

Trauma Malpractice: Steps To Mitigating Risk

Jennifer L'Hommedieu Stankus, MD, JD, FACEP

Attending contract physician, Madigan Army Medical Center, Department of Emergency Medicine, Tacoma, Washington



Introduction

The principles of medical malpractice liability for the emergency clinician remain fairly consistent whether discussing trauma or other types of cases. This chapter will cover the basics of medical legal liability, and will highlight those areas of particular relevance in trauma cases. In addition, liability for on-call physicians, such as trauma surgeons and neurosurgeons, including liability under the Emergency Medical Treatment and Active Labor Act (EMTALA), will be covered.

Building A Medical Malpractice Case

In order to prevail in a medical malpractice lawsuit, the plaintiff must prove 4 elements of negligence under tort law. The first element is a duty to the patient. In emergency medicine, this occurs as soon as a patient signs into the emergency department (ED). The emergency physician or qualified provider has a duty, under EMTALA, to provide a medical screening examination, and then to treat and stabilize any emergency medical conditions that exist. For an on-call specialist or consultant, the time that the duty begins is less clear. Beyond this statutory EMTALA duty, all clinicians involved in the care of the patient also have a duty to provide the standard of care for the emergency medical condition.

Second, once a duty has been established, the plaintiff must show that there was a breach of this duty. In other words, there must be proof that the standard of care was not met. This is done through expert witness testimony from another physician paid by the plaintiff's attorney. The choice to use an expert witness based on where the expert witness practices, how much of their practice is as an expert witness versus as a clinician, and their specialty depends upon state rules of evidence.

Third, there must be a direct and causal link between a failure to meet the standard of care, and that this failure results in an injury to the patient. For example, a

clinician may treat a trauma patient with multiple injuries, but may fail to identify a non-displaced rib fracture and a stable spine fracture. So long as there are no sequelae from these injuries, it would be very difficult for the plaintiff to argue for any damages from this failure to diagnose.¹ On the other hand, if the spine fracture was actually unstable and the patient developed paraplegia, there would be a direct link. The fourth element is damages. This means that there must be injury to the patient due to the above elements. For example, if there was a duty and negligence, but the patient was not harmed, there is no malpractice, or if a patient had a non-survival injury and several other injuries were missed due to negligence, there is likewise no malpractice.

Risky Business – The Liability Environment In Trauma

According to a study analyzing data from 5825 physicians responding to an American Medical Association physician information survey covering the period from 2007 to 2008, the prevalence of being sued as an emergency physician was approximately 1 in 2, with an incidence of about 9% each year.² The survey asked whether or not the physician had ever been sued and whether or not they had been named in a lawsuit in the past year. Half (49.8%) of the emergency physicians responding reported at least 1 claim, and 30.9% reported ≥ 2 . Of those emergency physicians aged > 55 years, 75% had experienced claims. Therefore, an emergency physician's chances of being sued at some point are more likely than not, based on this survey data.

Interestingly, there is a gender gap. When it comes to being sued, a male physician's risk is twice as high when compared to a woman's.² While the reasons are unclear, some theories include factors such as body language and techniques of establishing rapport that sometimes differ between men and women and can have a profound effect on the rate of lawsuits.

Trauma care is often viewed by on-call specialists as being highly risky. There is a perception that taking a trauma call increases a surgeon's medical legal liability exposure, and it is sometimes cited as a reason for avoiding this type of call. However, when looking at trauma surgery malpractice, 2 studies indicate no increase in risk. The first was a 2005 study from the University of Texas at San Antonio, where the Department of Surgery examined 62,350 operations performed over a 12-year period.³ Of the operations examined, 21 lawsuits were initiated; 7 of those were dismissed, and 3 were granted summary judgments to the

defendants. Ten were settled with payment to the plaintiffs, and only 1 went to a jury verdict in favor of the defendants. The types of surgery were broken down into elective, urgent, and trauma. The incidence of lawsuits varied little between the groups, despite there being an estimated 49,435 trauma patients evaluated. The incidence of lawsuits was as follows: trauma, 3.1/100,000 procedures/year; elective surgery, 3/100,000 procedures/year; and urgent surgery, 2.3/100,000 procedures/year. The authors of the study concluded that trauma surgery is no more risky than other types of surgery and that the actual risk of malpractice in trauma surgery is quite low. While it is often hard to make national generalizations based on individual states, these data are prior to tort reform in Texas, and their legal climate was likely no better than other states for physicians during this period.

