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Medical Malpractice and Risk Management — Part II of II

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Risk management is the process of identifying factors that may be a source of exposure to lawsuits and adverse outcomes. This process includes the evaluation of physical plant characteristics, work flows, processes, and individuals who may contribute to risk. Once factors are identified they should be eliminated or minimized to the extent possible. All risk cannot be removed so it is important to have policies and procedures, as well as insurance, for when problems do arise.

To understand how to limit risk, the emergency physician must be aware of the major sources of risk in the emergency department (ED). The ED is an inherently risky place to work due to a number of factors, some of which are listed in Table 1. These factors may lead to errors that may produce poor results and potentially result in litigation. The error types most commonly reported in emergency medicine include: diagnostic error or delay, treatment error or delay, improper performance of procedure or treatment, misinterpretation of tests, and failure to consult or refer.[1,2]

A recent study evaluating the sources of diagnostic errors in the ED found that cognitive errors encompassing errors in judgment, knowledge, and vigilance or memory contributed to 96% of claims with an identified error.[3] Communication errors, particularly as they relate to patient handoffs, were involved in 35% of diagnostic errors. System errors, including issues with supervision, workload, and fatigue, were noted in 37% of cases; these errors were more prevalent when students or residents were involved. Patient-related factors were involved in an additional 34% of cases. Of note, two-thirds of the errors involved cases where more than one provider participated in the patient's care.

Studies looking at the patient complaints associated with malpractice risk have consistently found certain diagnoses to be the highest risk.[1-5] These complaints are listed in Table 2. One compilation of the literature found missed

myocardial infarction (MI) to account for 10% of claims but 24% of total dollars paid.[5] This same study found missed wounds and fractures to account for significant percentages of both number of claims and dollars paid; however, the payment per case was relatively small. Some diagnoses, such as ectopic pregnancy, missed meningitis, and spinal cord injury, accounted for a small number of claims but a significant portion of total dollars paid. Some of these high-risk diagnoses, including cardiac ischemia and MI, abdominal aneurysm, and appendicitis, may present atypically, creating increased risk for the physician.

Reducing Risk

A review of the various risks and sources of error allows the department and staff to design systems and influence behaviors to minimize risk.

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Table 1. Elements that Increase Risk in the ED

- 24-hour operation (someone has to work night shifts)
- EDs frequently operate in excess of capacity
- Patient-provider relationship not established
- ED patients are high acuity
- Multiple distractions to providers in the ED
- No provider continuity due to shift work
- Patients are stressed, not always in ED of own free will
- Long patient waits

Source: Jonathan Siff, MD, MBA, FACEP, Cleveland, OH

Risks Inherent in the ED

While some of the issues outlined in Table 1 are simply facts of ED life, such as 24-hour operation, high acuity, and the absence of provider continuity, there are steps that can be taken to reduce risk. Around-the-clock operation means that people are working when their bodies want to be sleeping. Techniques such as anchor sleep, graduated scheduling, and full-time night staffs have been proposed as ways to reduce errors due to fatigue.[6] Adequate staffing to handle high acuity and reduce provider stress also can be beneficial. In many EDs, providers have numerous distractions including the next acute patient rolling in the door, pharmacy calls about prescription refills, and pages regarding requested transfers. These distractions should be minimized and referred to others when possible for resolution. Long waits, which are endemic in some EDs, create patient frustration that can lead to patient and family hostility. A simple apology for the wait from the provider can go a long way to changing the patient's perception of the situation.[17]

Review of Error Types

Cognitive errors can be addressed through regular training and the use of clinical guidelines for prevalent or common complaints.[1] Providers also should be aware of their limitations of practice and make liberal use of consultants when needed to assist with diagnosis or treatment.[7]

Communication errors are a source of many problems leading to risk and often are among the

Table 2. Complaints and Diagnoses Associated with High Risk of Diagnostic Error[1-4]

- Chest pain/missed myocardial infarction
- Wounds (retained foreign body, nerve or tendon damage, poor healing)
- Missed fractures
- Abdominal pain (including appendicitis and abdominal aneurysm)
- Pediatric fever
- Meningitis
- CNS bleed
- Embolism (pulmonary, stroke, extremity)
- Trauma related
- Spinal cord injuries
- Ectopic pregnancy

Table 3. Provider Interpersonal Behaviors that Can Reduce Risk[8,15]

