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Legal Issues Surrounding the Critically Ill Patient in the ED

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Emergency physicians (EPs) are often faced with caring for the impending or actual cardiac arrest patient. Time constraints in the emergency department (ED) often make it difficult to ascertain the resuscitation wishes of the patient. This issue of *ED Legal Letter* will discuss the legal implications associated with resuscitation care to include deciding whether or not to initiate resuscitation in a patient, issues regarding post mortem procedures, as well as guidelines in determining who is capable of making legal decisions for a patient.

To Code or Not to Code: That Is the Question

The decision of whether to resuscitate a patient has legal ramifications. In some instances, the EP may elect not to resuscitate the patient. In Wendland v. Sparks, the Iowa Supreme Court recognized an action for loss of chance to survive in a patient whose resuscitation orders were not followed by the physician.[1] A cancer patient was admitted for "failure to thrive," and her admission to the hospital was intended to allow her to regain strength. Three weeks into her hospital stay, she went into cardiac arrest, and subsequently died after the physician did not initiate resuscitation. The physician admitted telling the nurse that no resuscitation efforts would be started, announcing to the nurses, "I just can't do it to her," despite the fact that there was evidence that such efforts may have been successful.

The plaintiff's suit claimed that the defendant physician had failed "to promptly initiate appropriate care to treat the decedent's arrest."[2] In addition to this, the plaintiff went on to argue that the defendant's negligence deprived the decedent of a chance to survive. The court maintained that under this lost-chance theory, a victim with a pre-existing condition, such as cancer in this particular case, who is then subject to another source of injury (failure to resuscitate), may have a claim for the second event. The justification for this position states that were it not for the second condition (failure to resuscitate), the patient may have survived the initial condition (in this instance, the cancer). The court conclusion suggests that if a patient clearly expresses

a desire to be resuscitated, the physician exposes him- or herself to liability if he or she unilaterally disregards this request. In this case, the plaintiff became aware of the situation after a report by the nursing staff regarding the physician's comments. Regardless of the physician's decision to resuscitate a patient, care must be taken to maintain professional demeanor with comments and actions.

Contrary to the lost-chance argument in Wendland v. Sparks, there have been multiple claims for wrongful prolongation of life. In Anderson v. St. Francis-St. George Hospital (SFSG), the plaintiff sued on the behalf of the estate of Edward H. Winter.[3] The suit alleged battery, negligence, and "wrongful living" relating to care Mr. Winter received at SFSG. Mr. Winter presented to SFSG with chest pain and was subsequently admitted to the coronary care unit for further management. Dr. Russo, the patient's private physician, allegedly had a conversation with the patient regarding goals of care. In light of this discussion, Dr. Russo indicated on the chart that the patient was not to be resuscitated.

During the patient's hospital stay, he had an episode of ventricular fibrillation. The patient was subsequently defibrillated by a nurse, despite Dr. Russo's documentation. Upon awakening, the patient said to the nurse, "Thank you for saving my life." The patient survived the event, but then went on to suffer a paralyzing stroke several days later. Despite this, the patient went on to live several years and participated in many family events and vacations. The plaintiff maintained that the nurse's resuscitation prevented the patient's natural death. Also, the nurse's act of resuscitation was a battery to the patient. The plaintiff furthermore asserted that the nurse was negligent by resuscitating the patient contrary to Dr. Russo's orders. Lastly, the plaintiff maintained that, by keeping the patient alive, SFSG caused him "great pain, suffering, emotional distress, and disability," as well as medical and other financial expenses.[4] In summary, the patient claimed, "If you hadn't saved my life, I wouldn't have to live paralyzed."

After numerous appeals, the Ohio Supreme Court held that a patient cannot sue for damages for "wrongful living" as a result of the wrongful administration of life-prolonging medical treatment. Instead, damages for prolongation of life must be based on either negligence or battery. Mr. Winter suffered no injuries from the defibrillation. Although Mr. Winter was alive to suffer the stroke, numerous injuries could have followed resuscitation and, thus, revival did not cause the stroke. When battery is physically harmless, the plaintiff is entitled only to nominal damages, which the plaintiff had not sought. The court affirmed the ruling in favor of the hospital. The court held that "wrongful life" was an untenable concept that could not be supported. The court acknowledged that the true calling of the physician is to save lives.

