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What if Plaintiff Can't Prove EP Was Negligent?

Liability exposure still exists with 'loss of chance' claims

If a plaintiff can't prove that the EP's negligence directly caused a patient's bad outcome, it would seem at first glance that the chance of a successful malpractice suit is zero. However, in a "loss of chance" claim, the plaintiff only has to prove that the EP's actions cost the plaintiff exactly that — the chance of a better outcome.

"State laws on this vary, but the general consensus is that the loss of a chance of a better outcome is, in itself, considered an injury," explains **Denny Maher**, JD, MD, general counsel and director of legal affairs for the Seattle-based Washington State Medical Association.

Maher gives this example: An elderly patient with abdominal pain is discharged with a diagnosis of gastrointestinal illness, but several days later dies of a bowel obstruction and subsequent infarction. The patient might have presented with the bowel obstruction or an impending infarction at the first ED visit — and might have died from it even if it was diagnosed immediately.

"But the two-day delay in diagnosis might have resulted in a loss of chance of a better outcome, be it not dying or dying at a later point," Maher explains.

Keith C. Volpi, JD, an attorney at Polsinelli in Kansas City, MO, says loss of chance claims are "virtually never a plaintiff's choice of a cause of action, but rather, a fallback when all else fails."

History of Loss of Chance

Pursuing a loss of chance claim is appropriate when a plaintiff cannot meet the burden of demonstrating a causal connection between the negligence and the injury, Volpi says. Missouri first recognized this cause of action in 1992.[1]

"In the seminal case, the family of a patient who later died sued a radiologist for failing to identify gastric cancer on imaging," Volpi says.

Because the patient already had cancer and likely was going to die, the family could not bring a wrongful death

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action. It was impossible to prove that if not for the negligence, the patient probably would have survived.

"But they could prove that the patient had a chance, albeit small, of survival — and that the negligence further decreased or erased that chance," Volpi adds.

In Washington state, recognizing "loss of chance" claims started with a 1983 case. A patient who presented with upper respiratory symptoms was found later to have had lung cancer and died.[2]

"Rather than bringing a medical malpractice case, the attorney brought a wrongful death case," Maher explains.

The Washington Supreme Court accepted the plaintiff's argument that the delayed diagnosis might have cost the patient a loss of chance at living longer.

A 2011 case that established "loss of chance of a better outcome" claims in Washington involved an ED patient who presented with head trauma after an auto accident.[3] The patient's X-rays were negative and the facility discharged the patient with pain medication. She later returned with a stroke caused by an injured carotid artery, which went undetected at the first ED visit, resulting in a permanent neurological deficit.

"The plaintiff didn't say the EP's actions caused her problems completely. She had a bad injury and might have ended up with the same neurological deficit anyway," Maher says, noting the plaintiff successfully argued that the EP's actions contributed to loss of chance of a better outcome.

"The argument was that if she had been hospitalized rather than discharged, the stroke would have been identified sooner," Maher explains. The patient could have received medication and undergone surgery that might have reduced the extent of the stroke.

State law varies on whether loss of chance is recognized, and whether loss of chance is viewed as an injury or an element of causation. **Jennifer D. Koh**, JD, an attorney at Seattle-based Favros, says, "For example, in Washington, loss of chance is treated like any other tort that must be proved on a more likely than not basis."

The loss of a chance is viewed as the injury, as opposed to viewing the death or bad outcome as the injury.

"In contrast, Texas courts view loss of chance as a component of causation and do not recognize a loss of chance claim where the adverse result probably would have occurred anyway," Koh says.

Some states, including Kansas, Oklahoma, and Pennsylvania, have relaxed the plaintiff's burden on causation to allow loss of chance claims.

"States also differ in the way the loss is quantified, as well as how to properly instruct a jury on a loss of chance claim," Koh adds.

Claims Likely to Increase

As with any medical malpractice case, loss of chance has to be established by expert medical testimony produced by the plaintiff. However, there's not always hard science supporting opinions on what percentage should be used to determine the degree of culpability.

If a patient died eight months after a delayed diagnosis of cancer, and the survival rate for similar patients is one year, the expert could use that data to support testimony that there was a 25% loss of chance of a better outcome of one-year survival.

