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Expect ED Delays to Be Issue During Malpractice Litigation

Whether an emergency physician (EP) has deviated from the accepted standard of care on the basis of timeframe depends on the facts of the individual case, says **Robert D. Kreisman**, JD, a medical malpractice attorney with Kreisman Law Offices in Chicago.

"In the end, the standard of care is about medicine and not about wait times," says **Gregory M. Nowakowski**, JD, an attorney formerly with Rogers Mantese & Associates in Royal Oak, MI. "While attorneys may make a big deal out of a hospital's non-adherence to wait times or some other time-based guarantees, the fundamental question will always be, 'Did the ED physician meet the medical standard of care?'"

In one of Kreisman's cases, the patient presented to an ED vomiting and reporting "the worst headache of my life," shortly after being discharged from the same hospital with a diagnosis of meningioma, which was scheduled to be treated in the coming weeks.

The patient waited several hours to be seen by an EP, who then called the neurologist who had previously diagnosed her. "On the basis of that call and without further re-evaluation, the ED released her," says Kreisman. "It turned out that the patient was in the process of a brain herniation, which led to her premature death later that same night."

The case was settled for $2.1 million, but Kreisman says an analysis showed that the time spent waiting in the ED was not a factor. "The date and time of record entries are essential," he stresses. "The fact that the entries are not timed is often problematic for doctors in explaining why treatment of a patient went wrong."

In another case, both the EP and the hospital were named in a suit involving a young man with a history of heart problems who presented with dizziness and shortness of breath. "The triage nurse chose not to take a complete history that included the patient's heart condition history," says Kreisman. "The man was actually suffering from endocarditis that because of the delay in care and

treatment, led to his death." The case settled for $650,000.

If a critically ill or injured patient arrives in the ED and is evaluated as a patient in urgent need of critical care, but treatment is delayed because of other critically ill patients, hospital entries showing that could be utilized in defending a lawsuit for negligence, says Kreisman.

"That circumstance could lead to hospital policy and procedure changes in dealing with multiple critically ill or injured patients when capacity is reached," he says.

Misleading Claims Pose Risks

If EDs advertise wait times of 30 minutes or less, or post current wait times on the hospital's website, these claims could come up during medical malpractice litigation, says Nowakowski. "'Violating' your own wait time rules would be a difficult claim to make," he adds.

However, the plaintiff could argue that corporate policies resulted in understaffed EDs and undue pressure on EPs to rush patients through, and if a patient's care is delayed because a service marketed by the ED isn't available, a claim could be based on the theory of detrimental reliance, says Nowakowski.

Making claims that an ED's stroke, cardiac, or trauma care is equal to or better than a tertiary care center is "asking for trouble," according to **W. Ann Maggiore**, JD, an attorney with Butt Thornton & Baehr PC in Albuquerque, NM, especially when the ED doesn't deliver the kind of care advertised and a patient has an adverse outcome.

"Besides the obvious pitfalls, plaintiff's lawyers can use this 'false advertising' to support unfair trade practices claims that may circumvent negligence damage caps," adds Maggiore. "Some of these statutes carry stinging penalties."

If a patient's attorneys successfully demonstrate that delayed care resulted from false, deceptive, or misleading advertising statements that drew a patient into an ED that didn't deliver what they advertised, a hospital could be found liable, warns Maggiore.

"One hospital was bold enough to advertise that patients should not travel to the primary stroke center an hour away, but instead to their hospital for stroke symptoms — the opposite of what the American Heart Association advocates," says Maggiore. Another hospital received a punitive damages judgment after advertising that its ED had competent physicians and the plaintiff's attorneys proved that the hospital only used non-emergency medicine-boarded physicians in its ED in order to save money. In that case, a patient died after an abdominal aortic aneurism was missed.

"Any ED currently advertising 'no waiting' is asking for trouble because that can never be guaranteed," says Maggiore. "I haven't personally had a case where the 'no waiting' ads have come up, but I expect they will — and soon." ■

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What Can "Empty Chair" Defense Do for Sued EP?

If the hospital *isn't* named in a medical malpractice lawsuit, an emergency physician (EP) defendant can sometimes take advantage of the "empty chair" defense strategy, says **Joseph P. McMenamin,** MD, JD, FCLM, a partner at Richmond, VA-based McGuireWoods LLP and a former practicing EP.

If there is no codefendant hospital, and if the record supports the testimony, an EP might be able to able to claim, "The nurses didn't tell me x, y, or z, when in fact each was true," or "They didn't bring to my attention the alarming change in the patient's vital signs."

