ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

FEBRUARY 2020 Vol. 31, No. 2; p. 13-24

INSIDE

RELIAS MEDIA

Emergency Medicine Specialty Most Likely to be Named in Acute Stroke Malpractice Claims

Emergency physicians (EPs) are the specialty most likely to be sued in acute stroke cases, according to a recent analysis.[1] One-third of malpractice claims named EPs. In contrast, neurologists were named in just 17% of claims.

"We were interested in looking at malpractice litigation related to acute stroke in general to categorize the full medicolegal risk profile in treating these patients," says **Jack Haslett**, BS, the study's lead author and a clinical research coordinator at Mount Sinai Hospital's cerebrovascular neurosurgery department.

Haslett and colleagues found 56% of lawsuits ended with no payout. More than one-quarter of cases settled out of court, with an average payout of about $1.8 million. Of the 17% of cases that went to court and resulted in a verdict for the plaintiff, there was an average payout of around $9.7 million.

Cases were categorized into two groups: 26 malpractice lawsuits were related to intracranial hemorrhage, and 246 malpractice lawsuits involved acute management of ischemic stroke. Of this group, 71 cases alleged failure to treat with tPA. Seven cases alleged a failure to treat, or to timely treat, with thrombectomy.

Researchers were especially interested in how many lawsuits included this specific allegation for emergent large vessel occlusion (ELVO). The results of several recent studies suggest that for appropriate patients, thrombectomy makes regaining functional independence more likely.[2] Thus, there was plenty of evidence to support plaintiff experts' testimony that the standard of care was not met by EPs who failed to obtain this intervention.

The problem is the relevant studies were not conducted until after the patients' bad outcome occurred.

"It was very surprising to see several cases alleging a failure to perform thrombectomy for strokes that occurred prior to evidence of its efficacy being

Financial Disclosure: Kay Ball, PhD, RN, CNOR, CMLSO, FAAN (Nurse Planner), is on the speakers bureau for AORN and Ethicon USA and is a consultant for Mobile Instrument Service and Repair. The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: **Arthur R. Derse**, MD, JD, FACEP (Physician Editor), **Stacey Kusterbeck** (Author), **Jonathan Springston** (Editor), **Jill Drachenberg** (Editor), **Leslie Coplin** (Editorial Group Manager), and **Amy M. Johnson**, MSN, RN, CPN (Accreditations Manager).

ED LEGAL LETTER

ED Legal Letter (ISSN 1087-7347) is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *ED Legal Letter*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.

GST Registration Number: R128870672.

SUBSCRIBER INFORMATION
Customer Service: (800) 688-2421
customerservice@reliasmedia.com
ReliasMedia.com

ACCREDITATION
Relias LLC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Relias LLC designates this enduring material for a maximum of 1.5 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

AUTHOR: Stacey Kusterbeck
EDITOR: Jonathan Springston
EDITOR: Jill Drachenberg
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson, MSN, RN, CPN

published," Haslett offers. Seven plaintiffs suffered strokes before 2015, the year the first studies were published on the efficacy of thrombectomy. Three cases resulted in defense verdicts with no payout, one settled for an undisclosed amount, and one settled after mediation for $5.3 million.

Two cases went to trial, with verdicts for the plaintiff for $3.7 million and $38.6 million, respectively. The large verdicts were not based solely on failure to perform thrombectomy; there were allegations of failure to timely diagnose or transfer included in those cases.

"Nonetheless, the fact that this allegation was included demonstrates that adhering to medical evidence is not the only factor in successful medical malpractice litigation," Haslett observes. There were some other issues that arose repeatedly in stroke malpractice cases naming EPs:

• Atypical presentations were seen commonly. Stroke diagnosis was delayed in patients who presented with symptoms such as headache, dizziness, or personality changes.

"In one case, a patient was discharged from the ED with the doctor believing he was intoxicated when he was actually suffering a stroke," Haslett recalls.

• EPs failed to consult with a neurologist or neurosurgeon, even though they suspected a patient might be experiencing a stroke. This allegation was made in 22% of the cases. It was an underlying issue in even more lawsuits. "A number of other cases without this explicit allegation may have been avoided had a neurologist been timely involved," Haslett explains.

Some patients with stroke-like symptoms never were referred to a specialist. Others did receive a consult eventually, but not soon enough to prevent a poor outcome. In other cases, the stroke was diagnosed in the ED timely and treated appropriately. The problem in these cases was the EP failed to involve a specialist when treatment decisions were made involving tPA, thrombectomy, or surgical options.

• Only one case alleged complications from tPA administration. In this case, the patient suffered a hemorrhage. "The lawsuit alleged that doctors failed to adhere to protocols. The case was dismissed by summary judgment," Haslett reports.

In contrast, there were 71 cases alleging failure to treat with tPA. "There has been some suggestion that doctors have been reluctant to use tPA for ischemic stroke for fear of medicolegal risk due to the risk of hemorrhage," Haslett notes.

