

Chapter 41

Professional Liability in Emergency Medicine

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Professional Liability Claims
The "Duty" Element of Professional Liability Claims
Conclusion

The largest study into adverse patient events ever performed identified the emergency department (ED) as the hospital entity with the highest incidence of adverse patient events due to negligence.¹ When one considers the complex factors at play in the emergency medicine milieu, it should come as no surprise that emergency medicine is near the pinnacle of the ultra-high-risk specialties. Let us look at some of those factors.

First, emergency medicine operates 24 hours a day, 7 days a week, including weekends, nights, and holidays at times when many resources are unavailable. In addition, access to a patient's critically important medical records, prior EKGs, x-rays, diagnostic studies, and laboratory tests, as well as other vital information, may not be possible. It is also difficult or impossible to contact a patient's personal physician to discuss the patient's past medical history, medication history, or allergy history after "regular business hours" and on holidays.

Second, unlike virtually every other medical specialty, there is no limit to the number of unscheduled patients who may present for emergency care at any given time; the emergency physician and nurse may be responsible for the simultaneous care of a potentially unlimited number of critically ill or injured patients. In terms of sheer volume, our nation's emergency departments are faced with the crushing burden of serving as America's safety net. Emergency department visits have increased 15% since 1990 and today more than 100 million Americans annually depend on our EDs to come through for them in their hour of need. 42.6 million Americans had no health insurance in 1999² and the ED is their only source of medical care. In addition, another several million homeless Americans with no other source of health care depend on our nation's EDs for their medical care.³

Third, in addition to caring for the enormous volume of patients presenting to our nation's EDs, emergency physicians care for patients who are suffering from illnesses or injuries of much greater acuity than most other specialties. For example, 40% of all hospital admissions nationwide originate in the ED.⁴

Fourth, emergency physicians must operate within a very narrow window of time (minutes to hours) in which

to determine whether a patient is suffering from a potentially catastrophic condition. Furthermore, emergency patients, who may be suffering from a host of comorbid conditions, are virtually unknown to their emergency physicians and emergent treatment must be initiated with only limited and often no information available about a patient's past medical or surgical history.

Finally, and perhaps most importantly, the difficulties routinely faced by emergency physicians and nurses are further compounded by the fact that many of the highest risk emergency diagnoses, such as acute appendicitis,⁵⁻¹¹ myocardial infarction,¹²⁻¹⁸ pulmonary embolism,¹⁹ abdominal aortic aneurysm,^{20,21} or subarachnoid hemorrhage,^{22,23} may have atypical or ambiguous presentations (Table 41-1).

PROFESSIONAL LIABILITY CLAIMS

Failure to Diagnose

The majority of professional liability actions against emergency physicians arise under a "failure to diagnose" claim, i.e., where an ED patient's diagnosis is either missed entirely or the diagnosis is made but in a delayed fashion (Table 41-2). Specifically, the high-risk presentations of chest pain, abdominal pain (in a patient of any age or gender), febrile infants, headache, fractures, and wound management constitute 70% of professional liability claims against emergency physicians.^{24,25} Two important factors that contribute to the missed emergency diagnosis are (a) a failure to initiate an appropriate diagnostic evaluation, and (b) an atypical or ambiguous manifestation of the high-risk presentation may obscure the nature of the illness.

Failure to Initiate Appropriate Workup

Since each one of the above high-risk presentations suggests the possibility of a catastrophic illness, the emergency physician's evaluation of such presentations will ordinarily consist of an extensive workup appropriately tailored to the patient's complaint. Failure to initiate an appropriate workup of the high-risk patient may result in a delayed or

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1. Emergency patients are usually unknown to their emergency physicians; emergency medicine operates at times when vital patient records are inaccessible.
2. There are no limits to the numbers of patients that must be seen in emergency medicine.
3. Emergency patients suffer from illnesses and injuries of greater acuity than most other medical specialties.
4. Emergency physicians have a very narrow time frame within which to identify a life-threatening condition.
5. Many of the highest risk emergency diagnoses present in an ambiguous or atypical manner.

