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APRIL 2015 Vol. 26, No. 4; p. 37-48

INSIDE

AHC Media

Peer Review: How Protected Are You?

By Kevin Klauer, DO, EJD, Chief Medical Officer — Emergency Medicine Chief Risk Officer, Executive Director, Patient Safety Organization, TeamHealth

Quality assessment is a critical tool to determine the quality of the care provided. Many tools can be utilized to this end. In recent years, it has been recognized that a blame-free culture is optimal to identify opportunities for improvement and reduce barriers to reporting and participation. Although many aspects of quality assessment and performance improvement can, and should, easily conform to this laudable standard, peer review presents unique and significant challenges, particularly for the individual provider.

"Peer review is the process whereby doctors evaluate the quality of their colleagues' work in order to ensure that prevailing standards of care are being met."[1]

In the simplest of terms, traditional peer review is the assessment of one provider's care by a group of his or her peers. Thus, by design, traditional peer review is designed to focus on the care of one provider and to assign a judgment regarding the appropriateness of that care.

Peer-review Limitations

Peer review performed in this fashion has many limitations. The first is that broad generalizations are often made about the quality of care delivered by a provider based on one case or a relatively small number of cases.

Cases are evaluated under the construct of an inherently biased system. Such systems are biased toward the assumption that bad outcomes have occurred and that the provider is likely at fault. Thus, although not written in policy, it is often found in practice that the provider is "guilty" until proven otherwise, and, unfortunately, the bias may be so polarizing that the burden required for exoneration is too great to overcome.

Third, and perhaps the most

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ED LEGAL LETTER

ED Legal Letter™,
ISSN 1087-7347, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
ED Legal Letter
P.O. Box 550669
Atlanta, GA 30355.

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Back issues: $83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

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Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.
This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

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important, is that the definition of "peer" ranges dramatically between health care organizations, institutions, and regulatory bodies. This poses an especially worrisome challenge for the specialty of emergency medicine. Often, particularly at the hospital level, the peer group is identified as physicians, and not necessarily as emergency physicians (EPs). It has been this author's experience that many, if not most, hospitals allow peer review of EPs by non-emergency physicians. However, the converse is much less likely to be tolerated. For example, a group of non-emergency physicians serving as members of a hospital's peer-review committee may call into question the quality of care delivered by an EP. However, rarely, if ever, would you see a group of non-surgeons review a surgeon's outcomes and question his surgical technique, let alone levy sanctions against, mandate remediation of, or impact credentialing decisions of a surgeon.

Although speculative, this inconsistent treatment of EPs may be due to deep-seated roots and the historic culture of medicine. Although emergency medicine has evolved and matured over its 40 years of existence, it is still regarded by many as a young specialty and one that incorporates the emergency aspects of other specialties. The latter, perhaps, creates a sense of entitlement by other providers to assume that their knowledge regarding emergency medicine is adequate to judge the care provided by EP. Even if a specialist is included in the peer-review process just to address concerns that are related to his or her specialty, such bias may exist. This stems from the lack of understanding that emergency medicine requires a unique body of knowledge to practice the specialty. Thus, the standards relating to the emergency evaluation of possible pulmonary embolism or ectopic pregnancy should not be subject to the scrutiny of internists and pulmonologists or gynecologists and general surgeons. Although internists and pulmonologists evaluate and care for patients suspected of having pulmonary emboli, and gynecologists and general surgeons evaluate patients with possible ectopic pregnancies and both manage surgical disease, they are not uniquely qualified by training or experience to assess what would constitute an acceptable provision of care for such patients presenting as emergency department patients.

Case in point: Many of us have experienced a conversation much like this:

EP: "Mr. Jones is a 52-year-old male that presented with lower-sternal chest pain. He has a history of type II diabetes and hypertension and has been smoking 1 pack per day for 20 years. His ECG is non-diagnostic, and initial laboratory diagnostics are negative. However, I think he should be admitted for observation to rule out ACS [acute coronary syndrome] and, perhaps, obtain provocative testing."

Primary care physician: "Well, if he came to my office, I wouldn't be admitting him!"

Therein lies the problem. Patients who select the emergency department for evaluation of their symptoms are often very different than those who do so in other settings, such as a primary care physician's office. One study noted such a difference between patients presenting with chest pain to primary care and to the emergency department. Serious cardiovascular disorders were noted in 4.8% of those presenting to primary care, compared to 28.1% of those presenting to the emergency department.[2] In other words, whether an internist or family physician would admit a similar sounding patient from their office or not is immaterial and not germane to the question of whether an

emergency department patient should be admitted.

