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INSIDE

RELIAS MEDIA

Pushback Against EMTALA Misinterpretation Emerges

Misinterpretation of the Emergency Medical Treatment and Labor Act (EMTALA) is the focus of a recently published policy statement from the American College of Emergency Physicians (ACEP).[1]

"EMTALA should not be interpreted to extend beyond the actual statutory language with respect to an investigation or when considered in conjunction with medical malpractice litigation," the group wrote.

"This is a statement by a professional body that says, 'We want you to follow the law,'" says **Robert Bitterman**, MD, CEO of Harbor Springs, MI-based Bitterman Health Law Consulting Group. Bitterman argues that the Department of Health and Human Services' Office of Inspector General (OIG)'s interpretation of EMTALA is "dead wrong, legally."[2]

OIG spokesperson **Donald White** says, "OIG evaluates each enforcement case depending upon its specific facts and circumstances. Therefore, we cannot make any general statements concerning EMTALA." A CMS spokesperson said, "The EMTALA statute and regulations are unchanged. There is no effort to broaden the interpretation of these terms beyond the legislative intent and legal definitions by CMS Regional Office or State Survey Agency surveyors when assessing compliance with EMTALA requirements in hospitals and critical access hospitals."

Bitterman disagrees, asserting that CMS is disregarding the interpretation of the federal courts. "They are an executive branch of the government that says judicial interpretation does not apply to them."

Both CMS and OIG declined to comment specifically on the ACEP policy statement.

There are liability implications for both emergency physicians (EPs) and hospitals if EMTALA is misinterpreted to apply to conditions other than "emergency medical conditions" as defined by the federal statute.

"It threatens to turn EMTALA into a federal malpractice statute rather than an anti-dumping statute," says **Timothy**

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Gutwald urges EDs and hospitals to reexamine their current EMTALA policies and procedures regarding who is entitled to stabilizing treatment and what is required to stabilize a patient for transfer or discharge.

"Emergency medical condition" is defined narrowly in the statute and applies only to conditions that put the patient's health in serious jeopardy, Gutwald notes. The original intent of the 1986 law was to prevent hospitals from turning away very sick patients out of fear of uncompensated care.

"By broadening the types of conditions covered by EMTALA, the statute becomes much more than an anti-dumping statute," Gutwald says. Here are some concerns:

• **Some plaintiff attorneys are holding up EMTALA as representing the standard of care in malpractice litigation.** "Plaintiff attorneys are trying to apply the language of absolutes to the standard of care, which is very nuanced for a particular situation. There's not a one-size-fits-all definition," says **John Bedolla**, MD, FACEP, chair of ACEP's medical legal committee. Bedolla also is national director of risk for US Acute Care Solutions.

The legal standard of care is determined by multiple factors, including the most current literature and the most current state of practice. When plaintiffs misconstrue EMTALA in this way, ED defense teams now can reference the ACEP policy statement.

"It was put in place to stop that drift. It allows the defendant to say, 'It's inappropriate to use statutory language to determine the standard of care,'" Bedolla explains.

• **In some cases, an EP's decision-making as to the presence of an "emergency medical condition" as defined by EMTALA is looked at retrospectively.** "If our judgment is wrong, if the adequacy of the exam isn't correct, that's a malpractice question, like it's always been," Bitterman says.

If a patient is later determined to have had an emergency medical condition, even though the EP did not believe so at the time of the ED visit, it does not necessarily mean there was an EMTALA violation. "But CMS thinks that if their medical review physician evaluates the case and disagrees with the emergency physician, that's an EMTALA violation because they missed an emergency medical condition," Bitterman offers.

EPs worry that in the event an EMTALA violation is alleged, CMS investigators may investigate the EPs' medical decision-making. This can, in turn, trigger a state licensing board investigation. "Every judgment you make can be second-guessed and called an EMTALA violation," Bitterman adds.

• **Occasionally, CMS surveyors misconstrue requirements for stabilization.** "Medicine encompasses risks and probabilities," Bedolla says, noting that the legal definition of what care is required does not always equate to the medical definition.

Guaranteeing a patient will remain stable during transfer "is outside the realm of medical possibility," Bedolla argues. EPs can only do their best within a reasonable probability. Thus, the fact that a patient decompensated en route to the receiving hospital does not necessarily mean EMTALA was violated. Generally speaking, CMS investigators agree with this.

"But from time to time, CMS investigators have a retrospective bias," Bedolla notes. In some cases, a patient requires transfer who cannot be stabilized in the ED. In this scenario, the requirement is to stabilize the patient as much as possible prior to transfer.