- Introduce yourself to the patient and family
- Dress neatly and professionally
- Address patients respectfully
- Sit down at the bedside
- Discuss with patients their expectations of care
- Speak in clear, simple language avoiding medical terms
- Provide emotional support and show empathy

easiest for providers to address. First, communication with patients plays a significant role in patients' satisfaction with the visit.[8]

Some actions providers can take to establish the patient-provider relationship are noted in Table 3. A few of these actions merit additional discussion. Introductions are simple and important. Tell the patient your name and your place on the health care team (attending or supervising doctor, resident physician, nurse, student, etc). Often patients will not realize that a resident is actually a physician. Also, engaging family in the room in addition to the patient is important.[8] This makes the patient and family feel like you care about them and their involvement. Lawsuits often are initiated at the behest of unhappy family members. Patients often feel like the "doctor never told me anything." Confirming that patients understand their diagnoses and discharge instructions, particularly those related to follow up, treatment, and what to return to the ED for, are key elements which must be ensured prior to discharge. It was estimated that half of the lawsuits in one review were related to the patient's lack of understanding of the discharge instructions or inability to implement the instructions, such as where to follow up for care.[8] Patient handoffs are also a significant area of risk for patients and providers. One systems review found that half of hand-off related claims were high risk and 9% of those claims originated in the ED.[9] Providers may fail to consider all the possibilities in a transferred or signed-out patient because they receive the patient with a pre-existing plan and diagnosis. It is a good practice for providers to meet each patient signed out to them and to evaluate them as least once prior to discharge.[8,10]

System issues that lead to unrealistic work loads, high numbers of patients who leave without evaluation, and inadequate supervision of residents and students must be addressed. In some cases improvement of processes is enough to remediate the problem but in others additional staff or resources may be required.

Specific Diagnoses

Certain diagnoses present a high legal risk to emergency physicians. As noted in Table 2 these cover a wide variety of systems and mechanisms. Providers must be aware of these diagnoses and their atypical presentations and consider the possibility a of high-risk problem in every patient. Avoid placing a diagnosis on a patient without sufficient clinical certainty.[11] In addition to giving an appearance of error should litigation occur, an incorrect diagnosis might mislead later providers. When a diagnosis is uncertain, describe the patient's condition with symptoms. An example often cited is that of gastroenteritis. While it is tempting to give the patient with abdominal cramps, nausea, vomiting, and a benign exam the diagnosis of gastroenteritis, this should be reconsidered. Gastroenteritis is the mistaken diagnosis in a significant number of missed appendicitis cases.[12] By giving patients a less-specific diagnosis and educating them that it is unclear what is wrong and that they should definitely come back if they get worse, physicians can avoid locking themselves and the patient into an incorrect diagnosis that could come to haunt both of them later.

Treatment Errors and Delays

The ideal treatment of certain diseases is unclear. As a result, physicians may be at risk if they give or withhold treatment. In the case of stroke lawsuits, about half are filed because thrombolytic therapy was given and the other half because it was not.[13] Numerous similar situations exist where the standard of care is not well defined. Given this environment, physicians must have careful and well-documented discussions with patients and families about what treatments are or are not being given and why. Once treatment is clearly indicated, proceed with it as quickly as possible; do not delay to get one more test or wait for the results of a confirmatory lab or x-ray.[13]

General Rules to Avoid Trouble

Read the chart. Look at what the nurses and staff wrote. It may contain information of which providers were unaware. If something is inaccurate, providers should be sure to address the inaccuracy in their notes.[13]

Abnormal vital signs should be treated, clearly explained, or the patient admitted. One study that looked at unexpected deaths within seven days after ED discharge found that the majority of those patients whose deaths were determined to be related to the ED visit had abnormal vital signs. Most were discharged without explanation of the abnormal vitals signs or a documented recheck that demonstrated normalization. Tachycardia was the most common abnormality occurring in 83% of these patients.[14]

Avoid criticizing the care provided by other physicians.[15,16] This includes comments or gestures in front of patients or family as well as in the chart. This may only lead to increased litigation and your statements may be used against other providers in a lawsuit.[17]

Providers should not make inflammatory or disparaging remarks about patients, particularly in the medical record.

Never make guarantees. Although it is tempting to reassure patients that all the glass was removed from their wound, that their atypical chest pain was definitely not cardiac, or that nothing was broken, these types of reassurances should be avoided. Not all fractures appear on the initial x-ray (most notably scaphoid fractures). The literature also shows that retained foreign bodies, despite efforts to find and remove them still are going to escape detection occasionally.[5,8,18] The difficulties of diagnosing acute myocardial infarction in the ED are well documented.[19] When guarantees turn out not to be accurate, patients are likely to feel betrayed and lied to and may reach for the number of the nearest malpractice attorney.

