ED LEGAL LETTER™

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JUNE 2018 Vol. 29, No. 6; p. 61-72

INSIDE

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Many ED Visits Documented on Cellphones

Whether such recordings are admissible in court depends on many different factors

When a patient records an ED visit on a cellphone, he or she might be planning to share a selfie on Facebook, to post something negative about the hospital on social media, to file a malpractice lawsuit — or all of the above. If there is litigation against the ED, such photos, "so long as they are not overly inflammatory or are of other patients or visitors, are usually admissible," says **Amy Evans**, JD, executive vice president in the Bellevue, WA, office of Western Litigation, a professional liability claims and risk management company. Gruesome photos of a trauma patient who later died may be excluded by a judge due to the prejudice outweighing the probative value.

Proof of the date, time, and location usually has to be offered, Evans says. Audio can be determined inadmissible if state law prevents the audio recording when all parties to the recording do not consent, she adds. Admissibility of evidence is determined by the court. To be admissible, the evidence must be relevant and reliable.

"If a court rules that a recording doesn't tend to prove or disprove a material issue in the case, the evidence may be excluded," says **William Sullivan**, DO, JD, FACEP, an emergency physician at St. Margaret's Hospital in Spring Valley, IL, and a practicing attorney in Frankfort, IL.

In a recent case, surreptitious recordings were made of several phone conversations with a defendant and some witnesses.[1] However, the plaintiff's expert admitted that he did not listen to the tapes when forming his opinions about the case. "The court, therefore, ruled that the recordings were irrelevant and, therefore, inadmissible," Sullivan explains.

If the recording shows evidence of tampering, it also may be excluded as unreliable. One case involved a plaintiff who made unauthorized recordings of several phone conversations she had with hospital employees after she had been

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ED LEGAL LETTER

ED Legal Letter™,
ISSN 1087-7347, is published 12 times annually by AHC Media, a Relias Learning company, 111 Corning Road, Suite 250, Cary, NC 27518-9238. Periodicals Postage Paid at Cary, NC, and additional mailing offices.

POSTMASTER: Send address changes to: *ED Legal Letter*, Relias Learning, 111 Corning Road, Suite 250, Cary, NC 27518-9238.

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Customer Service: (800) 688-2421
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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.

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

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fired.[2] Afterward, forensic analysis by the defendant hospital showed that she had edited most of the recordings to bolster her case. The court issued sanctions against her for spoliation of evidence and fraud upon the court.

"In addition to meeting relevance and reliability thresholds, any evidence that would unfairly inflame a jury or that is misleading may also be ruled inadmissible," Sullivan adds.

Depending on what's depicted, cellphone recordings could make otherwise defensible cases possible candidates for settlement. "If there are issues in dispute that can be resolved by the recordings, then they can definitely help cases resolve," Evans says.

Cases involving cellphone videos taken in EDs "are starting to pop up," says **Rodney K. Adams**, JD, LLM, an attorney in the Richmond, VA, office of LeClairRyan. In one recent case, a patient's own photos of his ankle during the ED visit became an issue later when it was alleged that a foreign object should have been found and removed. "The patient had probably the best evidence of what his ankle looked like in the ED," Adams says. The pictures were produced as part of discovery early in the litigation. "But it could have popped up later, after we committed ourselves to whatever position we might have committed ourselves to," Adams notes.

After observing the family taking videos, the nurse practitioner took her own photos on her personal cellphone. For the hospital's privacy officers, this raised significant concerns about patient privacy and compliance.

"That gave the plaintiff a whole new angle of potential liability to go after," Adams says.

If the photos had been made part of the chart and deleted from her cellphone, the nurse practitioner would not have created any privacy issues. Some might contend that a patient's consent is required for photography, but that would not be applicable if the photos are used only for therapeutic care.

If a person is videotaping ED care, it should be taken as an implicit sign that that individual might be planning a lawsuit, according to **James B. Edwards**, JD, a Stafford, TX-based medical malpractice defense attorney. "The EP [emergency physician] needs to be sensitive not just to the medical issues anymore, but also the fact that he or she may well be a defendant."

If EPs pick up an explicit sign that the patient is going to sue, or an implicit one, such as the patient taking pictures, Edwards advises EPs to place a detailed entry in the ED chart. He advises this even if patients legitimately ask permission of the EP to record instructions. "Those recordings will be admissible in the event of litigation, even if it was done without the EP's permission, in most cases," Edwards cautions.

Invasion of Privacy

The Health Insurance Portability and Accountability Act (HIPAA) only applies to "covered entities" and "business associates" of those covered entities. Covered entities are defined as health plans, healthcare clearinghouses, and healthcare providers who transmit any health information in electronic form. Business associates are defined as entities that provide services on behalf of covered entities.[3] "Therefore, HIPAA does not apply to visitors or third parties who photograph or make video recordings of patients," Sullivan says.

