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JANUARY 2019 Vol. 30, No. 1; p. 1-12

INSIDE

RELIAS MEDIA

When Closed Claims for Pediatric ED Patients Resulted in Plaintiff Payout

A recent analysis of 728 closed claims in pediatric emergency care settings reveals how both the specific medical conditions triggering lawsuits and the overall malpractice climate have changed.

"We wanted to report an updated assessment of medical professional liability information about pediatric patients treated in urgent care or ED settings," says **Mark Zonfrillo**, MD, MSCE, the study's senior author.

Researchers conducted a retrospective review of 15 years' worth of closed malpractice claims that involved children in urgent care centers or in the ED. Investigators gathered this information from the Data Sharing Project of the Physician Insurers Association of America, now called the Medical Professional Liability Association (MPLA). The MPLA is an industry trade association representing medical professional liability insurers.

Of 728 claims reviewed, money was paid to the claimant in 30% of cases, with an average payout of $319,513.[1] In contrast, a 2005 analysis of more than 2,200 pediatric claims collected between 1985 and 2000 showed that the most common diagnoses were appendicitis, arm fracture, meningitis, and testicular torsion.[2]

The 2018 study revealed that the most common medical conditions involved in malpractice lawsuits were appendicitis, cardiac or cardiorespiratory arrest, and disorder of the male genital organs.

"It is important for emergency medicine providers to be aware of the most common medical conditions and factors involved in pediatric emergency care malpractice suits," says Zonfrillo, an associate professor of emergency medicine and pediatrics at Hasbro Children's Hospital and the Alpert Medical School of Brown University.

Informing ED providers of the risks contributing to malpractice claims "is critical to mitigating certain adverse events that lead to such lawsuits," says **P. Divya Parikh**, vice president of research and education for the MPLA.

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ED LEGAL LETTER

ED Legal Letter (ISSN 1087-7347) is published monthly by Relias Learning, 111 Corning Road, Suite 250, Cary, NC 27518-9238. Periodicals postage paid at Cary, NC, and additional mailing offices. POSTMASTER: Send address changes to *ED Legal Letter*, Relias Learning, 111 Corning Road, Suite 250, Cary, NC 27518-9238.

GST Registration Number: R128870672.

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

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Few researchers have analyzed malpractice claims involving pediatric patients in the ED setting specifically. Using the Data Sharing Project, Zonfrillo and colleagues set out to see how the medical liability climate has evolved since 2005. Some key findings:

• Diagnostic errors (41%) still most common medical factor in ED claims.

"That makes sense. In the ED, we make diagnoses; if something's going to go wrong, it's mostly diagnoses-related," says **Steven Selbst**, MD, an investigator who participated in both the 2005 and 2018 studies. "If you are going to be fair to the medical team, you have to recognize that another diagnosis made down the road doesn't mean it was missed in the ED."

Often it simply means that emergency physicians (EPs) could not make the diagnosis because it was too early in the course of the illness.

According to Selbst, the best defense in such a case is showing that the EP carefully examined the patient and performed the appropriate studies but still could not make the diagnosis If all that is well-documented in the ED chart, says Selbst, "you're going to have a very good chance of ending up in that category where there is no payout to the plaintiff."

• Appendicitis remains a common condition in malpractice lawsuits.

"It's a difficult diagnosis to make," says Selbst, an EP at Nemours/Alfred I. duPont Hospital for Children in Wilmington, DE, and professor of pediatrics at Sidney Kimmel Medical College. "Failure to make this diagnosis doesn't always equate to poor management."

Appendicitis cases evolve over time. After expert review of the ED chart, plaintiff attorneys sometimes realize that it was not possible to make the diagnosis at the time of the ED visit; some pursue the claim anyway. At least some of the closed claims involving appendicitis likely resulted in no payout for this reason, Selbst adds.

• Failure to diagnose fever and meningitis is alleged less often.

"It's moved further down on the list," says Selbst, adding that the decrease in litigation probably is due to vaccines that have resulted in fewer meningitis cases.

• Claims involving fractures are less common.

"It is difficult to determine why that was found," Selbst notes. "It's possible that EDs have gotten better at management of fractures."

• Cardiac or cardiorespiratory arrest is now the most common medical condition resulting in a claim.

These conditions almost always result in serious injury to the child or death of the child. "Thus, these cases are likely to result in litigation," Selbst notes.

Zonfrillo says it is unlikely there are more cardiac-related conditions. "It is more likely that there are more cases of patients who arrest and either have long-term harm or die," he explains. "We know that the most common cause of cardiac arrest is respiratory etiologies."

• Improper diagnosis of the male genital organs remains a common allegation in malpractice claims.

