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Liability for Ancillary Staff in the Emergency Department: Legal Case Studies of Nurses and Physician Assistants

By Brian Snyder, MD, Gregory Moore, MD, JD, and Christopher S. Kang, MD, Department of Emergency Medicine, Madigan Army Medical Center, Tacoma, WA

While nurses have always had a presence in the emergency department (ED), the increasing prevalence and utilization of physician assistants (PAs) in EDs across the nation is generating a new and unique liability for emergency physicians (EPs). This article will familiarize the reader with pertinent legal concepts and recent cases that enlighten the issue of liability for ancillary staff in the ED.

In order to fully appreciate the following cases, it is important to understand three legal principles that govern liability in these situations. The pivotal concept is whether the physician has the ability to control the actions of the nurse or PA.

Vicarious Liability

Most people realize that they are responsible for their own actions, and that if they are negligent, they will be liable for their wrongdoing. Vicarious liability is the legal tenet where, even though someone has done nothing wrong, he or she is responsible for the negligent acts of others. The main principle is: A master is vicariously liable for the negligence of his or her servants committed while the latter are acting within the scope of their employment.[1] This principle is based on the concept of "respondeat superior," which is Latin for "let the master

answer," dating back to Greek and Roman law. In order to apply "respondeat superior," a master-servant relationship must exist. The master is considered to have the power to control the servant, and although a salary is not required, this concept has traditionally translated to the boss-employee relationship. Vicarious liability has been considered a legal fiction that arbitrarily assigns blame, despite no negligence. The court's philosophy is that when a party has been wronged, someone must be responsible. The entity that is in the best position to prevent or mitigate the injury is the one who should be liable. A distinction to note is that an employer is generally not considered responsible for an independent contractor.

The case *Lauro v. Knowles* legally defined the elements that determine liability.[2]

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Please contact **Leslie Hamlin, Managing Editor**, at leslie.hamlin@ahcmedia.com.

Element 1: The principal "boss" indicates that the agent is acting for them.

Element 2: The agent accepts the undertaking.

Element 3: Both parties agree to the principal being in control.

In summary, the court stated that "the essence of the relationship is the right to control the work of the agent."

Borrowed Servant Doctrine

The "borrowed servant" doctrine evolved from old English law. In the past, farmers who needed help with their fields would "borrow" a servant from another farm to help. If there was a wrongdoing, the farmer who "borrowed" the servant was vicariously liable, not the servant's original master. The legal definition is: The common law principle that the employer of a borrowed employee, rather than the employee's regular employer, is liable for the employee's actions that occur while the employee is under the control of the temporary employer.[3]

A hypothetical medical example that illustrates this concept would be when a physician directly orders a nurse to do something that results in injury to a patient. Although the nurse is an employee of the hospital, the physician would be liable, as he has "borrowed" the hospital's servant. The hospital would not be liable. However, under vicarious liability, the hospital would be liable if the nurse unilaterally acted outside of the established scope of clinical practice for her assigned role.

Captain of the Ship Doctrine

Just as the captain of a ship is considered to be responsible for all that occurs with regard to the ship, the "captain of the ship" doctrine provides that a physician who exercises control over a group of other health care professionals will be held liable for their negligence. It parallels the "borrowed servant" doctrine but provides for a broader and harsher responsibility. This doctrine has been applied despite the fact that some health care professionals are not employed by the physician, but instead, by the hospital. In *Johnston v. Southwest Louisiana Association*, a surgeon was held responsible for a sponge being left inside a patient and an inaccurate sponge count, even though he did not participate in the actual count.[4] However, the captain of the ship doctrine has recently fallen into disfavor in the

courts. Courts are sympathetic that a physician rarely has complete control in the hospital environment, and that it is unfair to apply vicarious liability. The "captain of the ship" doctrine imposes liability primarily on surgeons in an operating room, in essence stating that they are responsible for the entire environment/arena. The doctrine has been confined primarily to the operating suite, but one can see where it could be applied to an EP in charge of a team.

