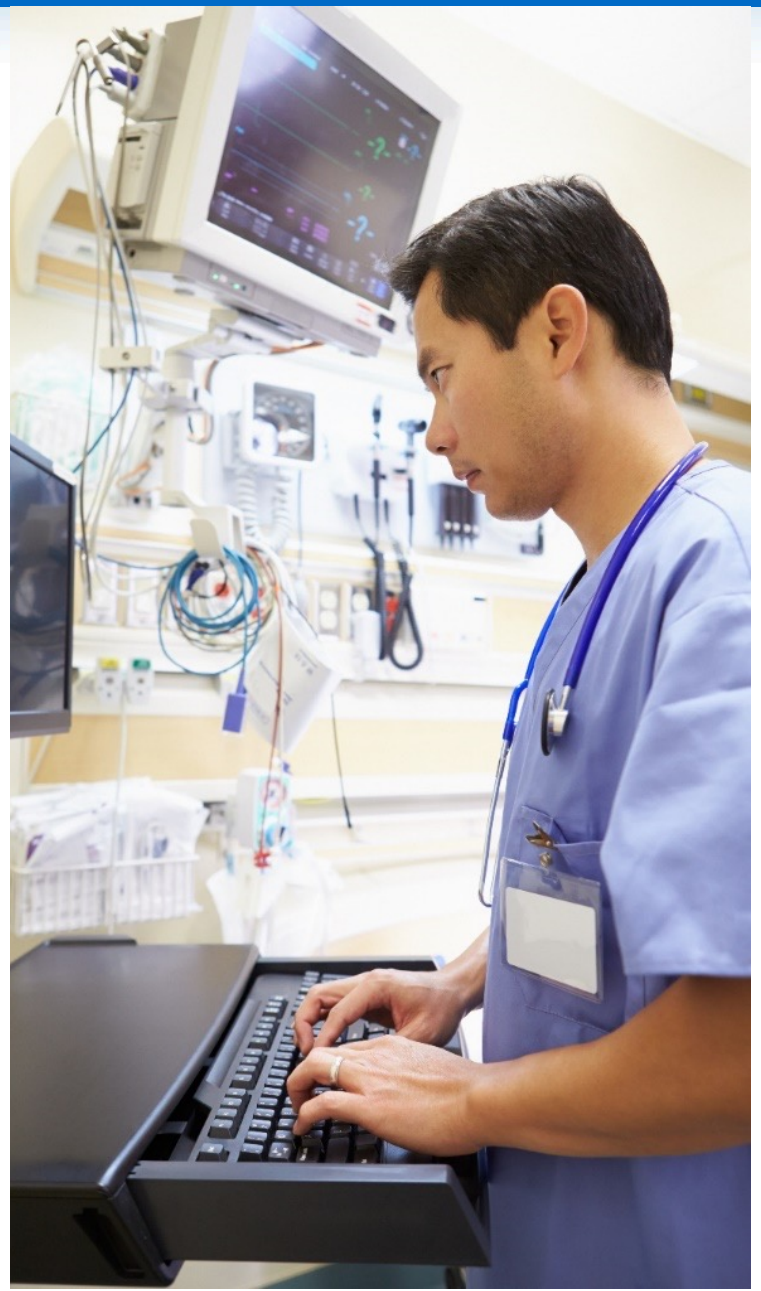
ACEP ED Medical Directors Academy: Risk Management – Define & Assess Risk

Daniel J. Sullivan MD, JD, FACEP

Case Presentation

- A 25-year-old man presented to ED with low back pain.
- Based on his history of recently lifting furniture, the emergency physician diagnosed musculoskeletal strain.
- Patient discharged on Motrin 800 mg tid, PRN follow up with physical therapy.



Case Continued

- Patient returned (Bounceback) 2 days later with worsened pain.
- Diagnosis: Spinal epidural abscess
- Patient had a lengthy hospitalization. Ultimately no malpractice claim was filed.

Cognitive Autopsy

- ED Doc never asked about a history of fever.
- Fever on the patient track board was not seen by the ED Doc.
- Temp of 102 F was auto-entered into chart but never seen by the EP.
- ED Doc did not consider a predisposition for an epidural process – patients was an IV drug user.
- ED Doc did not modify his DDx based on multiple levels of back pain.

Malpractice Claims

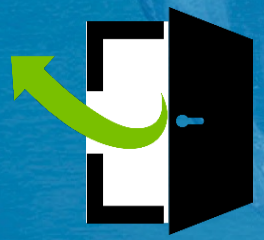
- 99% of ED practitioners sued by age 65
- 7% of Emergency Physicians sued each year
- AON national benchmark HPL cost $6.83 per ED patient

Medical Errors

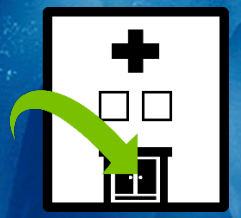
4th Leading Cause of Death in U.S.

Diagnostic Error Rate

SEA	AOD	Thrombosis	VTE/PE
62%	28%	24%	20%



9 Patients Die per 100K ED Discharges within 7 days from medical errors.



2.9% Bounceback Admit Rate many related to medical error

Key Points

- The ‘failure to diagnose’ is overwhelmingly the single greatest risk issue in emergency medicine.
- Litigation is an issue, but the sheer volume of medical errors and patient safety is far more important.

The Journal of Emergency Medicine, Vol. 55, No. 5, pp. 659–665, 2018

0736-4679/$ - see front matter

https://doi.org/10.1016/j.jemermed.2018.06.035

ELSEVIER

Clinical Reviews in Emergency Medicine

Check for updates

MALPRACTICE IN EMERGENCY MEDICINE—A REVIEW OF RISK AND MITIGATION PRACTICES FOR THE EMERGENCY MEDICINE PROVIDER

Brian Ferguson, DO, MPH,* Justin Geralds, MD,* Jessica Petrey, MSLS,† and Martin Huecker, MD*

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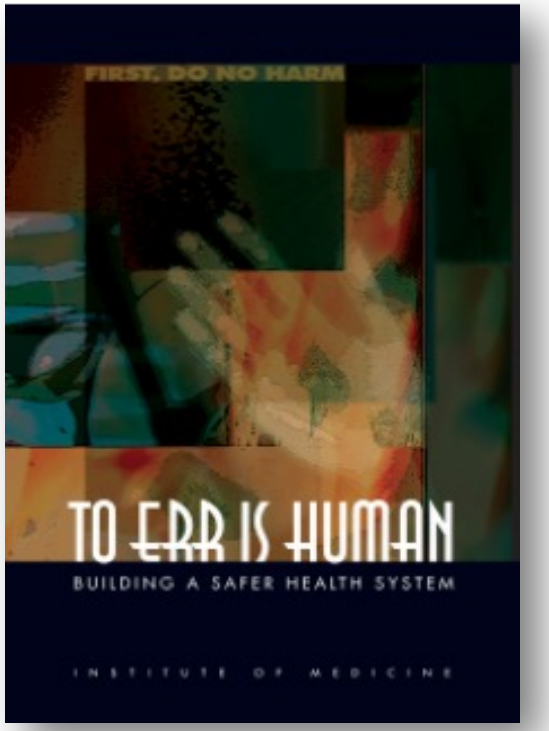
Most Recent/Largest Analysis of Claims (20 years)

- 6,779 closed EM claims
  - 4000 (65.9%) were dropped, withdrawn, dismissed
  - 1546 (22.8%) settled for an average indemnity of $297,709
  - 515 (7.6%) of cases went to trial
  - Verdict for the defense 92.6% of cases 477/515
  - 7.14% of cases 38/515 jury verdicts for the plaintiff. Average indemnity of $816,909.

Recent ‘Failure to Diagnose’ Research

The Next Frontier in Patient Safety: Diagnostic Error



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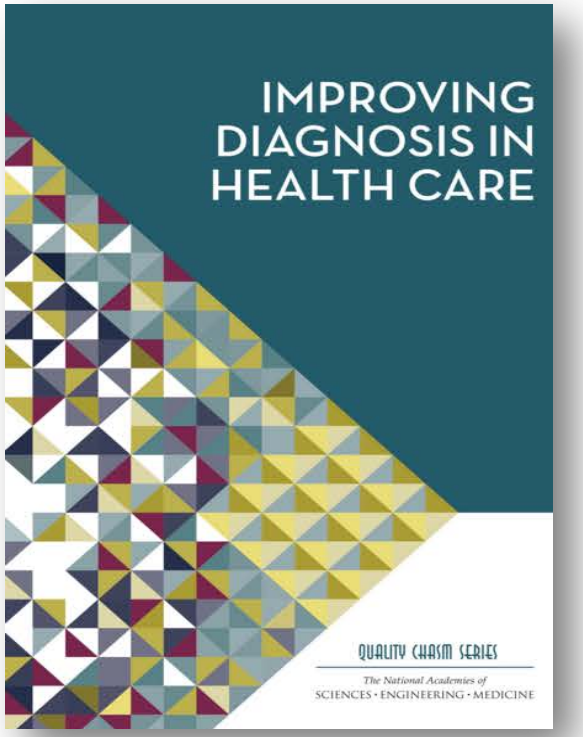


2015

The Administration and Congress Agree: Reducing Harm from Diagnostic Error is an Urgent Patient Safety Priority

Washington, March 31, 2022 –

"The President's budget recognizes and responds to growing awareness among health care quality and patient safety leaders and advocates of the foundational role that accurate and timely diagnosis plays in a safe, equitable, high-value health care system," said Dr. Ward-Robinson.

"In fact, research suggests that this previously under-recognized patient safety issue has a public health impact greater than all other healthcare-associated harms combined. SIDM remains committed to continued growth in awareness, funding, and public policies that can minimize patient harms brought about by diagnostic error," she said.

Rate of Diagnostic Errors

Diagnosis | Ahead of Print

Rate of diagnostic errors and serious misdiagnosis-related harms for major vascular events, infections, and cancers: toward a national incidence estimate using the “Big Three”

David E. Newman-Toker ✉, Zheyu Wang, Yuxin Zhu, Najlla Nassery, Ali S. Saber Tehrani, Adam C. Schaffer, Chihwen Winnie Yu-Moe, Gwendolyn D. Clemens, Mehdi Fanai and Dana Siegal ✉

DOI: https://doi.org/10.1515/dx-2019-0104 | Published online: 14 May 2020

"Big Three" Disease Diagnostic Error Rate – 1st visit misses

8.7%

VASCULAR EVENTS

Aortic Aneurysm / Dissection	27.9%
Arterial Thromboembolism	23.9%
VTE (Pulmonary Embolism)	19.9%
Stroke	8.7%
MI	2.2%

10.2%

INFECTIONS

Spinal Abscess	62.1%
Meningitis & Encephalitis	25.6%
Endocarditis	25.5%
Sepsis	9.5%
Pneumonia	9.5%

Spinal Epidural Abscess

Am J Med. 2017 Aug;130(8):975-981. doi: 10.1016/j.amjmed.2017.03.009. Epub 2017 Mar 31.

Errors in Diagnosis of Spinal Epidural Abscesses in the Era of Electronic Health Records

Viraj Bhise [1], Ashley N D Meyer [1], Hardeep Singh [1], Li Wei [1], Elise Russo [1], Aymer Al-Mutairi [2], Daniel R Murphy [3]

Affiliations + expand

PMID: 28366427 DOI: 10.1016/j.amjmed.2017.03.009

Spinal Epidural Abscess

Spinal epidural abscess (SEA) continues its long run in the top 10 most common and costly missed diagnoses. Yet another study found an extremely high rate of misdiagnosis (55%) and emphasized that the main problem lies with inadequate performance of the history, exam and test ordering for SEA.[14]

55%

Spinal epidural abscess diagnostic error rate

Neurologic Conditions

Multicenter Study > Ann Emerg Med. 2019 Oct;74(4):549-561.

doi: 10.1016/j.annemergmed.2019.01.020. Epub 2019 Feb 21.

Missed Serious Neurologic Conditions in Emergency Department Patients Discharged With Nonspecific Diagnoses of Headache or Back Pain

Nicole M Dubosh [1], Jonathan A Edlow [2], Tadahiro Goto [3], Carlos A Camargo Jr [3], Kohei Hasegawa [3]

Affiliations + expand

PMID: 30797572 DOI: 10.1016/j.annemergmed.2019.01.020

Stroke, Intraspinal Abscess, Cauda Equina Syndrome

HEADACHE and BACK PAIN
among most common chief complaints in EDs

2.5% | 2.4%
of 140M annual visits

Do the math, that's around:

3.5M
visits each

MISSED DIAGNOSES ARE FREQUENT AND LEAD TO SERIOUS DISABILITY AND DEATH.

Stroke, Intraspinal Abscess, Cauda Equina Syndrome

40K

estimated headache patients will have potential adverse diagnostic outcomes.

17K

back pain patients will have potential adverse diagnostic outcomes.

Stroke

is the most common misdiagnosed condition for patients with the chief complaint of headache.

Intraspinal abscess

is the most frequent back pain misdiagnosis (including spinal epidural abscess) followed by cauda equina syndrome.

Appendicitis

JAMA Netw Open. 2020 Mar 2;3(3):e200612. doi: 10.1001/jamanetworkopen.2020.0612.

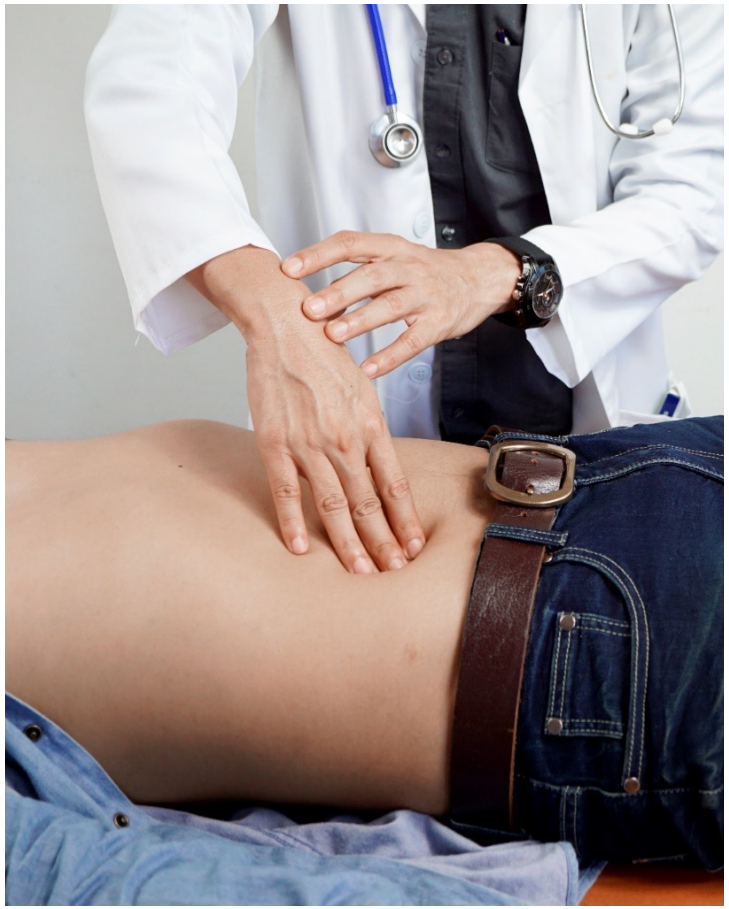
Factors Associated With Potentially Missed Diagnosis of Appendicitis in the Emergency Department

Prashant Mahajan [1], Tanima Basu [2], Chih-Wen Pai [1], Hardeep Singh [3 4], Nancy Petersen [4], M Fernanda Bellolio [5], Samir K Gadepalli [6], Neil S Kamdar [2]

Affiliations + expand

PMID: 32150270 PMCID: PMC7063499 DOI: 10.1001/jamanetworkopen.2020.0612

Appendicitis



Appendicitis never leaves the list of commonly misdiagnosed conditions due to its high incidence and frequent atypical presentations. Recent research estimated that appendicitis is misdiagnosed in about 6% of adults and 4% of children during the initial ED visit.[15] Interestingly, they also found that constipation in children with appendicitis was associated with a higher likelihood of misdiagnosis.

6% ADULTS | **4%** CHILDREN

Appendicitis diagnostic error rate during initial visit

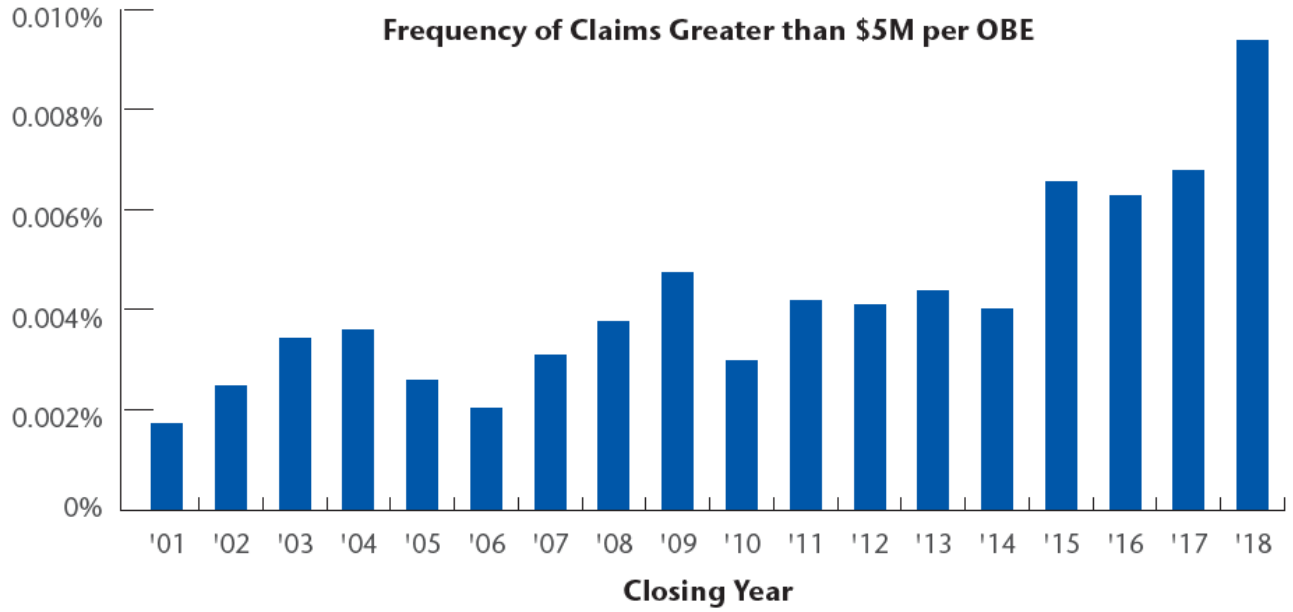
State of the Market 2020: Diagnostic Error is the Second Most Frequent Cause of Professional Liability Claims

Severity of Professional Liability Claims by Cause of Loss

Cause of Loss	Unlimited Average Claim Cost (Indemnity + Expense)	Unlimited Average Indemnity Cost	% of All Claims
Labor & Delivery Related Issue	456,000	1,121,000	6.4%
Diagnosis Error (Delay/Failure)	288,000	663,000	11.4%
Surgical Error	245,000	463,000	12.3%
Medication Related Issue	238,000	376,000	5.1%

