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INSIDE

RELIAS MEDIA

Supreme Court Ruling Provides Clarity on Law Enforcement-Requested Blood Draws

Police bring in an unconscious man suspected of driving intoxicated, and ask the ED nurse to draw a blood alcohol level. In this not-uncommon scenario, no warrant is necessary, according to a recent Supreme Court ruling.[1]

"If the patient is unable to submit or refuse because they are unconscious, controversy then arises. Perhaps the recent Supreme Court decision will resolve much of this controversy," says **James F. Holmes**, MD, MPH, professor and vice chair for research at UC Davis School of Medicine's department of emergency medicine.

The Supreme Court ruling "certainly provides more power for the ED physician to draw blood alcohol levels in unconscious patients," Holmes says. However, the same does not apply to drawing blood from the conscious patient who refuses, Holmes warns: "Doing this could definitely get the provider in trouble."

It always is possible that a patient, whether conscious or unconscious at the time of the blood draw, could file a complaint and trigger a police investigation.

"But it would be hard for me to believe that a district attorney, who wants the blood to prosecute the patient, would also prosecute the ED provider who drew that blood at the request of the police," Holmes offers.

The patient or family also could file a civil lawsuit against the ED provider who drew the blood.

"Again, it would be hard to believe that a jury would find against a provider who followed state law, hospital policy, and a police officer's request, especially after the Supreme Court ruling," Holmes adds.

In his experience, **Robert B. Takla**, MD, MBA, FACEP, says requests for blood draws arise under three scenarios:

• **Law enforcement wants the results on a patient who already is undergoing treatment in the ED.** Sometimes, the emergency physician (EP) already ordered a blood alcohol level for clinical reasons.

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"In this situation, we do not release the results to police, the prosecuting attorney, or any other person unless the patient gives consent to do so or a court order is provided," says Takla, medical director and chief of the emergency center at Ascension St. John Hospital in Detroit.

• Law enforcement wants the results, but the EP did not order it as part of the patient's workup because the EP did not believe it was clinically necessary.

"This situation also requires either the patient's consent or a court order," Takla explains.

• Law enforcement brings an individual in specifically requesting that ED providers draw that individual's blood for testing.

"Again, it requires either consent or a court order," Takla adds.

There also are times when the patient does not consent, and police have a court order. "If the individual is cooperative, it is easy. We draw the blood," Takla says.

If the patient physically resists, the specimen is obtained with the assistance of police providing reasonable force in restraining the individual. "If in the process of applying force, it appears excessive or is injuring the patient, we would direct the police to desist," Takla says.

In a now-infamous 2017 case, an ED nurse in Utah was handcuffed for following hospital policy and refusing to draw blood on an unconscious patient. *(Editor's Note: For an in-depth series of articles on this unfortunate episode, please read the November 2017 issue of our sister publication,* Healthcare Risk Management*, on our website at: http://bit.ly/37E7u3N.)*

"On the flip side, when the ED provider does it without patient consent, then the ED provider can be sued for battery. It's really a balancing act," says **Wakaba Tessier**, JD, a partner in the Kansas City, MO, office of Husch Blackwell, who co-authored a recent paper on this topic.[2]

Tessier advises hospital clients to secure the patient's consent to the extent possible before drawing blood, despite the recent Supreme Court ruling. "This case will not stop the patient or families from suing the hospital," Tessier cautions. It does provide one argument for the hospital to use in the event litigation arises, adds Tessier, "but it certainly does not dictate definitively what hospitals should do."

Roughly half of intoxicated drivers who present to an ED after a motor vehicle collision receive a DUI conviction, according to the authors of a study.[3] "This protection from prosecution unlikely is in the public's best interest," says Holmes, the study's lead author.

Most people, EPs included, would agree that intoxicated drivers who

EXECUTIVE SUMMARY

Law enforcement requests for blood alcohol levels are legally complex for ED providers. A Supreme Court ruling states no warrant is needed to draw blood from unconscious patients suspected of driving intoxicated. Some legally protective practices for EPs:

- Obtain consent or a court order when possible.
- Consult with hospital attorneys or risk managers.
- Document specifics on the urgency of the request.

kill innocent people should go to jail. "But we are obligated to care for patients, not serve as law enforcement agents," says **Corey M. Slovis**, MD, FACP, FACEP, FAAEM, professor and chairman of the department of emergency medicine at Vanderbilt University Medical Center.

