"Resolved, that the American College of Emergency Physicians (ACEP) Board of Directors appoint a task force to develop a standardized risk management curriculum and the needed supporting educational products to be used by residency programs in teaching risk management and tort law to residents and junior faculty."

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**ACEP RISK MANAGEMENT OUTLINE AND RESOURCES**

**Introduction:**

This document was developed by the ACEP Academic Affairs Committee and Medical Legal Committee as a resource document to utilize in risk management education. This document is not intended to be a comprehensive review of risk management, but rather a resource document for educators. Users are encouraged to use original references listed throughout the document, and to update educational material as new references become available.
I. **TOP TEN AREAS OF VULNERABILITY IN EMERGENCY MEDICINE (EM) PRACTICE**

As with any specialty, the practice of emergency medicine has its own vulnerabilities and potential for medical-legal land mines. Emergency medicine may be at higher risk than some specialties due to the acuity, fast speed of practice, limited information, time and relationship with patient, and inevitability of some bad outcomes.

Below is a list of the ten common vulnerabilities found in claims of medical negligence involving the ED. Not every bad outcome or lawsuit means malpractice. In fact, little correlation can be found between errors and claims and vice-versa. However, there are patterns of allegations that are instructive in suggesting actions to reduce the risk of being sued and to increase the chance of winning when sued.

Every emergency physician should be very familiar with the items in this list. Emergency physicians should actively participate in an educational program specific to EM to improve patient safety while reducing risk for patients and physicians alike. The importance of documentation can be summed up in this one quote: “Use the history, risk factors, exam, test results and ED course to shape your differential diagnosis and medical reasoning into a compelling story so logical that any reasonable physician and every juror can only come to one conclusion – yours.”

1. Knowledge deficit
Despite extensive education, training, and experience, the emergency physician will not have seen every variation of every diagnosis. For example, it may not be universally known that aortic dissection may present with stroke symptoms or abdominal pain with hematuria. While it is not possible to master the entire body of available medical knowledge it is important for emergency physicians to focus on learning as much as possible about the ED presentations which are high risk – both for the patient and for the physician.

2. Failure to take adequate history

The allegation of this “failure” is frequently found in medical negligence suits, and typically involves the absence of one or more key elements of the history of present illness, risk factors, past medical history, family history, or personal/social history. The basic skill of history-taking learned in medical school requires ongoing diligence and refinement in order to produce chart documentation which reflects the reasonable care delivered. One of the main areas of deficiency seen in suits is the lack of documentation of risk factors for serious conditions such as acute coronary syndrome, pulmonary embolism, aortic dissection, abdominal aortic aneurysm, and subarachnoid hemorrhage.

3. Failure to perform adequate exam

This “failure” may not be one of the most common allegations in malpractice suits, but when the allegation is made (and is true) the results can be disastrous. Every patient expects that an adequate physical examination will be performed and documented. If important elements of the physical exam are not documented, it can be assumed that
the physician simply did not perform the exam. Some classic examples include: failure to perform a neurological exam in a headache patient; failure to examine the mental status, neck, and skin in a febrile infant; and failure to document the presence or absence of a pulsatile abdominal mass and peripheral pulses in a patient over 50 who presents with abdominal or flank pain.

4. Failure to consider differential diagnoses

   Optimally chart documentation should reflect the physician’s medical reasoning, of which the differential diagnosis is a key component. Particularly for high risk chief complaints such as chest pain, abdominal pain, headache, and pediatric fever, it may be wise to document the principal differential diagnoses, accompanied by a brief discussion as to why those diagnoses were considered, dismissed or ruled out. If chart documentation does not include a discussion of medical reasoning and there is a bad outcome, the patient may resort to a lawsuit simply to find out what the physician was thinking. It's important to be aware of cognitive biases and recognize them in considering a differential diagnoses

5. Failure to order/interpret diagnostic studies

   For the lay public and medical profession alike, there are expectations that certain diagnostic studies will be needed based on the presenting symptoms and signs. This “failure” is a common allegation when a patient experiences an adverse outcome, and feels that blood work, x-rays, EKG, or other tests should have been done but were not. Examples include failure to perform an EKG to evaluate chest pain, failure to perform an
LP for the patient with sudden severe headache and negative head CT, or failure to perform a pregnancy test for women of childbearing age with pelvic pain. As a corollary, physicians are held responsible for interpreting the diagnostic studies they order. There are few circumstances more indicting than a physician who ignore or fail to recognize abnormal test results which he or she ordered.

It's also important to have a basic understand, however, that not every test has to be ordered to rule out a diagnosis from our differential. We evaluate pre-test probability, know the characteristics of a test, and order tests to narrow our differential and arrive at a post test probability.

6. Failure to diagnose

In emergency medicine this is probably the most common allegation of “failure”. It is the final common pathway leading to claims of negligence in the emergency department, and is usually accompanied by at least one of the other “failure” allegations. The emergency physician is expected to combine his knowledge with the patient’s history, exam, and diagnostic testing to arrive at the correct diagnosis.

