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INSIDE

Editor's Note: This is Dr. Vogel's first article for ED Legal Letter.

The Battle Against Protectionism in the Utilization of Telemedicine

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During early space travel, many remember watching NASA astronauts receive physician care from Earth via a grainy video link. From this pioneering use, telemedicine has been adapted for the diagnosis and treatment of patients in various innovative commercial settings. In fact, in 2011, approximately 11 million people were treated by telemedicine — a number that has grown rapidly over the past five years.[1] Telemedicine is in a remarkable growth phase, with its use expanding so quickly that the bureaucracy of medicine has failed to keep up with the technology. Legal and regulatory barriers, such as physician licensure requirements, reimbursement issues, and even attempts to block entry into the market completely, have placed medicine behind other industries in accepting technology that is beneficial to its consumers.[2] A recent ongoing court battle is emblematic of the impediments that may exist in a state regulatory regime regarding telemedicine.

> A RECENT ONGOING COURT BATTLE IS EMBLEMATIC OF THE IMPEDIMENTS THAT MAY EXIST IN A STATE REGULATORY REGIME REGARDING TELEMEDICINE.

Telemedicine is characterized by the geographic separation between two or more people engaged in the practice of medicine using

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telecommunication technology to gather, store, and disseminate clinically related information. The technology is then used to assess, diagnose, and treat medical conditions.[3] The telemedicine market is currently categorized into three models: the provider-to-provider model, in which two clinicians discuss a specific patient; the provider-to-patient model, in which a provider connects directly with a patient either by telephone or online; and the so-called mHealth model, which provides telemedicine services to a patient via a smartphone application.[4]

The rise of the importance of telemedicine has much to do with the failures of the U.S. medical care system. These include a lack of access to medical care in underserved geographical areas, lack of information sharing between physicians and patients, and the high cost of care.[5] Telemedicine allows technology to access patients, wherever they are, via cost-effective methods with documented quality outcomes.[6]

Current Uses of Telemedicine in Emergency Medicine

Telemedicine applications are used in many hospitals and health systems across the United States to support emergency medical care. For example, physicians at the University of Mississippi Medical Center have used telemedicine for emergency consults with outlying hospitals since 2003. Using online video and other technology, emergency medicine physicians, and now physicians from 30 other specialties, provide advice to rural hospitals and other clinical sites.[7]

George Washington University Department of Emergency Medicine offers emergency consult services to the maritime industry and to local nursing homes that are considering transport to their hospital.[8] Additionally, this facility recently commenced a fellowship training program in telemedicine.[9]

At Avera Health Care System in Sioux Falls, SD, emergency medicine physicians discuss cases with previously trained nursing staff through video, audio, and software links. They are available to consult on complex emergency cases and provide immediate medical direction.[10]

ACEP Adopts Telemedicine Policy

In January, the American College of Emergency Physicians (ACEP) adopted its own telemedicine policy due to the increase in the use of telemedicine, in both volume and scope, by emergency care physicians in the United States.[11] Because there are wide variations between state regulatory regimes concerning critical issues such as access to patients, medical licensure, and payment for services, ACEP thought it necessary to publish its own policies regarding the ongoing controversies.

Additionally, the use of telemedicine in emergency medicine, as compared to other specialties, can present the clinician with a unique set of circumstances. For example, emergency medicine's focus on unscheduled care may make it difficult to first establish a physician-patient relationship or conduct a face-to-face interview. The ACEP policy highlights these and other unique features of emergency care.

The importance of recognizing differences between emergency

medicine and other specialties becomes evident when examining the policy statements of other stakeholders. For example, the Federation of State Medical Boards (FSMB) model guidelines assert that physicians first must establish a physician-patient relationship before utilizing telemedicine without qualifying that this may not be possible in the setting of an emergency — a concept acknowledged in the ACEP guidelines.[12] In addition, protocols advocated by the American Medical Association support the use of face-to-face telemedicine consults exclusively, which could be a challenging and limiting provision in some emergency settings.[13]

The ACEP Policy

Credentialing and licensing: ACEP calls for the development of interstate medical licenses that would be offered based on reciprocity among states. This would evolve into uniform rules for physicians and the practice of medicine. ACEP believes that as it currently stands, all telemedicine providers should meet local credentialing and other qualification criteria as mandated by state and federal law.