"It's certainly the best chance for the patient versus staying where you cannot deal with the problem and they're unstable," Bedolla says.

But what if a CMS investigator concludes EMTALA was violated because the unstable patient was transferred or because a patient did not remain stable during transport despite the ED providers' best efforts? Hospitals are left with little recourse. "It is possible for hospitals to take the OIG to court. But that costs time and money. A lot of people just don't do it. It's cheaper to settle," Bitterman adds.

• CMS added the words "including psychiatric disturbances and/or symptoms of substance abuse" to the regulatory definition of an emergency condition and to the EMTALA physician review worksheet investigators use. The statute itself says nothing about psychiatric disturbances or substance abuse.

"The problem is that CMS and the OIG believe that psychiatric disturbances or symptoms of substance abuse are *themselves* an emergency condition," Bitterman argues.

The statute and CMS's own regulations state that the symptoms must be "such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual ... in serious jeopardy." *(Read more at: https://bit.ly/2RmRs5y)*

"CMS and the OIG ignore the fact the symptoms must need immediate medical attention to prevent harm to the individual," Bitterman argues.

Many EDs routinely board psychiatric patients while waiting for an available bed at a receiving facility to become available. "If we can stabilize [patients] in the ED, which we can do and have done for many years, EMTALA ends," Bitterman offers.

However, the newly added language indicates otherwise. "CMS claims that if the patient remains suicidal, then [there is] an unstable 'emergency medical condition' for the entire time they are in the ED awaiting transfer," Bitterman maintains.[2]

According to the expanded interpretation, someone presenting to an ED reporting substance abuse and asking for help equates to an "emergency medical condition" under the law, an interpretation Bitterman believes is "just false." The same concern pertains to patients with severe pain — by itself, that constitutes an emergency medical condition under EMTALA. "That is wrong, too," Bitterman argues. "Just like any other medical condition, it needs to be investigated to determine if there's an emergency present." If CMS' interpretation is correct, Bitterman adds, it means that under EMTALA, no managed care patients with psychiatric conditions could be transferred to another facility that takes the patient's insurance and that no indigent patients could be transferred to state psychiatric hospitals.

"It dramatically changes the ability to move patients around, both for efficiency and, sometimes, for economics," Bitterman offers. "It's not illegal to transfer patients for economic reasons as long as they can get there safely."

Bitterman sees these unintended consequences of misinterpretation of EMTALA regarding psychiatric patients:

• Hospitals with psychiatric units, which previously rarely kept psychiatrists on their call schedule, now require psychiatrists to take many more ED calls. In some cases, this has resulted in the psychiatrists dropping their inpatient privileges, according to Bitterman;

• Psychiatrists already on the call schedule are asked to come to the ED much more frequently, often unnecessarily.

If the increased on-call burden causes psychiatrists to resign from the medical staff, access to care is diminished. "This was not CMS' intent at all," Bitterman argues. "The flip side is on-call psychiatrists do come in now if you need them."

According to the CMS spokesperson, the EMTALA regulations at 42 CFR 489.24(b) have included

reference to "psychiatric disturbances and/or symptoms of substance abuse" in the definition of emergency medical condition for more than 20 years. "This is not new language," the spokesperson says. "Neither the definition nor our interpretation implies that every individual who presents with a psychiatric or substance abuse issue is experiencing an emergency medical condition in need of stabilizing treatment as required by EMTALA."

(Editor's Note: OIG declined to comment on Bitterman's assertions about the agency's interpretations of EMTALA.)

To avoid problems regarding EMTALA and psychiatric patients, Bitterman advises ED staff to ask themselves these questions:

- How is the ED taking care of patients when they are boarded?
- Does the ED take care of patients' medical needs?
- Does the ED protect patients from elopement and self-harm?
- Do ED providers attempt to address patients' psychiatric needs with medications or involvement of mental health psychiatric workers, where possible?
- Are available resources used?

Capitalizing on widespread confusion over its requirements, some plaintiff attorneys are adding EMTALA claims to ED malpractice lawsuits. "There are legitimate plaintiff attorneys who are out there for the truth," Bedolla says. "There are also attorneys who add gasoline to the fire to see what happens."

Making an EMTALA claim part of malpractice litigation complicates things for the defense for several reasons. "It ups the ante. EPs may be more inclined to settle," Bedolla notes.

Many settlements are confidential, making it impossible to know how many lawsuits with EMTALA allegations are settled.

"The key is to be able to make an argument to the judge that EMTALA cannot be used in litigation over and above the standard of care" Bedolla explains. The mere words "EMTALA violation" strike fear in the hearts of many ED defendants. "There is a perception that you have more to lose because this element of EMTALA hangs over the case," Bedolla adds.