However, the analysis by Haslett and colleagues points to far higher legal risks if tPA is not administered to patients. Previous studies revealed similar findings.[3]

Sometimes, EPs carefully consider tPA or thrombectomy, but ultimately decide against these interventions. In these cases, says Haslett, "clear documentation of the reason for deciding against treatment may be beneficial in avoiding or defending against medical malpractice lawsuits."

For example, an EP might chart tPA was not administered because the patient was known conclusively to be beyond the time window for treatment.

"This should provide good defense to malpractice related to a failure to treat with tPA," Haslett adds.

• Delay in transfer was a common allegation. Most of these cases occurred at smaller community EDs that failed to transfer the patient to either a primary or comprehensive

stroke center. "Given the expanded time window that patients may now be eligible for thrombectomy, this is likely to become an increasing issue," Haslett suggests.

Even some late-presenting ELVO patients are eligible for treatment. This means there is a larger pool of potential plaintiffs who could plausibly argue that a speedy transfer would have prevented a terrible outcome.

"Well-understood policies to allow for the timely transfer of patients presenting with stroke to the appropriate primary or comprehensive stroke centers may reduce the risk of litigation," Haslett offers.

• In 29% of cases, the patient was discharged from the ED, and suffered a stroke shortly after. The malpractice claims alleged the EP failed to diagnose the stroke. In most of these cases, the defense argued the patient did not exhibit stroke symptoms at the time of the ED visit. "Consultation with a neurologist or transfer may have been beneficial in select cases," Haslett says.

Stroke patients clearly are high-risk cases for EPs, says **Laura Pimentel**, MD, a clinical associate professor in the department of emergency medicine at University of Maryland. "Failure to perform and document a thorough history, neurological examination, and [National Institutes of Health Stroke Scale] score are common pitfalls," Pimentel cautions.

The appropriate imaging studies are not always ordered. "The noncontrast head CT is an insensitive test for acute ischemic infarcts," Pimentel notes. "Contrast CT and MRI or MRA [magnetic resonance angiography] are superior, if available."

As the study's findings showed, early diagnosis of large vessel occlusion is particularly important. This is because of the efficacy of thrombectomy in preventing severe disability, Pimentel notes.

"Imaging the neck is very important for patients with suspected [transient ischemic attack] or stroke."

CT angiography (CTA), carotid ultrasound, and MRA are all acceptable modalities. "Failure to consider cervical artery dissection or underlying cardiac disease as the etiology of stroke symptoms in younger patients is common," Pimentel adds.

Adam Hennessey, DO, an EP at Our Lady of Lourdes Medical Center in Camden, NJ, has reviewed multiple malpractice claims alleging missed stroke. He says a specific statement in the chart on whether the patient is a candidate for tPA can help the defense.

"Most charts make reference to tPA since it is the accepted standard of care. But their reasoning may not be specific enough," Hennessey says.

To be clear on this point, terms such as "time of onset," "last known normal," or specific exclusion criteria are helpful. Other helpful chart notes include:

• If the patient is not a candidate, the specific reason why and whether it is an absolute or relative contraindication;

• Specific treatment options were discussed with the family;

• If proceeding with tPA, risks were covered with the family;

• If the patient cannot take tPA, other options were considered.

Late-presenting patients still might be a candidate for interventional radiology or neurosurgery.

"Just because somebody is outside the window for thrombolytics doesn't mean you can just stop at that point," Hennessey explains. "You still have to be aggressive."

Additionally, the EP needs to document that he or she considered stroke as a possibility. Some failure-to-diagnose claims involve patients with posterior circulation pathology presenting with atypical symptoms. "A very detailed physical examination can sometimes be even more helpful than imaging studies in those," Hennessey says, noting such strokes can be discounted as something benign if someone reports only lightheadedness or headache. "Those are the patients with higher malpractice risks than those who suddenly can't move their right side with facial droop."

When a stroke diagnosis is even remotely possible, Hennessey suggests using the NIH Stroke Scale. "It is not a validated scale for posterior circulation strokes," Hennessey notes. However, even if the patient's score is zero, "at least you have documented that stroke is on the differential."

Lastly, EPs should document any relevant discussions with consultants. In some cases, the EP may believe interventional therapy is appropriate, but the neurologist does not agree. In this situation, the chart should include the specific reason why the patient is not a candidate.

"Since we are not the procedural experts for thrombectomy or focused thrombolysis, a thorough explanation of the specialist's thought process should be fairly protective for the EP," Hennessey says. ■

REFERENCES

1. Haslett JJ, Genadry L, Zhang X, et al. Systematic review of malpractice litigation in the diagnosis and treatment of acute stroke. *Stroke* 2019;50:2858-2864.
2. Balami JS, Sutherland BA, Edmunds LD, et al. A systematic review and meta-analysis of randomized controlled trials of endovascular thrombectomy compared with best

medical treatment for acute ischemic stroke. *Int J Stroke* 2015;10: 1168-1178.

3. Bhatt A, Safdar A, Chaudhari D, et al. Medicolegal considerations with intravenous tissue plasminogen activator in stroke: A systematic review. *Stroke Res Treat* 2013;2013:562564.