This doctrine has fallen out of legal favor since the pivotal case *Franklin v. Gupta*. [5] In this case, patient Franklin was scheduled for wrist surgery. He underwent initial evaluation with laboratory testing, EKGs, radiographs, and a preoperative visit from an anesthesiologist, Dr. Lee. Dr. Lee identified Franklin to be at significant risk for anesthesia complications due to a history of syncope, emphysema, asthma, hyperthyroidism, depression, and morbid obesity. Dr. Lee decided that Franklin should receive a nerve block instead of general anesthesia, but did not record or notify anyone else of his assessment or recommendation. The following day, Franklin was evaluated by a nurse anesthetist (NA), who also decided that a nerve block and opioid medications were the appropriate choice for anesthesia. The nerve block was found to be "patchy" and Franklin received multiple intravenous (IV) doses of opioid medication. The NA then left to consult the supervising anesthesiologist while a second NA monitored the patient. The consultation was requested by the surgeon, Dr. Gupta, who wanted the patient placed under general anesthesia. During the consultation process, Franklin developed shallow breathing and became cyanotic and bradycardic. Franklin was intubated, received IV atropine and CPR, and remained in the hospital for five days, never having the originally scheduled surgery.

The plaintiff, Franklin, claimed that Dr. Gupta was at fault under the "captain of the ship" doctrine, since the operating theater is historically under control of the surgeon, and that, in this situation, the NA or assisting doctors were borrowed servants in a temporary master-servant relationship. The defense responded that a surgeon should be judged in the capacity of a surgeon, not as an anesthesiologist. The court found that there was no evidence that Dr. Gupta exercised control or supervision. It also stated that due to the specialization in medicine as well as within the relationship of surgeon and NA or anesthesiologist, the "captain of the ship" doctrine is inapplicable. The final decision of the case by the court was to reject the "captain of the ship" doctrine.

Illustrative Legal Cases Involving Nurses

In *Minogue v. Rutland Hospital*, an obstetrical nurse was instructed by a physician to apply pressure to patient Minogue's chest and abdomen during the delivery of a baby.[6] The pressure was painful to the patient, who was quoted as saying, "You are breaking my ribs." The pressure did, in fact, break several ribs. The plaintiff, Minogue, brought suit, claiming that the employees of the hospital directly harmed her. The defendant, Rutland Hospital, argued that the physician was in control of the nurse's actions and, thus, the physician, not the hospital, was liable for the harm. The court concluded that the physician was liable, as he gave the order to apply pressure and the nurse was under his control, despite the fact that she was an employee of the hospital.

In contrast, a physician may not always be held liable for the actions of a nurse. In *Ferguson v. Dyer*, a 33-week pregnant woman, Ferguson, was evaluated in the ED and discharged home, but returned several hours later with worsening shortness of breath and respiratory distress.[7] Ferguson was intubated and admitted to the ICU under the care of the attending physician, Dr. Dyer. After two days of mechanical ventilation, Ferguson improved, was extubated, and did well for 27 hours before requiring re-intubation. The nurse alerted a resident physician (not Dr. Dyer) after Ferguson deteriorated. The resident physician arrived and had difficulty intubating the patient, which resulted in an anoxic brain injury. The plaintiff, Ferguson, brought suit and argued that Dr. Dyer was liable for the actions of the nurse, as she was a borrowed servant. Dr. Dyer argued that while he could give orders and direct patient care, he did not have true control over all of the nurse's actions since he had not been notified. The court agreed with Dr. Dyer that the mere potential or possibility of control is not sufficient by itself to find liability under the borrowed servant doctrine.[7]

These cases illustrate that a physician can be held liable for a nurse's actions under the borrowed servant doctrine, but that a physician may not necessarily always be held liable. The ability of the physician to control the actions of the nurse will be the determining factor in the case outcome.

Illustrative Legal Cases Involving Physician Assistants

In contrast to liability for nurses, cases involving PAs almost always hold the supervising or employing physician liable.

