ED Legal Letter™

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If Patient Videotapes ED Care, It Could Be Used as Evidence

Even unauthorized recordings possibly admissible

While unauthorized videotapes made by a patient in your ED may seem highly inappropriate, those recordings can often be introduced as evidence in medical malpractice lawsuits, according to **William Sullivan**, DO, JD, FACEP, an emergency physician at University of Illinois Medical Center in Chicago and a practicing attorney in Frankfort, IL.

He gives the example of a patient who alleges disability, but who is seen on surveillance video performing heavy manual labor. "The video was obviously unauthorized by the person alleging the disability, yet, with proper verification, will likely be admissible as evidence," he says.

Privacy laws generally don't apply to public activities, notes Sullivan. "In the closed room having a discussion with a patient, I don't think that an EP's invasion of privacy claim would be very strong if the patient or a patient's agent is the one doing the videotaping," he says. "If it is a third party videotaping through a peephole, then that would be a different story."

State Laws Vary

Whether video recordings made in your ED may be used as evidence largely depends upon state laws, says Sullivan, adding that several court cases give a general idea about the admissibility of such evidence.

The Supreme Court case of *Katz v. United States* held that Fourth Amendment provisions against unreasonable search and seizure applied not only to property but also to recording of oral statements and electronic surveillance, he notes.

"However, that decision applies only to police obtaining such recordings for use in criminal cases. The ruling does not apply to civil cases," he says. "In addition, the case involved oral statements, not video recordings."

In some states, video recordings may be admissible as evidence in civil matters regardless of how the recordings were obtained, adds Sullivan. The Missouri Appellate Court in *Lee v. Lee* held that "even evidence obtained fraudulently, wrongfully, or illegally is admissible."

In *Rogers v. Williams*, a Delaware family court would "not concern

itself with the means by which evidence has been obtained," holding that videotaping obtained during an illegal trespass to property was still admissible as evidence, he says.

"If relevant, the recording most likely gets in at trial regardless of how it is obtained," says Sullivan. "In other states, improperly obtained recordings of oral communications may not be allowed into evidence under any circumstances."

For example, Virginia statute §19.2-65 prohibits intercepted communications, and any evidence derived from those communications, from being received as evidence in any trial, hearing, or other proceeding. Here are some items to consider regarding the admissibility of videotapes of ED care:

Before video evidence may be used as evidence during a trial, the litigant generally must prove that the evidence is relevant and reliable.

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A court determines both requirements, says Sullivan, and may exclude evidence that has no bearing on a material issue in the case. He gives the example of a videotape of a patient's laceration being sutured when the issue at trial is misdiagnosis of a heart attack, which cannot be authenticated because there is no chain of custody to show that the video had not been altered, or that it is otherwise deemed unreliable.

"If an issue in the case is that a patient was ignored, and the videotape shows staff stepping over a patient who was passed out on the ground, then it will probably be admissible," he says. On the other hand, if the videotape shows the patient sitting in a chair with other patients waiting for a room to open up, then there is no relationship to the care provided and it is probably not admissible, adds Sullivan.

Video recordings that are not admissible at trial may still be admissible in administrative hearings or during arbitration hearings, he notes, since the rules of evidence are not as stringent in such proceedings.

"There is little that can be done to prevent patients from posting video recordings on the Internet, or sending the recordings to television stations so that videos can be scrutinized in the court of public opinion," adds Sullivan.

In addition to *using* recorded video, there are several legal issues involved in *obtaining* such video.

"By introducing audiovisual evidence to obtain an advantage at trial, a party to civil litigation may be admitting guilt of a crime," Sullivan says.

While there may be a distinction in the legality of obtaining purely video vs. audio and video recordings, for the most part, portable electronic devices record both audio and video streams, notes Sullivan, and there is usually no way to disable audio before recording begins.

Because most laws criminalize recording of unauthorized audio, he explains, an audiovisual recording in which an audio stream was later removed would still violate laws applicable to recording oral conversations.

"The right to take purely video recordings of another person is not absolute, either," says Sullivan. Making any type of recording in which an individual has a reasonable expectation of privacy may violate state or federal privacy laws, subjecting the person making those recordings to civil or even criminal liability, he adds.

