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Dodging the Bullet

A review and discussion of several close clinical encounters

By Larry Mellick, MD, MS, FAAP, FACEP, Editor-in-Chief, Professor of Emergency Medicine and Pediatrics, Department of Emergency Medicine, Medical College of Georgia, Augusta

In this article, we present a series of actual clinical scenarios that could have turned out differently if the wrong management decision had been made. There are two goals of this article. The first is to glean from each of the reported cases important points of educational value and learning. The second is to point out that clinical misadventures are often a single judgment call away from a potential tragedy. Every day, emergency medicine physicians find themselves in similar situations. Unfortunately, some disease presentations are not classic textbook descriptions, and atypical clinical presentations are common. Besides complex and atypical presentations, the emergency department is a relatively uncontrolled environment. We work under conditions that are cognitively demanding. Emergency health care providers experience frequent interruptions, care for a wide range of patients simultaneously, and experience surges in multiple patient care responsibilities.[1,2,3] The decision-making processes can be complicated, tenuous, and treacherous. The odds are not necessarily in our favor. Consequently, for every bullet successfully dodged, we are reminded that it may be just a matter of time before one finds its mark. If and when that happens, we can only hope that harm is minimized, our documentation supports our decision-making, and that the patient and his or her family are understanding and forgiving.

Blood Loss and the Pediatric Patient

A 6-year-old girl who lived in a rural area was playing outside with a stray dog recently befriended by the family. When the child's mother heard her screaming, she ran out of the house to find her daughter covered in blood and the dog standing quietly at her side. The little girl had sustained a major scalping laceration with a large anterior flap that exposed the skull bone. Emergency medical services responded to the emergency call and, at the mother's insistence, a decision was made to transport the young girl to the children's hospital emergency department rather than their local

emergency department. The prehospital providers described what appeared to be a large amount of blood loss at the scene. The gauze that covered the huge scalp wound was soaked with blood, and the wound continued to ooze blood from small arterial bleeders. (*See Figure 1.*)

The initial vital signs were blood pressure 103/57, heart rate 142, and the pulse oximeter reading was 100%. One 20-gauge intravenous catheter had been successfully placed in the right wrist. Despite multiple attempts, a second intravenous line could not be obtained. Pulse pressure, heart rate, capillary refill, and mental status were the parameters available for assessment of the patient's hemodynamic stability. Early in the patient's care, fentanyl was suggested for pain control. The patient was already quiet and, while

Figure 1: Blood, blood-soaked gauze, and elastic wraps

responsive to the pain from attempted needle sticks, already seemed a little too sedated. Since mental status was one of the few parameters initially available for monitoring the patient's circulatory status, we elected not to treat with fentanyl immediately. The normal pulse pressure is 30 to 40 and narrows with increased systemic vascular resistance. Despite the large amount of blood lost, her pulse pressure had not narrowed. Since bone injury and skull penetration are not uncommon following dog bites (which can exert a force more than 400 pounds per square inch), a computerized tomography (CT) scan of the head was obtained. The CT scan of head was normal.

The plastic surgery team was consulted, and they evaluated the patient in the emergency department. Because the child had something to drink at 10:00 a.m., the surgeons did not want to take the child to the operating room until 4 p.m. Furthermore, the consultants asked that the planned blood transfusion be held. Meanwhile, the ongoing blood loss from the scalp wound was proving resistant to our attempts at hemostasis. Despite pressure dressings, various hemostatic agents, and strategically placed staples, the oozing continued. The ongoing bleeding hidden under large amounts of gauze and pressure dressings was almost clandestine. Only when the dressings were removed to assess hemostasis did the continued blood loss become apparent. A repeat hemoglobin measurement demonstrated a dramatic drop from 12.0 to 8.2 g/dL. Because of the drop in hemoglobin and the planned delay in surgery, a transfusion of packed red blood cells was finally started. Later that afternoon, the patient's large scalp wound was repaired in the operating room.

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Figure 2: Small area of irritation in the patient's right pharynx

