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REVIEW ARTICLE

Risk and medical-legal conflict in hospital emergency department practice: the perspective of medical forensics

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Hospital emergency department practice gives rise to special concerns that differ from those of practice in other sections of the hospital. This review aims to inform emergency physicians about the most common conflicts that arise from the perspective of legal and forensic medicine. The scope of the review encompasses diagnostic error, confidentiality, relations with the courts and legal authorities, and the documentation that accompanies transfer of a cadaver. [Emergencias 2012;24:389-396]

Key words: Professional liability. Medical History. Confidentiality. Cadaver. Medical certificates.

Introduction

The medical profession was one of the first to develop its own code of conduct. The concept of professional responsibility dates back to 1760 B.C. with the Code of Hammurabi, although medical liability has evolved with society, the legal system and the practice of medicine. The most significant changes regarding medical liability have occurred as a consequence of current health management, the increasing complexity of therapies and new modalities of health service delivery[1]. Hospital emergency departments (EDs) today are high-risk health areas requiring close coordination between different levels of care, and organization involving different categories of professionals and specialties[2]. Accordingly, EDs are a source of complaints and medical errors[3]. Garcia et al[4] comment that medical acts performed in the ED have certain specific features that distinguish them from those made in primary care, outpatient consultations and hospital wards. Weingart et al[5] mention certain factors that may affect the risk of litigation in ED work, including the lack of specialized training in the field of emergency medicine (EM), the high demand for care, limited time for patient attention and the severity of the users. At the same time, more than most other medical departments, the ED routinely interacts with judicial authorities (on attending detainees, victims of violence, sexual assault and legal minors, as well as management issues related with both judicial and non-judicial cadavers), so acquiring basic knowledge in forensics is needed to manage and resolve some of the problems arising from urgent medical assistance.

The aim of this review is to orient health practitioners about the most common medico-legal conflicts, and establish the criteria of their relationship with the Administration of Justice.

Professional Liability

In 1923 Championiere Lucas said that the problem of medical liability was increasingly severe and distressing, a source of concern for all doctors, and that to preserve their initiatives to heal the sick it was necessary to protect honest and conscientious doctors against unjust persecution[6]. Currently this premise remains valid, although every year the number of claims of malpractice increases, as shown in a study by Hernandez-Gil[7] performed in the city of Barcelona, where such claims increased by 39% between 2002 and 2003. More recent work such as that by Rodriguez et al[8] shows the existence of legal pressure on medical professionals related with the current model of society with its emphasis on citizen rights, including compensation for damage, which favors an increased number of claims and lawsuits. In Spain there are few published studies on the number and circumstances of claims against doctors or health centers. However, a study by the "Subdirección Sanitaria de Insalud"[7] on medical claims made between 1995-1999 showed that 85% of them involved hospitals and only 13% health centers. Of the former, 27% were related to hospital EDs, 25% to operating rooms, 20% to outpatient consultations and 19% to inpatient areas. The main reasons for complaint were complications or poor results of treatment, misdiagnoses, organizational errors, lack of information and accidents. A study by Tudela et al[2] conducted at Hospital Germans Trias i Pujol, Badalona, showed that of 669 patients hospitalized from the ED, diagnostic error was detected in 6.2% of cases, 42.8% of which were errors in initial clinical assessment and 40.4% erroneous interpretation of the chest radiographs resulting in a delay in treatment in 2.7% of patients. The EVADUR study by Thomas et al[9], performed in the ED of 21 Spanish public hospitals where 3854 records were reviewed, showed that an adverse incident or adverse effect occurred in 12% of cases; 31.9% of these were attributed to health care received and 69.1% could have been avoided, with a mortality rate of 0.2%. The factors responsible for these adverse incidents or effects were physician-nurse communication (9.2%), physician-physician communication (6.4%), document loss (4.3%), errors in patient identification (6.4%), problems with the medical record (6.7%), delay in diagnosis (18.8%) and inadequate response to warning signs (6.7%). In contrast to Spain, in the USA there are numerous scientific publications analyzing multiple parameters regarding patient complaints resulting in legal claims, and the costs for medical insurance companies. Every year there are between 44,000 and 98,000 unnecessary deaths and approximately one million sequelae deriving from medical errors, primarily related to two items: inexperienced doctors (most occurred during the first year of residence) or the introduction of novel procedures. Contributing risk factors were the patient's age, ED attendance and prolonged hospital stay. On analysis of errors made by junior residents in the ED, one study noted the lack of training in EM, excessively high demand, limited time to establish the diagnosis and the high number of severely ill patients as the most common factors6. EM is one of the six medical specialties with highest risk of litigation, along with neurosurgery, general surgery, orthopedic surgery and traumatology, obstetrics and gynecology, and radiology. In 2005 Studdert et al[10] showed that delay in diagnosis and treatment are the two most frequent complaints. Despite controversies about health professional liability, 81% of Spanish respondents to questionnaires used in studies on the different health systems in Europe[11,12] believed that the quality of their health system quality was good and better than other foreign systems. These studies found that the most common adverse effects were hospital infections (36%) and incorrect diagnoses (37%). Interestingly, 9-17% of the respondents themselves had personally experienced some type of adverse effect.