Since patients or ED visitors are not "covered entities" under HIPAA, they are not required to comply with the regulations. "However, if

an individual takes videos or pictures that show other patients, those patients could potentially sue that individual for invasion of privacy," says **Timothy C. Gutwald**, JD, a healthcare attorney in the Grand Rapids, MI, office of Miller Johnson.

This is because third parties may be subject to a breach of privacy claim for making unauthorized recordings. "In states where a party's consent is required for audio recordings, such recordings may subject the recording entity to criminal liability," Sullivan notes.

Those patients also could sue the hospital under a negligence, breach of contract, or invasion of privacy theory. For instance, a plaintiff might allege that an ED visitor was taking pictures of other patients in plain sight. "I can see a plaintiff saying, 'There was somebody wandering up the halls and sticking a cellphone camera into treatment rooms, and nurses and physicians saw it, and nobody said a word to him, and the hospital is, therefore, responsible,'" Edwards offers.

Most hospitals have instituted policies that prohibit patients from videotaping or taking photos. "At least in Michigan, failing to adopt or enforce such a policy could be admissible in a negligence suit," Gutwald warns.

Also, if a hospital has not instituted such a policy, it will be harder for that hospital to argue that the photos or videos are not admissible. Evans says that hospitals should post clear policies and notice signs throughout public places noting that audio and video recordings of any kind are prohibited in the facility. "There could be a viable cause of action against a hospital for having no or inadequate policies and procedures," Evans offers.

However, it is unlikely that a court will deem recordings inadmissible based on a hospital policy. "Most claimants will allege that they were unaware of the hospital policy," Evans adds.

Vanessa L. Efremsky, Esq., a shareholder with Donnelly, Nelson, Depolo, Murray & Efremsky in Walnut Creek, CA, says the easiest way to convey this message is to post a sign in the waiting room or examination room to the effect of: "Recording of medical care on these premises is not permitted in order to ensure *all* patients' privacy."

"Another alternative is to include such language in registration documents, and request that patients advise their family members to adhere to the policy as well," Efremsky says. If ED staff become aware that a patient or visitor is surreptitiously recording any part of a visit, then there is an enforceable document to reference when asking the patient or visitor to cease recording.

"Furthermore, if a recording later surfaces in a medical malpractice case, a written policy can only bolster the inadmissibility of the unconsented recording," Efremsky adds.

However, if someone violates hospital policies, the hospital has little recourse. "Even if the person is violating the law, hospital employees generally don't have standing to arrest or detain the person involved," Sullivan says.

An exception might be an off-duty police officer who is providing security services at the hospital. The hospital or involved employees may choose to press charges against the violator, but often do not want to spend the time going through the legal process of doing so. "In most cases, then, the hospital is limited to requesting that the patient leave the premises," Sullivan notes.

If an ED patient has not received a screening exam or stabilizing treatment under the Emergency Medical Treatment and Labor Act (EMTALA), the hospital may not be able to request that the patient leave. "Even worse, once pictures have been taken or video recordings have been made, patients can later upload those files to social media and can portray the hospital or medical providers in a negative light," Sullivan says.[4]

However, HIPAA does not allow covered entities to disclose any protected health information about a patient in response. "HIPAA's privacy protections make it difficult to defend allegations of improper care under such circumstances," Sullivan explains.

EPs have a reasonable expectation of privacy while conducting their examinations of patients, even if a family member or companion is present in an exam room, Efremsky says. Unlike other states, California requires that all parties to a conversation consent to any recording.[5]

In a recent malpractice case, the plaintiff testified at deposition that he had recorded three interactions with the physician he was suing. The plaintiff claimed that the recordings were made during visits to the medical office, and that the physician admitted providing negligent treatment and apologized for the resulting harm to the plaintiff.

"The physician had no knowledge of the recordings until long after the lawsuit was filed," Efremsky says. "Recording conversations without this physician's consent was improper." The recordings likely will be inadmissible because they were obtained illegally.

"Under current case law, however, the plaintiff [attorney] might argue that the plaintiff may use the recording to refresh his recollection of the conversations, even if the recordings themselves are

inadmissible," Efremsky notes. In addition, if the plaintiff wrote down what was said during the recording, the written notes might be admissible at trial for impeachment purposes.

"If a plaintiff confesses that they have recordings of conversations with an emergency medicine physician, it may help resolve the case more quickly, but for a less obvious reason," Efremsky says. The allegedly injured plaintiff who is attempting to engender sympathy no longer has "clean hands" and has shown that he or she had no qualms about infringing upon the law. "Exposing this character flaw may make them less desirable to their attorney or, ultimately, a jury," Efremsky offers.

