ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

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Extending Care Outside ED Brings New Liability Risks

EPs face "double-edged sword" of liability

Were you called by the intensive care unit (ICU) because a patient needs emergent intubation due to a dislodged tube or deterioration of the patient's status?

The emergency physician (EP) could be held liable if the intubation is unsuccessful — if, for example, the patient is without oxygen for too long or there is an esophageal intubation — warns **Jill M. Steinberg**, JD, a shareholder at Baker, Donelson, Bearman, Caldwell & Berkowitz, PC, in Memphis, TN.

"EPs also could be liable if they address a non-emergent situation in another part of the hospital and there is a complication in the ED," says Steinberg. "When the EP responds, that may leave his or her ED patients unattended."

EPs are increasingly responding to codes, semi-elective intubations in critical care, and putting in lines, and may face increased legal risks as a result, according to **John Tafuri**, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland.

"This will become a bigger issue as time goes on," he predicts. "Hospital budgets are getting tighter. Everyone is trying to save dollars by not paying for separate house physician coverage, and assigning those duties to the EP on duty."

Steinberg says she has seen a number of claims involving EPs assisting outside the ED, particularly in smaller hospitals that do not maintain 24-hour coverage of the ICU by critical care specialists, and EPs being called to do deliveries in hospitals without 24-hour obstetrician hospitalists.

"As ER physicians provide care outside the ER, many of the same issues follow them," says **Joshua M. McCaig**, JD, an attorney with Polsinelli Shughart in Kansas City, MO. For instance, an EP called to perform a difficult intubation or line placement might arrive with little history on the patient and be asked to perform a procedure that has typically already been attempted unsuccessfully.

"If something occurs, even if there is no negligence, the ER physician is now a party," says McCaig.

Immunity Is Possible

In order to be covered under Good Samaritan immunity, the EP must receive no financial remuneration and have no duty to service, notes Tafuri.

"If the agreement with the hospital says you cover any in-floor emergency, then you have a duty to serve," he explains. "Consequently, the Good Samaritan law wouldn't apply." On the other hand, if the EP cares for a patient outside the ED with no contractual or understood duty to cover the floors, Good Samaritan protection might apply.

Tafuri says that caring for patients outside the ED presents a major liability risk for EPs, not only from the standpoint of the patients cared for outside the ED, but also the patients in the ED who may be considered "abandoned" by a physician who leaves the ED to attend to an in-house emergency.

"It's a double-edged sword, and both ends go against the EP," he says. To reduce risks, consider these strategies:

• Document when you were first called about the patient.

Another physician might have been responsible for the patient's deterioration, but the EP could still be held liable, says Tafuri. "You are jumping into a problem that may have been going on for a few days," he says. "You may be dragged into things you had no party to making, and everyone involved may be tarred with the same brush."

Timing will become critical in the event a lawsuit is filed. "There may be questions later such as, 'Why did the patient languish for four hours and was so critical that he was unsalvageable at that point?'" says Tafuri. "If you didn't get called until right after the patient crashed, document that."

McCaig represented an EP called for an emergency intubation outside the ED. "The patient ended up coding days after this procedure for unknown reasons," he says.

The EP's note stated simply that he performed an intubation. However, the hospital staff testified that the EP had a difficult time and struggled to finish the procedure. "This gave the patient enough ammunition to keep the ER physician in the case," says McCaig.

If the EP had described the procedure, noted the difficulty, confirmed his post-procedure evaluation and that the patient was doing well, his case could have been easily defended. "Instead, it took much longer and more of an expense to get him dismissed from the case," McCaig says.

• Document exactly how you followed up with the physician.

"If you are not going to be continuing to take care of the patient after the patient has been stabilized, it's important to communicate with that doctor if there was any problem with his or her patient," says Tafuri.

• If the attending physician is reluctant to come in and assume care for the patient who has deteriorated, or if there is a significant disagreement about how to treat the patient, consider having a nurse listen in on the call.

"When there are two people on the call, it's hard for somebody to say, 'No, it didn't happen that way,'" says Tafuri. "If a nurse is listening to the call, I believe that it is ethically appropriate to inform the attending physician that the nurse is also on the call."

