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Court Rulings Say EP, Not On-call MD, Was Legally Responsible for Patient

Hand-off process should be formalized

An on-call specialist may have given recommendations for an emergency department (ED) patient's care, but that doesn't mean he or she is legally responsible.

The emergency physician (EP) has responsibility for the patient as long as the patient remains in the ED, emphasizes **Glenna Schindler**, MPH, RN, CPHQ, CPHRM, a risk management specialist at Endurance Insurance — U.S. Healthcare in Chesterfield, MO.

"A formal hand-off communication is necessary for continuity of care, and assurance that one provider is giving responsibility for the care of the patient to another provider," says Schindler.

The EP must never assume that he or she is not ultimately responsible for a patient until the patient is transferred to an inpatient unit or to another facility, advises Schindler. "Increasing patient volumes may increase stress levels for ED staff, but it does not remove the obligation of supervision of a patient's care," she says.

Courts Say No Patient-physician Relationship

Courts may not see the on-call specialist as having "accepted" the patient from the EP, even if the specialist provides recommendations to the EP regarding the patient's care.

In a Texas case, an on-call specialist was contacted by an EP, and a patient's case was discussed.[1] The on-call physician recommended a particular treatment, which was implemented by the EP.

"The on-call specialist was again contacted following implementation of the recommended treatment, but the on-call specialist did not come to the ED," says Schindler. The patient subsequently stopped breathing, was unable to be intubated by the EP, and a tracheostomy was performed.

The on-call specialist then arrived at the ED, examined the patient, and had the patient transferred to the intensive care unit (ICU). The patient had suffered an anoxic brain injury and was declared brain dead three days later.

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"The trial and appeals courts determined there was no physician-patient relationship between the on-call specialist and the patient just because the ED physician had consulted with the on-call specialist," says Schindler. Ultimately, the on-call specialist was found not to be responsible for the patient, as the ED physician was free to accept or reject the on-call specialist's advice.

In a Kansas case, it was again found that an on-call specialist was not responsible for an ED patient just because of the specialist's on-call status.[2]

In that case, the on-call physician informed the EP that he would not come to the ED due to extreme fatigue. "Eventually, the patient was transferred to a medical center for care of his spinal cord injury and neck fractures," says Schindler. The patient alleged a delay in treatment by the neurologist caused his poor outcome.

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"In both of these cases, the ED physician was considered to be the treating physician, as the on-call specialists had not formally accepted responsibility for the patient," says Schindler.

Even patients requiring ICU care who have been accepted to the ICU but remain in the ED continue to be the responsibility of the EP, says Schindler. She points to a 2011 clinical practice committee statement published by the American Academy of Emergency Medicine regarding patients requiring ICU admission. (To view the statement, go to http://bit.ly/1ivqGkQ.)

"These patients should have expedited — less than two hours — admission to the ICU, to relieve the ED physician of the responsibility for these critically ill patients," says Schindler.

Legally, says Schindler, patients in the ED are the responsibility of the EPs and ED nurses until there is a formal hand-off to specialist care, or a shift change. The hand-off from one professional to another should be a formalized process that adheres to providing information in the same manner each time, she advises.

"This is not only for the sake of patient safety, but also for legal determination of responsibility," says Schindler. "Using a form developed for this purpose would benefit both off-going and on-coming professionals."

EP and Specialist Jointly Liable

Michael M. Wilson, MD, JD, a Washington, DC-based health care attorney, is aware of several claims involving bad outcomes that occurred during the period of time between when a specialist was contacted by the EP and when the specialist saw the patient or the patient was admitted.

"Under these circumstances, combined with a change of shift in the ER, there are plenty of opportunities for the patient to obtain less-than-optimal care, particularly when the patient is forgotten as other ER patients are seen," says Wilson.

Frequently, the patient scheduled for admission is boarded in the ED for long periods of time waiting for a specialist to render treatment, or waiting for a hospital bed to become available. "In general, of course, the EP is responsible for the patient until the patient actually leaves the ER," says Wilson.