Diagnostic error and professional liability

Not all misdiagnosis leads to a situation of professional liability. According to data for the period 1990-2003 collected by the Official College of Physicians in Barcelona (COMB in Spanish), of a total 3,875 claims, only 12.3% led to judicial liability[13]. Below is a real case as an illustration of a typical situation in EM.

Case report

A 50 year-old patient attended the ED after suffering head trauma with loss of consciousness during 5 minutes due to an accidental fall at work from a height of 2 meters. In the ED, the patient regained his normal level of consciousness; medical history was recorded and physical examination was performed. The attendance report noted that the neurological examination was consistent with normality. A plain X-ray of the skull was interpreted as normal. The patient was referred for

evaluation to the reference neurosurgical center where he showed a decreased level of consciousness (Glasgow Coma Score 4): urgent cranial CT scan revealed a fractured skull and brain hemorrhage. Emergency surgery was performed and a lesion of the middle meningeal artery was found. The patient was admitted to the critical care unit and remained there until he died two months later. The first plain skull X-ray performed with the patient in the ED, erroneously interpreted as normal, showed a skull fracture that went undetected. For this reason the family filed a criminal complaint for misdiagnosis. The case reached the Criminal Court, and the defendant was acquitted. Despite the initial diagnostic error, correct care practice had been carried out. "To err is human"[14].

Basic concepts

– Medical responsibility: the physician is obliged to repair and satisfy the consequences of their acts, omissions and errors, voluntary or involuntary, within certain limits, committed in the exercise of the profession[15]. Some authors define this as care that every practitioner must provide any patient in compliance with standardized norms of their scientific community[16].

– Medical error: this is not synonymous with negligence[17]. Among the many definitions of error, the following are instructive: failure of a planned action, choosing the wrong treatment plan[18] and harm suffered by a patient following a medical intervention (adverse event)[18,19]. Medical error can occur at any stage of the care process, eg. in the physical examination of the patient, indicating a complementary test or making a diagnosis, among others. According to Spanish law, the doctor-patient relationship can be considered a contractual relationship to provide services but not results, with the exception of "satisfactive" medicine (eg. cosmetic surgery). The legal parameters governing correct medical praxis are: attending the patient, diligence, expertise and prudence. According to the Supreme Court, for damage compensation to be awarded there has to be unlawful action[20]. By these criteria, all medical acts imply adequate history taking and clinical examination, the indication for complementary tests if needed, establishing a probable diagnosis, and treatment corresponding to the diagnosis. In the ED, the most frequent cause of complaint is diagnostic error. However, if the diagnosis is based on correct praxis, it does not generate any professional liability. The patient who visits the ED is at a certain evolutionary stage of a pathological process which, at the time of ED assistance, may be considered clinically banal, not requiring hospitalization or only needing symptomatic treatment. The condition may subsequently become serious, but this was not initially evident. Whenever the initial diagnosis is soundly based and meets the standards of good medical practice, it does not generate a liability situation.

Inherent professional factors that minimize the risk of claims of malpractice

– Training and professional experience (expertise). Various studies have assessed the lack of training as a risk factor for the occurrence of adverse effects in a patient[5,21]. As a result, professionals with expertise in EM should always be those who work in the ED and supervise the performance of doctors completing their residency training in various specialties. The creation of the specialty of Emergency Medicine will probably increase the quality of care and control of doctors in training.