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• **Don't refuse to provide care.**

"If you are the only one there, always provide care if you can. Sort out the legal issues later," advises Tafuri. "A jury of laypeople will get it when you are trying to do the right thing."

• **Be familiar with the hospital policies and procedures related to any duties the physician has outside the ED.**

If there are no policies, the ED physicians should clarify their responsibilities in other parts of the hospital, says Steinberg.

"Further, the EP should be familiar with the on-call system for physicians in other specialties. Understand how to get other backup for handling emergencies outside the department," she advises. ■

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Accept Responsibility for Boarded Patients, or Face Suits

Don't engage partway

If a nurse asks the emergency physician (EP) whether an arterial blood gas (ABG) is needed because a boarded patient's pulse oximetry is dropping, a busy EP's response might be to tell the nurse to order the test and let the admitting physician know about it.

"But the nurse forgets to call the admitting physician, and nobody checks it," says **Kevin Klauer**, DO, EJD, chief medical officer at Canton, OH-based Emergency Medicine Physicians. "The patient decompensates, goes into respiratory failure and dies — and you're the one who ordered the ABG."

This unfortunate scenario is commonplace, says Klauer, and comes from EPs making the mistake of "getting in halfway," in terms of their involvement with admitted, boarded patients.

"When a patient is an admitted patient, to some extent we write them off a bit and disengage, because that's what we are used to doing. The problem is, they used to leave and now they don't," says Klauer. "Ignoring these patients as though they are someone else's is the largest liability you can have."

False Sense of Security

If a boarded patient's pulse oximetry is dropping, this means the patient needs to be reassessed, he stresses, so the EP should order the ABG but also consider other tests that are needed, and should contact the admitting doctor for possible intensive care unit (ICU) admission.

The EP could call the admitting physician and state, "I stepped in to help you with your patient who's not on the floor yet, but I can't continue to manage them. Come down here and take a look at them."

"Now the admitting physician is re-engaged and the EP is back 'out.' What you can't do is get in halfway. That will always get you into trouble," says Klauer. "When the patient is in the ED, you are never fully 'out.' If they have a problem, you need to get back in."

Routine daily decisions such as dietary orders can and probably should be deferred to the admitting physician, says Klauer, but any unexpected problem or change in status that requires evaluation is going to fall to the EP.

"It's absolutely our responsibility," says Klauer. "EPs might think they are insulated because the patient is admitted to somebody else. That's a false sense of security because that patient is still in the ED."

It is difficult to know the number of ED medical malpractice claims that occurred as a result of boarding, since boarding isn't listed as the cause of action, says Klauer. A lawsuit might allege, for instance, that a patient developed sepsis and died because antibiotics weren't administered during the 15 hours spent boarding in the ED.

"When you dissect some of these cases, you

find that boarding is probably the reason a bad outcome happened," says Klauer. "There was no clear transition of care, and nobody was accepting responsibility for their care."

EP Is Responsible

Previously, EPs assumed that once they talked to the admitting physician and he or she agreed to admit the patient, the patient was no longer the EP's patient.

"That was true when they left the department. But now that they are staying in the department, there are some questions that need to be asked," says Klauer. "The transition of care that used to be the simplest of all is now muddy."

Klauer says to "look around. If the admitting physician isn't rounding on the patient, you are responsible. Even if they are, if there is a bad outcome, you are the physician of record."

Klauer has seen several claims in which there was a clear trend of decompensation over a period of hours, but the EP was never notified, and the admitting physician may or may not have been notified because he or she wasn't present.

"The patient decompensates in the ED, or after they get to the floor, or during transportation, and everyone wonders how it happened so quickly. It doesn't," he says.

The plaintiff attorney will track the bad outcome back to the ED and ask the EP, "Why didn't you do something?" he says.

"As busy as we are in the ED, the admitting physician is probably feeling just as much pressure on the floors," says Klauer. If the patient isn't upstairs and the admitting physician doesn't feel as though he or she is actively taking care of the patient, the physician is unlikely to come down to the ED and accept responsibility, he adds.