A similar study from the University of Michigan was completed over a 10-year period from 1992 to 2002 and analyzed 308 closed malpractice cases.⁴ The majority of the cases were in the surgery service alone, but 70 cases involved multiple services. The authors of this study concluded that trauma was not more risky or more costly than other cases overseen by surgeons, and that no case strictly related to trauma settled for > \$200,000.

The Most Common Causes Of Action

There are several studies that examined data between 1979 and 2008. One of the most widely cited studies was published in 2007; it analyzed 122 closed cases (settled, lost, or won) between 1979 and 2001.⁵ The study showed that the top 3 claims were for failure to diagnose (1) fracture, (2) infection, and (3) myocardial infarction (MI). Much farther down the list were stroke/cerebrovascular accident (CVA), pulmonary embolism (PE), and aortic disease (abdominal aortic aneurysm and aortic dissection). Another study with similar findings was published in 2010; it looked at insurers' data on 11,529 cases from 1985 to 2007. The study showed the leading claims to be failure to diagnose (1) MI, (2) fractures, and (3) appendicitis. The study also found that the cases were either dropped or there was a verdict in favor of the defendant 70% of the time.⁶ Within the pediatric population, a study published in 2005 that analyzed 443 closed cases between 1985 and 2000 showed that the leading missed diagnoses were (1) meningitis, (2) appendicitis, (3) fracture, and (4) testicular torsion. The rate of successful defense against these lawsuits was similar to the adult study at 71%.⁷ Therefore, the evidence shows that, in general, the most common lawsuits are for non-traumatic conditions, except for missed fracture.

A more recent study evaluated the types of medical malpractice claims against emergency physicians. The Doctors Company, the largest physician-owned

malpractice insurance company, looked at closed claims between 2007 and 2013, and found that the most common reason for a claim was diagnosis-related. This included failure to diagnose, delay in diagnosis, incorrect diagnosis, and, occasionally, a failure to obtain a consultation or discharging too soon from the ED (57% of claims).⁸ The study analyzed 332 claims and found that the most commonly misdiagnosed conditions in the ED included CVA, MI, spinal epidural abscess, PE, necrotizing fasciitis, meningitis, testicular torsion, subarachnoid hemorrhage, septicemia, lung cancer, fractures, and appendicitis. Of these, missed fracture, subarachnoid hemorrhage, and underlying medical causes of the trauma are most relevant to trauma care. The second most common patient allegation involving emergency medicine was improper management, including failure to stabilize a patient's neck following trauma to the head and neck that resulted in paraplegia, and failure to explore a wound that was infected

or found to contain foreign bodies (13% of claims). However, it would be hard to argue in a court that this is the current standard of care for a cervical spine fracture. The third most common cause involved improper performance of procedures, such as intubation, suturing, imaging, and insertion of peripheral intravenous or central lines (5% of claims). The fourth most common cause involved failure to order medications, including timely antibiotics in sepsis cases or fibrinolytic therapy in acute MI and stroke patients. This would also include a failure to properly reverse anticoagulation medications in patients with serious bleeding or intracranial hemorrhage, or improper implementation of massive transfusion in trauma patients. **Table 1** summarizes the common ED claims.

Trends In Payouts

The absolute number of malpractice lawsuits has stabilized or is slowly declining, according to a study looking at 77,621 cases between 2004 and 2010.⁹ However, catastrophic payouts, defined as payouts > \$1 million, have remained constant. Catastrophic payouts continue to account for 8% of all payouts, and the amount of payout has been steadily increasing. Factors associated with catastrophic payout include age < 1 year, quadriplegia, brain damage, lifelong care, and a court verdict as opposed to settlement of the case. A physician's time in practice was not a predictor, and, while death increased the chance for a verdict in favor of the plaintiff, it was not predictive of catastrophic payout.

Strategies To Mitigate Risk In Trauma

The most common claims in trauma cases include missed or mismanaged secondary injuries, fractures or dislocations, a foreign body in a wound, complications of lacerations (including tendon or nerve damage), complications of skull or facial fracture, and solid organ injury. Other areas of liability include

failure to diagnose an underlying medical condition that caused the trauma, failure to perform fetal monitoring in pregnant patients with blunt abdominal trauma, failure to obtain vascular studies when indicated, failure to repeat imaging and/or serial examinations in appropriate patients, or discharging an ED patient without an adequate period of observation. **Table 2** describes strategies to mitigate risk.

