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Does HIV Testing in EDs Carry More Legal Risks Than Other Tests?

A patient treated and discharged for pneumonia several times at an ED is later diagnosed with acquired immunodeficiency syndrome (AIDS). Could the ED be successfully sued for failing to test for human immunodeficiency virus?

"Someone could make the legal argument, 'Why didn't they test this person for HIV before the disease progressed to AIDS?'" says **Michael Waxman**, MD, an ED physician at Albany (NY) Medical Center, a proponent of HIV testing in the ED.

With HIV testing in the ED, "there is the very real possibility that a patient who is not tested, or does not receive accurate results, could seek legal reparations for damages associated with delayed diagnosis or frank malpractice," according to **Jason Leider**, MD, PhD, associate professor of clinical medicine at Jacobi Medical Center in Bronx, NY.

Lack of Understanding

"Regardless of how EDs do HIV testing, there will probably be people tested without having a full understanding of what's going on," says Waxman. "That probably has some legal implications, but in my opinion, not that much."

The same is true of any other medical test, explains Waxman, and in those rare circumstances when someone is tested who doesn't wish to be, the chances of that individual testing positive is somewhere around 1 in 1000.

"If the individual tests negative, there is no harm. If the individual tests positive, the vast majority of people would find help in that, not harm," says Waxman. "In the ED, we do this all the time for things that I think carry a lot more risk. We test for pregnancy and diabetes all the time and don't get permission for it."

Jeffrey L. Greenwald, MD, SFHM, co-investigator for the inpatient clinician educator service at Massachusetts General Hospital and associate professor of medicine at Harvard Medical School, both in Boston, MA, was lead author of a study that found that routine testing of inpatients led to twice as many patients being diagnosed as HIV-positive than would have occurred had routine testing not been offered.[1]

However, in the ED, says Greenwald, "there have to be mechanisms in

place that need to be particularly well attended to." Here are potential legal risks of this practice in the ED:

• The potential for lack of confidentiality.

"It's very difficult to give results quietly and confidentially in a loud setting without people in the next bay hearing the results. That could potentially put EDs at risk," says Greenwald. "Having said this, there are a number of examples of programs successfully doing HIV testing in EDs."

An EP who communicates the results of an HIV test to a patient does not risk exposing himself to liability simply because he or she was overheard by a patient in the next bay, according to **Justin S. Greenfelder,** JD, a health care attorney with Buckingham, Doolittle & Burroughs in Canton, OH.

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"Obviously, physicians want to be discrete about the communication of the results of any test," says Greenfelder. However, he says, if the physician did not actively communicate the test result to another person in breach of his duty of confidentiality, it is highly unlikely that he or she could be subject to liability.

• The potential for false-negative results.

If a patient had an exposure very recently and requests an HIV test, "the period of seroconversion is short, but not that short," Greenwald says. "It's not a morning-after phenomena."

ED staff need to be well-versed in current recommendations about advising patients of the need for retesting if they suspect the exposure was recent, adds Greenwald.

Since a discussion of the window period is part of the pre-test counseling required in New York state, notes Leider, *not* discussing this issue leaves the practitioner outside the standard of care.

Providers can give more attention to explaining the meaning of HIV test results in the primary care setting, Greenwald adds, whereas in the ED, the patient is presumably there for an emergency medical condition. "There is less attention that can be given to the HIV testing. There is also a sore throat or a heart attack that is demanding their attention," he says. "It can be done. It just takes planning, resources, and training — the way all high-stakes testing should be performed."

To reduce risks, be sure that whoever performs the test explains in very low health literacy language what the test results mean, advises Greenwald, and utilize translators for patients without extremely good English proficiency.

"As long as an ED physician communicates to the patient the possibility of a false-negative result and the need to return for later testing, the potential for liability is greatly decreased," says Greenfelder.

• The possibility of a false-positive.

If enough patients are tested, says Greenwald, a false-positive is eventually going to occur. "That is the nature of a not perfectly specific test," says Greenwald. "Most places aren't confirming rapid tests with other rapid tests. Serial rapid tests, as done in some overseas sites, might be one effective way to obviate the need for a [Western blot], which takes a long time to come back."

• Allegations of profiling.

