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EMRs: Risk of the Mouse Click

By Kevin Klauer, DO, EJD, Chief Medical Officer, Emergency Medicine Physicians, Canton, OH

Electronic medical records (EMRs) have quickly become the standard in most U.S. emergency departments. A few short years ago, working with an EMR was largely the exception and not the rule. However, following implementation of the meaningful use program, and its associated financial incentives, EMR use has exploded and become the new standard. Unfortunately, as with any other initiative, when incentives are misaligned, the consequences can be disastrous. Although many hospital administrators and providers are quick to embrace improved information exchange, data collection, patient tracking, and improved patient safety, the incentive that resulted in widespread EMR adoption was ultimately financial from revenue generated from meaningful use incentives and improved documentation and charge capture. However, currently available systems have not only fallen short in improving safety and reducing medical-legal risk, many providers and patients have fallen victim to the law of unintended consequences.

EMRs conceptually offer a great potential upside, particularly with broader application, such as a hospital system, but it cannot be overstated that much of actualized benefit is financial and results from standardization, reduced transcription costs, economies of scale, and found money (e.g., meaningful use payments). Data collection, for the purpose of performance improvement and utilization tracking of systems, individual departments, and providers is a value-added benefit if used effectively. You just simply can't expect to get something for nothing; there are real (not hypothetical) trade-offs with the use of EMRs.

Those trade-offs include reduced physician/provider productivity, billing and coding compliance issues, and new medical-legal threats uniquely introduced by EMRs themselves.

So, the ship has sailed. The days of running an ED without an EMR are virtually over. For hospitals, the math is just too simple. The sticker shock associated with EMRs was a previous barrier to implementation, a barrier allowing for healthy skepticism. However, once meaningful use incentives were entered into the equation and large-scale operational efficiencies (economies of scale) have been proved with their use, there is little hesitation on

the part of hospital administrators. Unfortunately, the return on investment seems pragmatically clear, but the inherent risks are not, and are only being recognized as our experience with EMRs grows.

The Business Case: Return on Investment

There are sufficient published data to seal the deal with hospitals, and particularly hospital systems. In a recent discussion paper published by the Institute of Medicine in January of this year, the case for the return on investment is adeptly made, highlighting the experience of three hospital systems, Kaiser Premanente, the U.S. Department of Veterans' Affairs, and Sentara (a small- to medium-sized system operating more than 100 sites of care, including seven acute care hospitals).[1] This is a 24-page report, highlighting their experiences with EMR implementation. The report stated that Kaiser: "Anticipated $2 billion cash flow from the $1 billion investment over the 10-year investment horizon (using medium implementation scenario). Long-term hospital cost structure reduction of up to 2.3% and increased revenue by 0.6%."[1] The V.A. system reported substantial value from implementation: "The total net value exceeded $3.09 billion, with annual net value exceeding $687 million. The gross value of the benefits was projected to be $7.16 billion, with 65% resulting from prevention of unnecessary care and 27% from eliminated redundancies. Reduced work, decreased operating expenses, and freed space accounted for the rest."[1] Sentara also made their business case for EMR implementation: "Higher benefit-to-cost ratios during each implementation year, resulting in cumulative benefits of $48.5 million for 2010."[1]

In a deeper exploration of Sentara's experience, they implemented EPIC across all of its seven acute care hospitals. The ownership costs were $237 million, $170 million of operational expense, and $67 million in capital expenditures. Their meaningful use revenue was $70 million, and their projected annual savings was $53 million.[2] Publishing such data will most likely prompt even the most reluctant hospital CEO to adopt this technology, and it is strongly suspected that once health information systems (HIS) are adopted, it is very unlikely that we will return to our former low-tech era; de-installations are fairly uncommon.

The Negative Impact on Productivity

Regarding provider productivity, EMRs have been reported to reduce productivity. With the combination of computerized entry (CPOE), with its complex matrix of drop-down menus and often intrusive attempts at clinical decision support, many physicians have reported increased charting time, less time at the bedside, and decreased productivity. Installations have been associated with reduction in physician productivity that, after considerable effort, may improve, but not necessarily return to baseline. A recent article in the *American Journal of Emergency Medicine* reported that 43% of emergency physician time is spent on data entry, while only 28% on direct patient care. In addition, the least number of mouse clicks necessary to complete an action was six (ordering an aspirin) and the highest number was 227 to complete documentation of a record for a patient with right upper quadrant abdominal pain. In addition, the authors estimate that a 10% increase in productiv-

