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Failure to Follow Own Policies Buries Hospital—Again

Tennessee Supreme Court says hospital is directly liable for failure to enforce its emergency department policy that required all patients be seen by an emergency physician.

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

Barkes v. River Park Hospital

One long summer morning, J. Wayne Barkes, age 48 and a platoon sergeant in the Tennessee National Guard, tilled his garden and cleared brush with an axe and chain saw. He stopped to rest because his left arm and shoulder started hurting. When the pain increased instead of diminishing, his wife took him to the emergency department (ED) at River Park Hospital in McMinnville, TN.[1]

Mr. Barkes was triaged by a paramedic, an employee of the hospital, but not by one of the ED nurses. His vital signs showed a blood pressure of 130/70, pulse 100, and respirations 20. Thereafter, his medical screening examination was performed by a nurse practitioner (NP), not a physician, though the NP did discuss Mr. Barkes' presentation, symptoms, and diagnosis of "left forearm strain due to overuse" with the emergency physician (EP) on duty. The EP agreed with the diagnosis and treatment plan, then signed the discharge papers. However, Mr. Barkes was never actually seen or examined by a physician—an important fact ultimately determinative to the outcome of this lawsuit.[1]

The NP sent the patient home with instructions to rest the arm, apply ice, and take an over-the-counter analgesic for pain control. Two hours later Mr. Barkes collapsed dead in his bathroom from an acute myocardial infarction.

Mrs. Barkes subsequently sued the hospital for wrongful death.[2] She also sued the NP and the EP, along with their employer PhyAmerica, the contract management group that staffed the hospital's ED. However, by the time of the trial, the wife had voluntarily dismissed her claim against the NP, the EP, and PhyAmerica because both PhyAmerica and its captive insurance company had entered into bankruptcy. Notwithstanding, the hospital continued

to maintain comparative fault claims against the clinicians and the company.[1]

At trial, the jury found the hospital 100 percent at fault for the death of Mr. Barkes, yet it found absolutely no fault on the part of the paramedic, NP, or EP responsible for his examination and misdiagnosis.[2]

The hospital appealed this rather strange decision, and the Tennessee Court of Appeals rescinded the jury's award of $7,206,907 in damages.[1,2] The court held that Tennessee law didn't recognize a theory of corporate liability under which the hospital could be found responsible for damages to a patient absent the jury finding vicarious liability for negligence by one of the treating health care providers.[1] The wife appealed to the state supreme court.

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Tennessee Supreme Court Holds Hospital Liable for Failing to Follow its Own Policies

The Tennessee Supreme Court noted, in an interesting twist, that Mrs. Barkes didn't claim the hospital was vicariously liable for the acts of its employee, the paramedic who triaged Mr. Barkes, or the acts of the NP or the EP. Instead, she a pressed a direct negligence action against the hospital for failure to exercise reasonable care in carrying out duties owed *directly* to its patients.

Specifically, Mrs. Barkes alleged that had Mr. Barkes been triaged by a nurse instead of the paramedic, and had he been examined by a physician instead of a NP, the warning signs of an impending heart attack would have been detected and treatment rendered that would have prevented his death.[1] (The patient was obese, a heavy smoker, had known high cholesterol and a family history of heart disease, and was pale, nauseated, and diaphoretic; which apparently escaped elicitation or appreciation by the NP.)

River Park had a written policy in effect at the time of Mr. Barkes' presentation that stated:

> "Any patient arriving at the Emergency Department will be seen by the emergency department nurse; triaged; and be seen by the appropriate physician." … and "All patients presenting for treatment in the emergency room are assessed by an emergency physician."[1]

The NP testified that she was wholly unaware of the hospital's policy that required every patient presenting to the ED be seen by a physician. The EP working in the ED at the time of Mr. Barkes' treatment (who signed the discharge papers) also testified she had no knowledge of the hospital policy requiring a physician to see and examine all ED patients.[1]

The plaintiff's experts had a field day at the original trial coupling the hospital's written policy with the "deer-in-the-headlights" lack of knowledge of its existence by the staff actually responsible for carrying out the mandates of the policy.

