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## ➔ INSIDE

Surprising malpractice risks if ED holds psychiatric patient involuntarily . . . . . 5

Avoid fines — or worse — if EP is target of state medical board investigation . . . . . 7

Successful defenses if patient discharged with life-threatening infectious disease . . . . . 10



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## Special Report: The 9th International Conference on Diagnostic Error in Medicine

By David Meyers, MD, FACEP, Sinai Hospital, Baltimore

**D**iagnostic errors and the need to improve diagnosis have been largely in the background since the early reports of the significance of medical error

first came into the national consciousness in 1999 with the publication of the report, *To Err is Human: Building a Safer Health System*,<sup>1</sup> by the Institute of Medicine (IOM, now known as the National Academy of Medicine [NAM]).

That report was the first under the auspices of the Committee on the Quality of Health Care in America. It burst onto the scene with its headline-grabbing assertion, derived from the Harvard

Medical Practice Study<sup>2</sup> and a separate study of medical errors in Utah and Colorado,<sup>3</sup> that between 44,000 and 98,000 deaths occurred annually due

to medical errors in the United States, including as many as 7,000 deaths due to medication errors alone. Total costs were estimated at between \$17 billion and \$29 billion, including “lost income, lost household production, disability, and healthcare costs.” The

report further noted

that these numbers were very likely significant underestimates, as both studies were of hospitalized patients and did not include outpatient or

**DIAGNOSTIC ERRORS AND THE NEED TO IMPROVE DIAGNOSIS HAVE BEEN LARGELY IN THE BACKGROUND SINCE THE EARLY REPORTS OF THE SIGNIFICANCE OF MEDICAL ERROR.**

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ambulatory settings. The report decried the silence on an issue of such magnitude and severity of outcomes and proceeded to lay out the detail of the problem, describing a series of recommendations to address it. Interestingly, diagnostic errors were mentioned twice in the entire 312 pages.

One year later, a second report in the series, "Crossing the Quality Chasm: A New Health System for the 21st Century," was issued.<sup>4</sup> Its opening words were "The American healthcare delivery system is in need of fundamental change," and went on to state its goal of "providing a strategic direction for redesigning the healthcare delivery system of the 21st century. Fundamental reform of healthcare is necessary to ensure that all Americans receive care that is safe, effective, patient-centered, timely, efficient, and equitable."

Detailed analyses of the problems with our healthcare system were carried out, and a series of recommendations were made to achieve these goals. The term "diagnostic error" was not used at all in the document, though it was alluded to once.

Over the succeeding 16 years, at least 10 more reports were issued as part of the "Quality Chasm series"<sup>5</sup> on a broad range of topics relevant to the understanding and resolution of factors that contribute to the quality of healthcare and which must be addressed to achieve the goals set for our healthcare system kin to meeting the needs of our patients.

It is known now that, in most professional liability insurers claims databases, the most frequently identified causes of such claims are related to diagnostic errors, accounting for more claims than all other causes combined. Similarly,

the most costly category of claims is related to diagnostic errors, again accounting for at least half or more of all payouts. And, of course, malpractice claims reflect just a portion of total injuries, though arguably those with, on average, the most harmful outcomes. Estimates of the frequency of diagnostic errors across all sites of care, including the ED, range from ~10-30%, depending on the source of data.

In 2013, thanks to a growing body of research, recognition of the significant mortality, morbidity, and cost burdens of diagnostic errors, through the efforts of interested parties, including payers, patients, and the Society to Improve Diagnosis in Medicine (SIDM), NAM convened a panel of experts to study the diagnostic process, diagnostic errors, and how to reduce harm to patients from them. The panel's report, "Improving Diagnosis in Health Care," was published in September 2015.<sup>6</sup> It, like *To Err Is Human*, generated headlines, particularly for its statement, "It is likely that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences."

