ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

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INSIDE

Did a Patient Exhibit Abnormal Test Results Post-discharge?

EP's next steps can determine med/mal outcome

An emergency physician (EP) believed she'd ruled out preterm labor in a patient pregnant with twins who presented with cramping and lower abdominal pain.

"The patient was sent home prior to results from a urinalysis," says **Stephen A. Barnes**, MD, JD, FACLM, a trial attorney at the lawfirm McGehee, Chang, Barnes, Landgraf in Houston.

An hour later, the results revealed a urinary tract infection — a risk factor for preterm labor. No one contacted the patient about this result.

"Within six hours of returning home, the patient gives birth to one twin in her bed. The other twin is born on the hardwood floor while paramedics rush in to cut the cord wrapped around the baby's neck," Barnes says.

The EP was sued for improperly discharging the patient from the ED. The hospital was sued for its deficient policies regarding contacting patients who have been discharged from the ED prior to abnormal laboratory results becoming available, Barnes explains.

If test results come back after an ED patient is discharged, "any positive results demand a timely follow-up process, including notification of the patient, if indicated," says **Mark F. Olivier**, MD, FACEP, FAAFP, an EP at Lafayette, LA-based Schumacher Clinical Partners. Failure to contact a patient has serious legal ramifications for the EP if a bad outcome results, Olivier warns.

That was the case when an EP diagnosed a patient with pyelonephritis. The patient presented with significant fever, right flank pain, and dysuria.

"Since the patient was stable after IV hydration and able to tolerate oral medications, a decision was made to treat the patient with outpatient antibiotics with close follow up," Olivier says.

Staff obtained urine and blood cultures. After receiving a dose of IV antibiotics followed by oral antibiotics, the patient was discharged with instructions to follow up with a provider in two days.

"On the following day, the blood

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culture is positive for growth in two bottles," Olivier notes. "The ED was notified. However, since it was a very busy day, the patient was not called until the following day."

The patient later returned with severe sepsis and had a prolonged ICU stay.

"A lawsuit was filed for delayed treatment," Olivier adds.

At the time of discharge, the ED should confirm a way of contacting patients with pending X-rays, cultures, or ancillary studies, Olivier recommends.

"Hospitals should have a system in place to identify any discrepancies, determine if the discrepancy will alter the patient's treatment plan, and contact the patient if the treatment plan needs adjustment," Olivier says.

The discrepancies — and any follow-up measures — must be documented and properly dated and timed.

"ED providers should play an active team role with the hospital in this process, and resist any temptation for delays," Olivier says.

If the EP fails to take appropriate action based on new information obtained after patient discharge, and the patient suffers an adverse result, "it will be a very uphill battle to convince a jury that the EP acted reasonably," says Los Angeles healthcare litigator **Damian D. Capozzola**, JD.

If EPs are hospital employees, this can bring the hospital into the suit.

"Hospitals should work with qualified counsel on the duties and protocols that apply when receiving material test results post-discharge," Capozzola says, noting patients sometimes feel a false sense of reassurance after discharge. "They get back to their daily lives, and don't heed calls from medical professionals to return for further follow-up."

If something goes wrong, patients still may blame the EP.

"Documenting the efforts to bring the patient back right away is one very important protective step in such situations," Capozzola says.

ID and Address Discrepancies

An EP diagnosed a patient with bronchitis after interpreting a chest X-ray as normal. The following day, the radiologist's report noted a faint small right upper lobe nodule worrisome for early malignancy, and recommended a follow-up CT scan.

"Unfortunately the patient is never notified of the finding. The report was not forwarded to their local physician, since they had none," Olivier explains.

Six months later, the patient returned to the ED with cough, fever, weight loss, and hemoptysis. A repeat chest X-ray showed a large right upper lobe mass with a post-obstructive pneumonia and mediastinal adenopathy.

"A workup of the mass indicated malignancy with metastasis. A lawsuit was filed for delayed diagnosis," Olivier says.

A 2011 retrospective study in the ED showed a discrepancy rate of 2.9% between the radiologist's X-ray interpretation and that of the ED provider.[1] Only 0.56% of the discrepancies resulted in a change in the patient management.

"However, the patient or their attorney may interpret the discrepancy as the cause of a poor outcome," Olivier explains. "If a significant discrepancy is overlooked and it causes harm to the patient, the ED provider and hospital may be liable."

Scott Martin, JD, senior counsel with Husch Blackwell in Kansas City, MO, has seen cases in which previ-

ously unknown ECG abnormalities were identified when a cardiologist reviewed the studies. The cardiologist noted these abnormalities on the report, but these were not forwarded to the patient or the patient's primary care physician.

