Academic Resident

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A Medical Liability Primer for Residents

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Medical malpractice lawsuits are a fact of life for medical providers. Hospitals, physicians, nurses, emergency medical technicians, and others who provide patient care can be named as defendants in medical liability lawsuits. The risk of residents being sued is unknown but because residents may become targets of a lawsuit, they must have a basic understanding of medical liability and learn strategies to mitigate the risk. This article describes the elements of a medical liability claim and describes some basic strategies to employ in the emergency department to avoid lawsuits. There are four components that must be present to prove a claim of malpractice: duty to provide care, breach of the standard of care, proximate cause, and injury/damage.

Emergency physicians assume a duty to care for every patient presenting to the emergency department because of the medical screening exam mandated by EMTALA. The first component is thus always present in emergency department malpractice claims. The second component mandates that the care provided to the patient meets the "standard of care". When a provider with similar training and expertise would provide like or similar care in like or similar circumstances, the "standard of care" has been met. Medical "experts" from both sides often testify as to what constitutes "standard of care" and whether it was met. While some circumstances may appear to be very straightforward, defining the standard of care is often the most debated element of a medical liability claim. After arguing to establish the "standard of care", the plaintiff's attorney must argue that the standard of care was not met. The third component requires that "proximate cause" be established. The breach of the standard of care must be the "proximate cause" for the injury suffered. In other words, the plaintiff's attorney must argue that the patient's injury would not have occurred but for the action (or inaction) of the physician being sued. Finally, the patient must have suffered some sort of injury. Injury can take many forms including death, dismemberment, pain, suffering, mental anguish, loss of consortium, and loss of income.

To prove or win a malpractice suit, the plaintiff must prove that all four elements are present. A medical error by itself does not constitute malpractice. If a duty to care, and breach of the standard of care are present, but not an injury, a claim of malpractice cannot be supported. If proximate cause is lacking, malpractice is similarly not supported. The burden of proof rests with the plaintiff. Many physicians are unaware that the burden of proof (weight of the evidence) is different in malpractice trials than criminal trials. In criminal trials, the burden of proof must show guilt beyond any reasonable doubt. In malpractice trials, the plaintiff only has to show that a preponderance of the evidence proves their claim of medical liability.

Plaintiffs attempt to recover economic damages and non-economic damages. Actuarial experts are retained to calculate to economic damages that may result from lost wages, lost benefits, and medical expenses. Non-economic damages are sought for "pain and suffering". Many claims of medical liability are never taken to trial but are settled by both parties. Both parties agree to a resolution of the case that usually involves a payment to the suing plaintiff. The decision to settle a case is complex but involves all parties weighing the risk of winning or losing a jury trial. The local liability climate, the nature of the allegation, and the type of patient all may influence a defendant's decision to offer a settlement or a plaintiff's decision to accept a settlement. If a physician loses a medical liability lawsuit, his or her name is often entered into the National Practitioner Databank. Settlements, even when no determination of liability is made, may also be entered into the National Practitioner Databank.

Many consider emergency medicine a specialty at high risk for medical liability. According to data from Pro Assurance Group, a multi-state malpractice insurance company, risky areas within emergency medicine include acute myocardial infarction, meningitis, undefined chest pain, fractures of the vertebral column, and appendicitis. Most suits against emergency physicians base their liability claim on an error in diagnosis, improper performance (of history, physical exam, or a procedure), or failure/delay in consultation or admission. Of the three, error in diagnosis is the most common alleged mistake cited in malpractice suits against emergency physicians. Factors that contribute to diagnostic error are found in Table 1. Avoiding common pitfalls can also reduce diagnostic error and improve patient care (Table 2). Documentation of the ED encounter is the most important element relied on to defend a malpractice claim. Unfortunately, sufficient documentation is lacking in many malpractice cases. Important aspects that should be documented for each patient encounter are found in Table 3. The last paragraph of the patient's ED record is often the most important. The differential diagnoses considered and the diagnostic, therapeutic, or disposition strategies employed are outlined in a statement of the "medical decision making". The patient's instructions and understanding of the disposition plan are described here.

Residents in training can learn to manage the risk inherent in the practice of emergency medicine and learn to accurately document the ED encounter to adequately convey the care provided. It is important for EM residents to understand the basic elements of a malpractice lawsuit and the high-risk

areas encountered daily. Residents must enhance diagnostic accuracy, avoid diagnostic and therapeutic pitfalls, and improve documentation. Doing so will improve patient care and assist in the navigating of a perilous aspect of our profession.

Table 1- Factors That Contribute to Diagnostic Error

- Incomplete patient history recorded
- Failure or delay in ordering appropriate studies, timely consultation, or admission
- Condition not considered (can't possibly be MI, meningitis, etc)
- Misinterpretation of studies, particularly equivocal results
- Physician not aware of results
- Failure to communicate results to the patient

Table 2- Strategies to Avoid Pitfalls

- Consider conditions with high mortality and morbidity
- The atypical presentation of common illness is more likely than a "zebra"
- Patients at extremes of age may present atypically
- Alcoholics or drug abusers may be at high risk
- If a disease is considered likely and initial studies are equivocal, consider more tests or admission
- Repeat visits mandate an expanded differential diagnosis
- Consider consultation, admission, or ED observation if the patient is symptomatic and diagnosis not established, particularly when serious illness or injury is contemplated

Table 3- Documentation

- Document the chief complaint
- Document personal/family history
- Document risk factors for disease
- Document the differential diagnoses considered
- Document why the diagnostic approach was selected
- Document the patient response to treatment
- Document consultations with other physicians
- Document why admission/discharge is appropriate
- Document the times of sentinel events during the encounter
- Document patient understanding/acceptance of treatment/disposition plan