ED Legal Letter™

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

From the publishers of *Emergency Medicine Reports* and *ED Management*

AHC Media

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March 2013
Vol. 24 • No. 3• Pages 25-36

Is Patient Leaving the ED Before Test Results Are Back?

Scenario is "legal landmine" for EPs

If a patient leaves your emergency department (ED) before the results of any test ordered by the emergency physician (EP) are back, the EP "still has an ethical and legal responsibility to the patient to utilize those results in directing their care, unless the EP has passed that patient's care on in a very clear manner," according to **Robert Suter**, DO, MHA, professor of emergency medicine at University of Texas (UT) Southwestern Medical Center in Dallas, TX.

"The clearest way to do that is if the patient is admitted to the hospital," says Suter. "Then the admitting physician, as part of the transition of that episode of care, takes responsibility for the tests ordered in the ED."

On the other hand, that is not the case if an ED patient is being discharged to home. "The test that you don't know the answer to before the patient is discharged home is always a problem," says Suter.

EDs Lack Good Systems

While most EDs have a good system for following up on X-rays or culture results, and tests for sexually transmitted diseases have public health processes in place to ensure follow-up, this is not the case for tests that would normally be ordered in a primary care provider's office, according to Suter.

"If there is an X-ray discrepancy, there is usually a process for follow-up that's been integrated," he adds. "But for other things, like outpatient imaging or labs that are part of a rheumatological workup, most EDs *don't* have a good system of making sure that those results are followed-up on and the patient informed of the results."

If a test result doesn't come back while the patient is still in the ED and a bad outcome occurs as a result of the patient not being informed of the abnormal result, the EP could be liable, warns Suter. "If the patient later dies, and in the course of investigating why this person died, all of a sudden, up pops this result that was grossly abnormal, but nobody ever did anything to follow-up, that's a big problem for the ordering physician," he says.

Suter says he is aware of a number of claims involving this scenario, including a 1980s multimillion dollar settlement involving a thyroid panel ordered by an EP that showed evidence of thyrotoxicosis.

EP Is Ordering Physician

The EP might be planning on admitting the patient or keeping him or her in the ED for a longer period of time, allowing for the results to come back or for the patient to be transitioned to the admitting physician, but the patient unexpectedly leaves against medical advice (AMA).

"That disrupts your timeline. You've already ordered those tests and, in most facilities, it is very difficult to cancel them," says Suter. "Now the patient is going to leave in such a way that you can't transition responsibility for those results or act upon them yourself."

Similarly, physicians who are going to see the patient for follow-up often ask EPs to order outpatient tests prior to seeing the patient in their office or clinic. The patient might get the tests done, but never sees the physician for follow-up. The patient might walk out because the office staff demands cash upfront to be seen, for instance.

"That physician has not truly accepted the patient until they are seen in their office. The patient has had their imaging test, which may be abnormal, and the only physician's name on them is yours," he says. "You are now responsible for those results." Suter says this is "potentially a loaded gun scenario" for EPs, and recommends considering these risk-reducing practices:

• EDs should develop processes to ensure that any results ordered by an EP that are not returned during the visit are reviewed by someone.

Some electronic health records systems return test results to the ordering physician, but typically *all* results are returned, including the ones that have already been seen, so the EP is required to sort through all of them, says Suter.

"A process is needed to ensure results are looked at systematically from the departmental standpoint, and not putting the burden on the individual EP who may have an inbox with hundreds of results at the start of a busy shift," says Suter.

• EPs should not order tests that aren't going to come back during the visit unless these are absolutely necessary.

At times, EPs order a test simply because they want to make the diagnosis, even if the result isn't going to come back for several hours or days. "That is the trap people fall into," says Suter. "While everybody likes making diagnoses, that is not our job, really. Our job is determining what the next step is in the treatment process for the patient. Sometimes that means letting the next physician make the definitive diagnosis."

• If a physician the EP is consulting with asks for a test to be ordered, EPs should ask the nurse or unit secretary to order the tests under that physician's name.

EPs often feel they are facilitating the patient's care by ensuring that the test results are back by the time the patient sees the primary care physician or specialist.

"That is true — but it's at a huge liability risk to the EP to do that if the patient doesn't follow-up," says Suter. "If a test is not essential for the EP, then they personally shouldn't order it because it is such a legal minefield. Ordering under the requesting follow-up physician's name mitigates this risk."

That way, the results go back to the consulting physician and he or she is responsible, he explains. If a test is ordered in the ED and a bad outcome occurs as a result of poor follow-up, it's unlikely that the EP would be dismissed from the case, adds Suter, except for one circumstance — if the EP's

ED Legal Letter™, ISSN 1087-7347, is published monthly by AHC Media, 3525 Piedmont Road N.E., Bldg. 6, Suite 400, Atlanta, GA 30305. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ED Legal Letter, P.O. Box 105109, Atlanta, GA 30348.