Once a plaintiff attorney reports an EMTALA violation to CMS, information on any resulting investigation can be obtained through the Freedom of Information Act. However, the results of investigations are discoverable, although not always admissible.

"One of the federal courts has said it's not admissible because it's not reliable or trustworthy," Bitterman says. The reasoning is that the fact that a government agency has said the hospital violated a statute is prejudicial because there is no due process, he explains. Still, plaintiff attorneys can use the information they obtained about the EMTALA investigation in depositions. Additionally, if peer review occurs on a potential EMTALA issue, the usual state law protections do not apply in federal court — and the information is discoverable. Including EMTALA in malpractice litigation can allow the plaintiff to get around state tort reforms, statute of limitation requirements, and damage caps. Perhaps most importantly, it keeps the hospital in the litigation as a "deep pocket."

"It's easier for juries to award money to 'bricks and mortar' rather than individuals," Bitterman argues.

Most plaintiff attorneys are aware the EP almost certainly will be dismissed from the EMTALA claim. The law is clear that only hospitals, not individual EPs, can be sued under EMTALA. "What they're trying to do is create a wedge between the institution and the emergency physician," Bedolla offers. The hospital is left to defend the dismissed EP's actions under the theory of apparent agency, or use the "empty chair" defense and blame the EP. Regardless, the hospital's policies and procedures relating to screening and stabilization will face close legal scrutiny. Many were not followed to the letter or are outdated in terms of EMTALA. "All of this means that the hospital has a very big interest in making sure thing are done right," Bitterman says.

Gutwald says EPs should be particularly careful to document why they concluded a patient did *not* have an emergency medical condition. This may include documenting that certain serious conditions were ruled out and why. Also, the EP should document that the patient was stable at the time of discharge.

The medical record should reflect that vitals were stable shortly before discharge and that the patient's condition improved during his or her ED course. This documentation allows EP defendants to argue that the patient did not have an emergency medical condition and that even if one existed, the patient had been stabilized prior to discharge or transfer. "Having both of these arguments available is very helpful in malpractice litigation or in an EMTALA investigation," Gutwald adds. ■

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No Professional Interpreter? ED Exposed to Med/Mal, Statutory Risks

Like most medical students, **Jay M. Brenner**, MD, FACEP, learned about the ethical obligation to offer professional interpreters instead of "ad hoc" interpreters (untrained staff, family, or friends) to patients who are deaf or speak a foreign language primarily. "It was drilled into us that ad hoc interpreters were suboptimal," says Brenner, now medical director of Upstate University Hospital Community Campus ED in Syracuse, NY.

Yet during his residency and as an attending physician, ad hoc interpreters were used routinely. ED providers often turned to whoever was at the bedside.

"This became even more concerning when access to professional interpreter services declined in my clinical setting temporarily," Brenner recalls.

Brenner submitted the use of professional interpreters as a topic for the ACEP ethics committee to consider. Subsequently, he led a subcommittee group in authoring a paper on the topic.[1] Language barriers during a medical emergency could compromise care, according to the case studies included in the analysis. "I was most surprised by the extent of consequences for not offering professional interpreters, including missed opportunities for recognizing human trafficking," Brenner offers.

Not surprisingly, the analysis pointed to access, feasibility, and timeliness as top reasons for failure to offer professional interpreters in the ED setting. Although it is believed to be commonplace, data are lacking on how often ED providers use ad hoc interpreters. "Providers often do not document when they do not use a professional interpreter," Brenner explains. Brenner and his colleagues recommended:

- improving physician education on policies and resources available in their clinical setting as well as awareness of the problems with ad hoc interpreters;
- partnering with organizations to identify and support specific local needs.

Some EDs serve special populations, such as refugee communities. "EDs should reach out to nonprofit organizations serving such populations to see what collaborations of providing interpreter services are possible," Brenner says.

Brenner and colleagues described several ED cases in which lack of an interpreter resulted in misdiagnoses and medical errors. "Obviously, not obtaining an accurate history from a patient can lead to devastating outcomes," Brenner says. He recalled one case in which ED providers wrongly believed a Spanish-speaking patient was intoxicated when he was showing signs of altered mental status. The patient died of a missed intracranial hemorrhage.[2]

"Not offering professional interpreters can not only contribute to medical malpractice but can also violate federal civil liberties and some state laws," Brenner warns. Title VI of the Civil Rights Act of 1964 requires healthcare facilities to provide competent interpreter services to patients with limited English proficiency. "Emergency physicians should be aware of the state laws related to this federal statute in the states where they practice," Brenner adds.