The Supreme Court, after reviewing its past precedents, held that the hospital had a duty to "exercise that degree of care, skill, and diligence used by hospitals generally in that community."[3,4] Furthermore, the court stated, the duty of reasonable care a hospital owes directly to its patients is independent of any liability based on the hospital's employees or agents.[1]

Therefore, the Tennessee Supreme Court overruled the appeals court and reinstated the jury verdict, stating that Tennessee law does permit a cause of action against a hospital for failure to enforce its policies and procedures in patient care. It determined, based on the material evidence presented at trial, that "the jury was entitled to draw the reasonable conclusion that the hospital's failure to inform the emergency room health care providers of its policies and its failure to effectively implement a system of oversight and enforcement of its policies was negligence that caused Mr. Barkes' death."[1]

Comments

The chief messages of this case are two-fold. First, hospitals must understand that they create self-imposed own standards of care through their written policies, and they will be held to those standards even if "higher" or not required by the prevailing community or professional standards of care. Second, if a hospital adopts a policy or procedure, it had better inform and educate the staff who will carry out the policy *and* ensure that they can meet its "standards" on a universally consistent basis. Otherwise, the hospital sets itself up for litigation under the theory of "failure to follow its own rules." The usual plaintiff's attorney argument goes something like this: "Mr. Hospital, you thought the procedures you should provide were so important to patient care and patient safety that you codified them into written policies, yet you didn't think it prudent or necessary to inform the staff, educate them on their responsibilities, and ensure that those critical procedures were actually carried out?"

Note that River Park Hospital's policy required all patients to be seen by an ***emergency*** physician. This policy not only meant the NP couldn't see a patient on her own in River Park's ED, despite having an independent license under state law that would allow her to do so and approval of the medical staff credentials committee (note that PAs, however, do not have an independent license and operate only under the license of their supervising physician); it also meant that no other credentialed member of the medical staff could examine and treat one of his or her patients in the ED, without the EP also seeing the patient.

Which providers are allowed to see and treat patients in the hospital's ED actually is controlled by federal law and regulations under EMTALA.[5,6] The process also is better stated as who is considered "qualified medical personnel" to provide the EMTALA-mandated "medical screening examination" (MSE) on behalf of the hospital.[7] The federal government requires the hospital's governing body to formally designate, in writing, who is a qualified medical person to perform medical screening on behalf of the hospital. The government's intent is to hold the hospital's governing body "properly accountable for this function." The regulations also specifically state that the hospital cannot allow the medical director of its ED to designate who is qualified to perform screening examinations on behalf of the hospital.[6,7]

The hospital's designation of who is qualified to perform an MSE also must meet the requirements of other Medicare regulations concerning emergency services personnel and direction, specifically 42 CFR §482.55.[8] These conditions require that the organization, direction, and personnel of emergency services be directed and supervised by a qualified member of the medical staff and that the medical care be a continual responsibility of the medical staff. Additionally, the screening processes and personnel must be "in accordance with acceptable standards of practice."[7]

The Joint Commission on Accreditation of Healthcare Organizations also has set standards related to the MSE, stating that a "licensed independent practitioner with appropriate clinical privileges" must be responsible for determining the degree of assessment and care of all patients presenting to the hospital for emergency care.[9]

It's certainly not illegal to use mid-level providers, such as the NP at River Park or PAs as is done in many hospitals across the country, but their use must be sanctioned, in writing, by the hospital and its governing body, and their scope of practice in the ED must conform to their training, certifications, and the limitations imposed by state laws, the medical staff by-laws, or by the hospital or emergency physician group.

One can't help but wonder why the plaintiffs didn't sue the hospital under EMTALA. The hospital clearly violated the statute by failing to follow its policy. Who could triage the patient (nurse or paramedic) and who could examine its ED patients constitutes part of its medical screening process, and thus failure to have the nurse triage the patient or an EP conduct the MSE violated the hospital's screening policy.

Plaintiffs increasingly are using these failure to follow policy claims or "failure to follow your own rules" to sue hospitals for the actions of its physicians under both EMTALA and state malpractice laws.[10] (Which, incidentally, is another

way to sue the hospital when its EPs or on-call physicians have no or inadequate malpractice insurance.) For example, in *Scruggs v. Danville Regional Medical Center*, the plaintiff successfully sued the hospital for failing to follow its policy requiring the triage nurse to reassess all triaged ED patients in the waiting room every 2 hours, after the patient languished unexamined for 11 hours.[11,12] In *Bode v. Parkview Health System,* the plaintiffs were allowed to sue the hospital for its failure to take a child's blood pressure at triage or repeat his vital signs before discharge, both of which were required under the hospital's written ED medical screening policy.[13]

