American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Top 10 Principles on How to Avoid Getting Sued in Emergency Medicine

an Information Paper

Developed by members of the ACEP Medical Legal Committee

October 2013

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Getting sued is an unfortunate inevitability of practicing emergency medicine. Although we cannot eliminate all bad outcomes, we can adhere to some basic principles to help minimize systems errors, provide better care for our patients, and decrease our risk of being sued as a physician.

1. Patient Satisfaction/The "Warm and Fuzzies"

Introduce yourself to the patient by name and shake their hand (if appropriate). Many studies have shown that making eye contact, addressing the patient by name, and sitting down increase patient satisfaction. If you are working with another provider or will be turning over to another physician shortly, introduce the other members of the care team to the patient.

Apologize for the wait. Wait times are generally the largest patient dissatisfier in the emergency department (ED). Even if they have only been waiting 5 minutes, this acknowledgement tends to decompress an angry patient or family and highlight your empathy as a physician.

Identify and meet patient/family expectations (overt and hidden). Incorporate and educate the patient and family on your thought process and plan for diagnosis and treatment. Give them a reasonable time frame for these tests to be performed and interpreted. Keep the patient and family informed of any delays in their evaluations. Consider the Walt Disney principle and estimate more time than you think is required to complete the work-up so they are pleasantly surprised if he or she is finished early.

Manage patient expectations of the ED visit up front. What do they expect or want out of this visit? Many patients may be unaware of the diagnostic limitations of the ED. We can't make every diagnosis, we can't do every test, and we may not be able to solve a chronic problem in one visit. But we can address their pain, we can try to rule out the life threatening or emergent diagnoses, and we can help refer them to other facilities for further evaluation. Set their expectations early as to what will be accomplished during this visit.

Attend to Creature Comforts. Often little actions go a long way to provide more comfort. Consider turning the lights back off, adjusting the bed, offering a blanket or drink of water, facilitating contact with family, etc. "Is there anything else I can do for you" before leave room.

2. Documentation/Chart Production

Date and time stamp all entries of significant events in your chart. The time noted on the electronic medical record (EMR) may not always be accurate. Given that many actions in the ED are time dependent, it is in your best interest to record accurate time stamps during critical actions or events.

Maintain consistency in documentation such that documented findings support ultimate diagnosis and disposition. The ED physician or provider needs to address any discrepancies with RN/triage/or EMS notes. If a patient mentions chest pain to the triage RN, but denies it later to the physician (such that a work-up is not performed), this should be explained in the medical decision-making. Any change in patient course or additional information from family, friends, or outside medical records should be discussed in the chart and should be consistent.

Describe ED course and address Medical Decision Making. Document and clarify significant events/changes that have occurred during the patient's stay and explicitly justify therapeutic intervention or nonintervention on clinical grounds. Document serial exams and progress updates that justify your disposition. Is the patient becoming more obtunded? Is her belly exam improving and is

she now tolerating fluids? Don't leave it to a retrospective evaluating body to subjectively deduce your intentions in filling in the gaps. Address your differential diagnosis and justify what you are working up and ruling out. If you considered a pulmonary embolism, but do not plan to work it up because it is extremely unlikely, state that in your documentation and refer to a low Wells score or PERC criteria. In any patient being discharged without a specific diagnosis, document their stable or improving exam, vital signs, and patient understanding of return precautions and need for close follow-up.

3. Transfer of Care

Patient Turnover between ED Providers. Transfer of care is one of the most dangerous periods in a patient's care. Clear communication and documentation is essential. System errors may be decreased by implementing a standardized process of sign-out that includes paperwork documenting times and exchange of information that occurs. Ideally, the oncoming provider introduces himself/ herself to the patients to 1) establish rapport and update the patient on the status of their ED course and 2) establish a baseline for the new provider to provide context in the event of any change in the patient's status. Any change in the plan or patient status after transfer of care should be clearly documented in the chart.