Videotape, audiotape, and/or photographs can be introduced at trial if a proper foundation is laid and the subject matter is relevant.

"To inform the jury, videotape could be intro-

duced to give time and place. On the other hand, it depends on the quality of the videotape and what it depicts," says **Robert D. Kreisman,** JD, a medical malpractice attorney with Kreisman Law Offices in Chicago.

If the purpose of the videotape is viewed by the court as a means to inflame the jury to one side or the other, it would be within the trial judge's discretion to bar the use of the videotape, says Kreisman.

"If the use of the videotape is to show some sort of improper conduct or negligent medical care, then the videotape could be utilized," he says.

Video Might Help EP

"From a practical standpoint, having audiovisual documentation of a patient encounter may not necessarily be a bad thing," says Sullivan. "A video may prove that a patient did or did not have pertinent medical findings that are important to the outcome of the case."

A video may also prove that a physician recommended preventative care or instructed the patient to follow-up if problems worsened.

In any case, Sullivan says that the hospital really cannot prevent a patient from recording an encounter, and has little ability to take action against a patient who has done so. "Realistically, the only action a hospital can take is to request that the patient leave the premises," he says. "By that time, the recording has already been made."

Juries may question the motives of a party that secretly tapes medical treatment. "While the plaintiff may allege that a recording was made so that he or she could 'remember everything,' the defense attorney would likely counter that concealing the fact that recording was taking place showed a less noble intent," says Sullivan.

In states where unauthorized recording is a crime, Sullivan suggests posting a sign in ED treatment rooms stating that unauthorized recording of another person is a felony, that recordings made anywhere on hospital premises are not authorized without advanced written consent, and that the hospital will immediately report anyone violating the law to the proper authorities.

"This is perhaps heavy-handed, but would be effective in deterring surreptitious recordings," says Sullivan. "I have caught one patient and one family member recording me without consent during my career. Both times I stopped and said, 'You know that doing that is a felony in Illinois, right?' Both stopped immediately and apologized." ■

Sources

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Is Your State "One-party" or "All-party?"

In some states, only one party to a conversation has to consent for a recording to be legal, while in other states, both parties have to consent unless one of several exceptions to the law is present, such as anticipation that a crime is going to be committed or use by law enforcement, says **William Sullivan,** DO, JD, FACEP, an emergency physician at University of Illinois Medical Center in Chicago and a practicing attorney in Frankfort, IL.

Unauthorized recording of oral communications is considered a felony in many states, while other states allow audio recordings if one party to the conversation consents to the recording, Sullivan explains.

- "One-party" consent states are Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Washington, DC, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.
- "All-party" consent states are California, Connecticut, Florida, Illinois, Maryland, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, Pennsylvania, and Washington.
- Vermont has passed no law specifically addressing this. ■

Source

For more information, see:

- National Conference of State Legislatures. Website: www. ncsl.org.

Don't Disregard *Any* Input on ED Patient

Concerns of team come up during suit

Some emergency physicians (EPs) have admitted that they don't take time to read the nursing notes, according to **J. Tucker Montgomery**, MD, JD, a health care attorney in Knoxville, TN. "Complaints recorded there that go unaddressed, or a particular abnormal vital sign, can come back to bite an EP," he says.

Gregory M. Nowakowski, JD, an attorney with Rogers Mantese & Associates in Royal Oak, MI, warns, "Miscommunication is not a defense to either an EMTALA claim or a malpractice lawsuit."

A nursing note Montgomery reviewed indicated an assessment consistent with saddle numbness, which was not addressed by the EP. "The patient with low back pain was discharged, and the acute cauda equina syndrome was missed," he says. "There was an angry patient and an angry jury, and a verdict for the plaintiff."

If a nurse documents that a patient is "lethargic," and the patient later sues due to a bad outcome from a missed infection or neurological condition, the question will become, "Why didn't the EP pay attention to the nurse's concern?" says **Barry E. Gustin**, MD, MPH, FAAEM, a Berkeley, CA-based medical legal consultant specializing in emergency medicine and a practicing emergency physician.

"If the nurse writes that the patient was lethargic, and you know that it's not lethargy because the patient was rousable and had a Glasgow Coma Score of 15, then you need to address that," says Gustin.