Analysis of Stroke Malpractice Cases Reveals Reason for ED Diagnostic Errors

Breakdowns in the initial patient-provider encounter were the most frequent source of diagnostic error in ischemic stroke malpractice cases, according to the authors of a recent analysis.[1] Researchers examined 235 medical malpractice claims involving diagnostic error in ischemic stroke patients from 2006 to 2016, using data from the Controlled Risk Insurance Company (CRICO) Strategies Comparative Benchmarking System database. In 109 of these cases, the diagnostic error originated in the ED. Some key findings:

• Failure to assess, communicate, and respond to ongoing symptoms during the ED visit was the source of misdiagnosis in most cases. "Some patients were seen right away, but it still took a while to make the diagnosis of stroke," says **Penny Greenberg**, MS, RN, CPPS, one of the study's authors and a senior program director of patient safety service at CRICO.

• Patients exhibited only atypical symptoms in 35.7% of cases. In another 30.6% of cases, patients presented with both traditional and nontraditional symptoms. "Some patients had symptoms of vertigo, but they also had symptoms that could be an evolving stroke," Greenberg reports.

What follows is a closer look at a few of the cases Greenberg and colleagues examined:

• A young woman hit her head while ice skating, with a brief loss of consciousness. The CT was consistent with a concussion, and the patient was admitted for monitoring. She was discharged the next day and instructed to follow up with primary care. No neuro consult was obtained.

An outpatient provider performed a head CT scan, which showed a resolved subarachnoid hemorrhage. The patient returned to the ED with right-sided weakness and slurred speech, and was finally diagnosed with stroke. "The patient requires full-time care, and was unable to return to work as a nurse," Greenberg notes.

• A 61-year-old woman fell at home and reported dizziness. "The family was present with the patient in the ED, but did not provide the EP with additional critical information," Greenberg says.

The patient complained of headache and nausea after running out of blood pressure medication. "The patient was a poor historian, and had other concerning symptoms that could have been a stroke. But the physician anchored on the patient's blood pressure, which was very high," Greenberg notes. The patient was so weak when she was discharged from the ED that she required assistance. "The family was uncomfortable with the discharge. In the morning, the woman returned to the ED and was diagnosed with stroke," Greenberg explains.

• A man with sudden onset slurred speech and left arm weakness was left waiting for two hours after arriving at the ED. By the time the man was finally seen, he was outside the treatment window for tPA.

• A young man complained of dizziness and inability to move his right arm and leg. The EP diagnosed right-sided weakness and vertigo, and ordered a head CT scan. An hour later, the patient was discharged with vertigo medication. No stroke workup was conducted, no neurology consult was obtained, and the patient never underwent the CT. "It was unclear who was responsible for ordering the test," Greenberg says.

When a different EP came on shift, the patient still was complaining of right-sided weakness. After discharge, the patient's symptoms persisted. He went to another ED, where he was diagnosed with cerebrovascular accident. "The patient suffers from permanent mobility loss and cognitive dysfunction," Greenberg reports.

Some EDs require that prior to discharge, providers stop to review the final vital signs, test results, and any other pertinent information.

"If they had done that in this case, they would realize that the CT had not been done," Greenberg says. ■

REFERENCE

1. Liberman AL, Skillings J, Greenberg P, et al. Breakdowns in the initial patient-provider encounter are a frequent source of diagnostic error among ischemic stroke cases included in a large medical malpractice claims database. *Diagnosis (Berl)* 2019; Jul 11. pii: /j/dx.ahead-of-print/dx-2019-0031/dx-2019-0031.xml. doi: 10.1515/dx-2019-0031. [Epub ahead of print].

Plaintiffs Use Loss of Chance to Prevail in ED Malpractice Claim

Plaintiff attorneys do not always need to prove that an EP's negligence directly caused a patient's bad outcome. Instead, they allege only that the plaintiff was deprived of the possibility of a better outcome. Often, these "loss of chance" claims involve missed or delayed diagnosis of stroke.

"Missed stroke cases often involve intoxicated patients, patients on a new medication, or patients with an atypical presentation," says **John C. West**, JD, MHA, DFASHRM, CPHRM, principal at West Consulting Services, a Signal Mountain, TN-based risk management and patient safety consulting firm. "The most common issue is a failure to diagnose the stroke at a time when something can be done to correct it," West says.

When this allegation is made, plaintiff attorneys do not always specifically claim that better ED care would have prevented the stroke. "In these cases, the claim is often one for loss of chance of a better outcome," West explains.

In one recent loss-of-chance claim in Mississippi, a patient's wife told nurses she thought her husband had suffered a stroke. For whatever reason, physicians did not find out about it until six hours later, which was too late to administer tPA.[1] The case occurred on an inpatient floor.

"But it would be equally applicable to the ED if the stroke patient is discharged, or the screening takes too long, and the window of opportunity closes," West notes.

Under the loss-of-chance doctrine, the plaintiff attorney must prove through expert testimony that the chance of a better outcome was over the percentage required by state law. In the Mississippi, this percentage was more than 50%, and the plaintiff failed to prove it.

There is no scientific test to measure the loss of chance. "It is entirely up to the experts. The one who is most credible is the one who wins," West reports. Experts rarely agree on the exact percentage. "Sometimes, as in this case, the experts did not say that the chance of a better outcome was greater than 50%," West says.