Subscriber Information: Customer Service: (800) 688-2421. Customer Service E-Mail Address: customerservice@ahcmedia.com. Editorial E-Mail Address: leslie.hamlin@ahcmedia.com. World Wide Web: http://www.ahcmedia.com. Subscription Prices: United States: $499 per year. Add $17.95 for shipping & handling. Multiple Copies: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Canada: $529 per year plus GST. Elsewhere: $529 per year. Back issues: $83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date. GST Registration Number: R128870672.

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

name is not on the test at all.

If the ED's order entry system won't permit that, Suter says the EP should document in the comments field, "This test or exam was ordered at the request of Dr. Smith, who will be following up with the patient. Please notify Dr. Smith of the results of this exam. Please page any grossly abnormal results to me or a designated person in the ED."

"Try to make it the radiology department or lab's responsibility to transmit the test results to the physician who is supposed to follow-up on the patient," Suter advises.

• If a patient is leaving AMA and an ordered test hasn't come back and can't be cancelled, EPs should specifically instruct the patient to return to the ED in whatever interval the results are expected back or to see their physician and ask for them to obtain the pending results.

This puts some of the responsibility for following up on the patient, Suter explains. "The patient may not return to the ED or see their physician, but any judge or jury looking at that interaction during the road will see that the EP thoughtfully attempted to do the right thing for the patient, and that the patient was the one who didn't follow-up," he says. ■

Source

For more information, contact:

- Robert Suter, DO, MHA, Professor of Emergency Medicine, UT Southwestern Medical Center, Dallas, TX. Phone: (214) 648-4838. E-mail: robert.suter@utsouthwestern.edu.

EPs Being Held Liable for Mistakes Made by NPs, PAs

"All right, so *technically* I'm responsible ... " or "Well, OK, I may be *legally* responsible, but ... "

These comments are common responses by emergency physicians (EPs) named in lawsuits involving mistakes made by physician assistants (PAs) or nurse practitioners (NPs) they're supervising, says **David W. Spicer**, JD, a health care attorney in Palm Beach Gardens, FL.

"My response is well, technically and legally, if they screw up, you are on the hook," says Spicer. "There is no way around that."

NPs and PAs are being used more often in EDs, and time-strapped EPs need to rely on them working somewhat independently, acknowledges Spicer, but "a lot of EPs don't understand that they are ultimately responsible for what they do. The fact that PAs and NPs are allowed to write prescriptions and to do certain orders blurs the line between the EP and the physician extender."

Spicer was involved in a lawsuit alleging that a PA gave incorrect discharge instructions to a patient, resulting in a 21-day hospitalization, which also named the EP.

"This occurred primarily because of a lack of communication between the EP and the PA," says Spicer. "The EP was saying, 'I have a licensed PA and she should know how to do this,' but she was coming right out of training without a lot of hands-on experience in the ED."

The fact that most PAs and NPs working in EDs have only short-term working relationships with EPs poses additional legal risks for the EP, says Spicer. "If the EP has a long-term working relationship with a PA or NP, that's great. But you are seeing less and less of that because EDs are being staffed by big companies, and they are hiring and firing people and moving them around," he explains. "The continuity between the EP and the PA generally isn't long term, and that's where the big problem comes in."

While it's safe to assume a board-certified EP has a certain level of competence, the same isn't true for PAs and NPs, says Spicer. "The busier the EPs get, the more they are going to be relying on these folks, and the more potential there is for miscommunication," he adds.

PAs filling out electronic medical records, for instance, are less likely to document the medical decision-making process in the comments section. "The subtleties that a doctor might pick up on — that there is a somewhat suspicious family history of heart disease, for example — will get lost on a PA," Spicer says.

EPs should never allow a PA to interpret test results, advises Spicer. Spicer was involved in a claim that named an EP, involving a patient who dislocated her knee, whose CT angiogram showing complete occlusion with minimal runoff was characterized by the PA as "she's got blood flow." "If you are letting a PA look at blood work or an X-ray report and telling you what it says, that is fraught with disaster," says Spicer.

Another issue is that PAs and NPs are doing clinical exams in the ED and "the clinical exam is only as good as the examiner," he notes. Spicer was involved with a lawsuit naming an EP alleging misdiagnosis of

epididymitis in a young man who presented with testicular pain. "The EP was involved only tangentially. The PA made the call, and it was wrong," he says.

EPs are increasingly relying on PAs or NPs to take the patient's history as well, says Spicer. "Previously, EPs got away with ordering a whole battery of tests, but now they have to have a real justification for that, which means they have to rely more on the history," he adds. "If you don't have a good history, things are going to fall through the cracks."

State Laws Vary

It's difficult for the EP to avoid legal responsibility for something a PA does because the PA has to be under the indirect supervision of the EP, whereas NPs pose more exposure to the hospital, says Spicer.

While state laws vary, as a general rule, if the NP or PA is working under the supervision of the EP, the EP could be liable for the NP's or PA's negligent mistakes on a theory of failure to supervise and to make sure no such mistakes occur, says **Richard D. Watters**, JD, an attorney at Lashly & Baer, PC, in St. Louis, MO.

"It is safe to say that if the law or the hospital obligates the EP to supervise the PA or NP, the EP may be liable for injury they cause if the EP failed to properly supervise the NP or PA," says Watters.