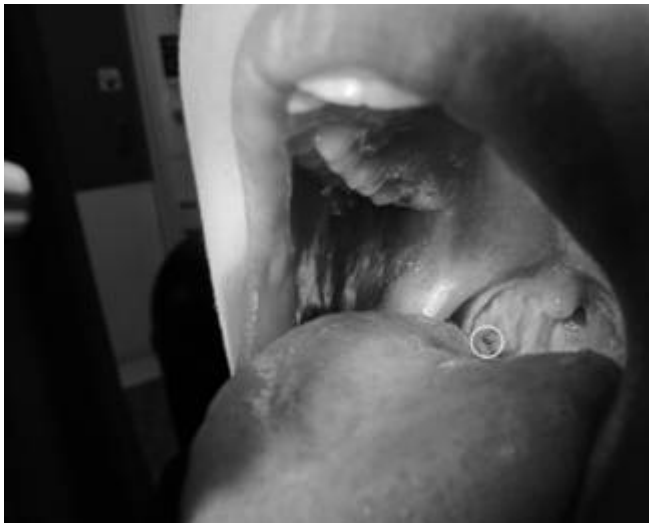


Figure 3: Fish bone removed from the teenager's right tonsil

Discussion

Blood loss in children can be easily underestimated. Furthermore, the total blood volume of a child is considerably less than that of an adult. Blood loss that might appear small by adult standards may very well be life-threatening for a child. And, as was described in this case, blood loss at the scene that appears large is more likely a critical loss of blood for a child. Additionally, despite massive blood loss, physiologic adjustments in systemic vascular resistance occur that maintain the child's vital signs at a near normal state. Once these compensatory mechanisms fail, sudden deterioration and death can occur. Our patient initially demonstrated a normal capillary refill, normal pulse pressure, and a normal skin color. Urine output was not immediately measured because urine standing in the bladder is of no clinical value. Only after a Foley catheter is placed, the bladder is emptied, and tracking is started is urine output of potential value. The only notable parameter on this child was the change in mental status. Nevertheless, the child demonstrated laboratory evidence of a major, life-threatening blood loss.

Delaying emergency, and possibly life-saving, care because a patient recently ate or drank is not well supported in the literature. At least for procedural sedation, there is sufficient evidence and expert consensus that the risk is small and the management of the emergency condition can take priority.[4,5,6] Even guidelines published by the American Society of Anesthesiologists indicate that in emergency situations, recent oral intake is not a sufficient reason to delay surgery, but the target level of sedation can be modified.[7]

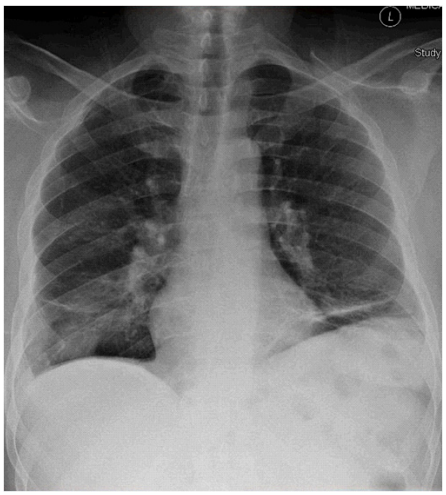
Learning Points

- Never completely trust your own estimations of pediatric blood loss.
- Respect the pediatric patient's ability to maintain normal vital signs despite major blood loss.
- Continually track and reassess the bleeding pediatric patient's physiologic status.
- Err on the side of early fluid and blood replacement.
- Be very mistrustful (even paranoid) of bleeding scalp lacerations.
- When a child last ate or drank should be a minimal consideration when it comes to timely management of his or her emergency condition.

A Fish Bone Story

A 17-year-old girl presented to the emergency department complaining that she had a fish bone stuck in her throat. She described an area of irritation in her right posterior pharynx. The initial examination with a tongue blade demonstrated no evidence of a fish bone. The entire area was viewed with a nasopharyngeal scope, and no evidence of a foreign body was noted at her vocal cords or valleculae. A radiograph of her neck demonstrated no foreign body. The search for a foreign body was nearly ending when the patient pointed out a more specific area of concern in her tonsil. (*See Figure 2*.) Further examination demonstrated the nubbin of an object that was slightly protruding from the tonsil. Using forceps from a suture kit, the emergency medicine resident extracted a fish bone that had been impaled into the tonsil. (*See Figure 3*.)

Figure 4: Abnormal chest radiograph of the patient



Discussion

Emergency physicians use a number of tools to search for pharyngeal foreign bodies. But what happens when these investigations fail to demonstrate a fish bone? Usually, the assumption is made that the persisting pain is secondary to an abrasion caused by a sharp foreign body passing through the pharynx. This case demonstrates that an impaled foreign body no longer visible can also be the cause of irritation. There are numerous case reports that describe the consequences of chronically impaled fish bones, and confirm that the associated morbidity to the patient can be severe.[8,9,10]

Learning Point

• If one cannot actually see the fish bone, it may be impaled into the tissues. Be careful about attributing persistent pain to a scratched pharynx.

