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THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

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Report: Teamwork Is 'Huge Problem in ED Setting'

Better EMRs, QA could prevent ED claims

Emergency physicians (EPs) aiming to reduce liability risks involving diagnostic errors have much to learn from the Institute of Medicine (IOM)'s September 2015 report, "Improving Diagnosis in Healthcare."

There is a lack of research on frequency and prevention of misdiagnosis in the ED, according to **Hardeep Singh**, MD, MPH, one of the IOM report's reviewers. Singh is a patient safety researcher at Michael E. DeBakey VA Medical Center and Baylor College of Medicine in Houston.

While there is some literature on disease-specific misdiagnosis, such as missed appendicitis, cardiovascular events, sepsis, and stroke, there is less data on the overall prevalence of ED-related diagnostic errors and how to reduce these, Singh explains.

"At least two cases of misdiagnosis have received substantial national attention in the last few years, and both have been ED-related," he says.

Singh refers to the 2012 case of Rory Staunton, a 12-year-old boy who died from misdiagnosed sepsis, and the 2014 misdiagnosis of Ebola patient Thomas Eric Duncan.

"The IOM report makes the important observation that diagnosis is often difficult — even under the best of circumstances and by the most knowledgeable clinicians," says **David Meyers**, MD, FACEP, an EP at Sinai Hospital in Baltimore, and principal of Baltimore-based DLM Consulting.

The ED setting is potentially vulnerable to errors and misdiagnosis due to both system and human factors, Meyers says. These system factors include a crowded environment, the large range of conditions seen by EPs, pressure to increase patient flow, cumbersome electronic medical records (EMRs), limited access to patients' previous medical records, and lack of readily available consultants.

"All add to the challenges posed by human factors such as knowledge

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customerservice@ahcmedia.com.
AHCMedia.com

EDITORIAL E-MAIL ADDRESS:
jonathan.springston@ahcmedia.com.

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EDITORIAL/CE DIRECTOR: Lee Landenberger
EXECUTIVE EDITOR: Shelly Morrow Mark
ASSOCIATE MANAGING EDITOR: Jonathan Springston
PHYSICIAN EDITOR: Arthur R. Derse, MD, JD, FACEP
CONTRIBUTING EDITOR: Stacey Kusterbeck

limitations, natural biases, fatigue, distractions, and the need for multitasking," Meyers says.

Errors will likely worsen as the delivery of healthcare and the diagnostic process continue to increase in complexity, according to the IOM Committee.

A 2014 study estimated that 5% of adults are misdiagnosed every year in the outpatient setting.[1] The ED was not included in this study.

"The problem of misdiagnosis in the ED is probably substantially higher than the 5% that we saw in our outpatient study," Singh says.

Malpractice lawsuits are relatively infrequent, Meyers notes.

"This is not to say diagnostic errors are not a serious problem," he says. "Each one has a huge impact on the patients, their families and friends, and also the physicians, nurses, and other clinicians involved in their care."

Meyers says that the ED is a fruitful "laboratory" to study contributing factors that lead to errors and identify ways to reduce them.

"The IOM report will guide us in doing just that, by driving research into better understanding the errors and correcting the factors which contribute to them," he says.

The conditions most frequently associated with claims against EDs have not changed much in 30 years, Meyers notes. These include chest pain, including acute myocardial infarction, pulmonary embolism, and aortic dissection; abdominal conditions, such as appendicitis, ruptured abdominal aortic aneurysm, ischemic bowel; strokes; and missed fractures.

"All are fairly common and expensive," Meyers adds. "In recent times, there are more claims related to sepsis."

Necrotizing fasciitis, spinal abscesses, and hematomas can have devastating consequences and, although rare, now account for more malpractice claims than in the past. Here are some of the IOM report's recommendations to reduce diagnostic error:

• Facilitate more effective teamwork among healthcare professionals, patients, and families.

"This whole teamwork concept that the IOM is trying to promote is a huge problem in the ED setting," says Singh, noting that problems with teamwork were a primary contributing factor in the missed Ebola case.

"The ED nurse did document a travel history from West Africa — but this was likely buried with other documentation, such as information about flu shots and other quality measures," he notes.

The EP did not note the patient's recent history of travel, although one might say in retrospect that the patient's African accent and the hospital's Ebola preparation efforts should have led him to that question.

"So ideally, yes, a travel history would have been great," Singh says. "But the nurse had that information. The problem is, most doctors don't read nursing notes."

In some EMRs, the physician and nursing notes are in two different workflows.

"We know that the ED triage nurse's notes might contain good information that the physician never sees," says Singh. "The question is, can we build strategies to get that critical information in front of the ED docs right away?"

• Establish a work system and culture that supports the diagnostic process and improvements in diagnostic performance.

"EDs need more infrastructure and resource investment to develop quality improvement programs that address diagnostic errors," Singh says.

