survive a massive brain hemorrhage. During subsequent litigation, in addition to allegations of delayed diagnosis, the plaintiff attorney alleged the physician failed to lower the patient's blood pressure, which caused the aneurysm to rupture. A jury found the hospital not liable. "Managing a patient's blood pressure can be tricky given the potential risks of causing an ischemic stroke, particularly in a patient that has a history of elevated blood pressure," Suarez notes.

Common allegations against emergency providers include missed or delayed diagnosis and failure to refer or consult with a specialist. "Documenting a thorough history and physical with a differential diagnosis is critical," Suarez says.

As a best practice, Suarez says ED clinicians should document the top two or three potential diagnoses and the plan. "Follow up on the results of any ordered labs or radiology imaging, and adjust the diagnosis or plan accordingly," Suarez advises.

Because of the potential for symptom overlap among various possible diagnoses in a fast-paced ED, documenting a differential diagnosis can be significant in cases involving missed or delayed diagnosis. "Without a through H&P and documented differential diagnosis, it can be difficult for the provider to recall what they were suspecting and the reasons for it," Suarez explains. ■

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Does a Clinical Decision Aid Constitute the Legal Standard of Care?

By Stacey Kusterbeck

A plaintiff attorney can argue that failing to follow a clinical pathway (computer-generated or not) indicates the emergency physician (EP) violated the duty of care. "However, a clinical pathway is always a suggestion, based on experiences. Each physician must determine in each case whether the pathway recommended is appropriate," says **Victor Moldovan**, JD, a healthcare partner in Holland & Knight's Atlanta office.

A computer-generated recommendation should not be adopted without the appropriate medical staff review and analysis, just like any other clinical pathway. "Hospitals using recommended pathways will typically use a process to vet the pathways to ensure they are appropriate," Moldovan observes.

An EP cannot avoid medical decision-making simply because there is a recommended course of action. "The fact that the EP may have deviated from a pathway does not mean the physician violated the duty of care," Moldovan explains.

The reverse also is true. Just because an EP followed a pathway does not inoculate him or her from a malpractice lawsuit. "If an outcome is negative, an attorney can argue that the physician violated the duty of care because the physician followed the recommendation when the patient's condition required an alternative path," Moldovan adds.

Each EP should undertake the appropriate medical approach to evaluating a patient, regardless of any recommended course of action. The medical record should support using the recommended path or justify another course of action.

Moldovan says the medical record should include the physician's medical assessment (a physical and medical history, including all known co-morbidities, medications, and other standard information). Clinicians also should provide support for whatever medical decisions are made (whether this follows the decision aid recommendations, or whether the EP chose another approach because of the patient's condition). "The medical record requirements are the same for all ED patients," Moldovan says.

The ED chart should reflect the patient's information and the decisions the EP made based on that information. "It's not required that a physician address explicitly a decision to follow or not follow a recommendation/pathway, as long as the record reflects the information showing the assessment and the course of action," Moldovan adds.

Plaintiffs can argue that failure to follow the recommendation of the decision aid creates a prima facie case of malpractice, according to **Kenneth N. Rashbaum**, JD, a partner at New York City-based Barton LLP. This is because the definition of malpractice is a deviation from the legal standard

of care. The defense has to counter the assertion that the decision aid constitutes the legal standard of care. "That could be difficult to argue, since the hospital should have vetted the decision aid before going live with it. Therefore, the plaintiff could argue that they wouldn't have used it if they didn't want it to be considered a standard of care," Rashbaum offers.

The plaintiff will argue the decision aid represents a standard of care. If the EP did something different, the plaintiff will argue the EP departed from the standard of care. "The only questions that should be sent to the jury are causation and damages. It's a frighteningly simple argument that may persuade many judges," Rashbaum says.

To counter this, the defense can argue "the decision aid has neither eyes nor hands nor instruments on the patient. The clinician does, and so can exercise clinical judgment in a patient with a unique set of symptoms, history, or complaints that the algorithm may not have found when it scraped the database of medical records," Rashbaum offers.

For example, the decision aid may not be able to determine when an off-label use of a medication is clinically indicated. Should ED providers document the fact they were aware of the decision aid recommendation? Rashbaum cautions such documentation would open the door for voluminous discovery requests about how the algorithm was developed. "This would be a budget-busting use of litigation, legal, and expert fees and resources," Rashbaum says.

The issue also could distract the jury from the facts of what happened. "It could also open the door to an argument that the clinician didn't use clinical judgment and just relied upon 'the machine,' to the detriment of the ED patient," Rashbaum warns. ■

Did EP Decide Not to Follow Recommendation of Computer Decision Aid?

By Stacey Kusterbeck

Emergency physicians (EPs) are using clinical decision aids more often, but the computer-generated recommendations sometimes are not appropriate. "Clinicians should never blindly follow any computer-generated recommendation," says **Dean F. Sittig**, PhD, professor at UT Health School of Biomedical Informatics in Houston.

Typically, the EP knows additional information about the patient the computer does not. "EPs should think carefully about what the computer is suggesting," Sittig stresses.

EPs may know something that makes the clinical decision support recommendation irrelevant for a particular patient. In most cases, clinical decision aid alerts are configured to increase sensitivity. "They don't want to miss anything, so they alert more often than needed," Sittig explains. "The override rate on most clinical decision support is over 90%."

This means clinicians ignore most decision support recommendations. Sittig says this is with good reason. "A major problem with computer-generated recommendations is that they can be totally wrong, whereas humans are often close to the right answer even when they are wrong," he notes.

Clinical decision aids can be wrong for many reasons.[1,2] For example, the data the tool uses might be wrong. The tool's logic can include an error (e.g., not including the route of administration of the medication in the logic for drug-drug interactions). An ED patient might be prescribed a topical medication, flagged by the clinical decision aid because the patient is taking another orally administered medication in which the ingredients normally would pose an interaction with the first medication. However, since the first medication was administered topically, there is no need to worry about the two drugs interacting. "Most alerts do not account for route of administration," Sittig observes.

The patient might tell the provider they are no longer taking a medication. The computer may not know this, so it produces an alert. Clinicians can help by taking the time to clean up the patient's current medication list. "However, this may not be realistic in the ED, since other physicians may have ordered and be managing the meds," Sittig admits.

Emergency providers can document the reasoning for following or not following the computer's suggestion. "Even if after the fact, it may be clear that the clinical decision support was right; at the time of the event, it wouldn't be so clear," Sittig explains.

The medical record should demonstrate the clinician saw the recommendation, thought about it, and decided what to do. "The clinician may still be wrong. But it is