ED LEGAL LETTER™

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'Patient Dumping' Still Happens 30 Years After EMTALA; EDs Face Significant Exposure

Have you ever heard the question, "What would you do if an ED patient behaved in an unruly manner?" If an investigator from CMS asked one of your ED's security guards this question, would the response reveal non-compliance with federal law?

During a recent investigation at the University of Maryland Medical Center (UMMC) in Baltimore, a security guard told surveyors that he would escort the patient from the premises or call the police if the patient did not leave.[1] This revealed that the hospital allowed non-clinical personnel to determine which patients could enter the ED for evaluation of an emergency medical condition.

This recent CMS investigation was triggered by a widely publicized video showing security leaving a patient dressed only in a hospital gown and socks in cold temperatures at a bus stop.[2] The incident underscores that if an ED patient is discharged improperly, "a hospital would be exposed to significant and varied legal risks," says **Timothy C. Gutwald**, JD, a healthcare attorney in the Grand Rapids, MI, office of Miller Johnson. These include, but are not limited to:

- a medical malpractice lawsuit;
- civil monetary penalties;
- fines or licensing actions by state licensing entities;
- accreditation issues with entities such as The Joint Commission;
- violations of patient privacy regulations.

CMS investigators found multiple deficiencies related to the incident. The hospital erected barriers to patients receiving emergency care, failed to discharge a patient in a safe manner, failed to protect a patient's right to be free from all forms of abuse or harassment, and violated the patient's right to receive care in a safe setting. Since staff also failed to record that the patient returned to the ED within several hours, no new medical screening examination was performed as required by the Emergency Medical Treatment

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and Labor Act (EMTALA). The hospital implemented a corrective action plan in response to the violations, according to the report.

Gutwald warns that there can be significant malpractice implications if patients are not stable at discharge. "EMTALA violations can lead to civil lawsuits, as well as civil monetary penalties." Even if patients are medically stable, hospitals could still face liability if the patient is discharged into an unsafe environment.

Documentation becomes very important. "ED staff will want to document they offered to provide the patient warmer clothes; [provide] cab or bus fare; to call a family member; or arrange for a bed at a local shelter," Gutwald says.

Case managers, social workers, and mental health providers likely will need to be involved in any situation in which a patient refuses discharge. On the other hand, UMMC was cited for privacy violations because it allegedly provided clinical information to non-clinical personnel. "Hospitals need to be careful to ensure individuals involved in the discharge are only given information they need," Gutwald cautions.

If the patient is moved outside without a proper discharge plan, then the hospital may be in violation of the Medicare Conditions of Participation related to safe discharge planning, says **Mary C. Malone**, JD, a partner at Hancock Daniel in Richmond, VA.

"In addition to those risk exposures, if that patient has not received a sufficient medical screening examination to determine whether or not an emergency medical condition exists, EMTALA may be violated," Malone warns. The same is true if the patient is identified with an emergency medical condition and is forcibly removed from the hospital prior to either stabilizing the emergency medical condition and/or arranging transfer of the patient to another facility for stabilizing treatment.

If security inappropriately held a patient during discharge or physically forced the patient's removal, the patient may have a claim for assault. "To prevail in this type of claim, the patient would need to prove that there was unwanted and unconsented physical contact," Malone explains. Recently, a New York hospital was sued after security guards allegedly assaulted a psychiatric patient who was attempting to leave.[3,4]

The exact elements of assault vary from state to state, and such lawsuits are relatively rare. "Broadly speaking, a plaintiff must show reasonable fear of an immediate harmful or offensive contact," Gutwald notes.

The discharge of a patient who needs either emergency medical care or non-emergency follow-up care, without a plan to obtain that care, is unlikely to meet the relevant community standard of care, Malone predicts.

While EMTALA is not a malpractice statute, the same set of facts may give rise to both EMTALA violations and malpractice liability. "The regulatory concerns are not dependent on any negligence analysis," Malone notes. With a patient-dumping case, "a number of legal theories could be likely advanced to assert liability and claim damages," says **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney.

Medical abandonment is one example. This refers to the unilateral termination of medical care without adequate notice to the patient to allow them to obtain alternative care. Frew says others might include:

• intentional infliction of mental pain and suffering;

• battery for exposing the patient to physical injury without his or her consent;

• elder abuse (if the patient met statutory age requirements);

• violation of various state laws for hospitals regarding patient care and safety;

• violation of civil rights under the Americans with Disabilities Act;

• wrongful death (if the patient had succumbed to the elements).

"Worse than malpractice, healthcare providers could literally go to jail if circumstances such as this resulted in harm or death of a patient," Frew cautions.

