



ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

FEBRUARY 2017

Vol. 28, No. 2; p. 13-24

➔ INSIDE

Why many cases are settled, even if ED met standard of care 18

Electronic medical record copying and pasting leaves some med/mal cases indefensible . . . 19

Prove ED patient who left against medical advice was fully informed of the risks 20

Effective responses if EP becomes focus of peer review inquiry 22



live & on-demand WEBINARS

- ✓ Instructor-led Webinars
- ✓ Live & On-Demand
- ✓ New Topics Added Weekly

VISIT US TO LEARN MORE!
AHCMedia.com/Webinars
(800) 688-2421

AHC Media

Hospital Mergers Usher in Changes for Healthcare Providers

By Robert B. Vogel, MD, JD, Retinal Ophthalmologist at Piedmont Eye Center, Lynchburg, VA; Attorney, Overbey, Hawkins & Wright, PLLC; Adjunct Professor, Liberty University College of Osteopathic Medicine, and Matthew Hadfield, BA, Medical Student, Liberty University College of Osteopathic Medicine

The rapidly increasing pace of hospital merger and acquisition (M&A) in the United States over the past several years may have gone unnoticed by the average healthcare provider. Hospital M&A doesn't appear as a major concern for the physicians or other healthcare providers in an ED. However, when hospital systems combine, the work environment and employment structure of physicians, nurses, and other healthcare providers, as well as the overall delivery of healthcare within the merged entity, changes. The institutional and workflow changes are of immense importance to ED personnel since they are based permanently in the hospital. ED staff would be affected more than other medical staff by institutional changes that result from an M&A. For example,

in Philadelphia, Abington Health proposed a merger with Holy Redeemer Hospital. Some physicians at Abington opposed the merger because although their hospital would continue offering many previously available services, abortion was to be banned because of Redeemer's affiliation with the Catholic Church. The merger was cancelled several months later, largely because of the protests of Abington's physicians who were concerned about changes in the delivery of care.¹ Although this is a more obvious example of disruption caused by the potential merging of entities with conflicting philosophies, there are other less obvious effects on institutional culture, job security, daily workflow, and patient care delivery and satisfaction, which should cause physicians and other stakeholders to

NOW AVAILABLE ONLINE! VISIT AHCMedia.com or CALL (800) 688-2421

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: **Arthur R. Derser**, MD, JD, FACEP (Physician Editor); **Stacey Kusterbeck** (Contributing Editor); **Jonathan Springston** (Assistant Editor); **Kay Ball**, RN, PhD, CNOR, FAAN, (Nurse Planner); **Shelly Morrow Mark** (Executive Editor); **Robert Vogel**, MD, JD (Author); **Matthew Hadfield**, BA (Author).



ED LEGAL LETTER™

ED Legal Letter™

ISSN 1087-7347, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at
additional mailing offices.

POSTMASTER: Send address changes to:

ED Legal Letter
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:

Customer Service: (800) 688-2421
Customer.Service@AHCMedia.com
AHCMedia.com

EDITORIAL EMAIL ADDRESS:

jspringston@reliaslearning.com

SUBSCRIPTION PRICES:

Print: 1 year with free *AMA PRA Category 1 Credits™*: \$519.
Add \$19.99 for shipping & handling.
Online only: 1 year (Single user) with free *AMA PRA*
Category 1 Credits™: \$469

Back issues: \$83. Missing issues will be fulfilled by
customer service free of charge when contacted within one
month of the missing issue's date.
GST Registration Number: R128870672.

ACCREDITATION: AHC Media, LLC is accredited by the
Accreditation Council for Continuing Medical Education to
provide continuing medical education for physicians.

AHC Media, LLC designates this enduring material
for a maximum of 1.5 *AMA PRA Category 1 Credits™*.
Physicians should claim only credit commensurate with
the extent of their participation in the activity. Approved
by the American College of Emergency Physicians for a
maximum of 1.5 hour(s) of ACEP Category I credit.

Relias Learning LLC is accredited as a provider of
continuing nursing education by the American Nurses
Credentialing Center's Commission on Accreditation.
Contact hours [1.5] will be awarded to participants who
meet the criteria for successful completion. California
Board of Registered Nursing, Provider CEP#13791.

This activity is intended for emergency physicians and
nurses. It is in effect for 36 months from the date of the
publication.

Opinions expressed are not necessarily those of this
publication, the executive editor, or the editorial board.
Mention of products or services does not constitute
endorsement. Clinical, legal, tax, and other comments are
offered for general guidance only; professional counsel
should be sought in specific situations.

SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

EXECUTIVE EDITOR: Shelly Morrow Mark

ASSISTANT EDITOR: Jonathan Springston

PHYSICIAN EDITOR: Arthur R. Derse, MD, JD, FACEP

CONTRIBUTING EDITOR: Stacey Kusterbeck

Copyright© 2017 by AHC Media, LLC. All rights reserved.
No part of this newsletter may be reproduced in any form
or incorporated into any information-retrieval system
without the written permission of the copyright owner.

pay attention to merger rumors. Why are more hospitals choosing M&A under the current operating conditions in the United States? A recent court case in which two hospital systems seeking to merge for improving efficiencies, a move opposed by the Federal Trade Commission (FTC) over antitrust issues, may help explain. Additionally, what changes may physicians and healthcare providers encounter should their hospital/employer merge with another entity?