In terms of legal risks for EDs, missing relevant information "is the major theme that comes up over and over again," says **Ken Marshall**, MD, assistant professor in the department of emergency medicine at University of Kansas Medical Center. Marshall says that ED documentation should make it abundantly clear that a qualified interpreter with relevant training and expertise to communicate the medical intricacies of the case was used.

Further, documentation should show that appropriate steps were taken if a translator is unavailable for any reason, such as the patient speaking a rare language. Legally protective documentation in cases like that

could include a note that indicates an EP called whatever interpreter services were available at his or her hospital, or that an EP managed to find a translator for the closest available dialect. In general, the ED chart should paint a clear picture of "a good faith effort to do right by the patient, as much as possible," Marshall advises.

ED patients sometimes appear to prefer a family member interpret on their behalf.

"If possible, EDs should have someone who speaks the patient's primary language convey that providers might miss something important for their care," Marshall explains. Ideally, the ED chart indicates that the patient was informed of this and was offered a qualified interpreter.

Also important: The use of an interpreter is documented in all the important places in the ED chart, not just the history and physical.

"It's crucial to document it specifically on the consent," Marshall stresses. Otherwise, it could appear as though no interpreter was used when the patient was informed of risks of an invasive procedure such as a lumbar puncture.

The same is true for discharge instructions. Some malpractice claims revolve around the fact that these instructions were given only in English.

"Even in cases where the ED provider did everything right and used a qualified interpreter, the plaintiff attorney could claim no translation was provided for the discharge summary," Marshall notes.

Putting discharge instructions in the patient's preferred language is best, Marshall says. If this is not feasible, another option is for the interpreter to review these instructions with the patient. The chart also should show that the ED provider reviewed the discharge instructions with the interpreter.

"If there's any kind of bad outcome, any kind of deviation from best practices — it is going to look suspicious even if it wouldn't have materially changed the care provided," Marshall adds. ■

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Ignored Red Flags in ED Missed Sepsis Claims

A 30-year-old woman presented to an ED with fever, chills, and nausea shortly after giving birth. The patient was sent home with a diagnosis of urinary tract infection and an amoxicillin prescription. Twelve hours later, she was returned to the ED after losing consciousness.

"By this time, the infection had progressed such that all efforts to save her were unsuccessful," says **Elizabeth Fors**, JD, an attorney at Minneapolis-based Robins Kaplan LLP. At the time of the first ED visit, blood tests showed an elevated white blood cell count and abnormally low platelet count. "Ignoring a red flag seems to be a common denominator in these tragic cases," Fors laments.

The malpractice lawsuit alleged failure to diagnosis sepsis and failure to provide immediate and appropriate treatment, including IV antibiotics.[1] The family was awarded $20.6 million. "At trial, the jury found that the ED provider's negligence was a direct cause of the patient's death," Fors reports.

Several recent malpractice cases alleging missed sepsis involved triage in some way, according to **Michelle Myers Glower**, MSN, RN, NEA-BC, a Bradenton, FL-based medical-legal nursing consultant. Often, the triage nurse does not recognize early signs of sepsis or identifies early signs of sepsis, but the patient remains in the waiting room because the ED is full.

When reviewing ED charts in missed sepsis claims, Myers Glower is concerned with the steps the triage nurse took to get the patient out of the waiting room to the back of the ED. She looks for documentation on who the nurse spoke with, whether the ED nurses notified the charge nurse to discuss which patients could be moved to a lesser care setting, such as hallway beds, and whether the ED nurse asked the nursing supervisor to assist with the process. Many ED charts contain none of this information. This allows the plaintiff attorney to convincingly argue the ED nurse did nothing to intervene on the patient's behalf.

"If there is no room at the inn, then what did you as a nurse do next to assist in getting the patient back?" Myers Glower asks. Specifics on who the ED nurse spoke to, and the response, become very important to the defense. The best legal protection, says Myers Glower, is to "document what you had to do to make this happen."

Published sepsis recommendations often become the central focus of malpractice litigation alleging missed or delayed diagnosis. "The guidelines lend additional support to our retained medical expert's opinion," Fors says. These include the Severe Sepsis and Septic Shock Early Management Bundle that CMS

adopted in 2015 to improve hospitals' identification and treatment of sepsis. "These initiatives give ED providers little excuse for failing to recognize and treat sepsis," Fors says.

