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Check-off Charting: Boon or Bust?

Change may be needed in emergency department patient charting

By Bruce David Janiak, MD, FACEP, FAAP, *Vice Chairman and Professor of Emergency Medicine, Medical College of Georgia, Augusta.*

Editor's note: *Dr. Janiak has been involved in medical-legal consulting for almost three decades. In the following article, he shares his insights about template charting.*

There are, of course, a number of chart documentation methods and the goals of the various methods are all the same: 1) to memorialize the patient encounter for future reference by other caregivers; 2) to provide information for billing purposes; and 3) to create a legal document that allows quality review whether in the medical setting or in the courtroom. The three main methodologies for accomplishing the task are handwritten notes, transcription (dictation or voice-activation), and check-off templates (paper or electronic). Each method varies in its ability to satisfy the three main goals of documentation.

Let the reader be aware that this author prefers dictation and considers it the best and most risk-free compromise. Even though the check-off template systems have found a significant following and popularity, they have specific advantages and drawbacks that deserve discussion.

The check-off or template record was developed to solve two major problems: the inordinate expense of dictation and the failure of emergency physicians to document appropriately for both clinical and billing purposes. The fact that a great many EDs in this country use such a template record system is a testament to its success. However, as with any process or system, there can be problematic issues, some of which are philosophical and some of which are practical.

How the template process works

The process of recording a patient's history and physical in a template can be simple and is accomplished (in some systems) by first selecting a template geared to his/her chief complaint (e.g., "chest pain" or "shortness of breath"). The physician then usually is prompted to answer, by checking a "yes" or "no" box, numerous questions regarding the history of the patient's present illness and review of systems. Answers that do not fit into this format can then be elaborated on by

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handwriting notes on the limited space on the form (or by using dictation). For the most part, the physical exam is dealt with in the same way by using a physical exam template. Other documentation systems may use a generic template format for every patient, that is, every template is general in terms of its questions, and specific complaint-related issues must be addressed or expanded upon by handwritten notes. All such systems, however, rely, at least in part, on hand written notes to record issues such as "medical decision-making" and "course in the emergency department." It is in this process that a significant problem exists. It is the patient's course in the emergency department and the narrative about decision-making that provides much of the data used to defend cases. Reading a note that indicates a patient was re-evaluated after lab and imaging offers more supportive material for the defense expert than checked boxes that may *imply* the same thing.

Time is a factor

Dictated records take time to transcribe, and the information may not be available to admitting physicians. Template records are immediately available to any physicians subsequently caring for the patient or for billing and coding because they are most commonly completed contemporaneously. Of course, dictations ideally should be completed as soon as possible, but depending on the time of day, transcriptions may not be available for many hours.

Too many template choices?

Having had the opportunity to work with a number of different template charts, those that are generated by the patient's chief complaint are at risk of causing some confusion or inefficiencies. For instance, it is a common practice for a nurse or clerk to compile an emergency chart by selecting a seemingly appropriate template according to the chief complaint of the patient. If the physician feels another template would have been more appropriate, inefficiency occurs as a more applicable template is selected prior to beginning documentation. Alternately, the physician may continue to use the nurse-selected template and attempt to make it a better fit to the patient's complaint by handwritten supplement.

Even when the deficit is corrected by making additional handwritten notes, there may be some "explaining to do" if the eventual diagnosis correlates better with the nurse's selection than the doctor's. Since handwriting can be notoriously difficult to read, this also may make the subjective and narrative part of the document less valuable. Using a generic template solves part of the problem, but it still relies on handwriting to fill in the information gaps. In summary, the highest paid person in the department (the physician) is forced to compensate for the template's lack of subjectivity by time-consuming handwriting. In the real world, this task often gets "short-shift" in a busy department, resulting in a less defensible record.

Creating a complete review with the template

When boxes are checked appropriately, they serve to communicate certain important elements effectively. When checked inappropriately, they can spell medical-legal disaster. If one checks the box "I have seen and agree with the nurse's note," he or she must be certain that statement is true. In a missed myocardial infarction (MI) case, a nurse's reference to chest pain may carry more credibility than a doctor's note that states "no chest pain" but also states "agree with nurse's note." When the eventual diagnosis is MI and the doctor "agreed with the nurse's note," defense is difficult. More than once, I have reviewed nurses' notes that reference a significant abnormal finding that was not

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addressed in the doctor's note. If that abnormal finding is a critical issue in a lawsuit, the plaintiff may have the upper hand.