Why Hospitals Merge

National healthcare policy drives the “urge to merge” that is endemic across the healthcare sector. Regulations aimed at making hospitals and providers accountable for cost and quality are forcing hospitals to consider best practices and consolidation in managing patient care. The merger of two small hospitals may allow the larger entity to experiment with models such as Bundled Payments for Care Improvement and other shared savings programs. Additionally, since government and private reimbursements for traditional fee-for-service care are decreasing and the cost for caring for indigent patients has not diminished, merging established institutions may be the only way for smaller hospitals to survive.

For example, in 2016 CMS announced their mandatory bundled payment program for joint replacement that holds hospitals accountable for the quality and cost of the surgery by capping the reimbursement. Recent announcements concerning certain cardiac surgery procedures show CMS intends to use this paradigm across the continuum. The change to so-called

value-based care motivates hospital administrators to look for partners that can provide a platform allowing for efficient delivery of care under these new models. This may take the form of a hospital-to-hospital merger or the acquisition of clinics and outpatient services. According to RSM Consulting,² whereas total healthcare M&A declined in the latter half of 2015, with the decline continuing into 2016, there was a steady quarter-over-quarter rise in M&A volume of transactions involving hospitals acquiring clinics and outpatient services from 2013-2015. This increase is predicted to continue despite the fact that in November 2015 CMS announced new rules lowering reimbursement for services performed at off-campus outpatient departments. Rural health clinics and EDs are not included in these new rules.³

Hospital administrators believe that hospital consolidation improves efficiency, increases access to care, and lowers costs due to economies of scale. The more patients a hospital cares for, the more efficient and less expensive the care should be.

Better Equipped Facilities

Larger systems may acquire better access to specialists and advanced medical technologies compared to smaller hospitals. Smaller hospitals have a more difficult time maintaining services; patients might have to travel to tertiary care hospitals for more advanced treatments because the cost of investing in and maintaining certain services may be prohibitive. Also, there can be difficulty in recruiting and maintaining a physician base to cover a particular specialty at a smaller hospital in a

less populated area. Coupled with statistics showing physicians prefer to live in larger cities with certain lifestyle amenities, mergers can help resolve the problem of physician shortages. Much of the difficulty also can be related to call issues, as there is a critical mass of physicians required to cover a given specialty.⁴

Hospital mergers creating larger systems may support capital needs as well as technology and infrastructure upgrades.⁵ Alternately, there are disadvantages to merging.

1. Smaller hospital systems generally are more tightly knit with their communities than larger tertiary care centers.

2. Smaller hospitals generally are more agile than larger systems because of fewer levels of approval are required to bring about change.

The Case

Penn State Hershey Medical Center (Hershey) is a 551-bed hospital located in Hershey, PA, offering tertiary medical services typical of an academic medical center. PinnacleHealth System (Pinnacle) operates three community hospitals in central Pennsylvania focusing on general acute care services and providing limited higher-acuity services.

Hershey and Pinnacle received their respective hospital boards' approval for merging in March 2015. The FTC blocked the merger, filing administrative and civil complaints in December 2015.

The FTC based its opposition on the concentration of control of the acute care inpatient hospital services that would be provided by the combined entity in the Harrisburg, PA, area. The FTC argued the transaction would lead to increased

healthcare costs and reduced quality of care for the residents of Harrisburg. The FTC chose Harrisburg as the "relevant geographic area" because it said that, "patients choose to seek care close to their homes or workplaces," and that hospitals outside the Harrisburg area were not meaningful competitors since they "draw very few patients from the Harrisburg Area." This, according to the FTC, would lead to difficulties for insurers who sought to provide affordable health plans because they would be limited to the use of the hospitals and doctors affiliated with the combined entity.

The FTC sought a preliminary injunction of the merger in the Federal District Court of the Middle District of Pennsylvania.⁶

Ruling on Preliminary Injunction

On May 9, 2016, District Judge John E. Jones III denied the FTC and the Commonwealth of Pennsylvania's motion for a preliminary injunction against Hershey and Pinnacle, allowing the merger to move forward. As is typically the case in hospital merger cases, the crux of the court's analysis was defining the "relevant market from which few patients leave and few patients enter." This is important because it defines the degree of control that the combined entity would have in that market. The court disagreed with the FTC's contention that Hershey held approximately a 36% share and Pinnacle a 40% share of the relevant market at the time, meaning the combined entity would control approximately 76% of the market post-transaction. The court stated there were 19 hospitals within a 65-minute drive of Harrisburg that provided alternatives for patient use.

The court also found it compelling that the merged entity would alleviate overcrowding at Hershey, allowing the hospitals to operate more efficiently and upgrade infrastructure.

Judge Jones leveled harsh criticism against the FTC's case, stating that consolidation of healthcare entities was inevitable when there is a "growing need for all those involved to adapt to an evolving landscape of healthcare" and perform efficiently under the Affordable Care Act. The opinion concluded by endorsing the merger as a reality of modern medicine, stating, "[l]ike the corner store, the community medical center is a charming but increasingly antiquated concept. It is better for the people they treat that such hospitals unite and survive rather than remain divided and wither."⁶

FTC Appeals Ruling

On Sept. 27, 2016, the Third Circuit unanimously reversed the lower court decision, finding in favor of the FTC on all the key issues. Most importantly, the Third Circuit agreed with the FTC on the core issue of the "relevant geographic area" definition. The Third Circuit found that Judge Jones' analysis was "economically unsound and not reflective of the commercial reality of the healthcare market."

Interestingly, the Third Circuit also raised questions about the availability of the legal arguments used by the hospitals advocating the transaction based on efficiencies that would be garnered through an otherwise anticompetitive merger.⁷

Soon after this decision, Hershey and Pinnacle abandoned their merger effort.