"When the hospital clearly doesn't send anyone to help you, what are they saying? 'It is still your patient,'" says Klauer. "Until that patient is gone from the department, you're not going to be actively managing each piece of lab work, but you still have responsibility."

Patients Status Evolving

The admission status of boarded patients is in a holding pattern, but the same isn't true of their disease process, and patients will get worse if no one is managing their care, warns Klauer.

"Every disease process we are managing, particularly on the inpatient side, is in evolution," he says. "This is a huge patient safety issue that subsequently translates into a huge professional liability issue."[1]

Klauer says he is seeing increasing numbers of claims alleging that a bad outcome occurred because of the EP's failure to intervene while a boarded patient was still in the ED. "There is a whole new class of cases developing involving patients who are boarded for many hours and need care," he says. The EP might be legally responsible for making sure these patients receive ongoing care that is normally considered beyond the scope of emergency medicine — deep vein thrombosis (DVT) prophylaxis, pulmonary hygiene, and decubitus ulcer prevention, for instance.

"The admitting physician and team aren't out there managing these patients most of the time," Klauer says. "If a patient is boarding in your ED for a day or two, you are probably going to be held responsible for complications such as DVT and decubitus ulcers." To reduce liability risks involving boarded ED patients, consider these practices:

• EPs should consider other options.

If you know a patient is going to be boarded for a lengthy time, consider placing him or her into observation status. "That way, we are formally taking care of them and haven't abdicated our responsibilities," says Klauer. "We haven't delegated it to somebody else who says they've admitted them, but isn't really engaged in their care, as there are no beds upstairs."

Transferring the patient is another option because it provides a clear transition of care, says Klauer. "If there is no end in sight, maybe they are better off being cared for at another facility," he adds. "If they are out of your institution and somebody else has accepted responsibility, you are no longer responsible."

• EPs should document any intervention they perform or anything they are notified about.

EPs often fail to document care provided to boarded patients, such as writing an order for another dose of pain medication, according to Klauer. "Calling the admitting physician to write the order usually doesn't work. They will say, 'Well, I haven't even seen the patient yet,'" he says. "If you intervene, you've got to document your involvement."

• The ED's policy should dictate that if there is any question or concern about any patient in the ED, the EP is the one who is notified.

"And they have to act on that," says Klauer. "Don't ignore what the nurses are telling you about an abnormal vital sign or any other issue with the patient."

Emergency nurses often do not have clarity in terms of who is managing the boarded patient, says **Tom Scaletta**, MD, ED medical director at Edward Hospital in Naperville, IL, and president of Smart-ER, a healthcare communications company in La Grange, IL.

"The emergency physician is reticent, unless the patient is crashing. And some inpatient docs are reluctant to do hallway evaluations of new admissions," he says.

If the hospital's policy requires admitting physicians to take full responsibility for boarded patients and round on boarded patients in the ED just as they would if the patient were upstairs, this would substantially reduce the liability of the EP, "but that is absolutely the exception and not the rule," says Klauer. "Also, if the admitting physician walked out the door and a minute later that person had a cardiac arrest, it would be the EP's responsibility to intervene."

EPs absolutely need to be aware of anything that is supposed to happen with a boarded patient, or anything that changes with that patient, emphasizes Klauer.

"There is no way to successfully explain to a jury of laypeople, being the only physician in the proximity of that patient, that you didn't have some responsibility to take care of their needs," says Klauer. "There is no way that is going to fly." ■

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Psych Patient Leaves AMA? Mental Capacity Will Be Issue

Poor charting can "doom the defense"

Malpractice litigation often arises from a psychiatric patient discharged from the ED against medical advice (AMA), according to **Robert Berg**, JD, an attorney at Epstein Becker Green in Atlanta, GA.

"Something bad happens, either to the patient or to others, and the plaintiff's lawyer commences the search for the proper — or deep pocket — defendant," he says. "Usually, that search focuses on or points to the ED and the emergency physician [EP]."