Documentation should provide a clear picture of the patient's presenting complaint, the history of the illness, examination, ED course, medical decision making, disposition, and plan. Many template systems substitute check boxes for a narrative description of the patient's history and course. Written or dictated narratives are very helpful to paint a clear picture of the entirety of care and can improve the physician's ability to defend a case.[7] Due to the frequent inclusion of issues surrounding consent in litigation, providers should consider including in every chart an adequate description and examination of the patient to validate the patient's capacity for medical decision-making.

Beware of the "drunk" or psychiatric patient. While some ED patients are intoxicated or have stable psychiatric issues, others actually may be exhibiting signs of an acute illness or injury. In addition, these patients are more likely than patients without substance abuse or psychiatric issues to die unexpectedly after ED discharge.[14] Good clinical evaluations of these patients each time they present and over time while in the ED will help to differentiate the stable or improving patient from the decompensating patient. This cohort of patients also is less likely to follow up, to take medication as directed, or to return if worse. Providers should consider a lower threshold to admit or further evaluate these individuals.

Repeat visits may be a sign that something was missed. Many providers view patients who return for the same problem unexpectedly as noncompliant, having psychiatric issues, or looking for a secondary gain.[16] In reality these patients may be giving the health care system another chance to get it right.[8] It may be helpful to have a different provider see the patient on subsequent visits when possible, and some emergency physicians recommend after a third presentation for the same undifferentiated problem that admission should be strongly considered; however, this clearly is not a standard of care.[8]

Repeat exams can help uncover the natural course of a disease. Documenting a repeat exam also may show improvement in symptoms, exam findings, and vital signs or may detect deterioration that needs to be addressed. Also consider re-examining the notes of other providers. These may show trends or changes that require action.[13] Providers should consider documenting a repeat abdominal exam prior to discharge on every

patient presenting with abdominal pain.

Patients leaving against medical advice (AMA) are also a source of high risk. As many as one in 300 of these patients may sue and some will win. Have patients sign the AMA form in addition to documenting a clear discussion in the chart that you reviewed the risks and benefits of the recommended treatment, that the patient refused, and that the patient had the capacity to make medical decisions. A complete discussion of leaving AMA and medical decision-making capacity is beyond the scope of this article. Providers should consider treating patients leaving AMA as well as they and their condition will allow. Always make it clear that you told the patients they are welcome to return at any time.

Discharge instructions can be the physician's best friend or worst enemy in the case of litigation. Discharge instructions should be time- and action-specific.[5,8] The instructions should tell patients specifically what to do, what not to do, when to return to the ED, and when to see a physician in follow up. Language in discharge instructions should be easy to understand and use of an interpreter should be considered if there is question of a language barrier. The purpose of any prescribed medications and the instructions for use also should be discussed with the patient. A discussion of medication side effects may reduce the providers' potential exposure to third-party liability lawsuits in addition to the benefits to the patient of this education. Since patients often are scared, tired, and ill, all instructions ideally should be written and reviewed verbally by someone on the health care team with the patient and any family present to help ensure understanding and recall.

Here are a few final points to help create a more lawsuit resistant chart. First, time every order and time key events, such as calls to consultants, requests for transfer or admission, and repeat examinations. It is also important to document your time of first contact with patients. When asked to come see patients because they are having issues, try to do so immediately and document your response as such, where applicable. Refer to other providers in the chart by name, not just their specialty. When calling a consultant or other provider, document that you spoke to "Dr. Smith" of orthopedics, not just that you spoke with the orthopedist on call. The reasons behind transfers should be clear and compliant with EMTALA regulations.[20] Finally, make the reasons behind your clinical decisions clear in the chart.

The high risk of emergency medicine practice makes it important that departments and individuals engage in high-quality medical practice and, where possible, implement systems to minimize risk and error. These efforts can reduce liability exposure and improve patient outcomes.[1]

The information and suggestions in this article are general rules and not applicable to every patient or situation. These suggestions do not constitute a standard of care but are the opinion of the author.

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ED Lawsuit? 'Boarding' Could Become a Factor

Did a "boarded" ED patient have a bad outcome that can be in any way associated with a delay in diagnosis or treatment, or a failure to properly observe?

"In this scenario, it is very easy for a plaintiff's attorney to argue to a jury that the injury would likely have been avoided if the patient had been transferred to an appropriate inpatient unit where better observation and treatment could have been provided," says **S. Allan Adelman**, JD, a health law attorney with Adelman, Sheff & Smith in Annapolis, MD.