Generally, the EP and the specialist are jointly responsible for the care provided. "If both the EP and the specialist err in treating the patient, it is

likely that both will be sued," says Wilson.

The specialist may argue that the EP failed to provide an adequate history or physical examination, or claim that he or she told the EP to provide different treatment than what the EP documented in the medical record.

"If the EP's history and physical examination were well done and documented, the EP followed the advice of the specialist, and the medical error was made by the specialist, it seems fair that the EP should avoid legal liability," says Wilson. "But this determination may ultimately be left up to the jury." ■

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Patient Sued Multiple EPs in Two EDs: One Settled, Others Dismissed

EP wrongly assumed patient was seeking narcotics

A male patient in his 30s was seen at an emergency department (ED), where he displayed some evidence of epidural abscess, but was discharged with a diagnosis of back pain. "Plaintiffs' counsel alleged that the emergency physician [EP] never ordered even a simple CBC [complete blood count] to investigate the possibility of infection because of the ED's conclusion that the patient, a heroin addict, was just looking for narcotics," says **Scott T. Heller**, Esq., an attorney with Reiseman, Rosenberg, Jacobs & Heller in Morris Plains, NJ.

Two days later, the patient arrived in a different ED at 1 a.m. on a holiday, paralyzed from the waist down due to an epidural abscess. He was evaluated by the EP and sent for imaging studies.

The EP also consulted a neurosurgeon and contacted an internist, who accepted the patient on her service. "The patient alleged delay in obtaining the necessary imaging studies while he languished in the ER for almost 20 hours," says Heller.

A second EP became involved due to a change of shift in the ED. "But he felt he was only 'babysitting' the patient, who had already been admitted — even though the patient remained in the ER until he was taken to surgery later that night," says Heller. During this time, it was alleged, the patient's chance of recovery deteriorated.

All three EPs, the internist, the neurosurgeon, and both hospitals were named as defendants. It was alleged that an order by the first EP for a CBC, MRI, or CT scan would very likely have resulted in diagnosis of the epidural abscess.

"By the time of admission to the second ER, the patient had already suffered sudden onset of paralysis, most likely due to occlusion of the blood supply to the spinal cord," says Heller. The defense's neurosurgical experts explained that by the time of admission to the second ED, the patient's paralysis was permanent, and would not have been reversed even with instantaneous diagnosis and treatment.

The physician from the first ED settled with the plaintiff. His documentation suggested he quickly concluded the patient was not ill, but merely sought narcotics. "The patient alleged the absence of an order for a simple CBC suggested the first EP never considered or investigated the possibility of infectious process such as an epidural abscess," says Heller.

Lack of Clear and Timely Communication

All of the doctors involved in the second ED admission were fortunate to be dismissed, says Heller. "Plaintiffs' counsel would likely have proven that misunderstandings and lack of communication combined to create an unreasonable delay of 20 hours in obtaining the necessary imaging studies," he says.

However, since even the plaintiff's expert agreed it was unlikely that the patient would have regained neurological function, even with immediate diagnosis and surgery at the second ED, no damages could be established.

Heller says the case raised these questions: "Who was responsible for the patient?"and "Who was obligated to see that tests and results were obtained in a timely fashion?"

"A note by the EP containing the date, time, and content of communication amongst the providers would have been helpful for the EP's defense," says Heller. For example, the EP could have charted: "Neurosurgical consult informed of imaging study results and will be in to see patient."

Since the patient remained in the ED, the plaintiff attorney argued that he was still the EP's responsibility. "It was also alleged the patient 'belonged' to the internist, whose service accepted him, even though he had not yet been admitted to a hospital room," says Heller. In addition, it was alleged that the neurosurgeon who had been consulted was responsible for the patient, since the patient's presentation was neurosurgical in nature.

"There was also some conflict regarding communications amongst these three physicians and the radiologist, who ultimately interpreted the delayed imaging studies," says Heller.