Undeterred, the plaintiff then argued that the "reduced likelihood" doctrine still applied. This allowed compensation for negligence, even if the chance of improvement fell below 50%. The court rejected the argument, and the case was dismissed.

"Different states have different opinions on how loss of chance cases should go," West explains.

Some states allow the case to go forward even if the plaintiff cannot show a greater than 50% chance of a better outcome, while others do not.

"One way to defend these claims is to prove that the plaintiff waited too long to come in," West says.

In delayed stroke diagnosis cases, knowing the specific time the symptoms started can help the defense. This documentation proves that by the time the patient came to the ED, it was already too late for treatment. "This shows that even if the diagnosis was made immediately, the golden window of opportunity had already closed," West adds. ■

REFERENCE

1. *Norman v. Anderson Regional Medical Center*, No. 2017-CA-00153-SCT (Supreme Court of Mississippi, Jan. 24, 2019).

EPs Named in Med/Mal Lawsuits Receive Higher Patient Experience Scores

The term "medical malpractice stress syndrome" refers to the personal toll litigation takes on EPs, a concept fairly well-established. "But we didn't know what effect getting sued has on their performance in the ED," says **Jestin Carlson**, MD, the study's lead author.

To learn more, Carlson and colleagues compared practice patterns of 65 EPs named in at least one malpractice claim, with a group of 110 EPs who had never been sued. The analysis included 59 EDs in 11 states from 2010 to 2015. To be certain the two groups of EPs were comparable, researchers identified EPs who were working in the same EDs at the same time. The researchers fully expected to see that the sued EPs admitted more patients, used more resources, or worked slower because they were afraid of missing something.

"We thought they might practice in a more conservative manner," offers Carlson, national director of clinical education at US Acute Care Solutions. In fact, the sued EPs' admission rates, resources used, and pace did not change. "This was

very surprising," Carlson reports. Researchers used "relative value units" to determine how much resources the EPs used. These give an overall idea of the amount of resources used, but do not give specifics on certain types of tests.

"We did not have details on how many times somebody ordered a lab test or CT scan or X-ray," Carlson notes.

It is entirely possible some sued EPs did, in fact, order more tests for specific patient groups. For instance, if someone was sued for failing to obtain a CT scan in a missed stroke case, that EP might have ordered more CT scans for patients with suspected stroke. Overall, though, the amount of resources used by the sued EPs did not change. "It really made us step back and ask why we might be seeing that," Carlson says.

The study revealed no concrete answers on that point. One possibility is that EPs' established practice patterns are so deeply ingrained that even litigation does not really change them much.

"It suggests that many of our practice patterns are less sensitive to a big event like a malpractice lawsuit than we would have thought," Carlson observes.

Another possibility is the sued EPs' practice did change, but only for the specific patient groups that were similar to the plaintiff in the malpractice lawsuit.

"They may change behavior only with a small set of specific cases that weren't captured in our data," Carlson suggests.

For instance, if the EP was sued for missed myocardial infarction (MI), that EP might be more likely to admit future patients with suspected MI.

"That same EP may be no more likely to admit other patients, though — such as COPD exacerbation or cellulitis — and continue managing them on an outpatient basis," Carlson says.

Patient satisfaction was the one thing that did change for EPs named in lawsuits. Researchers used Press Ganey scores to measure this. For the EPs who were sued, there was an immediate 6.5% boost. EPs named in failure-to-diagnose claims received an even bigger boost (10.5%).

Still, the study did not reveal why the scores of the sued EPs improved. "Exactly what they are doing differently is unknown," Carlson laments. "We don't know what led to a pretty dramatic, pretty quick, and sustained change in Press Ganey."

Possibly, an EP's personal interactions are affected by the experience of litigation, more so than their clinical practices. "That ties into what we know about malpractice stress syndrome, that being sued affects people on a very personal level," Carlson adds. ■

REFERENCE

1. Carlson JN, Foster KM, Black BS, et al. Emergency physician practice changes after being named in a malpractice claim. *Ann Emerg Med* 2019; Sep 9. pii: S0196-0644(19)30575-X. doi: 10.1016/j.annemergmed.2019.07.007. [Epub ahead of print].

ED Med/Mal Claims Can Become Licensing Board Actions Quickly

After an ED malpractice claim is filed, additional legal headaches often come in the form of licensing board actions. There are two ways this usually is triggered, according to **Nan Gallagher**, Esq., a Morristown, NJ-based healthcare attorney.

One, a patient reports the EP to the licensing board, starting an administrative action. Two, the hospital suspends the EP. "This starts a hospital administrative action against him or her — and gets him reported to the NPDB [National Practitioner Data Bank] and the licensing board," Gallagher explains. State board investigations against the EP can come at any time — before, during, or after a malpractice lawsuit.

"Some patients and their lawyers will test the waters by filing a report to the board before filing suit," says **Ashley Dobbin Calkins**, JD, an attorney in the Richmond, VA, office of Hancock Daniel.