Chest Contusion Conundrum

A 52-year-old man presented to the emergency department complaining of right-sided chest pain and "bruised ribs," as well as recent hemoptysis. (*See Figure 4.*) During the previous week, he lost his balance and fell against a coffee table. Other than some chest discomfort with inspiration, he denied any other complaints. In fact, most of his discomfort occurred when he was lying flat in bed. His past medical history was significant for diabetes mellitus, hypertension, and a lower extremity amputation below the knee several months prior. He denied any lower extremity swelling or pain. His initial vital signs were pulse oximetry 99%, blood pressure 116/66, heart rate 106, and respiratory rate 16. Subsequent vital signs showed a heart rate of 93, 101, and 97. Pulse oximetry readings remained at 99% and 97%. His chest radiograph demonstrated an area of haziness and a plate-like atelectasis that was considered consistent with an infiltrate or even a pulmonary contusion. (*See Figure 4.*)

The possibility of a pulmonary embolus was considered. However, the radiology findings were not classic ones for pulmonary embolus. Additionally, on repeated questioning, the patient denied any shortness of breath and stated that he "felt fine." Preparations were begun to discharge the patient home with a prescription for azithromycin to treat presumptive pneumonia. At the last minute, however, uneasiness with the decision resulted in a physician ordering a CT angiogram (CTA) of the chest. Besides emphysematous changes in the lungs and peripheral airspace opacities in the bilateral lower lobes, the CTA demonstrated bilateral pulmonary emboli with significant clot burden and deep vein thrombosis in the bilateral lower extremities.

Discussion

This patient did have several clinical findings consistent with a pulmonary embolus. The history of recent surgery was relevant, as was the pleuritic chest pain and hemoptysis. However, these same signs and symptoms could also have been consistent with a diagnosis of pulmonary contusion or pneumonia. The confounding historical variables that almost caused an errant clinical decision were the history of a recent fall and chest wall contusion. The lack of bruising to the chest seemed inconsistent with a significant injury and was one factor that caused the diagnosis to be reconsidered. The normal vital signs (except for the initial heart rate that demonstrated a tachycardia) and the pulse oximetry of 99% were inconsistent with the diagnosis of a pulmonary embolus, as was the patient's lack of symptoms. The patient repeatedly denied shortness of breath and stated that he "felt fine." The radiograph was abnormal but did not demonstrate the classic pulmonary embolus radiograph findings of Westermark's sign or Hampton's hump.

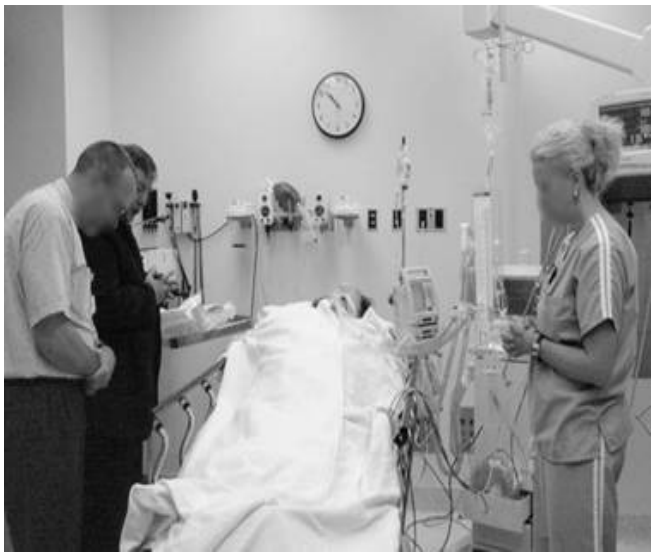
Learning Points

• Pulmonary emboli presentations can be subtle, and vital signs (heart rate, pulse oximetry, etc.) are not reliable indicators.

• Always beware of the "red herring" in the history that can distract you from the true diagnosis.

• Be sure that you have sufficiently ruled out the worst possible scenario before accepting your final diagnosis.

Figure 5: Priest, chaplain, and nurse perfoming last rites on the patient



Last Rites

An elderly woman in her late 80s was transferred from an outside hospital for management of a subarachnoid hemorrhage, as well as large amounts of free air discovered in her abdomen. After the neurosurgery team placed a pressure monitoring device in her head, the gastrointestinal surgery service was preparing to take her to the operating room. However, before any additional steps could be taken, the patient's son called and stated that the family wanted to withdraw care. The son was asked to fax a copy of the advanced directive to the emergency department. According to the advanced directive, the son clearly had decision-making responsibilities for his mother, but the patient had also clearly indicated that she wanted everything possible done to keep her alive. When the son called back on a recorded line to restate his wishes, the contradiction between his request and his mother's explicit wishes was discussed. The patient's son acknowledged the disparity between his request and the mother's wishes. And, in the same conversation, declined to come and be at his mother's bedside when she died. "We said our goodbyes last night just before she was transported to MCG." He said.

The obvious dilemma required careful management. Risk management was consulted. Members of the risk management department also communicated with the son. Additionally, an ethics committee meeting was set up for 1 p.m. the same day. The neurosurgeons and the gastrointestinal surgeons were present for this meeting. The consensus was that the patient's condition was indeed futile, and a decision was made to withdraw care, as requested by the son. Because the family was of the Catholic faith, a request had been made by the son for last rites to be performed. Last rites were performed earlier in the day by a priest and the hospital chaplain. (*See Figure 5*.) The patient was given morphine for comfort, and the endotracheal tube was removed. The ventilator was turned off, and the dying process commenced. Over a period of several hours, the patient's blood pressure and oxygenation continued to drop. Just after 5 p.m., the patient went into an agonal rhythm and was pronounced dead.