Plaintiff attorneys will look for discrepancies between what EPs are required to do in this scenario, according to the hospital's policies and procedures, and the way the EP acted in the particular case, says Berg.

"The wider the gap, the more a good plaintiff's attorney can pit one defendant against another, increasing the chances of obtaining a large damages verdict," he says. "A lack of proper documentation can also doom the defense of an action challenging the AMA discharge of a psychiatric patient."

Frequent ED users with psychiatric-associated visits were more likely to leave AMA, according to a study that looked at all ED visits at 18 San Diego hospitals occurring between 2008 and 2010.[1]

EPs might minimize the seriousness of patients with chronic psychiatric illness who use the ED frequently, says **Ted Chan**, MD, one of the study's authors and medical director of the EDs at University of California — San Diego Hillcrest Medical Center and the Thornton Hospital in La Jolla.

"You can become somewhat cynical or jaded because they are coming so frequently," says Chan. "You have to treat each patient as an individual, and try to get them to the resources that they need."

In a 1987 case involving a patient who stabbed a police officer, the decision of a medical center to release the patient against medical advice was challenged. "The court held that there were no reasonable grounds for the treat-

ing psychiatrist to seek involuntary commitment of [the patient], and judgment was made in favor of the medical center," says Berg.[2]

In a 1995 case, a family alleged that a veterans hospital and two of its nonpsychiatric physicians should not have released a patient who died by suicide within hours of his discharge against medical advice because he was a clear suicidal risk.[3]

"The court found that although the patient had expressed suicidal tendencies in the past, he showed no signs of being a genuine suicidal risk on the morning of his discharge," says Berg. "The physicians were not found negligent in their treatment of the patient."

Competence Is Issue

Because concern over a mental health condition raises the question of competence to make decisions, such as the decision to accept or refuse treatment and the decision to stay or leave AMA, the EP must quickly and efficiently determine whether the patient is competent to make his or her own decisions, says **Bobbie S. Sprader**, JD, an attorney with Bricker & Eckler LLP in Columbus, OH.

"Once the mental health assessment is complete, the conclusions reached will guide the care going forward," she says. Sprader says that the ED's policy should address these issues:

- Who can trigger a mental health assessment?
- What is the process for obtaining a mental health assessment?
- Who will perform mental health assessments?
- What is the timeframe for mental health assessments (stat, within 30 minutes, etc.)?
- How do you contact the assessor (pager, phone, computer)?
- What do you do on evenings and weekends?
- What should you do until the mental health assessment is complete?
- Can you prevent the patient from leaving? If so, how?
- Can you restrain or sedate the patient?
- Can you leave the patient unattended?

"If the policy is in place and is followed, hopefully lawsuits can be avoided altogether," says Sprader. "If there is a lawsuit anyway, having a good policy, *if it was followed*, should prove very helpful for everyone."

Berg says this documentation can help EPs defend themselves if a malpractice suit is filed:

• How the determination was made that the patient had the capacity to decide.

The decision to be discharged AMA is typically only valid if the patient has the capacity to understand the risks and make the determination to be discharged, Berg stresses.

"With psychiatric patients, there is always an issue involving mental capacity," he says. "If the patient does not have the mental capacity to make that decision, the ED doctor may face significant risk of liability for allowing the patient to be discharged AMA."

EPs should generally include more, rather than less, information concerning the patient's evaluation, says Berg. "A thorough history and examination, as documented in the record, can help support the validity of the decisions made by the ED doctor regarding mental capacity," he explains.

• That the patient was advised of the important points involved in the decision to be discharged AMA.

"Include a note that the patient was offered the opportunity to ask questions, and, at the end of the encounter, expressed a clear understanding of the items noted," says Berg.

• That any alternative courses of treatment or alternatives to signing out AMA were conveyed to and understood by the patient.

If the EP's actions are challenged after a bad outcome, proper documentation showing the lengths that the EP took in order to avoid an AMA discharge usually helps the defense, says Berg.