ED Provider to Admitting Doctor. Document time of discussion with the admitting doctor along with any important clinical information exchanged at the time of admission. Lastly, an agreed upon time that the admitting physician agrees to personally evaluate the patient is ideal-particularly important in the critically ill patient admitted to the ICU.

4. Care Within the ED

Initiate aggressive care early on patients likely to be admitted. Treat that which is treatable in the ED on admitted patients- administer antibiotics, transfuse packed red blood cells, inject low molecular weight heparin prior to transfer to the floor, etc. Be proactive in ED care. Delays between nurse order transcription in the ED and order execution upon floor arrival can be as long as 2-3 hours creating a hard to defend time lapse in the event of an unexpected bad outcome.

Treat Pain Expeditiously. Stay on top of treating and re-evaluating pain in the ED. Document your intervention and response to the intervention in a progress note. Communicate with both the patient and the nurse to determine if pain control is adequately addressed.

Communication. Adequate communication is of vital importance between all providers in the ED. As our patients are often poor historians, altered, unaware of their medical problems and complexity, or limited by language and other barriers, ED providers are required to make many decisions with little information. We often don't have the opportunity to know our patients or their families prior to their evaluation. We therefore depend on a teamwork approach to obtain accurate histories, coordinate a diagnostic approach and develop a therapeutic intervention and disposition.

- Communication between the physician and Emergency Medical Services (EMS):
  As the first responders, EMS is able to gather a lot of vital information at the scene and en route. Who called 911 and what was the initial call for? How did the patient look on arrival and what notable findings were present on the scene? What medical history were they able to obtain from the family (as family members are often not present upon arrival to ED). What were the patient's vital signs, blood glucose, and response to any intervention given en route? Document these important details.
- Communication between physician and nursing:
  ED nurses care for multiple ill patients at a time and often have many simultaneous tasks for each patient. Communication between the patient's physician and nurse helps to prioritize certain tasks and interventions that are time sensitive. Any change in vital signs, mentation, or condition must

be clearly communicated between the nurse and physician to ensure prompt reevaluation and intervention.

- Communication between physician and patient:
  The most important communication is between the ED provider and the patient. Obtaining an adequate history is fundamental to understanding what is going on with the patient and developing an assessment and plan. The provider should communicate with the patients frequently, updating them on their wait time, results, and ED course. Finally, the discharge instructions are the culmination of the ED visit and should address all relevant findings, incidental findings, diagnosis (or lack of diagnosis), and follow-up plan and time. The physician should ask what questions the patient and family have to ensure they understand and address any additional concerns.

5. Reexam Points

A frequently underdocumented but extremely important charting component is the documentation of patient condition at the time of disposition. As we endeavor to craft a defensible chart an important guiding principle is the creation of a consistent image that spans the encounter from beginning to end. A critical element in completing this accurate portrayal is the reexamination prior to disposition. Whether the patient is discharged or admitted, the dutiful documentation of patient status as he exits our care not only fills in the necessary details so important in finalizing our patient portrait, but also creates the image of a concerned, conscientious practitioner that takes the time to reassess and verify appropriateness of disposition. This is not only important in the discharged patient but is similarly desirable in the admitted patient who may have pathology that is clinically dynamic in nature- ie, patients with ongoing chest pain, evolving stroke symptoms, or abdominal pain. Some specific factors worthy of addressing in the reexamination include:

a) *Reevaluate and verify normalization of previously abnormal vital signs.* As the name implies vital signs are indeed vital both in initiating diagnostic evaluation, and also in guiding early treatment. Initial deviations in pulse and blood pressure can indeed be indicative of serious underlying pathology but also may be impacted by external factors such as pain, emotions or previously administered therapy. Thus, particularly in the case of a patient slated for discharge, it can be critical to document that these vital sign abnormalities have normalized at the time of disposition or, if they have not, to include benign reasons for persistence of the abnormalities.