Establishing a Physician-Patient Relationship: ACEP outlines the traditional establishment of a physician-patient relationship, formed by mutual agreement to collaborate on the patient's healthcare. It also includes specific informed consent that must be given to the patient in the setting of a telemedicine conference. This would include: the nature of the telemedicine conference, limits of confidentiality in electronic communication, the potential for technical failure, prescribing policies given state and federal guidelines, and the conditions under which telemedicine services may be terminated and a referral made for in-person care. ACEP recognizes that when telemedicine is used for urgent care, such as a stroke or cardiac issue, that this information might be provided in an abbreviated form because of the need to provide timely care.

PROTOCOLS ADVOCATED BY THE AMERICAN MEDICAL ASSOCIATION SUPPORT THE USE OF FACE-TO-FACE TELEMEDICINE CONSULTS EXCLUSIVELY, WHICH COULD BE A CHALLENGING AND LIMITING PROVISION IN SOME EMERGENCY SETTINGS.

Billing and Fair Compensation: ACEP advocates for appropriate billing and payment for telemedicine services. Only 22 states and the District of Columbia mandate coverage for telemedicine-provided services under private health insurance plans. There are 46 states that currently reimburse for telemedicine services under the Medicaid program. The Medicare program currently has only limited reimbursement for telemedicine-provided services. However, new legislation has been introduced that would allow for the expansion of the payment regime under Medicare. The CONNECT for Health Act modifies the current restrictions and allows for alterative payment models. There is nothing in CONNECT that directly addresses emergency medicine. CONNECT is currently under assessment in the Senate and has garnered wide support from stakeholder organizations.[14]

Internet Prescribing: ACEP supports internet medication prescribing given that a physician-patient relationship exists, an appropriate evaluation is performed, and a treatment plan is outlined. ACEP does not support the prescribing of medications without real-time interactive engagement between physicians and patients.

Professional Liability: This is not directly addressed in the ACEP document, although there is emphasis on the fact that the physical location of the patient defines that practice locale and, therefore, which state law applies.

As states grapple with their regulatory regimes, they may choose to incorporate the criteria called for by the various stakeholders as they promote their unique and overlapping interests. A recent court case, *Teladoc v. Texas Medical Board*, exemplifies the type of conflicts that may arise when the burgeoning use of telemedicine bumps up against state regulatory policy. In this case, the Texas Medical Board claims to be looking out for the best interests of the consumers of medical services, while Teladoc, the telemedicine

provider, claims the board is limiting access to patients to protect local providers from competition.

The Case: *Teladoc v. Texas Medical Board*

Teladoc is a telemedicine provider that uses the provider-to-patient model, utilizing phone and online video consultations. They are currently the number one provider of telemedicine services in the United States assessed by market share.[15] Teladoc services are available to patients either through their employer or through a personal account. The registrant uploads his or her medical history, medical records, and contact information of her personal physician. Members of Teladoc then may place a consultation request for a board-certified physician who is licensed in the state in which the patient resides and who is trained to provide diagnosis and treatment via telephone or video. The average call back time is 16 minutes after request. Based on a review of the medical records and a telephone conversation, a physician provides medical advice that can consist of prescribing medication (but no narcotics or "lifestyle drugs" such as Viagra or diet pills) or referral to a local physician or ED. The Teladoc physician's notes are then added to the patient's chart. There is an annual fee of $150, and the cost for a Teladoc consultation is approximately $40.

The Texas Medical Board (TMB) is typical of state medical boards in that it consists of physicians and members of the public appointed by the governor. The board's business includes interviewing licensure candidates, considering disciplinary matters, and adopting substantive and procedural rules affecting the practice of medicine in Texas. A majority of the board consists of so-called "active market participants" in that they are practicing the discipline that they oversee.[16]

What Started the Controversy?

In 2011, the TMB sent Teladoc a letter warning that its telemedicine model violated a TMB rule by claiming its physicians could use telephone consultations alone to prescribe medication for patients. Teladoc sought legal recourse by bringing suit against the TMB in Texas State Court. Teladoc won a restraining order against the TMB, allowing it to continue providing its services in Texas.[17] In response, the TMB issued a rule in April 2015 amending the Texas telemedicine rule to mandate a face-to-face visit before a physician could issue a prescription.[18] This effectively would have prevented Teladoc from operating in the state because the company mainly provided telephone consultations.