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ity in the community hospital studied would result in $1.77 million in increased revenue. Finally, seeing 2.5 patients per hour while working a 10-hour shift would require 4,000-mouse clicks.[3]

Other studies have also reported the increased workload created by EMRs. When the provider's attention and efforts are diverted from the bedside and away from direct patient care, the primary provider interface becomes with the computer, as opposed to the patient. Less face-to-face time with patients may result in a greater risk of medical error and suffering a risk management event (i.e., incident reports, claims, and lawsuits). In 2005, Poissant reported that EMRs increase documentation time by 17%, while CPOE was associated with a 98% increase in documentation time.[4] In addition to increased documentation time of four- to five-fold following EMR implementation in an academic emergency department, Park reported that the number of incomplete charts increased, attending documentation was exchanged for disproportionately more resident documentation, less time was spent at the bedside, and there was "increased cognitive burden."[5] In other words, the authors identified the additional concern that the complexities of EMR use added to the intellectual or cognitive burden of an already mentally exhausting environment.

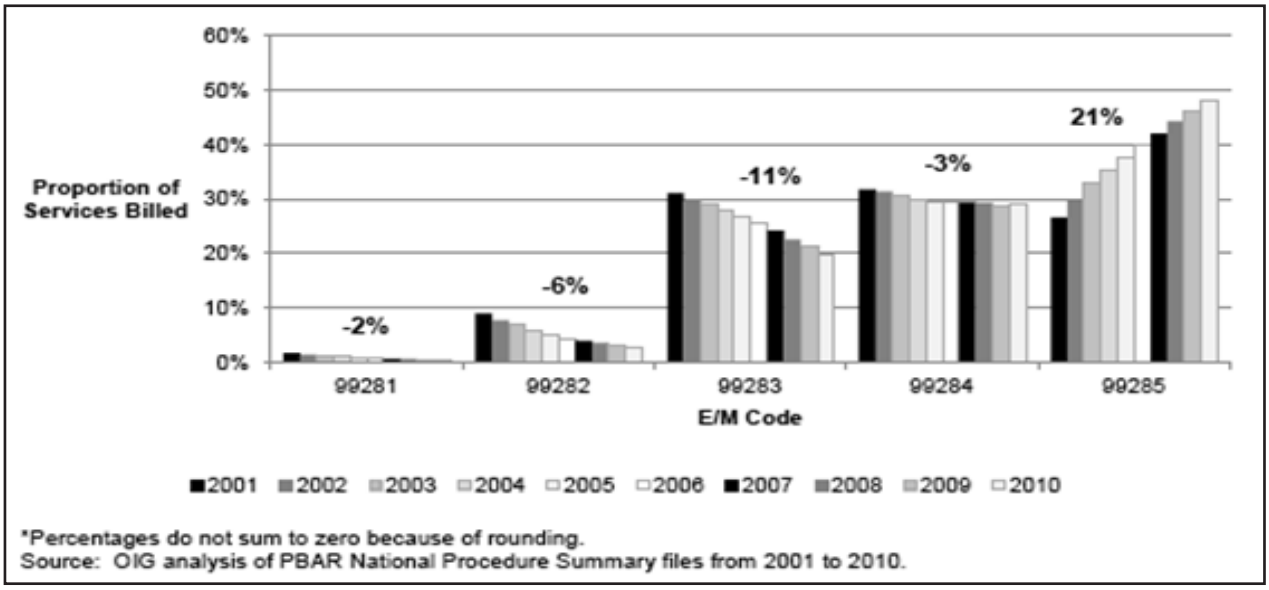
In the family practice setting, arguably less challenging than an emergency department, productivity increased (1.49 to 1.79 relative value units [RVUs]/hr) and documentation improved, but 66% of physicians stated that their workload was increased by the EMR.[6]

Despite the fact that sufficient evidence exists to support the negative impact EMRs have on physician productivity, it appears that as the transition becomes more commonplace, not all will experience the same impact. In January of this year, Ward et al evaluated the effects of electronic health record (EHR) implementation on 8 metrics (e.g., arrival to provider, overall length of stay, length of stay for admitted patients, length of stay for discharged patients, left before treatment complete, significant returns, overall patient satisfaction, and provider efficiency) in 23 community emergency departments.[7] They found no statistical differences in those categories. Nonetheless, the preponderance of data more than suggests that most EDs will be negatively impacted, in one way or another, by EMR implementation, and issues such as time spent away from the bedside, increased cognitive burden, and increased workload are likely to result in a commensurate increase in professional liability.

