ED LEGAL LETTER™

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INSIDE

Evidence of Race Disparities in ED Could Support Negligence Claims

If plaintiffs allege they received poor care in an emergency department (ED) because of their race, there is plenty of potentially admissible research that demonstrates it is indeed possible.

"It's important for the defense to consider evidence in the literature that the plaintiff attorney could use against the defendant," says **Jay M. Brenner**, MD, FACEP, medical director of the community ED at State University of New York Upstate Medical University in Syracuse.

People of Black or Latin American descent coming to the ED with cardiac symptoms were less likely to be admitted to specialized cardiology units than white patients, according to the authors of a study.[1] "Frontline clinicians have a unique vantage point to identify and characterize inequities in care," says **Regan H. Marsh**, MD, MPH, one of the study's authors and an assistant professor of emergency medicine at Brigham and Women's Hospital in Boston.

Marsh and colleagues decided to conduct the study because of a worrisome trend they observed in their own ED. They noticed Black and Latinx patients diagnosed with heart failure were frequently admitted to the general medicine service, as opposed to the cardiology service. "Our objective was to identify potential inequities in care and differential access to care," Marsh says.

Researchers analyzed 1,967 cases of heart failure patients who presented to the ED. The study was not designed to identify malpractice risks. "However, any time patients experience disparities in care, or challenges in access to care, based on race, ethnicity, or gender, it can lead to worse outcomes and greater legal risk," Marsh says.

Black and Hispanic pediatric patients were less likely to be classified as urgent or immediate than white pediatric patients, and also were less likely to be admitted to the hospital, according to the authors an analysis of 78,471 ED visits.[2] "There's an incomplete understanding of disparities in emergency care for children across racial and ethnic groups," says **Xingyu Zhang**, PhD, the study's lead author

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If the plaintiff in a malpractice lawsuit is Black or Hispanic, relevant studies could be used to support allegations not only of negligent care, but of negligent care due to racial bias. "Bringing up such papers would be a shrewd strategy to inflame the jury, even if allegations of racial bias were logically refuted," says **Daniel Pallin**, MD, MPH, former research director in the department of emergency medicine at Brigham and Women's Hospital in Boston.

Admissibility would depend on the judge and the jurisdiction. "Inconsistency from judge to judge makes admissibility hard to rule out," Pallin adds.

The plaintiff lawyer could use the research to paint a picture of racial bias leading to a poor outcome. Brenner says the ED defense team should consider these questions:

- Was there a delay in care because of undertriaging?
- Was there a missed opportunity to give treatment for myocardial infarction or hospitalization for heart failure?
- Was there a missed antidote or a paucity of analgesia offered?
- Was insufficient attention to follow-up and prescribing given with a seizure patient?
- Were antibiotics not prescribed for an infection?

"These are all potential situations that the plaintiff attorney could exploit in a malpractice case," Brenner explains. Here are some examples of findings that could be used to support allegations of racial bias in an ED claim:

- White patients are more likely than Black patients to receive thrombolysis treatment for myocardial infarction.[3]
- Black pediatric patients are more likely to receive an urgent triage score.[4]
- Black patients are more likely than white patients to present to the ED with breakthrough seizures because of missed anticonvulsant medications.[5]
- White pediatric patients are more likely than Black and Hispanic pediatric patients to receive antibiotics for viral upper respiratory infections.[6]
- White patients are more likely to be hospitalized for heart failure than Black patients.[7]

To refute allegations of racial bias, the defense attorney could ask ED providers about their typical practices.

"They would have to show that the care rendered was the same regardless of race," Brenner reports.

Character witnesses attesting to nondiscriminatory behavior could help the defense. An ED nurse could testify to a long period of observation of the defendant in the ED, and never once witnessing discriminatory behavior.

"It could help if they could testify to only seeing equal, consistent compassion without regard to race or ethnicity," Brenner suggests.

The ED medical director or ED nurse manager could be brought in as witnesses as to whether the defendant had received any other patient complaints alleging discrimination. "This could be helpful to the defense if there were none — and helpful to the plaintiff if there were," Brenner adds. ■

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Simple Care, Concern Refute Perception of Bias that Fuels Lawsuits

It is not hard to imagine patients suspecting racial bias if they experience a rushed exam, long delays, or poor communication in the emergency department (ED).

"There are good historical, and current, reasons for minorities to mistrust the healthcare system," says **Daniel Pallin**, MD, MPH, former assistant professor of emergency medicine at Harvard Medical School.

Race is much more likely to become an issue if an ED provider behaves disrespectfully toward the patient.

"A particular worry would be if a physician had posted racially insensitive comments on social media," Pallin notes.

