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INSIDE

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ED Claims Involving High-dose Analgesics Carry Jury Appeal

Plaintiff attorneys can use 'ready-made audience' to criticize EP

A young woman was discharged shortly after receiving high-dose intramuscular opiates in an ED. While driving home, she suffered a respiratory arrest and died. The resulting malpractice lawsuit included these allegations: The dosage was excessive for the patient's age and body weight, and the ED failed to monitor the patient appropriately after administering the drug.

The lawsuit also alleged that this ED patient never should have received opioids. "This is a common allegation that plaintiffs will need expert testimony to prove. That testimony should include a basis in medical literature that the patient was not a candidate for opiate analgesics," says **W. Ann Maggiore**, JD, an attorney at Butt Thornton & Baehr in Albuquerque, NM.

The lawsuit, which settled out of court for an undisclosed amount, demonstrates the risks involved with giving high-dose analgesics to ED patients. "With increasing public knowledge around this issue, people are looking at an old practice through a new lens," says **John Burton**, MD, chair of the Carilion Clinic's department of emergency medicine in Roanoke, VA.

Claims involving adverse events due to side effects or complications of high-dose analgesics given in the ED setting are appealing to plaintiff attorneys thanks to increased public awareness of the dangers of these medications, Burton notes. "Patients and family will not only question the wisdom of the discharge timing, but also the entire rationale of using opiates during the ED visit."

Maggiore agrees that such cases are bolstered because of the public outcry against opioid abuse and addiction. "Plaintiff attorneys have a ready-made audience to criticize the medical providers."

A recent malpractice case involved this scenario: ED nurses administered fentanyl to a man injured in a paragliding accident. While the man was under

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examination and receiving treatment, his respiratory status declined. Intubation resulted in a torn trachea, and the patient died.[1]

"His family alleged a fentanyl overdose that could have been reversed with Narcan, had it been recognized," Maggiore says. The plaintiff attorney relied on the ED chart to support the allegation that the patient died of a fentanyl overdose, and that the EP failed to monitor the amount of the drug administered.

"Narcotic analgesics should always be administered slowly, and with naloxone handy, in case the patient's respirations become diminished," Maggiore offers. Even with small dosages, some patients will experience respiratory depression that can lead to cardiopulmonary arrest.

"Failure to monitor patients to whom these drugs have been administered for respiratory compromise has resulted in significant risk exposure to EPs," Maggiore adds.

Reassessment and documentation may ward off a failure to monitor the claim, contribute to better patient outcomes, lower mortality, and increase patient satisfaction, says **Vanessa Mulnix**, RN, MSN, CPQC, director of patient safety and service excellence in the Okemos, MI, office of ProAssurance, a provider of professional liability insurance.

After the medication is administered, Mulnix says the EP or ED nurses should:

- reassess the patient's respiratory status and document the reassessment in the patient's medical record;
- reassess boarded patients, who may be in a hallway, and document reassessments and the patient's status.

Knowing the patient's medication history, including pain medication history, is important. Mulnix says asking a patient about pain medication usage and frequency could prevent the patient who comes in wearing an undetected fentanyl patch from receiving too much pain medication in the ED. "They are not just looking at oxygen saturation levels and respiratory rate, but whether you actually looked at the patient, rather than just jumping to the highest dose," cautions **Sheryl Lucas**, a claims director, also in ProAssurance's Okemos, MI, office.

One recent malpractice case involved medications given in the ED and the inpatient floor. The patient suffered respiratory arrest on the floor. The plaintiff alleged that no one monitored the patient after the medication was administered, either in the ED or on the inpatient floor.

"In this case, the nurse gave the medication, and didn't check on the patient again for over an hour. When they finally did go back, the patient was in respiratory arrest," Lucas says.

Without good communication, a patient could end up receiving narcotics in the ambulance, again in the ED, and then on the inpatient floor. "The question is, does everybody along the way know what was administered?" Lucas asks.

If the patient experienced a bad outcome after receiving pain medication in the ED, the plaintiff attorney is sure to ask these two questions:

- Did you check the patient's vital signs before you administered the pain medication?
- Did you check the patient again after you administered the pain medication?

ED charts lacking documentation of the patient's vital signs are difficult to defend, Lucas warns. Abnormal vital signs that are documented but not acted on also are problematic but at least give the defense something to work with. If the patient's documented respiratory rate was a little high, for instance, an ED nurse can point to

other high respiratory rates during the same ED visit to justify why no one acted.

