Medical/Malpractice Claims: Patient’s ED Course Was Unclear to Admitting MD

Suits unlikely when direct communication occurs

Lack of appropriate documentation about what occurred in the ED is a common issue in malpractice claims naming both the emergency physician (EP) and the admitting physician, according to David P. Sousa, JD, senior vice president and general counsel at Medical Mutual Insurance Company of North Carolina in Raleigh.

“There is not a clear pathway to make sure that continuity of care occurs between that which was started in the ED and that which must continue in the hands of the admitting doctor, such that the admitting doctor doesn’t have sufficient information from which to work,” he says.

Labs ordered in the ED might come back after the patient was admitted. In this case, Sousa says EPs should call the admitting physician directly to be sure he or she saw the results, particularly if there was a significant positive finding.

“The better and more complete the record, the less likely it is that the EP would ever be named in the suit, or even if they are, that they are going to stay in the case very long,” says Sousa.

“Failsafe” system needed

Notably, Sousa says that he almost never sees cases in which a specialist actually comes to the ED, where both the EP and the specialist are directly involved in the patient’s care. “I believe the reason for that is when they are both there, there is a greatly reduced chance of a problem in communication or a problem in both having access to the full record,” says Sousa.

In contrast, Sousa routinely sees malpractice cases in which the admitting physician lacked information about the patient’s ED course. One such case involved a patient who came to the ED and reported a family history of myocardial infarction and complained of exertional chest pain.
Although both findings were recorded by the triage nurse, neither was recorded by the EP as part of his recorded patient history. “The patient is admitted for cardiac monitoring but arrests and cannot be resuscitated,” says Sousa. The cardiologist indicated that his care would have proceeded differently had the significant history findings been made clear by the EP. The case was settled before trial at mediation.

In another case, the patient was seen in the ED after a motor vehicle accident with complaints of abdominal trauma in addition to other injuries. An abdominal CT was positive for free air and possible intra-abdominal tears.

The CT results were relayed to the ED after the patient was admitted under the service of a hospitalist. “Nobody from the ED reported the CT results to the admitting physician,” says Sousa. “The patient ultimately died from sepsis secondary to seatbelt syndrome evident on the CT.”

Sousa says that if both the EPs and the admitting physicians use the same EHR [electronic health record], “that can go a long way toward mitigating this problem.” In some hospitals, however, the EHR used by the ED isn’t integrated with the EHR used by the admitting physician.

“EPs need to make sure there is a mechanism for getting the whole ED record into the hands of the admitting physician, and also have a ‘failsafe’ system for ensuring that lab or radiological studies get to the admitting physician,” says Sousa.