

Malpractice and Emergency Medicine

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Every Emergency Physician fears being sued. Unfortunately, the practice of Emergency Medicine is high risk and malpractice claims stemming from emergency care number about 20% of all claims occurring in hospitals. The Emergency Department is the third riskiest area of the hospital following the operating room and the delivery suite. Malpractice premiums paid by Emergency Physicians have risen dramatically over the last years with a 200 % rise in some States.

Lawsuits against Emergency Physicians are not nuisance claims: more than half of legitimate claims involve serious disability or death. Surprisingly, the big payoffs do not go for the missed hard-to-diagnose Zebra conditions. They come from missed bread-and-butter cases such as missed M.I., ectopic pregnancy, appendicitis, meningitis, missed fractures and soft tissue foreign bodies. Half of all patients who file successful lawsuits met standard criteria for hospital admission, yet serious illness was not even considered by the Emergency Physician. As is often said, it is not the one you anticipate that gets you into trouble, but the one you never expect. In other words, if you knew or thought that a patient would have a bad outcome, you would have instituted means to protect both your patient and yourself.

Understanding the Law

There are two major bodies of legal action; criminal and civil. A criminal action is one in which the state or government sues an individual for a wrongdoing considered against public interest. Examples are murder, rape, theft etc. These are not usually the kind of suits brought against the Emergency Physician unless the physician willfully injured a patient (e.g. assault and battery- restraining a competent patient, forcibly giving an injection, without permission, doing a surgical procedure, sexual battery in the case of a refused pelvic exam). It should be recognized that a physician's malpractice insurance will not cover criminal liability. The other great body of lawsuits are civil actions which are in essence private disputes of one person against another. Within civil law is one subset of tort law. A tort is simply a wrongdoing. Negligence falls within tort law. Within the tort law governing negligence, is professional negligence or malpractice.

In cases of medical malpractice, the plaintiff (patient) has the burden of proof for four elements:

1. The physician owed the patient a duty of care- For the Emergency Physician this includes providing service in the first instance for any patient coming through the door (whether to be seen by the Emergency Physician or another physician or service). That liability may also lie outside his/her Emergency Department door in the case of patients transported under protocol or radio contact by EMS personnel. Patients transferred to the E.D. by consent of the Emergency Physician whether or not transfer occurs by ambulance are his/her liability as are patients who are given telephone advice.
2. The Emergency Physician's care fell below an acceptable standard- This is defined as the failure to provide care that an Emergency Physician of ordinary learning, judgment or skill in emergency medicine would do, or not do, under the same or similar circumstances. This is determined by the jury. If there is a protocol or nationally recognized standard, as in standards published by ACEP, this is the standard by which the physician is judged. Physicians who work (moonlight) in Emergency Departments but who are not trained in Emergency Medicine are held to the same standard of care as those trained/boarded in Emergency Medicine. The standard of care in Emergency Medicine is considered a national standard ,in most cases, rather than a local standard (e.g. assumed to be the same everywhere).
3. The plaintiff had sustained an injury or damages-this does not necessarily just mean a bad outcome. Death is often the result of a patient given CPR; however, the physician may not have delivered substandard care. The damages vary depending on the case. They may include loss of past or future wages, past and future medical expenses, pain and suffering and loss of consortium. Other damages include loss due to embarrassment,

humiliation or emotional distress resulting from the injury or disfigurement or loss of business because of inability to work.

4. The injury sustained by the plaintiff directly resulted from the physician's failure to meet an acceptable standard of care. In legal terms, the professional negligence of the defendant was a proximate cause of the injury and damages to the plaintiff.

OTHER TERMS

STATUTE OF LIMITATION- the length of time after medical care has been rendered that a lawsuit can be instituted. Although this varies from state to state, most states have two years as the limit. Some states have a clause that includes a wait of 6 months after the plaintiff discovered the alleged acts of malpractice. This would allow a suit to be instituted many years after the event if it was not discovered by the plaintiff (an example would be the discovery of a foreign body in soft tissue upon operation 10 years later for chronic pain at the site). In the case of minors, often it is stated that a suit can be instituted a period of time (most often 2 years) after discovery and after majority (18th or 19th birthday). Thus an injury that occurred at age 2 may be filed 20 years later! Exceptions to the statute of limitations include discovery prevented by fraudulent conduct of the physician, a foreign body wrongfully left in the patient's body, or an injury involving the reproductive system.

DOCTRINE OF COMPARATIVE NEGLIGENCE-The plaintiff's negligence, if any, does not bar a recovery by the plaintiff against the defendant doctor. If a physician's care falls below the standard and there is injury, even if the patient contributed to that negligence (not following instructions for example), even though the patient's negligence contributed to the bad outcome, the physician is still liable. Usually, the total amount of damages to which the patient would otherwise be entitled is reduced by the percentage that the patient's negligence contributed to his/her injury.