IF TELADOC WINS, IT WILL SEND A CLEAR MESSAGE TO OTHER STATE MEDICAL BOARDS THAT PROTECTIONISM WILL NOT PREVAIL IN THE UTILIZATION OF TELEMEDICINE.

Soon thereafter, Teladoc filed an action asking the United States District Court for the Western District of Texas to enjoin the TMB from asserting the new rule. The claim was based on antitrust law. Teladoc maintained that the effect of the new rule would be anti-competitive and lead to an increase in prices, fewer choices, less access, innovation stagnation, and a decline in overall supply of physician services. TMB countered that mandated face-to-face interaction would lead to improved quality of medical care in Texas. The court sided with Teladoc and issued a temporary restraining order, preventing institution of the new rule.[19]

The TMB countered with a motion to dismiss based on a claim that they were protected from these antitrust considerations by the so-called "state action immunity doctrine." This doctrine, first asserted by the Supreme Court in *Parker v. Brown*, maintains that if a state policy is both clearly articulated and actively supervised, then the state entity involved will be immune from anticompetitive related antitrust laws with respect to that policy.[20-22]

The parties disagreed about whether there was active state supervision of the TMB and whether it would qualify for state action immunity under *Parker* and its progeny cases.

The Texas Federal Court decided the motion to dismiss in favor of Teladoc on Dec. 14, 2015.[23] The Texas court based its decision about active supervision under the state action immunity doctrine on the recent Supreme Court decision in *North Carolina State Board. of Dental Examiners v. Federal Trade Commission*.[24] The North Carolina Board of Dentistry consists of practicing dentists and dental hygienists. In 2003, non-dentists began offering teeth-whitening services to consumers in mall kiosks and salons across the state. After

dentists complained, the board sent cease and desist letters to non-dentist teeth-whiteners, who subsequently complied with the board's demand. However, the Federal Trade Commission (FTC) subsequently charged the board with violating the Federal Trade Act by excluding non-dentists. The Supreme Court agreed with the FTC ruling, stating that when market participants operate a state agency, the agency is a private actor and subject to federal antitrust laws.

The Supreme Court made clear that a board consisting of active market participants enjoys *Parker* immunity only if it was subject to active state supervision. The Court said active supervision need not entail day-to-day involvement in an agency's operations, but rather the state's review mechanisms had to provide realistic assurance that the board's anticompetitive conduct promoted state policy, rather than merely the board members' individual interests.[25]

The Texas Federal Court held that the TMB was not subject to active supervision, as defined by the Supreme Court in the *North Carolina Dental Board* case, and therefore was subject to antitrust scrutiny. The case remains subject to the preliminary injunction won by Teladoc in April 2015 and will go to trial unless settled beforehand.

What Does the Teladoc Decision Mean?

The win for Teladoc at this stage of the case means the court believes there is merit to their argument, but it does not mean that they will ultimately prevail. If Teladoc wins, it will send a clear message to other state medical boards that protectionism will not prevail against the utilization of telemedicine.

There are many legal and regulatory hurdles that must be cleared before telemedicine is widely accepted and utilized. Emergency medicine physicians would be wise to keep abreast of the regulatory environment in their own state and at the federal level. ■