The current climate of healthcare in America has forced hospitals to

adapt to myriad new regulations. Mergers often provide the fastest avenue to fiscal stability and long-term survival. At the executive level, mergers can make financial and logistical sense. However, despite good rationale, mergers can create a great deal of stress among employees. Mergers change many aspects of the work environment as well as the institutional culture. It is understandable that this high degree of flux can create anxiety for employees. A clear understanding and communication of the changes, which will occur when the merger takes place, are imperative to smooth transitions. The M&A trend leads most healthcare professionals to wonder, “if it happens to my hospital, what should I expect?”

Effect on Employees

In 2014, 95 hospital mergers took place across the United States.⁸ Current trends predict that more than 20% of all hospitals will be considering a merger in the next four years.⁹ This trend signals the reality that soon every hospital employee in America will be faced with an M&A. The most serious concern for employees is job security. Data suggest that in the wake of mergers, employment for nurses may have a grim outlook. A recent study by Emory University showed that positions for RNs decreased roughly 10%, and LPN positions decreased 12% after hospital mergers.¹⁰ The loss of jobs from hospital mergers may be dependent on geographic circumstances, services offered at different facilities, and operating budgets. Proposed financial efficiencies include layoffs at the executive and management levels.

Additionally, there are fewer diverse employment opportunities in

circumstances in which hospitals form one system in a small geographic region. When a person is terminated or wishes to move on, it may be necessary to relocate to find a new position. Conversely, the strength created by an M&A can positively affect job security. The efficiency proposed when mergers take place could prove beneficial to the long-term outlook of the hospitals and employment opportunities.

Effect on Institutional Culture

A proposed merger between St. Joseph's Health System based in Orange County, CA, and Seattle-based Providence Health and Services was met with fierce resistance. The ACLU and women's health advocates raised concerns that, despite both hospital systems being Catholic institutions, the expectation of more stringent adherence to Catholic doctrine post-merger would change current services.¹¹ Proposed changes included provisions regarding abortions, emergency contraception, infertility treatment, vasectomies, and tubal ligations.

The merger also was met with opposition by National Nurses United, the nation's largest nursing organization. Concerns by union leaders targeted many stipulations in the agreement between the two hospital systems, ranging from issues of charitable care to nursing benefits, working conditions, and patient safety. The two systems officially merged in late 2016.

Similarly, the merging of Good Shepherd Health System in Longview, TX, with the international Catholic faith-based Christus Health, based in Irving, TX, likely will lead to dramatic changes in terms of

services offered.¹² Good Shepherd's CEO publicly announced the adoption of the principles of Christus Health concerning reproductive health and end-of-life issues. Changes in these institutional principles will affect hospital-based physicians, including ED doctors, in their practice of medicine. Services once offered by physicians may be prohibited post-merger. Conversely, physicians may be required to perform procedures or offer services that clash with their personal beliefs.

These cultural changes may prove difficult for healthcare employees who now find themselves at odds with the philosophy of their employer. These changes require an adjustment period for all employees.

Effect on Institutional Workflow

The long-term effect of M&A on patient care is the subject of fierce debate. One could argue that larger healthcare systems bring about standardization, resulting in easier access across the system to records and better patient experiences overall. A guide recently published by The Camden Group outlined important institutional steps that often take place after a merger.¹³ A critical early step, they argue, is establishing a clear and concise chain of command to ease the transition. A new hierarchy at the executive level can mean changes in managerial philosophies. Infrastructure changes can include the adoption of new technology, which means personnel training and adjustments in workflow.

Additionally, post-merger hospitals must consolidate human resources management for the new system. Details regarding hospital-based employee packages must be

reviewed prior to the merger. Retirement plans can change dramatically as a result of a merger. For example, since 401(k) plans are not compatible with non-profit 403(b) plans, it may be necessary to reconfigure employment packages.¹⁴ Changes in human resource management frequently involve software changes for reporting work time, registering sick days, and requesting vacation time.

Effect on the Consumer

Communities post-merger often find themselves dealing with major changes in where and how they receive healthcare. A long proposed benefit of larger hospital systems is their ability to use combined negotiating power with private insurers to control costs. However, this is not always the case, as several studies have shown the cost of services imposed by hospitals on private insurance companies can increase substantially as a result of M&A.¹⁵ A 1999 merger between two hospital systems in northern California resulted in price increases for healthcare as high as 44%.¹⁶ These price spikes lead to higher insurance premiums. Higher prices for healthcare affect patients paying the bills as well as employers who provide insurance to employees.

After merging, there is a critical transition period during which employees are trained for providing healthcare services as a new, larger entity. This period of adjustment may result in difficulty in management and administrative tasks, resulting in longer wait times and ultimately stress for patients. Dissatisfied patients are more likely to negatively affect the working lives of physicians and other providers.

Conclusion

As the delivery of healthcare in America continues to be a competitive and controversial industry, hospital systems will continue consolidating in an effort to best serve their communities while remaining economically viable. The effect of these mergers on employees, communities, and patients will vary from case to case based on the many factors involved in the process. However, it is certain that when two separate healthcare entities join together to create a new entity, there will be major changes for employers and employees alike. ■