An EP could take on the role of physician champion to help change the culture and create a quality assurance (QA) process to examine possible diagnostic errors, he suggests.

"We don't need a large-scale root cause analysis in every case," Singh says. "But there are so many opportunities we can learn from and use that information to make system improvements."

• Ensure that health information technologies support patients and healthcare professionals in the diagnostic process.

"Clinicians don't find current EMRs very usable," Singh says. "We need to have better EMRs that fit within the workflow of the ED and support team-based care."

• Develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice.

Singh says that like most areas of medical practice, very few EDs have systematic ways of learning from diagnostic errors and reducing them.

"I am not aware of many formal programs that look specifically for diagnostic errors and prevent them," he adds.

Singh says there is an ED that has a physician-led QA team that examines reported events, including diagnostic errors, and makes changes based on what they learn. EDs often perform callbacks of patients discharged with uncertain diagnosis, or track return visits within 72 hours, but how such data are used for QA related to diagnostic errors is not well-known.

"For those unexpected return visit cases where problems at initial visit were detected, the cycle doesn't get closed unless you identify missed opportunities, learn from them, and give feedback in a nonpunitive fashion," Singh says. "That is not an easy thing to do."

Singh stresses that being involved in QA should be "a part and parcel of all ED docs. Their organizations must support them and their activities in every way possible."

• Place more emphasis on identifying and learning from diagnostic errors and near misses in clinical practice.

A nonpunitive environment that supports learning from a failed diagnostic process is needed.

"That's what's going to move it forward for the ED," Singh underscores. ■

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- **David Meyers**, MD, FACEP, Principal, DLM Consulting, Baltimore. Phone: (410) 952-8782. Fax: (410) 367-0449. E-mail: dm0015@comcast.net.
- **Hardeep Singh**, MD, MPH, Center for Innovations in Quality, Effectiveness, and Safety, Michael E. DeBakey VA Medical Center, Houston. Phone: (713) 794-8515. E-mail: hardeeps@bcm.edu.

Best Defense Against Misdiagnosis Claim?

Show test wasn't indicated at time of visit

A current malpractice case alleges that the EP failed to perform the work-up and testing necessary to rule out a bacterial infection in an infant.

"The infant went on to cardiac arrest and died," says **Judy Greenwood**, JD, a Philadelphia-based medical malpractice attorney. She has represented plaintiffs in several other recent cases in which the ED chart contained no documentation showing that the EP considered the most serious conditions based on the patient's presentation.

"We have seen cases where the ER personnel assumed the most common cause for the symptoms, and when testing was negative for the assumed condition, discharged the patient without ruling out other serious causes," Greenwood says.

ED documentation should include not only the pertinent positives, but also the pertinent negatives, says **Pamela S. Gilman**, JD, a partner in the Boston office of Barton Gilman. Otherwise, plaintiff attorneys can convincingly allege that the EP never even considered the correct diagnosis.

Even the words "considered meningitis" for a patient with flulike symptoms can strengthen the EP's defense, if the patient later turns out to have meningitis.

"You can at least use that as a springboard to explain why you rejected it and didn't order a test," says **Jennifer K. Oetter**, JD, a partner in the Portland, OR, office of Lewis Brisbois Bisgaard & Smith.

Plaintiff attorneys sometimes allege that if the EP had only ordered a certain diagnostic test, the patient would have been admitted and the bad outcome prevented. This is rarely the case, however, according to Oetter. If an abnormal ECG is worri-

some enough to admit the patient, for instance, there are usually other symptoms apparent that would cause the EP to admit the patient.

"Usually the truthful testimony is, 'It would have been one more data point to consider,'" Oetter says.

In one recent case, a patient presented to an ED with a history of left-sided weakness and other symptoms.

"The physician didn't get a neurological consult because there appeared to be other explanations for the patient's symptoms and no evidence of an active event," Oetter says.

As it turned out, the patient had likely had a stroke in the weeks prior to admission, and suffered another stroke shortly after discharge from the ED.

Another malpractice case alleging missed meningococcemia involved a patient discharged from an ED with a diagnosis of viral illness. The plaintiff attorney alleged that the EP should have obtained a blood culture.

"The patient did not meet the SIRS [Severe Inflammatory Response Syndrome] criteria, and there was another, more common explanation for the signs and symptoms associated with infection," Oetter explains.

A current malpractice case involves a patient who presented with a headache and later died of an aneurysm. The plaintiff attorney alleged that the EP should have ordered a CT or MRI. The EP's documentation, which included his thought process, helped the defense since it showed there was no reason to suspect an aneurysm.

"Although imaging studies would have shown the aneurysm, they weren't indicated," Gilman says. The standard of care requires EPs to use reasonable clinical judgment as to the appropriate tests to order based on the patient's presentation at the time of the ED visit.