The report, which proposed a new definition of diagnostic error, contains three major themes: 1) a focus specifically on diagnosis and diagnostic errors; 2) recognition that the patient perspective is critical and diagnostic error must be defined from the patient's viewpoint, and 3) teamwork is essential to the diagnostic effort, requiring collaboration among professionals, patients, and their families. The report also noted that diagnosis takes place within our systems of care, and those systems and culture do not adequately support the diagnostic process, contributing

significantly to diagnostic errors. The report lays out eight goals for improving diagnosis:

- Facilitate more effective teamwork in the diagnostic process among healthcare professionals, patients, and their families;
- Enhance healthcare professional education and training in the diagnostic process;
- Ensure that health information technologies support patients and healthcare professionals in the diagnostic process;
- Develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice;
- Establish a work system and culture that supports the diagnostic process and improvements in diagnostic performance;
- Develop a reporting environment and medical liability system that facilitates improved diagnosis by learning from diagnostic errors and near misses;
- Design a payment and care delivery environment that supports the diagnostic process;
- Provide dedicated funding for research on the diagnostic process and diagnostic errors.

In response to this report, SIDM chose as its theme for the 2016 9th Annual International Diagnostic Errors in Medicine Conference (DEM9) “From IOM to Action.”<sup>7</sup> Held over five days in early November in Hollywood, CA, the conference and related events included special programs for patients and researchers, short courses for those seeking in-depth material on subjects critical to addressing diagnostic errors, numerous expert presentations, and breakout sessions with practical exercises and tools to take home.

Like the IOM report, the

conference provided material useful for many different sites of care, virtually all clinical specialties, nurses, insurers and risk managers, educators, researchers, institutional administrators, and quality and safety professionals.

## Patient Engagement Summit

The purpose of this event was to convene patients interested in improving diagnosis and provide a forum for sharing their experiences,

IT IS KNOWN NOW THAT, IN MOST PROFESSIONAL LIABILITY INSURERS CLAIMS DATABASES, THE MOST FREQUENTLY IDENTIFIED CAUSES OF SUCH CLAIMS ARE RELATED TO DIAGNOSTIC ERRORS.

ideas, and suggestions with professionals about how they can contribute. The role of patients in helping solve some of our biggest healthcare quality problems is under scrutiny from CMS and other bodies like the Patient-Centered Outcomes

Research Institute (PCORI), which is charged with assuring that research on quality and safety contains measures that are meaningful to patients.

Many of those who attended experienced delayed or wrong diagnoses with devastating and life-changing consequences for themselves or family members, and they were eager to share thoughts about what went wrong and what could have prevented or avoided those outcomes. In almost every case, communication, or lack thereof, among clinicians, patients, and providers played an important role in the harms the patients suffered. Their ideas related not just to the immediate physician-patient encounter, but also how education of clinicians and research on the diagnostic process could benefit with their input. In addition, tools for patient use, such as those produced by the Kaiser organization, SIDM, and others were discussed and shared.<sup>8</sup>

## Research Summit

This event provided an opportunity for clinicians and research scientists to discuss strategic issues in understanding, quantifying, and solving the problem of harm from diagnostic errors.

There was general agreement that the amount of research support is extremely low compared to the magnitude of the problem and its impact.

Getting widespread recognition of the need for research funding, establishing research priorities, patient involvement in the design, and carrying out of research as well as practical matters were identified as important priorities.

## Short Courses

An Introduction to Diagnostic Error contained a broad overview of the topic, including the System 1/System 2 model of decision-making based on the work of Daniel Kahneman and Amos Tversky,<sup>9</sup> as well as the many human and system factors, including unconscious biases, which are at work in diagnostic decision-making.

Reducing Diagnostic Errors in Clinical Settings focused on translating our knowledge into action plans, while two other workshops addressed cognitive psychology in depth and educational strategies to use in developing diagnostic capabilities in trainees. This latter subject attracted a lot of interest as medical schools are working hard to create more effective pedagogical approaches to teaching diagnosis.

## Addressing Institutional Culture

The opening keynote speaker, **Brian Goldman**, MD, from Mount Sinai Hospital in Toronto, addressed the role of institutional culture in diagnostic error, particularly the “blame and shame” model, which creates an atmosphere of defensiveness, denial, and antipathy toward transparency of disclosure. He also addressed the second victim, i.e., the clinician who made the error and suffers in a different way, with implications for quality of care, empathy, burnout, mental health, suicide, early departure from practice, and other consequences, as well as production pressures, the legal climate, and other factors that impede efforts to improve and correct contributory elements. A

panel comprised of representatives of patient interests, insurers and risk managers, and healthcare institutions discussed available tools and resources offered by various government and private agencies.<sup>10</sup>

**Catherine Lucey**, MD, the vice dean for education at the University of California, San Francisco Medical School, was the keynote speaker on the second day. An acknowledged thought leader in clinical education,

MEDICAL  
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Dr. Lucey’s personal anecdotes at the outset revealed personal and family experiences with harmful diagnostic errors, affirming the statement in Improving Diagnosis. She went on to elucidate what must happen in undergraduate medical education to produce better diagnosticians, including changes in pedagogical techniques, use of illness scripts, and coaching to expertise. She also exploded some myths about clinical reasoning.