Only 50% of patients received appropriate care for severe sepsis or septic shock in accordance with the CMS' sepsis treatment guidelines in 2017, according to Hospital Compare data. *(https://bit.ly/2P685FV)* Negligence claims are stronger if the plaintiff can show that ED providers did not follow recommendations to the letter, including the revised "hour-1 bundle," which focuses on beginning resuscitation and management immediately.[2]

"While a jury may not like the personal demeanor of an expert, they routinely assess high credibility to sepsis guidelines," says **Pamela L. Popp**, JD, executive vice president and chief risk officer for Western Litigation. EPs may have had good reasons for going down a different path, but failure to follow the guidelines makes care appear negligent. "This will always sway the jury unless the provider can show why their alternative theory made sense at the time," Popp says.

Plaintiffs in missed sepsis claims tend to present with generic complaints of pain, confusion, fever, or chills. Some are misdiagnosed with flu or panic attacks. "The key is taking the patient's complaints seriously and starting the sepsis bundle if the symptoms meet the criteria," Popp offers.

It is common for ED staff to disregard electronic medical record (EMR) alerts. However, if someone misses sepsis, the disregarded alerts can be used to prove negligence. "If [an EP or nurse] are going to disagree with a sepsis alert, they need to do more than just click it closed," Popp advises. ED providers need to show that they considered sepsis and that they chose to take other actions for good reasons.

Some plaintiff attorneys introduce the CDC's visually friendly patient education materials on sepsis as evidence. "If presented to a jury, this makes the diagnosis of sepsis appear to be very easy," Popp explains. ED providers might be tempted to explain that there is a need to limit the use of antibiotics, but this is a tough argument to make.

"To a jury, the giving of antibiotics — and they do not differentiate between oral and IV — is very easy," Popp adds.

The three most common allegations in missed sepsis claims are that antibiotics were not started promptly, lactate values were not determined, and the patient's complaints were somehow disregarded.

"Defending sepsis misdiagnosis cases is becoming much more challenging," Popp laments. The best defense? Strong documentation that the EP considered sepsis and ruled it out due to specific circumstances or symptoms. "For example, if a patient appears septic but lab results speak more to an underlying or chronic condition, this is what the physician should document," Popp explains.

An explanation of the EP's thought process, even if it was incorrect, gives the defense something to work with.

"The jury just needs to believe that the provider took into consideration all of the information available to them in making their diagnosis and treatment plan," Popp says. ■

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A Look at How ED Defendants Change Practice Habits After Litigation

One could argue that the threat of malpractice liability improves the quality of care delivered to patients.

"Some patients and family say they pursued a malpractice claim specifically to ensure that poor care didn't happen to someone else," says **Jestin Carlson**, MD, FACEP, national director of clinical education for US Acute Care Solutions.

Data were lacking regarding the connection between litigation and subsequent improved quality of care in the ED. To learn more about this, researchers analyzed data from a national EP group practicing at 61 EDs in 11 states between 2010 and 2015.[1] They assessed whether EP practice patterns changed after they were named in a malpractice claim, compared to unnamed physicians practicing in the same EDs.

Investigators included more than 6 million ED visits and 985 physicians in their analysis. Of this group, 72 EPs were named in 77 malpractice

claims. The researchers studied admission rates; relative value units (RVUs), a commonly used metric to gauge physician productivity per hour and per visit; ED visit length; and Press-Ganey percentile ranking.

The data was examined retrospectively for all patients, for all patients for whom a malpractice lawsuit was filed, for malpractice claims alleging failure to diagnose, and for malpractice claims that did not include that specific allegation. The study authors did not examine specific clinical practice changes, such as whether the ED providers ordered more diagnostic tests after they were sued.

"We looked at a large national group, but only at the macro level. We didn't have ability to drill down and look at specifics of cases," Carlson notes. Some key findings:

• EPs who had been named in malpractice claims logged lower RVUs per hour than they did before they were named in the lawsuit. Since the study was a retrospective review, this does not necessarily prove causation. Thus, researchers cannot say for sure that the decreased productivity resulted from litigation. "We can only say it's a correlation, but it looks like their practice tempo might be a little bit slower," Carlson offers.

• There was an immediate rise in satisfaction scores for EPs named in the 50 claims alleging failure to diagnose. The cause of this change is unknown. "But it would make sense that providers might slow down a little bit and take a little more time with the patient," Carlson suggests.

• Hospital admission rates were not linked to a plaintiff naming an EP in a lawsuit. This finding was somewhat surprising. "It would be reasonable to conclude that providers would become more conservative in admitting people to the hospital to avoid missing conditions. But that wasn't borne out in the data," Carlson says.

There are not much data to show how being a defendant in a malpractice claim affects EPs on a personal level. "We need to know more about the psychological and emotional impacts that it has on providers," Carlson says.