Additionally, sometimes a back or forward slash gets confused, or the direction of the slash is indeterminate. To make the task of completing a template more efficient, questions may be answered by a forward slash (/) in the box meaning "negative," or a backward slash (\) meaning "positive." "Positive" slashes usually require written explanation. In one case, an emergency physician inadvertently "slashed" in the wrong direction, indicating the existence of a penetrating injury to the globe of the eye even though he, in fact, believed that he was dealing with a simple corneal abrasion. Unfortunately, the patient did end up with a penetration and the case could not be defended. (This case never went to trial or discovery.) Therefore, if an inappropriate "slash" is linked to a critical issue in a lawsuit, settlement may be the only choice.

More subtly, I have seen a case where the "NAD" ("no acute distress") box was checked. During the ED course, the patient was given narcotic injections twice for pain. There was no explanation given as to why someone in "no acute distress" was given narcotics. Perhaps there was a reasonable explanation, but the chart gave no indication. Remember that a defense expert needs a record that is credible to offer vigorous support in court. If there were other issues in the patient record that focus on credibility (e.g., patient had chest pain but no ECG was ordered), the defense expert may choose to advise settlement or refuse to defend all together.

Since the subjective part of the ED record is addressed by adding hand-written notes, and since handwriting is time consuming, it should come as no surprise that emergency physicians often make their handwritten portion too brief. There is no doubt that checking a box is *efficient*, at least in paper format. The issue actually is ensuring that a complete recording of the subjective information is given so as to "connect the dots" or to tell a story of the patient's ED encounter that makes sense. In my experience, the defense bar prefers a dictated note over a check-off template because they have similar concerns about the replacement of a subjective narrative with a simple "yes" or "no." In reviewing cases, I have struggled over the handwritten portion of the template all too often, finding that the vital subjective information was both illegible and inadequate. This forced the defense team to rely in too great a measure on the statements in the defendant's deposition, often taken a year or two years after the patient encounter occurred.

So why isn't dictation for everyone?

Because of cost (several dollars per patient), hospitals often prefer the cheaper template (a dollar or less per patient) over dictation. ED groups are pressured to save the institution money, and they may embrace the template for this reason. Also, many ED doctors do not like to dictate or may never have learned the technique because a template format was used in their training programs. Certainly, the ability of the check-off sheet to list sufficient elements for billing and coding purposes is a big plus; however, dictation guides that address levels of service and elements of the review of systems and physical exam are available and can accomplish the same level of compliance with recording "elements" as a template. Additionally, there is a perception that dictation takes longer, but to my knowledge there are no truly comparative studies.

Conclusion

So, is there any documentation process that is legible, defendable, cheap, easily codeable, and quick? I suspect a combination of check-off charts and dictation may be an answer. The template sheet could be used for minor problems, while dictation could be employed for complaints related to the chest or abdomen, for example, or for the elderly or otherwise complicated patients. The key, as far as I am concerned, is to improve the subjective part of charting. Can I, by reading the chart, glean the thought process of the emergency physician, the patient's course in the ED, and the reason certain diseases in the differential were not pursued? There are very few who would be able to convey this information by hand written notes alone. In many legal cases I have reviewed, the defendant ED physician had to supplement these charting deficiencies with deposition testimony, relying on the memory of interactions that occurred long ago. In the dictated chart, the physician can tell the story of his/her thought process in a believable way.

For example, "although the patient had pleuritic pain and was pregnant, the pain was intermittent, there was no tachycardia or hemoptysis, and I do not believe she is suffering from a pulmonary embolus" or "I discussed the possibility of appendicitis with the parents, telling them it was unlikely, but advising them to return if any concerns." Or as another example, "I called the primary care physician and discussed the case with him, and we decided that office follow-up tomorrow is reasonable." None of these dictations is a guarantee of legal protection, but they go a long way to establishing credibility with the jury.

Perhaps emergency medical voice-activated dictation eventually will become a viable alternative. Current applications require "training" of the system to the user's voice and still require too much emergency physician keyboard time. Until then, a compromise solution as indicated above may be the best we can do.