Table 41-1 Factors contributing to risk in emergency medicine

a missed diagnosis and result in a professional liability claim against the physician.²⁶⁻²⁸ A typical jury instruction in a “failure to diagnose” case highlights the issue:

If you find from the evidence that the defendant doctor did not exercise the appropriate degree of skill and care, as to which you have been instructed, in making his/her diagnosis of the ailment which is the subject of this action, and that such erroneous diagnosis resulted in injury to the patient, you may find that defendant's inaccurate diagnosis or failure to diagnose the ailment constitutes malpractice.²⁹

Therefore, it is incumbent upon the emergency physician to demonstrate that he or she took the high-risk presentation seriously, and a mere cursory examination on the part of the physician in such patients is a recipe for disaster. However, an extensive diagnostic evaluation in the ED does not guarantee that a catastrophic diagnosis will be excluded, and a definite percentage of catastrophic diagnoses go undetected in the absence of any negligence, and despite an appropriate ED evaluation. For example, despite increased utilization of such technological advances as abdominal and pelvic computerized tomography (CT), ultrasonography, and laparoscopy, the timely and accurate diagnosis of appendicitis has not improved.³⁰ This technology has improved the diagnostic accuracy of appendicitis in children.³¹ It should be noted, however, that even with the availability of advanced technology the diagnosis of appendicitis in children remains difficult.^{32,33} The appropriate emergency evaluation and treatment of high-risk presentations is obviously beyond the scope of this chapter and the reader may wish to refer to a variety of references focusing on the high-risk patient.³⁴

1. Failure to initiate an appropriate diagnostic workup.
2. Atypical presentations of a high-risk diagnosis.
3. Failure to properly interpret diagnostic tests.
4. Failure to obtain a consult.
5. Failure to receive results of diagnostic tests.
6. Refusals of treatment.

Table 41-2 Factors that contribute to a delay or a failure to diagnose the high-risk patient

Atypical Manifestations of the High-Risk Presentation

A catastrophic illness may present with atypical or ambiguous symptoms that can lead to a delay or failure to diagnose. Many high-risk patients, particularly those at both extremes of age, will present to the ED with an atypical presentation of their illness. In addition, most of the potentially catastrophic illnesses share symptoms or signs with benign conditions that can lead to ambiguity in the high-risk patient's presentation. This will often result in the ED physician forgoing a particular diagnostic test that would have been routine had the presentation been “classic” for the high-risk illness. For example, it is estimated that at least 25% of myocardial infarctions occurring in patients over the age of 65 years have no chest pain.³⁵⁻³⁷ For another example, consider that the “classic” presentation of acute appendicitis with initial onset of poorly localized visceral pain in the periumbilical region and subsequent migration to the right lower quadrant of the abdomen occurs in only 60% of cases.^{38,39}

Other Factors Contributing to Delay or Failure to Diagnose

Other factors that have been cited as contributing to a delay or failure to make the high-risk diagnosis include misinterpretation of laboratory data or diagnostic studies, failure to receive the results of a diagnostic study, and failure to obtain a consult with a specialist.

Treatment Refusals: A Guaranteed Missed Diagnosis

Patients who are brought to the ED and who refuse evaluation are extremely high-risk in that it is a virtual certainty that the patient's illness will not be diagnosed. Great care must be made in these cases to ensure that the patient's refusal of care is voluntary and fully informed and is not based on an underlying organic process that may impair the patient's sensorium. The estate of a patient who dies shortly after he has been discharged from the ED against medical advice may have a valid claim against the emergency physician if it can be proved that the patient died of a condition that would have made it likely that he did not possess adequate decision-making capacity or was not in full command of his mental faculties at the time of his refusal of treatment. An understanding of the law concerning the management of patients who refuse emergency treatment is vital if we are to reduce the incidence of missed diagnoses in patients who refuse care (Table 41-3). (For excellent in-depth reviews of general consent theory and the evaluation of patient competence, the reader is referred to Chapters 32 and 33 of this volume.)

Most ED patients present for care of their own volition and are cooperative and eager to receive treatment. However, many patients are brought to the ED by paramedics or police not of their own choice but by virtue of an injury or illness that initiated an emergency medical services (EMS) response. Such patients may be uncooperative and refuse treatment and are often referred to as “difficult patients” in

1. A mental status examination must be performed on every ED patient who refuses treatment to assess the patient's decision-making capacity.
2. Patients who possess adequate decision-making capacity based upon the emergency physician's mental status examination may refuse treatment even if their refusal may result in their death.
3. Patients who do not possess adequate decision-making capacity may not refuse emergency medical treatment and treatment will proceed on the basis of the emergency exception to the general consent theory.
4. Suicidal patients may not refuse emergency medical treatment, even if they pass their mental status examination.
5. Documentation in the medical record must reflect the basis upon which the emergency physician either accepted or rejected a patient's treatment refusal.
6. Emergency treatment of a minor should never be delayed because there is difficulty in obtaining consent.