"In other situations, there's really no way to know the percentage, and

it could open up speculation," Maher says.

The jury first decides how much they would award the plaintiff if the EP were completely responsible for the injury itself. For instance, if it's $100,000, and the expert says the EP's actions caused a 40% loss of chance, the plaintiff is awarded $40,000.

"If the jury is sympathetic and wants to give the plaintiff something, loss of chance gives them an avenue to do so — if it is properly argued by the attorney," Maher notes.

Koh notes that if plaintiff's experts testify that a physician's negligence caused the patient to lose a chance of survival or a better outcome, many states will allow the plaintiff to ask the jury for compensation for the ultimate injury and/or compensation for the loss of chance.

"Because plaintiff attorneys appear to see the benefit of giving the jury an option to make a partial award, the number of loss of chance claims we see in the future can be expected to increase," Koh predicts.

Timeline Becomes Critical

Volpi has defended several "loss of chance of survival" lawsuits over the years. He recently defended his first "loss of chance of recovery" lawsuit.

A young man was involved in a water skiing accident and dislocated his knee. The dislocation caused popliteal artery and perineal nerve injuries.

"It took the patient a couple hours to take himself to a hospital, and it took the defendant ED physician a couple more hours to assess the patient, obtain necessary imaging studies and other tests, and consult orthopedic and vascular surgeons," Volpi says. By the time the patient was in the operating room, he had developed compartment syndrome.

"In the lawsuit, both sides agreed that the patient suffered a devastating knee injury, and that he may have had some permanent limitations, even if he underwent surgery immediately after the accident," Volpi says.

The patient could not demonstrate that, but for the EP's negligence, he would have recovered fully.

"His injury was devastating. More likely than not, he was going to be permanently impaired," Volpi adds.

Instead, the patient argued that the EP's delayed diagnosis caused his compartment syndrome, and that his compartment syndrome ensured a permanent impairment.

"In other words, the patient argued that his chances of recovery were greater, absent the compartment syndrome that he believed was preventable," Volpi says.

Defense experts countered that the patient's permanent impairment was due to his perineal nerve injury, and not his compartment syndrome.

"The lawsuit was resolved very favorably," Volpi notes. "But the theory was interesting, and made the timeline critical."

Lower Standard of Proof

Most states require the same level of proof for loss of chance claims as they require with ordinary medical negligence claims; that is, a "preponderance" of the evidence. The plaintiff must prove that more likely than not, the EP was at fault.

"While the idea of loss of chance goes back a long time, expansion in some states has been more recent," Maher says. Currently, the Washington Supreme Court is considering a case that would lower the standard of proof for loss of chance to a "substantial factor."[4] This is a lesser burden used by Kansas, Oklahoma, Colorado, North Dakota, and Pennsylvania.

Several of the state's recent supreme court decisions have overturned tort reform legislation that had been passed in 2006. Court rulings have emphasized plaintiffs' access to the courts to have their injuries or claims addressed.

"We're concerned that the courts may look at this as an access to court issue and decide to lower the standard of proof for loss of chance," Maher says.

In its amicus brief, the Washington State Medical Association argues that the higher "preponderance" burden should remain the standard of proof for loss of chance. The concern is that if "substantial factor" is used, it will be easier for plaintiffs to prevail in cases in which the connection between the EP's action and the patient's poor outcome is tenuous at best.

"It could increase the number of less substantive malpractice cases and resulting damages," Maher suggests.

EPs Vulnerable to Certain Claims

Loss of chance claims against EPs often involve an alleged failure to diagnose and stabilize a medical emergency, such as stroke or heart attack.

Koh says, "Claims with a slightly different flavor involve an alleged failure to diagnose an underlying life-threatening condition, such as lung cancer, when a patient comes to the ED complaining of what may or may not be an emergency, such as a persistent cough and allergy symptoms."

In both types of cases, plaintiffs claim that if the EP had conducted

additional tests, consulted additional specialists, or admitted the patient to the hospital, the patient would have had a greater chance of surviving or a better outcome.

"Even more complicated are cases involving difficult or multiple diagnoses," Koh says.

Koh's firm recently defended an EP who treated a patient for what appeared to be post-operative swelling after anterior cruciate ligament (ACL) repair surgery.