"If it's documented, a good ED nurse or physician can explain what the vitals mean to them," Lucas explains. "But if you don't have anything written down, it's hard to justify that you evaluated that patient and they were fine."

An ED patient presenting with vomiting, hematuria, and abdominal pain was diagnosed with kidney stones. Morphine and Toradol were administered prior to discharge. "His wife was en route to pick him up, but the man left the hospital. He attempted to cross an elevated road, fell 30 feet, and became paraplegic," Maggiore says.

The patient sued the EP, alleging that he was still disoriented from the narcotics and should not have been allowed to leave the ED. The plaintiff prevailed at trial.[2]

"Assuring an appropriate discharge, with documentation that the patient has a safe ride home, is an important part of the risk management picture for EPs," Maggiore notes.

Whenever narcotics are administered to an ED patient, it's important for the ED staff to release the patient to a responsible party and to document that action. "The ED staff should ensure that the patient is turned over to that person," Maggiore adds.

It's a difficult call as to how far the ED staff can go in preventing a patient from leaving.

"But certainly telling him not to do so and keeping an eye on him is warranted," Maggiore offers. A patient still can slip away unnoticed, but good documentation that he or she left against medical advice is legally protective.

Kevin G. Rodgers, MD, professor of clinical emergency medicine at Indiana University School of Medicine, says that ideally, both the ED nurse and the EP talk to patients who receive medications about how they're going to get home. This includes an assessment of the patient's ability to walk. "But patients don't always tell you the truth or use common sense," Rodgers says. "Some will claim they have transportation, then go outside and drive themselves home."

Rodgers says that patients who receive any type of sedating medication in the ED should be reassessed at discharge for their ability to get home safely. "If you do that 100% of the time, and follow a policy for post-administration, that keeps everybody out of trouble." ■

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Did ED Prescription Spark Opioid Addiction? Causation Tough to Prove

ED could be blamed for 'point-of-origin' prescription

As many as 87% of EPs report that the number of patients seeking opioids has increased or remained the same, according to a recent survey of 1,261 EPs conducted by the American College of Emergency Physicians.[1]

A likely tactic for plaintiff attorneys: Linking an individual's addiction to a "point-of-origin" prescription, perhaps from an ED visit.

"I have not seen any source addiction claims against acute care physicians, but sooner or later we'll see someone try a case with this supposition," predicts **John Burton**, MD, chair of the Carilion Clinic's department of emergency medicine in Roanoke, VA.

Legal exposure stemming from opioids prescribed in the ED setting is analogous to the legal risks involving radiation from CT scans performed in the ED, Burton says. Increased cancer risk from multiple CT scans is well-

established, as is the risk of addiction from opioid prescriptions. In both cases, a plaintiff attorney would face an uphill climb to prove the ED was liable.

"We know the link, but proving causation back to one specific event or physician is a substantial challenge," Burton says.

For instance, a plaintiff would have to prove that an inadequate history was taken that would have revealed prior use of narcotics, or the presence of a fentanyl patch went undiscovered.

"It's like someone coming into a bar who didn't appear drunk, but who had been drinking elsewhere. You serve them one drink, they leave, and get into a crash — and the bar is liable," explains **W. Ann Maggiore**, JD.

Still, the increasing prevalence of prescribed narcotics abuse has made it important for EPs to identify patients seeking medications for non-therapeutic purposes. Maggiore expects to see addicts file some claims against EPs in the near future. "Patients are no longer only suing 'candy store' medical practices who liberally dispense narcotics when a loved one suffers an adverse event," she notes.

There is no question that EDs are seeing a large rise in the number of people seeking opioids. These include individuals who travel long distances in the hopes of obtaining medications from an ED where they are unknown. "People who are addicted to opioid medicines are, unfortunately, going to try to get them any way they can," laments **Kevin G. Rodgers**, MD, professor of clinical emergency medicine at Indiana University School of Medicine. Rodgers says that EPs can reduce legal risks involving opioid-addicted patients by:

- posting clear guidelines in ED waiting rooms with statements such as "We do not prescribe opioids for over 48 hours";
- checking available registries before prescribing to determine if the ED patient was prescribed pain medicine recently.