Additionally, commonly accepted clinical decision-making rules (CDRs) should be used to meet the standard of care, avoid liability, and improve patient safety. A 2015 study from the Mayo Clinic College of Medicine reviewed liability risks when emergency clinicians face a decision on whether or not to order head computed tomography (CT) scans in patients with head trauma.¹⁰ Included cases alleging malpractice for failing to order CT imaging in the setting of head trauma came from jury verdict, settlement, or appeals court decisions between 1972 and 2014. Sixty cases were identified, including 8 children. Of those, 51 had a known outcome. Eleven found a jury verdict of clinician negligence, 10 were settled, and 27 found no liability for the clinician. The median settlement amount was \$1.5 million, and the median jury verdict was \$2.8 million. The most common injuries were subdural and epidural hematomas, resulting in 34 deaths. Of the 16 adult cases that were settled or found liability, use of any of the several accepted and applicable CDRs (American College of Emergency Physicians guidelines, National Emergency X-Radiography Utilization Study 11, New Orleans Criteria, and Canadian Head CT Rules) would have indicated the need for CT in 15 of those cases (94%). The only case that did not clearly meet applicable CDR criteria had other reasonable indications for CT. The remaining case had insufficient clinical detail to evaluate whether or not a CT scan was indicated. Of the 8 cases involving children that were settled or the clinician was found liable, use of the Pediatric Emergency Care Applied Research Network rule would have indicated the need for CT in 2 cases and recommended CT or observation (which was not provided) in 2 cases. As with the adult cases, the remaining cases had insufficient clinical data to make this conclusion.

While following clinical guidelines does not guarantee protection, and there is no clear standard at this time that specialty society or other guidelines clearly represent standard of care at trial, the use of clinical guidelines is likely to significantly strengthen the defense, and may even be able to prevent a trial in the first place. The authors of the Mayo Clinic study recommended, when appropriate, the use of validated rules and, just as importantly, documentation of this use. There is currently discussion in the literature about the use of “safe harbor” standards (ie, using validated guidelines) to attempt to prevent a lawsuit; however, it does not appear that this has been adopted at this time by any state.¹¹⁻¹⁴

The trauma evaluation should take into account the mechanism of injury, even with relatively benign examination findings. High-risk patients (eg, the elderly,

those with multiple trauma, or those who are intoxicated), have a low threshold for imaging, prolonged observation, or admission. One case with a \$3 million payout from 2005 exemplifies this concept. A 65 year-old man presented to an ED after a motor vehicle crash where he was the restrained driver. He had multiple fractures of his left clavicle and a seatbelt sign on the left lower quadrant, with mild tenderness in the left lower quadrant and decreased bowel tones. A focused assessment with ultra sonography for trauma (FAST) examination was negative for free fluid. The patient did not receive a CT scan of the abdomen, but instead had serial examinations of the abdomen (after being treated for pain in the clavicle) and a period of observation. After the period of observation, the emergency physician concluded that most of the pain in the left lower quadrant localized over the bony prominence of the hip. The patient was given return precautions, and did, in fact, return 3 days later, with a distended, acute abdomen requiring surgery for a nearly transected sigmoid colon. He had a prolonged and complicated hospital course requiring multiple surgeries and was left with pulmonary and kidney sequelae. The defense argued that the colon injury could not have existed at the time of initial presentation, otherwise the patient would have been more ill, and that it must have developed after discharge. The plaintiff countered that blunt abdominal trauma can present in a relatively benign way, but that the seat belt sign and abdominal tenderness warranted further evaluation and imaging.¹⁵

Emergency Medical Treatment and Active Labor Act Principles

EMTALA was passed by the United States Congress in 1986 in response to some highly publicized cases of uninsured patients being mismanaged by EDs, or having delays in or denial of treatment due to inability to pay. This “anti-dumping law” requires that any patient presenting to an ED, regardless of ability to pay, must receive a timely medical screening and evaluation, stabilization of their condition, and, when indicated, transfer to another facility with a higher level of care.¹⁶ An “emergency medical condition” is manifested by acute symptoms of sufficient severity (including severe pain) such that the lack of immediate medical attention could reasonably be expected to result in placing the health of the individual (or unborn child) in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part.¹⁷

