

Risk Management Monthly / Emergency Medicine

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Guest Commentator

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1. Trends in Malpractice Litigation in Emergency Medicine

- **Complications of Sepsis** – Initial treatment with pressors can be indicated in the patient with hemodynamic instability, but these agents can be associated with an increased risk for ischemic changes requiring amputation of digits or extremities. Because it is not possible to identify the patient at increased risk for this complication in advance, and because such complications are associated with increased liability, cautious use of pressors in the septic patient is advised. Revised 2012 guidelines narrow the spectrum of recommended pressors.
 - The development of sepsis protocols has increased the risk of medicolegal liability. Failure to follow protocols for early goal-directed therapy is often cited by plaintiffs' attorneys.
 - Although the sepsis protocol has become a political reality, more recent studies are questioning the merits of selected components of the protocol, suggesting that harms might outweigh benefits of some recommended interventions. There is no question that early fluids and antibiotics are important, but some of the remaining practices included in the protocol are being questioned.
 - Medicolegal risk might be mitigated if physicians do not comply with elements of the sepsis bundle that have been effectively discredited.
 - The criteria for "systemic inflammatory response syndrome" (SIRS) include two or more of the following: a temperature above 38C (100.4F) (or below 96.8F), a heart rate above 90/minute, a respiratory rate above 20/minute and a white blood cell count above 12,000 (or below 4000) or a band count above 10%. Some straightforward and easily treatable infections might fulfill two of these criteria. Might one be liable for failing to treat for sepsis in such cases? For example, patients with strep throat infections routinely have fever and tachycardia.
- **General Issues Relating to Protocols**
 - Many protocols that have been developed based on evidence that is available at the time of initial implementation are subsequently systematically dismantled by further scientific research. Protocols change as research advances. The ACLS protocol, for example, has undergone substantial changes since its initial publication.
 - ✓ It is now recognized that traditionally recommended ACLS drugs such as amiodarone, epinephrine, lidocaine and atropine don't significantly increase the likelihood of survival.
 - ✓ In "Implementation of the Fifth Link of the Chain of Survival Concept for Out-Of-Hospital Cardiac Arrest" (Circulation 126[5]:589, July 31, 2012), Tagami, et al, reported that, in addition to bystander CPR, early defibrillation and early advanced life support, the addition of a "fifth link" (multidisciplinary post-resuscitation care in a regional center) significantly improved survival with a good neurologic outcome after prehospital cardiac arrest. Elements of post-resuscitation care included appropriate hemodynamic and respiratory management, therapeutic hypothermia and PCI when indicated.
 - ✓ Although not yet formalized or implemented, the American Heart Association has already developed criteria for designation of regional centers.
 - The individual directing treatment (e.g., an emergency physician) is responsible for obtaining informed consent. When there is a scientific basis for doubting the safety and efficacy of a protocol (e.g., thrombolytic therapy for stroke), the manner in which the informed consent discussion is presented can influence perceptions regarding the advisability of the treatment on the part of a patient or his/her family.

