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INSIDE

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Report: 10% of ED Malpractice Claims Involve Medication Errors

Wrong drug orders and no drug orders are common reasons for lawsuits

About 10% of ED malpractice claims involve medication errors, according to a recent report.[1]

A careful analysis of the claims and their contributing factors "tells you a story about these ED cases," says **Penny Greenberg**, MS, RN, CPPS, editor of the report. Greenberg is senior program director of patient safety services for CRICO Strategies, which provides medical professional liability coverage for the Harvard medical community. Of 1,629 cases with emergency medicine as the primary responsible service, 155 involved medication errors.

The report is a product of CRICO Strategies' national Comparative Benchmarking System, the largest malpractice claims database with detailed coding in the world. The database contains nearly 400,000 medical malpractice cases from more than 20 insurers and more than 400 healthcare entities, comprising about 30% of all paid and unpaid malpractice cases in the United States. Cases are coded by allegation, severity, responsible services, initial and final diagnosis, clinical setting of the event, contributing factors, and human factors.

"When you have an event in the ED, most organizations conduct a cause analysis and develop an action plan. You think you have fixed the problem and a year later, a similar event happens again," Greenberg notes. The database allows for an analysis of many cases, and reveals the contributing factors and trends driving similar events.

The authors of the report examined closed cases involving a medication-related problem occurring from 2005-2014. Of the 351 closed cases that occurred in the ED setting, 38% closed with payment, with an average indemnity of about $230,000.

The analysis of the claims revealed that the top three risk factors for

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medication-related problems in the ED involved the EP's clinical judgment, selection and management of medications, and patient assessment. "These are the things to focus on when implementing patient safety initiatives," Greenberg adds. Some other findings about the medication-related ED cases:

• Fifty-two percent involved patient assessment.

"This should prompt EDs to question, 'Do we have a structured way to assess patients and communicate findings between providers? Are we moving too quickly?'" Greenberg says.

Of the cases with patient assessment as a contributing factor, 30% involved the history and physical. "Lack of a complete history and physical can affect the identification of a differential diagnosis and treatment plan," Greenberg says.

One case involved a stroke patient who received tPA despite registering a systolic blood pressure of 197 (the drug is contraindicated if the patient's systolic blood pressure is above 185). The patient suffered a hemorrhagic stroke, and the family successfully sued the EP. The case settled for $200,000.

"Lack of assessment and communication between providers regarding the patient's blood pressure and contraindications of tPA contributed to this event," Greenberg concludes.

Assessment and ordering issues "go hand in hand," she adds. "If the patient assessment is not complete and accurate, it can affect decision-making and the treatment plan."

• Communication was a factor in 39% of the cases.

"This is not surprising in ED cases," Greenberg says. Sixty-four percent of the cases with communication as a contributing factor featured a provider-to-provider communication issue. For 51% of this group of cases, the communication issue was between a provider and the patient or family member.

• Sixty-seven percent of cases involved ordering of medications.

Here are some actual malpractice cases included in the analysis:

A 32-year-old woman came to the ED complaining of slurred speech, along with numbness and tingling in her jaw and upper extremities. She reported starting methadone therapy recently, along with a history of chronic back pain and long-term use of opioid narcotics.

The patient was diagnosed with peripheral neuropathy and received a muscle relaxant. The patient was advised to take ibuprofen and to discontinue the other muscle relaxant she was taking.

"She was discharged, and died at home the next day," Greenberg says. The patient's family sued the EP for failure to diagnose methadone toxicity.

Vague discharge discussions complicated the defense of the claim. The instructions didn't tell the patient to discontinue the other muscle relaxant. "It just said, 'Take medications as directed,'" Greenberg notes. "It would have been helpful if the discharge instructions had been more specific." The case was eventually dismissed, but only after the EP paid $8,000 in legal expenses.

A woman with a history of recent head trauma presented to the ED with chest pain, and was diagnosed with an acute myocardial infarction.

"The EP's documentation noted she had been admitted 11 days earlier after falling at home and sustaining a head trauma that resulted in a laceration to the forehead," Greenberg says. The patient received nitroglycerin and morphine. The EP consulted a

cardiologist, but failed to communicate the patient's history of recent head trauma during the discussion.

The cardiologist recommended metoprolol and tenecteplase, a thrombolytic medication that is contraindicated in patients with recent trauma because of increased risk of bleeding. The hospital's policy listed head injury within the previous three months as a contraindication for tenecteplase.

