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Biggest Legal Risk Is Delayed Treatment, Not Parental Consent

Suits more likely if you wait to evaluate or treat

If a boy is brought to an emergency department after being injured in an all-terrain vehicle (ATV) accident while at a friend's house, do triage nurses wait to get in touch with the parents before treating him?

If they do, this may constitute a violation of the Emergency Medical Treatment and Labor Act (EMTALA), warns **Kevin M. Klauer**, DO, EJD, FACEP, chief medical officer of Emergency Medicine Physicians in Canton, OH.

"When a pediatric patient shows up in the ED, often the first thing staff do is to say, 'Maybe we shouldn't do anything until we get ahold of the parents or guardian,'" says Klauer. "Many people don't realize that this is delaying their medical screening examination (MSE), including stabilization, as required by EMTALA."

Successful Suit Unlikely

As a general rule, minors presenting without a parent should be evaluated for the presence of any emergency medical conditions, according to **Douglas S. Diekema**, MD, MPH, director of education for the Treuman Katz Center for Pediatric Bioethics at Seattle (WA) Children's Research Institute, and an attending physician in the ED at Seattle Children's Hospital.

"If something is discovered that requires intervention before the legal guardian can be reached, that intervention should be provided," says Diekema. "The child's welfare should always be the first concern, regardless of whether consent can be obtained."

Attempts should be made to reach a legal guardian or parent at the first available time, says Diekema, and if the child has medical findings that do not require urgent management or do not represent a threat to his or her well-being, the treatment of those can wait until consent can be obtained.

"In the trauma situation, the child should be evaluated like any other trauma victim, and provided with any standard evaluations, tests, or treatments that are necessary to assure that the child does not suffer significant

harm," says Diekema. This might include a CT scan, blood work, pain control, and even emergent surgery.

If the ED medical team provides standard care that is in the best interest of the child, and a good faith effort has been made to reach the legal guardian or parent while that is occurring, Diekema says that the likelihood of a lawsuit, particularly a successful one, is very low.

"On the other hand, the likelihood of a lawsuit is much higher if a child suffers significant harm because diagnostic modalities or treatments were withheld while waiting for someone who could provide consent," warns Diekema.

Once the MSE has been completed and the child is stabilized, the EMTALA obligation has been met, says Klauer, and the EP now must comply with state law requiring parental consent.

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"If the child is stable, then you should be observing the state statute that requires consent," says Klauer. "If you go beyond what you need to do to stabilize them, then that could be a problem."

On the other hand, if after the ATV accident, the child is hypotensive with abdominal pain, or a splenic laceration is identified on a CT scan, the EP should not wait to get parental consent to send the child to the OR, he explains, as the child is not stabilized as defined by EMTALA.

"If at some point you still haven't been able to reach the parents, and it's putting the child's life or limb in jeopardy, then you just go ahead and do what you need to do," says Klauer.

Don't Delay Initial Care

Delaying evaluation and stabilization of an ill child to obtain parental consent doesn't make sense, says Klauer, and may be deemed a violation of EMTALA. Parental consent is *not* always necessary to obtain a lumbar puncture on a child with a temperature of 104.5, for instance, because it is part of the MSE.

"Is a parent going to sue you for doing the lumbar puncture, which is very safe? Or are they going to sue you for a bad outcome because of a delayed meningitis diagnosis and management?" he asks. "The sicker the child, the more latitude you have."

Although parents could theoretically sue an EP because a child was given the lumbar puncture without their consent, says Klauer, "this is a hypothetical argument that doesn't make any sense. I don't see that happening if the child is ill and the parents aren't immediately available."

Klauer says that he is unaware of any successful cases in emergency medicine in which a provider was sued for lack of consent to treat a child with a serious illness or injury, when the parents could not be contacted.

"You are not going to get sued for trying to do the right thing for the patient when they require services and the parents aren't available," he says. "There are very few courts, or even plaintiff's attorneys, that are willing to say, 'You didn't have consent, so technically this is battery.'"