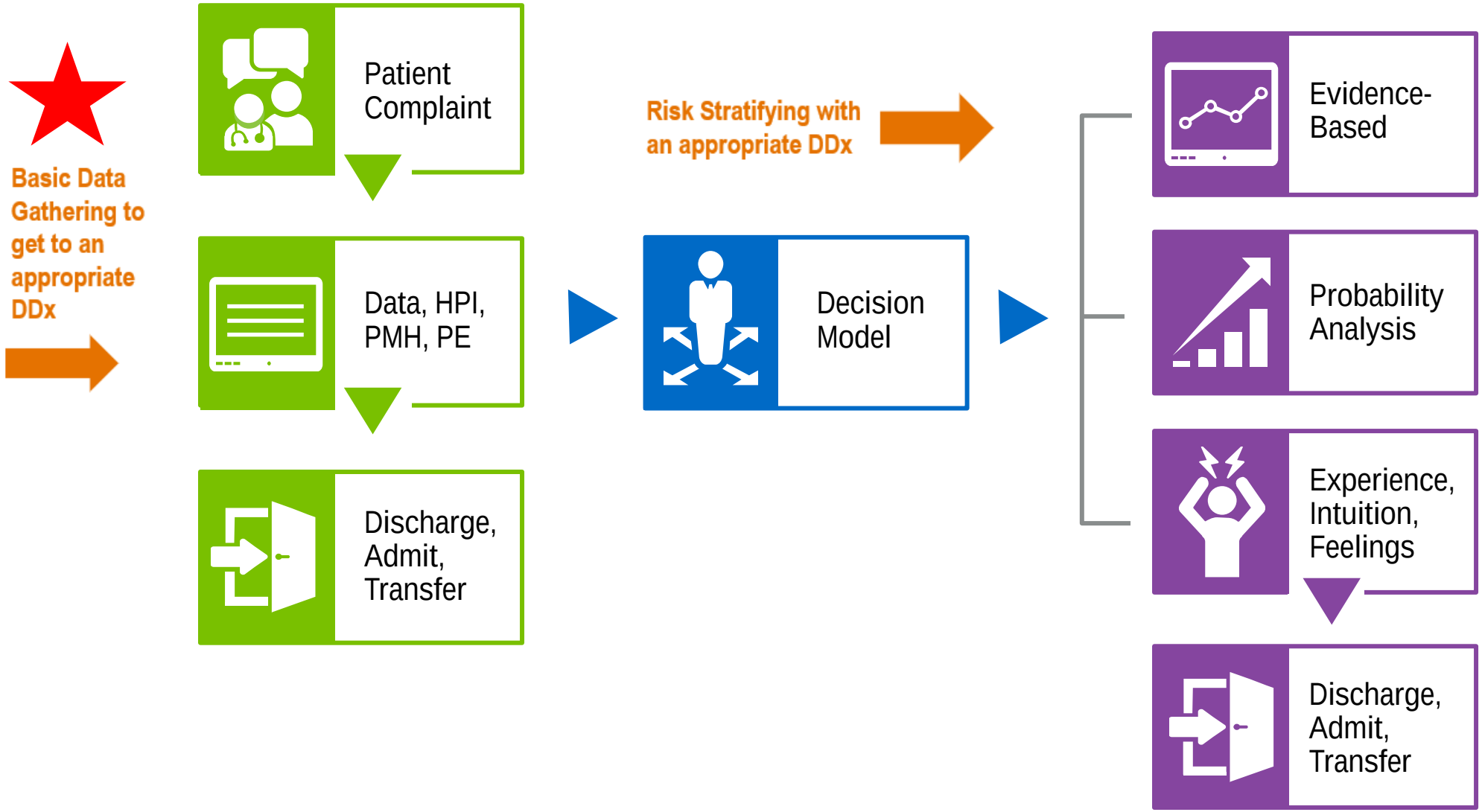
Source: 2019 Aon/ASHRM Hospital and Physician Professional Liability Benchmark Analysis. All rights reserved.

State of the Market 2020: Malpractice Insurance Just Got Very Expensive



Credit: Slide created by Aon Healthcare Practice. Presented in webinar on 10/6/2020 by Andrew Azan & Erik Johnson

TSG Research Into the Root Cause of the Failure to Diagnose in EM



Most Common & Costly Misdiagnosed Conditions (n = 7,211 claims)

CLAIMS ANALYSIS TARGETS TOP 14

In our unpublished analysis of over 7,000 emergency physician liability claims, we found that 14 diagnoses accounted for the greatest frequency and severity of indemnity losses in acute care medicine. The common thread among these diseases is that they present as a patient chief complaint (e.g., chest pain) that requires a high-reliability diagnostic process to avoid misdiagnosis.

TOP 14 MISDIAGNOSED CONDITIONS IN ACUTE CARE MEDICINE

1. Acute MI
2. Stroke
3. Peripheral Vascular Disease
4. Sepsis
5. Intracranial / Subarachnoid Hemorrhage
6. Cauda Equina Syndrome
7. Intestinal Perforation / Obstruction
8. Respiratory Infection
9. Meningitis
10. Spinal Infection (Epidural Abscess)
11. Pulmonary Embolism
12. Acute Aortic Dissection
13. Abdominal Aortic Aneurysm
14. Appendicitis

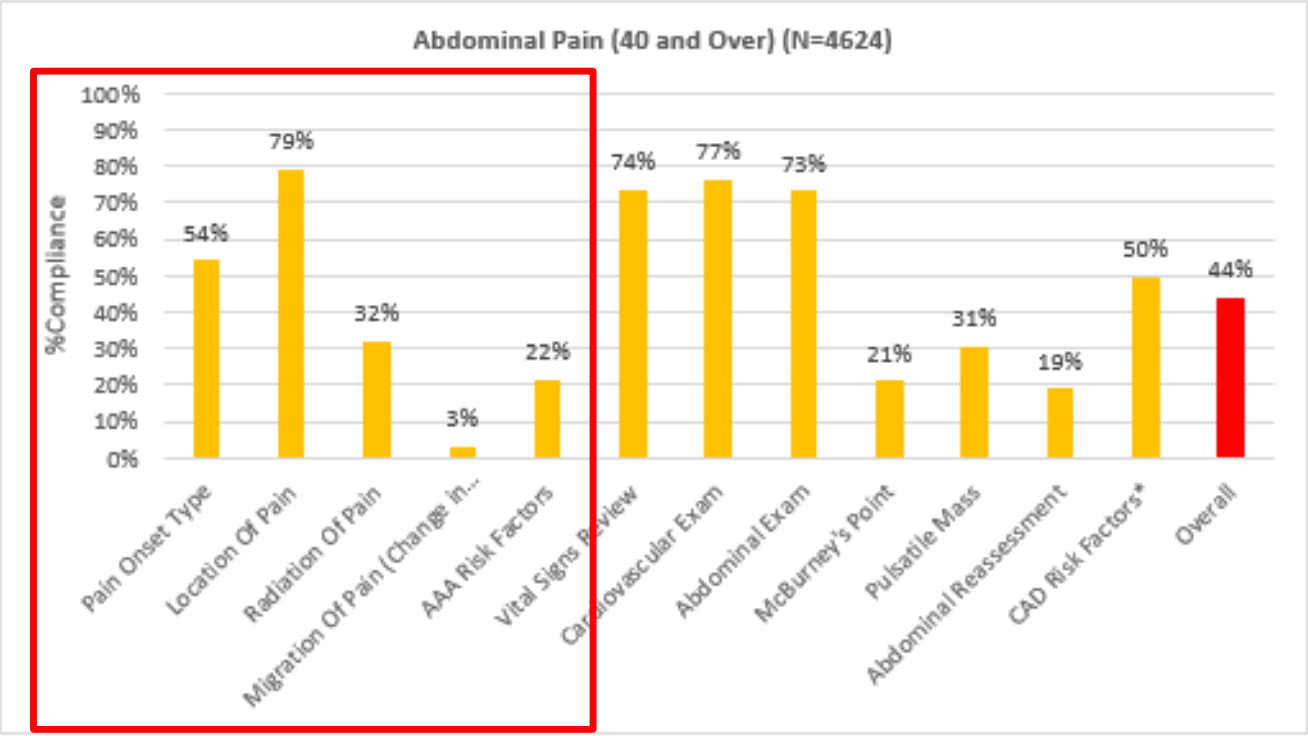
Abdominal Pain (40 and older) and AAA – National Profile

Appropriate H & P data set?

- Type of pain onset
- Location
- Radiation of pain
- Movement (e.g., chest to abdomen)
- AAA risk predisposition

Abdominal Pain (40 and older) Documentation (n = 4,624 patients 20 EDs) – Artificial Intelligence Analytics Program

Abdominal Pain (40 and Over)				
ED Guidance	Documented			
	YES	NO	Total	%YES
Pain Onset Type	2,506	2,118	4,624	54%
Location Of Pain	3,659	965	4,624	79%
Radiation Of Pain	1,478	3,146	4,624	32%
Migration Of Pain (Change in Lo	153	4,471	4,624	3%
AAA Risk Factors	997	3,627	4,624	22%
Vital Signs Review	3,413	1,211	4,624	74%
Cardiovascular Exam	3,540	1,084	4,624	77%
Abdominal Exam	3,392	1,232	4,624	73%
McBurney's Point	981	3,643	4,624	21%
Pulsatile Mass	1,418	3,206	4,624	31%
Abdominal Reassessment	880	3,744	4,624	19%
CAD Risk Factors*	673	686	1,359	50%
Overall	**23,090**	**29,133**		**44%**



HPI = 38%

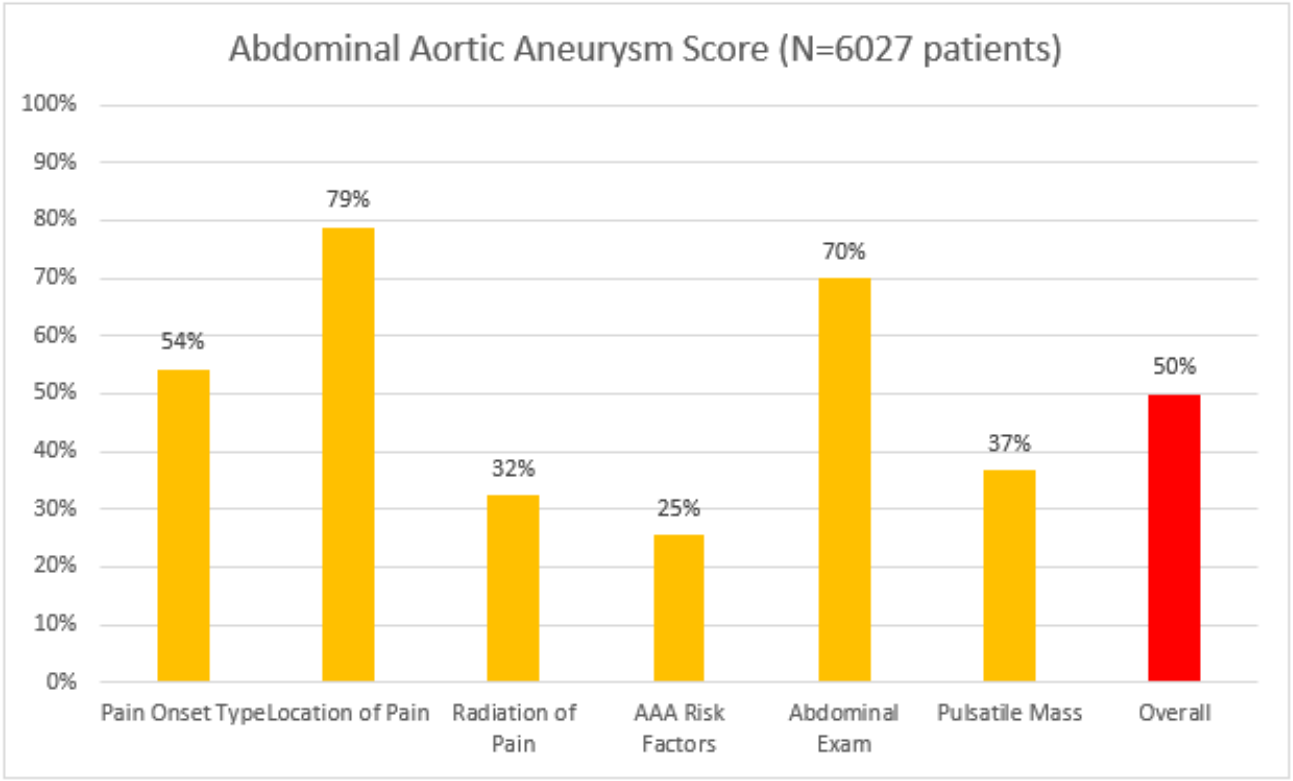
Abdominal Aortic Aneurysm Score (n = 4,221patients)

Summary of Literature on Frequency of Diagnostic Errors			
Chief Complaint	**% of ED Visits**[1]	**Missed Diagnoses**	**Diagnostic Error Rate**[2]
Abdominal Pain	8.8%	AAA Acute Aortic Dissection Acute Myocardial Infarction Appendicitis	**27.9%** **27.9%** **2.2%** **6.0%** Adult[3]; **4.4%** Pediatric[3]
Chest Pain	4.7%	Acute Aortic Dissection Acute Myocardial Infarction Pulmonary Embolism	**27.9%** **2.2%** **19.9%**
Back Pain	2.4%	AAA Acute Aortic Dissection Spinal Epidural Abscess Cauda Equina Syndrome	**27.9%** **27.9%** **62.1%** Unknown
Headache	2.5%	Stroke SAH	**8.7%** Unknown

Table Sources:

1. Data from National Ambulatory Medical Care Survey
2. Newman-Toker DE, et al. Rate of diagnostic errors and serious misdiagnosis-related harms for major vascular events, infections, and cancers: toward a national incidence estimate using the "Big Three". Diagnosis (Berl). 2020 May 14:/j/dx.ahead-of-print/dx-2019-0104/dx-2019-0104.xml. doi: 10.1515/dx-2019-0104. Epub ahead of print. PMID: 32412440.
3. Mahajan P, et al. Factors Associated With Potentially Missed Diagnosis of Appendicitis in the Emergency Department. JAMA Netw Open. 2020 Mar 2;3(3):e200612. doi: 10.1001/jamanetworkopen.2020.0612. PMID: 32150270; PMCID: PMC7063499.

Abdominal Aortic Aneurysm Score				
ED Guidance	**Documented**			
	YES	NO	Total	%Yes
Pain Onset Type	2291	1930	4221	54%
Location of Pain	3322	899	4221	79%
Radiation of Pain	1366	2855	4221	32%
AAA Risk Factors	1324	3890	5214	25%
Abdominal Exam	4215	1812	6027	70%
Pulsatile Mass	1741	3016	4757	37%
Overall	14259	14402	28661	50%



Chest Pain (40 and older) and TAD, PE, AMI – National Profile

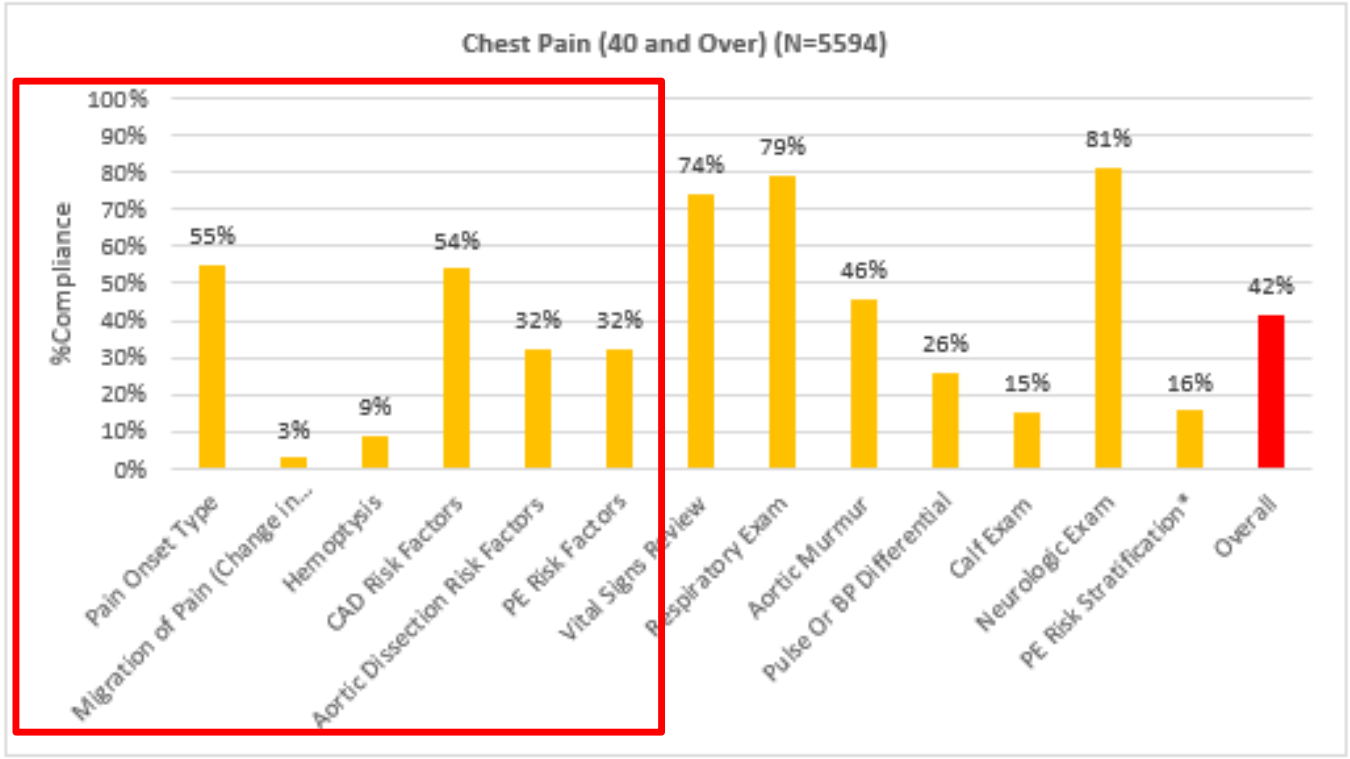
Appropriate H & P data set?