The best way for emergency physicians (EPs) to avoid this allegation in the first place is to "be sure to bond with their patients and demonstrate concern," Pallin says.

That means respecting that ED patients may be from cultures that differ from that of the EP, present with different levels of health literacy, and understand disease and treatment differently.

"Take the time to be sure you are explaining things in a way that accounts for this," Pallin suggests.

Involving family members whenever there is a sense of disconnect also is helpful. "Document that you talked to a family member. Document the point of view of both the patient and family member," Pallin says.

Concern for the patient's welfare should be clear to anyone who later reviews the ED medical record. "All documentation should be free from sarcasm or other tone or content that could imply lack of concern," Pallin cautions.

Sparse documentation can be used against the EP defendant easily. On its own, a statement like "patient attributes trouble to gas pain" can appear as though the EP did not take the patient's abdominal pain complaint too seriously. Pallin gives this example of better documentation: "She thought the discomfort might be due to gastrointestinal upset, but I am mindful of the possibility that it could be something more serious."

"Women and minorities are known to present with symptoms that aren't typical," Pallin notes.

Another example of documentation that appears dismissive: "He continues to complain of chest pain, and this is

his fourth ED visit. Prior providers explained the chest pain was due to costochondritis."

In contrast, Pallin says this charting demonstrates thoughtful concern: "I'm concerned this pain still is bothering him. However, the nature of the pain and its chronicity lead me to believe that the benefit of hospitalization would be outweighed by the risks and difficulties entailed. I spoke to his primary care physician, who will be sure follow-up occurs promptly."

ED nurses can demonstrate concern by checking on patients at regular intervals, and carefully documenting this. "Not to do so is asking for trouble," Pallin warns. "Nurses should demonstrate kindness, even by providing Tylenol or something to drink."

The way patients are described should reflect compassion, such as "gentleman" or "pleasant lady."

"Don't allow anything conceivably derogatory to make its way into the chart," Pallin says.

Even if there are patients who are rude, shouting, and intoxicated, there remains a way to convey compassionate care. Pallin offers these examples: "This is a 50-year-old man who, according to the medical record, suffers from alcoholism." Or "This is a 50-year-old lady who, sadly, is homeless."

Sometimes, the EP-patient relationship breaks down completely. It is still possible to convey the person was treated compassionately. Pallin offers these examples: "The patient seemed really upset, and I offered to provide a gentle medicine to alleviate the trauma of the emergency visit. She accepted. After receiving 1 mg lorazepam, she seems less upset." Or "The nurse and I met to talk about the case. We discussed that the patient seemed upset, and we met with the patient together. It didn't seem like we were very successful at winning the patient's trust, but we will certainly keep trying."

Poor pain management gives the impression no one cared about the patient. Black and Hispanic patients are less likely to receive analgesia for acute pain than white patients.[1] "Document your awareness of the patient's pain and your desire to mitigate it within the bounds of safety," Pallin says.

This means documenting the reason for withholding medication "in a tone of concern, not condemnation," Pallin adds.

A good example: "This gentleman really seems to be suffering, but I'm afraid that giving opioids would do more harm than good, considering the history of heroin use."

Implicit biases that affect the way providers care for one person vs. another probably are more common in the ED, according to **Nathan Irvin**, MD, assistant professor in the department of emergency medicine at Johns Hopkins.

"In the ED, where people have to think on their feet and make lots of decisions, subconscious bias probably tend to come out more so than other areas," Irvin observes.

Bias hinders good communication. "It provides the kindling for malpractice lawsuits," Irvin says.

Patients who perceive bias are less likely to tell EPs all the necessary details. EPs might not fully comprehend what the patients are trying to say. Additionally, patients from ethnic minorities may be less likely to follow through with recommended treatment plans.

"All of those things lead to opportunities for disparities to develop, and for patients to be harmed. And lawsuits can evolve," Irvin warns.

If patients believe they received poor care because of their race, it stands to reason they would be more likely to pursue litigation if a bad outcome happens. "There are times you make a mistake that exposes you to risk. In some of those situations, the patient's perception of their interaction with you can tip the scale on what they do," Irvin explains.

There is no easy way to eradicate bias. "It takes people being aware of their biases and pushing them to rise above it," Irvin says. "When you create an awareness that disparities exist, it's an opportunity."

In the ED, patients, providers, and (sometimes) family members share decisions on admissions or discharge. If communication is frayed, it is difficult to engage in meaningful discussions. "The answer is not to admit everybody," Irvin says. "You have to work to try to meet each patient where they are."