## Future Expectations

Two sessions on the expectations of purchasers, payers, and consumers presented the audience with ideas about how quality and cost will drive developments in the evolution

of our healthcare system and how incentives will affect how care is provided. Allusions to “choosing wisely” as a model for improving care were recognized. The future effect of CMS’s Quality Clinical Data Registries, MACRA, MIPS, and other initiatives on the reporting of errors, including diagnostics and reimbursement, also were addressed. The recently formed Coalition to Improve Diagnosis, a consortium of professional societies, patient advocacy organizations, quality- and safety-promoting groups, and government agencies, was described along with its goals of 1) raising awareness about diagnostic errors and the need to improve diagnosis, 2) developing an advocacy platform for securing research funding, and 3) identifying and disseminating effective tools for improving diagnosis. ACEP is involved actively with this organization.

## Breakout Sessions

A breakout session, led by **Doug Salvador**, MD, MPH, and **Harry Hoar**, MD, physicians at Baystate Medical Center, demonstrated a tool called “How To Engage Your Administration” to create an approach to generate support for a diagnostic error program, which was used successfully at their institution.

In another interesting breakout session on embracing uncertainty in the diagnostic process, Drs. **Gordon Schiff** and **Alexa Miller** spoke about how acknowledging uncertainty can facilitate more openness of thinking and avoiding pitfalls of early closure and other biases while also reducing risk of lawsuits when patients are aware of the clinician’s thinking.

Speaking on the role of certification in improving and

maintaining clinicians' diagnostic skills, Dr. Lucey moderated a panel of representatives from the American Boards of Emergency Medicine, Internal Medicine, and Medical Specialties during which the lively discussion and debate focused on the role of Maintenance of Certification, new approaches to assessing clinical reasoning, and testing of clinicians' diagnostic and patient management abilities.

The 9th Annual Diagnostic Errors in Medicine Conference covered a broad range of material of interest to anyone who deals with diagnosis — as a practitioner, educator, researcher, risk manager, or patient. And reminders were constant that we will all be patients at some time or another, so these efforts will help

us all receive better diagnostic care when we need it. ■

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# Should Psych Patient Be Held in ED, Or Discharged Home?

*Unrestrained patients bolt past ED security — and hospital gets sued*

It was clear to EPs at a small rural hospital that a motor vehicle accident victim brought by ambulance was a danger to himself or others, and required hospitalization due to a psychiatric condition.

“Because the ER was not equipped with an appropriate locked room for this situation, they placed a security guard at the door,” says **Derek S. Davis**, RPh, JD, a defense attorney in the Dallas office of Cooper & Scully.

The man pushed the security guard aside, ran out of the ED, and was struck by a vehicle. The family sued, claiming that the EP was negligent in failing to restrain the patient. The malpractice suit also alleged that the hospital failed to maintain the appropriate security for a psychiatric patient.

“Unfortunately, these situations present difficult medical-legal choices for ER physicians at smaller facilities,” Davis explains.

If the patient is restrained, the EP faces possible claims of assault or false imprisonment. Conversely, Davis says, “the patient can be left in a secure space, risking that the patient remains potentially active for escape or other risks of harm to self and others.”

**Sharon C. Peters**, JD, a partner at Portland, OR-based Lewis Brisbois Bisgaard & Smith, says, “Because of the defunding of state hospitals over the last half-century and the lack of community mental health resources, often psychiatric patients truly have no place to go but the ED. The ED door is always open.”