- Type of pain onset
- Movement (e.g., chest to abdomen…)
- Hemoptysis
- CAD, AoD, PE Risk Predisposition

Chest Pain (40 and older) Documentation (n = 5,116 patients 20 EDs) – AI Analytics Program

CP > 40y

Chest Pain (40 and Over)				
ED Guidance	**Documented**			
	YES	NO	Total	%YES
Pain Onset Type	3,077	2,517	5,594	55%
Migration of Pain (Change in Lo	166	5,428	5,594	3%
Hemoptysis	508	5,086	5,594	9%
CAD Risk Factors	3,020	2,574	5,594	54%
Aortic Dissection Risk Factors	1,818	3,776	5,594	32%
PE Risk Factors	1,801	3,793	5,594	32%
Vital Signs Review	4,155	1,439	5,594	74%
Respiratory Exam	4,439	1,155	5,594	79%
Aortic Murmur	2,554	3,040	5,594	46%
Pulse Or BP Differential	1,453	4,141	5,594	26%
Calf Exam	813	4,477	5,290	15%
Neurologic Exam	4,540	1,054	5,594	81%
PE Risk Stratification*	311	1,685	1,996	16%
Overall	**28,655**	**40,165**		**42%**



HPI = 31%

Acute Aortic Dissection Score (n = 5,116 patients)
AI Analytics Program

Summary of Literature on Frequency of Diagnostic Errors			
Chief Complaint	**% of ED Visits[1]**	**Missed Diagnoses**	**Diagnostic Error Rate[2]**
Abdominal Pain	8.8%	AAA Acute Aortic Dissection Acute Myocardial Infarction Appendicitis	**27.9%** **27.9%** **2.2%** **6.0%** Adult[3]; **4.4%** Pediatric[3]
Chest Pain	4.7%	Acute Aortic Dissection Acute Myocardial Infarction Pulmonary Embolism	**27.9%** **2.2%** **19.9%**
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Headache	2.5%	Stroke SAH	**8.7%** Unknown

Table Sources:
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2. Newman-Toker DE, et al. Rate of diagnostic errors and serious misdiagnosis-related harms for major vascular events, infections, and cancers: toward a national incidence estimate using the "Big Three". Diagnosis (Berl). 2020 May 14:/j/dx.ahead-of-print/dx-2019-0104/dx-2019-0104.xml. doi: 10.1515/dx-2019-0104. Epub ahead of print. PMID: 32412440.
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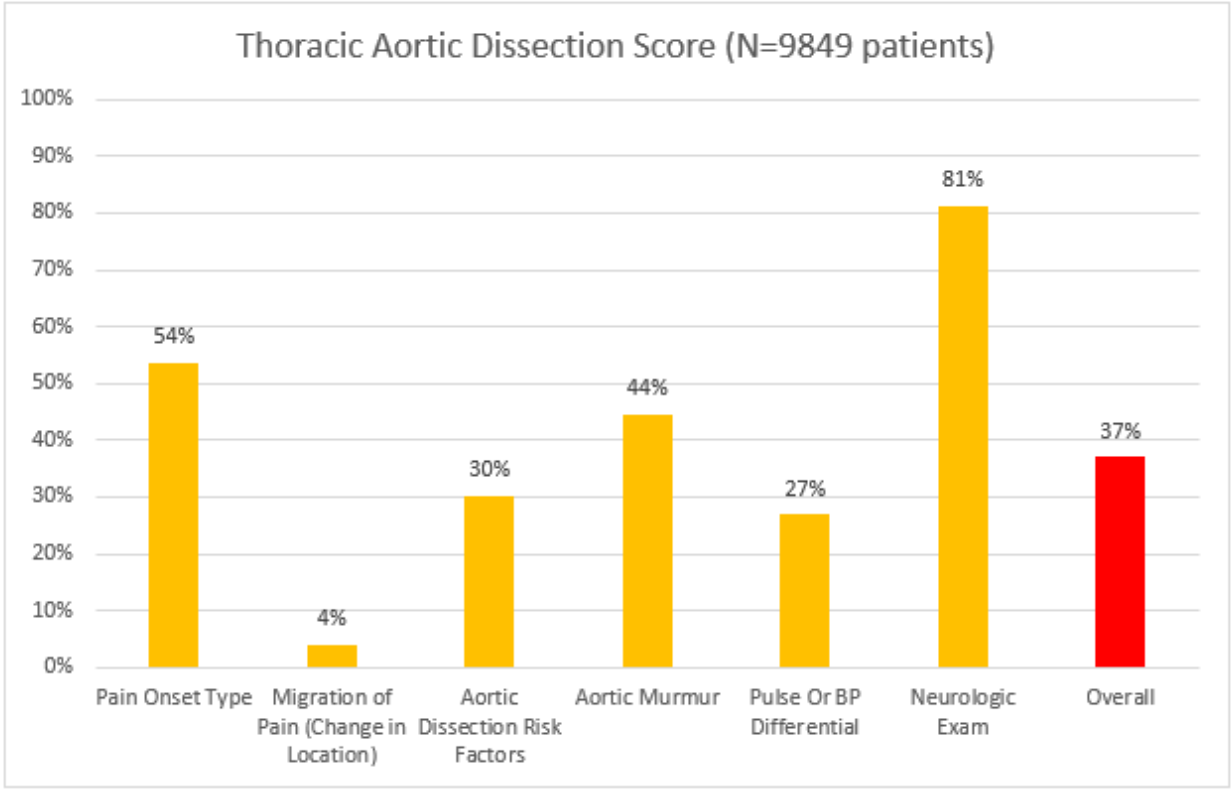
TAD

Thoracic Aortic Dissection Score				
ED Guidance	**Documented**			
	YES	NO	Total	%Yes
Pain Onset Type	5013	4350	9363	54%
Migration of Pain (Change in Location)	395	9454	9849	4%
Aortic Dissection Risk Factors	1759	4048	5807	30%
Aortic Murmur	2554	3193	5747	44%
Pulse Or BP Differential	1535	4180	5715	27%
Neurologic Exam	4157	959	5116	81%
Overall	15413	26184	41597	37%



Spinal Epidural Abscess Score (n = 2,708 patients)
AI Analytics Program

Summary of Literature on Frequency of Diagnostic Errors

Chief Complaint	% of ED Visits[1]	Missed Diagnoses	Diagnostic Error Rate[2]
Abdominal Pain	8.8%	AAA Acute Aortic Dissection Acute Myocardial Infarction Appendicitis	**27.9%** **27.9%** **2.2%** **6.0%** Adult[3]; **4.4%** Pediatric[3]
Chest Pain	4.7%	Acute Aortic Dissection Acute Myocardial Infarction Pulmonary Embolism	**27.9%** **2.2%** **19.9%**
Back Pain	2.4%	AAA Acute Aortic Dissection Spinal Epidural Abscess Cauda Equina Syndrome	**27.9%** **27.9%** **62.1%** Unknown
Headache	2.5%	Stroke SAH	**8.7%** Unknown

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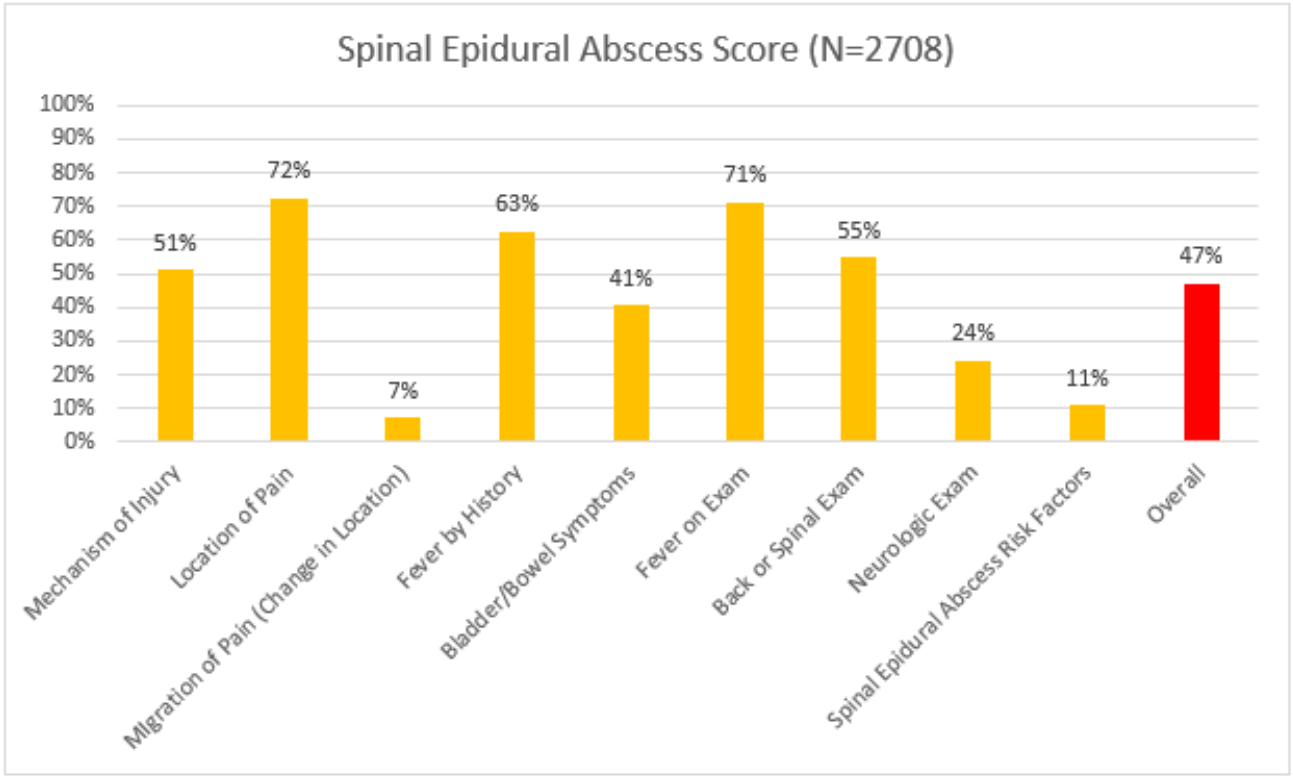
Spinal Epidural Abscess Score

ED Guidance	Documented			
	YES	NO	Total	%Yes
Mechanism of Injury	1386	1322	2708	51%
Location of Pain	1945	743	2688	72%
MIgration of Pain (Change in Location)	197	2511	2708	7%
Fever by History	1696	1012	2708	63%
Bladder/Bowel Symptoms	1101	1607	2708	41%
Fever on Exam	1928	780	2708	71%
Back or Spinal Exam	1486	1222	2708	55%
Neurologic Exam	633	1999	2632	24%
Spinal Epidural Abscess Risk Factors	62	503	565	11%
Overall	10434	11699	22133	47%



CHEST PAIN / EQUIVALENT

Time of Exam :_____

Level 1, 2, 3 Documentation 1 to 3 elements	Level 4 Documentation - 4 + elements	Level 5 Documentation - 4 + elements

CHIEF COMPLAINT & HPI : ☐ Unable to fully assess due to altered LOC or patient condition

History Obtained From: ☐ Patient ☐ Family ☐ Police ☐ EMS ☐ Other

Pain Grade 0 - 10: _____

ECG Completed ☐ **Y** ☐ **N** ☐ **NA**
- ☐ **Time of Interp.**_____
- ☐ **Nursing Notes Reviewed**
- ☐ **Vital Signs Reviewed**

Chest Pain: Y N | **SOB: Y N** | **Nausea: Y N** | **Vomiting: Y N** | **Diaphoresis: Y N** | **Radiation of Pain: Y N If Y, Where:**

Time Course: ☐ **NA** ☐ **Sudden** ☐ **Gradual** ☐ **Under 1 hour** ☐ **Hours :**_____ ☐ **Days :**_____ ☐ Constant ☐ Intermittent ☐ Resolved

Location: ☐ NA ☐ Substernal ☐ Epigastric ☐ Lt Chest ☐ Rt Chest ☐ Back ☐ Neck ☐ Other :

Quality : ☐ Pressure ☐ Sharp ☐ Aching ☐ Stabbing ☐ Dull ☐ Burning ☐ Cramping ☐ Fullness ☐ Same As Prior

Associated With: Fever: Y N Cough: Y N **Migration or Movement of Pain: Y N NA** ☐ Nothing ☐ Trauma ☐ Other :

Severity Maximum is: ☐ None ☐ Mild ☐ Mod. ☐ Severe | Severity Current is : ☐ None ☐ Mild ☐ Mod. ☐ Severe

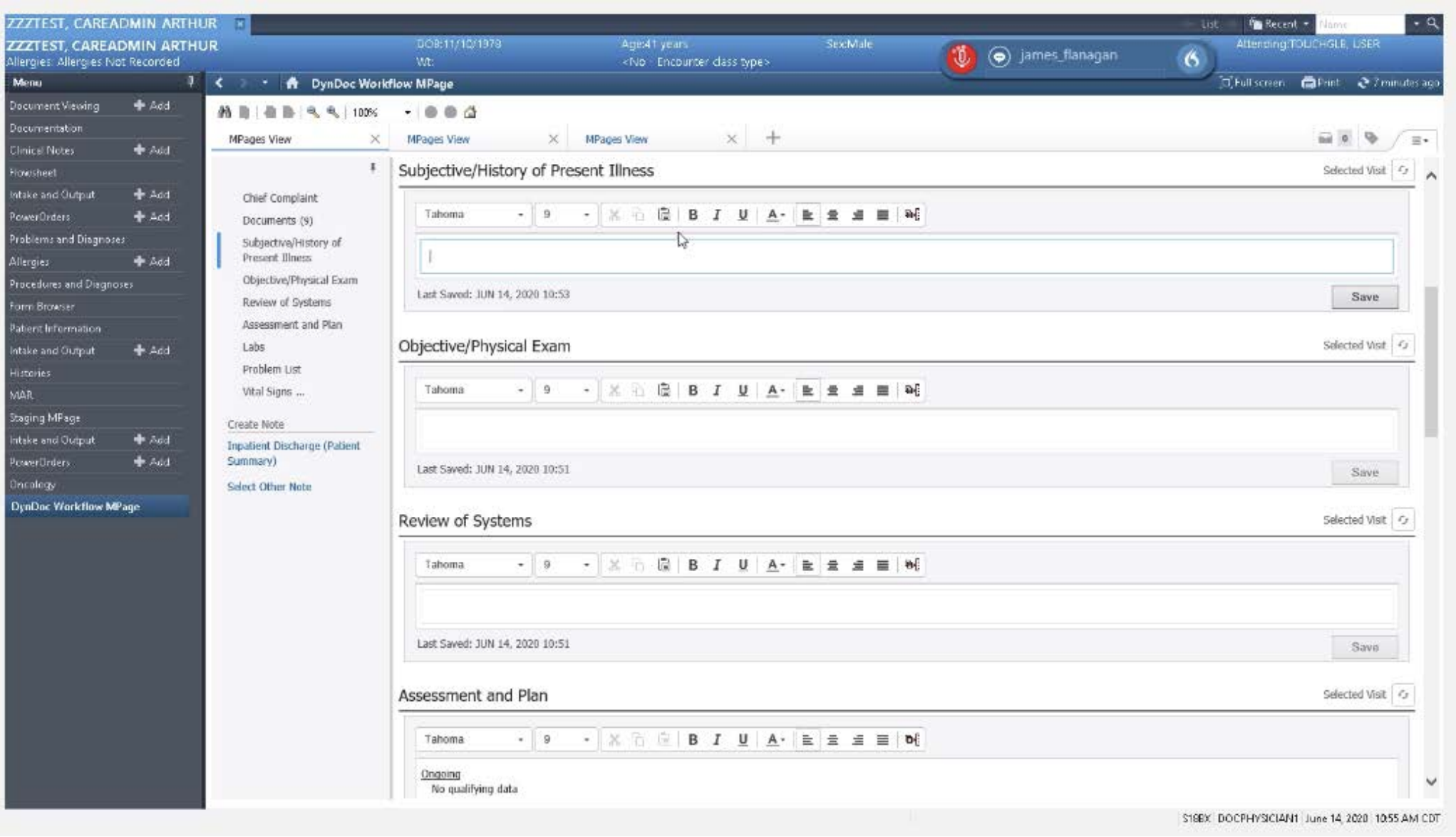
Exacerbated By: ☐ Nothing ☐ Exercise ☐ Palpation of Chest ☐ Movement ☐ Cough / Deep Breath ☐ Other :

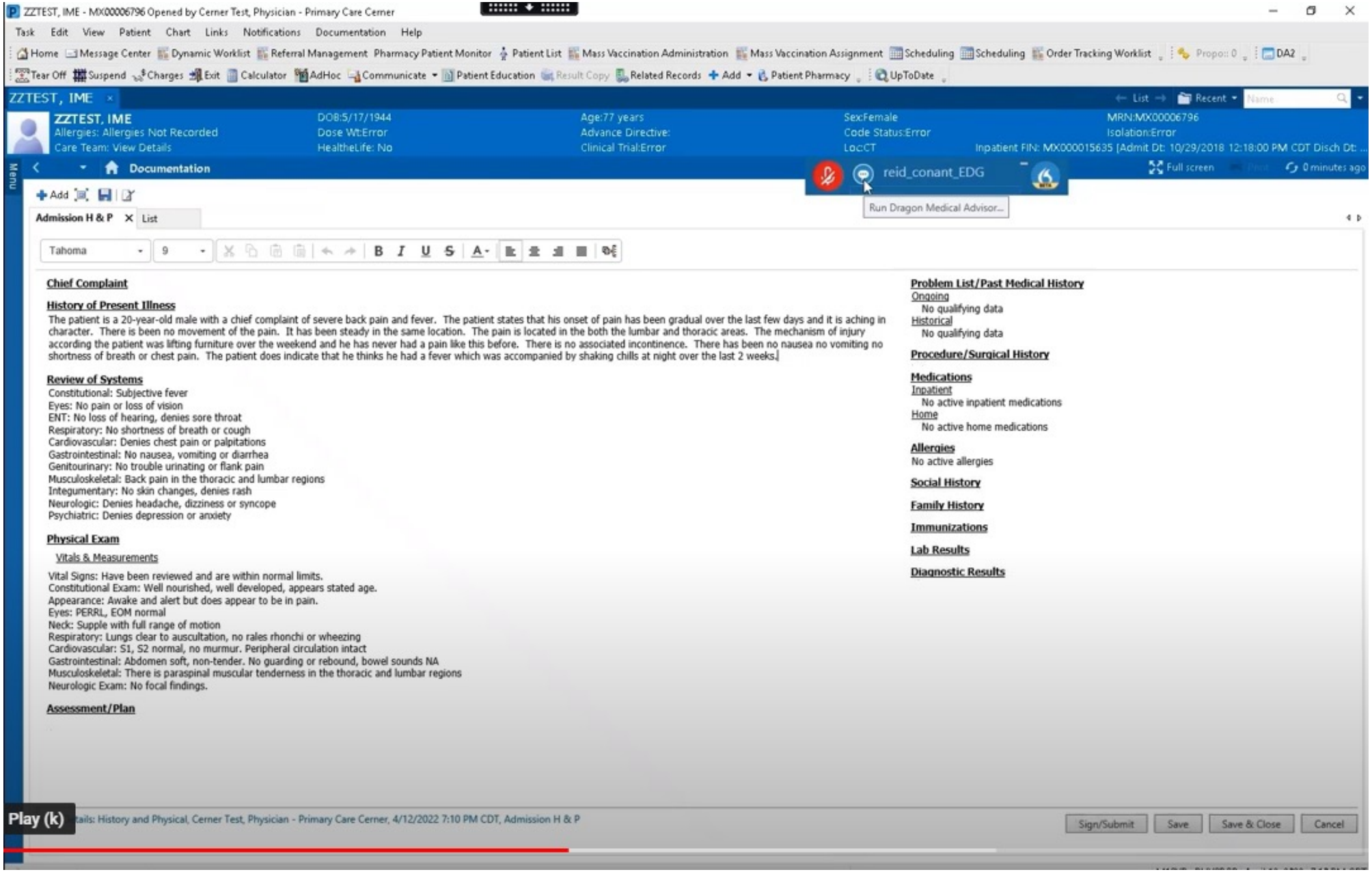
Relieved By: ☐ Nothing ☐ Nitroglycerin ☐ X 1 ☐ X 2 ☐ X 3 ☐ Oxygen ☐ Sitting up ☐ Supine ☐ Remaining Still ☐ Other :