The emergency chart memorializes a patient encounter and it is our best defense against an allegation of malpractice. Continued critical analysis of our documentation methodology is indicated. ■

Are recent big ED verdicts the wave of the future?

Jurors will award higher damages if displeased by ED conduct

A California jury awarded $11 million to a man because ED physicians failed to diagnose an infection that led to stroke and paralysis.[1] A Rhode Island family was awarded $21.5 million in an ED malpractice case involving a woman's complications from pneumonia.[2] A Tampa, FL, jury awarded $30 million to a woman who lost both legs and most of her hands due to negligent ED care after complications from surgery.[3]

These large ED verdicts, all from 2007, may seem to be bellwether cases that portend a change in jury opinions. On the other hand, a recent report says that ED claims have decreased, with claims per 100,000 visits dropping to 3.4 in 2006, down from 5.8 in 2001.[4]

It's hard to speculate what twelve individual jurors were thinking when they rendered a plaintiff's verdict, says **Dwight W. Scott, Jr.,** an attorney with the health care division of Houston, TX-based McGlinchey Stafford. Jurors could be sending a message to health care providers, punishing the perceived wrongdoers, or trying to award amounts sufficient to sustain the injured party for a lifetime.

"Without specific knowledge and post-verdict interviews of the individual jurors, it's impossible to say," says Scott. "It is quite possible that the jurors intended a message to be sent. However, every case is different."

Key Points

Large ED verdicts typically involve long-term costs such as medical care and lost income, which fall outside the caps some states are placing on non-economic damages. Other factors that may result in large jury awards include:

- A perception of carelessness or recklessness by the ED physician;
- Patients returning to the ED multiple times for care; and
- "Sympathetic" plaintiffs such as parents of small children.

What makes for a big verdict?

All medical negligence claims against EDs generally involve the same elements—that the physician owed the patient a duty, that the standard of care was breached in treating the patient, and that the breach caused the patient to suffer damage. There can be several elements that play into a large award, but the single biggest driver is the amount of the plaintiff's economic damages, says **Blake Delaney,** a health care attorney in the Tampa, FL, office of Buchanan Ingersoll & Rooney.

Juries often are asked to make an injured person "whole" by rendering an award sufficient to provide the necessary levels of care for that person for the remainder of his/her life. "Care over a lifetime is expensive," says Scott. "Imagine a 30-year-old man now paralyzed due to the alleged negligence of a health care provider. That man will likely require some level of round-the-clock care for the rest of his life."

Damages involving a permanent disabling injury to a young child at birth also may include care over a lifetime. "Jurors are likely to be asked to provide an award sufficient to sustain the child's health care needs for a long, long time," says Scott.

If the plaintiff is going to require medical and/or nursing care for many years as a result of the ED physician's negligence, the award can get "very high, very fast," says Delaney. In the above $11 million award case, the patient was paralyzed as a result of an ED physician's conduct.

The cost of around-the-clock nursing care, combined with a life expectancy of, for example, at least 15 more years, can easily produce a verdict in excess of $5 million without even accounting for pain and suffering or other non-economic damages.

"Another example is a case in which the plaintiffs, parents of a baby who was allegedly injured in the ED, are demanding in excess of $70 million in economic damages, based primarily on the fact that the child has a life expectancy of approximately 70 years," Delaney says.

The reality is that cases in which patients die often

produce lower verdicts than cases in which patients live, albeit having suffered paralysis or some other life-altering condition, says Delaney. "Another factor that can drive large economic damage awards is the amount of money the plaintiff would have been expected to earn for the rest of his life," he says.

An award can escalate very quickly, for example, if a plaintiff's projected loss of income is $100,000 per year—over 20 years this would add $2 million to the verdict.

Two other factors that can play into a jury's award are the ED physician's level of carelessness and the amount of sympathy for the patient. An ED physician does not need to have intentionally injured the patient to be liable for medical negligence; merely failing to act reasonably is sufficient. "However, in cases where the ED physician does act intentionally, or at least recklessly, juries will frequently show their displeasure with that conduct by awarding higher damages," says Delaney.