Attorneys and potential plaintiffs are allowed to observe the proceedings if there is an informal conference. Based on what they learn about the care the EP provided, "they may develop potential case theories," Calkins says.

State boards of medicine do not take adverse action against all EPs if a malpractice claim settles.

"But they do thoroughly investigate every report. And they do occasionally take adverse action against providers who have settled or lost cases," Calkins adds.

Depending on the specific conduct at issue, hospitals may be legally obligated to report a sued EP to the board. This triggers a mandatory investigation.

"At times, a board of health professions investigation and a malpractice suit will proceed concurrently," Calkins notes.

Whether a hospital suspends an EP sued for malpractice depends largely on the type of conduct alleged. "I have never seen a provider suspended by a hospital over a typical medical negligence malpractice case," Calkins reports.

Still, finding out that an EP was named in a malpractice lawsuit could prompt the hospital to initiate an internal investigation, if it has not already.

"This could potentially lead to suspension or other disciplinary action, which could itself also prompt reporting obligations to the board," Calkins says.

In some states, plaintiff attorneys are required to copy the licensing board with a notice of intent to sue. "It is up to the agency as to whether or not they want to investigate the matter," says **Carol Ann Lobacz**, LHRM, a claim consultant at Miami-based Claims & Risk Management Services.

Sometimes, the licensing board investigates and closes the file without an EP ever knowing about it. "Once the agency closes their file, it is rare that they will reopen it," Lobacz says.

Other times, the board waits until the malpractice lawsuit concludes before investigating. "Settlement of a case does not automatically mean that an agency will initiate an investigation," Lobacz notes.

If a patient files a complaint about an EP with the licensing board, the board is obligated to investigate. The board informs the patient of what they found and what action was taken. However, if the patient decides to sue the EP, he or she will find different standards apply for malpractice cases.

"The standards of evaluating a medical malpractice claim differs from that of a licensing board rendering a decision on the same set of facts and treatment rendered," Lobacz explains.

In a malpractice case against an EP, the standard of care, causation, and damages are what are considered. "On the other hand, a licensing board is process-driven and focuses on the standard of care," Lobacz observes.

Some ED providers settle malpractice cases in which the standard of care could not be defended, but face no consequences from the state licensing board.

"In some cases, they are investigated by the board, and no disciplinary action is taken," Calkins says.

It all depends on the facts of the case — and also how the EP responds to the allegations.

"If a provider can articulate a reason for an omission and a clear correction, the board does not always discipline a provider, even if there is a technical standard of care violation," Calkins says.

To avoid issues with state licensing boards in the event of malpractice litigation, Calkins suggests EPs check whether their professional liability insurance covers representation for a board action. Not all policies cover this.

"Having an attorney assist with the board investigation can be invaluable, especially if malpractice litigation is expected or ongoing," Calkins offers.

Also, Calkins says EPs should investigate what hospital bylaws say on the subject. "Some require reporting of a board investigation or informal conference," she adds.

Regardless of what triggered the investigation, Lobacz says EPs should notify their professional liability carrier immediately. Some EPs try to defend themselves. "The most innocent of comments can be misconstrued," Lobacz cautions.

Calkins has seen this happen to multiple EPs. "Accidentally providing inaccurate explanations or incomplete records at the outset of an investigation are common issues," she reports.

Hiring an attorney who is experienced in board investigations right from the start makes a favorable outcome for the EP more likely. "In most states, if no probable cause is found, the case is dismissed, and the investigation remains confidential," Lobacz explains. ■

ED Patients Taken Off Monitors, Alarms Ignored: Med/Mal Suit Likely

Any ED patient with symptoms worrisome enough to require cardiac monitoring reasonably expects that somebody is paying close attention. It does not always happen.

"It is not uncommon to discover at some point in the patient encounter that the patient has been removed from the cardiac monitor," says **Andrew P. Garlisi**, MD, MPH, MBA, VAQSF, medical director of Geauga County (OH) EMS and University Hospitals EMS Training & Disaster Preparedness Institute.

The same is true of patients who need frequent blood pressure monitoring, or those with signs and symptoms of sepsis. In some cases, patients deteriorate without anyone realizing.

"There have been septic patients who have presented relatively intact and viable, who expire right under the noses of the healthcare team who are too busy to notice," Garlisi reports.

Problems happen when a closely monitored patient leaves the ED, usually for a CT or MRI. "Patients who are transported to the radiology department, in my experience, are highly likely to return to the ED without being placed back on the cardiac and vital sign monitoring systems," Garlisi observes.

ED nurses assume the radiology technologists are going to put the patient back on the monitor. Radiology assumes the ED nurses will do it. The same issue happens when ED patients are removed from cardiac monitors to go to the bathroom.

"They are at risk for not being placed back on the monitors," says Garlisi, who is aware of two bathroom-related situations in EDs that resulted in unexpected patient deaths.

EDs do not always maintain good systems to ensure any patient temporarily removed from the cardiac monitor is placed back on the monitor. To alert the staff that a patient is off-monitor, Garlisi suggests placing a red "X" on the patient's room door. "This visual cue, hopefully, triggers someone to place the patient back on the monitor and remove the X from the door," he offers.