"We still have a fairly high number of these cases in older children. That was a little disappointing," Selbst laments. These lawsuits likely involve failure to promptly treat cases of testicular torsion. This was a finding in the 2005 study, too.

"The hope is that people being more aware of this would make them

more careful about examining a boy with abdominal pain or testicular complaints," Selbst says. Over the past few years, he adds, there has been growing focus on the need to promptly diagnose testicular torsion in the ED. "People are recognizing that it is a common diagnosis in malpractice lawsuits, and we have to pay more attention to it."

A protocol for testicular torsion was implemented recently at Nemours/Alfred I. duPont Hospital for Children.

"The patient with scrotal pain is seen almost immediately. The attending emergency physician is called out to triage whenever a child comes in with a testicular complaint," Selbst explains. Studies are ordered promptly, and a urologist is consulted simultaneously when there is a strong suspicion of torsion. Part of the reason for the new protocol is a recognition that malpractice lawsuits may occur if there is a delay in management in the ED.

"The goal is to get a doctor to put eyes on the swollen testicle, begin an immediate diagnosis, and call in the urologist as soon as possible so we can cut down on the delays — and, hopefully, malpractice lawsuits," Selbst adds.

Researchers were curious if the malpractice climate had changed since the release of the 2005 study. "It is difficult to say whether or not it changed for the better or the worse; it just has changed," Zonfrillo notes.

EXECUTIVE SUMMARY

Appendicitis, cardiac or cardiorespiratory arrest, and disorder of male genital organs were the most common medical conditions triggering malpractice lawsuits involving pediatric ED patients, according to the authors of a recent analysis. Other findings:

- Not all claims resulted in payouts due to factors such as difficulty making diagnoses at the time of the ED visit;
- Failure to diagnose meningitis is alleged less often;
- Error in diagnosis remains the most common medical factor in ED claims.

Claims that involved delay in hospital admission or failure to admit to the hospital (the eighth leading chief medical factor) resulted in the highest average indemnity. Of 728 closed claims, 220 involved a patient death. However, claims that concerned major permanent injury more often resulted in a payment.

The results of the 2018 study make it clear that the odds still are very much in the EP's favor when it comes to malpractice lawsuits. "Almost all are settled out of court. When it does go to court, it's very rare that there's a payout to the plaintiff," Selbst reports.

In the 2005 study, malpractice claims went to court 7% of the time. The authors of the 2018 study found a similar pattern, with cases going to court 8% of the time. Of the 57 cases that went to trial, verdicts favored the physician in 47. However, that does not mean it is going to be easy for the EP defendant. "It's unlikely the plaintiff is going to get money out of the lawsuit. But it's emotionally draining to be sued," Selbst says.

Understanding more about the causes of malpractice claims could help EPs avoid future litigation. "Knowing the epidemiology might not directly impact your management of patients, but, hopefully, it does help in your thinking," Selbst offers. ■

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Did ED Personnel Review EMS Findings? If Not, Expect Negligence Allegations

Did a neighbor tell paramedics that a patient saw a cardiologist regularly? Did a bystander observe the patient lose consciousness briefly before someone called 911? Did the patient's daughter mention that her mother fell a few days ago?

Any of these pieces of information could be pivotal in correctly diagnosing the problem and crafting a timely treatment plan — unless, of course, EPs never know about that useful information.

"By failing to review EMS records, the emergency physician caring for the patient could potentially miss an opportunity for early diagnosis or treatment," says **Katharine C. Koob**, JD, an associate at Post & Schell in Philadelphia.

It may be easy for a family member to jump to the conclusion that a terrible outcome is related to poor communication between EMS providers and EPs.

"Whether that perception is true or not, [family members] will be more likely to consider litigation," Koob warns.

Without the full story, ED providers are forced to make decisions based on incomplete facts. "Witnesses at the scene often possess valuable information that can be used in the ED to provide treatment immediately upon the patient's arrival," Koob notes. Discovery during delayed diagnosis litigation reveals the bombshell: All the answers were in the EMS report all along. There are a few examples of how failure to review EMS records could result in litigation, including:

- **Failure to learn about loss of consciousness at the scene.** This could delay recognition that a patient is suffering from a lethal heart arrhythmia rather than a benign episode.
- **Not knowing the time of onset for stroke symptoms.** This means ED providers are unable to administer tissue plasminogen activator since it is unknown if the patient was within the treatment window.
- **Failure to identify recent medical procedures.** For example, knowing about the patient's colonoscopy could help EPs make the correct diagnosis of bowel perforation.
- **Failure to be aware of a recent fall injury.** This could delay the diagnosis of an epidural abscess, causing spinal cord compression and permanent neurologic deficits or other injuries.