"The patient claimed that she actually had compartment syndrome, and would have had a better outcome if the emergency doctor had recognized it," Koh explains.

In that case, the experts disputed whether the patient actually suffered from compartment syndrome, which generally was unexpected in relation to ACL surgery.

"The ER doc consulted the surgeon and the on-call orthopedist, ruled out a more serious life-threatening diagnosis, and relied on examination and patient's description of the symptoms," Koh says, noting that, ultimately, the trial court did not instruct the jury on the loss of chance theory, as requested by the plaintiff. "This is because the plaintiff's expert did not assign a percentage of 50 or less to the chance allegedly lost, as required by Washington state case law," Koh explains.

Some "loss of chance" cases involve an underlying condition not easily diagnosed in a single visit, or unrelated to the emergency medical condition with which the patient presents. Koh believes EPs are not as vulnerable to these claims because in the ED, the goal is to treat or stabilize emergency medical conditions.

"Where ED docs rely on descriptions of the condition provided by patients, consult appropriate specialists, and order reasonably necessary tests and treatment, they will be more likely to prevail at trial," Koh adds.

Koh believes EPs are more vulnerable to loss of chance claims that involve the failure to diagnose or properly treat an actual medical emergency. Her firm recently handled a case involving a mistake during an emergency procedure on a patient with several unrelated conditions. Both sides agreed the patient could not have been expected to live more than five years, regardless.

"Even so, the mistake undoubtedly caused harm, such that it would have been very difficult to defend the loss of chance claim at trial," Koh says. "The case ultimately settled." ■

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Identify, Counsel EPs Frequently Targeted in Med/Mal Suits

Very small number of EPs account for vast majority of litigation

How many times has someone said, "He's a great EP, but ... ," wonders **Gerald B. Hickson**, MD, senior vice president of quality, safety, and risk prevention at Vanderbilt University School of Medicine in Nashville, TN.

What's usually said next — that the EP is notoriously difficult to deal with — probably means he or she is no stranger to a courtroom.

"We are gaining empirical knowledge of the 'whys' of suing for malpractice," Hickson says. "We can't just learn from people's anecdotes and war stories."

Why families choose to sue for malpractice, why certain physicians attract a disproportionate share of claims, and how to identify and intervene with high-risk physicians has been the focus of Hickson's research for the past 25 years.[1,2]

Some busy EPs come off as disrespectful without even realizing it.

"Sometimes, it's because we're in a hurry. Or, it may be the way we behave all the time," Hickson says. "Ultimately, it's about the importance of modeling respect and building trust."

About 1% of physicians accounted for 32% of paid malpractice claims, according to a recent analysis of 66,426 claims paid against 54,099 physicians from 2005 through 2014.[3] Only 6% had a paid claim.

The researchers expected to see a skewed distribution of claims.

"But the extent to which claims were concentrated among a small group of physicians was really surprising," says **Michelle M. Mello**, JD, PhD, one of the study's authors. Mello is a professor of law at the Stanford Law School and professor of health research and policy at Stanford University School of Medicine.

The researchers suggested that liability insurers and hospitals monitor how claims accumulate among their insured physicians.

"Intervene when the predictive factors for more claims, that our analysis identified, start to emerge," Mello recommends.

Risk varied widely according to specialty. The risk of recurrent paid malpractice claims for emergency medicine was greater than for cardiology, anesthesiology, family medicine, and pediatrics, but less than for neurosurgery, orthopedic surgery, and obstetrics/gynecology.

"The types of interventions that could be helpful include peer-to-peer counseling, additional training, and enhanced supervision," Mello says.

Early in his career, **Derek S. Davis**, RPh, JD, now a defense attorney in the Dallas office of Cooper & Scully, fielded calls for a plaintiff's medical malpractice firm. Few of the calls involved actual malpractice. The precipitating factor for most was that a healthcare provider was rude or unapologetic about a mistake.

"Bad bedside manner can motivate patients to make the call, even when there has been little or no harm," Davis warns.

EPs Can and Do Change

At the Vanderbilt University School of Medicine, patient complaints are reviewed and aggregated using the Patient Advocacy Reporting System. The program uses unsolicited patient complaint data as the basis for tiered interventions on high-risk peer colleagues.