"Patients have rights, regardless of the suffering, damage, or deaths they have caused," says Slovis, who believes EPs should not draw blood unless the patient agrees to it or there is a legally binding court order to do so. "Because most of us are not lawyers, it usually is best to wait until a hospital attorney confirms that the police officer's document is in fact is a court-ordered evidence request that should be honored."

The Supreme Court ruling clearly states that unconscious patients do not need to consent to a police officer-requested blood draw. Regardless, Slovis says EPs should either rely on a hospital policy or request hospital legal assistance. "Otherwise I still worry about a dammed if you do and dammed if you don't kind of situation," Slovis says.

A simple, well-written policy known to hospital staff and law enforcement avoids most conflicts. Still, says Slovis, "when in doubt, wait for definitive guidance from someone whose job it is to protect you."

Holmes says it is unlikely the plaintiff in a malpractice case would be able to prove the ED provider or hospital failed to meet the standard of care by drawing the unconscious patient's blood per law enforcement's request. It also is highly unlikely that a district attorney would prosecute the ED provider for battery. "Thus, the likelihood that the provider would be drawn into legal action for obtaining blood in the unconscious patient for legal purposes is low," Holmes offers.

Generally, neither courts nor the public consider measuring a blood alcohol level on an intoxicated driver as an unreasonable search and seizure, notes **Rade Vukmir**, MD, JD, FCCP, FACEP, FACHE, president of Critical Care Medicine Associates and clinical professor of emergency medicine at Temple and Drexel Universities.

Even before the recent Supreme Court ruling, more than half of states already had enacted statutes stating that drivers do not have the right to refuse a blood draw in this circumstance. Many vehemently object, and some threaten to sue. "But it usually gets done," Vukmir adds.

Usually, any trauma patient would undergo a drug and alcohol screen as part of the ED assessment. "Law enforcement can then subpoena the results," Vukmir notes.

More problematic, at least in the eyes of ED providers, is when law enforcement brings the patient to the ED for the express purpose of measuring the blood alcohol level. "It isn't something to be decided on a case-by-case basis or handled differently at 2 a.m. vs. 9 a.m.," Vukmir notes. "The more it's spelled out in advance and not in the heat of the moment, the better for all involved."

The Supreme Court ruling specified that there is an exigent circumstances exception to a warrant requirement. "Everyone would generally understand that when a patient presents in a potentially life- or limb-threatening situation for themselves or others, it's a time-sensitive analysis," Vukmir explains.

ED providers still worry about legal exposure drawing blood from an unconsenting patient. "This is so complicated it had to go to the Supreme Court," Vukmir notes. "If it's that complicated, you should have a policy in place to deal with it." ED providers "are not the final arbiter of this," he adds. "If there is a dispute, it should be referred to the onsite risk manager, and potentially the hospital attorney, for rapid resolution."

Risk managers must determine if the request is a lawful one, says **Rafael Villalobos, Jr.**, JD, attorney at Buchanan Ingersoll & Rooney. If a law enforcement officer believes a patient is under the influence, observed a patient operating a motor vehicle, and the patient now is unconscious, ED providers would be within their rights to perform a blood draw and share it with law enforcement. "It would be appropriate to nonetheless request that law enforcement provide a warrant," Villalobos suggests.

This would provide additional protection to ED providers and the hospital. If law enforcement says there is no time and that the evidence is literally dissipating by the minute, Villalobos says EPs should document the name of the officer involved, names of any witnesses present, and specifics on the representation made by law enforcement related to exigent circumstances. "This provides optimal protection for the providers involved," Villalobos adds. ■

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Opioid Prescribing Cropping Up in ED Malpractice Claims

The ED was the second most common location where opioid-related events occurred, according to the authors of a recent analysis of malpractice claims.[1]

The authors studied five years of closed claims, which included 165 patient events involving opioids. Half of all cases involved a high-severity patient injury, including death. The top opioids involved were fentanyl, hydromorphone, oxycodone and acetaminophen, and morphine. Many claims (41%) cited errors in screening and prescribing. More than half of patients in this group had either psychiatric or substance abuse history.

The following factors repeatedly came up in malpractice claims involving opioids in the ED setting, says **Ann Lambrecht**, RN, BSN, JD, a co-author of the report:

• No one checked the state's prescription drug monitoring program (PDMP). Except for Missouri, all states now have some form of PDMP in place.[2] These databases alert EPs if someone already has received multiple prescriptions for opioids. In one such case, a married couple came frequently to an ED, always complaining of pain — and always leaving with narcotics prescriptions. When one EP became suspicious, a quick check of the PDMP revealed that both "patients" were receiving opioids from multiple providers.