The patient was started on the medication, and a cardiac catheterization was performed. After the procedure, a change in mental status was noted, and a neurologist was consulted. On exam, the patient's pupils were fixed and nonreactive, and the patient was intubated.

A CT scan of the head showed a massive subarachnoid bleeding. "The family decided to provide comfort care for the patient, and the autopsy listed the cause of death as subarachnoid bleed due to thrombolytic therapy," Greenberg notes. "The case settled for $80,000."

An 84-year-old woman presented to the ED with symptoms of urinary tract infection. The patient reported a previous allergic reaction to ciprofloxacin. "The ED resident ordered [nitrofurantoin] after discussion with the attending," Greenberg explains. The patient was discharged to the assisted living facility.

Four days later, she was transported to the ED with severe back pain, and diagnosed with urosepsis and hyperkalemia. "The patient suffered acute delirium, pyelonephritis, urinary retention, and chronic back pain," Greenberg says.

After researching the patient's medication list during the second ED visit, the ED director established that nitrofurantoin was not appropriate for elderly females with urinary tract infection.

"Additionally, on review, it was noted that a kidney panel should have been done prior to ordering the drug," Greenberg says. "The case settled for $16,000." ■

REFERENCE

1. CRICO Strategies. Medication-related malpractice risks: CRICO 2016 CBS Benchmarking Report. Boston; May 27, 2017.

SOURCE

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Hospitals Increasingly Held Liable for EPs' Negligence

Plaintiffs might view an EP as another 'deep pocket'

Traditionally, hospitals could not be held liable for the negligence of EPs, because civil liability for damages was limited to only those individuals directly culpable for the injury. However, recent changes have eroded this protection.

"Until relatively recently, hospitals often enjoyed additional legal protection from liability under the well-recognized doctrines of charitable or sovereign immunity, depending upon the ownership of the facility," explains **Richard F. Cahill**, Esq., vice president and associate general counsel at The Doctors Company, a Napa, CA-based medical malpractice insurer.

Courts gradually expanded the scope of entities that may be found legally culpable for the conduct of others under theories such as the *borrowed servant rule* and *respondeat superior*. This meant that hospitals could be held responsible vicariously for the conduct of the EPs they employed.

"However, even those doctrines often produced inequitable results, and denied recovery where the injured plaintiff suffered damages clearly as a result of someone else's negligence," Cahill says. For example, courts consistently determined that hospitals could not be held liable for the acts of EPs acting as independent contractors in treating patients. "The rationale was that the facilities had no right to control the nature or extent of the care being delivered by practitioners rendering treatment in EDs," Cahill says.

Several recent changes have increased legal exposure for hospitals in the event someone sues an EP for negligence. "Appellate courts have systematically eroded the concept of independent contractor as a bar to hospital liability through the legal doctrine of apparent authority," Cahill explains.

"Apparent authority" or "apparent agency" means that a person may be deemed an agent of the principal

when that individual creates the appearance of authority, and when the person affected was reasonably justified in believing that the person was an agent, and then proves that such reliance was justified, explains **Robert D. Kreisman**, JD, a Chicago-based medical malpractice attorney.

Most jurisdictions, either by statute or through appellate decisions, have adopted the concept of apparent authority. "This creates another 'deep pocket' in the event of a favorable verdict for an injured patient-plaintiff," Cahill adds.

Additionally, Congress and state legislatures nationwide have eliminated, or significantly modified, certain statutory protections, such as charitable and sovereign immunities.

"After decades of appellate decisions, hospitals no longer can avoid culpability for the negligent acts of physicians working in their EDs," Cahill concludes.

Previously, hospitals escaped liability by asserting they had no control over the education, training, or experience of the providers or over the types of care and treatment rendered. This is no longer the case.

"If the patient-plaintiff establishes apparent authority or ostensible agency by a preponderance of the evidence as well as the underlying negligence of the treating physician, both the hospital and the provider may face significant exposure in the event of an adverse verdict," Cahill says.

