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Do You Know What You Need to Know About Informed Consent?

A Quiz for Emergency Department Providers

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The issue of informed consent is becoming increasingly common in court cases involving medical malpractice. This may be due to a physician's lack of awareness concerning the precautions that must be taken in select scenarios. There is substantial risk of legal penalties for the lack of informed consent when there are poor patient outcomes. It is important for physicians to understand the steps necessary to avoid these possible penalties. This article provides a brief quiz to test physicians' knowledge of informed consent and discuss some caveats that every ED physician should be aware of.

Question 1:What are the components of informed consent and what constitutes informed consent malpractice?

The first notable case concerning failure to provide information about what the objective patient would find material was *Canterbury v. Spence* (1972).[1] The patient presented to Dr. Spence with severe pain between his scapulae. Dr. Spence, a neurosurgeon, performed a myelogram to determine the location of the aberration. Once the location was determined, Dr. Spence decided to perform a laminectomy to repair a ruptured disc. He did not inform the patient of the risk of paralysis that could complicate the procedure. When the patient's

mother asked if the operation was serious, Dr. Spence replied, "Not any more than any other operation." He felt that it was poor practice to reveal the risks, as it could deter the patient from undergoing a necessary procedure. The day after the operation, the patient fell out of the bed while attempting to void. Hours later, he complained that he could not feel his legs. A second emergency operation was performed, but the patient was left with paralysis of the legs and incontinence. Four years after the laminectomy, the patient sued Dr. Spence for negligent care in the performance of the procedure and failure to inform him of the risks of the operation. The court ruled that there was no evidence suggesting that Dr. Spence's treatment was responsible for the negative outcome. However, the court determined Dr. Spence was guilty of failure to reveal the risk of paralysis that the surgery presented to the patient.

In its discussion of *Canterbury v. Spence*, the court defined what constitutes informed consent. The physician is mandated not only to treat the patient skillfully, but also to "communicate specific information to the patient when the exigencies of reasonable care call for it."[1] To summarize, the key components are that the physician discloses to the patient: 1) the risks and benefits of a procedure; 2) the alternatives to the proposed procedure; and 3) the consequences of not undertaking the procedure. The threshold for obtained consent involves exposing a risk when the patient would personally consider it significant to his or her decision.

The decision to inform, however, is made in foresight by the physician. The physician is only responsible to inform the patient based his or her personal knowledge and information base at the time of care. It is up to the provider to personally determine the necessity of information that should be relayed to the patient. Once again, this determination should be made in an effort to educate the patient on any possible elements involved in the care that they would personally like to know about before selecting a method of treatment.

Canterbury v. Spence also labeled lack of informed consent as true malpractice and defined the elements of negligence in this situation. The physician is negligent if: 1) an unrevealed risk should have been made known; 2) the risk does occur and causes harm to the patient; and 3) the patient would not have undergone the risk if he or she had been informed before the procedure.[1]

Question 2: Which of following scenarios is an exception to informed consent?

Scenario A: A 45-year-old female collapses at work. She arrives at the ED in shock. A central line is placed. The subclavian artery is punctured. The patient exsanguinates and dies. Will a lawsuit alleging lack of informed consent likely be successful?

Scenario B: A woman has idiopathic intracranial hypertension (pseudotumor cerebri). She undergoes a lumbar punctures on a regular

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Elements of Informed Consent Negligence

- The physician fails to properly inform the patient of a risk.
- A reasonable physician would have informed the patient.
- The patient is harmed by the very risk that was not discussed.
- Informing the patient of the risk would have changed the patient's choice of action.

basis. Does she require informed consent before each lumbar puncture?

The facts of Scenario A above are based on a recent actual case.[2] The court issued a defense verdict for the physician. In *Canterbury v. Spence*, the court also discussed exceptions to a physician's obligation to inform and obtain consent.[1]

The first exception to giving informed consent is an emergency situation: "When the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment. When a genuine emergency of that sort arises, it is settled that the impracticality of conferring with the patient dispenses with need for it."[1] "Even in situations of that character, the physician should, as current law requires, attempt to secure a relative's consent if possible. But if time is too short to accommodate discussion, obviously the physician should proceed with the treatment."[1]

A second exception is when a patient would generally already understand the risk. For example, most any person would understand that a surgery has a risk of infection. A third exception arises when the patient is already familiar with the proposed procedure. Thus, in scenario B, the physician would not be expected to give informed consent for each lumbar puncture. Although not required, repeatedly giving informed consent would further decrease liability. A final exception is if delivering informed consent would make the patient "so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient."[1] This is called the "physician privilege exception."