"This is problematic for the prescribing physician, because a simple check of the PDMP could have avoided the multiple prescribing," says Lambrecht, a senior risk specialist at Coverys, a Boston-based provider of medical professional liability insurance.

Neither the husband nor the wife had any type of bad outcome. "But they were most likely selling the narcotics to individuals who may have," Lambrecht adds.

• The patient was not screened carefully to determine if opioids really were appropriate. Not all patients can speak on their own behalf, and those who can are not always reliable historians. Thus, EPs find themselves treating people who are taking opioids with no idea how much or when the drug was last taken. This is a dangerous situation.

"Without this information, administering certain medications becomes risky and can be fatal," Lambrecht warns.

• The EP prescribed opioids for a diagnosis for which opioids are contraindicated. "The medical evidence advises that opioids should not be prescribed for certain conditions, like fibromyalgia and uncomplicated neck and back pain," Lambrecht observes. That does not stop patients with these conditions to come to EDs asking for opioids because their prescription has run out. This puts the EP in a high-risk situation. "While opioids should not be prescribed for these conditions, abruptly stopping opioids is not advised," Lambrecht explains. "Doing so could cause severe withdrawal symptoms."

EXECUTIVE SUMMARY

The ED is a common setting for malpractice claims involving opioid-related events, according to the authors of a recent analysis. Some legally protective practices:

- Check the state prescription drug monitoring program.
- Screen patients carefully to see if opioids are appropriate.
- Consider the adverse effects of abruptly stopping opioids.

• **There is no documentation on why the EP thought opioids were appropriate.** A 52-year-old woman was evaluated in an ED for unrelenting back pain. Despite the patient's history of narcotic addiction, the EP prescribed a fentanyl patch. Soon after, the patient was found unresponsive at home and was unable to be resuscitated.

"If the ED physician felt that narcotics were still appropriate, careful documentation would be critical in the defense of this case," Lambrecht offers.

There are two pieces of information that are particularly important to chart: the reason for prescribing and an indication that the patient was educated on the dangers of overdosing.

• **No one performed a urine or blood screen before administering opioids.** "This can result in adverse drug reactions," Lambrecht cautions.

• **No one contacted the patient's primary care provider.** "This could give rise to a number of risks," Lambrecht notes. "Chief among them may be the patient's prior adverse reactions to opioids."

• **ED providers failed to appropriately monitor patients on IV opioids.** "This can lead to fatal outcomes," says Lambrecht. "But it is challenging to do in a busy ED."

Recent prosecutions of physicians for inappropriate opioid prescribing have some EPs worrying about criminal charges if they prescribe opioids to anyone. This is unlikely, says **Tony Yang**, ScD, LLM, MPH, lead author of a recent paper on this subject.[3]

The central issue is whether the EP followed relevant regulations and guidelines for opioid prescribing. "The physicians with high legal risks are those with large doses, large numbers of prescriptions, frequent prescriptions, and an inability to document necessity," says Yang, professor and the executive director of the Center for Health Policy and Media Engagement at George Washington University School of Nursing.

Malpractice lawsuits against EPs for inappropriate opioid prescribing are uncommon, according to Yang. For criminal cases, the bar is even higher. "The physician has to engage in prescribing outside the usual and customary course of medical practice, for nonlegitimate reasons," Yang explains.

One former EP opened multiple clinics described as "pill mills" in the criminal complaints against him.[4] "A jury in federal court ruled him responsible for the overdose deaths of four of his patients," Yang notes. In 2012, he was sentenced to four consecutive life terms in prison.

Any EP who prescribes huge amounts of opioids, at higher-than-average doses, with multiple overdose deaths associated with those prescriptions, likely will be the target of an investigation. "Unless you have that kind of situation, you're not likely to be a target of criminal prosecution," Yang says.

Yet, EPs' opioid prescribing can come up during malpractice litigation, even if it is not the main focus of the lawsuit. "If plaintiffs can show that a reasonable EP would not prescribe opioids in the situation, or not as many and/or frequently, they will have a strong malpractice case," Yang suggests. ■

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Likeability of Plaintiff, Defendant Can Influence Med/Mal Outcomes

Every ED lawsuit involves an important, intangible factor: the "likeability" of the plaintiff and the defendant. In malpractice litigation, "sympathetic or unsympathetic parties are extremely important, just like a candidate's personal appeal is important in politics," says **Michael M. Wilson**, MD, JD, a Washington, DC-based healthcare attorney.