In virtually *any* case where ED personnel failed to review information gathered by EMS with the potential to speed up diagnosis and treatment, litigation can be triggered. The plaintiff attorney links the patient's bad outcome to the lack of information.

"Such allegations can be made even if the medicine and statistics suggest that the poor outcome was inevitable," Koob underscores.

It is no easy task for ED providers to defend themselves against an assertion that additional, overlooked information would have affected a patient's outcome. "No one can know this with 100% certainty," Koob notes.

Some EDs have not instituted a set process regarding how EMS providers give information to ED personnel. Legally speaking, this can be a "minefield" for EDs, says **Paul C. Kuhnel**, JD, an attorney in the Roanoke, VA, office of LeClairRyan. Factors such as whether the patient lost consciousness at the scene can become focal points during malpractice litigation. "If EMS leaves their record in the ED, then the ED personnel need to review it during the treatment of the patient," Kuhnel advises.

It is critically important for ED personnel to receive *complete* information from field EMS providers, says **W. Ann Maggiore**, JD, an attorney at Butt Thornton & Baehr in Albuquerque, NM.

"Paramedics are now sophisticated prehospital medical providers who are capable of administering numerous medications and performing complex procedures," says Maggiore, a practicing paramedic and a faculty member in the University of New Mexico's department of emergency medicine. The

EXECUTIVE SUMMARY

Plaintiff attorneys can link a bad outcome with failure to review EMS findings. Some risk-reducing tactics for EDs:

- Create and follow a clearly defined process for how EMS gives information to ED personnel;
- Ensure that ED personnel receive complete information from field EMS providers;
- EPs should review any EMS records available and consult with others who received verbal reports.

"handoff" of the patient from field providers to the ED is an important time for information to be exchanged and documented. "Failure to do so can expose the ED physician to liability for negligence," Maggiore warns. "A 'reasonable' physician would want to know what care had been rendered previously."

For example, if a paramedic treated a patient with cardiac problems and administered medications, ED personnel need to know the patient's condition when the 911 call was made and what EMS found at the scene. Failure to find out what medications were administered (and in what doses) and why could result in duplicate medications administered to the patient's detriment, Maggiore notes. Before electronic medical records, a physical copy of the EMS chart usually was left with the ED and was included in the patient's medical chart. Today, it is not always possible for field providers to do that electronically. "Even if a verbal handoff is done, the ED provider should include a statement in the patient's chart," Maggiore says.

For instance, such documentation might state: *"Per EMS, patient found supine on the kitchen floor with a heart rate of 40 and a blood pressure of 68/42; atropine 1.0 mg administered, and patient's heart rate came up to 64 with a blood pressure of 76/80."*

Ideally, each ED would create and follow a clearly defined handoff procedure, helping to ensure smooth transitions. However, following a specific process for communicating findings may not always be possible in hectic ED settings. "This is not always feasible based upon changes in staffing and other factors," Koob acknowledges.

A sudden emergency can interrupt communication between EMS and ED providers. Koob recommends ED physicians review any EMS records available and/or designate another provider, such as a resident, to review them where helpful and appropriate. Another option for ED physicians is to ask personnel who may have received a verbal report from EMS, such as a triage nurse, for information.

The key is for EPs to take ownership of getting information for each patient from EMS. This way, says Koob, "ED physicians are more likely to maximize their knowledge of all available material to evaluate and treat their patients." ■

Mitigate Legal Risks Before Angry Patient Calls Attorney

Often, ED providers do not receive notice of a malpractice suit against them until months after the patient (now plaintiff) presented. Sometimes, providers cannot even recall the case at all. But there also are ED visits in which it is immediately clear that something has gone wrong.

"The ER is very emotional and stressful for most individuals. Not knowing what is happening leads to further frustrations and lack of confidence in patient care," says **Linda Mueller**, MD, an EP at Edward Hospital in Naperville, IL.

Many times, poor communication is the underlying issue. Staff at the Edward Hospital ED take the following steps if a patient or family is angry:

• Address the patient or family in a polite, respectful manner, and provide updates on the ED course. "This will typically de-escalate most situations," Mueller notes.

• If the patient and family are still upset, the ED charge nurse gets involved and attempts to de-escalate the situation.

• If unsuccessful, patients are encouraged to contact the hospital's patient experience department for resolution. "The most important factor is that the patient has someone in a position of authority listen to their concerns and correct the situation to the best of their ability," Mueller adds.

The ED charge nurse puts these cases into an end-of-shift report for senior administration to review. "They do so regardless of whether they were successful in de-escalating the situation," Mueller explains.