However, in states where NPs or PAs have collaborative practice agreements that delegate medical decision-making to the NP or PA, the law may not make the EP responsible for supervising the NP's or PA's treatment decisions, adds Watters.

"Therefore, in such states, [the EP] may not be liable for their negligent acts," he says. "In such states, [the EP] may nevertheless be held liable if he delegated authority to the NP or PA that they were not qualified by education, training, skill, and certification to perform."

NPs and PAs have now been granted independent practice in some states, adds Watters, and the EP should not be legally responsible for them unless the workplace rules make the EP responsible for supervision or oversight.

For example, some hospitals grant PAs and NPs privileges only if they are sponsored by a staff physician, and the medical staff bylaws or the terms of their privileges make the sponsoring physician responsible for supervising the NPs or PAs, says Watters. "Many hospitals, in their employment agreements, require the EP to oversee or supervise an NP or PA. Those contracts may impose liability where it might not otherwise exist," he explains.

Know EP's Requirements

Steven J. Lempp, regional vice president of the MGIS Companies, a Salt Lake City, UT-based provider of insurance products and services for physicians, says the most common malpractice claims he has seen against NPs and PAs involve medication errors, communication oversights, and working while impaired. "A supervising ER physician was named in a claim involving a PA who had been accused of inappropriate touching," he says. "The claim was filed against the PA for the action and against the supervisor for poor supervision and training of the PA."

EPs often don't realize they can be held liable for failure to follow up with a PA or NP if the PA or NP delayed or failed to order specific labs critical to patient care, says Lempp. He recommends that EPs take these steps:

- Assure that all other health care providers under the EP's supervision have medical professional liability insurance;
- Have an attorney review all legal contracts pertaining to professional services to be provided by the EP to a third party;
- Contact their broker, insurance consultant, risk manager, or the insurance company's representative to review the EP's medical professional liability policy and to better understand how the contract may perform in the event a claim is made against the EP for the professional services provided by an NP, PA, or other health care provider under the EP's direction and supervision.

Supervising EPs commonly have these duties and requirements, says Lempp:

- Establishing and delegating the procedures performed by the provider within the scope of the practice of the supervising physician;
- Being responsible for a timely review of patient records;
- Being continuously available to consult with or collaborate with the provider;
- Reviewing the provider's performance;
- Designating an alternate supervising physician if the supervising physician is not available.

Lempp says that a common misconception involves the scenario of an EP signing a state medical or nursing licensing board application as a supervising physician for an NP or PA, wherein the provider is not employed by the physician practice, practices at a separate facility, and the EP does not see the patient.

"The medical and nurse licensing board of the individual states regulates professional licensing for NPs and PAs," says Lempp. "It is, therefore, incumbent on the EP to become familiar with the state rules, reg-

ulations, and statutes governing a physician's role and responsibility as a supervising physician when signing an application." ■

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For more information, contact:

- Steven J. Lempp, Regional Vice President, The MGIS Companies, Salt Lake City, UT. Phone: (800) 969-6447, ext. 128. E-mail: Steve.Lempp@mgis.com.
- David W. Spicer, JD, Palm Beach Gardens, FL. Phone: (561) 625-6066. E-mail: D.Spicer@davidspicerlaw.com.
- Richard D. Watters, JD, Lashly & Baer, PC, St. Louis, MO. Phone: (314) 621-2939. E-mail: rdwatters@lashlybaer.com.

EPs Face These Legal Risks if Discharging Psych Patient

"Legal environment has changed"

Recent mass shootings have resulted in psychiatrists being sued for failing to prevent one of their patients from harming others. Could the same thing soon occur with emergency physicians (EPs)?

"A plaintiff lawyer will name as many defendants as possible while they are sorting things out to determine, 'Of all the people who treated this patient in the days leading up to the event, where did things really go off the rails?'" says **Martin G. Tracy**, JD, ARM, president and CEO of Professional Risk Management Services, an Arlington, VA-based firm that manages professional liability insurance programs covering psychiatrists and neurologists.

Tracy recommends that EPs "look at the concept of a 'dangerous' patient broadly" when making the decision to discharge a patient. Whether a patient is discharged from the ED and has a myocardial infarction and kills several people driving home, or a discharged patient burns down a building in the middle of a psychiatric episode, "the fact remains that it's a dangerous patient," he says. "The greater amount of time between the ED encounter and the bad event, the less likely it is that the EP will be looked at as responsible."

Know When to Notify

It would be easier to defend an EP motivated by concern for community safety for allegedly improperly notifying law enforcement of a patient's threats of imminent harm, than to defend the EP after a community tragedy, according to **Richard S. Lovering**, JD, a partner in the litigation group of Bricker & Eckler in Columbus, OH.

"EPs would be prudent to notify law enforcement of threats of imminent harm made by patients in the ER," says Lovering. "Although the law has not changed, I think the legal environment has changed."