"We do have the occasional case where somebody goes to the ED with chest pain, a heart attack is ruled out, and the next day they die," Gilman says. Even cases with this fact pattern are defensible, if the EP had no reason to suspect a heart problem at the time of the ED visit, she says.

Medical malpractice attorneys say these practices strengthen the EP's defense against a malpractice suit alleging misdiagnosis of an ED patient:

• Don't omit documentation of "curbside" consults.

If an EP suspects compartment syndrome and briefly talks to an orthopedist who says the patient doesn't need to be admitted, this "curbside" consult probably won't make it into the patient's chart. But if the patient's family later sues the EP for failing to diagnose the condition, the EP will likely regret the decision not to document.

"Documenting that consult — even though the consultant didn't see the patient — can be very helpful," says Oetter.

Many EPs are reluctant to document such conversations, fearing that colleagues, upon learning they're being named in the chart, won't provide informal consults in the future.

"But if you ever get sued, and part of your defense is going to be 'I ran it by so-and-so,' and it's not anywhere in the chart, the only way we have to verify that is your memory of a conversation," says Oetter, adding that plaintiff's attorneys are predictably skeptical of anything that is not in the chart.

Oetter recommends having a straightforward conversation with the consultant about the need for some documentation of the discussion. Some consultants are more comfortable with a general note stating, "spoke with surgeon" without including their name; others may adamantly state that they don't feel comfortable with any documentation.

"But if somebody says 'No, I'd really rather you didn't,' maybe that's not somebody you want to be consulting with," Oetter says.

• Address inconsistent charting in real time.

"While emergency personnel and nursing staff often provide very helpful information, it is incumbent on the ER physician to take their own history, to make sure nothing has been overlooked," Greenwood emphasizes.

If the triage nurse's, nurse practitioner's, physician assistant's, or resident's history differs from the EP's, plaintiff attorneys can use the discrepancy to support allegations that the patient was misdiagnosed.

"Conflicting information is difficult for a jury to sort out," Gilman says.

If a nurse's history reports a cough that isn't apparent during the EP's evaluation, for instance, the EP should ideally address the inconsistency by charting, "the patient was noted to have a cough earlier, but the cough has now resolved."

• Include a narrative.

Gilman often sees EMRs without any narrative to counter a plaintiff's allegations of failure to diagnose.

"Often, an EP says something like, 'I know I would have asked the patient to explain what might exacerbate or mitigate his/her symptoms, but there is no place for me to include the information on the template,'" Gilman says. Without any documentation, the EP defendant is left to claim that it's his or her usual practice to do so. "Nothing takes the place of a detailed note," Gilman adds. ■

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- **Pamela S. Gilman**, JD, Barton Gil-

man, Boston. Phone: (617) 654-8200. Fax: (617) 482-5350. E-mail: pgilman@bartongilman.com.
- **Judy Greenwood**, JD, Philadelphia. Phone: (215) 557-7500. Fax: (215) 557-7503. E-mail: JudyWynnewood@aol.com.
- **Jennifer K. Oetter**, JD, Partner, Lewis Brisbois, Portland, OR. Phone: (971) 712-2809. Fax: (971) 712-2801. E-mail: Jennifer.Oetter@lewisbrisbois.com.

EPs May Be Unaware of Unique EMTALA Risks Posed by Obstetric Patients

Does a pregnant patient want to leave your ED and go to a different hospital — the one at which she plans to deliver? If so, the EP faces some potentially significant legal risks, warns **Nathan A. Kottkamp**, JD, a partner in the Richmond, VA, office of McGuireWoods.

"If the patient is insisting on going to her hospital of choice, that should be treated by the EP as any other decision to decline medical care," Kottkamp says. "The risks should be very well explained to the patient."

If the patient is in labor, he stresses, then the patient's emergency medical condition, as defined by the Emergency Medical Treatment and Labor Act (EMTALA), isn't over until labor stops or the baby is delivered. The on-call consultant can't refuse to come in if he or she disagrees about the level of risk to the patient or whether it can wait, Kottkamp adds.

"The EP makes the call as to whether the on-call physician has to come in. That's a simple, straightforward EMTALA rule," he says.

If the on-call physician refuses to come to the ED, the EP can invoke the hospital's chain of command.

"Maybe a chief of staff or some other individual will be able to assist in getting the on-call to cooperate," Kottkamp says.

The EP can also remind the on-call physician that if there is a transfer required as a result, the transferring hospital is required by law to identify to the receiving hospital the name of the physician who failed to show up.

"That is almost certainly going to result in a report to regulators," Kottkamp says.

Cases Have 'News Appeal'

Since EMTALA cases involving obstetric patients can have devastating outcomes, these tend to attract a lot of attention.

"The news appeal of these cases causes them to often be the subject of press reports when they do arise," says **Sandra DiVarco**, JD, RN, an attorney at McDermott Will & Emery in Chicago.