Sometimes, litigation arises because a patient leaves the ED without clearly understanding the cause of his or her symptoms. This can happen if

EXECUTIVE SUMMARY

Effective communication practices can mitigate malpractice risk in ED settings.
- Keep patients updated on the ED course;
- Ensure patients and family are well-informed prior to leaving the ED;
- Encourage patients and family to vent frustration and anger;
- Avoid assuming bad outcomes occurred because of an error.

the patient is discharged home or is admitted to a particular service. "ED physicians can sometimes be tempted to stabilize a patient and discharge the patient to another specialist in the hospital," says **Justin S. Greenfelder**, JD, partner at Canton, OH-based Buckingham, Doolittle & Burroughs.

This will not insulate an ED physician from a lawsuit if the patient experiences an adverse outcome and later alleges that there was a delay in diagnosis. One such case involved a patient with flu-like symptoms, the cause of which went unexplained when the patient's case was turned over to a hospitalist, who took over the patient's care.

"The ED physician did not communicate his findings to the patient's family, who were led to believe that the patient simply had the flu," Greenfelder reports. The patient decompensated quickly and died a few days later. "The ED physicians were named as defendants under a delay-in-diagnosis theory," Greenfelder says. In fact, the EPs had provided appropriate care. However, because of poor communication, the family believed the EPs had misdiagnosed the patient.

ED providers might be tempted to apologize if they believe an error contributed to a poor outcome, believing the apology cannot be used against them if someone sues. It is true that some states have created statutes that prohibit plaintiffs from using a physician's statement of apology as an admission of fault. However, this does not necessarily mean the EP's statements to the patient are going to be inadmissible. "The case law interpreting these statutes is inconsistent," Greenfelder explains.

Some courts have required specific "apology" language to exclude the statements. Others interpret the statute more broadly, excluding statements showing sympathy or commiseration. "Plaintiff's attorneys will often use a physician's well-meaning statements and twist them to infer an admission of fault," Greenfelder says.

As for what EPs can do in the moment to reduce risks, "it depends on the situation," Greenfelder says. If an unexpected adverse event occurs and the family is visibly upset, it may be best to inform risk management or administration so they can intervene and give proper guidance. "As a best practice approach, it is typically advisable to refrain from any unnecessary or prolonged contact with a patient's family after an adverse event has occurred," Greenfelder advises.

There is something else EPs can do to reduce legal risks. "The simplest and most effective thing a provider can do is simply to listen," says **Beth Norton**, JD, an attorney in the Richmond, VA, office of Hancock, Daniel and Johnson. Usually, an apology is not what a family member really wants when things do not as go planned in the ED. "It's to be heard and to have his or her feelings recognized and acknowledged," Norton explains.

This does not always come easy for most ED providers. Many find it hard to allow patients to vent frustration and anger without becoming defensive. "But it's the most effective — and often the *only* — way to assuage anger before that anger becomes the basis for a malpractice complaint," Norton says.

The ED provider does not need to agree with the patient's or family member's version of the events. "But arguing with them about it will only fuel their negative feelings," Norton cautions. Empathy is a more effective approach. Norton says there is no risk in sincerely saying, *"I understand how frustrated (or angry) you are. I'm very sorry that you're going through this."*

"Resisting the temptation to defend yourself in the ED may lessen the chances you'll have to defend yourself later in court," Norton adds.

Giving patients or family a chance to vent can cool extremely negative emotions. In turn, this reduces the risk of litigation. Still, there are always exceptions. Sometimes, the patient or family remain angry despite the efforts of the ED providers. "If you sense he or she harbors significant resentment toward you or the facility, that's probably a good time to contact your risk manager and/or administrator," Norton says. ■

A Bad Outcome Does Not Necessarily Mean ED Gave Poor Care

Despite the way it appears, an unexpected medical outcome is not always the result of someone's mistake. "It is important to avoid assuming an error has occurred without proper review and investigation," says **Renée Bernard**, JD, vice president of patient safety at The Mutual Risk Retention Group in Walnut Creek, CA.

For this reason, apologizing for a bad outcome is not always appropriate at the time of the ED visit. "The ED provider should reach out for just-in-time coaching from their insurance company or hospital risk manager prior to participating in a formal apology," Bernard advises.

EPs should never hesitate to express empathy for what the patient or family is going through.

"But formal apologies for a medical error should be undertaken only after proper investigation of the facts and vetting with the provider's hospital and insurance company," Bernard stresses.

Anytime there is a deviation in the standard of care that causes physical harm to a patient or financial impact due to increased care needs, Bernard says there is an ethical obligation to disclose it. Deviations in the standard of care that are apparent at the time of care include errors in medication or blood administration, mismanagement of psychiatric patients under involuntary hold statutes, and wrong-side procedures (such as a chest tube placement).