To protect themselves legally, Heller recommends that EPs communicate clearly with attendings and consultants regarding:

- the EP's evaluation and recommendations;
- what is to be done for the patient;
- who is ordering tests, obtaining results, and formulating the plan of care;
- who will be providing that care.

"Document the content and time of communications regarding these items," he advises. ■

Source

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Diagnostic Errors Are the Most Common Medical Factor in ED Claims

Emergency medicine in "top 10" for closed claims

Errors in diagnosis are the most common medical factor in malpractice claims resulting in payouts against emergency physicians (EPs), followed by improperly performed procedures, delay in performance, and medication errors, according to data from the 2013 edition of the PIAA Risk Management Review for Emergency Medicine.

Seventy percent of claims against EPs were closed, with no indemnity payment made to the patient. The average indemnity paid was about $362,000, compared to $383,000 in 2012.

"In looking more closely at medical liability claims alleging diagnostic error for emergency medicine over the past 10 years, the top condition named was symptoms involving the abdomen or pelvis," reports **P. Divya Parikh**, director of research and risk management for Rockville, MD-based PIAA.

Of the 92 claims reported against EPs, 28 resulted in payouts, with an average payment of $280,000. In contrast, about half of 66 closed claims for the next most common condition resulting in a claim — acute myocardial infarction — resulted in payouts, with an average payout of about $383,000.

Chest pain and back disorders were the next most common conditions in diagnosis-related claims against EPs.

Of the 28 medical specialties included the report, emergency medicine ranked eighth in the number of closed claims in the past 10 years. The average paid-to-close ratio is about 30% across all specialties, and is 24% for emergency medicine.

"Emergency medicine is one of our 'top 10,'" says Parikh. "It's a high-pressure area where physicians have to diagnose what's going on, having virtually no prior relationship with the patient." The average indemnity paid out for all emergency medicine claims is $330,000, compared to an average of $325,000 for all specialties.

The most prevalent issue in emergency medicine claims is the diagnostic interview, evaluation, and consultation. "Over the past 10 years, emergency medicine had a total indemnity of $293 million for 887 paid claims — and $77 million is attributed to that one procedure," Parikh says.

More EPs Insured By Employers

Each emergency department (ED) visit will generate a professional liability cost of $6.09 in 2014, according to Aon Risk Solutions' 2013 Hospital and Physician Professional Liability Benchmark Analysis, which analyzed the costs of professional liability claims occurring in EDs. The analysis looked at claim costs within a $2 million maximum because that amount is typical of hospitals' retained insurance layer.

"We estimate that in 2014, hospital systems will see 3.73 claims for every 100,000 ED visits; approximately one-third of these claims will result in an actual indemnity payment to a third party," says **Erik Johnson**, FCAS, MAAA, Aon Global Risk Consulting's assistant director and actuary.

The average size of an ED professional liability claim is an estimated $163,000 for events arising in 2013, including indemnity costs paid to claimants and the cost of defending the hospital.

"The average size of ED claims is similar to claims occurring in other hospital service areas," says Johnson. "Over time, the trends in ED claim costs are stable; these are neither significantly increasing or decreasing."

Many EPs are moving out of the individual malpractice insurance market because they're being covered by their employer's self-insurance plan instead. According to Aon's 2013 analysis, 70% of hospitals employ a large number of physicians and use their own self-insurance vehicles to insure them.

For some EPs, the employer may be the hospital; for others, the employer may be an organization that staffs EDs on a contractual basis. In either case, the employers are often self-insuring the physicians, rather than the physicians purchasing policies from the commercial market.

"There are some very valid benefits to commercial insurance," says Johnson.