Exceptions to Informed Consent

- A patient is unconscious or unable to consent, and failure to immediately treat would result in more harm than proceeding with the proposed treatment. The physician should still attempt to discuss the decision with a secure relative, but if time is pressed, the physician may proceed with the proposed treatment
- Any patient would generally understand the risks associated with the procedure
- The patient is already knowledgeable about the proposed procedure
- Disclosing informed consent would cause the patient to become so emotionally damaged that he or she may not choose a rational course of care.

Question 3: Is informed consent only required for procedures?

A patient, Thomas Jandre, came to the ED after experiencing drooling, slurred speech, and a facial droop on the left side. He also presented with dizziness and weakness. Dr. Bullis, the ED physician, took a medical, social, and family history. She then performed a physical exam and ordered a head CT scan. Dr. Bullis diagnosed the patient with Bell's palsy and ruled out a hemorrhagic stroke using the CT scan. Rather than order a carotid ultrasound, she listened to Jandre's carotid arteries to determine if she heard a bruit that would indicate an increased risk for thromboembolic ischemic stroke. Eleven days later, Jandre suffered a significant stroke. The carotid ultrasound performed following the stroke indicated that his right internal carotid artery was 95% blocked.[3]

Thomas Jandre and his wife brought suit, alleging that Dr. Bullis negligently diagnosed his condition and failed to provide the information necessary for him to make an informed decision regarding his treatment. They argued that the physician should have informed them of other tests that were available to assist in correct diagnosis (carotid ultrasound). The jury determined that the mistaken diagnosis of Bell's palsy was not negligent and, thus, not medical malpractice. However, Dr. Bullis was found negligent of a failure to achieve an informed

Correct Answers to Quiz

Question	Court Ruling	Summary
Question 1	For plaintiff	A physician must inform the patient of risks associated with a surgical procedure before performing the procedure.
Question 2 scenario a	For physician	Informed consent is not mandated in emergency situations when a patient is incapable of consenting.
Question 2 scenario b	For physician	Informed consent is not mandated when performing a procedure with which the patient is familiar.
Question 3	For plaintiff	A physician must make the patient aware of all possible routes of care that the patient may seemingly wish to take.
Question 4	For plaintiff	A physician must inform patients of more qualified physicians and give accurate statistics concerning a procedure.
Question 5	For plaintiff	Signed procedural forms are not independently sufficient to obtain consent.

consent from the patient. The jury awarded the Jandres approximately $2 million.

It is important for ED providers to be aware of this case. There are multiple other similar court cases stating that the principles of informed consent apply not only to procedures but also to medical decisions.

Question 4: Should a physician disclose his or her level of expertise when getting informed consent for a procedure?

Donna Johnson presented to her family physician with persistent headaches and had a CT scan performed. Her family physician referred her to Dr. Kokemoor, a neurosurgeon. He diagnosed Johnson with an enlarging aneurysm in her brain and recommended a surgery to remove it. Dr. Kokemoor spoke to Johnson and ensured her that he had performed the surgery "dozens of times," relating its seriousness to a tonsillectomy or gall bladder surgery. He revealed that the surgery had a 2% mortality rate, when, in truth, the rate was closer to 30% when performed by inexperienced physicians. He also failed to inform Johnson that she had an option to seek care from more experienced surgeons. There were complications from the operation that caused Johnson to become a wheelchair-dependent quadriplegic with impaired vision and speech.

Johnson brought suit against Dr. Kokemoor, claiming that he obtained inadequate consent for the procedure. The courts ruled in favor of Johnson, citing that Dr. Kokemoor failed to adequately inform the patient of the morbidity and mortality rates and refer her to a more experienced surgeon. A physician is required to give any information concerning what a patient would like to know to make an informed decision. The courts have decided that revealing more qualified physicians as an option is part of obtaining informed consent.[4]

By the very nature of the environment, ED providers likely will not have time in emergent situations to seek out and offer more experienced providers to ED patients. This case should not cause great alarm to ED physicians, but is informative and one to be aware of. What about training facilities? Are providers obligated to let only the most experienced clinician perform a procedure? In reality, when patients come to a teaching hospital, there is obvious acknowledgement that training is occurring and likely implied consent (i.e., assumption of risk). Thus, it is unlikely in a teaching environment that a court would enforce the same obligation as in the case above. If, however, a patient states that he or she does not want a training student/resident to perform a procedure, it would be optimal to honor the patient's desire.