REFERENCES

1. Barrett C, Gilroy AS. *What Is ... Telemedicine?* Chicago: ABA Publishing; 2015.
2. Id. at xiv.
3. Id. at 7-8. (From, Klein SR, Kim J. Telemedicine and mobile health innovations amid increasing regulatory oversight. 22 *Westlaw J Health Law* 3, 5. June 24, 2014.
4. Id. at 20-26.
5. Rice T. Market failure in health care: Still common after all these years. The World Bank website. Available at: http://bit.ly/1NlAcuk. Accessed April 25, 2016.
6. American Telemedicine Association. Research outcomes: Telemedicine's impact on healthcare cost and quality. Available at: http://bit.ly/1pPW8gK. Accessed April 25, 2016.
7. The University of Mississippi Medical Center, Center for Telehealth. Available at: http://bit.ly/1T2fTRG. Accessed April 25, 2016.
8. The George Washington University School of Medicine & Health Sciences, Department of Emergency Medicine. Available at: http://bit.ly/1WdPoNm. Accessed April 25, 2016.
9. The George Washington University School of Medicine & Health Sciences, Department of Emergency Medicine. Fellowship programs - telemedicine. Available at: http://bit.ly/1WNx7Vs. Accessed April 25, 2016.
10. Avera eCare. eEmergency. Available at: http://bit.ly/1WNxcbI. Accessed April 25, 2016.
11. American College of Emergency Physicians. Emergency medicine telemedicine policy. Available at: http://bit.ly/1QTPOQc. Accessed April 25, 2016.
12. Federation of State Medical Boards. Model policy for the appropriate use of telemedicine technologies in the practice of medicine. Available at: http://bit.ly/1YcDXTe. Accessed April 25, 2016.
13. American Medical Association. Coverage of and payment for telemedicine. Available at: http://bit.ly/1WNxCyM. Accessed April 25, 2016.
14. The 114th Congress. S.2484 - CONNECT for Health Act. Available at: http://1.usa.gov/1rxrte9. Accessed April 25, 2016.
15. Supra note 1, p.30.
16. Texas Medical Board. Texas Medical Board overview. Available at: http://bit.ly/1XccgM9. Accessed April 25, 2016.
17. *Teladoc, Inc. v. Texas Medical Board.*, 453 S.W.3d 606, 620 (Tex. App.–Austin 2014, pet. filed).
18. 22 Tex. Admin. Code § 190.8(1)(L).
19. *Teladoc, Inc. v. Texas Medical Board*, No. 1-15-CV-343-RP (W.D. Tex. May 29, 2015) (order granting preliminary injunction).
20. 317 U.S. 307 (1942).
21. *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S.Ct. 1003, 1010, 2013 (quoting *California Retail Liquor Dealers Assn. v. Midcal Alum., Inc.*, 445 U.S. 97, 105, 1980).
22. Ticor Title Ins. Co., 504 U.S. 621, 632, 1992 (citing *Parker v. Brown*, 317 U.S. 307, 350-51, 1942).
23. *Teladoc, Inc. v. Texas Medical Board*, No. 1-15-CV-343 (W.D. Tex. Dec. 14, 2015).
24. 135 S. Ct. 1101 (2015).
25. Id. at 1110.

EP Failed to Administer tPA for Stroke: Is Malpractice Claim Defensible?

Reasoning must be clear in ED chart

The EP failed to diagnose a stroke. The EP diagnoses stroke, but the neurology consult does not recommend tissue plasminogen activator (tPA) use. The EP diagnoses stroke but does not obtain a neurology consult, and decides not to administer tPA. These are typical fact patterns in cases alleging that EPs failed to administer tPA to a stroke patient, says **Jonathan A. Edlow**, MD, vice chairman of the Department of Emergency Medicine at Beth Israel Deaconess Medical Center in Boston.

In one malpractice case, the EP correctly suspected a stroke and implemented the hospital's "stroke activation." This included ordering an immediate CT scan and neurology consultation.

"The neurologist made a determination not to give tPA, but the EP was included in the legal action — although she was ultimately dropped," Edlow says.

In some cases, the EP has a valid reason for not administering the drug: The patient improves rapidly and is close to normal, or there is ambiguity about the last time the patient was normal. These legitimate reasons are sometimes documented poorly in the ED chart.

"One crucial point is that for every stroke patient, the EP should explicitly document the exact reason why tPA is not being given, even if the EP thinks it is obvious," Edlow says, noting he has been consulted on multiple malpractice cases in which the ED chart included good documentation of the EP's reasoning. "There were lots of good reasons for not giving tPA, so the lawyers did not pursue the case."

Here are some possible defenses to allegations that the EP failed to give tPA:

• The CT showed a hypodensity, which led the EP to question the time of onset.

Normally, the CT takes several hours to become positive.

"If a patient is telling you that the stroke started one hour ago and the CT already shows a significant hypodensity that fits with the clinical deficit, that would make me pause and ask enough questions of the right people so that I am absolutely sure about last time known normal," Edlow says.

Often, resolving this issue becomes a judgment call.

"As with any high-stakes decision, it's always best practice to document your medical decision making in the chart," Edlow says. "Explain your thought process to the patient or family, and document that too."

• The patient became normal.

"The EP must do a careful neurological exam, and document that it is normal," Edlow says. "Note that it is also possible to have a stroke with an NIHSS [National Institutes of Health Stroke Scale] of 0, usually in the posterior fossa."

Edlow says an NIHSS in every stroke patient is "a good idea for the sake of completeness, but also to better communicate with the neurologist and to quantify improvement or worsening." This means performing a second or third NIHSS test.

Edlow notes that contraindications to tPA are evolving rapidly.