Bernard offers several suggestions for ED providers seeking to mitigate legal risks in real time:

• Practice excellent communication.

This establishes trust. "Literature supports that patients are less likely to sue providers who they trust as forthcoming and genuinely caring," Bernard offers.

• Focus on the patient's care needs first.

Explain to the patient or decision-maker what changes are needed in the patient's care plan.

"This is required as part of the consent process," Bernard notes.

> "MAINTAIN A PATIENT FOCUS. AVOID SHIFTING INTO AN ADVERSARIAL POSITION WITH THE PATIENT."

• Make sure that an error cannot be repeated in the ED on the same shift or in the future.

"Initiate a review of the systems to make sure the same error won't happen to other patients," Bernard says.

• Keep the disclosure objective and based on medical facts.

"Often, providers do themselves no favors by attempting to explain an unexpected medical outcome or error prior to a full review of the care or facts," Bernard says.

A better approach is to inform a patient that the care will be reviewed to understand what happened and how it happened.

• Avoid speculating about what happened or blaming others.

"This simply does not help a provider," Bernard says. "In fact, it makes [providers] appear less professional."

• Continue caring for the patient medically or accommodate the patient's request for a new provider, if possible.

• Provide a point of contact for the patient or family member to follow-up with care questions and to learn more about what happened.

"It is very important that patients feel heard and receive responses to their concerns in a timely manner," Bernard explains.

• If the ED has instituted a communication and resolution program, this process should be followed once the patient is stabilized or it is safe for the provider to shift attention from patient care.

"It is important to maintain a patient focus. Avoid shifting into an adversarial position with the patient," Bernard cautions.

• Notify risk managers if the unexpected outcome appears to have been preventable.

This ensures everyone adheres to hospital policies and that the right person initiates an appropriate investigation of the outcome. "Providers need to be aware of both hospital policy and their insurance company policies for notification of unexpected medical outcomes that appear to be preventable," Bernard says.

Generally, patients will become distrustful if providers bring a risk manager or legal representative to the bedside. This can appear self-serving. "However, some risk managers are, in fact, patient liaisons and may be the exact patient representative that the provider needs to engage," Bernard says. ■

High-low Agreement Can Reduce Risk for Both Plaintiff and Defense

Does evidence show the EP met the standard of care, yet the patient suffered a devastating outcome? The defense team might put a high-low agreement on the table.

"This is an intermediate strategy between full settlement and trial," says **Laura Pimentel**, MD, a clinical professor in the department of emergency medicine at University of Maryland School of Medicine.

High-low agreements are used to bracket the range of financial outcomes in malpractice cases with high-dollar damages. "These structured settlements should definitely be reserved for situations where the defendant EP is reasonably at risk for a verdict beyond her policy limits," Pimentel notes.

Some malpractice lawsuits carry high potential for damages because the plaintiff is very sympathetic. Yet, the EP defense team and the insurance company still believe the case is defensible and want to proceed to trial. With a high-low agreement, "both the plaintiff and defendant receive protection from an excessive verdict," Pimentel explains.

Both sides agree that the settlement will not be lower than a minimum figure even if there is a defense verdict. This is the low side of the agreement. All parties also agree that there will not be payment higher than a maximum figure in the case of a plaintiff verdict, regardless of the amount awarded by the jury. This is the high side of the agreement.

"High-low agreements offer some attraction to both parties because of the notorious unpredictability of jury verdicts," Pimentel says.

Agreements may be made after a trial has begun but before the jury delivers the verdict. This can protect the defense if they believe the trial is not going particularly well. On the plaintiff's side, the high-low agreement means they will receive something, regardless of the outcome. "[The agreement] indemnifies [plaintiffs] against a pure defense verdict from which they would walk away with nothing," Pimentel says.

Another advantage: The finality of the litigation is ensured. "High-low agreements preclude the inevitable appeals that follow exorbitant verdicts," Pimentel says. This allows all parties to move on without incurring additional costs or uncertainty.

High-low agreements usually make sense for ED claims in these scenarios:

- **Cases in which patients sustained devastating injuries, such as neurological damage, and require life care plans.** "A pediatric patient who presented to the ED in diabetic ketoacidosis was appropriately resuscitated and treated but developed cerebral edema is [an example of] such a case," Pimentel says.
- **Cases in which the bad outcome with a sympathetic plaintiff may persuade a jury that a high-dollar plaintiff verdict is appropriate even though the ED care was timely and appropriate.** The main downside here is that a high-low agreement guarantees payout to the plaintiff. "This will trigger a report to the National Practitioner Data Bank," Pimentel cautions.
- **Litigation in venues where juries have been known to return disproportionately high damages awards.** Cook County, IL, and Bronx County, NY, are two examples. In these venues, "high-low agreements are often in place before a jury returns with a verdict," says **Anna Berent**, JD, claims counsel for Houston-based Western Litigation.