"Document confirmation that the patient clearly understood his or her medical condition, the risks of being discharged against medical advice, and the possible alternatives," says Berg. ■

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Standard of Care Breached with Boarded ED Patient?

Does a malpractice suit filed by a boarded ED patient allege he or she was being monitored differently in the ED than would have occurred in the intensive care unit (ICU)? In one claim that included this allegation, the ED nurse's notes clearly showed that the same standard was followed in the ED.

"It was just standard one-on-one nursing with a critically ill patient, which is something that ED nurses do just as well as ICU nurses," says **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA, who reviewed the claim. "Under those circumstances, when there is no particular difference in care, then the standard is the same for both places."

There is an exception, however, if special procedures are being performed that are not normally performed in the ED, says Lawrence. These include monitoring an arterial line, an aortic balloon pump, or dialysis — all procedures that might be done in the ED if a patient is boarded.

"If someone is on an aortic balloon pump, for example, an ICU nurse or pump technician should take care of it. That is a different standard of practice," says Lawrence.

Floor Nurses in ED

Patients admitted to ICU status who are boarded in the ED should receive the same standard of critical care nursing as if they were in the ICU, according to **William C. Gerard**, MD, MMM, CPE, FACEP, chairman and professional director of emergency services at Palmetto Health Richland in Columbia, SC.

Normally, an admitted patient in the ED has a brief period of transition where essential fluids and medications are administered, he says. "After that period, the care provided must be the standard of the location that the patient's inpatient status designates," says Gerard. "Just because the location is different, the skill set of the nursing care should not be different."

Gerard says that every attempt is made to bring critical care nurses down to the ED to care for boarded patients, but this rarely happens. "In my experience, we are held accountable to the admission status, regardless of location," he reports. "This is not realistic. But in the eyes of the regulators of health care, there aren't different tiers of admission based on location."

Gerard says that a plaintiff lawyer could argue that the standard of care was breached if he or she can prove that ED nurses do not have the same level of orientation, training, skills, competencies, and validation procedures that inpatient critical care nursing units have. "I believe it is a great argument that we don't provide the appropriate care," he says. "That is why [the Centers for Medicare & Medicaid Services] CMS is tracking ED throughput metrics, with formal reporting in 2014. They know this is a liability and a potential source of harm."

Although the most common legal definition of standard of care is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances, the standard of care is often a subjective issue and opinions can differ, notes Gerard.

"My biggest concern is that if we continue to have boarded ICU patients in the ED, and some facilities respond by consistently providing critical care nursing with additional skills, will this practice become the new routine norm?" says Gerard.

Lawrence says that since it's very institution-specific as to when and whether floor nurses come down to care for boarded ED patients, this can't be considered as the legal standard of practice.

Plaintiff attorneys wouldn't even be aware that other boarded patients were cared for by critical care nurses while their client was cared for by ED nurses, he adds. "What is otherwise happening simultaneously in the ED almost never gets admit-

ted into evidence as relevant," Lawrence explains.

An ICU nurse caring for a boarded patient in the ED almost always communicates with the admitting physician and not the emergency physician (EP), unless an emergency occurs, notes Lawrence, "so even though the patient is physically within the ED, it's really an ICU patient. Hospitals can almost never go wrong because they brought in an ICU nurse to take care of a boarded patient."

Patient Perceptions

Lawrence has reviewed several claims in which ED patients alleged they received inadequate care because they were placed in a hallway. The allegation in the complaint is almost always that the patient was left to languish in the hallway and didn't receive the same care and attention as if they were in a room, he says.

"But, in fact, they are being taken care of the same as anybody else," says Lawrence. "Patients that are not critically ill and don't need close monitoring are often put in hallways." The perception of ED patients and families that they are being ignored because they're in a hallway can be the instigating factor in a suit, however.

"Communication with the family is of the utmost importance," says Lawrence. "Every satisfaction survey I've ever seen says patients would rather be on a hallway on the floor, but trying to get hospitals to do that is difficult."

If boarding leads to substandard care, this can obviously result in a bad outcome, as well as litigation, says Lawrence, and can help paint a picture of an uncaring situation of a patient being abandoned out in the hallway.