Question 5: Does a signed consent form relieve a physician from liability if a complication mentioned on the form occurs?

Betty Havens was referred to Dr. Hoffman for an evaluation of a painful epigastric mass. A ventral hernia had developed due to a prior abdominal surgery. Dr. Hoffman and Betty Havens agreed that he would repair the ventral hernia and perform the procedure under anesthesia. As a result of the thoracotomy, one of Havens' ribs was broken and the costal cartilage was torn away at the costochondral junction. This injury resulted in permanent and chronic pain. This injury commonly occurs during this particular surgery in more than half of the cases. Havens brought suit against Dr. Hoffman, claiming that he failed to inform Havens that rib fracture and cartilage tearing are frequent complications of the procedure. She claimed that she was not informed that the procedure could specifically result in torn cartilage, chronic pain, or debilitating pain. Furthermore, she alleged that Dr. Hoffman did not inform her of alternative procedures that are less hazardous. Dr. Hoffman argued that Havens had signed a fully executed consent form for the procedure and offered this as evidence of informed consent. The court ruled that while an executed consent form is evidence that a discussion took place, it does not prove what the content of the discussion was. The content of the discussion must be determined from further testimony.[5] In other words, a signed form does not independently prove there was informed consent.

It is important for ED providers to be aware of this case and document components of an informed consent on the chart and not exclusively rely on signed forms.

Conclusion

We have provided a provocative quiz with legal case discussions to illustrate basic concepts and interesting caveats with regard to informed consent. *(See Table 3.)* The issue and utilization of informed consent are pervasive throughout the practice of emergency medicine. To avoid increased liability, it is imperative for ED providers to comprehend and utilize the legal requirements with regard to informed consent. ■

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Many Claims Alleging Failure to Follow up on ED Radiology Studies

EP should be called for unexpected abnormalities

After a patient presented to an emergency department (ED) with neurological deficits after a motor vehicle accident, a magnetic resonance imaging scan was ordered. However, the emergency physician (EP) never looked at the results or contacted the radiologist.

"Had the [EP] followed up, he would have noted a large hemorrhage developing," says Joshua M. McCaig, JD, a shareholder with Polsinelli in Kansas City, MO, who defended the EP named in the resulting malpractice lawsuit. "Unfortunately, it was not noticed until it was too late, and the patient died."

Since the EP ordered the test, the results were available prior to admission and there was time to operate on the patient, the case was settled quickly. "The [EP] was primarily on the hook, since he ordered the test," adds McCaig.

Failure to follow up on radiology studies has become a frequent claim against both EPs and radiologists, according to Darien Cohen, MD, JD, an attending physician at Presence Resurrection Medical Center and clinical assistant professor in the Department of Emergency Medicine at University of Illinois, both in Chicago.

"It is a big problem, and it is an increasing problem," says Leonard Berlin, MD, FACR, professor of radiology at Rush University and University of Illinois and author of *Malpractice Issues in Radiology*. "What I call 'failed radiol-

ogy communication' cases are increasing. Most of these cases are settled out of court," says Berlin.

Joint Liability Likely

EPs often believe radiologists should be responsible for failure to follow up because it's their reading that is delayed, while radiologists think EPs should perform the follow up since they are the ones with an in-person patient-physician relationship.

"Ultimately, there can be joint liability between these physicians when it is not made clear to patients that an incidental or abnormal finding requires follow up," says Cohen.

If a bad outcome occurs due to the report not being read by the EP, both the EP and the radiologist can be held liable, underscores Berlin. "If the EP says, 'I ordered the report, but I assumed that if there was something abnormal I would have heard about it,' that's not going to hold water," he says.

Some EDs have EPs make a follow-up call to radiologists about a study, and some require the radiologist do so. "Either policy can be effective, but responsibility must be made clear," says Cohen. "There needs to be a system in place for overreads and alerts to be identified."