EPs need to determine if the patient is safe to discharge, and, if not, the ED has an obligation to ensure

## EXECUTIVE SUMMARY

EPs face possible allegations of assault or false imprisonment if psychiatric patients are held involuntarily. This documentation can help the EP's defense:

- why the EP believed the patient needed restraints;
- why the EP believed it was unsafe to discharge the patient;
- quotes from the patient or family indicating the patient was a danger.

patients held involuntarily receive proper care.

“Sitting in a holding room in the ED is not effective treatment for a psychiatric condition,” Peters says. “And I don’t think anybody would say that it is.”

Yet private and state psychiatric beds often are full, with a waiting list of several months. In some states, this has led to litigation. For example, in Washington state, a court commissioner recently threatened to put a state psychiatric hospital CEO in jail if she did not accept a psychiatric patient held in a community hospital.<sup>1</sup>

**Michael Jay Bresler**, MD, a clinical professor of emergency medicine at Stanford (CA) University School of Medicine, views the root of the problem as “an absolutely unethical, immoral lack of support for psychiatric patients. The whole problem is basically dumped on the ED.”

Although some EDs offer social services and psychiatric backup, many offer neither. Bresler says that whether the EP chooses to involuntarily hold or discharge the patient, “there is liability both ways.” Here are legal risks for EPs in each scenario:

- **The EP determines that the patient does not pose an imminent risk of harm to self or others, and discharges the patient.**

If the EP turns out to be wrong, the family of a patient who commits suicide — or others harmed by the patient — can bring a claim for wrongful death against the EP. **Megan Kures**, JD, senior attorney in the Boston office of Hamel Marcin Dunn Reardon & Shea, says, “ED providers may find themselves facing claims that they failed to adequately assess the patient.”

Of course, plaintiff’s counsel has the benefit of hindsight in these cases.

“Although professional judgment plays a role in most medical care, it

perhaps plays an even larger role in these cases,” Kures adds. “There is definitely no black and white scenario in these cases.”

**Scott Zeller**, MD, vice president of psychiatry at CEP America in Emeryville, CA, says including a standard mental status exam in the documentation can help justify the EP’s decision to discharge a psychiatric patient.

“One or two sentences saying, ‘The patient looks OK’ is probably going to be insufficient,” he warns.

The mental status exam should drive the EP’s disposition decision.

“SITTING IN A HOLDING ROOM IN THE ED IS NOT EFFECTIVE TREATMENT FOR A PSYCHIATRIC CONDITION,” PETERS SAYS. “AND I DON’T THINK ANYBODY WOULD SAY THAT IT IS.”

“An outside person should be able to look at your documentation and say, ‘Based on this assessment, this disposition is reasonable,’” Zeller explains.

Kures has defended several EPs against claims brought by patients alleging civil rights violations because they were held involuntarily, searched, or restrained.

“The patients claimed that they posed no risk and did not meet the criteria for involuntary holds or restraints,” Kures says.

Other cases have been brought by patients who were injured while resisting treatment or attempting to elope from the ED.

“These have resulted in assault claims and further negligence claims,” she says.

Liability fears make some EPs think twice before holding patients involuntarily. Zeller counters, “What I’ve seen is that lawsuits tend to be about EPs not providing emergency care, rather than providing care against someone’s will.”

In one such case, a delusional patient was discharged from the ED, and later harmed himself and others. The EP didn’t believe the patient met the criteria for involuntary care.

“The whole litigation was about whether it was an accurate assessment, and why the ED doctors did not intervene when they had the opportunity,” Zeller says.

- **The patient is held involuntarily.**

In many jurisdictions, EPs do not have the authority to place patients on involuntary holds.

“In some cases, they need to engage police or a magistrate, or have a mental health professional initiate it,” Zeller explains.

In other jurisdictions, EPs can put patients on an involuntary hold if certain criteria are met. Bresler notes, “Of course, that opens you up to false imprisonment claims, or whatever lawyers want to allege.”

Most jurisdictions use a good faith standard for statutory immunity for providers making decisions about involuntary holds under civil commitment laws. Peters notes, “Good documentation can maximize the chance of being within the immunity.”

One recent malpractice case involved an ED patient on an involuntary hold who was admitted to the psychiatric service. The patient, who

had been calm for many hours, was not restrained. A security guard was stationed outside the door.