DiVarco says that many obstetric-related EMTALA cases arise as a classic "patient dumping" scenario: A pregnant woman in labor is turned away from an ED without an appropriate medical screening examination due to a lack of insurance, and is instructed to go to another facility to deliver her infant or to follow up on potential complications with the pregnancy.

Here are some actual EMTALA cases involving this scenario, reported on the Office of Inspector General's website:

• In a 1991 case, a physician refused to stabilize and treat a pregnant uninsured patient in active labor; instead, he inappropriately transferred the patient to another hospital.[1]

"This is the first case where a physician faced an individual fine for his role in an EMTALA violation — to the tune of $20,000," DiVarco says.

• In 2013, a hospital paid $50,000 in civil penalties in which it was alleged that the hospital failed to provide a medical screening examination and stabilizing treatment for a 30-year-old pregnant woman who presented to the ED experiencing chest pains. Both the patient and her baby died.

• In 2015, a hospital was fined $45,000; it was alleged that the hospital failed to provide an adequate medical screening examination for a patient who presented to the ED at 38 weeks pregnant, complaining of abdominal and lower back pain.

"Reportedly, the hospital, which means its employed or contracted physicians and/or nurses, allegedly did not take the patient's vital signs, confirm fetal well-being, or perform even a basic examination on the patient," DiVarco says. Instead, the EP referred the patient to see her own physician. "Settlement information reflects that, after leaving the hospital by private vehicle, she presented at the ED of another hospital, where she was admitted and delivered a stillborn baby," DiVarco says.

EMTALA was not intended, and is not enforced as, a federal negligence statute, DiVarco notes.

"It is more in the nature of an anti-discrimination statute, to avoid disparate care or refusal of ED treatment for uninsured patients seeking care for emergent conditions," she says.

A violation of EMTALA is not inextricably linked to a finding of medical negligence.

"Indeed, EMTALA requirements

can be followed to the letter, and there can still be poor patient outcomes or negligent care provided," DiVarco says.

Similarly, the presence of an EMTALA violation does not mean that a patient was the victim of negligent care.

"However, in the obstetric context, the concerns are heightened, as the potential damages in obstetric malpractice and birth injury cases can be high," DiVarco says.

DiVarco says that the classic "patient dumping" scenario presented by obstetric EMTALA cases provides facts to consider in light of the elements of a negligence case.

"But it is those facts, and not the determination of whether or not EMTALA was violated, that will control in a claim of negligence against the involved physician or hospital," she explains.

To avoid allegations of EMTALA violations involving obstetric patients, DiVarco recommends that EPs:

• Ensure that an appropriate medical screening examination is conducted to determine the presence or absence of an emergency medical condition, which could be active labor or something unrelated, regardless of the patient's insurance status or ability to pay for care.

"Ensure such patients receive stabilizing treatment, whatever that needs to be," DiVarco says.

• Carefully document the medical screening examination and decisions made as a result of that examination.

"This is helpful from both an EMTALA and general medical negligence standpoint," DiVarco notes.

EMTALA includes some additional protections for pregnant patients, stresses **Larry D. Weiss**, MD, JD, FAAEM, MAAEM, clinical professor of emergency medicine at University of Maryland School of Medicine in Baltimore.

When EMTALA was first being discussed by Congress before it was enacted in 1986, pregnant patients were a focal point of interest.

"A lot of horror cases that they heard about involved pregnant patients that were being shuttled from one hospital to another because they didn't have insurance," Weiss says.

An "emergency medical condition" as defined by EMTALA includes any pregnant woman having contractions.

"The only way to stabilize the patient is to deliver the fetus and placenta. If you transfer a patient having contractions, by definition, it's an unstable patient," Weiss says.

It is permissible for EPs to transfer an unstable patient under certain conditions.

"EMTALA has a detailed definition of what constitutes an appropriate transfer of an unstable patient," Weiss notes. "You have to sign an oath that the medical benefits outweigh the risks."

This might be the case if the EP works in a small community ED with no OB coverage, for instance.

The referring hospital has to stabilize the patient to its maximum potential; appropriate records, personnel, and equipment must accompany the patient; the patient or a representative must consent to the transfer; and the patient must be accepted in transfer by an authorized agent of the receiving hospital.

"Finally, the receiving hospital must have the capacity and the capability to care for the patient," Weiss adds.

Weiss points to a widely publicized 2011 case that generated much anxiety among EPs.[2] A pregnant woman was discharged home and sued the EP, alleging an EMTALA violation; a central issue became whether or not she was having contractions. The on-call OB described Braxton Hicks contractions; later in the chart, the OB referred to minimal contractions.

"If there was no evidence of contractions, then EMTALA was not violated," Weiss explains.

If the patient was having false labor, there was no emergency medical condition under EMTALA. If weak contractions were detected, on the other hand, then she was having an emergency medical condition under EMTALA.