"If the hospital isn't there, then you can criticize the hospital all day long and the jury might buy that. They might, indeed, find that the plaintiff has simply sued the wrong party," says McMenamin. "In certain circumstances, that can be an effective defense."

If the EP takes the same approach when the hospital is also a defendant, however, "it's dangerous, because if you criticize the hospital, its personnel may respond in kind," says McMenamin. Even if the EP uses the "empty chair" defense and blames the hospital, though, the plaintiff attorney isn't likely to let the EP off the hook. He or she might try to discover how long the EP was aware that a particular nurse wasn't very reliable, for instance.

"Never underestimate the creativity of the plaintiffs' bar," McMenamin warns. "These are clever people, and they will come up with ingenious, even diabolical, theories that can trip you up."

Additional Defendants

Naming other parties besides the EP in a malpractice lawsuit is "easy enough to do," says McMenamin. "Generally speaking, from the standpoint of the plaintiff, the more defendants the better," he says. "There are a whole slew of reasons why plaintiffs are very happy to have more defendants."

A lawsuit might include both a malpractice claim against the individual EP and a malpractice claim against the emergency medicine group and/or the hospital, based on the theory that the EP is acting as an agent for another party "and, therefore, his malpractice is now, it will be argued, their malpractice," says McMenamin.

From the EP defendant's standpoint, if the hospital is also named in the suit, there is the possibility of shared liability. If there is joint and several liability, as is often the case, the hospital would be liable for 50% of the verdict rather than the physician being liable for 100%, says McMenamin.

"Assuming you can fashion a united front, you have not one but two lawyers hammering away at the plaintiff's experts," he adds. "You perhaps even have the opportunity to share experts — maybe not on standard of care, for example, but on causation."

Juries typically have a low threshold for finding against an organization or institution, rather than an individual, notes McMenamin. "They may see the hospital as a pile of bricks, when, in fact, it's a bunch of human beings working with restricted resources often under difficult circumstances," he says. "From the EP's point of view, looking at it purely selfishly, that mistaken viewpoint may not be entirely bad."

If the jury finds against the hospital, however, there's a risk that the jury will "just lump the doctor in with the hospital and not draw a sharp distinction between the two," adds McMenamin.

Also, if the hospital is named in the malpractice suit, administrators might choose to defend themselves by criticizing the EP. "If that happens, then you are dodging bullets being shot at you not only by the plaintiff but also by your co-defendant, the hospital," says McMenamin. ■

Source

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A Simple Callback Might Stop Malpractice Suit

Measuring the number of ED malpractice claims that are avoided by calling patients post-discharge is difficult, acknowledges **Jeanie Taylor**, RN, BSN, MS, vice president of risk services for Emergency Physicians Insurance Company (Epic) in Roseville, CA. "It is hard to measure what did not occur, so the effectiveness of callback programs from a claims perspective is largely anecdotal," she says.

However, Epic promotes a callback program to all of its insured ED groups as a way to reduce risk. "We firmly believe that liability risk is reduced through an effective callback process, especially if the process focuses on high-risk patients who are discharged," says Taylor.

Emergency physician (EP) groups routinely report cases to Epic in which a bad outcome was avoided through its callback process. "Probably the most common situation we hear about is a patient who was discharged with abdominal pain who relays ongoing symptoms during the callback, and is diagnosed with appendicitis when they return to the ED for another visit, as advised during a callback," says Taylor.

In this scenario, the EP is viewed as the one who caught the appendicitis during the callback, instead of the provider who missed the appendicitis in the initial visit, says Taylor.

High-risk Patients

"Callbacks are a great way to catch misdiagnoses or missed diagnoses, to address misperceptions of care, and to get in front of potential legal issues," says Taylor. "Plus, they boost patient satisfaction in the process."

Taylor says it's important to have carefully scripted language for staff completing the calls. "You don't want to create any additional liability by having staff provide bad advice," she says. "Clinical staff is ideal for the callbacks. The facility must verify their competency in completing the calls."

She recommends these practices:

- Make sure all staff doing callbacks are trained on how to manage ongoing concerns the patient brings up during the call;
- Develop protocols so staff know how to handle issues that come up during the calls;
- Ensure that an EP is available to answer questions and speak with patients when needed;
- Document the call in the permanent medical record;
- Call patients discharged following treatment for higher-risk conditions such as chest pain, abdominal pain, pediatric fever, fractures, or headache, as well as patients the EP is especially concerned about; and
- Callback patients who leave against medical advice or without completing treatment.