"When the patients died from cardiac arrest, the families were surprised because they believed that there were no particular cardiac concerns," Martin says, explaining that both the hospital and ED can be sued in this situation. "There is a duty shared by a physician and the hospital or ED group to relay and respond to abnormal test results."

In many situations, the test results will not be available while a particular EP is completing the actual shift during which he or she evaluated the patient.

"But there must be a follow-up system," Martin stresses. "The claim will likely be that the hospital or ED group either had inadequate policies or failed to follow the policies."

Martin says EDs should implement clear policies and procedures to make sure the patient and the patient's primary care physician receive relevant test results.

"It will often be the case that the ED physician has ended her shift," Martin says. "But the department is still responsible to share the information."

If the patient is not notified of abnormal results, or there is a delay in notification, and the patient develops a complication or untoward event, a malpractice lawsuit could be initiated against the hospital, the EP, and the admitting physician.

"Unfortunately, everyone will probably be brought into the lawsuit," Olivier says. "The target may be the physician who ordered the test."

A pending malpractice lawsuit involves this scenario. The EP was notified of an incidental finding on a CT scan that required eventual follow-up.

"The admitting team was not notified, and the issue was never addressed, resulting in a delayed cancer diagnosis," says **Megan Kures**, JD, senior attorney in the Boston office of Hamel Marcin Dunn Reardon & Shea.

Olivier says that although the admitting team should review all diagnostic test results once the patient is admitted, the ED provider can minimize any breakdowns in communication and improve patient safety in these ways:

- If the finding is known in the ED, include this in the clinical impression so it's flagged for the admitting team.
- Alert the admitting team of the finding at the time of the handoff when the patient is admitted.
- Install a process to communicate the discrepancy to the admitting team if it's returned to the ED after admission.

"The key here is making sure the admitting team is aware of the finding, since they will be creating the discharge plan," Olivier underscores. ■

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What If a Patient Can't Afford Care?

Well-charted plan puts EP on firm legal ground

Does an ED patient say he or she can't afford recommended follow-up care? If so, emergency physicians (EPs) can protect themselves legally with good documentation, says **Aaron Hamming**, JD, risk resource advisor at Okemos, MI-based ProAssurance Companies.

"We have had good results defending claims when we clearly can show the physician made the appropriate medical recommendation, but the patient did not comply," Hamming says.

Hamming recommends EPs document recommendations consistent with their best medical opinions. If there is a deviation from the plan, then EPs should document why they are not using the preferred option. Cost, scheduling, or general unwill-

ingness could each play a role.

"It resonates with juries when we show physicians documenting thorough education of patients and appropriate treatment recommendations — and if the recommendations are not being followed, why," Hamming says.

Michael B. Weinstock, MD, is chair of the ED at Mount Carmel St. Ann's Hospital in Westerville, OH, and co-author of *Bouncebacks! Medical and Legal*. If the EP documents that the patient agreed to follow up, the EP gave the patient someone with whom to follow up, and then the patient does not follow up, Weinstock says it is unlikely the patient could prevail in litigation. Weinstock sees greater risk if a patient perceives the EP as disregarding his or her financial worries.

"If it seems like the EP didn't care, that is a problem," he warns.

A recent malpractice case that went to trial involved this scenario. Though the case didn't involve ED care, it has some important medical/legal implications for EPs, Hamming notes. An oncologist ordered a course of treatment that was considered less effective and significantly riskier, but was cheaper.

"The patient passed away, and a lawsuit was filed challenging the treatment decision," Hamming says.

The medical record indicated the physician extensively educated the patient on the risks and benefits of various options — and also that the patient chose the less standard treatment because it involved less out-of-pocket expenses.

"It clearly was documented why the patient would choose a procedure that may not be the gold standard, and that reason resonated with the jury," Hamming says, explaining that the factors below helped the defense:

• Excellent documentation of patient education regarding the various treatment options.

Several jurors interviewed after the case expressed appreciation that the physician documented extensively, especially the informed consent portion.

"Effective informed consent evidence is some of the most effective evidence we can show in a case like this," Hamming notes.

• A lengthy documented history of patient non-compliance.

This shifted the focus from the physician's actions to the patient's actions.

"The patient was seen by multiple providers throughout the hospital system, and there was evidence of non-compliance with provider recommendations," Hamming says.

This included failing to show up to several follow-up appointments, exceeding prescribed dosages of opioid medications, and discontinuing visits with certain specialists or providers because the patient thought they weren't doing any good.

"The patient also failed to get some medications filled, probably because of the co-pay, but we don't know for certain," Hamming adds.

• Specific reference to the patient wanting to use the less costly option.

"Ultimately, one of the most important pieces of evidence in the mind of the jury was some free text in the [electronic health record] informed consent document," Hamming says, noting this included the standard language of reviewing in detail the risks and side effects of the two main options. "But it continued that the patient asked several questions about the costs of the treatments."