It's easy to focus on the hospital security guards as the obvious "bad guys" when a patient is removed forcibly. "But in my experience with most security personnel, someone else gave the order," Frew notes. The treating physician, an angry nurse manager, or a hospital administrator may have told the security person to take the patient out of the ED.

"It might even have been a discharge planner," Frew adds. "Regardless, there is more than enough legal responsibility to pass liability on to everyone involved."

In a similar court case in which Frew was involved, it was the hospital that was the defendant. The case was brought under EMTALA. To prevail in such a claim, the plaintiff does not have to prove malpractice or any of the other theories of liability. The plaintiff only has to prove that the hospital, via its policies or personnel, violated EMTALA, resulting in an injury.

"The plaintiff's lawyer has the option of picking which theory of liability to pursue, or to pursue several or all of them at the same time," Frew says.

Each theory of liability requires different elements of proof, as well as different advantages or disadvantages. "An EMTALA case offers the lawyer the option of federal or state court and lots of different violations to allege in this situation," Frew explains. Sometimes, state patient abuse laws offer triple damages and attorney's fees, which greatly increase the size of a potential verdict.

"If the plaintiff were to simply sue the security guard for the event, the elements at trial would depend on the state definition," Frew says.

For instance, in Illinois, assault means unlawfully placing a person in reasonable fear of receiving a physical injury or physical contact of an insulting or provoking nature. In that state, actually causing unlawful physical injury or contact of an insulting or provoking nature would constitute battery. "Different states combine the terms or define them differently," Frew notes. In any state, though, physically removing the patient against his or her will from an area of relative safety to an area of exposure and risk, and then abandoning the patient, probably would constitute assault and battery theories of liability. "Physical contact with the wheelchair as an extension of the body would probably be sufficient for battery," Frew adds.

Security personnel may be sued for their actions in containing or removing patients and non-patients from the hospital. But the hospital, as the "deep pocket," typically is the primary defendant. "Everyone else is named as defendants to make sure all the necessary parties are in the case," Frew explains.

Why does "patient dumping" continue three decades after EMTALA became law, despite multiple highly publicized cases? "It used to surprise me that EMTALA violations continued to occur. But I have come to expect it, for many reasons," Frew offers.

One issue is that EMTALA attaches legal significance to commonly used medical terms such as "transfer," "stabilize," and "emergency medical condition."

"Healthcare personnel interpret the law with their medical vocabulary, and get a different message than the law requires," Frew explains.

Persistent miscommunication on this front requires more than one training session, or even annual training sessions, to overcome.

Adding to the problem is the fact that CMS does not make citations readily available to the healthcare community. These real-life examples would shed light on what the enforcement standards actually require. "This would shock many providers into awareness," Frew says.

Most ED providers use what they consider common sense practices. They're surprised to learn that, under EMTALA, the standard is literal compliance. "They expect a standard of quality improvement, while CMS applies zero tolerance," Frew explains.

Staff turnover is another confounding factor. "Those ED personnel who were around for the last CMS EMTALA enforcement visit and learned the lessons at that time are now at some other facility," Frew says. Many ED positions are vacant, and heavy workloads soon cause lessons on regulatory requirements to be forgotten.

Increasingly, EMTALA violations stem from the difficulties posed by treating patients with mental health and substance abuse issues. "This is particularly true of patients who frequently return to the ED or return soon after being discharged," Gutwald says.

It is not always easy to determine when someone with a mental health condition has been stabilized. "What may seem like drug-seeking behavior on one visit can easily turn into an emergency medical condition," Gutwald notes. Lack of mental health resources also contributes to EMTALA violations. "Under these circumstances, healthcare staffs do the best they can," Frew says. EDs are forced to deal with unstable and fragile patients for extended periods in overcrowded conditions, and without adequate or trained mental health staffing.

"Regulatory compliance tends to get overlooked — until CMS shows up with an EMTALA complaint survey," Frew says. ■

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Can Rarely Used 'Empty Chair' Strategy Help ED Defense?

Is the plaintiff attorney refusing to dismiss the emergency physician (EP) from a malpractice lawsuit — even after it's become quite apparent that another provider was primarily at fault? The reason may be fear of the "empty chair" defense.

"Usually, as defendants, we stick together. We don't point a finger at each other, and we don't bring in empty chairs too often," says **David A. Depolo**, Esq., an attorney with Walnut Creek, CA-based Donnelly Nelson Depolo Murray & Efremsky.

The "empty chair" strategy comes into play when there is a potential unnamed defendant with possible exposure. Using the empty chair defense, a named defendant would argue the liability of the unnamed defendant. "In order to do that, there has to be evidence of negligence on the part of that empty chair individual. You are arguing their liability for apportionment of the liability," Depolo says.