Appellate decisions have identified numerous considerations to determine whether "apparent agency" applies in a particular situation. Cahill offers these examples relevant to the ED setting:

- Did the ED post signage indicating clearly that the treating personnel were independent contractors, and not employees of the hospital?
- Does the facility's website identify ED providers as hospital employees or independent contractors?
- Did the patient sign a conditions of treatment form on arrival in the ED acknowledging that he or she understands that physicians and nurses rendering treatment are independent contractors, separate from the medical center?
- Were discharge instructions or other paperwork provided to the patient on hospital stationery?
- Did any of the ED providers wear clothing, such as lab jackets or scrubs, bearing the hospital's name or logo?
- What did any name badges worn by personnel display, in terms of name, title, or employer?

For a hospital to be held vicariously responsible for the alleged negligent acts of an EP independent contractor, the plaintiff must demonstrate these two things:

- that there was some representation by the medical center to the public, either explicit or implied, that the EP is affiliated with, employed by, or rendering care on behalf of the hospital;
- that the patient reasonably or justifiably relied on that representation, thereby sustaining injury.

"Not surprisingly, what constitutes a sufficient representation encompasses a wide spectrum," Cahill says. California, for example, requires the hospital to bear the evidentiary burden of demonstrating that the patient was on actual or constructive notice that the provider was an independent contractor and, therefore, was *not* an ostensible agent of the hospital.

"Ultimately, whether apparent agency exists is a question of fact for the jury and, thus, often is not suitable for dismissal by summary adjudication," Cahill notes.

Traditionally, under Pennsylvania law, an employer could be vicariously liable only for harm caused by an *employee's* negligence. "If the harm was caused by an independent contractor, then the employer traditionally would not be vicariously liable," says **A. Bryan Tomlinson**, Esq., an attorney in the Philadelphia office of Post & Schell. The doctrine of apparent or ostensible agency is a common law exception to this rule, codified by the 2002 Medical Care Availability and Reduction of Error Fund Act. This permits a hospital to be found liable for the conduct of an EP who is not employed by the hospital in two situations.

"The first is when a reasonably prudent person in the patient's position would be justified in believing that the care provided by the ED physician was being rendered by the hospital," Tomlinson explains. The other is when the care at issue in the case was advertised or represented to the patient as care rendered by the hospital.

Kreisman explains, "A hospital can be held vicariously liable for the negligent acts of an EP, even if the EP is not an employee of the hospital, unless the patient knows, or should have known, that the EP is an independent contractor."

This issue became a key focus in a recent malpractice case. Plaintiffs brought a lawsuit against a Chicago hospital after the premature birth of their daughter.[1] "This case came to the Illinois Appellate Court by the request of the defendant, Northwestern Memorial Hospital, regarding the doctrine of apparent authority in the medical negligence context," Kreisman says.

The question in that case was: "Can a hospital be held vicariously liable under the doctrine of apparent authority for the acts of

the employees of an unrelated, independent clinic that is not a party to the present litigation?" The court turned to the seminal case in the state of Illinois.[2] "Under the *Gilbert* decision, plaintiff must establish the three factors holding the hospital liable under the doctrine under apparent authority for acts of independent contractor physicians," Kreisman explains. These are as follows:

1. The hospital, or its agent, acted in a manner that would lead a reasonable person to conclude that the individual who was alleged to be negligent was an employee or agent of the hospital;

2. Where the acts of the agent create the appearance of authority, the plaintiff also must prove that the hospital had knowledge of and acquiesced in them;

3. The plaintiff acted in reliance upon the conduct of the hospital or its agent, consistent with ordinary care and prudence.

Most patients coming to a hospital ED will believe that the physicians and medical staff are employees of the hospital, Kreisman says.

"The apparent agency argument for plaintiffs, where a patient is injured, harmed, or died because of alleged negligence in the ED, is that the nurses and physicians were identified by their jackets, hospital logos, and nameplates that they wear and, thus, are associated with the hospital," Kreisman says. Kreisman has handled multiple cases in which the plaintiff has argued that the hospital should be held liable for an EP's negligence. In most of these cases, the EP defendants were independent contractors working for a separate company hired by the hospital to service the ED.

"Nevertheless, the argument for apparent authority usually is a winning one, placing liability on the hospital," Kreisman says. ■

REFERENCES

1. *Yarbrough v. Northwestern Memorial Hospital*, 2016 IL App (1st) 141585.
2. *Gilbert v. Sycamore Mun. Hosp.*, 156 Ill.2d 511, 524-25 (1993).