The issue is how the ED selects who is tested. "Are you doing screenings or doing targeted test-

ing? If HIV testing is not truly routine, I suppose you could run into the problem of profiling," says Greenwald.

Waxman says that reimbursement has potential legal implications for EDs. If the HIV test is offered as a routine screening to all patients, but self-pay patients are unable or unwilling to pay for it, he explains, the test may end up being done mostly for insured patients.

"No one quite knows know to handle this," he says. "Let's say a patient has no insurance. You cannot offer free HIV tests to some patients and not others, because Medicaid mandates you charge everyone regardless of whether they have insurance."

You can tell the patient they are responsible for the cost of the HIV test, says Waxman, but this would likely discourage most patients from being tested. "Ethically, it doesn't make sense to discriminate against the patients who need it the most, but then again, you need to charge people for services," says Waxman.

If a hospital has a policy of routine screening for HIV, and a low-income patient refuses the test because of its cost, the likelihood of a successful lawsuit for discrimination is not particularly high, says Greenfelder. However, if a low-income patient demands an HIV test and it is not provided because of the patient's economic status, there is greater potential for a meritorious lawsuit, he adds.

"From a legal perspective, taking economics out of the equation, the best policy for an ED is, assuming a patient wants an HIV test, to administer that test without consideration of whether the patient is capable of payment," says Greenfelder.

Indigent patients should be informed about free testing sites if free testing is not available at the medical center, advises Leider, and this should be documented in the medical record.

While some EDs offer HIV tests only if the patient requests it, or if a patient comes in with signs and symptoms suggesting HIV infection, some EDs offer it to all patients. "About a quarter of HIV-infected people don't know they are infected, and are unknowingly causing a great deal of the new cases," says Waxman. "Finding people earlier would prevent new transmissions."

A significant number of people detected with new HIV infections had been to an ED in the recent past, adds Waxman. "So it's probably true that if we did universal screening in EDs, we could have picked up these cases earlier," he says. ■

Sources

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Uptick in Lawsuits Involving Mid-level Providers in EDs

It will be EP "on the line"

As the number of mid-level providers (MLPs) staffing EDs increases, the number of lawsuits involving them is also increasing, reports **Jennifer L'Hommedieu Stankus**, MD, JD, a medical-legal consultant, former medical malpractice defense attorney, and a senior emergency medicine resident at the University of New Mexico Health Sciences Center in Albuquerque.

"One area of increasing liability for emergency physicians is being brought into a case that involved an MLP during the patient contact," says Stankus. "This is something that deserves much more scrutiny and thought on the part of EPs."

In 1997, 28.3% of EDs employed MLPs, with 5.5% of patients seen primarily by an MLP, and by 2006, 77.2% of EDs employed MLPs, with 12.7% of patients seen by the MLP.[1]

Each state has its own requirements for super-

vision of MLPs, as do individual hospitals, notes Stankus. In general, she says, the MLPs are practicing under the supervision of a physician, and the scope of their practice is limited to their abilities, training, and experience, and to the scope of practice of the supervising physician.

Only a certain percentage of charts must be signed by a physician, usually within a week, for the purposes of quality assurance under Medicare rules, says Stankus. However, most EDs have the doctor sign the charts before the patient leaves or at the end of the shift for billing purposes, she adds.

"If you sign a chart and don't know the patient and don't address problems, you will be crucified in court," says Stankus. "That is one thing you can take to the bank."

If the EP signs a chart of a patient who was seen by an MLP, says Stankus, "you better scrutinize it carefully. As the senior provider, it will be you on the line for mistakes that are made."

Even experienced EPs make a certain number of errors, notes Stankus, "and for less educated MLPs who are probably not trained to think of 'worst first,' as EPs are, that number may be frighteningly higher."

It behooves the EP to know what is going on with any patient whose chart he or she signs, says Stankus. "The EP should see that patient before they leave the department and write a brief note of their own," she says. To reduce risks, Stankus suggests these practices:

• Be sure that any abnormalities in vital signs or labs in the chart are addressed.

• Consider whether the diagnosis fits, or if anything has to be ruled out.