"The complaints are not randomly distributed," Hickson explains. "A small subset of our emergency medicine colleagues receive more than their fair share of complaints."

About 40% of EPs in any four- to six-year audit period don't receive a single complaint. A small subset of EPs — about 4% — receive about one-third of complaints, most often related to perceived disrespect.

"Those are the EPs most at risk for medical malpractice claims," Hickson explains.

Hickson's organization developed an approach, now used at 144 hospitals nationally.

"We train physician messengers to deliver the aggregated data, to show the EPs where they stand in relation to other EPs in their own ED, and also to EPs in the national database," Hickson says.

The EP has an opportunity to reflect on what it is about their practice that appears to create dissatisfaction.

"We tell them that the dissatisfaction they are associated with increases their malpractice risk," Hickson notes, adding that it's clear from previous research that dissatisfaction drives malpractice claims. "That's why we don't take a lot of stock in standardized satisfaction measures that focus on 'top box' scores. That isn't what predicts risk."

After receiving the peer intervention, about 75% of all physicians make changes in the way they practice.

"We've been doing this work since 2000, now with over 1,500 high-risk physician interventions. These numbers apply for all practices," Hickson says. "The effect is profound and long term."

A very small minority of the EPs — less than 1% — are unable or unwilling to respond to the intervention. This is a far cry from what some colleagues warned when Hickson began developing the program in the 1990s, that he'd never get physicians to change their practice behaviors.

"What our process does is put a mirror in front of people, and they often don't like what they see," Hickson says. "Once they see their data, most pause and reflect. Then they change."

Most of the EPs receiving the intervention simply have gotten used to a status quo. They don't even realize they are creating dissatisfaction.

"In any ED, if you ask, 'Who are your two or three most difficult people to work with,' people know right away who they are," Hickson says.

However, if one then asks, "Have you ever talked directly to them about their practice behavior," Hickson says the answer is almost always "no."

"Medical professionals are hesitant to have those conversations," he adds.

During the intervention, which another EP usually conducts, the EPs first receive a chance to figure out how to change on their own.

"We don't tell them a thing, except 'This is your data, you're a bright person, I trust you are going to figure it out,'" Hickson says.

Patient engagement training often falls on deaf ears until someone tells a high-risk physician that he or she has a problem.

"Once they understand they have needs, and that education is available if they choose, it's a very different phenomenon," Hickson explains.

For about 25% of EPs, no im-

provement occurs after the first intervention. A second intervention occurs within six to 12 months. If at that point no improvement occurs, the next step is a "guided intervention under authority." The EP is linked with a hospital leader who can apply consequences if the EP does not improve. Of this group, about half improve with additional training.

Outcomes Are at Stake

A recent study of 66 surgeons and 10,000 surgical procedures found that surgeons perceived as rude experienced more surgical complications. The findings have been replicated in a follow-up study conducted at eight hospitals employing 900 surgeons who conduct 32,000 procedures.

"It isn't that being nice makes patients happy so they won't sue you," Hickson says. "We now know that when physicians are disrespectful to other members of the surgical team, trust is reduced. That impacts team performance."

The same is true of EPs who are known to be disrespectful. Hickson offers one compelling reason: "Other team members are less likely to share observed concerns and ask for help."

Hickson believes rudeness actually can harm ED patients clinically, and conversely, "we know there are certain attributes that, if modelled, not only reduce the risk of claims, but also [increase] the probability of good outcomes." ■

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Who's Ultimately Responsible for Bad Outcomes?

In a recent malpractice case, the outgoing EP called for a stat surgical consult for a patient presenting with a perforated appendix. However, the surgeon never arrived. The incoming EP didn't follow up on the stat consult because she never was told about it.

"The patient develops septic shock and dies several days later. The outgoing physician was sued for failure to communicate the consult to the incoming physician," says **Stephen A. Barnes**, MD, JD, FACLM, a trial attorney at McGehee, Chang, Barnes, Landgraf in Houston.

The incoming EP was not named in the suit.

"The outgoing EP did not point any fingers at her because the patient already had admitting orders filled out by the outgoing EP," Barnes explains.