The challenge for both sides is to precisely compromise on the range between the low and high figures. The defense must determine what it is willing to pay despite a favorable verdict.

"The only time such an agreement backfires is if the high number [exceeds] what the jury awards the plaintiff," Berent explains.

The plaintiff in a recent lawsuit alleged that the ED team failed to diagnose and treat an arterial occlusion in the patient's leg, resulting in an amputation. The plaintiff demanded $1.8 million, and the defense offered $500,000. At the close of trial, before jury deliberations, the defense team entered into a high-low agreement with plaintiff's counsel.

"This was out of concern that the jury was not leaning in our favor," Berent recalls. Both sides agreed to a low amount of $750,000 and a high amount of $1.5 million. The jury returned a verdict for more than $5 million, which would have been reduced to $2.1 million given state damage caps. "But we paid $1.5 million pursuant to the agreement," Berent adds.

Another case alleged that the EP failed to evaluate a patient and failed to pass along key information to the on-call cardiologist. The plaintiff was in his 70s but was still working part-time, had a wife, and helped babysit his grandchildren. The plaintiff demanded $1.5 million from the EP. The defense proposed entering into a high-low agreement with a low of $100,000 and a high of $1 million.

The plaintiff counsel rejected the offer, stating that $100,000 would not even cover his fees and costs. Ultimately, the plaintiff received nothing from the EP defendant. "The jury returned a defense verdict in favor of our ED doc but penalized the co-defendant cardiologist to the tune of $250,000," Berent reports. ■

Many EPs Lack Due Process Rights; Legislation Offers Possible Protection

Newly introduced legislation aims to protect due process rights of EPs. "This is a dynamic and complex problem," says **Howard A. Blumstein**, a professor of emergency medicine at Wake Forest School of Medicine in Winston-Salem, NC.

Without due process rights, EPs lose the ability to advocate for patients without fear of termination. Typically, contract holders form arrangements with hospitals to staff EDs; the contract holder hires EPs to perform the actual work.

"The hospital wants EPs to provide certain treatments but cannot dictate physician practice," Blumstein notes. The hospital tells the contract holder what it wants from the EPs. "The contract holder then instructs the physicians to comply with the hospital's desires. Those desires are often contrary to the best interests of patients," Blumstein says.

EPs who do not comply can be fired without recourse since due process rights are waived routinely as a condition of employment. "Issues routinely happen where EPs are basically told how to treat patients," Blumstein says.

Many hospitals and universities, and all government agencies, guarantee due process. "Contract holders do not like due process because it interferes with their ability to terminate a physician," Blumstein notes.

It also gives EPs the opportunity to demand the reason for termination. "No contract holder wants to openly admit they are firing the physician for refusing to commit fraud," says Blumstein, noting that punishment can go beyond just losing a job. "Most contracts contain restrictive covenants. These are often disguised as 'trade secrets' clauses." Such clauses prohibit the fired EP from working within a given geographic area for a length of time, usually a 50-mile radius for two years. "This forces the physician to ... find a job more than 50 miles away, move, or quit medicine," Blumstein says.

When offered employment, EPs often do not realize exactly what rights they are signing away. Residents often ask Blumstein to review their employment contracts. About 80% contain waivers of any due process rights. "When a physician gives up her due process rights, it means that the person emptying the trash in the ED has more job protection than the physician. I am not OK with that," Blumstein says.

The residents have to make a judgment call on whether to accept the provision, and most do. Efforts to push back are mostly unsuccessful "A few who have tried to negotiate that clause have been told that is the company contract, and it's not open for negotiation," Blumstein reports.

In a 2013 survey of 389 EPs, nearly 20% reported a possible or real threat to their employment if they raised quality of care concerns.[1] Blumstein, one of the study's authors, says this remains a serious problem. "We know of some lawsuits where they reached a settlement without the hospital admitting guilt."

Existing standards from The Joint Commission require hospital medical staffs to grant due process rights to physicians. "In that sense, we already have some protection," says **Joseph P. Wood**, MD, JD, a Phoenix-based EP. Due process is not the only concern, according to Wood. Hospitals may resort to other tactics if they want to terminate an outspoken EP.

"They will suggest resigning with a clean record or otherwise they will have a hearing. If the EP is found culpable, he or she will have a blemish on their record," says Wood, noting that there is no legal course of action for the EP in this situation. "Even if the emergency physician can prove that's why he or she was fired, the courts would say there is no legal protection for that."