According to The California Invasion of Privacy Act, an EP who has been recorded without consent may bring a civil action to recover damages and/or to obtain injunctive relief. If successful, the EP could recover $5,000 per violation. "The potential for recovery against plaintiff for invasion of privacy can certainly be utilized as a bargaining tool to gain dismissal of the entire medical malpractice case — or, in the worst-case scenario, to lessen settlement value," Efremsky says. ■

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Survey: More Than Half of EPs Sued for Malpractice at Least Once

Fifty-one percent of EPs have been sued during their career, according to a recent report on medical liability claims frequency, the third highest percentage of all the specialties examined by the study's authors.[1]

Frequency of liability claims varies greatly between specialties, according to the report. Emergency medicine was the third most frequently sued specialty, after general surgery (63%) and obstetrics/gynecology (64%), compared with 34% of physicians overall.

After years of increasing frequency and payouts, "there was a decrease, and there is now a stabilization of claims overall," reports **P. Divya Parikh**, vice president of research and risk management for PIAA, a Rockville, MD-based industry trade association representing medical professional liability insurers. Parikh credits this change in part to risk management and patient safety efforts in the ED setting. "In the past few years, there has been notable attention on emergency medicine," she notes.

Nothing Paid for 75% of Claims

Between 2006 and 2015, 1,623 emergency medicine claims were reported to PIAA. The average indemnity payment was about $400,000 during the first five years of that period, but has decreased in recent years to about $315,000.

The top allegations in PIAA's ED claims: diagnostic error, improperly performed procedures, medical errors, and failure to supervise or monitor. The most common medical outcomes involved in the claims are cardiac and cardiac respiratory arrest, acute myocardial infarctions, aortic aneurysms, occlusion and stenosis of cerebral artery, and encephalopathy.

While the National Practitioner Data Bank includes only closed claims with an indemnity payment, PIAA's database also includes claims

that resulted in no payment. About 75% of the ED claims fell into this category. However, EPs named in these claims still incurred defense costs. In the 2006-2010 period, these averaged $46,700, but are now closer to $55,000.

"The higher costs suggest that plaintiff attorneys took on complex ED cases that were difficult to try," Parikh offers.

Notably, about 67% of the emergency medicine claims were dropped, withdrawn, or dismissed. About 17% were settled, about 10% resulted in a verdict for the defendant, 3% resulted in a plaintiff verdict, and the rest are attributed to alternative dispute resolution contracts.

"Cases against ED physicians are often rooted in a failure to detect or adequately treat a condition that later escalates," says **Timothy D. Patterson**, JD, an attorney at Richmond, VA-based Hancock Daniel.

Plaintiffs' lawyers must be certain they have evidence of causation. A common allegation is that had the EP performed a different test or admitted the patient, it would have changed the outcome.

"ED cases are susceptible to Monday morning quarterbacking. So, plaintiff's lawyers need a strong causal link to have a good case," Patterson explains. Since plaintiffs' lawyers also want some assurance of a sizeable recovery, usually only cases that entail significant injury or damages are pursued.

"Obtaining early expert reviews in the pre-litigation process helps plaintiffs' lawyers assess their chances of prevailing at trial, and determine what their case is worth," Patterson notes.

For example, early review by an emergency medicine expert might reveal that a particular test or assessment would only be performed upon admission, not in the ED. "That information, if discovered early, may alert plaintiffs' lawyers to a weakness in their case," Patterson says. This could result in a decision not to pursue the litigation, or to direct their case away from the ED care.

On the other hand, an early ED expert review could convince the plaintiff that the case is strong.

"It might identify abnormal lab values or other indicators, which, if noticed and treated in the ED, may have changed the patient's outcome," Patterson explains.

Decision to Pursue Claim

EPs diagnose patients previously unknown to them, often with comorbidities and an incomplete medical history, in a chaotic environment. "Because of these realities, ED cases may be the most difficult and expensive cases to handle — and, more importantly, the most difficult to prove," says **Karen W. Poole**, RN, JD, senior professional liability nurse consultant at Memphis, TN-based Sedgwick Claims Management Services.

Most attorneys reject more than 90% of the malpractice cases they screen, and won't accept a case unless expected damages are at least $250,000 if they believed winning is certain, or double that amount if the outcome was less certain, researchers discovered.[2]

"Potential clients often present with heart-wrenching stories about their experience at the ED. It is natural for the attorney to desire to help the client," Poole notes.

Making the wrong decision is costly for the attorney and plaintiff, both financially and emotionally. "Most people do not realize that plaintiffs' lawyers pay the case expenses for these lawsuits," says Poole, noting these expenses include filing fees, medical record copy costs, issuing subpoenas, and expert witnesses for depositions and in court. "In a medical malpractice case, an attorney automatically budgets for $85,000 to $250,000 in expenses." If the case is lost or not settled, the client typically does not reimburse the attorney for the expenses.