"But, in general, being a part of the employer's self-insurance plan is more cost-effective for the physician and employer." ■

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Which Patients Are Most Likely to Sue EP? There's No Particular Profile

Individual patient-physician interaction is far more predictive

When an emergency physician (EP) receives notice of a lawsuit, the plaintiff often turns out not to be the first patient who comes to mind, says **Jonathan D. Lawrence**, MD, JD, FACEP, an EP and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

"The squeaky wheels are not necessarily the ones who are going to get a lawyer," he says. "Lawsuits tend to come out of left field — you get the subpoena and say, 'Who the heck was that patient?'" In Lawrence's experience, demanding, unpleasant patients, "are not the ones you end up in court with."

No Particular Patient Profile

A patient with significant brain or spinal cord injury that requires ongoing care is likely to file suit, irrespective of whether actual negligence occurred, notes **Rade Vukmir**, MD, JD, FACEP, FACHE, chairman of education and risk management at ECI Healthcare Partners, a Traverse City, MI-based provider of emergency and acute care management services. Vukmir is chief clinical officer of National Guardian Risk Retention Group and clinical professor of emergency medicine at Temple University, Philadelphia, PA.

While some EPs believe disadvantaged patients are more likely to sue, a recent study shows that the opposite is probably true.[1] "There is clear evidence that people at a financial disadvantage actually sue less," says Vukmir. "People often don't sue because of money. There are more complex reasons that people sue their doctor."

The patient-physician interaction on an individual basis is more predictive of whether a suit will be filed than any particular patient population, or even whether negligence occurred, emphasizes Vukmir. "The distinguishing factor seems to be a communication issue," he says. "And there are factors that involve both parties."[1-3]

Generally speaking, EPs who tend to engage patients in conversation, demonstrate caring, and utilize humor appropriately in their interactions are sued less often, according to Vukmir. "The expectation of perfection is seldom achievable in any profession," he says. "But on any given day, EPs should strive to optimize effective communication and advocate for the patient as much as they can."

Whether a particular ED patient will file suit "is a more complicated dynamic than simply asking which groups are more commonly involved," says Vukmir. A better question to consider might be "Which EPs are more likely to be sued?"

"Patients will sue if they feel they haven't been heard or haven't had an audience with the EP," Vukmir says. "Unfortunately, that's more common in some specialties than others." EPs first need to recognize they are practicing in a high-risk medical-legal environment, says Vukmir, and "actively focus their practice to avoid that circumstance."

Areas of particular concern in EDs are well-known, he says, and include changes of shift, patient transfers, and on-call consultants. "The most important thing is to deliver the best quality patient care," says Vukmir. "Never do anything in the ED that makes you uncomfortable from a patient care perspective."

Vukmir acknowledges that circumstances or decisions are often imposed from outside the ED, and may be related to the admission process, a consultant, or hospital capability — "but EPs should strive to protect their patients as much as they can." ■

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Step in Before Patient Leaves ED Unhappy: Stop Possible Suit

In response to an irate emergency department (ED) patient saying, "I've been waiting here for two hours and 40 minutes," the emergency physician (EP) glanced at the chart and said curtly, "You've actually been here for two and a half hours."

"That's not the right way to approach people. You've maybe won a mini-battle, but you've lost the war," says **Kevin Klauer**, DO, EJD, who overheard this conversation.

EPs need to "validate the patient's concerns," underscores Klauer, chief medical officer at Canton, OH-based Emergency Medicine Physicians. "It's not just about making people happy. It's about making people happy as a risk-management strategy."

EPs should ask themselves as they leave their shift if they are going to wish they took the

time to resolve a particular issue. "You are the medical provider who was going to see them, or already started to see them, and they are leaving unhappy, most likely against medical advice (AMA)," says Klauer.

EPs have a choice, says Klauer: "To spend 10 minutes now with service recovery, or to spend months of your life later explaining to a jury how you provided good medical care."

While not all patients who leave the ED unhappy are going to file a lawsuit, says Klauer, "you are selecting out a high-risk group of patients who may very well sue if they do have a bad outcome or problem." Here are practices that can reduce the EP's legal risks:

• Enlist the help of others.