The doctor noted the patient "apparently is making most of his decision based on price in terms of the cost of either treatment," Hamming adds.

Address Concerns Over Costs

It is difficult for EPs to address patients' financial concerns directly.

"It is rare that we know what the price to the patient will be," Hamming says.

In some cases, the purpose of recommended follow-up is to connect the patient with outpatient care.

"A small minority of patients really have to see someone within a day or two," Weinstock says.

If the EP believes the patient truly needs follow-up within 24 to 48 hours — such as a patient with possibly evolving appendicitis — and the patient lacks the ability to pay for this care, Weinstock says, "your failsafe can always be to have that patient come back to the ED."

Another approach is for the EP to contact the patient's primary care physician or specialist and say, "I have a patient I'm really concerned about, with a decreased ability to pay. Would you agree to see them tomorrow?"

"I do that fairly frequently," Weinstock says, explaining that the EP can then tell the patient that he or she spoke with the doctor and the doctor agreed to see the patient.

Situations in which EPs take costs into account are "frequent and varied," says **Dan Groszkruger**, JD, MPH, principal of Solana Beach, CA-based rskmgmt.inc. EPs may provide non-emergency, stop-gap care in the ED if a patient says they can't afford to follow up with a specialist.

"But stop-gap care is just that," Groszkruger warns. "When the patient really needs long-term care to stabilize or recover, but no such care is available, merely providing stop-gap

care is insufficient."

Groszkruger says knowing that an uninsured or poor person is unlikely to obtain specialty follow-up care due to financial factors does not create a legal duty for the EP to provide or pay for follow-up care.

"But the lack of legal duties cannot ensure that an ED physician will not be sued if a patient dies or suffers serious harm as a result of no follow-up care," Groszkruger notes. "We recognize that 'big damages' drive malpractice litigation, not poor care."

If the patient clearly was non-compliant, contributory negligence will be pleaded as an affirmative defense in the defendant's answer, Groszkruger says. However, where the explanation is financial, the patient is less likely to be seen as negligent.

"Thus, any contributory negligence generally will be irrelevant," Groszkruger says.

Knowing that many patients will have difficulty accessing specialty follow-up care, some EDs routinely contact patients the following day to reiterate the need for follow-up care, Groszkruger adds.

"Documenting this type of communication may be the only feasible way to mitigate the risk that a patient's failure to secure follow-up care may result in death or permanent harm — followed by a lawsuit," Groszkruger says. ■

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EDs Still Tagged with EMTALA Violations

Experts say consistency prevents problems

The Emergency Medical Treatment and Labor Act (EMTALA) became law four decades ago — but a surprising number of hospitals still face investigations and, in some cases, costly fines.

From 2002 to 2015, the Centers for Medicare & Medicaid Services (CMS) conducted 6,035 investigations of EMTALA complaints against hospitals and physicians — an average of 431 a year, according to a recent study.[1]

Robert A. Bitterman, MD, JD, FACEP, says most EMTALA violations occur because hospitals simply aren't acting in ways that are in the best interest of their patients.

"They are usually doing something outside of their normal processes," he explains. "That's the same reason hospitals have always gotten in trouble — they're doing things outside the norm."

Bitterman, an emergency physician (EP) and attorney who advises hospitals facing EMTALA investigations, has seen these scenarios trigger complaints to CMS:

- A nurse running out to the ambulance bay to tell EMS the hospital doesn't take trauma cases;
- An individual found in the hospital parking lot who is known to be a difficult patient isn't brought in to be checked as the hospital would other patients;
- An on-call physician who refuses to come in;
- Hospitals that don't accept a transfer patient because the transferring hospital is outside state lines, or because the hospital frequently sends uninsured patients on a Friday night;
- ED providers who don't examine a patient brought from a prison thoroughly enough before transferring the patient back to prison.

Bitterman says the key to avoiding trouble with EMTALA is "taking care of everybody the same way, with no shortcuts." If all chronic pain patients are treated the same — as opposed to one receiving a cursory medical screening exam and another receiving a complete neurological exam — problems are less likely to occur. To trigger an EMTALA investigation, someone has to complain, Bitterman says.

"CMS or the state survey agency don't come in and do investigations on an ad hoc basis," he notes.

Mary C. Malone, JD, a partner in the Richmond, VA-based healthcare law firm of Hancock, Daniel, Johnson & Nagle, says the best thing EDs can do is work on patient satisfaction.

"Satisfied patients rarely complain," she says. "But there is no satisfying some people, and also no way to keep them from complaining to CMS."

However, plaintiff attorneys trigger some investigations.