A bad medical outcome doesn't necessarily equate to a winnable malpractice case.

"If an attorney chooses unwisely, either a case with good potential will be lost, or an unmeritorious case will tie the attorney up for long periods of time and at great expense," Poole says.

Either way, the ED chart is the core of every malpractice lawsuit against an EP.

"The records can be a sword or a shield for an emergency department physician," Poole adds. "The chart needs to be as specific as possible."

Elements to Prove

Claimants must prove several elements to sustain a claim for medical malpractice against an EP.

"If any of the elements are missing, the jury is instructed to find for the defendant," Poole says. Here are some of the elements:

• **A doctor-patient relationship existed.** Usually, this is easy to establish, since it's demonstrated when a physician examined and/or treated the patient in the ED.

"Liability for an emergency physician may also lie outside the emergency department door," Poole notes.

This can be true in the case of a patient transported under protocol or radio contact by EMS personnel, or for patients who are given advice over the phone. "Once an ED physician is involved in the decision to have

a patient transferred to the ED, the patient becomes his liability," Poole says.

This is true regardless of whether the patient arrived by ambulance.

• The care provided was negligent. "In Connecticut, any claim regarding a deviation in the standard of care would have to be substantiated by testimony of a medical expert who is also specifically trained as an emergency physician," Poole notes.

• There was a causal connection between the care provided in the ED and the harm that was suffered. "Causation in a medical malpractice case is not just cause and effect," Poole adds.

It is also proving that the deviation from the standard of care was the direct cause of the injury, and that it was preventable. "It is not enough to only prove that the emergency physician made a mistake," Poole cautions.

• The patient was harmed. The plaintiff may have undergone additional medical treatment due to a misdiagnosis, lost wages, or there may be other effects on the claimant's life, including pain and suffering.

"A plaintiff's attorney will always think twice if the damages resulting from the injury are too small to justify the time and expense of litigating the claim," Poole adds. ■

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Legal Exposure for ED and Hospital if Patients Refuse Discharge

EDs are well aware of the legal risks posed by patients who leave against medical advice, or "AMA." But the opposite scenario — patients who stay in the ED AMA — carries significant legal risks as well.

Robert N. Swidler, vice president of legal services at St. Peter's Health Partners in Albany, NY, says that, generally speaking, patients who refuse discharge fall into two categories: clinical and social. If a patient doesn't believe he or she is well enough to go home, "the obvious legal risk in such a case is malpractice liability if the patient was right, was pushed out without adequate treatment, diagnosis or instructions, and was harmed as a result," Swidler says.

A typical social reason is that the patient has no home, or views a hospital room as safer, more comfortable, or less lonely than going home.

"While there is no great *malpractice* liability risk in escorting this patient out, there could be regulatory consequences or reputational consequences if pushing the patient out would endanger the patient," Swidler explains.

There also could be civil liability if the patient is harmed when he or she is escorted out. "But in simple cases where the ED patient would not be harmed by being escorted out, the regulatory, reputational, and liability risks are low," Swidler says.

If a frequent ED visitor is escorted out, and while crossing the street is hit by a car, the hospital is not likely to have any liability because it was not foreseeable. On the other hand, if the patient has limited mobility, is pushed out into cold weather, and dies from hypothermia, "the hospital would almost certainly be held liable," Swidler notes. "The hospital should have foreseen that risk and guarded against it."

Regardless of the reason for refusal of discharge, EPs sometimes take an adversarial approach, says **Andrew Lawson**, MD, FACEP, acting director of quality assurance and quality improvement for the emergency physician group at Mission Hospital Regional Medical Center in Mission Viejo, CA. "We need to be more collaborative, not only with our colleagues, but also with our patients," he offers.

When patients object to discharge, Lawson finds these approaches helpful:

• Give patients some time, while checking in frequently to repeat recommendations. "Oftentimes, that will lead them to the conclusion that it's OK to go home," he says.

Lawson recommends giving patients a two- to four-hour window of time to reassure them that their condition is not worsening, and it is safe for them to be discharged. "As always, it is imperative to carefully document the reasons for discharge, and explain why you believe it is safe for the patient to go home," Lawson stresses.

• Convince others on the team to support the discharge decision. This protects the EP legally and reassures the patient that everyone agrees with the plan, Lawson explains. For instance, the EP might speak to the patient with an ED nurse present, and explain that he or she just spoke with the patient's primary care physician, who has agreed to see them the following day. Instead of curtly asking the patient to leave, Lawson uses language such as, "Let's have you sleep in your own bed tonight," and, "We certainly don't want to complicate anything by having you get the flu or an infection in the hospital."