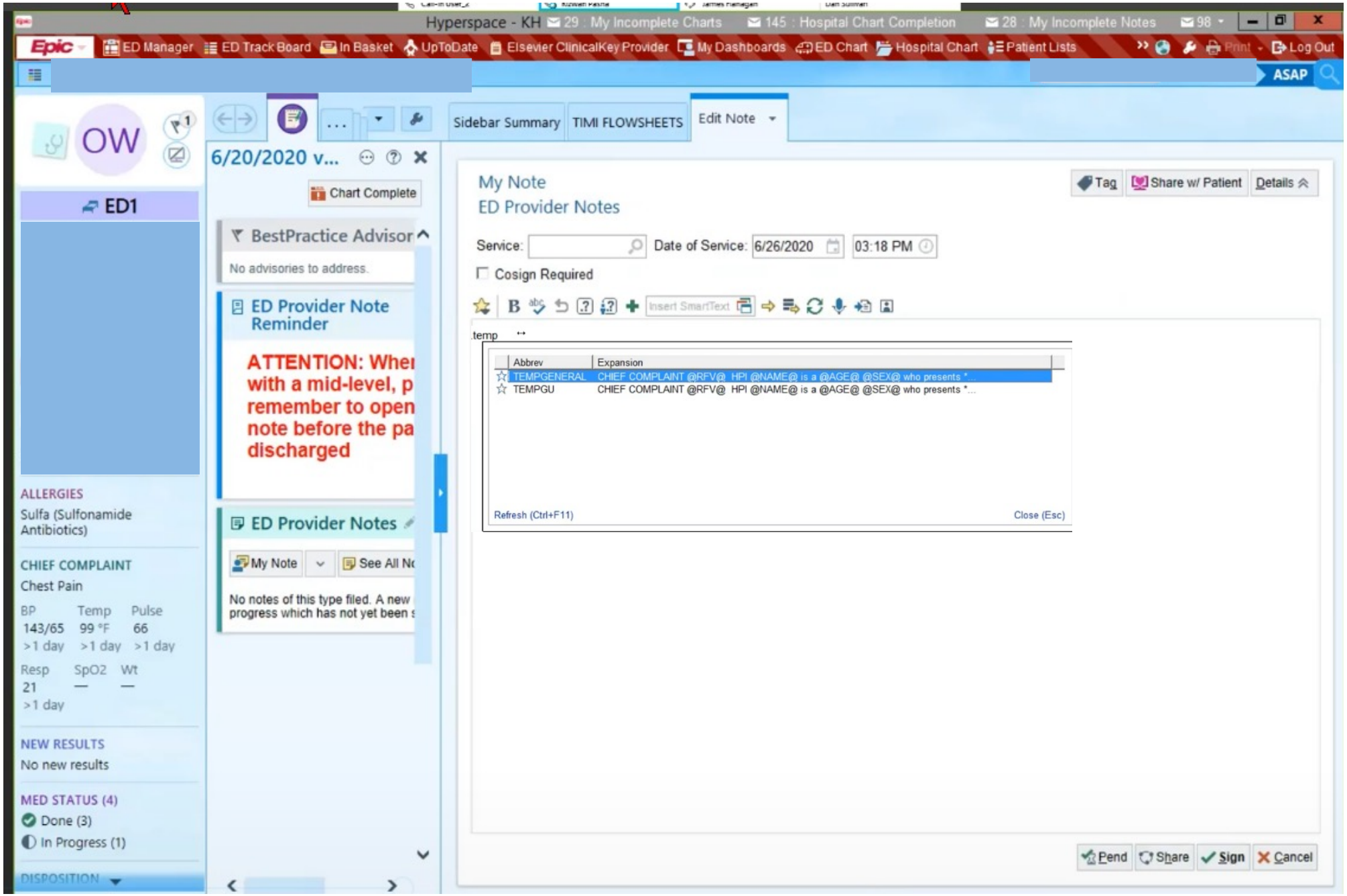
CAD Risk: ☐ **NA** ☐ **None** ☐ **Known CAD** ☐ **Smoking** ☐ **Cholesterol** ☐ **HTN** ☐ **Fam.Hx.** ☐ **Diabetes** ☐ **Cocaine**

TAD Risk: ☐ **NA** ☐ **None** ☐ **HTN** ☐ **1st Degree Relative** ☐ **Turner's** ☐ **Aortic Valve Disease** ☐ **Connective Tissue Disease (Marfan's, Ehlers Danlos)** ☐ **Pregnancy** ☐ **Others :**_____

PE Risk: ☐ **NA** ☐ **None** ☐ **Previous PE** ☐ **Malignancy** ☐ **Obesity** ☐ **Trauma** ☐ **Greenfield** ☐ **Pregnancy / Postpartum** ☐ **Smoking** ☐ **Prior DVT** ☐ **Immobilization (e.g. Leg Cast, Travel)** ☐ **Surgery Last 60 days** ☐ **Coagulation Disorder** ☐ **Estrogen Medicine** ☐ **Others** _____




ZZTEST, IME - MX00006796 Opened by Cerner Test, Physician - Primary Care Cerner
Task Edit View Patient Chart Links Notifications Documentation Help
Home Message Center Dynamic Worklist Referral Management Pharmacy Patient Monitor Patient List Mass Vaccination Administration Mass Vaccination Assignment Scheduling Scheduling Order Tracking Worklist
Tear Off Suspend Charges Exit Calculator AdHoc Communicate Patient Education Result Copy Related Records Add Patient Pharmacy UpToDate
ZZTEST, IME
ZZTEST, IME DOB:5/17/1944 Age:77 years Sex:Female MRN:MX00006796
Allergies: Allergies Not Recorded Dose Wt:Error Advance Directive: Code Status:Error Isolation:Error
Care Team: View Details HealtheLife: No Clinical Trial:Error Loc:CT Inpatient FIN: MX000015635 (Admit Dt: 10/29/2018 12:18:00 PM CDT Disch Dt: ...
Documentation
reid_conant_EDG
Run Dragon Medical Advisor...
Full screen
0 minutes ago
Add
Admission H & P
List
Tahoma
9
Chief Complaint
History of Present Illness
The patient is a 20-year-old male with a chief complaint of severe back pain and fever. The patient states that his onset of pain has been gradual over the last few days and it is aching in character. There is been no movement of the pain. It has been steady in the same location. The pain is located in the both the lumbar and thoracic areas. The mechanism of injury according the patient was lifting furniture over the weekend and he has never had a pain like this before. There is no associated incontinence. There has been no nausea no vomiting no shortness of breath or chest pain. The patient does indicate that he thinks he had a fever which was accompanied by shaking chills at night over the last 2 weeks.
Review of Systems
Constitutional: Subjective fever
Eyes: No pain or loss of vision
ENT: No loss of hearing, denies sore throat
Respiratory: No shortness of breath or cough
Cardiovascular: Denies chest pain or palpitations
Gastrointestinal: No nausea, vomiting or diarrhea
Genitourinary: No trouble urinating or flank pain
Musculoskeletal: Back pain in the thoracic and lumbar regions
Integumentary: No skin changes, denies rash
Neurologic: Denies headache, dizziness or syncope
Psychiatric: Denies depression or anxiety
Physical Exam
Vitals & Measurements
Vital Signs: Have been reviewed and are within normal limits.
Constitutional Exam: Well nourished, well developed, appears stated age.
Appearance: Awake and alert but does appear to be in pain.
Eyes: PERRL, EOM normal
Neck: Supple with full range of motion
Respiratory: Lungs clear to auscultation, no rales rhonchi or wheezing
Cardiovascular: S1, S2 normal, no murmur. Peripheral circulation intact
Gastrointestinal: Abdomen soft, non-tender. No guarding or rebound, bowel sounds NA
Musculoskeletal: There is paraspinal muscular tenderness in the thoracic and lumbar regions
Neurologic Exam: No focal findings.
Assessment/Plan
Problem List/Past Medical History
Ongoing
No qualifying data
Historical
No qualifying data
Procedure/Surgical History
Medications
Inpatient
No active inpatient medications
Home
No active home medications
Allergies
No active allergies
Social History
Family History
Immunizations
Lab Results
Diagnostic Results
tails: History and Physical, Cerner Test, Physician - Primary Care Cerner, 4/12/2022 7:10 PM CDT, Admission H & P
Sign/Submit
Save
Save & Close
Cancel
Play (k)


Hyperspace - KH
29 : My Incomplete Charts
145 : Hospital Chart Completion
28 : My Incomplete Notes
98
Epic
ED Manager
ED Track Board
In Basket
UpToDate
Elsevier ClinicalKey Provider
My Dashboards
ED Chart
Hospital Chart
Patient Lists
Print
Log Out
ASAP
OW
ED1
Sidebar Summary
TIMI FLOWSHEETS
Edit Note
6/20/2020 v...
Chart Complete
BestPractice Advisor
No advisories to address.
ED Provider Note Reminder
ATTENTION: Whe
with a mid-level, p
remember to open
note before the pa
discharged
ED Provider Notes
My Note
See All No
No notes of this type filed. A new
progress which has not yet been
ALLERGIES
Sulfa (Sulfonamide Antibiotics)
CHIEF COMPLAINT
Chest Pain
BP 143/65 >1 day
Temp 99 °F >1 day
Pulse 66 >1 day
Resp 21 >1 day
SpO2 —
Wt —
NEW RESULTS
No new results
MED STATUS (4)
Done (3)
In Progress (1)
DISPOSITION
My Note
ED Provider Notes
Tag
Share w/ Patient
Details
Service:
Date of Service: 6/26/2020
03:18 PM
Cosign Required
Insert SmartText
.temp
Abbrev
Expansion
TEMPGENERAL
CHIEF COMPLAINT @RFV@ HPI @NAME@ is a @AGE@ @SEX@ who presents *...
TEMPGU
CHIEF COMPLAINT @RFV@ HPI @NAME@ is a @AGE@ @SEX@ who presents *...
Refresh (Ctrl+F11)
Close (Esc)
Pend
Share
Sign
Cancel

Vital Signs Re-evaluation – National Profile

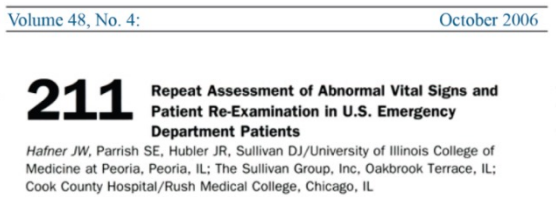
Common finding in failure to diagnose cases.

Vital Signs Re-evaluation – National Profile

90K
patients' vital signs we looked at.

9K
were very abnormal.

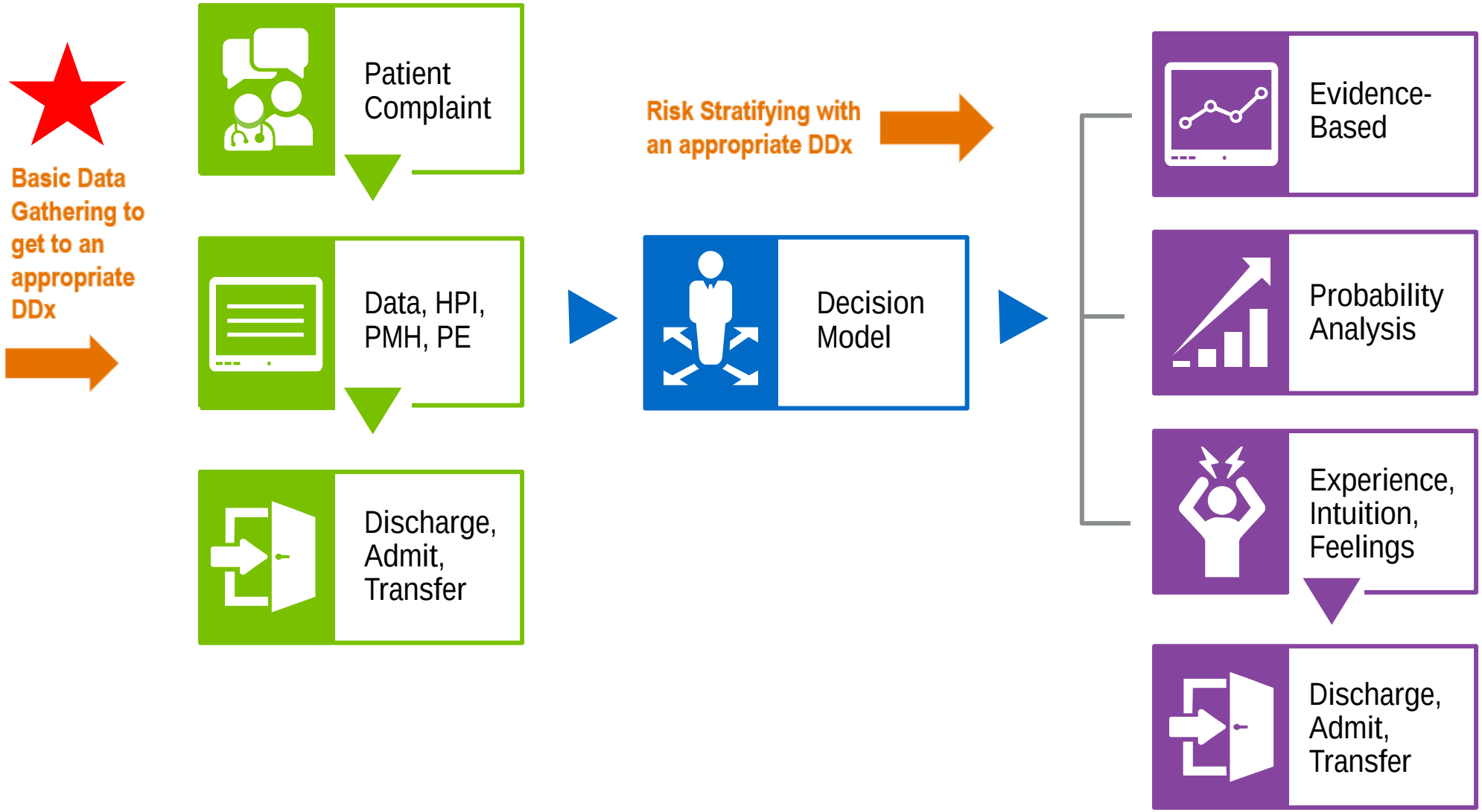
16%
of patients with very abnormal vital signs are discharged without a single repeat.



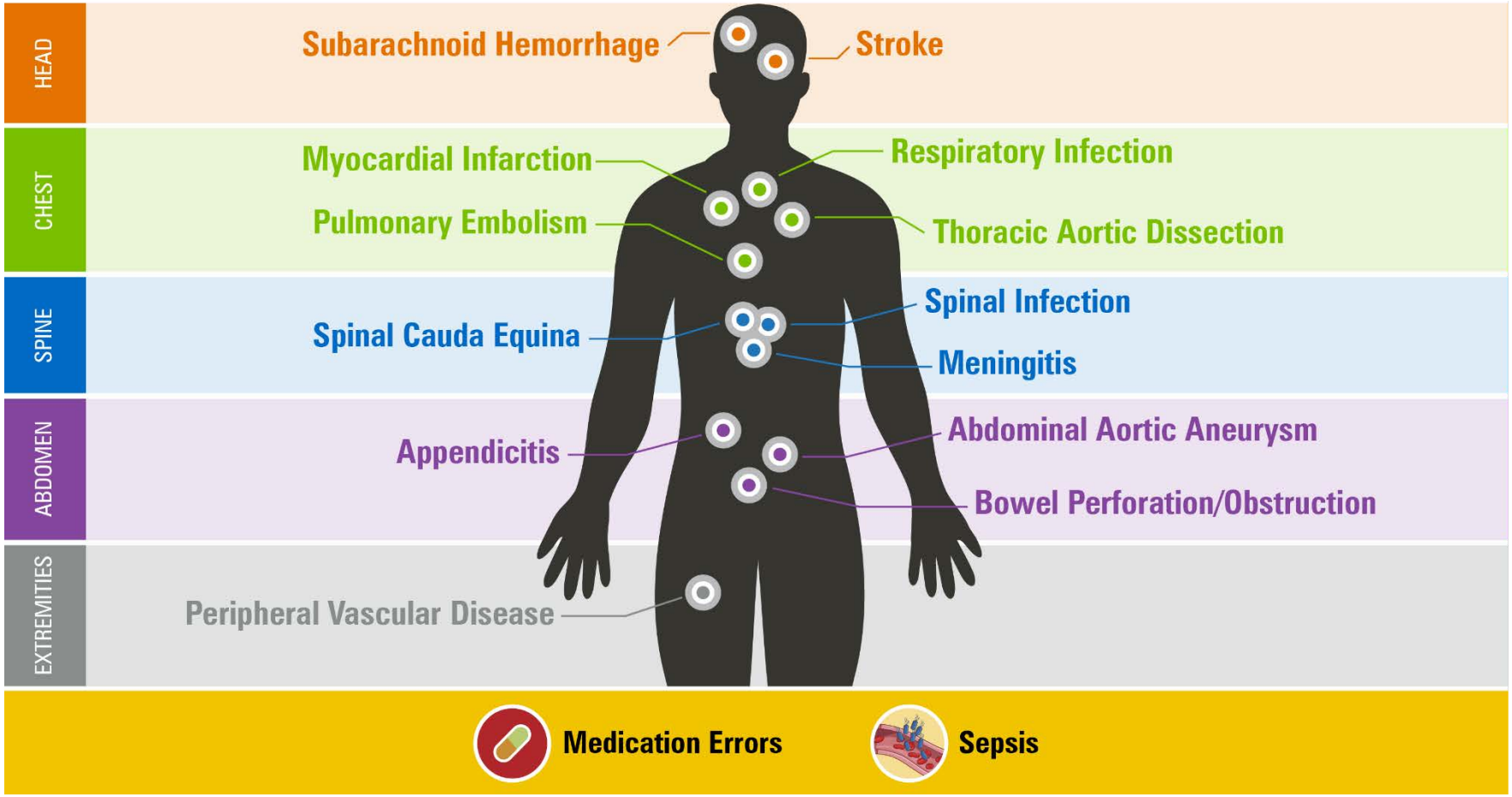
Volume 48, No. 4: October 2006

211 **Repeat Assessment of Abnormal Vital Signs and Patient Re-Examination in U.S. Emergency Department Patients**

Hafner JW, Parrish SE, Hubler JR, Sullivan DJ/University of Illinois College of Medicine at Peoria, Peoria, IL; The Sullivan Group, Inc, Oakbrook Terrace, IL; Cook County Hospital/Rush Medical College, Chicago, IL



Strategy – Target the Highest Risks

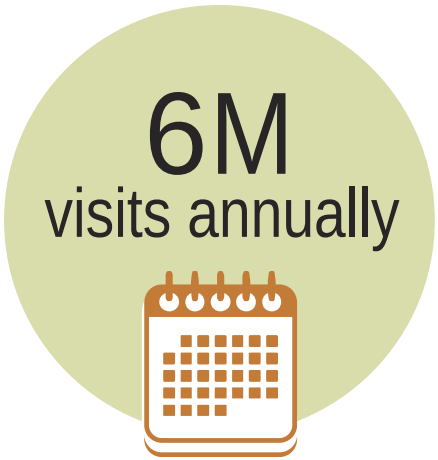


Driving Clinical Alignment Around Key Elements of Hx, PE, MDM Does That Work?