In Allore v. Flower Hospital, the plaintiff's decedent was diagnosed with asbestosis.[5] Eighteen years later, the decedent was admitted to the defendant hospital. At the time of admission, the patient executed a living will and durable power of attorney for health care. The living will stipulated that the patient wanted no "life-sustaining treatment" in the event the he suffered a "terminal condition" or was in a permanently unconscious state. The terms stipulated that the decedent's physician and another

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physician were needed to determine the presence of a terminal condition or permanently unconscious state.[6] The decedent's physician and hospital were both aware of the living will.

The patient was treated and subsequently released from the hospital; however, two months later, he was admitted to the hospital again. After consultation with a cardiologist, the patient was transferred to the coronary care unit. The defendant cardiologist and treating nurse had no knowledge of the living will that had been established with his primary physician. In addition to this, the decedent's chart did not contain a DNR order. Instead, the decedent's primary physician indicated on the chart that the patient was a "full code." Several days after the admission to the coronary care unit, the decedent had respiratory arrest. The defendant cardiologist ordered intubation. Later that day, the cardiologist learned of the decedent's living will. He then ordered that the decedent be extubated. Several hours later, the decedent died.

The suit filed by the plaintiff alleged that by disregarding the decedent's wishes outlined in the living will, the defendants were negligent in their care for the decedent. Also, the suit alleged battery, in that the intubation and ventilator support were performed without decedent's consent. The trial court granted the defense motion for summary judgment on the grounds that the defendants acted in compliance with the standard of care and that there was no battery because an emergency situation occurred. The plaintiff appealed, and the appellate court affirmed, citing the above case, Anderson v. St. Francis-St. George Hospital.[7]

The cases above outline the legal complexities associated with resuscitation care. In the first case, even though the physician was trying to be empathetic, he was still held liable. The patient who *wanted* resuscitation was not provided with this therapy in a situation where it likely would have been beneficial. In this setting, it is not the position of the doctor to play the role of God. In the second and third cases, a patient was resuscitated who *did not want* resuscitation. The take-home message for physicians is that courts are unlikely to go after a physician who sincerely is trying to preserve life. When in doubt, there is less liability when the decision is made to resuscitate the patient.

Post-Mortem Procedures

The use of recently deceased patients as an opportunity for physicians to practice procedures is a topic that has drawn a great deal of controversy. Proficiency in these skills is critical because they may be life-saving if performed correctly, and disastrous if done incorrectly. Advocates for this practice stress that the models, simulators, and cadavers lack the same tissue resilience of recently deceased bodies. While some advocate the use of the newly dead as a learning opportunity, the question invariably arises as to who owns the body. Dating back to the 13th century, the "no property" rule suggests that the body has no owner and is not the property of anyone, although the person charged with disposal has a right to possession for that purpose. This would imply that procedures may be performed without permission; however, many physicians are uncomfortable with this notion. Goldblatt argues that there are "quasi-property" rights that give the family fundamental rights to the body, and use of it without their consent violates common law.

Goldblatt maintains that, "Using newly dead bodies without permission often makes physicians and trainees uncomfortable, with good reason. Their actions are concealed, hidden from the public. Actions we conceal from others are often controversial and sometimes shameful."[8] Iserson, a well-recognized advocate for post-mortem procedures, argues that, "There is neither a legal nor a moral basis for requiring relatives to consent for minimally invasive and non-invasive port-mortem procedures. The obligations that society has placed on EPs dictate that they encourage the use of the recently dead for the practice and teaching of minimally invasive and non-invasive life-saving procedures."[9]

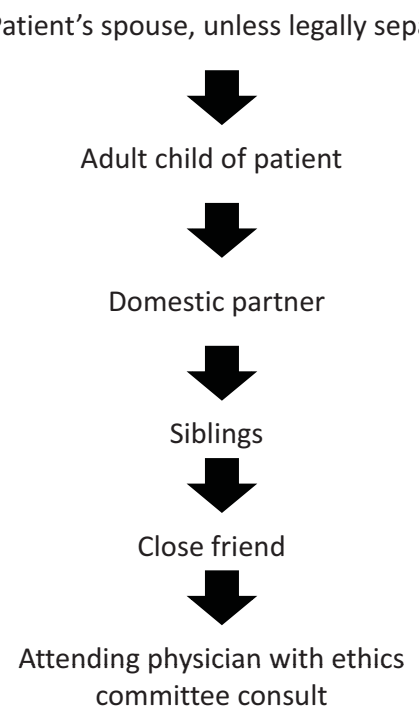
There is no reported case of court action concerning practice on the newly dead for educational reasons without consent. In order to evaluate whether consent is legally required, one must look to case law in closely similar situations. This has been reviewed in multiple instances where actions or procedures were undertaken on corpses without consent of the family, and they subsequently objected.