b) *Verify ability to tolerate fluids in both the young and the old vomiting patient prior to discharge.* Both the elderly and Infant/toddler age groups are particularly susceptible to dehydration in the setting of fluid loss due to vomiting and diarrhea. Infants and toddlers are vulnerable due to their relatively small body habitus and their high turnover of water and electrolytes. The threats to the elderly emanate mainly from a reduced ability to conserve water, sense thirst and respond to changes in environmental temperature. To compound matters, they are more commonly afflicted with chronic comorbidities such as diabetes and cardiac disease, which leave them easily destabilized by even minor ailments. Thus, in both of these groups, the added insult of protracted inability to keep up with fluid losses through oral intake can easily weaken them. Verification and documentation of ability to tolerate fluids prior to discharge can be very helpful in demonstrating stability and supporting a decision to discharge.

c) *Verify ability to ambulate in the previously ambulatory elderly patient post fall*. Elderly patients frequently present to the ED for evaluation of lower extremity injuries sustained during a fall. After confirming a benign etiology for the fall, our next task becomes assessing for structural damage via exam alone or more typically by added radiologic imaging. Plain x- rays are generally adequate for the initial evaluation of lower extremity injuries. However, should these films return negative for obvious abnormality, it is important to ensure functional stability through ambulation road testing in the patient who was previously independently mobile. This simple maneuver can be invaluable in identifying occult fractures not visible on initial films. If the patient encounters difficulty in walking, this should be a red flag for occult fracture and follow-up CT scanning of the affected area can be helpful in evaluating for subtle abnormalities. Even in the setting of

absent CT- identified radiologic findings, it must be emphasized that the ability to independently ambulate can be critical to performing activities of daily living and the new onset of a bedridden status should prompt serious consideration of admitting the patient for observation with concurrent involvement of social service.

6. Consultation Management

a) *When possible, enter into dialogue with consultants armed with a preconceived plan of action and a well-constructed case presentation that reinforces your point of view. This will thus assure follow-through with the disposition that you have predetermined to be appropriate for the patient.* Consultations are utilized frequently in the ED. They function in a variety of ways to improve patient care, both by facilitating continuity of care and by accessing specialist expertise to aid us in decision making. This can be invaluable in decreasing our day-to-day risk in the ED. Conversely, when used inappropriately, consultations can sometimes increase our risk. This tends to occur when we either depend on the consultant to do our decision-making for us or, worse, allow ourselves to be pressured into making decisions that are against our better judgment. The misguided sense that we are shielded from legal liability through these consultant conversations can at times encourage us to follow down that dangerous path of least resistance. The enduring message, as always, is to do what is right for the patient. Should the consultant resist what you know to be in the patient's best interest, you should not hesitate to move up the chain of command in initiating contact with the chiefs of the involved departments. In the rare case when this becomes necessary, see below:

b) *Remain professional in disagreements with consultants.* We talk a lot about the expectations of patients and the importance of striving to meet them. However, little dialogue has occurred regarding how to act when an EP's expectations are not being met in interactions with admitting doctors and consultants. When a discussion with a disagreeable consultant goes south and you, not only fail to get the help that you seek, but, in addition, are treated in a disrespectful or condescending manner, the atmosphere is ripe for taking out your frustrations by documenting the conversation in an accusatory or unprofessional manner. Though it is tempting to believe that you have covered yourself by documenting a breach in conduct on the part of the consultant, in many cases maligning your colleague can backfire and instead place yourself in legal jeopardy. To be clear, pointing fingers serves only one party and that is the plaintiff's lawyer who, when he sees smoke, just redoubles his efforts in search for fire. Should legal action be initiated and the consultant's care (or lack thereof) comes into question, all care received by the patient comes under scrutiny and should there appear a lapse in management, you may find yourself involved in the lawsuit you were attempting to avoid. Best tactics to utilize in these conflicts is to walk away, cool down and later document the details of your discussion in a dispassionate, "just the facts" sort of way. Do what you need to do to get the patient the care that they need and, should your grievance with the medical staff member rise to a high enough level, discuss with your facility's ED medical director the possibility of filing a separate formal complaint through an "incident report" type of mechanism.