– Communication with the patient and family or care-giver/s (criterion of patient attention). Since Hippocrates, communication has been the pillar and cornerstone of the physician-patient (or care-giver) relationship, which helps build confidence. In current EM we sometimes forget the importance of communication, both verbal and non-verbal, because of excessive ED demand which does not favor the personal approach, privacy and trust building between the physician and patient[6]. Communication is well-known to be one of the elements that minimize the risk of claims against medical professionals. To listen, respond to doubts and explain the technical reasons for therapeutic action requires time, so the most elementary principle is sometimes not observed and the simple becomes complex.

Professional liability and medical records (MR)

As reflected in the basic regulatory Law 41/02[22] on patient autonomy and their rights and obligations in terms of information and clinical records, the MR is the set of documents containing data, assessments and information of any kind on the situation and the clinical course throughout the patient care process. Since approval of the General Health Law in 1986[23], MR completion is mandatory for the health professional and the patient's right to it is guaranteed, but its main purpose is to document the care process, so it must be formalized. Every patient visiting an ED and treated

should receive a care report at discharge[24]. Currently, medical practice is inconceivable without the MR, and it acquires absolute importance in situations of possible professional liability. A basic premise of legal medicine is: "if it is not recorded in the MR, it has not been performed". Therefore it is necessary to record every clinical act in the MR. In the event of complications, the care process can be substantiated.

Conflictive aspects in the management of clinical documentation in relation with the Administration of Justice

1. Attention of detainees.

The police usually accompany detainees requiring ED attention. Detainees have the same rights as any other patient, but they are guarded by police officers and usually handcuffed. The recommendations for ED staff in these cases are:

– Try to carry out medical attention without delay and as quickly as possible.

– Follow the indications of the police regarding safety and security, provided they do not prevent medical attention.

– After attending the detainee, complete the ED report as for any other patient. However, a copy of the report must be given to the police officers, to be added to the police record as reflected in Act 38/2002 of 24 October[25].

2. Issuing a medico-legal report on lesions.

On treating any injury caused by a violent event, the attending physician must issue the corresponding medico-legal report. It is characterized by its brevity and directed to a coroner. Its aim is to communicate the fact of injuries associated with violence such as physical or sexual assault, workplace or traffic accidents, intoxication, gender violence, maltreatment of minors or the elderly, inter alia. This document does not require patient consent; it is mandatory, based on Articles 262 and 355 of the Criminal Procedure Act[26]. A copy must be forwarded to the court within 24 hours and another copy is included in the patient's MR. The format of the document is optional but it must contain a minimum set of data, including: identification of the issuing practitioner and the health center, patient identification, diagnosis, causal mechanism of the injury as manifested by the patient and the treatment provided. There are specific situations from the medico-legal standpoint:

– Attention of victims of sexual assault: this must be made known immediately by telephone to the court. A forensic doctor is called to the ED and jointly with the attending ED physician performs the physical examination and collection of samples which he/she will deliver to the court for processing. In the case of abortions in reported sexual assault patients, the abortion remains should be identified by the attending physician and kept by the hospital until the court takes the necessary action for transfer and delivery.

– Attention of abused children, women, men and the elderly: each region has its own protocol for detection and management, but in general all include direct communication of the event to the court to facilitate early intervention and preventive measures. ED physicians that detect such cases must report them to the court.

– Attention of cases of possible / probable acute poisoning from drug abuse (alcohol, pills, etc.) must always be made known to the court by an injury report. If a patient were to die during the care process, a judicial autopsy would be required since such deaths are considered of violent origin. Regarding blood samples in the ED which may subsequently be required in judicial procedures, the samples must be coded following the same rules as any other sample of the hospital where they were obtained. If the samples are required by the court, they will be requisitioned and delivered to an official center.

3. Involuntary psychiatric admissions.

A patient with acute phase psychiatric disease may be taken to the ED for assessment and treatment, and in some circumstances there may be an indication for urgent admission. It is also possible that the patient refuses consent or is not in condition to give consent. In such emergencies, clinical judgment will prevail over the will of the patient, and hospital admission is indicated. Nevertheless, since it violates the fundamental right of free self-determination, such hospitalization must be communicated to the court in a medico-legal report so that the judge has knowledge of the facts and authorizes the involuntary admission within 72 hours, as set out in Article 211 of the Civil Code[27].