Mark Tripp, MD, an EP with Winchester (VA) Emergency Physicians and Front Royal (VA) Emergency Physicians, is reviewing a malpractice case in which both the incoming and outgoing EPs have been deposed, with disagreement on who is responsible for the patient's bad outcome. Tripp says that in his experience, whoever saw the patient last generally bears the brunt of the blame.

"Usually, it's the last man standing that is held responsible," he says, noting he recently reviewed a case in which the EP made many mistakes. "But the patient did go to the urologist the next morning and was still OK at that time. So it ended up falling on the urologist."

Barnes says that incoming EPs face more liability exposure if they are left with a patient who is relatively early in the diagnostic and treatment phase. For instance, a patient might still be awaiting a CT scan to diagnose abdominal pain, with blood work results not yet returned.

The outgoing EP is more likely to be held liable in a malpractice lawsuit if he or she already initiated the workup and treatment plan, according to Barnes. An example would be an abdominal pain patient whose CT scan has revealed appendicitis, with blood work returned and the surgeon already called.

"It is far more persuasive to a jury that the doctor who came up with the diagnosis and plan is responsible

for making sure that the plan continues after she finishes her shift in the ED," Barnes says.

The Most Common Scenario

Barnes says that in his experience, "by far and away, the most common scenario where both outgoing and incoming EPs are sued together is when a patient presents with a STEMI [ST-elevation myocardial infarction] at a change of shift."

All the claims have one thing in common: The patient's window of time for treatment with thrombolytics elapsed during the change of shift.

"I have had three cases in five years with this scenario," Barnes says. In all three cases, the 90-minute "door-to-balloon" time began at the end of the outgoing EP's shift and elapsed during the incoming EP's shift. Both the outgoing and incoming EPs were sued in each case, and all three cases were settled.

One possible defense for an incoming EP is that the patient's bad outcome couldn't possibly have been prevented, because the outgoing EP's care was so poor.

"In this scenario, even if the incoming EP continues to provide substandard care, there is no liability," Barnes explains, noting this is because even if the incoming EP delivered perfect care, it wasn't enough to stop the patient's bad outcome.

In other cases, it is not too late for the incoming EP to rectify the situation. In this scenario, "the point of no return is reached after the second EP is caring for the patient," Barnes says. "So both the outgoing and incoming EPs who provided substandard care are liable."

Evidence of Communication

Catherine Vretta, MD, MPH, an EP at St. John Providence in Detroit, says the outgoing EP should state clearly two things in the ED chart:

- the patient's condition at the time the outgoing EP left;
- that care was turned over to the incoming EP.

Barnes says "hard evidence of communication" between the two EPs about the patient's diagnosis and treatment plan helps the defense. Ideally, the incoming EP documents, "From here on, the plan is ..."

"This is far better than testimony from an EP who is now being sued and thus subject to credibility issues, that 'Well, we talked about this patient when I came in,'" Barnes says.

Tripp likes to see the outgoing EP use these words: "Care has been transferred to Dr. X." This protects the EP in these two scenarios:

- If the diagnosis didn't need to be made before the patient left the ED;
- If the diagnosis did need to be made before the patient left the ED, but the timing wouldn't have changed the outcome.

EPs often argue, justifiably, that it is just not possible to document all the information that's discussed at change of shift.

"But a jury does not understand that, particularly when I can show them that nurses document such shift change handoffs as part of their own standard of care," Barnes notes.

Minimize Sign Overs

Patient handoffs during change of shift are a well-known area of risk for both ED patients and EPs.

"In my group, we try to minimize sign overs," Tripp says. At one ED, EPs are scheduled to work eight- or nine-hour shifts, with the understanding that they will stay until they're done with their patients.

Also, there is double coverage during the last hour of the EP's shift, with outgoing EPs handling the less complex cases.

"So they are not picking up a complicated case 30 minutes before the end of their shift," Tripp explains.

An outgoing EP might be unable to discharge a patient before the end of his or her shift. For instance, a patient with an ankle sprain might be delayed in obtaining X-ray results because radiology is busy. In this case, the outgoing EP can inform the incoming EP that if the X-rays are negative, the patient can be discharged. Otherwise, the incoming EP takes over the case, using his or her own clinical judgment.