Adelman says that boarding of patients can raise questions about whether the patient was in an appropriate location, and had appropriate evaluation, treatment, and observation, which contributed to some injury or undesirable outcome.

"Boarding patients in a hallway or some other area which is not intended to be used for providing patient care conveys the impression to patients and their families that the patient is not being monitored and observed as effectively as they would be on an inpatient unit, and that admission to the hospital, and the institution of definitive treatment, is being delayed," says Adelman.

Adelman cautions that the *perception* of substandard care, coupled with an outcome that does not meet the patient's expectations, is as much a cause of malpractice litigation as actual substandard care.

While Adelman does not think that boarding is, or will be, the focus of malpractice litigation, he expects that as it becomes more prevalent, it will be an issue that is raised more frequently, and "will undoubtedly be raised in every case where there is both boarding and a bad outcome."

Less than Ideal Care

"There is increasing litigation that swirls around the concept of boarding," says **Matthew Rice**, MD, JD, FACEP, senior vice president and chief medical officer at Northwest Emergency Physicians of TEAMHealth in Federal Way, WA. "Sometimes it's a little hard to sort out whether it's boarding that caused the issue."

Patients are being held in the ED when they should be in a different part of the hospital, because the other parts of the hospital don't have the resources to accommodate them. "They are kept in the ED waiting until those resources become available, or quite honestly, sometimes until they are better and go home," says Rice.

Tom Scaletta, MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL, says he is not sure if boarding has been the focus of litigation against EDs. "I suspect it will be, though, as soon as a caregiver uses this as an excuse," he says. "Hospitals do not like to admit that they have problems with boarding. It is presumed by many that no matter what the resources, ideal care should occur. We certainly cannot deliver ideal care with less than ideal space or staffing."

Scaletta says that boarding would become relevant in a lawsuit when a patient has a problem that occurs well after he or she would have been admitted to the hospital.

"Boarded patients often receive minimal care, as the ED staff is usually busy with the new, incoming cases," says Scaletta.

Although boarding is a problem experienced by the ED, it "is really not an ED-owned problem," says **Robert B. Takla**, MD, FACEP, chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI. "It's usually a capacity issue. We're only going to be as strong as our weakest link. If you've got some throughput issues, then patients are going to be held in the ED."

Debra J. Gradick, MD, FACEP, medical direc-

tor of the ED at Avista Adventist Hospital in Louisville, CO, and vice president of operations at Serio Physician Management in Littleton, CO, says that it's difficult to track whether lawsuits have alleged bad outcomes due to boarding. There are many factors that come into play in this scenario.

"It's kind of a domino effect," says Gradick. "The patient gets stuck in the hallway and forgotten about. The admitting physician doesn't get a chance to see them for whatever reason. The ED physician is busy trying to keep up with flow. The patient is 'out of sight, out of mind,' and things can fall through the cracks."

Reduce Risks

"The most dangerous aspects of boarding patients involve the possible deterioration of a patient that is not promptly noticed or addressed while the patient is being boarded," says Adelman.

Adelman says that the most effective way to prevent this from happening, and at the same time assure the patient and their family members that the patient is not being ignored or neglected, is frequent interaction with the patient that is documented in the medical record.

Another risk-reducing approach is to designate one or more nurses or other appropriate providers to carefully monitor boarded patients.

"Keep them advised of what is going on with regard to their admission," says Adelman. "This can go a long way to identify any deterioration in a patient's condition early enough to intervene. It also dispels any impression that the patient is not being appropriately attended to while waiting for an inpatient bed."

Gradick notes that solutions for boarding are hospital-specific. What works for one, such as cancelling elective surgery during surges in volume, may not fix the problem for others.

"In a perfect world, it's great to make sure your admitting physicians and hospitalists come down, with time-specific orders where they are actually seeing and evaluating patients in the ED," says Gradick. "But if they are treating 10 patients upstairs, they may not get down there."

Rice says to access additional resources if possible, such as additional nursing staff, or place the patient in a holding or observation area for better monitoring.

"Assuming you don't have those resources and those patients have to stay in the ED, then clarifying how you could get extra resources or help, and who is supposed to be giving orders, is very important," says Rice.

It makes sense to assure that only stable patients are in the hallway, says Scaletta, meaning those already adequately examined and felt to be at a very low risk for becoming unstable. "Often this represents patients waiting for a test or results. Calling in extra ED staff helps. Having a hospital-wide overflow plan is also important," he says.