Electronic health records (EHRs) can actually hinder this process, adds Cohen, as there are sometimes different EHRs utilized in the ED and in the radiology suite. He recommends these practices:

- ED policies should ensure that all radiology alerts are available in a single location, and it must be clear who is responsible for follow-up.
- Follow-up must be clearly documented in the medical record.
- Any incidental finding mentioned on the radiology report should be communicated to the patient, and this communication must be clearly documented in the medical record.

Assuming that the radiologist appropriately read the study and dictated even a preliminary report, says McCaig, "the report speaks for itself."

If the EP failed to review a report that could have prevented a bad outcome and the patient sues, the EP will need to explain why it happened.

"In a particularly bad case, there may be a duty on the part of the radiologist to actually call the EP," says McCaig. "But in general, if the report is dictated and in the system, the EP has the responsibility to read it."

If the EP learns of the findings after the patient is discharged from the ED, says Berlin, the EP should contact the patient to inform him or her of the results.

"If the EP tells the patient, 'The report just came in and we didn't see it until after you left, and you have to take care of this,' that's no harm, no foul," says Berlin. The damage isn't done unless the patient isn't notified.

Defensible Documentation

If the EP orders a test, he or she "had better follow up on the results and make sure it is documented," warns McCaig.

A jury will generally understand that medical emergencies are difficult, time-sensitive, and do not always have a good outcome, but will not look favorably on a serious finding being overlooked, says McCaig.

"No one wants to live with the thought that if they go to an emergency room with a real medical emergency, that the physician is going to miss something critical that could have or should have been caught," says McCaig.

Good documentation and well-reasoned testimony by the EP are the most important factors in defending these claims, says McCaig.

At a minimum, the documentation should state that the EP reviewed the films and/or the radiology report. "Just a simple 'Reviewed MRI report' is sufficient," says McCaig. "It is also important to document if the EP spoke with the radiologist."

McCaig has seen many EPs asked in depositions if they spoke with the radiologist. "The EP typically doesn't remember this, and then has to say that it is his habit and custom to do so, but that he can't specifically remember in this case," he says.

It is much better if the EP can simply point to the chart and say, "Yes, I spoke with the radiologist. He confirmed the findings in his report."

"Then the EP simply has to say he relied on the radiologist's findings," says McCaig. "That moves the primary responsibility, in most cases, to the radiologist and the interpretation of the radiology study."

Significant Abnormality

"When you read an X-ray that is done in the ED, does the ED doctor always read the report?"

"No, often they don't."

"Is that why you usually telephone with the results?"

"Yes. If I don't call the ED doctor, the report may get lost."

This was the general content of an exchange between the plaintiff's expert witness — a radiologist — and the plaintiff's attorney in a 2012 medical malpractice case involving an EP's failure to follow up on an X-ray result. This trial testimony was used to show jurors that an effective process to communicate significant unexpected abnormal findings between the interpreting radiologist and the treating EP was not in place.

The lawsuit named an EP who ordered a spine X-ray for a patient with a chief complaint of cervical pain. The radiologist's report recommended an additional study with contrast, due to enlargement of the lymph node and tonsil. The EP sent the patient for this second study, which recommended an ENT referral due to possible cancer of the tonsil.

Before the report came back, however, the patient was discharged from the ED. "No one ever read it. A year and a half later, the patient was diagnosed with metastatic cancer," says Berlin. The EP and the radiologist were both sued for malpractice, with a large settlement resulting.

"Had the radiologist picked up the phone and called the EP or the ED nurse and said, 'We were worried about the bones, and the bones are normal, but there is possible cancer of the tonsil,' [the bad outcome and lawsuit] might never have happened," says Berlin.

This case and others like it underscore the importance of ED protocols requiring radiologists to call the EP when there is an unexpected abnormal finding, says Berlin.

"Radiologists should know, and the courts will expect them to know, that EDs are chaotic places and that a significant report could be overlooked," says Berlin. "They have a duty to foresee that, and try to avoid it if they can."

Radiologists are sometimes reluctant to call a busy EP about an abnormal finding, or might believe it's not necessary to do so. "Radiologists may say, 'We always fax reports and we've never had a problem, so we don't need to call,'" says Berlin. "Well, you may run through four red lights without a problem, but the fifth time you do it you have an accident."