However, says Klauer, an EP *is* likely to be sued if treatment, management, or diagnosis is delayed for any reason, including waiting to obtain parental consent.

Alfred Sacchetti, MD, chairman of the depart-

ment of emergency medicine at Our Lady of Lourdes Medical Center in Camden, NJ, says that when faced with a child with an emergency, "there is no such thing as consent. There is no delaying initial care pending contact of anybody."

In a true emergency, he says, the EP should treat the child as though the parent was standing in the room. "You are always better off doing what is best for the child, rather than having to say, 'I was afraid the parents might not want me to do this, so I held off,'" says Sacchetti.

If the child has a nonemergent condition, he adds, care can still be provided anyway while simultaneously trying to contact the responsible party to obtain consent. "There is no way that anyone would say, 'Don't stop the bleeding on my child's cut until I get there.' That is just not going to happen," says Sacchetti.

This means that if a child comes in with a laceration, the EP stops the bleeding, he says, or if a child comes in with a sore throat, the EP is obliged to make sure there is no overwhelming infection or airway problem.

"Once you find they have no true emergency, now you are in a totally different ballgame," he says.

If a forehead laceration requires treatment but the child is stable, he says, you can now wait to discuss the care with the parent, he says, who may request a plastic surgeon to repair it or may be comfortable with the EP doing so.

"Now you are not delaying critical care. You are delaying care that has some viable options in its management," says Sacchetti, adding that the laceration should be repaired if you are unable to contact the parents after several hours, due to increased risk of infection.

A parent may sue the EP if the laceration is repaired without consent, explains Sacchetti, but a suit is far more likely if you send the child home hours later when it's too late to suture the wound.

"You're so much better off than if you say, 'I was afraid they'd sue me if I sewed it, so I sent the child home without sewing it,'" says Sacchetti.

In this case, Sacchetti says the EP's defense would be that the parents couldn't be located. "The parents will look like ungrateful individuals," he says. "The defense attorney will say, 'You weren't around, your kid was in desperate need, and you're going after the only person who had the guts to help?'" ■

Sources

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If Parent Refuses Treatment, Act in Child's Best Interest

If a parent objects to a medical evaluation or treatment of a child with a potentially life-threatening emergency, due to religious beliefs or any other reason, says **Kevin M. Klauer**, DO, EJD, FACEP, chief medical officer of Emergency Medicine Physicians in Canton, OH, the emergency physician (EP) can get a court order to get the child treated.

"The court may award temporary custody to a governmental agency or local authority to obtain the necessary care. The child will likely be brought back to the ED for treatment," he says.

If the EP has any bodily contact with the parents, or attempts to prevent the child or the parents from leaving the ED, however, he or she may face potential charges of assault and battery or false imprisonment.

"Although you are acting in the best interest of the child, you could run into trouble," says Klauer. "Unless it's an extreme case of abuse, you are going to be on less firm footing by physically removing the child from the parent."

Removing the child or detaining the parents is best deferred to law enforcement, he adds, once the appropriate authorization has been obtained.

If a delay in treatment is clearly harmful for a

child, the EP should contact the local magistrate in order to have custody removed temporarily and the child brought back for treatment. "You have done all you could to provide good care, and you haven't exceeded your scope of practice or violated their rights in the process," Klauer says.

Do What's Reasonable

To reduce legal risks for the ED, Klauer says, "if it makes sense from a common sense standpoint, most of the time, you should go ahead and do it."

For life- or limb-threatening emergencies in children, "we as EPs are covered by doing the right thing for the patient, even if the parents are not present, including giving blood to Jehovah's witness patients," says **Ghazala Q. Sharieff**, MD, MBA, director of pediatric emergency medicine at Palomar-Pomerado Health System in San Diego.

Many states rely on the legal tenet of "implied consent," meaning that a patient came to the ED because he or she needed treatment, according to **Michael Gerardi**, MD, FAAP, FACEP, director of pediatric emergency medicine at Goryeb Children's Hospital in Morristown, NJ, and president of Superior Risk Retention Group in Livingston, NJ.