These experiential similarities may create bias with those who care for similar types of patients, lending them to validate their assumptions that they don't need to have trained in or have practiced emergency medicine to be qualified to evaluate the care provided by an emergency physician.

The Effects of Non-peer "Peer Review"

Is peer review performed by non-peers just an annoyance, or does it have a material impact on a physician's career? Well, unfortunately, it's both. Oh, it certainly is beyond annoying when someone who doesn't understand your training, experience, care environment, or role in care delivery is empowered to judge you. However, it's even worse when that body is given authority to mandate remediation, place limitations on privileges, and even impact credentialing decisions. Thus, "peer review" performed by non-peers can result in suspension, mandated remedial actions, limiting of hospital privileges, and loss of hospital privileges altogether, with such actions possibly resulting in required reporting to the National Practitioners' Data Bank (NPDB).

The Medicare and Medicaid Patient and Program Protection Act of 1987 led to the creation of NPDB. The data bank requires that the following events be reported.[3]

- Medical malpractice payments;
- Federal and state licensure and certification actions;
- Adverse clinical privileges actions;
- Adverse professional society membership actions;
- Negative actions or findings by private accreditation organizations and peer review organizations;
- Health care-related criminal convictions and civil judgments;
- Exclusions from participation in a federal or state health care program (including Medicare and Medicaid exclusions); and
- Other adjudicated actions or decisions.

Title IV further states the following: "Professional review actions — based on reasons related to professional competence or conduct — adversely affect clinical privileges for a period longer than 30 days. Voluntary surrender or restriction of clinical privileges while under, or to avoid, an investigation."[3]

The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations, began requiring all accredited hospitals to perform physician peer review in 1952. However, in 1986, a landmark case illustrated how peer review could be and had been used inappropriately for economic advantage.

"The peer-review process further suffered a major blow in 1986 when Dr. Timothy Patrick, a general and vascular surgeon, sued Columbia Memorial Hospital (CMH) after being unfairly subjected to a bad-faith peer review for economic reasons. Upon starting practice in the small town of Astoria, Oregon, Dr. Patrick joined a group of established surgeons at the Astoria Clinic. After several years of employment, Dr. Patrick was offered partnership at the clinic, which he later refused in order to open his own competing surgical practice in the same geographic area. In retaliation, Patrick's former colleagues at the Astoria Clinic reported Patrick to the hospital executive committee at CMH for peer review. The charges levied claimed that Patrick exhibited irresponsible behavior toward patient care. An executive peer-review committee was formed and was chaired by Dr. Gary Boeling, a partner of the Astoria Clinic. After an investigation was conducted and subsequent false evidence concerning Patrick's care was presented, the committee voted to terminate Patrick's privileges at CMH. Fearing termination, Patrick instead chose to resign.

"A subsequent federal antitrust lawsuit filed by Patrick against partners of the Astoria Clinic, including Dr. William Burget, claimed that the defendants participated in a bad-faith peer review in order to stifle competition. The United States Supreme Court, which later ruled in Patrick's favor, awarded the plaintiff $2.2 million and further disbanded the Astoria Clinic based on the clinic's violation of the Sherman Antitrust Act."[4]

Following the Patrick case, physicians were reluctant to participate in peer review, and, thus, the Healthcare Quality Improvement Act (HCQIA) was introduced and enacted by Congress in 1986.[4] The Act had two components: Part B resulted in the creation of the NPDB, and Part A provided hospitals and reviewers immunity from litigation from providers subject to peer review. It is critical to note that this Federal protection was specifically aimed at limiting discovery of the peer-review process to protect those performing peer review, not to prohibit discovery of the peer-review process regarding claims (e.g., medical malpractice) filed against the provider being reviewed. If the following requirements are met, the hospital and reviewers are granted immunity:

"A professional review action must meet the standards set forth in the Act in order to qualify for immunity. The professional review action must be taken:

1. "In the reasonable belief that the

action was in furtherance of quality health care;

2. "After a reasonable effort to obtain the facts of the matter;

3. "After adequate notice and hearing procedures afforded to physician or other such procedures that are fair to the physician; and

4. "In the reasonable belief that the action was warranted by the facts known after the reasonable effort to obtain the facts and adequate notice and hearing procedures have been afforded to the physician.