Discussion

For the emergency medicine physician, similar situations are not uncommon. Despite apparent futility, the potential for violating the wishes and rights of a dying patient exists, and decision-making must be carefully navigated.[11,12,13] The AMA Council on Ethical and Judicial Affairs recommends a process-based approach to addressing futility, to include such actions as the following:[14]

1. Careful deliberation and resolution over what constitutes futile care;
2. Joint decision-making with physician and patient or proxy;
3. Assistance of a consultant or patient representative; and
4. Use of an institutional committee (i.e., ethics committee).

Learning Point

• When ethical dilemmas develop during the care of a patient, don't attempt to make these decisions alone. Bring in your clinical consultants, risk management representatives and, if necessary, convene an institutional committee to carefully deliberate the issues.

Summary

During every clinical shift, emergency medicine physicians find themselves making clinical decisions that have potential life or death consequences. Other decisions have the potential for serious patient morbidity. If an error in judgment occurs, harm may come to the patient, and the health care provider is at risk for allegations of malpractice. Unfortunately, there are many clinical situations that are not clear cut or in which the patient's own historical contributions are flawed. In these situations, the emergency medical care provider must rely on situational awareness, cognitive dissonance, instinct, and experience to help prevent clinical misadventures. Ordering additional studies or seeking input from colleagues or consultants may be the best decisions

when significant uneasiness remains about one's clinical decision. ■

REFERENCES:

1. Chisholm CD, Weaver CS, Whenmouth L, Giles B. A task analysis of emergency physician activities in academic and community settings. *Ann Emerg Med*. 2011;58(2):117-122.
2. Chisholm CD, Dornfeld AM, Nelson DR, et al. Work interrupted: A comparison of workplace interruptions in emergency departments and primary care offices. *Ann Emerg Med*. 2001;38(2):146-151.
3. Chisholm CD, Collison EK, Nelson DR, et al. Emergency department workplace interruptions: Are emergency physicians "interrupt-driven" and "multitasking"? *Acad Emerg Med*. 2000;7(11):1239-1243.
4. Molina JA, Lobo CA, Goh HK, et al. Review of studies and guidelines on fasting and procedural sedation at the emergency department. *Int J Evid Based Health*. 2010;8(2):75-78.
5. Green SM, Roback MG, Miner JR, et al. Fasting and emergency department procedural sedation and analgesia: A consensus-based clinical practice advisory. *Ann Emerg Med*. 2007;49(4):454-461. Epub 2006 Nov 1.
6. Mace SE, Brown LA, Francis L, et al. Clinical policy: Critical issues in the sedation of pediatric patients in the emergency department. *Ann Emerg Med*. 2008;51(4):378-399, 399.e1-57.
7. American Society of Anesthesiologists. Practice guidelines for sedation and analgesia by non-anesthesiologists. *Anesthesiology* 2002;96:1004-1017.
8. Mavili E, Oztürk M, Yücel T, et al. Tongue metastasis mimicking an abscess. *Diagn Interv Radiol*. 2010;16(1):27-9. Epub 2009 Oct 19.
9. Jeon SH, Han DC, Lee SG, et al. *Eikenella corrodens* cervical spinal epidural abscess induced by a fish bone. *J Korean Med Sci*. 2007;22(2):380-382.
10. Kiluchi K, Tsurumaru D, Hiraka K, et al. Unusual presentation of an esophageal foreign body granuloma caused by a fish bone: Usefulness of multidetector computed tomography. *Jpn J Radiol*. 2011;29(1):63-66. Epub 2011 Jan 26.
11. Basanta WE. Advance directives and life-sustaining treatment: A legal primer. *Hematol Oncol North Am*. 2002;16(6):1381-1396.
12. Siegel MD. End-of-life decision making in the ICU. *Clin Chest Med*. 2009;30(1):181-94, x.
13. Rondeau DF, Schmidt TA. Treating cancer patients who are near the end of life in the emergency department. *Emerg Med Clin North Am*. 2009;27(2):341-354.
14. Medical futility in end-of-life care: Report of the Council on Ethical and Judicial Affairs. *JAMA*. 1999;281(10):937-941.

Diagnostic Test *Not* Ordered? Protect Yourself Legally By Explaining Why

Document your rationale

Editor's Note: This is the first of a two-part series on liability risks involving ordering of diagnostic tests in the ED. This month, we'll cover the legal ramifications of deciding not to order a test, the legal risks of unexpectedly abnormal results, how ED protocols can help an EP's defense, and a new quality measure that increases liability risks for EPs. Next month, we'll report on possible lawsuits for future cancers, strategies if patients threaten to sue because a test wasn't ordered, and liability risks specific to pediatric patients.