SOURCES

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Med/Mal Suit Possible if EP's Name Appears in Adverse Event Report

Federal investigators demand 'anything and everything'

Did an EP's care result in an adverse event that triggers mandatory reporting to state or federal agencies? "If I'm that EP, I would want to make sure I understand what is, or isn't, being communicated," offers **Michael R. Callahan**, JD, a partner at Katten Muchin Rosenman in Chicago. He adds that EPs should know these two things if an adverse event is reported for an ED patient:

• Is an adverse event report, in fact, required?

• What information does the hospital have to provide?

"If I'm involved in a report, I want to know if my name is being used, and if so, whether it is really necessary," Callahan explains. "Is the hospital providing too much information, and now I'm exposed?"

Contrary to what many believe, the EP's name isn't necessarily required in an adverse event report. "Typically, the hospital only provides what they are required to provide, nothing more and nothing less," Callahan notes.

However, it's possible that the hospital decides to include the EP's name in the report regardless. This may be a misguided attempt to escape liability for the patient's bad outcome. "I don't think the hospital can completely wash its hands of responsibility when it comes to an EP, [which would be more likely if the defendant is] an independent surgeon," Callahan adds.

An ED's adverse event report could trigger an investigation by the state licensing board, by the Centers for Medicare & Medicaid Services (CMS), or even by an accredited body such as The Joint Commission. This is more likely to happen if there is a pattern of adverse outcomes in that ED, Callahan says.

Once an investigation occurs, it means the medical records surely will be reviewed. "They obviously can't

redact or delete the name of the EP involved, in that event, because it's part of the medical records, which are never privileged," Callahan explains.

CMS or state investigators are "going to want access to anything and everything, in order to determine if the hospital was or was not in compliance," Callahan adds.

This includes what the hospital did, if anything, because of the adverse event. "That's where it gets dicier," Callahan warns. The question then becomes: Is the information the agency is asking for privileged or confidential, either under state law or federal law?

Typically, an adverse event in the ED triggers a comprehensive internal peer review investigation and/or a root cause analysis. If the hospital conducted these activities under the umbrella of a patient safety organization, it's likely the material will be treated as a privileged patient safety work product. "Consequently, the hospital is not going to turn that over, at least initially," Callahan says.

The investigating agency might want to know if the root cause analysis or peer review evaluation revealed any problems with the EP who cared for the patient. Conflict over what the hospital will or will not agree to produce often ensues.

"Obviously, the hospital doesn't want to lose their Medicare eligibility, although that's rare," Callahan says. "They also don't want their hospital to be on the 'bad hospital' list, because they are then going to be visited by the state or the feds every other week."

State laws vary as to what information is privileged. If it's the state licensing body asking questions about whether any peer review was performed on the EP because of the adverse event, Callahan says, "Our response is, 'Sorry, under our state statute you are only entitled to medical records. We are not going to turn over our peer review files.'"

On the other hand, if a federal agency, such as the department of public health, is investigating, "they get access to everything," Callahan notes. "The hospital, at that point, might not have a choice."

However, if the internal review was conducted under the auspices of a patient safety organization, privilege applies to both state and federal proceedings. "Then there are the negotiations," Callahan adds.

The hospital might agree to turn over the action plan resulting from the root cause analysis, to show how ED policies were modified to prevent the incident from happening again. Likewise, the hospital might agree to allow ED nurses to be interviewed, but without turning over any internal analyses. The amount of push-back varies. "If the hospital says, 'We don't think we have to turn this over in order to demonstrate compliance,' many times the government will agree. But sometimes they don't," Callahan warns.

Depending on the facts of the case, investigators may not be focused on the EP at all. "It all depends on how deep the government wants to dive in terms of getting access to the information, and what the hospital is willing to produce," Callahan offers.

The state licensing board may want to conduct its own review and ask an expert to comment on the EP's care.

"They have that right," Callahan says. "On the other hand, they don't want to redo this work if the hospital has already done it."

The government's justification for demanding this information is that it is needed to determine if the hospital is in compliance or not. In malpractice litigation, the plaintiff doesn't have the same argument.

In a malpractice lawsuit against an EP, Callahan explains, "Even if you have to disclose information to CMS because you're not going to run the risk of getting kicked out of Medicare, you can do it without losing protection."

Five EMTALA Violations

Even a single adverse event in the ED could lead to an investigation and greater scrutiny of the patient's medical record. "Who knows where it goes from there?" Callahan asks. "EPs are independently exposed both from a regulatory and legal standpoint, as is the hospital."