These challenges are usually based on property rights and constitutional law (the 14th Amendment states that property cannot be taken without due process), with damages sought for the tort of "negligent infliction of emotional distress." The following are two classic cases that represent the legal status of this issue.

In one case, a mother of an infant who died from sudden infant death syndrome brought suit for wrongful removal of the baby's corneas. State law allowed removal of corneal tissue for the purpose of transplantation in cases where a coroner

Table 1

Decision-making Hierarchy



Source: Az.Rev.Stat. § 36-3231

takes possession of a body due to unexpected death, if no objection is made by the decedent in his or her life or by the next of kin after death. The mother was not aware of the intent to remove the corneas and, thus, did not object. The state court ruled that the law was unconstitutional in that it allowed removal without due process. On appeal, the Georgia Supreme Court reversed this decision, stating there is no constitutionally protected property right in a decedent's body and, thus, the law is constitutional. A dead body itself ceases to have rights of its own. Earlier case law stated there was no family property right in a dead body, but later there evolved the concept of "quasi-property rights" when referring to the interests of relatives in cadavers of their next of kin. Quasi-property rights allow the family to possess the body and control it for the purpose of proper disposal according to their beliefs and values. The court said, "It seems reasonably obvious that such 'property' is something evolved out of thin air to meet the occasion, and that, in reality, the personal feelings of survivors are being protected under a fiction likely to deceive no one but a lawyer." In a balancing act, it was decided that society's interest in obtaining corneas and promoting health outweighs the individual's interest; thus, a law such as this is acceptable. Many would use this case to argue, legally, that a physician's need to be proficient at life-saving procedures outweighs the mandate of prior consent of next of kin.[10]

Another case came to a different conclusion. An Ohio wife claimed that her husband's corneas were wrongfully removed. After his death, a possible suicide, she was approached to consider making an anatomical gift, but declined based on her husband's prior wishes, and this was documented. The coroner then allowed the corneas to be removed. The law allowed for removal, without consent, if the coroner had no knowledge of an objection by the next of kin. Normally, the records are not reviewed by the coroner. The court acknowledged that some kind of a right (quasi-property) exists in a cadaver that has previously been called a "legal fiction." But, there is definitely a legal right for the next of kin to pos-

sess a cadaver. The right to possess is one of the key components of the legal definition of property (along with right to use, to exclude, to profit, to dispose, referred to as the ''bundle'' of rights that define property). This court then made the jump that previous ones hadn't by declaring that this wife's right rose to the level of a constitutionally protected interest in her husband's body that would not allow it (or part of it) to be taken or used by others without her permission. Other court cases have not focused on the ''property'' issue but have awarded monetary damages when cadavers have been violated, without next of kin consent, via the legal concept of ''negligent infliction of emotional distress.'' This occurs when an individual, by his or her actions, causes severe distress by conduct so extreme that he or she knew it would cause psychological injury. The courts clearly seem willing, in many instances, to punish those who would violate a newly deceased person's body without permission.[11]

In summary, the courts consider the human body "property-like." As such, families will be intimately involved in a physician's pursuit of post-mortem procedures. A recent large-scale survey of 514 people showed that most participants would consent to having procedures practiced on their newly deceased relatives, but most would also want to be asked for consent by the physician prior to the performance of the procedure. Thus, legal cases and medical research have now made it clear; to avoid liability, the physician should obtain consent from family members before proceeding with a post-mortem procedure.

The Role of Decisional Capacity

In an emergency situation, it is often difficult for physicians to determine decisional capacity. The principle of autonomy maintains that an adult with decisional capacity may choose to forgo medical care, even if that choice may result in death. In order to determine whether a patient can choose to undergo, or forgo, medical care, someone must first assess for capacity to make that choice. Historically, this decision is made after assessment by a psychiatrist. This is not a realistic option for most patients treated in the ED.