"Some that were contraindications a few years ago are either not now, or have become 'relative' ones," he says.[1]

EPs sometimes use a patient's rapidly improving symptoms as a reason not to treat.

"But many of these patients do quite poorly," Edlow says. "It's one thing for a NIHSS to go from 15 to 10 — improving but still a big stroke — another to go from 10 to 5 — improving but still a moderate stroke — and quite another to go from 6 to 1 or 5 to 0."

Plaintiff attorneys often exploit the fact that information becomes available to EPs incrementally.

"It is quite common that the EP is not privy to information that might become available in 30 minutes or in an hour," Edlow says.

EXECUTIVE SUMMARY

Documentation of legitimate reasons for not administering tPA to a stroke patient is helpful to the EP's defense, though the EP still may be held liable by a jury. To reduce risks, EPs can:

- Explicitly document the exact reason why tPA is not administered.
- Clearly explain the reasons to the family.
- Bear in mind that contraindications to tPA are evolving rapidly.

By that time, the timeframe for tPA could be over.

"Every EP has had the experience of getting one story from EMS and then a very different story from eyewitnesses," Edlow says.

The EMS crew might state that the stroke started at 11:30, but when the family arrives, it becomes clear that the patient was found with a deficit at 11:30, but the last time known normal was actually 9:50. Depending on when the patient arrived, that 100-minute change could make the patient ineligible for tPA.

"One trick is to ask the EMS crew to radio the EP with the cell phone number of an eyewitness so that the information can be acquired while the patient is en route," Edlow says.

Edlow urges staff to presume stroke in every patient presenting with an abrupt onset of a neurological symptom until proven otherwise. For every stroke patient, Edlow says staff should document the following:

1. Last time known normal;
2. Results of a neurological exam, preferably including an NIHSS;
3. Results of a brain imaging study (usually CT) and read by a radiologist or equivalent;
4. The reason(s) why tPA was not administered, even if the EP thinks it's obvious.

Explain Why tPA Can't Be Administered

Andy Walker, MD, FAAEM, a Nashville, TN-based EP and legal consultant for EPs, says if EPs are not administering tPA, they should communicate the reason why to the patient and the family — and chart the discussion properly when it happens.

"When something is documented in real time, that carries a lot of weight with the jury," he says. "They take that very seriously."

Regardless of whether tPA is administered or not, Walker says EPs must prepare the patient and family for the possibility of a bad outcome.

"Make sure they don't look at tPA like it's a miracle drug, because it's not," he says.

EVEN A WELL-DOCUMENTED, VALID REASON FOR NOT ADMINISTERING TISSUE PLASMINOGEN ACTIVATOR IS NO GUARANTEE A JURY WON'T RULE AGAINST AN EMERGENCY PHYSICIAN.

Walker typically tells patients that without tPA the odds of a full recovery are just under 30%, and with tPA, that increases to just over 40%.

"The odds of a good recovery increase by about 12%. Of course, along with that comes the risk of bleeding, which can be devastating," Walker adds.

Most patients presented with the option of tPA ask Walker what he would do.

"I tell them I would rather be dead than disabled, so I would take tPA thinking that if it didn't help me, it just might finish me off," he says. "That puts things in stark terms that they can understand."

If the patient doesn't meet eligibility criteria for tPA, "you've got to explain why," Walker says. "Document that you're aware of it, you've thought of it, and that they don't qualify."

Walker says this type of clear communication is the best way to avoid lawsuits involving tPA.

"Thoroughly explain your reasoning in the chart, because any bad outcome can get you sued," he says. "And with a stroke patient, odds of a bad outcome are better than 50% no matter what you do."

One EP chose not to offer tPA because the patient was rapidly improving and appeared to be making a full recovery. However, once hospitalized, the patient got worse and had a bad outcome; the family sued the EP.

"Nowhere on the chart did the EP specifically state, 'I chose not to offer tPA because of the patient's rapid and dramatic improvement,'" Walker explains. Lack of serial neurological exams complicated the EP's defense.

"To understand what was going on, you had to cobble it together from a combination of brief doctor examinations and nursing notes," Walker says. "It made the case much harder to defend."

Damaging Expert Testimony

Even a well-documented, valid reason for not administering tPA is no guarantee a jury won't rule against an EP. Walker says this is especially true "in the face of a living but permanently disabled patient and a plaintiff's expert who will say anything for money."