One EP testified that the ED nurse never told him about a patient's deteriorating condition, recalls Gustin, but the nursing documentation indicated otherwise.

"The nurse said in the notes, 'The doctor was informed,' and the doctor said, 'That's not true, nobody told me anything,'" he says. "If the nurse documented something in real time, the jury will believe they're being truthful. It's hard for the doctor to get out from under that one."

Review All Comments

In another case, just before discharge, an orderly failed to communicate a tarry stool to the EP, and the patient bled out at home, says Montgomery, adding that the family sued and the case was settled.

"Some EPs have difficulty accepting input from other staff in the ED," he adds. "The input of the lowest-ranking provider can be as important as the highest."

The EP should take a quick look at the run sheet if the patient comes in by ambulance, advises Gustin. "It may give you vital information that the patient may not divulge, but will come back to haunt you if something goes wrong," he says.

If a patient, the patient's representative, a housekeeper, or anyone else in the ED tells you they've observed something about a patient that should put a "reasonable" person on notice that something bad is happening, then an appropriately qualified medical person needs to check on that patient, urges **Catherine Ballard**, JD, a partner and vice-chair of the Bricker & Eckler Health Care group in Columbus, OH.

If this doesn't occur and the patient sues, warns Ballard, "this could come up very easily. You can expect the plaintiff's counsel to interview or depose everyone who could have had contact with the patient during the time in question." ■

Sources

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Nursing Notes May Be Hard to Find With EMRs

Attorneys will make use of discrepancies

"This is a new electronic record, and it does not work very well." If an emergency physician

(EP) didn't review the nursing notes because these couldn't be located within the ED's electronic medical record (EMR), this statement could very well be the EP's only defense in the event a medical malpractice suit occurs, says **Michael Blaivas**, MD, FACEP, FAIUM, professor of emergency medicine at Northside Hospital Forsyth in Atlanta, GA.

"Physicians are left seeming poorly attentive when that is all they can say in a deposition," he says. "They will all say that they check nursing notes prior to seeing the patient. Then they have to go back and say, 'I never saw this,' or 'no one mentioned this.'"

Finding nursing documentation is quite cumbersome in some EMRs, in contrast to a simple written chart in which nursing notes are typically easy to see, says Blaivas.

"These may not even be available to the physician before the patient is seen and treatment decisions are made," he says. "The scripted style and large volume in EMR nursing notes makes it difficult to pick out specifics the nurse may have heard that would be helpful to know."

Robert B. Takla, MD, MBA, FACEP, chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI, says that unnecessary and irrelevant documentation and possible discrepancies in the record are created due to parts of EMR charting being auto-completed or pre-populated.

While the documentation may be difficult for the EP to find, the plaintiff's attorney will carefully review it, says Blaivas. "It is then much harder for the EP to say, 'this was not available,' or 'it was charted wrong,'" he says.

Here are strategies for EPs to reduce legal risks regarding nursing documentation in EMRs:

Add late entries if necessary.

"Electronic records may be filled in later, just like written ones," says Blaivas. "I think in some cases, there is no option but to add a late entry and to be quite honest about it."

The EP should note the discrepancy, that it was discussed with the nurse, and explain why it occurred, he says, and avoid accusatory statements such as "I saw this in the record and he or she is wrong." Instead, Blaivas says EPs should simply state what was noted in reviewing the nursing notes and the fact that the EP followed-up with the patient or family about it.

If the EP doesn't read the nursing notes, says Blaivas, this should be acknowledged with a statement such as "no notes were available at this time due to the urgency of the patient," or "I obtained all of the information from the patient."

EPs should document or dictate that they spoke with the triage nurse and/or patient's nurse and asked them what they found, saw, or learned.

Verbal checks are particularly important with EMRs because so many things can go wrong with documentation, according to Blaivas. "I have read multiple depositions lately where nurses are saying 'I don't remember documenting this — I am sure it was really the following ....'" he says.

Nurses should be careful not to assume that something they chart will be seen by the EP in a timely manner, stresses Takla. "All abnormalities or concerns need to also be brought to the physician's attention," he says. "In the same manner that laboratory abnormalities are highlighted, so should any nursing documentation that is abnormal."