"If a parent doesn't want to consent to a life-saving study, states have usually ruled in favor of the physician," he says. "They do not want to recognize the parent's authority to deny care to a child."

Even if parents are refusing treatment for a child due to religious or other beliefs, says Gerardi, EPs should follow the standard of care and what a reasonable person would want in the situation.

"Think about this issue ahead of time, and be familiar with your obligations. People sometimes get caught up in the legal aspect instead of what is reasonable," says Gerardi, adding that if you have a child with a life- or limb-threatening condition, you should proceed as if they have consented.

"If the child was given a transfusion because he was in impending decompensated shock, you may end up in a court of law but you are going to win," says Gerardi. "You don't want to see yourself in a *New York Times* story with the headline, 'Doctor lets child bleed to death because parent refuses to give blood.'"

States will back whatever the EP does to protect the rights of the child in this scenario, he says.

If you sense reticence on the part of the consenting adult, Gerardi recommends documenting, "The risk/benefit analysis was not as apparent to the parent as it was to the medically treating team. Extensive discussion ensued about the proposed procedure and the negative consequences of lack of consent. The decision was made to proceed because of risk of loss of life."

"Involve another colleague in the case anytime you have a significant disagreement and you can't get them to see your logic," he adds. ■

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Unrealistic ED Policies? Lawsuits Will Follow

If a lawsuit is filed alleging malpractice in your ED, the only thing worse for your defense than not having a policy covering an important subject might be having one but failing to adhere to it.

There are so many policies and bylaws that EDs adopt and update continually, however, that it's impossible for any emergency physician (EP) to follow all of them correctly, says **William J. Naber**, MD, JD, CHC, assistant professor in the Department of Emergency Medicine at University of Cincinnati's College of Medicine and a physician liaison at University of Cincinnati's Physicians Compliance Department.

"Usually, we are given a large binder during our orientation to a new job and emergency department. We are asked to sign an attestation that we read and understand the policies," he says. "If we don't sign it, we simply don't get to work."

Clauses in employment contracts stating that the EP will abide by and follow all policies and bylaws of the hospital he or she is working at create a dangerous situation for the EP, adds Naber, when a medical malpractice suit alleges that part of the breach of duty was not following a relevant policy.

A plaintiff attorney would likely put the EP's

contract on a big screen, says Naber, showing he or she is contractually obligated to follow hospital policies and bylaws, make the argument he or she violated the policy or bylaw that is part of the alleged breach of duty, then show how this breach of duty is proximate cause of the alleged harm done.

"This makes an easy-to-follow argument for jurors, who may understand breach of contract better than breach of the standard of care," says Naber.

The EP can document *why* a policy or procedure was not followed exactly in the relevant medical record, notes Naber, but since the hospital cannot document in the medical record, there must be an internal risk management system to track major policy violations and related documentation of the reasons for the violation.

"Remember, these issues can come up in legal situations years later, depending on the state or federal statute of limitations," says Naber.

Violations Are Common

When any chart is reviewed with a fine-tooth comb, a plaintiff's attorney will find failures to meet various policies and procedures that weren't completely complied with, says **Bruce Wapen**, MD, an emergency physician with Mills-Peninsula Emergency Medical Associates in Burlingame, CA.

"The old policies and procedures never go away — they only get updated, and new ones are constantly being added," he says. "The more policies you have, the more at risk you are for violating one of them."

If an ED nurse forgot to document the patient's pain level, it may be brought up in a lawsuit even if it's not relevant to the case. "Failure to meet a policy could be brought up as showing a laxity on the part of the EP or the department or facility," says Wapen. "The plaintiff's attorney can throw it into the mix, to add to the impression of the jury that this is a facility which is not up to snuff."

In reality, ED policies are violated on a daily basis, according to **Andrew Garlisi**, MD, MPH, MBA, VAQSF, medical director for Geauga County EMS and co-director of University Hospitals Geauga Medical Center's chest pain center in Chardon, OH.