"Bear in mind the framing effect that can occur when someone 'tells' you what a diagnosis is," says Stankus. "It is best to pop your head into the room, get a quick history to make sure it is the same as on the chart, and eyeball the patient."

• Consider whether the studies make sense and whether they accomplish their goal.

For example, you may see that a CT scan is negative in looking for a transient ischemic attack or ischemic stroke. "Does that rule it out? Absolutely not," says Stankus. "Make sure that appropriate follow-up studies are obtained."

• Make sure that the patient really does have follow-up.

"Telling a patient who doesn't have a doctor to follow-up with their primary care provider in a week doesn't quite cut it," says Stankus. ■

REFERENCE

1. Menchine MD, Wiechmann W, Rudkin S. Trends in mid-level provider utilization in emergency departments from 1997 to 2006. *Acad Emerg Med* 2009;16(10):963-969.

Source

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What Makes Successful Suit Against ED Mid-level?

There's a "common theme"

The number of lawsuits involving mid-level providers (MLPs) in the ED "seems to have skyrocketed in the last few years," according to **Michael Blaivas**, MD, FACEP, FAIUM, professor of emergency medicine at Northside Hospital Forsyth in Cumming, GA. "There are multiple scenarios that result in successful suits, and there is a common theme among them."

The common theme is lack of, or inadequate, supervision of the MLP, says Blaivas, and asking the MLP to do more than he or she is trained for.

Blaivas says that one of the most frequent problems is with failure of the MLP to recognize a critically ill patient, such as a patient presenting with signs of sepsis and vague complaints.

In this scenario, says Blaivas, going down the incorrect pathway results in missing the presence of septic shock and discharge or possibly admission to a floor where the patient deteriorates further and then expires.

"Many cases I have seen were very ill patients who were sent home," says Blaivas. "In almost every instance, the supervising physician never saw the patient. He or she just had a verbal presentation on them by the mid-level, and occasionally not even that."

Critical wounds and limb- or organ-threatening injuries or pathologies are also frequently missed, adds Blaivas. "Rare and atypical presentations that would be caught by an emergency physician if he or she saw the patient personally instead of relying on the mid-level evaluation and presentation are a

frequent cause of misses, poor outcome and then litigation," he says.

Avoid High-risk Practices

"Not seeing the patients is obviously high risk," says Blaivas. There is a tendency for some MLPs to minimize a patient's symptoms, he adds, possibly because the provider wants to feel like he or she can completely care for the patient.

In some charts reviewed by Blaivas, the MLP gave a misleading impression of the patient's condition, adds Blaivas. "This may be personality-specific, and such mid-levels put groups at risk," he warns. "Mid-levels that do not present patients right away may need to be remediated."

A bigger problem, though, may be EPs who refuse to see the patients seen by an MLP in person, says Blaivas, as with a fast track staffed by MLPs. "These are often slightly separate from the ED, and may be staffed by mid-levels only," he says. "The concept is that anything seen there is minor, and if anything more serious comes in, it will be sent to the main ED."

However, such patients are generally not seen by the supervising physician and cases aren't reviewed with the MLP, says Blaivas, and the charts may not be signed off on until days later, or at best, at the end of the day when the patient has already left.

"In general, such physicians are sued just like their mid-levels and look bad in front of a jury for not having seen a patient," says Blaivas. "Remember, most people still expect to be treated by a physician."

Don't Assume You're Protected

In some cases, EPs who were named in a lawsuit and never saw the patient treated by the MLP have successfully received summary judgments, says Blaivas. "I have seen one such case, but this is no protection. Physicians should not strive to hide behind 'I never saw the patient, I have nothing to do with this,'" he says.

In fact, says Blaivas, EPs are legally responsible for bad outcomes involving care of an MLP, when the MLP is working under the supervising physician. "This is often fought and not understood by the physician being sued," says Blaivas.

Many EPs don't realize that in most states they are responsible if the MLP is working under them, says Blaivas, or in an area they are technically supervising during that period of time. "The nuances of this change from state to state, depending on established case law and rulings," says Blaivas. "It is worth finding out more about that where you work."

Here are Blaivas' recommendations to reduce risks:

• EPs should avoid putting up barriers to MLPs asking questions and seeking consultation.

