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Many EPs Concerned About Risk of Med/Mal Suits Under ACA

Growing pressure on EPs to move patients through faster

Increased liability risks are top of mind for many emergency physicians (EPs) due to the possibility of increased volumes under the Affordable Care Act (ACA).

The average emergency department (ED) can expect about a 10% census increase, estimates **Robert Broida**, MD, FACEP, COO of Physicians Specialty Limited Risk Retention Group, a captive professional liability insurance company serving the Canton, OH-based Emergency Medicine Physicians medical group.

"If you give people a health care card, they will likely use it. If 30 million new cards go out, I would expect at least 10 million new ED visits," he says.

Broida adds, "To the extent that EDs do not have the excess capacity to care for that type of increased load, it will increase liability. System issues such as understaffing, delayed care, and boarding all increase risk."

When ED volume goes up, things fall through the cracks because there is simply not enough time to attend to everything , says **Michael Blaivas**, MD, FACEP, professor of emergency medicine at University of South Carolina Medical School and an ED physician at St. Francis Hospital in Columbus, GA.

From 2005 to 2010, the number of visits to California EDs rose by 13.2%, from 5.4 million to 6.1 million annually, according to a recent study.[1] A 35% increase in the number of patients insured through the state's Medicaid program drove this rise, says **Renee Hsia**, MD, the study's lead author and associate professor in the Department of Emergency Medicine at University of California San Francisco.

"Many people make the assumption that once someone is insured, they will automatically get access to a primary care physician," says Hsia. "While this is certainly the hope, the reality is that many patients who are already on Medicaid have difficulty finding access to both primary care doctors and specialists."

Previous research has shown that more than 30% of physicians nationwide are unwilling to take on new Medicaid patients. "Newly insured Medicaid patients may likely experience similar, if not even more severe,

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problems," says Hsia. "Even more people are now 'covered,' and thereby placing further demands on an oversaturated system."

It may become necessary for EDs to hire additional staff in order to comply with some of the anticipated changes under the ACA, such as document management and providing "patient-centered care," says **Kathleen M. Roman**, MS, a Greenfield, IN-based consultant and former assistant vice president of risk management education services at The Medical Protective Company.

"If this is the case, both the ED staff and hospital staff should be wary of 'dumbing down' job descriptions, recruiting, policies, training programs, and employee oversight," she says. "It is missteps in these areas that may expose patients to risk of injury — and physicians to risk of litigation."

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Questions & Comments
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As to whether EPs will be held liable — or the organizations with which they are affiliated — Roman says "only time — and ensuing case law — will tell."

System-wide Solutions Needed

It is important not to place blame on patients for seeking care in the ED, says Hsia, as systemwide solutions are needed to address the problem of access for all patients.

"This includes finding creative ways to convince primary care physicians and specialists to open their offices up to Medicaid patients," she says.

Erin C. Fuse Brown, JD, MPH, assistant professor of law at Georgia State University College of Law in Atlanta, says, "The conventional account is that in states that expand Medicaid, EDs will see an increase in volume because Medicaid populations tend to use the ED more than other subgroups."

This effect may be offset, though, due to increased emphasis and resources for primary care and community-based clinics under the ACA. "Also, the expansion population is different in many ways from the existing Medicaid population," says Fuse Brown. "Their utilization patterns may differ as well."

However, hospitals in states electing not to expand Medicaid will still see significant amounts of uninsured and indigent patients at a time when disproportionate share payments under Medicare and Medicaid are being cut. "That will cause a significant crunch for safety net hospitals and EDs," says Fuse Brown, adding that EDs in states that expand Medicaid will likely be better off than states that do not expand Medicaid.

"In sum, some of the ACA's provisions are good for emergency care providers, some may strain providers, and a lot depends on your state and local characteristics," says Fuse Brown.

EPs have direct control of their own staffing, says Broida, and need to provide adequate coverage.

"They should also attempt to educate and work with their hospitals to promote adequate nursing, ancillary, and housekeeping staffing for the expected patient influx," says Broida.

Operational issues, such as ancillary turnaround times, admission process, boarding, and psychiatric placement should be optimized as much as possible, says Broida, in order to "debulk" the ED.