Even if a case against an EP is technically strong, it can prove unwinnable if the plaintiff is unsympathetic. The same is true if the EP is charismatic. Recently, a particularly strong malpractice case ended up with a defense verdict.

"The defendant physician testified, and the jury obviously liked him," Wilson reports. During opening and closing statements, defense counsel

EXECUTIVE SUMMARY

How sympathetic parties to a lawsuit are can influence the outcome of ED malpractice litigation. If faced with an affable plaintiff, the defense can:

- express sympathy in opening and closing statements;
- remind the jury that verdicts cannot be based on sympathy;
- remain polite and professional.

can make it clear they sympathize with the patient. Concurrently, counsel can remind jurors that their verdict cannot be based on sympathy. The best approach, says **Ashley Dobbin Calkins**, JD, is to "remain polite and professional and avoid personal digs against anyone."

For instance, a defense attorney might say, "There is no doubt Ms. Jones is a kind woman and loving mother. That is not the question for you to consider. Instead, your job is to consider the evidence, and apply the law as the judge instructs you."

"Treating the plaintiff and his or her family very respectfully makes an attorney seem more sincere when asking the jury not to rely on sympathy in rendering a verdict," says Calkins, an attorney in the Richmond, VA, office of Hancock Daniel.

Likewise, expert witnesses are more effective if they treat opposing parties with compassion, according to **Ken Zafren**, MD, FAAEM, FACEP, FAWM, clinical professor in the department of emergency medicine at Stanford University Medical Center. "For a defendant's expert, this could include acknowledging the suffering, disability, or death of a patient, and the suffering of the patient's loved ones," Zafren says.

A plaintiff's expert can note that the defendant EP is not necessarily incompetent or heartless, but nevertheless, made a mistake that harmed a patient.

"It is counterproductive to minimize a patient's outcome or to vilify a caregiver," Zafren says.

The defense attorney may be tempted to blame a patient who did not follow instructions. Some plaintiff attorneys imply that the EP did not really care what happened to the patient. Such statements can backfire easily.

"Unkind or snide remarks against either side can be poorly received by the jury," Calkins warns.

A case with a terrible outcome naturally engenders sympathy for the plaintiff. To counter this, the defense "has to show that the EP truly cared about the patient, and took actions to try to avoid the bad result from happening," Wilson explains.

Some ED cases include facts that are so bad, and an EP defendant that is so unsympathetic, that the case cannot be defended.

"The best course of action is to settle the case before depositions are conducted that could cause the physician to have licensure problems," Wilson recommends.

Because of soaring expenses, caps on verdicts, and legal hurdles such as prefiling requirements, "most medical cases being filed now involve catastrophic, or at least severe, permanent injuries," Wilson observes.

The defense team cannot simply ignore the plaintiff's catastrophic injuries, such as permanent blindness, brain damage, or paralysis. These need to be acknowledged sensitively. "However, the defense team can show, through expert testimony, that the injury frequently is known to occur despite the best care," Wilson says.

A likable plaintiff with a terrible outcome is a difficult case to defend. That does not necessarily mean settlement. "In my experience, virtually every case has a sympathetic plaintiff," Calkins reports.

There may be other reasons to consider settlement. Difficulty obtaining solid support from expert witnesses or a truly catastrophic injury are among these. In such cases, says Calkins, "an extremely sympathetic plaintiff can factor into negotiations, and could even impact the settlement amount." ■

Defensive Charting Can Lead to Unintended Consequences for Everyone

A seemingly innocent statement such as "EP informed of changes" often is found in ED nursing notes, referring to the patient's deteriorating mental status, pain levels, or vital signs. "That type of chart entry does create legal issues. It sets the ED provider up for a claim that she or he actually knew what the changes were," says **Mark Kadzielski**, JD, a partner at BakerHostetler in Los Angeles. If a bad outcome happens, the chart entry can bolster allegations that the EP did not meet the standard of care.

"No one's needs are served by such 'finger-pointing' documentation," Kadzielski offers.

Many times, EPs are unaware of what nurses have documented at the time of the ED visit. They sometimes even struggle to find the nursing documentation at all.

"The EMR can be confusing to locum tenens providers in the ED, as well as other providers like consultants, who don't regularly work in the ED," Kadzielski notes.

If EPs do not see the nursing notes, they will not be able to address statements claiming they did nothing to address a patient's deteriorating condition.