A classic example of a hospital's liability under EMTALA for failure to follow its own policies is the St. Joseph's Medical Center case out of California.[14] The Office of Inspector General fined the hospital $50,000 for failing to appropriately triage an elderly patient who presented with a swollen tongue and trouble breathing. The hospital's policy required all nurses conducting triage in its ED to have worked at least 6 months in an ED and to have gone through qualifying triage training. The nurse who triaged the patient had neither the requisite experience nor the required formal training, and the judge in the case determined the nurse's outright callousness and grossly negligent care lead to the patient's death.[14]

The obvious implication of the St. Joseph's decision is that if the hospital had a qualified nurse triage the patient, then the care and medical decision-making would have been better and saved the patient's life—along the same lines as Mrs. Barkes' arguing that had the hospital had a nurse and EP care for her husband instead of the "unqualified" (at least by policy) paramedic and NP, her husband would still be alive.

Summary

Hospitals continue to buy themselves litigation and government scrutiny by boxing themselves through their own written policies and procedures. Does your hospital have a stack of binders sitting on the back shelves in the ED that govern the care provided in your ED? Has anyone reviewed those ED policies and procedures to determine if they contain pitfalls or they set expectations that the hospital will not be able to meet? Whoever reviews the policies must have sharp knowledge of the medical and legal implications under state malpractice law and federal EMTALA law, as well as a functional understanding of today's practice of emergency medicine and the interplay of how the law applies to the various medical scenarios or issues of the ED.

The vagaries of hospital-based emergency care make the practice difficult and a high-risk environment all by themselves; there's no need for a hospital to create additional liability for itself and its physicians through feeble drafting and implementation of its own polices.

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Too-stringent ED Policy Can Make Staff Appear Negligent

Leave discretion, 'wiggle room'

Does your ED have policies that leave no room for nursing judgment, and instead, require specific timeframes for procedures such as

re-assessments and checking of vital signs? "These are troublesome in lawsuits," says **Linda M. Stimmel**, JD, a partner at Wilson Elser Moskowitz Edelman & Dicker LLP in Dallas, TX. "I have *never* seen a perfect chart, graphic record, or flow sheet in almost 20 years of defending health care providers."

If an ED policy states, for example, "vitals every 15 minutes Q 1 hour," a plaintiff's attorney need only look closely at the ED policy and compare it with the patient's chart, says Stimmel. Then at trial, the attorney will argue, "This nurse did not even follow the hospital's own policies when caring for the patient," she says.

"I have seen many charts where vitals were taken, just not to the exact specific timing of a policy," says Stimmel. "We can argue that it did not cause any harm to the plaintiff. But if in trial, they have blow-ups of a chart with 10 or 20 entries that do not meet the specifics of a policy, the jury begins to believe the ED is staffed with careless, negligent staff."

Stimmel adds that she has seen very detailed, specific policies that were not followed used to attack a hospital or administration at trial. "The plaintiff's counsel will argue lack of supervision, training, and education of the ED staff," she says. "These are all attacks that we can avoid, with carefully written ED policies that allow discretion and 'wiggle room' for the ED staff."

John Burton, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA, says that it is important to "align the true life in the trenches with the administrative view and perfect-world policies."

Burton says that NPO (nothing by mouth) status for sedation patients is "an interesting example, as we ignore fasting guidelines all the time given that they have little to no relevance in our setting."

The Center for Medicare & Medicaid Services requires hospitals to have these and many other policies in place, notes Burton, but "the folks creating the institutional policies may have no clue as to what actually happens in the trenches."

Policies *Aren't* Standard of Care

Joseph P. McMenamin, MD, JD, FCLM, a partner at Richmond, VA-based McGuireWoods and a former practicing EP, says that he has often argued, generally successfully, that internal rules at a hospital do *not* define the standard of care.

"Standard of care is ultimately defined by a jury, but it is defined by comparing what is done in a particular situation with what a reasonable prudent provider would do under similar circumstances," says McMenamin. "I could, in theory, create an extraordinarily exacting standard for myself by developing internal rules that are very, very strict."

As a private individual, or a private institution, you cannot change what the law provides, says McMenamin. "The comparison to make is not one between your conduct and your own internal documents. Rather, the proper comparison is between your conduct and that of others in similar circumstances," he explains. "It would be theoretically possible for me to comply with the standard of care, and yet fall short of what my own policies and procedures say."

On the other hand, an ED can't develop documents setting out a policy that allows nurses or physicians to fall *below* the standard of care, notes McMenamin. "I can't very well ask a court to agree that because I have complied with my own internal rules, that I'm off the hook legally, and have no potential liability exposure," he explains.