"Primary or urgent care clinics for non-urgent patients, telemedicine services, and follow-up clinics all will have a place," says Broida. "Anything which serves to promote speedy throughput and outflow will reduce risk."

Liability Exposure Not Considered

Regardless of whether the ACA actually increases ED volumes, Blaivas says that a growing focus on metrics and throughput is already increasing legal risks for EPs.

"Many EDs, especially ones run by large corporate groups, are heavily focused on metrics," he says. "They will have no choice but to try to churn patients through even faster. This is when things are missed."

Blaivas says that after one large emergency medicine group urged its providers to complete workups in the ED more quickly, patients were being sent up without CTs completed, no antibiotics given, no real diagnosis, and other critical procedures not done. "This led to bad outcomes, and now the corporate group is having to backpedal to increase safety," he says.

EPs should be keenly aware of proposed quality measures that could impact their practice, advises Broida. "Many of these are designed to minimize cost as their primary goal," he says. "Increased liability exposure is frequently not even considered."

The concern is that while the payers are saving money, EPs are likely to end up paying more for liability claims.

"There will be a few win-win situations where cost savings are possible with little or no adverse impact on patient outcome," says Broida. "But these are few and far between."

Broida says the best risk-reduction strategy is for EPs to adhere to published, evidence-based treatment guidelines and rigorously document any deviations.

"Even if there is an adverse outcome, the fact that the physician used the guideline appropriately will do much to defuse a jury otherwise sympathetic to the plaintiff," says Broida.

Blaivas says that to reduce legal risks, EPs should avoid being caught up by pressure to move patients through as fast as possible. " If you want to protect yourself and your patient, think about what is right for the patient — not the group or the hospital," he says. "This is much easier said than done, however."

Blaivas adds, though, that a significant number of errors and oversights that occur are actually due to poor organization and multitasking on the part of EPs themselves. "Keeping charts, notes, and check box reminders of what needs to occur on a particular patient will often help," he says.

Additionally, if volume surges occur mostly in patients with minor illnesses, it might be helpful to send an EP out front to triage and even make disposition decisions right from the waiting room, says Blaivas.

"Ordering tests from triage is helpful, but only when done thoughtfully and efficiently," he says. "It takes a trained provider to accomplish this, not just a 'shotgun' approach, where every box is checked for every test, many of them not relevant."

Blaivas says he expects EDs to see a volume surge under the ACA of mostly minor illnesses and chronic complaints. "The tough decision will have to be made to see patients that require emergency care first, not just everyone who might fill out a patient satisfaction form," he says.

"There will continue to be two classes of patients — those who need to be in the ED and those who do not." adds Blaivas. "Continue to focus on those who do."

Jason Hockenberry, PhD, assistant professor in the Department of Health Policy and Management at Emory University in Atlanta, GA, says that essentially, the ACA has instituted quality metrics, and these metrics are supposed to be based on evidence.

"As such, these metrics could shift 'standards of care.'As a result, physicians are at risk if they are practicing outside of these standards," he says.

As has always been the case, EPs need to stay abreast of new evidence, and to integrate this evidence into their care processes, adds Hockenberry. "One way to do this is to have condition-specific treatment protocols in the ED, which are continuously reviewed and updated," he says.

Less Risk-averse Care

The ACA promotes greater quality and cost efficiency through hospital payment incentives with the Value-Based Purchasing Program. "To the extent that hospitals encourage or force physicians into more risky behavior, malpractice liability will increase," says Broida.

A simple example is the EP trying to admit a patient via the hospitalist. Since the hospitalist is pressured to admit fewer patients, it creates a situation in which the EP must discharge patients that formerly would have been admitted.

"Unless 100% of those discharged patients did not actually require admission, we will have some percentage of patients needing admission who are inappropriately sent back out into the community," says Broida. "This will certainly increase liability."

The ACA also promotes greater quality and cost efficiency through physician payment incentives and penalties with the Value-Based Payment Modifier. "To the extent that these payment adjustments encourage care that is less risk-adverse, liability will likely increase," says Broida. "Here, the devil is in the details."