"From a defense perspective, conflicting entries on a patient's chart are often cause for concern," says **Steven A. Medina**, Esq., an attorney in the Philadelphia office of Conrad O'Brien.

The EP in question may find out about the nursing notes only after someone sues, and those notes are produced in discovery.

"In the context of litigation, a physician who is unfamiliar with a particularly informative nursing note may find him or herself backpedaling if familiarity with the note may have changed a critical decision and, potentially, the patient's outcome," Medina explains.

The nursing documentation can paint a picture of an arrogant, uncaring EP. An EP's thorough documentation showing all available information was considered can refute this.

"Defensive documentation does not help the patient," Kadzielski says. "It can backfire on the person and/or the institution where it happens."

The better practice is for ED nurses to articulate any concerns regarding an EP in an incident report to risk management, Kadzielski recommends: "That is outside of the patient record, and is protected from discovery." ED nurses inform the EP about a patient's low potassium level, but the EP chooses not to treat it. The ED nurse writes, "Doctor notified of lab result, and does not want to give a potassium supplement."

"Nurses will use this terminology as a method to take the onus off of them and onto the practitioner when a patient condition changes," says **Mary Parsons-Snyder**, MBA, RN, patient safety analyst and consultant at the ECRI Institute. Many ED nurses believe these kinds of statements protect them legally. That is a mistake, Parsons-Snyder warns.

The reality is that placing blame on another ED provider can hurt everyone named in a lawsuit, including the nurse. Parsons-Snyder says a "strong culture of safety" in the ED includes these practices:

- ED nurses and EPs should engage in a dialogue if one provider disagrees with another's assessment;
- ED nurses should know how to use the chain of command to address issues they believe are detrimental to the patient;
- EPs should understand that ED nurses are trained to document what is going on with the patient and to whom they communicated the information.

If, instead of following these practices, ED nurses choose to point fingers at the EP in the chart, says Parsons-Snyder, "they are not thinking ahead to the potential consequences for everyone during litigation." ■

EXECUTIVE SUMMARY

ED nurses' defensive charting can backfire legally on all involved parties. Instead, to avoid increasing legal exposure, ED nurses can:

- articulate concerns about an EP's lack of response in an incident report to risk management;
- engage in a dialogue with the EP if there are disagreements on assessment;
- use the chain of command to address patient care issues.

ED Defense Can Counter Opposing Expert's 'Flagrantly False' Testimony

Expert witnesses in malpractice litigation, regardless of whether they are testifying for the plaintiff or the defense, are supposed to be unbiased and offer truthful statements. Yet, some testimony is "flagrantly false," says **Andy Walker**, MD, FAAEM, a Signal Mountain, TN-based EP who offers legal consultations on the defense of EPs.

In some ED cases, plaintiff experts make misleading statements about the legal standard of care. In one case, an expert testified that a patient with abdominal pain should have undergone a CT scan. The expert claimed this was the standard of care; therefore, the EP was negligent. "If that was true, it would have mandated a CT scan for every ED patient with abdominal pain. Of

course, that's ridiculous," Walker offers.

The volume of people presenting to EDs with abdominal pain, and the increased cancer risk from radiation from unnecessary CTs, would make this impossible and ill-advised. "If you point that out to the jury, they usually get it," Walker explains.

Jurors came back with a defense verdict. "The defense expert rebutted the plaintiff expert's testimony, and explained to the jury which abdominal pain patients get CT scans, and why scanning everybody would do more harm than good," Walker recalls.

Some plaintiff experts are "blinded by hindsight bias," Walker observes. If someone with abdominal pain turns out to be the rare patient with an ischemic bowel and sues the EP, the plaintiff expert already knows how the case turned out. It is easy to ask questions like, "How could you not undergo a CT scan? This person was in such terrible pain."

The defense team always can call their expert back to the stand to refute what the plaintiff expert stated. "The defense expert should use peer-reviewed evidence to back up what they are saying," Walker suggests. Another plaintiff expert testified that a patient with back pain who turned out to have an epidural abscess should have undergone a CT scan. The expert asserted the EP breached the standard of care by not obtaining the scan.

Walker, the opposing expert, talked about the reality of ED clinical practice. He noted that an EP would have to see 1,000 or more patients with back pain before finding just one person with an epidural abscess. This testimony allowed the defense attorney to tell jurors, "If you rule for the plaintiff in this case, you're going to tell emergency physicians that they have to get CT scans for every patient with back pain, which increases cancer risk. Think about the message you're going to send to doctors with this verdict."