Confidentiality and professional secrecy

Since ancient times, the doctor-patient relationship has been based on the doctor's duty of

professional confidentiality. As stated in Act 41/02[22], the healthcare organization must help ensure the right to health and respect for personal privacy and freedom at all times. Preserving patient privacy in the ED can be complex, but must be attempted. Also, patients must be asked if they want to be informed and if they want their family to be informed, as set out in Law 41/02[22]. The information is the patient's and other people shall only be informed to the extent that the patient expressly of tacitly permits it. The patient will be informed even in cases of incapacity, when his/her legal representative will also be informed, but the patient always has the right to refuse being informed and this must be respected. One of the most conflictive situations is the right of access to information about a minor by their legal representatives. Although Law 41/02[22] gives 16 year-olds the legal capacity to consent, the Civil Code establishes the lower limit of adulthood as 18 years of age. In some cases, a minor can openly express refusal for their parents to be informed, both in relation to diagnoses and therapeutic procedures, especially intimate aspects such as sexuality (eg. contraception or abortion). There is a legal vacuum in relation to the limits of confidentiality and right of access to clinical information about legal minors. However, the Civil Code provides for decision-making and intimacy of the mature minor in relation to their personal rights[27]. In circumstances of conflict, the assessment should be individualized, but always attempting to preserve privacy of the minor especially he/she is 16 years of age.

Certification of death in the ED

– Registration of death: short document which communicates the fact to the general public or an authority[28].

– Medical certificate: document containing a truthful fact or facts that is issued by a physician. The Law 41/02[22], Article 22 provides that all patients or users have the right to receive certificates accrediting their health status.

– Death certificate: the legal framework regulating the issue of a death certificate in Spain is the "Ley y Reglamento del Registro Civil"[29,30]. The new model certificate that came into effect in 2009 unified the old death certificate and the statistical death bulletin in the same document. The medical certificate certifies the death and is a prerequisite for registration and burial of the corpse. Any registered physician identifying a corpse may issue the death certificate[29]. The obligation to issue the certificate is based on the doctor-patient relationship and knowledge of medical history, which allows the physician to establish a causal link with death. ED physicians can certify the death of the patient after examining the body, excluding violent or criminally suspicious death, and having sufficient information to establish the cause. But they should not issue any death certificates if they do not have sufficient evidence to be able to determine the cause of death. There are few liability issues related with such certification. Most errors are due to the affiliation of the victim, not the diagnosis of the cause of death, since the available information presupposes adequate means for deducing the cause of death. In this regard it is worth recalling that medical action involves a contract to provide services but not results[28].

– ED physician certifiable and non-certifiable deaths

• What deaths can be certified in the ED?: Only natural deaths, i.e. those which are the end result of an endogenous disease process (except infectious processes), in which there is no participation by an exogenous or foreign agent.

• What deaths cannot be certified in the ED?: Violent deaths due to exogenous causes such as assault, fire or gunshot wounds, i.e. the immediate or deferred result of an exogenous process, including suicide, homicide or accidents. While there is no explicit regulation on this, Articles 340 and 343 of the Criminal Procedure Act 26 stipulate the need for forensic investigation of deaths that involve violence or suspected crime. Similarly, Article 262 makes it obligatory for the emergency physician to inform the court of any death which may be the result of a criminal act. What is communicated to the coroner is the fact of a death which is or may be related to an exogenous, violent, unnatural process, which can lead to third party liability, and is therefore subject to judicial investigation. The ED must have an established procedure and form for this purpose, directed to the relevant judicial authorities, specifying: the medical center and department, the deceased's affiliation with his/her full name, age and address, time and the date of attendance, diagnostic orientation and relationship with the referring physician (full name and medical college number). Also, the emergency physician should establish telephone contact with the coroner on duty, for extra details and to expedite the process of dealing with the corpse.

When trying to differentiate between certifiable and non-certifiable deaths, apart from those

where the existence of an exogenous cause is clearly evident, various doubts may arise:

– What is a criminally suspicious death? It is any death that, for medical or non-medical reasons, could be due to a criminal act, however remote the possibility. This category includes different types of death arising from combining the criterion of expected / unexpected death with the criterion of sudden / non-sudden death[31].