When facing a potential adversarial patient care encounter, the EP "should not try to go it alone," says **Rade Vukmir**, MD, JD, FACEP, FACHE, chairman of education and risk management at ECI Healthcare Partners, a Traverse City, MI-based provider of emergency department management services. Instead, enlist the assistance of the charge nurse, patient flow coordinator, case manager, or another independent third party to be present and assist the EP in any further patient care discussions.

The EP can make a first attempt to defuse the situation, "but if you are not making any headway, then you start involving other people," says **Jonathan D. Lawrence**, MD, JD, FACEP, an EP and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

Lawrence advises enlisting the help of a nursing administrator, charge nurse, clergy, or social worker. "Clue them in on what's going on, and let them take care of the patient or family," he advises. "Be sure that you fully inform the person who's going to be involved."

• Always include the patient's family.

Often it is a family member, not the patient, who instigates a malpractice lawsuit. "If the family has unrealistic expectations, those issues have to be addressed," says Lawrence.

• Give the patient or family a chance to be heard.

Vukmir says to ask, "What else can I do for you? What would you like to accomplish in this visit?" and to direct these questions to the family "as much as the patient," he says. Obviously, this approach requires the patient to consent to this family discussion. "Go through their expectations," says Vukmir. "A lot of times, they are reasonable and easily attainable if discussed."

It may be that the EP has provided excellent care, "but who wants to have that debate after the patient has contacted an attorney?" asks Klauer. He tells patients, "I'm really sorry you are unhappy. Tell me how I can help you. And while we are talking, can I get you something to drink?"

"In those couple of statements, you are addressing several things," he says. "You are listening to the patient, you are being reasonable, and you are addressing their comfort," he says.

Next, he underscores to the patient that he or she is just as important as everyone else, but that other ED patients had more time-sensitive problems. "If they still don't get it at that point, I use some examples to really appeal to their compassion," Klauer says.

• Do what you can for patients leaving AMA.

If someone is angry, they are likely to walk out of the ED. "Having them walk out without having the concern addressed is not a good risk-management strategy," says Klauer.

Vukmir says the EP should recognize the limitations of the AMA process. "Even though the AMA form is signed, it is clearly litigated as a point of controversy," he warns. "Patients allege that they truly didn't understand the repercussions of their decision."

Vukmir says EPs should advise patients that they are always welcome to return to the ED, and offer the patient any help they can with follow-up care. "Prescribe medications and follow up within reason, so you can still help with the case," Vukmir says.

• Avoid inflammatory charting.

Is an argumentative patient saying wildly inappropriate things? If so, document only what is medically necessary and appropriate, based on the patient's condition.

"If the patient makes a statement, you can put that direct quote into the document," says Vukmir. "But editorializing the patient's thoughts, your own impressions, or those of other health care providers is not appropriate."

These comments can make it more difficult to defend a malpractice claim against the EP. "If in addition to the standard documentation of the patient's evaluation there is a two-page addendum that describes non-medical, extraneous aspects of the event, that can potentially damage the EP's credibility," Vukmir explains.

Charting the fact that a patient used profanity and the EP tried to address their concerns is acceptable. "But the minute you start to get into, 'They were horrible in the way they spoke to me

and our staff, so we refused to provide them further care because of their inappropriate behavior,' — those type of comments will never help you," says Klauer.

Emotion and innuendo "should never find its way into the medical record," says Klauer. "Those can really come back to bite you, particularly if those end up being wrong. Stick to the facts."

While a jury might understand why an EP vented in the medical record, it doesn't mean they are going to be forgiving when they have to make a decision. "They expect you to function at the level of training and expertise and respect that you are given," says Klauer. "If you are going to be in a situation like that and are seen as acting inappropriately, they are not going to give you much of a pass."

On the other hand, if the patient was intoxicated and verbally abusive, and this is documented objectively in the record, "it really speaks for itself," says Klauer. Such documentation can weaken the plaintiff's case because it makes the patient appear less credible.