"The patient won at a jury trial. The hospital appealed, and the case was later settled," Weiss says. This caused many hospitals to revise policies to state that any pregnant woman who presented with bleeding should be admitted. "But that's not the standard of care," Weiss adds. "The standard of care for a threatened miscarriage is to send the patient home with bedrest."

EMTALA was meant to protect viable fetuses and their mothers, Weiss stresses.

"The regulations were not really aimed at problems in early pregnancy," he says. "The jury came up with the wrong result."

Weiss says the lesson from this case is for an EP to "properly and honestly document in their notes that there was no evidence of any contractions, before sending a patient home." ■

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- **Sandra DiVarco**, JD, RN, McDermott Will & Emery, Chicago. Phone: (312) 984-2006. Fax: (312) 984-7700. E-mail: sdivarco@mwe.com.

- **Nathan A. Kottkamp**, JD, Partner, McGuireWoods, Richmond, VA. Phone: (804) 775-1092. Fax: (804) 698-2072. E-mail: nkottkamp@mcguirewoods.com.
- **Larry D. Weiss**, MD, JD, FAAEM, MAAEM, Clinical Professor of Emergency Medicine, University of Maryland School of Medicine, Baltimore. Phone: (410) 328-8025. Fax: (410) 328-8028. E-mail: lweiss@em.umaryland.edu.

What If Med/Mal Payout Exceeds Policy Limit?

EPs might be viewed as 'deep pocket'

While defendant EPs might be alarmed over threats to seize property and other assets, such threats might be legally problematic for a plaintiff's attorney to actually carry out.

"But it's a very effective negotiating tool," says **John Tafuri**, MD, FAAEM, regional director of TeamHealth Cleveland (OH) Clinic and chief of staff at Fairview Hospital, also in Cleveland.

Losing Assets 'Exceedingly Rare'

Tafuri recommends that EPs protect as many assets as possible. However, the primary reason isn't because they're likely to lose those assets in the event of a high-dollar plaintiff verdict.

"Actually, losing personal assets in a malpractice case is exceedingly rare," Tafuri says.

With assets protected to the greatest extent possible, however, the EP won't be tempted to settle an otherwise defensible case out of fear personal assets will be seized.

"The EP might say, 'I didn't do anything wrong, and my documentation is good. I'm not going to settle. If I do lose, and a jury verdict goes over the policy limit, I'm not scared you'll try to take my personal assets, because you're not going to get anything,'" Tafuri explains.

Asset protection should be in place prior to the date on which the EP saw the patient who is the plaintiff in a malpractice suit.

"Otherwise, it will be viewed as a fraudulent conveyance, and be undone by the court," Tafuri warns.

The general perception among EPs who find themselves defendants in a malpractice lawsuit, says Tafuri, "is, 'They can take everything.' This is theoretically true, but from a practical standpoint, it is very rare."

Retirement plans, for example, are generally fully protected against seizure.

"A plaintiff attorney got a civil judgment against O.J. Simpson for $30 million," Tafuri notes. "I'm sure he was one of the best plaintiff attorneys in California, but he still could not attach his retirement fund."

EPs who are secure in this knowledge have a stronger negotiating position, regardless of the facts of the particular case.

"If the attorney sees you are not scared of him or her, it can be very powerful," Tafuri says. "They may say, 'I don't really have a good case from a medical standpoint,' and agree to settle for a lower amount than they otherwise would have."

Unscrupulous Insurers

Many EPs switched to lower policy limits when medical malpractice rates spiked in the early 2000s.

"The majority of doctors in Florida are now at $250,000," reports **Jonathan Katz**, president of Oros Risk Solutions, an Orlando, FL-based insurance and consulting agency specializing in selling medical professional liability insurance.

Due to the shift to lower limits, EPs were understandably concerned about the possibility of excess judgments. Some unscrupulous individuals sought to capitalize on these fears.

"Every town had lawyers advertising asset protection seminars, but most of the guys had no background in it," Katz says. "They were just out to make a buck; some were crooks."

Katz strongly recommends EPs consult with a qualified attorney specializing in asset protection, and to seek a similar level of expertise when shopping for malpractice insurance.

"I've seen cases where insurers wrote low-priced policies but lacked the proper staffing, and did a really poor job on claims," he says.

Some defendant EPs paid a heavy price for choosing a poorly capitalized startup company.

"They grew market share pretty good, but there was not a lot of intellectual capital in house," Katz says. "They were contracting claims out to third-party companies and yielded very poor results."

"I want a $250,000 limit because I don't want to be a target." This is a common misconception held by EPs, according to Katz.

"I've never seen a plaintiff's attorney say, 'I'm not going to sue Dr. X because he only has a $250,000 limit,'" he says. "If you touch the patient and they can bring you into the lawsuit, they will."

Katz often advises EPs to err on the side of too high of a limit rather than not enough.

"Nobody wants to see a doctor with a judgment over the limit. It's not a good result, but sometimes it's unavoidable," he says.