A jury is asked to apportion fault among all those whom the jury believes are at fault for the injury. If the jury finds that Defendant A is 30% responsible, and they find Defendant B 40% responsible, there still is 30% liability remaining. The jury could apportion that fault to a non-party wrongdoer. But for the jury to do that, there has to be evidence of the wrongdoing at trial. "In a med/mal case, that requires expert testimony, just like you'd need to have expert testimony against any defendant," Depolo explains.

The expert has to testify that there was negligence on the part of the

unnamed wrongdoer. Only if there is evidence of that negligence can the jury apportion fault to the unnamed party. The defense would need to disclose the expert's name, and have that expert testify as to the negligence of the unnamed person before trial. "There is always a tactical decision that has to be made about whether you really want to do that," Depolo says. It could trigger the plaintiff's side to ask for a continuance of the trial date to bring this previously unnamed party into the case as a defendant. That newly named defendant, facing negligence accusations from the defense, is very likely to respond by claiming the existing defendant is the one really to blame for the bad outcome.

Suddenly, the defense attorney is fighting not only the plaintiff attorney, but also the new defendant. "It's a lot harder to fight a war on two fronts than one. You have just made your case that much harder," Depolo says.

Depolo recently argued the empty chair defense for the first time in his career. The case involved an oral surgeon who performed a procedure, and a dentist who provided the follow-up care. The dentist was dismissed from the case. "The jury found in favor of my client, the oral surgeon, so there was no determination as to apportionment of fault," Depolo says.

However, the jurors commented after the trial that the outcome likely would have been different if the dentist had not been dismissed from the case during the trial. "Here, the ability to argue the empty chair may have made the difference in the complete defensibility of the case," Depolo explains. Since the dentist was not in the case, the dentist was not there to argue liability on the part of the oral surgeon. "I was able to insinuate that the unfortunate outcome was the entire fault of the dentist," Depolo explains.

In an ED case, a similar situation could come about with a consultant as the empty chair. Depolo gives this hypothetical example: The EP orders a CT scan, which the radiologist read incorrectly as negative. The EP relies on that interpretation, and the patient is discharged. The patient ultimately experiences a bleed, and it's discovered that the CT scan was misread and showed a hematoma. In this scenario, if the radiologist is not named as a defendant, the EP might want to argue that he or she relied on the CT scan, which someone else misread.

The plaintiff argues that the EP was negligent in discharging the patient, and sues the EP and the hospital, but doesn't name the radiologist. The plaintiff's expert testifies that the EP was within the standard of care to rely on the radiologist's interpretation. At this point, it's too late to bring in another party.

In this scenario, the defendants would argue the liability of the empty chair — the radiologist. The jury would be asked to decide whether the hospital, the EP, or the radiologist was negligent, and apportion liability to each party deemed as negligent. The jury decides the radiologist was 90% liable for misreading the film, while the EP was 10% liable; the hospital carried no liability. The jury awards $500,000 in non-economic damages and $50,000 in medical bills. In California, non-economic damages are capped at $250,000, and defendants are joint and severally liable for economic damages. "Even if the EP is 10% at fault, the EP is 100% responsible for the economic damages," Depolo adds.

The non-economic damages are apportioned according to fault. With non-economic damages reduced to $250,000, and the EP is found 10% at fault, the defendant EP is responsible for $25,000 in non-economic damages and $50,000 in economic damages. Even though the jury verdict was $550,000, the EP's responsibility is only $75,000. "That's how MICRA [The Medical Injury Compensation Reform Act] and an empty chair defense could reduce a substantial exposure to a more palatable one," Depolo says.

These cases underscore how careful plaintiffs have to be before they let someone out of a case. "If one of the codefendants argues — after the dismissal of another defendant — that there is liability on the part of the dismissed defendant, that's an empty chair," Depolo says.

Instead of dismissing a named defendant outright, the plaintiff attorney might agree not to oppose a motion for summary judgment. The hospital might file a motion for summary judgment. "Now, the emergency physician has to make a decision," Depolo says. If the EP doesn't oppose the summary judgment, and neither does the plaintiff, and the hospital gets out of the case, then there can't be any apportionment of fault because there has been a judicial determination of no liability on the hospital's part. "That happens a lot," Depolo adds.

The plaintiff attorney has to make sure that another defendant won't be able to argue that the EP is negligent. "This can explain why some defendants stay in cases longer than they otherwise would — to avoid an empty chair dilemma for the plaintiff," Depolo says.