Lovering points to a January 15, 2013, letter from the Department of Health & Human Services (HHS) Secretary, which confirms the provisions of Health Insurance Portability and Accountability Act (HIPAA) do *not* prevent disclosure of patient information to law enforcement with jurisdiction to protect third parties, when a patient has made threats of imminent harm. *(To view the complete HHS letter, go to http://www.hhs.gov/ocr/office/lettertonationhcp.pdf.)*

"The HHS has gone out of its way to notify the health care community, including ER physicians and staff, that HIPAA does not prohibit taking steps to protect potential victims of patient threats of imminent harm," says Lovering.

A jury verdict in a 1997 Ohio case involving a psychiatrist whose patient fatally shot his parents prompted the enactment of the immunity statute of R.C. 2305.51, which was upheld by the Ohio Supreme Court, notes Lovering.[1]

If threats of imminent harm are made by an ED patient, HIPAA does not prevent an EP from notifying law enforcement as to the nature of the threat, the identity of the patient making the threat, and the identity of each potential victim of the threat, says Lovering.

"If feasible to do so, HIPAA does not prohibit communication to each potential victim or victim's parent or guardian if the potential victim is a minor," he adds.

Know State Laws

There is often a distinction between involuntarily committing or "pink-slipping" a patient, and sending the patient to an ED in a regular hospital versus one certified by the state's Department of Mental Health, says **Samantha L. Prokop**, Esq., an attorney with Brennan, Manna & Diamond, LLC, in Akron, OH.

"For example, I have clients in Ohio who are hospitals but not certified mental health facilities,"

Prokop says. "The police will bring in a patient that they have pink-slipped."

Most EPs believe they have 72 hours to hold the patient before a court makes a determination regarding involuntary commitment, but in actuality, Ohio laws and regulations state that you can only hold the patient for 24 hours in a non-mental health facility, says Prokop.

"The question commonly arises as to what to do when you can't place a patient in that 24 hours and he or she demands to leave," says Prokop. "Under Ohio law, you can't issue another pink slip for the same episode."

The EP's dilemma is to determine whether to let the patient walk out with the potential that the patient will harm himself or others, or face potential civil or criminal liability by continuing to hold the patient against his or her will, says Prokop.

In a 2012 case, the spouse and children of a patient who committed suicide 36 hours after he was discharged from the ED brought a wrongful death action against the EP and the hospital.[2]

"A defense verdict was given at trial, and the plaintiffs appealed," says Prokop. "The Supreme Court held that an evidentiary presumption with respect to causation does not exist in medical malpractice cases involving suicide."

EPs need to know their state's laws regarding what it takes involuntarily commit a patient, advises Tracy. "Some of these are quite broad, and some are very limited," he says. "The standard of care doesn't exist in a vacuum. It is determined on a case-by-case basis."

Most states have some sort of statute or common law in place regarding a physician's duty to protect people from dangerous patients, says Tracy. "There are two or three different flavors of these laws and each state has modified them a little bit," he says. In some states, the physician has a duty only if the patient has identified a particular person or particular class of people, for instance.

If the EP decides to discharge the patient, the charting should answer questions such as, "What were the EP's findings?" "What did the patient say?" and "Why did the EP elect not to refer the patient to the on-call psychiatrist?" says Tracy.

The EP should document any efforts made to obtain a proper referral for the patient, such as the fact that a supervisor was called after a lengthy wait and asked whether there was any other way to get a behavioral health consultant to come down to the ED immediately, he says.

"There is no perfect record, and you can't provide a verbatim transcript of everything that went on," says Tracy. "But documenting the important parts of the treatment go a long way toward protecting the EP if something happens down the road." ■

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For more information, contact:

- Richard S. Lovering, JD, Partner, Bricker & Eckler, Columbus, OH. Phone: (614) 227-2307. E-mail: rlovering@bricker.com.
- Samantha L. Prokop, Esq., Brennan, Manna & Diamond, LLC, Akron, OH. Phone: (330) 253-3766. E-mail: slprokop@bmdllc.com.
- Martin G. Tracy, JD, ARM, President and CEO, Professional Risk Management Services, Arlington, VA. Phone: (703) 907-3872. E-mail: tracy@prms.com.

EP vs. Consultant: Who Said What to Whom?

Suit's outcome could hinge on who documented discussion

Did an emergency physician (EP) have a telephone consult without requesting that the specialist see or examine the patient? If a malpractice lawsuit is filed criticizing the EP's discharge decision, says **Bruce A. Vande Vusse**, JD, an attorney at Foster Swift Collins & Smith PC in Farmington Hills, MI, "that creates an issue of how much weight should the EP have given to those conversations, when the consultant didn't see the patient face-to-face."

When both the EP and consultant are named in a suit, "this is almost always going to lead to a tenuous co-relationship in the context of litigation," says Vande Vusse. "Ultimately, these cases can end up with tension between the physicians, with both pointing fingers at the other as the more responsible decision maker."

EPs generally claim they relied on the expertise of consultants, and consultants typically counter that EPs shouldn't have relied on them because

they didn't see or personally evaluate the patient, or weren't given all the pertinent data, he says.