If radiologists fail to call the EP about a significant abnormal finding, Berlin recommends the EP explain that the call is needed to protect the patient, the radiologist, and the EP. "If the call isn't made, the patient is going to suffer medically, and the EP and radiologist are going to suffer legally," he says. ■

Sources

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Info Often Missing from ED Charts, Forcing Settlements

Every emergency physician (EP) has heard the warning, "If it's not documented, it's not done," but malpractice attorneys still report seeing crucial pieces of information missing from emergency department (ED) charts.

"Despite the time constraints every [EP] faces, the importance of a complete chart that accurately 'tells the story' of the patient's ER encounter cannot be overstated," says Gary Genovese, JD, an attorney at Conrad & Scherer in Ft. Lauderdale, FL.

Missing documentation results in EPs being sued who otherwise would not be, and EPs having to settle otherwise defensible claims. "Time and again, I have seen the lack of com-

pleteness of a chart come back to haunt the physician, leaving him or her at the mercy of a swearing contest with the patient," says Genovese.

A complete chart doesn't guarantee that an EP won't be sued. However, it may dissuade a plaintiff attorney from taking the case, and will certainly make the defense attorney's job much easier, says Genovese.

Here are some items that defense attorneys frequently find are missing from ED charts, making otherwise defensible claims strong candidates for settlement:

• All pertinent positives and negatives aren't recorded, with boxes left unchecked for systems or symptoms which were assessed or examined by the physician.

This makes it appear that the EP failed to fully assess the patient, or did so hurriedly and missed something. "A good plaintiff attorney will fully exploit such an omission," says Genovese.

After the assessment has been charted, EPs should take a moment to review it for completeness and accuracy. "Do this with the view that you may have to someday explain or defend everything that you did for this patient," advises Genovese.

• The EP's diagnosis, reasons for the diagnosis, differential diagnoses, and treatment options aren't documented.

This documentation can be used to counter the plaintiff attorney's argument that the EP failed to consider an alternative diagnosis.

"It is difficult and sometimes impossible to list every potential diagnosis presented by the patient's symptom complex," acknowledges Genovese. "Nonetheless, thoroughness is never a bad thing when it comes to ER charting."

• The recommendations made to the patient for further care aren't included in the chart

The chart should make abundantly clear that the patient and family were clearly instructed on follow-up care, the timing of such care, and the provider of that care, including an immediate return to the ED if symptoms persist, worsen, or change in any way.

"The completeness of that ER chart will defeat the argument that the patient did not know what she was supposed to do for further medical attention when she left the hospital," says Genovese.

• "Normal" exam findings are incorrectly indicated.

"If you are using templates, be sure that you look at everything. It is a frequent error to put in 'normal exam findings' by accident,'" says Jennifer L'Hommedieu Stankus, MD, JD, an attending physician at Group Health Physicians, a Seattle, WA-based multispecialty group practice, and former medical malpractice defense attorney.

For example, if a patient has a long-standing heart murmur and the EP documents "heart rrr [regular rate and rhythm], no mrg [no murmurs/rubs/gallops]," it calls the entire examination into question.

"If you didn't document that correctly, there will be a question about what else you failed to examine," says L'Hommedieu Stankus.

• A review of systems is not documented.

"Believe it or not, major portions of records are often simply not completed," L'Hommedieu Stankus says. "Go back through every chart before you place your final signature."

• The chart fails to indicate that radiologic or laboratory findings were communicated to the patient.

This is particularly important for findings that won't be addressed during the ED visit, but which require further evaluation, such as a lung nodule. "If you release the patient, for whatever reason, prior to studies coming back, be sure to document how the patient was contacted with the information and when, or what steps will be taken to contact the patient," L'Hommedieu Stankus says.

• There is no documentation of conversations and precautions given when a patient leaves against medical advice (AMA).

"This is a very high-risk time for the patient," says L'Hommedieu Stankus. "Document that the patient understood the risks and benefits of treatment versus leaving against your medical advice."

Be sure to document the reasons a patient gives for leaving and what advice you gave for the patient to return or get help elsewhere, she advises.