More than half of emergency physicians (EPs) say the main reason they conduct the number of diagnostic tests they do is fear of lawsuits, according to a recent survey of 1,768 EPs conducted by the American College of Emergency Physicians in March 2011.

However, EPs have a "major false impression that you need to order tests because this will somehow be protective in a lawsuit," according to **Bruce Janiak**, MD, professor of emergency medicine at Medical College of Georgia in Augusta. "I don't think that is true at all."

In fact, ordering appropriate tests based on evidence-based medicine and good clinical judgment is the best possible approach, says Janiak. "The evidence that supports extra testing is simply not there," he adds. "And there is evidence that refutes extra testing."

While ordering tests won't necessarily prevent lawsuits, it will make them easier to defend, according to **Robert I. Broida**, MD, FACEP, chief operating officer at Physicians Specialty Ltd. in Canton, OH. It is extremely common for a plaintiff's attorney to allege that a particular test should have been performed that would have instantly made the diagnosis and saved the patient's life, he says.

"This has tremendous jury appeal, especially when it is a common test that the jurors might have experienced previously," says Broida. "Doing the test and having it be normal prevents this type of unfounded assertion. "

Since the assertion is made after the fact, when there has been an untoward outcome, says Broida, it's easy to criticize the EP for failure to order a test. "With the significant personal and professional impact of a lawsuit on the physician defendant, it is understandable why defensive medicine is so common," he says.

A lawsuit is one of the most distressing things an EP may encounter during an entire career, says **Ben Heavrin**, MD, assistant professor of emergency medicine at Vanderbilt University Medical Center in Nashville, TN. "It is tough to quantify the negative impact of this fear, but it is real and significant."

While testing should be ordered only when clinically indicated and not due to fears of litigation, says Heavrin, "unfortunately, the medical/legal environment makes this quite difficult to achieve."

Since each patient presents with a unique set of circumstances, says Heavrin, the decision to proceed with diagnostic testing depends on the EP's history and examination. "In emergency medicine, the stakes are high," he says. "Usually, the patient-provider interaction is an isolated one. A provider in the ED feels an obligation to rule out both emergent illness and occult illness."

For this reason, says Heavrin, there will always be legitimate legal risks to *not* performing a test. While EPs have several valid clinical decision support tools to dictate when radiographs should or should not be ordered, such as the Ottawa Ankle Rules and the National Emergency X-Radiography Utilization Study criteria, he says, these tools never get the odds of missed injury to zero.

"They come very close to zero, but a miss rate of almost zero is not the same as zero," says Heavrin. "In a medical/legal environment where standards of care are proven after the fact in court based on a reputed 'expert,' these decision support tools may not provide a perfect defense."

If the EP chooses *not* to order a test that is commonly ordered for a particular clinical condition, Broida advises discussing this with the patient and family. "Document both the rationale and the discussion in the medical decision-making section of the ED record," he says.

Heavrin says the ED chart should include a discussion of why certain tests were ordered or not ordered, and how such tests, if ordered, affected the treatments rendered and the ultimate disposition given.

"Such documentation of medical decision-making is the key to providing a defense, should litigation arise," says Heavrin. ■

Sources

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Unexpected Results of Needless Tests Can Cause Legal Problems

If you don't believe a diagnostic test is truly necessary but you order it anyway, you must be prepared for results to come back unexpectedly abnormal, even if these "incedentalomas" have nothing to do with what brought the patient to the ED, warns **Bruce Janiak**, MD, professor of emergency medicine at Medical College of Georgia in Augusta.

Janiak gives the example of a possible pneumonia patient who gets a chest X-ray that shows a dot on the other side of the lung. "So you get a CT scan, which comes back inconclusive, and you get a PET scan," he says. "You now have $10,000 invested in the case, and the patient didn't need the chest X-ray in the first place. That is a problem."

Similarly, says Janiak, you don't want to find yourself ordering a complete blood count, which is intended to look for secondary signs of infection, that comes back with an elevated white count that you dismiss as having nothing to do with the patient's presenting symptoms.

"You will find yourself on the stand, trying to explain why you ignored the result," Janiak says. "Imagine yourself having to tell a jury why you order tests you don't need, and when they come back abnormal, you don't do anything about it."

John Burton, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA, reviewed a case of an EP sued by a patient who came in with abdominal pain. As part of the workup, the EP decided to do an abdominal series X-ray that

included a single-view chest X-ray.

"It turned out that the patient died from an aortic dissection," says Burton. The plaintiff argued that this could have been visualized on the chest X-ray, which was part of the abdominal X-ray series that the EP ordered.