Many strategies have been utilized to buffer the negative impact on productivity, including increasing physician and advanced practice provider (non-physician clinician) coverage, increased resident coverage, and the introduction of scribes into the ED workflow. Perhaps, the most widely utilized and cost-effective option is the latter. Scribes have proven more valuable than ever when EMRs are implemented in the ED. Beyond documentation assistance, their role can be expanded to additional non-medical roles such as setting up suture trays and notifying the physician when a complete data set is available for a given patient, expanding their role to that of a patient flow tech. Becker's review reported that ED scribe programs may increase RVUs per visit and hour, reduce lost revenue from deficient charting, and reduce the number of incomplete and unbillable charts.[8] The business case for scribes is outlined in an information paper released by the American College of Emergency Physicians (ACEP) in 2011. The paper highlights that scribe expense ranges from $10 per hour to $26 per hour and that in one example, the use of scribes increased productivity by 17%.[9] Although scribes have proven to be a viable solution for EMR-induced productivity issues, there are limits to the application, and exceeding those limitations can result in serious compliance issues. First and foremost, scribes are not to provide medical treatment. For scribes without medical training, this is a very easy directive to follow. However, when a medical provider is functioning as a scribe, his or her duties must not include the provision of medical care.

For example, in 2007, a Tampa, Florida jury awarded a plaintiff $217 million for a missed cerebellar stroke. The physician assistant (PA) involved in the care of the patient was actually hired as an "expediter" or scribe.[10] However, it was later discovered in deposition testimony that the PA was unlicensed due to not passing the state licensing examination on four occasions. Although an extreme example, it is applicable nonetheless, illustrating how medical providers being employed as scribes can easily expand beyond their job description, resulting in disastrous consequences. What is the provision of medical care? Per The Joint Commission, entering orders via CPOE constitutes the provision of medical care, and scribes are prohibited from performing this function. The rationale is that when clinical decision support prompts are encountered, medical decision-making is required to address them. Thus, scribes are not qualified or allowed to make such judgments.[11]

FIGURE 1: PERCENTAGE OF E/M CODES BILLED FOR ED VISITS FROM 2001-2010



*Percentages do not sum to zero because of rounding.
Source: OIG analysis of PBAR National Procedure Summary files from 2001 to 2010.

EMRs Improve Charge Capture While Raising Red Flags

Enhanced charge capture is an inevitable incentive for EMR adoption. What is perplexing is that the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have identified EMR abuse as the newest target for false claims fraud and abuse surveillance, investigation, and enforcement. It is truly unconscionable that the OIG has been empowered to pursue increased revenues from EMR use as fraud and abuse when the federal government was the driving force for adoption of this technology, and that increased charge capture and associated Medicare claims was foreseeable.

Nonetheless, the OIG has made it clear that it has identified increased charges under the Medicare program between the years 2001 and 2010, and that it believes that such increases are substantially in part due to E/M service vulnerability to fraud and abuse.[12]

"OIG is conducting a series of evaluations of E/M services provided to Medicare beneficiaries in 2010. OIG plans to issue two others in addition to this report. One will determine the appropriateness of Medicare payments for E/M services. The other will assess the extent of documentation vulnerabilities in E/M services using electronic health record systems."[12]

Figure 3 from the report reflects the growth in E/M code 99285 (level 5) from 27% of charts billed to 48%, an increase of 21%.

For surveillance purposes, the OIG's report states that 1,700 physicians were identified with increased billing of higher E/M levels (e.g., the two highest codes in a visit type 95% of the time).[12]

In a rebuttal article in the *New England Journal of Medicine*, Pitts stated that use of lower codes has declined and use of higher codes has increased due to an aging and sicker Medicare population, as opposed to upcoding and improved documentation from EMR use.[13]

In January of 2014, the OIG fulfilled their promise from 2012 and released their report regarding EHR vulnerabilities and "program integrity practices" that have been implemented.[14] Two of the highlighted initiatives are "copy-pasting" and "over documentation." Although the OIG accepts transfer of information if accuracy is ensured, their description and intent are clear. Successfully complying with the regulations if you choose to cut and paste into the records is so unlikely, the practice should be abandoned. Below is the language directly from the report.[14]

"Copy-pasting, also known as cloning, enables users to select information from one source and replicate it in another location. When doctors, nurses, or other clinicians copy-paste information but fail to update it or ensure accuracy, inaccurate information may enter the patient's medical record and inappropriate charges may be billed to patients and third-party health care payers. Furthermore, inappropriate copy-pasting could facilitate attempts to inflate claims and duplicate or create fraudulent claims."