He gives the examples of ED patients examined in hallways or waiting areas despite patient confidentiality policies, and policies for cleaning treatment rooms after each patient encounter to avoid exposing the next patient to pathogens.

"In a sense, policies and procedures create a no-win situation for the hospital and ED," says Garlisi. "These will be one of the first items to be scrutinized by the plaintiff's attorney, who will look for any deviations."

In the event of an avoidable ED patient death, the ED will be blamed for not having policies and procedures for that particular circumstance, he explains, and if there are comprehensive policies and procedures, the EP and nurses would be held accountable for not following these to the letter.

ED-specific Risks

Stephen A. Frew, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney, says that policies and procedures are "a significant source of legal issues in the ED. These are involved in virtually every malpractice suit, to one degree or another."

ED malpractice lawsuits often involve compliance with, the presence of, and the reasonableness of policies and procedures, says Frew. Here are some specific risks for EDs:

• ED policies may duplicate existing hospital-wide policies, which can lead to inconsistencies between the hospital and department-level policies.

"Once we have inconsistencies, we are at the mercy of the plaintiff's lawyer," says Frew. "The inference is that we are either doing it wrong or that we have dual standards."

The way a test is ordered in the ED differs from the way it's done in the outpatient surgery unit, notes Frew, but these differences should be addressed in departmental guidelines.

If a falls assessment is done differently in the ED than on an inpatient unit after a patient has been admitted, the ED's policy should not duplicate what's already in the existing hospital-wide policy, says Frew. "Go ahead and reference that policy, then distinguish why the ED policy is different," he says. "Make it clear it's intended to be different."

Otherwise, says Frew, if someone changes the hospital-wide policy at some point in time, they may not take into account the fact that the departmental policy says something different, or vice versa, and you can end up with an unintended inconsistency.

• EDs may lack a policy that other hospital areas have in place.

Bruce Wapen, MD, an emergency physician with Mills-Peninsula Emergency Medical Associates in Burlingame, CA, reviewed a case involving an ED patient who presented with low back pain after falling off a ladder, and sustained an intracranial bleed after falling off the X-ray table during the ED visit. The patient was not assessed for fall risk.

"It was noted on the requisition from the ED to radiology that he had fallen, but there was no specific policy in effect as to how to manage someone at risk for falling," says Wapen.

The question became whether the standard of care was breached and, if so, who breached it. At first, it was Wapen's opinion that the problem was in the radiology department, not the ED, but he then learned that although a policy for fall risk assessment was in place in the hospital's intensive care unit, it wasn't in place in either the ED or radiology.

"That opened the door for a real problem. It then became a disparity, which is unacceptable. You cannot segregate out patients in one area of the hospital as being protected by a policy that you don't have for people elsewhere in the hospital," says Wapen, explaining that the patient would have been qualified as being at high risk for falling if he had been assessed in the ED.

The hospital settled the case, in large part due to the lack of a fall assessment policy in its ED, he adds.

• ED staff may ignore existing policies.

While observing an ED's operations, Frew noticed an ED nurse doing something that was contrary to the ED's policy, and asked her why. "She responded that policies were written by stupid administrators and lawyers that knew nothing about EDs, so the nurses just put them in a drawer and ignored them," he says.

Some EPs feel similarly, adds Frew, and may argue that policies aren't always followed because there are clinical exceptions.

"I'm not disputing that, but the important thing is that policies and procedures are not suggestions. They are mandatory," says Frew. "There is an idea that somehow these rules are somehow optional. If they are not followed, there needs to be enforcement and discipline imposed."

In order for ED staff to follow policies and procedures, however, they need to be written in a logical, understandable manner. "It takes a long time to figure out what most policies and procedures mean in a courtroom," says Frew. ■

Sources

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Don't Invite Lawsuits With Too-specific ED Policies

You're likely to fail to meet your own standard

An ED's policy may state that reassessments should occur every 30 minutes, or that EKGs should be given within 10 minutes of the patient's arrival, but there will always be circumstances in which these timeframes aren't met.