Penalties for noncompliance include fines and/or suspension or termination from Center for Medicare and Medicaid Services (CMS) reimbursement. One study of 5475 investigations between 2004 and 2014 found that 2382 cases (43%) resulted in a violation. However, the study also showed a linear downward trend in investigations over this time frame, perhaps from improved emergency care and

better education about EMTALA.¹⁶ Where violations were found, 10% involved trauma-related emergencies (47% of which were substantiated) and the other cases involved medical, psychiatric, surgical, and labor- related emergencies.¹⁶

Duties Of The On-Call Specialist

All hospitals that provide emergency services must maintain a schedule of medical and surgical specialists who are on call for the ED in a manner that best meets the needs of the hospital's patients who are receiving services. Under EMTALA, a specialist cannot only take calls for their own patients ("selective calls"). Furthermore, an on-call physician cannot list his or her physician assistant or nurse practitioner in their place, and is entirely responsible for the actions of their midlevel providers. The request for consultation does not have to be physician-to-physician for a duty to attach. The call can come from anyone at the direction of, or on behalf of, the physician or qualified medical provider.¹⁸ Hospital medical staff bylaws or rules and regulations delineate the responsibilities of the on-call physician. On-call physicians must be available within a reasonable time to provide necessary stabilizing treatment, without regard to the patient's ability to pay.^{19,20} And, in most cases, on-call physicians must come to the hospital to examine the patient when a request is made for their services.¹⁷

Specifics on what an emergency clinician can expect and the duties of the specialist when requested to evaluate a patient in the ED include:

1. Any delay beyond what is outlined in the by-laws of the hospital, or a delay that is unreasonable is a violation.
2. Once the request is made, a duty attaches, and the decision power of whether or not the specialist needs to come in rests with the physician who has eyes on the patient, and the requirement for the specialist to come in to evaluate the patient is not negotiable or debatable.
3. Refusal to see the patient, for whatever reason, or suggesting that another specialist is more appropriate, does not negate the duty to see the patient.
4. Phone evaluation is not sufficient, if the specialist is asked to see the patient.
5. Refusal to see the patient, citing the need for transfer, is not sufficient. Rather, the on-call physician has a duty to see the patient in the ED and then effect such transfer as needed.¹⁸

When Liability Begins And Ends

For an on-call specialist or consultant, the time that the duty attaches can be nebulous. However, once asked to see a patient in the ED, there is a duty to physically see that patient within a reasonable amount of time. Transfer of patient care responsibilities between physicians must be orderly, clearly defined, and properly documented. The mechanism for such transfers and for resolution of disagreements between physicians should be clearly defined in medical staff rules and regulations.¹⁹ Sometimes, duties are split in a trauma, where the emergency physician is responsible for airway and resuscitation fluids or blood products, while the surgeon is responsible for the remaining responsibilities. Regardless, where there is a lawsuit, each physician who cared for the patient will most likely be named in the suit, and a determination of standard of care will be made with respect to care provided based upon responsibilities in the case. Once a transfer to another facility has been initiated, as long as the patient was stabilized prior to transfer and any delays were not a cause of injury, subsequent care and liability now attaches to the new facility and treating physicians.

Transferring Care To Another Facility

If a hospital lacks the medical staff resources to provide on-call coverage for a given specialty, the hospital must have a plan that specifies how such referrals should be managed. All hospitals with specialized capabilities have a responsibility to accept transfer of patients, regardless of geographic location, when such transfer is necessary to stabilize an emergency medical condition.¹⁹ When contacted by another hospital seeking transfer of a patient, there is a duty to accept, assuming the resources are available and would be available for a patient who came to the facility directly at the time. Unless there is no more space to put the patient, the facility with the higher level of care must accept the patient. And if it appears that the first hospital's on-call system or physician violated EMTALA, the contacted facility must still accept the patient, and has a duty to report the violation within 72 hours.¹⁸ The physician ordering the transfer must sign the certificate of transfer prior to the patient's actual movement from the hospital.¹⁸