• Unexpected death: characterized by the absence of a pathological background explaining the death. It includes cases of people with symptoms who do not seek medical attention or do not inform their nearest about them; for this reason, "nobody suspected anything was wrong". It also includes cases of people with a medical history but death as final outcome was not predictable given the progression or stage of disease.

• Sudden death: the most commonly used criterion in current clinical practice is death of a patient within the first hour after the onset of symptoms[32].

• Sudden and unexpected death: this is not certifiable in any case. For example, the sudden death of a young man with no relevant medical history while playing a sport.

• Unexpected and non-sudden death: the patient may have received medical attention, usually in an ED, but the result is not conclusive and an exogenous unnatural cause cannot be excluded. In this case a problem of medical liability may arise, so it is not certifiable in any case. Example: a young, previously healthy man suffers syncope while playing sport and is attended at an ED but dies within a few hours. In this case the death is deferred because the patient does not die immediately and clinical study has been initiated but is incomplete and inconclusive.

• Expected death (sudden or not): this occurs when poor health status or advanced age leads to death which was expected. However, if the actual cause of death is doubtful or could involve an exogenous factor, as when someone dies in a public place or without witnesses, certification will be subject to clarification of the circumstances taking into consideration the medical history. Non-certification of death must always be justified in a report by the attending physician and the coroner on duty should be consulted in cases of doubtful cause of death.

• Delayed death: this refers to death triggered by one or more violent exogenous factors but occurring days or months after injury, either as a consequence of violence, disease or complications. For example, death due to respiratory infection in the context of coma secondary to head trauma suffered in a car accident three months before. This is a violent death but deferred, and the attending physician may not issue the death certificate. The main problem with violent delayed death is precisely identifying the exogenous cause, since it occurs for indirect reasons such as complications arising during evolution, and the time lapse between the initial injury and death is prolonged. In these cases, as when there is doubt about the causal relationship, a judicial report must be issued and failure to do so may lead to civil responsibility and legal liability issues.

Conclusions

Medical practice in the ED has special connotations according to the characteristics implied by the term emergency, objectively and sometimes subjectively interpreted by some users, so medical-legal problems differ with respect to other hospital departments. Professional liability and diagnostic error are the most usual reasons for claims of malpractice, although deficient information or breach of patient privacy also generate conflicts. In addition, the ED routinely interacts with the Administration of Justice. Basic knowledge about legal medicine helps avoid conflicts, and even when they occur, facilitates their processing and management, as well as minimizing potential professional liability situations.

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Riesgo y conflictividad médico-legal en los servicios de urgencias hospitalarios: valoración médico-forense

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El desarrollo de la actividad profesional en los servicios de urgencias hospitalarios (SUH) difiere de la realizada en otros ámbitos sanitarios. La finalidad de esta revisión es orientar a los profesionales de urgencias sobre los conflictos asistenciales más frecuentes que se plantean desde el ámbito de la medicina legal y forense, que abarca desde el error diagnóstico, la confidencialidad, las relaciones con la Administración de Justicia, hasta la tramitación de la documentación derivada del cadáver. [Emergencias 2012;24:389-396]

Palabras clave: Responsabilidad profesional. Historia clínica. Confidencialidad. Cadáver. Certificados médicos.

ERRATA

In the article "Atrial fibrillation management in the hospital emergency department: 2012 update" published in Emergencias 2012;24:300-324, the correct abstract is:

Atrial fibrillation is the sustained arrhythmia that must be managed most often in emergency departments. The prevalence of atrial fibrillation is high and increasing in Spain. Atrial fibrillation is increases mortality, is associated with substantial complications, and has a considerable impact of patient quality on life and the running of the health care system. Management requires consideration of diverse clinical variables and a large number of possible therapeutic approaches, justifying action plans that coordinate the work of medical staff in the interest of providing appropriate care and optimizing resources. These evidence-based guidelines contain recommendations for managing atrial fibrillation in the special circumstances of hospital emergency departments. Strategies for stroke prophylaxis, heart rate and rhythm control, and related diagnostic and logistic issues are discussed in detail. [Emergencias 2012;24:300-324]

Key words: Atrial Fibrillation. Emergency departments. Antiarrhythmic drugs. Cardioversion. Heart rate control. Anticoagulation. Stroke prevention.