Solving the problem of taking ED patients off monitors requires somebody to take ownership of it, Garlisi stresses. Hospital administrators may expect the ED staffing company to address it, and vice versa. Likewise, ED medical directors may believe it falls under the purview of nursing.

"Who would be held accountable for wrongful death, if and when a family member discovers that their loved one's death could have been prevented with appropriate cardiac monitoring and frequent vital sign assessment?" Garlisi asks. Despite the unnecessary loss of lives in many EDs due to this problem, Garlisi says "the issue remains unresolved to this day."

When a plaintiff attorney is evaluating a potential lawsuit arising from an ED visit, the monitoring data from the electronic medical record (EMR) is a key consideration, says **Sean P. Byrne**, JD, managing partner of Richmond, VA-based Byrne Legal Group. "Any abnormalities in that data will need to be evaluated in light of the patient's baseline, presenting complaint, and suspected diagnosis," Byrne says.

Cardiac monitors capture valuable data on the patient's condition over time. "It is important that the insightful data from these monitors makes its way into the version of the EMR that will be produced later in response to a subpoena," Byrne stresses.

The plaintiff attorney will examine trends in the data, and whether the EP acknowledged those trends. "If medications are given or other interventions are performed, the reviewing expert and attorney will look to see whether the monitor data demonstrated the expected and desired response," Byrne explains.

The plaintiff's expert also will look for evidence that ED providers responded appropriately if data fell outside the reference range of alarm parameters.

"If there are unexpected periods of time where monitoring data are absent because of equipment issues, monitor detachment, or something else, that may raise questions in the mind of the reviewing expert," Byrne cautions.

The chart should contain good answers to all these questions. "If litigation later ensues, providers should be able to explain the significance of all the data and numbers that appear in the record," Byrne offers.

Sometimes, the problem is not that patients are taken off monitors. It is that nobody pays attention when they go off incessantly. Recently, Carilion Clinic providers studied how often alarms were going off in the ED. They knew it was happening all the time, but just how often surprised them. "During a one-month period, we had over 350,000 alarms per month in the three main units, across 50 beds," says **John Burton**, MD, chair of the Carilion Clinic's department of emergency medicine in Roanoke, VA.

That came down to more than 400 alarms per hour. "In summary, the alarm fatigue was astounding," Burton reports. "It was happening to the point that no one was paying attention to them at all — except the patients." It became clear the alarms were constantly going off because they were far too sensitive. This was especially true for respiratory rate. "The alarms have this built into them by the manufacturers, who I assume have no clue as to how bad they are in the ED," Burton notes. Based on their own internal data showing the extent of the alarm problem, the ED made some important changes. "We adjusted the alarm parameter sensitivities where we could, and in some cases even shut a few down," Burton says.

Whenever patients moved, or when ED staff changed their positions for minor procedures such as IV placement or blood draws, it often set off monitor alarms because the data fell outside the expected alarm range. "When a device is created to measure a patient parameter, such as respiratory rate, there seems to be some imperative by manufacturers to engineer an alarm in the device," Burton observes.

This does not always make sense for the ED setting. "Shutting down some alarms and adjusting others substantially reduced the number of alarms, noise in the ED, and resultant staff alarm fatigue," Burton adds. ■

Most Common Allegation in PE/DVT Malpractice Claims? Failure to Diagnose and Treat

EPs were named in 18% of malpractice cases involving pulmonary embolism (PE) and deep vein thrombosis (DVT), according to the authors of a recent analysis.[1]

Some common allegations in 277 cases from 1987 to 2018:

- Failure to diagnose and treat (62% of cases);
- Failure to prescribe anticoagulation when the patient is discharged (8% of cases);
- Premature discontinuation of anticoagulation (2% of cases).

Researchers were surprised to see so many nonsurgeons, including EPs, among the named defendants. "The reasons the lawsuits were brought seemed to be very simple things that could be easily addressed," says **Issam Koleilat**, MD, one of the study's authors and a vascular surgeon at Montefiore Medical Center in Bronx, NY. Common issues included lack of adequate administration of prophylaxis or medications to prevent blood clots. Koleilat says this documentation is helpful to the defense:

- the reasons for treatment with anticoagulation when it is needed (or reasons why it cannot be given);
- the intended duration of anticoagulants, especially in cases where prolonged administration (such as after some orthopedic or cancer surgeries) is recommended;
- the EP's thought process.

"This can help with transition and continuity of care, and can also potentially serve to protect someone legally," Koleilat says.

For example, EPs could document: "Peroneal DVT with high risk for anticoagulation. Plan to repeat duplex in two weeks and reassess need for anticoagulation."

Missed diagnosis is the most common reason for ED malpractice lawsuits involving PE/DVT, according to **Jay M. Brenner**, MD, FACEP, medical director of SUNY Upstate University Medical Campus ED. In one malpractice case, the DVT was diagnosed properly, but the EP missed tachycardia suggestive of a PE.

"In this case, the patient was discharged, which was a disposition error," Brenner says. The tachycardia probably was representative of right heart strain and impending cardiac arrest from obstructive shock, he explains.