- Family presence during attempted resuscitation, which allows family members to witness treatment efforts and perhaps to better understand a bad outcome, might serve as a good risk management tool. This strategy is widely supported in the literature.
- Spinal Epidural Abscess – As has been previously noted in *RMM*, the frequency of this condition has been skyrocketing. Although it was once essentially limited to IV drug abusers, current widespread use of implanted hardware and immunosuppressive drugs expands the population at risk. Without a high index of suspicion it is very easy to miss this diagnosis.
- Electronic Medical Records
 - The paper “Medical Malpractice Liability in the Age of Electronic Health Records” by Mangalmurti, S.S., et al (N Engl J Med 363[21]:260, November 18, 2010) outlined the possible problems associated with three distinct phases of EMR implementation:
 - ✓ Initial implementation may be associated with gaps in documentation during the transition from paper to electronic records, errors due to inadequate training in data entry and communication failures, and vulnerability due to failure to implement procedures to avoid errors and/or failure to use the system consistently. Unanticipated “bugs” in the system might also adversely affect patient care.
 - ✓ As use of the system progresses, malpractice risk might be increased by provision of email advice without adequate patient evaluation, the creation of additional discoverable data for plaintiffs’ attorneys, perpetuation of mistakes through use of a “copy and paste” function, information overload, and a physician’s departure from the system’s clinical support algorithms.
 - ✓ Finally, widespread use of a system might place a provider at medicolegal risk resulting from an increased duty to act based on enhanced clinical information, solidification of debatable “standards of care,” and an increased duty to access patient information generated by other practitioners.
 - Multiple papers have been published on the potential pitfalls of EMRs. Multiple “clicks” are often required to generate even a simple order, increasing the potential for errors.
 - Read the nurses’ notes! EMRs generate voluminous amounts of data. Nurses’ notes, in particular, tend to be very repetitive and result in lots of paper. One must carefully scrutinize these notes in order to avoid missing any disagreement between provider entries or perceptions of the patient’s progress and those of the nurses, or any important “gems” for plaintiffs’ attorneys that a nurse might document.
 - The workflow changes with EMR use. In many situations, nurses enter important data (such as vital signs) after the patient has been discharged. When this occurs, the physician might be unaware of signs of a patient’s deterioration. In malpractice litigation, it will be the physician’s responsibility to explain why he or she didn’t have timely access to the data.
 - Acceptance of guidelines and pathways built into the EMR can establish a false standard of care, and the physician can get into trouble by failing to follow these standards.

2. How Does EMP Prepare a Generalist Advanced Practice Clinician for Practice in the ED?

- Many advanced practice clinicians (APCs) are entering the emergency medicine workforce due to a shortage of emergency medicine physicians and the desire to have appropriate level providers care for ED patients. Many may have little experience in emergency medicine. Due to time constraints, physicians might be tempted to disengage themselves from care provided by an APC in the ED based on an erroneous belief that their liability is limited if they limit their involvement. Every chart signed by a physician confers a certain level of responsibility, and exposure to liability for that physician, and malpractice cases in which both a physician and APC are named are on the increase.
- Physician assistants are required to have a supervising physician, although the definition of supervision is quite variable. Although nurse practitioners might not be so required (NPs can function independently in more than 26 states), the employer of the NP in the ED can establish levels of supervision in excess of state laws.
- Educational programs have been developed for plaintiffs’ attorneys regarding methods of prosecuting their cases when APCs are involved (what questions to ask, methods of challenging the care). What’s more, rising healthcare costs have generated resentment on the part of lay

jurors towards the healthcare profession, and the legal community is taking advantage of this attitude in the venue of malpractice litigation.

- The hospital and/or the physician group can be held liable if APCs are hired to work in the ED with inadequate orientation, training and supervision, depending on which of the two entities has hired the midlevel provider. It is important to develop this workforce resource so that it is an appropriate one for the ED environment. It is risky for the physician to assume that a newly hired PA or NP is qualified to provide many aspects of ED care. It is important to develop a structured orientation and policies for new APCs to ensure that they are effectively incorporated into the emergency medicine group.
- Although it might be ideal for a physician to see every patient presenting to the ED, this might not be the most efficient strategy. Every group should develop a list of high-risk conditions that must be seen by a physician. If an APC is appropriately trained, there is likely to be a subset of conditions that can be safely treated by an APC without physician involvement, but it can be a challenge to identify this subset of conditions. Use of a validated triage instrument, such as the Emergency Severity Index, can be helpful in developing a list of conditions to be seen by a physician. However, if an APC requests that a patient should be seen by a physician, this should be respected regardless of the patient's triage category. In addition, if the patient requests a physician, such requests should also be honored when possible.
- EMP is highly focused on risk management. All of their physician employees are invested in the group's proprietary malpractice insurance company so that they are incentivized to be cognizant of risk management issues. Training in risk management for physicians and APCs includes:
 - Mandatory attendance at EMP's High Risk in Emergency Medicine course during the first year of employment.
 - Completion of a 26-hour risk management orientation program at the start of employment.
 - Participation in periodic risk management and practice improvement programs.