In some cases, an "empty chair" situation occurs because a plaintiff attorney fails to name the provider who was really at fault. This was the situation in a malpractice lawsuit involving an ED patient who died of a gastrointestinal (GI) bleed. **Bruce Wapen**, MD, an EP at Mills-Peninsula Medical Center in Burlingame, CA, was retained as an expert on behalf of

the plaintiff. Here are the facts of the case: A female patient presented to an ED at 8 a.m. with a history of peptic ulcer disease and a present illness that included vomiting blood acutely. She was worked up in the ED and transferred to the med/surg unit five hours later. During the ED visit, the EP ordered blood to be typed and crossed, but no blood was administered. After admission to the med/surg unit, the patient went into shock, the rapid response team was called, and the patient went to the ICU, where the first units of blood were administered. During an upper endoscopy in the ICU, the gastroenterologist dislodged the clot that was covering a minimally leaking arterial bleeder. The patient began bleeding uncontrollably. She was rushed to the OR, but the patient coded and died before surgery could be performed. "She had bled out eight hours after presenting to the ED as a 'GI bleed,'" Wapen reports.

Communication between the EP and the GI specialist became a point of contention during the case. Both agreed they discussed the patient, but they differed significantly on how many times they talked about this case and what information was conveyed. The EP testified at deposition that he told the gastroenterologist he needed "to see the patient as soon as possible," but there was no documentation of this in the ED chart.

In contrast, the gastroenterologist claimed that the EP had failed to inform him that there had been a hypotensive event in the ED, that the patient had passed melanotic stool, or that she had been typed and crossed, indicating that the EP had already determined she needed a blood transfusion. "But most importantly, the gastroenterologist stated that the EP did not tell [the gastroenterologist] to cancel his elective procedures and to come to the ED 'to see the patient as soon as possible,'" Wapen says. The gastroenterologist insisted he was not aware of the critical nature of the patient until he was called to see the patient in the ICU. This was about six hours after an initial low hemoglobin level came back to the ED from the lab, and three hours after the patient had been deemed to be unstable in the ED secondary to her hypotensive event.

"Plaintiff's initial med/mal legal team assumed that the whole problem was with the EP, who hadn't ordered and administered blood ASAP," Wapen says. "But the initial hemoglobin was slightly over eight. So, failure to transfuse ASAP wasn't the issue."

Later, a second lawyer took over the case. In reviewing the case at that point, Wapen found that the EP had made some evaluation and management errors. However, critical questions regarding the lack of adequate communication between the EP and GI specialist were the crux of the case.

"The first lawyer assumed that the gastroenterologist was the good guy who did everything possible to save the patient, so the GI [specialist] wasn't named as a defendant," Wapen says. Thus, the gastroenterologist became the "empty chair."

The case went to trial, the gastroenterologist declined to testify, and the jury returned a defense verdict. "The EP's defense attorney painted a picture of a patient who was stable up until the point at which the gastroenterologist did his endoscopy," Wapen says. By not naming the gastroenterologist, the first lawyer left an empty chair. From that point forward, the plaintiff could not contend that any fault lay with that empty chair.

"It's always bad when a defendant is caught in a potential lie about what they said they did," Wapen says. However, the plaintiff attorney left an empty chair at the onset of the case by not naming the gastroenterologist. This removed the courtroom spectacle of watching the EP and the gastroenterologist point fingers at each other. "Had this drama unfolded, the case would likely have ended in a verdict favorable to plaintiff," Wapen predicts.

In another malpractice lawsuit, the "empty chair" strategy helped the ED defense team in an unusual way. The case involved a man who presented to the ED with acute coronary syndrome (but no evidence of myocardial injury) and was discharged with instructions to follow up with a cardiologist *that same day* after the EP talked with the cardiologist by phone. The patient followed up but couldn't get an appointment to be seen by the cardiologist in a timely manner.

When the patient was seen, the cardiologist missed some worrisome changes on the ECG. The patient subsequently died of an acute myocardial infarction. Wapen reviewed the chart for the plaintiff attorney and concluded that the EP was faultless. However, the plaintiff attorney was reluctant to dismiss the EP for fear that the cardiologist named in the lawsuit would try to shift blame to the EP's empty chair. Eventually, the plaintiff attorney agreed to dismiss the EP from the lawsuit, but retained Wapen as an expert in the case to defend the EP's care, should the need arise. Wapen could testify that the EP did nothing wrong and was left out of the case for good reason. Thus, the EP now had a report from both his own defense expert and also from the plaintiff's expert in emergency medicine saying that he met the standard of care. While the plaintiff attorney retained him, Wapen functioned as an expert for the defense. This would prevent the vilification of an EP who could be dismissed from the case without

concern regarding his empty chair. The case reveals why attorneys generally name every provider involved in the patient's care when filing a malpractice case.

"Until all the facts of the case are known, attorneys want to name everybody and sort it out later through the discovery process," Wapen notes.