The patient did not meet criteria for outpatient PE treatment, based on Hestia criteria, a tool that identifies low-risk PE patients. The criteria require the patient to be hemodynamically stable, with no need for thrombolysis or embolectomy, no active bleeding, and not at high risk for bleeding.

The patient must not need oxygen to keep oximetry over 90% and not receive anticoagulation prior to PE diagnosis. The patient's creatinine level should not be over 30. Also, the patient should present with no severe liver impairment, no pregnancy, no history of heparin-induced thrombocytopenia, and no medical or social reason for admission.

"Hestia criteria is well-validated. A patient who does not meet Hestia criteria should be admitted," Brenner suggests. For EPs, says Brenner, "the most important factor in these lawsuits is to document your medical decision-making."

One piece of documentation in particular helps to defend malpractice claims: The EP obtained a Pulmonary Embolism Rule-out Criteria or Wells risk stratification score, according

to Brenner. The score, noted in the chart, can justify why the EP did (or did not) obtain a D-dimer level to rule out venous thromboembolism (VTE), an ultrasound to rule out a DVT, or pulmonary vascular imaging (such as a CT or ventilation/perfusion ratio) to rule out a PE. "It is also important to be accurate about the knowledge base surrounding VTE if you are deposed," Brenner offers.

The EP defendant can expect to be grilled on whether the patient met Wells criteria and/or Hestia criteria. "It usually is safe to discharge patients home with a DVT, unless they require thrombolysis or have some other medical or social reason for admission," Brenner says.

However, patients with PE require more thoughtful consideration. "The Hestia criteria has been shown to be highly effective at identifying patients with PE for whom discharge to home is safe and acceptable," Brenner reports.[2] ■

REFERENCES

1. Wilson E, Phair J, Carnevale M, Koleilat I. Common reasons for malpractice lawsuits involving pulmonary embolism and deep vein thrombosis. *J Surg Res* 2020;245: 212-216.
2. Weeda ER, Kohn CG, Peacock WF. External validation of the Hestia criteria for identifying acute pulmonary embolism patients at low risk of early mortality. *Clin Appl Thromb Hemost* 2017;23:769-774.

Damage Caps Can Lead to Unintended Consequences for ED Malpractice

Back when **Gregory Dolin**, MD, JD, was a medical student, the party line among his colleagues was that damage caps were a good thing.

However, as a law student, and now as a law professor, "it becomes apparent that it's not that simple," says Dolin, co-director of the Center for Medicine and Law at University of Baltimore.

One concern is that state damage caps can result in plaintiff attorneys deciding not to pursue legitimate cases. Malpractice lawyers often take cases on contingency.

"As a result, they are more likely to take cases where the compensation is larger," Dolin explains.

In some cases, the medical compensation is negligible, but the potential for pain and suffering damages is large.

"Given that these noneconomic damages would be capped, it becomes not as profitable to take those cases," Dolin observes.

Damage caps render many cases economically unfeasible for plaintiffs' counsel to pursue. Nonetheless, many ED providers still fear losing what may be an otherwise baseless malpractice claim. **David Sumner**, JD, says this is highly unlikely: "Competent med/mal lawyers do not file specious claims, and carriers do not settle them. Tort reform legislation in most states virtually eliminates unworthy claims from being filed."

While most ED providers view tort reform favorably, it looks different from the plaintiff's perspective. "We cannot get carriers to settle even righteously meritorious claims until two to three years into litigation," Sumner explains.

Pursuing a typical ED malpractice claim costs well over $50,000, says Sumner, a Tucson, AZ, medical malpractice attorney. The plaintiff lawyer risks losing all that money, as well as hundreds (or thousands) of hours of professional time.

Thus, ED providers "do not need to be fearful of inexperienced med/mal lawyers pursuing nonmeritorious cases," Sumner says. "The carriers virtually always defend those cases successfully."

Sumner considers a meritorious ED case one with catastrophic injuries or death, supported by well-credentialed experts, where the care was not in conformity with national or organizational guidelines, peer review literature, or the hospital's own published written policies and procedures. "Even extremely meritorious cases are challenging to win as a plaintiff," Sumner notes. "Tort reform has changed the litigation landscape."

Some states give full and/or partial immunities to ED providers, or require that negligence be proven by a standard of "clear and convincing evidence."

"This can be an impossible burden of proof," Sumner says. "The immunity statutes have caused virtually all ED cases to be unprosecutable."

Even if an ED patient is seriously harmed by negligent care, there may be no hope of a fair recovery because of damage caps. "Even great cases have settlement or verdict recoveries that do not fairly match the true severity of injuries and damages due to unfair application of damages caps," Sumner says. If the plaintiff is retired, no lost earnings claims exist. Sometimes, the medical expenses related to negligence are inconsequential. "No reasonable

lawyer is going to risk $50,000 to $100,000 in expenses to litigate a case for two to three years when the maximum recovery available is $250,000," Sumner suggests.