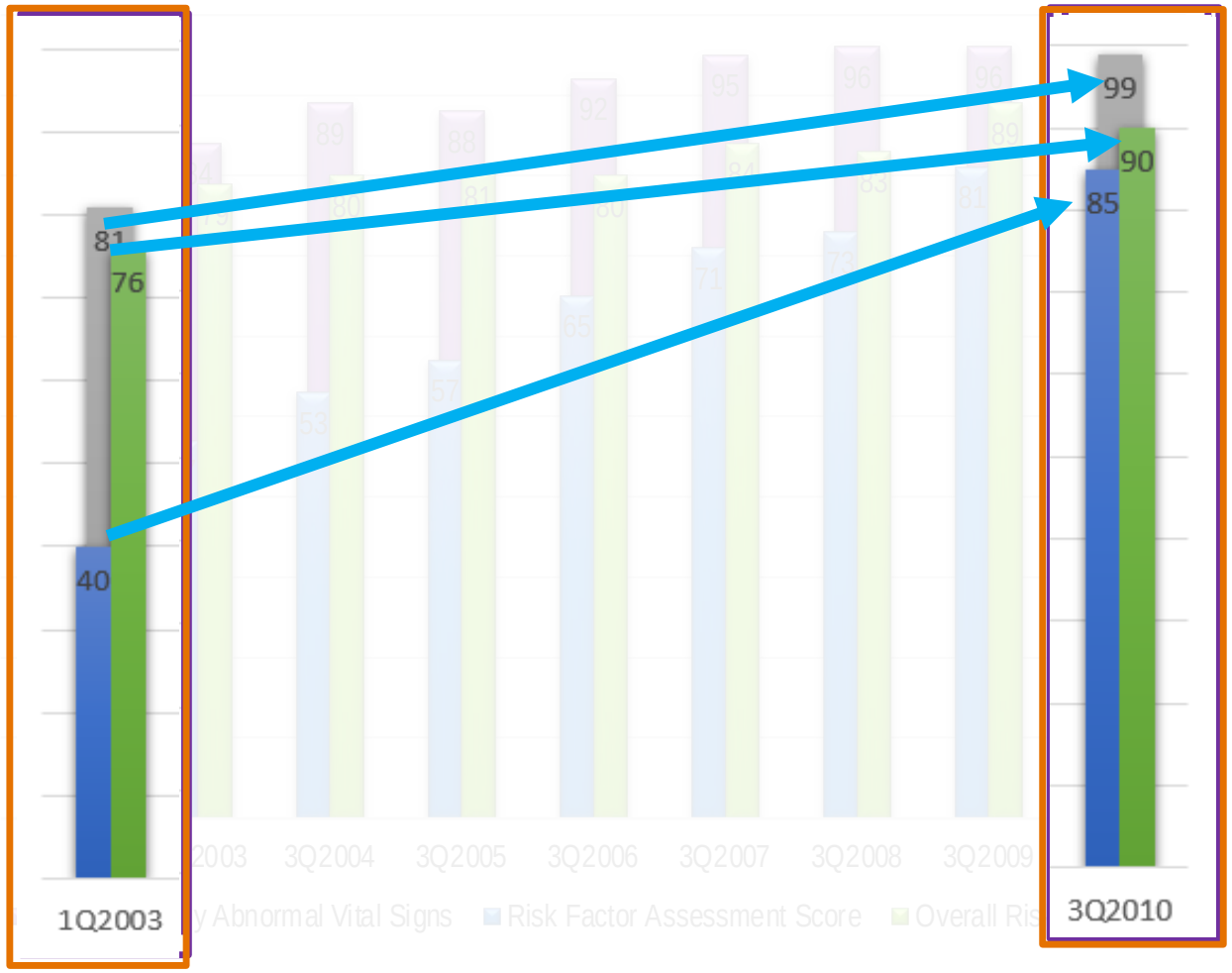
Does That Work?

- Data from a large U.S. healthcare provider

- Emergency Services



Large Hospital System: 190 EDs | >3000 practitioners | >6M Annual ED Visits

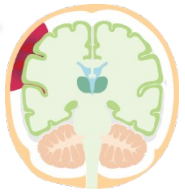
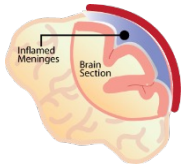
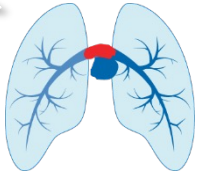
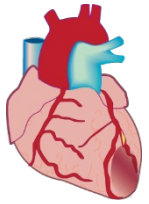
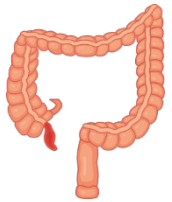
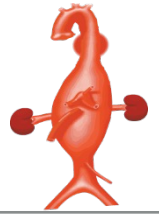


Clinical Alignment Over 7 Years

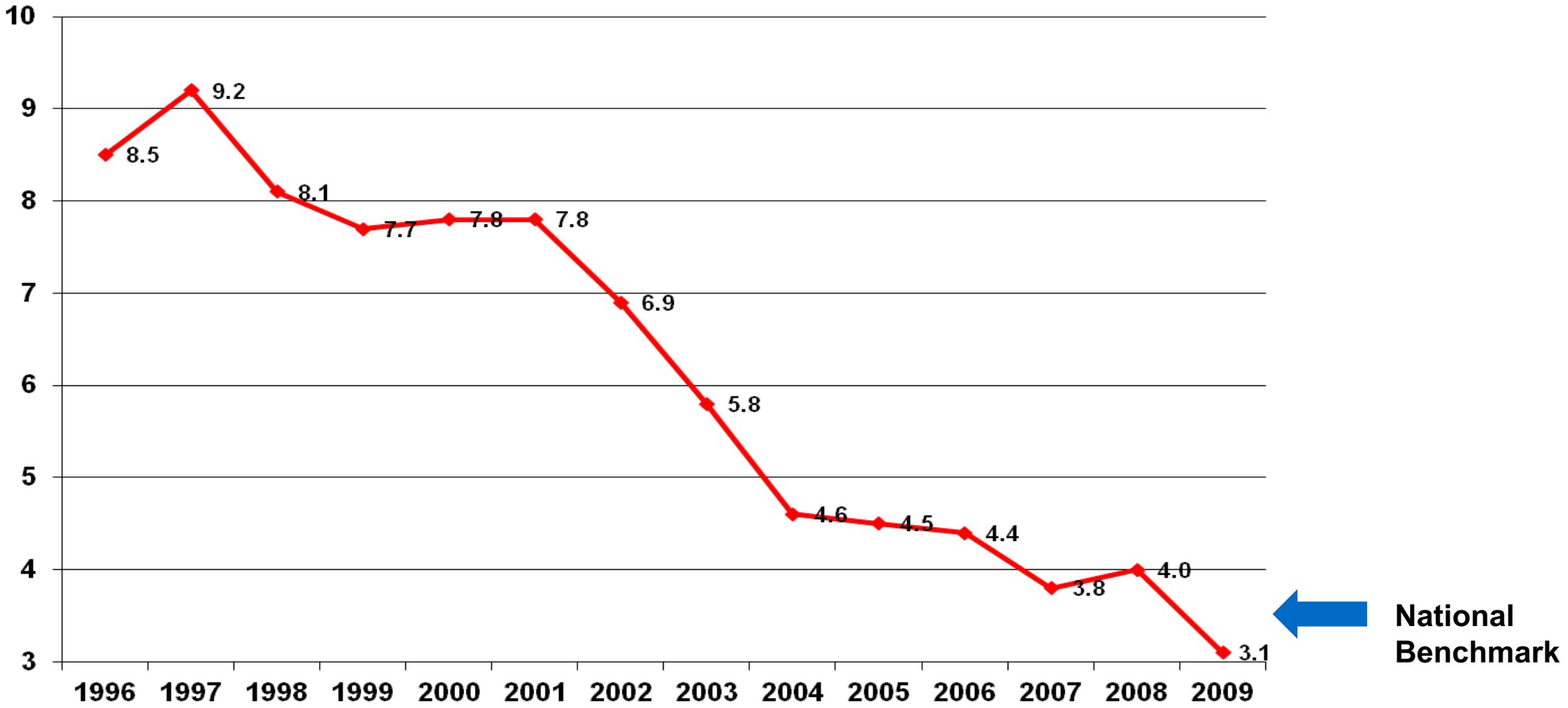
- Overall compliance with over 150 clinical drivers increased from 76% to 90%.
- The patients that presented with a very abnormal vital sign that was sent home with that same vital sign (no repeat) decreased from 19% to 1%.
- Overall compliance with risk factor analysis advanced from 40% to 85%.

Overall 74% Reduction in Dx-Related Claims

7 High-Risk Conditions

↓87%	 Subarachnoid Hemorrhage	 Meningitis	↓70%
↓84%	 Pulmonary Embolism	 Acute Myocardial Infarction	↓66%
↓48%	 Cerebrovascular Accident	 Appendicitis	↓66%
↓82%	 AAA & TAD		

EM Malpractice Claims Per 100,000 Visits

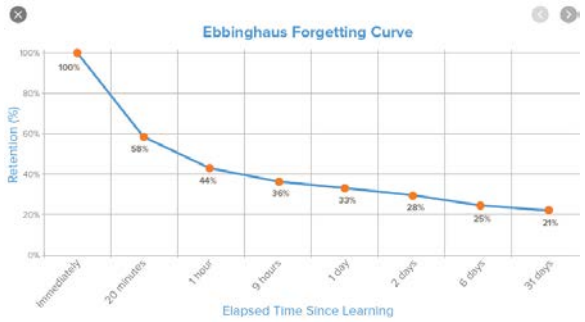


Solutions to Impact Dx-Related Errors
Decision Making & Documentation

Current Risk & Safety Paradigm

Current Approach

Books, lectures and on-line training.



Problem

The human forgetting curve, recall ability and memory loss. Key information is not front of mind at the bedside.

Impact

Over decades the frequency of errors and claims is steady to rising. The cost of claims is currently rising dramatically.

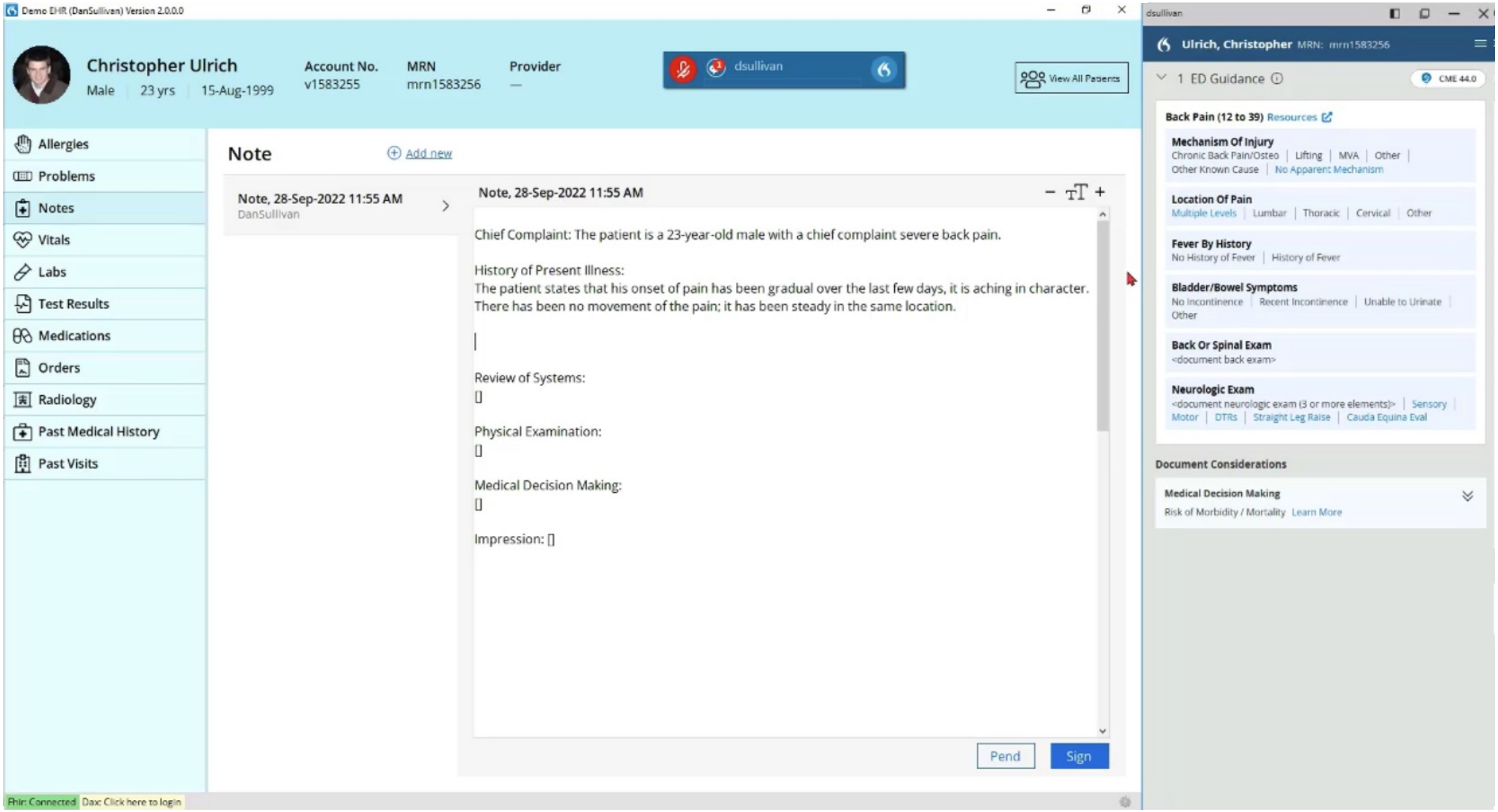
New EM Risk & Safety Paradigm

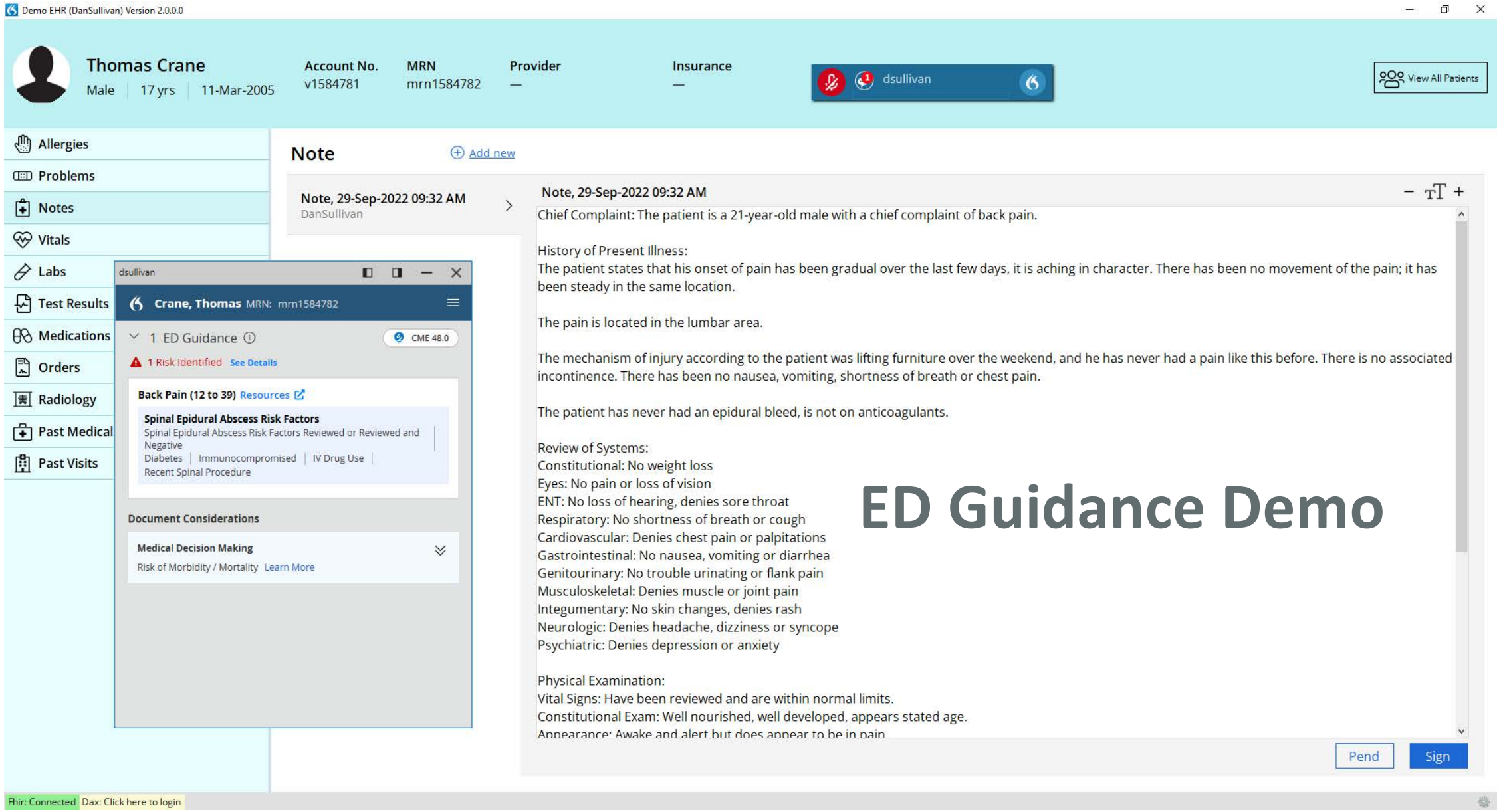
Using AI

provides conditional algorithms, checklists & decision support, real-time during the patient encounter.