Standard of Care May Be Breached with Boarding

Attorneys will claim poor care given

If a bad outcome occurs with a boarded patient, what standard of care will the ED be held to? "That's a big debate," says **Matthew Rice**, MD, JD, FACEP, senior vice president and chief medical officer at Northwest Emergency Physicians of TEAMHealth in Federal Way, WA. "What does *not* look good is if a patient is sitting in the hall."

The idea of being in a hall instead of a room may be viewed negatively by a jury. "Whether the care is better or the same is what juries will sort out in a trial, relative to their decision," says Rice. "But if the patient is in the hallway as opposed to a room with a private bed and more staff to watch them carefully, and there is a bad outcome, the theory is that the care was not as good as if the patient moved to an appropriate floor that took care of their medical or surgical problem."

The issue is whether the bad outcome occurred because the patient should have been somewhere else. "Was the standard of care breached because they were in the ED vs. a different location?" asks Rice. "Plaintiffs typically argue that care should have been, or would have been, better or different."

A patient with a neurosurgical emergency who is boarded in the ED because there are not enough beds in the intensive care unit (ICU) is monitored, but not to the same standard of care that they would be if they were in a neurological ICU.

"So the argument is, if you had moved them there three hours earlier, the patient would have had better, closer monitoring than you provided in the ED," says Rice. "Then you get into the argument, 'Should the nurse have known to do XYZ? Should the ED physician have been more involved in the care?'"

ED nurses may struggle to see new patients while taking care of the boarded patients. "Is there negligence because there is not appropriate nurse staffing to attend to the patient that had a bad outcome?" asks Rice.

Error-prone Situation

Boarding produces error-prone circumstances because of the inability to provide all services necessary for the patient, according to Rice. "Mistakes can occur with tests not being done or reviewed. The wrong medicines can potentially be given, or given at the wrong time," he adds.

Of course, the fact that a patient is boarded doesn't necessarily mean he or she is not getting good care. "But if they have a bad outcome, the question will be raised as to why they were there so long, and whether they could have gotten better care elsewhere," says Rice. "In raising the question, plaintiff's attorneys will try to stir the pot of what wasn't done right, and ask the question, 'Should they have been somewhere else?'"

Although crowding is a hospital-wide problem and is not the individual ED physician's fault, he or she typically still would be named in a lawsuit alleging poor care due to crowding. "Most litigation spreads a wide net. They try to include everybody and exclude them later," says Rice. "Part of that is the strategy that the more people you name, the more access you have to the deep pockets of more insurers, rather than just one insurer."

While a boarded patient can still receive good care in the ED, hospitals don't always have the ability to provide the same resources as ICUs. "Monitoring devices are limited in numbers, and care providers are limited in numbers," says Rice. "Often, hospitals cannot mobilize other resources to come to the ED to staff the patient relative to the usual accepted ratios of how many nurses you should have per patient."

If you have a ratio of one nurse to every four ED patients, and that same nurse has three patients in the hallway in addition to the four rooms that are filled, the argument is that the nurse shouldn't have had those three extra patients, and this caused the bad outcome.

Different Setting

"Putting a new ED patient in a hallway may lead to corner-cutting regarding the physical examination, as patients do not get undressed, and EKG testing, especially in women, due to lack of privacy," says **Tom Scaletta**, MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL.

Admission orders may not always be adhered to. "It is difficult for ED nurses to implement these. They are often involved, whereas ED orders are generally quite different," says **Debra J. Gradick**, MD, FACEP, medical director of the ED at Avista Adventist Hospital in Louisville, CO, and vice president of operations at Serio Physician Management in Littleton, CO. "We are addressing the acute problem at hand, and not ordering a plethora of tests which are extremely difficult to execute."

Boarded patients may not be assessed as often as they should be, simply because of inadequate staffing issues. One solution is to bring in an ICU nurse to care for the more critical inpatients being held. "Chances are if the ED is crowded, the ICU is as well. You can't always pluck out an ICU nurse or grab one to come in from home. That is not realistic," says Gradick.

Scaletta says that it is unfortunate that many hospitals still resist any form of inpatient boarding. "Many prefer having six non-ICU boarders in the ED rather than one boarder on each of six non-ICU units," he says. "Often this is a function of inadequate inpatient staffing, which may be an intentional means to shrink expenses."

Sources

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Pray with ED Patients? Don't Fear Lawsuits

But Tread Carefully

If highly religious nurses or physicians feel that it is appropriate to pray with patients and to share their faith, some patients will appreciate this while others may not. However, it's unlikely this practice will lead to a lawsuit.