"In that situation, the outgoing EP would be the one responsible because I'm not asking the incoming to do anything other than look at the report," Tripp notes

Incoming EP Can Re-examine

Incoming EPs might find that carefully reviewing the outgoing EP's history and physical, and re-examining the patient, is time well-spent. Vretta warns, "Their decisions for patient disposition will otherwise be made utilizing the outgoing physician's sign-out."

The incoming EP is the one who will discharge the patient.

"So it's really up to them to make sure they know the patient's situation. If it means you have to do another H&P yourself, you need to do that," Tripp says.

A complete head-to-toe physical exam might not be necessary, "but the

incoming EP should do whatever it takes to assure that he knows what's going on with the patient," Tripp emphasizes.

The outgoing EP's history could be incorrect, or the physical exam incomplete. Vretta gives this example: "A rectal exam may not have been performed on an abdominal pain patient. That ultimately ends up being a significant GI bleed with delay of diagnosis."

Another possibility: The ED patient deteriorates over time. The outgoing EP may have reported what, at the time, was a stable patient. "By the time the disposition arises, the incoming physician may be dealing with an entirely different level of patient stability," Vretta says. ■

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Keep in Mind Legal Risks When Transferring ED Psychiatric Patients

EDs report high volumes of psychiatric patients who often are held for hours, days, or even weeks awaiting transfer. EPs are eager to transfer the patient out of the ED into an appropriate facility, but what are the legal risks?

"Properly transferring a psychiatric patient should reduce the risk for an ED. But the emphasis is on properly," says **Mary Jean Geroulo**, JD, an attorney at Wilson Elser Moskowitz Edelman & Dicker in Dallas.

The Emergency Medical Treatment and Labor Act (EMTALA) applies to psychiatric patients, just as it does to typical medical patients.

"Medical screening exams need to be performed to determine if an emergency medical condition exists," Geroulo says, noting that the patient should be stabilized within the scope of the hospital's services prior to discharge. "If the hospital has no psychiatric services, it is appropriate to transfer the patient to a facility with the capability to care for the patient."

Scott L. Zeller, MD, vice president of psychiatry at CEP America, an Emeryville, CA-based provider of acute care management and staffing solutions, stresses that a psychiatric emergency, such as when patients are dangerous to themselves or others, is recognized as an emergency medical condition under EMTALA. For the transfer of a psychiatric patient to be appropriate, Zeller says EPs should ensure these things:

- that all non-psychiatric emergency medical conditions are stabilized;
- that the transfer is the appropriate treatment for the psychiatric emergency condition;
- that the transfer process occurs in accordance with EMTALA, with an accepting hospital and physician.

However, lack of inpatient psychiatric beds often prevents the transfer from happening at all.

"It is sometimes very difficult to accomplish a transfer quickly. This is where EDs and EPs are subject to potential risk," Geroulo says.

ED Dangerous for Patient

Most EDs lack the facilities to properly care for emergency psychiatric patients. This is of particular concern if the patient was brought to the hospital on a legal hold, or if one was imposed after the patient arrived at the ED, Geroulo explains.

"Holding an involuntary patient in the ED while waiting for a transfer can be dangerous for the patient, other patients in the ED, and the staff," she warns. Geroulo adds that resorting to physical or chemical restraint does not usually qualify as appropriate stabilization or treatment of the patient, according to the Centers for Medicare & Medicaid Services' interpretation.

"This can implicate the Medicare Conditions of Participation, or EMTALA," Geroulo adds.

Transferring the patient to an inpatient bed, when there are no psychiatric services available in the hospital, can result in the same problems.

"Admitting the patient can sometimes make it more difficult to find a facility willing to accept the transfer," Geroulo says.

Regulatory agencies have sanctioned some hospitals for transferring psychiatric patients without adequately stabilizing the emergency psychiatric condition, notes **Shelly Garzon**, JD, an attorney in the Tacoma, WA, office of Fain Anderson VanDerhoef Rosendahl O'Halloran Spillane.

"Even though these regulatory issues relate to the hospital, plaintiff attorneys may use them to try to

establish the standard of care in a malpractice case," she warns. ■

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Patient's Signature on AMA Form Won't Stop Successful Lawsuit

Supporting documentation in ED chart is vital

If a patient wants to leave the ED against medical advice (AMA), he or she typically has to sign the "AMA form." But how much legal protection does this really provide the EP? "Very little," without any additional supporting documentation, **Marc E. Levsky**, MD, warns.