Your own ED internal policies and procedures aren't designed to define the standard of care, says McMenamin. "They should do nothing more, and nothing less, than govern conduct within the walls of the institution, and should not be used for other purposes," he says.

For this reason, McMenamin says there is a good argument that from a legal standpoint ED policies are irrelevant, since they can't properly be used to determine what the standard requires.

While many courts do accept this argument, McMenamin cautions that many do not. "Depending on the state, there is a distinct possibility that, try as you might, and despite invoking QI statutes and so forth, you may be required in discovery to turn over your policies and procedures, even though you don't want to," he warns.

'Deplorable Development'

McMenamin says that ED policies should not impose unreasonably high standards. "When you write these things, write them carefully," he says. "Somebody somewhere out there is going to try to discover your documents, and might try to hit you over the head with them. If you have written them in such a way that no one could possibly achieve what you have set out, you are headed in the wrong direction."

This is especially important if you are located in a jurisdiction that doesn't carefully protect these kind of documents, adds McMenamin. "There has

been some erosion of the law in my state, and that is true in other states as well. I think it's a deplorable development in the law," he says. "But given that some judges are now more willing than they used to be to force defendants to turn over documents such as these, I usually advise against being unreasonably exacting or needlessly specific."

Years ago, McMenamin defended a hospital that had a policy stating that there was to be 1:1 nursing care in the intensive care unit. "They didn't have it, and nobody in the state had it, because nurses just weren't available," he says.

McMenamin was able to keep the document from being discovered. "The courts were more careful to prevent misuse of these documents in those days," he adds. "The document never saw the light of day, and I never had to worry about what it said."

After the case was over, though, McMenamin informed hospital administrators that because the court agreed with the reasoning that documents were not relevant for the purpose of determining the standard of care, the hospital was able to "dodge a bullet."

"But if some judge someday forces me to turn over this document or one like it, then you are stuck with the fact that you yourself wrote this," he told the administrator. "Nobody forced you to write this. Don't put down in writing some sort of directive that is substantially impossible to comply with."

McMenamin advises against writing "unrealistic words" that could be used to suggest an obligation exceeding that which really does prevail under law.

"If you had a policy somewhere that a patient has to be out of the ED within 15 minutes of the decision to admit, it's hard to imagine that any hospital would be able to comply with that 100% of the time," McMenamin says. "In attempting to define what the responsibilities of the parties are, be realistic about it. Stay cognizant of whatever limitations are imposed by circumstances."

Skeletons in Your Closet? Not Much 'Off Limits' in Deposition

But 'sideshow" evidence is frowned on

If an EP was caring for a patient while visibly intoxicated and a bad outcome occurred, you can probably imagine how that information would affect the outcome of a trial alleging medical malpractice. But what if an EP has a history of substance abuse, a criminal record, or a psychiatric history?

Linda M. Stimmel, JD, a partner at Wilson Elser Moskowitz Edelman & Dicker LLP in Dallas, TX, says to remember that not much is "off limits" in a deposition. "The discovery phase in a lawsuit is called 'open discovery,' which means the courts are very liberal in allowing the plaintiff and defendant to ask for all kinds of information on the parties."

Nearly every state, as well as federal courts, permits discovery into any matter that is reasonably calculated to lead to the discovery of admissible evidence, according to **Justin S. Greenfelder**, JD, a health care attorney with Buckingham, Doolittle & Burroughs in Canton, OH.

A physician's disciplinary history would rarely be discoverable, says Greenfelder, unless it can be shown that the discipline he received was somehow linked to the specific malpractice alleged.

"This is typically a high hurdle to overcome," says Greenfelder. "Many judges are loathe to permit plaintiff's attorneys to introduce such extraneous or 'side-show' evidence that has no bearing on the issues for the jury to decide."

In addition, Greenfelder notes, some states have enacted statutes that protect as confidential any information received by a state medical board in an investigation of a physician. In Ohio, for example, Revised Code Section 4731.22(F)(5) provides that any information received by the state medical board pursuant to an investigation is confidential and not subject to discovery in any civil action.

"It further provides that information may be admitted in a judicial proceeding in accordance with the Rules of Evidence, but that the court must take appropriate measures to protect confidentiality of information containing patient names, complaints, or information received by the board during the investigation," says Greenfelder.