"A professional review action shall be presumed to have met the HCQIA standards unless the presumption is rebutted by a preponderance of the evidence." (see: 42 U.S.C. 11112(a)).[5]

The case of Dr. Susan Meyer is an excellent example of the low bar that hospitals have to meet regarding immunity. Basically, if some form of due process is afforded and even a weak link to quality of care seems to be present, the organization and its reviewers will enjoy immunity from liability.[4]

Dr. Susan Meyer, an emergency room physician at Sunrise Hospital, was required to undergo review after her treatment of Adolph Anguiano, a homeless patient who, two hours after being seen by her in the ED, died in the parking lot of Sunrise Hospital. Upon entering the ED, Meyer performed a full physical exam, took vital signs, measured oxygenation levels of Mr. Anguiano, and subsequently determined the patient did not require any acute medical care and later discharged the patient from the ED. Upon discovering that Mr. Anguiano had died, Dr. Graham Wilson, Chair of the Department of Emergency Services, advised Dr. Meyer to finish her shift in the ED and subsequently informed her that she was being suspended due to her substandard care. She was advised to obtain legal counsel in order to undergo a fair hearing process.

Meyer, who later lost an appeal of her case in the Nevada Supreme Court, was later informed by Dr. Rick Kilburn, the Chief Operating Officer of Sunrise Hospital, that she would be suspended regardless of the result of her peer-review hearing. Despite knowing the final result beforehand, Meyer requested a formal peer review by the hospital in order to have her clinical judgment assessed by her colleagues. Despite several ED physicians testifying that Meyer's treatment was "well within the standard of care," the review committee found otherwise and recommended her suspension. The recommendation was reaffirmed by the Appellate Review Committee of the hospital.

Meyer, in turn, filed a civil action lawsuit against Sunrise Hospital alleging a breach of contract and breach of the covenant of good faith and fair dealing. The hospital, claiming immunity under HCQIA, in turn succeeded in dismissing the case in district court. The case was met with the same decision at the Nevada Supreme Court. However, the justices gave a rare glimpse into the reason for Meyer's loss and the extent of the powerful immunity granted to hospitals and peer reviewers in their concluding summary statement."[4]

Although the Act did provide immunity to reviewers, it attempted to bring fairness to the process for those being reviewed. The question is whether or not those efforts were balanced. Many feel that overwhelming share of benefit was granted to the reviewer's side of the equation.

Fortunately, this seemingly impenetrable immunity has been challenged. However, the Poliner case reflects exactly how strong this privilege of immunity really is, and concerns regarding the potential for abuse and "sham" peer review continue.

"In 2004, a Texas jury awarded Dr. Lawrence Poliner $366 million — one of the top ten largest jury verdicts that year — in his lawsuit against a hospital and several physicians for malicious peer review. Dr. Poliner left a large physician group and started competing with his former colleagues in the same hospital. According to the United States District for the Northern District of Texas, the hospital and peer-review committees effectively suspended Dr. Poliner's privileges to perform cardiac catheterizations summarily on the basis of one questionable case and without giving Dr. Poliner an opportunity to defend himself."[6]

On July 23, 2008, the Fifth Circuit Court of Appeals reversed the Poliner decision, including vacating a judgment of $30 million based on defamation claims that Dr. Poliner had asserted.

"Not only has Poliner failed to rebut the statutory presumption that the peer-review actions were taken in compliance with the statutory standards, the evidence independently demonstrates that the peer-review actions met the statutory requirements." Furthermore, "if a doctor unhappy with peer review could defeat HCQIA immunity simply by later presenting the testimony of other doctors of a different view from the peer reviewers, or that his treatment decisions proved to be 'right' in their review, HCQIA immunity would be a hollow shield."[7]

State Peer-review Protections Have Limitations

Processes for the purpose of assessment of individual provider quality are often touted as safe from discovery per "peer-review protection." In general, this may be true, as states recognized the need for individual provider protections against discovery, especially with respect to medical malpractice claims and lawsuits,

noting that a lack of such protection would result in a chilling effect on provider willingness to participate in peer-review processes. However, how much protection do you have? With striking precision, when these statements are made and relied upon, the presumed rights of protection are often exaggerated way beyond what is actually and practically available.

"Peer-review privilege is a privilege that protects from disclosure the proceedings and reports of a medical facility's peer-review committee, which reviews and oversees the patient care and medical services provided by the medical staff. This privilege prevents patient plaintiffs from obtaining the hospital records prepared in connection with quality-review proceedings. All 50 states and the District of Columbia have privilege statutes that protect peer-review records of medical staff members. Some states like Georgia and California also provide a statutory immunity from discovery of peer-review records. This protection excludes from discovery records containing performance reviews, and assessments of physicians by their peers, primarily in connection with their practices at hospitals."[8]

It is important to underscore that no federal peer-review privilege exists. Thus, all peer-review documents are discoverable in federal court.[9] So, if a case is brought in federal court (i.e., civil rights allegations), state peer-review protections are not recognized.