"A case where the plaintiff left AMA is most defensible if there is a thoroughly documented medical record that shows a clear, informed consent process regarding the patient's departure," says Levsky, the vice chair of the board at the Walnut Creek, CA-based The Mutual Risk Retention Group, and an EP at Marin General Hospital in Greenbrae, CA.

Levsky advises including these notes in the ED chart:

- The patient possessed the capacity to refuse further care;
- The patient understood the possible consequences of his or her departure;
- How the EP established that the patient demonstrated normal mental status, was not intoxicated, and was not psychotic or suicidal;
- Which person discussed the possible diagnoses and recommendations with the patient;
- How the patient responded to the recommendations;
- Efforts made to convince the patient not to leave;
- The patient was advised to return at any time if further care is desired;
- A short-term follow-up plan.

"If the medical record for the AMA departure is appropriately documented, it is likely that the defense will prevail," Levsky says.

Nan Gallagher, JD, is an attorney who has defended many medical malpractice claims alleging improper AMA discharges. She urges EPs to "be specific and verbose. A patient's signature on an AMA form is not enough anymore."

Gallagher encourages EPs to do more than simply complete the AMA form. She likes to see "a robust amount of details in progress notes and discharge summaries. Plaintiffs' attorneys and juries are delving deeper." They're looking at the totality of circumstances — patient capacity, documentation, and quality of communication — before deciding if the EP properly discharged a patient.

"In our litigious society, there is a growing trend toward patients disputing the authenticity of the signatures on an AMA form and challenging the quality of informed consent communications," Gallagher warns.

'Informed Refusal' Form

Laura Pimentel, MD, a professor at the University of Maryland, agrees that relying on the AMA form alone is a weak defense. A well-constructed narrative in the ED record is much more effective. However, she always has the patient sign the form if the patient is willing and able.

"A well-executed AMA or informed refusal form is helpful, though it certainly does not inoculate an EP from a claim or lawsuit," Pimentel explains. "The worst form that I have seen is one that only focused on the risk side from the hospital's perspective."

She says the form consisted of only one sentence. The form stated that the patient acknowledges that he or she is leaving at his or her own insistence and against the advice of the attending physician. Further, the form reads that the patient assumes all responsibility for the consequences of the decision, with a blank line for the EP to fill in with the risks of leaving.

"Most people would write 'death and disability,'" Pimentel says. "This was followed by signature lines for the doctor, the patient, and a witness."

Instead of an AMA form, Pimentel notes that the University of Maryland's ED uses an "informed refusal" form.

"In addition, I document my conversations and efforts to convince the patient to stay in my ED note," she adds.

The informed refusal is designed to educate the patient about two things: the benefits of completing treatment, and the risks of leaving before treatment is complete. It asks the EP to document that the patient appears to have the capacity to make an informed decision.

"It is a better approach, because it is very patient-centered," Pimentel argues. "The form is designed to convey the important information necessary to reach an informed decision."

Here are some steps EPs can take to reduce risks when patients leave AMA:

1. Inform the ED patient of the risks of leaving, including worsening or complications of the acute medical condition, permanent disability, or death, when these are real considerations.

"I believe that an attempt to individually list every possible complication or poor outcome from the patient's condition is weaker than the narrative that the patient was counseled about the potential for deterioration, disability, or death," Pimentel says. If the EP lists all the possible risks that come to mind, but omits something that ends up occurring, she explains, "it opens the door for the plaintiff attorney to argue that the EP didn't properly inform the patient."

2. Determine that the patient has the capacity to make the decision to be discharged AMA.

If a patient is not capable of making a decision, then a provider cannot ethically or legally allow a discharge that may imperil the patient's life or health, according to Gallagher.

"EPs must make a reasoned assessment of a patient's decision-making capacity before deciding to proceed down this path," she explains.

3. Educate the patient on the potential benefits of completing evaluation and treatment, and document the discussion.

"The patient should be given the opportunity to ask questions," Pimentel advises.

4. Inform the patient that he or she may return at any time.

5. Give the best possible care to the patient before discharge, including recommendations for outpatient care and prescriptions.