Brandy A. Boone, director, risk resource and education and quality improvement at the Birmingham, AL, office of ProAssurance, suggests that EPs use available screening tools to help determine if a patient could be at high risk for addiction if given opioids. She recommends:

- EPs should use caution about referring all screening to social workers or behavioral health specialists. "Screening tools should be employed by appropriately credentialed individuals," Boone says.
- If the patient complains of acute pain, and there is a need for opioids, EPs should prescribe acute dosages instead of long-lasting or time-release products.
- If the EP refers the patient to a specialist, the EP should communicate with that specialist about whether any medication was administered in the ED or if a prescription was provided.
- For patients who arrive at the ED specifically asking for opioids and/or claiming to be on opioid therapy, EPs should resist the temptation to provide opioid prescriptions or IV-administered opioids. "Physicians should be prepared to offer non-narcotic pain relief options, but also to admit patients, or arrange appropriate outpatient care, for those who are suffering from withdrawal symptoms," Boone offers.

Richard F. Cahill, Esq., vice president and associate general counsel at The Doctors Company, says EPs face "an increasing challenge" in assessing patients presenting with pain management issues. "In response to the increasing scope of the prescription drug epidemic in this country, all state legislatures have enacted, or are in the process of passing, statutes that establish mandatory pharmacy reporting and physician data-accessing requirements," Cahill notes. It's possible that an EP could be found negligent if he or she prescribes opioids to an ED patient without checking the available databases that would have revealed the patient was addicted.

"Strict requirements and statutory obligations are set out for individuals and entities covered by the terms of the legislation," Cahill explains. Monetary fines, administrative penalties, and disciplinary actions by professional licensing boards are possible in the event of a violation. "A court may ultimately determine that as a matter of law, a statutory violation of reporting, accessing, or prescribing requirements mandated by the state's prescription drug monitoring statute that is alleged in a pending professional liability lawsuit constitutes negligence per se," Cahill says.

In that situation, the patient-plaintiff does not need to prove independently with expert testimony that the care fell below the community standard. "This significantly enhances his or her chances of prevailing before the jury," Cahill adds. ■

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Surprising New Data on Missed Acute Coronary Syndrome in EDs

Atypical symptoms are common malpractice trigger

Lack of "typical" symptoms cannot rule out acute coronary syndrome (ACS), and "atypical" symptoms should raise the EP's index of suspicion, according to a recent review of the literature.[1]

"Traditional cardiac risk factors, such as hypertension, diabetes, hyperlipidemia, and a positive smoking history, are of limited diagnostic utility in evaluating these patients in the ED," concludes **Zachary Dezman**, MD, one of the paper's authors. Dezman is assistant professor in the department of emergency medicine at University of Maryland School of Medicine.

Researchers analyzed the literature on the ability of various components of the history and physical exam to identify which ED chest pain patients require further investigation for possible ACS.

"Clinician gestalt has very low predictive ability, even in patients with a non-diagnostic ECG. And gestalt does not seem to be enhanced appreciably by clinical experience," Dezman says. The findings suggest that:

- history and physical alone can't reduce a patient's risk of ACS to a generally acceptable level of less than 1%;
- EPs should set a low threshold to perform some testing whenever there is not an obvious alternative cause;
- pain that is sharp in quality, reproducible on exam, or pleuritic points away from cardiac causes;
- pain that radiates, is worse with exertion, or is associated with diaphoresis or vomiting should raise the EP's index of suspicion.

Documentation on whether these specific symptoms were or were not present at the time of the ED visit can help the defense to demonstrate why the EP believed ACS was unlikely. The same is true of a History, ECG, Age, Risk factors, and Troponin (HEART) score, which clinicians use to assess patients for risk of ACS.

"Emergency physicians should combine this information to appropriately disposition patients presenting with chest pain," Dezman advises.

'Incredibly Wide Net'

Vague chest pain and shortness of breath are common symptoms in missed ACS cases and for ED patients generally. "We all know these symptoms cast an incredibly wide net, as far as the differential," says **Jesse K. Broocker**, JD, an attorney at Weathington McGrew in Atlanta.

Plaintiff attorneys typically begin their line of questioning by asking the EP, "What is the most dangerous thing in the differential? Why didn't you rule it out?"

The next step is to ask about repeat cardiac troponins. "One is never enough," Broocker cautions. "Plaintiff lawyers always look for a trend, which, in their book, means several over the course of a number of hours."

One malpractice case involved a 40-year-old woman who was a current smoker, with a family history of coronary artery disease. She reported experiencing chest and jaw pain for two days. Two separate troponins drawn in the ED were normal. The ECG showed no ST elevations, but noted some other abnormalities. The patient was discharged with instructions to follow up with a cardiologist three days later, but died before she could do so. The family sued for wrongful death.