"We all know that patients who leave the ED against medical advice are high risk, both for an adverse event and the likelihood of pursuing a claim," says Taylor. Calling them the next morning might diffuse the situation if they left angry. It lets them know you are concerned and creates a safety net by encouraging them to return to complete treatment, she explains.

Taylor adds that a plaintiff's attorney with a case in which a patient experienced a bad outcome after leaving the ED against medical advice would likely not be pleased to read in the medical record that the physician or facility called the patient back the next morning to make sure they were O.K. and to invite them back to complete treatment. "In some situations, this, in itself, might influence the plaintiff attorney's desire to pursue a case," she adds.

Opportunity to Get Personal

Callbacks might be particularly beneficial in mitigating the unique legal risks faced by EPs because they lack the personal relationship with patients that primary care physicians develop over time, says Taylor. "This less personal relationship opens the door for patients to file a claim against a provider they don't know and sometimes don't believe cares about them," she explains.

When the patient gets a call from an ED repre-

sentative who says, "Dr. Smith saw you yesterday in the emergency department and asked me to call and see how you are doing today," it "makes the relationship more personal. It delivers more than the patient expected," says Taylor.

Taylor says the ED callback should focus on how the patients are doing, whether they understand the discharge instructions, and whether they filled their prescriptions, instead of asking if there is anything that would keep them from rating their care as excellent.

"This line of questioning is much more specific and productive," she says. "When patients are asked rating questions, they know the facility is only trying to boost their satisfaction ratings, versus really caring about their health." ■

Source

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Do You Rely on "Ad Hoc" Interpreters in Your ED?

Harmed patients have successfully sued

In one case involving the death of a 9-year-old girl from a reaction to metoclopramide, misdiagnosed as gastroenteritis, the patient and her 16-year-old brother were called on in the ED to interpret for their Vietnamese-speaking parents. The ED's written discharge instructions explaining when to return to the ED were signed by the parents, but the instructions were in English.[1]

"The hospital did not provide competent oral interpreters nor translation of important written documents." says **Mara Youdelman**, JD, managing attorney in the Washington, DC, office of the National Health Law Program. The case was settled for $200,000.

In another case, a 17-year-old high school girl born in Taiwan who came to the ED reporting a fever and headache after an injury, interpreted for herself until she suffered respiratory arrest. She was transferred to the intensive care unit and taken to surgery, where it was confirmed that she had a brain abscess.[1]

"She died the following day. The girl's parents alleged that a delayed response by the treating physician led to a delay in the surgery for her brain abscess," says Youdelman.

Lack of an interpreter for a 3-year-old girl presenting to an ED with abdominal pain resulted in several hours delay in diagnosing appendicitis, which later perforated, resulting in peritonitis, a 30-day hospitalization, and two wound site infections.[2] In another well-known case, misinterpretation by paramedics and emergency department personnel of a single Spanish word to mean "intoxicated," instead of its intended meaning of "feeling sick to the stomach," led to a $71 million malpractice settlement associated with a potentially preventable case of quadriplegia.[3]

Errors Very Common

An average of 33 interpreter errors are committed in ED encounters, with as many as 246 errors committed in one encounter, according to a study of two Massachusetts pediatric EDs.[4] **Glenn Flores, MD, FAAP,** professor of pediatrics, clinical sciences, and public health and director of the Division of General Pediatrics at UT Southwestern Medical Center and Children's Medical Center Dallas, and the study's lead author, says he was surprised at the frequency of errors.

"The number of errors in a single encounter is possible because in a longer encounter of an hour or more, an ad hoc interpreter, like a child or family member, could make dozens or even hundreds of errors of interpretation," he explains. About one in five errors had potential clinical consequences, with an average of six errors of potential clinical consequences per encounter, and up to 47 in a single encounter.

"These findings indicate that interpreter errors are common in the ED, and a not inconsequential proportion of these errors have potential clinical consequences," says Flores. This is concerning, he adds, because interpreter errors have been documented to cause or be associated with preventable harm and serious injuries, including overdoses, misdiagnosis, and quadriplegia.

Suits for Failure to Provide

Youdelman says that the biggest liability risk

she sees for EPs caring for patients with limited English proficiency is failure to provide competent interpreters. "Too many emergency departments rely on patients, family members, minor children, and other ad hoc interpreters who do not have sufficient command of both English and the non-English language, particularly with regards to medical terminology," she says.

