

## EMERGENCY DEPARTMENT MISDIAGNOSIS

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**I. HOSPITALS ARE DANGEROUS PLACES.** Each year as many people are killed in hospitals as a result of medical errors as would be if two jumbo jets collided mid-air killing all aboard every day of every week of every month of the year. Emergency Departments can be especially dangerous for patients.

### **A. DELAYS IN TREATMENT**

. . . [H]ospital Emergency Departments (EDS) are the source of just over one-half of all reported sentinel event cases of patient death or permanent injury due to delays in treatment. ... The reported reasons for the delays in treatment are many and varied with the most common factor being misdiagnosis (42%). Other delaying factors include: delayed test results (15%); physician availability (15%); delayed administration of ordered care (13%); incompetent treatment (11%); delayed initial assessment (7%); patient left unattended (4%); paging system malfunction (2%) .... Of the ... cases involving misdiagnosis, the most frequent diagnosis was meningitis ..., other misdiagnosis included various forms of cardiac disease, pulmonary embolism, trauma, asthma, neurologic disorder and ... cases of unknown diagnosis due to the patient leaving without being evaluated. ...

Multiple root causes identified: analysis of the cases reveal that multiple root causes contributed to each sentinel event, with most organizations (84%) citing breakdown in communication, most often with or between physicians (67%). Organizations also cited problems with patient assessment process (75%); continuum of care issues (62%), most often relating to discontinuity of care across settings or shifts; orientation and training of staff (46%); availability of critical patient information (42%); staffing levels (25%); and availability of physician/specialists (60%).”

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## **B. EMERGENCY ROOM PROVIDERS**

Increasingly, patients are not seen by physicians in emergency rooms but are instead only seen by physicians assistants. See sample deposition of emergency room physician assistant attached. Often, the emergency room doctor does not even review the patient's chart and approve the care given by the physicians assistant until after the patient has left the hospital.

Unfortunately, emergency room doctors also are increasingly relying on T-sheets (sample attached) to direct the scope of their examination of the patient according to a checklist directed toward what is supposed to be the patient's chief complaint. These T-sheet checklists are pulled off computer programs by triage nurses in the emergency room, usually before the doctor sees the patient. If the triage nurse pulls up the wrong T-sheet, many emergency room doctors will be led down the wrong path and miss the proper diagnosis.

## **II. ORGANIZATIONAL STRUCTURE.**

**A. STRUCTURE.** It is necessary to understand the organization structure and hierarchy at the hospital emergency department in order to determine who are the appropriate defendants and what standards apply.

**1. LARGE HOSPITALS.** For example, at a large hospital, a typical arrangement is that the emergency department is staffed by contract with an emergency room group of physicians, physician assistants who are employed by the physician group (or the hospital) and nurses and other ancillary personnel employed by the hospital.

**2. SMALL HOSPITALS.** At a small rural hospital, the emergency department is typically staffed by emergency department or other physicians under contract with the hospital and nurses employed by the hospital.

**B. DOCUMENTATION WITH RESPECT TO ORGANIZATIONAL STRUCTURE AND DUTIES.** To determine the organization structure and also the various duties amongst the health care providers, several references must be considered early on.

1. Medical staff bylaws;
2. Rules and regulations of medical staff;
3. Contract between emergency department group and hospital;
4. Contract between emergency department physician and hospital;
5. Contract between emergency department physician and emergency department group;
6. Contract between physician assistant and hospital;
7. Contract between physician assistant and emergency department group;
8. Medical Practice Act and Rules and Regulations of Board of Medical Examiners;
9. Physician Assistant Practice Act and Rules and Regulations of Board of Physician Assistant Examiners;
10. Nurse Practice Act and Rules and Regulations of Board of Nurse Examiners;
11. Physician personnel file;
12. Physician Assistant personnel file;
13. Nurse personnel file;
14. Supervision agreements between physician and physician assistant; and
15. Hospital policies and procedures.