Plaintiff attorneys "can't afford to leave someone out of the mix for fear of discovering, later, that such an omission left a crucial player unnamed, who then becomes the empty chair," Wapen explains. This is where experts in all relevant specialties become important. The earlier they become involved in a case, the sooner it may become obvious to a plaintiff attorney that a provider can and should be dismissed from the case.

The first attorney's mistake was failing to retain an expert in gastroenterology because he already considered the EP to be at fault.

"The result was that plaintiff's attorney found out too late where the bulk of the negligence lay, did not name GI [specialist] as a defendant, and the case was not successful," Wapen says. If a defense attorney is representing multiple physicians, occasionally he or she can convince the plaintiff attorney to dismiss one or more of the physicians from the case on the condition that the dismissed physician will not be blamed for the bad outcome. That way, says Wapen, "plaintiff's attorney agrees to let one or more providers off the hook without risking the potential consequence of the empty chair." ■

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Does Reassessment Before Discharge Reveal Abnormal Vitals? Documentation Is Key

Dozens of times each shift, EPs determine the appropriate disposition for patients. "Many times, what is appropriate and best, not to mention safest, is for our patients to be discharged home," says **David J. Ahee**, MD, medical director in the department of emergency medicine at St. John Medical Center - Macomb Township (MI).

A well-documented, appropriate reassessment can reduce legal risks, Ahee says, and should include proof that the EP spoke to and examined the patient, as well as repetition of pertinent portions of the physical exam. Two common examples: A repeat exam that documents less tenderness in an abdominal pain patient, or a repeat pulmonary exam that documents improved air entry and exchange with less wheezing in an asthmatic or COPD patient.

When it comes to obtaining an updated set of vital signs, this documentation should show improvement from the initial set of vital signs taken at triage. If a patient presented with fever and tachycardia, and no serious pathology was identified, then one would expect that patient to be afebrile and with a normal heart rate at time of discharge.

The medical decision-making involved in the reassessment process allows the EP to explain abnormalities and cite likely causes. For example, the EP might chart "patient tachycardic due to mild hypovolemia and fever." Then, the EP can document resolution prior to discharge after appropriate treatment (such as antipyretics and IV fluids).

When it comes to documenting both subjective and objective measures of clinical improvement, if a patient presented with nausea and vomiting, for instance, then the patient should report less nausea, absence of vomiting, and a successful oral challenge. "This should coincide with objective data," Ahee notes.

Exposure to Litigation

Sometimes, an ED patient's condition worsens during the hours he or she is in the department. "Not reconciling the subjective and objective data and citing clinical

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improvement and normalization of abnormal vital signs can certainly result in poor outcomes — and, hence, exposure to litigation," Ahee explains.

A good reassessment can prevent the bias of premature closure. "If abnormalities persist despite what should have been appropriate treatment, it should cause the emergency physician to explore alternative possibilities," Ahee offers.

Is the patient with fever and tachycardia showing no clinical improvement after appropriate treatment? It may not be a simple viral syndrome after all but a life-threatening thyrotoxicosis.

"However, for this to be recognized and addressed, a provider must return to the bedside, review the pertinent history, repeat portions of the physical exam, and obtain a new set of vital signs," Ahee cautions.

Lack of improvement, new symptoms, abnormal exam findings, or abnormal vital signs can go undetected. "Ultimately, this may lead to a bad outcome for both patient and physician," Ahee notes.

The EP may decide it's still appropriate to discharge the patient, even with abnormal vitals. But in that case, these three pieces of documentation are "imperative," according to Ahee:

1. The EP's rationale for the abnormalities;
2. A definite plan for follow-up;
3. Clear instructions as to when the patient should return to the ED.

For instance, it is not unreasonable to discharge an asthmatic patient with significant improvement in symptoms and an appropriate peak flow, even with an elevated heart rate. "But one must be clear that the patient's tachycardia is noted and thought to be due to administration of inhaled beta-agonist, and not a sign of respiratory distress," Ahee says.

Ideally, in this case, Ahee says the ED chart should contain documentation of a discussion with the patient's primary care provider regarding arrangement of follow-up care, as well as a discussion with the patient about the need to return to the ED with new or worsening symptoms. Sometimes, a reassessment prior to discharge results in patient admission. "It is not uncommon or unusual to have a planned disposition change following patient reassessment," Ahee notes.

Some common examples:

- a patient fails an oral challenge and is unable to remain hydrated without IV fluids;
- a patient who presented without fever spikes a fever while in the ED, prompting further investigation with an expanded differential diagnosis;
- a patient's initially non-localizing abdominal exam changes now demonstrate tenderness in the right lower quadrant.