When patients have the ability to communicate, the most commonly used test for decisional capacity is the ability to understand. Similar to laws of informed consent, this test requires the ability of the patient to understand the risks, benefits, and alternatives to treatment, including no treatment. Under this test, patients are allowed to make unwise choices, so long as the required elements are fulfilled. How the patient weighs these elements, values them, and synthesizes them to reach a decision is not important. In emergent situations, there is no readily available objective test that definitively determines a patient's capacity to make decisions. An ED physician should, therefore, clearly document his or her own impression of the patient's ability, or lack of ability, in making medical decisions regarding care. A key word the courts rely on is "understanding." Therefore, a powerful note that may be put on a patient's chart is, "The patient seems to understand the issues."

Frequently, EPs are faced with patients who are unable to make or communicate health care treatment decisions. It is important to know the legal hierarchy, and establish who has the authority to act. One should also realize this same person will likely have the authority to pursue subsequent litigation. Thus, these wishes should be acknowledged.

In these circumstances, courts usually honor an Arizona statute that attempts to address these concerns.[12] The statute stipulates a health care provider will make a reasonable effort to locate and follow any existing health care directives. If no such documents can be located, the health care provider will make a reasonable effort to consult with a surrogate. In circumstances where the patient has a power of attorney, this person will act as the patient's surrogate. However, if the court appoints a guardian, with the purpose of making medical decisions, that guardian will act as the patient's surrogate. If neither of these situations applies, the health care provider will make a reasonable effort to contact the eligible individuals, who may act as the patient's surrogate. The statue outlines a hierarchy of decision making (*Table 1*). The patient's spouse is regarded as the first point of contact. This is then followed by adult children and parents of the patient. In situations where the patient has more than one adult child, the physician should attempt to get the majority consent. The guidelines allow for a close friend to make decisions. This individual must be someone who has special care and concern for the patient, and is familiar with the patient's health care views.[13]

Conclusion

EPs are frequently called on to provide care to the critically ill patient. Resuscitations are frequently chaotic, and physicians are often presented with little information about the patient

regarding goals of care and resuscitation wishes. In these situations, most courts will rule in favor of the physician erring on the side of preserving life. Post-mortem procedures can provide a unique educational training opportunity. In light of a recent survey and several court decisions, physicians should ask family members for permission prior to performing any post-mortem procedures. Determining whether a patient has medical decision-making capacity follows a process similar to the informed-consent process. Patients must be able to understand the risks, benefits, and alternatives. In situations where a patient is unable to be the medical decision maker, physicians should be familiar with the hierarchy of medical decision-making recognized by the courts. ■

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Did a Patient Threaten to Sue You? *Don't* Panic or Argue

Let them vent frustration

It is not uncommon for a patient or family member who is unhappy with the services he or she receives in the ED to make threatening statements about filing lawsuits, says **Justin S. Greenfelder,** JD, a health care attorney with Buckingham, Doolittle & Burroughs in Canton, OH.

"In many cases, this amounts to merely an empty threat and no action is taken. This could occur for many reasons," Greenfelder says. The individual may calm down after a few days after the situation sinks in, he says, or may actually consult an attorney but is told that the case has a low probability of success.

While a patient may file a complaint "pro se" and represent him- or herself without legal counsel, Greenfelder says this is a rare occurrence. Here are the steps he recommends taking if a lawsuit is threatened:

• Allow the person to vent.

Greenfelder says not to panic if a patient threatens to sue you. "Do *not* argue with the patient or family member and try to justify the result," he says. "That may make the situation worse."

The best response may be to let the patient or family member "vent," says Greenfelder, so he or she can get his or her frustrations out. "That may be difficult to listen to, but it may cause a patient or family member to be less likely to file a lawsuit," he says.

• Learn whether your state has an "I'm sorry" statute.

An apology may be a natural reaction in response to a patient or family member's expressions of dissatisfaction, says Greenfelder. Many states have enacted an "I'm sorry" statute, he adds, making such apologies inadmissible.

"However, the degree to which such statements are inadmissible varies by state," says Greenfelder. In Ohio, he notes, an ED physician or nurse's expression of "apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence ... that relate to the discomfort, pain, suffering, injury, or death of the alleged victim as a result of the unanticipated outcome of medical care are inadmissible as evidence of an admission of liability or as evidence of an admission against interest." (Ohio Rev. Code 2317.43.)

Thus, in Ohio, Greenfelder explains, you may say something along the lines of "I'm sorry for your loss" or "I'm sorry this happened to you," and that statement cannot be used against you in court.