Although inadvertent over-documentation is relatively easy to do within an EMR with its various

drop-down menus and auto-populated fields, the OIG has a zero-tolerance policy. The following outlines the OIG's expectations.[14]

"Over-documentation is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher level services. Some EHR technologies auto-populate fields when using templates built into the system. Other systems generate extensive documentation on the basis of a single click of a checkbox, which if not appropriately edited by the provider, may be inaccurate. Such features can produce information suggesting the practitioner performed more comprehensive services than were actually rendered."

Risks Inherent to EMRs

Beyond compliance, EMRs have been shown to introduce new sources of risk and liability. In a landmark article published in the *New England Journal of Medicine*, several liability risks associated with EMRs were identified. Specifically, the authors note the potential risks during three phases of EMR use: implementation, as systems mature in place, and as EHRs become more widespread.[15]

Potential risks during initial implementation include:

- Transition from paper to electronic record may create documentation gaps.
- Failure to implement procedures that a prudent or reasonable provider would implement to avoid errors during the transition period may leave providers vulnerable in tort.
- Inadequate training on EHR systems may create new error pathways.
- Errors by new system users may create incorrect or missing data entries.
- Failure of clinicians to use EHRs consistently may lead to gaps in documentation and communication.
- Systemwide EHR "bugs" and failures could adversely affect clinical care, leading to injuries and claims.

As systems mature in place, the following risks are identified:

- E-mail advice multiplies the number of clinical encounters that could give rise to claims and may heighten the risk of claims if advice is offered without thorough investigation and examination of the patient.
- More extensive documentation of clinical decisions and activity creates more discoverable evidence for plaintiffs, including metadata.
- Temptation to copy and paste patient histories instead of taking new histories risks missing new information and perpetuates previous mistakes.
- Failure to reply to patient e-mails in a timely fashion could constitute negligence and raise patient ire.
- Information overload may cause clinicians to miss important pieces of information.
- Departures from clinical-decision support care guidelines could bolster plaintiffs' case.

As EHRs and health information exchanges (HIEs) become widespread:

- Better access to clinical information through EHRs could create legal duties to act on the information.
- Widespread use of clinical-decision support may solidify standards of care that might otherwise be subject to debate.
- The rise of HIEs may heighten clinicians' duties to search for patient information generated by other clinicians.
- Failure to adopt and use electronic technologies may itself constitute a deviation from the standard of care.

Of particular note is the creation of metadata, creating discoverable events and data generated from every entry, mouse click, and query behind the screen. As decision support becomes intrusive, the prompts are largely ignored, and widespread decision support becomes validated with every mouse click-generated answer.

Many other articles have been published highlighting these high-risk items and several others. Of particular importance is the concept of e-discovery. e-discovery is the request for all EMR screen shots and metadata, which is often in excess of $50,000 to produce.[15] Even EMR selection, implementation, and every aspect of use may be requested and examined in discovery.[17]

The OIG and plaintiff's attorneys have identified the value of audit logs, which can be queried to track chronological changes in a record, including date, time, and user stamps for every entry into an EMR, which are being used for noting inconsistencies in the record.[14]

The first step to avoiding risk with EMR use is to be aware of the sources of risk or pitfalls. Farley et al published a paper noting four common pitfalls in ED EMRs: communication failures, poor data display, wrong order-wrong patient errors, and alert fatigue.[18] Although operational redesign and user-centric solutions are essential to reduce risk, it is unlikely we will see them any time soon. Currently, the best approach is awareness. Being knowledgeable of the common pitfalls of EMR use, plaintiff's attorney strategies for use of EMR data, and the OIG's enforcement plan will go a long way to avoiding risk with your EMR. ■

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Discharge Instructions Can Help Plaintiff Depict EP as "Careless and Callous"

Discharge instructions frequently play an important role as evidence in medical malpractice cases, says **John J. Barton**, JD, a partner in the Providence, RI, office of Barton Gilman.

"Most often, such instructions are helpful to the defense," says Barton — as in cases in which the patient is told to return to the ED if symptoms persist or if new symptoms develop, and the patient fails to do so.

In such cases, the patient's own failure to act can give rise to a comparative negligence defense, a break in causation, or a failure to mitigate damages. "However, there are also many cases when discharge instructions are cited as evidence of a physician's allegedly callous and careless attitude," says Barton.