7. Disposition Issues

Admit to the patient and the family when the diagnosis is unclear at the time of disposition. A patient and detailed explanation of the limitations of time and technology that exist in the ED along with our commonly misunderstood mission of ruling out life threatening disease as opposed to identifying exact diagnoses can go a long way toward guiding and refining patient expectations at the end of the patient visit. Be sure to explain the need for close follow-up to obtain further workup in pursuit of an accurate diagnosis.

Discuss all abnormal findings including incidental lab and imaging findings. Reinforce the importance of following up on these findings through informative discussion of potentially significant

diagnoses that might arise from these findings (ie, cancer when a pulmonary nodule is found). Document the discussion and document who (nurse, family member) was present when this transfer of information took place. Provide follow up instructions (see below).

Provide clear, concise follow-up instructions that include a specific time frame for arrangement of an appointment with the designated practitioner along with her name and contact information.

When possible, call the provider that will be following up the patient to familiarize her with acuity and case specifics. This will often facilitate a timely appointment and allow for better information transfer.

Provide easily understood complaint-specific reasons to return/seek further care. Use lay terms to inform patients about what signs/symptoms may indicate a worsening of their condition and necessitate their return for urgent re-evaluation.

A note about the uninsured. Work with hospital administration/social workers to find local Federally Qualified Healthcare Centers (FQHCs), or reduced cost/free clinics. Provide a list of these to uninsured patients to help them obtain follow-up.

8. Higher Risk Scenarios

Acknowledge iatrogenic mistakes/therapeutic complications that may have occurred prior to patient disposition home or to the floor. Advise the patient and family truthfully and early of any unexpected or accidental occurrences. Inform them of possible complications or need for further monitoring/testing. Depending on severity of related damages consider contacting hospital risk management.

Before discharge, observe and document feeding in neonates and young infants. Charting their ability to take a bottle/nurse without respiratory distress, coughing, immediate vomiting etc. can go a long way in guarding you medical-legally. Consider this a "baby stress test" for young infants who present with most any complaint but especially anything respiratory. If the child is able to take a bottle without nasal flaring, retractions, or grunting this adds weight to the decision to send them home.

Image liberally in elderly patients especially those who present with abdominal pain or after a fall. The radiation exposure of a CT abdomen/pelvis or head/c-spine may be significant in the childhood years, but a missed injury or bowel obstruction is much more dangerous to an elderly patient than the radiation associated with these tests. Also consider adding a combination CT head/CT C-spine order to be used in elderly patients with a head injury, to prevent missed cervical spine injuries.

Consider early CT head in intoxicated patients. While closer observation and serial exams can also be used, consider early brain imaging in intoxicated (ETOH and other) patients with altered mental status (AMS). Consider also protocol creation to obtain blood glucose testing (accu-check) in triage for all patients with AMS to prevent missed hypoglycemia.

When in doubt, immobilize injured joints and secure close follow-up even in those with negative imaging studies, especially those involved with weight bearing. This is even more imperative in children, and if the emergency physician is interpreting the x-ray themselves. Never tell the patient they unequivocally do not have a fracture. Advise them that they have nothing grossly displaced or obvious, and that at times more subtle fractures may become evident by the time of follow up.

Perform a complete and thorough history and physical exam on all psychiatric patients prior to clearing them for mental health evaluation. Take the time to examine and complete a diagnostic

workup (if necessary as indicated by history and physical exam findings) to rule out organic causes for changes in psychiatric status.

Take a careful second look at frequent fliers. The tendency to preemptively attribute these patients' complaints to functional or chronic pathology present in previous visits can be great. Make a focused effort to take a fresh, unbiased look at these sometimes trying patients during each encounter. If there are any new staff (RN, MD, PA, etc) consider having them evaluate the patient for a truly unbiased opinion.

9. EMR Issues

Beware of the template and electronic medical record. We have moved into a new age of paperless charts and electronic medical records that have their own limitations. Although templates can streamline documentation of a history and physical exam by checking and unchecking boxes, the output is not always logical. Inconsistencies can be created by template-driven history and exam findings that don't make sense in the context of the visit. An EMR can combine various phrases and sentences into a history that is neither specific nor logical. When possible, try to free-text some specific details of the patient encounter and HPI that will trigger your memory when you review the case. This can serve to protect you legally if there is a bad outcome.