EPs with a low policy limit are often reluctant to go to court because of the risk of an excess judgment, even if the case is very defensible.

"If you want to defend yourself, you might be hesitant to do so because you are worried about your assets being exposed," Katz says. With a $1 million limit, he says, "everybody's more comfortable going to court — the insurer, the physician, and the defense attorney."

Could EPs with a higher policy limit be apportioned more liability than they otherwise would have received?

"That has probably happened," Katz acknowledges. "But when I weigh the issue, I'd rather have that happen once in a blue moon than be not adequately insured from a catastrophic judgment."

Michael G. Merlo, Esq., managing director of Casualty Legal and Claims Practice at Aon Broking in Chicago, sees high policy limits causing the plaintiff to view the EP as a "deep pocket" as a legitimate concern.

"If insurance is discovered in the litigation process, it can certainly have an impact on the way the plaintiff or attorney views what a reasonable settlement may be," he says.

With a higher limit, however, "it's the insurance company's pocket," Merlo says. "Most EPs would rather not have the deep pocket be their own." ■

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- **Jonathan Katz**, President, Oros Risk Solutions, Orlando, FL. Phone: (407) 745-2892. E-mail: jkatz@orosrisk.com.
- **Michael G. Merlo**, Esq., Managing Director, Casualty Legal and Claims Practice, Aon Broking, Chicago. Phone: (312) 381-5169. E-mail: mike.merlo@aon.com.
- **John Tafuri**, MD, FAAEM, Regional Director, TeamHealth Cleveland (OH) Clinic. Phone: (216) 476-7312. Fax: (440) 835-3412. E-mail: jotafu@ccf.org.

Legal Risks of Googling ED Patients Unclear, Cases Likely Coming

Document reason for clinically justified search

Of 530 medical students, residents, and EPs, 13% used Google to research a patient; 2% had searched for patients on Facebook, according to a recent survey.[1] One quarter of EPs surveyed considered using Facebook to learn about a patient "very unethical." Patient confidentiality, dignity, and consent were the most frequently cited ethical concerns.

The study's findings show that ED practitioners do, in fact, use social media in the ED setting to obtain patient information, says **Jonathan D. Rubin**, JD, a partner at Kaufman Borgeest & Ryan in New York City.

"This is the more modern version of searching through a patient's wallet for information when they present with an altered level of consciousness," he says.

Conducting Internet searches on ED patients "can be problematic, particularly when the physician does not have a clinically relevant reason for looking into the patient's online life," warns **Denny Maher**, JD, MD, general counsel and director of legal affairs for the Seattle-based Washington State Medical Association.

The issue of Googling patients has come before Washington's state medical licensing agency, the Medical Quality Assurance Commission (MQAC), which issued a set of guidelines in response to increased numbers of complaints regarding questionable use of the Internet and social media. The guidelines state that unless the physician is looking for patient information related to treatment, searching the Internet for information on patients is a violation of professional boundaries.

"Should MQAC investigate a patient's complaint and find that a physician has committed such a boundary violation, the physician may be disciplined for unprofessional conduct," Maher says.

New Legal Territory

It isn't always clear whether or how an EP's use of the Internet or social media will end up violating privacy laws or professional boundaries.

"This is proverbial new territory," says **Tierney Edwards**, JD, associate director of legal and federal affairs at Washington State Medical Association.

Any Internet search that does not have a specific clinically related

purpose, however, is potentially problematic legally.

"Whether such actions could result in any liability in civil court is something we can't opine on," Edwards says. "But it would cause problems with our medical licensing body, should a complaint be filed."

It's important that EPs understand that Googling a patient could complicate medical malpractice litigation, says **Lizabeth Brott**, JD, regional vice president of risk management at ProAssurance Companies in Okemos, MI.

"Clearly, if a patient is aware of inappropriate conduct and claims injury due to the conduct, a physician could have difficulty defending such a claim," she says.

Online searches of patient information may be justifiable in certain situations.

"However, physicians should be able to justify such searches," Brott adds.

U.S. licensing authorities have reported numerous professional violations by healthcare providers on social media that resulted in disciplinary action, according to Brott.

"We expect to see more similar cases in the future," Brott notes.

Googling ED patients would not violate the Health Insurance Portability and Accountability Act, since the search would only give an ED provider access to already-public information, "and anything one might find on Google is not Protected Health Information," Rubin says.

Consent and Accuracy

Nevertheless, an online search could cause problems with respect to patient consent and accuracy of information.

"Thus, it creates potential for other litigation and malpractice exposures," Rubin says.

Online searches could lead to a claim that a given patient was somehow treated differently because of something the ED provider found out about him or her.

"Furthermore, when these searches are conducted for reasons that could amount to boundary violations, such a claim could become part of malpractice litigation and also possibly a licensing board complaint," Rubin says.