7. Failure to treat

This vulnerability goes hand in hand with failure to diagnose. It follows logically if there was a failure to diagnose, then there will also be a failure to treat the “missed diagnosis”. This allegation is also made when treatment is delayed or not given at all. Examples of allegations in this category include: failure to use heparin, aspirin, and beta
blockers for acute coronary syndrome; failure to treat stroke with thrombolytics; and failure to administer antibiotics for pneumonia, meningitis, or sepsis in a timely fashion.

8. Failure to consult

This allegation is self-explanatory. When a physician would be reasonably expected to consult a specialist and does not, this allegation can be unfairly made when there is a bad patient outcome. Examples include early consultation for trauma patients; cardiology for acute myocardial infarction; orthopedics for open fractures; or vascular surgery for an ischemic limb.

9. Failure to admit

The majority of malpractice claims in emergency medicine involve a patient who was discharged home from the ED and ended up suffering a complication. This “failure” is usually coupled with the allegation of failure to diagnose. Of all the decisions made during the care of a patient in the ED, the single most important decision is the disposition – whether to admit or discharge. The emergency physician should use a written or mental “template” to consider this list of vulnerabilities prior to discharging a patient who came to the ED with a high risk chief complaint. The discharge instructions should always include three specific things: who to follow up with, when to follow up, and specific reasons to return to the ED.

10. Failure to communicate
Although this specific “failure” is rarely mentioned in a lawsuit, it serves as the foundation upon which other allegations are built. It should be a part of every physician’s routine to explain the “who, what, when, where, and why” of the workup to the patient. Strategies include listening to patients and their families, soliciting and listening to ED staff input, and delivering service to achieve best patient and family satisfaction. Striving to achieve optimal patient satisfaction by treating patients as if they were your own relative and communicating clearly and often, serves to increase patient safety and reduce risk. Obtaining and documenting informed consent is also a vital part of communication with the patient. The patient needs to be informed and agree to understanding the risks and benefits of any procedure or intervention.

11. Failure to re-evaluate
II. CHARTING AND DOCUMENTATION

A. Goals and Objectives:

1. Describe the purpose of the medical record
2. Identify the key components of the Physicians medical record
3. Make appropriate alterations in the medical record
4. Appropriately document discrepancies between physicians and nurses charting
5. List basic components of discharge/follow-up instructions
6. Describe different charting methods
7. Develop a plan to avoid risks with their specific charting method
8. Differentiate between effective and ineffective documentation with regards to risk management.
9. Analyze 5 of their charts and describe documentation deficiencies from a risk management standpoint

B. Content:

1. Purpose of Record
   a. Communicate to other healthcare providers the care given.
   They should be able to tell exactly how patient presented, what
care was given, how they responded, what the differential and provision diagnosis were, what the disposition was.

b. Justification of billing
c. CMS documentation guidelines
d. Documentation of care that protects the patient, hospital and health care providers. The medical record can be submitted as evidence.

2. Physician Record
a. History
   Chief complaint
   HPI
   ROS
   PFSH
b. Exam
   General Multi-System Examinations
   Single Organ System Examinations
   1. Emphasis on portion of exam pertinent to chief complaint
c. Complexity of Medical Decision Making
d. Number of Dx and Management options
e. Risk

3. Alteration of Physician Record
a. At time of care
Single line, error, initial, date and time

b. After care but prior to adverse outcome or notification of legal action

c. Addendum

d. After knowledge of legal action or outcome

May record recollection of case with legal counsel, not in patient chart.

4. **Nursing and Ancillary Staff Record**

a. Check for congruency and document if there is a discrepancy


c. Nursing education regarding appropriate documentation

5. **Disposition and Follow-up**

a. Working Diagnosis

b. Follow-up

c. Why they would need to return

d. Simple language

e. Expected course of illness or injury

6. **Consultations**

a. Risk of unofficial consult

b. Read and check for inconsistencies with your documentation
c. Realize there note may be slightly different form your conversation.

7. Incident Report
   a. Purpose
   b. Components
   c. Preventing Discovery

8. Types of Medical Records: Advantages and Disadvantages
   a. Handwritten
   b. Scribe
   c. Template
   d. Transcription
   e. Computer-generated Voice Recognition Programs
   f. Electronic Medical Records

9. High risk documentation

10. Miscellaneous
    a. Legibility
    b. Don’t place incident report, QI material in chart
    c. Lost record

References:


III. PRACTICE MANAGEMENT

Goals and Objectives

1. Maximize medical and legal risk reduction in the management of patients with high-risk chief complaints (i.e. chest pain, abdominal pain, pediatric fever, headache, etc).