Sometimes these higher awards are in the form of punitive damages, but other times juries simply award a high amount of non-economic damages, such as for pain and suffering, as a form of "quasi-punitive damages."

In the $21.5 million Rhode Island case, for example, the victim had gone to the ED three times in four days, each time complaining of symptoms, before eventually dying.[2] "This is appalling conduct to an average juror, who would expect the patient to be taken care of the first time, or at worst the second time," says Delaney. "But when a patient must voluntarily return to the hospital a third time, the implication is that the hospital really didn't want to treat this person."

Had this patient died during her first visit, even if the death were preventable, the jury award probably would have been less, he says. The case also is a good example of the way in which sympathy for the plaintiff can increase non-economic damages. "The death of an immigrant woman in her 30s with three young children is a much more sympathetic case than the death of a 65-year-old homeless man," says Delaney.

How much goes to the patient?

"The unfortunate reality of lawsuits is that the attorneys' fees and costs can consume much of a multimillion dollar jury verdict award," says Delaney. "At the end of the day, a plaintiff who has just been awarded a $10 million verdict might take home only $6 million."

Unless statutory or constitutional provisions provide otherwise, a typical medical negligence attorney's fee runs from 33% to 40%. The costs of the lawsuit are added on top of that, and they depend largely on how extensive the expert testimony in the case was. Some cases might incur only $20,000 in expert witness costs, while others might incur $250,000.

The amount received by the plaintiff would not be subject to taxation, but if the award is intended to cover economic damages over a long period of time, then the money will be redistributed through a structured settlement so that the plaintiff does not actually receive the full amount upfront. "A structured settlement broker will typically work with a financial institution to hold the money and distribute it in certain increments at certain intervals over a certain duration," says Delaney.

However, a growing number of states are capping non-economic damages awards, which would limit the role of the ED physician's carelessness and the amount of sympathy generated by the plaintiff in a jury verdict award. "But even in those states that have non-economic caps, there is never a cap on economic damages," notes Delaney.

State legislatures have attempted to limit liability in medical malpractice matters to certain levels of financial recovery. "Typically, however, claims for future economic damages such as lost income and future health care needs are legislated to be outside of those statutory caps," says Scott. "Therefore, large verdicts are still possible, even in 'tort reform' states." ■

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Know legal risks when consulting on-call specialists

ED physicians often "left holding the bag"

Do you believe that once your patient is evaluated by an on-call consultant in your ED, you are abdicated from any future liability? "ED physicians frequently believe this, but this is absolutely not true," says **James Hubler,** MD, JD, assistant clinical professor of emergency medicine at the University of Illinois College of Medicine at Peoria.

"Once the ED physician has evaluated the patient, there is the potential to be named in a lawsuit if there is an adverse outcome," says Hubler. "It is up to the ED physician to demonstrate that the standard of care has been met."

In a 2005 nationwide survey conducted by the American College of Emergency Physicians, 73% of 1,328 ED directors reported problems with inadequate on-call coverage by specialists, including neurosurgeons, orthopedic surgeons, and obstetrician/gynecologists.

Despite the reason for the failure to secure a consultation from an on-call specialist, the ultimate responsibility for the patient rests with the ED physician, according to **Edward Monico,** MD, JD, assistant professor in the section of emergency medicine at Yale University School of Medicine in New Haven, CT.

"Consequently, if a bad outcome were to arise from the delay or failure in obtaining a consult, the ED physician would more likely than not be included as a defendant," says Monico. "Whether liability would attach to the physician would depend on the scenario and whether the ED physician's efforts fell within the standard of care for ED physicians similarly situated."

If there is a disagreement between the ED physician and the consultant regarding treatment or admission, the ED physician may have to call the primary physician or another consultant to admit the patient, says Hubler.

Always document the time you paged the on-call physician and the response time. If the specialist refuses to come in, document this and go up the chain of command to the head of their department and then the administrator on call, advises Hubler. While awaiting transfer or for another specialist to come in, be sure to continue to use all of the available treatments to begin stabilizing the patient, he adds.

Lawsuits involving on-call physicians typically name the ED physician as well. However, the physician may later be dropped from the lawsuit if it is determined through discovery that the ED physician did what would have been expected of a reasonable ED physician given the same circumstances. "The lawyers will want to name all physicians involved in the case, in order to avoid missing a potential defendant or missing the statute of limitations," says Hubler.