In *Flaherty v. Bell*, a PA evaluated a woman with nausea and headache. He suggested several ancillary tests, prescribed an oral steroid medication without antibiotics, and recommended a follow-up appointment;[8] a supervising physician did not see the patient. The patient had a sinus infection that subsequently eroded into her brain. The patient was taken to an ED when she deteriorated and was evacuated by helicopter to a facility with a neurosurgeon for emergency surgery. The patient had an additional surgery with partial craniotomy repair several weeks later and was hospitalized or in a rehabilitation facility for six months. The plaintiff, Flaherty, brought suit and claimed that the supervising physician was liable for the PA's care. She argued that it was the obligation of the supervising physician to actively discuss the patient encounter with the PA, instead of passively adding to the chart within a certain amount of time. This requirement was actually stated in the contract regarding supervision of the PA, and since the physician did not see the patient, there was a breach of that responsibility. The defendants contended that the plaintiff was contributorily negligent because she failed to obtain an X-ray and the blood tests that the PA had prescribed for her. At trial, the jury found in favor of the plaintiff, and awarded the plaintiff $2,290,589.14 and her husband $1,000,000.00 on his loss of consortium claim.

In another case involving a PA, *Navarro v. Austin*, a man awoke with a headache and double vision, and was taken by his wife, who was a nurse, to a nearby ED.[9] They were greeted by a man named Mr. Herranz, who performed and recorded a history and physical exam. Mr. Herranz had trained as a PA, but failed licensure testing four times. He was contracted by a larger medical group as an expediter or scribe, but was not given limits on his duties. The attending EP, Dr. Austin, met the patient Navarro and ordered testing, including a computerized tomography scan imaging of the brain, and reviewed the results, but did not perform his own patient exam, thinking that Mr. Herranz was a PA. The testing was reported negative for an emergent condition, and the patient was discharged home with a diagnosis of sinus infection, and provided analgesics and antibiotics. The patient returned to the ED several hours later with progressive symptoms of gait disturbance, confusion, and worsening headache. A cerebellar stroke was diagnosed on repeat physical exam and testing. The patient fell into a coma after respiratory failure, requiring mechanical ventilation. The patient was determined nearly brain dead, but slowly recovered from his coma and moved to a specialized rehabilitation facility. After nearly a year, he was moved to another facility for five more years before returning home with his wife. At the time of the trial, the patient was able to move only his right hand slightly, could not control his bowel or bladder, and required a feeding tube because he was unable to eat due to multiple choking episodes.

The plaintiffs detailed a series of alleged failures by the medical providers. The larger medical group had never written a job description for Mr. Herranz that limited his role in the ED; never alerted its employees that Mr. Herranz was unlicensed and should not perform any clinical duties; billed for Mr. Herranz's work as if he were a doctor; and, although officially Mr. Herranz's role was as an expediter or scribe, had no policies or procedures that stopped Mr. Herranz from engaging in the unlicensed practice of medicine. The defense reasoned that Mr. Navarro's brainstem injury resulted from the stroke itself and not from delays in treatment. They relied on the fact that strokes happen and that cerebellar strokes are rare. Dr. Austin stated that he did not know that Mr. Herranz was only an expeditor or scribe and believed that he was a PA. The jury rendered a verdict for the plaintiffs and awarded $216.8 million. The EP, Dr. Austin, was held liable for 25%, Mr. Herranz was held liable for 25%, and the medical group employer was held liable for 50%.When physicians work with PAs, there are often state laws that define the scope of practice and relationships. Employer practice policies and procedures are often required, and will determine responsibility, involvement, and level of supervision by the physician. Compensating entities (insurance companies, state agencies, etc.) may require a defined amount of physician involvement for various levels of billing. While some states may allow PAs to work independently, in the majority of situations, the physician will be held liable due to the above factors.