Lawrence B. Stack, MD, associate professor of emergency medicine at Vanderbilt University

in Nashville, TN says he knows of no lawsuits involving praying in the ED. "There has been one case of a nurse suspended because a patient complained that she offered to pray for him, but there has been no legal action that I can tell," he says.

The one caveat that Stack offers is that "spiritual health care" in the ED should be treated like any other health care information, and is subject to patient privacy regulations.

Stack says that several hospital chaplains informed him that their organizations had no specific policy regarding praying with patients. "It has not been an issue, at least in our hospital," he says. "Prayer in the ED is not necessarily discouraged, or encouraged."

Stack has prayed with patients several times in the ED, usually at their request. "If you ask the patient, there is always risk of offending somebody, but it is highly unlikely for a lawsuit to occur when offering help for the spiritual component of their lives," he says.

Respect Patient

Jonathan D. Lawrence, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA, says that he has never heard of any litigation involving prayer in the ED.

"There would be significant problems proving damages because somebody prayed for you, so I don't know if it would go anywhere. It would be more of a nuisance suit," says Lawrence. "A patient could conceivably sue the physician or the facility for infliction of emotional distress, but I am not aware of any suit where that's actually happened."

Lawrence says that while there's nothing wrong with praying with a patient, the physician should not initiate it. A clinician's attempts to proselytize are an "unprofessional and ethically abhorrent abuse of power," he says.

"The reason it's an abuse of power is because of the unequal relationship," says Lawrence. "The patient is a dependent of the physician in their relationship. The same would be true if you tell a patient to vote Democrat. It is probably not illegal, but it is unethical."

Lawrence says that ED nurses and physicians should tread carefully in this regard. "This is why hospitals have pastoral care divisions," says Lawrence. "Hospitals are in the business of providing medical treatment, but recognize that for a lot of people, that includes a spiritual component." It is always helpful if the physician is the same religious background as the patient, adds Lawrence.

ED physicians should be sensitive to the patient's desire—or lack thereof—to have prayer brought into their care, says Lawrence. Also, a passive role, not an active one, should be taken by the physician—saying "Amen," but not leading the prayer, for example.

"I've been asked by patients and families if I would mind praying with them. I respectfully stand there, but I don't participate in an active way," says Lawrence.

Employees May Offend

Chris DeMeo, JD, a health care attorney with Munsch Hardt Kopf & Harr in Houston, TX, says that he isn't aware of any cases where a patient or family member sued a health care provider for expressing religious beliefs. It is more likely that if a patient or family member is offended by a care provider's religious expression, he or she will complain to the hospital.

"This puts the hospital in the position of balancing between patient satisfaction and its employee's religious freedom," says DeMeo. "Misapplying that balance can and does lead to litigation."

DeMeo says that the legal risks of praying with patients, with respect to professional liability or malpractice, should be "relatively minimal." This is assuming the religious expression does not interfere with the quality of patient care.

A physician or nurse praying with a patient or family, or otherwise expressing their faith, will not cause physical injury to the patient. "Most states do not recognize a cause of action for mental anguish absent a physical injury, unless the

Sources

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conduct causing the mental anguish is extreme and outrageous," says DeMeo. "Someone in the ED praying with a patient or sharing their faith wouldn't reach this level."

Conceivably, a patient could have a case if an ED staff person did something egregious, like telling a patient or family member that a terrible injury or death is a punishment from God. "Short of that, there is not much exposure to lawsuits from patients and families in this regard," says DeMeo.

DeMeo says that a bigger liability concern for EDs is in dealing with employees whose religious expressions may offend patients, families, or coworkers.

As an employer, the ED could have exposure under Title VII of the Civil Rights Act for taking adverse employment action against an employee for exercising his or her freedom of religious expression. An adverse employment action generally means termination, demotion, a material loss of benefits, or significantly diminished material responsibilities, says DeMeo.

An employer is required to make a reasonable accommodation for the religious expression that does not cause undue hardship. "That being said, an employer is not required to allow an employee to impose his or her religious beliefs on others," says DeMeo.

Therefore, if patients, families, or coworkers are offended by an ED provider's religious expression, or such expression is otherwise disruptive, the ED may be justified in disciplining the employee and curtailing the offensive or disruptive behavior. "Each case will depend on its specific facts," says DeMeo.

When Can ED Patients Sue for Wrongful Death?