For any of this information to be admissible in a court of law, Greenfelder says it must ultimately be relevant and probative to claim or defense, and not unduly prejudicial to the physician. "If the prejudice outweighs the probative value, the information would be inadmissible," he explains.

Is it Relevant?

Questions about a physician's prior indiscretions, which may not have been the subject of a medical board inquiry, may not necessarily

be improper at a deposition, says Greenfelder. However, he says that the likelihood of admission at trial is low unless there is a connection to the patient's care.

"Whether a physician uses drugs or alcohol would rarely be relevant, unless it could be shown that the physician was actually impaired at the time of the alleged malpractice," Greenfelder says.

The plaintiffs have to prove any "bad or harmful" information on a party is relevant to the issues in a lawsuit, notes Stimmel.

"If they find a physician had a drug problem in the past, I would argue there was no evidence the physician was under the influence of drugs during the care of the patient, and that if the court lets the information in the trial, it would be prejudicial and harmful," she says.

Most of the time, the courts will not let in "prior bad acts," such as drug convictions or revocation or suspension of the physician's license decades earlier, if the plaintiffs do not have evidence linking these to the patient in the lawsuit, says Stimmel.

However, if there is evidence of a past felony, or what courts determine as "moral turpitude" or evidence of untruthfulness of a party, "it will get into a trial," she says.

"We then have to argue that it has nothing to do with the case at hand," says Stimmel. "Even so, I will object and not let my witness answer some of those types of questions, arguing that it is irrelevant and there is a right of privacy. The plaintiff will then be forced to go to the court to seek permission to ask the question. They may or may not prevail."

To reduce risks in your ED, Stimmel advises making sure that prior histories are disclosed to you by staff during an interview or application process. "You will know what you are up against if a lawsuit ensues," she says. "Of course, you need to be consistent and ask those same questions of everyone."

A Balancing Test

Greenfelder says that in Ohio, if a physician pleads guilty or is convicted of a crime punishable by death or imprisonment in excess of one year, or if the crime involves fraud or dishonesty, that conviction is typically admissible unless it would be more prejudicial than probative.

"A plea of no contest, on the other hand, is typically not admissible," he says. The same is true, says Greenfelder, for a conviction that is more than ten years old, or a conviction that has been expunged, annulled, or pardoned.

Michael M. Wilson, MD, JD, principal malpractice attorney at Michael M. Wilson & Associates, Washington, DC, says that according to the District of Columbia statute, if the felony is less than 10 years old, it is generally allowed in. "Under the federal rules of evidence, it is a balancing test for the judge, of probative value versus prejudicial effect," he says.

Wilson says that the personal medical treatment of the EP is generally off-limits, as far as obtaining the medical records, unless the lawyer can show "good cause" to the judge.

Wilson once handled a case of a physician with a drug and psychiatric history, who spent months in rehabilitation. The case settled prior to the judge resolving whether the plaintiff's attorney could obtain the medical records of the physician, he adds.

The general rule for depositions, says Wilson, is that the plaintiff's attorney can inquire about anything, as long as it could potentially lead to relevant information. "The new federal rules have changed the test a little bit, to give the judge more flexibility to rule certain things off-limits," says Wilson.

Another possibility is that the information could be revealed to the plaintiff's attorney subject to a confidentiality order, says Wilson.

"Pretty much these issues would be decided on a case-by-case basis," Wilson says. "If the physician killed two persons, was declared insane, treated, and then allowed to practice medicine, it would seem that a judge would allow this information to come into evidence if the physician allegedly killed a patient."

However, if a physician was seeing a psy-

Sources

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chiatrist for therapy about a divorce, Wilson says it is unlikely this would be allowed to be revealed. "Many other situations would come between these situations," says Wilson. "At trial, it would be a balancing test as to whether the information would come in."

Want to Admit Patient, But Can't? Lawsuit May Result

Ultimate responsibility is yours

It may be in the best interest of your ED patient with chest pain, seizures, or transient ischemic attack (TIA) to be admitted, but this may not occur due to factors beyond your control.

Edward Monico, MD, JD, assistant professor in the section of emergency medicine at Yale University School of Medicine in New Haven, CT, says that the main problems EPs encounter when admitting a patient to the hospital involve lack of institutional resources such as specialty consultation, and lack of a willing inpatient service provider to accept responsibility for the care of the patient.