A CMS investigation of a possible violation of the Emergency Medical Treatment and Labor Act (EMTALA), for instance, has important legal implications for individual EPs. In a recent case Callahan reviewed, one EP's complaint about the care provided by another EP triggered an onsite review by CMS.

CMS determined that the EP had violated its conditions of participation. As part of the investigation, CMS requested copies of about 20 patient records, which were sent for review by a quality improvement organization and expert EPs. Based on a review of those records, CMS decided to investigate the EP independently.

"Almost a year after the complaint was originally filed, CMS came back to the hospital and said, 'Based on the cases that we reviewed, you now have five EMTALA violations,'" Callahan recalls.

The EMTALA violations involved patients who were not stabilized

adequately, a patient who had not undergone an adequate medical screening exam, and patients for whom required tests weren't performed before transfer. "The hospital has the obligation under EMTALA to provide these services," Callahan notes. The EP doesn't have an independent obligation and cannot be sued under EMTALA. "However, if found to have violated EMTALA, EPs are at risk for civil fines and penalties, and independent action as it relates to their continued participation in Medicare," Callahan notes. Additionally, if an EMTALA violation is found to exist, this could result in the patient or family filing a separate malpractice claim against the EP.

"An EMTALA violation can open up a whole can of worms in that regard," Callahan warns. The plaintiff attorney might allege, for instance, that the EP delayed treatment or should have consulted with a specialist, resulting in permanent harm to the patient.

"If a malpractice case against the EP does occur, the question arises as to whether the reports on any investigations by state or federal agencies are confidential," Callahan adds. If the EP takes any notes after an adverse event occurs, these may be discoverable. "Consult risk management and hospital counsel," Callahan advises. "You want to make sure the notes are not going to see the light of day, from a discovery standpoint." ■

SOURCE

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Don't Blindside Consultants Legally: Be Up-front About Charting Practices

Prevent adversarial relationship during litigation

Some consultant recommendations come in the form of a formal, face-to-face evaluation in the ED. Many more are "curbside" consults, or casual conversations that may or may not be documented in the ED chart.

"In a majority of cases, curbside consults can be brought into evidence," says **John W. Miller II**, principal of Sterling Risk Advisors in Atlanta.

If a malpractice suit occurs, the EP and the consultant likely will have different views as to whether their discussion constituted a "real" consult. "The vast majority of plaintiff's attorneys will seek to bring a curbside consult in," Miller says.

If the phone call from the EP arose because of the consultant's on-call status, it's clear that a patient/physician relationship was formed, says Miller, "but if it happened absent an on-call obligation, it's case law-specific in every state."

Miller says EPs should "make sure that the scope of the conversation is inclusive enough to provide a valuable opinion, rather than a cursory opinion based on limited facts."

Is the EP asking for a general recommendation from the consultant, or a recommendation for a specific patient?

If the EP were to obtain a surgical consult for a patient regarding appendicitis and describes a specific individual in the ED at that point, "that's more likely to come in, from a legal standpoint," says **John Tafuri**, MD, FAAEM, regional director of emergency medicine at Cleveland (OH) Clinic and chief of staff at Fairview Hospital in Cleveland.

If the consultant makes a recommendation for a specific patient, and the EP documents that the case was discussed, Tafuri says, "it probably varies from state to state based on court rulings, but I think the consultant should consider themselves involved in the case."

Many ED charts omit any mention of consultants. If so, it's unlikely the plaintiff attorney will involve a consultant in the lawsuit, unless the defendant EP brings up the consultation in discovery. "Generally, if things aren't in the medical record, plaintiff's attorneys are unaware of the discussion," Tafuri says.

On the other hand, if the EP documents, "Discussed with Dr. X, who told me it was safe to discharge the patient," the consultant likely will become a defendant.

"It's important for EPs to realize that when they start involving other physicians, if those physicians don't know they are being involved in the case, it's likely to result in an

adversarial relationship between the two physicians," Tafuri advises.

Upon learning that the EP documented every word of their "informal" conversation, consultants can become antagonistic. "This can be worse for the EP's defense than having no consult documented in the chart at all," Tafuri says.

The EP could end up in a situation in which the consultant and the plaintiff's expert both say that the EP did the wrong thing.

"The ER physician needs to clearly delineate to the consultant, 'I'm consulting you on this patient, and I'm going to mention your name in the chart,'" Tafuri explains. If EPs asks general-sounding questions, on-call doctors may not realize they're being consulted "officially."