If avoidable ancillary testing for chest pain is targeted and fewer routine coagulation studies are ordered, it is likely that few patients will be harmed, says Broida.

"However, if avoidable admissions for chest pain are targeted and fewer chest pain patients are admitted, it is likely that mortality will increase above the current 2% to 3% miss rate," he says. "Significant liability claims will follow."

Broida says that to mitigate the risk of inappropriate ED discharge, EPs should be diligent in assuring that hospitalists or other admitting physicians personally evaluate patients they refuse to admit.

"It is always better to have two policies on the settlement table, rather than just one," he says. ■

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Could New ED Boarding Standards Become Legal Standard of Care?

Joint Commission rules could come up during malpractice suits

In a recent medical malpractice case involving a child being held in the emergency department (ED) while waiting for an inpatient bed to become available, "the patient was more or less forgotten," says **Michael M. Wilson**, MD, JD, a Washington, DC, health care attorney.

"The ER thought that the attending was taking care of the child and vice versa. The child died soon after arrival to the floor," says Wilson. The case settled for an undisclosed amount.

Boarding is a challenge for all EDs, "but the literature strongly suggests that throughput is the real issue," says **Dan Groszkruger**, JD, MPH, principal of San Diego-based rskmgmt.inc — as patients tend to be boarded while waiting for an acute care bed to become available.

The Joint Commission standard requiring hospitals to set goals for curbing the boarding of patients in the ED, and recommendation that boarding times should not exceed four hours goes into effect in January 2014.

The standard won't necessarily be considered the legal standard of care in a courtroom. However, it would be hard for a defendant attorney to argue against national standards — even if that standard is not considered a legal standard, says **Glenna Schindler**, MPH, RN, CPHQ, CPHRM, a risk management specialist at Endurance Insurance in Chesterfield, MO.

"Certainly, CMS [the Centers for Medicare & Medicaid Services] sets legal standards of care," says Schindler. "As The Joint Commission has deeming status for Medicare standards, it could be argued that The Joint Commission standards are the legal standards. But it might be a hard argument."

EP's Credibility at Stake

National professional organizations are also setting standards that contribute to the development of national standards of care in EDs. "I

don't believe that four hours is going to become the standard of care," says Schindler. "I have not heard of a plaintiff attorney that has argued that The Joint Commission standards set legal standards of care."

Regardless, a plaintiff attorney could cite The Joint Commission boarding standard to put the defendant emergency physician (EP) on the spot to explain why the standard wasn't met.

"The emergency physician's credibility could be at risk if the attorney went down that track," says **Kathy Dolan**, RN, MSHA, CEN, CPHRM, a senior risk management consultant at ProAssurance Casualty in Madison, WI.

"If you are a Joint Commission-accredited facility, you paid good money to be held to that standard," says Dolan. "Failing to meet the standard could raise concerns about the facility as a whole: 'What other standards are they failing to meet?'"

In 2014, hospitals must begin reporting five ED crowding-related measures to CMS, under the Hospital Inpatient Quality Reporting Program initiative. "Plaintiff attorneys have sometimes attempted to use the public reporting of other CMS measures in malpractice cases," notes Schindler.

Groszkruger says the obvious challenge for EDs is their inability to predict patient demand, except in very general terms. When the waiting room is full and the ambulances are backed up at the emergency entry, boarding will occur unless there are sufficient available beds to accept all those patients after they receive emergency care.

"Any arbitrary limit adopted by The Joint Commission will hold potential for impact on the standard of care," says Groszkruger. "Courts will not adopt The Joint Commission standards, per se."

However, experts will be in a position to testify that The Joint Commission is a voluntary standard-setting organization, and that limits on boarding are important for patient safety. "Therefore, expert witnesses will testify that The Joint Commission standards affect, practically speaking, the legally recognized standard of care," he says.

Eliminate Prolonged Boarding

Groszkruger says that at a minimum, EPs involved in a malpractice suit involving a boarded patient will have to demonstrate that they have done everything reasonably necessary to minimize the duration of boarding in the ED.