Population-level data can show that for all ED patients with a certain condition, Black patients fared worse than white patients. This shows disparities exist in general. However, at the level of the ED visit, "it is much more personal," Irvin notes. "Individual patient interactions, how you address a certain medical condition for an individual patient — each of those matters a lot."

The antidote to bias, says Irvin, is "empathic, relationship-centered listening" on the part of the EP. "When people have our biases and are rushed, lots of that stuff goes out of the window. It creates opportunities for some patients to not do as well as others," Irvin explains.

Asking questions such as "Do you have any barriers to getting your medication?" are helpful. If the EP is aware the patient cannot afford medication, there may be other options. The same is true if a patient

is about to be discharged under the condition that follow-up within 24 hours with a cardiologist happens.

If the EP truly is concerned about the patient, and the patient is not really going to follow up as instructed, says Irvin, "that's a patient that you probably should have kept in the hospital."

Patients who previously experienced bias might be reluctant to visit the ED at all.

"If they've been mistreated as an 'other' or ignored or not given the dignity they deserve, they're very unlikely to come back even if they have to," Irvin reports. "They are going to come back under duress."

If patients in the ED waiting room suspect they are receiving subpar care because of their race, some will choose to leave. Of that group, some people will go home and experience a bad outcome. "We are the front door of the healthcare system," Irvin says. "That initial perception really matters. We definitely have to make a good impression from the jump." A relationship-centered approach to ED care can prevent bias, or the perception of it, from getting in the way of good medical care.

"It can overcome some of these troubles so patients feel safe and reassured that they are going to get excellent healthcare," Irvin adds. ■

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Delays After Triage Can Bolster ED Negligence Claims

The exact amount of time patients waited after arriving at the emergency department (ED) becomes a central issue in many malpractice claims.

"Triage mistakes may be life-threatening," says **Carolyn Dolan**, JD, MSN, FNP-BC, PCPNP-BC.

Dolan has reviewed multiple cases in which triage mistakes led to a bad outcome and litigation. In one case, a primary care physician sent a patient to the ED for a stroke workup. The "quick look" nurse assigned the man a level one acuity.

Minutes later, the triage nurse changed the severity code to level four and sent the patient to the urgent care department. This set into motion a chain of events that contributed to the patient's delay in receiving a stroke workup.[1]

A triage nurse's failure to notify the emergency physician (EP) of significant patient data, resulting in treatment delays, "may constitute or contribute to negligence," says Dolan, former president of the American Association of Nurse Attorneys. For example, this can happen if ED nurses triage a child with perceived minor trauma (such as a bump on the head) at a low acuity level.

"The wait time becomes extensive, and the child slips into a coma. The actual etiology was blunt trauma, producing a severe brain injury of an epidural hematoma," Dolan says.

Triage nurses face liability exposure if patients are not reassessed at regular intervals while waiting to be seen, says **Mark Kadzielski**, JD, a partner at BakerHostetler in Los Angeles. Triage nurses likely are aware of their obligation to patients waiting to be seen, Kadzielski says.

Triage nurses might be unaware of patients who were sent back for evaluation, but return to the ED waiting room for some reason. This can happen if an ED provider admits the patient for observation or telemetry, but no beds are available.

"The patient has now graduated from triage, but comes back to the waiting room," Kadzielski observes. The triage nurse does not check on that patient since from the triage nurse's perspective that patient has been taken care of.

"We've checked all the boxes and done everything right, but the patient is still sitting in the waiting room. That's where the liability is," Kadzielski notes.

If this patient leaves without anyone seeing him or her, there is potential legal exposure for the ED providers and the hospital. According to Kadzielski, in an ideal situation, the ED chart should show that someone checked the person at regular intervals. Documentation should note how nurses realized the patient had left without being seen shortly after the last assessment. Finally, there should be an indication efforts were made to locate the patient.

"The question is: Whose obligation is it to check on that patient for all the hours they spend waiting for a bed?" Kadzielski asks.

If it is unclear, the EP might assume it is the triage nurse's responsibility because the patient is

in the ED waiting room. The triage nurses might assume it is the EP's responsibility, since the patient has been evaluated. "From a nursing standpoint, it may not be a triage nurse's technical job responsibility. But it's got to be someone's responsibility," Kadzielski stresses.

Clarification on this important point may prevent finger-pointing during litigation.

"A well-written [ED] policy addressing who is responsible for monitoring admitted patients temporarily located in the waiting room or elsewhere goes a long way to avoiding liability claims," Kadzielski adds. ■

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ED Malpractice Claims More Likely to Succeed if Policy Not Followed

The odds of a medical malpractice claim resulting in a payment increase by 145% if a policy was not followed at some point, according to the authors a new analysis.[1]

"In my experience, ED [emergency department] policies represent acceptable community best practices," says **Paul D. Squire**, JD, head of the healthcare practice at New York City-based Kaufman Borgeest & Ryan.