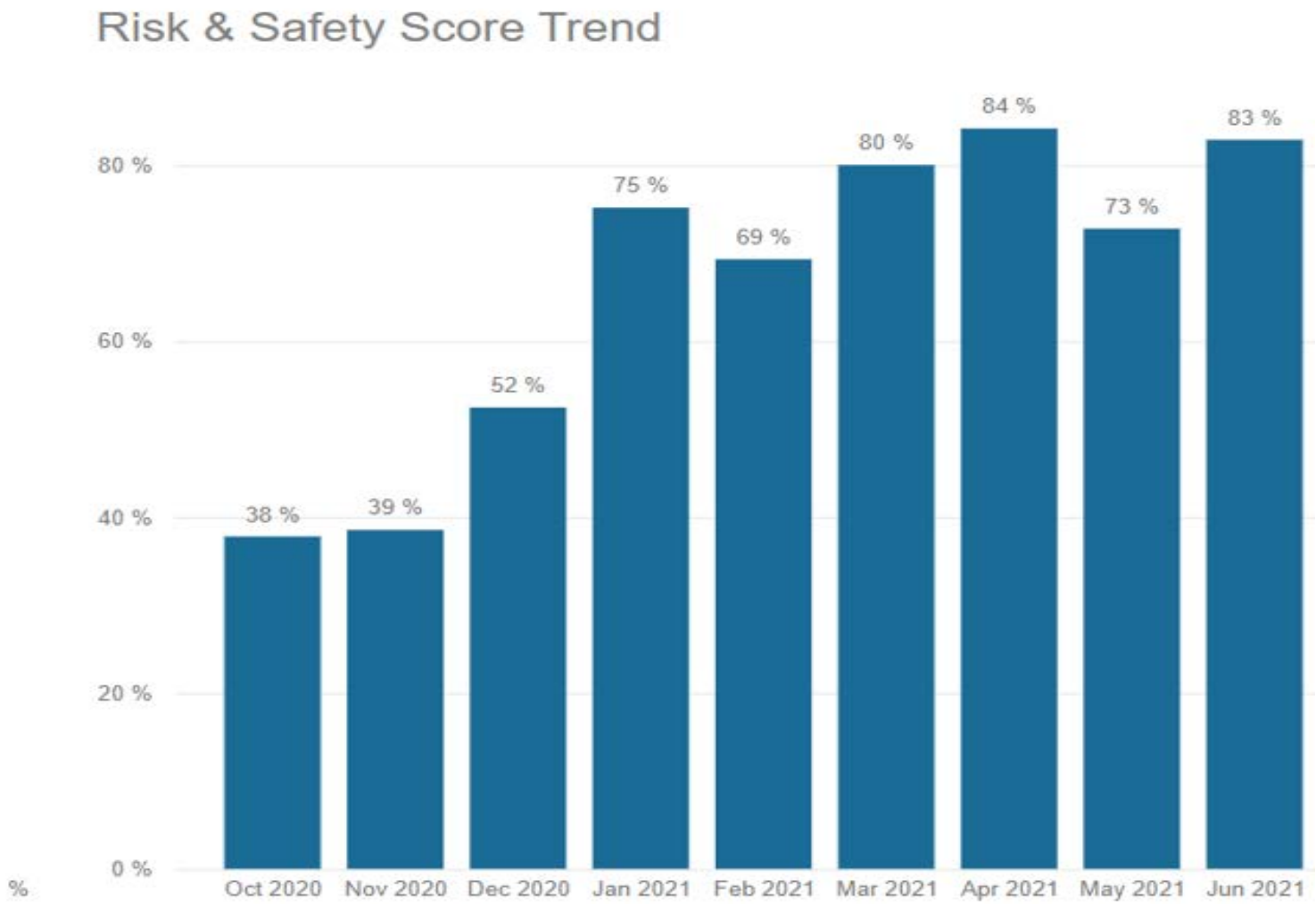
It Must Be

visually available & comfortably in the practitioner's workflow.

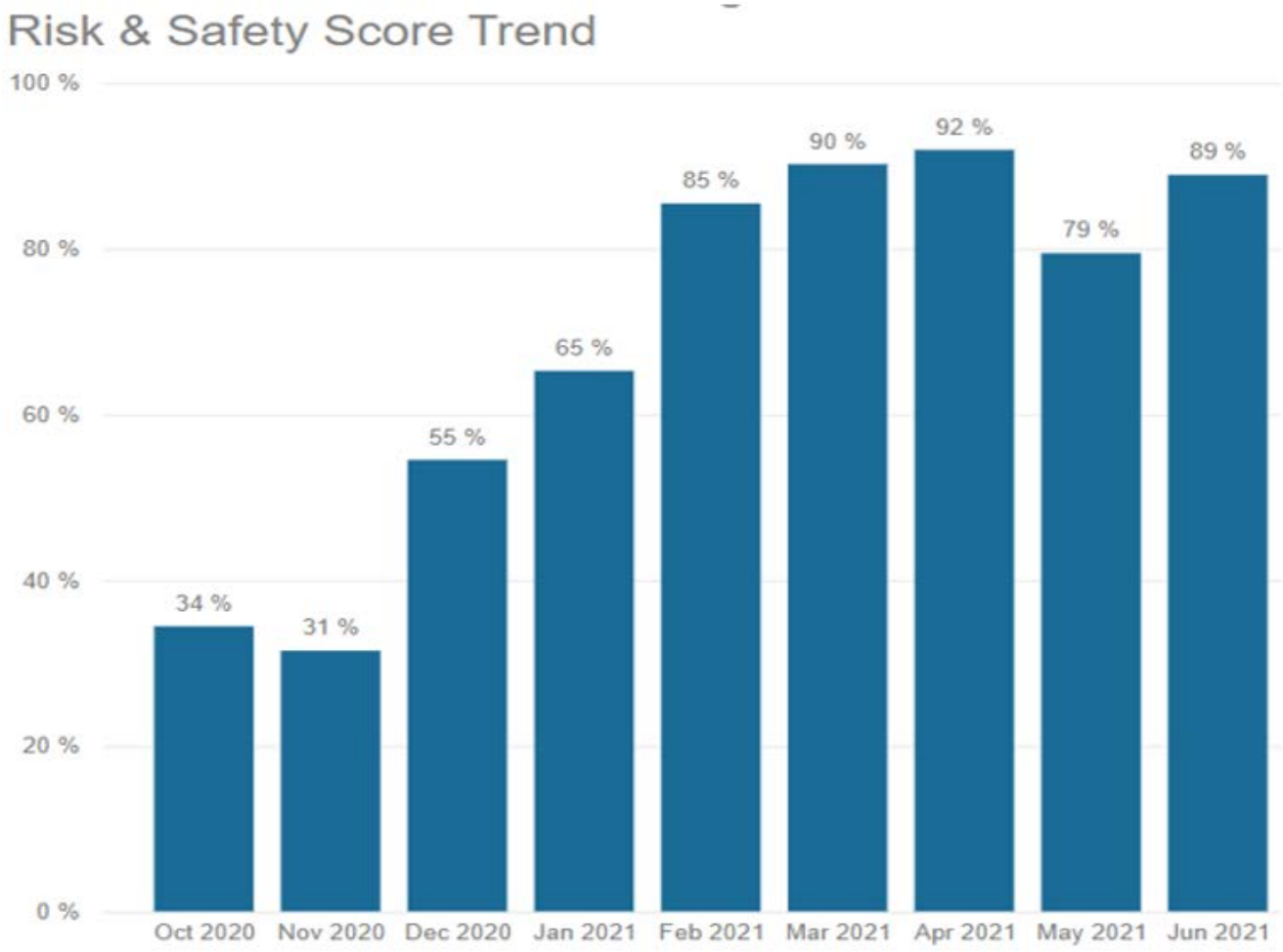

Demo EHR (DanSullivan) Version 2.0.0.0
Christopher Ulrich
Male | 23 yrs | 15-Aug-1999
Account No.
v1583255
MRN
mrn1583256
Provider
—
dsullivan
View All Patients
Allergies
Problems
Notes
Vitals
Labs
Test Results
Medications
Orders
Radiology
Past Medical History
Past Visits
Note
Add new
Note, 28-Sep-2022 11:55 AM
DanSullivan
Note, 28-Sep-2022 11:55 AM
Chief Complaint: The patient is a 23-year-old male with a chief complaint severe back pain.
History of Present Illness:
The patient states that his onset of pain has been gradual over the last few days, it is aching in character. There has been no movement of the pain; it has been steady in the same location.
Review of Systems:
[]
Physical Examination:
[]
Medical Decision Making:
[]
Impression: []
Pend
Sign
Fhir: Connected
Dax: Click here to login
dsullivan
Ulrich, Christopher MRN: mrn1583256
1 ED Guidance
CME 44.0
Back Pain (12 to 39) Resources
Mechanism Of Injury
Chronic Back Pain/Osteo | Lifting | MVA | Other | Other Known Cause | No Apparent Mechanism
Location Of Pain
Multiple Levels | Lumbar | Thoracic | Cervical | Other
Fever By History
No History of Fever | History of Fever
Bladder/Bowel Symptoms
No Incontinence | Recent Incontinence | Unable to Urinate | Other
Back Or Spinal Exam
<document back exam>
Neurologic Exam
<document neurologic exam (3 or more elements)> | Sensory | Motor | DTRs | Straight Leg Raise | Cauda Equina Eval
Document Considerations
Medical Decision Making
Risk of Morbidity / Mortality Learn More


Demo EHR (DanSullivan) Version 2.0.0.0
Thomas Crane
Male | 17 yrs | 11-Mar-2005
Account No.
v1584781
MRN
mrn1584782
Provider
—
Insurance
—
dsullivan
View All Patients
Allergies
Problems
Notes
Vitals
Labs
Test Results
Medications
Orders
Radiology
Past Medical
Past Visits
Note
Add new
Note, 29-Sep-2022 09:32 AM
DanSullivan
Note, 29-Sep-2022 09:32 AM
Chief Complaint: The patient is a 21-year-old male with a chief complaint of back pain.
History of Present Illness:
The patient states that his onset of pain has been gradual over the last few days, it is aching in character. There has been no movement of the pain; it has been steady in the same location.
The pain is located in the lumbar area.
The mechanism of injury according to the patient was lifting furniture over the weekend, and he has never had a pain like this before. There is no associated incontinence. There has been no nausea, vomiting, shortness of breath or chest pain.
The patient has never had an epidural bleed, is not on anticoagulants.
Review of Systems:
Constitutional: No weight loss
Eyes: No pain or loss of vision
ENT: No loss of hearing, denies sore throat
Respiratory: No shortness of breath or cough
Cardiovascular: Denies chest pain or palpitations
Gastrointestinal: No nausea, vomiting or diarrhea
Genitourinary: No trouble urinating or flank pain
Musculoskeletal: Denies muscle or joint pain
Integumentary: No skin changes, denies rash
Neurologic: Denies headache, dizziness or syncope
Psychiatric: Denies depression or anxiety
Physical Examination:
Vital Signs: Have been reviewed and are within normal limits.
Constitutional Exam: Well nourished, well developed, appears stated age.
Appearance: Awake and alert but does appear to be in pain
Pend
Sign
dsullivan
Crane, Thomas MRN: mrn1584782
1 ED Guidance
CME 48.0
1 Risk Identified See Details
Back Pain (12 to 39) Resources
Spinal Epidural Abscess Risk Factors
Spinal Epidural Abscess Risk Factors Reviewed or Reviewed and Negative
Diabetes | Immunocompromised | IV Drug Use | Recent Spinal Procedure
Document Considerations
Medical Decision Making
Risk of Morbidity / Mortality Learn More
ED Guidance Demo
Fhir: Connected
Dax: Click here to login

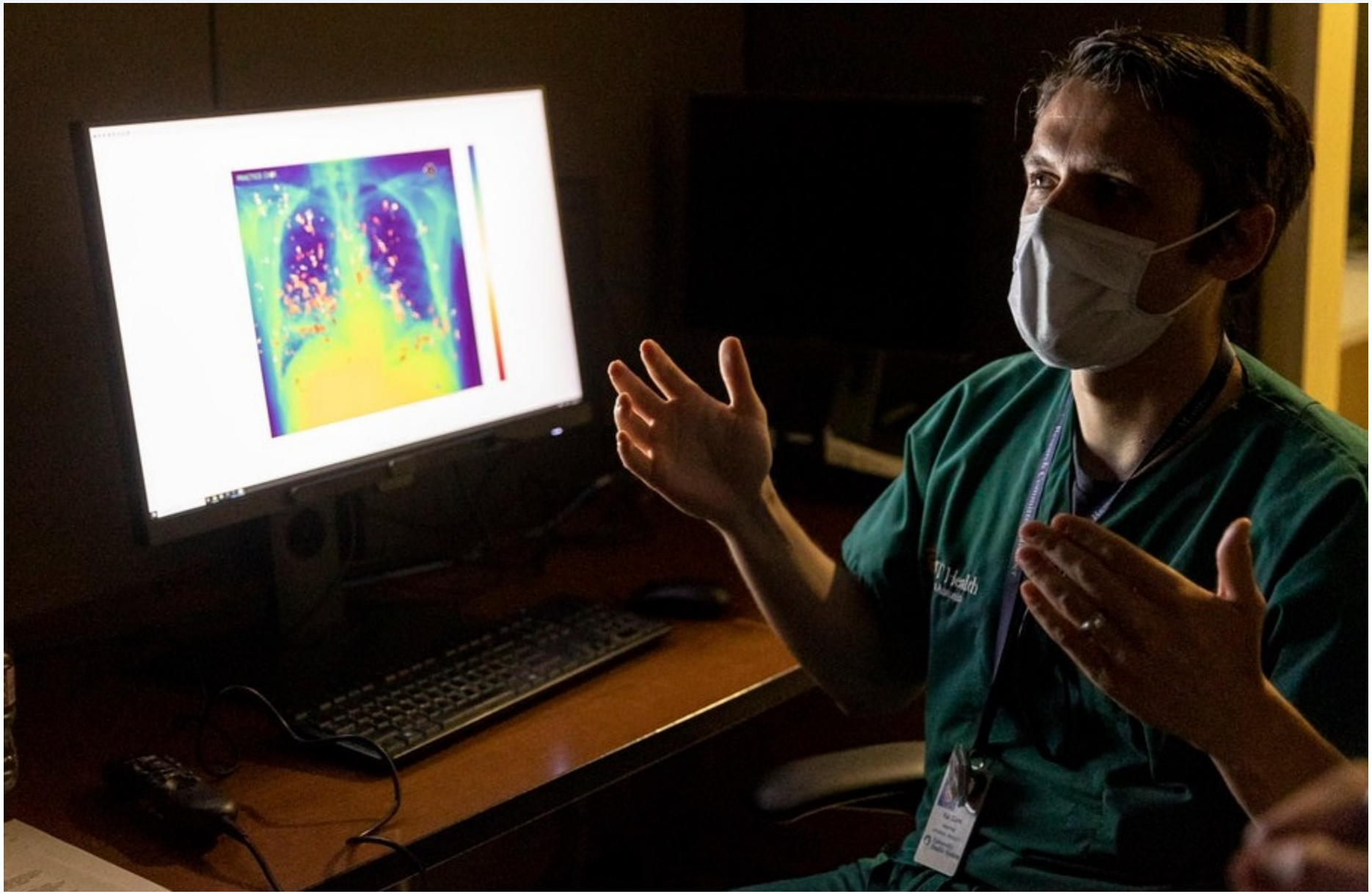
Abdominal Pain (40+ years of age)



Chest Pain (40+ years of age)




Alex Porter
Gender: Female, 44 YO, 07/12/1974
PCP: Roberta Montanaro, M.D.
MRN: 334129
P: 64
BP: 100 / 60
RR: 16
Medications
n't we give you an injection
your left knee a while ago?



6.5 Dermatome Map: Full Body Graphic

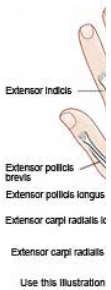
15.1 Ankle Anatomy: Ankle Ligaments Graphic

11.36 TSG RSQ® Summary: Hand Exam

Last Updated / Last Reviewed: 01/18/2018

17.14 Hip Posterior Dislocation: Allis Reduction Graphic

Hand Exte



Flexor Digit

Test the flexor digitoru
fingers in the hand full
the finger to be tested.
superficialis tendon, in
Apply resistance to the

Ankle Exam: Sumr

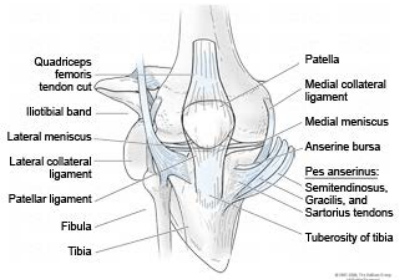
Hip Dislocatior

Hip Posterior D

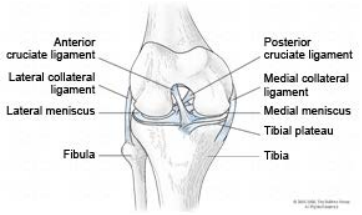
47.14 TSG RSQ® Summary: Knee Injury Exam

Last Updated / Last Reviewed: 01/18/2018

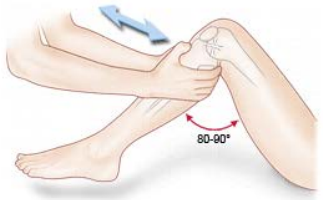
Knee Anatomy
Anterior



Knee Anatomy
Anterior With Patella Reflected

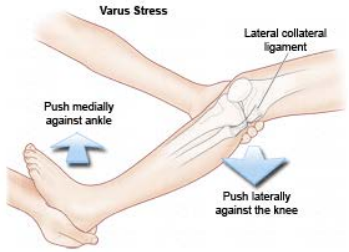


Anterior & Posterior Drawer Tests

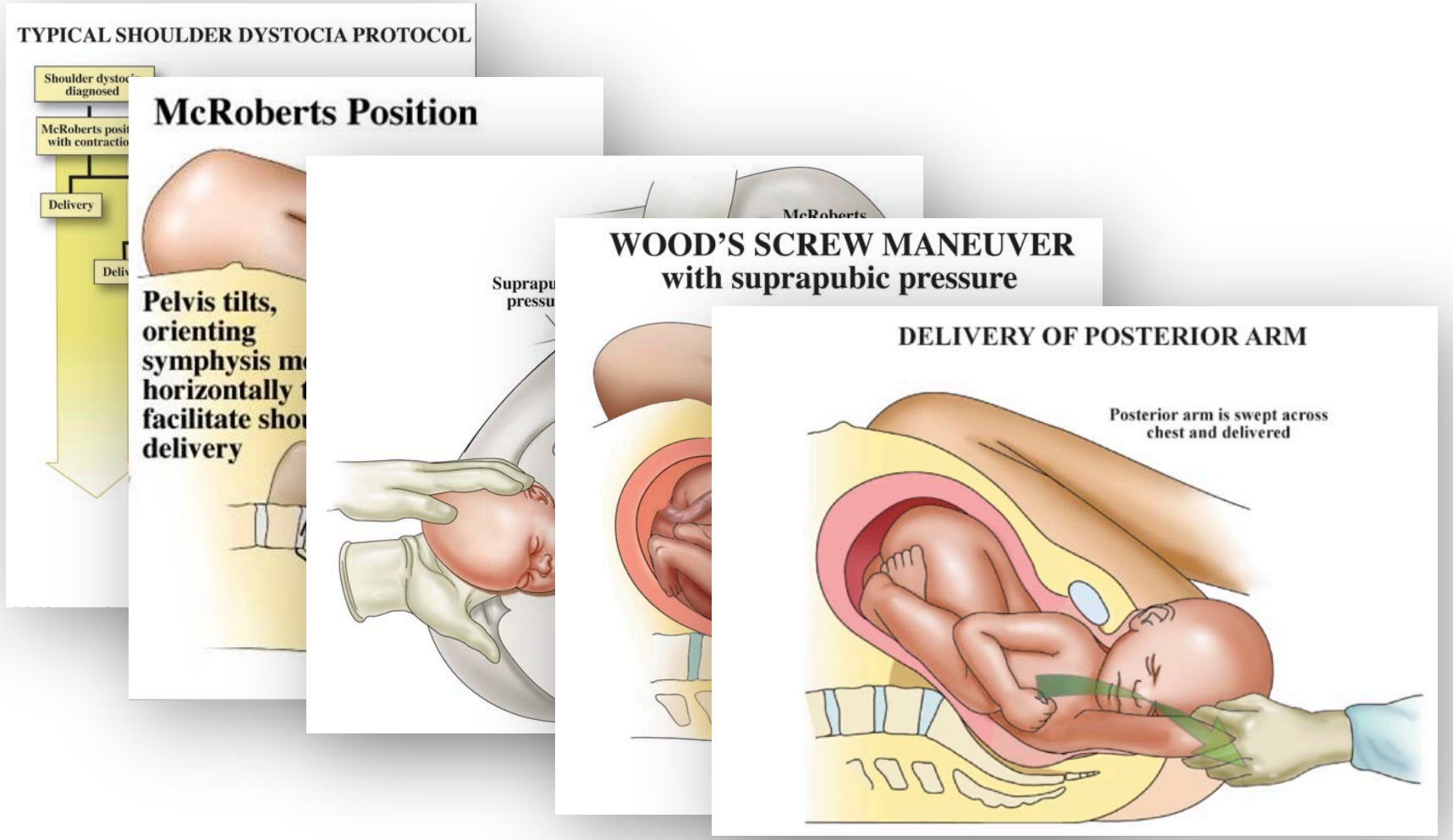


Patient in supine relaxed position. Hip at 45° flexion and knee at 80 - 90° flexion, foot immobilized. Place both hands on upper tibia with fingers in the popliteal fossa, hamstrings relaxed. Check for laxity by pushing in an anterior and posterior position. Compare injured and uninjured extremity. Anterior displacement = anterior cruciate ligament (ACL) rupture. Posterior displacement = posterior cruciate ligament rupture (PCL).