Involving a hospitalist, who can explain that he or she agrees with the decision to discharge, and that the hospital is not the best place for the patient to be, is helpful. That way, Lawson says, "if you do have to go to the point of security escorting the patient out, you've got a lot of support."

The hospitalist, nursing staff, and social workers won't necessarily document this interaction. "It is important, in this high-risk situation, to ask them specifically to document the reasons why we are all in agreement that the patient can go home," Lawson adds.

• Give the patient options. Social workers can arrange for taxi vouchers or shelters. Mission Hospital's acute care clinic is open two days a week, specifically for patients seen in the ED. "It gives them another touchpoint and place to go," Lawson says. "It's been very helpful when somebody wanted to be admitted."

• Reassess the decision to discharge. Lawson recommends using extra caution to make sure that clinical decision-making is as good as it can be.

"If a patient is refusing to leave, I feel that's a breakdown in communication," he says. "It should be seen as a red flag that something is not right."

The same is true for clinical assessment. "You do not want to sign somebody like this out with unexplained abnormal vital signs," Lawson warns. "Make sure they are documented as normal, or explain why they are not."

In performing quality assurance for his ED group, Lawson has seen one abnormal vital sign come up consistently in patients who are discharged home but return to the ED and are admitted: tachycardia. "If patient has a pulse over 100, they tend to bounce back," he notes.

Keith C. Volpi, JD, an attorney at Polsinelli in Kansas City, MO, served as a consultant for two cases that involved an ED patient refusing discharge. "The patient in the first experience was homeless, but savvy. During a cold Midwest evening, he determined that his sore leg required emergency evaluation," Volpi recalls.

The patient made it clear he was aware of EMTALA regulations that require a medical screening exam. The EP evaluated the patient and determined that he required no treatment or consultation. After the EP entered discharge orders and the ED nurse informed the patient of this, the man insisted on admission.

The providers were sympathetic to the patient's situation, but compassionately explained to him that he could not stay the night, as there was no medical indication for admission. They also offered to ask a social worker to find shelter for the patient for the night. "Unfortunately, the patient insisted on admission and required a bit of encouragement by hospital security before he would leave," Volpi says.

Volpi informed the hospital that there was little, if any, exposure to the hospital or EP for the discharge decision. "It was clear that there was no legitimate medical concern and that there was no concern for immediate decline in health status."

The second case involved a pregnant woman who presented with severely swollen lower extremities. Although she understood that edematous lower extremities are common late in pregnancy, she had recently read that the condition also is associated with a pulmonary embolus. The EP evaluated the patient and determined that the lower extremity edema was simply the result of the patient experiencing a busy day on her feet late in pregnancy. But the patient demanded further evaluation and testing. In response, the EP ordered a chest CT and a D-dimer blood test, both of which were negative. Nonetheless, the patient insisted on staying for overnight observation.

"Although no one but the patient believed that she was in any danger, the EP agreed to place her on 23-hour observation status," Volpi says.

Volpi thought this was reasonable under the circumstances, based on the fact that the worst-case scenario (the woman suffering a pulmonary embolism at home) presented both the EP and hospital with significant legal exposure.

According to Volpi, in any situation, the decision to discharge against a patient's wishes must balance the responsible use of medical resources as well as the risk and exposure associated with a negative event shortly after discharge.

In the example of the homeless patient, Volpi says that valuable resources would have been used in a situation in which there was no risk of a negative event shortly after delivery. Thus, the patient was discharged.

In the example of the pregnant patient, although there was only a small risk of a negative event shortly after discharge, that event was potentially threatening to two lives. Thus, the patient was admitted for a brief period.

Volpi says that anytime a patient is discharged from the ED, an EP should ask himself or herself this question: "If something terrible and unforeseen happens tonight to this patient, does the chart show that I did everything necessary to identify and prevent it?"

"That, of course, doesn't mean that an EP must do all kinds of unnecessary testing for every patient," Volpi offers.

It does mean that in those situations in which an EP is considering a test but decides against it, the EP should chart in detail why it was unnecessary and not required by the standard of care.

"A contemporaneous entry in the chart is always better than a great explanation developed after a lawsuit is filed," Volpi says. ■

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Good Documentation of ED Consult Makes It Clear EP Met Standard of Care

An obese male presents to an ED with an obstructed airway due to a peritonsillar abscess. While the EP had drained other abscesses in the past, he thought that the patient's airway seemed especially compromised, and called an otolaryngologist (ENT) for a consult.

The EP described the patient's symptoms and observation of the airway. He explained the challenges of draining the abscess to the specialist. The EP did not ask the specialist to come to the ED and treat the patient. The ENT gave advice on the drainage, but did not offer to come in.