EP defendants are not always aware of available support to help them deal with the stress and anxiety of litigation. "Medical malpractice claims are not necessarily a reference of the quality of care someone provides," Carlson notes. ■

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A Deeper Exploration of How ED Nurses Triage

Triage practices vary widely among emergency nurses and within EDs, according to the authors of a recent study.[1]

"We were interested in the clinical implications of the prevalence of 'pull-to-full' triage strategies," says **Lisa A. Wolf**, PhD, RN, CEN, FAEN, director of the Emergency Nurses Association's Institute for Emerging Nursing Research. This refers to an approach used at many EDs whereby less information is collected at triage and patients are put in treatment areas as such locations become available without prior screening.

Researchers conducted focus group interviews with 26 ED nurses. ED nurses reported a pervasiveness of "quick look" triage techniques, which do not rely on physiologic data, to make acuity decisions. Participants described processes that were manipulations of the triage system to "fix" problems in ED flow rather than a standard application of a triage system.

"Essentially, they triaged the emergency department to facilitate flow rather than assigning an accurate triage level based on the patient presentation," Wolf explains.

A 2010 observational study of triage revealed nurses were assigned acuity based on two things: patient volume in the ED and which providers happened to be working that shift.[2]

The authors of the 2018 study confirmed that these findings reflected what nurses themselves said about their triage practices.

"The triage acuity sets the trajectory for the patient visit," Wolf says. One important factor in delay in getting critical patients to the ICU from the ED is undertriage.[3]

"An inadequately staffed ED means nurses cannot focus fully on the patient in front of them," Wolf says. "[Nurses] may miss critical cues that guide acuity assessment."

Malpractice claims commonly allege that the ED nurse undertriaged a patient who clearly met criteria for a higher acuity level. The patient waits a long time and experiences a poor outcome.

"You could make the case that the driving factor in the delay in care was the lower triage level," Wolf offers. Triage nurse experience is another focus area in litigation. "Certainly, if

a hospital puts a new nurse, a float, or one who has inadequate training in triage, you could make a case that the hospital neglected its duty to provide safe care," Wolf says. The Emergency Nurses Association recommends that triage nurses work a minimum one to two years in the ED, obtain emergency nursing certification, and undergo training in trauma care and critical care management. "In EDs where you have the charge nurse also doing triage, or the newer nurses doing triage, it becomes potentially problematic," Wolf cautions. ■

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Poor Nurse-EP Communication Pits Hospital Against EP

Conflicting deposition testimony bolsters any medical malpractice case. "The classic situation is where the emergency physician says, 'The nurses didn't tell me,' and the nurses say, 'We're not doctors, and we don't make diagnoses.' It does put the two of them at odds against each other," says **James B. Edwards**, JD, a Stafford, TX-based medical malpractice defense attorney.

Communication gaps between EPs and ED nurses often become a central issue during malpractice litigation. "[EMRs] are now a major source of this risk," says **Marc E. Levsky**, MD, vice chair of The Mutual Risk Retention Group and an EP at Marin General Hospital in Greenbrae, CA. Levsky has seen these issues complicate the ED defense:

- Nurses do not document their findings contemporaneously, so an important piece of information was not available at the time of the ED visit;
- EPs have to click through multiple screens to find nursing documentation, so the documentation is never reviewed;
- EMRs do not notify EPs that nursing documentation has been created.

"If the physician is not aware of the documentation or cannot readily see it, he or she cannot address abnormal findings," Levsky says. A visual of exactly what was on the EMR screen can help the defense in such cases. "It shows the jury exactly what the physician was seeing at the time," Levsky adds.

Conflict over what, if anything, nurses communicated to the EP works to the plaintiff's benefit.

"I've seen cases where the emergency physician was as mad as could be," Edwards recalls. "Sometimes, there is just no way to have a unified defense."

Plaintiff attorneys will ask the EP to opine on whether a "prudent" or "reasonable" nurse would have acted as similarly as the defendant nurse. The goal is to prove the ED nurse breached the standard of care, which means the hospital can be held liable.

"It is generally recommended that defendants not comment on the actions of codefendants," Levsky offers.

Testimony by the EP such as *"I have no criticism of the care provided. I think the nurses provided good care"* can be helpful in this regard. "We can then try to have the hospital side echo the same kind of position with respect to the emergency physician," Edwards explains.