Walker has seen multiple plaintiff's experts blatantly misrepresent the data on tPA.

"Some make unjustified statements about what the outcome would have been, had tPA been given," he says.

While some studies show no benefit from tPA, others do. The original National Institute of Neurological Disorders and Stroke study showed an improvement in outcome from about 26% of stroke patients making a full or good recovery to about 39%.[2]

"Proponents of tPA, especially expert witnesses for plaintiffs, emphasize tPA's relative improvement over placebo of 33% rather than the much more modest-sounding absolute improvement of just 13%," Walker notes. In addition, he says, plaintiff experts "completely ignore the fact that even with tPA, the odds of a bad outcome — failure to make a good or full recovery — are greater than 50%."

Some neurologists testify that a stroke patient probably would have gone home without a deficit if the EP had just given tPA.

"Unfortunately, in most states, neurologists and other people who aren't EPs can testify as to the standard of care in emergency medicine," Walker says. "They show up in court saying more or less if the EP had only given tPA, this patient would have walked out of the hospital as good as new."

The expert might say, for instance, "Just last week I gave it to a stroke patient who was completely paralyzed on the right side and couldn't speak a word. That patient walked out of the hospital completely fine."

> THE ORIGINAL NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE STUDY SHOWED AN IMPROVEMENT IN OUTCOME FROM ABOUT 26% OF STROKE PATIENTS MAKING A FULL OR GOOD RECOVERY TO ABOUT 39%.

"They tell stories that are isolated bits of truth, but don't really reflect reality," Walker explains. "It's hard to keep that kind of expert testimony out of trial."

The defense's experts can only counter such testimony by "telling the statistical truth," Walker says. "They explain that tPA does provide some net benefit."

Defense experts point out that there are significant risks and many exclusions with tPA; in fact, most people aren't eligible.

"The problem is that now the jury has experts from each side saying completely different things," Walker says. "You never know what they are going to do in that situation." ■

REFERENCES

1. Demaerschalk BM, Kleindorfer DO, Adeoye OM, et al. Scientific rationale for the inclusion and exclusion criteria for intravenous alteplase in acute ischemic stroke: A statement for healthcare professionals from the American Heart Association/ American Stroke Association. *Stroke* 2016;47:581-641.
2. [No authors listed].Tissue plasminogen activator for acute ischemic stroke. The National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group. *N Engl J Med* 1995;333:1581-1588.

SOURCES

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Settlement of Med/Mal Claim Could Cause EP Unexpected Problems

A quick settlement can seem very appealing to any EP defendant facing protracted litigation. EPs should be aware of the repercussions of this, warns **Rodney K. Adams**, LLM, JD, an attorney in the Richmond, VA, office of LeClairRyan.

"Multiple reporting requirements and various repercussions are all a bit more salt in the wound for any emergency medicine physician that settles a case," Adams says.

In Virginia, these include reporting the settlement within 30 days to the Virginia Board of Medicine, up-

dating the physician profile webpage maintained by the Virginia Department of Health Professions, and disclosing the settlement in applications for credentials with hospitals and health insurers.[1]

"Many of these mandatory reporting requirements trigger further events," Adams says. "State medical boards can reprimand or otherwise sanction a physician, though it is fairly uncommon."

The board of medicine undertakes at least a perfunctory investigation of every matter that is settled. "This is becoming the practice in most states," Adams says. In fact, physicians licensed in multiple states are often surprised to be sanctioned by a board for failure to report a settlement or a disciplinary action in another state.

Virginia's board requires physicians to undergo a competency assessment if three medical malpractice claims of $75,000 or more are paid in a 10-year period.

"Some insurers and HMOs routinely remove a physician from their panels, and require them to appeal or re-apply to be reinstated," Adams notes.

Categorize Med/Mal Case

When **Jesse K. Broocker**, JD, an attorney at Atlanta-based Weathington Smith, advises EPs on how to approach settlement, his first step is to appropriately categorize the case.

"Is this a slam-dunk defense? Is this a really bad case? Or is it somewhere in the middle where both sides have a tenable theory?" he asks.

In Broocker's experience, if the plaintiff's case is really strong and there is significant exposure beyond insurance protection, EPs typically prioritize protecting their personal assets. Many cases fall into more of a gray zone, however.

EXECUTIVE SUMMARY

Once an EP defendant settles a malpractice claim, multiple reporting requirements and other repercussions result. These may include:

- an investigation by the state medical board;
- sanctions if the EP fails to report a settlement in another state;
- a competency assessment;
- removal from insurance panels.