“After many hours waiting for an inpatient psychiatric bed, the patient bolted from the room, ran into a random patient’s room, and assaulted a 90-year-old woman,” Bresler says, noting the woman’s family sued the hospital. Though the case was ultimately dismissed, Bresler adds, “From the woman’s and family’s point of view, you can understand their feeling that the hospital was responsible.”

## What’s Best for Patient?

Though cases are fact-specific, Zeller says the overriding issue always is what’s best for the patient at that point in time.

“There are times when the right to treatment can exceed the right to refuse treatment,” Zeller says. “This is a concept that is difficult for EPs to grasp.”

Some patients are too impaired or confused to make a decision in their own best interest.

“Based on a reasonable person standard, this person clearly needs help to prevent danger to life and limb,” Zeller explains. He gives this example: A patient goes into shock af-

ter a car accident. Clearly disoriented, he tells a paramedic he doesn’t want any help. “Will the paramedic let the patient bleed to death or take them to the hospital?” Zeller asks. “It’s a very similar thing with somebody who is impaired by an acute psychiatric condition.”

If the patient is not giving consent but is a clear danger to self or others, the EP has an obligation to treat that patient, just as the EP would with a confused trauma patient.

“People sometimes confuse long-term consent issues with what needs to be done in an emergency,” Zeller says.

If the document clearly shows that the patient didn’t meet the criteria to give consent, and the findings of the EP’s examination support that, “it should mean you are in pretty good shape,” Zeller says. The same is true if a psychiatric patient is sent home. Bresler suggests this charting: “Long discussion with patient. Adamantly denies being suicidal. Does not seem overtly depressed. Promised to return to ED if feeling worse.”

Such clear documentation might even deter a plaintiff attorney from taking a case in the first place.

“An ethical expert witness will give an honest opinion,” Bresler explains.

“It should be obvious that you did the right thing, regardless of the outcome.” ■

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# Is EP Target of State Medical Board Investigation?

*Much more than a fine could be at stake*

**W**hat EPs don’t know about state medical boards can hurt them if they become the target of an investigation.

“Physicians, by and large, pretty much have no concept of what the board does beyond issuing a license, or how to stay off the board’s radar

screen,” says **Jeffrey D. Lane**, a regulatory affairs consultant at Atlanta-based Allen & McCain.

**Lisa Robin**, the Federation of State Medical Boards’ chief advocacy officer, urges EPs to respond quickly, transparently, and honestly. “The worst thing a physician can do is to

ignore the initial letter and fail to respond,” she underscores.

**Allan Tobias**, MD, JD, principal of Walnut Creek, CA-based Healthcare Consulting and Law, says step one is to contact the malpractice carrier. Some cover representation by attorneys for state medical board

investigations. Regardless, Tobias urges EPs to hire an attorney with appropriate expertise.

“Consider how much you make in one year and multiply that by how many years you have left in practice,” Tobias says. “That is what is at stake.”

If licensing discipline is imposed on an EP, it may require reporting to employers, third-party payers, and hospitals in which the physician has privileges — and, in most instances, to the National Practitioner Data Bank (NPDB).

**David L. Rogers**, an attorney at Rogers & Associates in Farmington Hills, MI, adds, “Sometimes it is a basis for termination of employment. Also, most third-party payers will see the NPDB posting, which can lead to departicipation.”

Each time the EP applies for malpractice insurance, hospital privileges, or employment, the disciplinary action will come up.

“Every question asking about license discipline, on every one of those applications, will have to be checked yes, with an attached explanation,” Rogers says.

## Don't Complicate Matters

Lane, former chief investigator for Georgia's state medical board, notes that state law requires every com-

plaint to be investigated, “no matter how frivolous it seems on its face.”

Seemingly baseless complaints can become serious once the investigation gets underway. Rogers says, “Sometimes physicians lose cases they should have won.”

AN ED CHART WITH A CLEAR PICTURE OF THE EP'S RATIONALE MAKES IT EASIER FOR THE BOARD TO CONCLUDE THAT THE EP PRACTICED WITHIN THE STANDARD OF CARE.

Here are some factors that complicate state medical board investigations of EPs:

- **ED charts contain sparse documentation.**

An ED chart with a clear picture of the EP's rationale makes it easier for the board to conclude that the EP practiced within the standard of care. If there's little or no documentation, “the board has nothing to

work with,” Lane says. “The level of detail — or lack of detail — is going to save the ED physician or bury him or her.”