As such, failure to follow ED policies represents a deviation from accepted norms. "Recent cases ruled against motions for summary judgment and permitted negligence cases to proceed — in light of the fact that, in both cases, ED personnel did not follow ED protocols," Squire reports.[2,3]

The courts referenced such failure as a factor, but did not establish direct liability for failure to follow ED protocols, Squire notes. "Ultimately, state courts will consider ED policies as one of a number of factors in determining whether there was negligence and liability," Squire says.

Plaintiff attorneys will scrutinize hospital policies and compare them to what happened during the ED visit. "Plaintiff attorneys then use the policies to badger the physician on why everything wasn't followed exactly," says **Matthew Pirotte**, MD, FACEP, assistant professor of emergency medicine at Vanderbilt University Medical Center.

Months or years later, emergency physicians (EPs) usually cannot independently recall the particulars of the case. "At the deposition, they are trying to defend why they didn't do absolutely everything that's on a hospital policy," Pirotte says.

The EP is left to fall back on generic statements such as, "This is my usual and customary practice."

"That's when you get into these endless circular conversations about every line of a policy," Pirotte notes. "It can make for some painful moments in a deposition."

ED providers view hospital policies as general guidelines, as opposed to hard and fast rules to follow. "But plaintiff attorneys have gotten very good at exploiting the gap between a jury's knowledge of what a policy means to them and what clinical policies tend to mean in the ED," Pirotte observes.

The defendant EP is left to try to explain it. Making that distinction "can be very hard for an unprepared EP to navigate," Pirotte acknowledges.

The key is to respond to questions about policies in a way that a reasonable person will understand. Pirotte offers this response: "There are multiple policies that define certain aspects of patient care. But they never supersede clinical judgment. The way that I managed the case in question was consistent with my judgment on what was going on with that individual patient."

Sometimes, the care at issue was reasonable, but somehow fell short of what the policy recommended. Possibly, the EP did not give as much fluid as suggested, or the EP did not obtain a consultation within the stated time frame. "That lack of aggressiveness becomes hard for the EP to justify," Pirotte says.

One plaintiff attorney stated, "You have a sepsis policy, and you didn't follow it, and the patient died. Now, you are trying to argue that the care you provided was superior to the policy that your hospital had in place?"

It helps if EPs know what is in the policies. "It's pretty important these days for emergency docs to at least be somewhat familiar with the policies that surround the high-risk parts of our jobs," Pirotte suggests. In ED malpractice lawsuits, Pirotte says there are specific policies that arise continually, such as sedation, transfer agreements, sepsis, and diabetic ketoacidosis.

It is helpful for EPs to include a note in charts on why some action did not occur. EPs can explain why specific antibiotics were chosen, instead of the ones

recommended in the sepsis policy. EPs can explain why they chose to sedate a patient, even though the hospital's policy recommends against it based on the American Society of Anesthesiologists' classification system. "Many situations can come up where the safest option is to go ahead and sedate that patient," Pirotte says.

He gives this example of good ED charting: "Policy states we should consider anesthesia consultation, but this is urgent. Discussed risks and benefits with the patient."

"Generally, people understand that the whole point of being an EP is that you don't just follow rules rigidly without thinking about them," Pirotte explains.

If that patient ends up with a poor outcome, "then the policy becomes a very weak weapon," Pirotte says. "And you are in a very defensible position by addressing things head-on."

The ED defense team also should verify the policy at issue was, in fact, in place at the time of the ED visit. "You could be doing all this work to defend a doc on a policy that was put into place months after the case happened," Pirotte says.

Hospital policies do not automatically equate to the legal standard of care. "But it's certainly a bigger hurdle to cross as a defendant if you've clearly violated a hospital policy," says **Jesse K. Broocker**, JD, partner at Atlanta-based Weathington.

Virtually all malpractice claims involving ED nursing care involve some kind of policy that was not followed. "The policies are really more about nursing care. It's very rare to see a policy that dictates what a doctor does," Broocker notes.

Ideally, ED policies include language that makes this point clear, such as, "Our policies do not dictate the clinical judgment of our physicians who are not employees but have privileges here." Regardless, says Broocker, "plaintiff attorneys are trying to shoehorn policies against doctors now. We are seeing that a whole lot more."

The sheer number of hospital policies is one reason. Hospitals are required to develop many different policies to achieve various accreditations and certifications. During discovery, plaintiff attorneys comb through them all.