"What really helped in our defense of this case was the ED doctor using the HEART score algorithm," Broocker recalls. "We got two experts to support the care, and when they saw the doctor used the HEART score, they immediately were reassured."

A documented HEART score shows that the EP thought about ACS and made a reasonable decision, regardless of whether it turned out to be right or wrong with the benefit of hindsight.

Length of stay in the ED is another common area of focus in missed ACS cases. "Quick overturn can be used to spin an efficient evaluation and disposition as 'punting' on the patient," Broocker notes. The plaintiff attorney can use electronic medical record time-stamping to show there was a short exam, a long wait to be brought back to a room, and a discharge shortly afterward. "This paints a picture of a patient who was put on the 'fast track' to support their position that something was missed," Broocker adds.

The ED defense team is challenged to explain that just because something is in the differential does not mean it is reasonably indicated. "A fever has Ebola in the differential," Broocker notes. "But this is the tack plaintiff lawyers take."

Broocker says the HEART score is something of a "safety net" for EPs. "It's commonly accepted in the community, and there is a lot of literature on it." Appropriate use of the HEART score and pathway reliably risk stratifies patients, according to a recent review of the literature.[2]

"I have had docs use this to success in ACS cases," Broocker says. By assigning a certain score for each criterion and coming up with a number, the EP can assign a likelihood for the patient experiencing an acute event. Juries probably will appreciate that the EP took this number into consideration when deciding whether to discharge or admit the patient.

"Laypeople tend to understand the thought process behind following a guideline, even if it turned out to be wrong," Broocker adds. ■

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ECG Overload? EP Might Miss Subtle STEMI

Create a clear definition of the EP's goal

It's not uncommon for EPs to be presented with dozens of ECGs during a shift. "In a lot of EDs, when someone walks in with any symptom that is at all suspicious, an ECG is done at triage," says **Arlo F. Weltge**, MD, MPH, FACEP, clinical professor of emergency medicine at McGovern Medical School at the University of Texas at Houston.

Criteria for ECGs vary depending on the ED. Many are performed on low-risk patients. "Some EDs will do it on anybody with a fast heart rate, any shortness of breath, or anything related to the chest and even part of the abdomen," Weltge explains.

The large number of ECGs performed at triage could lead to an unintended legal consequence: increasing the possibility of missed ST-elevation myocardial infarction (STEMI), especially those that are subtle or atypical presentations.

"If you have an ED full of sick patients, there is the very real potential you will miss a subtle STEMI," Weltge says. When handed a patient's ECG, the EP's goal is very specific: He or she must answer the question, "Is this a STEMI?"

"Our goal at that point is not to do a full cardiology interpretation of the ECG," Weltge says. Rather, an immediate decision must be made about whether the patient should go straight to the cardiac catheterization lab.

Many ECGs are abnormal, but there is no evidence of STEMI. A conscientious EP may note the abnormality in the ED chart, and later find themselves named as a defendant in a malpractice lawsuit because an adverse outcome occurred later.

"The responsibility is really not to do a full interpretation," Weltge says. "But because the EP laid eyes on it and commented on the fact that the ECG is abnormal, it creates the possibility of a liability risk."

If the goal of the EP is to determine if a STEMI is present, and the answer is no, Weltge says the EP probably is best off simply documenting, "No STEMI" without additional commentary. "Otherwise, the argument can be made, 'If you looked at the ECG, and it was abnormal, why didn't you act on it?'" he explains.

The statement "No STEMI" makes it clear that the EP was focused specifically on determining if a STEMI existed at that point, not whether the ECG was completely normal. "The more one can define what question they are being asked and what question they are responding to, the better one is able to defend their actions if it's ever challenged," Weltge notes.

An abnormal ECG in and of itself doesn't necessarily indicate a problem, Weltge says. Unless the EP has previous ECGs for comparison, it's unknown if the abnormality is new or old. Thus, offering additional comments about the abnormalities on the ECG can mislead any subsequent reviewers of the ED chart.

"If you give a more robust explanation, it can imply you had a more robust relationship with the patient,

placing you at risk for something that is beyond one's control," Weltge warns.

With so many low-risk patients undergoing ECGs at triage, delays can occur in obtaining ECGs for higher-risk patients who are brought back immediately. "This is one of the unanticipated consequences of doing ECGs on so many people at triage," Weltge says. "For the person who needs it the most, it doesn't always get done quickly."