Frederick Blum, MD, FACEP, an associate professor in the Department of Emergency Medicine at West Virginia University in Morgantown and attending physician at West Virginia University Health Care, says he expects The Joint Commission standard will help to eliminate prolonged ED boarding and, therefore, reduce liability exposure for EPs. "We all believe that ED boarding is a major risk," he says. "It is not clear to me at this point how hospitals will operationalize this new standard. That will have a major influence on how this plays out."

Blum is not concerned about The Joint Commission boarding standard increasing liability for EPs. "I, like many ED physicians, believe that ED boarding, and the crowding that comes with it, to be the largest root cause of medical liability risks that we face," he says. "Anything that will reduce these can only help." ■

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How Much Legal Protection Does AMA Form Give EPs?

Patient's signature can help defense only to a point

If a patient signs a form stating that he or she is aware of the risks of leaving the emergency department (ED) against medical advice (AMA), a successful lawsuit against the emergency physician (EP) could still result.

"The patient may have a bit of an obstacle to overcome if they later wish to cry wolf and file a claim against the ED provider. But the presence of a signed AMA form in the medical record is not by any means foolproof," says **Jeanie Taylor**, RN, BSN, MS, vice president of risk services for Emergency Physicians Insurance Company in Roseville, CA.

Mortality rates associated with AMA discharges are up to 2.5 times higher than for other patients.[1] Additionally, 30-day readmission rates were found to be higher in patients who leave AMA.[2]

"In the old days, if a patient even suggested they were thinking about leaving without completing treatment, a nurse was at the ready with a pen and an AMA form," says Taylor. "AMA discharges were sometimes viewed as a gift in a busy ED."

However, a patient's signature on a form is not what gives EPs protection when patients decide to leave AMA, according to Taylor.

"The protection lies in the documentation of discussions informing the patient of the consequences of the AMA decision, and their ability to understand these consequences," says Taylor.

Refute Allegations

A signed AMA form, along with a detailed record of the circumstances surrounding the discharge, can "go a long way" to help an EP refute allegations that the discharge was negligent or the result of incomplete disclosures to the patient, says **Stephanie M. Godfrey**, JD, an attorney in the Philadelphia office of Pepper Hamilton.

"However, physicians should not assume that they are automatically protected against any future liability," says Godfrey. Courts will look beyond the signed AMA form, she explains, and will probe the circumstances surrounding the discharge to determine whether the patient or the EP should bear the responsibility for any subsequent injuries suffered by the patient.

"For example, was the discharge the result of a decision by a well-informed patient who was capable of weighing the risks involved?" asks Godfrey. "Or was there some conflict between the patient and the treating physician that led to the premature discharge?"

In a 2003 case, a prison inmate brought to the ED with lower abdominal pain, nausea, and vomiting left AMA after refusing a nasogastric tube. The ED nurse had the patient sign an AMA form and claimed she told him he could die, but the patient was not informed of his abnormal vital signs or lab studies, which included a life-threatening condition.

The patient was given no discharge instructions, and the EP was not involved in the AMA discharge. The patient died a few days following discharge.

"The hospital argued contributory negligence and prevailed at trial," says Taylor. "But the Alabama Supreme Court found that the lower court had erred in several areas, and found in favor of the patient's estate."[3]

Convince Patient to Stay

"EPs need to be involved every time a patient wants to leave AMA," advises Taylor. "The best scenario is that they can talk the patient out of leaving."

Often, an EP letting the patient know that they are concerned, and the possible consequences of leaving AMA, is all that is needed to dissuade the patient.

"Sometimes, patients feel they need to leave AMA because they have childcare, elderly parent care, or pet care issues," says Taylor. "They feel they simply cannot stay in the hospital."

EDs can sometimes overcome these barriers so the patient can remain for admission or to complete treatment. "I have known of situations in which ED staff has actually made arrangements for pet care so a patient could be admitted," says Taylor.

If the AMA discharge cannot be avoided, Taylor says these practices can offer some protection from legal risks:

• EPs should state in the medical record that they "advised" admission, and that the patient refused.