Miller agrees that EPs should tell consultants they are documenting their recommendations. "It's not fair for one party to document and the other not to."

Avoid Adversarial Relationship

Good documentation on a consultant's recommendations can bolster the EP's defense. However, the EP can't hide behind it completely.

"To the extent that the EP tries to deflect responsibility to the on-call physician, it's really detrimental to the defense," Tafuri notes. "The EP is always going to be involved in the case, no matter what."

Charting such as "Talked to Dr. X, and he said it's OK to send the patient home" won't get the EP off the hook legally. "If someone is sent home, and there's a bad outcome, trying to say the consultant made the decision — when it's really the EP's decision to send the patient home or not — just hurts the EP's position in the case," Tafuri says.

It also creates an adversarial relationship between the EP and the consultant. "It's one thing to say, 'I've discussed the patient with Dr. X, and he agrees with my plan regarding discharge and follow up as an outpatient.' It's another thing to try to lay it on somebody else," Tafuri warns.

It's fine for the ED chart to indicate that the consultant offered an opinion or a suggestion. "But it should be clear that the EP is the one making the final decision about the patient's disposition," Tafuri adds.

Consultants don't always agree to come to the ED to evaluate the patient in person, even when the EP believes it's necessary. "In that case, the EP needs to be very clear with the on-call consultant and say, I'm not comfortable with this,'" Tafuri says.

EPs should state clearly that an in-person evaluation is requested, Tafuri stresses. "Consultants do have a legal obligation under EMTALA to come in, if you request it when they are on call."

This is true even if the EP reflects on the situation after the initial interaction with the consultant and decides that an in-person evaluation by the consultant is necessary after all.

"It's important to be up-front and honest with the consultant so they don't feel as though you are trying to work them into a potential legal case," Tafuri offers.

When Tafuri has insisted that a consultant come down to see an ED patient whom the consultant wanted to send home and Tafuri wanted to admit, the consultant admitted the patient in every instance.

"They've never discharged the patient when they've seen the patient themselves," Tafuri recalls. "They usually see that the patient appears more ill than they expected." ■

SOURCES

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ED Care Difficult to Defend if Patient Died Shortly After Discharge

Such cases are 'every emergency physician's greatest fear'

A substantial number of patients die soon after discharge from EDs, despite no evidence of previous life-limiting illnesses, according to the authors of a recent study.[1] "A patient who dies unexpectedly soon after being sent home is every emergency physician's greatest fear," says **Ziad Obermeyer**, MD, the study's lead author. Obermeyer is an assistant professor of emergency medicine at Brigham & Women's

Hospital and an assistant professor of healthcare policy at Harvard Medical School in Boston.

Researchers analyzed claims data for Medicare beneficiaries who visited an ED from 2007-2017 and were discharged home, and found that 0.12% died within seven days.

The leading causes of death were atherosclerotic heart disease, myocardial infarction, and COPD. Altered mental status, dyspnea, and malaise/fatigue were more common among early deaths compared with other ED visits.

"These events point out the limits of our understanding of patients' problems," Obermeyer says. "It's a catastrophic failure of our ability to predict risk. And it's terrifying."

Another concerning thought is that deaths may be the tip of the iceberg and an indication of a broader patient safety problem. "A lot of bad things have to line up for a patient to die," Obermeyer notes. "A lot more patients could be seriously disabled or otherwise affected by missed diagnoses without dying."

Small increases in admission rates were linked to large decreases in risk. Hospitals in the lowest fifth of rates of inpatient admission from the ED demonstrated the highest rates of early death, despite the fact that hospitals with low admission rates served healthier populations. Considering this finding, Obermeyer suggests EDs study the percentage of all Medicare patients seen in the ED who are admitted.

"This is probably the best indicator of whether or not there could be a problem in your ED," Obermeyer offers. If the ED is near the lowest quintile of inpatient admission rates for these patients (less than 22%), it doesn't necessarily mean there's a problem. "But I would do some serious thinking about why that is happening and if there is anything you should be doing differently from a safety point of view," Obermeyer adds.

Cases involving patients who died shortly after discharge from an ED are difficult to defend. This is true even if there is no direct link between the ED care and the patient's death.