Flores says that while ED patients with limited English proficiency should always be provided with a trained professional interpreter or bilingual health care provider, this doesn't always occur. In a study of 530 Latino adults seen in one urban ED, no interpreter was used for 46% of patients for whom an interpreter was thought necessary by the patient or clinician. When both the clinician's Spanish and the patient's English were poor, interpreters were not called in one-third of the time, and among interpreters used, 39% had no training.[5]

"Ad hoc interpreters — untrained staff, family members, friends, or strangers pulled from the waiting room or street — should never be used," underscores Flores.

In the study of the two pediatric EDs, professional interpreters resulted in a significantly lower likelihood of errors of potential consequence than ad hoc and no interpreters.[3] Interpreters with at least 100 hours of training committed lower proportions of errors of potential consequence overall and in every error category.

Ka Ming Ngai, MD, MPH, a clinical instructor in the Department of Emergency Medicine at Mount Sinai School of Medicine in New York, NY, says that at a minimum, EPs should document the time and date an interpreting service is used; the name of the interpreter; whether it is an in-person interpreter provided by your hospital, certified ED staff as interpreter, or a phone or video interpreter provided by vendors; and whether the patient refused a professional interpreter offered by the ED. Youdelman says even if a patient refuses a professional interpreter, the ED should involve a professional interpreter to monitor the encounter, ensure accurate communication, and protect the ED from legal risk.

EPs with limited language skills are themselves at risk if they attempt to communicate with patients without using interpreters, cautions Youdelman. "Often, the provider may not have the knowledge of medical terminology in both languages or have insufficient language skills to accurately obtain a patient history, make a diagnosis, discuss treatment options, and obtain patient consent," she adds.

Youdelman adds that EPs face legal risks if they attempt to obtain informed consent from limited English proficient patients without competent interpreters and translated documents. "When a non-English speaking patient merely signs an English document, it is unlikely a court would recognize informed consent," she says. ■

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Patient Leaving Without Diagnosis? Avoid Suits By Clarifying Limitations

Charts often lack EP's thought process

The most significant legal risks in the ED are not those associated with boarding patients or high-acuity traumas, but rather, those associated with relatively stable patients with undifferentiated diagnoses, according to an analysis of malpractice cases occurring from 2006 to 2010 from Crico Strategies' Comparative Benchmarking System database. *(To request a paper or electronic copy of the report,* Malpractice Risks in Emergency Medicine, *go to http://bit.ly/Rsd5Ov.)*

For these patients, inaccurate assessments and loss of critical information between caregivers are noted to have led to errors in diagnosis and premature discharge, reports **Gretchen Ruoff, MPH, CPHRM,** program director of patient safety services for Crico Strategies, a Cambridge, MA-based patient safety and medical professional liability company.

Missed and delayed diagnoses were the most prevalent allegation cited in 47% of the 1,304 cases studied. "We started out looking broadly at all cases with a primary allegation relating to emergency medicine, and found that almost 50% of ED cases involved a missed or delayed diagnosis," says Ruoff. "The injuries in those cases were more severe than those resulting from other ED cases, thus resulting in higher payments."

The key drivers of missed or delayed diagnosis cases were inadequate assessments, judgment errors related to ordering a test or image, communication breakdowns among team members, and unreconciled clinical information at discharge.

Stephen G. Reuter, JD, an attorney with Lashly & Baer in St. Louis, MO, has defended a number of cases involving a bad outcome after patients were discharged from the ED without a clear diagnosis.

"I have seen medical records where the emergency physician's diagnosis is 'pain' or 'headache.'" That's not a diagnosis, that's a symptom," says Reuter. "I've also seen a number of records where the EP is sued and there is no diagnosis at all. If I'm a plaintiff lawyer, I'm jumping all over that."

Reuter says that an emergency physician (EP) should rethink discharging a patient if their diagnosis is a sign or symptom rather than a source of the sign or symptom, or should at least have a plausible explanation for the patient's particular symptoms, whether headache, back pain, or epigastric pain.

"Since we work in the hospital, we have access to every test the hospital can possibly run available. It's truly an overwhelming array," says **Bruce Wapen**, MD, an emergency physician with Mills-Peninsula Emergency Medical Associates in Burlingame, CA. "Yet, at the end of the day, there is a fairly significant subset of patients where we have not found anything that we can say caused the problem."

Onus on Patient

While the EP might admit an elderly patient with unexplained chest pain who doesn't look well for observation, he or she will probably discharge a younger patient with the same symptoms and no history or risk factors for cardiac problems.