Previously, most EPs were independent contractors. "The old paradigm created a healthy balance of power, if you will. ER doctors really had no problem voicing concerns, and administrators had to listen to them," Wood recalls.

When EPs can be fired without cause, they are less likely to voice concerns. "Most EPs would agree there are problems with crowding and that EDs tend to be understaffed," says Wood, adding that the lack of due process is linked to under-resourced EDs. "I never saw a surgeon operating in a hallway without proper equipment. They wouldn't put up with it. But most EPs quickly learn that they have no job security and that speaking up is dangerous."

Legally, EPs have a fiduciary duty to put patients' needs above their own monetary needs. This is not true of hospital administrators who are held accountable by board members, not individual patients. "The ER doctors' judgment should not be clouded by directives to increase profitability or fears of being terminated," Wood offers.

Regardless of the route they take to report safety concerns, there are considerable legal risks for EPs. Some EPs have filed *qui tam* lawsuits, a type of whistleblower suit brought under the False Claims Act. If successful, the whistleblowers potentially receive a share of recovered funds lost to fraud.

"If the lawsuit gets to a certain point, then the Department of Justice takes over and continues to pursue it," Blumstein explains. The people who originally filed the case receive a negotiated portion of whatever fines or settlements are collected.

However, if EPs voice concerns about safety to hospital leaders, they sometimes face immediate termination. "We know of a lawsuit where an EP got fired for complaining about working conditions in an elevator, and got fired that afternoon," Blumstein says.

Whistleblowing EPs also face possible repercussions from the physician group that employs them.

"An aggressive contract holder would not appreciate it if one of their doctors complained about staffing, and then the hospital complained back to the contract holder," Blumstein says. It all comes down to the hospital's culture. Some hospitals with a strong culture of safety encourage voicing concerns.

"On the other hand, if the working conditions are so bad and so dangerous that the emergency physician is frightened enough to formally complain about it, they wouldn't want to work in that ED anyway," Blumstein says.

The EP can always go public with safety concerns, but this carries risks, too. "You have to be very careful to get your facts straight, or you are putting yourself in legal jeopardy for slander," Blumstein cautions.

EPs also face malpractice risks if unsafe practices continue and a bad outcome occurs. For instance, EPs might report safety concerns as part of a peer review process. If a bad outcome later occurred as a result of the safety problem, the EP might want to blame the hospital administrators who failed to act. Yet, in this scenario, the fact the EP had reported the concern would not be discoverable due to peer review protections.

"If I wanted to protect myself from being sued, I would not use the hospital safety system. I would write a letter to the appropriate people. That would be discoverable," Blumstein offers.

Most states have enacted some form of whistleblower protections. "But that's all theoretical. There's no guarantee it would work," Blumstein adds. EPs could consider calling the appropriate state regulatory agencies or accrediting bodies like The Joint Commission, which have put mechanisms in place to report concerns. Before taking any action, Blumstein suggests EPs closely review employment contracts to see what these documents say about due process protection. It is also important to review state whistleblower rules and fully understand what protections those rules offer. EPs should follow efforts to introduce legislation at the federal level, too.

The American Academy of Emergency Medicine developed a bill that would require the Department of Health and Human Services to create a rule mandating due process for EPs employed by lay corporations. Other emergency medicine organizations, including the American College of Emergency Physicians, have endorsed it. *(Editor's Note: The most recent version of this legislation, HR 6372, is available at: https://bit.ly/2P8LK5t.)*

"We are currently working on getting bipartisan support for the legislation. Preliminarily, we've gotten nothing but positive feedback. We hope it will move forward," Blumstein offers.

However, due process protection is not a panacea. "Contract holders have other means of getting rid of doctors they do not like," Blumstein warns. "But denial of due process is a major tool they currently use to control doctors." Even if legislation requiring due process is passed, nothing is absolute. "There is certainly still risk," Blumstein notes. "But it would be much better if the EP had some form of protection. That's what due process is all about." ■

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.

REFERENCE

1. McNamara RM, Beier K, Blumstein H, et al. A survey of emergency physicians regarding due process, financial pressures, and the ability to advocate for patients. *J Emerg Med* 2013;45:111-116.

Patients Link Errors to Negative Physician Interactions: Important Risk Implications for EDs

Problems related to patient-physician interactions were found in a majority of patient-reported diagnostic errors, according to the authors of a recent study.[1]

"Diagnostic errors are underreported, and patients' unique perspectives are not well-incorporated in current patient safety and adverse event reporting mechanisms," says **Traber Davis Giardina**, PhD, MSW, the study's lead author.