"The jury expects you to be able to help everybody when they come to the ED. If the ED sent someone home who died, in their minds it's an inference that you didn't do everything you could have done," says **Joan Cerniglia-Lowensen**, JD, an attorney at Pessin Katz Law in Towson, MD.

A recent case involved a patient who presented to an ED with a vague history of periodic chest pain over the past few months. At the time of the ED visit, the patient was not actively experiencing chest pain. An ECG and the patient's blood pressure were both normal. The EP recommended the patient undergo a full cardiac workup, including a stress test, and gave the patient the name of a cardiologist to visit.

"Walking up the front steps of his house that same day, the patient had a sudden cardiac event and died," Cerniglia-Lowensen says.

The resulting malpractice lawsuit included these allegations:

• The history obtained by the EP was cursory.

"The plaintiff argued that had the ED provider explored what factors brought on the chest pain, it would have been a further indicator that the patient may have been having an ischemic event," Cerniglia-Lowensen explains. The ED defense team countered that the patient was stable at the time of discharge, and that appropriate follow-up instructions were given.

• The EP should have performed additional diagnostic tests and obtained a cardiology consult.

The plaintiff alleged that if the EP had done so, the patient still would have been in the ED when the cardiac event occurred. Thus, ED staff would have been able to save his life.

"The plaintiff was able to find an expert that said the report given by the patient was so concerning that we had an obligation to do further workup, and that it should have triggered the ED provider to get the cardiac consult right then and there," Cerniglia-Lowensen recalls.

The case was settled, but not because the EP had done anything wrong. "Because the timeline was so damaging, it would have been very difficult for a jury to find for the defendant," Cerniglia-Lowensen notes.

Cerniglia-Lowensen has handled three similar cases recently, all involving early deaths after discharge from an ED.

"Part of it is that families of patients who die in that manner think the ED must have done something wrong, so they tend to get a lawyer and file a claim," she says.

Plaintiff lawyers tend to take such cases. "We've all seen those cases of people who go to the ER and look completely normal, then walk out the door and drop dead," Cerniglia-Lowensen says. "Lawyers find them attractive claims, because they have a certain amount of jury appeal."

Cerniglia-Lowensen says this documentation is helpful to the ED defense:

• a complete description of the plaintiff's symptoms;

• documentation that the patient was stable at discharge, and/or exhibited no symptoms at the time of the ED discharge;

• that the EP gave the patient a clear timeframe for follow-up;

• that the patient understood when to return to the ED. "Be careful not to say, 'I can't find anything wrong with you,' because patients won't follow up," Cerniglia-Lowensen stresses.

• why the EP believed it was safe to discharge the patient.

Often, ED charts are silent on this important point. "Sometimes, you'll see a vague comment. 'Patient told to come back or dial 911 if symptoms return,'" Cerniglia-Lowensen says. This leaves a lot of room for a plaintiff attorney to argue that it was unsafe to discharge the patient. "You don't get a feel for what the doctor was thinking, about why it's safe for the patient to go home in the condition they're in right now," Cerniglia-Lowensen explains.

• the EP facilitated follow up by proving the name of a provider.

• names of individuals who were with the patient in the ED.

"You always wind up with family members who say, 'We told the doctor X, Y, and Z,' or 'The doctor never asked us about that,'" Cerniglia-Lowensen notes. "That's a big problem."

However, ED charts rarely document the presence of family members or the fact that the patient came alone. A recent case involved a patient who came to the ED by herself. After a malpractice lawsuit was filed, her daughter claimed to have been present the entire time.

"She claimed she saw the nurses do certain things, and the ED nurses said it never happened," Cerniglia-Lowensen says. "It was very helpful to have a nursing note stating that the patient was unaccompanied."

Typically, plaintiffs also argue that if the EP's differential diagnosis includes anything that's life-threatening, that the standard of care requires the EP to rule it out. "I hear that in every one of these cases. If the jury buys that, you're done," Cerniglia-Lowensen warns. ■

REFERENCE

1. Obermeyer Z, Cohn B, Wilson M, et al. Early death after discharge from the emergency departments: Analysis of national US insurance claims data. *BMJ* 2017;356:239:1-9.

SOURCES

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Hospital-run Urgent Care Center Is Subject to EMTALA

ED staff need training to ensure compliance

A district court in Rhode Island recently found that an urgent care center is subject to EMTALA requirements.[1]

The plaintiff presented to the hospital's urgent care clinic with severe pain and burning in her chest and right arm. She was discharged with a diagnosis of gastroesophageal reflux disease with no follow up ordered, and died of a heart attack the next day.