"Now, how do you protect yourself? The primary way is in the veracity of the discharge instructions," says Wapen. "They need to be time-specific. They can't say, 'Come back as needed.' That's not going to cut it."

At the very least, discharge instructions should always state, "Return to the ED immediately for new or worsening symptoms, or if your symptoms don't improve," says Wapen. "Now, anybody with a lick of sense would come back if they have a fever they didn't have before, if their pain gets worse, or if they don't get better," he says. "Otherwise, the patient may say, 'They saw me two days ago and they didn't figure it out; there's no point in going back.' Without clear, concise instructions, the onus is on you."

For instance, the EP may tell the patient, "Go see Dr. Smith tomorrow. Call the office and let them know you were seen in the ED for these symptoms." "The more documentation you have with people in the ED having had that conversation with the patient before they were released, the better off you are," says Reuter.

If you are concerned about a time-dependent diagnosis, refer the patient to the primary care physician (PCP) or to a specialist within one to two days and refer to a specific name, address, and phone number, advises Wapen. If the patient doesn't have a PCP, the EP might tell the patient to come back to the ED for a recheck in one to two days, he adds. This protects those patients who otherwise can't arrange follow-up.

While ideally the EP calls the PCP to arrange follow-up, he or she also has an obligation to manage multiple patients simultaneously, notes **Robert B. Takla**, MD, MBA, FACEP, chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI.

"The hard part comes when the patient doesn't have a physician," he says. In this case, the EP should play a part in the solution, such as arranging a clinic appointment, but if the EP has clearly stated, 'You need to follow-up with a doctor within three days,' the onus is still on the patient," says Takla.

Convey Limitations

"It's obviously preferable to get a diagnosis before you release someone from the ED. But often, that's not reality," says Reuter. "When a patient is discharged without a diagnosis, the plaintiff and defense attorney experts will argue about what the standard of care is."

The EP's duty is to rule in or out life-threatening problems that might have caused the patient's complaint, advises Wapen. "For chest pain, the things that have the potential to kill you are heart attack, collapsed lung, pneumonia, pulmonary embolism, and aortic dissection. They are all in the differential diagnosis," he says. "That said, we still wind up with lots of chest pain patients in whom we have no answer."

Wapen advises using the term "diagnostic impression" instead of "diagnosis." "Other doctors in private offices have the luxury of time and can wait for the patient to come back to the office after having a trial of some therapy or a consultation or two," he says. "In the ED, we have a short window of opportunity of a few hours or less to do the tests we need to do and come to a decision. It is not always possible to arrive at a firm diagnosis in that limited time frame."

EPs are "not held to a standard of perfection. That is an important concept," says Wapen. "The plaintiff attorney may act as though EPs are never allowed to miss a diagnosis, but that's not the case."

The EP is held to a standard of care that is what a reasonable physician with similar training would do in the same or similar circumstance, says Wapen. If the EP has done all the appropriate testing and still doesn't have a diagnosis, the EP is likely to be within the standard of care to discharge the patient with instructions to follow-up with a specific doctor in a specific timeframe, he adds.

"There comes a point where pursuing additional diagnostic studies is neither appropriate nor in the patient's best interest," Takla says. "The list of differential diagnoses may be very long. What we need to do as EPs is make sure life- and limb-threatening things are ruled out, or explain why they are so unlikely that they don't warrant investigation."

Takla says that honesty with the patient is paramount, and the EP should state clearly that his or her role is to rule out any life- or limb-threatening emergencies. "We should not make a diagnosis just for the sake of making a diagnosis," he says. "Making that diagnosis when you're not sure what it is has more liability than saying to the patient, 'I'm not sure what the cause is.'"

An EP might tell a patient, for instance, that they don't know the cause of his or her abdominal pain, but that diagnostic tests didn't suggest anything indicating that the pain is dangerous. Next, the EP needs to emphasize the need to follow-up with a primary care physician or return if symptoms worsen.

EPs sometimes feel pressured to come up with a diagnosis because patients don't like leaving the ED without knowing what's going on, explains Takla. Instead of admitting they don't know the cause of the abdominal pain, they might diagnosis peptic ulcer disease, gastroesophageal reflux disease, or irritable bowel syndrome. "Therein lies the danger of telling the patient a diagnosis, which the patient then carries with them," Takla says. "I think that's unethical and inappropriate."

Indicate Decision-making

Reuter says that too often, records reveal nothing about what the EP was considering in terms of the cause of a patient's symptoms. In this case, the defense attorney has to find other places in the record to piece together in retrospect what the EP was thinking.