REFERENCES

1. Arnosky M. Report: Abington docs meet to oppose proposed merger. *Upper Moreland Patch*, July 12, 2012. Available at: <http://bit.ly/2hul9E2>.
2. Brusuelas J. RSM Quarterly Spotlight, Healthcare. Available at: <http://bit.ly/2ien7bm>.
3. Ellis J, Razavi A. 3 reasons why hospital mergers are advantageous. *Healthcare Finance*, Feb. 8, 2012. Available at: <http://bit.ly/2iB7nvs>.
4. Curfman G. Everywhere, hospitals are merging — but why should you care? *Harvard Health Blog*, April 1, 2015. Available at: <http://bit.ly/1xAHZMz>.
5. Dunn L. To merge or not to merge: Benefits, challenges, and the future of stand-alone hospitals. *Becker's Hospital Review*, June 18, 2013. Available at: <http://bit.ly/2i6SF2k>.
6. *FTC v. Penn State Hershey Medical Center; Pinnacle Health System*, Memorandum Opinion and Order, United States District Court for the Middle District of Pennsylvania, May 9, 2016. Available at: <http://bit.ly/2i6Ve4y>.
7. *FTC v. Penn State Hershey Medi-*

- cal Center; Pinnacle Health System*, Opinion of the Court, United States Court of Appeals for the Third Circuit, Sept. 27, 2016. Available at: <http://bit.ly/2driBRG>.
8. Hirst EJ. Hospital mergers continued to create larger systems in 2014. *Chicago Tribune*, Feb. 10, 2015. Available at: <http://bit.ly/2driBRG>.
9. Creswell J, Abelson R. New laws and rising costs create a surge of supersizing hospitals. *The New York Times*, Aug. 12, 2013. Available at: <http://nyti.ms/2ho75Hl>.
10. DePasquale C. Hospital Consolidation and the Nurse Labor Market. Emory Economics 1413, Department of Economics, Emory University (Atlanta). 2014.
11. Proposed St. Joseph, Providence merger raises concerns over health services. *The Orange County Register*, June 3, 2016. Available at: <http://bit.ly/2igPe9G>.
12. Isaac J. Reproductive offerings could change at Good Shepherd under Christus. *Longview News-Journal*, Nov. 26, 2016. Available at: <http://bit.ly/2hof1s2>.
13. Gelineau S, Tyler V. Critical steps hospitals need to take post merger. *Becker's Hospital Review*, May 15, 2012. Available at: <http://bit.ly/2hwemtE>.
14. McLaughlin J. 5 Pitfalls to avoid in hospital mergers and acquisitions. *Becker's Hospital Review*, Jan. 18, 2013. Available at: <http://bit.ly/2hsQMwl>.
15. Delbanco SF. Medical mergers are driving up health costs. *The Wall Street Journal*, Sept. 30, 2014. Available at: <http://on.wsj.com/2i721LA>.
16. Federal Trade Commission. The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction. Working Paper No. 293. November 2008. Available at: <http://bit.ly/2iqykmu>.

Surprising Number of ED Cases End Up Settled

Even if standard of care was met, many factors, including the EP's emotions, come into play

Whether to quickly settle an ED malpractice case or defend it vigorously at trial is purely a business decision — for everyone except the EP defendant, that is. “Everyone else is just counting dollars and figuring which is the cheapest way out,” says **Jonathan D. Lawrence**, MD, JD, FACEP, an EP at St. Mary Medical Center in Long Beach, CA.

Faced with the EP's contention that the standard of care clearly was met, the defense attorney may counter, “It will cost \$40,000 to put on a trial. And something bad happened to the patient. Maybe it's not your fault, but the jury could award millions to this family.”

“The EP has got many more emotional irons in that fire,” Lawrence says.

Some EPs are so distraught by the ongoing litigation that they will do anything to put it behind them, including settling a very defensible case.

“It may not be very well thought out,” Lawrence notes.

On the other hand, some EPs dig in their heels, even when the facts of

the case suggest settlement is clearly the best option. Lawrence testified on behalf of the plaintiff in a recent case with multiple defendants in which the EP's care clearly was below the standard of care. Still, the EP refused to settle.

“Everyone else settled out — and the EP was left to face trial alone,” he recalls. “Fortunately for this physician, the gamble paid off, and she was found not liable.”

Jennifer L'Hommedieu Stankus, MD, JD, FACEP, an attending EP at Madigan Army Medical Center and founder of Gig Harbor, WA-based Comprehensive Medical Legal Consultants, says these factors make it more likely an ED claim will be settled:

- if a lengthy, expensive trial is expected;
- if an unfavorable legal climate exists, such as courts that tend to find in favor of plaintiffs or levy disproportionate judgments;
- if the patient is very sympathetic;
- if documentation is incomplete, making the case difficult to defend.

“The insurance company is a business that is always looking at risk and cost versus benefit,” Stankus notes. “Where there is an outside chance of a very large payout, settling will certainly be considered.”

Does EP Decide?

Assuming the EP's professional liability contract has a consent to settle clause, the EP makes the final decision. “But there are things that insurance companies can do to put the pressure on,” Lawrence cautions.

The insurer might inform the EP that he or she will be responsible for any amount in excess of what it would cost to settle the case. In other words, if the jury returns a \$1 million verdict, and the case could have been settled for \$100,000, the EP is “on the hook” for \$900,000.

Stankus says having the last word as to whether to settle a case is very important for EPs who believe the standard of care was met. “Any settlement, whether or not there was true malpractice, will land him or her in the National Practitioner Data Bank,” she notes.

Costs on both sides are always a factor. “The average cost of defending a lawsuit is approximately \$30,000 to \$40,000. For the plaintiff attorney, bringing one averages \$100,000,” Stankus says, noting this gives the plaintiff's attorney a strong incentive to settle early for as much as possible. “It minimizes the risk of a huge loss, and maximizes return on investment.”

On the defense side, settlement has to be a serious consideration if there is evidence of malpractice and the plaintiff's attorney indicates a will-

Data on ED Malpractice Claims and Lawsuits

Of all the emergency medicine claims and lawsuits from 2006-2015 in the Data Sharing Project of PIAA, a Rockville, MD-based insurance industry trade association, 65% were dropped, withdrawn, or dismissed, 19% were settled, 9% were defended at trial, 4% were resolved through alternative resolution or contract, and 3% were not specified.