Key Points

Once the ED physician has evaluated a patient, he or she can be named in a lawsuit if an adverse outcome occurs, even *after* the patient was seen by an on-call consultant. To reduce your liability risks:

- Document the time the consultant was contacted and the response time;
- If the consultant refuses to see the patient, use all available treatments while awaiting transfer, or give the patient instructions on when to return to the ED; and
- Be clear with consultants about the patient's status and what is required.

Be familiar with EMTALA risks

The Emergency Medical Treatment and Labor Act (EMTALA) impacts liability risks involving on-call physicians, because treating hospitals and physicians have an obligation to provide a medical screening examination that could invoke the use of ED resources, including specialized tests or consultations, says Monico.

"The use of specialty consultations must be included in this evaluation, if indicated and normally available in the ED," he says.

If the ED physician is unable to obtain a necessary consultation for whatever reason, the patient should be transferred to a hospital that is able to provide that consultation, says Monico. "ED physicians should document the time the consultation was requested, as well as any difficulty encountered in obtaining that consultation," he says.

More importantly, weighing the risks and benefits of transfer to obtain a consultation should be documented to reflect the physician's judgment in caring for the patient. "No doubt that ED physicians encountering such scenarios are caught between the Scylla of

civil litigation and the Charybdis of federal regulation," says Monico.

Watch for high-risk areas

One such area involves injuries that should be cared for soon, but not immediately, such as a lacerated tendon of the hand that has to be repaired within a week or so, but not at 2:00 a.m., says **Angela F. Gardner,** MD, FACEP, assistant professor in the division of emergency medicine at University of Texas Medical Branch, Galveston, TX, and former director of risk management for Dallas-based EmCare. "Typically, the hand surgeon will say 'I'll see them in my office, just close the wound and put them in a splint,'" she says. "That seems perfectly reasonable, until the patient shows up and is asked for a $5000 deposit that he or she doesn't have. The indigent patient is left with very few choices. That's an all-around bad situation."

That patient could be left with permanent deformity and loss of function of the hand. "Some medical staffs require that their specialists provide at least one visit, but many don't. And some specialists don't feel obligated if the patient can't pay," says Gardner.

If the patient finds a lawyer to take his/her case, the ED physician likely would be named for not insisting that the specialist come in. "Even if you get testimony that this is commonly done, the jury is not going to think that way," says Gardner. "The hand surgeon will say, 'If I'd only known it was this bad I would have come in.' The ED doctor is left holding the bag."

To protect yourself against this scenario, document your conversation as completely as possible. "This is a fine line, though, because what you say in the medical record could cause another physician to be sued. It will always turn in to a he said/she said situation," says Gardner.

For example, an ED physician may evaluate a patient for abdominal pain and suspect appendicitis. When contacted, the family physician says he has known the patient for years, he has the same symptoms every week, it's not his appendix, and requests that the patient be seen in the morning. "The ED physician is unlikely to write on the chart, 'Family practitioner refuses to see patient because he is a chronic pain patient.' Instead, they will write 'The doctor will see the patient in the a.m.,'" says Gardner. "Then, if it is appendicitis and it ruptures with complications and the ED physician is sued, the family practitioner will blame the ED physician, who is stuck between a rock and a hard place."

Make your documentation as complete as possible, such as "Discussed this issue with family care provider. Said patient has had similar symptoms many times in the past, and feels that this is the same as in the past."

"Documentation won't keep you from being sued, but it will help you defend your position if it gets to that point," says Gardner. "Then it is really up to the ED physician to give adequate warning to the patient."

In this case, that means instructing the man to return to the ED if he has vomiting or increased pain. If you truly believe it's appendicitis, you should go ahead and call the surgeon, advises Gardner. "But that is very hard to do—if you are in a small hospital it will not go over well if it turns out not to be appendicitis," she says.

Another legally risky situation involves high-risk patients who need to be transferred from a community hospital because they don't have a specialist such as neurosurgery, pediatric orthopedics, or ophthalmology.

"A lot of smaller EDs don't have access to any kind of coverage, so they have to transfer that patient," says Gardner. "If the patient is not stable, either the patient may die because he can't be transferred, or he may die because of the transfer process itself. When that happens, everybody gets sued."