EMERGENCY PHYSICIANS TYPICALLY WORRY ABOUT DISCLOSING A SETTLEMENT DURING THE CREDENTIALING PROCESS, BUT THEY MIGHT NOT GET AWAY WITHOUT DISCLOSING THE SUIT, EVEN IF THE PHYSICIAN PREVAILS AT TRIAL.

"We feel like we can defend the case," Broocker says. "But a reasonable settlement provides some surety, because we know the plaintiff has a legitimate case. A jury of 12 random people may like their story better."

The EP faces a difficult decision as to whether to refuse to settle a defensible case, Broocker warns. There's always a chance of losing at trial.

"There are no guarantees in this business," Broocker says. "But no defense attorney worth his or her salt should be pushing settlement for the sake of settlement."

Rather, the EP and defense attorney together should analyze the strengths, weaknesses, and potential exposure of the case.

"EPs are in a better position compared to other specialties to engage in a true cost/risk benefit analysis," Broocker adds, noting other specialties have more to worry about regarding public disclosure. "But for the ED physician, the public disclosure requirement is not really much of a concern, because patients don't choose their ED doc."

No one wants to "acquiesce" on a strongly defensible claim, says Broocker, "so usually we are all on the same page for defending. But I never tell my docs to ignore truly reasonable settlement offers."

Ball in EP's Court When Reporting

EPs typically worry about disclosing a settlement during the credentialing process. In reality, they might not get away without disclosing the suit, even if the EP prevails at trial.

"We are seeing more and more

hospitals requesting disclosure of even being named in a lawsuit," Broocker says.

However, credentialing and licensing committees won't necessarily view a settlement as evidence of negligence.

"They'll look to the whole picture," Broocker explains. "They can understand why an EP who provided good care may still want to settle a particular case if the price is right."

For instance, a case involving a large amount of potential damages may have been in a jurisdiction notable for large jury verdicts.

"Risk folks understand why docs settle cases — especially ED cases, where the outcomes can be catastrophic, and jury verdicts can be huge," Broocker says.

As far as reporting to the state licensing board, EPs can mitigate the negative repercussions of this as well.

"The ball is in our court initially as far as reporting," Broocker notes. "We choose how these folks get introduced to the prior 'incident.'"

If the case is legitimately defensible, says Broocker, defense attorneys "can usually present the case in a pro-defense way." Barring extreme circumstances, such as large numbers of lawsuits or egregious negligence, review committees typically work with the defense to understand the nuances that led to settlement of a claim.

"If we know the case has a legitimate defense, we should not be worried that these reviewers will see settlement as an admission of fault," Broocker says. ■

REFERENCE

1. Adams R. *Virginia Medical Law*. Third Edition. Commonwealth Medico-Legal Press; 2012.

SOURCES

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Does Phone Consult Establish Patient-Physician Relationship?

If a consultant says, "I think it's fine to discharge the patient for follow-up in the morning," and such advice produces a devastating outcome, leading to a lawsuit, does the consultant who provided the advice to the EP face any liability?

"Whether or not a phone consultation results in a physician-patient relationship is a difficult question to answer," says **W. Ann Maggiore**, JD, an attorney at Butt Thornton & Baehr in Albuquerque, NM.

Maggiore has seen several recent malpractice cases in which this issue became a point of contention. One named an EP who called for a surgery consult on a patient who presented with severe abdominal symptoms, consistent with food-borne illness.

"After the patient's information was exchanged, the surgeon felt that the patient was not a surgical candidate at that time," Maggiore explains.

During litigation, there was a dispute about what the surgeon was told over the phone, and whether it was the EP's responsibility to inform the surgeon of a key piece of clinical information, or the surgeon's responsibility to ask for it.

"The surgeon claimed that the ED physician had not provided him with the patient's lactic acid level, and that this was critical in determining whether he needed to see the patient," Maggiore says.

This makes it clear how important it is for an EP to document what information the consultant received, Maggiore underscores, adding that EPs should include the following documentation on phone consults:

• the name and phone number of the physician consulted and the service he or she is with;

• whether the consultant physically saw and examined the patient or just gave advice over the phone;

• a summary of the information provided to the consultant by the EP, and the consultant's response;

EXECUTIVE SUMMARY

EPs cannot safely assume that a consultant who gives advice over the phone will be held liable if a bad outcome results. Relevant documentation includes:

- what specific information the consultant received;
- whether the consultant actually examined the patient;
- whether the consult resulted in a change to the treatment plan.