"Let's say the EP orders or prescribes [sumatriptan] for the patient with a headache and happens to write down 'history or migraine.' We can cobble together a diagnosis, even though it wasn't in the chart," he says.

Takla has reviewed many charts involving ED patients discharged without a clear diagnosis in which the EP's care was appropriate but lacked any documentation of medical decision-making. "That is the number one problem I see in the cases I review. From reading the chart, it has to be clearly understood that the dangerous stuff was considered and ruled out," he says.

Takla adds that a set of discharge vitals is often missing from charts. "If somebody comes in with abnormal vitals and you send them home without a repeat of normal vitals, that is a little more difficult to defend," he says.

Wapen recently cared for a patient who reported a two-week history of a gurgling sound in the left ear. He considered an atypical presentation of a carotid artery lesion. However, it was Saturday and the vas-

cular lab at his hospital wasn't open.

When the patient returned on Monday, as instructed, the carotid Doppler ultrasound showed a lesion. The vascular surgeon was consulted, and a CT angiogram of the head and neck revealed a 4 cm dissection of the internal carotid.

Wapen says that if the patient had had a bad outcome before returning to the ED, documentation indicating the nondiagnostic presentation, consideration of possible diagnoses, and appropriate care given the limitations at his facility would have made a lawsuit defensible.

"If a plaintiff attorney claimed that a reasonable physician would have sent the patient by ambulance to a vascular lab for an immediate study, we would need to provide documentation that the way we did things was within the standard of care," he says. ■

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Copy and Paste in ED: "Dangerous Practice"

Don't rely on inaccurate information

An elderly man presented to an emergency department (ED) with new-onset chest pain. In reviewing the patient's electronic medical record (EMR), the emergency physician (EP) noted a history of "PE," but the patient denied ever having a pulmonary embolus. Further investigation revealed that many years earlier, the abbreviation had been used to stand for "physical examination," but someone had mistakenly copied and pasted "PE" into the patient's past medical history. The error was carried forward for years.[1]

Cutting and pasting of an ED patient's history without verifying the data is risky, as there is no guarantee that the information being copied into the new record is accurate and current, warns **Edward Boudreau**, DO, FACEP, FAAEM, president and CEO of Epic, a Roseville, CA-based professional liability insurer.

"What is meant as a time saver and efficiency booster can indeed be a dangerous practice," says Boudreau. However, some ED EMRs allow for past medical history from previous visits to be imported into a current document.

"Most physicians would not consider reviewing the paper record of a prior visit and copying it verbatim into the record for a new visit without verifying it with the patient, especially if they do not know that particular patient," says Boudreau.

If EMRs automatically populate data into new records, "the clinician can ill afford to accept any imported document without careful review," warns **Sam Bierstock**, MD, founder of Champions In Healthcare, a consulting company in Delray Beach, FL, specializing in advising hospitals, physicians, and technology companies on implementing EMRs and health care information technology.

For instance, an EP might import the history and physical from a patient's initial visit for an injury when the patient returns three weeks later with a wound infection. If the patient had been in the ED with an unrelated event in the interim, information from the wrong visit could be imported.

"The problem arises, in general, from the reluctance of many hurried clinicians to deal with structured data entry and templates," says Bierstock.

An ED nurse might use "copy and paste" to document that a patient has no reported history of cardiac risk factors, without realizing that the history stored in the EMR was recorded *before* the patient was seen at another facility with an ST-elevation myocardial infarction the previous year.

"A physician who relies on this information and fails to verify it with the patient risks making a potentially critical error regarding the patient's plan of care and the need for admission versus discharge," says Boudreau. The EP would surely be named in the claim if a bad outcome occurred, he adds, even though the error stemmed from nursing documentation.

Samantha L. Prokop, JD, an associate at Brennan, Manna & Diamond in Akron, OH, says that one of the most common issues related to EMRs she sees in emergency medicine litigation involves copying and pasting outdated or incorrect information. "It is important that if the copy and paste function is used, that the health care provider independently verify the information and indicate this in the record," she advises.

Here are some legal problems that can result from use of copy and paste functions for ED documentation:

• The EMR autofills data fields.

For example, if an ED nurse is documenting fluid intake and output every hour, the EMR might allow the nurse to enter the volume in and out the first time, and automatically populate that same information every hour.

If the nurse gets busy, forgets to change the values, or looks at the record and thinks he or she has already completed the documentation because it's in the record, the values never get changed.