Speculating about a codefendant's motivation or what a codefendant should have done can backfire quickly. Edwards offers this less inflammatory response:

Plaintiff attorney: *Do you believe the nurses should have alerted you sooner about the elevated heart rate?*

EP defendant: *These are good nurses. I have had good experiences with them in the past. I can't tell you what the patient's condition was at that time because I wasn't present.*

Likewise, if the EP is asked why nurses did not call until a specific time, resist the temptation to speculate. A well-meaning EP might try to defend the nurses by pointing out the department was slammed with high-acuity patients at the time. Or, the EP might see it as an opportunity to deflect blame by suggesting the nurse seemed very distracted that shift. Either response is problematic.

Instead, Edwards suggests responding: *"You'd have to ask the nurses why they didn't call until 11:00"* or *"You'll have to take that up with the nurse."*

The same holds true for the testimony of ED nurses. It is easy to answer affirmatively to a question such as *"Don't you think a reasonable emergency physician should have acted when the patient's sodium levels were 700 and rising?"*

Instead, the ED nurse can refuse to comment on what is "reasonable" for an EP in this scenario, Edwards notes.

Toning down the nurse's testimony can help promote a unified defense. It also can go wrong if the EP ends up settling out of the case.

"The hospital is then at a disadvantage because they have softened their defense in the deposition," Edwards says.

The EP is out of the case but presumably still is a fact witness. Thus, the EP can help the hospital by testifying, *"This was my decision. I think it was the right decision, but it definitely wasn't the nurse's decision."*

The dismissed EP can help the defendant hospital to demonstrate that the bad outcome was not the nurse's fault; therefore, the hospital should not be held liable. "This is one reason for the plaintiff attorney to keep the emergency physician in the case," Edwards adds. ■

Claims Allege Life-saving Information Was Hiding in Plain Sight

The patient history, labs, and radiology — that was the extent of the information available to EPs historically. "But the EMR has changed the paradigm with so much information available at the click of a mouse," says **Kenneth N. Rashbaum**, JD, a partner at New York City-based Barton LLP.

EPs argue they do not have time to hunt for every possible piece of information that could have prevented a bad outcome. But that is beside the point when lawyers get involved: "Every investigation and lawsuit is a retrospective analysis," Rashbaum notes. The question for the EP becomes: Will a grieving family, state regulator, or jury be sympathetic to the defense that the information was available — but there was simply no time to read it?

"A jury is going to expect a physician to obtain *any* relevant information, especially with the widespread utilization of EMRs," says **David S. Waxman**, JD, an attorney in the Chicago office of Saul Ewing Arnstein & Lehr.

Critical information might be hiding in plain sight — the hospital's own EMR. Modules used by pathology or radiology are not always easily accessible, but ED providers should not expect a jury to be too sympathetic to this dilemma.

According to Waxman, "Different systems that do not speak with each other will not present an adequate justification" if someone is harmed just because an abnormal test result was tough to view.

Unlike in the primary care setting, the ED is "the ultimate focused visit. Patients come with a very specific problem, and that's the focus of the visit," says **Frederick M. Cummings**, JD, an attorney in the Phoenix office of Dickinson Wright. Regardless, failure to obtain relevant information from outside sources still can be a problem, legally speaking.

"Where it becomes dangerous for the ED practitioner is if in your EMR you have months or years of the patient presenting with progression toward a serious disease, and nobody's put it together because they haven't gone back," Cummings says. This might be the case with a mental health patient who each time presents with increasingly serious concerns. "If they refuse treatment, there's not much more you could do. But if you had seen the progression of the condition, you probably could have demonstrated they were a danger to themselves or others, and could have gotten court-ordered treatment," Cummings offers.

EPs' likely response is that there was not enough time to search through previous visits or hospitalizations. "But that may not preclude the other side from using the information in a way that can be harmful to you," Cummings cautions.

It is unlikely that a jury would hold an EP accountable for reviewing a patient's entire medical history. They *would* expect the EP to contact another provider when appropriate. When a patient presents with a surgical complication, Cummings says "the first call [the EP] makes is to the surgeon. The same issue exists for any other condition."

The relevant question is: Is there a reasonable chance that the EP could get information from that practitioner that could assist in evaluating a patient's emergency medical condition? "Then, yes, you'd better call," Cummings offers.

The EP's decision-making will be judged on "what they knew or should have known," Waxman notes. If the EP learns that the patient sought care elsewhere previously,

whether at a physician's office or another ED, it might be advisable to contact that provider. "Those efforts, if contemporaneously documented, should help to insulate that ED from any subsequent criticism," Waxman adds.