"The emergency physician should have followed his initial instinct — that this was more complicated than what he'd seen in the past, and the expertise of the specialist was needed," says **Jayme T. Vaccaro**, JD, vice president of specialty operations for professional liability in the Lafayette, CA, office of Sedgwick.

When the EP administered an anesthetic, the patient immediately gagged on secretions and control of the airway was lost. Intubation failed. A cricothyrotomy was unsuccessfully attempted by a trauma surgeon and a tracheostomy was performed. The patient suffered severe brain damage and died. The family sued the EP, the ED group, the ED nurses, and the ENT. All parties were dismissed from the lawsuit — except for the EP and his group.

The primary allegation: If the EP had asked the ENT to come in, the abscess drainage might have been successful, and all the other complications would have been avoided.

"Even if the complications still occurred, the EP would have met the standard of care by properly calling for a specialist," Vaccaro notes. The following issues complicated the defense of the claim:

• The EP assumed he could care for the patient, even though the treatment was beyond his expertise;

• The EP did not communicate clearly with the specialist;

• The EP never asked the specialist to come to the ED;

• The EP failed to document the entire discussion with the specialist.

"Taking on the care of a specialist, or not conferring with a specialist, can lead to a plethora of challenges for the emergency physician," Vaccaro says.

To avoid needless legal entanglements, Vaccaro says EPs should know when they're in over their heads and remain firm about what they need from the consultant. Invariably, specialists testify that while the EP asked for their opinion, the EP never asked or insisted that the specialist come in — and that had the severity of the situation been explained, the specialist certainly would have come to the ED, says Vaccaro, who recommends EPs take these steps:

• Thoroughly document the consult, including the patient's condition and the specialist's advice;

• If the specialist is asked to treat the patient or come into the ED,

clearly document the request and the specialist's response;

• If the specialist refuses to come to the ED, attempt to find another specialist;

• If the specialist takes too long to come in, document all attempts to follow-up;

• If the EP is inexperienced or new to the department, find a senior physician for guidance and assistance.

"If life-threatening treatment is needed, and the EP proceeds with care without a specialist, this documentation will usually shed light for a jury on the genuine, repeated, and sincere efforts of the emergency physician," Vaccaro notes.

As EPs see undifferentiated patients, a multidisciplinary approach to care is needed. This is true even if patients don't require a specialist, says **Michael B. Weinstock**, MD, associate program director of Adena Emergency Medicine Residency and director of medical education and research at Adena Health System.

"Emergency medicine systems typically get into trouble when an emergent consult is needed. To some degree, we are at the mercy of the consultant's decision," says Weinstock, who also serves as an adjunct professor of emergency medicine at Wexner Medical Center at The Ohio State University.

On the other hand, the consultant's decision-making is dependent on the EP's accurate description of the patient's condition.

"So, it's a symbiotic relationship," Weinstock offers. "It's important that both sides are truthful and express accurately the urgency of the situation." The documentation of the interaction becomes very important if litigation occurs. Occasionally, ED charts even omit the name of the consultant. This wouldn't be an issue in a rural ED with only one consultant on call at the time of the ED visit. "However, if you are in an academic institution, there are multiple possibilities of people you could have spoken with, and you won't remember who it was months later," Weinstock cautions.

Poor communication further complicates matters. In Weinstock's experience, EPs sometimes fail to give consultants a good picture of what's going on at the bedside. They either overestimate or underestimate the urgency of the situation.

"From working in large EDs, and listening to many people, speaking with consultants, I can tell you that, often, the way they describe the encounter is actually nothing like the way the encounter actually occurred," Weinstock reports.

Omitted Facts

It's important for EPs to give the specialist an opportunity to ask questions. "At 3:00 a.m., we have an interest in trying to make the presentation brief and pointed," Weinstock says.

Sometimes, information omitted by the EP is very important to the specialist. An EP might inform the consultant that a patient experienced right lower quadrant abdominal pain, with a CT scan that showed non-specific findings, while omitting two other pieces of information: The blood pressure was 50, and there was altered consciousness.

"That would totally change the equation in terms of the urgency of the situation," Weinstock says. The omitted facts would raise the possibility of a ruptured bowel or appendix that can cause sepsis.

Weinstock would like to see this documentation in the ED chart for this case: "I discussed the case with Dr. X, including a blood pressure of 50, a heart rate of 140, and a CT scan that shows non-specific findings. Dr. X said he will be down to see the patient within the hour."

While the EP might prefer the specialist come sooner, an hour could be reasonable. The delay doesn't necessarily rise to the level of needing to call the department chair. If, on the other hand, the specialist insists he will see the patient in the morning, the EP needs to escalate the situation.