Some plaintiff experts have not worked in an ED in decades, if ever. This does not stop some of them from testifying about the standard of care in the ED. "They don't realize how little they know about emergency medicine," Walker says.

The problem, of course, is that most jurors will not realize it, either. "Laypeople can't sort through medical evidence themselves. All they have to go on is what the experts say at trial," Walker observes.

The question, "When was the last time you worked in the ED unsupervised?" can be effective. "Some experts claim that admitting patients from the ED or taking phone consults or transfers from the ED qualifies them to testify on emergency medicine," Walker notes.

In the end, jurors will go with the expert they find most credible and believable. "Most experts are not unethical. But occasionally you do find one who is just going to say anything for money," Walker laments.

The defense team can diminish the expert's credibility with questions such as:

- How many cases have you testified in?
- How many cases in the last year?
- How many were for the plaintiff?
- How much money do you make in a year from legal work compared to your total income?

"If the expert is clearly earning their living by testifying in malpractice cases, they are going to be much less credible," Walker says. ■

Analysis Reveals Med/Mal Risks for Antibiotics Administered in ED

Prescribing antibiotics was associated more often with malpractice claims than failure or delay to prescribe antibiotics, according to the authors of a recent analysis.[1]

"These findings may be surprising to clinicians who tend to err on the side of prescribing an antibiotic when there is an uncertain diagnosis and the patient is not very ill," says **Sarah Kabbani**, MD, MSc, the study's lead author and medical officer at the CDC's Antibiotic Stewardship Office.

Researchers analyzed 767 antibiotic-related malpractice lawsuits from 2007 to 2016. About 11% of these claims involved the ED.

"Fear of medical liability is often cited by clinicians as a cause for unnecessary or inappropriate antibiotic prescribing," Kabbani reports.

However, evidence on actual legal risks of failing to give antibiotics is lacking.

Part of the problem is that both clinicians and patients frequently believe that taking an antibiotic is the safest practice in cases where it is unclear if antibiotics are needed.

"Recent data describing a high frequency of adverse events and side effects associated with taking antibiotics call this belief into

question," Kabbani says. Poor communication with patients was a top contributing factor in the malpractice claims.

Kabbani says that to reduce risks of antibiotic prescribing, ED providers should carefully weigh the risks and benefits of prescribing antibiotics. They should communicate effectively with the patients and their families about antibiotic use, and ensure monitoring and follow-up of hospitalized patients on antibiotics.

"This is important to ensure that patients receive the right drug, the right dose, and the right duration," Kabbani adds. ■

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Sparsely Charted History and Physical Complicates Med/Mal Defense

Thorough charting on the history and physical (H&P) of an ED patient can prove the standard of care was met. Still, the medical record often contains little more than a series of checkboxes.

"Lack of documentation may lead to questioning of the care that occurred," says **Bryan Baskin**, DO, FACEP, associate quality improvement officer at the Cleveland Clinic's Emergency Services Institute and assistant professor at Cleveland Clinic Lerner College of Medicine.

The ED chart should clearly show what was considered, and what was ruled out, during the visit.

"This is primarily dictated by the H&P, which is where much of emergency medicine malpractice is alleged," Baskin observes.

Thoroughness in this regard leads the EP to the appropriate testing, treatment, and disposition. A poorly documented H&P leads to the exact opposite. "That is where we have less optimal outcomes," Baskin says. "When a bad outcome occurs, plaintiffs will point to a lack of H&P as to why said outcome occurred."

David Sumner, JD, a Tucson, AZ, medical malpractice attorney, warns: "If you are over-relying upon electronic record templates for charting, you may be in trouble."

An EP defendant can prevail in malpractice litigation even if the diagnosis turned out to be wrong — if the chart demonstrates sound decision-making. "Free texting, even in electronic records, is your ally," Sumner stresses.

Many times, ED template charts are silent as to the EP's rationale and differential diagnoses. "I exploit all charting omissions and irregularities at provider depositions," Sumner reports.

The EP may offer a good reason for withholding aggressive IV fluid therapy in an acute pancreatitis patient. "The contraindication to otherwise appropriate treatment needs to be charted," Sumner says.

For example, the patient might present with a history of congestive heart failure or chronic renal insufficiency.

If this is not charted contemporaneously, Sumner warns "your after-the-fact explanation will sound self-serving at deposition three years later."