• Don't argue with the patient or family.

Comments such as "I'll call my lawyer and sue you" are often empty threats, but the EP shouldn't respond with angry comments such as "Go ahead!"

"You don't want to do any of that," says Klauer. "Ignore the inflammatory statement that the patient or the family member made, and don't engage in arguments."

• If a patient says he or she has contacted legal counsel, stop the conversation there.

"It should end nicely, and it's not that you can't have further discussion. But you should get hospital risk management involved before you do," says Klauer.

Klauer says that having discussions with the patient, the family, and legal counsel present before a claim is filed is an excellent approach. "But you have to do so with risk management and legal counsel present so that you don't put yourself or the hospital in an untenable situation, because it's all discoverable," he says. ■

Source

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Poor Communication Between Triage and EP Can Result in Lawsuits

A toddler is triaged as a level 3 on the Emergency Severity Index scale, and the nurse entered vomiting as the chief complaint, but this did not tell the whole story. "Her documentation clearly pointed toward possible diabetes, based on a family history of diabetes related by the concerned mother," says **Jeanie Taylor**, RN, BSN, MS, vice president of risk services for Emergency Physicians Insurance Company (EPIC) in Auburn, CA.

The emergency physician (EP) didn't become aware of the possibility of new-onset diabetes until she saw the child an hour later. "Since all the EP saw was the data on the tracking board: 'Level 3; vomiting for the past day,'" the child was not seen as timely as was indicated by their condition and history," says Taylor. "Fortunately, the child did well in spite of a diagnosis of diabetic ketoacidosis."

Patients are put at risk when EPs are not given key pieces of information. "EMRs are sometimes a barrier if it limits the information that is readily and easily available to the physician," notes Taylor.

Information Varies Greatly

Triage nurses can easily become overwhelmed trying to keep up with incoming patients. The amount of information gathered in triage varies greatly by facility. "Some do only a brief rapid assessment, which doesn't always include vital signs," says Taylor. Others gather more data than is needed for triage, such as starting the medication reconciliation process or documenting the regulatory-required data such as screening for domestic abuse.

"In EPIC's review of medical records, we have noted a trend of under-triaging patients; but rarely are patients triaged to a higher category than warranted," says Taylor. "When patients are under-triaged, risk is created."

Another problem is that some EPs do not consider someone to be "their" patient until the patient is in an ED bed and assigned to them.

"Add in the chaotic and busy environment in the ED, conflicting priorities, and the list of tasks

needed to care for patients already in ED beds, and you've got a real problem," says Taylor.

In one case, a 26-year-old intoxicated male was brought to an ED by emergency medical services. He was belligerent, combative, and had difficulty speaking and walking — none of which promoted accurate triage.[1]

"The patient was placed in 'bypass' — an area thought to be a hallway. No vital signs were taken," says Taylor. Nursing documentation indicated only that he was uncooperative and had no apparent trauma.

"An hour later, he was noted to be cyanotic and pulseless and could not be resuscitated," says Taylor. "He was not seen by the physician on duty before he arrested."

The court found that the EP on duty was negligent in failing to examine the patient, and that it was his responsibility to know who was waiting for care and how critical the need for care was.

"This case carries a valuable lesson for EPs, related to their responsibility to be aware of patients waiting for care," says Taylor. Strategies for EDs to reduce legal risks involving communication between triage nurses and EPs include:

• Ensure that the triage process is efficient and does not create a bottleneck, yet gathers sufficient detail so that key data on patients presenting for care can be communicated to the EP.

"This is especially important when patients are backed up and waiting for care," says Taylor. "Analyze the triage information readily available to the EP to be sure it provides them with adequate detail."

• Ensure that triage staff is highly skilled at triage assignment and recognizing sick people.

"Physicians should feel the triage staff is saving their hide by directing them to the high-risk patients, versus worrying that triage assignments are not accurate," says Taylor.