"Despite these obstacles, the ultimate responsibility for the disposition of an ED patient rests with the emergency physician," says Monico. A patient requiring admission for inpatient monitoring and/or treatment should receive inpatient monitoring and/or treatment, he explains, and the physician best situated to make that determination is the EP.

"Emergency physicians who acquiesce to a consultant's request for office follow-up in lieu of necessary inpatient treatment, or succumb to the rationale of a hospitalist or private physician unwilling to provide required inpatient care, could be liable for harm realized if injury arose from an inappropriate discharge from the ED," warns Monico.

To reduce legal risks, Monico gives these recommendations for EPs facing obstacles during the admission process:

1. Be prepared for this scenario.

"Institutional contingency plans should exist for when opinions differ as to whether a patient needs admission," says Monico. "Admitting patients to a default physician until delineation of inpatient responsibility can be assigned is one option."

Monico says that another option would be to call the administrator on-call to resolve the issue in real time.

2. Transfer the patient when appropriate.

Transferring a patient in need of specialty consultation to a "willing and able accepting hospital" capable of providing that consultation far outweighs discharging a patient from the ED when ED consultation is required, says Monico. "The need for the consultation and the reason for the transfer have to be documented and made known to the patient," he adds.

3. Communicate with the patient.

"Patients have a right to know of problems that impact their health care, such as what underlies the need for transfer to another hospital," says Monico.

4. Document your medical decision-making.

"Although actions speak louder than words, documentation of a physician's thought process remains a fundamental risk management strategy, in cases when other physicians pose obstacles to the emergency physician trying to abide by the standard of care," says Monico.

Speak Up for Patients

EPs should never allow administrators to dictate admission criteria, underscores **Tom Scaletta**, MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL. "This is a form of a lay entity practicing medicine," he says. "While they may cite utilization criteria, every patient is different in terms of their presentation, reliability, and willingness to accept risk."

EPs should avoid practice settings where they feel their job may be in jeopardy as a result of speaking up on behalf of their patients, adds Scaletta. "The ED medical director needs to advocate for patient care and staff rights," he says.

Scaletta acknowledges that an EP who is a clear outlier regarding utilization may need to be "reeled in" by the director. However, he says, "Working under the direction of an unreasonable, reactive medical director that puts corporate interests above patient care precipitates lawsuits and burnout."

Scaletta says that patients can be observed in the ED when they are not ready for discharge, while admission to another area of the hospital is not possible. "This is not ideal, since it contributes to ED overcrowding and spreads the ED staff thinner than it should be," he notes.

Patients should be involved in "gray area" decisions regarding admission versus discharge,

says Scaletta. Using the example of a TIA patient, Scaletta notes that in the lower risk cases with an ABCD score less than five, stroke occurring in the next 24 hours is unlikely.[1]

An informed patient may prefer to go home on aspirin, complete further testing as an outpatient, and return at the first sign of any worsening, says Scaletta.

"If family members are willing to observe such patients at home, there is usually no disadvantage as long as they rapidly return to the hospital should any neurological signs return," says Scaletta.

No One to Admit Them To

John Burton, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA, says that "TIAs remain problematic for EPs. It is a very challenging issue. The problem is that they can't get anyone to admit those patients to the hospital."

Although EPs and neurologists in large stroke centers will admit all TIA patients to the hospital, this often is not the case in community hospitals.

"ED physicians will generally agree with the data that says patients are at increased risk for having a stroke in the next couple of days," says Burton. "But the neurologist won't admit them, or even be available to see the patient. The hospitalists and intensivists will say there is nothing they can do for them."

The EP is then put into the difficult position of being told by the literature to admit TIA patients, when there is no one to admit them to.

"What happens is an event where the TIA patient is discharged from the ED. Within a week, the patient returns with a substantial debilitating stroke," says Burton. The plaintiff then argues that failure to admit and properly treat the TIA visit resulted in the subsequent stroke by neglect.

"What's generally lost in the details is that there is often no clear management strategy or therapy for the TIA patient during hospitalization that could have prevented the stroke," says Burton. "However, it just looks bad. Therefore, the compulsion to settle a case, or the threat of a case, is rather high."

If EPs at your hospital are encountering this problem, you need to have a plan in advance for how you are going to handle it, advises Burton. Whether or not the TIA patients are going to be transferred to a stroke center, he explains, it's important to have a dialogue about the care of these patients.

"Medicolegally, that is a good strategy. Your plan may be, 'There is nothing we can do, and we just have to send those patients home.' On the other hand, once you look at it, sometimes there is a hospital that will take the patients," says Burton.