Vande Vusse recently represented an on-call pediatrician who was called by an EP about a 9-month-old child who was eventually diagnosed with *Haemophilus influenzae* type F meningitis. "The EP had made a determination that he wanted to discharge the patient, and was using the pediatrician largely as a rubber stamp to verify the EP's analysis," he says.

When the two physicians were deposed, there was a dispute in terms of what the pediatrician was told. The EP's note summarized what was discussed, but didn't include everything contained in the chart, and the in-house pediatrician consultant didn't take any notes about the phone conversation with the EP.

"The only written record was the ED doctor's. A significant question became how much responsibility the consultant had for the discharge decision," says Vande Vusse. "Here's where you can have a real fight between the two physicians about whether the EP was entitled to rely on the 'recommendation' of the consultant."

The pediatrician pointed out that the EP had the patient in front of him, access to imaging studies and laboratory results, had not asked the pediatrician to examine the patient, and seemed to be looking for approval of a discharge decision that the EP had already made.

"The pediatrician consultant said, 'I wasn't making a decision about how sick this kid looked or whether she needed to be admitted. I just gave the EP limited advice, based on what he told me,'" Vande Vusse says.

The EP's defense was made more difficult because he didn't ask the consultant to come see the patient, even though the consultant was in the hospital at the time, giving the impression that he had already made his discharge decision without relying much on the pediatrician's input. "When the case settled in mid-2012, the pediatrician consultant was dismissed without payment, and the EP paid in the six-figure range," says Vande Vusse.

When an EP consults with a specialist, he or she should ask the consultant, "Based on this, do you think you ought to come in and see the patient?" and document the consultant's response, advises Vande Vusse.

"Whoever documents the details of what was discussed has an advantage," he says. "If the consultant is sitting at home or in the office and isn't privy to the person's chart, he or she isn't likely to be making notes. They will be relying on their memory of the conversation, not a contemporaneous written record."

Plaintiff's attorneys will often focus on what was *not* documented, and will argue that failure to provide appropriate information to the consultant resulted in bad decision-making. "If the consultant claims he wasn't told something, but the EP's charting indicates otherwise, the EP's testimony is probably more credible," says Vande Vusse.

EP Found Negligent

Janice M. Ginley, assistant claims manager for MIEC, an Oakland, CA-based malpractice carrier, handled a claim involving an infant who presented with a two-day history of fever and new-onset focal seizure. The EP performed a lumbar puncture, obtained laboratory studies, and contacted the child's pediatrician to report the history and findings.

"The private pediatrician advised the EP that he would manage the course of care from that point," says Ginley. "The EP relied on direction given to him by the pediatrician."

Aseptic meningitis was the working diagnosis, with no CT scan obtained or requested despite the reported history of seizure, and herpes encephalitis was not included in the differential diagnosis. "The pediatrician requested transfer to a higher level of pediatric care where the pediatrician had privileges," says Ginley. "The child remained in the ED for almost five hours prior to transfer."

The admitting resident at the pediatric hospital recommended a CT scan on admission, but the pediatrician didn't obtain one until 36 hours later, and the child was diagnosed with herpes encephalitis. "Despite intensive treatment, the child experienced profound brain damage," says Ginley. A lawsuit was filed against the EP, the hospital, and the pediatrician, alleging failure to obtain a CT in the ED for history of focal seizure, which would have provided evidence of herpetic brain lesions. The plaintiff also alleged the EP had failed to provide acyclovir in the earliest hours of care, which would have prevented the brain injury.

The pediatrician settled for his policy limits in advance of trial. "Despite strong support on standard of care and causation for our insured EP, who relied on the direction of the pediatrician in the early hours of care, a jury found him negligent at trial, and awarded a substantial seven figure verdict," says Ginley.

While the EP had good documentation of the verbal consult, the pediatrician did not. "Had the child not been severely injured, the likelihood of the EP's dismissal from the suit would have been higher," says Ginley.

While the EP had reasonably good documentation of the verbal consult with the pediatrician, at trial the plaintiff focused on what was *not* documented in the discussion with the pediatrician (i.e., herpes encephalitis and the treatment that was not provided, which *might* have made a difference in outcome).

"Failure to have a thorough differential diagnosis with complete documentation in an extremely sympathetic case led to an adverse verdict," says Ginley.

Inadequate Documentation

Claudia Dobbs, loss prevention manager at MIEC, says she often reviews charts with inadequate documentation on telephone consults with EPs, such as, "Spoke with cardiologist, Dr. x." Dobbs says that EPs can significantly decrease their liability by clearly documenting the verbal consult and how it affected their medical decision-making.

EPs should document details of the conversation with the consultant, review of pertinent differential diagnoses, the patient's course of treatment, the informed consent discussion with a patient and participating family members, and specific aftercare instructions, she advises. "Documenting the patient's understanding of the treatment plan and agreement also is protective," adds Dobbs. ■

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For more information, contact:

- Claudia Dobbs, Loss Prevention Manager, MIEC, Oakland, CA. Phone: (510) 596-4956. E-mail: claudiad@miec.com.
- Janice M. Ginley, Assistant Claims Manager, MIEC, Oakland, CA. Phone: (510) 596-4936. E-mail: janiceg@miec.com.
- Bruce A. Vande Vusse, JD, Foster Swift Collins & Smith PC, Farmington Hills, MI. Phone: (248) 538-6330. E-mail: bvandevusse@fosterswift.com.