• Reassess patients at reasonable intervals of 15 minutes to one hour, depending on acuity.

"Two hours is too long for all but urgent care patients," says Taylor. "Ensure that physicians are kept abreast of the results of the reassessments."

• Ensure that EPs keep an eye on the tracking board and know who is waiting for care.

If they notice a patient who might be high risk — an elderly patient with abdominal pain or an infant with a fever — physicians should speak to the charge nurse about bringing the patient back for an exam, or consider going to the waiting room to look at the patient. "While we know that most ED physicians are very, very hesitant to venture into a waiting room of unhappy patients, sometimes it is the right thing to do," says Taylor.

While triage is a nursing and facility responsibility, says Taylor, it behooves EPs to occasionally insert themselves into the process.

"In high-volume EDs staffed with more than one physician, consider assigning a physician each shift to keep abreast of who is in the waiting room," she suggests. "Lay eyes on patients with complaints that could be high risk — or have them brought back to an ED bed."

• Consider a process in which patients are assigned to an EP, or a team that includes an EP, right after the triage evaluation.

This can promote greater responsibility for getting patients back to the ED. "Even when the patient cannot be brought back to the ED, treatment may begin in the waiting room when an assigned physician feels responsible," says Taylor.

• Ensure that patients are brought back to the ED as soon as possible.

Use wheelchairs, hallway carts, rotating exam rooms, and any other means at your disposal to get patients out of the waiting room and under the physician's care, urges Taylor.

• Remember that triage does not meet the Emergency Medical Treatment and Labor Act's requirement for a medical screening examination.

"Long delays can be interpreted as a 'constructive denial' of a patient's right to treatment under federal law," says Taylor.

• Remember that EPs are responsible for a patient from the minute the patient enters the department, not from the time the patient is assigned to a bed.

"If your facility has issues with wait times, be part of the solution," says Taylor.

• Address discrepancies in nursing notes.

When reviewing ED charts, **William J. Naber**, MD, JD, frequently sees statements such as "nursing notes reviewed and agreed with unless discussed in my note."

"This is very dangerous if the provider fails to document a disagreement with something in the triage nurse's note, says Naber, associate medical director of the Center for Emergency Care at University of Cincinnati Medical Center and associate professor in the Department of Emergency Medicine at University of Cincinnati's College of Medicine.

A classic example is when the triage nurse documents a child is "lethargic" but the EP does

nothing to address this. "If the child does not do well, and the provider has no documentation to dispute the lethargy, it makes for a very difficult case to defend," says Naber. ■

REFERENCE

1. *Joseph R. Feeney, administrator vs. New England Medical Center, Inc.* Retrieved May 31, 2013 from http://law.justia.com/cases/massachusetts/court-of-appeals/volumes/34/34massappct957.html

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This Charting Can Prevent Allegations of Delayed Transfer Against EP

Emergency physicians (EPs) have a legal obligation to transfer a patient when the patient's medical condition exceeds the capability or capacity of the hospital, says **James R. Hubler**, MD, JD, FACEP, FAAEM, FCLM, medical director of the emergency department at Proctor Hospital and president and CEO of Emergency Physician Staffing Solutions, both in Peoria, IL.

"This situation may arise when there are a lack of specialists, or even if your facility is full. Those working in the trenches know that it can take over an hour to find an accepting physician," says Hubler, adding that delays in transfer are common allegations in malpractice claims he's reviewed.

Additional delays might occur waiting for the accepting hospital to provide a bed number and take report. Furthermore, just because the transferring hospital is ready does not mean the ambulance is ready to immediately take the patient.

"Ambulance services will not send a unit until they have both an accepting physician and a bed number," says Hubler. He recommends that EPs:

- Inform the patient and family that transfers take time.
- Update them on communication with providers and what to expect.

The most common allegation in a malpractice claim arising from a delayed transfer from the ED or a failure to transfer is negligence, says **Damian D. Capozzola**, JD, a Los Angeles-based health care attorney.