There are several types of documents that

are used to describe how a physician and PA will work together. These documents are often referred to as "supervision agreements," "delegation agreements," "job descriptions," "physician-PA practice agreements," or "supervision protocols." Whatever they're called, the purpose of the documents is to describe how the supervising physician and PA will work together; outline any specific requirements the physician has for the PA; explain how supervision will be documented; and provide general expectations for the physician and the PA. Some state laws require specific information to be included in the practice agreement. The best supervision agreements are general one- or two-page documents that allow flexibility and do not have to be modified every time the PA learns a new procedure or takes on a new task.[10]

Summary

Emergency physicians may be held vicariously liable when working with nurses and PAs. The key determinant is whether the EP has control of the nurse or PA. This control can occur either through actual direct employment or via a "borrowed servant" relationship. In light of the evolving composition of and dynamics within the ED workforce, especially in cases involving PAs, liability will be reduced if the EP follows established guidelines and personally evaluates the patient. ■

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Do ED Patients Have Legal Right to Receive Narcotics?

Mitigate risk of misdiagnosis

Your ED patient has the right to receive a medical screening examination and a thorough evaluation, but he or she does *not* have a legal right to obtain specific pain medications, according to **Knox H. Todd**, MD, MPH, professor and chair of the Department of Emergency Medicine at the University of Texas MD Anderson Cancer Center in Houston.

"Emergency physicians [EPs] often voice concerns that patients can demand opioids with backing of the legal system, but these concerns are unfounded," says Todd. "Patients may have a right to appropriate pain treatment, but there is no right to receive opioids."

EPs are often worried that patients can successfully sue simply because they aren't given narcotics to manage their pain, acknowledges **Andrew Lawson**, MD, FACEP, CPCC, acting director of quality assurance and quality improvement for the emergency physician group at Mission Hospital Regional Medical Center and principal of Lawson Coaching and Consulting, both in Southern California.

In fact, says Lawson, plaintiff attorneys aren't looking for battles — they're looking for low-hanging fruit.

"They're not going to go after EPs for not giving narcotics, and if they are, they're not going to be successful," he says. "It is exceedingly rare that a lawsuit is going to occur if a non-narcotic medication is offered, unless there is an obvious severe injury."

The EP may give acetaminophen to a chronic back pain patient with no legal repercussions, but if that same patient presents with a broken femur, "you have to take them off the wagon and given them narcotics," says Lawson.

"You will get burned by EMTALA [the Emergency Medical Treatment and Labor Act] if a chronic pain patient comes in with a truly acute condition and you refuse to adequately manage their pain, which could very well involve the administration of narcotics," he warns.

Risk of misdiagnosis

An EP may suspect a patient is a drug seeker

because he or she asks for Dilaudid by name, and this "will often be correct, but not always," says **Michelle M. Garzon**, JD, an attorney with Williams Kastner in Tacoma, WA. "There is a risk of missing something real."

Garzon has represented several EPs who were sued by patients alleging misdiagnosis where pain management was a component.

"If the patient is reporting a nine out of 10 pain score and is sent home with just one Percocet and not a thorough workup, that leaves a big gap for the plaintiff to say, 'They were treating me like they thought I was drug-seeking, and that is why they missed my diagnosis," she says.

If the EP's documentation shows, however, that a complete head-to-toe examination with a focal examination to address the pain complaint was done, says Garzon, "that can take the wind out of the plaintiff's sails. You can document that the patient's pain was out of proportion with the objective evaluation, as long as you can show that a thorough evaluation was done before you came to that conclusion."

Garzon says that once the EP has ruled out underlying causes of the pain, the best practice is to address the pain complaint, prescribe a limited amount of medication, and advise the patient to follow up with his or her primary provider within a certain period of time.

No SOC for Monitoring

Prescription monitoring programs are often unusable in the acute setting, according to Todd. The EP's judgment may be informed by data from a prescription monitoring program when available, but there is no standard of care that requires an EP to make routine requests for this data, he says.