"Documenting that you 'offered' admission, but the patient decided not to be admitted, does

not protect you," says Taylor. "Patients are not qualified to determine if they need to be admitted. Emergency medicine providers should not make patients believe admission is a choice, and that they can safely decide to be discharged."

Explain that the AMA discharge in no way prevents the patient from changing their mind. "Be non-judgmental, and welcome their return at any time," says Taylor.

• EPs should never let the nursing staff handle an AMA discharge without physician involvement.

"The EP should be involved in all AMA discharges and refusals of care," says Taylor.

• The ED should provide the highest level of care the patient will accept.

If a chest pain patient refuses admission and the EP suggests alternatives such as observation, serial testing in the ED, and very specific follow-up, this discussion must be carefully documented, says Taylor.

Some EPs are hesitant to provide prescriptions to patients leaving AMA, believing that this might encourage the patient not to seek follow-up care, or that doing so implies that the EP agreed to the discharge.

"This is simply not true," says Taylor. "All patients should be prescribed appropriate antibiotics, analgesics, and other medications indicated by the clinical condition."

For instance, if the EP recommends admission and intravenous (IV) antibiotics for a patient with pneumonia, but the patient refuses admission, the patient should receive a dose of IV antibiotics in the ED and a prescription for oral antibiotics, says Taylor.

• EPs should ensure the patient has the capacity to understand the implications of refusing care or treatment.

"This is especially important in patients who have been drinking, have altered mental status, and/or have psychiatric symptoms," says Taylor. Taylor says these items should be assessed: oriented to person, place, and time; appropriate answers; no slurred speech; no sign of psychosis, no hallucinations or delusional thinking; no suicidal ideation; no homicidal ideation; rationale for refusal of care; and ability to verbalize and understand the risks of refusal.

• EPs or ED staff should call all AMAs back the next day.

"Invite them back to complete their care," says Taylor. "Determine how they are faring, and document the call in the medical record." ■

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Patient Did Not Follow Up? EP Faces These Legal Risks

Case could turn on whether efforts are documented

Even if a patient fails to follow discharge instructions, he or she could still successfully sue the emergency physician (EP) if a serious illness or injury occurs.

"If the jury feels the potential diagnosis was serious enough for the emergency physician to ensure the patient have a follow up, you may very well have a large verdict against the emergency physician," says **Linda M. Stimmel**, JD, an attorney at Wilson Elser Moskowitz Edelman & Dicker in Dallas, TX.

A jury will usually find a patient has some responsibility to follow a physician's direction to follow up, says Stimmel. However, they will assign the EP a much larger burden of responsibility due to the provider's increased knowledge on the issues involved in the patient's care.

"One of the saddest cases that I have had was a case where this exact scenario occurred," says Stimmel. A young man came into the ED with symptoms of a cold or flu, and the EP thought he might have heard a slight heart murmur.

The EP ordered a blood test for bacterial endocarditis, and told the patient to return a few days later for a second follow-up blood test, as stated in the ED's protocol. The patient was given discharge instructions telling him to return to the ED for fever or other symptoms.

"The young man failed to return for the second blood test. No one followed up, as is the case in many ERs," says Stimmel. The first blood test came back positive in the early morning hours, but, for some reason, the results were never communicated to the EP or the patient.

"Of course, had the young man returned for a follow-up appointment, as was instructed, the first results would have been read by a physician," says Stimmel. "Most likely, the appropriate medications would have proven successful."

Eight days later, the patient returned by ambulance in a vegetative state from bacterial endocarditis, and died soon thereafter. The family sued the EP and the hospital, and the case was settled for a large amount.

"They realized that even though the young man did not follow the discharge instructions and failed to return for a follow-up appointment, the jury would find that in case of the potential of a serious illness such as bacterial endocarditis, the hospital would have a greater duty to protect the patient," explains Stimmel.

EPs document efforts made to contact patients when they fail to return for a follow up, urges Stimmel. In this case, the EP charted that the patient was to return three days later for the test, but there was no documentation that anything was done when he failed to show up.

"If our chart had said, 'Failed to follow up. Called patient's emergency contact and left message,' it would have been a much different case for the defense," says Stimmel.