Table 41-3 Management of treatment refusals

the medical literature.⁴⁰⁻⁴⁷ Many difficult patients brought to the ED are suffering from subtle or profound mental impairment due to a traumatic head injury, the influence of alcohol or drugs, or an acute psychosis,⁴⁸ and their impaired sensorium renders them lacking in the decision-making capacity requisite to an informed treatment refusal.^{49,50}

A major tenet of Anglo-American law is the respect accorded individual autonomy and the protections afforded the integrity of one's person. This respect for individual autonomy is translated into our modern consent theory, very clearly expressed in the immortal words of the great Justice Benjamin Cardozo nearly one hundred years ago: "Every human being of adult years and sound mind has the right to determine what shall be done with his body."⁵¹

Emergency physicians may proceed with treatment and evaluation of their patients only after obtaining the patient's permission.⁵²⁻⁵⁷ In the case of a minor patient, authority to consent is transferred to the patient's legal guardian or closest available relative.⁵⁸ Emergency treatment of a minor, however, should never be delayed because of difficulty in obtaining consent. In essence, no treatment may be initiated on behalf of a patient until the physician has explained the material facts concerning the treatment, including its risks and its alternatives (including nontreatment). The objective is then to obtain the patient's competent, voluntary, and understanding permission to proceed.⁵⁹⁻⁶⁵ The corollary to the informed consent theory is the doctrine of "informed refusal" whereby a patient's refusal of a recommended diagnostic or therapeutic course of action must be based on a full understanding of the risks associated with that refusal.⁶⁶

In order for a patient to give a valid consent for treatment, he or she must be legally competent to do so. Competence is a *legal* and not a medical concept. All adults are presumed by law to be competent, and only a judge may declare an individual incompetent, usually in the setting of a formal judicial proceeding. If a patient presenting for treatment has been declared *incompetent* by a judge, consent must be obtained from the patient's designated

conservator or guardian *ad litem* prior to initiating treatment. Otherwise, every adult patient is presumed to be legally competent to accept or refuse treatment. With notable exceptions, minors are legally incapable of giving consent⁶⁷⁻⁶⁹ (see Chapters 32 and 55 of this volume).

Capacity, on the other hand, is a *medical* concept and is the basis by which physicians can determine whether a patient is capable of granting an understanding and informed consent (or refusal) to treatment.⁷⁰ Capacity implies that the patient is in sufficient command of his or her mental faculties to understand the ramifications of the proposed diagnostic workup or treatment regimen and is capable of giving his or her informed consent. There are many medical conditions, acute and chronic, that may impair an individual's capacity to adequately understand the nature of his or her illness and the recommended course of treatment. These conditions are never at greater play than in the emergency department.

The Emergency Privilege

Many patients presenting to the ED for care are unable to provide a valid refusal or consent to treatment because they are suffering from an organic process that renders them lacking in capacity. For example, patients with cardiac arrest, ventricular fibrillation, diabetic ketoacidosis, shock, or status epilepticus are unable to consent to treatment. Obviously such patients will suffer catastrophic consequences if emergent treatment is delayed or withheld on the basis of a lack of consent. To avoid such an unfortunate result, the law has created a legal fiction known as the "emergency privilege" or "emergency exception to the consent doctrine" that allows for the treatment of emergency patients to proceed in such cases without the patient's informed consent.⁷¹⁻⁷⁵ Three requirements must be met in order for the emergency privilege to apply:

*(a) the patient must be unconscious or without capacity to make a decision, while no one legally authorized to act as agent for the patient is available; (b) time must be of the essence, in the sense that it must reasonably appear that delay until such time as an effective consent could be obtained would subject the patient to a risk of a serious bodily injury or death which prompt action would avoid; and (c) under the circumstances, a reasonable person would consent, and the probabilities are that the patient would consent.*⁷⁶

A mental status examination must be performed on every patient who refuses treatment in the ED to determine whether he or she possesses adequate decision-making capacity.⁷⁷⁻⁷⁹ Any patient who on the basis of an emergency mental status examination is found to lack decisional capacity may not give a valid refusal of emergency treatment and the emergency physician should reject the patient's refusal and proceed to treat on the basis of the emergency exception to the consent doctrine.⁸⁰⁻⁸² On the other hand, if the patient has a normal mental status examination and can articulate understanding of the risks and benefits of the proposed evaluation or treatment, the patient may refuse treatment even if the patient's refusal

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may result in his or her death.⁸³ It is vital that the emergency physician carefully document the results of the mental status examination and the basis on which the physician either accepted or rejected the patient's treatment refusal. The following short paragraph is one method of documenting the basis upon which a physician has accepted a patient's treatment refusal:

The patient has refused any further evaluation or treatment in the emergency department. I have carefully explained the risks (including death) as well as the benefits of my proposed treatment and evaluation and I have answered each one of the patient's questions pertaining to my proposed care. The patient has articulated understanding of the risks and benefits, which I have explained to his/her satisfaction. Based upon the patient's completely normal mental status examination [which must be documented in the medical record] I have determined that the patient possesses adequate decision-making capacity and I have accepted the patient's refusal of emergency evaluation and treatment. The patient is discharged from the emergency department against medical advice (AMA) according to his/her wishes.