"If you think you should order some tests to protect yourself, you should be careful which tests you order," warns Burton. "Some of those tests may bring information into the medical record that you really don't want in there, because you weren't considering those things to begin with."

In the case of the patient with abdominal pain, the EP had never contemplated aortic dissection, says Burton. "The plaintiff had him in a tricky spot. He had ordered a test, but had not thoroughly interpreted that test on behalf of the patient," he says. "He was only looking at the belly, but the chest X-ray was clearly done."

Be Very Strategic

Since delayed-diagnosis lawsuits often involve the EP's failure to act appropriately on a test that was ordered, says Burton, "you may get into more trouble by ordering a bunch of tests. You've got to be very strategic about what you order."

Look at each individual patient, he recommends, and consider whether you can defend ordering a test, based on the patient's presenting signs and symptoms. If you have every reason to believe a patient has a certain diagnosis based on their signs and symptoms as charted in the medical record, says Burton, then you should be ordering a test to pursue that diagnosis.

Some ED medical records reviewed by Burton have indicated that a patient presented with signs and symptoms consistent with subarachnoid hemorrhage, but the EP didn't order a CT scan and may not have even done a lumbar puncture.

In one case, the EP documented that a patient's headache symptoms were consistent with prior migraine headaches, but the patient actually did have a subarachnoid hemorrhage and a lawsuit ensued. During discovery, it was noted that the triage notes conflicted with the EP's assessment, and stated that the presenting symptoms were, in fact, very different from the patient's previous headaches.

"The EP never addressed that conflict in the medical record," says Burton, adding that the case settled out of court. In addition, the patient had no apparent history of migraines, which conflicted with the EP's charting.

"This suggested that the EP was documenting this purely as a defensive move, and was clearly positioning themselves in the medical record to say that this was not consistent with the diagnosis for subarachnoid hemorrhage," says Burton. ■

Source

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Why Did You Order Unnecessary Test? Protocol Is One Defense

If there is absolutely no credible reason to think that a patient's symptoms are due to a heart attack, says **John Burton**, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA, you shouldn't be ordering tests such as cardiac enzymes. If you do, and the patient later sues because he or she had a cardiac condition that wasn't identified in the ED, he says, the plaintiff's attorney will be able to ask the question, "If you didn't believe it was a heart attack, then why did you order that test to begin with? You must have been considering it."

"They will try to shoehorn the medical decision-making from the back end, by the tests that you ordered," says Burton. "That is something we see a lot in these cases."

An ideal answer to this question, says Burton, would be: "As part of the routine workup at this ED for patients who arrive with chest pain, we do a standardized evaluation using an agreed-upon protocol."

"That is a very strong argument for the defense," says Burton. "The EP can then say, 'I was acting within the context of this protocol, and this patient fell within that context.'" The argument is that the protocol is what drove the ordering of the test, explains Burton, not the fact that the EP had any particular suspicion of myocardial infarction or unstable angina.

"You can't rest your entire defense on a protocol," says Burton, but it's increasingly the case that tests may be ordered on patients because of a protocol, which an individual EP assessing that patient wouldn't necessarily have ordered.

Details Can Backfire

Burton sometimes sees a very detailed explanation in a patient's chart about why the EP isn't

considering a certain diagnosis. "The EP may say, 'I don't think this is meningitis because the patient doesn't have A, B, or C.' Then the patient is discharged and dies of meningitis," he says.

A plaintiff's attorney or expert later reviewing the medical record gets the impression that the EP is trying to talk him or herself out of a diagnosis being considered, says Burton. "When the EP gets very detailed about why they *don't* think the patient has something, it can be injurious," he says. "When the patient does have that illness, you can attack the EP on their medical decision-making and rationale."

If the EP says, "The chest pain was reproducible and, therefore, I didn't think it was a heart attack," for example, a plaintiff's attorney can go find something in the literature to refute this, says Burton.

For this reason, Burton advises using the "less is more" approach when charting medical decision-making. If an EP charts, for instance, that, "based on the Pulmonary Embolism Rule-out Criteria (PERC) rule, this patient did not appear to have a PE," the plaintiff can argue the relevance of the PERC rule, says Burton. It then becomes a question of whether the PERC rule is strong enough for a successful legal defense, which depends on the diagnosis.

"In the case of PE, probably so. In the case of a chest pain patient, probably not," says Burton.

The bottom line, says Burton, is that, "if you're going to quote it, you're going to have to live with it, even if the patient has what you're saying they don't have. If you get very specific, you are locked into a certain argument. The plaintiff's attorney can always make a counterargument."

Burton advises using more general terms, such as, "Based on today's evaluation in the ED, the patient did not appear to have a presentation consistent with pulmonary embolism."