"There is a whole host of reasons why plaintiff attorneys want to use EMTALA instead of an ordinary negligence claim," Bitterman says.

An EMTALA claim may allow

the attorney to sidestep state expert witness requirements. It also may enable the attorney to get into federal court to avoid certain state peer review protections that don't apply in federal court proceedings. Under EMTALA, only hospitals, not physicians, can be sued.

"So everything the physician does with respect to EMTALA — the hospital is directly liable for that," Bitterman explains. "The plaintiff attorney can blame the hospital for the doctor's actions, rather than sue the EP personally."

Malone says plaintiff attorneys often allege EMTALA violations to get information through discovery by obtaining the CMS 2567 via a Freedom of Information Act request.

EMTALA violations don't necessarily constitute malpractice, Malone emphasizes. The fact an EP misdiagnosed a patient doesn't necessarily mean the EP did not perform an appropriate medical screening exam — and vice versa.

"However, the same set of facts might be ripe for both a malpractice claim and a civil EMTALA suit," Malone says, noting many recent violations involve the failure to provide an appropriate medical screening exam as well as inappropriate transfers.

"One of the issues is related to the chaotic nature of a busy ED and the consequent failure to 'cross Ts and dot Is' with respect to following policies and doing a complete job of documenting what happened during the patient encounter," she says.

Malone sees a marked increase in the number of EMTALA violations involving behavioral health patients. Bitterman notes, "EMTALA considers psychiatric patients as a protected class, so they do heightened scrutiny on those cases."

Many aspects of EMTALA requirements relating to psychiatric patients remain unclear. Controversy exists about how to screen, who can screen, where EDs can screen, when the patient is considered stable under EMTALA, and when patients can be transferred from a private hospital to a public hospital.

"All these psychiatric issues are up in the air, and there is an enormous amount of disagreement," Bitterman adds. "It's caused hospitals a great deal of grief in dealing with psychiatric patients."

For instance, CMS says in the regulatory language that hospitals should consider severe pain, psychiatric disturbances, or symptoms of substance abuse to be emergency medical conditions. This conflicts with what the EMTALA statute says.

"What CMS forgets is that the rest of the statutory language requires that those symptoms must be such that in the absence of immediate medical attention, serious bad things will happen," Bitterman says.[2]

Therefore, he says, substance abuse, severe pain, or psychiatric disturbances do not necessarily constitute emergency medical conditions.

"What they are is symptoms," Bitterman explains. "Just like any other symptoms, they need to be medically screened to determine if they are, or are manifestations of, an emergency medical condition."

This misinterpretation, he adds, "drives hospitals and physicians crazy, and disseminates wholly inappropriate interpretations of the law. It is unquestionably legally incorrect. But instead of challenging it, hospitals are running scared."

Many hospitals revised their policies to include this language, which could complicate the defense of a subsequent malpractice lawsuit.

"If your EMTALA policies create higher expectations than what is required by the law, the hospital will be held to those higher expectations created by hospital policy," Malone warns.

This opens the door for a plaintiff attorney to argue that, according to the hospital's own policy, any patient with severe pain, psychiatric disturbance, or substance abuse has an emergency medical condition and the hospital has a duty to stabilize it.

"Once you put this stuff into your policies, that's the standard to which you will be held," Bitterman stresses, adding that hospitals should be very careful about writing their policies so they don't box themselves in. "Hospitals get themselves into trouble by writing policies and not complying with them, particularly with screening exams. Hospitals should put together reasonable policies and procedures, and do it the same way every time."

Here are pitfalls Malone often sees that trigger EMTALA investigations:

• Directing a patient already on hospital property to another ED (i.e., when the hospital is on diversionary status) without any medical screening exam.

"Once that patient is on hospital property and in need of emergency medical care, EMTALA is triggered regardless of diversion," Malone says.

• Inappropriate delegation of the medical screening examination requirement to persons who are not physicians or otherwise designated as Qualified Medical Personnel.

"This seems to happen pretty frequently with behavioral health patients," Malone says. These patients often are screened for psychiatric issues (and treatment decisions) by community health resources who are not Qualified Medical Personnel and are not even employed by the hospital.

• Failure of on-call specialists to

assist in screening or the provision of stabilizing treatment when requested by the EP.

"Those call failures generally require that the patient be transferred to another facility, and for the sending hospital to indicate on the transfer form that the patient was transferred based on the failure of the call physician to respond," Malone says. The receiving hospital then is required by law to report the sending hospital to CMS for an inappropriate transfer, thereby triggering an investigation.

• Failure to provide stabilizing services.

"Oftentimes, neither the ED physician nor on-call specialists realize that the on-call physicians are on call for the full scope of their medical staff privileges," Malone explains.