"The old-time practice of not prescribing medications to patients who leave AMA is inappropriate," Levsky says.

Instead, EPs should give patients appropriate treatment for their condition, within the limits of what was known about their condition at the time of departure.

"This shows a future reviewer or court that the physician did his or her best to care for the patient," Levsky says. "It speaks against an adversarial relationship between the physician and patient."

One of Levsky's patients left AMA instead of being admitted or transferred, as the MRI needed for evaluation of his back pain with new leg weakness was not readily available. Levsky prescribed appropriate pain medications, intended to last the patient until his planned follow-up appointment on the next business day. In the interim, the patient returned to the ED with worsening symptoms, and was admitted.

"When he returned, he stated that he was grateful for the thoughtful care during his first visit to the ED," Levsky notes.

6. Include nurses and family members in discussions with patients about the benefits of completing treatment and the risks of leaving.

"Failing to document the inclusion or presence of witnesses to the informed refusal discussion is a pitfall that may weaken the EP's defense," Pimentel explains, noting that nursing documentation of the discussions can help the EP's defense. "Nurses may be persuasive and are good witnesses of your efforts to care for the patient."

An ED nurse recently documented: "Patient states desire to leave AMA at this time. He states that Dr. Levsky told him that he might die from his condition if he leaves. He states that he must leave anyway due to personal matters, but will return when he can, and he appreciates care provided."

While this documentation didn't involve a litigated case, Levsky believes it would have helped the defense in the event a malpractice suit was filed.

"If the documentation is good, the plaintiff has little chance of success. It is relatively unlikely that the case will be litigated," he adds.

7. Make an effort to convince the patient to stay.

Hospital social workers and family members sometimes can persuade the patient to complete treatment in the ED.

"They may be able to mitigate reasons that a patient wants to leave, such as concerns regarding childcare or other responsibilities," Pimentel says.

8. Contact patients who leave AMA by telephone, and document the call.

Levsky typically does this eight to 24 hours later, depending on the time of day the ED staff saw the patient.

"If the patient left before being seen by a provider, we try to call them back within one or two hours," Levsky says, which allows the EP to improve the relationship, to briefly

reassess the patient's condition, and to again offer further treatment.

Levsky recently saw an older woman who presented with generalized weakness.

"She appeared ill, but without focal signs of a source, and had a slightly elevated white blood cell count, but no other significant laboratory findings," he recalls.

Levsky recommended admission, which she declined. During a follow-up phone call eight hours later, her daughter reported her mother had developed a high fever.

"I recommended that she return. She did return, and she was found to have meningitis," Levsky says. ■

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

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CME/CE QUESTIONS

1. **Which is true regarding an intervention for EPs who receive more complaints than their peers?**

   a. Typically, just a small minority of EPs are able to make successful practice changes and reduce the number of complaints they receive.
   b. Data clearly ties EPs' success in reducing complaints to patient engagement training or threats of consequences.
   c. Most EPs are unable or unwilling to respond, even if a second intervention occurs.
   d. After receiving a single peer intervention, most EPs make adjustments in the way they practice with no further instruction.

2. **Which is true regarding "loss of chance" claims?**

   a. If a plaintiff attorney can't prove negligence in a medical malpractice lawsuit, EPs still may be held liable under "loss of chance" claims.
   b. States require a higher burden of proof for loss of chance claims than for medical malpractice claims.
   c. Expert medical testimony produced by the plaintiff generally is not required to establish loss of chance.
   d. Loss of chance claims commonly are used even in cases in which the plaintiff can demonstrate a causal connection between the negligence and the injury.

3. **Which is true regarding transfer of psychiatric patients?**

   a. The Centers for Medicare & Medicaid Services has clarified that both physical and chemical restraints qualify as appropriate stabilization or treatment of the patient.
   b. If the hospital offers no psychiatric services, it is appropriate to transfer the patient to a facility with appropriate capabilities.
   c. EMTALA requirements for medical screening exams generally do not apply to psychiatric emergencies.
   d. Transferring the patient constitutes an EMTALA violation if the patient was brought to the hospital on a legal hold or one was imposed while at the ED.

ED LEGAL LETTER

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