The central issue was whether the urgent care clinic constituted a "dedicated emergency department" as defined by EMTALA. This would have required the clinic to perform a medical screening exam and stabilize the patient. At issue was whether an individual would perceive the clinic as an appropriate place to go for emergency care. The court found that a person who needs emergency care would not distinguish "urgent" care from an emergency medical condition.

"The court ruling was not surprising for a couple of reasons," says **Douglas B. Swill**, JD, a partner at Drinker Biddle & Reath in Chicago. The fact that the urgent care center was hospital-owned was a key factor. "Many of my health system clients set up such urgent or immediate care centers in non-hospital corporate affiliates so as to avoid EMTALA application," Swill explains.

The case also showed that the facts that may be in dispute, or factual issues that may not be resolved, become important when deliberating on a motion for summary judgment. In this case, the defense argued that the center's website made it clear it does not offer emergency care.

However, the plaintiff produced text messages she'd sent to coworkers. These indicated she had seen

signage for the center, and thought she was going to an ED.

Such factual issues, says Swill, "become especially important where the hospital needs to defend itself more robustly that the urgent care center did not hold itself out as a place to treat emergency medical conditions."

More Cases Likely

Similar cases challenging urgent care centers' falling under EMTALA are likely to occur.

"We are already beginning to see more investigations and surveys resulting from complaints similar to this case," Swill adds.

The increasing number of urgent care centers is one reason. Finances are another, as hospitals strive to guide patients into the most cost-effective facility for appropriate care.

"EPs who work part time in urgent care centers should consider requesting a legal position of their counsel on whether EMTALA applies to their urgent care center," Swill offers. If so, they should find out:

• whether they have appropriate procedures and policies to comply;

• whether the organization and its staff have developed and implemented the appropriate education, training program, and training materials tailored to the facility.

"Attempts by ED staff to 'suggest' a more appropriate setting for people with possible urgent medical needs may backfire on them," Swill warns.

This is more likely if the appropriate setting is an urgent care center operated by a hospital as an outpatient department.

"EMTALA applies to that facility," Swill notes. "Therefore, staff need to have the training and education related to EMTALA compliance." ■

REFERENCE

1. *Friedrich v. South County Hosp. Healthcare*, C.A. No. 14-353 S.

SOURCE

- **Douglas B. Swill**, JD, Partner, Drinker Biddle & Reath, Chicago. Phone: (312) 569-1270. Fax: (312) 569-3270. Email: Douglas.Swill@dbr.com.

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After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

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- How new stroke guidelines will change ED litigation
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ED LEGAL LETTER™

CME/CE QUESTIONS

1. **Which is true regarding consultants giving recommendations on ED care?**

   a. "Curbside," or informal, consults generally cannot be brought into evidence.
   b. Court rulings have held continually that phone calls to an on-call consultant are insufficient to constitute a patient/physician relationship.
   c. Deposition testimony on a consultant's recommendations is generally inadmissible at trial if there is no mention of the consult in the ED chart.
   d. Consultants have a legal obligation under EMTALA to evaluate an ED patient if the EP requests it.

2. **Which are plaintiffs required to prove to assert apparent agency?**

   a. There was some representation, either explicitly or by implication, by the medical center to the public that the EP is affiliated with, employed by, or rendering care on behalf of the hospital.
   b. An average patient would assume the EP was an independent contractor.
   c. The patient was put on notice as to whether the EP was an employee or an independent contractor.
   d. At least one EP at the hospital was an employee.

3. **Which is true regarding mandatory reporting of ED adverse events?**

   a. Hospitals are required to include the EP's name in an adverse event report involving ED care.
   b. Hospitals usually can escape liability by including the EP's name in the report.
   c. Investigations are triggered only if the ED has a documented pattern of adverse outcomes.
   d. ED medical records are not privileged in the event an investigation occurs.

4. **Which is true regarding EPs and EMTALA?**

   a. If an EMTALA violation is found, it could result in the patient filing a separate malpractice claim against the EP.
   b. EPs can be sued for failing to comply with EMTALA.
   c. Hospitals risk independent action for an EMTALA violation regarding continued participation in Medicare, but the same is not true for EPs.
   d. EPs are independently obligated to provide a medical screening exam as required by EMTALA.