"If the patient feels they were treated badly and then something bad does happen, the patient connects dots that shouldn't necessarily be connected, but they do it anyway," he says.

Gerard says that increased liability risks of caring for patients in a hallway are due more to patient dissatisfaction than quality of care, and recommends that EPs sit down with the patient and family and explain the situation.

"Simply rotating patients in and out of rooms and hallways for 'discharge' is a strategy we have used. This allows everyone to be in a 'room' for at least a portion of their stay," says Gerard. "Quality of care is the same, but their perception is that the experience was more meaningful when they get in a 'real' bed."

Lawrence says that careful charting that meets the standard of care in both frequency and content for boarded and hallway patients will refute any contention that patients are being abandoned.

"Frequent communication between the EP and the patient and the patient's family as to the status of treatment and the availability of a floor bed will prevent most feelings of abandonment experienced by these patients," he adds. "As usual, communication and documentation are the keys." ■

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New ED Protections Already Challenged

In Georgia, statutory protections for emergency physicians (EPs) have survived two constitutional challenges.

The 2005 enactment of tort reform in Georgia "has been beneficial to all physicians, but is particularly helpful to those providing care in an emergency department setting," according to **Joe Cregan**, vice president and general counsel at MagMutual Insurance Company, an Atlanta, GA-based medical professional liability insurance company.

Georgia's tort reform act of 2005 contained a section that changed the standard of proof in cases involving any physician providing care in an emergency setting to gross negligence. "So in order to find a medical provider to be liable, you would have to prove the physician's conduct constituted gross negligence — essentially, a gross disregard for the care of the patient," says Cregan.

Secondly, the new law upped the evidentiary standard from preponderance of the evidence

to a standard of clear and convincing evidence. "What this means is that it is now more difficult for a plaintiff's lawyer to establish liability in an ED setting," he says. "Once those provisions were enacted into law, we expected there would be constitutional challenges, particularly on the issue of equal protection, among other things."

Two Georgia Supreme Court cases have already challenged the provisions. The first was *Gliemmo v. Cousineau*, a March 2010 decision involving the emergency treatment of a female patient for what later turned out to be a stroke.

"The ED doctor was being sued because he had sent the patient home earlier in the day without doing a CT scan or [magnetic resonance imaging]," says Cregan. "The case was dismissed by the trial court on the grounds that it didn't meet the standard of gross negligence."

The plaintiffs appealed, arguing the tougher negligence standard for emergency medicine violates the state constitution. The Georgia Supreme Court disagreed, upholding the gross negligence standard, and thus, the statute survived.

The next case, *Watkins v. Anegundi*, involved a separate challenge to the ED gross negligence standard that involved whether the expert affidavit attached to the plaintiff's original complaint alleged gross negligence. "The determination of the trial court was that the affidavit did not establish gross negligence occurred," says Cregan. "The Supreme Court, citing the Gliemmo case from two weeks earlier, agreed, again finding the statute to be constitutional."

The first case was a 4-3 decision and the second was a 7-0 decision, both in favor of the constitutionality of the gross negligence standard in ED care. "Since both cases were decided favorably, it's clear that in Georgia, going forward, that emergency room care is going to be protected to a higher degree," he says.

Since 2005, MagMutual's reaction to tort reform has been to file and receive three rate decreases for EPs in Georgia, reports Cregan. "The statute enacted in 2005 has survived its most difficult constitutional challenge," he says, adding that there are still two undecided cases in which plaintiffs allege the ED statute's language is unconstitutionally vague.

Cregan says it appears that plaintiff lawyers have abandoned further direct challenges to the constitutionality of the emergency care statute and, instead, are attacking their cases factually. For example, they are focusing on how they can demonstrate that the patient's presentation to the ED was not truly an emergency.

"Or sometimes, they argue that the emergency situation was resolved before the allegedly negligent care took place, so they can get that analysis back to an ordinary negligence standard," Cregan says. ■

ED Peer Review Process IDs Trends Before Suits Occur

A new peer review and quality improvement process at the University of Michigan Hospital and Health Systems in Ann Arbor methodically samples patient safety indicators in the emergency department (ED) to spot trends that signal problems.