"This is simply the idea that the physician failed to live up to his or her responsibility to act reasonably under the circumstances," he says.

Capozzola says the most important thing an EP can do to protect him- or herself against this allegation is to document thoroughly and contemporaneously why the transfer was delayed or did not happen.

"Perhaps there was no superior or alternate facility available at the time. Perhaps the patient refused further care," he says. It's also possible that the patient's symptoms — as they were at the time the treatment decisions were being made — did not warrant transfer.

There are multiple legitimate reasons why a transfer was delayed or didn't occur. "But unless these are thoroughly and contemporaneously documented, they will look more like after-the-fact excuses and less like legitimate justifications shielding the physician from liability," says Capozzola.

Documentation May Prevent Claims

When a subsequent reviewer looks at the ED chart, the reviewer needs to see that the EP's attempts at transfer were timely and without extraordinary delay, says Hubler. "Preventing the claim through detailed documentation is the key," he says.

EPs should document:

- When they paged or called the transfer hospital;
- When the physician called back;
- When the ambulance was called;
- Rechecks and interventions.

"I have seen several cases where delays were unavoidable, but the transferring physician did

not continue to aggressively manage the patient prior to transfer despite nursing requests," says Hubler. "It's still your patient."

This is particularly important with sepsis patients. Patients' vital signs can change prior to transfer, requiring additional fluid boluses or vasoconstrictors to help with perfusion. "When the physician is notified and the nurse writes 'no additional orders received,' someone may challenge the lack of interventions," explains Hubler.

The plaintiff's attorney must prove that the EP did not act as a similar provider would have, given the services available at that facility. "Every facility does not need to be a tertiary hospital," says Hubler. "But there should be a plan of coordinated care on where certain patients will go." ■

Sources

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After completing this activity, participants will be able to:

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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.

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CNE/CME QUESTIONS

1. Which is true regarding the likelihood of patients suing an emergency physician, according to **Rade Vukmir**, MD, JD, FACEP, FACHE?
   A. There is clear evidence that disadvantaged patients are much more likely to sue.
   B. The patient/physician interaction on an individual basis is more predictive of whether a suit will be filed than any particular patient population.

C. There are more claims against EPs who tend to engage patients in appropriate conversation and humor.
D. Research indicates that the vast majority of claims involve patients who were demanding and unpleasant during the ED visit.

2. Which is recommended to reduce legal risks involving dissatisfied ED patients, according to **Kevin Klauer**, DO, EJD?
   A. EPs should always avoid involving hospital administrators.
   B. EPs should focus solely on the patient's expectations, as opposed to those of family members accompanying the patient.
   C. It is not advisable to prescribe any medications if the patient is leaving against medical advice.
   D. EPs should get risk management involved before further discussion occurs if patients have contacted legal counsel.

3. Which is recommended to improve communication between triage nurses and EPs, according to **Jeanie Taylor**, RN, BSN, MS?
   A. Two hours is a reasonable interval to reassess all waiting patients, regardless of their acuity.
   B. It is not advisable for EPs to go to the waiting room to assess patients.
   C. EPs should be aware of who is waiting for care, and assess patients who might be high risk.
   D. EP are responsible for a patient only from the time the patient is assigned to a bed, not from the time the patient enters the department.

4. Which is true regarding claims alleging delayed transfer of ED patients, according to **James R. Hubler**, MD, JD, FACEP, FAAEM, FCLM?
   A. Emergency physicians (EPs) have a legal obligation to transfer a patient when the patient's medical condition exceeds the capability or capacity of the hospital.
   B. It is not advisable for EPs to document rechecks and interventions that occur after the request for transfer is made.
   C. EPs cannot be legally responsible for bad outcomes that occurred due to unavoidable delays, even if the EP fails to aggressively manage the patient during that time.
   D. EPs are not responsible if a patient's vital signs change prior to transfer, as long as the receiving center facility was contacted in a timely fashion.

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