Many providers and institutions assume that "peer review" provides an all-encompassing, blanket coverage prohibiting discovery. This simply is not the case and is subject to much scrutiny on a case-by-case basis. In *Giusti v. Akron General Medical Center*, an overly broad interpretation was asserted. The court determined that the privilege must be "strictly construed" and that the party asserting the privilege has the burden of proof with respect to the specific information requested. At the very least, the hospital must prove it has a peer-review committee and that the actual incident was investigated.[10]

"If a hospital were to establish that a qualifying peer-review committee investigated a particular incident, the next question for the trial court would not be whether the privilege applies to some general category of communications among peers. The question would be whether the privilege actually does apply to each question the hospital's lawyer instructed its witness not to answer at deposition."[10]

Although all states provide some degree of protection, each state's statute varies in its scope and application. In general, a more narrow intent should be assumed. For instance, many states do not include incident reports as part of the peer-review process and, thus, are discoverable. As with *Giusti*, claims of peer-review protection are likely to be challenged, but unlike the immunity privilege of the HCQIA, such challenges are often successful.

Another limitation to state peer-review protection is waiver of the privilege. In *West Covina Hospital v. Superior Court*, the California Supreme Court ruled that a party could waive their privilege and testify. However, such testimony has the effect of waiving privilege for all of those involved, considerably weakening the intended privilege.[11]

In addition, providers, under the assumption of peer review, assume they have privilege, which simply does not exist. The peer-review process must be clearly defined and communications outside of that process will not enjoy protection. So, as an example, if a case is discussed at a staff meeting, non-physician peer hospital employees are in attendance. Although not clearly defined as part of the hospital's peer-review process, the conversations that occur are likely discoverable. Although this is a hypothetical example, it is an all too common practice.

All providers need to be mindful of the immunity afforded to hospitals and reviewers. In addition, it is critical to recognize the limitations of state peer-review protections. Assumed privilege often results in no protection at all. ■

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Will EPs Be Dismissed — or Get 'Stuck' in the Claim? These Are Determining Factors

Understandably, emergency physicians (EPs) who believe that allegations of malpractice are unfounded don't want to suffer through litigation one minute longer than necessary. However, getting "out" of a claim, regardless of the merits of the case against the EP, is often no easy task.

The safest route for a plaintiff is to sue everyone involved in the patient's care for malpractice and then use the discovery process to figure out who is actually liable, says **Christopher Robertson**, JD, PhD, associate professor at University of Arizona's James E. Rogers College of Law.

"And that approach is not necessarily improper," he adds. If the discovery process exonerates one defendant, the plaintiff is often happy to let him or her go — as long as there is a strong case against another defendant.

Regardless of the facts of the specific case, malpractice litigation is likely to drag on much longer than the EP is comfortable with. "Oftentimes physicians think, 'Why am I still in this? Why isn't something happening?'" says **Michael J. Sacopulo**s, JD, founder and president of the Terre Haute, IN-based Medical Risk Institute. "The way the system is set up, it does not quickly adjudicate cases. We can have months with no activity." Here are some factors that can determine whether an EP can be dismissed from a malpractice claim:

• Dismissal is more likely if the lawsuit is mainly focused on a physician in a different specialty, and the EP is named along with multiple other physicians.

For instance, a malpractice case may allege that the patient had a bad outcome because of a mistake made by a surgeon, and the EP is only named because the patient was admitted from the ED. "That's a situation where it's easier to get out of a case because there are still other people left in it," says Sacopulos.

• Dismissal is more likely if the exonerated defendant is willing to serve as a friendly, or at least reliably neutral, fact witness, in a way that benefits the plaintiff.

"In my view, one of the best ways to get dismissed is actually to show the defense attorneys that you will be more helpful to them as a witness than as a defendant," says Robertson. A signed affidavit can help reassure the plaintiff that he is not letting go of the wrong person when dismissing the EP.

"The fact that an affidavit is sworn under penalty of perjury helps to make sure that no surprises pop up later to hurt the plaintiff," adds Robertson. Such an affidavit might attest that the EP did not treat the plaintiff, and/or establish whatever facts that the plaintiff believes may be useful against the other EP defendant.

"Nonetheless, it may turn out that the emergency physician still has to testify to those same facts in deposition and/or trial, depending on how important they are to the case," says Robertson.

• The EP's defense attorney can move for dismissal if allegations of negligence are not made against the EP specifically.

"One potential response to such a motion, however, is for the plaintiff to simply amend the complaint to properly state such a claim," says Robertson. If such allegations are made against the EP in bad faith, however, there may be a basis for disciplining an attorney. "Sometimes a strongly worded letter can nudge an attorney towards a voluntary dismissal," says Robertson.