"We monitor cases for peer review monthly, based on a predetermined set of criteria," says **Steven Kronick**, MD, MS, service chief of adult emergency medicine and associate professor in the Department of Emergency Medicine.

These criteria are deaths in the ED, deaths within 24 hours of admission, transfers of admitted patients to the intensive care unit from the floor within 24 hours, deaths within 24 hours of admission, and admissions to the hospital seen and discharged from the ED within the previous 72 hours.

"We also review all cases referred to us by other services, as well as any case referred from anyone in the department," says Kronick. "Cases may also be self-referred."

Cases are reviewed by a committee of emergency medicine faculty, and there is also an institutional safety monitoring reporting system. Cases referred through this system are reviewed if the care delivered by the provider is implicated in the report.

One particular area of concern is identifying risk in patients with gastrointestinal hemorrhage. Patients can seem to be relatively stable, and when there is deterioration, it is frequently sudden, explains Kronick.

Although hundreds of cases are reviewed every year, there have been remarkably few trends identified, says Kronick. "One specific trend is the identification of those patients who are at risk for deterioration within the first 24 hours of admission,"

he reports. "Aggressive care in the first few hours can have a significant impact on outcome. It is extremely important to be able to identify these patients."

Variations Identified

"If we identify a trend, we perform a root cause analysis to determine if we think there is some element of the trend on which we think we can have impact," says Kronick.

For example, a review of suspected ectopic pregnancy cases revealed that there was a lack of standardization around the management of these cases. "We adopted the method used at another site that involved standard management and follow up. There have not been any further concerns to date," says Kronick.

By comparing emergency physicians against their peers, it was discovered that there is great variation in individual practice. "In some cases, that has led us to consider standardization. But in many cases, there is not enough evidence to recommend one practice over another," says Kronick.

Kronick says that it is difficult to demonstrate that the frequency of ED malpractice claims has decreased, since the number of claims is low to begin with.

"But there is a sense that practice is more safe," he says. "Patients are getting better care when we standardize the care delivered around high-risk diagnoses." ■

Sources

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One in Three ED Suits Involve Poor Communication

Can patients truthfully claim that ED staff ignored their complaints and communicated poorly with one another?

"In litigation, patients' families love to talk about how 'No one would listen to me!' to garner sympathy and paint the ED nurses and doctors as rushed and uncaring," says **W. Ann Maggiore**, JD, an attorney at Butt Thornton & Baehr, PC, in Albuquerque, NM. "This is a very familiar refrain, and juries don't react well to it."

One out of every three ED malpractice claims involved breakdowns in communication by physicians, nurses, or both, according to an analysis of 1,304 cases occurring from 2006 to 2010 from Crico Strategies' Comparative Benchmarking System database.

"Effective communication is critical when providers are managing multiple patients with diverse needs," emphasizes **Gretchen Ruoff, MPH, CPHRM,** program director of patient safety services for Crico Strategies, a Cambridge, MA-based patient safety and medical professional liability company. *(To request a paper or electronic copy of the report,* Malpractice Risks in Emergency Medicine, *go to http://bit.ly/Rsd5Ov.)*

Multiple providers might be involved in the care of ED patients without a clear diagnosis, notes Ruoff. "If the problem is not immediately clear, those are the patients who spend the most time in the ED," she says. "The process of ruling out life-threatening diagnoses and zeroing in on the right diagnosis occurs over a longer span of time than a patient with a high-acuity trauma."

Various consultants might be involved, says Ruoff, and "all of those loops need to be closed, while each provider is balancing multiple patients."

Over-reliance on electronic medical records (EMRs) as a primary means of clinical communication increases legal risks for EDs, according to Ruoff. "This has reduced face-to-face interaction and led to a loss of natural 'touch points' for providers to synthesize independent bits of knowledge about their patients, especially at change of shift," she says.