Policymakers hope damage caps will stop physicians from practicing defensive medicine and over-ordering tests. However, in states with damage caps, spending on cardiac stress tests and other imaging tests rise, yet there is no increase in cardiac interventions, according to the authors of a recent study.[1]

"Damage caps do have a strong effect in reducing the number of claims and payout per claim," says **Bernard S. Black**, JD, one of the study's authors. Black and colleagues did not look specifically at ED claims. "But the strong overall pattern should apply there also," adds Black, professor at Northwestern University Pritzker School of Law. Malpractice premiums in states with damage caps have declined somewhat, "but by much less than they should have, given the drop in payouts after caps are adopted," Black observes. ■

REFERENCE

1. Moghtaderi A, Farmer S, Black B. Damage caps and defensive medicine: Reexamination with patient-level data. *J Empir Leg Stud* 2019;16:26-68.

Any Discrepancy in ED Chart Hurts All Med/Mal Defendants

With multiple providers documenting in the ED medical record, there are bound to be some discrepancies from time to time. Not everyone is going to agree on how the patient looked, what the family stated, or on overall clinical impressions. "However, the chart must reflect that discrepancies were recognized and considered by the ED provider," says **Amy Evans**, JD, executive vice president of business development and liability claims division at Intercare Insurance Services in Bellevue, WA.

When confronted with a discrepancy at deposition, most ED providers testify that they did see the entry, Evans says. Often, the conflict is between something the EP charted and something an ED nurse charted. "The ED provider explains the discrepancy by saying that the patient's condition changed after the nurse examined them," Evans notes.

The problem is that this change in condition is not noted anywhere in the ED chart. "The biggest problem for ED providers is the lack of charted acknowledgment of the discrepancy," Evans says.

A brief note on this point is all that is needed. For instance, if nursing notes significant abdominal pain (8 on a scale of 1 to 10, but it is completely resolved since then), the ED provider is going to chart a pain score of zero. The EP can document "Pain decreased to 0/10 since triage."

"That indicates that the provider saw the 8/10 score," Evans suggests.

There is no way around it — any discrepancies in the ED chart are a problem for the defense. "It's one of the easiest ways for a plaintiff's attorney to poke holes in the credibility of the hospital," says **Kenneth N. Rashbaum**, JD, a partner at New York City-based Barton.

Rashbaum has seen inconsistent charting on just about every aspect of the ED evaluation. Defendants in malpractice claims have charted conflicting entries on the medications taken by the patient, substance abuse history, illness history, and physical exam findings such as stiff neck or drooping eyelids. "I have seen all of these become points for cross examination because the ED notes were inconsistent with those entered on the floor," Rashbaum reports.

Inconsistent notes sometimes happen because one ED provider fails to review another's notes. It also can happen because of a good faith difference of opinion. However, the plaintiff attorney can make it look as though the rushed, careless ED provider confused the patient with someone else. If an ED nurse stated the patient was in severe pain, and the EP says the patient was pain-free, it is easy for jurors to believe an overwhelmed EP was mixed up while caring for multiple high-acuity patients. "The record is the foundation of the defense," Rashbaum stresses. "If doubt is cast upon the accuracy of the record, the entire house of the defense can collapse."

In the days of paper medical records, ED providers often did not make entries until after the patient had left the ED for the inpatient floors. This was sometimes hours or days later. "The floor clinicians created a record without input from, and sometimes contrary to, the history, physical, and impression findings of the emergency clinician," Rashbaum recalls.

In theory, at least, EMRs should have stopped this from happening. Inpatient clinicians now can read the notes of ED providers before documenting. But this takes time, which is scarce on both the ED and inpatient floors. "Failing to find that time can do more than damage the defense of a lawsuit," Rashbaum warns. "It can compromise the patient's care." ■

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 **ReliasMedia.com** and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online test 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 test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

CME/CE QUESTIONS

1. **Which is true regarding malpractice lawsuits involving acute stroke?**
   a. Neurologists are the most frequently named specialists.
   b. The vast majority of cases naming emergency physicians (EPs) are settled out of court.
   c. Failure to treat with thrombectomy is alleged, even if strokes occurred prior to evidence of its efficacy.
   d. Most cases involving tPA allege complications such as hemorrhage.

2. **What do plaintiffs need to demonstrate with the loss of chance legal doctrine?**
   a. Negligence directly caused the patient's bad outcome.
   b. Substandard care deprived the patient of the possibility of a better outcome.
   c. The chance of a better outcome was more than 75%.
   d. A scientific test proves the chance of a better outcome was more than 50%.

3. **Which change occurred in practice after EPs were sued for malpractice, according to a recent study?**
   a. More patients were admitted.
   b. More CT scans were ordered.
   c. Fewer patients were seen per hour.
   d. EPs received higher patient experience scores.

4. **Which is true regarding licensing board actions against EPs?**
   a. State board investigations must be put on hold until after malpractice litigation is resolved.
   b. Some plaintiff lawyers test the strength of a malpractice case by filing a report to the board before filing suit.
   c. Once a malpractice claim settles, the board is obligated to take action against the EP defendant.
   d. The same standards and criteria must be used for malpractice claims and board investigations.

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;
3. Integrate practical solutions to reduce risk into daily practice.