Lane has seen EPs investigated for inappropriate prescribing of narcotics.

“Sometimes, the EP will write a prescription just to get the patient out of there,” Lane says, noting that many times, the ED chart contained virtually no documentation showing the need for the prescription. “That doesn't necessarily mean the prescription was not legitimate. But if it's ever questioned, it's hard for the EP to back it up.”

In another case, an EP was investigated after a successful malpractice litigation alleged missed pulmonary embolism.

“The documentation was cursory at best,” Lane says, recalling that the board concluded that the pulmonary embolism was not recognized early enough due to the EP's failure to follow up on diagnostic testing. “The EP didn't lose his license, but was fined and reprimanded.”

The question that the board has to answer, says Lane, is: “Do we have an EP who just made a poor decision? Or do we have an EP who has a chronic habit of this kind of thing?”

“Poor or no documentation to justify your treatment could bring you in before the board for an interview,” Lane warns.

- **The EP under investigation strikes an adversarial tone with investigators.**

“We understand they may be indignant and scared,” Lane says. “But one thing the board really doesn't appreciate is a doctor coming in and talking down to them.”

Lane wishes physicians would realize that investigators aren't necessarily out to get them.

## EXECUTIVE SUMMARY

EPs often are unaware of the serious ramifications of state medical board investigations, which can lead to various forms of disciplinary action. These EP actions frequently result in additional scrutiny:

- taking an adversarial stance;
- sparse documentation in the ED chart;
- placing blame on other providers.

“The board tries hard to separate the really bad doctor from the good doctor that had a bad day,” he adds.

- **The EP misses timeframes to deliver medical records or respond to subpoenas.**

“They delegate it to somebody else to deal with, and then it doesn’t get done,” Lane says. “That can turn into a credibility issue.”

- **The EP tries to go it alone.**

A written response submitted by an EP can turn quickly into a multi-page document that is full of incoherent rambling, overly defensive, or full of eyebrow-raising facts.

“A lawyer can help you craft it in a way that’s more helpful than hurtful,” Lane notes.

Once contacted by an investigator, some EPs don’t want to appear “lawyered up.” However, simply stating, “I would like to consult with an attorney before I make any comments to you about this” is a smart move.

“It’s not looked at as a negative. The board understands that physicians have a right to counsel,” Lane says.

- **The EP discusses the investigation with colleagues.**

“Those people may become witnesses. And those conversations are not protected by attorney/client privilege,” Lane explains.

- **The EP hides, alters, or destroys records.**

“That’s a good way to lose your license pretty quick,” Lane warns. “The truth is a lot easier to deal with, even if it’s ugly.”

One physician client, under investigation for improper prescribing practices, fabricated a fax containing information pertinent to the investigation.

“The fax was dated two days before our meeting, but the events it portrayed had allegedly occurred

a year ago,” Lane recalls. “At that point, we suggested that he seek counsel elsewhere.”

Rogers has seen physicians add something to a chart before submitting copies to a licensing agency. Much to their surprise, an unaltered version of the record exists, either because they’d been submitted previously in response to a subpoena in a malpractice case, or because the patient or EMS requested a copy. Eventually, someone compares the copies and sees the alterations.

“ALTERING RECORDS IS ALMOST ALWAYS WORSE THAN WHATEVER THE PHYSICIAN WAS TRYING TO HIDE AND LEADS TO SERIOUS LICENSING AND CRIMINAL PENALTIES,” ROGERS SAYS.

“Altering records is almost always worse than whatever the physician was trying to hide and leads to serious licensing and criminal penalties,” Rogers says.

- **The EP blames others for bad outcomes.**

**John Bedolla**, MD, FACEP, assistant director of research education and assistant professor of emergency medicine at the Dell Medical School at The University of Texas, advises EPs to “be very neutral with how

you present the information.”

For instance, if it took 30 minutes to deliver a tracheotomy kit, and the delay harmed a patient, the EP will be tempted to respond, “It took them over 30 minutes to deliver that damn thing!” A better approach is to state simply, “I had to do a tracheotomy. I called for a kit, and two minutes later I called again. I called until the kit was delivered. All the times are documented in the chart.”