"If you are faced with explaining that when a suit is brought against you two years later because the patient died of pulmonary embolism, you can provide the details," he says. "Of course, at that time, you will know what the diagnosis was." ■

Quality Measure Brings Additional Risks for ED

EPs in "huge bind"

Quality measures from the Centers for Medicare & Medicaid Services (CMS) and other groups are putting EPs "in a huge bind," according to **Sandra Schneider**, MD, professor of emergency medicine at University of Rochester (NY) Medical Center.

Schneider is referring to Use of Brain Computed Tomography in the ED for Atraumatic Headache, included in CMS's Hospital Outpatient Quality Data Reporting Program. "Based on very loose data, measures are being promulgated that suggest we do far too many CT scans for atraumatic headache," explains Schneider.

According to the measures, patients should never be given a CT scan if certain criteria are not present, notes Schneider, but the problem is that 2% of people with subarachnoid hemorrhage will not meet the criteria. "So if the EP follows these guidelines, then they would miss 2% of subarachnoid hemorrhage cases, which would cause them to be sued," says Schneider.

Claims data were used to evaluate the quality indicator, adds Schneider, but this approach will miss some of the criteria that would show a CT scan was indicated for a given patient. According to the guidelines, for instance, one of the indications for a CT scan is a thunderclap headache. "I may have written 'thunderclap headache' on the history or the X-ray requisition, but not as a discharge diagnosis," says Schneider. "Since this measure will only look at discharge diagnosis, it will not pick that person up as meeting the criteria for a CT scan."

Schneider says that another problem is that the CMS measure pertains to patients over 65, "and there is absolutely no evidence that elderly people have an increased risk of cancer from CT scans. It doesn't make scientific sense to decrease the number of CT scans in this population. It just increases the liability for emergency physicians." ■

Source

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Are Personnel Files, QI, or Incident Reports Discoverable?

Imagine a plaintiff's lawyer poring over stacks of documents provided by the defense as a result of a lawsuit alleging ED malpractice, and finding the statement, "This nurse will eventually kill a patient."

"You cannot imagine how many comments like this have been turned over to a plaintiff in a lawsuit," says **Linda M. Stimmel**, JD, a partner at Wilson Elser Moskowitz Edelman & Dicker LLP in Dallas, TX.

You may wrongly assume that certain pieces of documentation or information are not ever discoverable, or admissible in a court of law, warns Stimmel. "This can cause huge problems in the defense of a lawsuit," she says.

A key issue in any ED malpractice lawsuit is what documents will be available to the plaintiff's counsel and, eventually, to a jury. "The critical document will almost always be the chart," she says. "Strive for accuracy and completeness — and objective, not subjective, charting."

Do not assume that incident reports and personnel files that contain nursing evaluations and past complaints will always be confidential, advises Stimmel. In many states, incident reports are considered documents created "in the regular course of business" and will be discoverable in a lawsuit, she explains, and most states also allow plaintiffs to have copies of the personnel files of staff that provided care to the patient.

"I have defended many lawsuits where we were damaged by notations in a personnel file that showed prior disciplinary actions toward a nurse for the same issues in the lawsuit," says Stimmel.

That allows the plaintiff to argue that the emergency department administration had "notice" of potential harm and ignored it, says Stimmel, and to argue that the plaintiff should be awarded damages for "gross negligence."

While staff evaluations that document disciplinary issues do need to be created, Stimmel says to have medical staff or hospital committees direct these evaluations. "You can then keep those out of a personnel file," says Stimmel. "The safest method is to always realize that any of those documents may be discoverable in a lawsuit."

Not Necessarily Inadmissible

In Illinois, the Medical Studies Act ensures that any documents created and used for the purposes of internal quality control or medical studies done to lower death rates and improve patient care cannot be admissible as evidence or discoverable.

The purpose is to encourage medical professionals to be candid when conducting internal reviews and medical studies, according to **Robert D. Kreisman**, a medical malpractice attorney with Kreisman Law Offices in Chicago.

"However, not every document a peer review committee uses is necessarily inadmissible," says Kreisman. While any document generated or created specifically for the peer review committee is protected, he explains, documents that aren't necessarily an integral part of the peer review process are not privileged.

For example, minutes of the peer-review meeting would be privileged, while anything that is a part of the medical chart itself would not be privileged. Since only documents that can be shown to have been generated specifically for the peer-review process are privileged, any documents generated before or after the review process formally begins or ends are not covered, adds Kreisman.

"Even peer-review summaries made in interviewing doctors before the peer-review process officially begins are not privileged," he says.

Since the Medical Studies Act is not intended to protect hospitals from potential liability, but rather to help improve patient care, any documents or information that do not specifically serve this purpose are not privileged, says Kreisman. For example, any documents generated in the normal course of hospital business are not privileged, such as regulations and bylaws, credentialing requirements, and staff memos.