### **C. INSTITUTIONAL NEGLIGENCE.**

In addition to the negligence of the physicians, physician's assistant, and nurses, it is important to look at the institutional negligence that set in motion the structural problems that put your client in jeopardy. For example, in most states, the hospital will have an affirmative duty to hire competent staff, to periodically test core competencies and retrain and retest staff, and to develop **AND** enforce appropriate policies and procedures. *See, e.g., AirShields, Inc. v. Spears*, 590 S.W.2d 574 (Tex. Civ. App. – Waco 1979, writ ref'd n.r.e.)

### **III. JCAHO ACCREDITATION.**

#### **A. DEEMED STATUS.**

The Social Security Act §1881(e) and §1865(a) permit for deemed status of hospitals that are accredited by the Joint Commission on Accreditation of Health Care Organizations. This means that they are deemed to meet all of the Medicare Conditions of Participation.

#### **B. ACCREDITATION STANDARDS.**

JCAHO publishes a Comprehensive Accreditation Manual For Hospitals: *The Official Handbook* (See e.g. [www.JCAHO.org](http://www.JCAHO.org)). These standards set forth the standards for accreditation in several areas, including: ethics, rights, and responsibilities (R.I.); provision of care (P.C.); medication management (M.M.); improving organizational performance (P.I.); leadership (L.D.); management of the environment of care (E.C.); and management of information (I.M.).

#### **C. EXAMPLES:**

R.I.1.10 and R.I.1.30: Emergency Department Policies Procedures and performance must be in compliance with the organizational's ethical code and staff members must be well informed about the content and application of the code to ensure business is conducted in an ethical manner. Care and treatment of patients must be delivered based on patient need,

regardless of the organization's financial implication.

R.I.2.90: It is essential that the patient is informed regarding the outcomes of care, including unanticipated outcomes. The licensed independent practitioner or his/her designee must inform the patient, and when appropriate family members regarding any unanticipated outcome.

R.I.2.160: Policies and procedures should address the care of emergency department patients to define when pain should be screened, assessed and reassessed, and to provide for communication to patients about effective pain relief.

P.C.2.20, P.C.2.120 and P.C.2.130: The emergency department assessment and reassessment policies and procedures must be defined in writing. The standards are for performing a thorough initial assessment and reassessment in specified time frames of the patient care needs. Information collected on patients entry into the emergency department may indicate the need for further assessments. Triage, used to determine the order in which patients will be treated, does not meet the criteria of patient assessment.

P.C.2.150: These standards concern the reassessment of patients to meet their continuing care needs. The emergency department of assessment and reassessment policies must meet applicable law and regulatory requirements.

P.C.3.230: These standards concern performing tests in a timely manner to determine a patient's health care or treatment needs. Diagnostic tests and procedures require an order. Clinical information regarding the reason for the test is submitted with the order based on organization policy and applicable law and regulation. Testing that requires clinical interpretation must have appropriate information supplied with the order.

**D. EMERGENCY DEPARTMENT COMPLIANCE MANUAL, 2006 Edition, Rusty McNew Consulting Editor, Aspen Publishers.**

The Emergency Department Compliance Manual is a helpful resource with respect to determining the obligations of the hospital organization. It sets forth comments on the various standards, evidence of organizational compliance and importantly staff questions the type of which are used in a JCAHO audit. These provide a useful starting point for an outline of the types of questions which need to be asked of hospital management personnel responsible for the emergency department.

**IV. OTHER SOURCES.** The American Academy of Emergency Medicine and The American College of Emergency Physicians have set forth several policy statements, clinical practice guidelines, information papers and other materials. These should be consulted on a variety of issues. Healthcare Standards Directory.