Template charting makes it easy for plaintiff attorneys to paint a picture of subpar care.

"They are a real time-saver, but also a real trap," says **Mark Spiro**, MD, FACEP. "We have records that are incredibly long and complex. But it often misses what's important."

A recent malpractice case involved a man with a missed epidural abscess. The plaintiff attorney made a big issue of an incorrectly checked

box. The checkbox indicated the presence of "abnormal vaginal discharge."

"Malpractice did not occur because the emergency physician clicked the wrong box. But it did make it look like the ED care was sloppy," says Spiro, chief medical officer of the Walnut Creek, CA-based The Mutual Risk Retention Group.

Sparse, thin documentation, even if accurate, is just as problematic. If all the ED chart shows for the H&P on a missed epidural abscess patient is a bunch of checkboxes, it does not give the defense anything to work with.

"We have had a number of cases where it was just a templated exam," Spiro recalls.

For instance, documentation on the neurological exam merely indicated "cranial nerves normal" and "no focal neural findings." It did not say whether the patient could walk.

"This has come up on more than one occasion when patients had spinal masses. It has led to really bad outcomes for patients, as well as really large settlements," Spiro says.

The same issue arises with cardiac workups. Several cases of missed aortic dissection lacked any evidence in the ED chart indicating the EP checked for abnormal pulses. On this crucial point, the template offered little in the EP's defense. There were only generic comments such as "cardiac exam normal" and "no murmurs or extra sounds."

"There was no detail," Spiro says. "It really doesn't help us when the exam is so skimpy." Considering that a lawsuit happens many months after the ED visit, it is doubtful an EP defendant recalls the patient or the specifics of the case. Thus, the EP who documented with checkboxes and no narrative is left with one unappealing option: To say it is their "usual and customary" practice to check pulses.

This was the EP's testimony in a recent malpractice claim. The plaintiff attorney focused on the complete lack of documentation on assessment of pulses.

"The attorney said, 'You didn't have two minutes to check this, and it would have saved the patient's life? The patient's life was not worth two minutes?'" Spiro recalls.

Conducting a careful neurological exam as part of the H&P, and documenting it just as carefully, gives the EP a strong defense in the event something is missed.

"If there is a bad case, it can help the defense to show that you were thorough," Spiro suggests.

Also, there is a more intangible benefit to this kind of narrative charting. "It forces the emergency physician to slow down for a moment to document the findings," Spiro adds.

In some cases, taking a minute to write something about the evaluation may cause the EP to rethink the patient's disposition entirely. Possibly, the back pain patient's story is suggestive of a spinal mass or cauda equina syndrome, at least enough so to cause the EP to hold off on discharge or to order an additional test.

"By documenting, you are also thinking about it, and then you look for it," Spiro explains.

The patient might register an unexplained low-grade fever or mild tachycardia.

"By putting a little bit of narrative in your medical decision-making that kind of describes what you are thinking, you could be preventing a devastating injury for the patient," Spiro says.

Lack of clarity as to timing of when the evaluation occurred also is problematic for the defense. In one case, an intoxicated woman was brought to an ED, and the template charting indicated an inability to move her left side.

"The patient was too uncooperative to examine in any but the most cursory manner," Spiro says.

Later, the EP testified this worrisome finding was noted four hours after the patient's arrival. The checkbox-style charting did not indicate one way or the other. This allowed the plaintiff attorney to argue the finding was there at the time the patient arrived.

This possibility made it difficult for the defense to refute the main allegation in the lawsuit, that delayed diagnosis of stroke caused the patient to miss the treatment window for tPA.

The EP continued to insist there was no such finding at the time of presentation, but there was nothing in the chart to prove it. The case settled out of court for an undisclosed amount.

"In almost all of these cases, we do the right thing," Spiro says. "We do the neuro or cardiac exam. We just don't document it." ■

COMING IN FUTURE MONTHS

- Plaintiffs use "loss of chance" to prevail in ED lawsuit
- "Copy and paste" can legally compromise entire ED record
- Legal disasters involving ED patients on cardiac monitors
- Allegations in successful missed pulmonary embolism cases

Claims Allege ED Failed to Diagnose Fracture; Cases Feature Similar Fact Patterns

Not surprisingly, orthopedists were the most frequently named specialty in fracture-related malpractice lawsuits, according to the authors of an analysis of claims occurring from 1988 to 2015.[1]

While 88% of the 201 lawsuits included in the analysis named orthopedists, EPs were defendants in eight cases.