"Timing is everything if litigation occurs. The most common reason for ED lawsuits is failure to diagnose, but the second most common is failure of timely management of a patient," Weinstock warns. The EP may have diagnosed abdominal aortic rupture correctly but waited an hour to contact the consultant, delaying the necessary surgery and resulting in a poor outcome.

Weinstock says EPs should remember why they are calling the consult in the first place: Because the specialist has specific expertise that's needed.

One patient who presented to an ED in cardiac arrest was resuscitated, and the ECG was concerning for ischemia. The EP contacted the on-call cardiologist to perform an emergent catheterization, presuming that the patient was suffering a myocardial infarction. The cardiologist declined, and recommended that the patient undergo a CT scan of the brain. The EP called the chair and hospital administrator.

"It turns out that the patient had a subarachnoid hemorrhage," Weinstock relates. "The specialist was correct, in the sense that the patient did not have a coronary occlusion."

To reduce the likelihood of similar misunderstandings, Weinstock recommends stating the reason for the call first, such as "My patient is having a STEMI. I need you to come in and do an emergent cath."

"That is what they need to know upfront. They can hear about the family history later," Weinstock adds. ■

SOURCES

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Undetected Medical Conditions in 'Psych' Patients Are Legal Landmine

An ED patient was so terribly anxious that he could not lie still for a CT scan. The patient was given a benzodiazepine, but the true problem was discovered minutes later when the patient went into cardiac arrest.

"Psychiatric" patients may present with an underlying medical condition that's causing a mental status change. "This is a frequent medical/legal problem that comes up," says **Bruce Janiak**, MD, a professor in the department of emergency medicine at Medical College of Georgia at Augusta University.

Once EPs conclude that a patient's behavior is psychiatric, they may miss underlying medical conditions that are the real cause of the symptoms. This is less likely if a patient is behaving bizarrely, presents with a psychiatric history, and is taking psychiatric medications. "Otherwise, you need to look at the medical things first," Janiak offers. "Get a good history before you decide it's psychiatric."

In one case, paramedics said the patient refused to walk because he was under a great deal of stress. The EP didn't conduct a careful neurological exam, put the patient on an involuntary psychiatric hold, and missed a stroke. In another case, a patient did have a psychiatric history, but the ED missed an underlying medical condition. EMS brought the man to an ED after a violent altercation.

"EMS said only that the man was acting crazy and fell on his head," Janiak reports. "It turned out that they tasered him, and he fell off the porch, landing on his head."

The patient spent the next 18 hours in the ED waiting to be transferred.

"Once the individual was in jail, they found out they missed a neck fracture. The man ended up being quadriplegic," Janiak says.

The subsequent malpractice lawsuit alleged the EP ignored the patient's neurological symptoms. For instance, the man wanted something to drink, but would not use his dominant arm to pick it up.

"Instead of saying, 'Maybe he has a neurological injury,' they thought he was just being uncooperative," Janiak explains.

Do What's Reasonable

Alan Gelb, MD, clinical professor in the department of emergency medicine at the University of California San Francisco School of Medicine, is aware of multiple malpractice cases in which the EP failed to rule out a medical condition that was causing psychiatric symptoms. "Someone comes in, and they look psychotic," he says. "You assume it's schizophrenia or depression or manic depression."

A typical fact pattern in these cases: During the ED visit, the patient's symptoms are controlled with sedatives or antipsychotics. It later turns out that the patient has a medical condition such as encephalitis or meningitis.

"There are a lot of medical conditions that can cause a psychosis, and may appear to be psychiatric in origin," Gelb cautions. Infections, stroke, head trauma, and drugs can mimic psychiatric conditions. Uncommonly, a brain tumor can present as a psychiatric disorder.

The difficulty of obtaining a good history and conducting a thorough evaluation is a complicating factor. For instance, if a patient is experiencing an aortic dissection, the EP would expect to see severe back pain and high blood pressure. "But if the patient is completely out of it, and yelling about Martians, and is not saying anything about any back pain, the high blood pressure would probably be attributed to their agitation," Gelb notes.

In one case, a charge nurse told an EP to clear a patient for psychiatry. No one took the patient's

temperature, likely because he was yelling and acting bizarrely, but all other vital signs were normal. The patient was cleared to go to psychiatry, where it was discovered he had a temperature of 103. The patient was brought back to the ED for a spinal tap, which revealed meningitis.

This case reflects the pressures EPs are under to quickly place a patient in a psychiatric setting when they appear "psychiatric." Crowding adds to the pressure. If there are no beds available at the transfer facility, keeping the patient in the ED could necessitate the ED going on diversion. "The on-call administrator is saying, 'You've got to get these beds cleared out,'" Gelb says. "The mistakes you make are when you try to cut corners, for whatever reason."