"They get a boatload of material, and find something that wasn't followed to the letter," Broocker reports.

At deposition, attorneys try to talk EPs into agreeing with statements like, "According to this document generated by the hospital at which you have privileges, this patient should have been deemed an intermediate risk for stroke."

One plaintiff attorney argued, "This policy was generated for the specific purpose of patient safety by an all-star cast of people that the hospital deems to be the best of the best to determine what is the best thing to do in this kind of case. And it wasn't done here."

"The plaintiff lawyers can take the position that the hospital the EP works in [created] policies that dictate the standard of care, and that the EP did something they shouldn't have done," Broocker says.

In Georgia, while a policy does not set the standard of care, it is evidence of it.

"These policies can come in even if they are not directly applicable to the doctor," Broocker notes.

Needlessly inflammatory language makes matters worse. Some hospitals use terms such as "threat-level vital signs." Plaintiff attorneys then can say, "Your own hospital says that any temperature over 103 is a threat-level vital sign." Language that's more equivocal, such as "should be considered," is less problematic, Broocker says.

As part of some accreditation processes, hospitals are required to define criteria for risk stratification. Some ED malpractice lawsuits focused on the fact a patient was considered to be "high risk" based on hospital policies.

"The criteria aren't meant to dictate the EP's clinical practice," Broocker says. "But now there's a piece of paper out there that the EP is not aware of that says patients meeting these criteria are high risk." Regardless of anything EPs say in their defense, plaintiff attorneys always can retort, "According to the hospital you work at, he or she is high risk."

To avoid medical/legal landmines, hospitals can involve risk managers in drafting policy language, Broocker says. For example, a policy might state that a certain pulse oximetry score "can be a sign of respiratory distress." That is better than stating, "A pulse oximetry score below 92 is emergent and needs immediate intervention."

"Then you've got no wiggle room," Broocker adds. ■

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Courts, Plaintiff Attorneys Scrutinizing ED Boarding of Psychiatric Patients

The length of stay for psychiatric patients held in emergency departments (EDs) is growing longer, according to an analysis.[1]

"Any clinician working in an ED already knows that patients who require admission or transfer for a mental health diagnosis generally have long lengths of stay," says **Genevieve Santillanes**, MD, the study's lead author. Some key findings of the study, which included an analysis of ED visits from 2009 to 2015:

- Mental-health related visits increased by 56.4% for pediatric patients and 40.8% for adults;
- Median length of stay in the ED for patients who needed an inpatient bed increased from 6.5 hours to nine hours;
- For patients who needed a transfer to a psychiatric hospital, average length of stay increased from eight hours to 11.4 hours.

"The magnitude of the increase over such a short time was surprising," says Santillanes, an associate professor of clinical emergency medicine at Keck School of Medicine at the University of Southern California.

EDs often lack the appropriate resources to provide ongoing mental health treatment.

"Patients with non-mental health diagnoses generally receive treatment for their underlying conditions while boarding in the emergency department," Santillanes notes.

Patients with infections are treated with antibiotics; patients with asthma receive breathing treatments and steroids. Patients with mental health emergencies "frequently do not receive specific mental health treatment. Boarding in the ED waiting for a bed ultimately delays their care," Santillanes says. The vast majority of patients held involuntarily present with psychiatric emergencies, according to the results of another study.[2] Of 251 patients on involuntary holds in the ED of a tertiary care center between 2013 and 2015:

- 51% presented with a psychiatric disorder;
- 9% presented with a substance use disorder;
- 34% presented with both psychiatric and substance use disorders;
- 5% of patients on involuntary holds presented with neither psychiatric nor substance use disorders.

Meanwhile, the number of hospitals with adequate psychiatric services continues declining. "Every year, you have more and more hospitals that are just getting out of the psychiatric business," says **Todd B. Taylor**, MD, FACEP, a Phoenix-based Emergency Medical Treatment and Labor Act (EMTALA) compliance consultant.[3,4]

Patients still visit EDs with acute psychiatric illnesses that need to be addressed. The problem is that hospitals are not providing those services on an outpatient or inpatient basis. At some facilities, there are no medical staff available to consult. "Emergency physicians, in that circumstance, become the de facto onsite psychiatrist that has to deal with that situation," Taylor notes.

If the ED psychiatric patient requires inpatient services, there may be nowhere available to send the patient locally — or even regionally. Hospitals are not obligated to accept the patient if all beds are full.

"You end up boarding psychiatric patients in a facility that has no psychiatric services," Taylor says. "It doesn't take a rocket scientist to figure out that's a problem." Taylor is aware of one patient who was boarded in an ED for six weeks. "What happens then is an opportunity for failure," Taylor notes.