Take a careful look at the electronic records generated on a patient, especially a complex one, after their care is finished.

"You may be surprised just how much is not accurate, difficult to follow, and how much room there is for error," says Blaivas.

Utilize a system that makes it easy to locate nursing documentation.

Ann Robinson, MSN, RN, CEN, LNC, principle of Robinson Consulting, a Cambridge, MD-based legal nurse consulting company, says the particular EMR she uses requires multiple "point and click" steps to move from page to page.

Robinson advises purchasing systems that automatically put nursing and physician documentation in an easy-to-find location. "There are such systems out there," she says. "The issue is often a financial one, of course, since the systems that are easier to navigate are often more costly." ■

Sources

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Unmonitored Vital Signs "Disasters Waiting to Happen"

Many medical conditions aren't possible to diagnose without appropriate cardiorespiratory monitoring, vital sign reassessments, and diagnostic testing, and these are "disasters waiting to happen," warns **Andrew Garlisi**, MD, MPH, MBA, VAQSF, medical director for Geauga County Emergency Medical Services (EMS) and co-director of University Hospitals Geauga Medical Center's chest pain center in Chardon, OH.

Once in the ED, patients may be inadvertently ignored, unmonitored, or improperly monitored, adds Garlisi. Patients with cardiorespiratory symptoms, trauma, change in mental status, hemodynamic instability, bleeding, acute severe abdominal pain, metabolic derangement, medication or toxic overdose, sepsis, or anyone who simply looks very ill should be placed on a cardiac monitor with oximetry and continuous waveform capnography measurements, he advises.

"Waveform capnography, now a standard of care for EMS, seems not to have 'caught on' in mainstream ERs," says Garlisi. Capnography provides valuable insight into metabolism, perfusion, effectiveness of ventilation, adequacy of endotracheal tube placement, and effectiveness of cardiopulmonary resuscitation and return to spontaneous circulation in the cardiac arrest patient, he notes. Garlisi gives these examples of high-risk ED patients:

The geriatric patient with acute coronary syndrome.

Experienced emergency physicians (EPs) are acutely aware of the difficulty in evaluating geriatric patients, who often present with atypical or minimal symptoms of serious illness, says Garlisi.

"Over the decades, I have personally encountered many geriatric patients with acute STEMI [ST-elevation myocardial infarction] who only complain of weakness, not feeling right, nausea, upset stomach, and even ear pain," he says.

The geriatric patient with vague abdominal complaints.

Pain perception may be significantly altered in the geriatric patient for a variety of reasons, says Garlisi, including acute appendicitis, leaking abdominal aortic aneurysm, ischemic or perforated bowel, mesenteric thrombosis, pancreatitis, inferior wall myocardial infarction, and cholangitis.

"This can lead to catastrophic gastrointestinal emergencies being initially missed by the triage nurse or EP," he says.

The female with acute pelvic pain and normal vital signs initially.

"For the woman with ectopic pregnancy, delay in diagnosis and intervention is lethal. Unfortunately, the literature is replete with case examples," says Garlisi.

Ectopic pregnancy should be on top of the list for female patients of childbearing age with acute abdominal-pelvic pain, syncope, orthostasis, pain referred to the shoulder area, or vaginal bleeding, says Garlisi.

If there is any such suspicion, Garlisi says that aggressive treatment with intravenous (IV) crystalloid, type and cross match blood, early consultation with an obstetrician, a qualitative pregnancy test and, if positive, a quantitative HCG, and transvaginal pelvic ultrasound are key initial steps.

If the patient is hemodynamically unstable, the physician should order a bedside portable ultrasound procedure, adds Garlisi. "Torsion of the ovary causes acute pelvic pain. Pelvic ultrasound with Doppler flow studies is an essential test to rule out or rule in the diagnosis," he says.

The diabetic patient.

Type I diabetes is often associated with neuropathy and altered pain perception, says Garlisi, and patients often have subtle and atypical presentations for STEMI, epidural abscess, and serious abdominal conditions. "Diabetics have altered immunity and are prone to septic complications, he adds.

The ill infant.

Infants with bronchiolitis, meningitis, intussusceptions, urinary tract infection, and frank sepsis may not present initially with classic textbook symptoms and signs, says Garlisi.