Neurological Misdiagnosis in ED: Uncommon, but Suit Likely

Approximately 5% of patients presenting to EDs have neurological symptoms such as headache, dizziness, back pain, weakness, and seizure disorder, but little is known about the factors that led to misdiagnoses of neurological emergencies in the ED, according to a 2012 review of studies.[1]

"Neurological emergencies tend to be more complicated than a lot of things that we see," says **Jonathan Edlow**, MD, co-author of the study and vice-chair/director of quality in the Department of Emergency Medicine at Beth Israel Deaconess Medical Center in Boston.

"The approach to chest pain, belly pain, or vaginal bleeding tends to be more algorithmic in people's minds," says Edlow. "Before leaving the room, the emergency physician [EP] pretty much has an idea of what the next steps are."

Less than 20% of emergency medicine residencies require a neurology rotation.[2] "This knowledge gap is fixable by individual EPs, in the short term, by boning up on neurology," says Edlow, such as by attending a course or conferences, or reviewing films with neuroradiologists. "While individual physician education is very important, it won't solve the systems issues."

Headaches indicating a neurological emergency, stroke, and subarachnoid hemorrhage (SAH) are all likely to result in malpractice lawsuits if these are missed in the ED, says **Joseph Shiber**, MD, FACEP, FACP, FCCM, associate professor of emergency medicine and critical care at University of Florida College of Medicine – Jacksonville. Consider these risk-reducing strategies to prevent misdiagnosis of neurological emergencies:

• Take the time to do a thorough history and physical examination.

Patients with neurological emergencies often present with extremely common symptoms such as dizziness and headache, notes Edlow. "This is an area where the history and the physical exam are very important," he says. "I don't think EPs are as comfortable with their neurological exams as they are with their heart or lung or abdominal exams."

"And if you miss a problem with a neurological emergency, the stakes are high. Stroke, a bleed, or cord compression are major life-altering events for the patient," warns Edlow.

From a defense lawyer's perspective, the best evidence to support the EP's decision-making is a well-documented medical chart that delineates the medical management of the patient, from the history and physical exam to the ordering of medications, tests, and consultations, says **James P. Donohue**, Jr., Esq., an attorney with Diedrich & Donohue, LLP, in Boston, MA.

Failing to do a thorough history and examination might prevent EPs from including a neurological

condition in their differential, says Shiber. If patients have a cardiac condition such as decompensated heart failure or atrial fibrillation, they are more likely to have a embolic stroke, for instance, he explains.

Similarly, if a patient complains of back pain and the EP doesn't obtain a history of the patient's intravenous drug use, "not realizing they are at risk for an epidural abscess is obviously a huge miss," Shiber says.

• Keep in mind that the patient might be presenting early or with a mild presentation.

Most patients with SAHs that were missed at the time of the initial ED presentation had small amounts of bleeding and initial normal mental status and neurological examinations, according to a 2007 study.[3]

"The only complaint they had was headache, and it might have been mild. That's the difficulty," says Shiber. "If someone still looks well and does not have physical examination findings that push the EP to consider a serious and dangerous condition, it may be missed during the initial contact."

• Recognize the limitations of diagnostic tests.

Assuming the history and physical examination point the EP in the direction of a possible neurological diagnosis, appropriate neurological testing and consultations should be ordered, says Donohue, adding that initiation of medical management might be indicated while awaiting the results.

EPs don't always consider the limitations of diagnostic tests when neurological conditions are a possibility, however, says Edlow. "Although the CT is a fabulous test, it has limitations. Certainly in the first six to eight hours, it's limited in terms of diagnosing or excluding acute stroke," he says. "It is very limited with respect to cerebellar stroke."[4]

Magnetic resonance imaging (MRI) isn't available off-hours in many EDs. "It's not a test that you can order and an hour later you've got the result. So the best test is a slow test when we get it, and is often not available," says Edlow. "That's a systems issue. But we should still remember that a negative CT does not mean there is not a problem."

EPs who wouldn't think of sending a chest pain patient home based solely on an initial negative troponin result might not have the same skepticism about a negative CT scan in a dizzy patient. "They don't have that same reflex to say, 'This could be a false-negative CT, so I need to examine the patient more carefully or observe them, or get an MRI to be sure this is peripheral and not central,'" says Edlow.

• Have an alternative approach for when real-time neurological consults are unavailable off-hours, such as transferring a patient to get an MRI or obtaining a teleconsult with a neurologist.

If MRI is not available and the EP is concerned about spinal cord compression, "getting the patient transferred rapidly is necessary," says Shiber.

If systems problems exist, "you are not going to fix it tonight in the ED," says Edlow. "But you can sit down Monday morning and work with hospital administration."

• Ensure that appropriate tests are ordered and correctly interpreted.