"You can hang yourself with your own regulations," says **Bruce Wapen**, MD, an emergency physician with Mills-Peninsula Emergency Medical Associates in Burlingame, CA. "You put yourself at risk of liability if you fail to meet your own standard."

Wapen says you do need to specify times if the purpose of a policy is to identify a timeframe beyond which it is unacceptable to have an intervention done, such an EKG for a chest pain patient. "If you make it vague, the performance will be sloppy," he says. "You need to have the policies, but as you get more and more of them, it becomes progressively harder to get them all done."

Build in Flexibility

Routine clinical practices, such as starting intravenous lines or taking a patient's blood pressure, should not be included in an ED's policies and procedures, advises **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney, because the specific way these are done varies depending on what equipment is in a given room or a nurse's individual style.

The way handoffs occur during shift changes shouldn't be specified in too much detail in policies, adds Frew, and should instead be stated as general principles, such as "a nurse-to-nurse exchange on each patient must occur at the time of a handoff."

"That can be in the policy, because it is something we want to occur all the time without exception," he explains. "But those kind of things are often handled differently shift to shift. The fact that shift A does it differently from shift B shouldn't expose us to questions."

Frew has reviewed cases in which plaintiff attorneys made an issue of the fact that ED handoffs were handled differently on a given shift. "I've seen that come up, with the attorney attempting to show that the ED didn't pass along appropriate information and the patient was harmed by it," he says. "Be clear that handoffs were never intended to be done the same way every time on every shift."

The goal is to create flexibility in the rule, says Frew, and make it clear that the ebb and flow of patients and resources in the ED may make different courses reasonable at different times.

Allow for Clinical Judgment

ED policies should specify timeframes only if this is required by regulations or if there is a clearly recognized standard of care that requires specific timeframes to be met, advises Frew. "Otherwise, we need to use what I call 'lawyer weasel words,' like 'appropriate' and 'reasonable,' to make it clear this isn't intended to be a 'one size fits all' rule," he says.

When timeframes *are* specified in ED policies, these must be followed to the letter. "If we specify a response time for on-call physicians or trauma surgeons in minutes, we have to make sure it's adhered to," says Frew. "When we set time limits, we set ourselves up to violate them. Liability could flow from that."

Frew recommends putting as little as possible in policies and procedures, and all else in the form of guidelines. If the ED sets a goal of 30 minutes for a patient to be seen by an EP, he adds, this should be stated in the department's quality improvement objectives.

"You don't want to hold yourself to liability standards for what your aspirations are," says Frew. "If it's not a clear standard of care, keep it out of the policies and procedures."

Make it clear that the guidelines are subject to the clinical discretion of the EP, Frew recommends. "That way, when they do something different, it's not 'Aha, we got you,' but 'I followed my clear-cut right to use my clinical judgment.' The plaintiff's lawyer may still try to make something out of it, but you are in a much stronger position."

Policy Not Followed? Explain Reason Why

Ryan R. Domengeaux, JD, vice president of risk management at Schumacher Group in Lafayette, LA, says, "Policies and procedures are not only driven by statutory requirements, they are also necessary to memorialize service expectations."

Legal risks related to ED policies are primarily driven by how well they're put together and how well people actually abide by them, he says. "They should always be as specific as possible, without being overly detailed," says Domengeaux. "I don't think any policy or procedure should ever be vague. The person who's going to pick it up and read it, quite often, is trying to understand what they should be doing."

An EP may have a justifiable reason for going outside a policy, he adds, but his or her documentation must support this. "If I have a policy in front of me and I decide it's not in the patient's best interest in that instance to follow that policy, then I have to be able to support my reasoning for that," says Domengeaux.

"Is it in the patient's best interest to go outside the policy?" and "Have I well documented my reasons?" are the two questions EPs should answer, he says.