• whether the EP requested that the consultant come in to see the patient.

If the consult results in a change in the EP's plan or a new medication, it is likely a court will find a physician-patient relationship existed, Maggiore says. This exposes the consulting physician to liability. However, Maggiore occasionally sees ED charts that don't mention a phone consult took place at all.

"If there is a note from the consultant, this may reveal more about what took place," she says. "But it is best for the EP to do their own documentation and not rely on the consultant to write a comprehensive note."

Many Factors Come into Play

There is some case law indicating that the physician-patient relationship requires the understanding and consent of both the physician and the patient, Maggiore says.

Courts generally hold that merely being "on call" does not automatically create a physician-patient relationship, nor does it impose a duty. Likewise, Maggiore says, "simply accepting a consult for future evaluation does not create a physician-patient relationship."[1]

Under those circumstances, a doctor is not agreeing to enter into a contract with the patient, and no physician-patient relationship can be alleged to have existed, Maggiore explains.

"Merely listening to another physician's description of a patient's problem and offering a professional opinion regarding the proper course of treatment is not enough," she says.[2]

Lisa Schmitz Mazur, JD, a partner in the Chicago office of McDermott Will & Emery, says these facts can become important in determining if a patient-physician relationship existed between a consultant and an ED patient:

• whether the consulting physician had access to and/or reviewed the patient's medical file in connection with the consultation;

• whether the consultant received compensation for his or her services;

• the nature of the consultant's recommendations.

"It is risky to assume that any consultation — even a phone consultation between two providers — is 'informal' and will not create a physician-patient relationship," Mazur says.

The standard for what constitutes a physician-patient relationship is "constantly evolving," Mazur notes. "New connected health technologies are changing the manner and modes in which patients and providers communicate with one another."

Maggiore says video consults "raise a whole new level of risk" when EPs consult specialists. She advises including a copy of the videoconference in the electronic medical record, so there is no question about what information was conveyed, and what the consultant's recommendations were.

"It is prudent to properly document correspondence between the EP and the consultant in the patient's medical record — particularly when the correspondence relates to information on which the treating physician's diagnosis and treatment plan is based," Mazur advises. ■

REFERENCES

1. *Ortiz v. Glusman*, 334 S.W.3d 812, 817 (Ct. App. El Paso 2011).
2. *Oja v. Kin*, 229 Mich. App. 184, 190, 581 N.W.2d 739, 743 (1998).

SOURCES

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CME/CE 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.

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- Address valid complaints *before* ED patient calls a lawyer

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CME/CE QUESTIONS

1. **Which of the following statements is true regarding contraindications for tPA?**

   a. The standard of care is that tPA should not be administered if the patient's symptoms improve rapidly, but the neurological exam is still significantly abnormal.
   b. If the patient experienced a complication from tPA, this indicates that the EP breached the standard of care or tPA administration.
   c. Contraindications to tPA continue to evolve, with some original contraindications now classified as "relative" contraindications.
   d. If the EP decides to forgo tPA for a patient with an acute stroke when there are obvious contraindications, there is no need for the EP to document the rationale.

2. **Which of the following statements is true regarding settlement of a medical malpractice claim?**

   a. Settlements less than $75,000 generally do not trigger reporting requirements for state medical boards.
   b. State medical boards rarely undertake investigations of settled malpractice claims unless the allegations are egregious.
   c. Insurers are legally barred from requiring physicians to reapply for reinstatement as a result of a single malpractice settlement.
   d. Barring extreme circumstances, such as large numbers of lawsuits or egregious negligence, review committees typically work with the defense to understand the nuances that led to settlement of a claim.

3. **Which of the following statements is true regarding when a consultant gives advice about an ED patient's care?**

   a. Advice given during a telephone consult clearly constitutes a physician-patient relationship between the consultant and the ED patient.
   b. Court rulings predominantly hold that a patient-physician relationship does not exist unless the consultant examines the patient.
   c. If a consultant's advice results in a change in the EP's plan, or a new medication, it is likely a court will find a physician-patient relationship existed.
   d. Merely listening to the EP's description of a patient's problem and offering a professional opinion on the proper course of treatment constitutes a patient-physician relationship under the law.