"This is very common, and results in mid-levels flying on their own and reluctant to communicate with the EP," says Blaivas. "Since it is all a numbers game and the mid-levels may be seeing less ill patients and, thus, are less likely to get sued, it is just a matter of time."

• Ideally, EPs should see every patient seen by an MLP.

Blaivas acknowledges that this isn't always possible, adding that many EPs outright refuse to do this. "However, if the mid-level is working in your care team, or you are the only EP in the department at that time, you better know about every patient," says Blaivas. "The care patients receive will be better if you see each one yourself. The reality of what goes on will continue to be a struggle, and not an easy one."

Blaivas says that seeing all patients above a certain triage level and all patients being admitted is a good start. "You are still relying on the triage nurse to catch all moderately sick patients and above, and this is clearly not possible," he says. "However, at least this way you would catch the majority."

• All patient encounters should be documented by the EP.

If the MLP sees a patient, the EP needs to make a note, adds Blaivas, and you never know what the MLP will write, dictate, or remember at deposition and trial.

Also, some juries do not like to see a physician who did not bother to write anything, says Blaivas. If the case is about carelessness, you may look more careless by not keeping a medical record of the encounter and decision making, he says.

"The real problem with convincing EPs to do this is for the standard strep pharyngitis," says Blaivas. "No one worries about documenting on one until they get served for a missed retropharyngeal abscess that leads to tragedy."

• It is critical to have the MLP present every patient in your care team or area of responsibility.

This way, subtle problems can be picked up on, says Blaivas. "The mid-level can get used to running everything past the EP, without worry of sharp rebukes for bothering the physician in the middle of an interesting YouTube video," he says.

In six of the last seven cases Blaivas has seen involving MLPs, the EP never saw the patient. "In the seventh, their involvement was two hours into a tragic case, and too little, too late," he says. "There is no easy answer, other than doing our job and properly supervising those working under us." ■

Source

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Be Direct, But Diplomatic, If Assessment Differs From EP's

Don't include opinions in chart

If nursing assessment conflicts with an emergency physician's (EP), the ED nurse should speak privately with the EP about this, advises **Mariann Cosby,** MPA, MSN, RN, LNCC, principal of MFC Consulting in Sacramento, CA. Document subjective and objective patient data, what was communicated to the EP and other providers, their response, and then the nurses' actions, she recommends.

"There can be many dynamics underlying the causes and reasons for disagreements," she says. "Diplomatic communication with the EP is often the best place to start."

Often, says Cosby, disagreements arise over discharge orders. The EP may want to discharge a patient who was treated for acid indigestion, with a workup consisting of an EKG, chest X-ray, labs, and some antacid. While attempting to discharge the patient, however, the ED nurse may learn that the patient has increased pain, appears more anxious, and has an elevated respiratory rate.

In this case, says Cosby, the ED nurse should document these findings, recheck the vital signs, and report them to the EP. "Tell the EP of your concerns, and why you are concerned," she advises.

Cosby says that if the EP dismisses the findings and says, "Oh, he comes in all the time with that problem. He has had his medication. Just send him on his way," and the ED nurse is concerned that the patient might be having a cardiac or other event that may warrant further intervention, the nurse should reiterate his or her concerns to the EP.

"The ED nurse should also suggest the EP take one more look at the patient," says Cosby. "This should all be documented as it occurs, in very straightforward language."

Go Up Chain of Command

If the EP insists the patient be discharged, Cosby says the ED nurse should consider going up the chain of command, which would include involving the charge nurse, nurse manager, or other nursing administrative personnel as needed.

"Depending on the circumstances, the nurse's concern may get fleshed out, and the issue resolved," says Cosby. In this situation, Cosby says the ED nurse should be certain to document the conversations that transpired with the providers and nursing supervisory staff, and any interventions that occurred to reevaluate the patient.

"Communicate and document the discharge instructions to the patient," says Cosby. "These should include the reasons indicating a need to return to the ED, and the patient or family's understanding of the discharge instructions."

In rare instances when the ED nurse has communicated his or her concerns with the EP, has started up the chain of command, and still feels uncomfortable with the decision made by the providers to discharge the patient, he or she has a decision to make, says Cosby.