Give "crystal clear" instructions

Many times, patients are discharged from the ED with instructions to follow up with a primary care physician or specialist. If a bad outcome occurs, the patient may later claim the instructions were unclear.

In this scenario, several factors can determine whether the EP is held liable. "The patient might not end up being seen by the subsequent physician for any number of reasons," says **David P. Sousa**, JD, senior vice president and general counsel at Medical Mutual Insurance Co. of North Carolina in Raleigh. Even if the patient is seen, the subsequent physician isn't necessarily made aware of what occurred in the ED that would be relevant to subsequent care decisions.

"If the patient chooses not to go, then arguably that's the patient's fault and their problem," says Sousa — and perhaps even contributory negligence in those states that recognize and allow such a defense.

"But if the patient does go, and there were significant findings in the ED that then were not

communicated well to the subsequent treating doctor, that can be a problem for the EP," says Sousa. Here are common allegations in claims involving this communication breakdown:

- that the EP failed to follow up with either a patient's primary care physician or cardiologist concerning heart issues;
- that the EP failed to recommend that the patient see an orthopedist for worsening pain, loss of function, numbness, or bluish color or redness following a traumatic injury with non-specific ED findings;
- that the EP failed to consider poly-pharmaceutical issues for a patient already taking various medications prior to drugs being prescribed in the ED.

"If the potential harm to the patient for failure to follow up is significant enough, then many ED physicians are coordinating the follow-up appointment with the community physician before discharge of the patient from the ED," says Sousa.

In the absence of such a process, Sousa recommends these practices:

- giving the patient clear written instructions as to the needed follow up, why, and the dangers in not doing so;
- making a follow-up call to confirm with the patient that the follow-up appointment was, in fact, scheduled, and then charting that conversation.
- taking extra care to ensure patients who are under the influence of drugs or alcohol, who are unconscious at the time of arrival, and who are non-English speaking are aware of what needs to happen next.

"Handing that patient very clear written discharge instructions can go a long way toward getting the monkey off the ED doc's back if something goes wrong," he says.

Sousa has seen cases in which the patient was discharged with a set of instructions, but the EP failed to keep a verbatim copy of what the patient was given. The EP is then in the position of claiming the patient was told exactly what to do, while the patient insists otherwise. This complicates the EP's defense.

"Another area where we see deficiencies in ED discharge summaries is assuring that the patient is crystal clear about meds that need to be taken, or that need to be started or stopped, as a result of treatment that occurred in the ED," says Sousa.

A common example of this would be a patient who comes to the ED on an anticoagulant, is stopped from any further dosages due to the EP anticipating the patient's possible need for surgery, but no surgery takes place. "The patient is not told to restart their anticoagulant at discharge," says Sousa. "The patient leaves the ED and then later dies from a stroke."

Likewise, responsibility for educating the patient on potentially dangerous drug interactions with medications given in the ED "is going to fall back on the EP," warns Sousa. ■

Sources

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Instructions an Issue in Missed Ectopic Claim

A recent malpractice claim involved a 30-year-old woman who complained of severe lower abdominal pain and vomiting. She told both the triage nurse and the emergency physician (EP): "This feels just like the pain I experienced several months ago when I had kidney stones."

"She denied having any urinary symptoms, and estimated that her last menstrual period had occurred one month earlier," says **John J. Barton**, JD, a partner in the Providence, RI, office of Barton Gilman. "She failed to mention that she had had a history of a prior ectopic pregnancy."

Upon reviewing the patient's medical chart for prior ED visits, the EP noted that the patient had been treated five times for kidney stones within the previous three years. No information about the prior ectopic pregnancy was referenced in the records available to the doctor.

"On examination, the physician noted that the patient had normal vital signs, and mild tenderness on palpation of her mid and lower abdomen," says Barton. "She denied having any flank pain, and all other physical findings appeared to be normal."

The EP ordered a complete blood count, a

metabolic screen, lipase, and urinalysis. "He also ordered an HCG pregnancy test, to be followed by an abdominal CT scan if the pregnancy test was negative," says Barton.

All blood study findings came back as normal, except for the white blood count, which was elevated at 14.98, and the creatine level, which was low at .49. The results of the urinalysis and HCG pregnancy test were not reported in the record. "It was later discovered that these tests were never performed, though the physician's order had been initialed by a member of the nursing staff as confirmation of those tests having been performed," says Barton.