Weltge is aware of several malpractice claims involving delayed ECGs for ED patients who were brought back directly and worked up for non-cardiac conditions who actually had STEMIs. "Any slip up or delay becomes another target for the plaintiff to attack," he says.

If there is an abnormality noted on the ECG that might affect the subsequent care that's provided, the ED has a responsibility to be sure it gets communicated to the subsequent treater, Weltge explains. This might be the oncoming EP, or a cardiologist in the outpatient setting, depending on the specifics of the case.

Another legal landmine: Some ECGs are not documented by the triage nurse. Therefore, the EP never sees the ECG. "Then, you've got an ECG that hasn't been interpreted," Weltge says. "There are obvious liability issues involved in failing to close that loop." The triage nurse might later document the ECG was done, so the ED chart is complete. "But if that happens after the EP sees the patient, it leaves a potential gap," says Weltge.

Overreliance on Normal ECGs

Failure to diagnose a STEMI on initial ED presentation can lead to a post-ED discharge out-of-hospital cardiac arrest and death, or permanent disability, warns **Charles A. Eckerline, Jr.**, MD, FACEP, vice chairman in the department of emergency medicine at the University of Kentucky Medical Center.

Eckerline says these two factors are the most frequent causes of missed myocardial infarction:

- Failure to recognize atypical presentations, particularly in women and diabetics;
- Overreliance on normal or nondiagnostic ECGs and normal enzymes.

A recent malpractice case involved both these issues. A woman with type 2 diabetes presented to an ED with transient sharp chest pain, dizziness, numbness, and hyperventilation.

"These symptoms were clearly atypical, and were believed to be due to anxiety and hyperventilation," says Eckerline, who reviewed the case. The patient's ECG was non-diagnostic, and two cardiac troponins were negative. Her symptoms resolved promptly without treatment, and she was discharged from the ED. "She suffered a cardiac arrest a short time later at home due to a critical coronary lesion," Eckerline says.

The patient died at home within 24 hours of the ED discharge. A lawsuit, which was settled for an undisclosed amount, included these allegations:

- The EP failed to diagnose a STEMI or acute coronary syndrome;
- The standard of care required the patient to be admitted for observation and a stress test or cardiac catheterization.

"The lawsuit alleged that if these things had been done, her critical and ultimately fatal coronary artery lesion would have been diagnosed, stented, and her death prevented," Eckerline says. ■

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Some Plaintiffs' 'Experts' Have Never Worked in ED

It's never easy for an EP to listen to an expert witness testify that their care was negligent, but it's harder to take coming from someone who hasn't worked in an ED in many years — or ever.

"It's completely unfair to let anybody talk about the standard of care in emergency medicine except an emergency physician. They wouldn't let me get on the stand and talk about the standard of care in neurosurgery or cardiology," says **Andy Walker**, MD, FAAEM, a Signal Mountain, TN-based EP who offers legal consulting services.

Each state has instituted its own rules concerning who is admissible as

an expert in a particular case. "In my state, Tennessee, we have no relevant standards as to who can testify against an EP," Walker notes. "If we had a fair system, then the only people who could testify as to the standard of care in emergency medicine would be emergency physicians."

Physicians from a variety of other specialties are found on the witness stand commonly, though, freely offering their opinions on the care provided in the ED. "In almost every case I've been involved in, there is someone from another specialty testifying that the EP violated the standard of care," Walker says.

Cardiologists frequently testify in missed myocardial infarction (MI) cases. "Cardiologists know how to take care of MI patients. The problem is that's not what they're testifying about," Walker says.

The expert in an ED case testifies about the standard of care for how to work up patients with undifferentiated chest pain, whereas cardiologists see patients who have been worked up already. "Cardiologists have no idea of the number of chest pain patients we send home," Walker explains. "It's basically a signal-to-noise problem, like a lot of missed diagnoses are."

An EP might see 100 patients with chest pain before identifying someone who actually has an MI. "The background noise is so huge, sometimes it's hard to pick out that signal," Walker says. "Cardiologists are wholly ignorant of that. They don't even think about that problem."

The defense's job is to explain that the issue at hand is not how to take care of a heart attack patient. Rather, it's how to work up a patient with undifferentiated chest pain. The cardiologist's typical testimony goes something like this: The EP missed the heart attack, he or she should have diagnosed it, and the EP violated the standard of care by sending the patient home. "That is completely unfair, because they know in retrospect that it was a heart attack," Walker says. "Cardiologists do not see the undifferentiated chest pain patient."