If the allegations in the complaint are completely frivolous, as they relate to one of the defendants, then that defendant's attorney could threaten discipline against the plaintiff's attorney, with the court or the bar. "However, it bears emphasis that the plaintiff has a right to conduct discovery," says Robertson. "So there is a judgment call here as to whether the plaintiff's attorney is breaking any rules."

In some cases, a friendly phone call may work better than a stern letter. "The plaintiff's attorney ultimately just wants to get whomever is actually liable," says Robertson. "Ultimately, however, defendants may have to wait until summary judgment, once discovery is held."

• Dismissal is more likely if the EP is helpful to the defense attorney.

Sacopulos says it's particularly helpful if the EP writes a narrative stating what they've alleged to have done wrong, and any information that refutes it. "The easier that you can

make it to get you out, the quicker that can happen," he says. "I always enjoy it when my clients are proactive and provide me with information, instead of just saying, 'Here's a big file; good luck to you.'"

• Dismissal is less likely if the EP places blame on co-defendants during the discovery process.

"In an effort to get out of a case, the EP says, 'It wasn't me. So and so made the mistake.' But all the EP is doing is digging the hole deeper. I see that happen often," says Sacopulos.

During the EP's deposition, the plaintiff attorney is likely to ask a question such as, "The patient was also seen by Dr. X, who did A, B, and C. Do you think that was appropriate?" The EP will invite trouble if he or she makes disparaging comments such as "I personally don't believe the care was appropriate," or "Well, he never orders CT scans."

A better answer is, "I don't practice that area of medicine so I'm not the right one to ask what the standard of care is."

"Nothing good that can happen to you by talking about other people's care. You need to focus on your care," says Sacopulos. "Was somebody else negligent? That's not your responsibility."

There are many ways in which two EPs, jointly named in a malpractice suit, could be pitted against each other, says Robertson. For example, one EP may observe the plaintiff's condition, prior to departing, in a way that establishes certain facts that the plaintiff would like to prove against the other defendant.

"Likewise, an emergency physician might be able to speak to staffing levels, equipment levels, or even the treatments that were provided by another emergency physician," says Robertson.

Such finger-pointing gives the plaintiff attorney a good reason to keep the EP in the case as long as possible. "Expert witness testimony is expensive," says Sacopulos. "If you can get it for free from one of the defendants, you don't want to have them dismissed and go pay for it." ■

SOURCES

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EPs Seeing Many More Incidental Findings: Take Steps to Reduce Liability

Failure to notify patients and their primary care providers of incidental radiology findings "definitely poses significant medicolegal liability for the emergency physician (EP)," according to **Sayon Dutta**, MD, an attending physician in the emergency department (ED) at Massachusetts General Hospital in Boston.

Discharge-relevant recommendations for additional imaging were found in 4.5% of ED radiology reports, but 51% of discharge instructions failed to note those findings, according to a 2013 study.[1] "When the patient and their primary care doctor do not know of these findings, they have no chance to follow up as needed," says Dutta, the study's lead author.

Similarly, a 2010 study found that incidental findings were noted in 285 (15%) of 1930 trauma CT scans done during the ED evaluation of trauma patients, but follow-up was poor, even for potentially serious findings.[2]

"At Massachusetts General Hospital, we've taken steps within our electronic health record to promote the communication of important incidental findings," notes Dutta. "Despite this, the responsibility for these findings, in large part, lies with the person who ordered the study."

ED Never Conveyed Results

A recent malpractice claim alleged failure to timely diagnose a recurrent brain tumor. "The woman presented to an ED on two separate occasions complaining of headaches," says **Angela L. Carr**, Esq., a partner in the Providence, RI, office of Barton Gilman. The CT scan report indicated that recurrent neoplasm couldn't be ruled out, and that an MRI may be appropriate if clinically indicated.

"For some reason, no one conveyed these results to the woman and her family, and an MRI was never ordered," says Carr. An MRI, ordered three months later by a gastroenterologist, showed a progression of the tumor, but the results were incorrectly reported and the patient was never forwarded a copy of the report.

Three weeks later, the woman returned to the ED for the second time complaining of headaches. At this presentation, a CT scan confirmed the tumor progression seen on the earlier MRI. "Again, her headaches were noted to have resolved, and the results of the CT scan were not reported to the woman or her family," says Carr. The woman learned about the tumor recurrence several months later, during a follow-up appointment with her neuro-oncologist.

"The defense theory posited by the ED physicians that the discharge instructions provided by the ED and signed by the woman clearly directed her to follow-up with her neuro-oncologist would have been stronger if someone in the ED had reported the actual findings on the CT scans to her," says Carr.