In a 2010 study on missed SAHs in the ED, failure to order a CT scan was the most common underlying reason for the misdiagnosis.[4]

The EP might have ordered and performed the appropriate tests, but failed to interpret them correctly, such as attributing red blood cells in the initial lumbar puncture sample to capillary bleeding and missing an SAH, notes Shiber.

• If a patient is discharged, be sure the chart indicates why the EP didn't think the patient was at risk.

This makes a missed diagnosis case more defensible, according to Shiber. For instance, charting, "The headache was not acute thunderclap onset," or "patient's symptoms improved with mild analgesics" shows that the EP considered SAH. "If you documented that you thought about it, evaluated the patient, and the process led you away from a serious condition, that's hard to argue with," says Shiber.

• Document a full neurological examination, including the patient's level of alertness, mental status, a motor strength exam, and a sensory exam.

"It doesn't have to include all the modalities of sensation, but at least touch. Also, evaluate the patient's ambulation and gait. Some people forget that, and only examine the patient in bed," Shiber says. "If that's all done and is all normal, it's quite reassuring."

• Keep the patient long enough to do a reassessment, even if the patient appears well and has a relatively reassuring presentation.

"It's very difficult to get a full picture of what's happening with a snapshot in time," says Shiber. "It doesn't need to be necessarily six to 12 hours, but should be more than one initial contact." The EP can then document, "On reassessment, the patient continues to have a normal examination," and that the complaint the patient came in with is resolved.

"It's hard to discharge someone when they are still complaining of the same exact symptoms," says Shiber. "It's always good to have more than one set of vital signs, with nursing documentation in agreement with your physician documentation."

• Document that a rectal examination was done, especially if patients report bowel or bladder complaints.

If the patient reporting back pain doesn't have risk factors, has a normal neurological exam, normal

strength and sensation of legs, and normal bowel and bladder function, "then the back pain typically can be treated as such, but otherwise you must pursue it," says Shiber. "It's been shown that a delay in surgery of decompression of the spinal cord is associated with a favorable verdict against the provider." ■

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For more information, contact:

- James P. Donohue, Jr., Esq., Diedrich & Donohue, LLP, Boston, MA. Phone: (617) 367-0233. E-mail: jdonohue@ddcounsel.com.
- Jonathan Edlow, MD, Vice-chair & Director of Quality, Department of Emergency Medicine, Beth Israel Deaconess Medical Center, Boston, MA. Phone: (617) 754-2329. E-mail: jedlow@bidmc.harvard.edu.
- Joseph Shiber, MD, FACEP, FACP, FCCM, Associate Professor of Emergency Medicine and Critical Care, University of Florida College of Medicine – Jacksonville. E-mail: joseph.shiber@jax.ufl.edu.

Demanding Upfront Money from ED Patient?

Lawsuit could allege insufficient MSE

Some EDs are charging uninsured patients upfront fees for problems deemed nonemergent, with 88% of EDs reporting an increase in the number of "self-pay" patients seen in 2012, according to the Healthcare Financial Management Association. If a patient leaves the ED because of an inability to pay and later sues because a bad outcome occurred, will the emergency physician (EP) be liable?

"There are few obstacles to prevent an enterprising medical malpractice plaintiff's lawyer from filing a lawsuit on the patient's behalf. But whether the EP is ultimately found liable will turn on testimony concerning the specific facts of the case," says **Damian D. Capozzola**, JD, an attorney with Crowell & Moring, LLP, in Los Angeles, CA.

Experts on both sides will offer opinions as to whether the determination that no emergency condition existed at the time was reasonable, in light of the objective data available to those in charge of the patient and subjective symptoms reported by the patient, he says.

"If a medical screening examination [MSE] initially showed no emergency but the patient subsequently presented within days or even hours complaining of a potential emergency situation, the ED would be obligated to reassess the situation," Capozzola says. "An MSE is not an isolated event. It is an ongoing process."

When a patient presents with symptoms suggesting the possible existence of an emergency condition, "the more prudent course may be to commence the MSE and treatment as though an emergency existed, until it becomes clear that no emergency exists," he says.

Resources Are Key

If a patient with a bladder infection is screened out of the ED because of an inability to pay, he or she could end up with pyelonephritis and be admitted for intravenous antibiotics, when it could have been taken care of with three days of oral medications, says **William C. Gerard**, MD, MMM, FACEP, chairman and professional director of emergency services at Palmetto Health Richland in Columbia, SC.

Similarly, a patient with a sore throat could develop a peritonsillar intraoral abscess that needs to be surgically drained, which could have been managed with some penicillin or amoxicillin in the ED. "The patient might not get follow-up, just because you hand them a card," Gerard adds. "There might be transportation and child care issues. People don't want to take off work in this environment."

If EDs are screening out patients after an appropriate MSE has revealed no emergency medical condition, "they need to have an extremely developed superstructure in the community to refer people to. That is really a key component," says Gerard.

This might be the organization's physician-owned practices or a Federally Qualified Health Center, says Gerard, "but patients need to be walk-

ing out of there with an appointment to see somebody, not fending for themselves, because many will never get seen anywhere."