If there is good documentation to support the EP's decision-making process to clearly explain

why following the policy was not in the patient's best interest, this is a very defensible position for an EP, says Domengeaux. "What a jury looks for is common sense, and an explanation," he says. "Absent both of those, you will have a tough time defending why you didn't follow a policy."

Domengeaux says that in his experience, high-risk areas involving ED policies involve failure to follow policies for diagnostic overread discrepancies, such as when an EP doesn't see a fracture on a patient's X-ray but the radiologist later identifies one, and policies related to monitoring a patient who was administered narcotics.

If a patient is given a narcotic for pain and a bad outcome results, the issue is whether there was a procedure that the nurse or doctor should have followed, but didn't, in monitoring the patient. "In most instances, there is a policy in place for monitoring a patient being administered a strong narcotic, but these aren't always followed," he adds.

It's already difficult to defend a case when a breach in the standard of care has occurred involving requirements from the Joint Commission or other organizations, says Domengeaux. "If you don't follow your own policies and procedures, it becomes even tougher to defend," he says. ■

Source

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Bad Outcome in Waiting Room? Defense Is Difficult

Jury won't want to hear about crowding

Jurors might be able to understand the fact that patients can't always be treated immediately in a busy ED, particularly if a plaintiff didn't have obviously life-threatening symptoms at the time.

"What *doesn't* play well with a jury is someone is left out in the waiting room to deteriorate and no one's even noticing," says **John Tafuri,** MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland. He points to a recent high-profile case involving a patient collapsing and dying in an ED waiting room, which was quickly settled.

"Obviously, that is an egregious case, but it is something the public does not want to see," he says. The public perception is that people are sometimes left out in the ED for unreasonable periods of time, explains Tafuri, so juries won't be sympathetic if they perceive that somebody was ill and not attended to.

"What is helpful in a lot of EDs if someone is not immediately evaluated, is that someone does a repeat assessment or sometimes repeat vital signs, every 15 or 30 minutes," says Tafuri. "Certainly, that will mitigate the fact that there was a delay in care."

Having a policy for reassessment, though, is a "double-edged sword," says Tafuri. "If you think you can comply with the policy, it's probably good because it can be brought in as evidence that you are being proactive."

On the other hand, a policy can be very detrimental to the ED's defense if it *wasn't* complied with and a bad outcome occurs. "What better thing to show to a jury that you didn't meet a standard of care, than saying, 'Look at this, this is not my expert talking. This is their own policy, and they didn't live up to it,'" he says.

Inadequate staffing is becoming more of a problem, says Tafuri, due to the financial pressures hospitals are under. "In the past, we always had excess staff. Now that we're living closer to the edge, if it is a weekend night or there are not enough people, patients are placed at risk," he says.

Tafuri says that having a critical care float pool of nurses to help when the ED is short-staffed can reduce legal risks. "The reality, though, is that although it may be a little bit more efficient than having a well-staffed ED, it still costs money," he says. "A lot of hospitals are reticent to have any person around who is not being utilized, because of the cost pressures."

The jury isn't likely to be sympathetic to an EP named in a lawsuit if he or she makes the excuse that the ED was short-staffed and overcrowded, adds Tafuri. "When you end up in a legal situation, they are only focused on one person — the plaintiff," he says. "They don't want to hear about

all the other patients you were treating, or that you didn't have enough nurses."

The jury will want to know why you didn't treat the plaintiff in an expeditious way, says Tafuri, adding that he has seen successful defenses for delays in care that occurred during a well-publicized mass casualty incident.

Another possible defense is when the patient's presenting complaints are clearly unrelated to the eventual diagnosis. "But even then, there is no guarantee of what a jury may perceive as a legitimate delay," says Tafuri. "What may be perfectly reasonable and understandable to a physician or nurse may fall short in a juror's eyes." ■

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Reassess Boarders, or Risk Bad Outcomes and Lawsuits

Even though the admission handoff has occurred, the "boarded" ED patient is often still managed by the admitting emergency physician (EP) or another ED attending physician many hours after the shift has ended, warns **Uwe G. Goehlert**, MD, MPH, an ED attending physician at Northwestern Medical Center in St. Albans, VT, and principal of Goehlert & Associates in South Burlington, VT.