Lawsuits involving neurosurgery in particular are "horrible cases," says Gardner, because consequences can be devastating. "Communicate clearly with consultants and be very clear about your impression of the patient and what should be done," she says. ■

Sources

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Lawsuits, complications lower for febrile children

But vaccine doesn't prove that disease is not present

The introduction of vaccines that prevent bacteremia has significantly reduced the risk of serious bacterial infections associated with *Haemophilus influenzae* and *Streptococcus pneumoniae.* How does this impact liability risks when caring for febrile children?

"There will always be risk, but the risk is arguably lower. The prevalence of the disease and serious complications is lower today than it was," says **Steven Krug,** MD, chair of the American Academy of Pediatrics' Committee on Pediatric Emergency Medicine.

Vaccines dramatically lower risk

A recent study on vaccines and their benefits reported a 92% reduction in cases and a 99% reduction in mortality of diphtheria, mumps, pertussis, and tetanus.[1] "Of course, endemic transmissions of polio, measles, and rubella have been eliminated in the U.S., and smallpox is no longer a threat worldwide," says **Matthew Rice,** MD, JD, FACEP, an ED physician with Northwest Emergency Physicians of TeamHealth in Federal Way, WA. "These are all due to vaccinations."

Vaccines have been the single most important method to prevent bacteremia, says **Rakesh D. Mistry,** MD, MS, an ED physician at Children's Hospital of Philadelphia. Before 1990, *Haemophilus influenzae* type b (Hib) produced countless numbers of patients with so called "occult" bacteremia in well-appearing febrile children, he notes. "Furthermore, the associated infectious complications from Hib bacteremia were significant," says Mistry. "Although the data is scant, it is believed that Hib vaccination reduced the incidence of occult bacteremia as much as tenfold."

Post-Hib vaccination, the leading cause of bacteremia is now *S. pneumoniae,* with studies from the 1990s estimating the rate of occult bacteremia at 1.5-2%, says Mistry. Less virulent than Hib, the invasive complication rate from *S. pneumoniae* has been estimated as low as 1 in 5000 cases of febrile young children under 36 months of age, he says.

"However, institution of pneumococcal vaccination since the turn of the century has cut these risks even further," says Mistry. Recent evidence has estimated current occult bacteremia rates at less than 0.5%, with complication rates over 1/10000, he notes.

Introduction of several vaccines have markedly reduced various bacterial infectious diseases, including meningitis. "Studies vary, but there is no doubt that some bacterial infections have been reduced at least 50% or more in those who have been appropriately vaccinated," says Rice. "If there is less likelihood of bacterial infections, there is less chance of that disease presenting and thus, all else being equal, less chance of the disease being 'missed.'"

However, Rice points to recent cases in Maryland in which parents were threatened with jail and fines for not vaccinating their school age children.[2] "Thus, the risk of increasing outbreaks of previously unlikely diseases may reappear if society ignores vaccine requirements and diseases begin to emerge," he says.

Don't assume disease isn't present

It is possible to defend a malpractice lawsuit involving missed bacteremia and associated complications with the argument that it is a much more rare event, providing it is occult bacteremia, says Krug.

However, defending a medical malpractice case is complicated and dependent on the circumstances and facts, says Rice. "Of course it is possible to use the 'rare event' defense. But misdiagnosing a bacterial infection, especially ones with more devastating outcomes such as bacterial meningitis, is always difficult to defend because of the some of the severe damages," says Rice.

Emergency physicians are trained to think of the worst possible scenarios and sort out in the differential diagnosis those diseases that must be identified in

Key Points

Vaccines that prevent bacteremia have significantly reduced the risk of serious bacterial infections in febrile children. Since the prevalence of the disease and serious complications is lower, liability risks are arguably lower. However, misdiagnosing a bacterial infection is difficult to defend because of the severe damages involved. To reduce risks:

- If a severe disease like meningitis is a possibility, evaluate and treat the patient aggressively, including spinal tap and antibiotics;
- Never assume that administration of a vaccine is absolute proof that a disease is not present; and
- Keep in mind that testing and treatment are not indicated for most cases of well-appearing febrile children age 3-36 months old.

the patient's best interest, says Rice. When administered to enough vulnerable patients, most vaccines provide a "herd" immunity, but vaccines are not all completely successful for eliminating the possibility of disease.

