Sullivan. "but obviously doesn't exclude the diagnosis of appendicitis."

Discharge diagnosis of gastroenteritis. Sullivan says that care should be taken when discharging a patient with a diagnosis of gastroenteritis. "If a patient doesn't have the triad of vomiting, diarrhea, and crampy abdominal pain, physicians may want to reconsider their gastroenteritis diagnosis," he says.

The problem with providing a definitive diagnosis when patients have a vague presentation is that the diagnosis may cause premature "closure" of the problem. "It may cause a patient not to seek further evaluation for continuing or worsening symptoms," says Sullivan. "In the patient's minds, they have a self-limiting disease because that was what the doctor diagnosed."

If the pain worsens, instead of seeking care, the patient may just consider the pain as part of the course of the "gastroenteritis" when the pain may actually represent a worsening appendicitis.

"If doctors aren't sure about their diagnosis, make sure that the patient is aware that the diagnosis is uncertain, and that follow-up is important so that the patient can be re-evaluated," says Sullivan. "A diagnosis of 'undifferentiated abdominal pain' or 'abdominal pain–etiology undetermined' helps to illustrate the uncertainty of the patient's symptoms."

Lack of timely follow-up. "Re-evaluation is an underutilized method of diagnosing abdominal pain," says Sullivan. If a stable patient with improving or minimal abdominal pain does not warrant admission to the hospital, it is perfectly acceptable to have that patient return to the ED in eight to 12 hours for a repeat examination, he says.

Overreliance on normal white blood cell counts is also another problem that may lead to a missed diagnosis of appendicitis. "Depending on the study cited, between 10% and 60% of patients with appendicitis have a normal white blood cell count," says Sullivan.

Radiologic testing has significantly improved the ability to diagnose appendicitis, says Sullivan. He notes that CT scans are 95% to 97% accurate in diagnosing appendicitis, and depending on the experience of the technician, ultrasound scans are up to 90% sensitive in diagnosing appendicitis.

"Note that both tests still have a false negative rate of 3% to 10%, though," says Sullivan. '

Another problem to watch out for is a radiologist's report that does not mention the appendix. If the report does not state that the appendix was visualized and was normal, contact the radiologist, clarify the report, and ask for an updated report reflecting the normal appendix in writing.

"If the appendix cannot be visualized, then admission or additional testing may be warranted," says Sullivan.

Reference

1. Vissers RJ, Lennarz WB. Pitfalls in appendicitis. *Emerg Med Clin N Am* 2010; 28:103-118.

pain and no re-examination was performed," says Sullivan. "When bad outcomes occur, it is more difficult to justify medical treatment that does not involve re-examining the patient and documenting whether the symptoms have progressed or resolved."

- **Recommend short follow up intervals.** "If you decide to discharge a patient with abdominal pain, don't feel strange about requesting that the patient have another physical examination performed within 12 to 24 hours," says Sullivan. He also rou-

tinely recommends that patients seek immediate follow-up if their symptoms worsen, if they develop new symptoms, or if problems occur.

- **If you aren't sure about the diagnosis, emphasize that your diagnosis is not definitive.**
  "Don't provide patients with premature closure to their symptoms," says Sullivan. "In cases where the diagnosis is unclear, I often document that I discussed the uncertainty of the diagnosis with the patients and the need for follow up if their symptoms do not resolve. Knowing that their diagnosis is uncertain will encourage patients to follow up if problems occur."
- **Have a low threshold for admitting elderly patients.**
  "Older patients with appendicitis are more likely to have nonspecific presenting symptoms, and to have worse outcomes when compared to younger patients with appendicitis," says Sullivan.

Reference

1. Hendrickson M, Naparst TR. Abdominal surgical emergencies in the elderly. *Emerg Med Clin North Am* 2003;21: 937-969.

CNE/CME QUESTIONS

6. The 6th Circuit Court of Appeals ruling invalidating the CMS regulation ending a hospital's obligations under EMTALA after a patient is admitted has had the effect on hospitals in Michigan, Ohio, Tennessee, and Kentucky of:

   A. imposing more civil liability under EMTALA than the states in the rest of the country.
   B. permitting suits alleging that too-early discharge resulted in "failure to stabilize the patient before transfer."
   C. voiding, for purposes of civil litigation, the 2009 CMS regulation holding that hospitals are not required to accept inpatients in transfer from other hospitals.
   D. All of the above

CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

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

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. ■

7. Which is recommended regarding ED documentation?

   A. Avoid charting in detail what was told to a consulting physician, and instead, document a general statement such as "I informed the physician of the status of the patient."
   B. Always explain your medical decision making process, such as why a certain diagnosis was considered or excluded.
   C. An explanation of any critical abnormalities the patient presented with initially is necessary, but this is not necessary for any additional critical abnormalities found during the examination.
   D. Avoid putting statements made by patients about non-compliance in quotation marks.

8. Which statement is true regarding cases of missed appendicitis?

   A. Almost no appendicitis cases have a normal white blood cell count.
   B. Most elderly patients have a classic appendicitis presentation.
   C. Elderly patients account for half of all appendicitis deaths.
   D. Elderly patients make up the majority of total appendicitis cases.

9. Which is recommended to reduce risks of missed diagnosis of appendicitis in the ED?

   A. If your suspicion for appendicitis is high, consider admitting the patient for observation regardless of what test results show.
   B. If you decide to discharge a patient with abdominal pain, avoid requesting that the patient have another physical examination performed within 12 to 24 hours.
   C. Never document that you discussed the uncertainty of the diagnosis with the patient.
   D. Have no more or less of a threshold for admitting elderly patients than you would for younger patients.

Answers: 6. D, 7. B, 8. C, 9. A

Special Update to *ED Legal Letter* – August 2010

Just days after the print version of the August 2010 *ED Legal Letter* went to press, the Wisconsin Supreme Court issued its decision in *Wisconsin Medical Society, Inc. v. Morgan*. In a "win" for the Medical Society and physicians, the court ruled that the state legislature violated the state constitution when it voted to take money from the malpractice patient compensation fund ("the Fund") to balance the state budget. The court determined that the legislative enactment of the Fund created an irrevocable trust protected by the Constitution's Takings Clause – prohibiting an unconstitutional taking of property without just compensation. Therefore, the court ordered the state to pay the money back to the fund, including interest and lost earnings.

— Robert A. Bitterman, MD, JD, FACEP, Contributing Editor