Many electronic templates for the physical exam default to a normal exam. Remember to address the abnormal findings on your exam, reconcile those findings with those populated by a normal template, and ensure that there are no conflicting reports in the final document. Also, make sure you are not documenting aspects of the physical exam that you did not actually perform. If a focused exam was performed, the template must be adjusted or modified to reflect a limited exam to avoid mistakes and discrepancies.

The initial implementation stage of a new EMR can be very dangerous. These complex and frequently nonintuitive documentation instruments may be difficult to maneuver and are often replete with an overload of clinically irrelevant information that is confusing and can result in missed critical information. Also included in this fresh modality, is a newfound ability to copy and paste patient histories from prior visits instead of creating novel H and P's with each visit. This practice should be discouraged as it can unintentionally perpetuate previous mistakes.

Improved access to clinical information through EMR's is a definite benefit to patient care but has had the side effect of creating unappreciated new legal duties to access old records and act on the contained information.

Metadata - Be aware of its existence and understand its implications. The EMR not only provides a document of noted clinical findings but also contains an electronic time stamp of all physician and nursing activity during the entirety of an encounter. This includes entries and deletions made in the chart by anyone with charting privileges. It consists of computer generated time documentation of all activity, from time of order entry by the physician to the time of initiation of therapeutic activity by nursing and ultimately to time of disposition of the patient. This heretofore diffuse and difficult to obtain data, also known as metadata, has, since the advent of the EMR, proven to be a treasure trove of information for plaintiff attorneys as they endeavor to reconstruct specific time-lines in provision of care. A notable aside is that this advance in technology serves as another deterrent to surreptitious practitioner attempts at late insertion of self-serving information into previously prepared charts.

Simultaneous data entry by physicians and nurses leads to loss of ability to review and respond to nursing documentation. This not only may lead to misinformed decision-making in treatment and disposition but can also lead to discrepancies between caregivers in documentation that may weaken the ability to defend the physician in the event of litigation.

EMR's pull providers from the bedside and can hinder personal interaction/communication so important to the provision of optimal patient care. Be aware of this fact and work with nursing to overcome this issue and to make sure critical patient information is provided via face-to-face communication.

10. AMA (Against Medical Advice)

Documentation of the discussion between the physician and the patient is paramount in AMA cases. While the "AMA form" provides useful evidence of the patient's decision to leave in the face of recommendations to the contrary, a documented, witnessed discussion between physician and patient detailing the explanation of specific risks of leaving, alternate treatment options (if any exist), the patient's capacity to understand and make their own decisions, and their ability to state back to the physician their understanding of the situation is more important than a patient's signature on a mostly blank form. If there is any question of patient intoxication or drug use, make sure to document that the patient appeared clinically sober at the time of the discussion. It can also be helpful to document the patient's cited reasons for leaving and their understanding of their medical condition.

Identify a patient's agenda and attempt to work with him and/or his family to dissuade him from making a dangerous decision. With a little patience and effort, a substantial number of patients can be convinced to change their mind. If available, have a social worker help the patient to make phone calls etc. Document family involvement and your discussion with the family as well.

To sum up, there are a number of characteristics unique to our clinical practice that make emergency medicine a medical-legally risky specialty. From the highly emotional, volatile environment in which we work to the frequently severely ill and injured population that we serve to the constraints imposed by lack of prior clinical history and an established patient relationship there are undeniable challenges in minimizing the dangers of being involved in unwanted litigation. Some of these features are structural and absolute. However, there are factors that we can address in our approach, behavior and documentation that can aid in mitigating our risk. Familiarizing ourselves with the challenges and following the above suggestions can create a strong foundation and a sound initial strategy as we work toward achieving that goal.

Created by members of the ACEP Medical-Legal Committee, August 2013
Reviewed by the ACEP Board of Directors, October 2013
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