"If any abnormal labs or radiologic results return after the patient leaves, it is still your responsibility to try to contact that person to get them this information," says L'Hommedieu Stankus. "The gravity of the situation will dictate the appropriate action."

A patient complaining of chest pain may leave AMA just after a second troponin is drawn and refuses to wait for the results, for instance. While all other studies have been normal, the second troponin comes back elevated.

In this case, says L'Hommedieu Stankus, "you may need to go so far as to send out police to try to get the patient back to the ED if you cannot contact them directly yourself."

• The chart makes it appear that the patient wasn't reassessed prior to discharge.

Genovese has seen many EPs testify that they rechecked the patient prior to discharge, but there was nothing in the chart to substantiate it, and the ED nurse could not recall it.

"Rest assured that in such an instance, the plaintiff attorney will argue that the patient was discharged without being seen again by the physician," he says. "This can be avoided with a quick note stating why the patient was cleared for discharge."

Lack of patient reexamination at the time of disposition leaves the EP vulnerable to plaintiff allegations that the patient was discharged or admitted in an unstable condition, says **Pete Steckl**, MD, FACEP, director of risk management at EmergiNet in Atlanta, GA.

This documentation is important in all patients with any protracted length of ED stay, particularly in patients with any disease process and pathology that has a tendency to evolve with time, says Steckl, such as abdominal pain, stroke symptoms, or ongoing chest pain. He says documentation of these items is legally protective for EPs:

- a re-examination indicating a benign abdominal exam at the time of discharge for patients who present with abdominal pain and evidence of a tender abdomen;
- recheck of abnormal vital signs at the time of discharge;
- a patient's ability to tolerate fluids at the time of discharge, for pediatric patients who present with complaints of vomiting;
- the ability to ambulate, for any ambulatory elderly patient who presents with a recent history of fall and lower extremity injury, even with normal imaging studies.

• The chart doesn't "tell the story" of the EP's medical decisionmaking and the patient's ED course.

"This section of the chart is a woefully underdocumented area," says Steckl. "Lack of completion can contribute substantially to difficulties defending suits."

Failure to address the decision-making allows the retrospective evaluating body, whether it be the courts or the medical board, says Steckl, "to fill in the informational gaps with frequently biased, subjectively derived reasoning that may not reflect at all what was going on real-time during the encounter." ■

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Could Patient's Non-compliance Be Life-threatening?

If so, protect yourself legally

In a recent malpractice case, the plaintiff failed to follow up in two days, as instructed by the emergency physician (EP), and died a month later from an ectopic pregnancy. Yet the EP was still held liable and ended up settling the claim.

"Clearly, if she had followed up even days later, she would have been just fine. She did not, and caused her own death without a doubt," says **Michael Blaivas**, MD, FACEP, professor of emergency medicine at University of South Carolina Medical School and an ED physician at St. Francis Hospital in Columbus, GA. "Yet the insurance company caved in and forced a settlement. "

If patients fail to follow up, the EP is "still on the hook, especially if the patient was young and the outcome bad," says Blaivas. "Several

juries have held the EPs responsible for complete disregard by patients regarding follow up, even with iron-clad documentation."

ED Held Responsible

Blaivas has reviewed several malpractice cases involving non-compliant ED patients that were settled by the insurance company, even with good documentation and defensible care.

"If a young patient dies, in my experience, you are still facing an uphill battle," says Blaivas. In one case, a patient failed to follow up on a possible lung nodule with suspicion for early cancer. "The patient went on to develop advanced lung cancer and died. The jury held the EP responsible for the fact that he did not follow up," says Blaivas.

Blaivas has reviewed several cases in which patients were sent home after cardiac workups in the ED and suffered cardiac-related deaths. The documentation was vague in each case, although each patient clearly received instructions to follow up.

"In each case, the jury appeared to hold the EP responsible," says Blaivas. "One common thread through the cases is that a family member stated they clearly recalled the EP not advising the patient to follow up."

Blaivas recommends these practices to reduce legal risks if a patient's non-compliance could be life-threatening:

• Call a primary care physician or other follow-up site to arrange an appointment for the patient.

"This is very hard in a busy ED, yet I still see some of my colleagues accomplish this," says Blaivas. "They basically impact their productivity by doing so. Having a secretary or someone similar who can do this is key."