In this scenario, Burton recommends documenting in the medical record that you have spoken to the doctors on call for admission, and they are not agreeable to admitting the patient. Also document that you have arranged appropriate follow-up for the patient in the next few days, adds Burton, and told them when to return immediately to the ED.

"This isn't meant to be inflammatory. You shouldn't throw everybody else under the bus because they won't admit the patient," says Burton. "But be clear in your rationale, and realize there is some risk there, if there is a bad outcome."

Reference

1. Chandratheva A, Mehta Z, Geraghty OC, et al. Population-based study of risk and predictors of stroke in the first few hours after a TIA. *Neurology* 2009; 72(22):1941-1947.

Sources

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More Pressure on EPs Means More Legal Risks

Emergency physicians have been "deluged with ever-increasing responsibilities and higher performance expectations," according to **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. Garlisi points to electronic health record physician order entry, patient satisfaction ratings, and increasing medical record documentation, as some examples.

"Many hospital administrators are eager to harvest potential gains in market share by instituting some variant of 'doc at the door' or '30-minute guarantee,'" adds Garlisi.

Garlisi warns that placing pressure on the emergency team to move faster on the front end, to decrease the timeframe between the ED patient's entry and initial evaluation to disposition, without adding staff or resources, is a "double-edged sword. It can lead to error, and back-end overload."

These performance expectations may be reasonable if looked at solely from a patient safety and customer satisfaction standpoint, says Garlisi, but they may be difficult to achieve at best given the economic constraints which limit staff and resource allocation.

Garlisi says many EDs "have not been able to resolve 'back end' issues of getting the admitted ED patient out of the ED and into the appropriate unit bed."

Risk of medical error

Garlisi says some of the factors that result in ED overcrowding are limited nursing staff in intensive care units (ICUs) or medical/surgical units, a limited number of available hospital beds, delays in transferring or discharging patients from the respective units, and inability of the ED to manage surges in patient volume and/or acuity.

The end result, says Garlisi, is "stagnation of ED operations. These patients, often boarded in the ED for many hours, not only tie up the limited ED staff and ED resources, but also are at increased risk for medical error."

Garlisi says that these questions should be considered for admitted, boarded patients:

- Does the ED have the appropriate staff to provide one-on-one care to the boarded critical care patient?
- Does the ED have the capability to provide all boarded patients with the medications, treatments, recheck of vital signs, and admission orders in a timely manner?
- Does the ED provide a mechanism or protocol which dictates how, and to what extent, the EP is involved in the care of the boarded patient?

Garlisi says it can be argued that the medical care provided to the patient boarded in the ED should be equal to care provided in the ICU or respective ward to which the patient is admitted.

On the other hand, Garlisi says that one could argue that an unstable patient in the ED with a physician available is a safer situation for the patient than being in the ICU with no intensivist, specialist, or primary care physician on site until the next morning, as is often the case on nights, weekends, and holidays.

"'Phone call coverage' for patients in the ICU may be acceptable in certain circumstances, but this can only go so far," says Garlisi. "It poses a dangerous situation for the patient."

Jury won't understand

Garlisi says that it would be difficult for a jury to understand how and why a physician would not be at the bedside for a critical ICU patient in the event of a bad outcome. "Telemedicine, used by some facilities, would be preferable to phone call coverage. It at least provides the physician with more personalized interaction with the patient in real-time," he adds.

Garlisi says that if an admitted, boarded patient experiences a bad outcome, the plaintiff's attorney would want to know the following:

- How long was the patient in the ED?
- Was the patient personally examined by the admitting physician?
- Was the admitting physician a hospitalist or resident physician who would be on site and readily available?
- Were admission orders written, called in or entered electronically?
- Were all admission orders carried out in an accurate and timely manner by the ED nurse, or a nurse "borrowed" from the wards or ICU?
- To what extent did the "handoff" from one EP to the next shift physician occur?
- To what extent did the EP assure that all orders and vital sign rechecks occurred?
- For the patient with sudden, serious deterioration in clinical status, did the EP intervene and attempt to stabilize the patient?

Garlisi recommends the following system-wide solutions:

- Have a statistical analysis of daily admissions from all sources—the ED, direct admits from physician offices, transfers in from other facilities, and admissions from post-op recovery units.
- Have an on-site dedicated "bed czar" or bed coordinator available during peak admission times.
- Create policies among admitting physicians regarding timely discharge.
- Identify a threshold that triggers a system-wide process early, to mobilize all depart-

ments and individuals.
- Identify patients who can be safely moved out of ICU when beds are tight.
- Engage the physician staff in discharging patients as soon as possible, and make sure paperwork is completed prior to discharge.
- Implement ED point-of-care testing and use of physician scribes to maximize physician-patient contact time.