> "THIS IS A BALANCING TEST, AND EACH CASE MUST BE TAKEN ON ITS INDIVIDUAL FACTS."

Rubin says it is unlikely that Google searches obtained without the patient's knowledge that were not for demonstrable safety concerns would reduce the EP's legal risks.

"On the contrary, they could be heightened," he says. "It could impact the credibility of the chart and the provider during malpractice litigation."

If an EP cannot reach a patient or a patient's family in an emergent situation, Googling address information could be helpful and even life-saving.

"Where a provider has a reasonable suspicion based on conversations, observations, and clinical assessment that is recorded, that a patient may be at risk to themselves or others, Googling the patient could be justified and defended," Rubin says.

In the context of a lawsuit or licensing board investigation, an EP who can demonstrate that he or she Googled a patient for safety reasons will likely have a good defense to any claim of a boundary violation.

"This is a balancing test, and each case must be taken on its individual facts," Rubin notes.

Such Google searches, however, should then be recorded in the chart so the EP can later defend his or her actions and reasoning.

"They should be able to clearly explain and justify why they believed such a search was necessary and in the patient's best interest, in keeping with the adage of doing no harm," Rubin says. ■

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- **Lizabeth F. Brott**, JD, Regional Vice President, Risk Management, ProAssurance Companies, Okemos, MI. Phone: (800) 282-1036, ext. 6217. Fax: (205) 414-1192. E-mail: lbrott@proassurance.com.
- **Tierney Edwards**, JD, Associate Director of Legal and Federal Affairs, Washington State Medical Association, Seattle. Phone: (206) 956-3657. Fax: (206) 441-5863. E-mail: tee@wsma.org.
- **Denny Maher**, JD, MD, General Counsel, Director of Legal Affairs, Washington State Medical Association, Seattle. Phone: (206) 956-3640. Fax: (206) 441-5863. E-mail: denny@wsma.org.
- **Jonathan D. Rubin**, JD, Partner, Kaufman Borgeest & Ryan, New York City. Phone: (212) 994-6515. Fax: (212) 980-9291. E-mail: jrubin@kbrlaw.com.

Are ED Policies Inflexible?

Very simple changes can avoid legal problems

After noting a violation of ED policy, the plaintiff attorney typically tells the jury that by failing to follow the ED policy, the EP defendant breached the standard of care.

"The defense is left to explain that the ED policy is not the standard of care. It puts the burden on the defense when it ought to rest with the plaintiff," says **Andy Walker**, MD, FAAEM, a Nashville, TN-based EP.

During malpractice litigation, plaintiff attorneys frequently bring up the fact that an ED policy wasn't followed to the letter. "EDs draft policies and procedures at their peril," says **William M. Mandell**, JD, an attorney at Pierce & Mandell in Boston, who frequently advises hospitals and medical groups on health law and compliance.

Compliance with ED policies, on the other hand, can provide a strong defense for EPs. "If you followed your policy, and your policies are reasonable, that can bolster a defense that you acted in a compliant fashion with any external mandates and that you complied with the standard of care," Mandell says.

ED policies are "neither a perfect sword nor a perfect shield," says **Gregory Dolin**, MD, JD, co-director of the Center for Medicine and Law in Baltimore. "If the policy says you should do A, and for some reason you didn't do it, it doesn't mean you committed malpractice."

The policy may not be applicable to a particular patient; what the EP did could have been reasonable even though there was a bad outcome. "The burden is on the EP to explain why the policy was not followed," Dolin says. "The jury may be skeptical and think, 'Maybe you screwed up.'"

Walker says that in his experience reviewing ED charts as an expert witness for the defense, there are two problems with ED policies. "One is that no one ever reads them — except when you are first hired, or when someone is trying to get someone else in trouble," he says.

The second problem is that ED policies are often too specific or rigid. Sometimes, this is due to hospital administrators and risk managers trying to cover every possible scenario. "These are people who either have never done patient care, or if they were involved, it was many years ago," Walker says. Poorly drafted ED policies may be well-intentioned, he adds, but often backfire on EPs who find themselves defendants in malpractice cases. "I continually see plaintiff attorneys trying to use policies against the EP and against the hospital," Walker notes.

Here are some reasons why ED policies can complicate an EP's defense in malpractice litigation:

• If ED policies have additional requirements than the law requires, the failure to follow the ED policy can be introduced as evidence of negligence.

EDs should constantly be reviewing and modifying policies as warranted in response to changes in regulations or legislative rulings, Mandell says.

• If ED policies leave no room for clinician discretion, the plaintiff attorney can make an issue of the fact that policies weren't followed to the letter.

"It is a real challenge for counsel and clinical and administrative leadership to make sure policies are carefully drafted," Mandell says. "You want to be clear and complete, but leave some level of discretion and flexibility."