The patient needs the services, but the hospital does not offer the services, and the ED has no place to send the patient. "You do the best you can. Sometimes, the best you can doesn't meet the standards CMS [Centers for Medicare & Medicaid Services] says you should meet," Taylor laments.

Nevertheless, complaints can trigger an investigation. "Anytime CMS comes in, they're going to find all kinds of stuff you did wrong. They're going to find something they don't like," Taylor observes.

EDs also face potential legal exposure under tort law related to malpractice, informed consent, battery, false imprisonment, and commitment law. "These vary tremendously from state to state. The patient's status as voluntary or involuntary matters a great deal in many of these state-based claims," notes **Susan Stefan**, JD, a visiting professor of law at the University of Miami.

Stefan is former senior staff attorney at the Center for Public Representation in Newton, MA, where she directed the Emergency Department Project, focused on improving the treatment of people with mental health issues in EDs. "There are two ways to mistreat people in psychiatric crisis," Stefan notes. One is to hold people involuntarily for days or weeks without any treatment. The other is to discharge or exclude patients without any treatment.

CMS cited a Maryland hospital for discharging a woman wearing only a hospital gown and socks in freezing weather.[5] "The problem there isn't that we're holding her and giving her no treatment. The problem is that we're

not holding her, we're kicking her out," says Stefan.

Instead of taking in psychiatric patients, two hospitals in Maine were accused of asking law enforcement to arrest these patients, a violation of EMTALA. One of the two facilities simply asked law enforcement not to bring in these patients.[6] *(Editor's Note: The two accused facilities worked with state and federal regulators and issued corrective action plans, which can be found at the bottom of the link associated with Reference 6.)*

Increasingly, plaintiffs are going to court to challenge the practice of holding patients with psychiatric crises in EDs while waiting for an available bed.[7,8] A recent psychiatric boarding case went all the way to Massachusetts' Supreme Judicial Court.[9] When the state's commitment law was passed in the 1970s, there were many state hospitals to take people in psychiatric crisis, Stefan explains. The commitment law authorized involuntary detention for long enough to transport an individual to a psychiatric facility.

"The statute did not include any time limitations for this stage of detention," Stefan notes.

Once at the facility, the law limits involuntary detention to three business days. After that, the person has to be discharged or a petition must be filed for involuntary commitment.

"But the time limits on involuntary detention don't start until the person arrives at the psychiatric facility," Stefan explains.

In effect, the Massachusetts law now permits indefinite involuntary detention in EDs. "It wasn't really anticipated because the statute wasn't written for that," Stefan says.

The plaintiff spent five days in the ED. The court ruled the three-day time limit for involuntary detention at a psychiatric facility began when the patient arrived at the ED. The court declined to impose an arbitrary time limit on ED boarding of psychiatric patients in light of indications the state legislature and department of mental health were working to address the problem. However, the court warned that "any unnecessary delay [in finding a facility to evaluate the patient] is unconstitutional."[9]

"It's better in some ways to try to solve ED boarding legislatively because it's such a complicated issue," Stefan offers.

Simply imposing time limits will not solve the problems that result in boarding. "Yet with extended ED boarding, there's also clearly a constitutional violation," Stefan notes. "You can't have indefinite involuntary detention without judicial oversight." If people could receive decent community-based mental health services, they might avoid crisis, Stefan says. If they receive community-based crisis services, people might avoid going to the ED. "EDs are scapegoats for diminishing social services," Stefan says.

ED providers believe if a patient is in psychiatric crisis, that person needs an inpatient bed. "It is in fact easier, although it takes much longer, to allow them to fester in the ED waiting for a bed than it is to actually work on creating a good community discharge plan," Stefan says. She recommends EDs use these approaches to reduce risks when holding psychiatric patients:

• Provide all staff with good training in de-escalation techniques, and consistently evaluate whether security guards are appropriate. "This needs to be reinforced by the culture in the ED and the hospital, and often it's not," Stefan laments.

Certain times, security guards are the source of problems. This is because behavior due to a person's mental health condition is interpreted as a security problem. "If security guards are called often in an ED because of psychiatric patients, that's a bad sign," Stefan cautions.

• Identify the sources of escalations that take place in the ED. If patients in psychiatric crisis are calm enough to answer questions at triage, yet end up in restraints, "that's a good way to figure out if the ED is having problems," Stefan offers.

Frequent checks during long waits is one way to avoid needless escalation. Psychiatric patients often are left to guess why they are waiting so long.

"If there's nothing to report, they don't check in with the person. Their idea is 'well, we're waiting for a bed. We don't know anything,'" Stefan says.