In asthmatics or COPD patients, a simple resting pulse oximetry might be inadequate to assess the ability to return home. "What is more crucial is obtaining a functional test, such as an ambulatory pulse oximetry," Ahee says. This can determine that a patient has shown enough improvement to return to his or her normal daily activities. On the other hand, says Ahee, "a simple walk around the ED may demonstrate a degree of tachycardia, tachypnea, and hypoxia that is not appreciated with the patient at rest, thus, changing the anticipated disposition."

In ED medical malpractice cases, it's not uncommon that the patient was discharged with abnormal vital signs — most commonly, tachycardia — according to **Mark Spiro**, MD, chief medical officer of the Walnut Creek, CA-based The Mutual Risk Retention Group.

Even if the abnormal vital sign is in no way relevant to the bad outcome, "it's one more issue that the defense has to overcome if this is not addressed in the chart. It's a strike against them," Spiro warns. The unaddressed abnormal vital sign suggests the EP is sloppy, rushed, and careless, instead of the cautious, caring provider the defense team aims to portray. At deposition, the EP can expect a question such as: "Is a heart rate of 110 normal, doctor?" and will have to answer "No."

A worst-case scenario: The abnormal vital sign was relevant to the patient's bad outcome, but the EP wasn't aware of it until the litigation. Sometimes, this happens when nursing documentation went unread because it was buried within the EMR.

"EMRs, ideally, will 'pop up' the discharge vital signs so the EP can see them. If [the vital signs] are hard to find, then the system needs to be addressed," Spiro says.

To guard against this possibility, Spiro recommends a "team discharge" process conducted by the EP and nurse at bedside. This is a golden opportunity for any missing information, or contradictory information, to be aired and addressed. "In some EDs, team discharge has become the standard. And since this process was implemented at those sites, malpractice risks have decreased," Spiro reports. Here are some benefits of the team discharge process:

- **It limits the plaintiff's ability to argue that inadequate or no discharge instructions were given to the patient.** This is a common allegation in ED-related medical malpractice litigation. "Patients either claim that they weren't given discharge instructions, or they claim that they thought the ER would make a follow-up appointment for them," Spiro notes.

• **It guards against cognitive bias.** Perhaps someone disregarded an abnormal vital sign, such as tachycardia, because it contradicted the EP's initial impression. "Taking that step back and saying, 'Why is the pulse so high?' is good for patient care. It is also legally protective if there's a bad outcome," Spiro says.

• **It prompts the EP to document *why* the patient is discharged with an abnormal vital sign.** "The disease process may be such that that's what you expect, or maybe the patient is on some medication that would cause tachycardia," Spiro offers.

Whatever the reason, it's incumbent on ED providers to explain their rationale for saying the discharge decision is still appropriate. This needs to be charted — and not just to prevent malpractice litigation. "It serves two purposes. It also provides better care, because the EP has actually thought through why this patient is OK to discharge with abnormal vitals," Spiro says.

Some EPs direct nurses to discharge the patient. Regardless of how minor the chief complaint, the EP always should see the patient prior to discharge, Spiro advises. Sometimes, it becomes apparent that the patient shouldn't be discharged after all.

"That's probably happened to all of us," Spiro says. In one case, a young person who had presented with chest pain showed what appeared to be a normal workup. But right before discharge, Spiro thought the patient "just didn't look quite right." Spiro found a thoracic aortic dissection after a reassessment. Such "near-miss" cases underscore the need to ask the question "Is there something else going on?"

"You should be careful not to have tunnel vision — the mindset that your initial impression is correct — and, therefore, contradictory findings are disregarded as irrelevant," Spiro cautions.

The EP does not always have to be right to have met the legal standard of care. But the EP *does* need to have thought through the reasons for the decision to discharge in a rational manner. "What hurts you is when you *don't* address an abnormal finding," Spiro adds. "That hurts patient care — and it increases your malpractice risk." ■

SOURCES

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'Divide and Conquer' Is Plaintiff's Strategy With ED Co-defendants

When both ED nurses and EPs are named in a malpractice suit, a unified defense is the goal. "Plaintiffs' attorneys love to set up finger-pointing situations by naming as many individual defendants as possible," explains **Dan Groszkruger**, principal of Solana Beach, CA-based rskmgmt.inc.

The plaintiff's side intentionally casts a "wide net" when it comes to named defendants. The strategy is to purposely include clinicians who had little or nothing to do with diagnosis or treatment. Individuals whose names merely appeared in the medical records, such as a specialty consultant, often feel unfairly singled out. "Their natural defensive reactions prompt finger-pointing at other, more-involved clinicians," Groszkruger notes.