"Clinicians are responsible for making a clinical judgment regarding a patient's risk for opioid misuse, and prescribing accordingly," he adds. Here are other risk-reducing strategies for patients who are possibly drug-seeking:

Be specific about what you excluded and why.

Incomplete charting can make it appear as though the EP was rushing through the process because he or she assumed the patient was a drug seeker, says Garzon.

Garzon notes that many of the EPs she's defended have told her they weren't surprised when a particular patient filed a lawsuit, saying, "I just had a bad feeling about this."

"If you are feeling that way about a patient you suspect is drug-seeking, you may want to be especially careful in documenting how you ruled out that the pain was not indicative of any kind of clinical problem going on," she says. "Show what diagnoses you considered and why these were ruled out."

Be specific in discharge instructions as to exactly where the patient should obtain follow-up care.

If the patient doesn't have a primary care physician, you can put in the name of a community clinic, says Garzon. "Putting in the phone number is an extra step you can take," she adds. "If you want to go one step further, you could say in the narrative notes, 'I discussed follow-up and provided a phone number.' That usually seals that issue. I haven't seen plaintiffs get past that."

Do not prescribe long-acting opioids to patients with acute pain or acute exacerbations of chronic pain.

The patient is at risk for over-sedation and respiratory depression, particularly if long-acting opioids are taken as needed, explains Todd. "Such adverse effects can lead to litigation if long-acting opioids are prescribed inappropriately," he adds.

Long-acting opioids are not indicated for acute pain, he explains, and requests for refills of long-acting opioids should prompt the EP to refer the patient to a chronic pain specialist or contact the patient's primary care physician.

"An opioid-related bad outcome occurring after prescribing unduly large quantities of short-acting opioids or long-acting opioids for the non-opioid-tolerant patient would seem to pose the most risk," says Todd.

If you document your belief that the patient has a drug dependency, be sure there are enough data in the chart to support this.

It's not enough to chart that the patient has a toothache and hasn't gone to his dentist, says Lawson. "You don't want to jump to that conclusion unless you have some pretty good support," he says.

For instance, the EP might chart, "I saw Mr. Jones before, and my partners have seen him 17 times in the last months. He asks for narcotics by name. I tried to contact his primary care doctor and was unsuccessful," says Lawson.

Involve the patient's primary care physician, the ED charge nurse, and the patient's family members.

"There is safety in numbers. If you have a

united front, that is going to protect you from any legal risk you might encounter," Lawson says.

If a family member acknowledges the patient's drug dependency or the primary care physician advises the EP against giving the patient narcotics, document this, advises Lawson.

Don't give narcotics unless you know the patient has transportation.

"We have all probably heard of the case of the patient who gets narcotics, gets discharged, and then gets pulled over by the police and arrested for driving under the influence, or even worse, harms someone while driving under the influence," says Lawson.

This can be prevented by having a policy in place stating that patients will not be given narcotics until a family member is present to drive them home, says Lawson.

Allow the record to show your concern for the patient's well-being.

For example, the EP may chart, "I am concerned about a drug dependency issue," or "The patient felt cold so I got him a blanket."

"That is a bulletproof chart in my mind. When somebody is blowing the chart up in the courtroom, it's very clear to everyone that the EP was concerned about the patient," says Lawson.

If the patient later claims the EP was callous and rushed the exam, "this is contemporaneous documentation and should win out," says Lawson. "Don't let the lawyer spin any tales." ■

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For more information, contact:

- Michelle M. Garzon, JD, Williams Kastner, Tacoma, WA. Phone: (253) 552-4090. Fax: (253) 593-5625. Email: mgarzon@williamskastner.com.
- Andrew Lawson, MD, FACEP, CPCC, Lawson Coaching & Consulting, Newport Beach, CA. Phone: (949) 400-5216. Email: drew@thelawsuitcoach.com. Web: www.thelawsuitcoach.com.
- Knox H. Todd, MD, MPH, Professor and Chair, Department of Emergency Medicine, The University of Texas MD Anderson Cancer Center, Houston. Phone: (713) 745-9911. Fax: (713) 792-8743. Email: KHTodd@mdanderson.org.