Despite this oversight, the patient was taken to radiology for an abdominal CT scan. "The radiologist who interpreted the CT scan verbally reported to the ER physician that the abdominal scan showed no evidence of genitourinary obstruction, but did reveal a small amount of perihepatic fluid in the subscapular area," says Barton.

The formal written report on the CT scan, which was posted three hours later, after the physician last re-examined the patient, reported an additional finding of "free fluid in the pelvis, which may represent blood."

When the patient was re-examined by the EP, she reported that her abdominal pain had diminished, but was still present. The physician ordered pain medication and an anti-nausea medication. Based on the patient's history, physical examination, and lab results, the EP concluded that the patient's resolving abdominal pain was likely due to a kidney stone that had passed.

"He assumed that the pregnancy test he had ordered had in fact been done and was negative," says Barton. "This assumption was based on the fact that the nurse had initialed his order and that the staff had proceeded to take the patient to radiology for the CT scan."

Nevertheless, the EP elected to monitor the patient for a further period of time before she was released. Two hours later, the patient was cleared by the physician for discharge. At that time, her condition was described by the nursing staff as "stable" and "improved."

"The physician did not see the patient at the time of discharge, but he did sign the discharge orders," says Barton. The discharge orders instructed the patient to "take one 324 mg tablet of [oxycodone and acetaminophen] every four to six hours as needed, and to follow up in two days with your regular treating physician," and were delivered to the patient by the nursing staff.

Seven hours later, the patient was brought back to the ED by ambulance, suffering from severe abdominal pain and seizures. An HCG pregnancy test performed at the time of the second admission was positive.

An exploratory laparotomy confirmed the ectopic pregnancy, a uterine fundal rupture, and a 10 cm blood clot containing chorionic villi and fragments of placental tissue. "The patient required multiple transfusions, and suffered the loss of one of her fallopian tubes," says Barton. "She was discharged after a five-day hospitalization," says Barton.

The patient filed suit against the EP and the hospital. No members of the hospital's nursing staff or radiology department were named as defendants.

"However, the patient asserted vicarious liability claims against the hospital based on the acts and omissions of these staff members," says Barton. "Ultimately, the lawsuit was settled by the hospital's carrier on behalf of all defendants for an undisclosed amount."

Here are two of the plaintiff attorney's allegations:

• That the EP, not the nurse, should have handled the patient's discharge.

The plaintiff attorney was highly critical of the fact that the EP did not personally check on the patient at the time of discharge, but instead had a nurse pass along the discharge instructions.

"Counsel argued that if the physician had seen the patient at the time of discharge and accessed the chart one last time, he might have noted that the HCG pregnancy test had never been performed," says Barton.

The plaintiff's attorney also argued that had the EP accessed the chart just prior to discharge, he might have seen the formal CT scan report, which noted "free fluid in the pelvis which may represent blood."

"Had he taken five or 10 minutes to personally deliver the discharge instructions, the patient might have felt more respected and less abandoned," adds Barton. "Studies of malpractice cases have consistently shown that patients who believe that their doctors care about them as people, and not just as patients, are much less likely to sue."

The EP may not always be able to handle the discharge personally, acknowledges Barton, "but lawsuits are also time-consuming and inconvenient for ED personnel. Finding time to do the discharge saves more time and aggravation later."

• That the EP should have instructed the patient to return to the ED if symptoms persisted or worsened.

"Telling the patient to follow up with her regular treating physician in two days, as was done in the above case, does the patient no good if her uterus is in the process of rupturing from an ectopic pregnancy," says Barton.

In addition, Barton says that telling the patient to follow up with someone else is "the kind of instruction which can easily be recharacterized as 'buck passing' by a clever plaintiff's attorney." ■

Outside Evaluations Identify Risk-prone Practices in EDs

Stephanie C. Sher, Esq., an attorney with Stevens & Lee in Lancaster, PA, says that outside evaluations of an emergency department (ED)'s processes can identify risk-prone practices that could result in bad outcomes and malpractice claims.

"In collaboration with a quality and safety consulting firm, we are often asked to evaluate ED operations from both a clinical and process standpoint," says Sher. A thorough analysis of patient flow, clinical protocols, and policies and procedures can often identify areas of weakness or exposure in which recommendations can be made for decreasing that exposure, she explains.

Because this is a collaborative effort between Stevens & Lee and SE Healthcare Quality Consulting, all findings are protected by attorney client privilege to the extent allowed by local state law. Here are some risk-prone practices frequently seen in the EDs:

• Inappropriate handoffs.