The same problem occurs when neurologists testify in missed stroke ED cases, or orthopedists testify in missed epidural abscess cases. "They see a tiny sliver of our patients, the ones we have preselected them to see," Walker says. "But they get up on the witness stand and claim they're qualified to pass judgment on our decision-making."

EDs see a handful of patients with back pain caused by something that actually threatens the spinal cord. "If you see them early enough, before they have a neurologic deficit, you're not going to diagnose it," Walker says.

A plaintiff expert likely will counter that the EP should have diagnosed the condition with neurological studies. The problem is that such tests probably weren't indicated at the time of the ED visit.

"Unless the patient has a neurological deficit, there is no justification for imaging, which means all these epidural abscesses are going to get missed until the patient starts to get weakness in the legs," Walker explains. The defense expert has to convey an important point, that even though there was a bad outcome, the patient received proper medical care in the ED.

It's possible that an epidural abscess patient will be sent home because it's too early to identify the condition at the time of the ED visit, and end up experiencing a bad outcome. "We get sued over that, but missing that is not malpractice, it's unavoidable," Walker adds.

Faced with a specialist opining on ED care, the defense team's only recourse is to put their expert on the stand to explain why the plaintiff's expert should be disregarded. "Under cross-examination, the defense attorney can say, 'You've never worked in an ED, have you?'" Walker explains. The plaintiff expert likely is well-prepared for this line of questioning. The expert might respond that he or she worked in an ED while in training, goes to the ED frequently to admit patients who experience heart attacks, and routinely accepts transfers from EPs on the phone.

"They have tangential contact with emergency medicine, but they are not in the trenches and making decisions," Walker underscores.

When Walker takes the stand as a defense expert, he looks forward to the defense attorney's question, "What do you think about the other expert saying that the emergency physician violated the standard of care?"

"That gives me a chance to explain to the jury that the issue is what it's like to be in the ED with the chest pain patient in real time, making decisions with the data you had on hand," he offers.

The legal question is not whether the EP's decision proved to be correct. It's whether the EP behaved reasonably, based on what he or she knew at the time.

"If the defense expert can get the jury to focus on that, and understand it, they've got a good chance of winning the case," Walker adds.

In Massachusetts, the applicable standard of care is limited to the standard of care for the specific specialty of the defendant provider. "The jury is instructed specifically that the standard of care pertains to the defendant provider's specialty," says **Megan Kures**, JD, a senior attorney in the Boston office of Hamel Marcin Dunn Reardon & Shea. In a malpractice claim against an EP, the jury would be instructed explicitly that the defendant is to be held to the standard of care of average

qualified physicians practicing in the area of emergency medicine. Jurors are instructed further to look beyond what one specific EP would have done, and to consider the community of average qualified EPs.

"We do occasionally see plaintiff's counsel call an expert outside of the specific area of the defendant's specialty," Kures notes. "This is typically something we attack on cross-examination."

Faced with a situation in which the plaintiff seeks to hold the EP to a different specialty's standard of care, defense counsel makes a point of educating the jury on the differences between the specialties, as well as their education, training, and experience.

"The defense team points out to the jury that an EP does not have the same training and expertise as a spine surgeon, for instance," Kures adds.

Many states have created statutes or rules of evidence that limit the ability of a plaintiff's expert to qualify to testify on the standard of care for an EP if he or she does not practice or teach in the field of emergency medicine.

"Thankfully, in most cases, it is fairly clear that an EP will not be held to the same standard that applies to a cardiologist or neurologist," says **Ryan M. Shuirman**, JD, an attorney at Yates, McLamb & Weyher in Raleigh, NC. However, in some cases, a non-EP is permitted to testify on the standard of care applicable to an EP — if both the non-EP and the EP perform the same procedure that is at issue in the case.

For instance, both cardiologists and EPs obtain and interpret ECGs. If a plaintiff alleges that an EP failed to properly interpret an ECG, the plaintiff arguably can rely on a cardiologist to testify how the EP misinterpreted the study.

"Such a strategy is vulnerable, however, to the defense putting on evidence from an EP expert who will distinguish the training of an EP and a cardiologist," Shuirman warns. The defense informs the jury that the plaintiff is unfairly attempting to hold the EP to an arguably higher standard.

Many states have instituted pre-suit certification requirements mandating that a plaintiff attest that the medical care at issue has been reviewed by someone reasonably expected to qualify as an expert witness against the defendant, and who has opined that the care provided by the defendant was substandard.