If one defendant blames another, the overall defense strategy usually is weakened. "Almost always, only the plaintiff will reap major benefit from a resulting divide-and-conquer attitude among named defendants," Groszkruger says. To counter this, the defense team generally adopts a "circle the wagons" tactic. "The challenge is to persuade each defendant of the wisdom of this approach," Groszkruger says.

Medication errors are a common example in ED cases. The patient's overdose or adverse reaction may have been caused by the EP's rushed decision-making when deciding to order the medication, or in determining the appropriate dosage for the patient. Even so, the EP's initial reaction often is to blame the ED nurse who gave the drug. "The prescriber has a natural tendency to suspect that the individual who actually prepared or administered the drug was careless and made a mistake causing harm," Groszkruger explains.

The defense attorney's job is to caution providers to resist the urge to defend themselves by placing blame on others. "Only the plaintiff will benefit in the end," Groszkruger adds.

If the named EP and ED nurse are insured by the same policy, "the risk of finger-pointing will be top of mind," Groszkruger says. "The

defense attorney will counsel them that such actions tend to work only to the plaintiff's benefit."

If EPs are independent contractors, not employees covered by the hospital's insurance, "the defense strategy will require putting all defense attorneys in touch as early as possible," Groszkruger says. Ideally, hospital risk managers will do this before attorneys are able to secure witness statements.

"Clever plaintiffs' attorneys know that if they can secure a statement at an early stage, named individuals will be more easily persuaded that they can protect themselves by blaming others," Groszkruger says.

By the time formal depositions are scheduled, the circumstances that prompt defendants to blame one another already are in place. "Plaintiff attorneys who detect a tendency to finger point will attempt to strengthen such motivation by strategic bargaining," Groszkruger says.

For example, attorneys may assure a potentially favorable witness that he or she is not their target — in exchange for testimony implicating another provider. "Defense attorneys typically instruct their respective clients not to respond to questions that seek opinion testimony that is outside their expertise," Groszkruger says.

For instance, EPs are not qualified to assess the nursing standard of care, just as ED nurses are not qualified to offer opinions about the standard of care for EPs. The defense attorney should object to the form of the question on the grounds that it calls for expert opinion testimony from a non-expert witness, or that the question addresses subject matter that is beyond the witness's expertise, and instruct the witness not to answer.

"Even if the defense attorney fails to object, the witness may ask for clarification," Groszkruger says. For example, an EP under deposition might respond by saying "Are you asking me, a physician, what an ED nurse should do under these circumstances?" The EP can decline to answer if the question is confusing or not easily understood. Likewise, an ED nurse may be asked whether available diagnostic tests that in retrospect could have produced helpful information were overlooked by the EP. "But a nurse's 20/20 hindsight cannot substitute for a physician's expertise that guided his or her choice of diagnostic testing based on the patient's presentation," Groszkruger says.

The prescribing EP might be asked whether a nurse was negligent for delaying administration of an injection for over an hour while caring for another patient. "The ordering physician will generally assume that the medication was administered promptly — within a few minutes of receiving the order," Groszkruger says.

However, the EP should resist speculating as to the ED nurse's negligence. The EP may be unaware of the emergent needs of other ED patients for whom the nurse was responsible, which delayed administration of the medication. "In any event, the physician is unlikely to know whether delayed administration, under these specific circumstances, violated the nursing standard of care," Groszkruger adds. ■

SOURCE

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Significant Legal Exposure for Hospital if Patient Assaulted in ED

Recently, a young woman presented to a Michigan ED after a "slip and fall" accident, but ended up with an intentional injury. Shortly after her arrival, the patient was assaulted by a male visitor who struck her as she was checking in. The incident was captured on the hospital's surveillance video. The resulting lawsuit alleges that the attack could have been prevented if the hospital had monitored the patient properly.[1] According to a police report, the man charged in the attack had been discharged but was lingering in the ED lobby and was previously warned about bothering others. "The hospital has a fiduciary obligation to protect the safety and well-being of every patient that they accept control and care over," says **Steven S. Wilder**, BA, CHSP, STS, chief operating officer of Sorensen, Wilder & Associates in Bradley, IL. Seldom does a person go from a state of calm to physical violence without warning, Wilder says. "A lot of it comes down to early recognition: Do the staff recognize when the aggressive patient's behaviors are escalating?" This is why Wilder recommends that all ED staff, not just the clinical team, receive appropriate training. Wilder says hospitals can expect plaintiff attorneys to explore these questions:

• What type of intake assessment was conducted on the aggressive patient to determine if he or she was a risk to others?

• What type of training did the staff receive to be able to recognize and defuse the aggressive behavior?

• Did the aggressive person have any history of violent outbursts or threatening behavior on past visits?