"But a statement *would* be admissible if the physician admits to culpability," says Greenfelder, with statements such as "I'm sorry I did the wrong

test," or "I'm sorry I missed that artifact on the X-ray."

"The scope of protection in other states may be broader," he says. "It may be wise to check whether your state has an 'I'm sorry' statute, and to the extent your statements are protected."

• **Alert the appropriate individuals.**

When a threat of a lawsuit is received, Greenfelder says the emergency physician should contact hospital risk management, and if he or she is a member of a group, the president of the group should be alerted. An ED nurse should contact his or her nursing supervisor, he advises.

"It is not necessary to contact an insurance carrier or private attorney at that time," says Greenfelder. "If a complaint is actually filed, *then* the physician or nurse should take the next step of informing their carrier."

Don't Distance Yourself

If a patient is yelling about the horrible care he or she received in your ED, your first reaction is probably to distance yourself. "That's a mistake," says **Linda M. Stimmel**, JD, a partner at Wilson Elser Moskowitz Edelman & Dicker LLP in Dallas, TX.

Instead, says Stimmel, try to understand *why* the patient is unhappy, and bring your risk manager into the situation. "Many times, such patients or their families will start taking notes and pictures," she adds.

The hospital may have a policy against taking photographs in the department due to patient privacy regulations, notes Stimmel. "However, don't become paranoid and tell the patient they cannot take notes," she says. "Give the impression that you want to learn why they are unhappy but that you are not 'afraid,' since you know good care was provided."

Many times, says Stimmel, an angry patient or family member will demand the hospital write off their medical bills. "If you receive such a call, *listen*, foremost. Don't become defensive and say that you did nothing wrong," she says. "Tell them you will research it and get back to them."

*Alway*s make sure you do get back to the patient and/or family, says Stimmel. "Depending on the situation, you may want to offer some write-off if there are concerns, or, if the care was appropriate, tell them so," says Stimmel.

Stimmel says to always document conversations with the patient or family members. "It is very helpful in a trial, possibly four years later, to show the plaintiffs were demanding money immediately," she adds.

If a patient or family threatens litigation prior to care, during care, or after care is provided, says Stimmel, document exactly what they said in the chart.

"Do *not* give your opinions or document subjectively," says Stimmel. "It is not helpful to a legal defense months later if your chart entry says, 'Patient seems unhappy and they might sue.' Chart the facts and put the patient's exact words in quotes."

What you should *not* document in the patient's chart is internal hospital or committee investigations, says Stimmel, as these may be covered by attorney/client or peer-review privilege.

"If you put that information in a patient's chart, you may waive the confidentiality and privilege," warns Stimmel. "Chart the facts of what was said by the patient and/or family. This will be very helpful to know if the care results in a lawsuit." ■

Sources

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Nurses' Charting May Deter Patient from Filing Lawsuit

Simply hearing the words, "I am going to sue you ... can send shock waves up your spine," says **Michelle Myers Glower**, RN, MSN, LNC a health care consultant based in Grand Rapids, MI.

"Precise nursing documentation can either dissuade a plaintiff *or* provide the leverage that is required to initiate one," says Glower. "Nursing

documentation is often the starting point in many malpractice cases," she says.

Jurors and attorneys view what is written in the patient's record as the best evidence of what really occurred, explains Glower. "It is extremely important that nursing documentation is timely, accurate, and complete," she says. Glower gives these recommendations to reduce risks, in the event a patient threatens to file a lawsuit:

• Make sure that a hospital occurrence form is filled out.

"This form serves as a resource for you later, to refer back to when being deposed," says Glower. "It is *not* part of the medical record."

• Document the worries or concerns expressed by the patient or family.

"Then, document the nurse's actions to calm their fears," says Glower. "Medical mishaps should be documented concisely." The incidents should not be overstated or misrepresented, says Glower, but also should not be concealed or understated.

Glower says that legal threats and complaints about the quality of care may be briefly documented in the patient's record in a non-judgmental, neutral manner. "Do not use terms such as 'vicious,' 'nasty,' or 'malicious,' in the medical record," she says. "Never record personal opinions, judgments, or conclusions about what happened."

A detailed report of the threat or complaint should be documented, precisely as stated in the incident report, says Glower. "Statements that may have legal significance, but which have no direct bearing on the care of the patient, should *not* be written in the record," advises Glower.