"EPs are certainly at risk, due to the fact that they are on the frontlines when these patients come in," says **Alan H. Daniels**, MD, one of the study's authors and an assistant professor of orthopaedic surgery at Brown University's The Warren Alpert Medical School.

Researchers used "orthopedic" as one of the search terms in the medicolegal database. Thus, relatively few cases naming EPs were identified. "We likely could perform additional studies looking just for emergency physicians, and find many more with similar findings," Daniels offers.

Often, trauma patients are left with permanent disability and inability to work.

"Essentially, they are looking for someone to blame, hold accountable, and help with their finances. They will often do that with lawsuits," Daniels observes.

Even if an EP was not directly responsible for the bad outcome, a plaintiff may be able to apportion some blame onto the EP.

"The paper's data show that people with neurological injuries are more likely to sue and win in court," Daniels reports. He says this finding underscores the importance of handling these tasks immediately if ED patients appear to exhibit any type of neurological deficit or vascular injury:

• Obtain appropriate imaging. This includes an X-ray of the fractured bone, including the joint above and below.

"Consider CT angiography if there is vascular injury, but don't delay orthopedic and vascular surgery consultation to get it," Daniels advises.

• Obtain appropriate consultation from whatever services are necessary.

"Get rapid orthopedic and vascular surgery consults if there is concern for vascular injury," Daniels says.

• If consultation is unavailable, transfer the patient to a facility where it is available.

"Stabilizing the fracture with splinting is always an essential first step, whether the patient has a neurological or vascular injury or not," Daniels adds.

Failure to diagnose a fracture is the most common allegation in ED malpractice claims related to orthopedic injury, says **Jill M. Steinberg**, JD, a shareholder at Memphis, TN-based Baker Donelson.

Many of these claims share similar fact patterns. Typically, someone visits an ED after a fall or other injury, and one of two things happens: Someone performs an X-ray of the affected bone, or someone performs an X-ray, but the EP misses the fracture.

The radiologist's overread, conducted the following day, becomes a central issue in the resulting malpractice claim. The plaintiff can prove the EP missed the fracture during the first read. By the time the radiologist identifies the fracture, the patient has been discharged.

Steinberg says two practices, if performed consistently, can help prevent malpractice lawsuits:

• The radiologist should communicate directly to the EP who ordered the test;

• The EP who ordered the test should take responsibility for notifying the patient personally.

Busy EPs often rely on hospital staff to handle this important latter task.

"We have had cases where messages were left on answering machines that were not picked up," Steinberg recalls.

Sometimes, the hospital employee who originally called the patient goes off shift. The oncoming shift does not realize nobody ever contacted the patient successfully. Thus, the patient never receives a proper notification about the fracture. ■

REFERENCE

1. Ahmed SA, DeFroda SF, Naqvi SJ, et al. Malpractice litigation following traumatic fracture. *J Bone Joint Surg Am* 2019;101:e27.

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

ED LEGAL LETTER™

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CME/CE QUESTIONS

1. **Which is true regarding a recent Supreme Court ruling on blood draws requested by law enforcement?**
   a. No warrant is legally necessary for a blood draw if police bring in an unconscious person suspected of driving intoxicated.
   b. ED providers must have a warrant to draw blood from a conscious patient, regardless of whether the patient consents.
   c. In determining whether the blood draw is a lawful request, it is irrelevant whether the patient is conscious or unconscious.
   d. ED providers now have more legal protection when drawing blood from a conscious patient who refuses.

2. **Which is true regarding legal risks of opioid prescribing in the ED?**
   a. Patient privacy regulations make checking prescription drug monitoring programs legally problematic for EPs.
   b. EPs cannot be held liable for bad outcomes resulting from administering opioids if the medical record shows the patient failed to disclose that they were taking opioids already.
   c. Criminal charges are unlikely if EPs follow relevant regulations and guidelines for opioid prescribing.
   d. Documentation that the EP informed the patient of the dangers of overdosing is highly likely to be used as evidence against the EP, since it shows the EP anticipated a bad outcome.

3. **Which is true regarding ED nursing documentation?**
   a. Repeated entries noting that a specific EP was informed of a patient's deteriorating condition shield the hospital from liability.
   b. Concerns about an EP's responsiveness to nursing communications should be documented in the chart rather than shared in an incident report to risk management.
   c. ED nurses should know how to use the chain of command to address issues they believe are detrimental to the patient.
   d. Incident reports to risk management involving an EP's lack of response generally are not protected from discovery.