The following language may express the basis for an emergency physician's rejection of a patient's treatment refusal and should be included in the patient's medical record:

The patient has refused any further evaluation or treatment in the emergency department but is unable to articulate understanding of the risks of his/her treatment refusal. Based upon the patient's mental status examination, which he/she failed, [the mental status examination must be documented in the record] I have determined that the patient lacks adequate decision-making capacity and may not refuse treatment in view of the potentially serious nature of his/her illness/injuries. I have initiated emergency treatment and evaluation for the patient on the basis of the emergency exception to the general consent doctrine.

THE "DUTY" ELEMENT OF PROFESSIONAL LIABILITY CLAIMS

The four elements of a professional liability claim* have been reviewed in considerable detail in Chapter 25, but it is highly worthwhile for physicians practicing emergency medicine to acquaint themselves with two potential landmines that can extend physician liability under the "duty" element of professional liability actions: (a) admission orders

*The four elements that a plaintiff must prove in a professional liability action against a physician are: (1) the physician owed the patient a duty of reasonable care to conform to a certain standard of conduct; (2) the physician must have breached that duty; (3) a causal connection between the physician's conduct and the resulting injury, i.e., legal or "proximate" cause; and (4) actual loss or damage to the patient. (W.P. Keeton, D.B. Dobbs, R.E. Keeton, et al., *Prosser and Keeton on the Law of Torts*, 5th ed., 164-65. St. Paul, MN: West Publishing Co., 1984).

written by ED physicians, and (b) coverage of in-house emergencies by ED physicians.

When Physician's Duty to Patient Is Terminated

The "duty" element of professional liability actions against physicians is not a major point of contention in most medical malpractice claims, and in most cases it is fairly clear whether a doctor-patient relationship has been created or terminated. The general rule is that a physician's duty to a patient ends when the patient's care is entrusted to another physician.⁸⁴⁻⁸⁷ However, when ED physicians write admitting orders⁸⁸ or respond to in-house (i.e., non-ED) emergencies,⁸⁹ ambiguities may arise that cloud the issue of which physician is responsible for a patient's care and make it difficult to ascertain when the doctor-patient relationship was terminated.

Admission Orders

Emergency physicians do not admit inpatients to hospitals nor do they care for inpatients following admission to the hospital. Rather, responsibility for inpatient care lies with the patient's admitting and consulting physicians. However, as a service to its admitting physicians, many hospitals have policies whereby ED physicians write admission orders as a courtesy to admitting physicians on behalf of patients admitted from the ED. Such orders have the potential of creating an ambiguity as to who is responsible for the patient's ongoing care and may extend the liability of the emergency physician based upon a continuation of the doctor-patient relationship. The American College of Emergency Physicians has delineated a wise policy concerning the writing of admission orders by emergency physicians and opposes such orders if they "extend, or appear to extend, [emergency physician] control and responsibility for the patient beyond treatment in the emergency department to the inpatient setting."⁹⁰ It is prudent for emergency physicians to clearly indicate on the admission orders who is responsible for the patient's inpatient care and to limit admission orders from the ED to items that address only urgent therapeutic interventions pending timely definitive orders from the admitting physician.

In-House Emergencies

Emergency physicians at many hospitals respond to in-house emergencies and thereby create a doctor-patient relationship with the accompanying legal duty of care owed to the patient.⁹¹ This situation may give rise to a difficult question as to when the emergency physician's duty to the in-house patient is terminated. When emergency physicians respond to in-house emergencies, it is imperative that the formal transfer of care back to the patient's admitting physician is achieved and that it is carefully documented. This generally requires a note in the medical record stating that the patient's admitting physician has been notified and is aware of the patient's deterioration in clinical status, that the admitting physician is either present at the hospital or is en route to the hospital to assume responsibility for

the patient, and that the care of the patient has been transferred back to the admitting physician. Failure to formally transfer the patient's care back to the admitting physician can result in an extension of the emergency physician's responsibility to the patient and liability in the event of an adverse outcome. Obviously the emergency physician's first obligation is to provide emergency medical care to patients presenting to the emergency department, and the added responsibility for in-house emergencies may place a hospital's regular emergency patients at increased risk, a situation that is to be avoided at all costs.

CONCLUSION

It is important to remember that the real risk is to the patient, not the physician. The greatest liability exposure in emergency medicine is the missed critical diagnosis. There are a number of factors unique to the specialty of emergency medicine that contribute to the missed high-risk diagnosis, and it is vital that rigorous scientific research be conducted into how these factors can be effectively neutralized. Until the results of such research are forthcoming, however, it is virtually certain that emergency medicine will remain one of the highest risk specialties in medicine.

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