Risk-prevention activity, such as completion of an incident report, risk management, should not be within the record, she adds. This may inadvertently disclose information that should have been privileged, but because of disclosure, could be used by the defendant in a lawsuit, explains Glower.

"Do not make accusatory remarks against any provider in front of or near families, other providers, or visitors," says Glower. "Remember your elevator etiquette, as well."

• Inform hospital risk management.

Glower says to do this "the first chance you get. Their expertise is invaluable." Rather than getting angry or defensive if a patient threatens to sue, Glower says to remember the acronym LEAD (L = Listen; E = Empathize; A = Act; D = Document.)

"Not all complaints are valid, and not all problems can be fixed," says Glower. "But giving the upset patient an empathetic ear can make a world of a difference, even to the most distressed patient."

Before you say anything , however, Glower advises working in tandem with your risk manager. "You need to monitor what rolls off your tongue carefully in these situations," she says. "It should be well discussed, *prior* to meeting with the family."

The nursing leader will need to review the chart and consult with the risk manager before contacting the patient, says Glower, so everyone is on the same page. "The sooner you get the appropriate people to have a conversation, either on the phone or in person, the better," she says. "Have your ducks in a row and the chart in front of you." ■

Source

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Risk Increasing for Lawsuits Involving Delayed ED Diagnoses

Specify reasons for delays

Errors related to missed or delayed diagnoses are a frequent cause of patient injury and, as such, are an underlying cause of patient-safety-related events, according to new research from the Harrisburg-based Pennsylvania Patient Safety Authority,[1] which reviewed 100 events related to diagnostic errors between June 2004 and November 2009, 23 of which originated in the ED.

According to **Cynthia Lacker**, RN, MS, LNCC, CPHRM, the study's author and a patient safety analyst at Plymouth Meeting, PA-based Pennsylvania Patient Safety Authority, medication errors probably receive a disproportionate amount of media attention because they are relatively easy

to detect, and can sometimes result in catastrophic patient harm.

"However, if you look at medical malpractice claims data, you will see that a high percentage of claims are related to diagnostic error," says Lacker. "This is reflective of the fact that diagnostic error often results in catastrophic injury, too."

Detection is the biggest problem with diagnostic errors, says Lacker, and there isn't always agreement on when a diagnostic error has occurred. "Diagnostic errors also encompass a broad array of cognitive and systems factors, including education, training, setting-of-care, and disease-specific issues," she adds.

Commonly missed diagnoses in the ED include fractures, infections, myocardial infarction, cancer, and cerebral vascular disease, says Lacker. "System issues that are problematic include ordering, receiving, and interpreting tests, thorough history and physical, and appropriate consultations," she says.

Risks Rising for Acute Diseases

There are "huge numbers" of cases in recent years involving claims of delays in diagnosis that the plaintiff's lawyer alleges would have made a difference in the patient's outcome, according to **Matthew Rice**, MD, JD, FACEP, former senior vice president and chief medical officer at Northwest Emergency Physicians of TEAMHealth in Federal Way, WA.

"A classic one in the ED is a patient comes in with a cough, a chest X-ray is taken, and a nodule or abnormality is missed," says Rice. "Six months later, it's diagnosed as a tumor."

At the time of the ED visit, says Rice, the nodule may not have been picked up by the radiologist, or *was* picked up by the radiologist but without good feedback to the patient by the emergency physician (EP). Either way, he says, the end result is a delay in diagnosis.

Another scenario could involve a delay in diagnosis of an infectious disease process, says Rice, which allows the patient to become more ill or other people to become infected.

Delay in diagnosis is an issue that's pertinent only if it makes a *difference*, relative to that diagnosis, notes Rice. If a patient has a certain symptom and it is diagnosed incorrectly, and there is a difference in outcome when it is later diagnosed, then it becomes more of a risk for the EP, he says.

Rice says that he *doesn't* think risks of delayed diagnosis are increasing with chronic diseases. "They may actually be improving, due to risk-management procedures," he says. If an ED physician misses a radiographic or laboratory abnormality, a good-quality assurance process should assist in picking up the abnormality, he explains.

Rice says he does see increased legal risks for EPs involving acute diseases, however, "where time is of the essence. The cardiovascular diseases are the chief ones, whether strokes, aneurysms, or heart attacks."

The longer you wait before you treat the problem, says Rice, the more impairment the person has after he or she recovers. "A delay in diagnosing a stroke means more dead brain tissue and more disability," says Rice. "Time issues become imperative for the EP."