An ED physician, like any health care provider, can be sued for wrongful death whenever there is evidence that medical malpractice has caused a patient's death. A case generally will not be successful where there is no good evidence of medical malpractice, or where there is significant evidence that the patient caused or contributed to the death, says **Andrew Slutkin**, an attorney with Silverman Thompson Slutkin & White in Baltimore, MD.

While each state's law is different, Slutkin says the term "wrongful death" generally refers to a claim for negligence brought by the surviving immediate family members of the deceased—the parents, spouse, and children.

Damages Computed

In a wrongful death claim, the immediate surviving family members assert that negligence has caused them to suffer mental anguish over losing their family member, and economic losses as a result of the death of their loved one, such as lost income and lost household services.

"A wrongful death claim usually is brought along with a claim by the estate of the deceased," says Slutkin. This is called a "survivor action" because the claim survives the deceased's death, for the pain, suffering, and mental anguish of the deceased from the time of the negligence until the time of death.

Justin S. Greenfelder, JD, a health care attorney with Buckingham, Doolittle & Burroughs in Canton, OH, says that each state has enacted a particular statutory scheme with regard to wrongful death claims. Ohio's wrongful death statute permits the personal representative of a decedent to bring a legal action for the benefit of the decedent's beneficiaries for damages resulting from a tortious injury that caused the decedent's death.

Elements of damages include loss of consortium, loss of society, loss of services, loss of prospective inheritance, and mental anguish by the next of kin. "This is distinct from a 'survival' action, which is brought by the decedent's personal representative on behalf of the decedent for injuries suffered during the decedent's life," says Greenfelder.

Damages on the survival claim are measured by the extent of the physical and emotional injury suffered by the decedent before he or she died. "These claims are often joined together in a single lawsuit," says Greenfelder.

For a wrongful death claim against the ED to be successful, the plaintiff—in this case, the decedent's personal representative—must prove that the ED physician breached the standard of care, and that the breach was a proximate cause of the decedent's death.

"There are several permutations that courts have created over the years, one being a 'loss of chance,'" says Greenfelder.

Normally, the plaintiff must prove that the decedent would have survived an appreciable period of time but for the negligent treatment. However, in a loss of chance case in Ohio, if a decedent had less than a 50% chance of survival, a plaintiff may still prevail if he or she can prove

that the decedent lost that chance of survival as a proximate result of the negligent treatment.

"A jury's damage award is multiplied by the percentage of chance lost to determine the amount of damages properly awardable," says Greenfelder.

Large Settlement

Greenfelder says that a wrongful death case against the ED would not be successful if the plaintiff fails to prove that the physician breached the standard of care, or if the plaintiff fails to prove that any breach was not a proximate cause of the decedent's death.

In many cases, the defense will argue that the circumstances that caused the decedent's death were not foreseeable or were unavoidable. "That is, no matter what the physician did, the patient would not have survived," says Greenfelder.

Greenfelder recalls a case involving a patient who previously had been diagnosed with cancer but was in remission, who came to the ED for a severe sinus infection. A head CT was ordered, which the ED physician read as clear, and discharged the patient.

The next morning, the radiologist read the CT and noticed an artifact that should be checked out further. He sent his report to the ED physician, but the physician never notified the patient. Several months later, the patient had another CT scan which showed a much larger artifact that was determined to be a tumor.

"The plaintiff presented expert testimony that it was too late to save her at that point, but if she had been informed of the results of the earlier CT scan, she would have had a better than even chance of survival," says Greenfelder. "That case resulted in a large settlement by the ED physician and the hospital."

Sources

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To avoid wrongful death cases, Slutkin recommends these practices:

- Strive to meet the standard of care.
- When there is a death that is unexpected, contact the risk management department. After speaking with risk managers, clearly document facts and circumstances that indicate that the person was sick and was treated properly.
- Document any evidence that the patient was not compliant, or accepted risks of a procedure.

Greenfelder says when a death is involved, a physician's final notes summarizing treatment become very important. Physicians and nurses should accurately chart the course of treatments.

"The accuracy of the medical record is of the utmost importance in a death case, because the decedent is not around to tell their story by giving a deposition," says Greenfelder. "It is to the medical provider's benefit that the record be well-kept and accurate."

Nursing notes should be clear, and medication records must be accurate. Physicians and nurses must resist the temptation to make changes to the record after a lawsuit has been filed.

"This can lead to potentially very serious repercussions that go beyond simply being held liable for causing a patient's death," says Greenfelder. "Licenses would potentially be in jeopardy."