**V. MEDICAL ASPECTS OF RECURRING CASES**

- A. Failure to diagnose acute myocardial infarction.
  - 1. EKG not taken;
  - 2. EKG misread as negative;
  - 3. EKG negative, but patient still needing admission.
- B. Failure to diagnose cerebral vascular accidents (“strokes”) – the TPA window and controversy.
- C. Failure to diagnose spinal cord involvement – subluxations, acute disc herniation, spinal epidural abscess.
- D. Inappropriate triage. Patient seen by a physician assistant on fast tract.
- E. Repeat visits to emergency department. Previous records not accessed.

## **VI. EMTALA**

### **A. THE EMERGENCY MEDICAL TREATMENT IN ACTIVE LABOR ACT.**

This is a federal statute that was enacted because hospitals were refusing to treat uninsured or unprofitable emergency or labor patients. *See 42 U.S.C. §1395(d)(d)*. A hospital assumes obligations under EMTALA in order to participate in the United States Medicare program by way of its Medicare provider agreement that it signs with the United States government. *See 42 U.S.C. §1395(c)(c)*. The hospital's obligations include meeting the emergency needs of patients in accordance with acceptable standards of practice. *See 42 C.F.R. §482.55*.

**B. THE HOSPITAL'S DUTIES UNDER ENTALA.** A hospital has three-fold duties under ENTALA:

1. When a patient arrives at a hospital, the hospital must provide an emergency medical screening examination in order to determine whether an emergency medical condition is present. *42 U.S.C. §1395dd(a)*. The duty to provide a screening examination is not limited solely to the emergency room, it applies where ever the patient presents at the hospital. *42 C.F.R. §489.24(a)*.

2. The hospital must provide stabilizing medical care for all known emergency conditions. *42 U.S.C. §1395dd(b)(1)*; *42 C.F.R. §489.24(c)*. Duty to provide stabilizing care is separate and independent of the duty to provide an emergency medical examination. *See Marrero v. Hospital Hermanas Melendez*, 253 F.Supp. 2(d) 179 (Dist P. Rico 2003).

3. A hospital may only transfer the patient to another medical facility when:

- (a) qualified personnel are used for the transfer. *42 U.S.C. §1395dd(c)*.

- (b) Proper equipment appropriate for the particular subject patient accompanies the patient during transfer. 42 U.S.C. §1395dd(c); and
- (c) The transfer is accomplished in a medically appropriate manner from physician to physician and from hospital to hospital. 42 C.F.R. §482.11.

**C. LIMITATIONS.** Assume the EMTALA statute of limitations will be different from the applicable state law. The EMTALA statute of limitations is two years. There is no tolling or provision for minority or incompetence. There is no notice provision. See U.S.C. §1395dd(d)(2)(C).

**D. OTHER ISSUES.** Other issues to keep in mind with respect to EMTALA claims are that contributory negligence is not a defense. A hospital is strictly liable for all personal injury damages that result from a violation. See e.g., *Abercrombie v. Osteopathic Hospital Founders Association*, 950 F.2d 676 (10<sup>th</sup> Cir. 1991); *Reid v. Indianapolis Osteopathic Medical Hospital*, 709 F.Supp. 853 (S.D. Ind. 1989). Moreover, depending on your circuit, the state law medical malpractice caps may not apply to the EMTALA cause of action. See *Jeff v. Universal Health Services, Inc.*, 2005 W.L. 2036893 (E.D. La). Accord, *Root v. New Liberty Hospital*, Dist. 209 F.3d 1068 (8<sup>th</sup> Cir. 2000), *Brooks v. Md. Gen. Hosp., Inc.*, 996 F.2d 708 (4<sup>th</sup> Cir. 1993) (applying the Maryland Medical Malpractice Act) (*but see Power v. Arlington Hospital Assn.*, 800 F.Supp. 1384. Ed Va. 1992, Rev'd in part, 42 F.3d 851 (4<sup>th</sup> Cir. 1994) (applying Virginia Medical Malpractice Act). And in any event, many of the new procedural hurdles enacted by the various tort reformers at the state level may well not apply in a federal EMTALA cause of action.