2. Through an in-depth interactive presentation on medical and legal issues in patients with high-risk medical complaints, the resident will be able to discuss the following:
   a. common pitfalls of these clinical conditions and how best to document care in a defensible manner (advice given to the patient, the thought processes behind diagnostic workup and management plan).
   b. life-threatening diagnosis that should be considered in the differential diagnosis of these patients.
   c. appropriate diagnostic strategies and management of these patients.

7. Given recent cases at a monthly EM Morbidity and Mortality conference, the resident will be able to:

8. identify possible deficient areas in the workup of the ED patient in each case.

9. discuss how, if at all, the patient (s) could be managed differently to minimize any medicolegal risk for each case

10. discuss how to document care in a defensible manner
11. discuss the importance of a multidisciplinary approach to quality assurance
(involving nursing staff, radiology, lab)

12. Perform operational risk reduction in the ED in the following areas:
   b. Facility
   c. Privacy
   d. Equipment
   e. Security
   f. Safety
   g. Credentialing
   h. Orientation
   i. ED staff
   j. Patient satisfaction
   k. Consent
   l. Telephone
   m. Special patients
   n. Discharge instructions
   o. Specific problems
   p. Test follow-up

13. Optimize superior patient satisfaction by attaining a general understanding of the
    “do's and don'ts” in regards to EM practice.
Suggested Reading


Davenport J. Documenting high-risk cases to avoid malpractice liability. October 2000. Accessed August 1, 2005
http://www.aafp.org/fpm/FPMprinter/20001000/33docu.html?print=yes


IV. HIGH RISK CHIEF COMPLAINTS/CONDITIONS IN EMERGENCY MEDICINE

A. COMPLAINTS

- CHEST PAIN
- ABDOMINAL PAIN
- HEADACHE
- PEDIATRIC FEVER
- WOUND CARE

B. CONDITIONS

- ACUTE CORONARY SYNDROME
- PULMONARY EMBOLISM
- AORTIC DISSECTION
- AAA
- APPENDICITIS
- SUBARACHNOID HEMORRAGE
- STROKE

  I. CAROTID AND VERTEBRAL DISSECTION

- MENINGITIS
- HEAD INJURY
- SPINE INJURY
- FRACTURES
- TESTICULAR / OVARIAN TORSION
- ECTOPIC PREGNANCY
- SEPSIS
- MESENTERIC ISCHEMIA
VI. HIPAA

Goals and Objectives:

1. Understand basic concepts of HIPAA and related regulations.
2. Describe basic potential breaches of confidentiality of protected health information and how to avoid them.
3. List elements of protected health information.
4. Describe system mechanisms to protect patient confidentiality.

References:


VII. **EMTALA**

**Goals and Objectives:**

1. Discuss the intent of the EMTALA legislation
2. Identify providers and facilities governed by EMTALA
3. Give examples of an emergency medical condition (EMC)
4. Describe the purpose of a medical screening exam (MSE)
5. Disposition emergency department patients in accordance with EMTALA
6. Evaluate one’s personal and facility documentation practices with regard to EMTALA

**Content:**

A. What is EMTALA?
   1. Original intent (1985)
   2. Major changes

B. Whom or what providers/facilities does it govern?

C. To which patients does EMTALA apply?

D. What is an emergency medical condition (EMC)?

E. What is a medical screening exam (MSE)?
   1. What is the purpose?
   2. Who needs one?
   3. Who performs the MSE?
   4. Within what time period must the MSE be performed?
   5. What is considered part of the MSE?

F. Stabilization of an EMC
1. Who must be stabilized?
2. What is stabilization?
3. Who has the duty to stabilize?

G. Disposition Requirements

1. Admission and consultation
2. Transfer
3. Follow-up

H. Documentation

1. Central Log
2. Transfer Log
3. Medical Record
VIII. MALPRACTICE

Goals and Objectives:

1. State the definition of “tort” and “negligence”
2. Name the four elements of malpractice
3. Guide professional interactions and documentation to minimize medicolegal risk
4. Identify pre-trial and trial phase events and expectations of the malpractice defendant

Content

A. Statistics
B. Tort = a civil wrong, whether intentional or unintentional
C. Negligence -> professional negligence -> malpractice
   1. Negligence definition
   2. Elements: Duty, Breech of duty, Harm, Causation
   3. Contributory negligence
   4. Comparative negligence
D. Why do people sue?
E. How to avoid lawsuit?
   1. Be nice
   2. Documentation
   3. Disclaimers
F. What to do if sued?
1. Basics  
2. Timeline  
3. Deposition  
4. Testimony  

G.  

References:  


To Err is Human: Building a Safer Health System. Institute of Medicine, November, 1999.


Croskerry P. The importance of cognitive errors in diagnosis and strategies to minimize them. Acad Med. 2003;78:775-80


Collins MF et al. Massachusetts Risk Management Survey (MaRMS) of teaching hospital physicians. J Healthc Risk Manag. 1997 Spring;17(2)