Ruoff recommends that ED caregivers use "diagnostic huddles" to improve communication and reduce liability risks. "Providers can come together and make sure they know all of the information about the patient, not just the view of the screen they are looking at," she says.

Crico's researchers wrote the report partly because of findings from an emergency medicine leadership council held in 2012, which analyzed ED malpractice cases and found many were linked to breakdowns in communication among caregivers due to over-reliance on EMRs and other factors.

"So we started looking at the data through that lens," says Ruoff.

Having conversations about diagnostic questions enhances clinical decision-making, advises Ruoff. "Huddling as a group of caregivers with the intent of ensuring awareness of the patient's situation and the developing plan of care is critical," she says. "It doesn't hurt to do it as much as possible — at the beginning and end of every shift."

Extra Set of Eyes and Ears

"The ED is at extremely high risk for communication errors because of the environment," says Maggiore. "Shift change is a particularly high-risk time."

Information that is brought in by emergency medical services personnel, for example, must be documented and communicated to the ED receiving nurse so that the nurse has information about the scene and any treatment that has been rendered to the patient prior to arrival, says Maggiore.

"Communication between shifts is critical, as is the communication between paramedics and ED staff," she emphasizes. If paramedics have given medications in the prehospital setting, and this is not communicated to the ED staff, duplication can occur.

"If an outgoing shift has given medications and not documented this properly, the incoming shift may administer additional medications," adds Maggiore.

Even a non-clinical person is able to make important observations, such as that a patient has stopped moving, stopped breathing, is heading out the door in a hospital gown, or has pulled out a line or tube, says Maggiore.

"In the ED, an extra set of eyes and ears can't hurt," she says. "It is important to let these people know that their observations are important, and that if they see something going on with a patient that doesn't look right, that they should let clinical staff know right away."

To insure that information is taken seriously and acted upon, some hospitals have initiated "Speak Out" programs, in which everyone on staff is trained to be observant and to report anything that doesn't look right, notes Maggiore.

"Family members are encouraged to be observant, and to speak out if there is anything that doesn't look as it should," says Maggiore. "Any time a patient's or family member's concerns are not handled in a respectful way, the road is paved for a lawsuit if the patient has a poor outcome." ■

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. ■

Sources

For more information, contact:

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CNE/CME QUESTIONS

1. Which is true regarding whether emergency physicians (EPs) caring for patients outside the ED are covered by Good Samaritan immunity, according to **John Tafuri**, MD, FAAEM?
   A. Good Samaritan immunity doesn't apply under any circumstances if emergency physicians provide care outside the ED.
   B. EPs are always covered by Good Samaritan immunity in this scenario, even if there is an agreement with the hospital that EPs cover any in-floor emergency.
   C. EPs are covered by Good Samaritan immunity even if they receive financial remuneration for their duty to cover the floors.
   D. If the EP cares for a patient outside the ED with no contractual or understood duty to cover the floors, Good Samaritan protection might apply.

2. Which is recommended to reduce liability risks involving extending care outside the ED, according to **John Tafuri**, MD, FAAEM?
   A. EPs should avoid specifying in the medical chart the exact time they were first called about the patient.
   B. EPs should avoid documenting any follow-up that occurred with the patient's physician after the patient was stabilized.
   C. If the attending physician is reluctant to come in and assume care for the patient who has deteriorated or there is a significant disagreement about how to treat the patient, EPs should consider having a nurse listen in on the call.
   D. EPs should refuse to provide care outside the ED, as this will significantly reduce legal risks.

3. Which is true regarding liability risks of psychiatric patients who leave the ED against medical advice, according to **Robert Berg**, JD?
   A. EPs should thoroughly document the patient's evaluation, as this can support the validity of the decisions made by the EP regarding mental capacity.
   B. The decision to be discharged AMA is always valid even if the patient does not have the capacity to understand the risks and make the determination to be discharged.
   C. Even if the patient does not have the mental capacity to make the decision to be discharged, the EP doesn't face any liability risks for allowing the patient to be discharged AMA.
   D. EPs should not document any alternative courses of treatment or alternatives to signing out AMA that were conveyed to the patient.