Lawsuits Alleging Under-triage Likely to Increase

Was a patient with an acute myocardial infarction (AMI) placed in your ED's fast track because he was mistakenly thought to have bronchitis?

"Under-triage is basically delay in diagnosis," says **Robert Dunne**, MD, FACEP, vice chief of emergency medicine at St. John Hospital and Medical Center in Detroit, MI. "It can result in serious liability."

Overcrowding, boarding, a growing elderly population, and more patients with complex technologies are some of the factors resulting in increased risk of under-triage, warns **Jonathan E. Siff**, MD, MBA, FACEP, director of emergency informatics and assistant director of medical operations for the Department of Emergency Medicine at MetroHealth Medical Center in Cleveland, OH.

"I don't see how it's going to get better without a major focus on addressing the issues of overcrowding, and specialized triage nurse training for at-risk populations that EDs are likely to encounter," he adds. Here are risk-reducing strategies to avoid under-triage:

EPs should not assume that all important questions were asked at triage.

"Even some low-priority triage patients have a serious medical condition," Dunne warns. "If you are stuck with a big volume, send someone out to the waiting room to eyeball folks."

EPs should "start from scratch" when taking the patient's history, says Dunne. "Do not start with the triage chief complaint. The triage does not matter at all once you see the patient," he adds.

EPs should document new information if this changes the patient's triage level or acuity.

Document the changes that occurred during the time the patient was in the ED, advises Siff, such as, "The patient arrived with stable vital signs and was in no distress. On repeat evaluation, patient now has tachycardia and chest pain."

EPs should also note when they obtained additional history that may change the course

of the evaluation, says Siff, such as a patient reporting weakness for three days whose daughter later says that the weakness started 30 minutes ago.

"You have a change in the triage priority based on new data," says Dunne. "So this is not really 'under-triage,' as there was no way to know originally."

If a nurse asks the EP to evaluate a patient whose condition has changed, Siff says the EP should go see the patient right away and then document that he or she responded "immediately."

"'Immediately' is a word that everyone understands," says Siff. "There is not a lot of ambiguity for plaintiff attorneys to work with."

If a patient turns out to have more serious illness or injury, do not hesitate to move him or her to a higher acuity area in your ED if available.

"There is a temptation to leave a patient in the room they were placed in, and not move them to [a resuscitation room] even if their condition changes," says Dunne.

Elderly at High Risk

"Most triage nurses are really good at their jobs. But there are a number of things that can result in mistriage, even by experienced triage nurses," says Siff. Here are some factors putting patients at risk for under-triage:

Patients with common diseases may present uncommonly.

The uncommon presentation of a common disease can trip up even the most experienced clinician, says Siff. For instance, elderly patients having an MI may present with only dyspnea.

"If the nurse at triage is not familiar with this, they may not get that stat EKG and expedite care for the correct, time-dependent diagnosis," he says.

The vital signs of elderly patients may be misinterpreted.

"The elderly seem to be at high risk for under-triage," says Siff. "Unless we see a big increase in training for triage nurses specifically targeted at evaluating the elderly patient, we will see an epidemic of under-triage as the population ages."

An elderly woman who reports vomiting for a week may still be dehydrated even with a heart rate of 70, notes Siff, if she is taking medications to keep her heart rate from becoming elevated.

"If you know you are going to start seeing more elderly people, which I think we can all say is going to be the case, make sure training for all ED staff is being done in anticipation of that increase," says Siff.

The triage nurse may decide not to assign the appropriate value.

Although the ED's guidelines say that every chest pain patient is to be triaged as a Level 2, the triage nurse may choose to send a healthy-looking young man complaining of chest pain to the fast track.

"The nurse may decide, 'He's young, he's not having a heart attack, I'm going to make him a Level 4,'" says Siff. "The problem is that your triage rules exist for a reason."