With ED overcrowding and the frequent scarcity of inpatient beds, patients will often remain in the ED across multiple shifts, with multiple care providers overseeing their care. "It is important to have effective handoffs between shifts, as well as from the ED to the admitting physician," says Sher.

Significant diagnostic results are often overlooked because of ineffective handoffs. "We recommend use of checklists as communication tools," says Sher. Sher also recommends using electronic health records to ensure that subsequent providers are aware of what occurred during the patient's ED course. "As more patients move to post-acute settings directly from the ED, the discharge summary becomes a communication tool to enhance those types of transitions," she says.

• Incomplete or ineffective documentation.

"This can be an area of weakness and/or exposure by not being comprehensive enough to justify the rationale between the presenting complaint and the subsequent treatment plan," says Sher.

With a series of physicians covering a patient during a prolonged ED stay, it is important to document a differential diagnosis and proposed plan of care, in addition to having a verbal discussion at the time of handoff. This helps to avoid the scenario in which there are differing opinions reflected in the notes that can be easily picked up on by a plaintiff's attorney in the event a claim is filed.

"This is a pathway for the plaintiff lawyer," Sher says. "It's always beneficial to the plaintiff when providers are pointing fingers."

• Failure to follow policies regarding supervision of advance practice professionals.

EDs are increasingly using advanced practice professionals to address volume surges. "This is not a new issue, but it is becoming a much more common practice to have advanced practice providers functioning very independently in a 'fast track' type of setting," says Sher.

EDs generally have these policies in place, but compliance is often the problem. "That is something that is very important from a risk perspective," says Sher. "Things are getting done, and done effectively, but not necessarily in accordance with protocols."

• Lack of documentation of phone calls made to other physicians.

ED clinicians sometimes call a patient's physician to get background information on the patient, but there is no documentation of the conversation. In subsequent malpractice litigation, the provider claims he or she never knew the patient was in the ED and never got a call.

"This can impact not only the care provided in the ED, but also the follow-up care provided in the outpatient setting," says Sher.

• Failure to follow up with the patient about test results after the patient has left the ED.

"If the X-ray is read in the ED but the official — abnormal — reading comes back the next day, they've got to be sure they've followed the protocol, notified the patient — and documented that the process was followed," says Sher. This is especially true at night, when often the ED providers will read their own films and/or EKGs.

"It is critical to have a consistent system in place to follow up with patients to provide significant findings in a manner that facilitates ongoing continuity of care," says Sher. ■

Source

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Staffing of ED Could Become Central Issue During Med/mal Suit

One emergency physician (EP) found himself in the position of giving orders for an emergency department (ED) patient in cardiac arrest by phone, while nurses remained in the ED to run the code, while responding to and running another code on the floor of the hospital.

This scenario — when the EP is working single coverage in the ED, yet is expected to respond to codes in other areas of the hospital — presents significant liability risks, says **Jennifer L'Hommedieu Stankus**, MD, JD, an attending physician at Group Health Physicians, a Seattle, WA-based multi-specialty group practice, and former medical malpractice defense attorney.

"The chances for error are incredibly high," she says, if there is a critical patient in the ED and the EP responds to another code.

"There is no way to run two different codes in two different areas in an effective and safe manner, without the benefit of seeing cardiac rhythms and the patient," she says. "Yet the EP is expected to do so."

L'Hommedieu Stankus says hospital bylaws and ED policies should clearly state that the EP can respond to the codes in other areas of the hospital only when appropriate to leave ED patients alone.

"If there are critical patients who cannot be left safely, then leaving them to care for patients who are not the primary responsibility of the EP could result in negligence," she says.

Another question is where the responsibility and duty of the EP stop, when the EP is responding to a code outside the ED. "Most of the time, EPs are asked to respond to help secure an airway, get a central line, and assist in a code," says L'Hommedieu Stankus. "Yet the patient is not the primary responsibility of the EP."

The question is whether, once the EP has done what has been asked, if the patient deteriorates after that point, was there an ongoing duty for which he or she will be liable?

"Some cases have alleged this," L'Hommedieu Stankus says. "However, the duty is limited, and hospital bylaws should outline this clearly."

Long Waits Due to Understaffing

Some have argued that delays in the medical screening examination (MSE) longer than 30 to 60 minutes may amount to a violation of the Emergency Medical Treatment & Labor Act (EMTALA). "I do not believe a blanket requirement such as this will be imposed," says L'Hommedieu Stankus — as the Centers for Medicare & Medicaid Services investigates EMTALA violations on a case-by-case basis.