Successful Lawsuits in Emergency Medicine: Most Frequent Cases*

1. Failure to diagnose a fracture or dislocation
2. Failure to diagnose a foreign body in a wound
3. Failure to diagnose complications of lacerations, including tendon or nerve damage
4. Failure to diagnose and treat myocardial infarction
5. Failure to diagnose appendicitis
6. Accident in the Emergency Department
7. Failure to diagnose meningitis
8. Failure to diagnose skull or facial fracture
9. Failure to diagnose ectopic pregnancy
10. Failure to diagnose ruptured spleen, liver or other viscus
11. Failure to diagnose respiratory obstruction

* taken from Risk Management in Emergency Medicine ACEP 1985

High-Risk Situations in Emergency Medicine

“TEMPORAL FACTORS- approximately 63% of all malpractice incidents occur between the hours of 6 pm and 1 am on weekends and holidays. These are generally the busiest hours in the ED and waiting times tend to be longer and patients are apt to be angry. The hours from midnight to 7 am on weekdays tend to be the second highest risk period.”¹ Perhaps the ED is staffed with fewer nurses and doctors during these times or staffed with part-time physicians or moonlighting physicians. Fatigue also undoubtedly plays a role in the early morning hours unless the physician is working permanent night shift. Ancillary tests (X-ray, lab, CT etc.) may not be as available during these times.

SHIFT WORK- The risk of malpractice increases with the duration of the physician's shift. The problems with shift work include sleep disorders, decreased vigilance, and poor job performance.

PHYSICIAN SHIFT CHANGE- Change of shift is considered by physicians, risk managers and attorneys to be an extremely dangerous time for patients. Normal vigilance is relaxed when a physician thinks a patient has already been evaluated properly by another physician. Change-of-shift lawsuits can be complicated. First, two physicians are involved in the case which may double awards available to the plaintiff. The exact point at which one physician's responsibility ceased and the others began is difficult to determine and may lead to infighting and bickering between the two defendants."¹ Frequently, there is lack of documentation or contradictory documentation. To guard against this problem, the physician who discharges the patient should be the physician of record and carries the responsibility for the evaluation of the patient and for the discharge program. Normally, every patient turned over at shift change should be re-evaluated by the responsible physician within 15 minutes of assuming care.

RETURN VISITS-The question of return visits to the ED has been carefully studied. The impression of most Emergency Physicians that such patients are abusing or misusing the emergency department is incorrect. The diagnosis on the first visit may be wrong in up to 25% of the cases."¹ Physicians should view the patient with a return visit as a patient that is giving the physician and institution a second chance to solve the problem and should be evaluated as if he/she were a completely new patient.

LANGUAGE BARRIERS- Communication is a key element of medical practice. A physician who can not understand his patient or a patient who can not understand his doctor is a high risk situation. Interpreters must always be available. Cases are not dismissed and injury forgiven because of a language barrier.

PHYSICIAN ORDERS BY TELEPHONE- An Emergency Physician should never defer to a consultant who has not seen the patient. All too often if a problem arises, the consultant will forget the conversation or say "if I knew he was that ill (or if you would have told me), of course, I would have admitted him". If the consultant disagrees with the Emergency Physicians evaluation, it is the consultant's responsibility to personally examine the patient and make a disposition regardless of the time of day or night or the inconvenience to the consultant.

INFORMED CONSENT-Obtain informed consent when performing procedures that carry some risk to the patient. Physicians should explain risks involved with the treatment, the alternatives and consequences that would ensue should the patient refuse treatment. The general consent form that patients sign when entering the E.D. do not protect against specific injury. Obtain consent for L.P.'s, cardioversion, chest tubes, repair of extensive lacerations, tendon lacerations, removal of foreign bodies, and reduction of fractures. Not only is this good sense- it also is required by the State of Georgia to maintain your license to practice medicine in the State!

ADDENDUM: Obtaining consent to treat patients who present for care to the Emergency Department

Valid consent to treat is obtained from every patient seeking care in an Emergency Department. This is informed consent and the patient may expect to be informed to the risks versus benefit of seeking or not seeking care. There are several important considerations:

THE PATIENT WITH AN EMERGENCY UNABLE TO GIVE CONSENT- The emergency medicine exception to the informed consent doctrine can be summarized by the statement that a physician may treat a patient, in a true emergency, without the patient's consent. This practice assumes that the average, reasonable, competent patient would agree to treatment in an emergency situation if he/she were able to do so. Disagreement ensues over what is an emergency situation (most generally defined as "life or limb threatening"). The responsibility is usually placed upon the physician to make a clinical determination of when an emergency exists.

MINOR NOT ACCOMPANIED BY A PARENT OR GUARDIAN- authorization for treatment of a minor is necessary for all children except:

1. Patient is in danger of losing life, limb or body function. Two physicians need to document this in the medical record.

2. Patient is seeking treatment for pregnancy or venereal disease, in which case the minor may consent to treatment of those specific entities- that consent is binding and valid
3. Patient is an emancipated minor (e.g. patient is of minor age but has severed all legal ties with parents or guardian and maintains own separate residence)

UNACCOMPANIED UNCONSCIOUS PATIENTS- Patients who arrive in the E.D. unconscious are evaluated and treated upon arrival under the implied consent doctrine.

TREATMENT OF INCOMPETENT ADULTS- Incompetent adults are treated without a court order if they are in danger of losing life, limb or body function under the implied consent doctrine. In the case of an incompetent adult patient not under guardianship or conservatorship where the attending physician is of the opinion that emergency treatment is not immediately indicated, treatment should be withheld until a court order is issued authorizing such treatment.

1. Emergency Medicine Reports, Volume 11, No 2, January 15, 1990.