ED staff still can ask if it is too warm, too cold, if the patient wants something to eat, wants lights dimmed, or if they are worried about their kids, their job, or their pets. Frequent checks send the message, "We haven't forgotten you."

"Just paying attention to that kind of stuff can help. Those things are relatively easy to do," Stefan adds.

• Examine the spaces in which psychiatric patients are boarded. EDs should conduct an environmental assessment for safety. "Do this in all the spaces where patients will be held, including bathrooms," Stefan says.

Staying safe does not have to mean depressing and prison-like. In one ED, most treatment areas included artwork on the walls and were relatively bright and cheerful. In contrast, the room for psychiatric patients included a concrete floor with a drain and leather restraints on the bed — and no windows. "It looked like a solitary confinement cell," Stefan says. "What kind of message did that convey to the patient?"

• Identify staff who are good at de-escalating psychiatric patients.

Some ED staff are not fazed by people with psychiatric disorders, and have a talent for de-escalating tension. "It's a particular skill, and you have to find and reward those people," Stefan says. A reserved parking space for a month or a shout out at a staff meeting are two possible ways to recognize these employees, according to Stefan.

• Intervene if the chemistry is not good between a particular ED team member and the patient. If a patient is not getting along with a certain ED team member, it is worthwhile to send someone else in instead.

"The idea is to try to figure out the chemistry that works here," Stefan says.

• Reassess patients carefully at least once a shift. "Maybe you saw them in the first hour, and they really needed a bed, but now they're ready to go home," Stefan says.

Without frequent reassessment, the patient is just left to wait indefinitely, even if they no longer require inpatient care.

• Ask family members for more information, when possible. Some ED staff misunderstand confidentiality requirements, Stefan observes.

Patients may insist, "I don't want you talking to my family." Patients can make that request, but there is nothing to stop ED staff from listening to the family. "Sometimes, families lie. Sometimes, they are the source of the problem," Stefan acknowledges. "But the more sides of the story you hear, the better."

• Document the thought process behind the decision to discharge. "The biggest mistake is people documenting as though they are advocating for their own decision, rather than explaining how they got to that decision," Stefan says.

ED providers may only document information that supports discharge, and leave out anything that argues against it. For example, during an assessment, an ED nurse may have discovered the patient had access to lethal weapons at home. Providers can work with the patient and family members to ensure the weapons are removed.

Good charting should show the ED providers carefully considered all the available information.

"You are not liable for bad outcomes. You are liable for not weighing the options carefully and using good professional judgment," Stefan says. ■

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Simulated Lawsuit Teaches Emergency Medicine Residents How Med/Mal Works

Most emergency medicine (EM) residents have no idea how malpractice litigation works. A residency program collaborated with a law school to create a realistic, fabricated case to dispel misconceptions. *(Learn more at: https://bit.ly/2PufUTj)*

Mark Curato, DO, assistant director of the EM residency program at St. Barnabas Hospital in Bronx, NY, wanted his students to know what it was like to be the subject of litigation. Curato connected with **Adam Shlahet**, JD, director of the Brendan Moore Trial Advocacy Center at Fordham University's School of Law in New York City. Together, they created a medical malpractice litigation practicum for a group of eight advanced students. "We came up with a fact pattern that was both

typical and balanced, where it's a real judgment call," Shlahet says.

An EM resident volunteers to play the part of the defendant and becomes the "client" of the law students. "We tweaked the facts so it is a pretty even case. It's not a slam dunk for either side," Shlahet notes.

The case involves a man in his 60s who goes to the emergency department (ED) complaining of chest pain. Emergency physicians (EPs) perform several tests, including an ECG that could be interpreted in different ways. The patient is sent home with a diagnosis of anxiety and panic attack. The following morning, the patient dies of a heart attack in an ambulance on the way to the hospital.

The EP defendant is served with a complaint, but does not recall the patient, even after reviewing the ED medical records. "This is much like a true-life scenario. When you see so many patients, and it happened two years ago, it's a real possibility that there is no independent memory of the patient," Shlahet observes.

Next, the EP defendant meets with the defense team. The plaintiff attorney meets with an actor portraying the widow of the decedent. Some students produce an actual transcript of the depositions. At the end of the semester, it all culminates in a trial, with expert witnesses (the chair of the ED and another EP) testifying on both sides. The remaining EM residents serve as jurors, or simply observe.

The EM residents always start off wanting to explain what really happened to clear their names. "But telling their side of the story is really not the goal of the deposition," Shlahet explains.

Law students convey the importance of giving honest, accurate answers while not offering any additional information. They also train defendants to pause to think about questions before responding. "That's something that's counterintuitive, and that requires real practice," Shlahet says.