"Imagine you have a lawsuit a year later where the intake and output information is crucial," says Prokop. "The plaintiff now puts the records in front of your nurse and asks why she never reported to the physician that the patient had no urinary output for 12 hours."

The nurse might claim that he or she would have called the physician, and questions why all the entries are the same, says Prokop, but the defense later learns that the nurse was unaware that the data were being automatically filled in by the EMR. "Further, we discover that the nurse's 'live' computer screen looks different than the final medical record that the medical record department prints out and provides in litigation," says Prokop.

The ED nurse has no idea what her documentation looks like in final format, and has no idea that when she electronically signs off on a record as being accurate, she may not be viewing all applicable information, explains Prokop.

• The copy and paste function is used to document assessments that never occurred.

Vital signs might be documented consistently in the patient's chart, but interestingly enough, are all identical. "When the IT department performs an audit of the documentation, it is apparent the nurse created one entry at the end of her shift and copied and pasted all other entries within minutes of the first entry," Prokop says. She recommends EDs use these risk-reducing strategies:

• Create policies and procedures indicating limitations on the copy and paste function, and set forth who is responsible for verifying the accuracy of the information if the copy and paste function is used;

• Implement an auditing process for copied and pasted entries, and keep track of the error rates;

• Provide education to practitioners on the patient safety risks and financial risks of using a copy and paste function improperly;

• Educate practitioners on how their entries in the "live" version of the computer screen will appear in the official legal copy of the medical record, to avoid inconsistencies and ensure that all information is accurately reflected;

• Ensure that the EMR has an audit function to track copied and pasted entries and ensure that it is being used to monitor such entries;

• Implement a process to notify practitioners when copy and paste functions were improperly used, or information was not accurately recorded;.

• Implement a mechanism where copied and pasted entries will look different than manual entries, such as italicized text or different colors;

• Ensure that copied and pasted data are attributed to the original author, and indicate that the practitioner reviewed and verified the data in the current assessment; and

• Consider disabling the copy and paste functions for certain fields.

John Lee, MD, an EP and informatics director at Edward Hospital in Naperville, IL, says these parts of the EP's documentation lend themselves to inserting predetermined content:

• data entered by other providers, such as nurses, physicians, or other ancillary staff, either during the current visit or carried forward from previous visits;

• data generated by diagnostic or therapeutic departments, including lab and radiology results; and

• content in template format, either from the information system or the documenter. "For instance, a doctor may always have a certain pattern when performing a physical exam," says Lee.

In the past, EPs would have to actively search for this type of information to incorporate it into a note, making errors unlikely, says Lee. "The ease, speed, and volume of current electronic systems make it much more likely a key piece of data may be missed or erroneous information entered," he says.

Lee says that resulting conflicting documentation will hurt an EP's credibility in the event a lawsuit is filed. For instance, an EP might document a normal musculoskeletal exam in a patient who has had an amputation, or order a test to rule out a disorder that the patient has already been determined to have.

"However, I also believe that these issues will become less of an issue as more of the data become discrete, and that data circle back to the clinician in

the form of decision support," says Lee.

Switching from the subjective/objective/assessment/plan format to the assessment/plan/subjective/objective format should make copying and pasting in EMRs less relevant, adds Lee, as "it will highlight our cognitive processes better and deemphasize the copy forward data." ■

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1. "Case Report: Sloppy and Paste." [Commentary by R. Hirschtick]. July 2012 AHRQ Web M&M: Morbidity and Mortality Rounds on the Web. Agency for Healthcare Research and Quality, Rockville, MD. Available at http://webmm.hrq.gov/case.aspx?caseID=274.