Researchers analyzed a largely unexplored data source: What patients and families had to say about errors. Diagnostic error literature has, so far, focused mainly on clinician decision-making and healthcare system design.

"This effectively leaves out the patient experience. The patient voice is essential to highlight hidden factors that may contribute to diagnostic error," says Giardina, a researcher at the Michael E. DeBakey Veteran Affairs Medical Center's Center for Innovations in Quality, Effectiveness, and Safety.

These include patient-physician interactions that may not be captured via any other method. Giardina and colleagues analyzed 184 patient- or family-reported error narratives submitted from January 2010 to February 2016.

"We were interested in gaining a better understanding of patients' and families' experiences of diagnostic errors," Giardina says.

The analysis identified 224 instances of behavioral and interpersonal factors that reflected unprofessional clinician behavior. These included ignoring patients' knowledge, disrespecting patients, failing to communicate, and manipulation or deception. Giardina says this revelation was not too surprising.

"Patient advocates have been discussing this for some time," she says. More intriguing was that patients associated the behaviors with unsafe care. "This highlights the importance of including and engaging patients in safety initiatives."

Giardina says it is important for EDs and health systems to provide opportunities for patients, clinicians, and staff to easily report unprofessional behaviors without fear.

"The unprofessional behaviors outlined in our study are not being systematically collected, and there are not national guidelines or policies to do so," Giardina laments.

Hardeep Singh, MD, MPH, another of the study's authors, adds that the ED is a "high-risk environment as far as diagnosis and related patient-provider interaction is concerned."

Patients usually present with undifferentiated symptoms. Generally, these patients are new to the ED provider. Additionally, data to make an accurate and timely diagnosis are not often easily available.

"The chaotic ED work environment is stressful for all parties. More often than not, providers are facing a lot of uncertainty in their diagnosis," says Singh, chief of Health Policy, Quality & Informatics Program, Center for Innovations in Quality, Effectiveness and Safety, Michael E. DeBakey VA Medical Center.

For these reasons, effective patient-provider interactions are paramount in EDs. Singh says it is especially crucial for ED providers to carefully listen to patients' concerns.

"Our prior research shows that poor data-gathering through history and exam is often a significant factor involved in certain types of diagnostic errors," Singh notes.[2]

Singh believes the study's findings send a strong message to ED providers. "There are many opportunities for improving patient-provider interactions and related communication to improve diagnosis-related outcomes," he says. ■

REFERENCES

1. Giardina TD, Haskell H, Menon S, et al. Learning from patients' experiences related to diagnostic errors is essential for progress in patient safety. *Health Aff (Millwood)* 2018;37:1821-1827.
2. Medford-Davis L, Park E, Shlamovitz G, et al. Diagnostic errors related to acute abdominal pain in the emergency department. *Emerg Med J* 2016;33:253-259.

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- Shared decision-making mitigates malpractice risk
- How speech recognition documentation can lead to litigation
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ED LEGAL LETTER™

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CME/CE QUESTIONS

1. **Which is less frequently a cause of malpractice lawsuits involving pediatric patients than in previous years, according to a recent study?**

   a. Cardiac or cardiorespiratory arrest
   b. Appendicitis
   c. Disorder of male genital organs
   d. Meningitis

2. **Which is true regarding missed diagnosis in the ED, according to a recent analysis of closed claims?**

   a. Allegations of delayed diagnosis of testicular torsion have increased, but the claims are against urologists instead of EPs.
   b. Improper diagnosis of the male genital organs remains a common allegation in ED malpractice claims.
   c. Far fewer pediatric claims are resolved with out-of-court settlements.
   d. The plaintiff prevailed in more than half of cases that went to trial.

3. **Which is true regarding review of EMS findings in the ED setting?**

   a. ED providers cannot be held liable if EMS providers failed to transmit findings electronically.
   b. Allegations that bad outcomes were caused by failure to review information can be made even if the poor outcome was inevitable.
   c. The legal standard of care requires the triage nurse to review EMS findings, but there is no similar requirement for EPs.
   d. Verbal handoffs constitute a breach of the standard of care because electronic transmission of information is now the standard.

4. **Which is recommended to reduce legal risks in the ED, according to Justin S. Greenfelder, JD?**

   a. EPs are legally protected from delayed diagnosis allegations if they stabilize the patient in the ED and discharge the patient to another specialist in the hospital.
   b. Statements expressing sympathy are inadmissible in court regardless of the specific wording of apology state statutes.
   c. Plaintiff's attorneys often will use a physician's well-meaning statements and twist them to infer an admission of fault.
   d. Any apologies that are made should occur during the ED visit and not afterward.