"We had a recent case in which a plaintiff sued an EP for failing to diagnose appendicitis, and relied on a general surgeon to review the case pre-suit," Shuirman recalls. On a motion to dismiss, the defense maintained that the plaintiff could not have reasonably expected a general surgeon to qualify to testify on the standard of care applicable to the defendant EP because they practice different specialties.

The plaintiff countered that both EPs and general surgeons are called on to diagnose appendicitis. The plaintiff reasonably expected the general surgeon to qualify to testify on the standard of care because the surgeon and the EP perform the same procedure at issue in the case.

"The judge agreed with our position that it would be unfair to permit a plaintiff to go forward with a claim against an EP premised on the opinions of a surgeon who typically operates after the EP has made a diagnosis," Shuirman says. The judge dismissed the plaintiff's case.

Many juries will understand the inherent unfairness of holding an EP to a "higher" standard, and will reward a defendant who has support from EP experts.

"In some ways, then, plaintiffs almost do the defense a favor when they rely on experts who do not practice emergency medicine — if we can find good support from qualified EPs who can help us defend the case," Shuirman adds. ■

SOURCES

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Excessive ED Waits Are Trigger for Malpractice Lawsuits

Plaintiff will look at reassessment, acuity level

A recent ED malpractice case involved a patient who presented with a severe headache. "He was under-triaged and experienced an unacceptably long wait," says **Laura Pimentel**, MD, vice president and chief medical officer at Maryland Emergency Medicine Network in Baltimore.

When the patient finally was evaluated, the ED diagnosed an intracranial hemorrhage with a mid-line shift on CT scan. Despite receiving proper treatment and a transfer for neurocritical care management, the patient died. A lawsuit was filed against the EP and the hospital. The plaintiff alleged that ED staff failed to follow policies for reassessing patients in the waiting room.

The EP was dropped because he argued credibly that triage is the responsibility of the hospital nursing staff. "Once the patient was brought to an ED bed, his care was timely and appropriate," Pimentel explains. "The hospital settled with the plaintiff."

EPs can expect wait times to become an issue in any litigation in which an ED patient was diagnosed with a time-sensitive disease process. "Cases in which significant delays in care exist are difficult to defend," Pimentel notes.

Acute stroke, ST-elevation myocardial infarction, and sepsis are three conditions for which there is good evidence that timeliness in diagnosis and treatment correlate with better outcomes. "Triage protocols should be in place in all EDs to screen for these disease processes," Pimentel offers.

ED records contain time stamps for key events such as arrival, triage, initial physician or provider evaluation, room placement, and orders. This makes it easy for the plaintiff attorney to prove exactly how long a patient waited.

"Now that most EDs use [electronic medical records], it is very easy to obtain and follow the timeline," Pimentel says. Here are some ways plaintiffs can try to prove that the wait time exceeded the standard of care:

• The attorney can argue that the patient experienced an excessive wait based on his or her triage level.

For example, one could argue that a patient triaged as an Emergency Severity Index Level 2, who waited an hour to be seen by an EP, did not receive an acceptable standard of care.

• The attorney can argue that the patient was improperly triaged to a less urgent Emergency Severity Index level than the vital signs and chief complaint warranted.

• The attorney can argue that the patient presented in stable condition, but deteriorated while in the ED waiting room.

Without routine reassessment, a patient's worsening condition can go unrecognized. "Plaintiff attorneys may use this to claim that there was a delay in diagnosis and treatment," Pimentel says. Cases alleging that patients waited too long often become "battles of the experts."

Often, delays are sources of liability for hospitals rather than EPs. This is because hospitals are responsible for their triage policies, ancillary services, and patient flow.

"The EP may be dropped because the delays occurred before the patient was ever seen by the physician," Pimentel adds. ■

SOURCE

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Take Steam Out of Plaintiff's Missed Fracture Claim

Treat sprains as though subtle fracture could be present

About 2% of minor trauma patients presenting to a Belgian ED leave with a missed diagnosis, according to a recent study.[1] Of 56 minor trauma patients with missed diagnoses, the most frequently missed diagnoses were ankle, wrist, and foot fractures.

"The gross amount of missed fractures and fracture types were comparable to international literature," says **Pieter-Jan Moonen**, MD, the study's

lead author and a physician in the department of anesthesiology, critical and emergency medicine, and pain therapy at Ziekenhuis Oost Limburg, a hospital in Genk, Belgium.

The two main causes for diagnostic error were:

• failure to perform an adequate history taking and/or a physical exam;

• failure to correctly interpret technical investigation.