"The evaluation and treatment for each patient is contingent on the possibility of disease," he says. "If a severe disease like meningitis is a possibility, physicians must evaluate and treat the patient aggressively. You should *not* assume that administration of a vaccine is absolute proof that a disease is not present."

From a risk perspective, if a patient appears ill and part of the differential diagnosis is meningitis, then the best "risk adverse" practice is to rapidly progress with an evaluation and treatment with spinal tap and antibiotics, and readjust your strategy as more facts become clear, advises Rice.

Your clinical assessment is key

However, for cases of well-appearing febrile children age 3-36 months who present with fever, testing and treatment are not indicated based on the current evidence, says Mistry. "The most important aspect of this is 'well-appearing,'" he says. "The treating physician must be able to make this clinical assessment appropriately."

The ED is always subject to legal vulnerability, says Mistry. "We are in the unique position of evaluating a child for no more than one hour, and then having parents ask us to predict the future," he says. "The overwhelming majority of pediatric emergency physicians would defend a case of missed occult bacteremia, because, frankly, we would need to subject 10,000 children to antibiotics to potentially prevent just one complication."

Furthermore, there is no evidence to support the notion that antibiotics are 100% effective in preventing complications, adds Mistry. More and more febrile children will be discharged from EDs without testing and empiric treatment, since the rates of bacteremia are dropping, he says. "The overwhelming majority of physicians see this as a good thing—the less we subject children to unnecessary interventions the better," he says.

In these cases, however, two things are most important to protect EDs from legal complications, says Mistry. First, proper assessment of the clinical situation is critical, especially the appearance of the child, with good documentation. Second, and most important, remember proper anticipatory guidance and discharge instructions.

"ED physicians must counsel parents to monitor fever and control it appropriately, follow up for sequential evaluations with primary care physicians, and return for changes in the child's appearance," says Mistry. ■

Sources

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Older, controversial guidelines still play role in lawsuits

Guidelines for the management of febrile children dating back to 1993 have complicated liability risks for EDs since they were published, and continue to play a role in ED medical malpractice litigation, says **Jim Wilde,** MD, director of pediatric emergency medicine at the Medical College of Georgia, who also is fellowship-trained in pediatric infectious diseases.[1]

"The guidelines were never endorsed by any major medical organization, and they were roundly criticized from the moment they were published, for a lot of very good reasons," says Wilde.

Although the guidelines stated that they were not

meant to represent the standard of care, there was still the appearance of setting in stone how physicians should evaluate a child with fever, says Wilde. "They do have some value for giving us some framework in which to work, but they also gave all sorts of ammunition for trial lawyers," he says.

ED doctors: Not guilty

Wilde has testified at a number of trials alleging malpractice because the ED physician failed to order one of the diagnostic tests suggested in the guidelines, such as obtaining a complete blood count (CBC) or a blood culture. "The plaintiff's lawyers go after the ED doctor because they didn't meet a standard of care. The big question is whether the guidelines are standard of care. The answer is no, they are not," he says. In each case, the ED physician was found not guilty.

If the ED physician fails to order a CBC for a child with fever and vomiting but no other symptoms, the fact that the child comes back with bacterial meningitis two days later does not necessarily fit the definition of medical malpractice, says Wilde.

"I have not been involved in a case yet when the physician was faulted for not having followed the guidelines and as a result lost the case," he says. "If there was no clinical reason to order a CBC other than the mere presence of fever, the doctor was not at fault."

The recommendations for diagnostic testing in the guidelines have been largely abandoned because they were written before the advent of the Hib and Prevnar (pneumococcal 7-valent conjugate) vaccines, says Wilde. "A lot of folks argue that now that we have vaccines for the two main causes of occult bacterial infection in children, the guidelines are basically moot, so broad scale testing for children over 3 months of age with fever is not warranted anymore," says Wilde.

Key Points

Although 1993 guidelines for febrile children don't represent the standard of care, they still play a role in ED malpractice litigation. To reduce risks:

- Focus your evaluation on the patient's history and physical;
- If a child presents with signs and symptoms consistent with meningitis, further testing is warranted; and
- Screen for urine infections in boys younger than age 1 and in girls younger than age 2 with fever without a source.