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. ■

CNE/CME QUESTIONS

22. Which is true regarding reducing liability risks involving the practice of boarding in the ED?
    A. Frequent interaction with ED boarders should be documented.
    B. Designating specific nurses or other providers to monitor boarded patients can increase legal risks for ED physicians.
    C. It is not advisable to bring in an ICU nurse to care for critical inpatients being held.
    D. Inpatient boarding on non-ICU units should be avoided, as this is significantly more dangerous than boarding in ED hallways.
23. Which is true regarding liability risks involving religious expression in the ED?
    A. Patients have successfully sued EDs because they were offended by a care provider's religious expression.
    B. A patient conceivably could have a successful case if an ED staff person did something egregious, like telling a patient or family member that a terrible injury or death is a punishment from God.
    C. Under no circumstances would an ED have exposure under Title VII of the Civil Rights Act for taking adverse employment action against an employee for exercising his or her freedom of religious expression.
    D. All states recognize a cause of action for mental anguish absent a physical injury, even if the conduct causing the mental anguish is not extreme.
24. Which is true regarding damages for wrongful death?
    A. A case generally will not be successful if there is no good evidence of medical malpractice or if there is significant evidence that the patient caused or contributed to death.
    B. Elements of damages cannot include loss of consortium, society, or services, but can include loss of prospective inheritance and mental anguish by the next of kin.
    C. The extent of the physical and emotional injury suffered by the decedent before death is not considered when computing damages.
    D. If the decedent had less than a 50% chance of survival, a plaintiff's wrongful death claim cannot prevail in any state, even if he or she can prove that the decedent lost that chance of survival as a proximate result of the negligent treatment.

25. Which is recommended to reduce risks when an unexpected death occurs?
    A. The ED physician should not contact the risk management department directly, and instead, should wait to be contacted.
    B. After speaking with risk managers, the ED physician should clearly document facts and circumstances that indicate that the person was sick and was treated properly.
    C. It is not advisable to specifically document any evidence that the patient was not compliant, or accepted risks of a procedure.

Answers: 22. A, 23. B, 24. A, 25. B.

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PLEASE NOTE: If your correct name and address do not appear below, please complete the section at right.

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E-mail: _____

CNE/CME Evaluation — Vol. 21, Nos. 7-12

Please take a moment to answer the following questions to let us know your thoughts on the CNE/CME program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your letter of credit. ACEP members — Please see reverse side for option to mail in answers.** Thank you.

CORRECT ● INCORRECT ⊘ ✓ ✗ ⚠

1. In which program do you participate? ○ CNE ○ CME
2. If you are claiming physician credits, please indicate the appropriate credential: ○ MD ○ DO ○ Other_____
3. If claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other_____

After participating in this program, I am able to:	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
4. Identify legal issues relating to emergency medicine practice.	○	○	○	○	○	○
5. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.	○	○	○	○	○	○
6. Integrate practical solutions to reduce risk into the ED practitioner's daily practices.	○	○	○	○	○	○
7. The test questions were clear and appropriate.	○	○	○	○	○	○
8. I am satisfied with customer service for the CNE/CME program.	○	○	○	○	○	○
9. I detected no commercial bias in this activity.	○	○	○	○	○	○
10. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
11 This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how?_____

12. How many minutes do you estimate it took you to complete this activity? Please include time for reading, reviewing, answering the questions, and comparing your answers with the correct ones listed. _____ minutes.
13. Do you have any general comments about the effectiveness of this CNE/CME program?_____

_____

I have completed the requirements for this activity.

Name (printed)_____ Signature _____

Nursing license number (required for nurses licensed by the state of California) _____

In accordance with ACEP requirements, below we provide the option for ACEP members to submit their answers for this CME activity. If you wish to submit answers to this activity, please refer to Vol. 21, Nos. 1-6, and circle the correct responses.

July 2010
State Medical Malpractice - 1

1. A B C D
2. A B C D
3. A B C D
4. A B C D
5. A B

August 2010
State Medical Malpractice - 2

6. A B C D
7. A B C D
8. A B C D
9. A B C D

Sept. 2010
Impaired Practitioners

10. A B C D
11. A B C D
12. A B C D
13. A B C D

October 2010
Hospital Policies

14. A B C D
15. A B C D
16. A B C D
17. A B C D

Nov. 2010
Medical Malpractice

18. A B C D
19. A B C D
20. A B C D
21. A B C D

Dec. 2010
Risk Management

22. A B C D
23. A B C D
24. A B C D
25. A B C

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