3. What is the Ideal Staffing Model in the ED?

- Personnel account for nearly 80% of healthcare costs in the US. There is no set formula that dictates the safest and most cost-effective personnel package in the ED. It is important to make certain that the department has the optimal balance of quality care, risk management and cost-effectiveness.
- According to a summary of this issue by Dr. Klauer to be published in a future issue of the Canadian Journal of Emergency Medicine, the average compensation for providers working full time in the ED is about \$130,000 for an APC vs. \$250,000 to \$300,000 for a physician. It might be tempting to over-staff with APCs to save money, but costs cannot be the only consideration. Having the right balance, with policies and procedures in place, is of prime importance.
- The importance of hiring the right personnel, selecting the right high-risk presentations for physician involvement and developing protocols is stressed.
- Defining the appropriate scope of practice for APCs and ideal staffing levels would best be done by an organization like ACEP. It would be less than optimal if these variables were determined by others outside of the emergency medicine community.

4. Cases

- The panel solicited Dr. Klauer's opinion about a case discussed last month involving a patient with a finger laceration who was taken to a sink in the ED to wash out the laceration who fainted, struck his head and sustained significant chronic neurologic sequelae. Dr. Klauer suggested that the doctor should not be held liable unless he (or she) was the person who instructed the individual to go to the sink. He further suggested that it's prudent to develop a protocol for these situations, possibly mandating that someone from the department accompany the patient in these circumstances. It might be prudent to include a checkbox in the chart to indicate that the patient has been asked about his/her ability to ambulate or to target those patients who are perceived to be at increased risk for syncope or a fall. But in reality, these vasovagal syncope spells may be very hard to anticipate.

- In a case reported in the LA Times, an internist was sued by the family of a 90-year-old “boyfriend” of an 85-year-old driver with dementia who was killed in an accident caused by the driver. It was alleged that the internist had a duty to report the driver to the DMV or other authority, as he had been treating the driver with anti-dementia drugs for several years.
 - Some states require reporting of such patients and others do not. Be aware of the laws in your state. This case appears to involve the duty to warn a third party. It is estimated that by 2030 there will be 57 million drivers over the age of 65 in the US. Drivers aged 75 and older have been found to have the highest likelihood of involvement in a fatal crash.
 - If failure to report is a criminal offense in your state, your malpractice insurance might not cover you in this situation, as malpractice insurance generally addresses civil cases only.
 - Also be aware of the medicolegal implications of prescribing medications that can alter a patient’s ability to drive and failing to advise the patient of this effect (and documenting the discussion)
- Missed appendicitis – Most physicians would consider appendicitis in a younger patient with abdominal pain. In this case, a 75-year-old woman presented with slight nausea and abdominal discomfort with no positive clinical findings. She was reassured by the ED physician and instructed to see her PCP the next day. The family physician diagnosed constipation. She presented a week later with a large abdominal abscess on CT.
 - Be very careful with the elderly patient reporting abdominal pain. Surgical disease is always a consideration. Have a lower threshold for doing a work-up.
 - Because the principal concern in the older patient with abdominal pain is a surgical condition, be sure to refer the patient to the correct clinician for follow-up. An internist does not specialize in surgical disease. It would be prudent to instruct such patients to return to the ED within a prespecified time, or to refer them to a surgeon.
 - Don’t allow your opinions to be influenced by the diagnosis of another physician.

5. Patient Surveys

- The HCAHPS Survey – CMS mandates that a certain percentage of patients admitted to the hospital complete a survey about the care that has been provided, including pain management (which is very relevant to the ED setting). Results are publicly reported.
- As a provision of “Obamacare” beginning in May 2013 patients will be permitted to report complaints about their care directly to the federal government. This can be quite problematic. A patient’s perceptions of your level of caring can be very subjective. What’s more, patients might be qualified to voice their perceptions about your level of caring but they are not necessarily qualified to judge quality of care. Examples of items on the pilot reporting form include: did the physician communicate well with the patient and family; did the physician respect the patient’s race, language or culture; did the physician seem to care about the patient; did the physician seem to be “too busy;” did the physician spend enough time with the patient; did providers fail to work together; were providers unaware of care received elsewhere.

Wine of the Month

This month we’re recommending another reasonably priced California wine. This one is from Tatomer Vineyards in Santa Barbara County, a producer of dry riesling wines. Their Vandenberg Riesling (so named because most of the fruit comes from a ranch located about a mile from Vandenberg Air Force Base) is rated a 91 by Parker’s Wine Advocate, at about \$25 a bottle.

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