- A majority of emergency medicine claims and lawsuits (65%) were shown to lack merit. These claims were resolved when they were dropped, withdrawn, or dismissed, with no indemnity payment to the claimant, but with an average defense expense of \$28,475.
- Less than 10% of claims were resolved through a verdict, with the jury finding in favor of the defendant 96% of the time. The average expense to defend these claims was \$127,090. ■

ingness to settle early. “This is particularly true in cases where there may be a large payout,” Stankus adds.

Settling baseless claims for “nuisance value,” however, is a poor strategy. “Once it is known that an insurance company will settle quickly and early, it follows that claims will go up,” Stankus says.

The fact that defendant physicians prevail in the vast majority of malpractice cases that go to trial is

another consideration. (*See box on previous page for current data on ED claims.*) “Some insurance companies have a policy of defending all but the most egregious cases of malpractice,” Stankus says. “Over time, it is a cost-saving measure.” ■

SOURCES

- **Jonathan D. Lawrence**, MD, JD, FACEP, Emergency Department, St.

Mary Medical Center, Long Beach, CA. Phone: (562) 491-9090. Email: jonlawrence48@cox.net.

- **Jennifer L’Hommedieu Stankus**, MD, JD, FACEP, Attending Physician, Madigan Army Medical Center Department of Emergency Medicine; Founder, Comprehensive Medical Legal Consultants, Gig Harbor, WA. Phone: (253) 820-9343. Email: jenniferlhs@me.com.

Plagiarized Passages in ED Chart Cause Legal Problems

Copied and pasted information complicates defense for EP

An ED intern “copied and pasted” a preliminary report by a resident radiologist into his notes, giving the appearance that the intern actually had reviewed the images, with the attending EP signing the note.

“The final report by the attending radiologist was exactly opposite,” says **Rodney K. Adams**, LL.M., JD, an attorney in the Richmond, VA, office of LeClairRyan. A resident’s concern about hemorrhage in the brain, which was vetoed by the attending, was followed by administration of tissue plasminogen activator. “The patient suffered a serious bleed later,” Adams says.

Legal problems can occur if information pulled into the electronic medical record (EMR) doesn’t match the chief complaint or the physical exam. “These plagiarized passages often contain information that is out of date or inaccurate,” Adams warns. “My favorite is a benign history and physical, followed by a treatment plan of intubation and admission to ICU.”

According to the Federation of State Medical Boards, “it is unethical and inappropriate to ‘copy and paste’

or otherwise document an entry that is not derived from a patient encounter at the time of the visit without indicating that the information is copied and pasted from another record.”¹

A recent PIAA survey showed that more than half of member malpractice companies reported EMR-related malpractice cases. Copy and paste was the most common allegation, identified in 71% of cases.²

Incorrect copied-and-pasted information quickly complicates the defense of a subsequent malpractice claim. The plaintiff’s lawyer will contend one of two things, says Adams:

“That the information should have put the EP on notice of the claimed issue, or that the EP never took a history or conducted the exam.”

EP Discredited

Evidence of copying and pasting can help a plaintiff’s counsel discredit an EP during the course of litigation.

“Information from the EMR showing that the physician did not independently assess the patient — but, rather, copied and pasted other clinicians’ history and physical notes — reflects poorly on the physician,” says **Graham Billingham**, MD,

EXECUTIVE SUMMARY

Copied and pasted information in the ED chart might contain information that’s outdated or inaccurate, and can complicate the defense of a subsequent malpractice claim. To reduce risks:

- review all available data in patient records, and ensure that the information is up to date and accurate;
- establish standards for when this practice is prohibited, and when it may be used with extreme care;
- bear in mind that it’s particularly risky to copy vital signs with the intention of updating them with the current values.

FACEP, chief medical officer of Fort Wayne, IN-based MedPro Group.

This can make the EP's defense an uphill battle. "Evidence presented from copied-and-pasted records may show clinical information that is inaccurate, no longer current, or incorrectly attributed to the patient," Billingham explains.

In one case, a patient with a complicated medical history, including cancer, spinal problems, and a recent knee surgery, presented to a local ED with complaints of leg cramping. "The EP documented the patient's immediate concerns, but failed to document a detailed medical history," Billingham says. Instead, the EP opted to copy and paste the nurse's written summary of her evaluation.

"Further, information from the patient's chart that had been copied and pasted from previous medical visits within the same health system was accessed and replicated again during the ED visit," Billingham says.

Ultimately, the patient required bilateral below-the-knee amputations, likely due to acute arterial occlusion. A malpractice lawsuit alleged delay in diagnosis. "The issue of the copy-and-pasted information in the patient's record was used by the plaintiff's counsel to cast doubt on the accuracy of the physician's documentation and the quality of the care provided," Billingham says.

He suggests EPs review all available data in patient records to ensure that the information is up to date and accurate.

"Because copy and paste is a top concern in EMR-related liability, healthcare organizations should establish standards for when this practice is prohibited, and when it may be used with extreme care," Billingham adds.

Billingham says ED policies should align with hospital policies regarding copy and paste, and should emphasize these things:

- obtaining and documenting an independent history of the present illness;
- performing a physical exam and documenting the results;
- ensuring that the EMR contains adequate information related to the clinician's medical decision-making.

Dean Sittig, PhD, professor in the School of Biomedical Informatics at the University of Texas Health Sciences Center in Houston, says it might be appropriate to copy and paste a long, complex, past medical history from a recent visit. "The key is that only accurate, historical information that cannot change should be copied," Sittig recommends.