"There is always another order for an analgesic or antiemetic that goes under your name long after you are gone," he says.

In more serious cases, boarded ED patients evolve their myocardial infarctions or strokes, perforate their viscus, become more septic, seize, or stop breathing while the EP is seeing new patients, he says.

"We are all quite shocked when we see a surveillance video in the news of an unexplained death in the waiting room," Goehlert says. "Even more disturbing is the news of a bad outcome while the patient is actually in the ED, after an apparent complete evaluation while waiting for an inpatient bed."

This may be an exaggeration for some EPs, he adds, but it's a challenge EPs in high-volume and underserved areas face every day.

"ED overcrowding and inpatient resource limitations have left us in an uncomfortable and, sometimes, uncontrollably dangerous situation for which we will be held accountable," says Goehlert.

Focus on High-risk Conditions

"Some strategies for ED overcrowding have been successful on the front end," says Goehlert. "But once patients are 'in,' they are often forgotten in the hustle and bustle of the busy ED, awaiting tests and then a bed in the hospital."

Due to limited ED resources, strategies that focus on higher-risk clinical conditions make most sense, he says.

"A suit will be imminently more defensible if you document a periodic reassessment," Goehlert says. "Remember that we are ultimately responsible for the patients until they physically leave the premises."

EPs, he says, should have a heightened vigilance for these high-risk presentations: chest pain, acute neurologic change, severe dyspnea, children with fever, seizures, acute unexplained abdominal pain — especially in the elderly, and trauma with significant mechanism.

"Documenting awareness, clinical reasoning, and a plan if any clinical change occurs, will buttress a malpractice defense," says Goehlert.

Clinical reassessment and reconciling documentation of abnormal vital signs, physical findings, lab values, EKGs, and other initially abnormal findings is the best way EPs can mitigate any claim of negligence while patients under ED care are waiting for a bed, he advises.

"The record should read like a journey in time, with at least hourly updates on what is pertinent to your workup and treatment plan," says Goehlert. Most electronic health records have the capacity to set up macros to make the reassessment documentation less burdensome, he notes, or to order the nurse or technician to recheck abnormalities that can be flagged and then reconciled in the diagnostic impression section.

"Every order has to have a result, and every action has to have a reaction and a note that it was done," he says. "Sometimes, it is more important to document why we did *not* do something."

An ED patient recently presented with chest pain that initially appeared to be non-cardiac. He developed a positive troponin level on the fifth sample and was classified as failing core measures because aspirin wasn't given.

"Now, I have a macro in my medical decision-making section of the electronic health record explaining, 'Why I did not give aspirin for chest pain initially, due to lack of clinical suspicion or evidence for acute ischemic heart disease," Goehlert says. ■

Source

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Battle of the Experts: Be Truthful and Direct

When experts on either side of a lawsuit alleging ED malpractice make misleading or false statements, this reflects badly on the whole legal system, according to **Ken Zafren**, MD, FAAEM, FACEP, FAWM, EMS medical director for the state of Alaska and clinical associate professor in the Division of Emergency Medicine at Stanford (CA) University Medical Center.

"The expert is assisting the finder of fact, and has to be truthful," he says. Here are recommendations for EPs involved in expert witness work:

• Don't be intimidated by an opposing expert's credentials.

These may not carry as much weight with a jury as you might think, since credentials don't necessarily make the expert more believable as a witness. In one case, Zafren testified for the plaintiff, while a prominent emergency medicine textbook author testified on the defense side.

"I'm not going to be intimidated by these people because I reviewed the case and I have my opinion," he says. "Unless they can come up with something that is going to change my opinion, their opinion is not worth any more than mine."

• Don't try to show off your knowledge.

If the jury likes an expert witness, says Zafren, they tend to believe he or she is being truthful. "How do you get the jury to like you? You can't go on the stand and try to impress people with your superior knowledge. It doesn't work," he says.