One big exception is children younger than 1 month of age who develop a fever, in whom an aggressive workup usually combined with admission is still common practice, notes Wilde. Some screening also is still done on children ages 1-3 months, depending on the clinical scenario. He also screens for urine infections in boys younger than age 1 and in girls younger than age 2 who have fever without a source.

By taking a good history and physical exam, you are screening for serious bacterial infections, which is what the guidelines purportedly were for in the first place, says Wilde. "There is a fairly substantial literature showing that the history and physical is where the evaluation should be focused," says Wilde. "Most children outside the neonatal period with serious bacterial infections are going to be recognized that way. If you have a sick 6-month-old, you don't need a bunch of laboratory tests. You need a good doctor, possibly combined with selected laboratory tests."

Since the guidelines were never standard of care, an ED physician who chooses to disregard them is on very solid legal ground, says Wilde. Only 2-5% of children who come in to an ED with fever end up having a serious bacterial infection such as pneumonia, cellulitis, sepsis, or meningitis, he adds.

If the child has signs and symptoms that are consistent with meningitis, then further testing is absolutely warranted, says Wilde. "If they don't have specific signs or symptoms pointing to meningitis, it's highly unlikely that is what they've got, but it's not impossible," he says. "The problem is that the public has come to believe, because of the legal profession, that if somebody comes in at the very beginning of a very serious illness and the doctor doesn't recognize it, then the doctor has screwed up."

If a child presents in the first hour of bacterial meningitis, it is unlikely that any ED physician will recognize it, says Wilde. "Does that mean I have to do a spinal tap on every child that comes in with a fever? Of course not. We'd be doing spinal taps on every child in America if we did that, several times a year," he says.

Sources

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If the amount of information that is available points to a problem that is not serious and there are no signs or symptoms to warrant additional testing, then the ED physician has not committed malpractice even if the patient returns with meningitis 24 hours later, says Wilde. "Doctors are not required to have crystal balls," he says. "They are required to use sound clinical judgment." ■

Reference

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CNE/CME *Questions*

5. According to the story on large ED verdicts, all medical negligence claims against EDs generally involve which of the following elements?
   A. the physician owed the patient a duty
   B. the standard of care was breached in treating the patient
   C. the breach in standard of care caused the patient to suffer damage.
   D. All of the above.

6. Which of the following is accurate regarding caps placed on jury awards in "tort reform" states?
   A. Multimillion dollar verdicts are no longer possible.
   B. Lost income can no longer be claimed for the plaintiff's projected life span.
   C. Damages for future health care needs are limited to two years.
   D. Even in states with caps for non-economic damages, there is no cap on economic damages.

7. Which of the following is recommended regarding documentation when an on-call physician refuses to come to the ED?
   A. Avoid documenting specific remarks by the consultant about the patient's condition.
   B. Record the time the consultant was contacted and the response time.
   C. Don't document any involvement of the administrator on call.
   D. Never comment on the risks and benefits of transferring the patient.

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8. Which of the following is recommended regarding the workup of febrile children in the ED?
   A. ED physicians can safely assume that administration of a vaccine is proof that a disease is not present.
   B. ED physicians should rapidly progress with evaluation and treatment if the child appears ill.
   C. ED physicians should proceed with testing and treatment even for well-appearing febrile children age 3-36 months presenting with fever.
   D. ED physicians should take into consideration that antibiotics are 100% effective in preventing complications.

9. Which of the following scenarios fits the definition of medical malpractice?
   A. If the ED physician fails to follow guidelines for diagnostic testing for any case of a child with fever.
   B. If the ED physician fails to order a complete blood count for a child with fever and vomiting but no other symptoms.
   C. If broad scale testing is not done for a febrile child who presents in the early stage of a serious bacterial illness that is not yet clinically apparent.
   D. If the child has specific signs and symptoms consistent with meningitis and further testing is not done.

Answers: 5. D; 6. D; 7. B; 8. B; 9. D

CNE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

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After completing this activity, participants will be able to:
1. Identify legal issues relating to emergency medicine practice;
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■