Factors that Make Psych Lawsuit Easier to Defend

Patients with psychiatric illness who present to the ED "are frequently a challenge," according to **Robert B. Takla**, MD, FACEP, chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI. "Trying to determine if a patient is truly suicidal or a real danger to themselves or others is not always straightforward."

With resources becoming scarcer, placing a patient into a facility is often very difficult, adds Takla. A large ED probably has psychiatric social workers that will see the patient and discuss the case by telephone with the psychiatrist on call, he says. "They will make recommendations, such as, 'This patient is OK to go and has an appointment in two days to see a psychiatrist,'" says Takla.

Smaller EDs, adds Takla, may not have a psychiatric social worker and physicians are making that assessment on their own. "Often they are so busy, that taking the time to do a good assessment may be difficult," he adds.

If you make the decision to let a patient go home and the patient injures him/herself or others, says Takla, "not only are you liable, but you will have to contend with the consequences of your decision."

"Obtaining a history and trying to put the picture together so you have an objective differential diagnosis is not always easy or without prejudice," says Takla. "It is well known that psychiatric patients have a higher mortality, and that is in part because physicians often dismiss their medical complaints as psychiatric."

Mental or Physical?

For example, an ED workup of a headache in a psychiatric patient may not include a CT or lumbar puncture, because the headache may be dismissed, or is attributed to the psychiatric complaint, says Takla. In some cases, he adds, EPs "just don't listen as seriously, and that is very unfortunate. This is especially true because about 50% of psychiatric illness that presents to the ER is dual diagnosis with substance abuse, either illegal drugs or alcohol."

Evaluating Suicidal Risk

Takla says that if a malpractice lawsuit is filed involving ED care of a psychiatric patient, these things would make the case easier to defend:
- An appointment made for follow-up shortly after discharge;
- A list of resources the patient has such as friends or family support;
- A signed contract from the patient agreeing to not harm themselves;
- A written explanation of the rationale that the patient is no longer interested in harming themselves or others because of ED interventions or an upcoming appointment;
- Documentation that you have told the patient to return to the ED at any time if they feel like they want to harm themselves or others;
- Documentation of an agreement from the family that the patient will not be left alone.

Inconsistent, incomplete documentation would undoubtedly make a lawsuit more difficult to defend, says Takla. He gives the example of a triage note stating that the patient is suicidal and wants to kill himself with a gun, a nursing assessment stating that the patient wants to end his life and says that he has nothing to live for, and then the ED physician sends the patient home without documenting the rationale behind this decision.

"The worst thing the plaintiff's attorney can find is documentation of suicidal or homicidal ideation, plans, and means, yet the patient is allowed to be discharged without documentation of the thought process as to why the patient was discharged," says Takla.

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

5. Which is **true** regarding personal information about an EP in the event of a malpractice lawsuit?
   A. Nearly every state, as well as federal courts, permits discovery into any matter that is reasonably calculated to lead to the discovery of admissible evidence.
   B. A physician's disciplinary history is always discoverable.
   C. A physician's disciplinary history is not discoverable, even if it can be shown that the discipline received was linked to the specific malpractice alleged.
   D. "Prior bad acts" are generally always admissible even if there is no evidence linking these to the specific malpractice alleged.

6. Which is **true** regarding ED policies and liability risks?
   A. ED policies that allow "wiggle room" for staff may decrease legal risks.
   B. The standard of care is defined by the hospital's internal rules.
   C. EDs may legally develop documents setting out a policy that allows nurses or physicians to fall below the standard of care.
   D. ED internal policies should be designed to define the standard of care.

7. Which of the following is recommended to reduce liability risks if an EP encounters problems admitting a patient to the hospital?
   A. EDs should avoid developing institutional contingency plans for scenarios involving differing opinions as to whether a patient needs admission.
   B. EPs should allow administrators to dictate admission criteria.
   C. EPs should avoid involving patients in "gray area" decisions regarding admission versus discharge.
   D. EPs should document in the medical record if they have spoken to the doctors on call for admission, and they are not agreeable to admitting the patient.

Answers: 5. A, 6. A, 7. D.