Patients with cancer.

These patients can present with unusual complications, including pericardial effusions, metastases to the spine, pulmonary emboli, sepsis, post-radiation complications due to scarring, and fibrotic organ damage, says Garlisi.

Immunocompromised patients, including those taking immune modulators used in treatment of rheumatoid arthritis, ankylosing spondylitis, lupus, and post-transplant patients.

"These patients are prone to septic complications," says Garlisi. "Sometimes these medications are overlooked as a risk factor for sepsis, and early sepsis signs and symptoms are missed in the ED."

Hemodialysis patients.

These patients are at risk for a variety of serious

medical problems, including hyperkalemia, congestive heart failure, pericardial effusion, line infections, sepsis, and respiratory complications, says Garlisi, and may present with subtle signs and symptoms.

The patient with neurological symptoms.

A patient complaining of dizziness may have a benign etiology, but subtle signs and associated symptoms of posterior cerebral circulation disorders may be missed, says Garlisi.

Subtle transient ischemic attacks, subarachnoid hemorrhage, and other intracranial bleed syndromes may present subtly, and may be missed without comprehensive evaluation, he adds.

"The ED neurological exam, in my experience, is often the most persistently missed or 'glossed over' portion of the physical examination," says Garlisi. ■

Source

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No System to Respond to Acuity, Volume Surges?

Make changes before letter of intent to sue arrives

Lawsuits related to treatment delays in EDs aren't limited to patients in the lobby who are waiting to be seen, says **Andrew Garlisi**, MD, MPH, MBA, VAQSF, medical director for Geauga County EMS in Chardon, OH.

"I have personally witnessed more delays in patients who have already been seen once by the EP," he adds. In a busy ED with a continuous influx of patients, the EP is racing around trying to "beat the clock" for each patient, says Garlisi.

"The physician has very little time to enter orders, recheck multiple established patients who have had medications and interventions, review results of labs, scans, X-rays, discuss diagnosis and results of ancillary studies and disposition plans with patient and families," he says.

Delays in care, multiple distractions, and unmonitored patients all put patients at risk for preventable adverse events, says Garlisi, with many falling into the "near-miss" category and barely escaping an adverse outcome for one reason or another.

Delays in diagnosis and treatment probably occur on a daily basis in every ED nationwide, says Garlisi, but too often, he says, "near-miss" events aren't taken seriously. "It is business as usual for the ED, with no lesson learned, no process improvement, and no intervention, until the untoward event leads to preventable death or disability," he says.

At this point, says Garlisi, the sentinel event is typically dissected, a root cause analysis is performed, certain individuals or systems will be criticized, and changes may be made. If a patient dies because of a treatment delay, the ED could disclose the untoward event to the family and hope for a reasonable financial settlement in lieu of dealing with a formal malpractice action, advises Garlisi.

"If no disclosure process occurs, nothing is done until the letter of intent to sue arrives," he says. "This is life in the ED as we know it today."

Crowding No Excuse

In the event of a bad outcome caused by a treatment delay, the fact that the ED was crowded, if brought to light in a deposition or during a malpractice court hearing, would probably not influence the final judgment decision, says Garlisi.

The judge and jury might be empathetic toward an EP dealing with several simultaneous near critical or critical cases, notes Garlisi. "But an astute prosecuting attorney will correctly point out that the hospital and emergency staffing company were well aware of the likelihood of a deluge of complex cases," he adds.

EDs need a system in place to consistently respond to volume or acuity surges, argues Garlisi, as an overwhelmed ED is now "a well-known fact of life. It is an expensive proposition to call in extra staff, mobilize a team to create bed space, or pay for back-up coverage," he says. "But the choice boils down to 'you pay one way or the other.'" ■

Boarded Patients May Be "Out of Sight, Out of Mind"

Problem may go "from nuisance to lawsuit"

Admitted ED patients are "definitely in a gray zone," according to **William C. Gerard**, MD,

MMM, FACEP, chairman and professional director of emergency services at Palmetto Health Richland in Columbia, SC. "Fortunately, they are admitted, and that takes your [Emergency Medical Treatment and Labor Act] risk away. But then you get into the malpractice risks," he says.