Chart Reason for Delays

Was a heart-attack patient not given thrombolytics at your facility because he or she was 20 minutes from a facility with a cardiac catheterization lab? Rice says in a case like this, it's important to document the reasons for delays that occur between the time of diagnosis and the time treatment is actually implemented.

"This is critical," he says. "There may be an appropriate antibiotic available, but the patient is allergic to it, and there is a delay in getting a different antibiotic." Document this clearly, he says, so it doesn't later appear as though there was an inexplicable delay in treatment.

If you are unable to obtain a CT scan because of a patient's weight, says Rice, document the reason why. "If a patient weighs 400 pounds, you may have to transfer them to another facility," he says. In this case, Rice recommends charting, "In evaluating the patient and trying to make a diagnosis, I am not able to obtain a CT scan, which is important, so I have to transfer the patient elsewhere to get the CT scan." Also, include any mitigating factors, says Rice, such as treatment that occurred while the patient was waiting for the CT scan.

If an ED patient sues for delayed diagnosis, Rice says the claim is likely to be multifaceted. "One claim would be a failure to evaluate, diagnose, and treat," he says. "If the person is waiting, they probably didn't get evaluated at all, so there are potential [Emergency and Medical Treatment and Labor Act] issues there."

Rice points to a nationally publicized case of a septic child who came to an ED and died while waiting to be seen. "Those kind of cases have

always existed, but I think they have increased in frequency over the past ten years," says Rice. Crowding is the main reason for this, he adds.

"As long as you have hospitals with particularly crowded EDs, you will see a continuation in litigation because of the failure to assess, diagnose, and treat patients," says Rice. To reduce these risks in crowded EDs, Rice recommends restructuring triage and adding extra personnel.

If the ED is particularly crowded on a given day, Rice says it's best to keep this information out of the patient's chart. "Documenting that may make ED staff feel better," he says. "But if you look at it purely legally, I think that can be used as much against you as much as it may help you."

Unless a serious mass-casualty situation occurs, says Rice, a jury will expect an EP to respond to unexpected surges in volume by adding more personnel or other resources.

"You want to try to defend yourself, and not the process," says Rice. "It's not good to say, 'I was too busy trying to take care of trauma patients to take care of a sick child.'"

If you try to pin the blame on the hospital's failure to supply appropriate resources, Rice says that the hospital could then turn around and accuse the ED physician group of not putting enough doctors in the ED. "My advice is not to cite specific circumstances, unless they are really unusual," says Rice. "Otherwise, it looks like you are trying to rationalize what turns out to be a bad outcome." ■

REFERENCE

1. Lacker C. Diagnostic error in acute care. *Pa Patient Saf Advis* 2010;7(3):76-86.

Sources

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"Spike" in Suits for These Missed, Delayed Diagnoses

Don't give plaintiffs' attorneys an "in"

To have a successful lawsuit in cases of missed or delayed diagnosis, a plaintiff needs at least two things, according to **Michael Blaivas**, MD, professor of emergency medicine in the Department of Emergency Medicine at Northside Hospital Forsyth in Cumming, GA.

"The patient must feel they have cause to claim injury, and an attorney has to be interested in taking a case," says Blaivas. "There are two types of cases that I am mostly seeing."

There are "small, nuisance cases," says Blaivas, where the patient suffered little injury, such as delayed diagnosis of a small foreign body that required some antibiotics, possibly minor surgery, and resulted in no long-term deficits. "The insurance company may pay out a bit with no fight," says Blaivas.

The other type of case that Blaivas sees increasing involves a significant bad outcome with severe injury or death. "Most of these are due to incorrect reading of high-end imaging, or not using the high-end imaging," says Blaivas. "Testicular torsion is quite a common suit, and I see lots of them."

While there are more claims that an ultrasound should have been done and was not done, adds Blaivas, the number of claims where the ultrasound was done or read improperly does not seem to be changing.

Diagnostic Tests Are Issue

The other trend for increasing litigation is any devastating event not diagnosed during a visit that might have been caught on an imaging study, says Blaivas, whether it was indicated or not. "One area with a big spike in litigation has been CVA (cerebrovascular accident) detection, especially for those cases of subtle or confusing presentation," he says. "Strokes later found on CT or MRI (magnetic resonance imaging) are being picked up as cases by lawyers."