The expert should comfortably explain the medicine involved in the malpractice suit, in a language that laypeople will understand. "You tell them medically what's going on, then explain the medical terms in lay language," says **Jonnathan Busko**, MD, an EP at Eastern Maine Medical Center in Bangor and medical director of Maine EMS Region IV. "You don't want to be so humble that it seems like you don't know medicine either."

When addressing a jury, Busko recommends speaking as though you were teaching an introductory medical course to a group of students in a lecture hall. "They have to be able to understand medically what was going on, but they don't come in with a baseline medical knowledge," he says.

• Be objective from the very start.

If experts don't approach a case objectively, they may appear to be giving answers simply because these reflect the need of whichever side they're working for.

"It's very hard, once you are involved with a case one way, to back up and look at it another way," says Busko. "At least initially, consider yourself an expert for 'the case,' not one side or the other."

• Don't attack the opposing expert directly.

It is the attorney's job to discredit the opposing witness, and the expert's job to present credible information, according to Busko.

There are many ways in which an attorney can subtly remind the jury that the plaintiff's expert has never practiced in the ED, for instance. "The attacking of another expert witness will make a jury uncomfortable," says Busko. "And once they are uncomfortable with an expert witness, they become uncomfortable with their testimony."

In one case, Zafren watched an opposing expert give incorrect information on a frostbite case, when the last case of frostbite the expert had seen was 20 years ago as a resident. At the same time, the opposing attorney was challenging Zafren's own testimony.

Instead of saying that the other expert had no idea what he was talking about, Zafren explained, in straightforward terms, the reasons why he disagreed with him, allowing the jury to learn more

about his own expertise in frostbite.

"But I couldn't do it in a way that put the other guy down," he says. "Their expert is not on trial. You have to present to the jury whatever information you have that contradicts what that person said." ■

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

1. Which of the following is true regarding the legal risks of obtaining parental consent for pediatric trauma patients presenting to the ED, according to **Douglas S. Diekema**, MD, MPH?
   A. Waiting for consent before treating a child does not constitute delaying the medical screening examination required by the Emergency Medical Treatment and Labor Act (EMTALA).
   B. Minors presenting without a parent should not be evaluated without first obtaining consent, because this is a violation of state laws.
   C. Even if the child has been evaluated and has medical findings that do not require urgent management, any delay in treatment at that point constitutes an EMTALA violation.
   D. A child presenting without a parent should be evaluated like any other trauma victim, and provided with any standard evaluations, tests, or treatments that are necessary to assure that the child does not suffer significant harm.

2. Which is true if a parent objects to a medical evaluation or treatment of a child with a potentially life-threatening emergency, according to **Kevin M. Klauer**, DO, EJD, FACEP?
   A. If the EP attempts to prevent the parents from leaving the ED, there is no risk of charges of assault and battery or false imprisonment so long as the EP is acting in the child's best interest.
   B. If a delay in treatment is clearly harmful for a child, the EP should contact the local magistrate in order to have custody removed temporarily and the child brought back for treatment.
   C. It is not advisable for the EP to attempt to obtain a court order awarding temporary custody to a governmental agency or local authority to obtain the necessary care for the child.
   D. States have always ruled against physicians in cases in which the parent doesn't want to consent to a lifesaving study.

3. Which is recommended to reduce legal risks involving timeframes specified in ED policies and procedures, according to **Stephen A. Frew**, JD?
   A. Policies and procedures should contain only clear standards of care, and all else should be put in the form of guidelines subject to the clinical discretion of the EP.
   B. ED policies should never specify timeframes, even if there is a clearly recognized standard of care that requires specific timeframes to be met.
   C. Routine clinical practices, such as starting intravenous lines or taking a patient's blood pressure, should always be included in an ED's policies and procedures.
   D. The way handoffs occur during shift changes should be specified in great detail, and should state that handoffs must be done the same way every time on every shift.