As for who’s at fault, Bedolla says, “someone else has to explain that piece.” He suggests this language: “I asked the nurse for the kit. The kit arrived 30 minutes later. For further information, you have to ask the nurse.”

Is the request to participate in an interview an invitation the EP can’t refuse? State laws vary on this. Rogers notes, “Even where it’s not required, the letter or phone call from the investigator usually makes it sound like the interview is required.”

If the interview is optional, the EP has an important decision to make.

“It should be made carefully,” Rogers stresses. “An interview during an investigation is a very important event.”

Some EPs jump at the chance to explain things, assuming (sometimes falsely) that the board surely will see the complaint has no merit.

If the investigator will accept written answers to questions, Rogers says, “in some cases, this is a more reliable way to be sure the correct answers make their way into the investigation file.”

Since EPs generally are not allowed to review reports during active investigations, it’s impossible to correct mistakes or misunderstandings.

“This is important, because if a formal complaint is later filed and the case goes to a full hearing, the

physician may well have to testify at the hearing,” Rogers explains. If the EP’s testimony conflicts with the report, the investigator can be called as a rebuttal witness.

“The investigator will testify that he or she conducts many interviews and doesn’t specifically remember what the physician said, but then can read from the report that was prepared at the time,” Rogers notes. The investigator then testifies that the report correctly states what the EP stated.

“Who does the administrative law judge believe? Maybe the physician, maybe the investigator,” Rogers adds. For this reason, agreeing to a non-mandatory interview could backfire.

“The EP may end up with an inaccurate report that leads to a formal complaint and ultimately to a hearing where the report is used against the physician,” Rogers concludes.

After the interview, the EP may receive a letter saying all is well. “Or you may receive a notice from the state attorney general who is tasked with the prosecution of physicians,” Tobias says.

Either way, Tobias urges physicians to, “involve your attorney at all phases of the investigation and hearing — and above all, listen to him or her.” ■

#### SOURCES

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## If Missed Infectious Disease is True ‘Zebra,’ It Can Help EP’s Defense

*Sparse charting greatly hinders the defense*

The more unusual the presentation of an infectious disease, the easier it is for the EP to defend the fact that it was missed, according to **Rodney K. Adams**, LLM, JD, an attorney in the Richmond, VA, office of LeClairRyan. Here are some recent “missed infectious disease” malpractice cases Adams has handled:

- **Endocarditis misdiagnosed as flu in a teenage girl who presented**

**with no history of cardiac abnormalities.**

The otherwise-well girl presented with flu-like symptoms on the first ED visit. She was discharged with instructions to rest.

“She returned to the ED somewhat dehydrated, with what looked like the flu, and was told to push fluids and let it run its course,” Adams says.

By the third ED visit, the patient was in extremis with bacterial endocarditis, necessitating mitral valve replacement and multiple neurosurgeries.

“She didn’t have any implants or prior surgeries. No abnormal heart sounds were heard,” Adams says. “There was no reason to think she had this nasty bug. It was a zebra.”

An ED nurse practitioner (NP) saw the patient for the first two visits. The plaintiff alleged that the EP should have examined the patient.

“It wasn’t clear what the EP would have seen differently. It appeared to be a viral illness,” Adams says.

Still, the case resulted in an \$850,000 verdict for the plaintiff.

“Some of the jurors, when we talked to them afterward, thought the EP left the NP hanging by

### EXECUTIVE SUMMARY

Defendant EPs can point to a patient’s unusual presentation to refute allegations of failure to diagnose infectious diseases. Recent malpractice cases have involved:

- endocarditis mistaken for flu;
- spinal abscess presenting as low back pain;
- toothache as the only symptom of necrotizing fasciitis;
- meningitis misdiagnosed as an upper respiratory infection.

herself, which was an unfortunate perception,” Adams recalls.

The defense was hindered by a sparse ED chart. “We could have done a much more thorough job of documenting vital signs and describing her condition,” Adams concedes. “Otherwise, it was what you see 30 of every day during flu season.”

• **A spinal abscess, with low back pain as the only symptom, in a middle-aged man.**

“The patient didn’t have any neurologic involvement,” Adams notes. The EP elected not to order a CT scan or MRI because it appeared the patient suffered from typical lower back pain. “The EP was distraught at being sued, and requested the case be settled,” Adams says. “Likely, the case could have been successfully defended.”