Decrease EP's Risks

A patient's failure to follow discharge instructions may be raised as an affirmative defense to a malpractice claim, if such failure is found to contribute to the bad outcome in question, says **Andrew H. Koslow**, MD, JD, an assistant clinical professor of emergency medicine at Tufts University School of Medicine and an EP at Steward Good Samaritan Medical Center in Brockton, MA.

Depending on the forum, state, and the effect of the patient's behavior, a finding of negligence on the part of the patient could reduce a payment to a plaintiff or even mandate a defense verdict.

"There are many scenarios, however, in which a patient could bring a claim despite not following up as instructed," says Koslow. "Much of the time, the instructions are given, but the intended message does not get through to the patient."[1]

Koslow says some contributing factors to this problem are the use of medical jargon, written material beyond the patient's reading comprehension level, language barriers, instructions so voluminous that the key elements are hard to find, and lack of patient capacity to understand due to a medical condition, medication, or other factors altering the patient's ability to understand.

"Any of these can interfere with the patient's ability to take the steps that the EP recommends post-discharge, and could be used against the EP if there is a bad outcome," says Koslow. He gives these risk-reducing strategies for EPs to decrease risks of successful suits involving a patient's failure to follow up:

• Give instructions that are legible, at the appropriate reading level, and concise.

Discharge instructions should state the diagnosis, what was done, what to do next, and reasons to return to the ED. "The next steps for the patient should be specific as to what, where, and when," says Koslow.

• Have a pre-discharge conversation with the patient, especially for high-risk diagnoses.

"Document the patient's understanding of the important issues as indicated by the situation, and potential for a bad outcome if the plan is not followed," says Koslow. "This is also an opportunity to answer questions."

• Be clear when something serious cannot be ruled out in the ED, as with incidental findings on radiologic studies.

In a 1987 case where the possibility of a patient's symptoms being heart related was not well-communicated, the court considered this as a factor in determining the patient's responsibility to follow up.[2]

"It is important that the patient understands why follow up is so important, and perhaps given some motivation to do so," says Koslow. "This can be done by giving the patient a sense of serious potential diagnoses, in layman's terms, that need to be addressed post-discharge."

• Document the presence of others when telling the patient about the need for follow-up.

Family and friends can help influence the patient to follow up when he or she might otherwise be reluctant to do so, which could avert the bad outcome in the first place.

"Also, one-on-one 'he said/she said' controversies in a case can introduce uncertainty that a plaintiff's attorney could use to his or her advantage," says Koslow. "Naming witnesses to the conversation introduces specifics into the chart that make it more believable, thereby supporting the provider."

• Communicate with the patient's primary doctor or applicable specialist.

"This is good risk management as well, depending on the potential consequences of the patient not following up and the perceived reliability of the patient," says Koslow.

• Consider whether the discharge instructions are achievable for the patient.

If the patient has no primary care doctor at the time of the ED visit, he or she is very unlikely to be seen by one the next day for a recheck. Likewise, your ED patient's lack of resources may prevent him or her from picking up a prescription.

If the plan the EP has outlined is impossible or unlikely for the patient to accomplish and the EP is aware of this, it is a disservice to the patient and a potential source of liability, warns Koslow.

"I view discharge instructions as if I were asking the patient to sign an agreement to follow the plan contained therein," says Koslow. "Are the things the EP is asking the patient to do achievable?" If not, the EP could be portrayed as uncaring or even unethical in court.

Some sort of compromise may be needed in order to get the patient's compliance, says Koslow. If a patient isn't willing or able to travel to a regional center for follow-up care, a more local solution may be needed.

"Sometimes a less-than-ideal plan is less risky to the EP than one the EP knows will fail," says Koslow. "If the plan is tenuous, or if the availability of a follow-up physician is not clear, the patient should be made aware that the ED is there as a backup." ■

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EMR Charting: A Solid Defense for Sued EP?

Plaintiffs can't argue with time-stamped entries

Time-stamped entries or other information in the electronic medical record (EMR) can sometimes make cases indefensible for emergency physicians (EPs). On the other hand, an EMR entry could end up providing a sued EP with a strong defense.