She gives the example of a patient who needs an endoscopy to be stabilized, when there is no gastrointestinal coverage. In this scenario, if the general surgeon on call has endoscopy privileges, the failure to call on the general surgeon can result in a violation for the hospital's failure to provide necessary stabilizing services that are within its capabilities.

• Inappropriate refusal of transfers.

If a hospital has the capability and capacity to accept a requested transfer of an unstable patient, it must do so. Malone has seen violations tied to refusal of the on-call specialist to be available to treat the transfer patient, and for the hospital's failure to accept for unacceptable reasons.

"This 'reverse dumping' seems to occur most frequently in connection with transfer requests for behavioral health patients," Malone says. ■

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Is Everyone Misinterpreting EMTALA?

Courts typically do not allow the Centers for Medicare & Medicaid Services (CMS)' interpretation of EMTALA violations as evidence in medical malpractice litigation.

"It may be discoverable, but it is typically not admissible under the federal rules of evidence," says **Robert A. Bitterman**, MD, JD, FACEP, an emergency physician (EP) and attorney who advises hospitals facing EMTALA investigations. He adds that most EMTALA violations occur because hospitals simply aren't acting in ways that are in the best interest of their patients.

A non-attorney in a regional CMS office deciding that the hospital violated the civil statute is unreliable, legally speaking, Bitterman says, because there was no due process involved in that determination.

"It is not allowed, and that is as it should be," he says. "Also, a significant portion of the time, CMS is just dead wrong."

Bitterman says the following are examples of misinterpretations of EMTALA:

• EDs are no longer allowed to ask for money, even if this does not delay the stabilization process in any way.

In December 2013, CMS issued a memo involving EMTALA and the Affordable Care Act (ACA).

"[CMS] changed what they deemed to be appropriate behavior in the screening process as it relates to asking for money," Bitterman explains.

Previously, EDs could go through normal registration processes, such as asking patients for co-pays.

"It was OK to ask for money, as long as hospitals did so in a non-economically coercive way," Bitterman says, noting that it was never acceptable for EDs to tell patients to pay to be seen, for instance. "But because CMS 'reinterpreted' EMTALA in light of the ACA, it's now an abuse of patients' rights if you actually ask them to pay for services."

This means EDs can't ask for any money at all until the screening exam is complete and the patient is stable (or the patient is admitted).

"And that's not what the statute says at all," Bitterman notes. "It says you can't delay access to the screening and stabilization on account of the patient's insurance status."

The change stems from the increase in high-deductible plans offered on healthcare exchanges.

"There are a lot more financial questions happening," Bitterman adds. "CMS didn't want money in any way to be in the middle between patients and providers."

• CMS has taken the position that any medical misadventure, such as an EP misdiagnosing a patient, is a violation of the screening

component of EMTALA.

"This turns an ordinary negligence issue into a regulatory violation of federal law," Bitterman says.

Courts take a different position — that issues of medical negligence belong in state courts under state malpractice law.

"Federal and state courts, which interpret federal law, say it's got to be something outside your normal screening procedures — 'disparate screening' — other than questioning the judgment of the examining physician in the hospital," Bitterman says.

CMS says the court's interpretation of the law does not apply to it because CMS may interpret the law differently from a regulatory perspective.

"This puts physicians in a bind," Bitterman notes. "Ordinary malpractice has been turned into a regulatory nightmare because of the way CMS interprets and enforces the statute."

• The 10 regional offices of CMS are allowed to interpret EMTALA in different ways.

"CMS will not step in and tell each office how to interpret the law. So you can have different enforcement in different areas of the country," Bitterman explains.

EMTALA requirements end when the patient is stabilized, according to the statute. However, some CMS regional offices believe that EMTALA governs any transfer, regardless of whether the patient is stable or unstable.

"They also believe that if the patient is stable, the hospital doesn't have to accept the transfer," Bitterman adds. Others say that the hospitals have to accept even a stable patient, if the patient has an emergency medical condition that the accepting hospital can treat.

"Hospitals have no redress to go to CMS if they believe one of the regional offices is misinterpreting the law," Bitterman says. "In other words, there is no due process."

The only thing the hospital can do is comply with the CMS regional office's interpretation of the law.

"If the hospital wants to challenge that interpretation, in the meantime, they'd be terminated from Medicare," Bitterman warns. "So rather than say, 'You're wrong — back off,' hospitals have to go through the process of coming under compliance."

• CMS induces hindsight bias by giving peer reviewers after-the-fact information.

To determine if an EP acted appropriately, peer reviewers should receive only the information that the EP had at the time, Bitterman argues. If the EP's judgment about a child with a fever is questionable, for instance, the reviewer should explore the medical records from the ED visit — but not the records of the patient's subsequent visit to another ED, including the fact that the patient experienced an adverse outcome.