However, only a minority of missed diagnoses could be attributed to negligence on the part of the ED. "Most of the cases could only be discovered by follow-up and advanced imaging, which is beyond the scope of the ED," Moonen notes.

Missed fractures don't necessarily result in significant injury, making it unlikely a plaintiff attorney would pursue a malpractice claim. **Robert B. Takla**, MD, MBA, FACEP, medical director and chief of the Emergency Center at Ascension St. John Hospital in Detroit, says this depends on many different factors, including whether:

• the fracture is open or closed;

• the fracture is stable or unstable;

• the fracture will result in deformity if it's not caught and corrected;

• the fracture must be corrected immediately, or whether an equally good outcome is possible if this is delayed.

"Missed fractures that result in non-union or deformity are much more significant than a simple fracture that heals with minimal or no incident," Takla says. Takla instructs his residents to treat every sprain as if it is a fracture that they do not see. In his own practice, Takla tells patients that while he doesn't see a fracture, there still may be a subtle fracture that is not possible to detect at the time of the ED visit, and that he is going to treat the patient as if there is a subtle fracture. "I splint the majority of my sprains, and give them non-weight bearing or limited use instructions," Takla says. He instructs patients to follow up with their doctor or orthopedic surgeon in the next few days and return to the ED if anything worsens.

"The physical exam, and documentation, is critical," Takla adds. He says EPs should chart these items:

• neurovascular exam, including sensory, motor, and vascular;

• exam of the joint above and the joint below;

• exam of the skin for open wounds and soft tissue for compartment pressure;

• a repeat exam after splint application to make sure it is not too constricting.

Takla often sees ED charts missing this documentation. "If the physician documents a suspicion or concern, but does not provide the appropriate treatment, that looks even worse than missing something subtle," he notes. For instance, if the EP documents a possible fracture, and does not investigate further, and does not treat appropriately, it's a difficult case to defend. A better approach is to communicate this possibility clearly to patients, emphasizing the need to follow up. "Document this, and treat accordingly," Takla offers. ■

REFERENCE

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SOURCES

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CME/CE 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.

COMING IN FUTURE MONTHS

- Effective defenses if EP overrode drug safety alerts in electronic medical record
- Late electronic medical record entries complicate defense of ED claims
- Plaintiff attorneys using inadequate neurologic exams against EP
- EPs face unexpected liability with "captain of the ship" legal doctrine

ED LEGAL LETTER™

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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

2. Log on to **AHCMedia.com** and click on My Account. First-time users must register on the site using the eight-digit subscriber number printed on their mailing label, invoice, or renewal notice.

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CME/CE QUESTIONS

1. **Which is true regarding missed acute coronary syndrome (ACS) in EDs?**

   a. Lack of typical symptoms can rule out ACS.
   b. Clinician gestalt has very low predictive ability, even in patients with a non-diagnostic ECG.
   c. Hypertension, diabetes, and smoking history have high predictive ability.
   d. History and physical alone can reduce risk of missed ACS to less than 1%.

2. **Which is recommended to reduce liability exposure involving reviewing ECGs in the ED?**

   a. ECGs on high-risk patients should be performed in treatment rooms instead of at triage.
   b. When reviewing an ECG, the EP should document clearly that his or her specific goal was to identify if a STEMI exists.
   c. EPs' documentation should reflect that the ECG interpretation will be judged by the same standard of care as a full cardiology interpretation.
   d. Any abnormalities should be noted by the EP in the ED chart, even if they are not acted on at the time of the ED visit.

3. **Which is true regarding legal risks involving high-dose analgesics administered in the ED?**

   a. Plaintiff attorneys need expert testimony to prove the ED patient never should have received opioids.
   b. Any abnormally high respiratory rate that ED nurses fail to act on is evidence of negligence.
   c. Widespread opioid abuse has made it more difficult for plaintiffs to prevail in ED cases involving side effects or complications of high-dose IV analgesics.
   d. EPs' liability exposure does not include adverse outcomes that occur *after* patients given sedating medications have left the ED.

4. **Which is true regarding wait times and malpractice litigation?**

   a. Most cases in which significant delays in care exist are difficult to defend.
   b. Triage protocols for sepsis and stroke have been shown to increase liability risks for EDs.
   c. Time stamps showing the time of a patient's arrival generally are inadmissible.
   d. Hospitals cannot be held liable for delays involving ED care caused by problematic triage policies.