The ED nurse can either follow the EP's orders, says Cosby, or redirect the discharge to his or her superiors. "The ED nurse should never lose sight of his or her duty to advocate for the patient," she says. "Continue to elevate the situation or issue of concern to the next level in the chain of command to ensure safe patient care."

Don't Discuss in Chart

If **Ann Robinson**, MSN, RN, CEN, LNC, principal of Robinson Consulting, a Cambridge, MD-based legal nurse consulting company, thinks

that a really bad judgment call was made on the part of an EP, she doesn't document this in the patient's chart. Instead, Robinson speaks to the physician directly, or goes up the chain of command to report it.

"The chart is *not* the place for that forum of discussion," says Robinson. "The chart is a reflection of the visit, the evaluation, and what was done. A sit-down with the risk manager would be the time to discuss a difference of opinion between providers."

Robinson says that if there are discrepancies between the nursing and physician documentation, "an astute observer will pick up on that and utilize it to peck away at the credibility of whoever is being deposed."

In one case Robinson reviewed, an ED nurse documented the time she informed a physician of something and when it was acted on. "There was a lag time there. The physician countered that he was certain that the lag time didn't take place, but based on the chart, it sure looked like that was what did take place," says Robinson. "It had a negative impact on the credibility of the testimony of the physician at the time." ■

Sources

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ED Nurses Face Increased Risk of Malpractice Suits

Have you ever made an honest mistake that a family member caught before you did, or given the wrong dose of a medication? "These scenarios, unfortunately, can make the news, and they make us look careless," says **Michelle Myers Glower**, RN, MSN, LNC, a health care consultant based in Grand Rapids, MI. "But how we handle them can make or break us."

As ED nurses assume an ever-widening list of patient-care responsibilities, many are concerned about possibly facing a lawsuit one day, according to Glower.

Fortunately, says Glower, only a small percentage of the mistakes made by emergency nurses actually produce injury to patients. "Of this small number of injured patients, even smaller percentages go on to seek compensation for damages through legal action," says Glower. "Nevertheless, the numbers of lawsuits filed against nurses continue to increase."

These four conditions must be present for nurses to be considered guilty of malpractice, says Glower. The plaintiff must prove that:

- The nurse owes the patient a duty;
- The nurse has breached that duty or standard of care;
- Harm or damage has resulted and can be linked to the duty owed;
- The breached duty is the proximate cause of the harm or damage.

Since situations involving a dissatisfied patient and/or family member are common in today's health care environment, adds Glower, "this is all the more reason to practice safe medicine. Patients complain when there is a mismatch between expectations and reality."

For this reason, says Glower, it is important to be honest and transparent with your patients. "Tell your patients, 'If you are happy with us, please tell the world! If you are not happy with us, please tell us, so we can fix the problem,'" she says. "Knowing how to address patient relations issues is key." Glower gives these recommendations for emergency nurses to reduce legal risks:

• Review your "chain of command" policy.

"Know this inside and out. This will jump start you on how issues are processed," says Glower. "This will at least give direction as to the process in your institution on how critical information is communicated, regardless of the topic, to the right people."

• Chart factual information.

When an emergency physician was unable to remove a chicken bone stuck in the throat of a 60-year-old woman, he contacted the on-call

ear, nose, and throat physician, who also wasn't able to remove it, then called the on-call gastrointestinal physician. "He refused to come in, stated he was watching the basketball playoffs, and instructed the ED to transfer the patient," says Glower.

"The daughter became hysterical, pointed at the physicians and nurses, and yelled, 'If my mother dies, I will sue you!'" says Glower. "The patient was transferred to a Level I Trauma Center and died en-route. The family did sue." In a situation like this one, says Glower, emergency nurses should chart factual information, including the times calls were made, the time the call was returned, and the time a specialist arrived in the ED.

• Stay on your patient's good side.

"Trial attorneys have a saying: 'If you don't want to be sued, don't be rude.' Always remain calm when a patient or his family gets upset," says Glower. Glower says guaranteeing unrealistic outcomes, a condescending attitude, lack of openness, failing to inform patients, and lack of empathy are all characteristics of what she calls "the litigious clinician profile."