"This is something that is very well-established in statistical analysis and any kind of peer review mechanism," Bitterman notes.

CMS, however, gives the peer review physician information about the patient's subsequent treatment and outcome.

"That induces hindsight bias on behalf of CMS, so the process is rigged," Bitterman concludes. "All hospitals are asking for here, is, 'If you are going to question our judgement, do so in the correct manner.'" ■

Unique ED Program Educates Clinicians on Med/Mal Risks

Malpractice attorneys who need a physician to review a case often come to **Bruce Janiak**, MD, for his help. But Janiak usually declines.

"In the past five years, I've only found one surgeon who is interested in reviewing cases," says Janiak, a professor in the department of emergency medicine at the Medical College of Georgia.

Since most faculty members lack interest in medical/legal topics, they're not covering the information with residents.

"Residents have an intense interest in the medical/legal pitfalls that emergency physicians can get into," Janiak says. "They want to know how to manage their risk."

Janiak and several colleagues regularly discuss ED malpractice cases. In the course of these conversations, Janiak came up with the idea of setting up a center with two objectives: education and research.

"Most EDs don't do much to educate other departments," Janiak says. "But when you think about it, so many lawsuits that happen in other departments involve the ED. That's where things begin."

The group wanted to create the Center for Medical Legal Education and Research. The dean pointed out that a "center" required a level of bureaucracy that one would not see in an "office," since an office can be created within the department of emergency medicine. So Janiak's group received approval to establish the Office of Medical Legal Education and Research.

"The dean says if it grows and becomes a big deal, he will support the name change from 'office' to 'center,'" Janiak notes.

The group began by inviting interested faculty members to develop curriculum for residents and/or provide lectures to other hospital departments on their unique medical/legal risks and how these relate to emergency medicine.

"We will not be limiting our educational process to our department. We will be contacting every department within our medical school," Janiak explains.

One likely topic is the system for reviewing discrepancies in radiology studies performed in the ED. Physicians in other specialties often have no understanding of EMTALA requirements and associated legal risks, Janiak adds. Other planned topics include:

- introduction to the legal process;
- pitfalls in charting;
- importance of medical decision-making documentation;
- triage notes;
- actual case reviews;
- high-risk patients;
- irrational malpractice fears.

"We expect to get an enthusiastic response," Janiak says. "We have fairly significant institutional support."

One of the hospital's risk managers joined the group, emphasizing that he was there to give advice as needed and to serve as a link to the administration.

"It is not an attorney-run project, but rather a physician-run project," Janiak notes. "He will report what we're doing to the president and some of the higher-up physicians in charge of education."

Janiak would like to expand the project outside the institution by providing rural hospitals with education via telemedicine.

The group, which consists of seven EPs, plans to present at grand rounds, focusing on the medical/legal aspects of cases instead of the clinical aspects.

"Getting that scheduled won't be easy, because every resident's schedule is packed with lectures that relate to the core competency of the specialty," Janiak notes.

However, interest and need are both high. Medical students receive "pretty much zero" education on medical/legal issues in medical school, Janiak says. How much information residents receive in the clinical setting usually depends on whether faculty members have expertise in the topic.

"Frequently, a staff attorney speaks to them, but that's it. They don't get the nuances of things that get people in real trouble," Janiak says.

The idea, Janiak adds, is to "deal with risk that's already occurred and prevent further harm."

Janiak points to the example of a chart that notes an abnormal vital sign, but says nothing about what the EP did to address it.

"It requires not an attorney but a clinician to explain to a provider what the clinical and quality pitfalls are for the patient — and what the legal pitfalls are for the physician," he says.

If the education comes from an attorney, "it's not very well-absorbed, because it's coming from someone who doesn't speak medical language as well as we do," Janiak adds.

The education will identify clinical behaviors that can improve care and avoid lawsuits.

"But much more importantly than that, we can learn from other people's unfortunate mishaps and hopefully avoid repeating that same problem," Janiak underscores.

The group is unaware of any institution undertaking something similar but would be open to a joint venture with another hospital.

"I don't see any downside to this," Janiak says. "This is a major gap, at least in our institution ... The first phase is to get the database going. We will then open it up to those with an interest."

Janiak has already started creating a database with some malpractice cases he personally reviewed.

"The database is still a work in progress. We have some technical issues to resolve — not only how we create it but also how we access and store it," he says.

The goal is to create the ability to search using keywords such as "meningitis" and "multiple visits" so users can track ED malpractice cases in a variety of ways.

The group now has about 2,000 cases to include in the database. Faculty members reviewed all cases in the past 30 years.

"None of the cases came from our own department," Janiak notes. "Looking at every one of those will be a lot of work."