It is particularly risky to copy a patient's vital signs with the intention of updating them with the current values. "Often, EPs forget to update a critical value," Sittig says. ■

REFERENCES

1. Federation of State Medical Boards. Report of the Committee on Ethics and Professionalism in the Adoption and Use of Electronic Health Records, April 2014. Available at: <http://bit.ly/2ilOTgV>.
2. PIAA. Special feature: Part 2 of 2: Electronic health records in MPL. Research Notes, April 2016. Available at: <http://bit.ly/2hzc78S>.

SOURCES

- **Rodney K. Adams**, JD, LeClair-Ryan, Richmond, VA. Phone: (804) 343-4173. Fax: (804) 783-7637. Email: Rodney.Adams@leclairryan.com.
- **Graham Billingham**, MD, FACEP, Chief Medical Officer, MedPro Group, Ft. Wayne, IN. Phone: (800) 463-3776. Email: Graham.Billingham@medpro.com.
- **Dean Sittig**, PhD, Professor, School of Biomedical Informatics, The University of Texas Health Sciences Center, Houston. Phone: (713) 299-2692. Email: Dean.F.Sittig@uth.tmc.edu.

RESOURCE

- A free Toolkit for the Safe Use of Copy and Paste, developed by ECRI Institute's Partnership for Health IT Patient Safety, can be downloaded at: <http://bit.ly/28YYInU>.

Does ED Chart Leave AMA Patient Free to Claim, 'If Only I'd Known the Risks?'

Give solid evidence patient was fully informed before discharge

A patient with a known 2.75 cm thoracic aortic aneurysm presented to the ED complaining of unusual heartburn. A CT showed that his aneurysm had grown by 1.3 cm in

the previous nine months; there was no dissection or bleeding.

The EP contacted the on-call thoracic surgeon, who recommended that the patient be admitted for ob-

servation overnight or, if the patient wished, see his or her own surgeon the next day.

"The patient chose to go home, and was found deceased the next day

of an autopsy-proven tamponade,” says **John Davenport**, MD, JD, physician risk manager of a California-based HMO.

The malpractice trial focused on two things:

- whether the EP’s recommendation was appropriate;
- whether there was informed refusal.

The ED chart only documented the recommendation and the advice to “RT ER if worse.” The EP testified that she told the patient of the significant risk of leaving the hospital, including death.

“But her chart and the patient’s family did not support her testimony,” Davenport says. After a large settlement, the EP also faced a hearing before her state medical board to determine if discipline was warranted.

“Patients leave AMA [against medical advice] for a variety of reasons: human frailty in making bad decisions, concern about cost of care, fear of learning something they don’t want to know, psychiatric issues, and others,” Davenport notes.

ED patients have a right to decline treatment, even if the decision might harm them. **Edward Monico**, MD, JD, assistant professor in the department of emergency medicine at Yale University School of Medicine, says, “All I can do as an EP is to inform patients of what I am thinking and why, and enable them the best I can to make an informed decision, even if I think that decision ultimately is wrong or dangerous.”

Informed Refusal

If a bad outcome occurs after a patient leaves the ED AMA, patients or family often claim they really didn’t understand the risks. Malpractice cases often hinge on whether the

EXECUTIVE SUMMARY

Malpractice litigation involving patients who leave EDs against medical advice (AMA) frequently allege the patient wasn’t fully informed. Documentation that can help the EP’s defense should include:

- that the EP encouraged the patient to stay;
- that risks specific to the patient’s condition were discussed;
- specifics on what the patient was told.

EP informed the patient of potential consequences of leaving AMA. “This is the concept of informed refusal,” Davenport says. EPs must tell the patient about any risk of death, serious injury, or significant potential complications that may occur if the patient refuses care.

Davenport says the easiest way to understand informed refusal is to consider what the ED patient would testify to in court. The patient must prove that, “Had I only been told of the consequences of my not following doctor advice, I would have certainly followed it, and thereby not been injured.” The most obvious defense for the EP is, “I did tell you, and you left anyway.”

“It’s very helpful if this is documented in the chart,” Davenport advises.

Such documentation recently helped an EP defend against a malpractice suit filed by a patient who left AMA, refusing a CT scan to rule out appendicitis. “The chart noted the patient ‘was told he risked death by refusing the CT,’” Davenport says. “The patient was readmitted with ruptured appendix, and had a prolonged hospital stay.”

Protocols and Templates

Monico likes to see EDs use a standardized AMA discharge protocol.¹ “This ensures important steps are carried out,” he says, noting

the protocol should include this information:²

- a statement that the patient had decision-making capacity;
- an explanation of the extent and limitation of the ED evaluation;
- presenting signs and symptoms and their significance;
- risks of forgoing or delaying the recommended medical interventions;
- alternatives to suggested interventions;
- an explicit statement that the patient is leaving AMA;
- the patient was provided an opportunity to ask questions.

Robert Broida, MD, FACEP, director of Canton, OH-based US Acute Care Solutions’ risk management department, and chief operating officer of Physicians Specialty Ltd., a South Carolina-based captive insurance company, says a good informed refusal form is essential.

“This replaces the old AMA form, and can be used for refusal of exams, tests, procedures, admission, and transfer,” Broida says. The form documents that the patient has medical decision-making capacity, with a section clearly describing the risks and benefits.

“Some basic ones, such as ‘loss of life or limb’ or ‘access to specialty care,’ are commonly used. But it is best to add some disease-specific information that is pertinent to that particular patient,” Broida says, noting this documentation tends to be

more legally protective. “Our group addressed this specifically in the setting of stroke.”