"Litigious-prone profiles are not just limited to nursing," says Glower. "They include all health care providers — physicians, physician's assistants, emergency medical technicians, and nurse practitioners."

• Enlist help from risk management when appropriate.

Patients need to know the truth about mistakes, says Glower, but this information should be communicated with discretion. "It is not our place in the ED to give out every detail of a bad outcome," she says. "We have experienced professionals that know how to manage these very types of situations." ■

Source

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Clinical Conflicts: Should You Go Up Chain of Command?

Imagine finding a note in your ED patient's chart from a consultant, which recommends care that you believe is totally inappropriate. Should you quietly seethe, or report it to a higher-up?

The answer may depend on whether the emergency physician (EP) truly believes his or her patient's welfare is at significant risk. If this is the case, it may be important enough to escalate the issue to other members of the team, such as your medical director, chief nursing officer, or chief of staff, according to **Randy Pilgrim**, MD, FACEP, chief medical officer for the Schumacher Group in Lafayette, LA.

"Although it can be difficult, and may raise a number of relationship issues, it can also be a tremendous learning opportunity," says Pilgrim. "If it's the best thing you can do for the patient, it should be done."

In some lawsuits, plaintiff's attorneys have attempted to show that escalating an issue highlighted a problem with the patient's care. "If it's done properly, however, escalating an issue can show that parties acted responsibly and diligently," says Pilgrim.

Pilgrim indicates that he would much rather deal with a chart that has a clear, respectfully documented difference of opinion than one in which a difference of opinion went undocumented and wasn't addressed at the time of the patient's care.

"If you always keep the patient first, show that you cared, and communicate and act prudently, you have the best opportunity to defend the care that is now in question," says Pilgrim. "Without a clear patient-centered focus or good communication, cases are much more difficult to defend."

If a jury was to learn that you believed the patient was not being taken care of properly, and was possibly even endangered, says **Hartmut Gross**, MD, a professor of emergency medicine at Medical College of Georgia in Augusta, they would expect to hear that you went to the chief of staff or hospital administrator to seek resolution.

"Instead, you merely whined about it on the chart," says Gross. "If something bad happens subsequently, you'll be on the hook — not for error in medical practice per se, but deliberate neglect." ■

Sources

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You Say Admit, Consultant Says Discharge? Do This

What if the emergency physician (EP) strongly believes a patient needs to be admitted, but a consultant gives a recommendation over the phone to discharge the patient? If a bad outcome occurs as a result, the EP will possibly share liability with the consultant, warns **Debra J. Gradick**, MD, FACEP, medical director of the ED at Avista Adventist Hospital in Louisville, CO, and vice president of operations at Serio Physician Management in Littleton, CO.

In this kind of situation, says Gradick, the EP should try to get a different physician to admit the patient, or go to the department head or chief medical officer.

"It is the nature of emergency medicine to rely heavily on consultants," says **Chad Kessler**, MD, FACEP, FAAEM, section chief of emergency medicine at Jesse Brown VA Hospital, and associate program director for the combined internal medicine/emergency medicine residency at the University of Illinois, Chicago. "Oftentimes, the EP will discharge a patient home based on a phone call from a consultant without a formal written consultation, and end up sleeping uneasy that night."

Rade B. Vukmir, MD, JD, FACEP, chief clinical officer of the National Guardian Risk Retention Group and chairman of education at Emergency Consultants, Inc., both based in Traverse City, MI, and adjunct professor of emergency medicine at Temple University Clinical Campus Pittsburgh, says that although the primary care physician and the specialist are the ones who technically have admitting privileges, the EP is the physician who has examined the patient and done the H&P and the decision-making. Therefore, he says, the EP is actually legally responsible for the patient.

"If you document, 'I wanted to admit the patient but the patient's doctor didn't want to admit them, so I'm sending them home,' you have clearly memorialized the potentially suboptimal decision-making that took place," says Vukmir.

A better option, says Vukmir, may be to take a five- or 10-minute break and then approach the primary care physician or specialist again, and sometimes even a third time.

Ask the patient and family what their preference is, and potentially involve nursing or administration in the decision-making, he says. Then, approach the physician again and say, 'This is our current set of circumstances. For all these reasons, admission would be the preferential pathway. Would you like to re-evaluate the admission process?'" he suggests.