• Does the ED have a way to document or flag patients with a history of violent behavior so it can be noted for future visits?

One defense strategy for the ED is to argue that staff are not always stationed at patients' bedside; therefore, no one observed the changes in behavior that were occurring.

"If the aggressor is giving off early warning signs, a trained person would likely recognize them," Wilder offers.

"The nature of the care provided in the emergency department may predispose staff, visitors, and patients to violent encounters," notes **Edward Monico**, MD, JD, assistant professor in the department of emergency medicine at Yale University School of Medicine.

These factors include continuous, uninterrupted accessibility; the potential for inadequately trained or visible security guards; patient pain and discomfort; family member stress; inadequate communication between staff, patients, and family members; and overcrowding resulting in long wait times.

To prevail in a malpractice claim involving an ED assault, the first step is to prove the hospital has a legal obligation. "A plaintiff could demonstrate that maintaining safety in the emergency department is the responsibility of the hospital," according to Monico. The plaintiff could use guidelines from various organizations to support this. Some "on-point" examples:

• The Emergency Nurses Association's 2014 position statement on violence in the emergency care setting, which states that "healthcare organizations have a responsibility to provide a safe and secure environment for their employees and the public";

• The Joint Commission's requirement that "hospitals must maintain a safe environment";

• In *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, OSHA established that "employers must furnish a place of employment free from recognized hazards."

"An allegation of assault and battery, followed by an allegation of negligence on the part of the hospital, involve two separate burdens of proof," Monico says.

The elements of assault include showing that an act was intended to create a reasonable apprehension of imminent harm that is either harmful or offensive.

The elements of battery include demonstrating an unlawful or unauthorized application of force to another person, resulting in harmful or offensive contact.

Hospital negligence would involve demonstrating that the hospital owed a duty to the injured party, as well as showing it was negligent in discharging the duty.

"The plaintiff would first prove that the alleged act was foreseeable, and that hospital staff were aware that a violent act might ensue," Monico notes. Once an obligation on the part of the hospital to maintain a safe environment is established, liability can fall on the hospital for failure to meet it.

The next step: An allegation that the hospital failed to act to prevent the injury, or that the actions taken were insufficient. A disruptive, aggressive, intoxicated patient is a common example.

"If that patient subsequently injures another patient, it could be possible to show that the behavior of the patient should have put the staff on notice that the patient could be dangerous and should not have been left alone," Monico says. If an ED patient is assaulted, Monico says these will be points of contention:

• whether the hospital had policies in place to help personnel recognize and mitigate violent situations;

• whether existing hospital policies were followed by the staff involved;

• whether hospital staff were on notice of impending violence;

• what steps were taken, if any, to prevent violence from materializing.

There is legal exposure for the hospital, concludes Monico, "if the hospital staff knew or should have known the aggressor was violent or had the potential to be violent, and failed to take reasonable steps to mitigate harm." ■

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ED LEGAL LETTER™

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. Which is *true* regarding improper discharge of ED patients?

a. There is no liability for hospitals if patients are medically stable.
b. Case managers and social workers should not be involved in difficult discharges due to patient privacy regulations.
c. Hospital policies should reflect that EMTALA is a malpractice statute.
d. The same set of facts may give rise to both EMTALA violations and malpractice liability.

2. What must the plaintiff prove to prevail in an EMTALA case?

a. Medical abandonment
b. Intentional infliction of mental pain and suffering
c. Only that the hospital, via its policies or personnel, violated EMTALA and that an injury resulted
d. Violation of various state laws for hospitals regarding patient care and safety

3. Which is *true* if the EP and ED nurse are co-defendants in a malpractice lawsuit?

a. The plaintiff must dismiss any named individual who can demonstrate lack of involvement in the ED patient's care.
b. The defense most often benefits from a "divide and conquer" attitude among named defendants.
c. Securing statements at early stages makes it easier for plaintiff's attorneys to persuade named individuals that they can protect themselves by blaming others.
d. Plaintiff attorneys are barred from assuring witnesses that they are not the target of litigation in exchange for testimony that implicates another provider.

4. Which is *true* regarding liability exposure if an ED patient is assaulted?

a. A plaintiff cannot use various organizations' guidelines to demonstrate that maintaining safety in the ED is the responsibility of the hospital.
b. Once an obligation on the part of the hospital to maintain a safe environment is established, liability can fall on the hospital if the hospital failed at their obligation.
c. While plaintiff attorneys can argue that steps instituted to prevent violence should have been taken but weren't in other hospital care settings, such arguments don't apply to the ED setting.
d. Demonstrating that the hospital owed a duty to the injured party isn't necessary for plaintiffs to prove negligence on the part of the hospital.