If a patient is admitted to the intensive care unit (ICU), the admitting ICU physician is responsible for the patient, says Gerard, "but it's kind of 'out of sight, out of mind.'"

The admitting physician assumes since the patient is still in the ED, the EP will take care of the patient, explains Gerard.

"Meanwhile, the EP is constantly evaluating new patients, knowing that the admitted patient has a disposition with the appropriate service," he says. "That is where a risky gap in patient care can exist."

Risks Increase With Time

"The risk ends when the patient leaves the ER and is no longer boarding," says **Tom Scaletta**, MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL. "That is certainly an inconvenient truth, and EPs cannot wishfully think away this risk."

When sick patients are promptly admitted, there is little risk of their demise in the ED after the original EP has gone home, says Scaletta. "Conversely, the more time an admitted patient lingers in the ED, the more chance issues will arise necessitating physician action," he says. "Clearly, ED boarders remain problematic even when exam space for new cases is available."

Scaletta says risks are highest during off-hours. "Coverage whittles down to one EP. Evening shift admits are then awaiting bed assignment, often in hallway spaces," he warns. "When a patient's condition suddenly worsens, the boarder problem can go from nuisance to lawsuit."

Scaletta says EDs should have adequate physician coverage, including shift overlaps and rapid inpatient bed assignments.

"When you use forecasting to determine proper staffing levels, the boarder load ought to be considered," he says. "This is especially important in centers where the EPs are more relied on to handle issues that arise with boarders." Scaletta recommends these strategies:

Get a good report on boarders, and periodically check these patients.

"Do not become an ostrich with regard to sign outs," says Scaletta. "Even though the patient has been admitted, our geographic proximity means we remain responsible when major issues continue to unfold while the patient is in the ED."

As emergency nurses change shift, oncoming nurses become less aware of the initial patient presentation, warns Scaletta. "Nurse-to-nurse reports should include updates on boarders — not the same report for multiple shift changes," he says.

Document accurately and contemporaneously.

"This is very protective from a legal perspective," says Scaletta. "We need to debunk the myth that putting your name on the chart when someone else started the case creates liability. The complete opposite is true."

Examine the patient, review the chart, act accordingly, and update the admitting physician.

"Admittedly, it is a lot of work to address a condition change on a patient you did not work up," says Scaletta. "Regardless, this is the safest course. Since procedures and critical care time are billable, the 'complete waste of my time' argument is moot."

Instruct ED nurses to let EPs know when a patient's condition changes in any way.

"Essentially, every patient admitted to the hospital has reasonable potential for a debilitating problem," Scaletta says. "The key is being on top of things."

Requiring an emergency nurse to get direction from the admitting attending is fraught with inherent delays, says Scaletta, and practicing medicine via telephone descriptions of what is happening often results in substandard care.

EPs should be informed of any new symptom, abnormal vital sign, mental status deterioration, or new test result. "Certainly, it is reasonable to request that the ED nurse obtain guidance from the admitting attending whenever the issue is not particularly time-sensitive," adds Scaletta. ■

Lessen "Boarder" Risks With These Three Practices

When an ED patient is being held while waiting for an inpatient bed, **Rolf Lowe**, JD, an attorney with Rogers Mantese & Associates in Royal Oak, MI, says "there is no bright line cut off for liability. Substandard care in the ED that has an effect on the patient's outcome can result in

liability for the EP and the ED staff."

If the hospital utilizes a hospitalist for admitting patients, the hospitalist typically will become responsible once the patient is on the floor, says Lowe.

"In hospitals that utilize an 'on call' physician for admissions, the EP should have an understanding of the hospital policies," he adds. "In most instances, it can be presumed that the patient becomes the admitting physician's patient upon transfer to the floor."

To reduce risks of lawsuits involving boarded patients, Lowe recommends these practices:

1. The EP should make a conscious effort to be informed about the patient waiting to be transported to the floor.

"The patient's condition will dictate the type of attention the EP should give the patient while they are waiting to be transferred," he says, such as performing periodic reassessments.

2. EPs should make a point of asking nurses to inform them when the patient has left and that their condition was unchanged.

"There is no sure-fire way to eliminate potential exposure for claims following a patient's admission," says Lowe.