Another malpractice claim against an EP involved a man who presented to an ED complaining of abdominal and flank pain. The EP ordered plain abdominal films, and the impression of the interpreting radiologist was possible right nephrolithiasis, recommending further evaluation with non-contrast CT or an intravenous pyelogram.

"He then underwent a CT of the kidneys and pelvis to rule out a kidney stone," says Carr. The CT report described a 6.3 mm stone in the upper right ureter, and also described multiple bilateral renal cysts and a hyperdense cyst on the left kidney.

"Neither the ED nor the radiologists had contact with the patient again," says Carr. "At the time of the original films, there were no findings to suggest the presence of cancer or anything other than benign processes."

The medical records and subsequent films showed that the hyperdense cyst never changed, confirming that it was not cancer. In addition, when the patient's cancer was ultimately diagnosed six years later, the lesion in the kidney was found to be in the right kidney, as opposed to the left kidney where the hyperdense cyst was located.

"However, the plaintiffs claim that had the physicians recommended and implemented monitoring following the discovery of the hyperdense cyst, they would have inadvertently discovered the cancerous lesion," says Carr. "The parties ultimately settled the case prior to trial."

Surge in Incidental Findings

With incidental findings becoming increasingly common in CTs obtained for ED patients, "sometimes emergency physicians don't give it the importance they should," says **William J. Naber**, MD, JD, CHC, an associate professor in the Department of Emergency Medicine at University of Cincinnati.

In some cases, the EP does a preliminary reading on an X-ray, but a final reading done by a radiologist the following day includes an incidental finding. "Or it might be that the EP simply didn't read the full report of the X-ray and didn't see that an incidental nodule was mentioned," says Naber.

The surge in the number of CT scans done for ED patients has resulted in a commensurate increase in the number of incidental findings. About 14% of ED patients received a scan in 2007, compared to about 3% in 1996, according to a 2011 study.[3] A 2013 study found that CT scans were performed for 11.4% of all ED visits in the United States.[4]

Another factor is the increased sensitivity of CT scans. "The technology is improving every year; therefore, we see little densities that we would have never seen before," says **Leonard Berlin**, MD, FACR, professor of radiology at Rush University and University of Illinois, both in Chicago, and author of *Malpractice Issues in Radiology*. According to a 2015 study, important incidental findings occurred in 12.7% of non-enhanced CT scans performed for suspected renal colic in the ED.[5]

A 2011 study found that incidental findings were documented in 33.4% of 682 CT scans performed in the ED on discharged patients; of these, only 9.8% were reported to patients, according to discharge paperwork.[6]

The question for the EP, says Berlin is, "What do we do with these? The radiologist has to decide whether to tell the EP, and the EP then has to decide what, if anything, to tell the patient." Here are some strategies that may reduce legal risks for EPs involving incidental findings:

• Follow the ED's policy consistently.

"Consistency is very important," says Berlin. "Whatever is decided, it should be a consensus. If somebody does one thing and somebody else does something different, that doesn't look good at all." If the ED's policy states that incidental findings under 2 mm won't be addressed, for instance, this can help the EP's defense in the event a lawsuit is filed. "At least it's some kind of defense," says Berlin. "The worse thing is for the EP, when asked, 'Why didn't you follow up on this?' to have to say, 'I had no particular reason.'"

• Give the patient a copy of the radiology interpretation stating the incidental findings.

Naber says this documentation strengthens the EP's defense in the event a malpractice suit is filed: That the patient was given a copy of the report; that the patient was advised to follow up with his or her primary care physician; whether others were

present, such as the patient's spouse; and the recommended timeframe for follow-up.

"The more specific you are, the better off you are if the patient doesn't follow-up," he adds. If Naber learns of an incidental finding after the patient is discharged, he contacts the patient and documents the conversation, such as "I called Mrs. Smith and notified her of the 6 mm module and the need to follow-up with a CT scan in six months for change in size or shape."

"The pitfall is when the EP calls but does not document it in the medical record," Naber says. "If the patient doesn't follow-up, you have no record that you actually talked to her about it."

Naber has reviewed several claims involving incidental findings that were not noted during the EP's nighttime interpretation. One such case resulted in a seven-figure settlement. "The findings were identified when the radiologist overread them, and were included in the radiologist's report," he says. "But there was no documentation that the patient was ever notified."

• Document that the finding was discussed with the admitting physician.

If the patient is seen in the ED for chest pain, and a CT scan shows a lung nodule, EPs should document that they discussed the need for follow-up with the admitting physician. "You can't assume the admitting physician is going to discuss that with the patient," says Naber. "You have to do it and document it yourself as the ED physician."