"Oftentimes, that is enough to do it," says Vukmir. "An alternative is involving another specialist, or the patient's primary care physician. Approach the dilemma as the problem solver to assist the admitting physician in their care responsibilities as well."

If you believe a patient is truly at risk, says Vukmir, "from a medicolegal position, you are actually *required* to proceed up your chain of command." Typically, says Vukmir, the EP would contact the ED director, and if he or she is not available, then the administrator on duty or the chairman of the department.

Vukmir says that he has seen pleadings and allegations regarding the EP's failure to go up the chain of command, listing this as a point of alleged negligence.

"Continue your interventions while working on that process," advises Vukmir. "Just because the patient can't be admitted doesn't mean you can't observe him or her on your own until the next shift, or sometimes the next day," he says. "Never discharge the patient if it's not in their best interest."

Win the Battle

If you believe your patient should be admitted and the consultant disagrees, **Frank Peacock**, MD, vice chief of emergency medicine at The Cleveland (OH) Clinic Foundation, says, "Your diplomatic

skills have to come out at this point. You need to win that battle," he says.

Hospitals that do not allow EPs to have admitting privileges have more bad outcomes than those that do, notes Peacock. "The reason for that is that the EP is more likely to be right than the guy at home talking on the phone," he says.

If you cannot force the admission, says Peacock, you'll need to transfer the patient and document that you believe the patient should be admitted but the hospital has refused. "You are the patient's advocate," says Peacock. "If you think they need to be admitted to the hospital, you are ethically and, generally, legally bound to do your best."

Here are strategies to reduce risks involving differences of opinion as to whether a patient should be admitted:

• Be familiar with your hospital's conflict resolution policy before this scenario occurs.

For instance, the policy may call for the department head to get involved if the emergency physician and specialist cannot agree on a course of action, says Gradick.

• Discuss the difference of opinion in a private area away from the patient.

"If your discussion doesn't really resolve the problem in the patient's best interest, you are still ultimately responsible for the patient," adds Gradick. "You've got to do what is right for the patient."

• Present both opinions to the patient or family and give them your advice.

"Document that there was a thorough discussion," says Gradick. "Should the patient opt to follow the consultant's treatment plan, then obviously you would have the consultant assume full responsibility for the patient."

By informing the patient of both opinions, says Gradick, the patient can make an informed decision about treatment. "It may be easier to disagree privately," she says. "But if the consultant is making a bad decision and your opinion differs, it's incumbent on you to be honest with the patient."

Stick to the facts, says Gradick, such as stating, "'Your physician would like you to be transferred to hospital A and we think you should stay here at Hospital B,' or, 'He would prefer you go home and I would prefer you stay.' You can make the decision."

Document the patient's response in quotes, advises Gradick, and avoid making statements to the patient like, "Well, he doesn't ever want to admit anybody."

• If necessary, obtain a second opinion.

"You can always consult a second physician," says Gradick. "You may have to go to through the chain of command or to the department chairman in order to resolve the issue. Always attempt to do what you feel is best for the patient."

• Document the difference of opinion *without* inflammatory remarks.

If a case goes to trial, you'll be asked to tell the jury what exactly you said to the consultant to the best of your recollection, says Gradick. "Documenting a brief synopsis of your discussion is the only way to protect yourself," she says.

Finger pointing is never appropriate in the chart, however. "If the record were ever to be subpoenaed, the plaintiff's attorney would have a heyday with inflammatory remarks," says Gradick. "They like nothing better than to pose a physician against another physician. It implies guilt on the part of another physician, which can never accomplish anything good." ■

Treatment Delay? ED Patient May Sue For "Loss of Chance"

Flood gates for suits opened

Lawsuits for "loss of chance" involving ED care are increasing, reports **Jennifer L'Hommedieu Stankus**, MD, JD, a medical-legal consultant, former medical malpractice defense attorney, and a senior emergency medicine resident at the University of New Mexico Health Sciences Center in Albuquerque. "This is a tricky legal concept that is gaining in popularity, particularly for things such as failure to offer [tissue plasminogen activator] to patients with acute ischemic stroke," she says.