However, he says that compliance with the hospital policies and procedures and acceptable standard of practice and care for the presenting condition and eventual diagnosis, along with good documentation, will reduce legal risks for EPs.

3. Oncoming EPs should make sure they are aware of the patient's presenting condition, diagnosis, and current status.

While there is no need to question the diagnosis they are given from the EP they are relieving, oncoming EPs should consciously perform their own exclusions based on the information they have, and after having seen and/or examined the patient, says Lowe.

"Charting this is an important factor," he says. "It will show that the EP didn't just accept the patient and push them on to the floor." ■

Should You Hold Off on Orders for ED Boarders?

There's risk of adverse events

EPs may try to put off intervening on admitted patients waiting for inpatient beds to become available to avoid confusion about what was already done for the patient and what the inpatient care plan is, says **William C. Gerard**, MD, MMM, FACEP, chairman and professional director of emergency services at Palmetto Health Richland in Columbia, SC.

"We try not to give any non-emergent orders on an admitted patient because it can cloud the picture. You've got to make sure you're in sync with the admitting team," he says. "You don't want two doctors ordering things without the other one knowing."

Since EPs and admitting physicians are, in effect, "comanaging" the boarded patient, there is a risk of duplicate orders and therapies. "You can't ignore somebody on a ventilator who is waking up agitated and needs to be sedated," says Gerard. "So we do intervene, and there is some potential there for risk and adverse events."

Handoffs Pose Legal Risks

A patient may be in the ED for two days and go through multiple attending EPs. "As new people come on, EDs probably don't do appropriate handoffs on admitted patients," Gerard says. "There is some exposure for liability here."

Oncoming EPs may be unaware of the boarded ED patient's overall clinical picture. "If somebody sticks their head out of the room and says, 'I need a doctor in here,' you don't really know how far along the patient is in their treatment and response to the continuum of care," says Gerard. "Are they getting better? Are they getting worse? Who is involved in their care?"

To reduce risks involving handoffs of boarded patients, Gerard's ED is developing a standardized form within the hospital's electronic medical record, to give oncoming EPs more information on the patient. "It covers where that patient is in their stay and what is going on with the patient," he says. "We will incorporate that into our daily workflow."

Notify *Both* Physicians

Ideally, says Gerard, the admitting physician should be the one responding to the boarded ED patient's need for intervention. At the same time, he says, the EP should also be notified that there is a situation going on, so the EP is on standby if the admitting physician doesn't respond in a timely manner.

"Morbidity and mortality increases every hour

that a patient who is critically ill boards in the ED and not in the appropriate inpatient unit," he says.

While the intensive care unit strictly adheres to staffing ratios, notes Gerard, this is not the case in the ED where staff must continually prioritize which patients need care most urgently.

"Physicians and nurses can be pulled away from a patient on a ventilator for an extended period of time to care for an acute stroke or trauma patient," he says. "So it's not only knowing when to notify somebody, but when to even get an opportunity to go back in and reassess the patient."

Know When to Notify

To reduce risks, Gerard suggests that EDs develop formal criteria for when an EP should be notified about a boarded patient's changing condition.

"At triage, we use multiple parameters to prioritize care. We'll rush the patient back if the oxygen saturation is less than 93% or the blood pressure is greater than 190/120," he says. "But once the patient gets into a room, we haven't set up parameters for when you need to grab somebody to take a look."

Gerard sees boarded patients as an area of increasing legal risks for EPs. "There is a lot of staff turnover in EDs right now on a national level, and a lot of inexperienced nurses are working in a chaotic environment. People are getting pushed to their limits," he says. "EDs really need to tighten things up to protect the patients and themselves." ■

Sources

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Screening Out of ED? There Are Legal Risks

Lawsuit possible even if no EMTALA violation

Is your ED considering screening out non-critical patients by giving medical screening examinations (MSEs), as required by the Emergency Medical Treatment and Labor Act (EMTALA), then giving patients a choice of seeing a primary care doctor or paying a fee?

"This practice could lead to an EMTALA violation if some patients receive more thorough screening exams than others," warns **Johanna Novak**, JD, an attorney at Foster Swift Collins & Smith in Marquette, MI.