"There have, however, been findings of EMTALA violations in extreme cases," she says. Many of these resulted in dramatic news stories about patients dying after many hours in the ED waiting room.

"Yet long waits are not at all unusual in EDs, and hospitals are stretched to the brink," she says. "Where I trained, there were times when patients waited up to 24 hours to be seen."

Where there is a problem with monitoring patients regularly in a busy ED waiting room, staff will often complain that it was because they were understaffed. "Those statements can be damaging in court," says L'Hommedieu Stankus.

She recommends EDs have a system in place so that the triage staff documents re-evaluations on a regular basis while patients are in the waiting room, and documents when check-in patients return to the desk, what their complaint is, how it is addressed, and re-evaluation.

"This may seem overly burdensome, but EMTALA requires such monitoring," says L'Hommedieu Stankus. "While MSEs may be quite delayed, by many hours, it is an EMTALA requirement that patients be closely monitored in the waiting room."

Having an experienced, well-trained practitioner with a high index of suspicion and a low threshold for asking providers on duty questions or for help is essential, she says. "Vital signs and history of present illness are key," she adds.

Patients who continually complain to the triage staff about their non-emergent conditions are somewhat akin to "alarm fatigue," says L'Hommedieu Stankus, because there are other

times when patients or family members complain about a declining condition and are ignored.

"In these cases, unless there is a clear reassessment documented, with no change of condition, there will likely be an EMTALA violation for failing to provide a timely MSE for an emergency medical condition," she says. In addition, the hospital would likely be at risk for negligence if there was inadequate staffing that caused the problem.

"The more patients in the waiting room, the bigger the risk," she says. There must be adequate staff to monitor patients in the waiting room, and to be able to reassess them regularly."

Understaffing of physicians, nurses, and all members of the team, including the ancillary staff, can result in suboptimal or even substandard care, says **Robert B. Takla**, MD, MBA, FACEP, medical director and chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI.

There is no one-size-fits-all approach to ED staffing, says Takla. "I have worked in an ER where we saw 30,000 patients a year with single physician coverage — we just had excellent nursing and midlevel assistance," he says, while other EDs have much more attending physician coverage.

Regardless of the staffing model used, says Takla, "understaffing will lead to longer wait times, walkouts, and greater patient dissatisfaction — all of which increase risk and liability."

He gives the example of a 62-year-old male patient with hypertension and noninsulin-dependent diabetes mellitus who presents with chest pain, whose first EKG reveals an acute myocardial infarction. If that patient experiences a subsequent delay in angioplasty, or an acute stroke patient gets a CT scan three hours after arrival and misses the window for tissue plasminogen activator, "it is honestly hard to defend," says Takla. ■

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. Scan the QR code below, or 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 emergency department (ED) staffing practices and liability risks, according to **Jennifer L'Hommedieu Stankus,** MD, JD?
   A. Hospital bylaws and ED policies should clearly state that the EP can respond to the codes in other areas of the hospital only when appropriate to leave ED patients alone.
   B. The EP cannot be held liable for negligence for leaving critical patients in the ED, as long as the EP is responding to a code in another area of the hospital.
   C. Hospital bylaws need not specifically state that the EP's duty is limited when responding to code outside the ED.
   D. There is no Emergency Medical Treatment & Labor Act requirement that patients be closely monitored in the waiting room.

2. Which is true regarding liability risks involving discharge instructions given to ED patients, according to **David P. Sousa**, JD?
   A. It is not necessary for EPs to keep a verbatim copy of what the patient was given.
   B. EPs do not have a legal obligation to educate the patient on potentially dangerous drug interactions with medications given in the ED.
   C. Discharge instructions should instruct patients who are experiencing problems to follow up with the primary care physician or specialist, instead of returning to the ED.
   D. Discharge instructions should caution patients to return to the ED if their symptoms persist or worsen.

3. Which practices are recommended for ED handoffs, according to **Stephanie C. Sher**, Esq.?
   A. EDs should not use checklists as communication tools, since no studies support their effectiveness.
   B. Emergency physicians (EPs) should use electronic health records to ensure that subsequent providers are aware of what occurred during the patient's ED course.
   C. EPs need not view the discharge summary as a tool to improve communication when patients are transitioned to post-acute care, since all the important information is documented in other portions of the medical record.
   D. Verbal discussions of the patient's status are not necessary when a series of physicians are covering a patient during a prolonged ED stay, since the important information is documented in the patient's record.