All lawsuits include something an expert can point to as an apparent egregious error, says Blaivas, typically omitting a CT of the chest or abdomen, or occasionally omitting MRI in spinal injury cases.

"The jury pools know about these tests, and

feel they can be performed endlessly and with little recourse," says Blaivas. "Thus, when an expert says he or she would have ordered a CT of the abdomen for sure, and the appendicitis would have been found for sure, the jury may buy it." The same is true for thoracic dissection and pulmonary embolism (PE), he adds.

"Obviously, for big awards, there has to be some significant damage," says Blaivas. "Death may seem like the best from the plaintiff's perspective, as far as impressing the jury, but, in reality, long-term disability of a young patient may bring in the largest amounts."

Anything to do with pediatric patients will typically be looked at more closely for litigation potential, says Blaivas. "I have repeatedly seen cases where everything was done correctly and the child expired and suits are successful," he says. "Many insurers and physicians are so scared about juries blaming someone for the child's death that they settle."

Blaivas says that "the very things we try to teach the public will be coming back to haunt us. CVA not diagnosed right away, and [myocardial infarctions] not caught right away and taken to the cath lab, will be in the cross-hairs more than ever."

There is greater awareness by the lay public about high-end testing such as CT and MRI, says Blaivas, with many presenting with minor complaints and requesting CTs. "They often mention having heard of someone who did not get one and something was missed," he says. "This means people are looking for the test, and potentially for the mistakes."

One of the first questions Blaivas is often asked by attorneys is, "Would a CT have caught this?" Pulmonary embolism and thoracic dissection are becoming more and more frequent as cases, he adds.

"Plaintiff's attorneys are exploring a possible 'in' for failure to meet the standard of care," says Blaivas. "Sometimes, the only thing stopping them is that the outcome may not have been altered in many people who had a massive PE or dissection and expired in the ED." ■

Source

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Answers: 17. D; 18. B; 19. B

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

17. Which is recommended in the event an emergency physician receives a threat of a lawsuit, according to Justin S. Greenfelder, JD, a health care attorney with Buckingham, Doolittle & Burroughs?
    A. Emergency physicians should not alert hospital risk management if the threat of a lawsuit is received, and should only do so if a complaint is actually filed.
    B. Emergency physicians should contact an insurance carrier or private attorney whenever the threat of a lawsuit is received, even if a complaint has not been filed.
    C. Emergency physicians should avoid alerting hospital risk management directly if a patient threatens to sue.
    D. When a threat of a lawsuit is received, emergency physicians should contact hospital risk management, and should contact an insurance carrier or private attorney only if a complaint is actually filed.

18. What should *not* be documented in the patient's chart, in the event an ED patient threatens to sue, according to Linda M. Stimmel, JD, a partner at Wilson Elser Moskowitz Edelman & Dicker LLP?
    A. The patient's exact words in quotations.
    B. Internal hospital or committee investigations.
    C. Conversations with patients and family members.
    D. The fact that the patient or family was demanding money immediately.

19. Which documentation practice is recommended to reduce legal risks of delayed diagnosis involving ED care, according to Matthew Rice, MD, JD, FACEP, former senior vice president and chief medical officer at Northwest Emergency Physicians of TEAMHealth?
    A. It is inadvisable to document the reasons for delays that occur between the time of diagnosis and the time treatment is actually implemented.
    B. Emergency physicians should always document the reasons for delays that occur between the time of diagnosis and the time treatment is actually implemented.
    C. Emergency physicians should avoid documenting the reasons why a time-sensitive treatment *isn't* given.
    D. If the ED is particularly crowded, this should be documented in detail, as it can significantly reduce legal risks in the event of a bad outcome.

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CNE/CME Evaluation — Vol. 22, Nos. 1-6

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. 22, Nos. 1-6, and circle the correct responses.

January 2011 Prescription Liability		February 2011 Following Hospital Policy		March 2011 Online Postings		April 2011 Managing Acetaminophen		May 2011 EMTALA Case		June 2011 Risk Management	
1.	A B C D	5.	A B C D	8.	A B C D	11.	A B C D	14.	A B C D	17.	A B C D
2.	A B C D	6.	A B C D	9.	A B C D	12.	A B C D	15.	A B C D	18.	A B C D
3.	A B C D	7.	A B C D	10.	A B C D	13.	A B C D	16.	A B C D	19.	A B C D