If the EMTALA-required MSE is performed but does not detect an emergency medical condition, the hospital would not necessarily have violated EMTALA but could still face a medical malpractice lawsuit, she adds.

"Courts have held in the past that a hospital that conducts an appropriate medical screen, yet fails to detect or misdiagnoses an emergency medical condition is not liable under EMTALA, even if the hospital is negligent and liable under medical malpractice laws," says Novak.

Inadequate MSE?

Richard D. Watters, JD, an attorney with Lashly & Baer in St. Louis, MO, says regulators could determine that the screening examination was inadequate and did not reveal an existing emergency medical condition as defined by EMTALA.

"So by asking for payment or having the patient see a primary care physician at a later scheduled appointment, you violate EMTALA's requirement to provide stabilizing treatment," he says.

There is also the risk that even though the ED provided an appropriate screening exam to satisfy EMTALA requirements, it failed to uncover a medical condition that a more complete examination would have uncovered, says Watters.

"You can do these things to the satisfaction of EMTALA requirements, but still do them negligently," Watters says. "In this case, the patient can sue for malpractice even though there would be no claim for violating EMTALA obligations."

If the original MSE was competently performed and no emergency condition was found to exist,

then the ED should not be liable if the patient's condition changed at a later time, says Watters. "The only exception would be if the physician knew, or should have known, that whatever condition the patient did have at the time of the MSE was likely to get worse before the patient could see a primary," he says.

Incomplete MSE Often Cited

A rushed or incomplete MSE is one of the most common citations under EMTALA, according to **William R. Forstner**, JD, an attorney with Smith Moore Leatherwood in Raleigh, NC.

There are also potential liability risks involving harm arising from a patient's "non-emergent" medical or psychiatric concerns, says Forstner. "Even if a hospital and physician comply with all applicable EMTALA regulations, some non-emergent patients still face risk of harm from their injury or disease," he says.

A patient who leaves the ED and deteriorates, leading to a bad outcome, potentially avoidable medical treatment, or death has a claim against the emergency physician and the hospital if the conduct falls outside of the standard of care, he says.

"Depending on the facts of the case, a jury often will not feel that 'the patient was not suffering from an emergency' is a sufficient explanation or defense," Forstner says. ■

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. ■

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CNE/CME QUESTIONS

1. Which is true regarding liability risks of screening out non-critical patients by giving MSEs as required by the EMTALA, then giving patients a choice of seeing a primary care doctor or paying a fee to be seen in the ED, according to **Johanna Novak**, JD?

A. This practice could lead to an EMTALA violation if some patients receive more thorough screening exams than others.
B. The hospital cannot be held liable for the patient's bad outcome under medical malpractice laws if the EMTALA-required medical screening exam is performed and does not detect an emergency medical condition.
C. If there is no claim against the hospital for violating EMTALA obligations, this means the patient has no basis to sue the EP for malpractice.
D. If the MSE was competently performed and no emergency condition was found to exist, the ED cannot be held liable if the patient's condition changed at a later time, even if the physician was aware the patient's condition was likely to get worse before the patient could see a primary care physician.

2. Which is true regarding videotapes of ED care being used as evidence in medical malpractice lawsuits, according to **William Sullivan**, DO, JD, FACEP?
A. If video recordings are obtained fraudulently or illegally, they are never admissible as evidence in civil matters in any state.
B. In some states, video recordings may be admissible as evidence in civil matters regardless of how the recordings were obtained.
C. Litigants don't ever need to prove that the evidence is relevant and reliable in order for videotapes made in the ED to be used as evidence during a trial.
D. If video recordings are not admissible at trial, these will always be inadmissible in administrative hearings or during arbitration hearings.

3. Which is recommended to reduce legal risks involving nursing documentation in electronic medical records (EMRs), according to **Michael Blaivas**, MD, FACEP, FAIUM?
A. EPs should never make a late entry in the patient's electronic medical record, even if a discrepancy is later noted.
B. If the EP is unable to read the nurse's notes, this should not be acknowledged in the patient's chart.
C. If the EP notes a discrepancy in the nurses' EMR charting, it should be noted that it was discussed with the nurse and followed up on.
D. If the EMR record is complete, it is not advisable for EPs to document or dictate that they spoke with the triage nurse and asked what was found, seen, or learned.