Users will be able to access not just a summary of the cases, but also the ED records with identifying information redacted.

Other databases might indicate the number of malpractice lawsuits against EPs alleging missed heart attack, but that doesn't say whether the diagnosis was truly missed, or if it was, how that happened.

"Existing databases are based on allegations and not clinical behaviors," Janiak says. "We want to understand the nuances of the problem with the interaction with the patient." ■

SOURCE

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How Defense Lawyers Bring Up ED Patient's Own Negligence

Did a patient wait too long to come to the ED, fail to follow discharge instructions, or hide important information about his or her medical history? If the patient later sues for malpractice, his or her own actions can be part of the emergency physician (EP's) defense.

In some instances, the actions or omissions of the patients themselves rise to the level of "contributory negligence" or "comparative negligence."

"When that occurs, it creates some opportunities for physicians facing medical negligence actions," says **Bobbie S. Sprader**, JD, an attorney at Bricker & Eckler in Columbus, OH.

Asserting contributory or comparative negligence can be an effective strategy for an EP to reduce or eliminate his or her responsibility for any harm the patient alleges to have sustained.

"Because the plaintiff may be seen as a victim by the jury, this needs to be done thoughtfully, but it can be done effectively," Sprader notes.

These legal doctrines refer to situations in which the patient's own actions or inactions are found to be negligent and to have contributed to whatever harm they allege to have experienced.

"How this is applied will vary by state, but it can reduce or completely eliminate any recovery by a patient, even if he or she is able to prove that the physician was also negligent," Sprader explains.

In Ohio, for example, Revised Code Section 2307.22 provides that if a jury finds more than one person negligent, each person is only responsible for his or her proportionate share of the non-economic damages. If any one defendant is found to be more than 50% responsible, he or she will be 100% responsible for any economic loss. However, if no one defendant is found to be more than 50% responsible, then each negligent person will only be responsible for his or her proportionate share of economic losses as well.

"This includes such things as past and future medical expenses and lost wages," Sprader notes.

The total amount of responsibility allocated by a jury must equal 100%, but the jury can allocate responsibility to the plaintiff and to nonparties.

"Any percentage of responsibility allocated to either the plaintiff or a nonparty is a percentage that will not be the responsibility of any of the defendants," Sprader says.

Here is an example of how this works: A plaintiff brings a lawsuit against an EP and a physician assistant (PA) and receives a judgment of $1 million. The jury completed an interrogatory allocating 25% responsibility to the plaintiff, 25% to the physician, 25% to the PA, and 25% to the general surgeon whom the EP consulted but did not name.

"In Ohio, the physician and PA would each only be responsible for paying the plaintiff $250,000 — 25% of $1 million," Sprader says, noting the plaintiff would have to bring a separate action against the general surgeon who was not named to receive any recovery. "The plaintiff will not be able to recover the amount that was attributed to his or her own negligence — from anyone."

Defendants need to be thoughtful with respect to how they "blame" an injured plaintiff for his or her injuries, Sprader cautions. Important considerations are the nature and extent of injuries involved and the expected degree of sympathy the jury may have for the plaintiff.

"It may be best to provide the jury with the information they need to identify the plaintiff's negligence on their own, and then ask them to consider that factor in their deliberations," Sprader suggests.

In other cases, it may be appropriate to overtly blame the plaintiff for what happened and ask the jury to attribute 100% responsibility to the plaintiff.

"This will always be a judgment call by the defendant and her counsel," Sprader says. Here are two common examples of an ED patient's contributory or comparative negligence:

• The patient did not follow ED discharge instructions.

"Once the patient leaves the ED, the physician has absolutely no ability to monitor the patient's condition," Sprader says. If the patient receives instructions to "return to the ED if symptoms progress or do not improve in the next four to six hours" and does not return for three days only to report progression over that entire time frame, there is a good basis for a contributory negligence claim.

"To take full advantage of this situation, it would be best if the discharge instructions were signed by the patient after they were reviewed with her by someone — physician or nurse — who also signed them and then gave a copy to the patient to take home," Sprader recommends.

• The patient omits important

information about his or her medical history, such as a drug allergy or known diagnosis.

"However, the argument made in this type of situation is the information was available to the EP, either in the system from a prior visit or from another provider," Sprader explains.

Unfortunately, there is often no time in the ED setting to hunt down information from all available sources.

"Therefore, documenting what the patient reported and whether the patient appeared to be a good historian are a couple of ways to protect the physician from responsibility for an inaccurate history," Sprader adds.

Ryan M. Shuirman, JD, an attorney at Raleigh, NC-based Yates, McLamb & Weyher, says "contributory negligence" is a somewhat antiquated concept that only a handful of U.S. jurisdictions still follow. North Carolina is one of those.