If a policy doesn't leave room for the clinician's discretion, this raises the EP's legal exposure. "You can be arguably compliant with the law, but you didn't follow your own policy and procedure — and that is what creates the exposure," Mandell explains.

For example, an ED's Emergency Medical Treatment and Labor Act (EMTALA) policy can include some level of discretion as to when patients can be transferred. "If the policy is not artfully drafted, you can act in a clinically appropriate way and an EMTALA-compliant way, but still in contrary to your policy," Mandell says.

ED policies should be "short, general, and flexible, and give as much wiggle room as they can," says Walker, in order to leave as much room for the EP's individual professional judgment as possible.

"Not only is that better for patients, but it can be a defense for EPs at trial. It gives them a chance to explain why they did what they did," Walker says.

Walker suggests this wording for transfer policies: "in compliance with applicable laws and regulations and in accordance with professional judgment and medical ethics."

For ED policies on consent, Walker suggests this wording: "ED personnel should consider the possibility of implied consent in anyone who presents to the ED, and exercise professional judgment in evaluating a patient's competence to make treatment decisions."

Walker says ED policies should avoid words such as "shall" and instead, use phrases such as "should consider" and "based on professional judgment applied to the individual patient's condition."

Walker has seen plaintiff attorneys allege that ED nurses failed to follow the ED's policy requiring repeat vital signs to be obtained at specific intervals, such as every 15 minutes, on a patient who appears to be stable but eventually has a bad outcome.

"The plaintiff's attorney then accuses the ED nurse of negligence as a way to bring the hospital into the case as a defendant, with its deep pockets," Walker says. "They do this in case their attempt to make the hospital a defendant under the doctrine of 'apparent agency' fails, assuming the EP is not a hospital employee."

Instead of giving a specific timeframe, Walker says to use wording such as "as often as professional judgment indicates and practical circumstances allow."

Walker also sees ED policies wielded as a weapon by the plaintiff in malpractice cases involving falls, fall precautions, and fall risk rating scores. "In real time, the ED nurse will rate a patient's risk of fall at one score," he explains. After the fact, the plaintiff's attorney will argue the score was miscalculated according to the hospital's policy and procedure manual.

"Writing too much detail into a policy book is always foolish and dangerous, and will eventually come back to bite you," Walker warns.

• ED policies are sometimes inconsistent with other hospital policies that address similar or identical areas.

"ED policies should not be drafted in a vacuum. You should be looking at the entire collection of policies within a hospital," Mandell says.

• Some EDs lack policies that are required by federal law.

EDs are required to have certain policies under the Center for Medicare & Medicaid Services' Conditions of Participation, and as a condition of licensure under state licensing rules.

"If under one of those authorities you fail to have a policy where you were required to do so, the evidence of the lack of the policy can be used to support claims of both facility and provider negligence," Mandell warns. ■

SOURCES

- **Gregory Dolin**, MD, JD, Associate Professor of Law/Co-director, Center for Medicine and Law, Baltimore. Phone: (410) 837-4610. E-mail: gdolin@ubalt.edu.
- **William M. Mandell**, JD, Pierce & Mandell, Boston. Phone: (617) 720-2444. Fax: (617) 619-7231. E-mail: bill@piercemandell.com.
- **Andy Walker**, MD, FAAEM, Nashville, TN. E-mail: awalkermd@comcast.net.

CME/CNE QUESTIONS

1. Which is recommended to reduce diagnostic errors in the ED setting?

A. Having physician and nursing notes in two different workflows in EMRs could reduce the risk of diagnostic errors.
B. Callbacks of patients discharged with uncertain diagnosis are unnecessary for the vast majority of cases.
C. EPs should be more involved in quality assurance efforts.
D. EDs should generally not examine suspected diagnostic errors, to avoid legal discoverability, if a formal root cause analysis is not possible.

2. Which is true regarding an EP's defense in a misdiagnosis claim?

A. EPs should generally avoid documenting conditions that were considered and ruled out.
B. ED charts should include not only the pertinent positives, but also the pertinent negatives.
C. Documentation of informal consultations increases legal risks for both the EP and the consultant.
D. An explanation of why a diagnostic test wasn't ordered increases the EP's legal exposure.

3. Which is true regarding ED obstetric patients and EMTALA?

A. If a pregnant patient wishes to leave the ED and go to a different hospital, EMTALA requires the EP to override the patient's wishes.
B. The on-call consultant can refuse to come to the ED if he or she disagrees about the level of risk to the patient.
C. EMTALA includes no additional protections for pregnant patients.
D. An "emergency medical condition" as defined by EMTALA includes any pregnant woman having contractions.

4. Which is recommended for ED policies to reduce an EP's legal exposure?

A. ED policies should give specific time frames for how often vital signs should be checked.
B. ED policies should leave ample room for the individual EP's discretion.
C. EMTALA policies should not include any level of discretion for when patients can be transferred.
D. ED policies should be referred to as the legal standard of care.

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