Triage nurses should feel free to increase a patient's acuity, but should never lower the acuity, from what the ED's policies state, says Siff. "Failure to follow your own rules is a sure way to lose a civil lawsuit," he warns. "It can serve as ammunition in an [Emergency Medical Treatment and Labor Act] investigation, as well."

Nurses may feel they need to "protect" the ED.

"Management needs to tell triage nurses not to try and protect the doctors and nurses in the back, where it may be very crowded," says Siff. "They should tell triage nurses, 'Follow the rules, follow your instincts, and we'll deal with it once the patient is in a room.'"

Make your clinical decision-making clear.

If the initial evaluation was delayed because the patient was triaged as Level 3 when he or she should have been a Level 2, and therefore the EP saw the patient an hour later than they would have otherwise, "then have a good clinical discussion of your thinking," says Siff, adding that this is advisable for all patients who are not low-risk.

"You don't need it for the ankle sprain or toothache," he says. "But for high-risk presentations — the worst headache of their life, back pain, fever — you need to have some clinical discussion of why you did what you did, and what you were thinking, regardless of the appropriateness of their initial triage."

As long as the EP follows the standard of care, he or she can be wrong and still not lose a lawsuit, notes Siff. "But if you can't justify why you did what you did, and you are trying to explain yourself three to five years later when a lawsuit comes up, it's pretty tough if that explanation is not in the chart," he says. ■

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For more information, contact:

- Robert Dunne, MD, FACEP, Vice Chief, Emergency Medicine, St. John Hospital and Medical Center, Detroit, MI. Phone: (313) 343-7398. Fax: (248) 735-2751. Email: Robert.Dunne@stjohn.org.
- Jonathan E. Siff, MD, MBA, FACEP, Director, Emergency Informatics/Assistant Operations Director, Department of Emergency Medicine, MetroHealth Medical Center, Cleveland, OH. Phone: (216) 778-7907. Email: jsiff@metrohealth.org.

Is ED's Quality Data Legally Relevant?

It could bolster plaintiff's claim

Is it a matter of public record that your ED scored in the lowest percentile in the state for meeting recommended timeframes for administering antibiotics?

If so, "I can't imagine how you can prohibit an attorney on either side from introducing that data," says **Alfred Sacchetti**, MD, FACEP, chief of emergency services at Our Lady of Lourdes Medical Center in Camden, NJ, and assistant clinical professor of emergency medicine at Thomas Jefferson University in Philadelphia, PA.

"If the plaintiff's attorney can nudge the jury the ED didn't meet the standard of care — because look, they almost never meet the standard of care — now you are in trouble!" he says.

Underscore Limitations

If the plaintiff alleges that the EP deviated from the standard of care because the patient failed to receive antibiotics in a timely fashion, and the ED has a track record of failing in this regard, that failure could bolster the claim, says **Edward Monico**, MD, JD, assistant professor in the section of emergency medicine at Yale University School of Medicine in New Haven, CT.

The defense would then need to have an expert question the validity and limitations of the data — in particular, that aggregate data can't be applied to an individual case, says Sacchetti.

If a patient developed an infection following a laceration repair in your ED, for instance, the plaintiff's attorney may try to bring into evidence data showing that the hospital has a higher infection rate than others in the state.

"They will say, therefore, you must have done something wrong," says Sacchetti. "A good expert should be able to take a jury through the difference between aggregate data, which looks at a whole year's worth of people, and what happened in this individual case."

While unimpressive quality data could make a case more difficult for the ED to defend, there are also potential disadvantages for the ED in calling attention to impressive quality data, says Monico.

For instance, the fact that the ED reduced its average length of stay could be an opportunity for the plaintiff to claim that a patient received short shrift because of administrative pressure to achieve a predetermined goal. On the other hand, prolonged length of stay data could open the door to complaints about delayed care resulting from a system issue.

"This could incorporate not only health care providers directly responsible for the patient's care, but administrative personnel, such as the department's medical director, if the issue was negligently addressed," says Monico.