The EP can still get named in a malpractice suit, but strong documentation that the patient, the admitting physician, and/or the patient's primary care provider were notified is "a pretty solid defense that the EP did the right thing and that the patient didn't follow-up properly," says Naber. "It's a much better defense than doing nothing." ■

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State Medical Board Complaint Can Fuel ED Med/Mal Suit, and Vice Versa: Don't "Go It Alone"

EP can expect "aggressive" investigations

It's difficult to imagine most emergency physicians (EPs) choosing to defend themselves in a malpractice lawsuit. However, many respond to state medical board investigations without legal representation. "Many medical board complaints end up being more serious than medical malpractice lawsuits," says **Ellen M. Voss**, JD, a medical malpractice defense attorney at Williams Kastner in Portland, OR.

This is because state medical boards have the power not only to suspend or revoke licenses but also to restrict or place conditions on the practice of

medicine. "Furthermore, a medical board complaint can quickly expand to areas well beyond the subject of the initial complaint, similar to an 'incidental finding' in medicine," says Voss.

If during the course of its investigation, the medical board identifies anything that may violate the applicable medical practice act, it will delve into the issue. For example, the original complaint against an EP may involve a failure to diagnose a certain condition. "But if the medical board becomes concerned about documentation or inappropriate prescribing practices while reviewing the patient chart, the investigation will expand to include the new issue or issues," says Voss.

This often entails review of additional patients' charts. "There are many instances where a complaint by, or on behalf of, one patient led to disciplinary action based on the physician's care of several patients," says Voss.

A physician may request an evidentiary hearing before final disciplinary action is taken by the board; at the hearing, the board will present its case. "The record of the hearing is available to the public. It could influence a patient's decision to file a civil medical malpractice case," says **Joseph J. Feltes**, JD, a partner in the Canton, OH, office of Buckingham, Doolittle & Burroughs.

While the record itself would not be admissible into evidence at trial, it would be discoverable in a civil case. "This could give the plaintiff's attorney a 'road map' for cross-examining the physician at deposition or at trial," says Feltes.

Lawsuits Trigger Investigations

State board investigations can trigger or bolster medical malpractice lawsuits. Conversely, civil medical negligence lawsuits often trigger state board investigations. "The boards are very interested in pleadings in the civil actions," says **Keith C. Volpi**, JD, an attorney at Polsinelli in Kansas City, MO. Volpi practices medical negligence defense primarily in Missouri and Kansas.

A few years ago, the Missouri Board of Registration for the Healing Arts adopted a policy that the Board would review the care and treatment at issue in every medical negligence case filed in the state. "In other words, in 100% of the medical negligence cases that I defend in Missouri, there is a simultaneous board review occurring," says Volpi, adding that this occurs for about a third of cases in Kansas.

The board reviews are similar in both states. They begin with the physician receiving a cover letter and subpoena for all medical records in the physician's control regarding the plaintiff and a narrative summary of the physician's care and treatment.

"In both states, everything provided to the boards by the defendant physicians is afforded broad statutory privilege," Volpi notes. Thus, there is no concern that a physician's communication with the board will be discovered in the corollary medical negligence lawsuit.

"But the opposite is not true," says Volpi. "The boards have broad subpoena power, and can gain access to anything filed or submitted in the civil lawsuit." Volpi recently accompanied an EP during a board review of a case alleging failure to timely diagnose compartment syndrome and vascular injury. Six months before the hearing, the EP submitted a narrative response to the board; in the interim, the EP was deposed in the civil lawsuit.

After the EP's deposition, plaintiff's counsel filed a motion, including quoted portions of the physician's deposition testimony. "During the board hearing, a board member asked the physician some questions on the same issue as the quoted deposition testimony," says Volpi. "It was clear that the board member had reviewed the motion that the plaintiff filed."

A good plaintiff's attorney is skilled at cross examination and knows the right questions to ask. "This is not the skill set of an average board member," says Volpi. "So it makes sense that the boards will allow attorneys to ask the tough questions, and then review the testimony to aid the board's investigations."

EP Lacked Legal Representation

Usually, the initial letter the EP receives from the board includes a request for medical records or other pertinent information, followed by an interview by a board investigator. "The emergency physician should involve counsel even at these preliminary phases, and should not participate in the interview without counsel," advises Feltes.

A recent state board investigation was triggered by a family's complaint that an EP's negligent care resulted in their mother's death. A representative from the state medical board asked the EP to come down for an informal conversation and a "chat" about the patient's care. "Lo and behold, this so-called 'chatting' was suddenly under oath, just like a legal proceeding. The emergency physician proceeded to tie his noose and put it around his neck," says **Jonathan D. Lawrence**, MD, JD, FACEP, an EP and medical staff risk management liaison at St. Mary Medical Center in Long Beach.