The patient with new onset of psychosis, with no previous history of psychiatric disorders, is a major red flag, Gelb warns. This is particularly true for older patients, since psychiatric disorders typically begin in late teens to early 30s.

"If you're seeing somebody who is having a new psychosis at the age of 50, you have to be really worried that this is a medical problem," Gelb notes.

Even in a younger patient, if there is no history of psychiatric disorder, seriously consider a head CT, Gelb offers. "That is something that if you don't do it, and you miss something, you can just start writing the check."

The duration of the behavior also is a clue. If it's a true psychiatric disorder, family or friends typically report the patient has been acting strangely for weeks or months.

"If, over a couple of days, the patient goes nuts and has no history of acting strangely at all, then you need to be more worried about a medical problem," Gelb says. Documentation of the EP's thought process can help the defense. The ED chart should be clear as to why the EP didn't order certain tests, why the EP didn't think the patient had particular problems, and why the EP thought the patient was clearly psychiatric.

"When there is a problematic outcome, we can later point to the thinking behind the care plan. This protects physicians and their organizations, as it provides insight into the case as it unfolded in real-time," says **Scott L. Zeller**, MD, vice president of acute psychiatric medicine at Emeryville, CA-based Vituity. Zeller also is a clinical assistant professor of psychiatry at University of California, Riverside.

In some cases, the EP made an obvious mistake by failing to order a test, such as a head CT scan in a patient who exhibits neurological symptoms.

"In others, there is no way they would have known what was going on," Gelb says. Documentation of the EP's medical decision-making can explain why it was not possible to identify the underlying medical condition at the time of the ED visit.

The EP's legal obligation is to act reasonably based on the state's definition of negligence. "It's not ruling out every possible condition a person may have. It's what's reasonable," Gelb stresses.

If nurses see something has changed, alerting the EP is legally protective for everyone involved in the patient's care. "Otherwise, ED nurses will simply document the changes without telling you. That will kill you in a med/mal case," Gelb cautions.

Failure to review nursing notes is a common complicating factor in these claims. EPs sometimes check the box stating that they've reviewed the nursing notes when they actually haven't. Sometimes, EPs have read the notes up until that point in time, but don't review the rest.

"I've seen those depositions," Gelb recalls. Some EPs try to defend themselves by explaining that nursing notes are difficult to find because they're on a different system, or are on a clipboard at the nursing station. "It can be more difficult in some places than others," Gelb acknowledges. "But you *can* see the nursing notes."

Before the patient leaves the ED, the EP must look at what other providers have documented in the chart. "If a psychiatric patient is in your ED for 12 or 24 hours, there's going to be lots of nursing notes," Gelb says. "Make sure there is nothing new going on. You also need to go look at the patient."

This is difficult in a busy ED when the patient has already been accepted at another institution.

"The patient is finally getting out of your ED. The last thing you want to do is make more work for yourself," Gelb says. "But you need to go reassess them." ■

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.

ED LEGAL LETTER™

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CME/CE QUESTIONS

1. **Which is true regarding ED malpractice claims?**
   a. Often, ED claims are rooted in a failure to detect or adequately treat a condition that later escalates.
   b. No causal link is necessary for plaintiffs to prevail in most cases.
   c. Most emergency medicine claims that go to trial result in a plaintiff verdict.
   d. If deposition testimony suggests that the ED care was egregiously negligent, the requirement for medical expert testimony is waived.

2. **If ED patients refuse discharge, risk-reducing practices include:**
   a. involving security for all patients who refuse discharge to demonstrate that the hospital's response is consistent.
   b. informing patients that they need to be discharged home without providing the option of observation, since otherwise, the ED is establishing a precedent that could affect the legal standard of care.
   c. avoiding involving hospitalists because it will later appear the EP was incompetent.
   d. arranging for taxi vouchers, shelters, or other care sites, as appropriate.

3. **Which is true regarding admissibility of cellphone video recordings?**
   a. Courts uniformly allow it if it is by patients, even without proof of the date, time, or location.
   b. Audio recordings are admissible in all states, even when all parties to the recording have not consented.
   c. If a court rules that a recording doesn't tend to prove or disprove a material issue in the case, the evidence may be excluded.
   d. Recordings where patients received permission to record the EP's instructions generally are inadmissible.

4. **Which is true about liability exposure regarding assessment of ED psychiatric patients?**
   a. EPs should not reassess patients before discharge as the ED then will be held to a higher psychiatric standard of care.
   b. If the hospital can demonstrate that nursing notes are so difficult to find that they take time from patient care to locate, EPs cannot be held liable for failing to review them.
   c. The ED chart should be clear as to why the EP didn't order certain tests, didn't think the patient had other specific problems, and thought the patient's primary problem clearly was psychiatric.
   d. Generally, EDs should not reassess patients once they've been accepted at another institution because it will expand their liability.