Law students see that clients are more than just fact patterns — they are real people who have lost someone. "They need to be brought into the process, not as an impediment to the process, but almost [as] the whole point of the process," Shlahet offers.

Reactions at the end of the trial always are interesting. The EM residents usually are surprised at what the jury paid attention to and what they disregarded.

"Some jurors focused on the conduct of the widow and how her delay in calling 911 may have been the real cause of death, even though the defense lawyers never made or even implied that argument," Shlahet reports.

Initially, most EM students expect the case will center solely on whether the standard of care was met. They are confused when the plaintiff attorney argues medical "facts" they know really are not accurate. "They see that the only medicine that matters in the courtroom is what the experts explain," Shlahet says.

If nothing else, the EM residents leave the experience with a keen understanding of the significance of documentation. Seemingly inconsequential details quickly become the entire focus of the trial. "They understand the gravity of each of their notations, not just what they are documenting but what they are not documenting," Shlahet explains.

As the litigation progresses, expert witnesses and attorneys on both sides are brought in to speak about relevant topics. "As a lawyer, we tend to think that everyone thinks like a lawyer," Shlahet says.

The law students realize defendants are thinking like doctors, not legal experts. "How a case would play out in litigation is the last thing most of them are thinking about," Shlahet adds.

When actual cases go to trial, damages and liability often are decided concurrently. The jury is deciding if the EP did commit medical malpractice; if so, how much is the plaintiff awarded? In the fictitious case, the closing arguments detail how the decedent left behind a daughter, and the struggle of how to put a dollar amount on that loss. "These are really powerful concepts, and some doctors are really moved by that," Shlahet observes.

The medical students see how difficult it is to look at facts in a cold and clinical way. They are much more comfortable focusing on whether there was a standard of care deviation. "But the jury hears a lot of information and evidence about the loss that this death that has caused," Shlahet says.

In the first two years of the program, the jury returned a verdict for the defendant. In the third year, the jury found for the plaintiff. "The three big factors are the conduct of the lawyers, the performance of the experts, and who the jury is," Shlahet says. "The juror's life experiences completely shape how they take in facts and testimony."

The law students learn they really need to understand everything in the ED chart. "If you don't take the time to learn what an acronym stands for, it's the one thing that's going to come back at you at trial," Shlahet cautions.

Medical students come to see that malpractice cases are not really as frivolous as they had imagined. "People come in with very black and white notions," Shlahet adds. "They leave with a much more nuanced understanding about how cases actually play out." ■

ED LEGAL LETTER™

CME/CE QUESTIONS

1. **Which is true regarding allegations of racial bias in emergency department (ED) malpractice litigation?**

   a. Plaintiff attorneys cannot produce enough peer-reviewed literature to support the allegation of racial disparities in ED care.
   b. Literature on racial bias in the ED always is going to be inadmissible because it is irrelevant to the specific care at issue.
   c. Character witnesses attesting to nondiscriminatory behavior could help the defense refute allegations of racial bias.
   d. Previous complaints alleging discrimination, or lack of such complaints, cannot be brought up by either side because they are prejudicial.

2. **Which is true regarding delays stemming from triage mistakes?**

   a. Treatment delays stemming from triage mistakes may indicate departure from the standard of care and may even give rise to claims of gross negligence.
   b. Triage nurses' failure to alert emergency physicians (EPs) about an impending crisis is not enough, on its own, to support a medical malpractice claim.
   c. Triage nurses' liability stops at the point where the ED patient goes back for evaluation, regardless of whether the patient returns to the waiting room.
   d. EPs cannot be held liable for what happens in the ED waiting room if the plaintiff can demonstrate triage nurses failed to reassess the patient.

3. **Which is true regarding hospital policies and ED malpractice claims?**

   a. State courts will consider ED policies as one of several factors in determining whether there was negligence and liability.
   b. Judges often instruct juries that hospital policies supersede the EP's clinical judgment.
   c. EPs should avoid documenting the reason something was not handled according to hospital policy because this allows attorneys to show the EP was aware of the policy.
   d. EPs can be held to policies put into place after the ED visit at issue in the lawsuit.

4. **Which is true regarding ED boarding of psychiatric patients?**

   a. EDs face potential legal exposure under tort law related to malpractice, informed consent, battery, false imprisonment, and commitment law.
   b. There is significantly less legal risk if patients are discharged without treatment than if patients are held without treatment.
   c. If patients state they do not want ED staff to talk to their family, ED staff are legally obligated not to document anything the family tells them.
   d. If a patient is not doing well with a certain ED team member, it increases legal risk if another ED team member is sent in instead.