Additional Strategies To Mitigate Risk

Establishing Rapport

A 2013 study demonstrated that, in a small number of payouts, there is clearly no medical error.²¹ This leads into the importance of risk mitigation strategies and avoiding claims. Patient rapport cannot be emphasized strongly enough. Patient complaint rates and lawsuits are linearly related. Compared with a physician in the lowest third of complaints, the physician in the middle third has a 26% greater incidence of lawsuits, and the physician in the highest third has a 110% greater

incidence.²² Similarly, communication style and tone of voice also make a difference, as an explanatory, collegial style is associated with a higher percentage of decisions for the defendant physician.²³ On the other hand, a brusque and directive style of communication will have the opposite effect.²⁴

There are many things that can be done to increase rapport with patients. Sitting down when talking gives the perception of spending more time with the patient.²⁵ Listening without interrupting the patient, sitting forward with feet at on the ground, laughing or crying with them, asking personal questions about things such as family and hobbies, all go a very long way in the patient's perception that the clinician cares about them. It is a win-win situation, as increased rapport is associated with therapeutic benefit,²⁶ but will also help avoid lawsuits. Patients who like their doctors are much less likely to sue them.²⁷ Another potential benefit is that increased rapport results in greater patient satisfaction, which may lead to increased compensation for the physician, group, and hospital.^{28,29} Another way to establish rapport, while also potentially decreasing cost, is to involve patients in shared decision-making.³⁰ This allows active participation by patients in their care, giving them a sense of control, and makes the physician appear less dictatorial in the process. Of course, standard of care must still be met, and this is not protective where it is not. As an example, a discussion of the risks and benefits of CT scanning in a competent patient in a low-speed motor vehicle crash with minimal tenderness versus discharge to home or ED observation for a period of time allows the patient to participate in a decision with several reasonable options.

Documentation In The Medical Record

The physician has significant control over the medical record for mitigating risk. The medical record is what the plaintiff's attorney will start with when evaluating a case. Detailed documentation of the examination, medical decision-making, and treatment plan is critical, as 58% of lawsuits are dropped before they get started. The primary reason is that some cases have enough information within the chart that the plaintiff's attorney understands that a victory is unlikely, and the attorney will be unwilling to assume the financial risk of taking the case.³¹ Under a contingency fee system of personal injury, the plaintiff's attorney supplies all of the costs of the lawsuit up front, and only recovers the costs if there is settlement or a jury verdict. It can cost upwards of \$50,000 to bring a case to trial, so well documented medical records make lawsuits much less likely.

First, a well-documented, thorough, and clinically appropriate physical examination is key. Neurologic cases, for example, have a high incidence of catastrophic payout due to life-long disability and death. Any time there is numbness, weakness, back pain, headache, etc., be sure that the neurologic

examination is complete and that, when necessary, repeat evaluations are performed and documented. A synergistic benefit is that a thorough physical examination is associated with higher patient satisfaction and rapport.³²

Second, always include relevant clinical decision rules and the presence or absence of risk factors. In head trauma, if the CDR is documented well in the case of no imaging, and a patient returns later, you are in a much better position to argue either that the standard of care was met or that there was subsequent trauma.

Third, include a section on medical decision-making for high-risk entities. Even if a diagnosis is missed, but the standard of care was met and there was a valid reason for what a clinician did or did not do, the suit may never be led. This section is the area that is the most difficult to complete for emergency clinicians because it can take extra time.

It does not have to be done for all patients, only for those who are considered to have a high-risk condition, and the clinician has taken steps to address the risk, through physical examination and history, by using CDRs, or through diagnostic testing and imaging.

Lastly, perform a final review of your chart prior to discharge. Ensure the following: (1) abnormal vital signs have been addressed; (2) the physical examination is complete and all necessary elements are present; (3) major diagnoses have been considered and addressed in a medical decision-making section of the chart; (4) the diagnosis fits with the clinical picture and diagnostic data; and, (5) the chart is complete and you would be able to tell what happened during the visit if the case goes to court.

Conclusion

Lawsuits are a cost of doing business in medicine, as most clinicians will be sued during their career. However, trauma is no more risky than other areas of emergency medicine or surgery. Furthermore, there are many actions that a clinician can take to mitigate the risk of a lawsuit and to increase the chances of a positive outcome should one occur. Ensure that the risk-mitigation strategies noted in this chapter are employed, establish rapport with patients, and document the patient's record completely and accurately.

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