The complaint involved a patient who presented with chest pain; after a

thorough workup, the EP concluded it was non-cardiac. The EP diagnosed pneumonia, after consulting with the patient's primary care physician, and discharged the patient from the ED with instructions to continue the antibiotic she was currently taking.

"The woman began having trouble breathing and died two days later," says Lawrence. During the ensuing investigation, the state medical board asked the EP detailed questions about angina and cardiac disease. "They were making the assumption that she must have died of cardiac causes, when there was no such assumption to be made," says Lawrence. The EP quickly became defensive, complicating the situation further.

"This never would have happened if he had had counsel there, who would not have let him answer self-incriminating questions," notes Lawrence. The proceeding was followed by a formal hearing, after which the EP was exonerated. "But it took a lot of money and time to extricate him from the ammunition that he gave the attorney general," says Lawrence. "He's really a poster child for, 'Don't go it alone.'"

Feltes underscores the importance of the EP, guided by legal advice, cooperating with the board, especially during the initial phases of the investigation. "Failing to cooperate, or worse yet, adopting a belligerent or disrespectful attitude, will only compound the problem," he says.

Information Is Possibly Discoverable

Most state medical boards will do whatever is necessary to avoid institutional embarrassment for failure to protect the public from problematic licensees, says Voss. "By nature, state medical boards are suspicious. They see a lot of bad behavior, and their objective is to protect the safety of the public," she explains. "Thus, medical boards conduct aggressive investigations."

Unless a state has a law prohibiting discovery or use of medical board documents in civil suits, it is possible that the information collected by the medical board could be used against the EP in a malpractice suit. "If the medical board investigation leads to discipline, that information most likely will be publicly available," adds Voss.

The disciplinary information, in turn, may give rise to questions from plaintiff attorneys in future medical malpractice lawsuits. "Also, a patient may use a medical board complaint as a trial balloon," says Voss. If a state medical board disciplines an EP as a result of his or her care of the patient, it is likely that a plaintiff attorney will file a medical malpractice lawsuit on behalf of the patient.

"Conversely, if the state medical board closes its investigation without discipline, the likelihood of a lawsuit being filed decreases," says Voss. Rules about admissibility of evidence in medical malpractice cases vary by state. "But it is always best to be careful about the evidence developed in the medical board investigation as it might give rise to, or affect the defense of, a potential medical malpractice lawsuit," says Voss.

This is one reason to get an attorney involved early on in the medical board investigative process. "Not only does legal representation benefit the physician during the medical board investigation, it may also result in fewer issues to defend in any subsequent medical malpractice lawsuit," says Voss. ■

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CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

COMING IN FUTURE MONTHS

- Dispute consultant's inaccurate testimony during malpractice suit
- How ED protocols could help plaintiff to establish the standard of care
- Legally protective charting for potentially suicidal patients
- Legal risks for EPs when parents sign children out against medical advice

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CNE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right, or log onto AHCMedia.com and click on MyAHC. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.

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CNE/CME QUESTIONS

1. **Which makes it more likely that the EP will be dismissed from a malpractice claim, according to Michael J. Sacopulos, JD?**

   A. if the lawsuit is mainly focused on a physician in a different specialty
   B. if the exonerated EP has nothing to offer that helps the plaintiff's case
   C. if the EP places blame on co-defendants during the discovery process
   D. if the EP testifies that a co-defendant gave inappropriate care

2. **Which practice is likely to reduce legal risks of incidental findings in the ED, according to William J. Naber, MD, JD, CHC?**

   A. Only the radiologist should address incidental findings with patients.
   B. EPs should document discussions about the need for follow-up with admitting physicians.
   C. EPs should not give patients a copy of the radiologist interpretation, since it is only a provisional interpretation.
   D. ED policies need not address incidental findings.

3. **Which is true regarding state medical board investigations of emergency physicians, according to Ellen M. Voss, JD?**

   A. A medical board complaint may not expand to additional areas beyond the subject of the initial complaint.
   B. State medical boards do not have the power to restrict or place conditions on the practice of medicine is very circumscribed.
   C. State medical boards are unable to delve into other aspects of the physician's care.
   D. State medical boards typically conduct aggressive investigations.

4. **Which is true regarding information collected during a state board investigation, according to Voss?**

   A. Information collected by the medical board be used by insurers to deny claims.
   B. It is possible that the information collected by the medical board could be used against the EP in a malpractice suit.
   C. If the medical board investigation leads to disciplinary action, that information is not publicly available in any state.
   D. Plaintiff attorneys in future medical malpractice suits are barred from asking about disciplinary actions taken by state medical boards.