EPs may be sued after an adverse outcome regardless of whether tissue plasminogen activator is administered. “Patient teaching provided during the consent discussion could be critical in the defense of the claim,” Broida explains.

The ED group developed a standardized patient education tool and matching consent/refusal form, just for stroke patients, which includes very simple graphic representations of the risks and benefits.

“In this manner, the defendant physician can prove what was communicated during this stressful time for the patient and family,” Broida says. ■

REFERENCES

1. Hwang SW. Agency for Healthcare Quality and Research. Discharge Against Medical Advice, May 2005. Available at: <http://bit.ly/2hz8Fv1>.
2. Monico EP, Schwartz I. Leaving against medical advice: Facing the issue in the emergency department. *J Healthc Risk Manag* 2009;29:6-9.

SOURCES

- **Robert Broida**, MD, FACEP, Director, Risk Management Department, US Acute Care Solutions, Canton, OH. Phone: (941) 960-1695. Email: rib@ed-qual.com.
- **John Davenport**, MD, JD, Irvine, CA. Phone: (714) 615-4541. Email: Doctordpt@cox.net.
- **Edward Monico**, MD, JD, Department of Emergency Medicine, Yale University School of Medicine, New Haven, CT. Phone: (203) 785-4710. Email: edward.monico@yale.edu.

EP's Defensive Response to Peer Review Inquiry Complicates Matters

Feeling personally attacked during peer review inquiries, EPs might claim the investigation is a sham, is harassment, or that the investigator holds a personal grudge.

However, an emotional response is detrimental to the EP, cautions **Karin M. Zaner**, JD, a director at Dallas-based Kane Russell Coleman & Logan PC, who frequently represents physicians facing peer review investigations.

“You don't want your explanations to signal to a third party that you are a problematic person,” she explains. “The reality is that peer review happens all the time.”

Zaner says the best approach is “to be the most reasonable, credible person in the room. If a nurse is crying and pointing fingers at you, you need not respond in kind.”

A better approach is for EPs to answer all possible questions anyone could have regarding the allegation that they didn't meet the standard of care.

“The worst responses I see are chock full of finger pointing,” Zaner

says. “If you are hostile and blaming other people, then it looks like a fight.”

Taking an adversarial approach may be tempting, but it can backfire quickly. “The reality is, the more you fight, the more they fight back,” Zaner says. Instead, EPs should give all the information that's needed to provide assurance. “In the long run, this is better because you will end up with more of a benign report,” Zaner adds.

Here are some actions by EPs that have needlessly complicated the peer review process:

- **The EP resigns in the middle of an investigation.**

“That's the worst thing you can do,” Zaner says. Leaving in the middle of an investigation, or even an inquiry, has an unintended consequence. It means the hospital then is required to report it to the National Practitioner Data Bank.

“What you want to do is hold on, don't panic, and get some legal help,” Zaner says. It might be that the hospital ultimately closes the case

against the EP. If the EP wants to resign at that point, he or she can do so without triggering a Data Bank report.

“Reporting stays with you until the end of your career. The stakes are really high, because it's a permanent effect on your record,” Zaner warns.

- **The EP refuses to cooperate with the committee's recommendations.**

“The best story you can have is that the hospital raised the issue and the EP completed whatever it was they wanted, and the hospital found no issues,” Zaner says. The hospital might ask the EP to have a certain number of cases retrospectively reviewed, require proctoring, require preapproval for cases, or sign a behavior agreement. “The best thing to do is cooperate with the hospital and give them the assurances they need,” Zaner says. “But get legal assistance, as these often are reportable.”

Once the required action is completed, the matter might be resolved. “The EP gets a seal of approval from the entity that raised the issue in the

first place. That is your golden standard. To anyone looking at it in the future, it just looks like a matter that was dealt with," Zaner says.

• **The EP tries to go it alone.**

As soon as the EP knows a peer review is focused on him or her, says Zaner, "a call to a qualified peer review lawyer absolutely makes sense."

The attorney can make it less likely that privileges or credentialing are curtailed or lost, or mitigate the effect of reporting that may occur as a result of actions taken against the EP. "If I had a choice, I would rather have an EP with a few minor malpractice settlements than action taken on privileges," Zaner advises. "That is a more serious issue."

A well-informed EP is more likely to respond in a way that's helpful, rather than hurtful. "When the whole process is mysterious, that causes the EP to be nervous and lash out," Zaner says. The key is to come at it with a reasonable, credible explanation for what happened, and willingness to collegially work things out, if possible.

"If you know you had a bad month in the ER, and situations happened that were difficult, it might just be something that needs to be explained," Zaner notes.

There is a chance that the EP's explanation might be sufficient, and can clarify what happened. "If it's a tech, nurse, or other EP accusing you, you can say, 'I understand how this may have been misperceived, but here's what happened,'" Zaner suggests. "It might go away, or might end up being something less draconian than when they misunderstand the facts."

Since it's not a malpractice case, EPs facing peer review typically don't reach out to a lawyer right away. Once they do, it might be too late to avoid serious repercussions. "If you

only call at the end of the process, you have missed a lot of opportunities to resolve it beforehand," Zaner says. "Any negative actions taken are now set in stone."

• **The EP threatens a defamation suit, only to find out there's no legal ground to stand on.**

A common reaction from EPs is, "They shouldn't be able to do that."

"But the reality is that in the courts, in the area of peer review, there is so much immunity and privilege," Zaner says. "Your lawsuit after the fact is not one you want to bring."