Failure to consult with a previous provider became an issue in a recent malpractice claim. The case involved a pregnant patient with asthma whose OB/GYN sent her to the ED. A decision was made to discharge the patient without contacting the OB/GYN. At deposition, the EP was asked, *"Shouldn't you have included the OB/GYN in the decision-making?"*

The ED chart was unclear as to whether ED providers were even aware the OB/GYN had sent the patient. "If you are aware a patient was sent in by a physician for a specific concern and then proceed to make a decision without their input, you are putting yourself singularly on the line," warns **Marc J. Farraye**, MD, FAAEM, president of FarrayEMed Emergency Medicine Services in St. Augustine, FL.

Questions regarding the progression of the symptoms or condition, imaging or test results, variation in history, or assessment of pain complaints all could be reasons to reach out.

"If there is information that can be accessed by the ED in the normal course of business that can either help the patient or prevent injury to the patient, failure to obtain and use that information will subject the ED to professional criticism," Waxman explains.

Patient privacy regulations may pose a barrier to the flow of information between providers. If so, "it is imperative that the ED promptly employ the assistance of risk management, medical records, or hospital counsel in allowing for an appropriate transfer of information," Waxman suggests.

Failure to access information arises often in cases with multiple ED visits. "It often appears as though the ED providers recognized that the patient had been evaluated for the same problem previously. Yet their treatment plan didn't change," Farraye says.

A recent claim involved an elderly woman with abdominal pain who ended up experiencing infarcted bowel mesenteric ischemia and dying of complications.

"Each time she came to the ED, she got basically the same workup she got the prior time. They just kept ordering the same thing and coming up with the same lack of results," Farraye reports.

The plaintiff attorneys alleged that had the ED providers ordered a CT angiogram of the abdomen, it could have presented the patient from losing her bowel and suffering complications. Further, plaintiff attorneys alleged the woman's risk factors (hypertension, current smoker, and high cholesterol) should have made infarcted bowel mesenteric ischemia part of the differential.

The case underscores the importance of expanding the differential diagnosis when a patient returns to the ED. "That is a concept I see over and over again in these cases," Farraye says. "The differential doesn't change despite the fact that it ought to."

In several other malpractice cases reviewed by Farraye, the triage nurse noted prior ED visits, yet this information was not mentioned at all in the EP's documentation. "The emergency physicians are left trying to explain, with difficulty, why they don't appear to be aware of these prior visits," Farraye says.

If a piece of information is contained within the ED's EMR and is "just a click away," says Farraye, "the EP is left in a precarious position if they state they were unaware of those records."

One asthma patient had returned three times to the same ED. Each time, the patient was discharged on the same therapy. The previous visits were noted in the ED chart. "But it appeared to be forgotten when it came to the decision-making," Farraye recalls. "In my experience, most such cases seem to settle." ■

CME/CE OBJECTIVES

After completing this activity, participants will be able to:

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

COMING IN FUTURE MONTHS

- Liability implications of newly developed electronic triage tools
- Analysis of ED pediatric closed claims reveals worrisome legal risks
- Controversy over legislation protecting EPs' due process rights
- Mitigate legal risks while angry patient or family is still in ED

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CME/CE QUESTIONS

1. Which is true regarding EMTALA requirements?

a. "Emergency medical condition" is defined broadly in the statute.
b. EMTALA compliance determines the legal standard of care.
c. Only hospitals, not individual EPs, can be sued under EMTALA.
d. The legal and medical definitions of requirements for stabilization are identical.

2. Which is true regarding EMTALA and psychiatric patients?

a. EMTALA does not apply to psychiatric patients.
b. It is illegal to transfer stable psychiatric patients to state psychiatric hospitals for purely economic reasons.
c. EDs should examine how they care for boarded psychiatric patients, including medical needs and preventing elopement and self-harm.
d. Hospitals with psychiatric units are no longer required to keep psychiatrists on their call schedule.

3. Which is true regarding interpreters in the ED setting?

a. Professional interpreters should be offered only if ad hoc interpreters are unavailable.
b. A documented patient preference for family or friends acting as interpreters overrides any legal obligations to provide professional interpreters.
c. Federal law requires healthcare facilities to provide competent interpreter services to patients with limited English proficiency.
d. Documenting that an interpreter was provided in multiple places in the ED chart should be avoided because it appears overly defensive.

4. Which is true regarding nurse and physician codefendants?

a. EPs can testify as to the standard of care for nursing in most states.
b. Nurse practitioners can testify on the standard of care for physicians.
c. A dismissed EP may be able to help the defendant hospital demonstrate that the bad outcome was not the nurse's fault.
d. EPs cannot be held responsible for reviewing nursing notes if it can be demonstrated that a poorly designed EMR made it unreasonably difficult.