"Loss of chance" is also applicable to any sort of delayed diagnosis if there is a possibility that a sooner diagnosis would have limited the patient's injury in any way, says Stankus. "Of note, this legal doctrine is available in most, but not all, states," she says.

The traditional tort law of negligence requires that plaintiffs prove that it was more probable than not that the alleged negligence caused the injury in question, says Stankus. Under that rule, she explains, a plaintiff must prove that there is a greater than 50% chance that an injury would not

have occurred but for the action(s) or omission(s) of the defendant(s).

"The legal doctrine of 'loss of chance' dramatically changed centuries of tort law," says Stankus. "It has had a huge impact on medical malpractice litigation."

Whereas before, a medical expert was required to testify that "within a reasonable degree of medical certainty" there was a greater than 50% chance that the injury would not have occurred but for negligence, Stankus explains, many jurisdictions now recognize an injury for negligence based upon a *possible* loss of a chance for a more favorable outcome.

"In other words, it is this loss of a chance that is being compensated rather than the outcome itself, which cannot be known," she says. Under this doctrine, Stankus explains, a medical expert must merely testify that there was a chance, however slim, for a better outcome.

"It would be difficult to think of a scenario in which that would *not* be true. So the flood gates for medical malpractice suits have been opened," says Stankus. "This theory is highly speculative, and the speculation ultimately rests with the jury, not with the medical expert."

To protect yourself, Stankus says to be very careful with discharge instructions and make the patient feel comfortable returning to the ED if he or she has any concerns. "Timing and delays are *huge* in this legal theory," she says. "Allow for the possibility that you do not know what is going on with the patient. "

Stankus gives the example of an EP diagnosing a sinus infection in a patient presenting with headache. "Never make up a diagnosis. If you don't know, you don't know," she says. ■

Source

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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

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.

2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME QUESTIONS

5. Which is true regarding potential liability risks of HIV testing in the ED, according to **Justin S. Greenfelder,** JD?
   A. If the EP did not actively communicate the results of an HIV test to another person in breach of his or her duty of confidentiality, it is highly unlikely that he or she could be subject to liability.
   B. An EP who communicates the results of an HIV test to a patient has significant liability exposure if this was overheard by a patient in the next bay.
   C. If a hospital has a policy of routine screening for HIV, and a low-income patient refuses the test because of its cost, there is a high likelihood of success in a lawsuit for discrimination.
   D. If a low-income patient demands an HIV test and it is not provided because of his or her economic status, there is very little potential for a meritorious lawsuit.

6. Which of the following is recommended to reduce risks of lawsuits involving mid-level providers in the ED, according to **Jennifer L'Hommedieu Stankus**, MD, JD?
   A. Routinely seeing patients already seen by the mid-level provider before they leave the department can increase legal risks.
   B. EPs should avoid writing a brief note of their own if a patient has already been evaluated by the mid-level provider.
   C. EPs should consider whether the studies ordered by mid-level providers make sense and whether they accomplish their goal.
   D. It is not advisable for EPs to get a quick history from the patient if a history has already been obtained by the mid-level provider.

7. Which is true regarding lawsuits against ED mid-level providers (MLPs), according to **Michael Blaivas**, MD, FACEP, FAIUM?
   A. The number of lawsuits involving MLPs in the ED is decreasing.
   B. Most successful lawsuits involve lack of, or inadequate, supervision of the mid-level, as well as asking the MLP to do more than he or she is trained for.
   C. Lawsuits rarely involve the failure of the MLP to recognize a critically ill patient.
   D. In the event the EP is named in a lawsuit involving an MLP, he or she can rely on receiving summary judgment as long as the EP never saw the patient.

8. Which is recommended if an ED nurse's assessment differs from an emergency physician (EP)'s, according to **Mariann Cosby,** MPA, MSN, RN, LNCC?
   A. The ED nurse should avoid speaking privately with the EP.
   B. The ED nurse should document subjective and objective patient data, what was communicated to the EP and other providers, their response, and then the nurses' actions.
   C. If the ED nurse suggests that the EP take another look at the patient, this should not be documented.
   D. If the ED nurse believes the EP made a bad judgment call, the difference of opinion should be documented on the patient's chart.