Not only will the lawsuit be dismissed due to immunity, the EP might also end up liable for the hospital's attorney fees. "It's a real David and Goliath situation that does not bode well," Zaner warns. "It leaves you in a place with no good options when it all goes south." ■

SOURCE

- **Karin M. Zaner**, JD, Director, Kane Russell Coleman & Logan PC, Dallas. Phone: (214) 777-4203. Cell: (214) 236-9956. Fax: (214) 777-4299. Email: kzaner@krcl.com.

CME/CE INSTRUCTIONS

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

1. Read and study the activity, using the provided references for further research.
2. Log on to **AHCMedia.com** and click on [My Account](#). First-time users will have to register on the site using the eight-digit subscriber number printed on their mailing label, invoice, or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

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

- Legal risks if police ask for blood alcohol level for DUI suspects
- Why quality assurance material can end up being discoverable
- How ED nursing documentation can save EP from liability
- Plaintiff attorneys might add EMTALA claim to malpractice suits



ED LEGAL LETTER™

PHYSICIAN EDITOR

Arthur R. Dorse, MD, JD, FACEP
Director and Professor, Center for Bioethics and Medical Humanities, Institute for Health and Society, Medical College of Wisconsin, Milwaukee

NURSE PLANNER

Kay Ball, PhD, RN, CNOR, FAAN
Associate Professor, Nursing, Otterbein University, Westerville, OH

EDITORIAL ADVISORY BOARD

Sue A. Behrens, RN, DPN, ACNS-BC, NEA-BC
Senior Director, Ambulatory and Emergency Department, Cleveland Clinic Abu Dhabi, Abu Dhabi, United Arab Emirates

Robert A. Bitterman, MD, JD, FACEP
President, Bitterman Health Law Consulting Group, Inc., Harbor Springs, MI

Kevin Klauer, DO
Chief Medical Officer, TeamHealth, Knoxville, TN

Jonathan D. Lawrence, MD, JD, FACEP
Emergency Physician, St. Mary Medical Center, Long Beach, CA

William M. McDonnell, MD, JD
Clinical Service Chief, Pediatric Emergency Medicine Medical Director, Emergency Department Children's Hospital & Medical Center, Omaha, NE

Larry B. Mellick, MD, MS, FAAP, FACEP
Professor of Emergency Medicine, Professor of Pediatrics, Department of Emergency Medicine, Augusta University, Augusta, GA

Gregory P. Moore, MD, JD
Attending Physician, Emergency Medicine Residency, Madigan Army Medical Center, Tacoma, WA

Richard J. Pawl, MD, JD, FACEP
Associate Professor of Emergency Medicine, Augusta University, Augusta, GA

William Sullivan, DO, JD, FACEP, FCLM
Director of Emergency Services, St. Margaret's Hospital, Spring Valley, IL; Clinical Instructor, Department of Emergency Medicine, Midwestern University, Downers Grove, IL; Clinical Assistant Professor, Department of Emergency Medicine, University of Illinois, Chicago; Sullivan Law Office, Frankfort, IL

Interested in reprints or posting an article to your company's site? There are numerous opportunities for you to leverage editorial recognition for the benefit of your brand. Call us at (800) 688-2421 or email us at Reprints@AHCMedia.com.

Discounts are available for group subscriptions, multiple copies, site-licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at Groups@AHCMedia.com or (866) 213-0844.

To reproduce any part of AHC newsletters for educational purposes, please contact The Copyright Clearance Center for permission:

Email: info@copyright.com
Website: www.copyright.com
Phone: (978) 750-8400

CME/CE QUESTIONS

1. Which is true regarding settlement of ED malpractice claims?

- Jurisdiction is irrelevant when making the determination to settle or defend a claim.
- The insurance company makes the final decision to settle a claim against an EP, even if there is a required consent to settle clause in the professional liability contract.
- If an EP refuses to consider settling a claim despite the insurer's recommendation to do so, the EP might be held responsible for any verdict in excess of the amount of the agreed settlement.
- Low-dollar settlements are not reported to the National Practitioner Data Bank unless there was actual malpractice or gross negligence.

2. Which is true regarding copy and paste in ED charts?

- Recent court rulings have clarified that EPs are not legally responsible for documentation problems stemming from poorly designed electronic medical records (EMRs).
- Evidence of copying and pasting information from the EMR can help a plaintiff's counsel discredit an EP during the course of the litigation.
- ED policies should address EMR documentation more generally instead of specifically commenting on copy and paste or other high-risk charting activities.
- The Federation of State Medical Boards approves of EPs copying and pasting without indicating that it came from another record if EPs believe the information to be current and accurate.

3. Which is recommended regarding informed refusal for ED patients leaving against medical advice?

- Documentation showing that disease-specific risks were discussed is helpful to the defense.
- A simple statement that the patient should return to the ED if the condition worsens is preferable to a list of specific possibilities of worsening from the condition.
- Documentation listing risks that can cause loss of life or limb increases the EP's exposure since the plaintiff can use it to argue that these risks should have caused the EP to have the patient involuntarily held.
- EPs are expected to include their medical decision-making as to why each of the listed conditions in the documentation of the patient's refusal of treatment was believed unlikely to happen to the patient.

4. Which is recommended if EPs are the focus of a peer review inquiry?

- Involvement of attorneys is advisable only if the EP's privileges are threatened, because it makes the process adversarial.
- EPs should strongly consider resigning if the investigation is unwarranted, since it sends a message to future employers that the EP stands behind the care he or she provided.
- EPs should consult with a qualified peer review lawyer when considering how to respond to recommendations.
- EPs should not hesitate to submit written responses that make it clear they believe others are at fault for an adverse outcome.