Calling the primary care physician puts some liability on their part to get in touch with the patient, says **Sandra Schneider**, MD, FACEP, a professor in the Department of Emergency Medicine at Hofstra North Shore — Long Island Jewish School of Medicine in Hempstead, NY.

"It would be great if you can make an appointment time from the ED, but that is rare because so much of our care is after hours," says Schneider. "Some hospitals have walk-in clinics where a patient can go the next day."

Plaintiff attorneys can easily ask the EP, "Well, why didn't you just call the physician with whom you were going to have the patient follow up, and make the appointment for tomorrow?"

"It is clear that some juries seem to expect the EP to make complete arrangements for the patient to be followed up, no matter how unrealistic this is," says Blaivas.

While some EDs contact physician offices the next business morning to let them know about referrals, says Blaivas, "for most of us, all we can do is make sure a patient has a name, phone number, and well-documented instructions."

It can be legally protective for EPs to show the efforts made to get the patient follow-up care, such as faxing information to physician offices, making appointments, or requesting consultations. "If documented well, you may still get sued, but it will be a very uphill battle for the plaintiff," says Blaivas.

• Make it clear in the chart that the EP stressed that the patient's life might depend on their following instructions.

"Stress that although it is safe to discharge them now, it is important they follow up, and tell the patient what could happen if the worst case scenario comes true," says Blaivas.

• Document that the patient understood the EP's instructions, and the gravity of the situation.

"The nursing record has to independently corroborate this as well," says Blaivas.

Tell Patient the Reason to Follow Up

Juries are often swayed by a bad outcome, and might not want to hold the patient liable for their own misjudgment, says Schneider.

One malpractice case involved a patient who failed to return to the ED the following day for a wound check after a complex laceration repair of his hand. The patient also failed to see a surgeon for follow up in three days.

"He never cleaned the wound, as instructed, nor did he fill or take the antibiotics prescribed," says Schneider. "His hand became badly infected. He stayed home for days while it swelled and pus ran from the wound."

Eventually, the patient returned to the ED with extensive damage, which resulted in several fingers being amputated. Despite good documentation of the patient's non-compliance, the patient sued the EP.

"However, the case against the physician was dropped," says Schneider. The chart was

very clear about what the patient was told, and stressed the importance of the patient returning to ED.

"The thing that saved the physician were very clear and easily understandable instructions," says Schneider. "These included not only what he needed to do, but why he needed to do it." ■

Sources

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CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

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

CNE/CME INSTRUCTIONS

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.

2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME QUESTIONS

1. Which is true regarding liability for failure to follow up with abnormal findings of radiology studies ordered in the ED, according to **Leonard Berlin**, MD, FACR?
   A. The EP cannot be held liable under any circumstances if the radiologist failed to inform the EP of the results.
   B. Radiologists always have a legal duty to inform the EP verbally of any abnormal findings, even if the report is dictated and in the system.
   C. The EP can only be held liable if the radiologist informed the EP of the results verbally.

D. If a bad outcome occurs due to the report not being read by the EP, both the EP and the radiologist can be held liable.

2. Which is recommended to reduce legal risks of failure to follow up with radiology studies, according to **Joshua M. McCaig**, JD?
   A. It is not advisable for EPs to document telephone conversations with the radiologist confirming the findings in the report.
   B. At a minimum, the EP's documentation should state that the EP reviewed the films and/or the radiology report.
   C. ED protocols should not require radiologists to call the EP when there is an unexpected abnormal finding.
   D. Radiologists should be instructed not to call the EP routinely for significant abnormal findings.

3. What documentation makes claims against EPs more defensible, according to **Pete Steckl**, MD, FACEP?
   A. a note stating why the patient was cleared for discharge
   B. a reexamination indicating a benign abdominal exam at the time of discharge
   C. recheck of abnormal vital signs at the time of discharge
   D. all of the above

4. Which is true regarding an ED patient's noncompliance, according to **Michael Blaivas**, MD?
   A. EPs cannot be held liable if there is good documentation of a patient's complete disregard of follow up.
   B. It is helpful for EPs to show they made extra effort to arrange follow-up care.
   C. Contacting patients' primary care physicians to arrange follow up increases legal risks for EPs.
   D. EPs should not state in the chart that they informed the patient of the worst case scenarios of failing to follow up.

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