Sources

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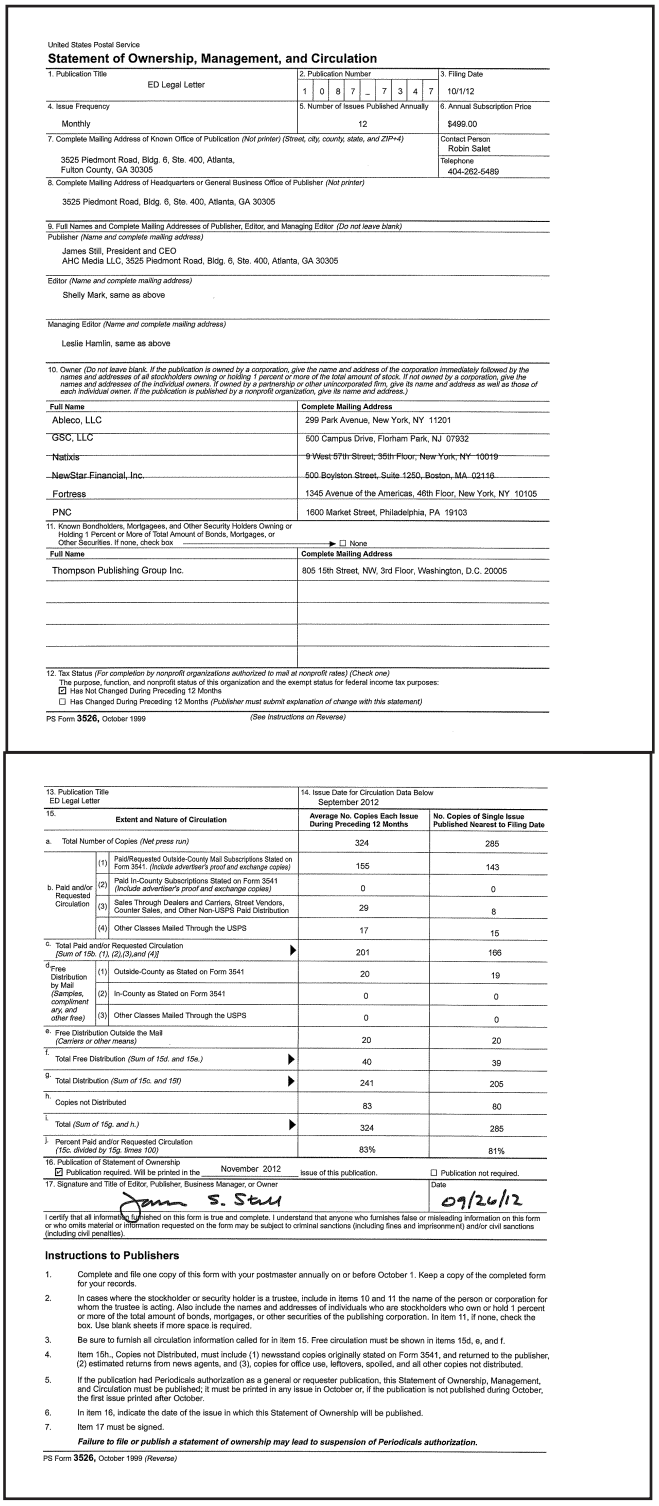
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice. ■



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PS Form **3526,** October 1999 *(Reverse)*

CME/CNE QUESTIONS

1. Which is true regarding ED malpractice cases, according to Crico Strategies' Comparative Benchmarking System report?
   A. The most significant legal risks in the ED are those associated with boarding patients.
   B. The most significant legal risks in the ED are those associated with high-acuity trauma patients.
   C. The most significant legal risks in the ED are those associated with relatively stable patients with undifferentiated diagnoses.
   D. Only a small percentage of cases included an allegation of missed and delayed diagnoses.

2. Which is recommended regarding discharge instructions for patients without a clear diagnosis, according to **Bruce Wapen**, MD?
   A. Discharge instructions should not specify the timeframe the patient needs to follow-up within.
   B. Discharge instructions should always state, "Return to the ED immediately for new or worsening symptoms."
   C. It is not advisable to include a specific name, address, and phone number if a patient is being instructed to follow up with a specialist.
   D. It is not advisable for the EP to contact the primary care physician directly to arrange follow-up.

3. Which is recommended to reduce legal risks involving patients discharged from the ED without a diagnosis, according to **Robert B. Takla**, MD, MBA, FACEP?
   A. EPs should avoid charting the term "diagnostic impression" instead of "diagnosis."
   B. EPs should avoid telling patients directly that they are not sure what the diagnosis is.
   C. EPs should explain to patients that their role is to rule out any life- or limb-threatening diagnoses.
   D. EPs should keep in mind that documenting a set of normal vital signs at discharge for a patient who presented with abnormal vitals might make a case less defensible.

4. Which is true regarding legal risks involving the copy and paste function in the ED's electronic medical record, according to **Samantha L. Prokop**, JD?
   A. To reduce risks, copied and pasted data should be attributed to the original author and indicate that the EP reviewed and verified the data in the current assessment.
   B. Having copied and pasted entries appear different than manual entries, such as italics or different colors, increases legal risks for EPs.
   C. Disabling the copy and paste functions for certain fields will make a lawsuit less defensible.
   D. The EP cannot be held liable for a bad outcome that occurred due to reliance on an incorrect patient history resulting from nursing documentation which improperly used the copy and paste function.