Lateral Collateral Ligament (LCL) Stress Testing



Place one hand on the heel, the other hand on the medial aspect of the knee. Flex the knee 20°. Apply a lateral (varus) force and evaluate for laxity. It is essential to compare the injured and uninjured extremity. Joint opening indicates a rupture of the LCL.



Failure to Diagnose Summary

- EM is one of the highest risk specialties for patients and practitioners.
- Our documentation of high-risk presentations is inadequate and probably reflects a high frequency of inadequate basic data gathering.
- The 30-year paradigm of the talking head has not significantly impacted medical error and the failure to diagnose in EM.
- The solution is part human and part tech and has to be focused at the point of care.
- The EHR companies do not have this on their roadmaps. Solutions will be coming from outside.

Medical-Legal Issues

The ED After Roe

Your Patient is Diagnosed With an IUP During the ED Visit

- Work with OB and your hospital admin/legal to create a list of referral options. Provide to all pregnant patients seeking pregnancy related care.
- Provide that approved list to the patient as a routine part of the discharge instruction process.
- If your state has criminalized abortion, don't engage in the conversation "Where can I get an abortion".

Your Patient Had a Self Managed Abortion (SMA) or is Miscarrying

- EDs are likely to see an increase in the number of patients post SMA.
- Post Roe state criminalization of abortion should have no zero impact in this scenario.
- In fact, evaluation and stabilization are required under EMTALA.
- There appears to be clarity on this issue from Health and Human Services. EMTALA preempts contradicting state law.

Your Patient Attempted an SMA but US shows a Fetal Heart-Beat

- Evaluate and stabilize as required (allowed) under EMTALA.
- Carefully document your findings.
- Consult with OB as needed, refer to the community resource list is appropriate.

When Abortion is Required to Stabilize Your Patient

From HHS: July 11th, 2022

Thus, if a physician believes that a pregnant patient presenting at an emergency department, including certain labor and delivery departments, is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment. And when a state law prohibits abortion and does not include an exception for the life and health of the pregnant person — or draws the exception more narrowly than EMTALA's emergency medical condition definition — that state law is preempted.

Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-21-22-Hospitals- UPDATED JULY 2022), available at https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/reinforcement-emtala-obligations-specific-patients-who-are-pregnant-or-are-experiencing-pregnancy-0

Legal Considerations

- Does the First Amendment protect your right to give medical and legal information about self-managed abortion? Probably – Maybe!
- Post-abortion care after fetal demise is no legally riskier than miscarriage management.
- At the moment, there are no mandatory reporting provisions regarding SMAs. Doing so is likely a HIPAA violation and possibly an invasion of privacy. If mandatory reporting provisions are created, leave that entirely to your administration.
- Post-stabilization care is required under EMTALA.
- Avoid patient criminalization. Don’t document information in the chart not required by law nor clinically significant for subsequent providers.

EMTALA covers abortion in Idaho hospitals, judge rules

Molly Gamble (Twitter) - yesterday

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A federal judge temporarily blocked a portion of an Idaho law that would criminalize medical professionals who performed abortions in medical emergencies.

U.S. District Judge B. Lynn Winmill ruled Aug. 24 the state law, set to take effect Aug. 25, violates the Emergency Medical Treatment and Labor Act. The federal law, enacted in 1986, requires that Medicare hospitals provide all patients appropriate emergency care — including medical screening, examination, stabilizing treatment and transfer, if necessary — irrespective of any state laws or mandates that apply to specific procedures.

HHS directed hospitals in July that if a hospital is in a state that prohibits abortion by law and does not make exceptions for the health or life of a pregnant person, EMTALA preempts that state law.

Idaho's abortion law was set to criminalize the performance of most abortions except for limited scenarios, including those where abortion is necessary to prevent the death of a pregnant

https://www.beckershospitalreview.com/legal-regulatory-issues/emtala-covers-abortion-in-idaho-hospitals-judge-rules.html?origin=BHRE&utm_source=BHRE&utm_medium=email&utm_content=newsletter&oly_enc_id=9107H5403578H0D

California Hospital Begins Medication Abortions in the ED -- A Possible First

— "Our job is to treat all comers no matter their medical issue," says researcher

by Randy Dotinga, Contributing Writer, MedPage Today October 5, 2022

SAN FRANCISCO -- A California hospital has initiated at least 50 elective, non-emergent medication abortions in the emergency department (ED) since February, a physician reported here.

Stanford University Medical Center may be the first in the nation both to facilitate non-emergent medication abortions within the ED -- patients are seen and discharged from there -- and have a protocol to do so, said Monica Saxena, MD, JD, of Stanford University School of Medicine in California, at the American College of Emergency Physicians (ACEP) annual meeting.

Criminal Trial Begins For Nurse Who Made Fatal Drug Error

- Nurse charged with reckless homicide and impaired adult abuse.
- Instead of Versed gave Vecuronium. Patient then transported to for CT. Left alone for 30 minutes in scanner before staff realized the patient was not breathing. She died the next day.
- Performed an override of the hospital's electronic medication cabinet.
- Fired and stripped of nursing license.

Former Vanderbilt nurse found guilty

Molly Gamble (Twitter) - Friday, March 25th, 2022 Print | Email

A jury convicted former Vanderbilt nurse RaDonda Vaught of criminally negligent homicide and abuse of an impaired adult, *The Tennessean* reports.

The jury deliberated for approximately four hours before reaching their verdict on March 25. A practicing registered nurse and a former respiratory therapist made up two of the jurors. Ms. Vaught will be sentenced by Davidson County Criminal Court Judge Jennifer Smith — who heard the case — on May 13. She faces up to 12 years in prison.

Emergency Physicians Wary of Unintended Consequences from Criminal Prosecution of Medical Errors

"ACEP strongly supports the culture of safety in medicine and efforts to reduce, prevent and disclose medical errors. However, the recent criminal prosecution of medical errors sets a worrisome precedent.

"Every medical error is regrettable and emergency physicians are trained to operate and thrive in complex and pressure-packed scenarios. Still, all clinicians are human, and mistakes can happen. Emergency departments that successfully embrace a culture of safety are those that encourage every clinician to report, assess, and learn from an error. The threat of criminal prosecution can undermine these efforts.

"Physicians and administrators can also work together to limit errors by reducing the factors that contribute to them. These efforts should include prioritizing fully resourced, sufficiently staffed, and safe work environments for emergency physicians and care teams.

"Every health care professional should be able to rely on their institution to support an environment where efforts to improve patient safety constructively focus on training, education and continuous improvement, rather than criminal punitive action."

Jury deadlocked in murder trial of Ohio physician

- April 2022
- Dr. William Husel ordered fatal dose of fentanyl for patients who were near-death in intensive care.
- That's potentially murder in Ohio.
- Ohio has failed to pass a death with dignity law that would allow terminally ill patients to request life-ending medication.
- Prosecution has to prove guilt beyond a reasonable doubt. Jury struggling with that issue (i.e., firmly convinced of guilt).
- Acquitted!

Current State of EDs Nationally

- Crisis standards of care
- Clearly increases the overall risk to the hospital and practitioner (malpractice, burnout…)
- Document status of ED in an ED log program (hospital obligation)
  - Hallways
  - Holds
  - Waiting Room
  - Diversion, emergency standards
- Document in your note anything unusual about the H&P setting (e.g., waiting room, bathrooms, etc.)

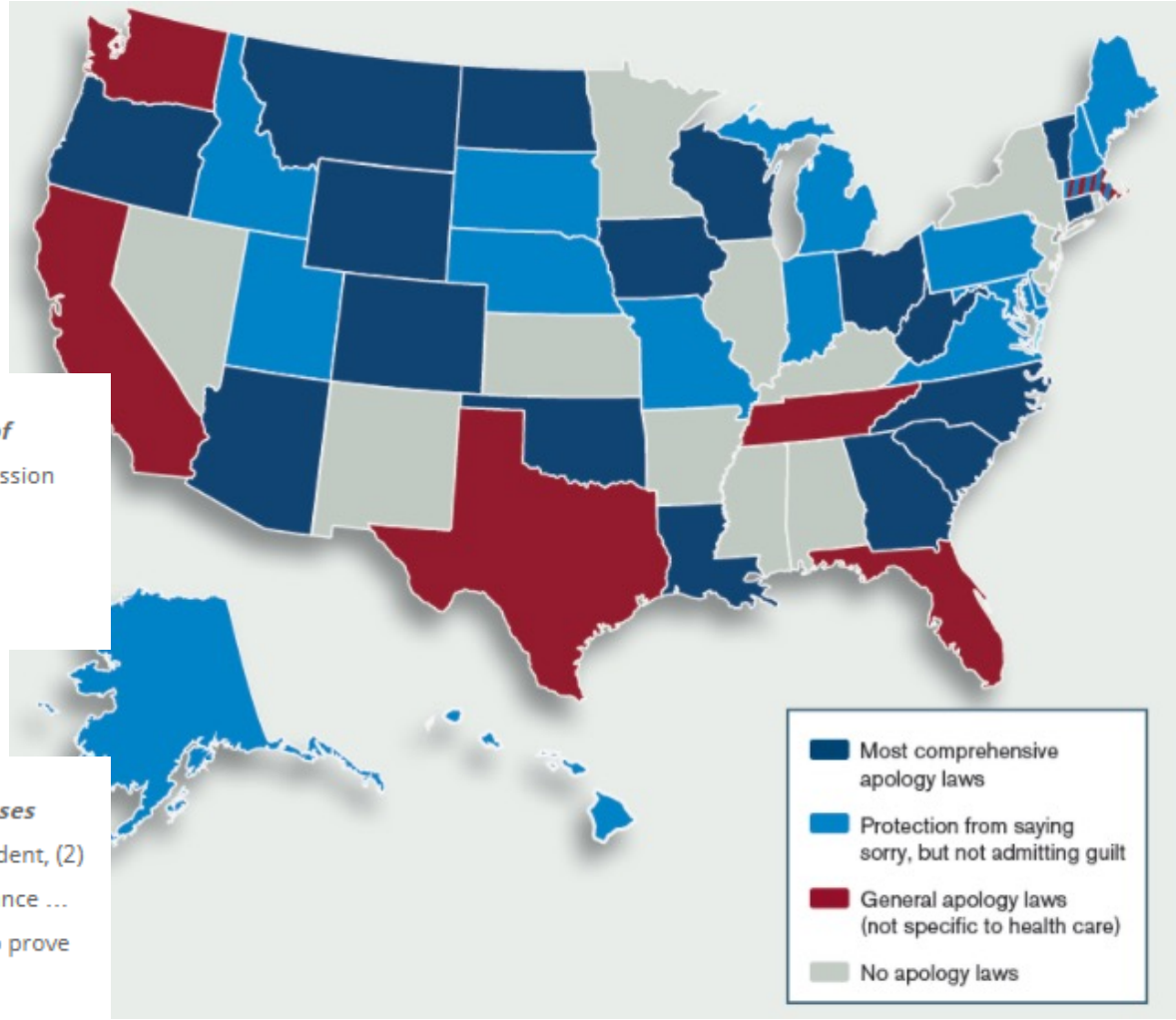
Apology and Disclosure

(1) In any civil action brought by an alleged victim of an unanticipated outcome of medical care … ***any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, error, fault, or a general sense of benevolence that are made by a health care provider*** … that relate to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care ***are inadmissible as evidence of an admission of liability*** or as evidence of an admission against interest. [emphasis added]

A statement, writing, or action ***that expresses sympathy, compassion, commiseration, or a general sense of benevolence*** relating to the pain, suffering, or death of an individual … ***is inadmissible as evidence*** of an admission of liability in an action for medical malpractice.

This section ***does not apply to a statement of fault***, negligence, or culpable conduct … [emphasis added]

Communications of Sympathy (a) A court in a civil action ***may not admit*** a ***communication that: (1) expresses sympathy*** or a general sense of benevolence relating to the pain, suffering, or death of an individual in an accident, (2) is made to the individual or a person related to the individual … ***a communication***, including an excited utterance … ***which includes … statements concerning negligence*** … pertaining to an accident or event, ***is admissible*** to prove liability of the communicator. [emphasis added]



Admission Orders (ACEP 2018)

- Patients are best served when there is a clear delineation of which clinician has patient care responsibility.
- The best practice for patients admitted through the ED is to have the admitting physician (or designee) evaluate and write admitting orders for ED patients requiring hospitalization at the time of admission or as soon as possible thereafter.
- The emergency clinician is responsible for ongoing care of the patient only while the patient is physically present in the ED and under his/her exclusive care.

Admission Orders (ACEP 2018)

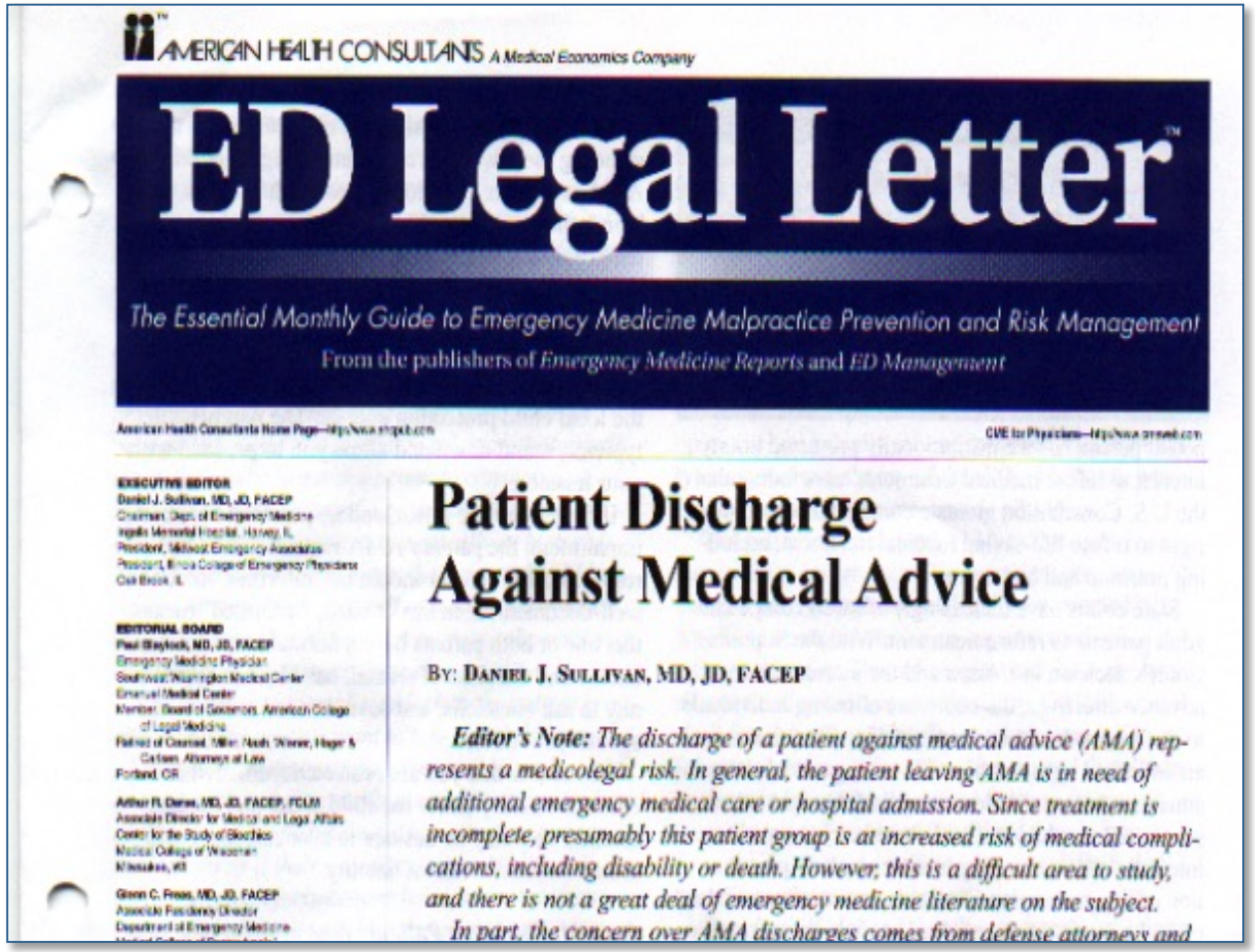
- The admitting physician (or designee) is responsible for ongoing care of the patient after accepting responsibility for the patient's care whether verbally, by policy, or by writing admission orders, regardless of the patient's physical location within the hospital.
- The emergency clinician is responsible for ongoing care of the patient only while the patient is physically present in the ED and under his/her exclusive care.