"True contributory negligence bars a plaintiff's recovery completely if the plaintiff was in any way, regardless of how insignificant, responsible for her adverse outcome through her own negligence," Shuirman explains. In contrast, comparative negligence, followed in the majority of jurisdictions, generally asks a jury to apportion damages depending on the level of defendant fault.

"Contributory negligence, because it acts as a complete bar to recovery, is a real threat to a plaintiff in any lawsuit in which the plaintiff's own conduct is questionable," Shuirman says. It can dissuade a plaintiff's lawyer from even taking a case, and usually can be used as a means of mitigating damages during settlement negotiations.

A common scenario is the inebriated patient who fails to provide the EP with an adequate history, which would have made a difference in the decision-making process. Another common scenario is an ED patient who leaves against medical advice (AMA) and experiences a bad outcome.

"While that patient likely will complain about the treatment provided, which compelled her to leave AMA, if a jury finds that her decision to leave was unreasonable, she would be contributorily negligent, and she would be barred from recovering any damages in our state," Shuirman says.

Shuirman notes one should distinguish this from attempts to blame a patient for bad choices that led to comorbidities. "Attempts to blame an obese smoker for a myocardial infarction occurring after a questionable discharge from the ED likely will not be successful," Shuirman warns.

Just as a plaintiff has the burden of proving the EP is negligent, the defendant EP has the burden of proving that the ED patient was negligent.

"This typically means that the defendant must prove not only that the plaintiff patient acted unreasonably, but also that the plaintiff patient's unreasonable conduct was a proximate cause of her damages," Shuirman notes.

Shuirman says a decision about whether to assert contributory negligence must be made at the time of responding to the initial complaint. However, "the assertion typically can be alleged in a somewhat benign fashion, allowing for the prospect that discovery may or may not support the assertion," he says.

There is no doubt asserting contributory negligence can inflame a plaintiff. "It can prove to be an obstacle to resolving a case that needs to be resolved for other reasons," Shuirman notes. EPs should consider asserting a contributory negligence defense if they truly believe the plaintiff has been unreasonable, he says. "But later withdrawing it does not necessarily protect you from a jury hearing that your initial reaction to being sued was to blame the plaintiff rather than objectively assessing your own conduct," Shuirman cautions.

Shuirman says if EPs encounter a patient who appears to be acting unreasonably, the best defense comes from thorough documentation of the patient's behavior and how the patient's behavior limits the EP's ability to deliver care effectively.

"Document whenever the patient provides you history that you question or otherwise is in a state where she cannot be trusted to be providing accurate information so that it is clear how that misinformation impacted your decision-making," Shuirman says.

Even if the EP's state does not recognize true contributory negligence, jurors use common sense to analyze whether a plaintiff patient has been reasonable.

"You have to have faith that jurors will see through an unreasonable plaintiff's story and want to believe that you, as a provider, were put in an untenable position by the plaintiff being unreasonable," Shuirman says. ■

SOURCES

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ED LEGAL LETTER™

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **Which is true regarding legal risks if ED patients cannot afford recommended follow-up care?**

   a. Knowing that an uninsured individual is unlikely to obtain follow-up care due to financial factors is a failure to adhere to the emergency medical standard of care.
   b. If, due to cost, the patient chooses to receive a less effective treatment than the emergency physician's (EP) best recommendations, this constitutes a breach in the emergency medical standard of care.
   c. The existence of documentation detailing that the EP educated the patient on the risks and benefits of various treatment options makes a claim of substandard treatment easier to defend.
   d. Evidence of a patient's history of non-compliance relieves the EP of legal responsibility for the patient's current failure to adhere to the EP's current recommendation.

2. **Which is true regarding abnormal test results that come back after an ED patient is discharged?**

   a. If results come back after the ordering EP is off duty, the ordering EP does not have a responsibility to inform the patient because the new EP now has sole responsibility.
   b. At the time of discharge, the ED should confirm a way of contacting any patient with pending X-rays, cultures, or ancillary studies.
   c. The majority of discrepancies between ED and radiologist interpretations result in some type of change in the patient's treatment plan.
   d. The provider who conducted the final reading is legally responsible for following up with the patient, not the provider who first ordered the test.

3. **Which is true regarding the Emergency Medical Treatment and Labor Act (EMTALA)?**

   a. CMS and state survey agencies conduct random investigations on an ad hoc basis to ensure that investigations aren't always complaint-driven.
   b. Hospitals cannot be held to higher standards than what is required by law, regardless of what their EMTALA policies state.
   c. The fact that an EP misdiagnosed a patient indicates that under EMTALA, there must have been an insufficient medical screening examination.
   d. If a hospital has the capability and capacity to accept a requested transfer of an unstable patient, it must do so.