"Likewise, any information the hospital is required to generate for government agencies, such as data concerning the number of MRSA patients in a hospital at a given time, is not privileged," says Kreisman. "Such data is not aimed at internal review."

However, even those documents that *are* integral to investigating poor hospital or medical care are not necessarily privileged unless they are specifically related to the peer-review process, notes Kreisman.

If the hospital investigates a patient's complaint about the quality of care in order to avoid a potential malpractice claim, none of the documents generated in the course of the investigation would be privileged, explains Kreisman, unless the investigation was initiated by a peer-review committee.

"Any conversations or reports generated by staff following an unusual event are not privileged, even if they were done in anticipation of the peer-review process," says Kreisman.

In order to be privileged, the information needs to be generated during the limits of the peer-review process only, says Kreisman, and investigations into hospital quality control issues that are not directly related to patient care, such as slip and fall accidents, are not privileged.

While documents and information generated for a peer review committee or for medical studies is privileged, Kreisman says that there are even some exceptions to that rule. "For example, the actual results of a peer review committee hearing are not privileged, nor are any resulting changes to hospital policies," he says.

Any resulting suspensions or revocation of privileges are not privileged, and can be submitted into evidence, says Kreisman. "While the results of the peer review committee are not privileged, the internal conclusions of the committee that might have led to those results are privileged," he says. While the formal results of a peer review are therefore discoverable in Illinois, items such as committee meeting minutes are not.

To establish that certain documents are, in fact, privileged, simply asserting that documents and information were generated for a peer review committee or for use in a medical study is not enough, says Kreisman.

Unless the hospital attorney proves this to the court, he explains, refusal to produce requested documents will lead to a motion to compel brought by plaintiff's counsel. "A court hearing will follow to determine the propriety of the hospital's refusal to produce the requested documents," says Kreisman.

Typically, the attorney will be required to generate a log of all the documents and information that he or she considers privileged, says Kreisman, but the ultimate determination rests with the court.

"In some cases, the court might require an *in camera* inspection of the privileged documents in order to establish that they are, in fact, privileged," he says. "Whether the documents requested are privileged as part of a peer review process or medical study is a fact issue decided by the court."

In one case, a hospital physician wrote a letter to his department head outlining the course of events surrounding a complicated birth that resulted in disabilities to the child.[1] The delivering doctor assumed that his letter would be used for internal quality assurance issues and was, therefore, privileged, says Kreisman, and the obstetrics department head confirmed that the letter triggered the internal quality control proceedings regarding this matter.

However, since the internal review process did not formally begin for several months, the court held that the physician's letter was not generated specifically for the peer review committee, because it preceded the committee meeting and was not specifically done on behalf of the committee.

In order for documents to be privileged, they have to be generated specifically for the peer review committee, at the committee's request, and during the timeframe of the review process itself, explains Kreisman. "Any information that does not satisfy these requirements may be ruled discoverable by a court, and be admissible into evidence," he says. ■

REFERENCE

1. *Berry v. West Suburban Hospital Medical Center*, 338 Ill. App.3d 49 (1st Dist. 2003).

Sources

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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

9. If the EP chooses *not* to order a test that is commonly ordered for a particular clinical condition, which of the following is recommended, according to **Robert I. Broida**, MD, FACEP?
   A. Avoid discussing this with the patient and family.
   B. Omit any discussion of your rationale in the ED record.
   C. Discuss this with the patient and family, and document both the rationale and the discussion in the medical decision-making section of the ED record.
   D. Avoid specific references to any diagnostic tests that were not ordered in the ED in your documentation.

10. Which is true regarding liability risks involving diagnostic tests ordered in the ED, according to **John Burton**, MD?
   A. There are no additional legal risks involving ordering of tests such as cardiac enzymes, even if there is no credible reason to think a patient's symptoms are due to a heart attack.
   B. EPs may expose themselves to additional legal risks by giving a very detailed explanation about why a certain diagnosis isn't being considered.
   C. An EP cannot use the fact that the ED has a standardized evaluation using an agreed-upon protocol as part of his or her defense to explain why a particular test was ordered.
   D. If an ED has a standardized protocol that includes ordering of a specific test, the plaintiff's attorney can't question the EP about why the test was ordered.

11. Which is true regarding admissibility of documents in the event a malpractice lawsuit is filed against the ED, according to **Robert D. Kreisman**?
   A. While any document generated or created specifically for the peer review committee is protected, documents that are not an integral part of the peer-review process are not necessarily privileged.
   B. In all states, incident reports are not considered documents created "in the regular course of business" and are therefore not discoverable in a lawsuit.
   C. Documents that are integral to investigating poor hospital or medical care are always privileged, even if they are not specifically related to the peer-review process or involve investigations not initiated by the peer review committee.
   D. Simply asserting that documents and information were generated for a peer-review committee or for use in a medical study is sufficient to establish that documents are, in fact, privileged.