Primary care physicians might not offer same-day appointments for ill patients. "Until primary care can match the services we offer, the ED is the one-stop shop. We're always there and available," he says. "People don't want to be seen in four days when they're sick."

Insufficient MSE

According to a 2010 study from the Rand Corporation, approximately 17% of ED visits could be treated at retail medical clinics or urgent care centers, potentially saving $4.4 billion annually in health care costs.[1]

"I do not believe that referring a patient with a non-emergent condition to a more appropriate level of care, in and of itself, offends EMTALA or constitutes malpractice," says **Edward Monico**, MD, JD, assistant professor in the section of emergency medicine at Yale University School of Medicine in New Haven, CT.

However, liability can arise if a plaintiff alleges the MSE failed to uncover an emergency that was, in fact, present at the time of presentation and the patient was "turned away" in the face of this emergency, says Monico.

EDs face potential EMTALA violations if they screen patients out without an appropriate MSE, which is not equivalent to triage, warns Gerard. "Ruling out an emergency medical condition could involve a lot of tests and diagnostic procedures," he says. "It isn't as simple as just saying, 'Well, you probably shouldn't be here. Go see your doctor down the street.'"

EPs should remember that "EMTALA's notion of an MSE can be quite broad," warns Monico. "Liability could attach even if the emergency could not be readily discovered at triage, but required an evaluation conducted in the emergency department."

For instance, if a patient who complained of unilateral leg pain for several days was triaged as non-emergent, but later suffered a pulmonary embolism (PE) caused by a deep venous thrombosis (DVT), a lawsuit could allege that an ultrasound performed in the ED would have revealed the DVT and anticoagulation could have prevented the PE.

"The patient, in this instance, could allege that the MSE under EMTALA was insufficient, and a medical emergency did, in fact, exist at the time of presentation," says Monico.

Capozzola is unaware of any lawsuits involving EPs screening out apparently non-emergent patients because of inability to pay, who later turned out to have had an emergency medical condition, but says he expects to see a case within the next year alleging that an ED required payment from someone with an emergency situation, resulting in an adverse cascading series of events ending in a lawsuit.

"It is somewhat surprising that there seem to be few, if any, reported judicial opinions concerning this," he says. "I expect we will see these issues trickle through the courts and start to surface in appellate opinions in coming years."

This will provide important guidance to EDs on where the legal boundaries are, says Capozzola. "Until we get more clarity, it may be wise to be liberal in providing MSEs, on the theory that an ounce of prevention is worth a pound of cure," he says. ■

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For more information, contact:

- Damian D. Capozzola, JD, Crowell & Moring LLP, Los Angeles, CA. Phone: (213) 443-5503. E-mail: dcapozzola@crowell.com.
- Edward Monico, MD, JD, Department of Surgery, Section of Emergency Medicine, Yale University School of Medicine, New Haven, CT. Phone: (203) 785-4710. E-mail: edward.monico@yale.edu.
- William C. Gerard, MD, MMM, CPE, FACEP, Chairman/Professional Director, Emergency Services, Palmetto Health Richland, Columbia, SC. Phone: (803) 434-3319. E-mail: bgerardmd@gmail.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 QUESTIONS

1. Which of the following is true regarding liability risks involving verbal consultations with specialists, according to **Claudia Dobbs**?
   A. EPs cannot be held liable under any circumstances for a bad outcome that occurred as a result of their reliance on a consultant's recommendation.
   B. The EP cannot be liable if the consultant agreed with the decision to discharge the patient, even if the consultant never personally evaluated the patient.
   C. It is not advisable for EPs to ask consultants whether, based on the information provided, they feel they ought to come in to see the patient, and to document the consultant's response.
   D. An EP should clearly document the details of communication with a consultant and how the consultant's recommendation affected the EP's medical decision-making.

2. Which of the following is recommended to reduce the risk of misdiagnosing neurological emergencies in the ED, according to **Joseph Shiber**, MD, FACEP, FAC?
   A. EPs can safely discharge a patient with dizziness or other neurological symptoms based on a negative CT scan.
   B. Transferring the patient to obtain an MRI scan is not recommended if the EP is concerned about spinal cord compression.
   C. EPs should keep the patient long enough to do a reassessment, even if the patient appears well and has a relatively reassuring presentation.
   D. EPs should never indicate in their charting why they didn't believe a discharged patient was at risk.

3. Which is true regarding obtaining a medical screening examination as required by EMTALA, according to **Edward Monico**, MD, JD?
   A. If an MSE initially showed no emergency, but the patient subsequently presented within hours complaining of a potential emergency situation, the ED is not obligated to reassess the situation.
   B. Liability could attach to the EP if an emergency could not be readily discovered at triage, but required an evaluation conducted in the emergency department.
   C. Liability cannot attach to the EP if an emergency could not be readily discovered at triage without additional diagnostic testing.
   D. Liability cannot arise if a plaintiff alleges the MSE failed to uncover an emergency that was, in fact, present at the time of presentation and the patient was "turned away" in the face of this emergency.

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. ■