• **A young woman with a toothache that was a life-threatening head and neck infection.**

A dentist was the defendant in the ensuing malpractice litigation. However, the scenario also is applicable to EPs, Adams notes. The dentist contacted an oral surgeon to report the patient presented with some swelling in the lower jaw, consistent with an abscess. The recommendation was pain medication and a follow-up appointment.

“Lo and behold, the patient comes to the ED shortly after with necrotizing fasciitis all the way down into her chest,” Adams says.

The patient was on long-term antibiotics and endured several debridements of the neck and chest.

“It was a fairly tough course and was very difficult to treat, but she survived it,” Adams says.

The EP and surgeon moved aggressively, taking the patient to the OR promptly. The plaintiff attorney alleged the condition could have been detected if the dentist had

ordered a CT scan or MRI.

“The jury returned a defense verdict for the dentist, based on testimony from most of the experts on both sides as to the rarity of necrotizing fasciitis in this setting,” Adams adds.

• **Meningitis in young children, misdiagnosed as an upper respiratory infection.**

“We’ve had a couple of those cases. The ED folks can get burned by those,” Adams says. The problem is that the presentation of meningitis can be fairly subtle. “You’re not going to do a spinal tap on every infant who comes in with a runny nose that’s not quite as active as they normally are,” Adams notes. “They’re

not benign procedures and can have complications.”

Documenting that the EP examined the child thoroughly and that there was nothing pointing to a neurological disorder is helpful. Typically, the description of the child’s condition by the parents conflicts with the EP’s.

“But the jury tends to believe what’s in the ED chart more so than the parents,” Adams notes. ■

## SOURCE

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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.

## COMING IN FUTURE MONTHS

- EPs can be sued successfully — even if they never saw ED patient
- EMR “cut and pasting” makes some med/mal cases indefensible
- Make sure jury hears about ED patient’s noncompliance
- React immediately if ED visitor is observed carrying a gun



# ED LEGAL LETTER™

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## CME/CE QUESTIONS

- 1. Which is true regarding legal risks for EPs if psychiatric patients are held involuntarily?**
  - a. Including a standard mental status exam in the documentation can help justify the EP's decision to discharge a psychiatric patient.
  - b. If at all possible, EPs should avoid involving local law enforcement in the process of placing patients on involuntary holds.
  - c. Barring extreme circumstances, only mental health professionals have the authority to place patients on involuntary holds, regardless of the jurisdiction.
  - d. In most jurisdictions, EPs are not covered specifically by statutory immunity when making decisions about involuntary holds under civil commitment laws.
- 2. Which is true regarding state medical board investigation of EPs?**
  - a. Most states require malpractice carriers to provide representation for state medical board investigations.
  - b. When licensing discipline is imposed on an EP, it may require reporting to employers, third-party payers, and hospitals.
  - c. The percentage of investigations escalating to a peer review hearing is significantly higher for EPs who are represented by an attorney early in the process.
  - d. Hospitals are legally prohibited from terminating an EP's employment solely on the basis of disciplinary action imposed by state medical boards.
- 3. Which is true regarding state medical board investigators contacting an EP regarding an interview?**
  - a. EPs should decline to participate if the interview is not mandatory since the information only can be used against them.
  - b. Investigators are required to weigh written responses more heavily than information gleaned from in-person interviews.
  - c. EPs often are permitted to review the report while the investigation is still active so misunderstandings can be corrected.
  - d. If the EP testifies truthfully in a way that differs from what the report says, the investigator can be called as a rebuttal witness.
- 4. Which is true regarding the EP's defense in malpractice litigation alleging missed infectious disease?**
  - a. Highly unusual presentations of infectious disease make it easier for EPs to defend the fact that it was missed.
  - b. Policies should require midlevel providers to directly involve EPs in the care of any patient with flu-like symptoms to avoid missing unusual presentations.
  - c. Well-documented vital signs are of no real use to the defense if bacterial endocarditis is missed, since any reasonable EP would diagnose it based on its pathognomonic murmur.
  - d. A CT scan or MRI are considered standard of care for low back pain patients in most jurisdictions due to the distinct possibility of spinal abscess being overlooked.