Patient, Not Group

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, says he has heard of the possibility that a plaintiff's attorney might claim an Emergency Medical Treatment and Labor Act violation and subpoena, for example, every case of chest pain in the previous six months, to see if their client was treated differently from other patients.

"That is a legal quagmire, and what can they prove? They won't be able to subpoena the care in other cases because it is protected health information," he says. "Also, it's unlikely to lead to any discoverable evidence that would be relevant."

Similarly, Zafren says that juries aren't likely to be interested in an ED's overall performance or miss rate, even if this were to be brought into evidence by either the plaintiff or defense attorney.

"The fact that EDs are sending home 2% of people with missed [myocardial infarctions] is well-reported in the literature," he says. "If the miss rate is lower than the average ED, that's wonderful. But the jury is just going to say that the plaintiff is one of the unfortunate ones that got missed." ■

Sources

For more information, contact:

- Edward Monico, MD, JD, Department of Surgery, Section of Emergency Medicine, Yale University School of Medicine, New Haven, CT. Phone: (203) 785-4710. Email: edward.monico@yale.edu.
- Alfred Sacchetti, MD, FACEP, Chief, Emergency Services, Our Lady of Lourdes Medical Center, Camden, NJ. Phone: (856) 757-3803. Fax: (856) 365-7773. Email: sacchettia@lourdesnet.org.
- Ken Zafren, MD, FAAEM, FACEP, FAWM, Alaska Native Medical Center, Anchorage, AK. Phone: (907) 346-2333. Fax: (907) 346-4445. Email: zafren@alaska.com.

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 is true regarding liability risks involving pain management in the ED, according to **Knox H. Todd**, MD, MPH?
   A. ED patients clearly have a legal right to obtain specific pain medications.
   B. Successful lawsuits are very likely if patients aren't given narcotics to manage their pain, even if a non-narcotic medication is offered.
   C. There are no grounds for a successful lawsuit or violation of the Emergency Medical Treatment and Labor Act if a non-narcotic medication is offered, even if the patient has an obvious severe injury.
   D. The EP's judgment may be informed by data from a prescription monitoring program when available, but there is no standard of care that requires an EP to make routine requests for this data.

2. Which is recommended for EPs to reduce liability risks involving patients presumed to be drug-seeking, according to **Michelle M. Garzon**, JD?
   A. It is not advisable for the EP to document that a focal examination to address the pain complaint was done.
   B. If follow-up is required, EPs should include the name and phone number for the clinic or physician in the discharge instructions.
   C. EPs should prescribe long-acting opioids to patients with acute pain or acute exacerbations of chronic pain.
   D. EPs should generally avoid documenting a family member's acknowledgement of the patient's drug dependency.

3. Which is recommended regarding liability risks involving undertriage, according to **Jonathan E. Siff**, MD, MBA, FACEP?
   A. EPs should document new information if this changes the patient's triage level or acuity.
   B. If a patient turns out to have more serious illness or injury than the initial triage presentation, it's generally not advisable to move the patient to a higher acuity area in the ED.

C. Triage nurses should never increase a patient's assigned triage level from what the ED policies state.
D. Triage nurses should feel free to assign a lower triage level to a patient than what the ED's policies state is appropriate.

4. Which is true regarding an ED's quality data in the event a malpractice lawsuit is filed, according to **Edward Monico**, MD, JD?
A. If the plaintiff alleges that the EP deviated from the standard of care because the patient failed to receive antibiotics in a timely fashion, and the ED has a track record of failing in this regard, that failure could not be used by the plaintiff to bolster their claim.
B. If publicly available quality data are introduced by the plaintiff, the defense would not be allowed to have an expert question the validity and limitations of the data.
C. The plaintiff would not be allowed to argue that a patient received poor care because of administrative pressure to reduce the ED's length of stay.
D. Data indicating a prolonged length of stay in the ED could open the door to complaints about delayed care resulting from a system issue.