Against Medical Advice

- Document functional competence.
- Explain the life or limb threat very carefully and document the informed refusal.
- Have a second person witness and document the refusal.
- Provide the patient with an opportunity to change his or her mind.
- Try and go for the ‘partial refusal of care’.

Against Medical Advice

- Do not let the patient's decision affect your duty to provide the best care possible.
- Take all steps to provide treatment and follow-up to the best of your ability, under the circumstances.
- Document your efforts.
- Beware AMA in the patient with head trauma or EtOH.
- AMA is a process, not a form!
- AMA, properly done, will win a lawsuit.



AMERICAN HEALTH CONSULTANTS A Medical Economics Company

ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

From the publishers of *Emergency Medicine Reports* and *ED Management*

Patient Discharge Against Medical Advice

By: Daniel J. Sullivan, MD, JD, FACEP

Editor's Note: *The discharge of a patient against medical advice (AMA) represents a medicolegal risk. In general, the patient leaving AMA is in need of additional emergency medical care or hospital admission. Since treatment is incomplete, presumably this patient group is at increased risk of medical complications, including disability or death. However, this is a difficult area to study, and there is not a great deal of emergency medicine literature on the subject.*

In part, the concern over AMA discharges comes from defense attorneys and

Advanced Practice Clinicians

- Major driver in EM.
- Malpractice Experience – the failure to diagnose
- Issues:
  - Protocols
  - Supervision
- Discussion

Amended X-Ray & Lab Follow Up

- For various reasons, emergency physicians misread x-rays.
- Amended x-ray systems can have a clinical impact.
- This system is protective.
- Make sure the system works well, otherwise it is a liability!
- AI systems that evaluate reports output and automate follow-up.

Amended X-Ray & Lab Follow Up

- Certain labs need a follow up (e.g., blood cultures).
- Patient and PMD contact should be timely.
- Result and action taken must get into the medical record.
- Recommendation:

Use a form or digital strategy for F/U on x-rays, labs, etc.

Gotcha! Condescending Comments

"Trample out the vintage where the grapes of wrath are stored."

Gotcha! Condescending Comments

"Beware the Demon Rum."

Communication & Professionalism (with COVID caveats)

- Critical risk management tool.
- Introduce yourself, shake a hand, touch a shoulder.
- Sit down.
- Close the door (if there is one).
- Let the patient know you are ready to listen.
- Let the patient participate.

Communication & Professionalism

- Communication with:
  - EMS
  - ED team
  - Consultants and on-call physicians
  - Family
- Communication after the patient encounter ends: the call-back system

Communication & Professionalism

- Patient perception “The physician never examined me.”
- Don’t set unrealistic expectations
- Comments about or by fellow health care providers.

Defamation

- Definition: communication to a third party of false information that injures reputation
- Slander and Libel
- Don’t fall into this trap
- Intentional Tort
- Not covered by malpractice or any other insurance policy.

Cures Act

- If you don’t want to see your documentation blown up on a 4’ by 6’ Powerpoint, take care.
  - Patient is a drunk (patient is ataxic and has slurred speech)
  - Patient is a frequent flyer (patient known to make frequent visits to this ED)
  - Behavioral health issues
  - Sexually transmitted infection
- Patient may know their lab results before you do.
- ACEP working to get ED information transmission delayed at least until the end of the visit.

Patient – Physician Relationship

- Does the EP have a legal relationship with:
  - The patient in the ICU whose x-ray was just checked for NG tube placement?
  - The child in the waiting room with a temp. of 103°F?
  - The burning man?
- Discussion

Patient – Physician Relationship

- Does the EP have a legal relationship with:
  - The patient sent in by the PMD for direct admission, perched in your ED?
  - A 2 y.o. child in route to your hospital with shortness of breath?
- If so,

when does the relationship end?

In-House Emergencies

- Recognize as a high-risk venture.
- Good Samaritan coverage?
- EPs will want to be sure that their malpractice insurance policy specifically covers in-house.
- Contract issue:

> In-house can only be covered when it's reasonable to leave the ED.

Duty to Third Parties

- At common law, no duty to protect one person from another.
- Courts are increasingly recognizing the physician's duty to third parties.
- General Premise:

> You are required to use reasonable care to protect your patient, and you may be required to prevent reasonably foreseeable injuries to third parties.

Duty to Third Parties

- Does the EP and ED staff have a duty to keep third parties safe from harm?
  - A patient you sent home with an eye patch gets in a car accident. You did warn about driving. The driver of the other car sues you for negligent discharge.
  - A 25-year-old homicidal patient absconds because you did not restrain him. He kills a patient on the sidewalk outside the ED. Are you liable?

EtOH = RED FLAG!

- Alcohol intoxication is a red flag.

- Key Points:
  - Don’t delay the H & P in the intoxicated patient.
  - Be aware of the high risk of head trauma and spinal injury.

Malpractice Insurance Coverage

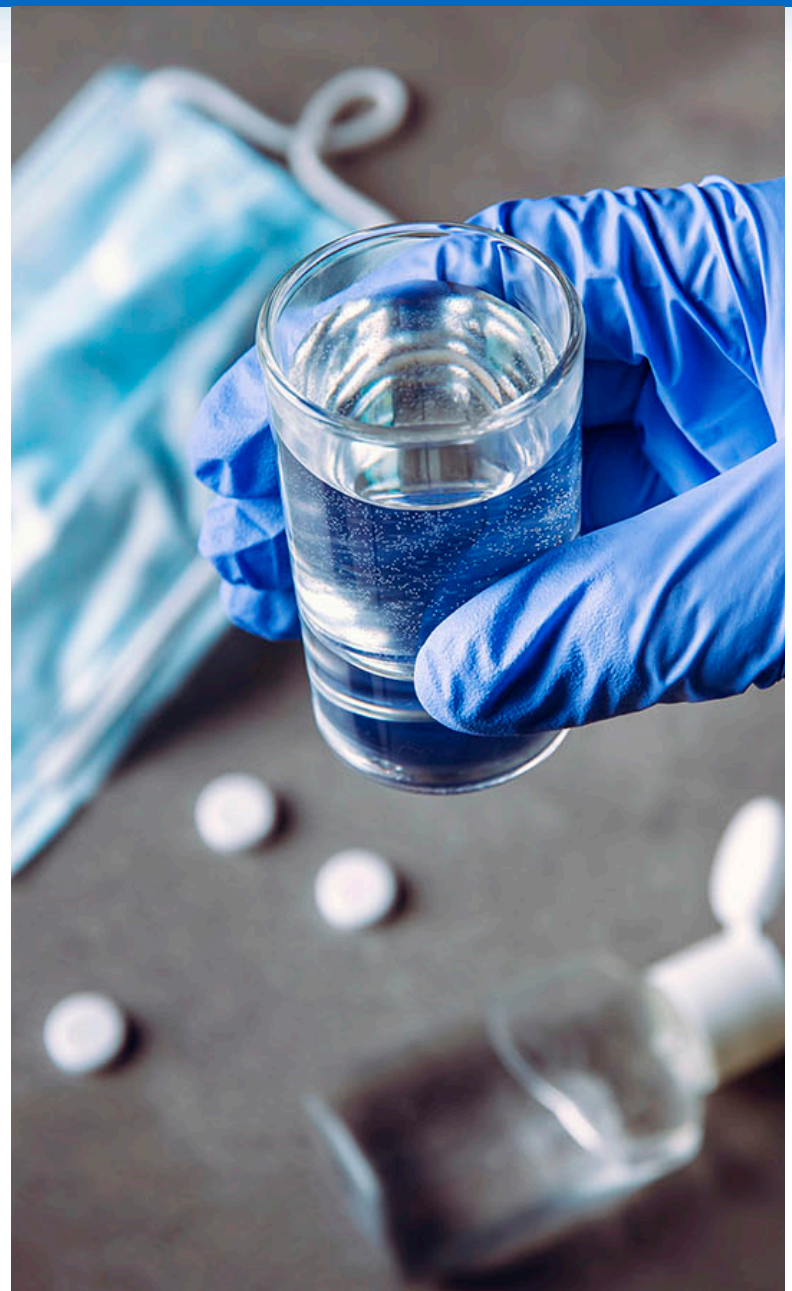
- Errors and omissions in direct patient care
- Medical care outside of the emergency department related to the contract for emergency services:
  - Codes
  - Deliveries
  - Inpatient restraint application
  - Out of hospital care but on hospital property
  - Medical care in the community related to the emergency medicine contract or at the direction of the hospital
  - EMS activities

Malpractice Coverage Exclusions

- Community activities unrelated to the group contract or hospital
  - Church events
  - Sporting events
  - Curbside consults from friends
  - Good Samaritan Activities
  - Prescribing medicines for acquaintances

Malpractice Coverage Exclusions

- Individual physician contract often contains specific exclusions even if the conduct occurred in the course of an ED shift:
  - Under the influence
  - Criminal conduct



Judgments in Excess of Policy

- Policies typically 1M per occurrence
- The vast majority of settlements and verdicts occur within this limit
- Anything above the limits can come from the physician or group
- Asset protection planning
  - Tenancy by the Entirety
    - Real Estate
    - All property
  - Retirement accounts
  - Give it away

Refusal of Care

- Parent refuses care for a minor:
  - If non-emergency, courts support parent's decision
  - If emergency, courts mandate treatment. Therefore, treat, and consider taking temporary protective custody.

- Parent refuses care for a minor:
  - If it's an emergency, courts assert the states interest in protecting the child.
  - Parents may not make martyrs out of their children.

Religious Beliefs

- Jehovah's Witness
  - Transfusion will lead to loss of eternal life.
  - No whole blood, packed cells, white cells or plasma
  - No autotransfusion of pre-deposited blood
  - Many permit the use of albumin, immunoglobulins, hemophiliac factor, hetastarch, dialysis and heart lung equipment

Refusal of Care

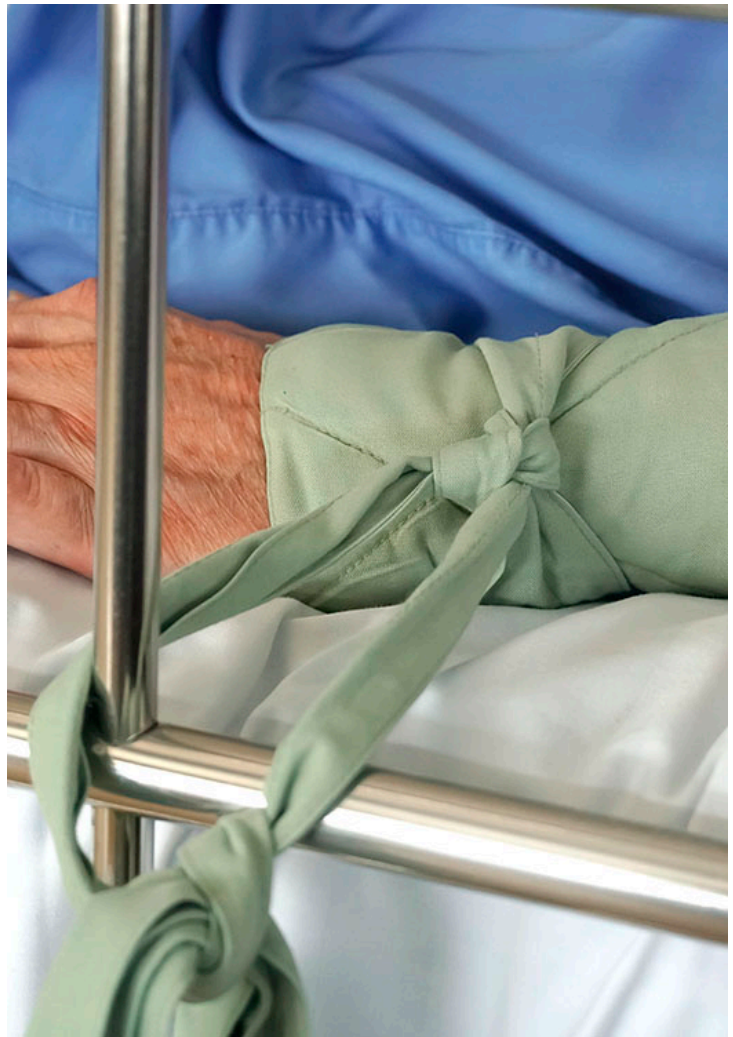
- Based on Religious Belief:
  - Patient competent - Respect his/her wishes
  - Patient not competent:
    - Patient's wishes clear: withhold tx.
    - Patient's wishes not clear: treat

"Don't Go It Alone. Get Help!"

Civil Commitment (Assault & Battery)

- Involves infringement of civil liberties and may create a special liability risk for ED personnel
  - Know how to do it. Comply with:
    - Law
    - Regulation
    - Documentation
    - patient rights.
- Perform a careful H & P with focus on both psych and other causative underlying medical problems.
- Respect patient's rights to confidentiality and privacy.

Patient Restraint (Assault & Battery)



- Restraints should be individualized to the situation, maintain patient's privacy and dignity.
- Protocols should be in place to ensure patient safety.
- Consider search on all restrained patients for dangerous items.
- Least restrictive restraint possible.
- Document carefully.

Patient accuses former Tennessee hospital CEO of assault with a deadly weapon

Ayla Ellison (Twitter) - 3 hours ago Print | Email

The former CEO of Bristol (Tenn.) Regional Medical Center who participated in a surgical procedure without a medical license is being accused of assault with a deadly weapon by the patient, according to *WJHL*.

Greg Neal stepped down as CEO of the hospital, part of Johnson City, Tenn.-based Ballad Health, in August 2020 and subsequently said he was asked to resign for participating in a surgical procedure. The resignation came after a cardiothoracic surgeon, Nathan Smith, MD, invited Mr. Neal to enter the operating room to observe the surgery and asked him to make the initial incision for the procedure.

Mr. Neal admitted his role in the incident, saying he regretted making the incision and accepted accountability.

"More importantly, I apologize to the patient and their family. I apologize to the team members of Ballad Health, and to the leadership of Ballad Health," Mr. Neal told the *Bristol Herald Courier* in 2020.

Ballad officials launched an investigation, which concluded with asking Mr. Neal to resign and firing Dr. Smith.

The patient sued Ballad Health, Mr. Neal and Dr. Smith in 2021, alleging medical malpractice and civil tort battery.

Assault and Battery

- Unusual but certainly not unheard of in the ED
- Particularly in restraint cases

Assault definition

Act with intent to batter, hit, or wrongfully touch the victim.

Battery definition

Intentional or wrongful touching.

- Intentional torts not covered by malpractice or any other type of policy

False Imprisonment

- Complete restraint upon a person's liberty of movement without legal justification
- Most commonly alleged in restraint cases
- Intentional tort not covered by malpractice or other insurance policy

Child Abuse

KNOW THE LAW

in your jurisdiction.

KNOW HOW

to take protective custody.

BE AWARE

that physicians have immunity from liability for any action taken in good faith.

Evaluation and Treatment of Minors

Absent Parental Consent

If in your discretion, delay may result in injury, treat the child. (state law)

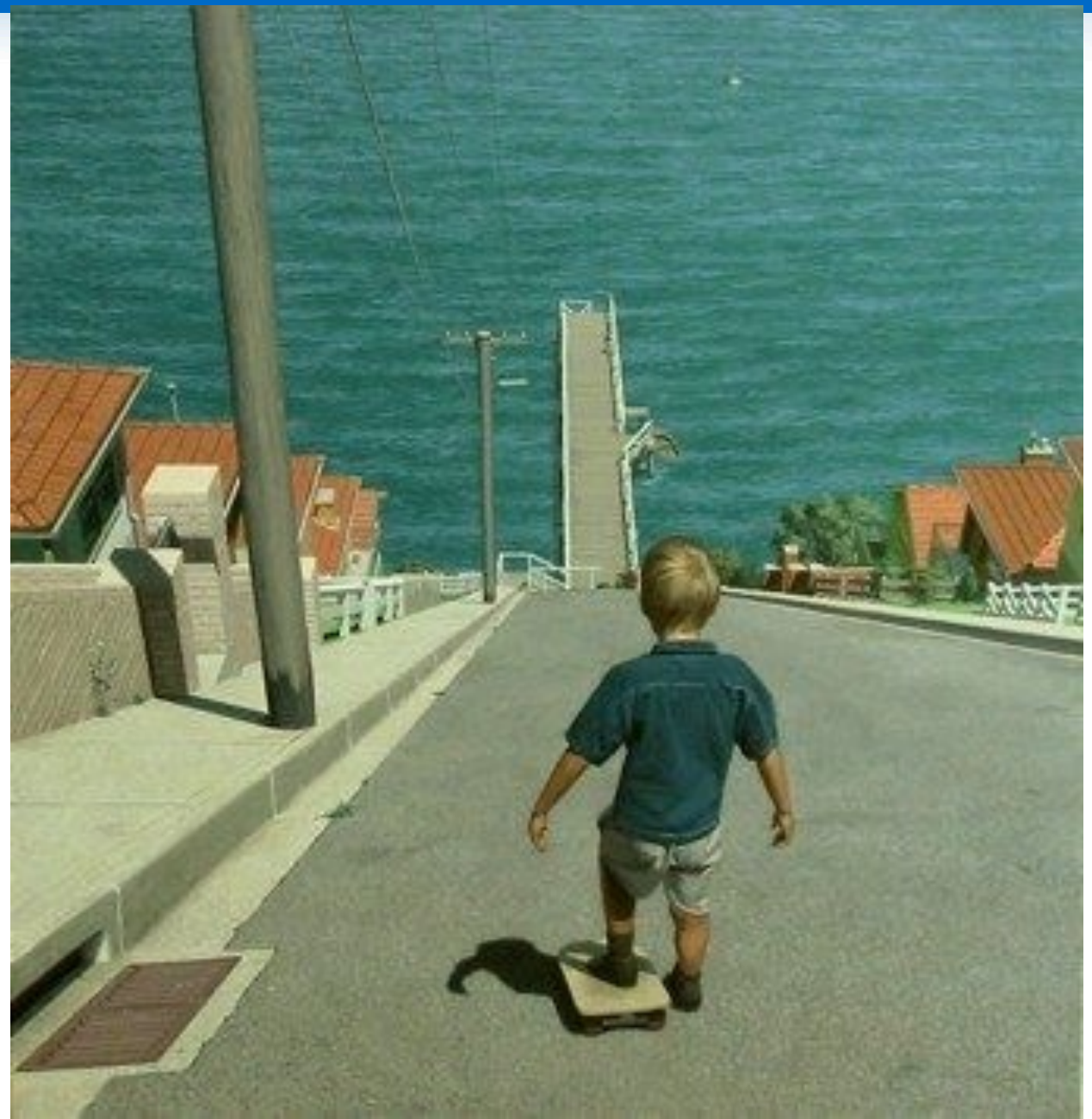
EMTALA

Also provides a basis for providing a medical screening examination without parental consent.

ACEP

Don’t delay treatment for consent.

www._____.com



Thank You

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