John Tafuri, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland, reviewed a recent malpractice case involving a patient who died of an allergic reaction after being given cephalosporin.

The plaintiff attorney alleged that an EMR entry to the patient's chart was made much later than represented. The note in question stated that the patient was allergic to penicillin, but had taken cephalosporin without any difficulty in the past.

The patient left with a copy of the ED records without this entry, but the copy of the chart obtained by the plaintiff's attorney did contain the

entry. Due to this discrepancy, the plaintiff alleged the entry was made by the EP after the patient's death.

In reality, the copy the patient had left with was printed right before the EP was able to complete the documentation. The entry about the allergy was added shortly afterward.

"A forensic analysis of the records showed that the entry was made contemporaneously with the treatment of the patient," says Tafuri. "Therefore, there was no cause of action against the emergency physician."

Additional Layer of Protection

EMR systems that allow for patients to "acknowledge" steps in their medical care, such as risks and benefits of a procedure, can decrease legal risks for EPs because they remove the ability of the plaintiff to allege that something was not discussed with them, says **Molly Farrell**, vice president of operations for MGIS Underwriting Managers, Inc., in Salt Lake City, UT.

"EMR systems that interact with other providers and send out follow-up letters to patients offer another layer of protection, as one of the biggest issues with ER care is the lack of follow up," adds Farrell.

One radiology group that does numerous reads at community EDs sends a follow-up notice to patients who receive X-rays, stating, "You recently had an X-ray read at X hospital, and the results may require follow-up. Please take this report and share it with your primary care physician at your next visit."

"Often, patients remember that the X-ray ruled out pneumonia, but don't recall the small mass that requires further work-up," says Farrell. "The radiology group has seen a significant drop in their failure to diagnose claims since they implemented this follow-up method." Consider these other EMR charting practices that may reduce legal risks:

• Don't assume important information will be conveyed electronically.

Robert J. Conroy, JD, MPH, an attorney at Kern Augustine Conroy & Schoppmann in Bridgewater, NJ, says some hospitals are having problems interfacing their ED's EHR with a second system used by the rest of the health care system or facility.

"Some ED-specific EHR systems are so well-adapted to that environment that practitioners are loathe to switch," he says. "A facility-oriented system, while suitable for its intended purpose, may be too slow or cumbersome for ED use."

Unless everyone is using the same EHR platform or the different platforms are better integrated, says Conroy, problems like lost orders, test results, and notes can be expected.

Conroy says EPs should not trust the interface between two systems to convey critical information in a timely fashion. "If necessary, pick up the telephone and relay the information," he says. "Of course, such a call should be documented in the chart."

• Include your medical decision-making in EMR documentation.

"'How did you get there?' and 'What happened while the patient was in the ED?' are essential parts of the medical record," says **John Burton**, MD, chair of the Department of Emergency Medicine at Carilion Clinic in Roanoke, VA.

When EPs dictate a note, they tend to be very thoughtful in their account of events or the patient treatment course, he explains. "The modern EMR often is completely void of this information," says Burton. "This is a real problem in defending physicians."

Burton recommends that EPs be sure the medical record includes their side of contentious events that occur, which they suspect may lead to complaints or litigation in the future.

"If it has to be 'hunt-and-peck' on the keyboard to enter the information, then get it done," he says.

General comments noting the absence of risk factors or findings during the visit that did not prompt consideration for life-threatening illnesses to be considered, or diagnostic testing to be pursued, should be routine in the EMR just as they were in the dictated medical record, adds Burton.

"Common examples where medical decision making should be entered would be chest pain patients, headache patients, and back pain patients," he says.

• Don't put unprofessional entries or blow-by-blow accounts in the EMR.

"The medical record is not the place to rant, argue, or state one's opinions on individuals, health care processes, or events that transpire in the ED," says Burton. In Burton's experience, these inappropriate comments are more commonplace in EMRs than in dictated or paper records.

"I have seen many a record where a well-intentioned physician entered a note in the EMR that was entirely out of line for professional standards in emergency medicine," says Burton. ■

Sources

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